Agenda Item No:5

JOINT WORKING WITH HEALTH - PRIORITIES

To:	**Adults Committee**
Meeting Date:	**15th November 2018**
From:	**Will Patten, Director of Commissioning**
Electoral division(s):	***all***
Forward Plan ref:	**N/A** *Key decision:* **No**
Purpose:	**The report provides an overview and approach to joint working with health and the current priorities.**
Recommendation:	**To note and comment on the report.**

	Officer contact:		***Member contacts:***
Name:	**Caroline Townsend**	Names:	Councillor Anna Bailey
Post:	Head of Commissioning Partnerships and Programmes	Post:	Chair
Email:	Caroline.townsend@peterborough.gov.uk	Email:	Anna.bailey@cambridgeshire.gov.uk
Tel:	07976 832188	Tel:	01223 706398

1. BACKGROUND

1.1 This paper provides a deep dive on joint working with health and the current priorities.

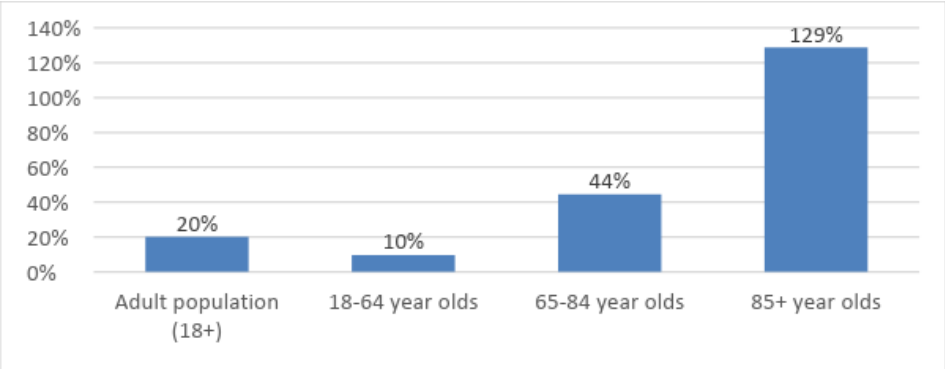
2. MAIN ISSUES

2.1 System Challenges

2.1.1 Population Growth

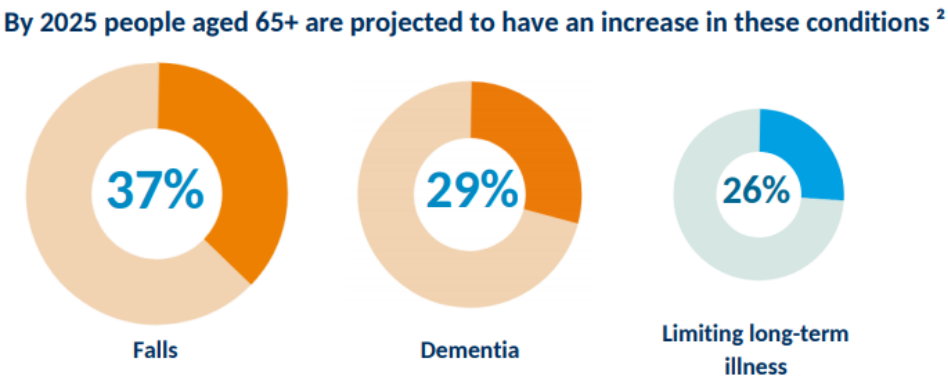
Cambridgeshire's population is growing significantly, with an increasing older population. Cambridgeshire and Peterborough's population of people aged 18+ is estimated at 690,000. Local forecasts suggest this will increase to approximately 827,000 by 2036, equating to a 20% increase. Forecasts suggest significant and disproportionate growth is expected, with those aged 65-84 expected to increase by around 44% and those aged 85+ expected to grow by nearly 130% by 2036, as can be seen in the chart below.

Cambridgeshire and Peterborough projected population growth 2018-2036



(Source: Cambridgeshire Business Intelligence Team)

The majority of adult social care service users within older people's services are aged 85+, so the expected population growth is likely to lead to a significant increase in demand. And by 2025, it is forecast that there will be a significant increase in the following conditions.



