Integrated health and social care for Buckinghamshire

Outline Business Case

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Version 1.4

Ernst & Young LLP

NHS Chiltern Clinical Commissioning Group

Buckinghamshire County Council

NHS Aylesbury Vale Clinical Commissioning Group

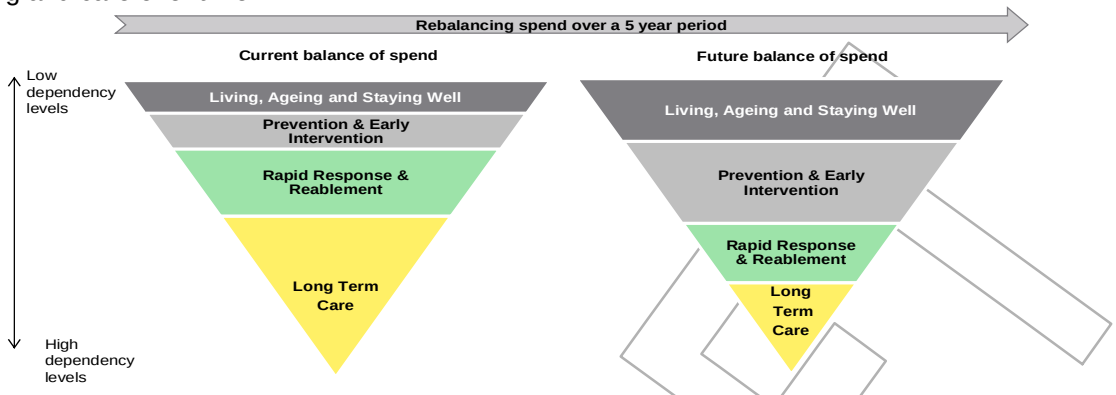
EY Building a better working world

Contents

1. Executive Summary

The purpose of this Outline Business Case is to build on the work done in developing Buckinghamshire's Better Care Fund submission, and the Case for Change which was developed in February 2014. This Outline Business Case articulates a new integrated system of health and social care for Buckinghamshire and provides a framework for discussion and further consideration and development of how this model will be delivered in the next phase of work to develop a Strategic Business Case. The wide programme of transformational activity which has been described takes account of existing initiatives that aim to optimise current service delivery and put in place the foundations for the new model of care.

By co-commissioning a new integrated model of care for Older People, the process of whole system reconfiguration will be initiated. The case for change is aimed at improving outcomes and delivering a better user experience in a more financially sustainable way. This will be achieved by moving to a model that invests more funding in lower level and wider preventative support, shifting the balance of spending and care over time:



The operating model will be implemented over the next five years and represents a radical shift from traditional models of service delivery. It moves away from providing services that can create dependency, discourage self-care and undermine people's confidence, to those that inform and empower individuals to manage their own health and wellbeing and make informed, personalised decisions. It will also provide targeted and tailored support to enable those who face the greatest challenges around maintaining their own health, wellbeing and personal care.

The new model for integrated care consists of four tiers, comprising a number of different components:

Tier	Objective	Components
Living, ageing and staying well	*Providing coordinated, responsive and sustainable health promotion services, and bringing partners together to tackle negative lifestyle choices, to transform the overall health of Buckinghamshire*	a. Multi-agency prevention strategy b. Behaviour Change programmes c. Integrated Lifestyle Service d. Planning for older age
Prevention and early intervention	*Identification of and support for individuals who are vulnerable, and at risk of requiring support in the future*	a. Proactive case finding and referrals b. Integrated case management c. Community based prevention services d. Digitalisation, adaptation, equipment and housing
Rapid response and reablement	*Co-ordination of services to individuals during a period of rapidly escalating health or social care need, in order to avoid attendance at hospital or the requirement for a long-term care package*	a. Rapid response b. Reablement
Integrated	*Reshaping long-term care services around a*	a. Integrated locality teams

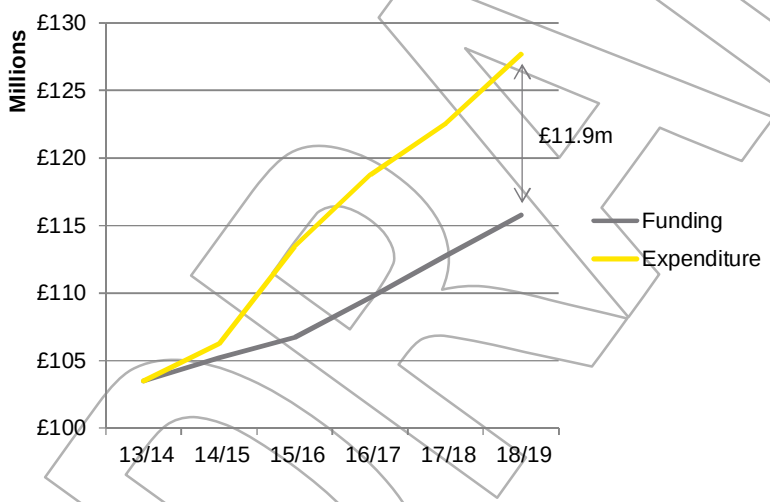
long-term care	*common understanding of service users' needs and establishing a single approach to market management across the health and social care economy*	b. Joint commissioning of placements c. End of life care

Reflected in the above tiers is the objective to reduce demand from within the Older People cohort in Buckinghamshire through a range of preventative and healthy lifestyle measures targeted at adults of all ages, in order to maintain or improve their physical and mental health for as long as possible before they require additional support. This is underpinned by a cross-cutting theme of self-management in order to help people to help themselves at every opportunity.

The successful implementation and operation of the new model requires full engagement of services within Primary Care for all Tiers. For the purposes of this OBC, the current commissioning spend on Primary Care services is outside of the financial scope of the programme. However, it is fully anticipated that the services which are delivered by Primary Care, including community pharmacy, GPs and Practice Nurses, must be prepared to adapt in order to become embedded as a critical element of the model. This may result in new ways of working in Primary Care, increased spend in Primary Care as services are transferred to Primary Care out of Secondary Care, or new roles and responsibilities within Primary Care. The delivery of the integrated care programme relies on its full alignment with the joint primary care strategy which is to be developed over the next few months.

The integrated model requires a series of enablers in order to be implemented and successfully sustained. The key enablers that feature within all tiers are ICT infrastructure, stakeholder engagement, workforce development and routing and pathways. The enablers are not all at the same stage of development, and further work to assess the development required for each enabler will be undertaken as part of the Strategic Business Case.

The scope of the programme includes £103.4m of services commissioned by BCC, AVCCG and CCCG. If these services continue to be delivered as-is, it is estimated that there will be a £11.9m gap between income available and expenditure, having factored in organisations' savings plans.



Over the next 5 years, income growth will fail to match demographic growth and cost inflation, and the annual gap increases to £11.9m by 2018/19, with the total deficit over the period being £41.0m. The assumptions used factor in the effect of QIPP and MTP savings plans. Best practice examples from elsewhere show that it is possible to close this gap using tried and tested interventions within the four tiers of the mode although this does not take account of the potential implications of the Care Bill.

In order to successfully deliver the integrated services, five delivery vehicles have been considered as follows:

- Current status quo – with reconfigured services
- Alliance contract
- Providers services integrate but not into a single entity

- Accountable lead provider model/Accountable Care Organisation
- Commissioners recommission as an integrated service from one provider

At this stage no recommended delivery vehicle has been identified as this options appraisal will form part of the Strategic Business Case. It is likely that the integrated care model will be delivered via a range of vehicles focusing on discrete components or tiers of the overall model.

An assessment of progress to date towards integration, and the potential benefits of each component, indicates that the priority areas of focus should be:

- Rapid response
- Reablement
- Joint commissioning of placements
- End of life care

In order to minimise duplication and manage risks, the programme will be delivered under three projects:

- Develop BCF (s75) working arrangements
- Service alignment and specification development
- Strategic Business Case for integrated care

The programme cuts across multiple agencies and as such will require support and commitment from all partners in order to ensure coordination, active engagement and enable resources to be harnessed and deployed appropriately.

These projects will occur between May and August 2014, at which point the Strategic Business Case will be delivered, and alignment with the Whole System Profit and Loss Account work will take place. There are other key interdependencies with implementation of the Care Bill by BCC, AVCCG's IT interoperability business case, and provider CIP activity, and also the CCGs' submission of their five year plans in June.

There are number of key points for decision to be made at this stage and these are highlighted throughout this Outline Business Case.

2. Vision for integrated care in Buckinghamshire

The vision and priorities for Buckinghamshire are set out in the Health and Wellbeing (HWB) Strategy. These are:

1. Every child has the best start in life
2. Everyone takes greater responsibility for their own health and wellbeing and that of others
3. Everyone has the best opportunity to fulfil their potential
4. Adding years to life and life to years

Within Buckinghamshire, to ensure the priorities defined through consultation with the Public and Providers are delivered, the BCF Plan is aligned to the HWB Strategy and will incorporate initiatives as appropriate to gain as much momentum as possible. For example, the HWB Strategy contains the objective of working with key organisations to support the early diagnosis of long-term conditions, and where these have been identified we will support people to manage their long-term condition. The activity to deliver this, such as implementing Autism, Dementia and Stroke action plans, will be supported by the BCF plan of work.

Senior managers, clinicians and councillors have built on the HWB strategy to develop a vision across the system:

'Everyone working together to provide high quality, prevention and personalised care to help keep Buckinghamshire people happy and healthy (optimising value from our collective efforts)'

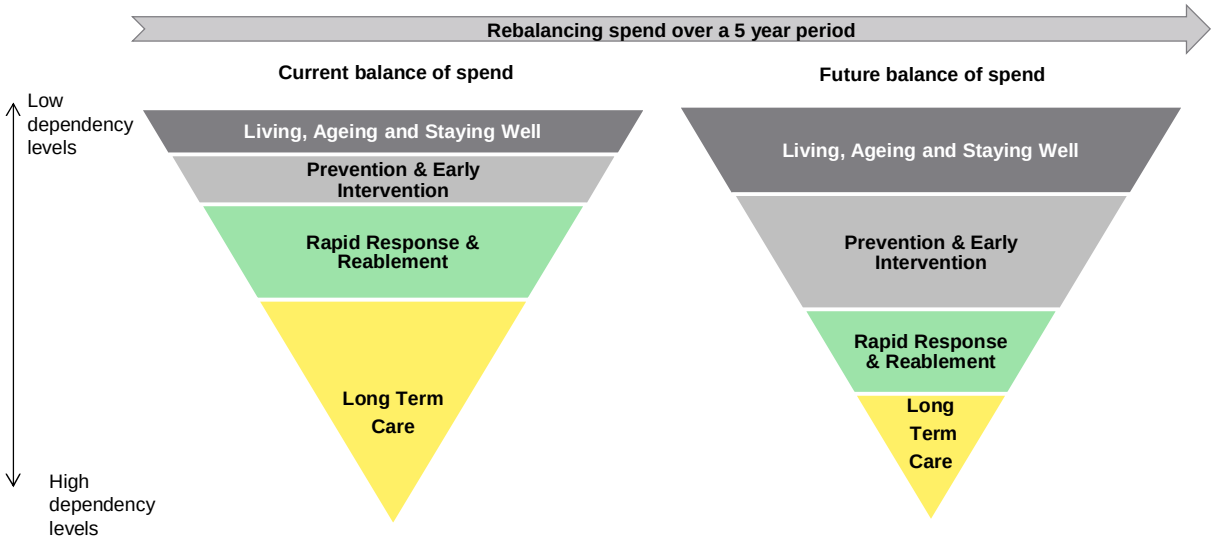
The Better Care Plan focuses on the delivery of an integrated model of care for older people across the county, as this is the largest cohort of the population concurrently receiving both health and social care, and as such the cohort which is most likely to benefit from an integrated system.
This vision drives the development of joint plans to deliver person centred care in, or as close as possible, to people's homes. Older people will be the primary focus of services in the first instance for the BCF, but many of the proposed changes will have a wider impact.

By delivering this vision, commissioners will:

- **Improve the health and wellbeing of Buckinghamshire people:** Keeping them happy and healthy with better quality physical and mental health and well-being, striving to deliver high quality outcomes for all
- **Provide integrated support with no distinction between services:** Seamless service provision support where we work together and everyone plays the part, using the combined genius of organisations, communities and people's solutions
- **Deliver quality across the whole pipeline:** High quality personalised care based on a consistent, common assessment of needs
- **Enable people to take greater responsibility for self-care:** Ensuring integration between what practitioners do and what people and their families do themselves, as well as between primary and secondary health and social, physical and mental wellbeing services

In essence, care will become significantly less dependent on bed based care, instead delivering high quality services in people's homes and community settings. In practice, delivering the vision will mean putting service users and patients at the centre of services, providing what they need at, or as close as possible, to home, only using bed-based health and care services when necessary. This drive applies to primary care, secondary care (elective and emergency) and social care services. The Better Care Fund will act as a lever to facilitate the co-commissioning of all current and proposed community based health and social care services for frail older people as the primary area of focus, to deliver coordinated care that integrates across the WHOLE spectrum i.e. **with** rather than just **for** patients and their carers.

By co-commissioning a new integrated model of care for Older People, the process of whole system reconfiguration will be initiated. The case for change is aimed at improving outcomes and delivering a better user experience in a more financially sustainable way. This will be achieved by moving to a model that invests more funding in lower level and wider preventative support, shifting the balance of spending and care over time:



Buckinghamshire has a strong track record of collaborative working, and to ensure maximum buy-in from key stakeholders (providers, commissioners, GPs and other professionals), the integrated care programme will build on the already strong platform of joint initiatives. What this means for Buckinghamshire is optimising and growing the things that are working well, as well as radically transforming elements of provision that are not.

Success will be when there is:

- An all-inclusive, personalised service for the citizens of Buckinghamshire
- Service delivery without duplication
- Seamless, high quality, safe and effective pathways of access
- Users driving services and a robust and sustainable model of community engagement
- Evidenced multiagency working through integrated care pathways and excellent care navigation optimising the use of resources
- The full integration of prevention into care pathways

In addition to the potential benefits (outcomes, experience, operational and financial), Health and Social Care commissioning organisations recognise the significant level of risk associated with transforming care services. The Strategic Business Case will seek to set out more clearly the commissioning and governance arrangements and appropriate commercial models and mechanisms across commissioners and providers.

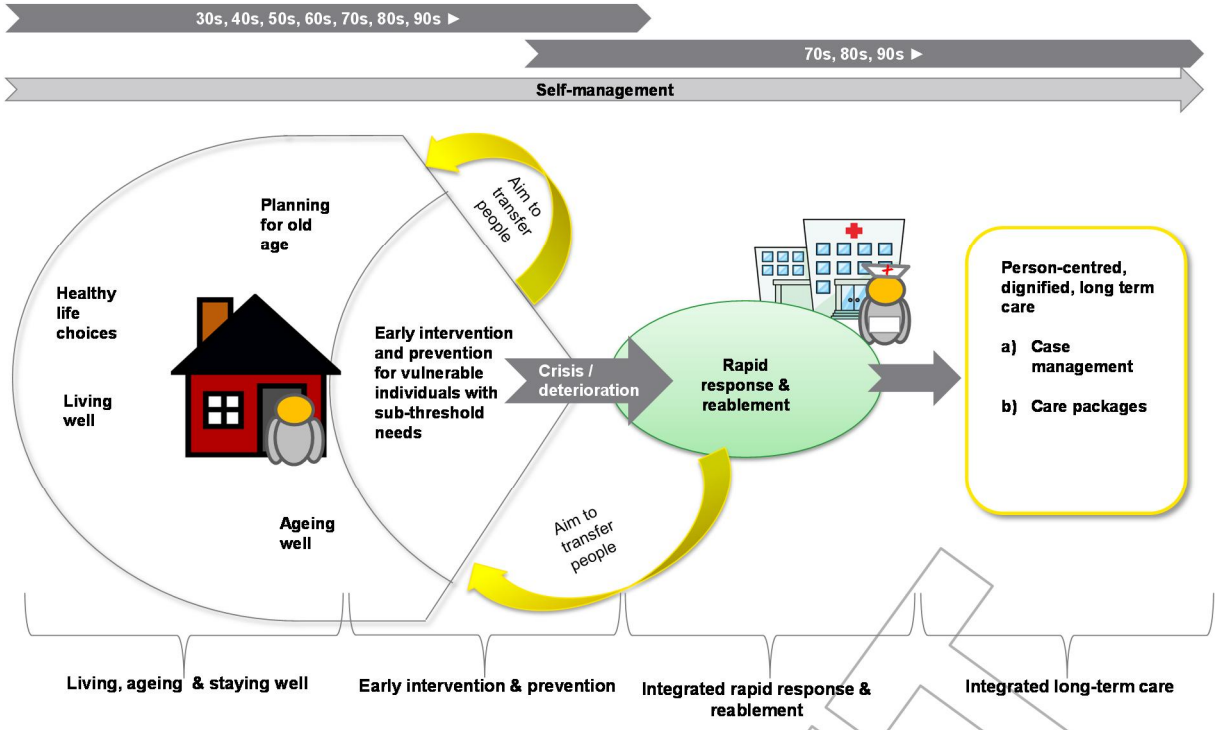
3. Operating arrangements for Buckinghamshire's integrated care system

The following section outlines the operating arrangements for the new delivery model by component correlating with the following model. However, it is recognised that for different elements of the service e.g. Health and Wellbeing, the offer and response will also have an impact on other parts of the population and pathways.

Commissioners have agreed a set of joint commissioning intentions which will inform the delivery of the new integrated model of health and social care. These commissioning intentions were agreed at the time of development of the Better Care Fund plan. Since the plan was submitted, further understanding of the importance of universal health and wellbeing services for all adults, as a driver for living, ageing and staying well, was agreed. This has resulted in a model of integrated care for Buckinghamshire which recognises the importance of this function and associated interventions in the successful management of demand for services in later life.

Buckinghamshire has used the Kings Fund model of health and social care services to help design 'what better would look like' to inform the development of a new, 4-tier integrated model for health and social in Buckinghamshire. The operating model will be implemented over the next five years and represents a radical shift from traditional models of service delivery. It moves away from providing services that can create dependency, discourage self-care and undermine people's confidence, to those that inform and empower individuals to manage their own health and wellbeing and make informed and personalised decisions. Buckinghamshire also recognises that individuals will vary in the personal resources they have available to them (including personal confidence and capability and external social and economic challenges) and while moving away from approaches that create dependency will provide targeted and tailored approaches that provide individuals with effective support to take personal responsibility for their own health and wellbeing.

The aim of the model is to manage demand appropriately, so that a greater number of people are supported to make healthy, positive lifestyle choices from early in their adulthood in order to reduce the size of the population who require intensive support and intervention in later life. The model is also designed to ensure that when people do require more intensive support, it is delivered in a joined-up way, focusing on maximising an individual's positive outcomes, so that their dependence upon long-term intervention is minimised. In line with this, the intended objective is to reduce demand for high cost services and redirect this funding to earlier intervention and similar low cost, high impact provision to a wider audience.



The four tiers of the integrated service are as follows:

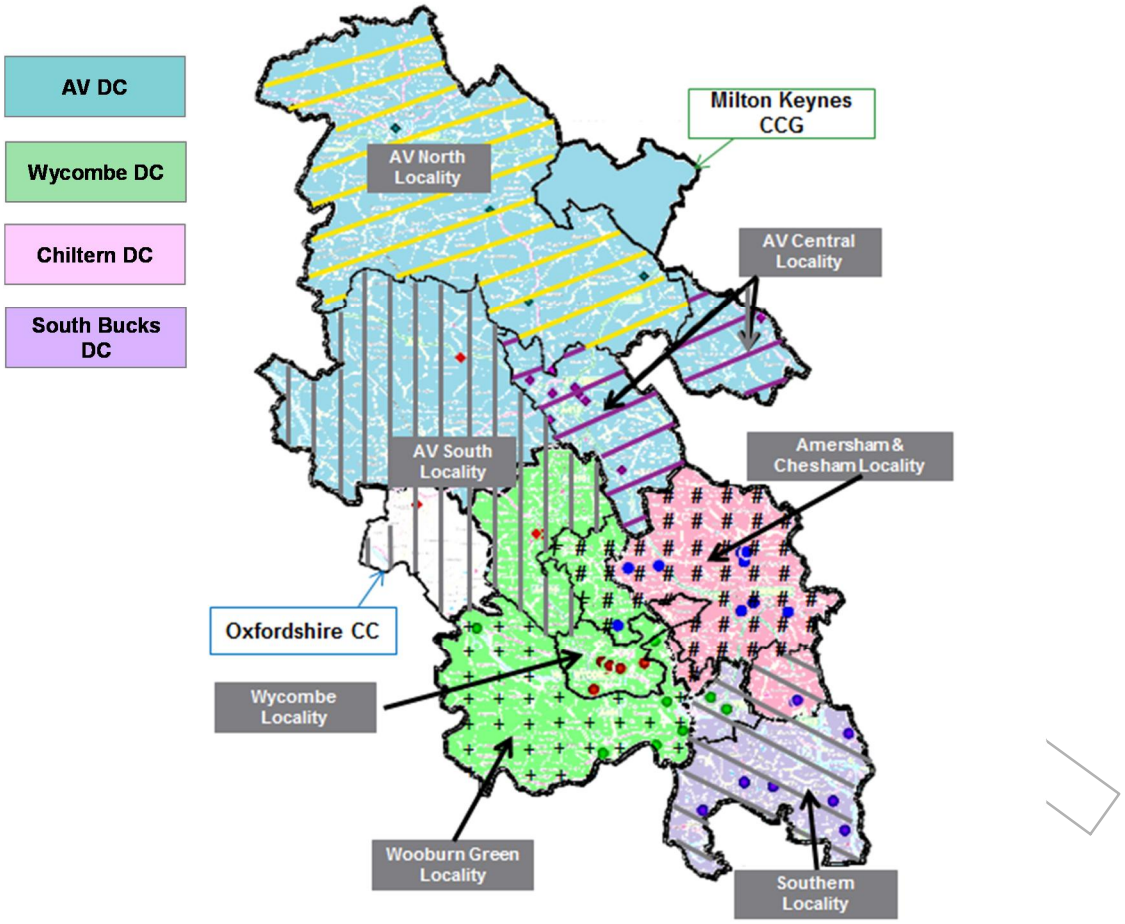
- Living, ageing & staying well
- Early intervention & prevention
- Integrated rapid response & reablement
- Long-term care

These are described in more detail in the following section.

