Appendix A

Cambridgeshire Better Care Fund

2016/17 Narrative Plan

Version 1.1

Version control			
Version	**Author**	**Date**	**Notes**
1	Geoff Hinkins	4 May 2016	Version submitted to NHS England
1.1	Geoff Hinkins	4 May 2016	

Contents

Authorisation and sign-off

Local Authority	**Cambridgeshire County Council**
Clinical Commissioning Groups	**NHS Cambridgeshire and Peterborough Clinical Commissioning Group**
Boundary Differences	For NHS Cambridgeshire and Peterborough CCG there are two differences to the boundary when compared with those of Cambridgeshire County Council and Peterborough City Council. From 1 April 2012, several practices from North Hertfordshire and Northamptonshire became part of NHS Cambridgeshire and Peterborough CCG: *North Hertfordshire – Royston* Three Royston practices provide care for a patient population of 24,142 residents in the town of Royston itself and the surrounding villages and they comprise Royston Medical Centre, Roysia Surgery and Barley Surgery *Northamptonshire* The Oundle and Wansford practices provide care for a patient population of 17,448 residents in the town of Oundle itself and the surrounding villages and they comprise Oundle Surgery, Wansford Surgery and Kings Cliffe (branch surgery).
Date agreed at Health and Well-Being Board:	**21 April 2016**
Date submitted:	**4 May 2016**
Minimum required value of BCF pooled	**£39,134,365**

budget: 2016/17	
Total agreed value of pooled budget: 2016/17	**£48,350,614**

a) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Cambridgeshire and Peterborough Clinical Commissioning Group
By	 Tracey Dowling
Position	Chief Operating Officer
Date	4 May 2016

Signed on behalf of the Council	Cambridgeshire County Council
By	 Adrian Loades
Position	Executive Director: Children, Families and Adults Services
Date	4 May 2016

Signed on behalf of the Health and Wellbeing Board	Cambridgeshire Health and Wellbeing Board
By	Tony Orgee Councillor Tony Orgee
Position	Chair of Health and Wellbeing Board
Date	3 May 2016

Signed on behalf of Cambridgeshire and Peterborough NHS Foundation Trust	Cambridgeshire and Peterborough NHS Foundation Trust
By	A. M. Thomas
Position	CEO
Date	03.05.16

Signed on behalf of Cambridge University Hospitals NHS Foundation Trust	Cambridge University Hospitals NHS Foundation Trust
By	
Position	AD CEO Director Workforce
Date	29/4/16.

Signed on behalf of Hinchingbrooke Health Care NHS Trust	Hinchingbrooke Health Care NHS Trust
By 	Cara Charles-Barks
Position Chief Operating Officer / Deputy CEO	

Date	3 May 2016

1. Introduction and approach

This document forms part one of Cambridgeshire's Better Care Fund (BCF) Plan for 2016/17. The other part is the 'template for BCF submission' spreadsheet, which contains financial and performance targets. This purpose of this submission is to:

- Outline our vision for integration across the Cambridgeshire system and how this has developed in the past year.
- Describe our specific priorities for delivery of further integrated working in Cambridgeshire in 2016/17
- Describe the context for the vision and priorities, including an overview of changes across the Cambridgeshire system and a brief overview of progress against the BCF plan for 2015/16
- Describe our approach to the Better Care Fund budget in 2016/17, including:
    - Use of the budget
    - Arrangements for risk sharing
- Describe how we will meet each of the national BCF conditions.

To avoid repetition, this document references last year's plan where applicable rather than repeating sections of it. The 2015/16 plan can be downloaded from:

http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=10965

2. Vision, Priorities and Delivery Plan

Purpose of this section:

- To describe our overall vision and the specific priorities that will set the framework for delivery of the BCF Plan during 2016/17.

Our vision

In our 2015/16 we expressed our vision as follows:

Over the next five years in Cambridgeshire we want to move to a system in which health and social care help people to help themselves, and the majority of people's needs are met through family and community support where appropriate. This support will focus on returning people to independence as far as possible with more intensive and longer term support available to those that need it.

This shift is ambitious. It means moving money away from acute health services, typically provided in hospital, and from ongoing social care support. This cannot be achieved immediately – such services are usually funded on a demand-led basis and provided as they are needed in order to avoid people being left untreated or unsupported when they have had a crisis. Therefore reducing spending is only possible if fewer people have crises: something which experience suggests has never happened before. However, this is required if services are to be sustainable in the medium and long term.

This vision has been the guiding principle for our work in developing our 2016/17 BCF Plan.

Our priorities and delivery plan

This section aims to set out in simple terms how we want the 'system' that supports older people, people with long term conditions including disabilities, carers and families to work in future and to set out set out a plan for delivery. By the 'system' we mean the NHS, Social Care, District Councils, Housing, Voluntary and Community sector and independent sector organisations providing services for people. This paper prioritises those people who are currently living independently but are vulnerable to becoming frail or needing higher levels of support or intervention in future. This paper is aspirational – it describes where we want to get to in the next 3 to 5 years, building on work that is developing across the health and wellbeing system in Cambridgeshire and Peterborough.

We hope that in 12 months' time, implementation of many of these changes will be underway. These priorities will form the basis for the Cambridgeshire and Peterborough Better Care Fund Plans for 2016/17 onwards; and builds on the work that has taken place so far and the '10 Aspects of an Integrated System' that have previously been agreed at the Cambridgeshire Executive Partnership Board (CEPB). The BCF plans will operate in conjunction with those of the 2016 /17 Urgent and Emergency Care Vanguard plans, the CCG's one year Operating Plan for 2016/17 and five year Sustainability and Transformation Plan (STP).

The narrative set out here will underpin the ethos of the 2016 Urgent and Emergency Care Vanguard work and the whole system Sustainability and Transformation Programme.

Broadly speaking, these changes can be divided into support for people who do not have, or have not yet developed, significant ongoing health needs; and support for those people that have

significant ongoing needs and receive support from a range of organisations. To achieve our ultimate aim of a shift away from long term social care or care that is provided in the acute setting to preventative services that are focused on keeping people well, we need to focus on our response across both cohorts.

Before people have significant ongoing needs

Healthy ageing and prevention

We are increasingly focused on establishing and implementing approaches that prevent or delay the need for more intensive health (specifically admissions and re-admissions to hospital) and social care services, or, proactively promote the independence of people with long-term conditions and older people and their engagement with the community. This includes specific and planned evidence based public health programmes with an emphasis on falls, social isolation, malnutrition, dementia and promoting continence. A lot of work is already happening in this area. It will remain a key priority across our organisations into 2016/17, informing the Proactive and Prevention workstream that has been set up as part of the NHS System Transformation Programme.

Eyes and ears – indicators of vulnerability

We want our staff across the system to be able to act as 'eyes and ears' – spotting indicators that someone is becoming more vulnerable and referring them to appropriate support. This includes not just medical or social care staff but any public or voluntary sector staff that come into contact with the public. This might include support for staff to enable them to go beyond their main role to provide some low level interventions, where appropriate.

To support this, we will develop a list of 'triggers' which indicate that someone has, or may develop, increased vulnerability. Examples include someone asking for assistance with their wheeled bin, a request for a personal alarm/life line, a concern raised when a housing provider carries out a routine visit, a death is registered or a blue badge is requested. It will also include medical triggers such as low mood/depression, continence/ frequent Urinary Tract Infections (UTIs), injuries caused by falls, or frequent missed medical appointments. When these triggers are noticed the system will have a planned response to offer support, advice and information.

Clear and joint sources of information

People will be able to access a consistent library of health, social care and wider information from a number of places - including web sites, a library or community hub or their GP surgery. Information will be available in print, digitally or through trusted sources. Consistent and up-to-date digital information will be available, as each source will call on a shared information hub so that organisations offering support only have to update their information in one place – and it is available across all sources. From accessing this information it will be easy for people to find out how to make contact if they need further support.

A real or virtual 'single point of access' for advice and support

Identification of these triggers, or a member of the public making contact, will result in a referral to a co-located or virtual single point of access where advice can be sought. Those who take the call can check existing levels of involvement with our agencies across different information systems via

appropriate look-up access to records. There will be joint single point of access based on the assumption that 'there is no wrong door'. This will be based on the different referral points for health, social care and the Voluntary and Community Sector (VCS) operating as one virtual front door. Ensuring that once a referrer or patient or carer has entered the system they are effectively directed to the right service quickly and are not aware of potentially moving between providers as part of that navigation process. This will be available for planned and unplanned care therefore ensuring all needs are met effectively.

If a follow-up appointment is needed there will be capacity for health and social care staff to make contact in person if a face to face conversation is needed with the individual or their carer, partner or relative. This could take place in someone's home or in the community.

Holistic identification of need with a coordinated response

Two types of 'assessment' tool will be available to support staff to identify levels of need and easily communicate that to people in other disciplines.

First is a tool that can be used quickly in any setting as a basis for a shared language across sectors when identifying what the level of need is, with a view to deciding what action would be most appropriate. The Rockwood Frailty tool will be used to assess an individual's level of physical frailty. We will investigate whether it would be useful to supplement this with another simple tool that can quickly summarise levels of social and community need.

As well as that simple tool, a more in-depth holistic needs assessment process will be available that could be used to assess the full range of needs (physical, mental, social); and identify what support could prevent further escalation. A virtual 'team around the older person' would be established with all involved in this team (e.g. GP, District Nurse, Social Care practitioner Housing provider, home care agency, local voluntary organisation, neighbour) being able to work to a shared care plan based on shared information. A lead person or professional would be identified for as long as was needed as a key point of contact, to coordinate support and to simplify a complex system for people requiring support. This would most likely be the person who has most contact with the person and as circumstances change, the lead professional may also change. The purpose of this team would be to support the person and put measures in place which improve outcomes and avoid, as far as possible, escalation of need and admission to hospital or nursing/residential care.

Support for people with significant ongoing needs

Clear, coordinated pathways and hand overs

Services for people with significant ongoing needs will be well coordinated. Our health and social care teams will work in a different way with more of a focus on outcomes than process. We will work together in order to ensure the whole pathway of care is delivered as an integrated set of providers, and therefore hand overs will be seamless. For example a call may come into the Joint Emergency Team (JET), yet the best response would be a social care response/ social care may already be involved. A hand over would take place, with the patient getting the timely response most appropriate to meet their needs and prevent escalation. Our staff will be co-located wherever possible, and if not will work as a virtual team to ensure there is a seamless joined up and coordinated response.

Neighbourhood teams and Multi-Disciplinary Team (MDT) working

Twelve neighbourhood teams will be embedded and operating effectively. Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) have restructured and established a number of integrated mental and physical health Neighbourhood Teams, each of which has a Neighbourhood Team Manager. An 'extended' Neighbourhood Team will be established which includes a range of other organisations that will work with the Neighbourhood Team to ensure integrated working. It is proposed that the next stages focus on integration with primary care, social care and the third sector. This will include social care staff who will be aligned to, or 'vertically integrated' with Neighbourhood Teams to ensure the appropriate person is identified as the lead professional. There is the potential to link this work with the move towards GP practices working much more closely together ('Primary Care at Scale'), and to consider designating some Neighbourhood Teams as 'demonstrator' or pilot sites where there is the potential to develop integrated working at a faster pace, providing valuable learning for other areas to accelerate local integrated working.

The benefits of MDT working will be built upon with an assumption that this is a way of working that won't always rely on a set meeting; more a team around the person mode where the relevant professionals come together.

Case finding and case management

A clear understanding of the whole system pathway and robust case finding and case management techniques will help us to anticipate future need and also to wrap integrated services around the patient, preventing them from going into crisis and therefore hospital. Joint Care and Support Plans will be developed on a multi disciplinary basis. In each Neighbourhood Team area work would be undertaken to ensure that there is a shared understanding about the profile of that population and where additional support and intervention is most likely to have benefit.

Working with Care Homes

Although our focus is on supporting people to live independently we recognise that residential care is the most appropriate choice for people that need it. We will continue to support care homes to ensure that their residents continue to receive high quality support that is focused on preventing their needs from escalating. We will continue to invest in training for care homes. We will expand older people's Crisis Resolution and Home Treatment with new resources to support people with dementia and complex needs in care homes. We will prioritise funding services to ensure that people are supported to live independently as long as possible. We will ensure that all residential home residents are known to the Neighbourhood Team , who will be notified as the patient deteriorates – in order to prevent a possible hospital admission as a patient's needs transition from residential to nursing care.

Working with housing providers

Supporting people to live independently requires that they have access to homes that are appropriate to their needs. We will work together with housing agencies to co-ordinate health, housing and social care to ensure that people with long-term conditions have access to accommodation that they want to live in, that enables them to remain independent within their community wherever possible. We hope that this will help people to have a choice about where they live, even if their health and social care needs are high or escalating. We will work to explore a range of opportunities linked to use of the Disabled Facilities Grant; and support for equipment and

adaptations that enable people to remain at home for longer. People will also have early access to advice on the housing options available to them, to ensure that they can make choices and plan for their future.

Enablers – support for delivery

These arrangements will be supported by the following more general 'enablers'. These are activities that will have an impact on success across the whole system, including things such as better use of technology, better use of our assets, having a well-skilled workforce, and better relationships with communities and the voluntary sector. We will focus on:

Joint outcomes

The Outcomes Framework was developed as part of the Older People and Adult Community Services (OPACS) procurement process, with input from a wide range of stakeholders and a review of scientific evidence. The Framework contains a number of agreed outcomes for measuring quality of care. Each outcome and metric was tested against a range of criteria to ensure that they would add value; and be feasible to implement. The framework is already being used in reporting on delivery of integrated services locally; and we will maintain the benefits of an integrated, outcomes-based model. We will look to include relevant outcomes framework measures in 2016/17 NHS contracts (and other contracts where relevant), joint programmes of work across the health and social care system including the Sustainability and Transformation Plan (STP) and Better Care Fund plans.