2.1.2 Financial Pressures

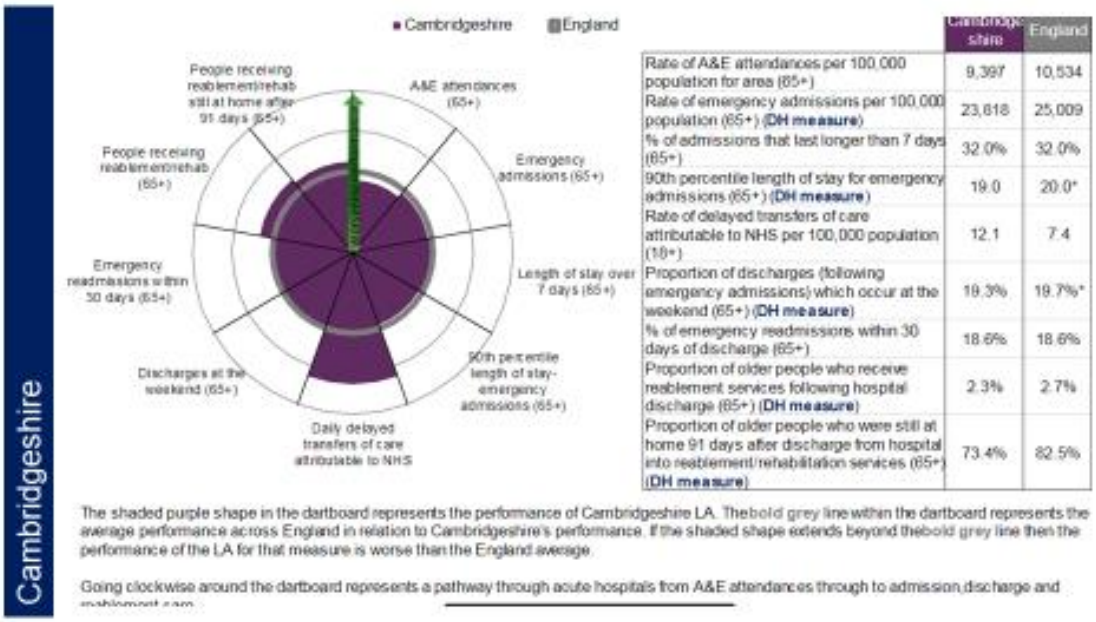
Underfunded system which means we have to address increasing demand with decreasi budgets. Cambridgeshire and Peterborough is one of the most financially challenged hea economies nationally. Cambridgeshire County Council is facing a £12 million budget gap 2019/20, and a further £16 million gap for 2020/21.

In addition, we are seeing financial pressures as a result of increasing costs of care, whic symptom of a market where demand outstrips supply and where providers face cost pres that they seek to pass onto the Council. The supply of market capacity is a result of a nur of factors linked to attracting and retaining staff, the complex nature of care requiring dou packages and the rurality of parts of Cambridgeshire. Although the Council is working ha mitigate pressures, additional provider pressures have resulted from legislative changes as automatic enrolment into pension schemes, national living wage increases and inflatio

To ensure we have financial sustainability for the future, we are working jointly with healt develop community capacity and capability to meet the needs of local communities in the cost effective way, supporting people to maintain their independence and wellbeing. In tu preventing the unnecessary escalation of needs and the provision of more expensive ser (e.g. domiciliary care, residential and nursing care, acute hospital intervention).

2.1.3 System Performance

The below diagram shows how Cambridgeshire is performing comparatively across a key range of health and social indicators.



	Cambridgeshire	England
Rate of A&E attendances per 100,000 population for area (65+)	9,397	10,534
Rate of emergency admissions per 100,000 population (65+) (**DH measure**)	23,618	25,009
% of admissions that last longer than 7 days (65+)	32.0%	32.0%
90th percentile length of stay for emergency admissions (65+) (**DH measure**)	19.0	20.0*
Rate of delayed transfers of care attributable to NHS per 100,000 population (18+)	12.1	7.4
Proportion of discharges (following emergency admissions) which occur at the weekend (65+) (**DH measure**)	19.3%	19.7%*
% of emergency readmissions within 30 days of discharge (65+)	18.6%	18.6%
Proportion of older people who receive reablement services following hospital discharge (65+) (**DH measure**)	2.3%	2.7%
Proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (65+) (**DH measure**)	73.4%	82.5%

The shaded purple shape in the dartboard represents the performance of Cambridgeshire LA. The bold grey line within the dartboard represents the average performance across England in relation to Cambridgeshire's performance. If the shaded shape extends beyond the bold grey line then the performance of the LA for that measure is worse than the England average.