The 2011 national census indicates that the current population of Buckinghamshire is 505,300. Administratively, the county can be divided as follows:

One County Council:	Buckinghamshire CC, serving all 505,300 residents within the county
Two CCGs:	Chiltern CCG, comprising 35 GP practices serving a population of over 320,000. Aylesbury Vale CCG, comprising 21 GP practices serving a population of over 200,000 (this includes some population in Oxfordshire)
Four district councils:	Aylesbury Vale Chiltern Wycombe South Bucks

In addition, the CCGs divide their areas of responsibility into seven 'localities' – three within AVCCG (AV North, Central and South) and four in CCCG (Amersham & Chesham, Wycombe, Woodburn Green and South Bucks). These divisions are shown on the map below:



The map also shows two areas which are not coterminous with the county boundary: one to the north east, which is within AVDC but for which Milton Keynes CCG is responsible for health services; one to the west which lies in Oxfordshire CC but for which AVCCG is responsible for healthcare. Both of these areas are recognised in the BCF by a transfer from MKCCG to Buckinghamshire, and from Buckinghamshire to Oxfordshire CC.

The detail of the future operating model for Buckinghamshire will be developed through the Strategic Business Case. The delivery of services will take account of a wide range of delivery, from individual citizens receiving primary care services and social care Direct Payments, through districts which will host facility-based services and integrated case management teams which will be allocated to particular localities, to centrally coordinated and delivered services such as A&E services.

This is likely to resemble a 'hub and spoke' approach, where a large number of services are coordinated from a district 'hub' (such as the Community Wellbeing Centres discussed later), with outreach services into localities.

The successful implementation and operation of the new model requires full engagement of services within Primary Care for all Tiers. For the purposes of this OBC, the current commissioning spend on Primary Care services (i.e. the spend by NHS England on commissioning General Practice) is outside of the financial scope of the programme. However, it is fully anticipated that the services which are delivered by Primary Care, including community pharmacy, GPs and Practice Nurses, must be adapted in order to become embedded as a critical element of the model. This may result in new ways of working in Primary Care, increased spend in Primary Care as services are transferred to Primary Care out of Secondary Care, or new roles and responsibilities within Primary Care. The Strategic Business Case will be driven by Design groups which will have representation from (and in some cases, may be led) by Primary Care. In addition, the successful delivery of the integrated model

relies on full alignment with the joint primary care strategy which is to be developed over the next few months.

3.1 Self-management

The entire model is underpinned by a cross-cutting theme of self-management and personal responsibility. This support comprises a portfolio of techniques and tools to help patients choose and manage healthy behaviours and develop the patient-caregiver relationship into a collaborative partnership.

Self-management begins with the promotion of personal responsibility for health and wellbeing and with active citizenship for all residents of Buckinghamshire. This places an expectation on all citizens to uphold their rights and responsibilities for positive self-management by actively exhibiting positive behaviours and living positive values to be equal participants in meeting their health and care needs at all stages of their lives. This requires a major shift in how many citizens perceive themselves, from the current perception of being passive recipients of services to a new identity as active participants who make lifestyle choices which will not only benefit themselves but potentially their community as well. It also places a responsibility on the organisations that shape the environments in which individuals live, work and socialise to develop policies that support healthy lifestyle choices. Achieving this shift presents a cultural challenge across society, as people are encouraged to engage in local democracy. This requires a coordinated, whole system response in order to embed participation at the heart of all public service delivery.

Self-management applies across the whole spectrum of need, from active, independent citizens through to those individuals who require a level of care and support, in order to maximise outcomes and minimise public cost. People with long-term conditions are the most frequent users of health care services, accounting for 50 per cent of all GP appointments and 70 per cent of all inpatient bed days: around 70-80 per cent of people with long-term conditions can be supported to manage their own condition, and self-management has potential to improve health outcomes in some cases, with patients reporting increases in physical functioning, leading to a complementary reduction in demand for medical intervention. The use of lifestyle changes such as becoming more physically active, losing weight, stopping smoking and reducing alcohol intake can also have therapeutic effects and prevent or slow the progression of long term conditions. Establishing more robust mechanisms and approaches to raising healthy lifestyles with individuals who are well or have long term conditions and ensuring referral into lifestyle support is key to reducing longer term demand. Primary care has a key contribution to make to this.

Self-management programmes have been shown to reduce unplanned hospital admissions for chronic obstructive pulmonary disease and asthma, and to improve adherence to treatment and medication regimes, but evidence that this translates into cost savings is more equivocal. A cost analysis performed in the United States did indicate that expenditure in other parts of the system can be reduced.

There are a number of well-established self-management programmes that aim to empower patients to improve their health. The approach to self-management varies depending on the condition which is being addressed. For example, structured patient education can be beneficial for people with diabetes, while people with depression may benefit more from cognitive and behavioural interventions.

Recent work conducted by the Richmond Group of Charities and The King's Fund (2012) called for patients to be offered the opportunity to co-create a personalised self-management plan which could include the following:

- patient and carer education programmes
- medicines management advice and support
- advice and support about diet and exercise
- use of telecare and telehealth to aid self-monitoring
- psychological interventions (eg, coaching)
- telephone-based health coaching
- pain management
- patient access to their own records.

Self-management is applicable across all stages of the model. Beginning at Tier 1, the vision for Buckinghamshire is to enable large scale access to behaviour change support through access to online behaviour change programmes and tools and to provide more targeted and intensive support for those individuals who require additional support to become fully responsible for their own wellbeing. Although it contributes most to the positive impact of interventions outlined in Tier 1 (Living, Ageing and Staying Well), there are self-management techniques which can be promoted and utilised to minimise the level of need and impact of certain conditions even if an individual has different needs arising from separate causes. For example, an individual can continue to manage their own diabetes even if they require assistance to meet long term needs which are caused by another condition, such as arthritis or stroke. This promotes the individual's independence in meeting their own needs and reduces the requirement for a more complex package of support.

3.2 Living, ageing and staying well

3.2.1 What are the objectives of this tier?

- Provide coordinated, responsive and sustainable health promotion services that enable residents of Buckinghamshire to live well throughout all stages of adulthood
- Build citizens own responsibility for care and well-being, so that people are helped to help themselves, whoever they are and wherever they live
- Tackle negative behaviours and lifestyle choices (e.g. sedentary lifestyle, smoking and/or poor nutrition) to create lasting improvements in the health and wellbeing of the residents of Buckinghamshire
- Support all residents of Buckinghamshire to make positive life choices to become more self-reliant now, and to effectively plan for older age
- Ensure health promotion activities are fully co-ordinated and that primary prevention is developed as a fully integrated component of care pathways and therefore aligns with, and is complementary to other higher-tier health and social care systems (e.g. early intervention, reablement and long-term care)
- Bring health, social care, and voluntary sector and community support services together to transform overall health of Buckinghamshire

These consolidate to a three-pronged approach to living, ageing and staying well in Buckinghamshire to:

- Encourage and facilitate self-management, autonomy and independence
- Ensure services are accessible, flexible and equitable
- Facilitate co-ordination of knowledge and skills sharing throughout services

3.2.2 Who is this tier for?

This tier comprises a universal, community-based primary prevention and self-management offer to all residents of Buckinghamshire.

Notably, as demographics vary across the county, delivery of locality-based services need to be flexible, and where necessary, tailored to particular groups and/or needs.

3.2.3 What are the key components for this tier?

- A multi-agency prevention strategy
  - This strategy will ensure that the opportunity to maximise the potential of improving healthy lifestyles is used at all Tiers and that prevention activity is fully integrated into care pathways. This would range from prevention activity to keep people well and early identification of

conditions or problems through to prevention and lifestyle changes as a way to assist in the management of long term conditions.

- This countywide prevention strategy will aim to increase the reach of promoting lifestyle changes by utilising countywide communication programmes and face to face contacts through a range of public, third sector and community organisations. It will also focus on the development of health promoting environments by working with policy makers.

- Buy-in across health and social care commissioners and providers is central to building effective and sustainable live well initiatives. As such, commissioning intentions need to shift from 'do these services save money', to 'do these programs offer good value'. Likewise, it is also necessary to commercially re-incentivise service providers towards a model of prevention and well-being

- This will be achieved by re-incentivising partners away from reactive models of care, to proactive self-management and support strategies. Early evidence from Accountable Care Organisations and the implementation of shared savings programs in the USA indicates that providers can be encouraged to deliver better quality, integrated health and support services that keep people well and out of hospital or long term care

- Behaviour Change programmes and tools through online support

  - A local web and mobile app personal health management resource. This will offer personally tailored programmes and general health information and support. It will be tailored to include the development pf local online communities around making lifestyle changes and information on relevant local services.

  - In addition to the value this provides to local residents, it will provide health and social care staff with an easy information source for them to share with their clients. This resource would be the primary support to individuals who have sufficient personal resources to self-manage their own behaviour change programmes.

  - Operating these schemes will encourage resident-to-resident, resident-to-professional, and professional-to-professional information sharing that will help community based resource and capabilities to grow organically. This will strengthen the competencies of everyone involved in supporting the well-being of residents, create a robust and sustainable approach to health promotion, and ensure ongoing oversight of the changing needs of the community

- An integrated lifestyle service

  - This service will bring together existing lifestyle support services (such as smoking cessation services, health trainers) into one service. It will operate as a single point of contact for anyone needing advice and support on making positive lifestyle changes.

  - The service will primarily focus on delivering preventative lifestyle advice and tailored interventions. It would be targeted at individuals who need additional support to achieve lifestyle changes. It would utilise the online resource as a tool and would signpost resourceful individuals to the online tool as their primary support and move people onto the online and other self management tools as soon as they were able to self help.

  - It would also seek to address the wider social and economic factors that restrict individual's ability to be healthy by undertaking an holistic assessment of the factors affecting current lifestyles. The service would develop referral pathways into wider determinants of health issues such as housing, debt and unemployment. The service would seek to support self-management across these wider determinants by supporting confidence building and other skills that enable people to actively address a range of life issues.

  - The service will be accessible to key target groups and will be delivered from a range of locations across the county, depending on the best model within each local geography.

These locations could include healthy living centres, leisure centres and community wellbeing centres (explained later in the document). There would be accessible opening hours including evening and weekend access and provide a point of focus for local community networks and 3rd sector/voluntary organisations to empower people to take control of their own lives and maintain their health and independence

- Planning for old age
    - This will involve working with local employers to provide advice and guidance to younger adults (those of working age) to help them plan for old age. This includes how to pay for care and understanding the implications of their decisions. It will signpost to financial products such as insurance and independent financial advice to younger adults helm them save for their care
    - Easily accessible by all and for all, it will be a universal offer that everyone can access for advice and guidance.
    - It will have a training and advice element for employers to help them help their staff plan for retirement. Bigger businesses will be encouraged to support smaller businesses in this process.
    - The service will sit outside of social care and will have a broad remit.

3.2.4 What is the evidence for this tier?

Partnership for Older People Projects (POPP) were designed to promote health, well-being and independence in older people and preventing or delaying their need for higher intensity or institutional care. These projects ranged from low level services, such as lunch-clubs, to more formal preventive initiatives, such as hospital discharge and rapid response services. Key evidence for the success of POPP:

- A reduction in hospital emergency bed days, and considerable savings, where for every extra £1 spent on POPP services, there has been was a £1.20 additional benefit in savings
- Overnight hospital stays were reduced by 47% and use of A&E departments by 29%. Reductions were also seen in physiotherapy/occupational therapy and clinic or outpatient appointments with a total cost reduction of £2,166 per person
- Overall improvements in perceived quality of life

An assessment of the cost-effectiveness of public health interventions was conducted in 2012 by the National Institute for Health and Clinical Excellence (NICE) 11. Reviewing NICE public health guidance from 2006-2010, they concluded that the majority of the 200 cost-effectiveness estimates for public health interventions were cost effective and represented good value for money. These include interventions around smoking cessation, increasing physical activity including exercise on referral programmes and preventing harmful drinking.

The Liverpool Public Health Observatory review of wellness services concluded that the majority of services showed potential to give a return on investment and save future costs due to ill health. Some initiatives not only made savings in care costs, but improved quality of life, enabling individuals to live

independently. The report also found that wellness services could provide an effective response to frequent attendees in primary care by tackling the underlying causes of their visits. Many of the services (such as social prescribing where patients are linked to the non-medical facilities and services available in their wider community) had zero cost when compared to medical treatment

In 2009, the Eastern Region Public Health Observatory (ERPHO) published high level indicative cost savings and concluded that tackling obesity, vascular risk and smoking are worthwhile investments

Evidence from other countries also supports the cost effectiveness of prevention initiatives.

- *F*or each 10% increase in local public health spending on health promoting activities (e.g. smoking cessation, nutrition, exercise) in the US, deaths from cardiovascular disease dropped by 3.2%. This 10% represents spending $312,274 at the local health agency level, compared to the $5.5 million required to achieve the same reduction in cardiovascular mortality through clinical care interventions

- An investment of $10 per person on community-based disease prevention programs on physical activity, nutrition, and reducing tobacco use can lead to reductions of:
  - Type 2 diabetes and high blood pressure by 5% in 1 to 2 years
  - Heart disease, kidney disease and stroke by 5% in 5 years
  - Some forms of cancer, COPD and arthritis by 2.5% in 10 to 20 years

  This would yield net bi-annual savings of almost $18 per-person, a return on investment of 6.2 for every $1 invested

It has also been observed that health promotion initiatives are associated with the following improvements to mental health:

- Exercise interventions and improving social support through befriending have been successful in improving the mental health of elder populations (Jané-Llopis et al., 2005).
- Exercise, such as aerobic classes and t'ai chi, provides both physical and psychological benefits in elder populations such as greater life satisfaction, positive mood states and mental well-being, reductions in psychological distress and depressive symptoms, lower blood pressure and fewer falls (e.g. Li et al., 2001)
- Befriending is a widely used strategy to increase social support and to significantly reduce loneliness and increase the making of new friends (Stevens & van Tilburg, 2000)

It is known that health inequalities result from social inequalities, and that action on health inequalities requires action across all the social determinants of health. Actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. The impact of this action will have a multifactorial benefit on society, through reduced losses from illness arising from poor health such as productivity losses, lost tax revenue, increased welfare payments and the cost of treating the illness. The Marmot review described the wider public sector business case of reducing health inequalities as follows:

> *If everyone in England had the same death rates as the most advantaged, people who are currently dying prematurely as a result of health inequalities would, in total, have enjoyed between 1.3 and 2.5 million extra years of life. They would, in addition, have had a further 2.8 million years free of limiting illness or disability. It is estimated that inequality in illness accounts for productivity losses of £31-33 billion per year, lost taxes and higher welfare payments in the range of £20-32 billion per year, and additional NHS healthcare costs associated with inequality are well in excess of £5.5 billion per year. If no action is taken, the cost of treating the various illnesses that result from inequalities in the level of obesity alone will rise from £2 billion per year to nearly £5 billion per year in 2025.*

- Age UKs *Health Ageing Evidence Review* cites a number of interventions as having a positive impact on supporting people to live and age well.
  - Health promotion services that are effective are often providing more than just activities and information – they involve adopting approaches that can change people's behaviours. In general, peer mentoring can be very effective and cost-effective.

- Volunteering has benefits not only for society but for older volunteers, who often gain or regain a sense of usefulness and purpose.
- The lay health educator model (the Senior Health Mentor) has been effective in improving healthy behaviours and reaching hard-to-reach groups, and has the potential to be sustained as a low-cost model.
- The Fit as a Fiddle programme includes a significant range of healthy ageing initiatives.

3.2.5 How could these components be deployed in Buckinghamshire?

Work has already been undertaken by the Buckinghamshire County Council Public Health Team on a programme to increase healthy lifestyles in Buckinghamshire.

- Multi-agency prevention strategy
    - It is important to harness the resources available in local communities. The prevention strategy will explore effective ways to stimulate and maintain community level activities to promote health and wellbeing. This could include approaches such as a community wellbeing challenge including:
        - Asset and skills mapping (linking with other organisations and programmes that currently undertake asset mapping such as Prevention Matters and Community Impact Bucks.
        - Individuals earn well-being points for their communities or other networks such as workplaces by engaging in relevant activities. This could be tracked by the online resource tool and could be linked to time credit awards
        - Supporting a network of health champions that can provide information, signposting and training within their own communities
    - The strategy will also consider how community activities can be co-ordinated to ensure a collective impact that would provide sufficient scale. This could include activities such as common branding of community level programmes to develop a broad awareness and impact (for example the Birmingham 'Be Active' programme branded all projects at small and large scale under the same brand to create a social awareness of the importance of being physically active).
    - Ensure health promotion and reduction of preventable LTCs are made a priority within the commissioning and provision of health-promotion services. Suggested ways of achieving this include:
        - Ensure clear communication and buy-in with commissioners and providers round the remit of an integrated health and well-being offer
        - Emphasise the importance of 'playing the long game'
        - Build in commitments to disease prevention within procurement arrangements and contractual obligations with Providers
        - Upfront agreement with partners to share any benefits realised from reductions in user demand of health and social care services that result from the health and well-being offer
- Behaviour Change programmes and tools through online support
    - Commission local web and mobile app personal health management resource and promote the usage of this through a wide range of front line interactions (including but not exclusively health and social care).
    - Develop within the system a management information module that allows evaluation of the general use and effectiveness of the tool, but also its attractiveness and effectiveness for specific population groups. The tool will be modified to improve usage by specific population segments.
    - Provide wearable technologies that can monitor and measure activity levels – which could tie in with the Community Wellbeing Challenge

- Run webinars and digital workshops that residents can log into remotely on handheld devices and home computers

- Training workshops and skills support to ensure residents and front line staff can interact with technology

- Set up a Community Well-being Challenge within Buckinghamshire work-places and existing community clubs and societies to engage, encourage and incentivise health promoting activities. This could help to ensure responsibility and accountability not just for individual health, but the collective efforts of your team. Suggested features of the Community Well-being Challenge:
  - Community teams (e.g. church groups, local rugby clubs, BCC employees) pick a particular area of health and well-being to focus on – i.e. exercise, diet or hobbies
  - Teams conduct skills mapping to identify areas of strength and weakness to provide those who need extra support
  - Individuals earn well-being points for their team by engaging in relevant activities
  - Teams track their own, and other teams activities and progress via digital applications and social media
  - All teams have the potential to win time credit rewards for hitting well-being points milestones
  - Time credits can be organised and spent through a community-based timebank schemes, which can be traded between members of the community (i.e. help with chores or home improvements), between members if the community and local agencies, or between agencies (i.e. hiring a minibus or sportshall)
  - The timebanking scheme will help to reward Community Wellbeing teams for their hard work and increase the flow of social capital within the community (ref http://www.timebanking.org/about/)

- Integrated Lifestyle Service

  - Achieving lifestyle changes on a scale that is adequate to reduce the current increase in unhealthy lifestyles and the resulting long term conditions will be important for the sustainability of the system. Based on preliminary investigations by the Public Health Team, integrated lifestyle services of the type proposed for Tier 1 for a population the size of Buckinghamshire would cost around £3.5 – 4m, to be funded from the pooled fund from health, social care and other delivery partners.

  - These locality partnerships will emphasise community capacity and volunteering by building on local assets, and harnessing the expertise of communities and the voluntary sector. Suggested features of locality-based Integrated Lifestyle Service are:

    - Based in the heart of Buckinghamshire communities and open during the day, evenings and at weekends
    - A place to share information and knowledge, run training workshops and promote public health initiatives
    - Engagement with existing clubs, societies and businesses within the community to deliver services
    - Equipment, facilities and advice to facilitate and support people in health promoting activities
    - Opportunities to train, educate and support carers within the community
    - Opportunities for older people and others to keep active and healthy by participating in volunteering or offering their skills through 'time banking'

- Planning for old age
  - Run workshops that bring together residents with Buckinghamshire employers and financial advisors to embed planning for old age. This could involve partnerships between HSC/Primary Care and Buckinghamshire businesses to develop a model that encompasses health and wealth aspects

- Encourage financial planning in early adulthood akin to pension-planning will reduce the risk of people being unable to afford the first £72K of their care. It will also give them more choice about the services they are able to access.

- Provide training and advice for Buckinghamshire employers to help them help their staff plan for retirement. Bigger businesses will be encouraged to support smaller businesses in this process.

- Mainstreaming financial planning function into advice and information services by working with agencies such as the CAB and IFAs operating in Buckinghamshire

- Financial products such as insurance will also be promoted to younger adults. The offer for those in their forties to sixities will still focus good health and wellbeing, however there will also be support to help people make good decisions about where they live and having a 'home for life.'