Information and data sharing

Provision of the best quality and most appropriate services to adults in need of help and support can only be delivered if agencies have access to the correct information about service users' individual circumstances. We will work to ensure that practitioners have the data that they need to make the best possible decisions about people's care; to develop preventative strategies, and to ensure that patients do not have to tell their story to all of the different agencies involved in delivery of their care and support. We will work to ensure that professionals in one organisation can access information that is held by others – with appropriate consent in place.

A common language

By January 2017, we will have established a common language, using the methods described previously, that will give us the assurance we are able to work effectively and efficiently as a whole system, this will ensure that our well defined pathways can be navigated by any provider or user of the system.

Workforce development

Greater integration means new ways of thinking, behaving and working across the whole system; and everyone working in all of our organisations will need to think differently about their role, with a clear expectation about how practice by all professionals will change to support a multi-disciplinary approach. Staff will need to develop new skills and work across traditional boundaries. Common approaches to training and development, as well as a common language across services, will be needed to achieve the full benefits of integration.

Property co-location

Where possible, we want staff from across the system to be co-located or able to share working space in a variety of settings. As partner organisations move towards more mobile working and reduced office space, there will need to be a better join up in relation to planning use of estates to achieve vertical or functional integration. In addition it will be important to make use of existing assets such as libraries and other community buildings to act as a point of information and advice. We will use technology to help us work more closely where we cannot be co-located and for such services as the Single Point of Access (SPA) this will be essential.

Joint commissioning of the voluntary and community sector

Service transformation approaches across both health and social care are increasingly focused on early help and linking people into services commissioned through the voluntary sector. Co-ordinating support for people who do not yet meet the threshold for statutory services or formal interventions will be key to reducing admissions. Many of these services and interventions are provided by Voluntary and Community Sector (VCS) organisations. VCS provision is therefore becoming increasingly valuable and all commissioners are looking to work more closely with the VCS. Joint commissioning could allow greater coordination of such services, which have benefits across the health and wellbeing system.

Specific priorities

The specific components of this model that we will focus on in 2016/17 are:

Prevention

- An explicit prevention programme with an emphasis on falls, dementia and promoting continence; and on improving outcomes for people with long term conditions and their carers
- A joint set of standards for information making consistent information and advice available from a variety of different sources
- 'Eyes and ears' - a clear agreement about what the triggers for support should be and how the system will work

Joint planning and commissioning

- A joint approach to commissioning the voluntary and community sector between the Clinical Commissioning Group (CCG) and local authorities
- Reviewing our approach to housing adaptations and the Disabled Facilities Grant to ensure they are supporting as many people as possible to live independently
- Joint risk stratification of the population to inform Neighbourhood Team working
- Joint approach to the commissioning of beds and accommodation across the CCG area

Neighbourhood Team working/Local team around the person

- Aligned social care and community health staff
- Co-location at every opportunity
- The Rockwood tool used to quickly assess physical frailty; and investigation of alternative quick tools for social and community needs – with an agreed set of possible actions at each level.
- Information sharing – with staff able to access data held in different systems
- A joint holistic assessment tool, with information gathered from range of sources and the outcome of the assessment shared, with appropriate consent
- Lead professional identified where needed to avoid escalation

- Joint work force development programme for all staff working in this way

Integrated pathways

- Front doors operating as if one
- An integrated pathway for the intermediate care tier
- Delegated tasks and trusted assessor approach- carrying out tasks on behalf of each other within clear accountability framework
- Joint approach to care homes prioritising investment in training to prevent residents' needs from escalating

3. Strategic context

Purpose of this section:

- To review the approach to and performance of the BCF in 2015/16
- To describe the changes that have taken place across the system since 2015/16's plan
- To provide updates on the 'case for change'

Reviewing the Better Care Fund in 2015/16

In developing its approach to BCF for its first year, Cambridgeshire County Council and Cambridgeshire and Peterborough CCG jointly considered the distribution of the minimum NHS contribution towards the Better Care Fund. Overall, the approach recognised the responsibilities associated with the Care Act and new initiatives through the BCF balanced against the fact that the BCF involved no additional funding. There was also a need to maintain service delivery and contractual commitments in both health and social care.

This cautious and pragmatic approach meant that in broad terms the money in the BCF remained in the same area of the system as it was previously. In the first year of BCF most funding remained in existing budgets, and the small amount of repurposed spending was focused on areas that would begin to develop a transformation in services. The expectation was that in future years there would be more funding available to support different services as our work began to have an impact. In the first year of the BCF, our major areas of spending were:

- £18.1 million on community health services in the NHS, mainly on the CCG's Older People and Adult Community Services (OPACS) contract
- £14.5 million on social care services, with the majority spent on services that reduce demand for NHS services. This was mainly sourced from the previous section 256 agreement funding that supported social care services which delivered benefits to the health service.
- £0.9 million on transformation projects that were intended to help to shift demand away from emergency hospital services towards services provided in the community and helping people to stay more independent
- £1.9 million on Disabled Facilities Grants, awarded by District Councils to make changes to people's homes to support them to live independently – such as access ramps, internal modifications to make rooms easier to access, and improving heating and lighting controls to make them easier to use.

BCF Performance against metrics

Performance against the target metrics in the BCF has been mixed. The key indicator was for a reduction in non-elective admissions, for which the Health and Wellbeing Board agreed to set a target of a 1.0% reduction. However, non-elective admissions have continued to rise across the county, with performance at the end of quarter 3 showing an increase in non-elective admissions of 6.7%. Other indicators are either cumulative or only measured once a year; these factors have combined to make it difficult to demonstrate a link between BCF activity and performance at this stage of the financial year. This is an issue that we will address through the 2016/17 plan.

Transformation supported by BCF

The most significant investment through BCF was in the CCG's Older Peoples and Adults Community Services (OPACS) contract, awarded to UnitingCare Partnership. The five year contract was ended early on 3 December 2015, with the contract no longer financially viable. The immediate focus was on securing a safe transition of all service contracts to the CCG; and service continuity for patients and assurance for staff.

Although the contract with UnitingCare ended prematurely, the procurement process led to the creation of an innovative Outcomes Framework, a detailed service re-design process, comparison of alternative service options, extensive stakeholder engagement and public consultation and ultimately delivery of the first phase of the preferred service solution. Among the most significant achievements of OPACS under UnitingCare were:

- TUPE transfer of over 1300 staff into CPFT
- Set up of 16 neighbourhood teams
- Set up of Joint Emergency Team (JET)
- Set up of Onecall as single point of access

In addition to the UnitingCare contract, five BCF transformation projects were established, aimed at transformation over the medium term. Because many health partners in Cambridgeshire work across both Cambridgeshire and Peterborough, and recognising that many of the challenges faced by the system are common across both areas, these were established across Cambridgeshire and Peterborough:

- **Data sharing**: to ensure an effective and secure way to share data across health and social care, to help coordinate and join up services for adults and older people.
- **7-day services**: to expand 7 day working to ensure discharges from hospital and other services are planned around the needs of the patient, not when organisations are available.
- **Person Centred System**: to ensure services are focused around the needs of the patient, across health and social care. Care and support will be planned and coordinated by 'integrated care teams' made up of professionals from a range of organisations to ensure services are more joined up.
- **Information and Communication**: to develop and deliver high quality sources of information and advice based on individuals' needs, as opposed to organisational boundaries.
- **Healthy Ageing and Prevention**: to develop services in the community focused on preventing people falling unwell; in particular, to support older people to enjoy long and healthy lives and feel safe.

These projects have progressed at varying speeds this year. Many of the projects were closely integrated with work being undertaken by the UnitingCare Partnership; thus much of the work has been subject to review following the OPACS contract termination and the subsequent contract review. An example is the Data Sharing work, which was focused on extending the OneView system that UnitingCare were set to develop to improve sharing of information about patients and service users. Following the termination of the OPACS contract, the contract for this service has also been terminated for financial reasons, leading to delays in the work. As a result there are currently underspends in the project budgets, although in accordance with the section 75 financial agreement governing use of the BCF these will be carried forward into the 2016/17 BCF in Cambridgeshire.

Learning for 2016/17 and new initiatives

Lessons Learned from OPACS Contract

Since 3 December the CCG has discussed the OPACS services and workstreams with a wide range of stakeholders during December 2015 – March 2016 including Healthwatch organisations, Local Authorities, CPFT and other providers.

Since the termination of the contract there has been an internal (CCG led) review and an independent internal review as well as a further review. The CCG Governing Body agreed a process for reviewing the OPACS model and workstreams in January 2016, and the resulting draft Service Review was presented to the CCG Governing Body in April 2016. This review made recommendations on the way forward and further work required. It took into account the current position on the Sustainability and Transformation Programme (STP) work, the Better Care Fund and agreement of 2016/17 contracts. This Review is still confidential and in draft status at time of BCF submission and will be publicised later in May 2016.

An Internal Audit[1] was also undertaken in March, providing a crucial opportunity for reflection and identification of lessons learnt. The principle reason for the termination of the contract related to a mismatch in financial expectations of the CCG and provider and did not relate to service quality. The lessons learnt relate primarily to procurement and contract management and have shaped the approach to ongoing delivery. There has also been an external review conducted by the NHSE whose findings were very similar to the Internal Audit. Further, a third review is soon to be undertaken conducted by the National Audit Office. The CCG has assimilated all learning in relation to these reviews / Audits into its systems and processes moving forward.

Under the previous OPACS head contract, UnitingCare provided strategic oversight and programme management for the new delivery model. Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) were sub-contracted as a local delivery provider. The CCG does not plan to undertake a re-procurement of the OPACS contract. The subcontract that CPFT held has now passed directly to the CCG and the CCG will provide the programme management function in-house, to enable a more cost effective approach. CPFT will continue to be the local community delivery provider.

The CCG has therefore been – and will continue to - working with providers to directly commission what was the OPACS model. Now with the broadening of the programme to all adults it is known as the Integrated Adults Community Health Services (IACHS) model. The CCG will ensure this model progresses towards the agreed vision.

The CCG is committed to continuing with the service model developed through the contract, and this is reflected in the above priorities for delivery for 2016/17. The CCG is also committed to learning from the contract termination.

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[1] Review of Procurement, Operation and Termination of the Older People and Adults Community Services (OPACS) Contract.
http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/Priority%20Older%20Peoples%20Programme/Internal-Audit-OPACS-Report-10-March-2016.pdf

Five Year Sustainability and Transformation Plan

In accordance with national guidance, Cambridgeshire and Peterborough Clinical Commissioning Group is also developing its five year Sustainability and Transformation Plan. The plan encompasses five key programme areas:

- Urgent and Emergency Care Vanguard
- Proactive Care and Prevention
- Elective Care Design Programme
- Maternity and Neonatal
- Children and young people

There is strong alignment between the BCF Programme, Proactive Care and Prevention and UEC Vanguard work-streams (particularly admissions avoidance, post hospital discharge and integrated urgent care clinical hub). In particular, there are strong links between the BCF 7 day services and person centred system schemes and Vanguard. In addition, close alignment with the Proactive Care and Prevention programme and the BCF Healthy Ageing and Prevention and Wellbeing schemes are being established.

Urgent and Emergency Care (UEC) Vanguard

During 2015/16, Cambridgeshire and Peterborough was chosen as an Urgent and Emergency (UEC) Care Vanguard site. The Cambridgeshire and Peterborough UEC Vanguard (which is part of the STP Programme) is an ambitious and challenging programme. The vision is to accelerate the implementation of the Keogh Review to realise the quality, patient experience and financial sustainability benefits that transformation of urgent and emergency care across health system will realise. The aim is to provide clarity to patients regarding the most effective and efficient way to access UEC, and then to be clear on what to expect when the call or visit to UEC is made. This requires patients to understand what's available from a local UEC offer, why this might be different across the system's geography, and what this means regarding the future configuration of UEC services. In return, providers will be better able to manage and, in turn, plan their service capacity within a system which is less susceptible to huge variations in demand. The aim of this is to enable resources to be used in a more economical way, by reducing demand on expensive emergency hospital services and establishing better local services for patients. In this way it is envisaged that patient satisfaction will be improved and people's associated health outcomes, whilst supporting staff to be more fulfilled in their roles. In short, the Vanguard Programme will look to demonstrate how and where 'value' can be added across the UEC healthcare system.

The case for change

Overall the case for change remains the same at the start of 2016/17 as it did one year ago. Our key challenges include:

- Population Growth: Cambridgeshire has a growing and changing population. There will be large increases in the number of older people, children and people from different backgrounds living in the county in the next 10 years and beyond. This creates particular challenges for planning and managing health and social care services.
- Financial: Cambridgeshire and Peterborough collectively is one of 11 'challenged health economies'; this means that if we change nothing, then in five years' time local health services

would need an extra £250 million - £300 million, with local social care services facing similar challenges.

- Over-reliance on emergency care: too many people are treated in our acute hospitals and numbers of people admitted to hospital as an emergency has been growing by around 2% each year. Supporting people earlier, in their own homes, in order to prevent emergencies will achieve better outcomes.