Going clockwise around the dartboard represents a pathway through acute hospitals from A&E attendances through to admission,discharge and

Key features highlighted from this data profile are:

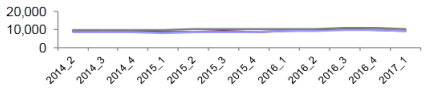
- Cambridgeshire has high rates of delayed transfers of care from hospital
- Cambridgeshire has high levels of GP referrals to A&E (see below graph);
- Attendance at A&E and avoidable admissions to hospital from care homes are lower than the national rate for Cambridgeshire (see below graph), as are avoidable admission rates.

Cambridgeshire — Comparator — England ◆ Significantly worse ■ Significantly better

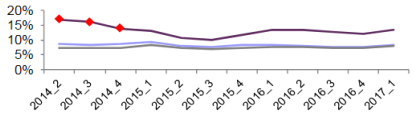
Activity – A&E Attendance aged 65+

CareQuality Commission

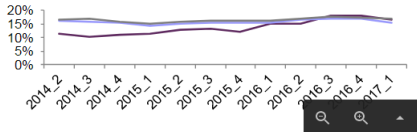
Rate of A&E attendances per 100,000 population aged 65+



Percentage of A&E attendance that were referred by GP aged 65+



Percentage of A&E attendances referred by GP that are discharged without follow-up aged 65+



This slide provides data to highlight if there are high rates of A&E attendance for people aged 65+ that may be putting pressure on the system or potentially indicating problems with primary or community care.

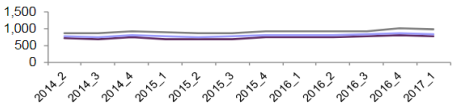
It also identifies whether there are high volumes of people aged 65+ attending A&E as a result of a referral from their GP and whether or not these people were subsequently discharged without follow-up (i.e. not admitted to hospital). The measures are intended to identify potential issues in primary care, including inappropriate referrals from GPs to A&E.

Area	Time period – calendar quarter			
	2016_2	2016_3	2016_4	2017_1
Cambridgeshire LA	9,638	10,320	9,825	9,397
Comparator average	9,375	9,889	9,713	9,192
England average	10,613	11,017	10,969	10,534
Cambridgeshire LA	13%	13%	12%	14%
Comparator average	8%	8%	8%	8%
England average	8%	7%	7%	8%
Cambridgeshire LA	15%	18%	18%	17%
Comparator average	16%	17%	17%	16%
England average	17%	18%	17%	17%

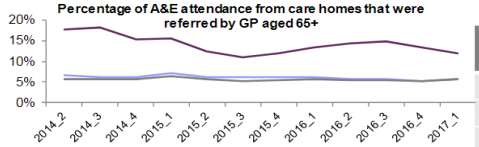
Activity – A&E Attendance from care homes

CareQuality Commission

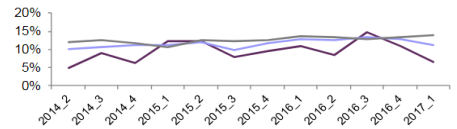
Rate of A&E attendances from care homes per 100,000 population aged 65+



Percentage of A&E attendance from care homes that were referred by GP aged 65+



Percentage of A&E attendances from care homes referred by GP that are discharged without follow-up