3.2.6 What are the current projects supporting integration of components in this tier?

The Buckinghamshire County Council Public Health Team have already been undertaking some preliminary work on the development of an integrated lifestyle service. This work has identified this model of service as a desirable future, but requiring significant investment and further more detailed work on costings and effective implementation. The development of a lifestyle hub has been identified as a potential interim model until the fully integrated model can be achieved.

The Healthy Communities Partnership has already identified that silo delivery of lifestyle programmes is an issue in Buckinghamshire and as started a Multiple Risk Factor project which aims to provide more effective responses to individuals who present with multiple risky lifestyles and this project includes developing more effective working and signposting across the existing lifestyle services

3.2.7 What is the current level of spend in this tier?

Model tier	Example services	BCC budget	CCGs budget	Total Budget in scope	% of total budget
1. Living, ageing and staying well	Public Health (including health checks and integration funding)	1,390,000	-	1,390,000	1%

3.2.8 What are the key activities for this tier to develop the strategic business case?

- Consider wider scope to understand the impact on this tier of other community based services such as pharmacies, parks and health and leisure centres

- Understand the current community asset base

- Identify opportunities to enquire about retirement planning with big local employers

- Develop stakeholder engagement strategy

- Develop design principles of the operating model for this tier – how much do you lead locally versus centrally

- Design specification for integrated living, ageing and staying well model

Key points for Living, Ageing and Staying Well

- Currently, less than 10% of in-scope spend is within this tier
- Existing progress towards implementing this tier of the model is limited
- Payback from investment in this tier is likely to be longer than for other tiers
- Work to develop this tier of the model will require engagement of a broad range of partners, including the private and voluntary sector, and District Councils

3.3 Prevention and early intervention

3.3.1 What are the objectives of this tier?

- Provide a clear prevention and early intervention assessment function that can be directly accessed by residents, as well as professional health and social care services
- Process referrals back from reablement and crisis response where individuals are capable of returning to the community
- Proactively identify and treat residents at moderate to high risk of developing LTCs and deliver effective clinical and lifestyle interventions to mitigate these risks
- Provide targeted community-based care and self-management support to adults with LTCs and sub-threshold needs to prevent declining health or development of complex co-morbidities
- Ensure elderly residents with escalating care needs have access to support within the community so they are empowered and enabled to live independently
- Facilitate, streamline and consolidate the delivery of effective multi-agency prevention and early intervention services according to the individual needs of patients
- Encourage cross organisation working, and build partnerships with voluntary sector and community support to build capacity, and enhance access to community-based services
- Improve long-term outcomes for patients, reduce incidents of crisis, and unnecessary use of hospital and long term care

3.3.2 Who is this tier for?

While tier 1 relates to a universal offer designed to keep people well and plan for old age, many residents of Buckinghamshire with developing health and social care needs will fall outside of the remit of these services. Notably, these individuals will also drop below the threshold for the crisis response, reablement and long-term care services in tiers 3 and 4. We identify these people as:

- Older people with escalating health needs
- Adults identified as having a moderate to high risk of developing an LTC (e.g. smoking, obesity and alcohol abuse)
- Adults with established LTCs, but current social care needs are sub-threshold
- Residents who have received a period of reablement, but do not currently require long-term care interventions

3.3.3 What are the key components of this tier?

- Proactive care referrals

  - Implement an comprehensive approach to risk stratification to proactively identify individuals whose needs may be at risk of escalating. This component will enable timely identification of at risk groups to ensure they are picked up and put on the right care path as early as possible

  - Provide a single self-contained prevention and early intervention access point and assessment function to coordinate services. A single access will ease the burden on primary care, and also ensures that individuals with up-to-date and comprehensive oversight of the available services are in charge of assessing the individuals needs of at risk individuals

- Integrated case management

  - Provide Integrated Locality teams that are based in the community to support a whole system approach to early intervention and enable good oversight, communication and understanding of individuals with high risk profiles. These teams are expanded upon in more detail the Long-term care section (i.e. Tier 4). In the context of prevention, these teams will provide care and to build patients' knowledge, confidence and self-management skills, and improve outcomes. Complex cases will be assigned their own prevention case manager who will help patients to interact with the Integrated Locality teams, navigate services, and provide ongoing management of care pathways

  - Provide effective community-based alternatives to statutory provision in local communities. These would comprise patient centred clinical prevention and self-management programmes, which pull together generic and specialist health, social care and community based support services from multiple agencies (i.e. nursing, mental health, PT, OT)

- Community-based prevention services

  - Provide opportunities to educate and inform older people with escalating health needs, adults with LTCs, carers and health care professionals about available low level prevention and intervention activities and services

  - Enable coordinated delivery of low level prevention support within the community via the use of Community Well-being centres. These services closely align with the delivery of community-based health promoting activities described in tier 1. These relate to encouraging patients to engage with professional and other residents in the community, attend health promoting workshops and participate in lifestyle programs. These will complement some of the more targeted and/or specialist intervention activities for those with complex conditions

  - Ensure primary care professionals are sufficiently trained and informed for effective prevention and early intervention signposting

- Digitalisation, adaptations, equipment and housing

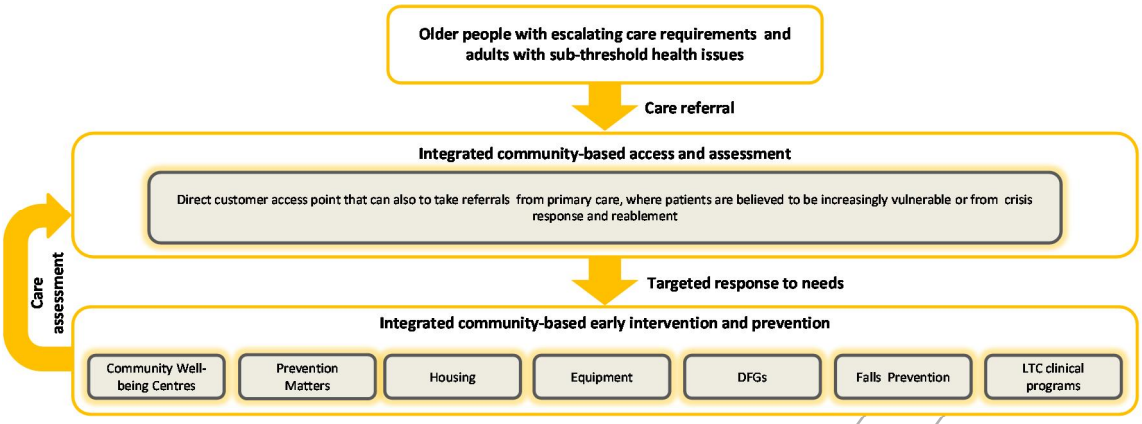
  - Similar to the use of ICT to support self-management and health promoting behaviours in tier 1, multi-disciplinary low level prevention services and patient centred clinical programs could be digitalised. This will enable improved, more targeted prevention services and assist clinical interventions to those with sub-threshold health requirements. Digitalisation of prevention support will also help to create virtual early intervention networks

  - Provide at risk patients with the right physical apparatus, equipment and adaptations to keep them functional and independent in their homes. By aligning multi-faceted equipment functions to the other components of the prevention and early intervention tier, patient needs will be identified, and the required equipment provided and installed as a priority. This will ensure that high risk individuals and patients with complex health needs have access to the required equipment in the community and at home

  - Health and Wellbeing Boards should be supported to recognise the preventative benefits of housing provision in making best use of Care & Support Housing Funds at the local level and to identify the role of housing in their new Joint Strategic Needs Assessments and local clinical

commissioning plans; and recognise in its budgeting the centrality of housing in preventing and addressing health and social care problems

- Upwards of 80% of older people choose to stay put in their homes. However, by providing a significant increase in attractive housing suitable for older people where they could maintain links to family and friends and retain ties to the local community could help encourage a move.



3.3.4 What is the evidence for this tier?

The below evidence is from similar models of integration that are expanded upon in more detail in section 4.3:

- The multi-agency prevention and intervention scheme implemented in North West London realised 30% reductions in A&E admissions and 15% reductions in unnecessary admissions to the acute. Introducing a similar program could deliver benefits of £9m per year in Buckinghamshire
- The WELC initiative, designed to co-ordinate and deliver targeted care in the most appropriate setting to very high risk, high risk and moderate risk elderly patients, and people with LTCs and mental health problems. A like scheme could deliver £9m in benefits, through a 20% reduction in non-elective admissions

It has also been observed that prevention and early intervention initiatives are associated with the following improvements to mental health:

- Effective preventative mental health interventions for selective elder populations include the use of patient education methods among chronically ill elderly and their caregivers, early screening, interventions in primary care and programmes using life review techniques
- Brief behavioural interventions, such as structured interviews and advice giving, can reduce alcohol misuse and hazardous drinking among older adults
- Screening and assessment instruments can improve identification of older at-risk drinkers and enhance clinician interactions to prevent or reduce alcohol misuse
- A mix of problem solving therapy (PST) and exercise can prevent the onset or worsening of depression
- Targeted outreach is effective in engaging isolated and vulnerable older adults in mental health care

Solutions to health and social care problems so often lie in provision of specially designed, high quality homes: these reduce risks of falls; provide safety and security; protect against the effects of cold homes and fuel poverty; enable earlier discharge from, and fewer re-admissions to, hospital; prevent the need (both temporary and permanent) for institutional residential care. Additionally, the companionship that comes with retirement housing can combat the depression and poor health that so often results from isolation and loneliness . These factors can save public (NHS and Council) funds as well as conserving private resources. In 2012, the DCLG calculated that the total cost of building-related hazards(including falls) is calculated to be approximately £2.48bn per annum in direct health costs or £40bn as a potential cost to society. In considering the costs to society, the savings are likely to be much higher: it is suggested that a home built to current building regulations could save £83,000 during a 60-year lifespan, compared to the average for the current stock. Building to the Lifetime Homes Standard could provide a further £1,600 in savings, or £8,600 if the potential adaptations are

made.

In 2009 the Homes and Communities Agency conducted research into how best to address the challenge of providing homes that meet the needs and aspirations of older people. The HAPPI (Homes for our Ageing Population: Promoting Innovation) report found that accommodation for the older population should have the following design principles:

- Generous internal space standards
- Plenty of natural light in the home and in circulation spaces
- Balconies and outdoor space, avoiding internal corridors and single-aspect flats
- Adaptability and 'care aware' design which is ready for emerging telecare and telehealthcare technologies
- Circulation spaces that encourage interaction and avoid an 'institutional feel'
- Shared facilities and community 'hubs' where these are lacking in the neighbourhood
- Plants, trees, and the natural environment
- High levels of energy efficiency, with good ventilation to avoid overheating
- Extra storage for belongings and bicycles
- Shared external areas such as 'home zones 'that give priority to pedestrians

An example in Sunderland of where these HAPPI design principles have been implemented within new housing design has found the following outcomes have been achieved:

- Keeping couples together within their own homes
- Enabling older households to live in their own homes independently for longer
- Giving people a choice of tenure which best meets their financial circumstances
- Offering sustainable accommodation which is well insulated, warm and efficient
- Resolving under occupation by providing accommodation which meets the needs and aspirations of older households
- Delivering more personalised care to individuals
- Reducing carer fatigue with increased support to carers from care staff and peers
- Delivering accommodation which prevents bed-blocking in hospitals enabling people to be re-skilled and reabled in a domestic setting before returning to their home

3.3.5 How could these components be deployed in Buckinghamshire?

- Proactive case finding and referrals
    - Continue and extend the use of MAGs for the purpose of proactive case management for 'at risk' service user/patients
    - Provide a single access point to assess needs of the individual and coordinate access to preventative and early intervention services. This access point could comprise:
        - A level of response for access and assessments for prevention and intervention services 7 days a week
        - An initial point of access for primary care (i.e. GPs) and community support functions to provide proactive support to sub-threshold patients
        - A clear prevention pathway to support the operation of the proactive risk stratification tool
        - A direct entry for Buckinghamshire residents who have lower level intervention needs and/or have not previously accessed a health/social care service
        - Process referrals back from reablement and crisis response where individuals are capable of returning to the community, and coordinating sub threshold support
- Integrated case management
    - Integrate Prevention casework into Locality-based support teams (ref. Tier 4) within Buckinghamshire communities to support patients with escalating and increasingly complex sub-threshold clinical needs. In this function, individuals known to the Integrated Locality Team will be offered support from the prevention worker, who can provide a single point of contact between the individual and community support networks, oversight of available

services relative to the individual's needs, and coordination of required interventions, whilst freeing up frontline staff to deliver care services

- Develop robust clinical programs that can deliver universal self-management support and advice and/or more targeted interventions for certain patient groups that can be delivered, where possible, in Buckinghamshire communities and using community based resources (i.e. Community well-being centres and pharmacies). Examples of these programs could include:
    - A Dementia Friendly Community programme where Buckinghamshire residents ill be educated about dementia, suffers of dementia and their carers can seek help and support. This will help people with dementia to feel included in the community, be more independent and have more choice and control over their lives
    - Expansion of the current the Live Well offer so that it is available to all residents in Buckinghamshire, covers a greater range of generic treatment and self-management support, and delivers more tailored and patient group/disease specific interventions

- Community-based prevention services

    - Enable coordinated low-level intervention services. Suggested features of community-based services:
        - Work across organisational boundaries and in partnership with voluntary and community services to build capacity, and enhance access to community-based services to support individual's self-management and wellbeing
        - Co-locate community services for early intervention and prevention, including the base for outpatient appointments, clinics, wellbeing classes, and integrated community teams of health and social care staff
        - Provide face-to-face, email and phone access to voluntary community prevention coordinators to help assess, provide and facilitate a residents low level community support requirement
        - Run one-to-one sessions and workshops to deliver motivational coaching techniques that focus on the person's aspirations to help build self-confidence and personal resilience, as and to avoid creating dependencies on one specific individual or service
        - Re-educate service users around the role of pharmacies to reroute primary care demands from GPs back into the community
        - Tie in with an expanded Prevention Matters service to create a floating community support offer, with which to replace Supporting People
        - Provide resource to develop residential communities based on shared care and support needs (i.e. care villages)

- Digitalisation, adaptations, equipment and housing

    - Enhanced specification and automatic deployment of free telecare equipment to all those Buckinghamshire residents with low to moderate risks. This will help to enable digitalisation of self-management and virtual deliver of prevention and early intervention community based clinical support. Ultimately, this will shift focus and reliance away from GPs as a source of primary care in Buckinghamshire

    - Work closely with DCs and RSLs in Buckinghamshire to develop 'Homes for Life', investing in or converting/selling off old existing sheltered accommodation to create Extracare type facilities. These will enable flexible packages of home-based care and provide support for couples with different needs to stay together

    - BCC to work with District Councils and Planning Committees to work with house builders and housing associations to use their entrepreneurial and marketing skills to accelerate the trend toward retirement housing as a lifestyle choice, bringing forward more projects that accord with HAPPI standards and meet the breadth of retirement needs including shared ownership and 'co-housing'; and to make best use of technological changes to support independence and security while reducing requirements for expensive communal facilities and on-site staff

3.3.6 What are the current projects supporting integration of components in this tier?

Prevention matters

The Prevention Matters Programme operates to enable earlier identification of need, and provide community based interventions and initiatives in response to the requirements of locally defined communities.

This introduced Community Practice Workers (CPWs) and Community Links Officers (CLOs), as well as Intelligence and Volunteer Hubs. CPWs act as the motivating and enabling force, connecting people with community activities, services, social networks and volunteering opportunities. This is done through helping individuals to plan, confidence building, and linking with CLOs to identify local support.

The efforts of this scheme could be extended to support integrated case management and community based services to imbed it within the new operating model. There is also scope to re-locate CPW and CLOs into Community Well-being centres to further facilitate integration of prevention and early intervention services.

Integrated falls prevention (phase 1)

Work is already been done around creating a multi-agency community-based falls service commissioned by Public Health and 256 monies. Planned activities of the scheme include:

- Telephone/web-based self-referral
- Falls Information and advice
- Multifactorial falls risk identification and prevention
- Post fall assessment and support
- Care home and general social care training

Phase 1, which is currently in the development stage, is primarily focused on piloting the service to target those most at risk of falling. It is planned that, if phase 1 proves successful the service will be expanded backwards across risk groups to first cover those at moderate risk, and then low.

In order to accelerate delivery of phase 1, an integrated and clear governance structure to improve reporting and accountability is required. There also needs to be a robust strategy around community-based up skilling and recruiting the required specialist staff.

Live Well

This scheme is currently operating and is primarily focused on providing patients with LTCs with psychological help and support in managing their health needs. This initiative is proving to be an effective way of helping people manage complex LTCs, improve quality of life, reduce anxiety, frustration and depression caused by these conditions and encourage self-management. Overall patients are able to remain independent for longer and there is also associated reduction in of hospital admissions.

Currently the scheme is being piloted in a single locality. In its current operation, patients attend one clinic session in their own GP practice, after which they take the manual home and complete the week-by-week sections with telephone support from trained Healthy Minds staff to help.

There are plans to roll the service out into all localities and to extend the services to include dietary and exercise advice, tie more closely with Prevention matters for signposting and information sharing, and develop more disease specific interventions. There is also discussion around developing an official live-well work force development program.

As there is keen buy in from all interested partners and the governance structures around the scheme are relatively straightforward, there is no reason to see why the planned service extension and rollout cannot be realised.

3.3.7 What is the current level of spend in this tier?

Model tier	Example services	BCC budget	CCGs budget	Total Budget in s
2. Early intervention and prevention	Prevention Matters, dementia advisors, meals, wheelchair service, chronic pain and fatigue management, Supporting People, telecare, equipment	5,289,470	5,424,685	10,714,155

The current services which are operating in this part of the model are:

- Prevention Matters
- Housing
- Community Links Officers
- Buckinghamshire Community Foundation
- Integrated Falls Prevention
- Telecare/Telehealth
- Older People MH workers

Primary care also plays a lead role in this tier. The spend on primary care is currently out of the scope of this project. However, the successful delivery of the integrated model relies on full engagement with primary care professionals, and alignment with the joint primary care strategy which is to be developed over the next few months.

3.3.8 What are the key activities for this tier to develop the strategic business case?

- Understand and define target populations within this tier to tailor prevention offer
- Assess the current MAGs projects to identify opportunities to optimise service
- Map current community capacity to support low level intervention and prevention programs
- Model the demand for interventions such as telecare, equipment and housing adaptations
- Work with DCs and RSLs to discuss potential to create homes for life scheme
- Develop design principles of the operating model for this tier – how much do you lead locally versus centrally
- Design specification for integrated prevention and early intervention model

Key points for Prevention and Early Intervention

- Currently, less than 10% of in scope spend is within this tier
- There has been good progress to date in implementing initiatives in this tier of the model – examples include Live Well and Prevention Matters
- Evidence indicates that focusing effort in this area can have a measurable positive impact on outcomes
- Successful implementation of this tier will manage demand to prevent people from requiring more complex or crisis services

3.4 Rapid response and reablement

3.4.1 What are the objectives of this tier?

- Coordinate services to support the avoidance of attendance and admission into hospital in the event of a rapidly escalating level of health or social care need
- Coordinate services to facilitate the discharge from any bedded facility within the pathway as quickly as possible to reduce bed and excess bed days and improve outcomes for patients
- Coordinate and deliver time-limited intensive support at home or in a community facility setting to maximise independence and enable service users to resume living at home safely in a time efficient manner
- Deliver a pathway across all settings to ensure seamless, risk managed care, with reduced duplication of assessment, diagnostics and enhanced communication
- Provide a single ongoing point of contact and signposting for service users and carers for up to 6 weeks

3.4.2 Who is this tier for?

Tier 3 is for any adult within the community who is experiencing a health or social care crisis and/or requiring a period of reablement. These services will help to ensure a rapid and appropriate response is administered to avoid unnecessary admissions to hospital and long term care and/or delayed discharges from hospital. These service users would include:

- Older people whose escalating health needs have reached a critical state and require intervention
- Adults who are based in the community with above threshold health and social care needs, but do not currently require long-term care interventions
- Adults admitted A&E or the acute, who will require formal reablement services to regain their functional and psychological independence
- Adults admitted to A&E or the acute, who do not require reablement but could benefit from some lower level support to settle them back at home

3.4.3 What are the key components of this tier?

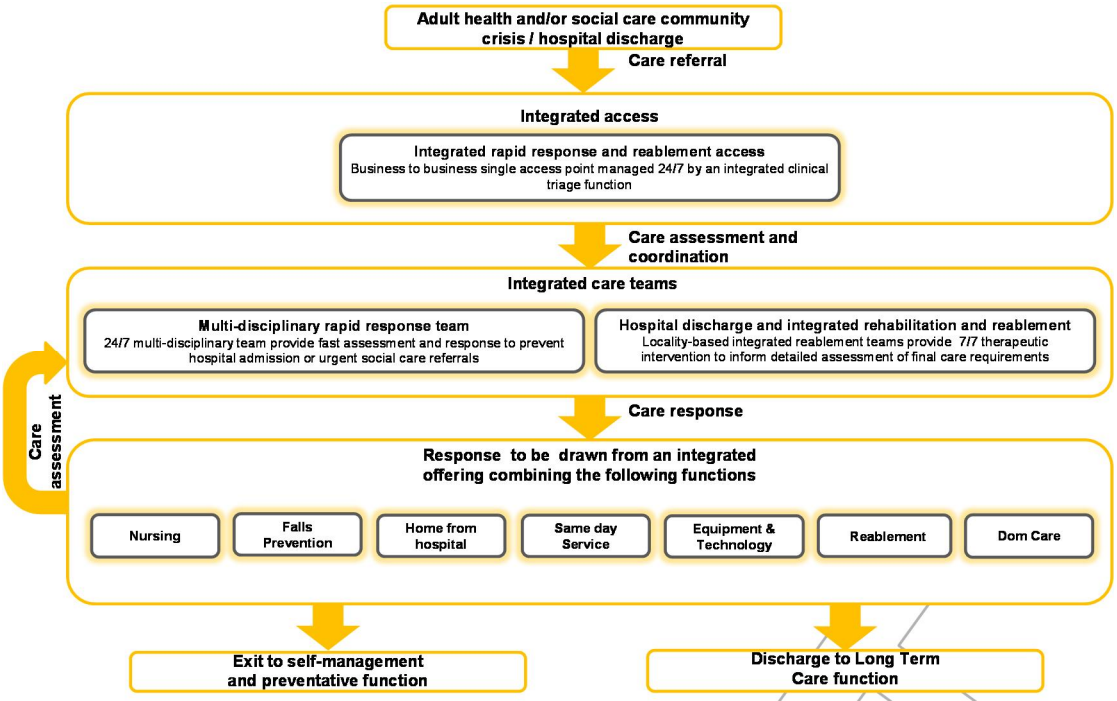
This tier comprises two key components:

- Rapid response
- Preablement
- Reablement

Rapid Response can be defined "as a situation which would result in admission to an acute or residential bedded facility within 24hrs if support is not provided to the individual".
Preablement is the maximisation of an individual's fitness and recovery potential prior to receiving planned surgical intervention. It is provided to in the community to individuals who have been referred for surgery and who will benefit from support to increase their levels of health and fitness so that their recovery period is minimised and they are able to regain equal, if not better function following their procedure.