The population of Cambridgeshire has continued to grow and the estimated population in 2014 was 639,800 with 17.7% of the population (113,500 people) aged 65 and over, which is the same as the England average.[1] The population is more ethnically diverse in Cambridge, with just 66% white: British compared with 87-90% elsewhere.[2] The population of Cambridgeshire is forecast to grow by 23% between 2016 and 2036, an additional 147,700 people; the areas forecast to see the biggest growth are South Cambridgeshire (34%) and East Cambridgeshire (29%).[3] This makes Cambridgeshire the fastest growing shire county in the UK. Cambridgeshire's population is also ageing: the population aged 65+ in Cambridgeshire is expected to increase by 64% between 2016 and 2036, an additional 76,300 people; the area forecast to see the biggest increase in people aged 65+ is Huntingdonshire (67%).[3]

Levels of deprivation are low for the county as a whole but this varies by district; the most deprived district in the county is Fenland, the 80th most deprived local authority district out of 326 in England. The least deprived district is South Cambridgeshire (ranked 316).[4] Compared to 2010, Fenland and East Cambridgeshire now rank as more deprived in national terms than previously; Cambridge City ranks as less deprived. Cambridgeshire now has 16 LSOAs in the 20% most deprived nationally – this is compared to 9 in 2010. Average life expectancies for men and women in Cambridgeshire are higher than the national averages at 81.2 years and 84.5 years respectively.[5] Average life expectancy varies by district: for both men and women, the lowest life expectancies are found in Fenland (79.4 and 82.6 years respectively) and the highest in South Cambridgeshire (82.7 and 85.6 years respectively).[5] Age-standardised all-age all-cause mortality rates are lower in Cambridgeshire compared with the England average.[6] By district, age-standardised all-age all-cause mortality rates were highest in Fenland for men and women; premature mortality (deaths before the age of 75) follow the same pattern.[6]

No single organisation can meet these challenges alone and there is the need to develop a system together in a way that is based upon the real experiences and needs of people, families and carers rather than on organisational arrangements.

>> Further reading:

BCF Plan 2015/16, page 27

4. Delivering the Better Care Fund

Purpose of this section:

- To describe the approach to setting a BCF budget for 2016/17 in Cambridgeshire
- To provide an overview of the major budget lines being supported
- To describe governance arrangements for the BCF budget
- To describe the approach to Programme Management of the transformation to be delivered through the BCF.

Setting a Better Care Fund budget

One limitation of the approach to the BCF budget in 2015/16 in Cambridgeshire is that it was difficult to monitor the impact of the BCF as a whole. The Council and CCG have agreed as guiding principle for the Better Care Fund in 2016/17 that there should be greater transparency over the budget lines in the BCF pool. By this we mean that wherever possible budget lines will have clear performance metrics attached; and that clear and realistic expectations should be set for the transformation projects undertaken through BCF. It is expected that this approach will assist all partner organisations, and the Cambridgeshire Health and Wellbeing Board, in better assessing the impact of the BCF. This will become increasingly important as we move towards longer-term, more integrated planning across the system beyond 2016/17.

As the BCF does not contain any new investment, a significant proportion of the fund will be supporting existing services. We have attempted to bring service budgets into the BCF where a clear benefit can be realised through aligning service budgets in health and social care. The expectation is that this will drive further joint commissioning and support an expansion of integrated working in future years. This has increased the overall size of the BCF in 2016/17, which will be made up as follows:

BCF Funding 2016/17

	CCG (k)	County Council (k)	Other (k)	TOTAL (k)
Revenue	££41,261	£1,352	£700	**£43,313**
Capital		£5,038		**£5,038**
TOTAL	**£41,261**	**£6,390**	**£700**	**£48,351**

'Other' line relates to project funding carried forward from 2015/16. Figures have been rounded – see BCF planning template for precise figures.

BCF Budget categories, 2016/17

The spend making up the BCF has been found from the following categories:

Scheme	Amount (k)	Type	Responsible Commissioner	Notes
Integrated Adults Community Health Services (IACHS)	£17,012	Revenue	CCG	
CCG Re-ablement funding	£2,000	Revenue	CCG	
Risk share	£836	Revenue	CCG	
CCG Carers Funding	£350	Revenue	CCG	
Protecting social care	£2,500	Revenue	LA	
Former s256	£10,652	Revenue	LA	
Care Act Implementation	£1,367	Revenue	LA	
Additional Local Authority contribution (revenue)	£1,352	Revenue	LA	
Additional CCG contribution	£5,605	Revenue	CCG	
Transformation team	£300	Revenue	Joint	
Transformation projects	£1,338	Revenue	Joint	Includes 15/16 underspend of £700k
Disabled Facilities Grant	£3,480	Capital	LA	
CCC Capital	£1,559	Capital	LA	Funding removal of ASC Capital Grant
Total	**£48,351**	Combined		
Figures have been rounded –see Planning Template for precise figures				

Budget categories

All of the areas of spend of the Better Care Fund are considered to be part of a single Pooled Budget for the purposes of the Better Care Fund. In recognition of the fact that significant portions of the budget are to be passported to other services, a principle has been agreed that partners will seek to limit physical transfers of funding, to reduce transaction costs. To achieve this, categories of spend have been created as follows:

- Contribution: for funds that are being contributed to an existing service budget or project from the Better Care Fund pool
- Project: for funds that are reserved for spend on transformation projects under the governance of the Better Care Fund
- Risk Share: funding previously used as the performance-related pay element of BCF and now reserved for the local risk share agreement in relation to achievement of non-elective admission targets

For “contribution” funds, a Responsible Commissioner is identified for each spending line. That Responsible Commissioner is authorised to arrange services or service contracts up to the approved expenditure from the Better Care Fund. To avoid unnecessary financial transactions, ‘Contribution’

funding for which the Responsible Commissioner will be the CCG will not be physically transferred into the pooled fund. Contribution funds will be the sole responsibility of the Responsible Commissioner identified within the Section 75; but the Responsible Commissioner will report progress on spending and performance as part of the overall reporting on the BCF. In particular this means:

- Responsibility for and control of the funding does not pass into the BCF pooled budget;
- No assumption is made by either party about this funding remaining in the BCF in future years;
- the Responsible Commissioner may make changes to, or reduce, or re-allocate the budget in year – but will advise the other partner that it is doing so; and
- any underspend will be retained by the Responsible Commissioner; and the Responsible Commissioner will be liable for any overspend; i.e. there will not be a call on the pooled budget for any overspend.

For "project" funds, the amount identified is available to joint commissioners for project spending towards the agreed BCF plans. Any underspends will be reinvested in the pooled budget.

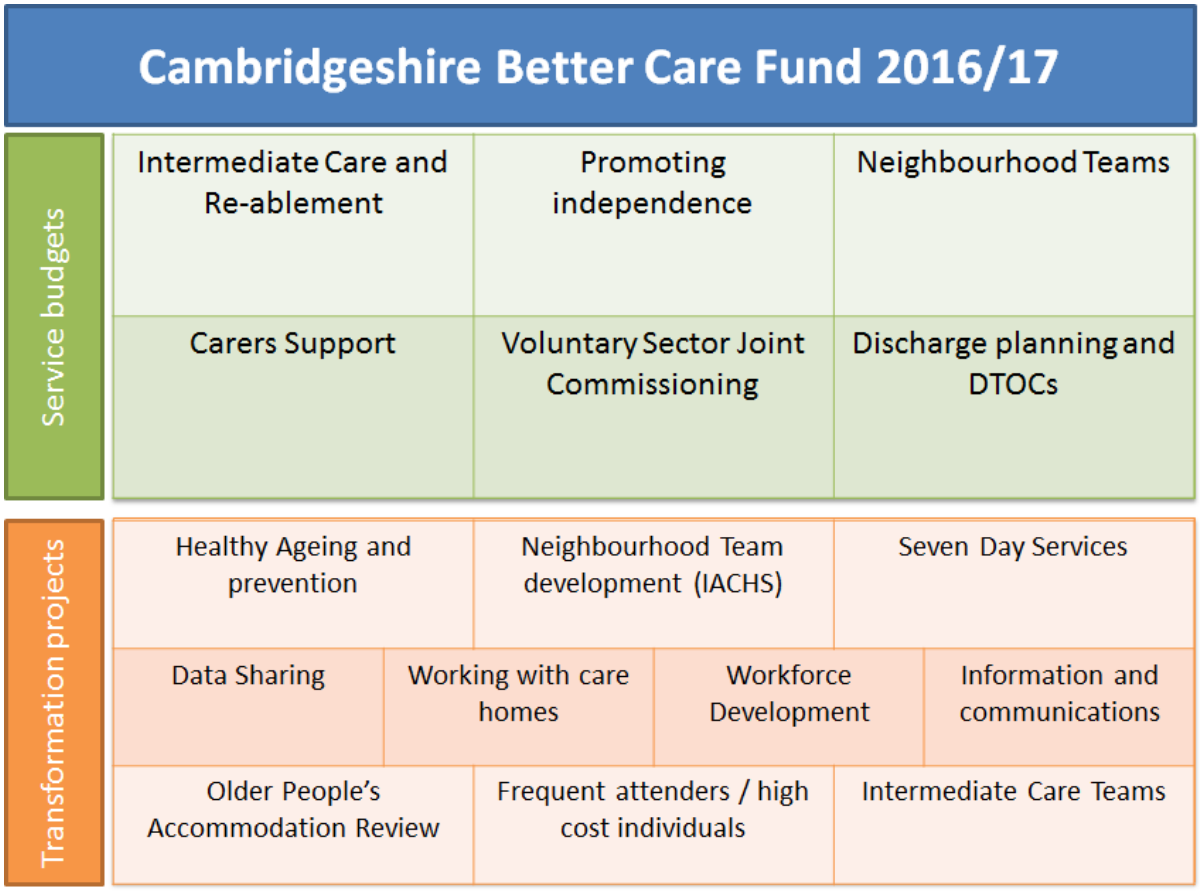
For 'Risk Share' funds the CCG will set the Risk Share aside within the CCG budget and it will only be released into the pooled budget at the beginning of the following financial year based on performance against the target for non-elective admissions. Any funding not released into the pool will be used to compensate acute providers. The methodology for the risk share will be agreed as part of the sign-off process for the section 75; the proposed risk share process is described at Annex A.

Budget management

The County Council will act as host partner for the pooled fund and will be responsible for holding the budgets transferred; administering the budgets; and nominating a 'pooled fund manager' to ensure that the Council complies with its obligations.

Key activity areas

The BCF is divided into 'service budgets' and 'transformation projects':



Service budget spending

As the BCF does not contain any new investment, a significant proportion of the fund will be used to support existing services. However, this year we have attempted to bring service budgets into the BCF where a clear benefit can be realised through aligning service budgets in health and social care. The expectation is that this will drive further joint commissioning and support an expansion of integrated working in future years. This will allow joint planning and monitoring of activity and outcomes in key areas across the system. Alongside existing service spending, we are also investing in key transformation projects that will support the shift that we want to see away from long-term and acute care towards care that is increasingly personalised and provided to people in their homes and communities.

Our BCF activity areas are as follows:

Service area	Amount	Description
Promoting independence	£9,343k	A wide range of services that provide support to people to enable them to remain living independently in their own homes. Services include the Integrated Community Equipment Service; Handyperson scheme; Home Improvement Agency; Assistive Technology and provision of the Disabled Facilities Grant.
Intermediate Care and Re-ablement (bed and non-bed based)	£12,832k	Short term interventions in both health and social care which support people to retain or

		regain their independence
Neighbourhood Teams	17,049k	Neighbourhood teams are integrated community-based physical and mental health care teams for over 65-year olds and adults requiring community services. They work closely with GPs, primary care, social care and the third and independent sector to provide joined-up responsive, expert care and treatment.
Carers support	£1,850k	Advice, information and direct support for carers
Voluntary sector joint commissioning	£2,902k	A variety of contracts held with the voluntary sector that support our goals
Discharge Planning and Delayed Transfers Of Care (DTOCs)	£1,900k	Services that promote effective and timely discharge from hospitals back into the community
Transformation team	£300k	Investment in transformation capacity to support the transformation projects contained within the BCF plan
Transformation projects	£1,338k	Investment in a range of transformation projects that will support our goals (see below)

Full spending plans are contained within the Submission 3 Template on Tab4 (HWB Expenditure Plan); for each budget line the relevant category is indicated at the end of the 'scheme name' field.

Transformation projects

Our service spending is complemented by a range of transformation projects that will support the aims of our joint delivery plan. Some of these projects continue from 2015/16, whilst others are newly established for 2016/17. A brief description of each project is below along with a summary of funding agreed in principle to support the project. Full business cases are in development for each project where funding is to be provided, which will include a summary of the benefits expected for both health and social care; these will be agreed between partners as part of the sign-off process for the section 75 agreement.

Healthy ageing and prevention

The Healthy Ageing and Prevention Project will establish and implement preventative approaches that prevent or delay the need for more intensive health (specifically admissions and re-admissions to hospital) and social care services, or proactively promote the independence of people with long-term conditions and older people and engagement with the community. Areas of focus will include falls prevention, older people's mental health, social isolation and loneliness, and promoting continence.

Two project areas are to be supported financially via the BCF in Cambridgeshire:

- Developing social prescribing

  Social Prescribing aims to increase the capacity of GPs, community health and Local Authorities to meet the non-clinical/non-service threshold of Adult Social Care needs of a variety of different people in need of non-medical services that aim to prevent worsening health for people with

long-term health conditions. In recent years locality-based social prescribing services have increasingly been developed by health and social care commissioners to provide a mechanism for linking patients in primary care with sources of social, therapeutic and practical support in the voluntary and community sector. Social prescribing is being promoted by the Department of Health and NHS England as a vital component in the transformation and integration of health and social care.