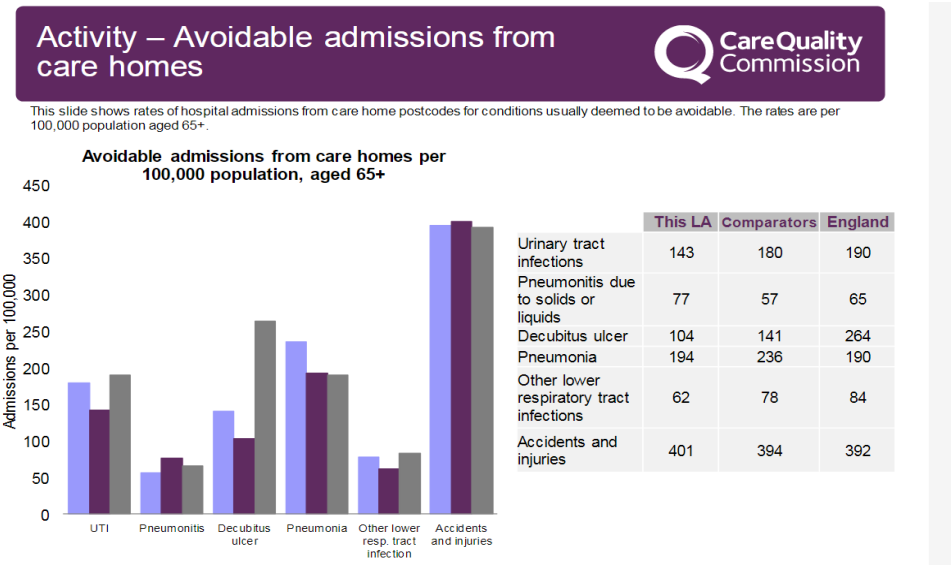


This slide provides data to highlight if there are high rates of A&E attendance from people aged 65+ coming from care homes that may be putting pressure on the system or indicate problems with primary care or community care

It also identifies whether there are high volumes of people aged 65+ living in care homes that are attending A&E as a result of a referral from their GP and whether or not these people were subsequently discharged without follow-up (i.e. not admitted to hospital). The measures are intended to identify potential issues in primary care, including inappropriate referrals from GPs to A&E.

Area	Time period – calendar quarter			
	2016_2	2016_3	2016_4	2017_1
Cambridgeshire LA	759	767	808	769
Comparator average	819	830	882	853
England average	918	922	1,006	979
Cambridgeshire LA	14%	15%	13%	12%
Comparator average	6%	6%	5%	6%
England average	6%	6%	5%	6%
Cambridgeshire LA	8%	15%	11%	6%
Comparator average	13%	13%	13%	11%
England average	13%	13%	13%	14%

Analysis based on attendances from postcodes containing a registered care home. Data could pertain to other addresses within the postcode. Due to low numbers the percentage of A&E attendances from care homes referred by GP that are discharged without follow-up has not been z-scored.

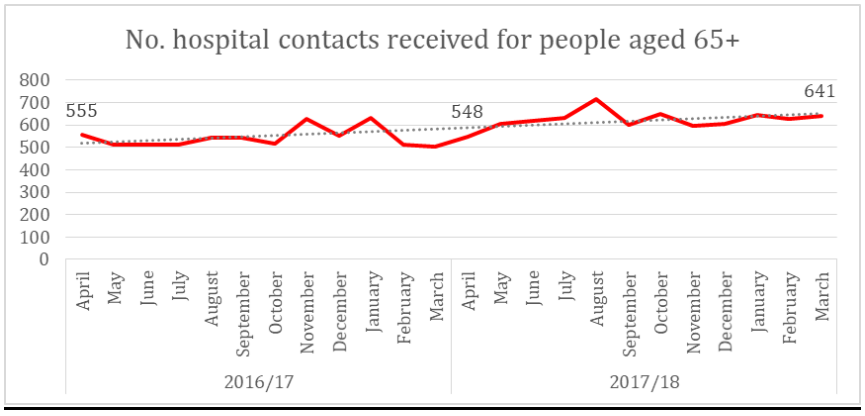


In addition, hospital admissions of over 80 year olds in 2017/18 has increased significantly since 2016/17 (see below table). This in turn has had a significant impact on social care and community services post discharge, as well as on the overall DTOC performance figures.

Admissions of over 80 year olds from April 2017 to August 2017 compared to the same period in the previous year

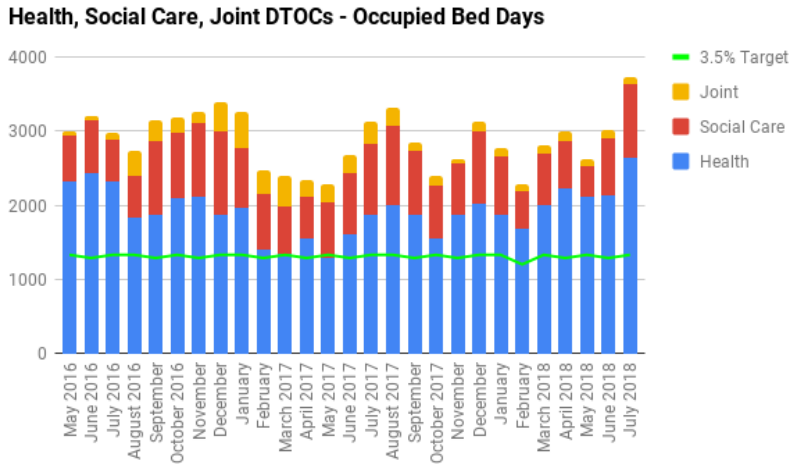
Hospital	Increase 2017/2018	% Change
Addenbrookes (CUHFT)	245	+7.9%
Hinchingbrooke	34	+2.2%
Peterborough City Hospital	-79	-3.4%
Queen Elizabeth Hospital (Kings Lynne)	119	+24%
TOTAL	335	+4.4%