Reablement can be defined as the provision of short-term health and social care intervention to maximise the independence of individuals who:

- Are medically fit to be discharged from hospital
- Are safe to be discharged from Rapid Response
- Are experiencing an increased level of need which would not require admission to an acute or residential facility



The suggested pathway to access these services:

- Professionals contact a single point of access to refer individual's for the service
- Cases assessed as routine are referred into the integrated reablement team
- Cases requiring as urgent are referred in to the multidisciplinary rapid response team
- Where required, closed urgent cases are referred back to the access point for a routine reablement assessment

Both components will be accessed and coordinated via a central, single point of access (SPA), operating extended hours Mon-Sun to provide a consistent response to requests for support. Referrals to the hub can only be made by professionals who will be required to state which response (Rapid or Reablement) is needed.

Following referral and agreed response, an assessment will completed to establish the individual's needs and develop a personalised and multi-disciplinary package of care. This support will include comprehensive range of mental health specialities (e.g. mental health liaison).

The Rapid Response and Reablement function will be delivered by a single, multi-disciplinary team who are coordinated via one SPA for the county. Delivery may be based in localities, for operational ease. The function will manage the facility-based services across the county, and will also be responsible for discharging individuals from these facilities and keeping the average length of stay below 21days. This will ensure the facilities are used for their defined purpose.

Suggested attributes of the Rapid Response function:

- A multi-disciplinary care team which is able to use rapid care to stabilise and maintain independence
- Provide holistic response to crisis including social care, mental health and physical health for a period of up to 72 hours in order to stabilise and calm the initial crisis phase of need
- Provision can be facility-based or home-based, but will provide 24/7 support including live-in support if required
- The default assumption is that people remain in or return to their own home

The Reablement function will have a key role in supporting hospital discharge. The SPA will receive referrals for Buckinghamshire individuals from acute facilities (e.g. BHT or HWP) and therefore have dedicated resource (discharge teams) to support discharge from hospital.

Knowledge of the community resources available (e.g. community beds, services provided by the integrated community teams and voluntary and community sector organisations) will enable the

discharge teams to operate a "pull-model", identifying individuals who could be supported in a less intensive setting, and facilitating hospital discharge as soon as possible.

Hospital clinicians will identify patients who are medically fit for discharge and refer to the SPA. The discharge team within the Reablement function will be responsible for establishing the patient's ongoing needs, deciding where they will be discharged to and putting arrangements in place. The default assumption is that a person will return home. The team will operate a 'discharge to assess' model, which discharges people from hospital as soon as possible and assesses their ongoing needs in the community. This will focus on supporting individual's to self-manage and make best use of community resources.

Suggested attributes of the Reablement function:

- Offered in a range of settings in order to best meet the needs of the individual and can be either facility-based or home-based – these have been expanded below
- Individuals referred to the Reablement function will be at home or will be on a discharge pathway from an acute or Rapid Response setting
- Provide a support package combining a number of interventions in order to work with the individual to maximise their independent living ability and self-care

Reablement (facility based)	A step up or step down unit to initiate or finish a course of treatment where the frequency or complexity cannot be managed in the home (usually greater than 3 visits a day and/or high level therapy problems requiring equipment, resources and facilities), or where the service user has problems with activities of daily living, including transfer, mobility and safety. Goal is to initiate, maintain and complete a programme of therapy so the service user can return home with maximum functional capability. For people who no longer require skilled nursing input above the level that can be provided by a community team, but do require an ongoing period of rehabilitation, which is not necessarily a social care need, and whose care needs and / or personal circumstances mean that they cannot yet be supported at home. These are primary care-led beds, with nursing and therapy input from an integrated multi-disciplinary team. Delivered by an integrated health and social care reablement team based in the with clear links to other pathways, processes and organisations Essential criteria: • Service user requires low level of nursing input. • Care level cannot be managed via home-based support. • Medical care to be provided by primary care when required • Interventions to be provided by OT's, physiotherapists or therapist technician once or twice per day. • Health or social care needs that can be delivered by a multidisciplinary team Some facilities may also provide intervention in a specialist setting e.g. physiotherapy gym for those individuals receiving home-based reablement

It is likely that there will be four facility-based reablement centres across Buckinghamshire, and that where these are established they will also fulfil the purpose of the Community Wellbeing Centre. This may involve re-commissioning of existing Community Hospital estate, but where these are not fit for purpose, commissioning of suitable facility-based provision in alternative locations, such as a care home. The detailed operating model for this Tier will take into account and appraise options for facility-based reablement within each district and develop an appropriate model and specification with which to commission these.

Reablement (home based)	The service aims to initiate, maintain or complete a course of treatment or short-term intervention that requires supervision, but where a person can be safely supported at home. The goal being to maximise independence whilst minimising dependency on ongoing services. Individuals will receive a single assessment from a member of an integrated health and social care reablement team with clear links to other pathways, processes and organisations. They will remain under the care of their own GP The integrated reablement services will secure and coordinate a comprehensive range of functions in the community focused on promoting self-care, rehabilitation and independent living e.g. from small therapeutic interventions to intensive support from Multi-Disciplinary teams. Essential criteria: • Care level same as for facility-based service, but where support needs can be met in the home environment. • Individual monitoring infrequent (e.g. three times a week or up to three times a day) • Staffing ratios dependent on individual service user need and capability of the individual and their carer

3.4.4 What is the evidence for this tier?

The below evidence is from similar models of integration that are expanded upon in more detail in section 4.3:

- Creating a reablement function with a single point of access in Greenwich was associated with 7% reduction in admissions to care homes per annum, and an estimated 150 A&E admissions avoided per quarter. Additionally, 64% of first time referrals to reablement require no further services after completing the pathway. These impacts could sum to £9m of potential savings in Buckinghamshire
- Northamptonshire Integrated Care Partnership Frail and Elderly Programme, designed around 75+, comprised multi-disciplinary crisis response and reablement teams, geriatrician led interventions, coordinated crisis response and a home from hospital discharge planning. This resulted in reductions of 10% in social care dependency, 30% in A&E admissions and 44% non-elective acute admissions. A similar initiatives in Buckinghamshire, could save £6m per annum
- Joint commissioning and provision of community health and social care services in Torbay created a 33% reduction in the number of occupied beds over a 10 year period. If similar initiatives were adopted in Buckinghamshire there would be potential benefits of £16m per annum
- The WELC initiative, designed to co-ordinate and deliver targeted care in the most appropriate setting to very high risk, high risk and moderate risk elderly patients, and people with LTCs and mental health problems. A like scheme could deliver £9m in benefits, through a 20% reduction in non-elective admissions

3.4.5 How could these components be deployed in Buckinghamshire?

- Extension of working hours of service of all rapid response and reablement services so that they are available (to a required level) 24hrs/7days, and agree referral protocols to enable professionals from any health or social care organisation to access the service on behalf of individuals in need

- Design a new, world class Rapid Response and Reablement model

    - Agree design principles which will govern the development of Rapid Response and Reablement Services throughout the county, to strategically manage the function and

coordinate local development and specification to allow for local variations but consistent quality of offer and impact management across the county

- Create a specification for a single, co-commissioned Rapid Response and Reablement service which will deliver the entire pathway. This will require contracting and commissioning a single, new, integrated service which supports the entire Rapid Response and Reablement pathway

- Informed by the design principles for the new Rapid Response and Reablement model, review the Community Hospital estate for its suitability to develop Community Well-being centres offering bed-based reablement services, and consider alternative options for bed-based facilities elsewhere in Buckinghamshire (i.e. if Community Hospital estate is not fit for purpose or is not available in a locality) such as procurement of beds in private care home facilities

- Explore options for joint development and procurement of reablement facilities in order to capitalise on elements of partnership working e.g. VAT concessions for BCC compared to NHS, grants which one partner can draw down which may not be available to the other

- Agree and implement new discharge process

  - Adopt a "Discharge to Assess" model e.g. to enable people to be discharged from a hospital setting as soon as is clinically possible and back to their home environment in a timely manner and supported in their own home. A small percentage of people will not be eligible for reablement but will also be unable to return home with their previous support arrangements e.g. prior support arrangements have broken down or are unavailable; or a significant change/increase in need. Most of these people will be able to:
    - Return home for a further assessment of their needs to be carried out whilst being supported up to 24 hours a day; or
    - A transfer to a reablement bed may be more appropriate

- Implement "Pre-ablement" to support people who have planned medical episodes, to maximise pre-operative fitness and subsequent recovery, and to plan for discharge

3.4.6 What are the current projects supporting integration of components in this tier?

Adult Community Health Team (ACHT) review

The ACHT was subject to a review in 2013, which recommended the following developments for the service:

- Service specification should articulate quality of care outcomes
- Out of hours capacity to be increased
- Productivity to be consistent and increased to match national average for nursing
- Aim to work more closely with social care
- Primary care and community teams need to ensure good communication all the time
- Need to introduce technology to support mobile working
- Devote a greater level of resource to supporting Buckinghamshire patients at Wexham Park Hospital

A project to act upon the recommendations has been initiated. The project will be delivered through a staged approach in order to design and implement changes to the ACHT function which will deliver improvements in the short-term, while a second stage will be delivered in conjunction with the wider Integrated Care programme in order to ensure that the current ACHT resource is included in the design of the future model of integrated care, such as the development of integrated locality teams and integrated reablement function.

Crisis response access point

This scheme focuses on a new way of working to better coordinate access to current Crisis Response services by providing a single point of access in each locality for a joined up response from both health and social care to both crisis and out of hours care. This will be supported by clear and concise supporting communications and material to clarify if and when crisis response support is required.
In the event of a crisis in or out-of hours, a clear access pathway for GPs will reduce the likelihood that other, potentially more expensive, services are inappropriately contacted (i.e. 999 or A&E). It will enable timely assessment of an individual's care and support needs to stabilise a crisis, preventing people falling into a worsening health and avoiding unnecessary hospital admission, and reduce duplication of initial enquiries, referrals and effort across crisis response type services, and across health and social care reablement services.
The new way of working offers a cost effective solution to facilitate integrated working across a number of service providers to ensure effective support in a crisis in and out of hours, and is especially important to support frail elderly people and reduce the number of inappropriate ambulance journeys, visits to A&E, and admissions to hospital and care homes. Ensuring its success will help to deliver a number of key integration aims including reducing inappropriate admissions and duplications of efforts across health and social care, which can be built upon as the wider integrated model is developed.

Home from hospital (HfH)

The existing HfH service has run successfully and autonomously for 6years and supports people in their homes post- planned hospital discharge. The service comprises low level follow up support services at least twice in a two week period.

It is based in Stoke Mandeville A&E, commissioned by BCC and provided by Red Cross 365 a year (except Christmas & Boxing Day) and provides support to individuals who have presented at A&E and following treatment are discharged home, with no requirement for statutory care, but who are likely to need support to settle back at home due to the unavailability of an informal support network.

There are plans in progress with the provider to expand the service under a 1 year pilot to offer transport to these individuals during evenings and weekends when patient transport is less available to avoid inappropriate readmissions, and ensure they are settled at home on arrival.

There are proposals to extend this service to cover discharges from Wexham Park and is also due to help provide self-funders with information, support and advice post-discharge to ensure they get an appropriate care package.

3.4.7 What is the current level of spend in this tier?

Model tier	Example services	BCC budget	CCGs budget	Total Budget in s
3. Rapid response and reablement	Hospital social work team, social work duty team, reablement, ACHT, community inpatient, MuDAS	2,684,730	24,382,613	27,067,343

The current services which are operating in this part of the model are:

- Home from Hospital
- Community Hospitals
- Hospital SW Team
- Hospital Discharge Team
- Integrated Falls Prevention
- ACHT Reablement (OT, PT, Technicians)
- ACHT District Nurses & HCAs
- Social Care OTs
- Social Workers
- Telecare/Telehelath
- Older People MH workers
- Same Day Service Domiciliary Care

3.4.8 What are the key activities for this tier to develop the strategic business case?

- Combined demand and capacity for Rapid Response and Reablement function across the county
- Develop countywide pathways and delivery framework for Rapid response, Discharge to Assess, and Reablement functions
- Modelling of combined demand and resource required and model cost and activity for how this will be deployed in each locality
- Assess the Community Hospital estate for its suitability to become Community Wellbeing Centres offering bed-based reablement services, and assess alternative options for bed-based facilities elsewhere in Buckinghamshire (i.e. if Community Hospital estate is not fit for purpose or is not available in a locality) such as procurement of beds in private care home facilities
- Explore options for joint development and procurement of reablement facilities in order to capitalise on elements of partnership working e.g. VAT concessions for BCC compared to NHS; grants which one partner can draw down which may not be available to the other etc
- Design specification for new Rapid Response and Reablement model

Key points for Rapid Response and Reablement

- Currently, 27% of in-scope spend is within this tier
- There has been good progress to date in implementing components of this tier but organisational boundaries have created barriers to progress – examples include duplication of Reablement Function in both health and social care
- There are a number of quick wins in this tier which don't require wholesale change
- Evidence indicates that a co-ordinated rapid response and reablement offer, with a clear pathway, has a beneficial impact on acute admission avoidance

3.5 Long-term care

3.5.1 What are the objectives of this tier?

- Remove the barriers that prevent effective collaboration to create a health and social care system without borders
- Shape services around a common understanding of the outcomes important to individuals
- Design end of life services to support greater choice and control in end of life care
- Reduce duplication which causes cost and delay within the system
- Establish a single approach to market management across the health and social care economy
- A more generalist workforce - up skilling of staff to better understand the roles of others in order to get optimal use of resources

3.5.2 Who is this tier for?

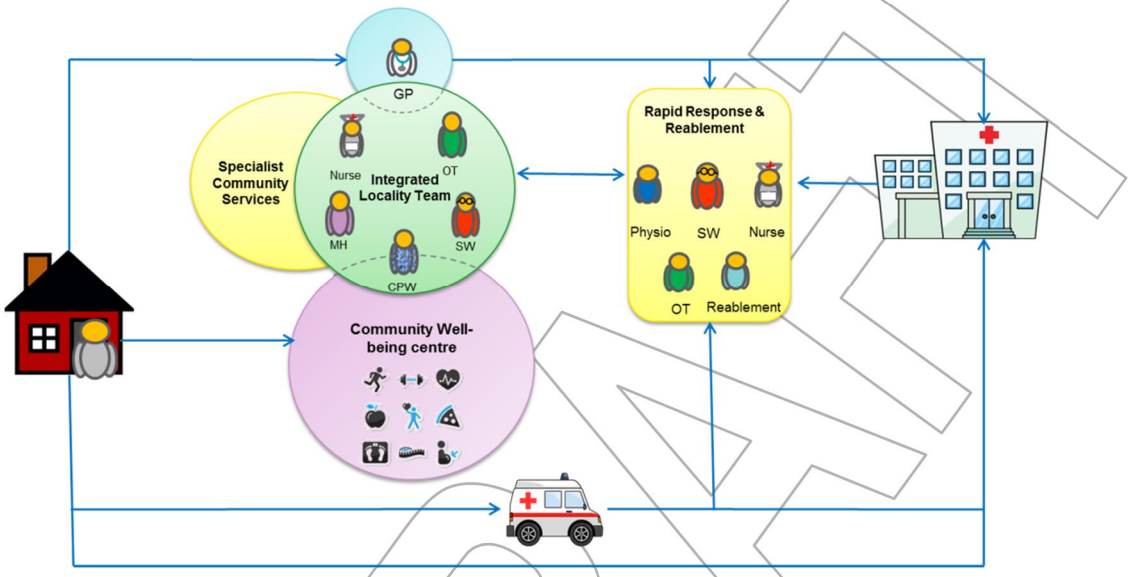
Tier 4 comprises a multi-channel access point to long term care (online, phone, smartphone app, in person), based in the Community Well-being centres proposed in tiers 1 and 2. Service users whose health and social care needs hit the threshold for long-term care include referrals from:

- Primary-care
- Hospital discharge teams
- Rapid Response and Reablement services
- Community-based Integrated Locality teams via discussions at Multi-Agency groups or through identification of need via alternative route
- Self-referrals via Community Well-being centres by individuals and carers for support directly to the locality team

3.5.3 What are the key components of this tier?

- Integrated Locality Teams
    - A single point of access within each locality for all health and social care services, which can be accessed by professionals or individuals directly if required. These could operate out of Community Well-being centres in the Living, ageing and staying well tier (i.e. Tier 1)
    - Locality-focused multi-disciplinary teams (e.g. Social care, Health, Mental Health, OTs) working across organisational boundaries, linked to clusters of GP practices, providing assessment, direct intervention, and coordination of indirect intervention to individuals with an ongoing need
    - Linking in with the Prevention and early intervention tier (i.e. Tier 2), prevention workers embedded within Integrated Locality teams to raise awareness of local community networks and 3rd sector/voluntary organisations to empower people to take control of their own lives and maintain their health and independence - making best use of community resource and reducing the need for statutory health and social care services
    - Multi-disciplinary case management function, with a Lead Professional who coordinates (and may deliver) intervention to provide personalised support (integrated health and social care services) provided in conjunction with specialist community services
    - Single assessment format accounting for an individual's holistic needs - mental, physical, environmental and social needs - used by all professionals, which is recorded in a shared electronic record
    - Use of a risk stratification tool to proactively identify individuals whose needs may be at risk of escalating and proactive case management to support those individuals
    - Embedding Social Prescribing into the roles of health and social care professionals, to help practitioners work in collaboration with individuals to select and make referrals to community based services to address the wider social and lifestyle aspects of their life. The tool helps practitioners understand the social context in which people live their lives, which often determines their health and wellbeing
- Joint commissioning of placements
    - Default position should be that individuals are supported to stay living at home
    - Develop a joint Market Position Statement and joint Commissioning Strategy
    - Implement a new process for procuring placements, including the development of a new jointly 'approved list' of home care, residential and nursing care providers, with a joint fee framework
    - A joint commissioning and procurement team to oversee all health and social care commissioning and spend in Buckinghamshire
- Integrated End of Life Care
    - Default position is that individuals should be supported to die at home or in a place of their choosing

- Outcome-based, co-designed integrated health and social care pathways based on the needs of patients and carers for all end-of-life care for people with all types of long term conditions
- Transformed service design and delivery focused on the patient and outcomes along an integrated pathway, not on individual providers
- Better quality of care and greater choice in End of Life Care, to increase the number of people who are able to exercise a positive choice about their place of death.
- Encourage people to discuss death and dying to increase understanding and reduce the idea of death and terminal illness as a lonely and stressful experience, both for the person who is dying and for their friends and family. Encouraging people to talk to their family and friends about dying will make it more likely that people will plan for their deaths and die as they wish to. Share this information across the various organisations involved in individual's care
- Delivered in partnership with the voluntary sector, health, social care and patients in commissioning services and to embed a collaborative approach to put patients' needs and outcomes first



The intention is that the Community Wellbeing Centres will, as a minimum, fulfil the function of:

- Providing a focus in each district from which to coordinate health and social care activity detailed in each Tier of the model
- Host integrated locality teams which will be allocated to particular geographic localities
- Providing a location for facility-based Rapid Response and Reablement services (however, it is recognised that the existing Community Hospital estate may not be fit for this purpose, and an alternative location for this provision may need to be sought)
- Host Reablement teams which will provide community services covering particular geographic localities

3.5.4 What is the evidence for this tier?

The below evidence is from similar models of integration that are expanded upon in more detail in section 4.3:

- The multi-agency prevention and intervention scheme implemented in North West London realised 30% reductions in A&E admissions and 15% reductions in unnecessary admissions to the acute. Introducing a similar program could deliver benefits of £9m per year in Buckinghamshire
- Northamptonshire Integrated Care Partnership Frail and Elderly Programme, designed around 75+, comprised multi-disciplinary crisis response and reablement teams, geriatrician led

interventions, coordinated crisis response and a home from hospital discharge planning. This resulted in reductions of 10% in social care dependency, 30% in A&E admissions and 44% non-elective acute admissions. A similar initiatives in Buckinghamshire, could save £6m per annum
- Joint commissioning and provision of community health and social care services in Torbay created a 33% reduction in the number of occupied beds over a 10 year period. If similar initiatives were adopted in Buckinghamshire there would be potential benefits of £16m per annum
- The WELC initiative, designed to co-ordinate and deliver targeted care in the most appropriate setting to very high risk, high risk and moderate risk elderly patients, and people with LTCs and mental health problems. A like scheme could deliver £9m in benefits, through a 20% reduction in non-elective admissions

There is also evidence that psycho-educational interventions for family caregivers of older adults, such as information on the care receiver's disease and available resources and services, and training to respond effectively to disease-specific problems have shown significant improvements in caregiver burden, depression, subjective well-being and perceived caregiver satisfaction (Sorensen, Pinquart & Duberstein, 2002)

3.5.5 How will these be deployed in Buckinghamshire?

- Integrated Locality Teams

    - Agree the functions of the integrated team and review and analyse the combined capacity of the existing supply of these functions against the demand across the county (e.g. Social Worker, ACHT, Mental Health HR establishment) to understand activity and resource across the county

    - Agree design principles which will govern the development of the Integrated Locality Teams throughout the county, to strategically manage the function and coordinate local development and specification to allow for local variations but consistent quality of offer and impact management across the county

    - Create a specification for a single, co-commissioned Integrated Locality Team service provider which will deliver all specified functions. This will require re- commissioning existing ACHT/Social Work and Mental Health functions and selecting a commercial model which best delivers the desired outcomes

    - Co-locate and develop a more generalist, multi-skilled workforce to gain the most from the existing workforce and to help close gaps where recruitment and retention challenges exist. This could operate out of the Community Well-being centres in the Living, ageing and staying well tier of the model (i.e. Tier 1). Over time the locality model will seek to develop a multi-skilled workforce which could mean, for example:
        - A practice nurse rotating through the district nursing team
        - District nurses undertaking elements of social care
        - Social workers undertaking some aspects of mental health work

      This more generalist, multi-skilled workforce will expand the capacity of locality services to care for individuals, drawing on specialist skills as required.