Funding of £100k will be made available through the BCF to support the development of a business case and initiate development of a service model for social prescribing.

- Falls Pilot

£42.5k of BCF funding will be used to support a pilot project in St Ives, to ensure implementation of NICE guidelines for falls and improve joined up working between different community teams. The pilot will include approaches to case identification; multifactorial falls risk assessment; and linking people to appropriate falls prevention provision in the community. The pilot will be used to establish approaches that will reduce the number of falls in the community; and will be used to inform the roll-out of a wider service across the county following evaluation.

Information and communication

This project is working to provide consistent, accurate and comprehensive health and social care information and advice regardless of the access channel used or partner organisation contacted. The project will develop access to consistent 'front doors' for information or advice. The project will develop shared information management standards across the partnership and a model for feeding data to a range of partners – a local information platform. The project will enable partners to collaborate better, by developing a deeper understanding of their shared customers and available community resources.

Data sharing

In order to support effective care, access to, and integration of, health and care information is a key enabler in ensuring patients receive the right care at the right place at the right time. These activities also need to be aligned with patient/ citizen sharing preferences as owners of their health and care information and that information where available is used to ensure the care they receive reflect their choices where possible to do so and alleviates the requirement for patients to tell their story multiple times to health and care professionals as they move through their health/ care pathway(s). The Data Sharing Project was established with four objectives for data sharing:

1. To enable decision makers within health and wellbeing pathways to be well informed.
2. To complement and facilitate delivery the preventative / admission avoidance agenda including, but not limited to, the risk stratification process, the person-centred system and the joint assessment process.
3. To improve people's experience of and confidence in the health and wellbeing system; patients will not have to 'tell their story' to a number of agencies involved in delivery of services to them; the relevant information will be accessible to all agencies across the system as required
4. To improve strategic commissioning, planning and delivery.

The focus of the work in 2016/17 is to support the joint delivery plan, via enabling data sharing in 'trailblazer' neighbourhood teams; ensuring that professionals can access each others' systems as appropriate; promoting early sharing of information about people whose needs are increasing; and

developing an approach to information governance that supports the above priorities. Work will also continue on development of the county's Digital Roadmap which will describe how we will move towards 'fully interoperable electronic health records so that patient's records are paperless'. £200k of BCF investment has been agreed to support development of the project in 2016/17.

Seven day services

The Seven Day Services project will enable discharge planning to be undertaken in response to patient need as opposed to organisational availability and will improve outcomes for patients because they will be able to leave hospital as soon as they are clinically fit and it is safe to do so. The Seven Day Services Project will deliver an integrated approach to discharge planning and admission avoidance ensuring that the right services are available across the system when needed and will include expansion of health and social care services, and residential and nursing home services. In addition this project will focus on out of hours admission avoidance in order to ensure that the increased pace and capacity created by improved 7 day discharge planning is not just filled by an increase in admissions. Priorities for 2016/17 include working with providers to achieve clinical standards, mapping of services to identify priority areas for further planning /investment and discharge planning. No funding is included within the BCF for seven day services; in the short term it is intended that each organisation will meet its own costs. Seven day services form an important part of the CCG contracts with its acute providers.

Neighbourhood Team Development, with links to the Integrated Adult Community Health Services (IACHS) Programme

The Neighbourhood Team (NT) is central to the Integrated Adults Health Services (IACHS) model, delivering care organised around the patient. NTs are the physical and mental health care hub of the local community, working in an integrated way with GPs, primary care, social care, housing and local community support services (voluntary and community sector and independent sector) to provide responsive expert care and treatment to local people. NTs are focused on admission avoidance and high quality care and management of patients with complex long term conditions. Multi-disciplinary integrated NTs consisting of Community Matrons, Community Nurses, Allied Health professionals, Mental Health Social Workers are operational across the county. The continued development of these teams will include Adult Social Care and each recipient of a service will have a named lead professional.

The NTs will be supported by case finding, case management, risk stratification and frailty tools and associated processes, along with a common assessment framework, to ensure appropriate timely interventions are made. These all form key parts of our Delivery Plan.

Working with care homes

This project will provide resource to recruit Care Home Educators. Building upon a successful recent pilot, the educator scheme is already operational in Peterborough, providing clinical review, support, and training to care home staff. The educator provides a link between care homes and other health services to embed alternative pathways to prevent avoidable admissions, and, between the acute trust and care homes, to improve discharge pathways. The role supports medication reviews, improved care quality to reduce incidences of pressure sores, deep vein thrombosis (DVT), urinary tract infection (UTI), and falls. The care home educators will support a system-wide approach to reduce the number of hospital admissions relating to urinary tract infection (UTI) or blocked

catheters. An analysis of UTI (ICD10: N39) recorded over 2,600 emergency admissions and over 32,500 bed days at a total cost of £8.6m. Whilst not all these admissions are from care homes, it is realised that care homes have a significant part to play in reducing UTIs and with regards to catheter care for patients at risk of UTIs. Investment of £113.5k has been agreed from the BCF transformation fund to support this work.

Workforce development

We are committed to the development of joint workforce development approaches. We will focus on developing capacity, capability and work to change attitudes and behaviour regarding integrated working across the health, social care, voluntary and private care system. To this end we are in the process of developing a BCF Integrated Workforce Group, which is aligned with the work of the Local Workforce Advisory Board. This Board will oversee the delivery of the Sustainability and Transformation Plan workforce requirements for health. Across the health and care system there are three main areas to be explored:

- Career pathways
  The sector as a whole is facing severe personnel shortages at all levels of health and care, and so we need to create attractive career pathways in the care and health sector as a whole; supporting people to develop their skills whilst staying within the sector. This will mean understanding people's current pathways; understanding the reasons that people join and leave the sector; and understanding where the gaps are that cause people to leave for a new career elsewhere. This will help us to identify opportunities for new training opportunities, support and new role types. If these pathways are not coordinated across health and care then any significant recruitment in one sector will lead to shortages in another, destabilising the whole system.

- Training and skills
  New or changed roles will require individuals to learn new skills. Practitioners will need training that supports them to develop through more integrated career pathways. Individuals will need training to become more flexible in providing care and health tasks; and will need longer term support to develop into their future career. This will require a mix of short term learning opportunities; informal courses and development; and longer-term vocational and professional qualifications. We will work with our own learning and development functions as well as other education providers to understand what new opportunities may be needed for the future - and work with them to design the right training mix to realise this.

- System culture
  Learning and Development interventions that are focused on practitioners' role as part of a wider system - instilling a culture that helps practitioners at all levels think about people's needs wider than their own organisation. helping them to understand how their role links with others in different organisations; and focused on giving people the common skills and common language to pull together for the benefit of residents, patients and service users.

Up to £100k funding will be made available from the BCF to support this work in 2016/17 and the plan is to match funding with other funding sources in year.

Older People's Accommodation Review

Our Older People Accommodation Programme brings together partners from across the system to co-ordinate health, housing and social care agencies so our work supports older people's access to accommodation that they want to live in, that enables them to remain independent within their

community wherever possible. By co-ordinating activity, we hope to help older people to have a choice about where they live, even if their health and social care needs are high or escalating. The Programme will be supported in order to make use of specialist technical expertise during 2016/17 to inform planning for future accommodation needs. £50k of BCF investment is available to support this work during 2016/17.

Frequent attenders / high cost individuals

Research has shown that small numbers of people can have a proportionately high impact on the system, whether this is through frequent attendances at Emergency Departments (ED), frequent visits to primary care, high levels of hospital admissions or because their needs mean that they receive significant care on an ongoing basis from a range of different organisations. Based on our local research to date, in many cases there will be opportunities to provide better care for those people more efficiently, in ways that are tailored to their individual needs and circumstances and closer to home.

This work is currently being scoped will explore three areas to better understand how we can identify and meet the needs of groups of patients more effectively:

- Frequent attenders/ frequent admissions – identifying patients who are frequently attending at or admitted from ED and seek to work with them to understand their needs. We will aimt to coordinate support for them more effectively in the expectation that this will reduce their attendances and admissions and ensure that they are getting the care that they need.
- Most expensive patients – identify the patients known to an acute setting that are most expensive over a period of time; explore whether they are known to other agencies and whether it would be possible to meet their needs in a different way
- Identifying patients at risk of becoming high users of health and social care services – Coordinating support through neighbourhood teams, identifying the patients that are receiving regular and intensive support from a range of different organisations to explore whether their support can be provided in a more joined up way.

The methodology for the work is to be developed, but in each of the three areas is likely to include elements of:

- Automated, data driven identification of individuals
- Holistic and collaborative assessment of their needs
- Development of a shared care plan that will coordinate their support across a number of agencies, with an identified lead professional
- Regular review of individual needs to ensure that they are receiving the support they require
- Evaluation to understand whether closer collaboration around those patients will reduce costs to the system and improve people's care.

Up to £70k of BCF transformation investment is available to support the development of this work during 2016/17.

Intermediate Care Teams (non-bed based provision)

Review the intermediate tier to ensure that neighbourhood teams are complemented by a resilient, integrated intermediate care tier offering home-based services and intensive rehabilitation services

(therapy). This will involve all local partners, including commissioners and providers. The aim is that there will be co-ordination, co-location, and co-operation between re-ablement, rehabilitation, neighbourhood teams, primary care, housing and the voluntary sector to make best use of the total resources available. This would result in the creation of a strengthened, integrated intermediate care suite of health / social care services to:

- prevent unnecessary admission to hospital
- support early discharge from, or prevent unnecessarily prolonged stays in, hospital as well as supporting early discharge from community hospital rehabilitation units
- prevent premature admission to long-term residential care
- maximise health and self-confidence and chances of living independently.

The service includes the recruitment of integrated care workers, intermediate care therapists and nurses. The best means of delivering this service is currently being explored with the community services provider CPFT.

Programme Management

As part of our 2015/16 plan, it was intended to establish a multi-agency transformation team to develop the BCF transformation projects. After further discussion this was established as a 'virtual team' comprising officers from Cambridgeshire County Council, Peterborough City Council, Cambridgeshire and Peterborough CCG, and (until December 2015) UnitingCare Partnership. Wherever possible, projects are being developed jointly across both Cambridgeshire and Peterborough Health and Wellbeing Board areas. Dedicated Programme Managers are based within each local authority, and project sponsors and leads are drawn from across the partnership as appropriate. This arrangement will continue for 2016/17. In 2016/17 wherever possible there will be system-wide design of the joint projects with consideration being given to local implementation where it makes sense to do so.

Risk Management

Below are details of our respective approaches to the most important risks and our plans to mitigate them.

Cambridgeshire has adopted a proactive approach to risk and issue management, based on best practice methodologies. The risk and issue management pathway includes a sequence of activities to identify, assess, prioritise and mitigate the risks and issues. This incorporates robust engagement with local stakeholders.

The CCG's Assurance Framework and risk register (CAF) was last reviewed and updated in March 2016. It sets out the high level organisational risks that could potentially impact upon the CCG and its ability to deliver its responsibilities. The CAF brings together all of the evidence required to support the Annual Governance Statement. It clearly identifies the risks of failing to meet the CCG's Strategic Aims and also its agreed Values. The 2015-2016 CAF is also linked to the relevant domains within the DH Annual CCG authorisation process. The CAF clearly identifies the strategic risks to the organisation. It identifies the controls in place to mitigate the risks, the assurances on these controls and the action plans that have been established to address any gaps. The CAF should be seen as a living document which will be updated regularly by the Corporate Governance Team and reported to the CCG Governing Body and relevant sub-committees for monitoring purposes. The 2015-2016 version of the CAF comprises risks that were transferred from the 2015-2016 CAF together with new risks identified following review at the end of 2015-2016. Following recommendations made by

Internal Audit, the design of CAF has included changes to include target risks scores and also reflect the organisation's risk appetite. This latter recommendation will continue to be developed as the current year is progressed. As set out in our Risk Management Policy the CAF is linked to the Local Commissioning Group (LCG) Board Risk Registers and also the individual directorate registers which have now been established. These Risk Registers are reviewed on a quarterly basis by the CCG Secretary and High Risks are reported through to the Clinical and Management Executive Team (CMET), and escalated to the CAF where appropriate. Risk Registers have been developed for each of the CCG's Programme Boards. These registers are monitored by the respective Programme Boards. Each Urgent Care Network has established risk registers which have been combined to form an Urgent Care Collaborative Board Risk register. The risks on the Assurance Framework have been evaluated and scored using the NHS Patient Safety Agency's Model Risk Matrix. The CAF design is based around the CCG's Strategic Aims agreed for 2014/15. The CCG's extensive risk plans incorporate those risks relating to the high risk areas within BCF plan delivery relating, for example, to QIPP, financial balance, increasing NEAs, DTOCs etc.

The County Council also has a robust risk management policy to identify, evaluate and manage risks. Major risks to the delivery of outcomes and services are identified and included within the risk register. For each risk, a risk owner is identified who is responsible for reviewing and monitoring the risk. All risks, including the effectiveness of mitigating actions, are reviewed on a quarterly basis. Directorates each have their own risk register. Where risks cannot be managed at a directorate level, they are escalated to the Corporate Risk Register for discussion by the Council's Strategic Management Team (SMT). SMT review all 'red residual' risks each quarter. A quarterly report detailing key changes to corporate risk and its profile is presented to Committee.