More older people than ever are being discharged from hospital and referred into Adult Social Care Services (see below graph), which has led to increased demand and a pressure to find care places much quicker than in the past. This is combined with a greater complexity of care needs of these people. As hospitals respond to their pressures the average length of time older people are in hospital has reduced from 8.1 days in April to 5.6 days in October – older people are leaving hospital in higher numbers, more quickly and in a more fragile state.

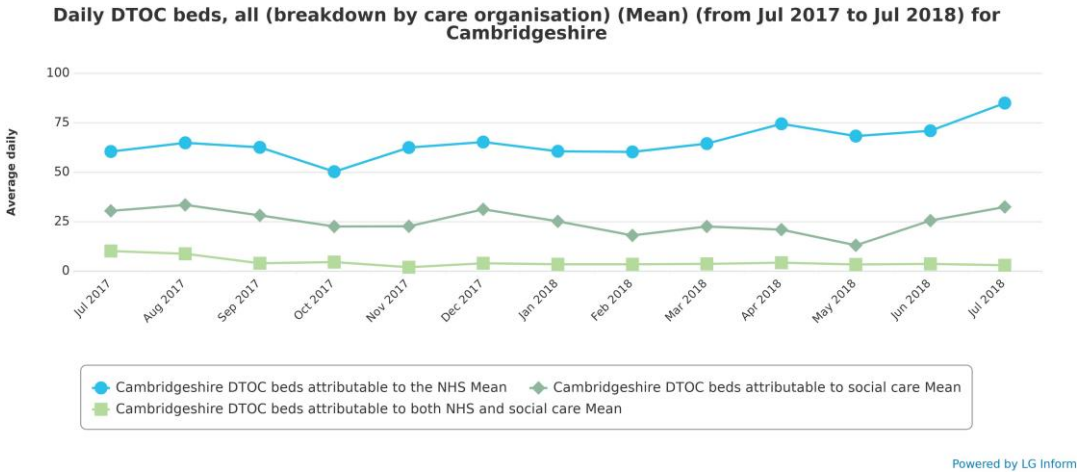


2.1.4 Delayed Transfers of Care (DTOCs)

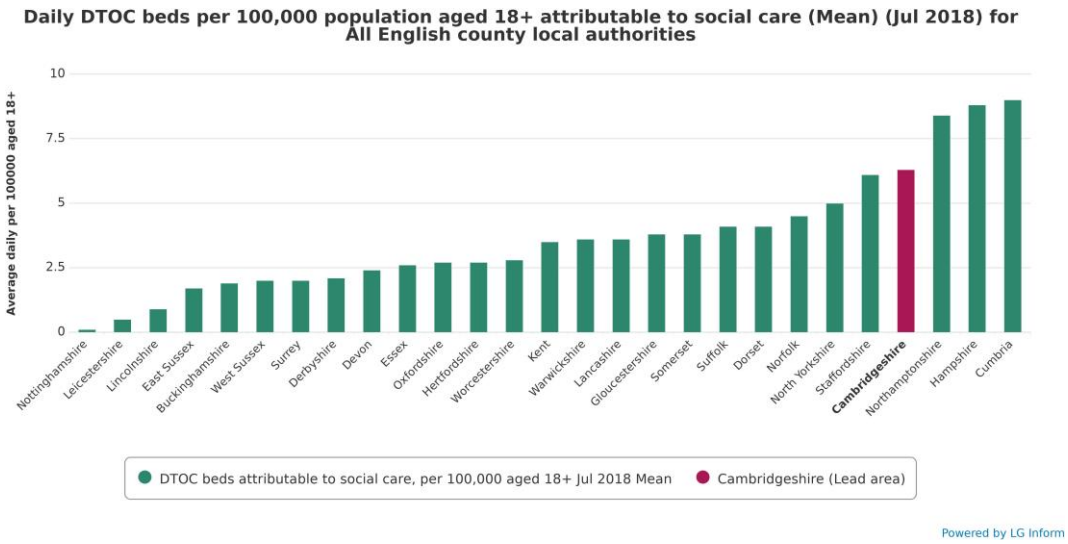
Despite continued effort, DTOCs continue to be a real pressure for the Cambridgeshire system. Based on the latest NHS England published DTOC statistics, the below graph shows month on month DTOC performance across Cambridgeshire against the 3.5% target, highlighting that performance is significantly underperforming against target.