    - Develop an integrated assessment tool which integrates practitioner assessments, providing a holistic picture of an individual's needs to provide suitable information to facilitate delivery of integrated services. This will reduce duplication, the burden on those being assessed and provide an overall better experience. The assessment will include common components that can be used by any health and social care practitioner whilst recognising there will remain elements which are a specialist area for a particular professional.

    - Care planning will be personalised, empowering and support the individual by providing clear information on the resources available so that people can plan for themselves with support from family, carers, friends and peers. This plan will be holistic, exploring the individual's health and well-being needs (e.g. they will still continue to access and receive support from sub-threshold services as well as statutory services

- Joint commissioning of placements
    - Joint analysis of data and costs to establish a baseline for a joint fee structure or pooled budget. This includes analysis of the types of placements made and other factors such as age, level of need; and the costs of different types of placement, different providers, costs for different need level and additional services etc.
    - Engage with the social care and health service provider market to secure high cost/low volume care packages. Coordinate across commissioners in terms of negotiating with providers, controlling and coordinating costs and monitoring standards and communicate with providers with regard to promoting the development of a range of services to meet service modernisation requirements and current and future demand
    - Develop a joint commissioning partnership to:
        - Rationalise the different and separate purchasing processes across health and social care commissioners into a single agreed purchasing point of contact with the provider market
        - Contribute to the management of the market by establishing a cost base line for differing levels of need, minimising negative competition for placements and preventing inconsistent cost outcomes between purchasers and providers
        - Deliver a cost saving or cost avoidance for new placement activity
        - Feed into and shaping the wider collaborative, partnership working and modernisation of commissioning approaches.
- End of Life Care (EoLC)
    - Aim for integrated cross-boundary care by developing strategic partnerships between health and social care, HWB Boards (to include all aspects of health and social care) and voluntary/third/ independent sector and ensure agreed outcomes and alignment of goals, shared funding, service specifications and means of practical collaboration
    - Ensure that EoLC is considered as part of four other key areas of care: reducing hospitalisation, long-term conditions and care for the elderly, frail and those with dementia and join up and overlap commissioning and procurement to ensure seamless service delivery
    - Co-design and co-commission complete end of life pathways, including a fully developed Out of Hours End of Life Care function and rapid access to services including 24/7 community services, and which will achieve the following outcomes:
        - 'Demedicalise' aspects of end of life care
        - Avoid crisis situations such as a breakdown in carer support
        - Enable a patient to remain in their preferred place of care
        - Avoid inappropriate hospice or hospital admissions
        - Allow rapid discharge home from hospital / hospice to support preferred place of care/death
        - Care after death is sensitive and responsive to the cultural and spiritual needs of the deceased and their families
        - Shape market capacity to deliver end of life care
    - Implementation of a single assessment process and a shared budget for provision in order to accelerate provision of support packages, equipment and an alternative place of care at the end of life within 7 days at the longest
    - Improve the use of end of life tools to increase identification of patients who are in the last year of their life, increase the number of people who are given the opportunity to plan their care in advance, improve co-ordination of care, and further develop community based services

- Engage with local communities to develop an awareness campaign that aims to break down taboos and encourage people to talk about their wishes towards the end of their lives, including where they want to die and their funeral plans with friends, family and loved ones

- Commission training on advance care planning for health professionals in primary care, community services and the acute sector. Ensure that each person receiving end of life care has an opportunity to make an advanced care plan. Care plans should be available to out of hours and emergency services

- Workforce development on managing patients at the end of their life, particularly in care homes; and support for delivery of wider, whole system changes (e.g. the expansion of Hospice at Home, roll-out of just-in-case bags – containing palliative medication for use with sudden or unexpected deterioration in the patient's health)

3.5.6 What are the current projects supporting integration of components in this tier?

Community Hospitals

Buckinghamshire Healthcare Trust has proposed a programme of work to develop the community hospital estate into integrated health and wellbeing centres. The community hospitals in Buckinghamshire are strategically well placed to provide hubs of community support services. The programme describes the objective to be to establish "centres where clinical specialists, social care, therapists and voluntary services are able to come together with GPs to provide a proactive, holistic service to patients that enables them to actively manage their health and wellbeing...this highly accessible, multi-disciplinary approach to population health management, centred on localities will reduce the need for inpatient admission both to specialist acute centres and community hospital beds".

This Community Hospitals programme was initiated by providers but is aligned in principle to the joint commissioning intentions, and will be brought into the scope of the Integrated Care Programme so that whole system impact, risks and benefits can be managed.

3.5.7 What is the current level of spend in this tier?

Model tier	Example services	BCC budget	CCGs budget	Total Budget in s
4. Integrated long-term care	Residential care, nursing care, dom care, community placements, palliative and end of life care, CHC, FNC, Social work assessment and case management	37,684,073	26,643,342	64,327,416

The current services which are operating in this part of the model are:
- ASC Community SW Teams
- ACHT District Nurses
- Health Care Assistants
- OTs
- Technical Assistants
- Older People MH workers

3.5.8 What are the key activities for this tier to develop the strategic business case?

- Combined demand and capacity for Integrated Long Term Care function across the county

- Agree services to be delivered on a county or locality model and develop countywide operating framework for Integrated Locality Teams to integrate the functions currently performed by the

ACHT workforce, social care staff, and OTs and co-locate these under single line management based in localities, to facilitate co-working, delivery of coordinated care and development of a flexible integrated workforce

- Modelling of combined demand and resource required and model cost and activity for how this will be deployed in each locality
- Design specification for new Integrated Care locality model
- Consider options for delivery model for integrated teams i.e. TUPE staff into one existing organisation; create new Integrated Care Organisation; commission a provider to deliver the model; joint venture with another public or private organisation
- Assess options for combining health and social care commissioning functions into one joint commissioning team in order to better manage the market, develop integrated specifications and realise potential efficiencies through headcount reduction

Key points for Long Term Care

- Currently, 57% of in-scope spend is within this tier
- This tier will require a decision on the future delivery of the largest remaining area of BCC direct provision (SW function)
- To date, there has been little progress towards implementing the components of this tier, but the Care Bill provision for externalising Social Work may stimulate this
- Assuming all tiers of the integrated model are implemented, benefits from reduced demand will be delivered in this tier, as well as in acute services

3.6 Enablers

Below is a summary of the key enablers for required across the model as a whole, and a breakdown of the additional enablers required within tiers

All tiers	
Enabler	**Description**
ICT Infrastructure	• Reliable digital advice and information • Personalised response to service user enquires • Tailored data access levels for professionals, service users, providers and commissioners • Interoperability of systems between organisations • Real-time availability of community assets, resources and capacity
Stakeholder engagement	• Appetite to upscale resources to support whole system integration • Robust communication and engagement strategy with residents and other key stakeholders
Workforce development	• Knowledgeable frontline staff for signposting and delivery of integrated services • Optimal skill mix across integrated services and within Multi-Disciplinary teams • Single line of management to co-ordinate and reduce duplication • Flexible, community-based skills and capabilities • Indirect clinical and professional supervision arrangements

	• Bridge organisational or cultural divides
Community assets	• Map community-based resource, skills and capabilities • Consolidate community assets within Community Well-being centres • Build community capacity via development of voluntary services and residents
Information sharing	• Real-time information sharing for professionals and users of services • Clear and robust agreements around information governance to support integrated IT systems
Shared governance	• Shared governance to embed integration at the heart of services • Robust reporting lines to ensure good oversight • Clear lines of accountability and decision-making for timely sign-off
Performance monitoring	• Stable and measureable performance indicators • Proactive monitoring of the success of initiatives • Reliable health and wellbeing indicators from an earlier age • Quality and safety standards embedded within performance monitoring
Financial investment	• Agreement from partners to secure the funding • Ongoing commitment from partners to lever additional funding • Pump priming of initiatives to manage demand

1. **Living, ageing and staying well**	
Enabler	**Description**
ICT Infrastructure	• Virtual well-being networks • Digitalisation of health promotion and self-management initiatives
Workforce development	• Technical skills of frontline staff to support virtual well-being networks, digitalisation of health promotion and champion the digital service offer
Financial investment	• Fund local voluntary and community organisations, groups and activities

2. **Prevention and early intervention**	
Enabler	**Description**
ICT Infrastructure	• Virtual prevention and early intervention networks • Digitalisation of health promotion and self-management initiatives • Digitalisation of prevention support and advice • Reliable and accessible risk stratification tool
Routing and pathways	• Customer facing access and assessment function to co-ordinate and navigate services • Streamlined end-to-end pathways across services • Coordinated 'routing' of patients to the right service
Workforce development	• Understanding of available services within prevention access point • Technical skills of frontline staff to support virtual prevention networks, digitalisation of early intervention and self-management and champion the digital service offer • Technical skills of primary care to interact with risk stratification • Improved brokerage of available services

3. **Rapid response and reablement**	
Enabler	**Description**
Routing and pathways	• Professional-to-professional access and assessment function to co-ordinate and navigate services

	• Streamlined end-to-end pathways across services • Effective hand-off between rapid response and reablement functions • Robust step-up and step-down scenarios • Coordinated 'routing' of patients to the right service
Workforce development	• Clinical oversight for effective triage within integrated access and assessment function • Improved brokerage of available services

4. **Long-term care**	
Enabler	**Description**
Routing and pathways	• Customer facing integrated access and assessment function to co-ordinate and commission services • Streamlined end-to-end pathways across services • Robust step-up and step-down scenarios • Coordinated 'routing' of patients to the right service
Workforce development	• Skills to manage, advise and plan long-term care options • Educate frontline staff around end of life services • Improved brokerage of available services

3.7 Key points for decision

- Acceptance of the proposed model as the structure for the process towards implementation
- Whether to implement by tiers or by component, such as devising joint commissioning arrangements for placements before setting up integrated locality teams and redesigning end of life pathways in Long-Term Care
- Are there any components described which are 'off the table' at this time?

4. Financial case

4.1 Current financial context

The scope of the programme will cover a range of services currently commissioned or provided by BCC's Adult and Family Wellbeing Directorate, and a range of community health services that are commissioned by AVCCG and CCCG.

The following criteria have been devised to establish a baseline of services across BCC, AVCCG and CCCG that are within the scope of the programme.

Service spend is in scope if:

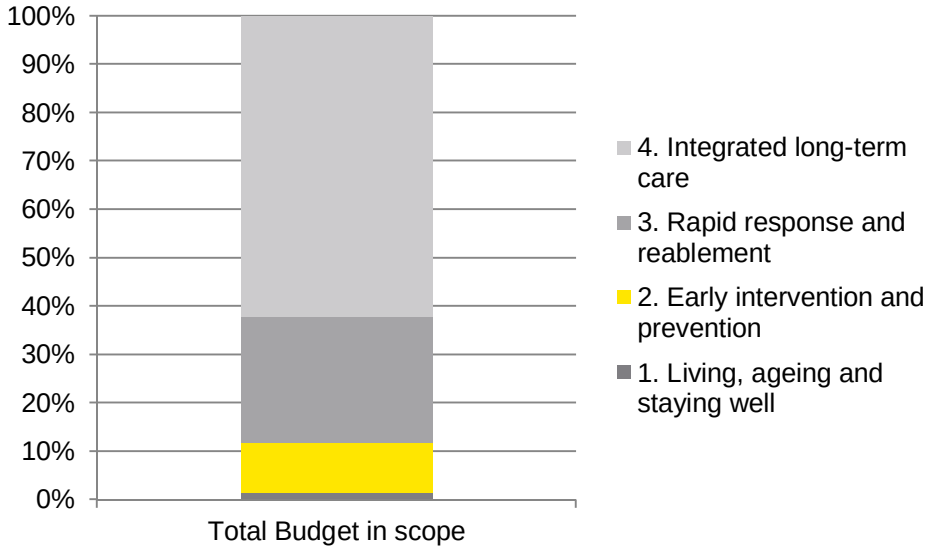
- Some or all service outcomes are shared
- Service requires input and decisions from two or more parties

Service spend is out of scope if:

- Outcomes are aligned but not dependent on others
- Service operates effectively independently of others although activity and spend may be
- impacted by changes in other service areas
- Limited overlap in service users

Services in scope have also been assigned to the different tiers of the integrated model outline in Section 3 of this business case, to give an understanding of the current resource allocation across the four tiers of care. At the moment, 52% of the total budget in-scope is spent on services in tier 4 (long-term care), whilst only 19% is spent in tiers 1 and 2 (self-management, and living, ageing and staying well).

Model tier	Example services	BCC budget	CCGs budget	Total Budget in s
1. Living, ageing and staying well	Public Health (including physical activity, dietary advice, smoking, health checks)	1,390,000	-	1,390,000
2. Early intervention and prevention	Prevention Matters, dementia advisors, meals, wheelchair service, chronic pain and fatigue management, Supporting People, telecare, equipment	5,289,470	5,424,685	10,714,155
3. Rapid response and reablement	Hospital social work team, social work duty team, reablement, ACHT, community inpatient, MuDAS	2,684,730	24,382,613	27,067,343
4. Integrated long-term care	Residential care, nursing care, dom care, community placements, palliative and end of life care, CHC, FNC, Social work assessment and case management	37,684,073	26,643,342	64,327,416
	Total		Total spend	103,498,913

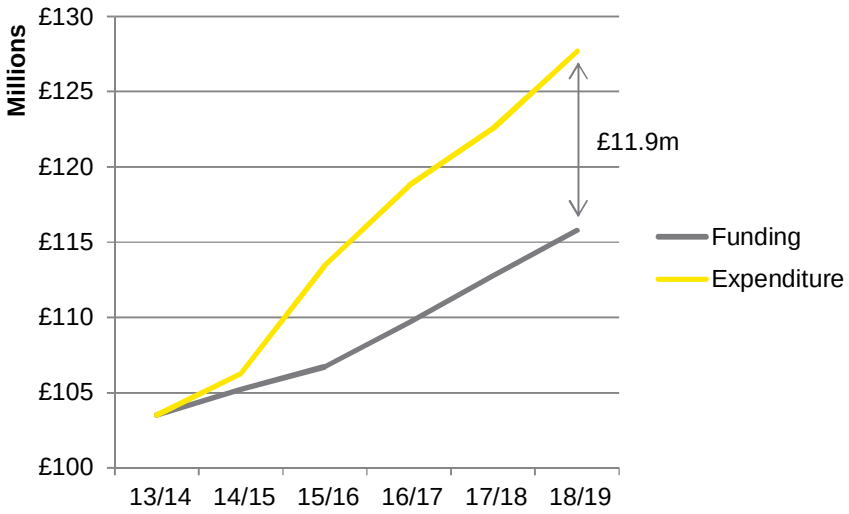


The table shows that 57% of spend in scope is currently spent on long-term care, and this does not include spend on acute services. The programme for integrated care will aim to reduce spend in this area by making investments in other tiers of the model.

4.2 Current financial gap

The following table and graph show the combined effect of the reduction in funding and projected increase in expenditure, to illustrate the possible financial gap if no action is taken until 2018/19:

	13/14	14/15	15/16	16/17	17/18	18/19
Recurrent Funding	£103,498,914	£105,196,459	£106,721,106	£109,652,811	£112,753,020	£115,776,446
Non RecurrentFunding	£0	£0	£0	£0	£0	£0
CHC (AVCCG)	-£7,966,195	-£8,540,148	-£8,922,017	-£9,423,058	-£9,684,603	-£10,262,010
Independent Sector (AVCCG)	-£510,585	-£509,417	-£518,095	-£533,345	-£534,262	-£544,469
Mental Health (AVCCG)	-£1,848,964	-£1,844,734	-£1,876,158	-£1,931,385	-£1,934,705	-£1,971,665
Reablement (AVCCG)	-£471,611	-£470,532	-£478,547	-£492,634	-£493,481	-£502,908
Community health services (AVCCG)	-£16,842,240	-£16,461,991	-£18,683,530	-£19,270,370	-£19,383,689	-£19,674,015
Other (AVCCG)	-£268,000	-£267,387	-£271,942	-£279,947	-£280,428	-£285,785
CHC (CCCG)	-£8,072,699	-£8,654,325	-£9,041,300	-£9,549,040	-£9,814,081	-£10,399,208
Independent Sector (CCCG)	-£1,002,698	-£1,000,404	-£1,017,445	-£1,047,395	-£1,049,196	-£1,069,239
Mental Health (CCCG)	-£2,003,044	-£1,998,461	-£2,032,504	-£2,092,334	-£2,095,930	-£2,135,971
Reablement (CCCG)	-£750,715	-£748,997	-£761,756	-£784,180	-£785,528	-£800,534
Community health services (CCCG)	-£16,280,889	-£16,342,887	-£19,435,000	-£21,673,150	-£23,377,709	-£25,341,632
Other (CCCG)	-£433,000	-£432,009	-£439,368	-£452,302	-£453,079	-£461,735
Adult's Residential (BCC)	-£23,039,327	-£23,993,478	-£24,473,394	-£25,085,301	-£25,787,297	-£26,560,916
Adult's Community (BCC)	-£24,008,947	-£25,003,254	-£25,503,367	-£26,141,027	-£26,872,566	-£27,678,743
Surp/ Def	£0	-£1,071,563	-£6,733,319	-£9,102,656	-£9,793,533	-£11,912,384



This analysis has been constructed from assumptions around future income and cost projections provided by BCC, and from AVCCG's and CCCG's draft five-year operating plans, submitted to NHS England on 4th April 2014. The detailed assumptions underpinning this analysis are included within the resource allocation projection spreadsheet model, at Appendix A.

The analysis indicates that the gap between income and expenditure for the services in the scope of this Outline Business Case will grow from £1.4m in 2014/15 to £7.3m in 2015/16. This is principally due to an increase in the anticipated cost of delivering community services for both CCGs, due in part to the requirement to set aside funding to deliver the Better Care Fund. In subsequent years, income growth fails to match demographic growth and cost inflation, and the annual gap increases to £11.9m by 2018/19, with the total deficit over the period being £41.0m. The assumptions used factor in the effect of QIPP and MTP savings plans, and therefore this indicates the need for all organisations to find additional savings above and beyond those budgeted for in future years, to ensure the sustainability of the local health and social care economy.

There are a number of areas of high cost, high volume activity commissioned by both BCC and the CCGs, where benefits for the programme could expect to be derived. For BCC, the key areas of high cost, high volume spend are residential and nursing care. Using data provided by the Business Intelligence team, in the 10 months to January 2014, there were an average of 607 older people in residential care, with an average weekly unit cost of £550., There were an average of 615 older people in nursing care, with an average weekly unit cost of £763 (including Free Nursing Care). Residential and nursing care packages for older people are budgeted at £23.0m for 2013/14, which equates to 41% of the value of BCC services in scope.

The Care Bill is also likely to have a significant impact on BCC finances, with recent modelling estimating the annual impact to BCC at £35.7m. This is principally due to the impact of the cost of care cap on self-funders (£10.5m) and the impact of care market price equalisation (£15.9m).