Governance and Programme Alignment

One of the lessons learned during 2015/16 was the need for much greater scrutiny across the system of BCF plan delivery and on the reduction of non-elective admissions (NEA). In order to achieve the level of shift from acute to community care the rapid but sustainable development of community health, Local Authority, and VCS systems and services as part of the integrated solution is necessary. This is of paramount importance during 2016/17 given the scale of the financial challenge facing both the CCG and Local Authority. The reduction of NEAs, and demand on long term social care services, are key components of the QIPP and Local Authority plans to move towards greater financial sustainability.

The governance landscape around the BCF Plan has changed this year, and is set out in a diagram at Annex G. The Sustainability and Transformation Programme (STP) leads on the development of the five year Sustainability and Transformation Plan, overseen by The Health and Care Executive, which is a Chief Executive Officer-level group comprising CCG, Providers, Local Authorities and NHS Improvement. Workstreams overseen by this group include the Urgent and Emergency Care (UEC) Vanguard, which reports locally to the Super-System resilience Group (SSRG) and through to the Health Executive. Another programme included as part of the STP is the Proactive Care and Prevention Programme (PCPP), which includes the BCF Healthy Ageing and Prevention workstreams.

The Programme is now referred to as the Integrated Adults Community Health Service (IACHS) in view of the fact that all adults and not just older people are incorporated within the way forward. The mechanisms / governance for IACHS will be as straight-forward as possible, recognising it is a

complex system. Most IACHS planning and service development work fits well with the new STP structures, and joint working associated with the Better Care Fund. As there are already a number of existing local system structures, there will be a CCG wide Integrated Adult Community Services Joint Clinical and Management Team responsible for continued operational delivery. It will also form part of the Urgent and Emergency Care Vanguard structure, but through its membership link strongly with Proactive Care and Prevention STP workstream, and Better Care Fund work. The value of this joint clinical and management team will be reviewed at 6 months, recognising the rapidly changing environment.

As the CCG area is comparatively large, it contains four Local Health Systems, with six Local Commissioning Group (LCG) Boards. The LCGs are responsible for driving the System Resilience Groups (SRGs). The role of the three local SRGs is to ensure systems are in place around each acute hospital to ensure patient flow across the system. SRGs comprise representation from the acute hospital, CCG, Local Authority, VCS, Ambulance Trust and member of the BCF team. The SRGs are responsible for developing and delivering the DTOC plans locally as well as monitoring the non-elective activity and implementing the new ways of working coming out of the Vanguard Programme.

The Cambridgeshire Health and Wellbeing Board has overall responsibility for BCF Plan delivery, whilst regular monitoring of the Plan and budget is delegated to the Cambridgeshire Executive Partnership Board (CEPB), which brings together all key partners across the county. As well as overseeing the BCF Plan delivery, the purpose of CEPB is to provide whole system leadership and coordinated multi-agency oversight of health and social care service transformation for older people and vulnerable adults in Cambridgeshire. In order to further strengthen BCF plan delivery during 16/17, a BCF Delivery Group has been established, reporting to the CEPB. This Group will ensure there is the appropriate level of drive and focus on programme delivery in 2016/17. The Group's core members are representatives from the County Council and CCG; the group will engage with other partners regularly as required.

With such close inter-relationship it is crucial that there is clarity on where the governance and thus decision point sits for each workstream. A review of governance and delivery arrangements is scheduled to take place during the first quarter. The aim will be to rationalise and integrate the governance and delivery arrangements of workstreams across the health and care system whilst also ensuring alignment across Cambridgeshire and Peterborough wherever possible.

>> Further reading:

BCF Plan 2015/16, page 47

5. National Conditions

Purpose of this section:

- To describe how each of the National Conditions for the BCF will be met in Cambridgeshire

Local plan to reduce Delayed Transfers of Care

A Delayed Transfer of Care (DTOC) is experienced by an inpatient in a hospital, who is ready to move on to the next stage of care but is prevented from doing so for one or more reasons. Timely transfer and discharge arrangements are important in ensuring that the NHS effectively manages emergency pressures. The arrangements for transfer to a more appropriate care setting (either within the NHS or in discharge from NHS care) will vary according to the needs of each patient but can be complex and sometimes lead to delays.

In Cambridgeshire, non-elective admissions for over 65 year olds account for 47% of all non-elective admissions and 62% of spend in acute hospital care. Older patients are more likely to have a longer length of stay, even after their acute medical problems have been resolved. Prolonged hospitalisation not only increases costs, it is also associated with other complications especially in older patients such as infections, immobility, pressure sores, Deep Vein Thrombosis and deconditioning, thus worsening the patient's quality of life and outcomes.

Recognising that patient flow has a significant impact on the effectiveness of emergency care, we have a robust approach to DTOCs which operates at three levels:

- Our strategic approach to DTOCs is being coordinated through the Urgent and Emergency Care Vanguard;
- Our System Resilience Groups (SRGs) have plans for reducing DTOCs
- Each system has operational arrangements to respond to short-term increasing pressures, which allow for quick escalation; improving use of capacity and procuring additional capacity where necessary; and establishes regular conference calls at times of significant pressure to ensure that the system is doing everything possible to alleviate the situation.

There are a number of factors that affect Length of Stay (LoS), some of which are associated with internal hospital processes such as waiting for tests, specialist review, or Occupational Therapist (OT) review. Issues associated with processes and behaviours within the acute hospitals are addressed within the Vanguard's 'In Hospital' workstream through embedding the SAFER Bundle of interventions as well as the standardisation of pathways for common conditions.

There is also a strong focus on discharge planning and DTOCs from each of the Hunts and Cambridgeshire SRGs and this work is in turn also supported by both the BCF and UEC Vanguard work streams. On this basis a gradual reduction in DTOCs has been seen as realistic, with the aim of reaching the nationally recommended target of 2.5% occupied bed days in by June 2016 for Cambridgeshire and July 2016 for Huntingdonshire. These slightly differential targets underpin the single Cambridgeshire-wide target set out in the Part 2 DTOC Plan metric.. The local Cambs and Hunts DTOC plans are attached. Both are undergoing significant revision by each SRG at time of BCF

plan submission in order to strengthen the delivery and risk sections of the plans. They will be signed off in June 2016.

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Key deliverables regarding discharge planning across the Cambridgeshire and Peterborough system in 2016/17 include:

Discharge Planning Protocol

We will develop and implement consistent discharge protocols across acute and community hospitals, with pathways for discharge well defined and streamlined. The protocol will bring consistency in the processes and definitions used to identify and act upon delayed transfers of care. The local system of notification will alert community and social services to the likely need for services post-acute discharge and will facilitate forward planning for discharge.

Intermediate Care Teams (non-bed based provision)

Recent work has been undertaken to reconfigure existing community services to develop multidisciplinary, locally-based community health and social care services, working with clusters of GP practices. These services, set out around Neighbourhood Teams (NTs), include integrated case management, community nursing, community therapy, and mental health support. We now need to take this to the next stage to establish a resilient intermediate care tier that can provide home-based services and intensive rehabilitation services (therapy).

This service will be aligned with the robust reablement service provided by Cambridgeshire County Council to form a truly integrated intermediate tier. It is envisaged that there will be co-ordination, co-location, and co-operation between the services to make the best use of the resources available.

These services will build the community service base necessary to enable safe and timely discharge.

Discharge Home to Assess pathway

Discharge home with 'live in' care support and wrap around care from community teams for complex patients. This is a time-limited intervention for patients that will benefit from a period of care and support at home before their final care needs are assessed. This will complement the intermediate care tier service for those patients that require more intensive support (e.g. 24 hour care) in the initial weeks of their recovery, or for those patients who are on the final stages of an End of Life pathway.

This service has already been piloted successfully in the Cambridge system focusing on Continuing Health Care (CHC) Fast Track patients and self-funders with very positive results. MIDAS care, an independent sector provider, provides support for six placements at any one time with either live-in care or two shifts of 12-hour care if the patient's home cannot accommodate a live-in carer.

Early evidence suggests that 15 patients have already been discharged from Addenbrooke's hospital over a seven week period with an average length of stay in the pathway of nine days. Of the 15 patients, two were self-funders (13%) and 13 were Fast Tracks (87%). A previous audit of CHC Fast Track patients in hospital before the pilot started showed average length of stay from fast track referral to discharge to be 5.4 days. Of the 13 patients in the pilot, 30% were discharged within 24 hours, 54% were discharged within 48 hours, and 92% within 72 hours, with 100% of patients discharged within four days. In addition, there are invaluable benefits to patients by going through

this pathway as 46% of them passed away at home in line with their wishes. The feedback from carers has also been extremely positive.

The service will be rolled out incrementally across the full CCG geography to enable providers to deploy additional resources without destabilising the existing capacity. The cohort of patients will be expanded beyond those selected for the initial pilot to include patients with other complex needs that are often difficult to place in interim health settings while they recover, such as patients presenting with slow-resolving delirium.

The final complement of 30 placements or "virtual beds" with an average length of stay of four weeks in the pathway would provide support for approximately 500 patients in a year.

Community Based Intermediate Care Beds

A review of community based intermediate care beds, covering community hospitals and care home settings, will be undertaken during 2016/17 to ensure that commissioned capacity is aligned to reduced demand levels expected as a result of developing and investing in community intermediate care teams and home based services resulting in a need for fewer beds. Investment in the development of community intermediate care capacity, as stated in the points above, has the potential to enable care at home for over 3000 patients per year.

More home care will also support greater patient flow within community beds increasing throughput and reducing Length of Stay (LoS). We are aiming to reduce LoS in community beds to an average of 14 days.

Overall Impact in 2016/17

We have agreed the following targets / objectives at present for the post-hospital discharge workstream:

- Achieving the nationally recommended target of a reduction of 2.5% occupied bed days by June 2016
- 20% reduction in spend on excess bed days (based on spend across the three main acute hospitals, all Health Resource Group (HRG) codes)
- 20% reduction in NE readmissions in acute hospitals
- 20% reduction in the use of escalation/contingency beds within the three acute hospitals
- Improved staff satisfaction and reduced sickness absences, staff turnover/vacancy levels, and spend on agency staff. This will be monitored during 2016/17 with a view to gathering evidence/baseline data of the impact proposed schemes have on the staff satisfaction and related metrics)
- Improved patient and carer experience of care and support at home/in the community
- In addition to the benefits already received through reablement it is expected that there will be a further reduction in demand for long-term social care packages. This is estimated to be 20% of the total patient throughput supported by the Intermediate Care Tier and expected reduction in local authority spend on long-term care packages
- Reduction in LoS down to an average of 14 days in community hospital beds to improve throughput

Approach to DTOC fines

In line with Care Act guidance and practice across the Eastern Region, the County Council has stated that it does not expect to be paying DTOC fines to acute hospitals on the assumption that it is doing everything within its power to effect a timely transfer from hospital of people CCC is responsible for supporting. The effective delivery and implementation of the Better Care Fund Plan will ensure that the health and social care system is working to maximum effect to prevent admissions where appropriate and enable appropriate discharge.

>> Further reading:

UEC Vanguard Value Proposition 2, page 22

Plans to be jointly agreed and Impact on providers

Provider engagement and sign off of the BCF plans is an intrinsic part of the process in Cambridgeshire – to ensure that plans are jointly agreed and that the impact of our proposals on providers is considered. The Cambridgeshire BCF plan is closely aligned with the CCG-wide Sustainability and Transformation Programme; particularly through its Proactive Care and Prevention and UEC Vanguard workstreams, both of which involve partners from across the system.

The BCF Plan is a standing item on the agenda for the Cambridgeshire and Huntingdonshire monthly System Resilience Group (SRG) meetings, which include health and social care commissioners and providers alongside members of the VCS. Further the plan is the subject of ongoing discussion at the Cambridgeshire Executive Partnership Board (CEPB) which includes District Council representatives and is accountable to the Health and Wellbeing Board for the BCF Plan development. Comments and input from CEPB means that the plan has been commented on by commissioners and providers in social care and health. The final plan has been approved by the Health and Wellbeing Board and signed off by the County Council and CCG Governing Body and also Hinchingbrooke Hospitals NHS Trust, Cambridge United Hospitals NHS Trust (CUHFT) and Cambridge and Peterborough NHS Foundation Trust (CPFT), our community and mental health services provider.

The plan has thus been discussed throughout its development and jointly agreed by local partners across health, local authorities and the VCS. The transformation priorities have been discussed widely across the system, and build on the Joint Older People Strategy agreed by our system in 2014.

The CCG will also include the Cambridgeshire BCF Plan as part of the Cambridge University Hospitals Foundation Trust (CUH), Hinchingbrooke Healthcare NHS Trust (HHT) and CPFT contracts as a document to be relied upon. The detail of the plan will be incorporated within the post contract agreement in the next routine contract meeting.

Our 2015/16 Plan (page 80) describes our approach to engagement in developing the first year's BCF Plan. Cambridgeshire Executive Partnership Board Members have continued to be engaged in development of the plan and the projects which sit underneath it; and continue to take responsibility for engaging with their own organisations and sectors.

>> Further reading:

Annex D to this submission is our high level communications plan – this is being further developed. **BCF Plan 2015/16, pages 80, 82**

Maintaining provision of social care services

The locally agreed definition of protecting social care services is maintaining the existing thresholds for social care eligibility criteria, ensuring that social care services are able to meet the national minimum eligibility criteria.

There are no proposals to reduce social care services within the plan, in the sense of changing the eligibility criteria as per the definition above. £2.5m of the BCF has been allocated to the CCC budget to ensure that services can be protected, alongside the continuation of the funding that was previously in section 256 allocations, and there are no plans to reduce the amount of resources dedicated to supporting reablement.