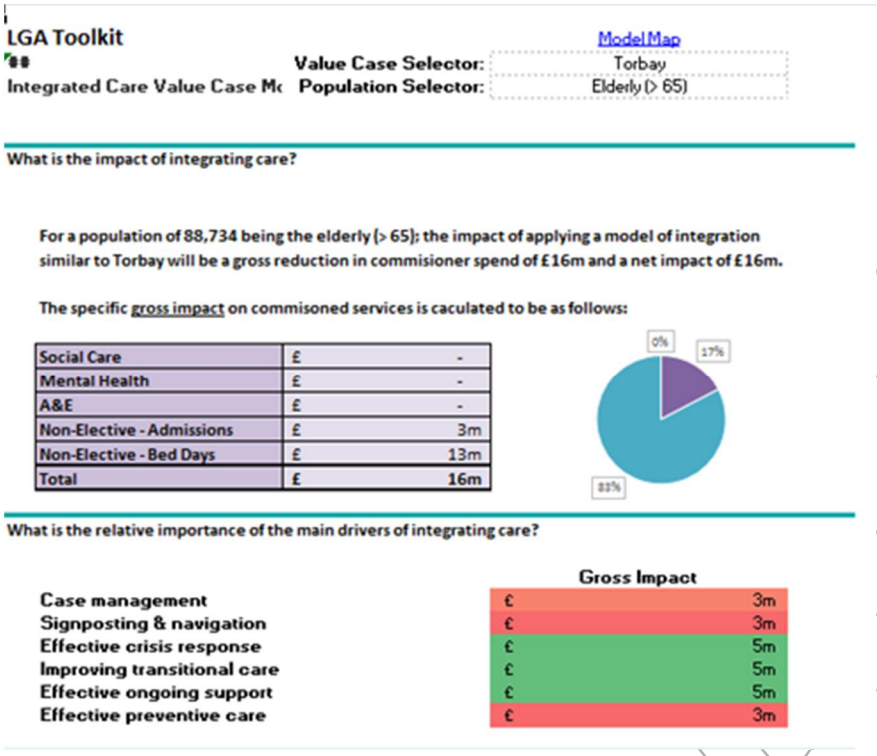
For CCG commissioned activity, the key areas of high-volume and high-cost are typically acute services, particularly non-elective admissions and treatment. Although these budgets are not directly within the scope of this programme, it is anticipated that many of the benefits from the programme will crystallise in reduced non-elective admissions and A&E activity among the population cohort. For Aylesbury Vale CCG, the highest volume acute activities in 2013/14 amongst over 65s are elective daycase gastroenterontology , with 1,287 expected admissions, elective daycase ophthalmology with 1,189 expected cases, and non-elective emergency general medicine, with 1,033 cases. For Chiltern CCG, the highest volume acute activities in 2013/14 amongst over 65s are elective daycase gastroenterontology , with 1,845 expected admissions, non-elective emergency general medicine, with 1,587 cases and elective urology daycases, with 1,449 expected cases.

4.3 Examples of interventions and indicative benefits from elsewhere

In order to understand the potential benefits of integrated care in Buckinghamshire, the programme team has used the Local Government Association's integrated care value case toolkit. The financial model included within this toolkit calculates potential impacts of integration, as defined by the Value Cases, for a given local health and care economy. The Value Cases highlighted are a set of examples of integrated care implemented in other areas across England.

The financial model applies the benefits observed in other areas, and applies them in the Buckinghamshire context, using health and social care activity data from 2013/14. Evidence for the benefits identified is provided in the Appendix.

Example 1 – Torbay



LGA Toolkit

Integrated Care Value Case Mc

Model Map

Value Case Selector: Torbay

Population Selector: Elderly (> 65)

What is the impact of integrating care?

For a population of 88,734 being the elderly (> 65); the impact of applying a model of integration similar to Torbay will be a gross reduction in commisioner spend of £16m and a net impact of £16m.

The specific gross impact on commisoned services is caculated to be as follows:

Social Care	£	-
Mental Health	£	-
A&E	£	-
Non-Elective - Admissions	£	3m
Non-Elective - Bed Days	£	13m
Total	£	16m

What is the relative importance of the main drivers of integrating care?

	Gross Impact	
Case management	£	3m
Signposting & navigation	£	3m
Effective crisis response	£	5m
Improving transitional care	£	5m
Effective ongoing support	£	5m
Effective preventive care	£	3m

In Torbay, community health and social care providers merged to form one care trust, which took responsibility for commissioning and providing community health and social care services. Care teams were focused around GP clusters, not residential boundaries, with a single point of access for each cluster. The effect of these interventions was to reduce the average length of a non-elective stay to the lowest in the South West, which created a 33% reduction in the number of non-elective bed days over a 10 year period.

If similar initiatives were adopted in Buckinghamshire across levels three and four of the model, then there would be potential benefits of £16m per annum in reduced non-elective admissions and length of stay.

Example 2 – Greenwich

LGA Toolkit

Cover | Integrated Care Value Case Mc

Model Map

Value Case Selector: Greenwich

Population Selector: Elderly (> 65)

What is the impact of integrating care?

For a population of 88,734 being the elderly (> 65); the impact of applying a model of integration similar to Greenwich will be a gross reduction in commisioner spend of £09m and a net impact of £09m.

The specific gross impact on commisoned services is caculated to be as follows:

Social Care	£	9m
Mental Health	£	-
A&E	£	-
Non-Elective - Admissions	£	-
Non-Elective - Bed Days	£	-
Total	£	9m

What is the relative importance of the main drivers of integrating care?

	Gross Impact	
Case management	£	2m
Signposting & navigation	£	2m
Effective crisis response	£	3m
Improving transitional care	£	3m
Effective ongoing support	£	3m
Effective preventive care	£	2m

In Greenwich, a reablement service with a single point of access was created out of a remodelled home care service offering, and so the interventions described apply to level 3 of the model in Buckinghamshire. The revised structure put in place includes a Community Assessment and Rehabilitation Team, Joint Emergency Team and Hospital Integrated Discharge Team, supported by specialist teams from social care, community health and mental health providers. All new contacts are referred to the Joint Emergency Team for short term stabilisation and reablement, to prevent hospital or residential care admissions.

By putting this structure in place, with the emphasis on a co-ordinated response to initial contacts through a multi-disciplinary team, there has been a 7% reduction in admissions to care homes per annum, and an estimated 150 A&E admissions avoided per quarter. Additionally, 64% of first time referrals entering the pathway require no further services after completing the pathway. In Buckinghamshire, this reduction in social care dependency could have a beneficial effect of £9m per annum.

Example 3 – Northamptonshire

LGA Toolkit

Model Map

Cover — **Value Case Selector:** Northhamptonshire

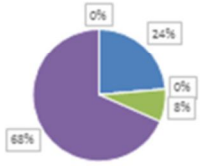
Integrated Care Value Case Mc — **Population Selector:** Elderly (> 65)

What is the impact of integrating care?

For a population of 88,734 being the elderly (> 65); the impact of applying a model of integration similar to Northhamptonshire will be a gross reduction in commisioner spend of £06m and a net impact of £06m.

The specific gross impact on commisoned services is caculated to be as follows:

Social Care	£	1m
Mental Health	£	-
A&E	£	0.5m
Non-Elective - Admissions	£	4m
Non-Elective - Bed Days	£	-
Total	£	6m



What is the relative importance of the main drivers of integrating care?

	Gross Impact	
Case management	£	1m
Signposting & navigation	£	1m
Effective crisis response	£	2m
Improving transitional care	£	2m
Effective ongoing support	£	2m
Effective preventive care	£	1m

The Northamptonshire Integrated Care Partnership (NICP) started the Frail and Elderly Programme in July 2012, aimed at patients aged 75+. Five interventions were implemented:

1. Multi Disciplinary Teams (MDTs)
2. Crisis intervention by community geriatrician led 'Crisis Response Teams' (CRTs)
3. Admission avoidance at A&E by managing the crisis response through a co-ordination hub
4. In reach service by the acute hospital geriatrician to work with the integrated area teams
5. Discharge to assess through integrated teams into the 'hospital at home' environment

By implementing a set of similar initiatives in Buckinghamshire, as is proposed within Level 3 of the Buckinghamshire model for integrated care, partners could save £6m per annum, through a 10% reduction in social care dependency, a 30% reduction in A&E admissions amongst over 65s, and reduced admissions to hospital for non-elective treatment by 44%.

Example 4 – North West London

LGA Toolkit

Model Map

Cover | **Value Case Selector:** NWL

Integrated Care Value Case Mc | **Population Selector:** Total Population (excl. Children)

What is the impact of integrating care?

For a population of 401,259 being the total population (excl. children); the impact of applying a model of integration similar to NWL will be a gross reduction in commisioner spend of £09m and a net impact of £09m.

The specific gross impact on commisoned services is caculated to be as follows:

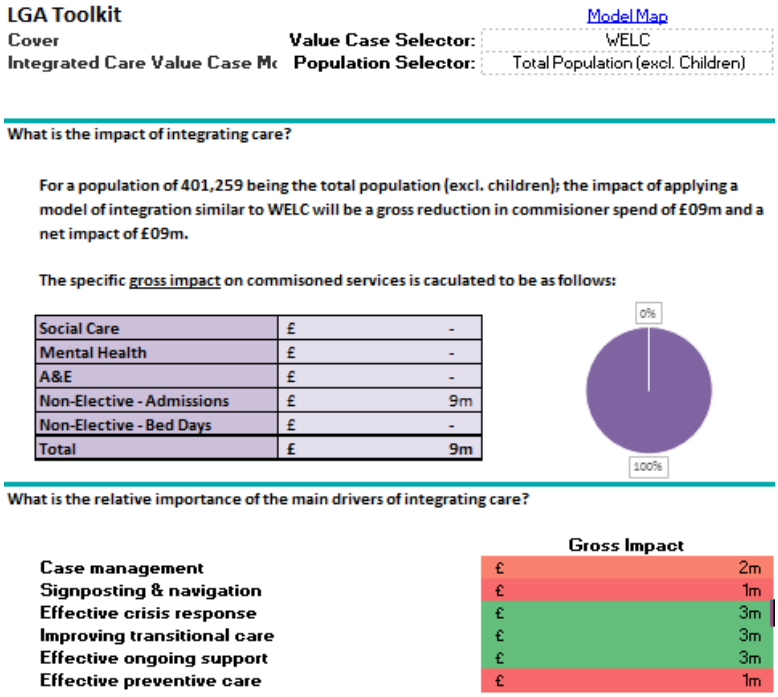
Social Care	£	-
Mental Health	£	-
A&E	£	2.2m
Non-Elective - Admissions	£	6m
Non-Elective - Bed Days	£	-
Total	£	9m

What is the relative importance of the main drivers of integrating care?

	Gross Impact	
Case management	£	2m
Signposting & navigation	£	1m
Effective crisis response	£	3m
Improving transitional care	£	3m
Effective ongoing support	£	3m
Effective preventive care	£	1m

10 local multi-disciplinary groups were formed working in a multi-disciplinary system. Groups consisted of GPs and practice nurses at the practice level, social work, community matrons and district nurses and community mental health at the locality level, and specialist acute, social care and mental health input. Seven core elements to the system include a group level patient registry, risk stratification, shared clinical protocols, care planning, coordinated care delivery, multidisciplinary case conferencing for complex patients and performance review. The offer is similar to the MAGs which currently operate in Buckinghamshire, across levels 2 and 3 of the Buckinghamshire model. The benefits of taking the MAGs approach further, as has been done in North West London, could be £9m per year in Buckinghamshire.

Example 5 – Waltham Forest, East London and the City (WELC)



LGA Toolkit

Model Map

Cover | Value Case Selector: WELC

Integrated Care Value Case Mc | Population Selector: Total Population (excl. Children)

What is the impact of integrating care?

For a population of 401,259 being the total population (excl. children); the impact of applying a model of integration similar to WELC will be a gross reduction in commisioner spend of £09m and a net impact of £09m.

The specific gross impact on commisoned services is caculated to be as follows:

Social Care	£	-
Mental Health	£	-
A&E	£	-
Non-Elective - Admissions	£	9m
Non-Elective - Bed Days	£	-
Total	£	9m

What is the relative importance of the main drivers of integrating care?

	Gross Impact	
Case management	£	2m
Signposting & navigation	£	1m
Effective crisis response	£	3m
Improving transitional care	£	3m
Effective ongoing support	£	3m
Effective preventive care	£	1m

WELC aims to co-ordinate care around the patient and deliver care in the most appropriate setting. It will target very high risk, high risk and moderate risk patients – those with long-term conditions, the elderly and people with mental health problems – and build a model of care that looks at the whole person by 2017/18. The new model provides for 9 key interventions for the population, across three areas – self-care, care co-ordination, and ensuring patients are in the most appropriate setting of care. The model also includes dementia services, which have been integrated into community teams serving the three boroughs covered by the programme. The initiatives used in WELC could be applied across all levels of the Buckinghamshire model, and could deliver £9m in benefits, through a 20% reduction in non-elective admissions.

4.4 Priority areas of investment and development of financial case in Strategic Business Case

The financial case within the Strategic Business Case will take forward the analysis presented in the Outline Business Case, and develop a detailed demand and capacity model to illustrate in further depth the current activity and financial flows within the system, and provide detail as to the investments and disinvestments across the system that will be required to shift activity as commissioners desire. This will specifically need to address the capacity required in acute care to understand whether it is possible to reduce activity by 15% for the population of Buckinghamshire, and whether, taking in to account the demographic challenge, this volume of transfer is tenable. This analysis will also include further detailed analysis of acute spend and activity, which is not within the scope of this programme, but is likely to be impacted significantly as a result of the interventions proposed, to ensure the impact upon the rest of the system and the stability and viability across the whole. The new model is predicated on an assumption that delivering services in a community setting is has greater benefit than if delivered within an acute setting, but this assumption will need to be challenged and modelled within the benefits case.

In addition the detailed demand and capacity modelling undertaken as part of the SBC process, will identify the level of funding which can be released over short and longer periods of time in order to pump prime the initiatives described to deliver the new model. This will range from driving out efficiencies within existing service provision to the realisation of medium and longer term benefits derived as a result of implementing the new model.

The Strategic Business Case will also seek to use partners' input to determine the level of investment each party is prepared to make into the in-scope services, as well as further analysis of the schemes identified in section 4.3, to determine indicative levels of investment from other areas. The whole system cost and benefit will be modelled in order for all partners to understand the investment model required and the level of joint funding to be committed, both in the transitional phase and the future state.

It will also be necessary to include activity and spend from functions such as Housing, including the fitting of equipment, and certain areas of District Council spend, such as DFGs and gyms, to build a complete picture across all tiers of the model.

In order to progress the financial case within the Strategic Business Case, and to support the construction of the detailed model, further capacity and demand data for the services in scope, as well as acute services, will be obtained. A strategic planning tool, allowing for analysis of capacity vs. demand across a care economy will be utilised. This will link the impact of changes in demand, cost and volume across systemwide commissioners and providers and provide an output for the economy which will support decision makers to think strategically across organisational boundaries and answer the question "if we were all one organisation, what would the best strategic option be?"

Based on the analysis included within this Outline Business Case, spend is concentrated in the top two tiers of the model, with 81% of total spend in scope. A consistent message presented through the Integrated Care Value case studies in section 4.3 is the effectiveness of a co-ordinated reablement or crisis response service with a single point of access, as was implemented in Greenwich, Torbay and Northamptonshire. This is a key component of tier 3 of the Buckinghamshire model – Rapid Response and Reablement – and partners may therefore view this as an appropriate initial priority area for investment. Assuming benefits from this intervention correlate to the benefits found by applying tier 3 interventions in Grewnwich, Torbay and Northamptonshire, there is the potential to generate between £6-16m of benefit in Buckinghamshire, and if the benefit achieved is in the upper end of this range, this would be sufficient to close the potential funding gap which has been identified (taking into account QIPP and MTP), before considering the implications of the Care Bill. The Strategic Business Case will also consider capital costs, particularly in respect of community hospitals. Although partners may not wish to make additional capital investments, there is a need to make better use of the capital estates the organisations currently utilise.

4.5 Key points for decision

- Acceptance of the programme scope and grouping of services across the tiers of the model
- Agreement of assumptions underpinning future income and expenditure projections
- Agreement of indicative benefits derived using LGA value case toolkit financial model

5. Commercial case

5.1 Options for a new contracting model

Currently, services within scope are provided through a range of commissioned and directly delivered arrangements.

The successful integration of services will require a system change which depends on the development of new delivery arrangements. It is to be expected that a significant number, if not all, existing delivery arrangements will be reappraised and new arrangements be implemented. These decisions will be based upon the commissioner appetite and ambition for integration at each tier of the model, and may encompass a combination of different arrangements which fall along a spectrum towards integrated delivery:

This section describes the high level structures (i.e. which could fit a number of different configurations/variations within that setting), spanning across the entire spectrum (i.e. traditional delivery of services in-house, through to complete outsourced solutions). For example, the delivery model *Providers merge but not into a single entity*, could have a *Prime partner/provider* configuration or an *Alliance* between the partners or have only a *Joint management structure.* This sub-section is intended to provide a structured evaluation of approaches that could be adopted rather than an exhaustive analysis of every conceivable model.

Through the SBC process, each option will need to be assessed against a set of criteria to understand the implications of each in addressing the issues/opportunities for improvement identified in the current delivery model. A summary of each option including the main characteristics, benefits and dis-benefits are included on the next two pages.

Delivery model	Characteristics	Benefits	Dis-benefits
Option 1: Current status quo – with reconfigured services	• Existing provider landscape with some reconfigured services Can be underpinned by Section 75 • Jointly funded and managed by partner organisations • Partner organisations remain separate statutory bodies • Supported by shared infrastructure, e.g. co-location and shared IT/ assessment processes • Multi-disciplinary teams, enabling coordination around a specific care pathway	• Relatively easy to gain partner sign up • Low political risk • Maintains competitiveness in the marketplace, which could reduce costs • Builds on well-established partnership arrangements and organisation infrastructures • No increase in transaction costs • Retain separate statutory bodies – autonomy and identity • Each organisation could potentially adapt more quickly (due to established decision making environment) • Exit strategies are easier to implement • Skills and capability – specific expertise throughout the care pathway	• Sharing information can be difficult - Information governance is complex • Does not align organisation and system goals and therefore little opportunity to remove duplication • There would be limited incentives to change and improve cultures within the partner organisations • Lack of right incentives in the system to drive step change in moving balance of care from acute to community and delivering efficient care provision • Retains all organisation overheads and management costs. Limited ability to deliver the cost benefits of integration • Requires alignment of strategy and vision among partner organisations. This could be complex and difficult to achieve • Difficult to re-allocate and distribute funds to providers

This option does not necessarily drive the focus away from an organisational model of care to a person-centred one, as existing organisational boundaries still exist. In addition, it does not involve radical change to the current service model and therefore offers limited cost saving and embedded cultures in place and unchallenged. There is a risk that the experience of individuals would not improve because this option would not result in a seamless customer experience.

Which tiers of the model would this delivery vehicle suit?

This type of delivery vehicle will be effective during a transitional phase as the integrated model and new ways of working are developed. This is the type of model which has been used in the North West London pilot, which has improved outcomes and delivered quantifiable savings, but it relies on significant cultural change within existing organisations if it is to overcome the barriers that may prevent the sustainable, transformative change required in the long term.

Delivery model	Characteristics	Benefits	Dis-benefits
Option 2: Providers services integrate but not into a single entity	• Formal partnership arrangement, usually underpinned by section 75 • Focus on coordinated service delivery in a range of areas • Overseen by integrated Board, but local partners remain accountable for individual functions • Supported by shared infrastructure, e.g. co-location and shared IT/ assessment processes	• Potentially least difficult of the options to implement and there is a track record of having done it • Shared commitment to common vision and goals • Maintains the identity to each of professional services incorporated • Easier to involve the third sector • Moderately easy to exit from the model • Allows new entries to the market • Permits locally responsive elements to service • Direct accountability to respective organisations – greater degree of confidence as more control retained. • Allows different delivery models in localities rather than one size fits all • Finance, performance and governance arrangements stabilised by e.g. S75, SLA • No staff transfer – avoidance of TUPE	• Lack of true partnership • Potential for unwanted variation by locality • Potential for challenges in sharing information • Potential for duplication remains • Organisational alignment is not guaranteed i.e. continuation of operational status quo – executive sponsorship but partner organisations view themselves as separate and distinct • Limits opportunities to alter skill mix • Need to align incentives across organisations • Duplication of governance functions (may be immaterial)

In this option an Integrated Care Board acts as a governance body, but local partners remain accountable for individual functions. The option involves integrating services, but without formal organisational merger. Merging will create additional critical mass for providers, but a complexity of contracting mechanisms still exists and the risk sharing approach could become complicated. Accountability for whole system still remains with commissioner only which make managing demand and financial risk a bigger issue for one party .Whilst the option does not provide a seamless organisation, it drives a shared commitment to a common vision and goals.

Which tiers of the model would this delivery vehicle suit?
This option could be considered as a step in the process towards integration as the new operating model is implemented, and would best suit tiers 3 &4 of the model. It allows for variations in each locality which could mean services are more locally responsive and suited to the needs of particular communities, although there is an increased risk of fragmentation if this is taken to extremes.