Our overall level of support specifically identified to maintain provision of social care services has remained the same in 2016/17 as in 2015/16. More information on our overall approach is contained within our 2015/16 BCF Plan.

>> Further reading:

BCF Plan 2015/16, page 66

Care Act requirements

£1,367,000 has been allocated to support our local response to the Care Act, including meeting the new duties placed on local authorities. As a result of Part 2 of the Care Act being delayed to 2017, the programme set up to deliver the requirements of the Care Act was merged with the Transforming Lives project in July 2016. Governance arrangements were reviewed and projects were re-scoped to deliver by April 2016. The Transforming Lives/Care Act programme portfolio of projects is as follows:

- Transforming Lives (including Workforce Development) – a new model of social work for Adult Social Care
- Adult Early Help – a new model of front door access to Adult Social Care
- Communication and information
- Care markets – managing the market to meet Care Act requirements
- Safeguarding – set up to deliver 'making safeguarding personal', transferring safeguarding referrals to the Multi-Agency Safeguarding Hub (MASH) and to meet Care Act requirements
- Advocacy – set up to commission and procure a new advocacy service
- Supporting Systems – to deliver the changes to the contributions policy to meet the Care Act requirements
- Community Navigators - set up to commission and procure a new contract for community navigators

The programme will be reviewed again in April 2016.

Support for Carers

Our 2015/16 BCF contained £350k as the minimum amount of carer specific support included within the BCF, which is used within CCG budgets for their support for carers. The total £350k was transferred to the UnitingCare contract for the purposes of commissioning carers' support from the Carers Trust. This responsibility has now returned to the CCG who are using it to support the Carers'

Prescription (£278k); along with other carer liaison and support and other posts within the voluntary sector. More detail is contained within our 2015/16 plan.

To support a more joined up service for Carers in future, the County Council has brought some of its own services for carers within the scope of the BCF budget in Cambridgeshire, alongside the services already included.

>> Further reading:

BCF Plan 2015/16, page 80

7 day services

All partners maintain a strategic commitment to 7 day working where appropriate. Many services are already operating seven days a week; our focus locally is ensuring that the right services are available at the right time to ensure that patients are kept safe, and that patient flow is maintained.

During 2015/16 whole system workshops were held in each of Cambridgeshire and Huntingdonshire System Resilience Groups (SRGs). These took a whole system pathway approach to ensuring the development of seven day services in addition to working on the imperative to deliver the ten clinical standards. A common set of principles has been agreed, predicated on the need to ensure patients flow through the system irrespective of day of week. The resulting delivery plans are owned and being driven by each SRG and service mapping and communication of service availability via the Directory of Service as well as delivery against the ten clinical standards and discharge planning will be a key part of the delivery plan for 2016/17 BCF.

Better Data Sharing, based on the NHS Number

NHS Cambridgeshire and Peterborough CCG mandates the NHS Number as the primary identifier for correspondence through the NHS Standard Contract for providers, while at the same time ensuring compliance with the NHS Care Records Guarantee and Patient / Citizen privacy mandates.

The County Council has completed a procurement for a new social care management information system, which will be implemented during 2016/17. The new system will allow easier sharing with partner organisations based on open Application Programming Interfaces (APIs).

A project is underway to establish and implement an effective and secure approach to data sharing across the whole system in order that the provision of all services will be better co-ordinated and integrated, and support the delivery of person centred care in the most beneficial setting. The project will ensure the use of the NHS number as primary identifier. It will include the delivery of an overarching solution that will make available data from several systems across Cambridgeshire with the provision of APIs for each core system. This will be aligned with the production of Information Sharing protocols and a phased roll-out plan for Data Sharing.

Original plans for 2015/16 focused around the development of the UnitingCare system 'OneView', which would offer a single view of the patient record. In light of the UnitingCare contract changes a decision was taken to not proceed with OneView, so further scoping is underway to determine

alternative options. A focus on immediate practical data sharing options are being progressed to facilitate better data flow and integrated working practices (e.g. local data sharing agreements, cross-organisational access to existing systems). In addition, Cambridgeshire County Council has recently procured a new adult social care system, which will incorporate open APIs. This system is expected to be operational in Autumn 2016. This work is aligned with the CCG's local digital roadmap and digital maturity work.

Joint approach to assessments and care planning

Our approach to joint assessments and care planning is described in our 2015/16 BCF Plan. The plan described how the contract delivered by the UnitingCare contract would support a step change in our efforts around multi-disciplinary working and joint case management. During 2015/16, Neighbourhood Teams have been established to provide better and more holistic support for older people and people with long-term conditions. Further development of risk stratification, proactive case management and identification of a lead professional are priorities for 2016/17.

>> Further reading:

BCF Plan 2015/16, page 77

Reduction in non-elective admissions

The target 1% reduction in non-elective admissions (NEA) was not met in 2015/16, resulting in many increasing pressures on the system.

During 15/16, the BCF non elective target of 1% was based on Monthly Activity Returns (MAR) data, which includes all CCGs and is not hospital specific. As the CCG Operating Plan was based on SUS data the alignment between the two plans was not easily understandable.

For 2016/17 the BCF non elective data will instead be based on SUS data and will be directly extrapolated from the CCG's Operating Plan's non elective trajectory plus the non elective QIPP plans. The NEA target is thus based on 2015/16 outturn, which has growth built in. The impact of the non elective QIPP plans – those plans required to reduce NEA down to a sustainable and affordable level has then been added which gives a challenging 6.6% reduction in NEA during 2016/17. . This level of reduction is necessary in view of the deficit the CCG faces during 16/17 largely as a result of the OPACS contract and in order to move the system towards greater financial sustainability as discussed above. Partners acknowledge that this is a very challenging target and will require even greater collaboration, partnership working and scrutiny this year to enable this target to be achieved.

The achievement of the NEA target will therefore need to be achieved through composite activity from the UEC Vanguard, Proactive Care and Prevention Programme and the BCF Plans working closely together. It is not possible to ascribe targets to each individual part of the system, as they are interdependent.

One of the lessons learned from 2015/16 is the requirement for more detailed scrutiny by provider, GP practice and by neighbourhood teams on a monthly basis during 2016/17. The fact that the target is this year derived from SUS activity will make it much easier to understand what is

happening and where in order to ensure appropriate mitigating actions can be put in place. Therefore monitoring will not only be from the BCF Delivery Group but also the local SRGs and the Super SRG which governs the non-elective care Vanguard so that mitigating actions can be put in place across the whole system from primary care, community services, through to District Councils and voluntary sector as required.

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

Cambridgeshire has committed £20,866,310 of funding for 2016/17 to NHS Commissioned out-of-hospital services. This exceeds the minimum local BCF ring-fenced amount of £10,132,282. This is comprised of the following elements:

- £836,000 allocated to a local risk sharing agreement (described above)
- £19,680,310 allocated to the commissioning of providers to deliver local integrated adult community health services
- £350,000 dedicated to services for carers commissioned by the CCG.

Integrated Adult Community Health Services (IACHS)

The level of funding for IACHS in 2016/17 has provisionally increased to £19,012,000 from £17,808,000 in 2015/16. In 2015/16 this funding was invested in the OPACS contract, which was a key enabler for health and social care integration across the local system. Despite the provider UnitingCare no longer holding the contract, the local system partners remain committed to the integrated community model of delivery going forward. Cambridgeshire and Peterborough Clinical Commissioning Group have taken on direct responsibility for direct commissioning of the IACHS model and continued work to further develop the model is planned in 2016/17. This increase in funding allocation for provision of the IACHS model is necessary as the CCG has inherited an £8.4m deficit as a direct result of the transfer of the OPACS contract from UnitingCare to the CCG. This contract was specifically designed to develop community based services to enable people to be cared for closer to home, thus reducing the level of non-elective demand on acute hospitals. Within this context, the CCG has a duty to ensure that the appropriate level of health investment continues to be made in community services in order manage the health aspects of the urgent care demand in the system so that patient flow is maintained.

Use of the Disabled Facilities Grant

For 2016/17 there has been a significant uplift in the Disabled Facilities Grant (DFG), from £1.9 million in 2015/16 to £3.4 million in 2016/17. The full budget is included within the scope of the BCF. This uplift recognises the important part that housing adaptations play in supporting people to live more independently in their communities.

Social Care and district council partners have a good track record of partnership working and have previously worked collectively to review and establish the best model to deliver disabled facilities grants. This was partially achieved with the development of the shared service home improvement agency covering Cambridge, South Cambridgeshire and

Huntingdonshire in 2012. However, we do still have inconsistent arrangements across the county.

Cambridgeshire Executive Partnership Board (CEPB) members believe that the uplift in BCF presents an opportunity to take a more strategic approach to housing adaptations, encompassing both capital and revenue funds contributed by a range of partners countywide. We have locally established a DFG Review project, reporting to our Older People Accommodation Board.

We recognise that we need to take a planned approach. For 2016/17, the new DFG allocation will be passed in full to District Councils from the County Council; whilst the DFG Review project examines our overall approach and develops any changes to budgets through its work over the course of 2016/17. We will aim to make any changes to budgets from the 2017/18 financial year. Each District will use the increased allocation to meet the local need for housing adaptations. DFG allocations for each district are included within the BCF Spending Plan as part of the BCF submission template.

The focus of the DFG Review is on three key areas:

1. Review of current delivery model and time taken to deliver adaptations

    - Desktop analysis of quarterly monitoring information including: Time taken to deliver DFGs, analysis of types of adaptation, location, etc.
    - Research models of delivery in other areas including Peterborough
    - Consider fast tracking standard works i.e. Level access showers, outside of DFG
    - Consult with home improvement agency providers on possible options going forward.

2. Review early intervention and Occupational Therapy referrals

    - Consider options for providing early housing options advice before an OT assessment is requested, including potential use of the Early Help team, Reablement, Handyperson Service, Home Visiting Service, etc.
    - Explore use of Trusted Assessors for standard works i.e. level access showers and whether this would meet the duty to consult Social services
    - Review OT practices in relation to DFGs in child, physical disability and older people cases
    - Ensure adapted homes are considered as part of developing new communities/large sites
    - Look at OT waiting times and whether these could be reduced through alternative ways of working or redeployment of resources.
    - Consider how this work links with the new multi-disciplinary teams

3. Making best use of both capital and revenue funding

    - Review the need/demand for DFGs by district and by household type.
    - Identify any gaps/surplus in capital funding following new BCF allocations.
    - Review current DFG ‘top up’ policies in districts and at the County to identify possible alternative options/mechanisms.

- Consider current discretionary grant/loan policies at district level and possible use of DFG capital for relocation, etc.
- Consider current revenue funding for HIAs from both CCC and Health and assess the impact of any reduction.
- Consider the use of a Memorandum of Understanding in relation to the use of both capital and revenue funding.
- Agree recommendations for best use of capital and revenue funding for 2017/18 onwards

The review group will report back to the Cambridgeshire Executive Partnership Board in summer 2016; and any proposals will be agreed by respective partner organisations and discussed at the Health and Wellbeing Board.

Annexes

Annex A	Proposed Risk Share Agreement
Annex B	Milestone Plan
Annex C	Risk Log
Annex D	Communications plan
Annex E	Huntingdonshire System DTOC Plan
Annex F	Cambridgeshire system DTOC Plan
Annex G	Governance diagram

Annex A: Proposed Risk share agreement

This risk share approach will be finalised and included within the Section 75 Agreement

1. Context

During 2015/16, the BCF non elective admissions (NEA) target of 1% reduction against 14/15 outturn was based on Monthly Activity Returns (MAR) data which includes all CCGs and is not hospital specific. Further as the CCG Operating Plan was based on SUS data, the alignment between the two plans was not easily comparable. For 2016/17 the BCF non elective data will instead be based on SUS data.

2. BCF Guidance

The performance element of the Better Care Fund has been replaced in 2016/17 by 2 national conditions:

- Local areas to fund NHS commissioned out-of-hospital services
- Develop an action plan for managing Delayed Transfers of Care

The local risk sharing agreement refers to the first of those conditions. BCF Guidance states that local areas can choose to put an appropriate proportion of the performance element into a local risk-sharing agreement, as part of contingency planning in the event of excess NEA in year. Given the upward trajectory of NEA in 2015/16 and the financial position of the CCG, it has been agreed to establish a Risk Share Agreement between the CCG and Cambridgeshire City Council.

3. Risk Share Fund

The Fund comprises 100% of what was the 'performance fund' in the 2015/16 BCF Plan. The risk share value for Cambridgeshire is £836k. For clarity, this is the figure used when referring to the Risk Share Fund. The Risk Share Fund will be part of the CCG's minimum BCF allocation, and not in addition to it.

4. 2016/17 NEA Target

The 2016/17 NEA target aligns with the CCG Operating Plan 2016/17 NEA target plus the impact of NEA QIPP plans. This forms the BCF NEA target in Part 2 of the 2016/17 BCF Plan.

5. Ownership of the Risk

It is acknowledged that the risk sits with the CCG as the CCG is liable for payment to its acute providers in the event of over performance of NEA.

6. Risk Management

The risk will be monitored, managed and mitigated through the Strategic Systems Resilience Group (SRG), which governs the Vanguard Programme and oversees transformation

projects to reduce NEA, as well through the Cambridgeshire and Huntingdonshire SRGs which meet monthly, the BCF Delivery Group and the Cambridgeshire Executive Partnership Board (CEPB) which meets bi-monthly. NEA at Cambridgeshire University Hospitals NHS Trust (CUHFT) and Hinchingbrooke Hospital Trust (HHT) will be scrutinised on an ongoing basis. Where increases in NEA are identified, the reasons for this will be established and mitigating actions taken at the earliest opportunity. The SSRG and each SRG incorporate representation from primary care, local providers and Local Authority. The work of the SSRG, SRGs and CEPB will be overseen by the Health Executive and Health & Wellbeing Board.