Delivery model	Characteristics	Benefits	Dis-benefits
Option 3: Alliance contract	• A collaborative contract across organisations • A form of gain-sharing and risk-bearing arrangement • A strategic planning and service development alliance • Based on extensive clinical engagement and leadership	• Builds on / leads to good relationships • Organisations maintain identity and professional identity • Explicit about where risk sits and quantifies this • System goals • Exit costs are cheap if it fails	• Limited potential/incentives to remove duplication • Cost of tracking information to quantify risk • Information governance issues • Added complexity to deliver locally tailored solutions • Input/output focussed rather than outcome • Limited incentives because of contractual control • Limited experience in NHS/social care – not proven that the model is transferable. • Likely to be significant set-up costs. • Limited examples of this having been implemented

As the option employs an alliance as opposed to a hierarchical leader, it should provide a greater opportunity to drive the use of a social model of health. There is limited experience of implementing this model within the NHS, although there are examples within Social Care, such as that in Cambridgeshire. However, the set-up costs are not well known and could be significant, and ensuring provider accountability may be challenging as it is not clear which provider is responsible for delivering outcomes. There is added complexity to deliver locally tailored solutions, although the model could be used in each locality to exploit community assets. This option does not provide a seamless organisation and information governance issues still exist, therefore the customer journey may not improve

Which tiers of the model would this delivery vehicle suit?
This option lends itself to components of the model which benefit from plurality of provision, such as Tiers 1 & 2, in order to capitalise on the community asset base, but it should also be considered for other components

Delivery model	Characteristics	Benefits	Dis-benefits
Option 4: Accountable lead provider model/Accountable Care Organisation	• An entity that takes responsibility for the care of a registered population • Services are commissioned from a principal provider who then subcontracts to other providers where necessary within the service provision • Partner organisations remain separate statutory bodies • Contractor responsible for appropriate 'make or buy' decisions • Supported by similar/well interfaced IT and assessment systems	• Centralised governance and management • Easier to incentivise performance - single point of responsibility to improve care and deliver better outcomes and better health • Clear accountability • Removes transaction costs from commissioners • Facilitates strategic commissioning • Reduces commissioning costs • Maintaining market diversity • Encourages system wide thinking • Supports locality service models (if several lead providers were commissioned for different localities) • Reduced risk of provider failure • Allows for sub-contracting with the third sector - opportunity to attract new providers offering cost/quality improvements	• Hard to embed consistent culture and behaviour • Limited choice for lead • Increased financial risk on lead provider • If lead provider applies a clinical led model, access to other services goes through a costly route • Information governance issues • Challenging to exit (but not impossible) • Potential increase in transaction cost • Limited experience at implementing this model (as commissioners and providers) • Commissioners have less direct influence • Staffing transition costs and implications where lead provider chooses to 'make' the service – potential TUPE

The choices for a lead provider are limited: if the lead provider is health-focused there is risk of a medicalised model of care being implemented. The option offers some potential for cost savings as it removes transaction costs from commissioners and allows for subcontracting with the third sector, although as each provider is likely to load overheads into their costs it may not be possible to achieve significant cost reductions using this model and poor visibility of sub-contractor relationships can cause complexities. Closer working between providers should also reduce duplication of effort. Partner organisations would remain separate bodies and therefore it will be difficult to embed consistent culture and behaviour. However, as this option drives clear accountability, it makes it easier to incentivise performance improvement and support locality service models which improve the customer Journey.

Which tiers of the model would this delivery vehicle suit?
This option would suit components of the model which have clear performance measures and associated incentives, such as Rapid Response & Reablement and End of Life care. Learning from the US, where ACOs are common, suggests that this option should be considered suitable for discreet components of the model, as it can focus on a small proportion of people who account for a high proportion of use and cost.

Delivery model	Characteristics	Benefits	Dis-benefits
Option 5: Providers merge into a single entity	• Formal merger to create single legal entity • Can be underpinned by Section 75 • Single commissioning entity, with pooled budget • Integrated processes for finance, performance and governance • Single CEO and Board • Supported by single IT and assessment systems	• Fully integrated processes for finance, performance management and governance • Commissioner will need to manage only one provider relationship • Clear accountability for delivery • Reduced back office costs and support costs • Simplicity of Information Governance • Potential removal of duplication • Potential efficiencies from reduction in management costs • Economies of scale • Promotes system thinking • Seamless organisation from patient perspective - easier to navigate • Potential to minimise variation • Single strategy and vision • Shift of control could improve innovation • Greater ability to build in workforce flexibility/ resilience	• Incorporation of health services will limit the market for providers • Barriers to entry for potential new entries to the market, due to scale of model • Time to implement – complex model and would potentially take place over a protracted period. There could be a risk to service standards during that period • Clash of cultures between professionals. • Increased risk on a single provider • Control moves to the provider - risk of care budgets sitting with providers. • Risk to skill mix i.e. wrong skill mix or in the wrong areas • Reduced ability to connect to local providers knowledge required to manage effectively (e.g. not just health or social care knowledge) • Potentially high exit costs • Challenges of managing the politics of significant change and gaining commitment and buy-in

There are significant opportunities for cost saving and the development of a sustainable model of care. Bringing providers together in a single entity will reduce overheads and management costs. This option delivers a single provider entity which will enable the development of a seamless customer journey, with clear accountability for delivery and quality, along with potential to minimise variation throughout the service, should also enhance the customer experience. Clear joint commissioner and provider quality improvement plans will be required to ensure quality is incentivised in a more straight forward funding arrangement (i.e. move away fromPbR).

Which tiers of the model would this delivery vehicle suit?

This vehicle has been shown to drive significant improvements in outcomes and quantifiable benefits, for example in Torbay where the Care Trust delivers integrated community care. This vehicle could be effective for the coordination and provision of statutory services, e.g. Rapid Response & Reablement and Long Term Care. However, it does not encompass the plurality of local assets within the community with which to deliver the earlier components of the model. Nevertheless, it should be considered as an option to be adopted in combination with other vehicle options.

Conclusion

This business case provides an outline of a range of different delivery vehicles, but does not give a recommendation for a specific delivery vehicle.

It is likely that the final model will be served by a number of different delivery vehicles, working together across the system. It is recognised that the 'lead provider' as defined in option 4 may be, in some instances, a management function for a range of services, as opposed to being the main delivery mechanism for these services. Equally across the five options there may be a number of lead providers for different service packages and an alliance may need to be formed between these for pathway coordination focused on the individual.

Based on the local provider landscape, and discussions with commissioners from BCC and both CCGs, it is felt that market testing will be an important part of the commissioning process, as this may drive innovation within the sector.

Commissioners have expressed a need for a staged approach to integrated provision to be undertaken in a staged process:

1. Design and build the operating arrangements, and develop service specifications
2. Market test appropriate 'components' of the model
3. Assess which delivery vehicle and payment mechanism will deliver each component
4. Initiate procurement or implementation process

This enables commissioners to work in partnership with providers to build the new operating arrangements using front line operational insight and resource and test elements of the new operating model before a commissioning decision is taken regarding implementation.

5.2 Joint funding arrangements

The BCF must be managed using a Section 75 agreement, and it is this mechanism which will form the basis of co-commissioning of the integrated service components described in the model. This refers to an agreement made under section 75 of National Health Services Act 2006 between a local authority and an NHS body in England. It makes provision for NHS and local authority bodies to:

- undertake each other's functions, i.e. in commissioning or provision
- create pooled funds. These might be used for commissioning from a single pot or to integrate the resources of provision, i.e. some or all staff and their functions to be merged and delivered from within a single pool of service.

The BCF funds will come through the CCG allocations and then transfer into a pooled budget. Whether the pooled fund sits within the CCG or the Local Authority is up to local agreement. The partners are not automatically empowered in their own right to undertake another's duties. Therefore, they will need to have in place proper arrangements that can demonstrate clear governance, accountability and control.

Section 75 allows for one partner to take the lead in commissioning services on behalf of the other (lead commissioning) and for partners to combine resources, staff and management structures to help integrate service provision. The Council can be the Lead Commissioner for some elements of these Service and the CCGs can be the Lead Commissioner for other elements of service.

S75 agreements offer a range of pooling flexibilities in order for organisations to retain more or less control over pooled budgets. No matter which combination of pooling flexibilities are used to establish the pooled budget, clear and effective arrangements for decision making which are underpinned by a common understanding about authority, responsibility and accountability for services are essential

The partners will have decided that they wish to use one or more of the flexibilities in order to aid the delivery of local objectives. The key flexibilities are sometimes more generally referred to as:

- lead commissioning
- pooled budgets
- integrated provision

In brief the partners may choose:

1. One partner to manage commissioning for another and itself using aligned budgets under the management of one partner e.g. the 'host partner' might be a Council who has been delegated the commissioning of NHS services. Here, the NHS partner wishes to see their resources remain separate in their use (i.e. for NHS purposes alone) but they wish to reduce bureaucracy and transaction by having the Council undertake all of their NHS commissioning for them alongside its own local authority commissioning i.e. arranging services from the two separate budgets (NHS and local authority) but according to a jointly agreed plan that can 'dovetail' through a single approach to managing commissioning.
2. One partner commissioning from a pooled fund where the partners wish to establish a single approach to service commissioning e.g. for arranging placements, services with the third sector or single community teams. Here they do not wish to separate their resources but combine them into a pooled fund for efficient use.
3. A combination of pooled and non-pooled resources within one agreement 'hosted' day to day by one partner.
4. One partner to manage the services/staff of another. This might be described as 'integrated management'.
5. One partner to manage a combined staff resource where staff can be designated to undertake the duties of both partners e.g. creating 'generic care workers' or simply staff that under the agreement are able to act for each other in their roles (subject to usual competencies and training). This might be described as 'integrated provision'.
6. A combination of 'managed' and 'integrated' staff resources within one agreement 'hosted' day to day by one partner.

The Health and Wellbeing Board can use as many S75 pooled budgets as it wishes to in order to deliver the BCF, provided that each of the pooled budgets so established meets the governance requirements (e.g. joint CCG/LA sign off of plans) set out in the BCF guidance and each of the pooled budgets helps to deliver the national conditions on the BCF funding.

The aims of aligned and pooled budgets are broadly the same: to help minimise overlap/gaps in service delivery, increase efficiency, improve value for money and ensure that services are designed to meet the needs of service users. They can help improve services, as well as reduce transactions, minimise bureaucracy and improve productivity

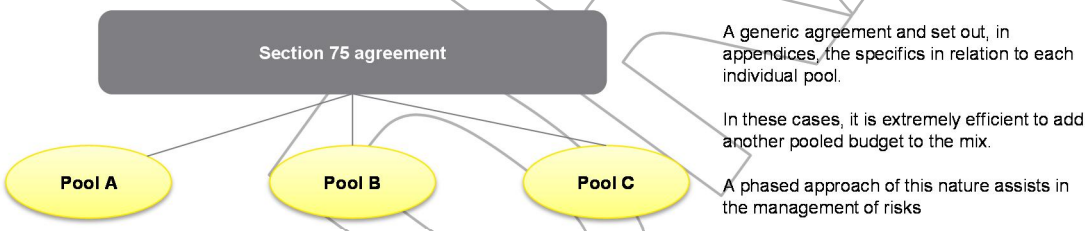
Aligned budgets
Aligned budgets involve two or more partners work together to jointly consider their budgets and align their activities to deliver agreed aims and outcomes, while retaining complete accountability and responsibility for their own resources. Buckinghamshire currently operates a S75 with an aligned budget for the Integrated Community Equipment Store. Both BCC and CCGs pay into the contract value, but control their own spend within the total fund. Although this provides clear accountability over spend, and manages risk-sharing, the arrangement continues to present operational barriers to frontline staff.

Pooled budgets
A pooled budget (or fund) is an arrangement where two or more partners make financial contributions to a single fund to achieve specified and mutually agreed aims. It is a single budget, managed by a single host with a formal partnership or joint funding agreement that sets out aims, accountabilities and responsibilities.

Aligned budgets	Pooled budgets
Achievement of aims is better supported by individual organisations redirecting their own mainstream activity. May be used as a step towards a pooled budget where greater collaboration is needed and where local evidence to support pooling is lacking and/or when key partner/s need to address critical internal issues before a pooled arrangement can commence.	Clear set of activities or service that one organisation is able to host and oversee effectively on behalf of all parties. Where evidence shows that concentrating money in the pool can better enable more efficient services leading to better outcomes for service users and/or help better enable radical redesign of the service around the user.
Tends to be adopted where partnerships are yet to mature. Or where there is a concern that	Pooled budgets often follow positive experience of joint working. They tend to exist where partners

partners will be over cautious or under-fund pooled budgets.	have a strong track record of partnership working and trust and relationships between partners are good. However, partnerships can decide to use a pooled budget as a way of helping their organisations to work together better, if informal arrangements are not working sufficiently well.
Aligned arrangements can more flexibly include partners from private and third sectors. Aligned budgets can help where there are no legal powers to pool.	Pooling arrangements primarily involve public sector partners. As, for example, private and third sector partners may be contracted to provide the service.
Outcomes, objectives, strategies are jointly agreed by partners but greater detail is necessary in order to pool. Tend to occur where arrangements between partners are less formalised.	Partners have shared and clearly defined outcomes, objectives, and strategies that enable them to sign up to a clear formal agreement which sets out the activities or service to be delivered via the pool. The agreement ought to cover governance and technical aspects including accountability, financial reporting, management of risks, exit strategy, treatment of overspends etc.
Aligning is less bureaucratic and resource intensive in the short term. But could be more bureaucratic than a well run pooled budget over the medium to long term as it requires separate decision-making processes and does not necessarily contribute to overcoming cultural differences between partners. Therefore, medium to long term benefits may be relatively less than for pooling.	Helps enable faster shared decision-making, effective use of resources and economies of scale. Pooling is cost-effective in decision-making and planning in the medium and longer term, whilst being resource intensive in the short term. Can help eliminate the need for repeated renegotiation of joint agreements.
Tends to occur where, despite discussion, agreement has not been reached on how to overcome internal disputes, fears of 'cost-shunting', risk of overspends and changing partner priorities.	Where agreement has been reached on how to manage risks. An agreement could help protect essential services from detrimental changes in priorities and inspire greater trust and confidence in partners when agreements withstand challenging circumstances.

It is possible to have a single agreement that covers a number of separate pools and alignments, and this approach may be advantageous in delivering the integrated model of care which has been described, as it allows for a staged approach as components of the model are implemented, and the pooled funding for each component to be closely monitored and performance managed:



In establishing the s75 agreement, there are three key areas to address:

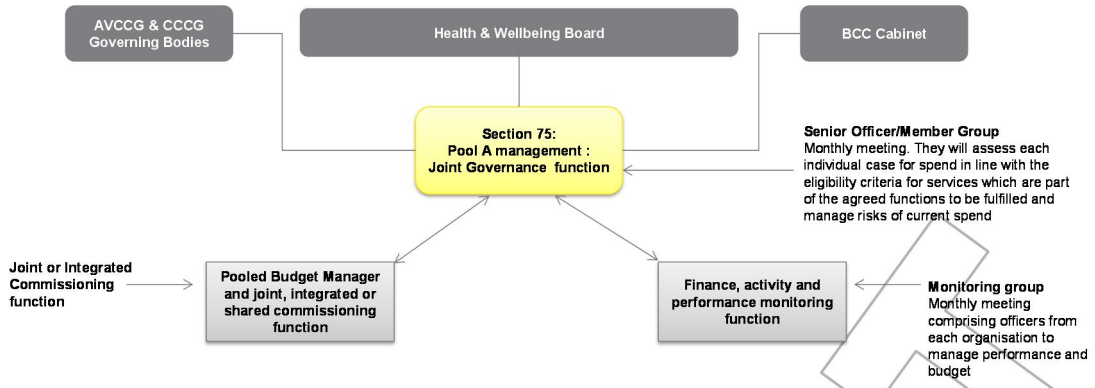
1. Governance arrangements
2. Financial accountability, including audit
3. Risk and benefit management

Governance arrangements

A pooled fund enables partners identified in the agreement to access and take decisions on the use of the resources in the pool, according to the process agreed locally between those staff and the pooled fund manager.

This process to authorise and the staff identified to do this must be agreed early on. It is normally necessary to establish a joint governance management function to act on behalf of the partners and an effective group is usually relatively small, with delegated powers to manage day-to-day performance matters.

An example s75 governance structure



Key considerations for the Strategic Business Case:

- How will a balance of representation on the board be ensured?
- Who will be responsible for the nomination rights?
- Who will be represented on the board and how will they be selected?
- Who will make decisions about budget allocations?

Financial accountability

A pooled budget must have a host organisation and it is that organisation that is responsible for monitoring expenditure against the budget in accordance with whatever requirements are set out in the pooled fund agreement. The agreement must set out the types of expenditure that can legitimately be charged to the pooled budget and the reporting requirements of the partners.

Factors such as CCGs being unable to hold a cash surplus from one year to the next will need to be carefully considered when agreeing the host organisation. The VAT regimes that apply to individual partners such as local authorities and NHS bodies differ. Local authorities can reclaim most of the VAT they incur in performing their functions from HMRC. NHS bodies are recompensed through their funding for any VAT that cannot be reclaimed, although they can reclaim from Customs VAT incurred on certain contracted-out services. In this case, it would be advantageous for BCC to take on the host organisation function.

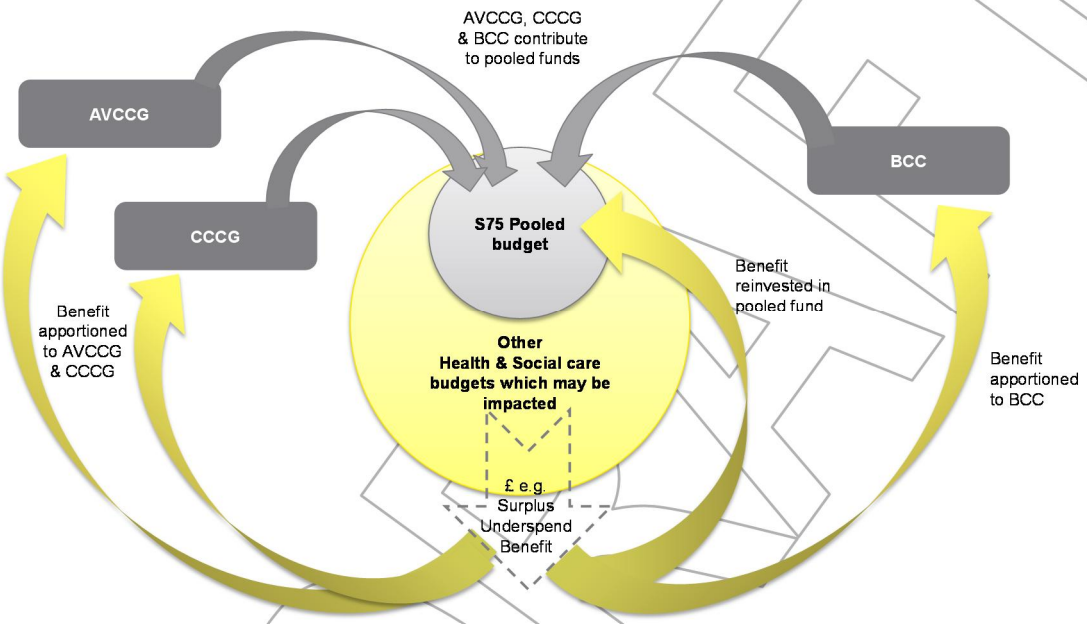
It is important that monitoring requirements specify that any projected over or under spends are drawn to the attention of the partners at the earliest possible opportunity with reasons for their occurrence and options to address. Dialogue at the earliest stage will enable partners to manage this before the year-end.

If a pooled commissioning budget is used to commission a specified set and volume of services from a provider, commissioners can be clear through the contracted payment mechanisms, that the responsibility for any overspend and benefit of any underspend rests with the provider. However, if services are commissioned on a spot purchase basis from the independent sector, for example, both CCGs and local authorities will expect to retain any underspend and will know that, as commissioners they have to address any overspend. If BCC remains both a commissioner and a provider of services within the integrated model, options for handling this to avoid conflicts of interest will need to be considered.

In addition, the pooled budget arrangement will need to ensure that providers are accountable for the outcomes delivered through the programme, and ensure that outcomes are measurable and directly attributable to initiatives within the pooled budget.

The significant budget pressures facing BCC and both AV & C CCGs may require that the chosen contracting model allows for a portion of the benefits of integration to be 'cashed' by each organisation against their respective financial challenges. The diagram below illustrates how such a reward mechanism may work.

Benefit could be derived from either the core services within the pooled budget arrangement, or from other health and social care budgets that may be impacted by the change (e.g. acute budgets). The benefit could be derived from a reduction in spend due to reduced activity, or the decommissioning of a particular budget in response to a change in service profile. If the benefit is derived from a service within the pooled budget arrangement, then partners can agree to reinvest the benefit into other initiatives within the arrangement, or apportion the benefit amongst partner organisations (or a combination of the two). Where benefits accrue outside of the pooled budget arrangement, monitoring arrangements would need to be put in place to ensure that the benefits are the result of interventions within the scope of the pooled budget arrangement. Once this has been established, partners can jointly agree to reinvest the benefit in interventions within the scope of the pooled budget arrangement, or to retain the benefit amongst partner organisations. Further work within the Strategic Business Case will be required to build up the level of expected benefits from selected interventions, and how this can be optimally distributed amongst partner organisations.



The proportional risk / reward sharing arrangement will need to be configured jointly between the partners and detailed in the s75 agreement, to identify how benefits:

- Are retained in the pooled budget and reinvested in integrated services
- Contribute to reducing the individual organisations financial deficit/funding cuts
- Make provisions for the individuals organisations risk exposure (for example the Care Bill or the changes to allocation for CCGs (for example reallocation of money as a result of 'specialist' commissioning activity to the local area NHS teams)

Key considerations for the Strategic Business Case:

- Which organisation will host the pooled budget, and what are the VAT implications of this?
- How will over/underspends be treated?
- On what basis will services be purchased, and how this relates to risk

Risk management

Risk sharing between organisations reflects a truly pooled budget arrangement, working to a joint strategy with joint decision making. Risks are jointly owned and managed rather than seen as the responsibility of one partner or the other. Risk sharing between the CCGs and BCC should be directly proportional to the contributions of both parties.