7. Operation of the Risk Share

The CCG will set the Risk Share aside within the CCG budget and it will only be released into the pooled budget at the beginning of the new financial year (2017/18) based on year end performance against the BCF NEA target as shown in the below scenarios:

Scenario 1

If there is evidence that the BCF NEA target is met in full, or exceeded, at the end of the financial year (2016/17) then the Risk Share Fund will be paid in full into the pool for 2017/18.

Scenario 2:

If there is evidence that there is over-performance against BCF NEA target (i.e. that there is more-non elective spend due to increased activity than planned) but that the cost of that over-performance is below £836k the CCG will pay the balancing sum into the pool in 2017/18. The remaining element of the risk share will be retained by the CCG in order to compensate acute providers; thus that proportion of the sum will not be available for investment into the pool in 2017/18.

Scenario 3:

If there is evidence that there is over-performance against the BCF NEA target (i.e. that there is equal to or greater than £836k additional spend on NEA than planned) the CCG will retain the £836k in order to compensate acute providers thus this sum will not be available for investment into the pool in 2017/18.

Any funding released into the pool under Scenarios 1 and 2 will be made available for spending on joint transformation projects during 2017/18 as part of the BCF plan; the Council and CCG will collectively decide how the payment would be spent, in consultation with CEPB member organisations and the Health and Wellbeing Board.

Reporting on Risk Share Spend

This will be reported to the BCF Delivery Group through to the CEPB and NHS England through the quarterly reporting mechanism

Annex B: Milestone plan

Healthy ageing and prevention

Workstream	Milestone	Start date	End date
Overall:	Project plan for 2016/17 updated and approved	01 March 2016	01 May 2016
Falls prevention:	Early trigger action plan developed and approved	01 March 2016	01 May 2016
	Design whole system joint falls pathway		01 July 2016
	Agree data set and collect data		01 July 2016
	Falls pilot delivered in St Ives – to form basis for upscaling model across Cambridgeshire and Peterborough	01 July 2016	01 January 2017
	Plan implementation and confirm operational readiness	01 January 2016	01 April 2017
	Implementation commenced	01 April 2017	-
Dementia:	Early trigger action plan developed and approved	01 April 2016	01 June 2016
	Develop joint pathways and best practice guidance across the whole system		01 September 2016
	Agree data set and collect data		01 September 2016
	Pilot/test new pathway or model	01 October 2016	01 February 2017
	Plan implementation and operational readiness	01 February 2017	01 April 2017
	Implementation commenced	01 April 2017	-
UTIs/Continence:	Finalise project lead and project team members	01 March 2016	01 May 2016
	Develop clear vision and objectives	01 May 2016	01 July 2016
	Early trigger action plan developed	01 July 2016	01 September 2016

	and approved		
	Develop joint pathway across the system	01 September 2016	01December 2016
	Agree data set and collect data		01 December 2016
	Pilot/test new pathway model	01 December 2016	01 April 2017
Social Isolation:	Early trigger action plan developed and approved	01 April 2016	01 June 2016
	Develop joint pathway across the system to improve service join up and coordination	01 June 2016	01 October 2016
	Develop strategic evaluation tool to aid local commissioning of high quality social isolation services	1st October 2016	01 March 2016
	Implementation plan and operational readiness	01 February 2017	01 April 2017
	Evaluation tool being practically used to support local commissioning	01 April 2016	-
Wellbeing Service & Social prescribing	Develop Business case for social prescribing	01 May 2016	01 June 2016
	Action plan developed and approved	01 June 2016	01 July 2016
	Agree system wide commissioning model for 'Wellbeing Service'	01 April 2016	30 July 2016
	Implement delivery plans	01 August 2016	01 March 2017
Overall:	Evaluate and plan 2017/18	01 January 2017	01 March 2017

Information and communication

Workstream	Milestone	Start date	End date
	Project plan for 2016/17 updated and approved	01 April 2016	01 May 2016
Local Information Platform	Mapping of existing directories and services completed		01 June 2016
	Options appraisal and approval of technology solution		01 August 2016

	Development of information sharing protocols and agreement of sharing data sets and consent models	01 August 2016	01 December 2016
	Development of technology solution		
	Plan implementation and operational readiness	01 December 2016	01 April 2017
	Implementation commenced	01 April 2017	-
Front door:	Sharing of FAQS and referral pathways between CCC and health front doors Explore opportunities to align One call,111 and CCC SPA	01 June 2016	01 September 2016
	Detailed design	01 September 2016	01 January 2017
	Plan implementation and operational readiness	01 January 2017	01 April 2017
	Implementation Commenced	01 April 2017	-
Change management:	Communications plan developed	01 March 2017	01 April 2017
Overall:	Evaluate and plan 2017/18	01 January 2017	01 March 2017

Data sharing

Workstream	Milestone	Start date	End date
Overall:	Project plan for 2016/17 updated and approved	01 April 2016	01 May 2016
Joint approach to consent and fair processing:	Joint approach to consent and fair processing agreed	01 April 2016	01 October 2016
Protocol for working with patient held records	Protocol developed as part of pilot project	01 May 2016	30 September 2016
	Protocol shared with all health and social care delivery staff	30 September 2016	31 March 2016

Summary care record content signed off and extracts / views created for all systems.	Social care summary content extracts developed	01 May 2016	30 August 2016
	Summary views made available to support dual record access by front line and front door workers	01 September 2016	30 December 2017
Development of longer term plan to demonstrate progress towards common APIs:	Development of 5 year data sharing plan and approval	01 April 2016	01 November 2016
Interim solutions for improved data sharing across existing systems	Implementation of interim solutions (e.g. cross-organisational log ins/access to existing systems)	01 April 2016	01 August 2016
Overall:	Evaluate and plan 2017/18	01 January 2017	01 March 2017

7 day services

Workstream	Milestone	Start date	End date
Mapping of current 7 Day Service provision	Complete mapping of existing whole system 7 day service provision	01 March 2016	01 June 2016
	Review status of each clinical standard within each acute hospital	01 April 2016	30 ay 2016
	Prioritise areas for 7DS on basis of review	Ongoing	01 July 16
	Project plans for 2016/17 updated and approved by each SRG	01 April 2016	01 June 2016
Overall:	Evaluate and plan 2017/18	01 January 2017	01 March 2017

Neighbourhood Team development, linking to the Integrated Adult Community Health Services (IACHS) programme

Workstream	Milestone	Start date	End date
Overall:	Commissioning Project lead from Vanguard Team established	01 March 2016	01 May 2016
	Work plan for 2016/17 incorporated within work of Integrated Adults Community Services Joint Working Group.	01 April 2016	01 May 2016
Population risk stratification and case management:	Case finding approach agreed Test the 'Rockwood' Frailty Score across the system Refine Operational Policy for case management across the health and social care system for 2016/17; Agree a consistent approach to effective MDT coordination across Cambridgeshire and Peterborough,	01 April 2016	01 July 2016
Integrated Neighbourhood Teams:	1.Continued support of NT development 2.Plan for co-location / vertical integration / alignment of Integrated Neighbourhood Teams with Adult Social Care. 3.Develop closer working with Primary Care and the VCS 4. Greater co-working with Primary Care at Scale including selection of NT as demonstrator sites.	01 April 2016	Ongoing
Joint early assessment framework:	Develop joint assessment (pre statutory assessment) approach – including joint framework and joint	01 July 2016	01 January 2017

	response, including lead professional		
	Engagement and roll out plan	01 January 2017	-
	Engagement and roll out plan	01 May 2016	01 July 2016
	Phased roll out commenced, starting with Neighbourhood Teams	01 July 2016	-
Overall:	Evaluate and plan 2017/18	01 January 2017	01 March 2017

Working with care homes

Workstream	Milestone	Start date	End date
Working with Care Homes	Mobilisation plan agreed	2 May 2016	15 May 2016
	Recruitment	May 2016	Aug 2016
	Assessment of care homes	1 July 2016	31 July 2016
	Training in care homes where gaps are identified.	1 July 2016	31 July 2016
	Outcomes /impact report		1 Feb 2017

Workforce development

Workstream	Milestone	Start date	End date
Workforce Development	BCF Sub Group of Integrated Workforce Development Group established.	1 May 2016	31 May 2016
	Agree scope and workplan and opportunities to maximise funding through matched funding	1 May 2016	31 May 2016
	Implementation of plan	1 June 2016	30 March 2017

Older People's Accommodation Review

Workstream	Milestone	Start date	End date
Older People's Accommodation Review	Appointment of external consultancy support	April 2016	May 2016
	Review of DFG/ Home Improvement Agencies	May 16	October 2016
	Fully costed implementation Plan for Residential and nursing Care development		December 2016
	Extra Care Sheltered Housing Strategy and Market Position Statement		October 2016
	Hinchingbrooke Development plan		September 2016

Frequent attenders / high cost individuals

Workstream	Milestone	Start date	End date
Frequent attenders / high cost individuals	Lead identified in Hunts and Cambs Scoping work and project plan to be agreed	1 May 2016	1 July 2016

Intermediate care teams (non-bed based provision)

Workstream	Milestone	Start date	End date
Intermediate Care Teams (non-bed based provision)	Proposals signed off for new model with early implementation plan	1 April 2016	15 May 2016
	Recruitment	May 2016	June 2016
	Implementation	June 2016	August 2016
	Review and evaluation	Sept 2017	December 2017

Delayed Transfers of Care

Workstream	Milestone	Start date	End date
Locally agreed DTOC plan:	Re-develop DTOC delivery and risk plan for 2016/17 and approval by each SRG	01 March 2016	30 June 2016
	a) Complete development of discharge planning protocol	01 March 2016	01 May 2016
	Conduct intermediate care review (Vanguard)	April 16	Sept 16
	Community intermediate care tier is developed (see plan)	May	June onwards
	Evaluate and plan 2017/18	01 January 2017	March 2017

Annex C: Risk Log

There is a risk that:	How likely is the risk to materialise? [1]	Potential impact[2]	Overall risk factor	Risk Owner	Mitigating Actions
Overall BCF Programme					
1. If there is no strategic vision, oversight or direction of travel, or if there is too much focus on small scale initiatives, opportunities to undertake critical and joined up transformation of services will not be maximised.	**4**	**4**	**16**	Cambridgeshire Executive Partnership Board	· Agreed vision and principles which are incorporated within service core planning documents. · Implementation of the 5 year strategic plan and other relevant strategic commissioning plans. · Re-visit governance to maximise opportunities for join up across Cambridgeshire and Peterborough and key areas of transformation (e.g. Cambridgeshire and Peterborough CCG Sustainability and Transformation Programme) to ensure proposals are mapped back to the agreed vision before approval, and to maintain oversight and monitor progress at all stages. · Client groups are identified and reflected in the future vision. · Development of local delivery governance structure to oversee local project delivery
2. Lack of transformational change strategic leadership capacity across the system	**3**	**4**	**12**	CCG/CCC	· Continue development of a Transformational System leadership capacity / capability building programme

leading to inability / unwillingness of partner organisations to provide the sign up and required cultural shift to deliver the whole-scale change, then the transformation will fail to achieve the necessary financial benefits and improvements for customers, staff and stakeholders.					for all executive system leadership · Agreed vision and principles which are incorporated within service core planning documents. · Demonstrable leadership through the delivery of the engagement plan. · All organisations represented by the right people empowered to make decisions.
3. Complex governance arrangements and matrix working lead to confusion on point of decision making	**3**	**4**	**12**	Whole system	· Review whole system workstreams · Align / dovetail where possible · Create governance structures around these · Co-locate meetings wherever possible
4. Lack of organisational capacity and capability to deliver	**3**	**4**	**12**	Whole system	· Ensure alignment across Peterborough and Cambridgeshire wherever possible to maximise use of project resources · Single reports to different fora – e.g. falls reporting to both BCF Delivery Group and PCP Programme to Health Executive) · Strong programme management systems in place · Clarify design and delivery elemens of tasks ·

5.	If the demand for social care services increases more rapidly than the profiled rate, the original plan will not be deliverable. Additional investment and transformation activity will, therefore, be required.	**3**	**5**	**15**	CCC	· Effective monitoring of demand for social care arising from the demographic change. · Effective monitoring of demand for social care arising from statutory duties under the Care Act. · Contingency plans prepared and in place for early intervention if anomalies or variations are identified. · Re-prioritisation of existing resources.
6.	If investment in prevention fails to sufficiently reduce demand for acute services, this will increase the financial and resource challenges for acute and related services.	**5**	**3**	**15**	CCG	· Effective monitoring of demand for acute services arising from the demographic change. · Effective monitoring of demand for acute services arising from statutory duties under the Care Act. · Contingency plans prepared and in place for diversion of funding where necessary. · Continued review of whole system transformation to reduce demand for acute services.
7.	If staff are not fully aware of, nor engaged with, the changes arising from the BCF Plan there may be a negative impact on implementation of BCF plan	**3**	**4**	**12**	CCC/CPFT/CCG	· Comprehensive engagement plan in place with clear and timely objectives and targets. · Development of appropriate workforce and associated operational development plans.
8.	If there is ineffective or insufficient engagement with stakeholders, including partners and customers, in developing and delivering the BCF then they may feel marginalised and	**3**	**3**	**9**	CCC/CCG	· Comprehensive engagement plan in place, developed with partners, which clearly segments the key stakeholder groups and the specific activities required to effectively reach them. · Clearly articulate the benefits and apportion to each partner organisation.

excluded. Transformation may, therefore, be ineffective.					· Ensure appropriate involvement of key staff in programme planning and implementation. · Clearly document the governance and ownership of the engagement plan and the relevant reporting and monitoring processes.
9. If there are multiple and/or uncoordinated changes to service delivery this could destabilise provision and performance.	**4**	**4**	**16**	CCC/CCG	· Ongoing review of strategy and vision. · Robust arrangements in place to coordinate delivery timetables across all change activities. · Appropriate investment in effective models and methods of communication with users and staff. · Develop and implement a whole system organisational development programme to work out delivery together. · Development of integrated project governance and management structure to ensure integration across different programmes of work.
10. If the data used to develop the BCF Plan is inadequate, delayed or unavailable, then there may be unforeseen and unplanned service delivery or financial impacts/demands.	**2**	**4**	**8**	CCC	· Ensure plan is updated regularly to reflect the emerging position and any agreements or changes which have been made. · Ensure effective coordination of the work of different project teams to allow timely update of assumptions. · Validation of data used and assumptions made are clearly evidenced and documented.
11. If there is insufficient project control, transparency and accountability, delivery of the	**3**	**3**	**9**	CCC	· Programme management resources in place to deliver the plan to agreed milestones.

BCF Plan and strategic vision may be compromised.					· Strong governance and effective PMO processes in place to monitor and oversee delivery of the plan, milestones, risks and issues. · Strong and effective leadership from key stakeholders.
12. If there is a delay in developing the BCF Plan, it may not be finalised and approved by the due date for submission.	**1**	**5**	**5**	CCC	· Build on the agreed vision and development of work within 2015/16 · Detailed plan to oversee development, taking into account all necessary requirements for adequate discussion, challenge and sign-off. · Early identification and engagement with officers and teams who will need to contribute and develop the plan.
13. If changes are made to national policy in respect of urgent and emergency care this could negatively impact the BCF Plan content and timetable.	**2**	**3**	**6**	CCG	· Effective links in place with local and national NHS policy makers.
14. If increased demand for carers' provision, as a direct result of the Care Act, exceeds that which has been profiled then there will be additional costs and demand on resources.	**3**	**3**	**9**	CCC	· Ongoing monitoring and profiling of demand. · Development of community capacity through commissioned activities and close working relationship with voluntary sector . · Re-prioritisation of existing resources.
15. Changes to the OPACS contract may delay projects or add complexity, as new arrangements are made to carry out the work previously	**4**	**4**	**16**	CCG	· Detailed and early discussions with CCG around key personnel who will lead on each of the areas of work. · Dedicated resource to oversee transfer of contractual responsibilities of UnitingCare

undertaken by UnitingCare, the delivery provider					to new lead personnel within CCG. · Strengthened focus on governance to oversee the change process and ensure the pace of change, project plan and delivery is maintained. · Programme Review and lessons learned process · Contract review and negotiation with CPFT as local provider of delivery model to ensure financial and contractual risks agreed between parties and clear expectations in place.
16. Financial impact of termination of UnitingCare contract on CCG	**5**	**4**	**20**	CCG	· Exit agreement with UnitingCare agreed. · CCG in formal recovery · Service provision continued to deliver with no disruption · Finance and sub-committee ongoing review · Finance & Planning Programme Board · Internal and external audit undertaken · Contracts overview group · Weekly finance meetings and finance reports to Governing Body
Data Sharing					
If systems are unable to record or match the NHS number, or staff fail to adopt new processes to record and use it, then data may be ineffective and unusable.	**2**	**2**	**4**	CCC/CCG	· Facility in place across all service areas/organisations to ensure NHS number can be populated either manually via process or automated. · New processes are embedded across all services areas/organisations.

					· Memorandum of understanding re sharing data is agreed.
If there is no clear agreement on data sharing and governance between partner organisations, this could compromise or delay progress in monitoring or delivering the BCF Plan.	**3**	**5**	**15**	CCC	· Data sharing agreements and protocols documented and signed off between all partners for the collection, storage and processing of data. · Agree strong joined up governance arrangements relating to data.
7 Day Services					
Inadequate engagement with Care Homes impacts on 7 day discharges	**4**	**4**	**16**	CCC/CCG	· Care Home contract management robust · Close working and engagement with care homes to identify areas of issue and support · CCG reviewing approach to commissioning of GP support for care homes · Workforce development/training support of care home staff · Care home educators being recruited
Significant culture change required for all providers	**4**	**4**	**16**	CCG/CCC/Providers	· Workforce and development plans · Commitment to joint workforce development approaches · Change management support · Communications and engagement plan
Inadequate community provision impacts on discharges	**3**	**4**	**12**	CCC/CCG	· Engagement with the voluntary sector to utilise current resources · Review and alignment of intermediate care teams to support smoother discharge

Neighbourhood Teams					
Slow development of NTs and behaviour change impeding community capacity to provide admission alternatives	**3**	**4**	**12**	CPFT/CCC/CCG	· Review NT development framework · Consider team building / working · Workforce development plans to ensure sufficient capacity and capability
Inadequate co-location and integration of staff across health and social care will not enable effective MDT working	**3**	**4**	**12**	CPFT/CCC	· Co-location of neighbourhood teams to facilitate MDT working · Development of case management and joint assessment approaches, underpinned by data sharing · Implementation of Integrated Care Workers
Information and Communications					
Cost of IT solution that meets the requirements of the specification	**2**	**3**	**6**	CCC	· Commercial agreement with partners to spread of the cost · Investment from LGA bid to support development
All partners across the system do not agree with the solution and implement individual options	**3**	**3**	**9**	CCC	· Local providers engaged in steering group · Organisational leads establish working group · Review of local issues and gap analysis to ensure clear scope
Data on information in sources becomes unreliable and inaccurate	**3**	**3**	**9**	CCC	· Dedicated resource for management of platform established · Contracts/SLAs for the maintenance of information sources
Customer interface is not effective – the information on sources are reliant on the way data is	**3**	**4**	**12**	CCC	· Understand customer and best practice on information presentation · Investment in research into customer

presented to the customer					needs from LGA bid
Healthy Ageing and Prevention					
Financial and resource limitations may limit extent of activity and will need to be fully understood and considered by the appropriate organisation / governance structure.	**3**	**3**	**9**	CCC/CCG	· Joint commissioning approach established to support best use of resources · Ensure best practice and guidance from HEAP adopted by local commissioners · Specific investment allocated to key areas of work
Lack of GP engagement in falls pilot impacts on effectiveness	**3**	**4**	**12**	CCG	· CCG leading on GP engagement and communications · Clear scope of service and expectations · Local Falls Leads established to aid implementation on a local level

Performance Metrics – Risks and Issues

There is a risk that:	**How likely is the risk to materialise?**	**Potential impact**	**Overall risk factor**	**Risk Owner**	**Mitigating Actions**
Non-elective admissions					
Failure to deliver 2016-17 CCG Operational Plan objectives and Non elective QIPP	**4**	**4**	**16**	CCG	· SSRG and BCF Delivery Group scrutinise monthly returns on NEA and conduct analysis to identify root problems and where thesea are occurring.

					· Monthly reporting to CMET and Finance and Performance sub-committee · PMO in place · LCG accountability reviews · Standard agenda item on COG · Action plan in place overseen by COO and Head of Planning · NHSE quarterly assurance meetings · Performance dashboard
Failure to implement major service and contract change from 1st April 2016	**4**	**4**	**16**	CCG	· Plans developed as part of LCG Operational plans to deliver service changes and manage in line with contract changes · Monthly reporting to CMET and Finance and Performance sub-committee · LCG accountability review · Internal and external audit of UnitingCare contract impacts
Risk to delivery of Urgent Care Network Plans	**4**	**5**	**20**	CCG	· Monthly reporting to CMET and Patient Safety and Quality Committee · COO leading and chairing SRG · Monthly and quarterly reviews with NHS England
DTOCS					
Ward staff in acute don't implement the learning from training/development	**4**	**4**	**16**	Acutes	· Workforce development plan in place · Pathways Coordinator pilot to support culture change · Closer working and integration with the voluntary sector · Development of joint workforce initiatives (e.g. training, rotations, recruitment

					processes) across CCC, Acutes, and CPFT
High numbers of new DTOCs on a daily basis prevent reduction to trajectory	**4**	**4**	**16**	Acutes/CCC/CCG	· Agreement from all SRG partners to proactively assess and plan discharge for patients; · Daily calls, escalation and solving of current issues with organisations to reduce numbers and solve blockages · Monthly DTOC meetings for each acute setting to address issues and create new ideas · Closer alignment of intermediate care teams to aid discharge · Admissions avoidance team and JET to manage admissions to acute
Care provider market can't meet need within certain geographical areas	**3**	**3**	**9**	CCC/CCG	· CCC and CCG to work to develop market in areas known to have poor provision · Joint commissioning approaches being developed · Clear commissioning strategy in place · Investment in strengthening the local market · Monitoring of local performance and issues to identify early issues
Residential Admissions					
Increased provision of beds in the system impacts of admissions rate	**3**	**3**	**9**	CCC	· Close monitoring of self-funders to manage longer term ASC financial impact · Develop stronger relationships with providers for more integrated planning approaches · Close management of CHC delays and CCG step down bed purchasing in the system
Increase in under 65s accessing residential admissions due to mental	**3**	**3**	**9**	CCC	· Widened scope of JET to offer intermediate care and emergency response from 65 to 50

health/long term conditions, impacting on target					year olds · Scope of age for the Wellbeing Service been widened to all adults over 18, enabling stronger community support provision · UEC Vanguard 24/7 mental health service implementation planned
Effectiveness of Reablement					
Discharge from acute into reablement happens before medically fit resulting in readmissions to hospital	**3**	**3**	**9**	Acutes/CCC	· Discharge protocol agreed · Pathways coordinator pilot · Workforce development and training plan agreed · Review of discharge procedure in line with Care Act requirements
Reablement pathway redesign results in higher level of inappropriate referrals	**3**	**3**	**9**	Acutes / CCC	· Early discharge issues being addressed with further integrated working/workforce development · Refinement and embedding of pathway · Embedding of integrated assistive technology offering across health and social care · Pathway coordinator pilot · Monitoring and review of performance to identify and address issues early
Long-term users of social care					
Preventative interventions fail to reduce the number of longer-term social care users	**3**	**3**	**9**	CCC	• Continued monitoring of number of service users through CFA Performance Board • Discussion at BCF delivery group of performance and any mitigating actions required
Friends and Family Test					

Inadequate number of people complete the questionnaire, affecting the impact of the results	**2**	**3**	**6**	CUH/HHT	· Commitment from acute provider to undertake the F&F test with patients · Good uptake to date · Workforce and training to support · Monitoring of uptake for early identification of issues, through contract reporting to CCG
Friends and Family metric does not provide whole system customer satisfaction feedback	**4**	**5**	**20**	CCG	· Development of appropriate customer satisfaction metrics as part of outcome framework development · Provider contracts incorporate relevant metrics where relevant · Utilise other methods (e.g. CPFT feedback) to gather qualitative information to support wider system feedback

[1]Likelihood - How likely is the risk to materialise? Rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely.

[2]Potential Impact - Rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact. If there is some financial impact specify in £000s, also specify who the impact of the risk falls on.

Annex D: Communications Plan

Communications with key stakeholders across the local system is a crucial element of the success of the Better Care Fund plans for 2016/17. Cambridgeshire plans to develop a detailed communications strategy outlining the key objectives, underpinned by more detailed communication plans for implementation of local projects. Communication objectives are:

- Engagement and buy in from local providers and strategic partners
- Explain the benefits and strategic business reasons for new approaches to workforce
- Ensure consistency of messages through all communications
- Gain support from key influencers
- Manage expectations and overcome any potential resistance to the changes by proactively addressing negative reactions up front.

A high level overview of the key stakeholders and communications is outlined in the below table:

Target audience	**Deliverable / Description**	**Methods**
Strategic stakeholders: • Cambridgeshire & Peterborough Clinical Commissioning Group • Cambridgeshire County Council (Staff and Members) • Peterborough City Council • Cambridgeshire & Peterborough NHS Foundation Trust • Cambridge University Hospitals • Hinchingbrooke Health Care NHS Trust • Fenland District Council • Cambridge City Council • South Cambridgeshire District Council • East Cambridgeshire District Council • Huntingdonshire District Council	Consultation and engagement on key changes Updates and reports to governance meetings Active involvement in development of approaches	Workshops / consultation papers • Cambridgeshire Health & Wellbeing Board • Cambridgeshire Executive Partnership Board • Huntingdonshire System Resilience Group • Cambridge System Resilience Group Involvement in programme steering groups

• Public Health • VCS		
Local providers	Workforce training and development Embed change management	Briefing sessions / staff newsletters / workforce development plan Change management plans
Public / Service Users / Patients	Engagement in local system plans Communicate local approaches to delivering better services Promote new local services / projects	Consultation papers Health and Wellbeing Strategy / BCF information on website / link to local campaigns (e.g. National Dementia Awareness Week) Project communication plan developed with consistent information and messages
Programme / Project management teams	Regular updates on progress Staff knowledge and awareness of BCF work	Project highlight reports / reports to governance meetings Briefing sessions / staff newsletters / information on intranet

Annex E: Huntingdonshire System DTOC Plan

Attached as a separate file

Annex F: Cambridgeshire System DTOC Plan

Attached as a separate file

Annex G: Governance Diagram