It will be the responsibility of any joint governance function to ensure that spending is contained within the resources available and where financial pressures arise, to look at options to contain total spending within the resources available. Partners will have to share new risks that they would otherwise not have to consider. Examples of these risks include:

- The level of contribution to the pooled or aligned budget does not meet the level of expenditure
- Partners are unable to agree on how to deal with overspend
- Partners cannot meet their contributions due to income reductions within their separate organisations
- Change of partners' objectives and responsibilities during the pooled or aligned budget period
- Future pressures on services delivered through the pooled or aligned budget
- Potential financial exposures
- Partner organisation risks
- Risks for each partner performing their duties through the partnership arrangement (e.g. failure to achieve aims, efficiencies etc.) could lead to greater pressure on individual organisations
- Arrangements are not sufficient to help respond to changes in circumstances and new events – and can lead to break down of partnership
- Separability from ongoing schemes and activities

5.3 Payment mechanisms that may be used in the contracting model

In order for the programme to deliver savings, a set of alternative payment mechanisms should be devised and agreed with partners. The current mechanisms that are in place include a block contract for community health services, payment by results (PbR) for acute hospital services, and a framework for purchasing residential and nursing care placements. Although these mechanisms are simple, and understood by stakeholders, they do not provide incentives to move activity away from high cost, high volume areas such as residential and nursing care, and aspects of A&E and acute non-elective activity, and improve outcomes for patients and service users.

In order to incentivise providers to work with the partner organisations in developing the Buckinghamshire model of integrated care, and enacting the required shift in activity to maintain each organisation's financial sustainability, alternative payment mechanisms will be considered.

1. *Social Impact Bonds (SIBs)*

    - Intended to improve the social outcome of public services by making funding conditional on achieving results

    - Through a Social Impact Bond, private investment is used to pay for interventions, which are delivered by service providers with a proven track record. Financial returns to investors are made by the public sector on the basis of improved social outcomes. If outcomes do not improve, then investors do not recover their investment

    - Social Impact Bonds provide up front funding for prevention and early intervention services, and remove the risk that interventions do not deliver outcomes from the public sector

    - In the Buckinghamshire integrated care model, SIBs could be used to encourage private sector investment in the Living, Ageing and Staying Well tier. Partners could be incentivised to invest in universal services that improve the health of communities

- Outcomes from Living, Ageing and Staying Well are likely to be measured over a number of years, so it may be challenging to find a partner willing to provide up-front investment with a lengthy payback period

- SIBs could also be used in the Early Intervention and Prevention tier of the model, as part of a targeted prevention offer for vulnerable older adults. The impacts of this type of initiative is likely to crystallise sooner, and it may therefore be easier to find partners willing to fund these schemes

2. *Year of Care*

- Single payment for all provision in a defined cycle of care

- Transfers the financial risk of delivering agreed services from commissioners to providers

- Includes mandatory outcome based reporting, to incentivise an improvement in outcomes and engineer the desired shift in activity

- May be challenging for providers to adapt to the outcomes based reporting required
- Southwark and Lambeth ICO is working with the National Commissioning Board to develop a single payment of care methodology for people with long term conditions

- In the Buckinghamshire integrated care model, the Year of Care methodology could be used across tiers 2, 3 and 4 (ie covering all elements of care apart from Living, Ageing and Staying Well) for people with LTCs

3. *Outcomes-based capitation*

- Combines fixed payments per patient or service user with performance incentives based around the outcomes framework

- Providers collectively agree with commissioners to share in a proportion of savings delivered provided certain quality standards are met

- Transfers the financial risk of delivering agreed services from commissioners to providers

- Encourages providers to work together to achieve outcomes and would therefore be well suited to an alliance of providers

- In Buckinghamshire's integrated care model, this payment mechanism may be suitable for services in tier 2 of the model (Prevention and Early Intervention)

- Providers such as BHT may resist as they are experiencing financial pressures of their own, and hence may not have the resource to develop a complex mechanism such as this

- The mechanism has been used in the USA as part of the Affordable Care Act, and is being piloted by Oxfordshire CCG for frail elderly services, with estimated benefits of 2-3% per annum on a budget of £215m

Summary: The final decision on a preferred payment mechanism will need to be made in conjunction with a decision around the preferred contracting model. In the Buckinghamshire model, it is likely that different payment mechanisms and contracting models will be used to incentivise providers in each tier of the model. However, the options outlined above will allow commissioners to incentivise new or existing providers to improve outcomes, rather than paying for activity undertaken, or even the payment of a fixed amount under a block contract. This will be a key enabler in delivering improved health and wellbeing outcomes amongst the wider adult population, and reducing the impact of demographic growth on costly acute activity and care home placements.

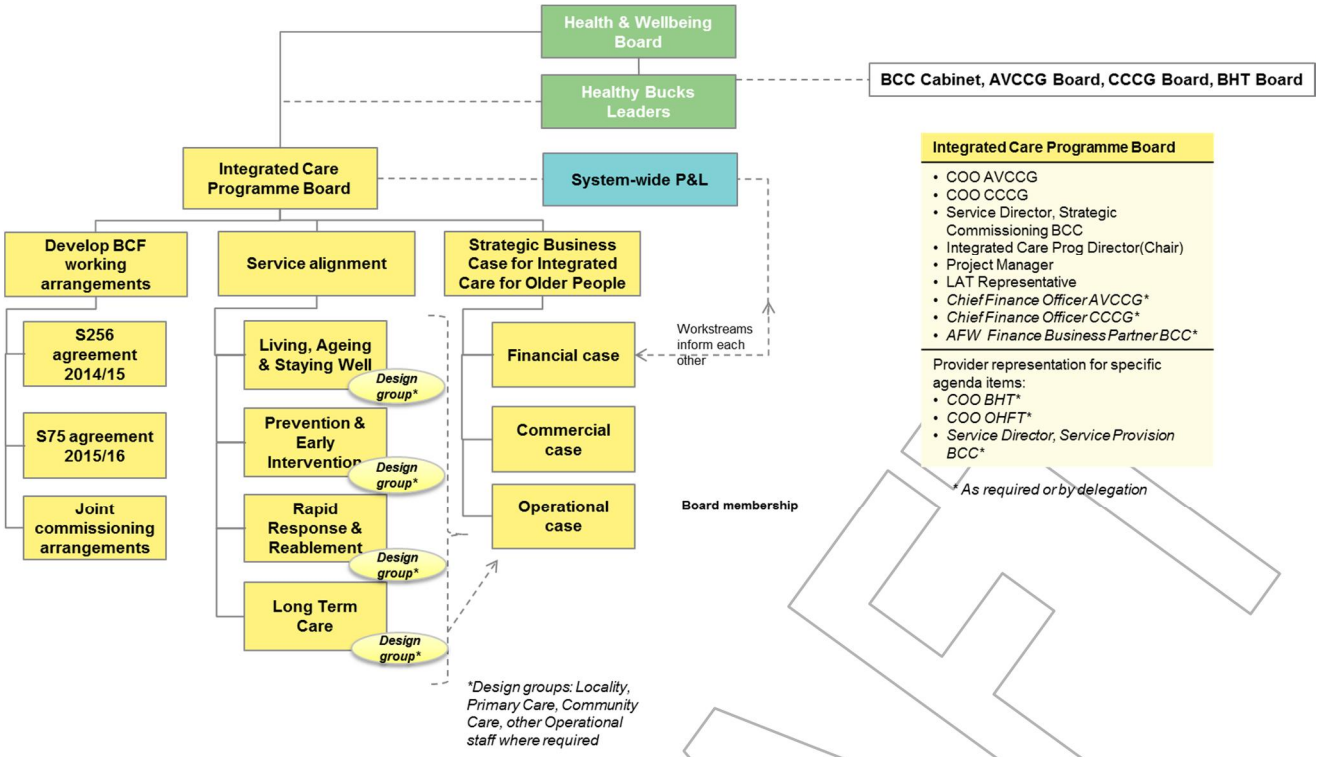
5.4 Key points for decision

- Are there any delivery vehicles which are not to be considered for further investigation?
- Do commissioners wish to consider an integrated commissioning function across partners?
- Are there any current delivery arrangements which must remain unchanged?
- Do commissioners accept the proposed structure for the s75?
- Are there any payment mechanisms which are not to be considered for further investigation, and are there any other mechanisms commissioners wish to include?

6. Management case

6.1 Programme structure

In order to minimise duplication and manage associated risks, the programme will be governed under the following framework:



The roles and responsibilities of the governance groups are as follows:

Health and Wellbeing Board

- Set strategic direction
- Monitor progress against strategy
- Meets monthly

Healthy Bucks Leaders

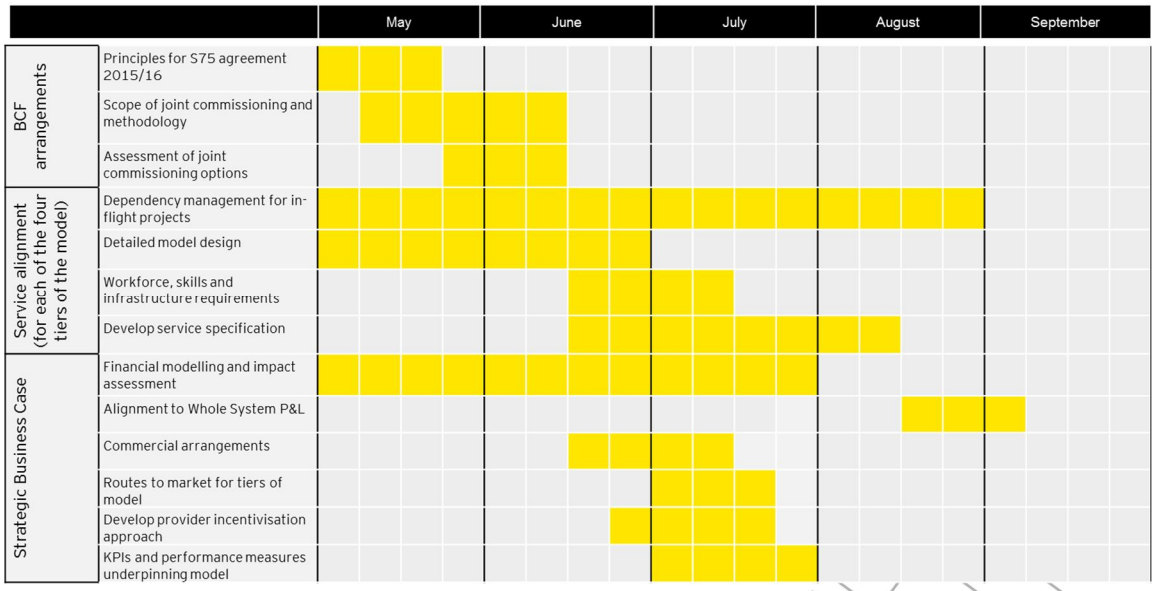
- Executive Board of the Health and Wellbeing Board
- Oversight of the Health & Social Care system in Bucks
- Oversight of a range of programmes designed to deliver Health and Social Care Strategy
- System un-blocking
- Performance management of programmes
- Meets monthly

Integrated Care Programme Board

- Commissioners, with providers invited when necessary
- Drives delivery of the Integrated Care Programme
- Make decisions regarding the programme
- Meets fortnightly

6.2 Programme plan

The programme will consist of three projects, and covers activity from May 2014 – August 2014.



6.3 Programme workstreams

The key activity next steps to develop the model are listed in Section 3. The tables below list the outputs for each project during the course of this programme are listed in the following tables:

Project: Develop BCF working arrangements	
Purpose: To develop operating arrangements for the pooled budget created by the Better Care Fund, and to plan future commissioning arrangements	
Workstream	**Key outputs**
S256 agreement 2014/15	1. Monitoring framework for tracking s256 spend and performance of services in 2014/15
S75 agreement 2015/16	1. Decision on quantum of pooled budget in 2015/16, and how this will expand in future years 2. Principles for s75 agreement for the pooled budget to be created as part of the Better Care Fund in 2015/16
Joint commissioning arrangements	1. Agreement for which services are to be jointly commissioned, and hence the capacity required to jointly commission these services 2. Methodology for jointly commissioning 3. Contract/performance management responsibilities 4. Assessment of integrated commissioning options

Project: Service alignment	
Purpose: Managing ongoing project activity and detailed design for each of the four tiers of the Buckinghamshire model: *Living, Ageing and Staying Well* *Prevention and Early Intervention* *Rapid Response and Reablement* *Long Term Care*	
Workstream	**Key outputs**

	1. Dependency management for in-flight projects that have been identified in this Outline Business Case 2. Detailed model design, facilitated by design groups 3. Research of good practice in this area from elsewhere 4. Minimum workforce standards and skill requirements 5. Future system and infrastructure requirements 6. Service specification for future delivery of the tier

Project: Strategic Business Case	
Purpose: Document that brings together the service specification, financial analysis and commercial considerations for programme board sign off	
Workstream	**Key outputs**
Financial case	1. Financial model with supporting commentary that shows: a. Potential benefits of moving to a new model of care and timescale for realisation b. Impact on current provider landscape 2. Service investment strategy, and how shift in activity around the system can support this 3. Capacity and cost of Buckinghamshire integrated care model 4. Alignment and revision based on Whole System P&L work
Commercial case	1. Commercial arrangements to complement specification 2. Commercial risk log and steps taken to address risks 3. Options appraisal of delivery vehicles for components and/or tiers of the model 4. Options appraisal of payment mechanisms for each component/tier
Operational case	1. Functional analysis of model 2. Redesigned operational tier 3. KPIs and performance measures to inform commercial strategy 4. Enablers required (workforce, ICT, etc) to deliver specification

6.4 Interdependencies

The Integrated Care Programme has a number of interdependencies with other programmes and projects which are being delivered across the health and social care system. These interdependencies must be managed in order to minimize delivery risk. The following key interdependencies have been identified:

1. **Care Bill implementation**
   BCC are undertaking a programme of work to prepare Adult Social Care for the introduction of the Care Bill. This has the below interdependencies with the Integrated Care programme:

- Financial impact

  BCC estimate that the financial impact of the Care Bill will be approximately £35m annually by 2018. Local authorities are currently awaiting further detailed guidance on implementation and information regarding the financial allocation they will receive in order

to meet the increased costs. Until this information is known, there will remain uncertainty about the impact this will have on the ability pooled funding arrangement.

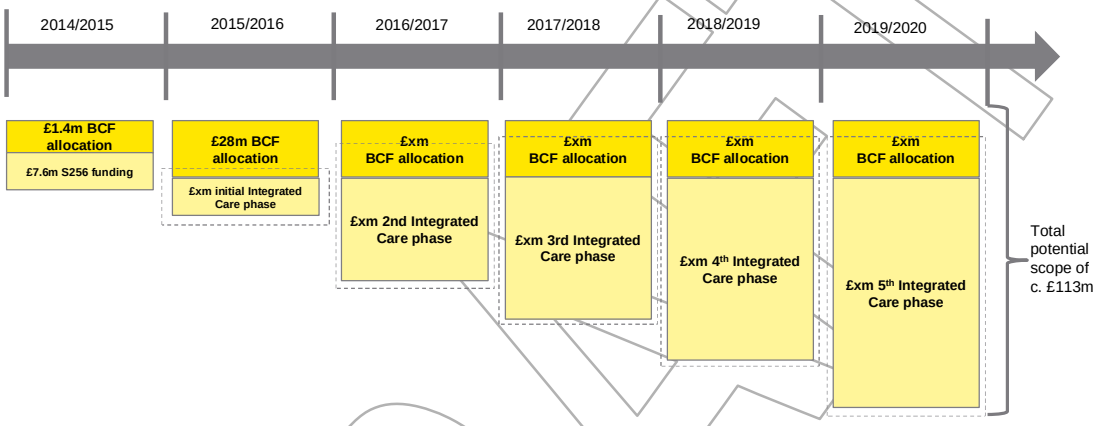
- Operating model

The Care Bill programme is concerned with the development of a 'blueprint' for the future operating model of adult social care. Decisions regarding the level of integration which BCC and both CCGs are prepared to enter into will greatly affect the development of this blueprint.

If BCC and the CCGs decide not to integrate services at every tier, decide not to develop an integrated approach for every component within each tier, then this will have a key impact upon the scope of the work which will be delivered within the Care Bill blueprint project.

The proposed scope is a maximum combined resource of £103.4m, which will be built up over a five-year period:

The final, confirmed scope of integrated health and social care provision will not be known until delivery of the Integrated Care Strategic Business Case, which will provide the financial and benefits analysis which will drive the decisions regarding scale and pace of integration.



However, the final, confirmed scope of integrated health and social care provision and the phasing of the pooled fund will not be known until delivery of the Integrated Care Strategic Business Case, which will provide the financial and benefits analysis which will drive the decisions regarding scale and pace of integration.

2. System-wide Profit & Loss (P&L) account

Healthy Bucks Leaders have commissioned an analysis of the financial flows within Buckinghamshire health & social care economy. The new integrated model will have an impact on these flows and therefore the outputs from the Integrated Care Progamme will need to ensure that information regarding cost and activity is shared expediently with the P&L project to enable the future P&L to take account of the proposed changes and informing the scope of the financial envelope for integrated care.

3. IT interoperability Business Case

AVCCG is currently leading a project focusing on IT interoperability, with a full business case due to be submitted to the Adult Joint Executive Team in July 2014. The outcome of this Business Case, including timescales, the future IT Infrastructure and operating principles will inform the detailed design of the integrated operating model. Therefore it is essential that this information is shared with the Integrated Care programme so that an appropriate level of IT capability is built into the design.

4. **Provider CIP activity**

   Acute providers are managing their own programmes of with to deliver financial efficiencies and performance improvement. The impact of activity within these programmes may have implications for the detailed design of the new integrated operating model, and so it will be critical to involve providers within the design groups at the earliest opportunity. However, it is recognized that there may be conflicts of interest in provider involvement in the design of the operating model, and therefore these will need to be carefully managed.

5. **Other health projects**

   There are a number of other programmes of work underway led by CCGs, focusing on areas of provision which are outside of the scope of the Integrated Care programme. However, it is likely that the programmes will have some indirect interdependencies so health commissioners will need to have strategic oversight of activity and ensure information flows both ways between relevant programmes.

6. **Primary care**

   Spend on primary care and the development of the Primary Care Strategy are currently out of the scope of this project. However, the successful delivery of the integrated model relies on full engagement with primary care professionals. Primary Care representatives will be play a key role in designing the new model for integrated care through active participation in the design groups. Decisions made regarding the model for integrated care may impact upon both Primary Care spend and the Primary Care strategy.

6.5 Key points for decision

- Acceptance of the proposed programme structure
- Decision-making remit of the Programme Board
- Role of Provider representatives on the Programme Board – voting or non-voting?
- Establish understanding of the status of Healthy Bucks Leaders as Programme oversight

7. Conclusions and next steps

There is recognition between key stakeholders that it is appropriate to approach integrated provision for the population cohort in a phased approach. The four tiers of the new integrated model, broken into their component parts, allow partners to take such an approach. Each component has been rated for its achievability and the likelihood of delivering saving. The outcome of this assessment is shown in the table below:

Tier	Component	Time required to implement tier	Enablers in place or available	Payback timeframe post-implementation	Ability to generate financial return
Living, ageing and staying well	Community wellbeing centres	Unknown	Low	Unknown	Unknown
	Healthy lifestyles	1-2 years	Low	Unknown	Unknown
	Proactive provision of health promotion	1-2 years	Medium	Unknown	Unknown
Prevention and early intervention	Proactive care referrals	12-18 months	High	2+ years	Medium
	Integrated case management	2-3 years	Medium	2+ years	Medium
	Community based prevention services	1-2 years	Medium	2+ years	Low
	Digitalisation, adaptation and equipment	1-5 years	Medium	2+ years	Medium
Rapid response and reablement	Rapid response	6 - 18 months	High	1-2 years	High
	Reablement	6 - 18 months	High	1-2 years	High
Long term care	Integrated locality teams	2-3 years	Medium	2+ years	Medium
	Joint commissioning of placements	6-12 months	High	1+ years	Medium
	End of life care	6-12 months	High	1+ years	Low / Medium

From the above assessment, it is recommended that initial effort is focused on developing the following components:

- Rapid response
- Reablement
- Joint commissioning of placements
- End of life care

As the SBC develops, more information will become available on each of the components, and this will inform the phasing of the model implementation.

7.1 Summary of key points for decision in this OBC

Key points for decision – Operating arrangements

- Acceptance of the proposed model as the structure for the process towards implementation
- Whether to implement by tiers or by component
- Are there any components described which are 'off the table' at this time?

Key points for decision – Financial Case

- Acceptance of the programme scope and grouping of services across the tiers of the model
- Agreement of assumptions underpinning future income and expenditure projections
- Agreement of indicative benefits derived using LGA value case toolkit financial model

Key points for decision – Commercial Case

- Are there any delivery vehicles which are not to be considered for further investigation?
- Do commissioners wish to consider an integrated commissioning function across partners?
- Are there any current delivery arrangements which must remain unchanged?
- Do commissioners accept the proposed structure for the s75?
- Are there any payment mechanisms which are not to be considered for further investigation, and are there any other mechanisms commissioners wish to include?

Key points for decision – Management Case

- Acceptance of the proposed programme structure
- Decision-making remit of the Programme Board
- Role of Provider representatives on the Programme Board – voting or non-voting?
- Establish understanding of the status of Healthy Bucks Leaders as Programme oversight