During July, 81% of delayed days were within acute settings. 70.6% of all delayed days were attributable to the NHS, 26.9% were attributable to Social Care and the remaining 2.5% were attributable to both NHS and Social Care. The below graph shows the trend of DTOCs, by attributable organisation.



For July 2018 Cambridgeshire, compared to all single tier and county councils in England, is ranked 149 on the overall rate of delayed days per 100,000 population aged 18+, with a rank of 151 given to the area with the highest rate. It is ranked 148 on the rate of delayed days attributable to the NHS, and 136 on the rate of delayed days attributable to social care. The below graph shows how Cambridgeshire compares with other county local authorities.



2.2 Drivers and Strategic Priorities for Change

The Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP) key priorities, also illustrated below, mirror our system's principles around prevention, healthy lifestyles, early intervention, promoting independence, system sustainability and integration.

Priorities for change	10-point plan
At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs
Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care 5. Continued world-famous research and services
We're only sustainable together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 9. Using our land and buildings better 10. Using technology to modernise health

Peterborough and Cambridgeshire STP priorities for change

Our shared system vision for integration was articulated in the 2017-2019 Better Care Fund (BCF), as outlined below:

Our vision across Cambridgeshire & Peterborough

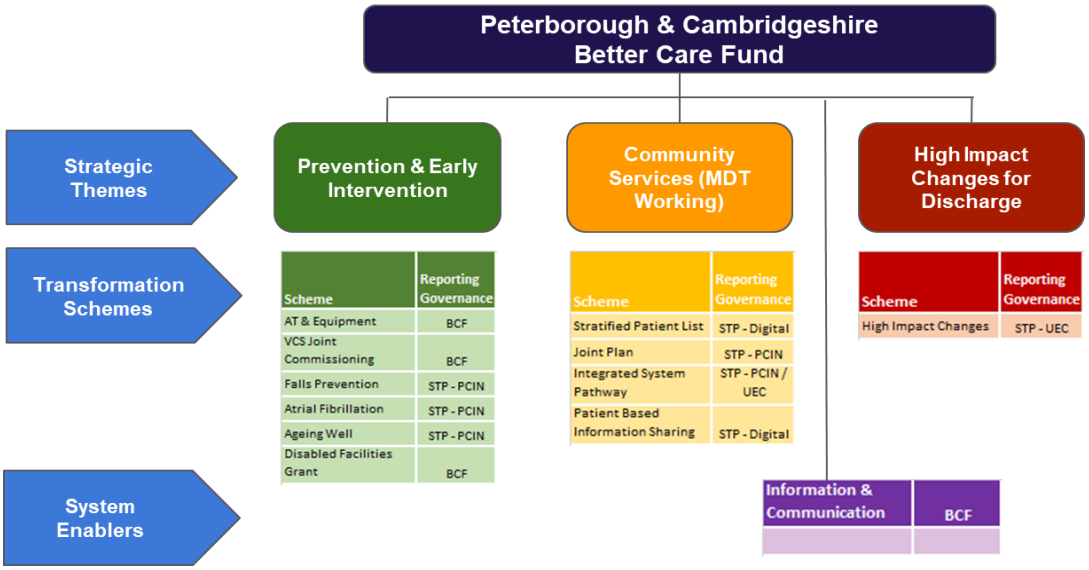
"Over the next five years in Cambridgeshire and Peterborough, we want to move to a system in which health and social care help people to help themselves, and the majority of people's needs are met through family and community support where appropriate. This support will focus on returning people to independence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

This vision is underpinned by seven core principles to make sure we make a long-term difference to health and wellbeing throughout the county and that we help those who need it most. We aim to:

1. Reduce inequalities by improving the health of the worst off fastest;
2. Focus on preventing ill health by promoting healthy lifestyles while respecting people's choices and for those who have an illness, preventing their condition from worsening;
3. Make decisions which are based on the best possible evidence;
4. Develop solutions which are cost-effective and efficient;
5. Recognise that different groups and communities have different needs;
6. Encourage communities to take responsibility for making healthy choices; and
7. Make sure services are sustainable.

Improved integration and joint working between health and social care has been a long-term strategic priority in Cambridgeshire. The Better Care Fund (BCF) 2017–2019 sets out four strategic themes as illustrated below.

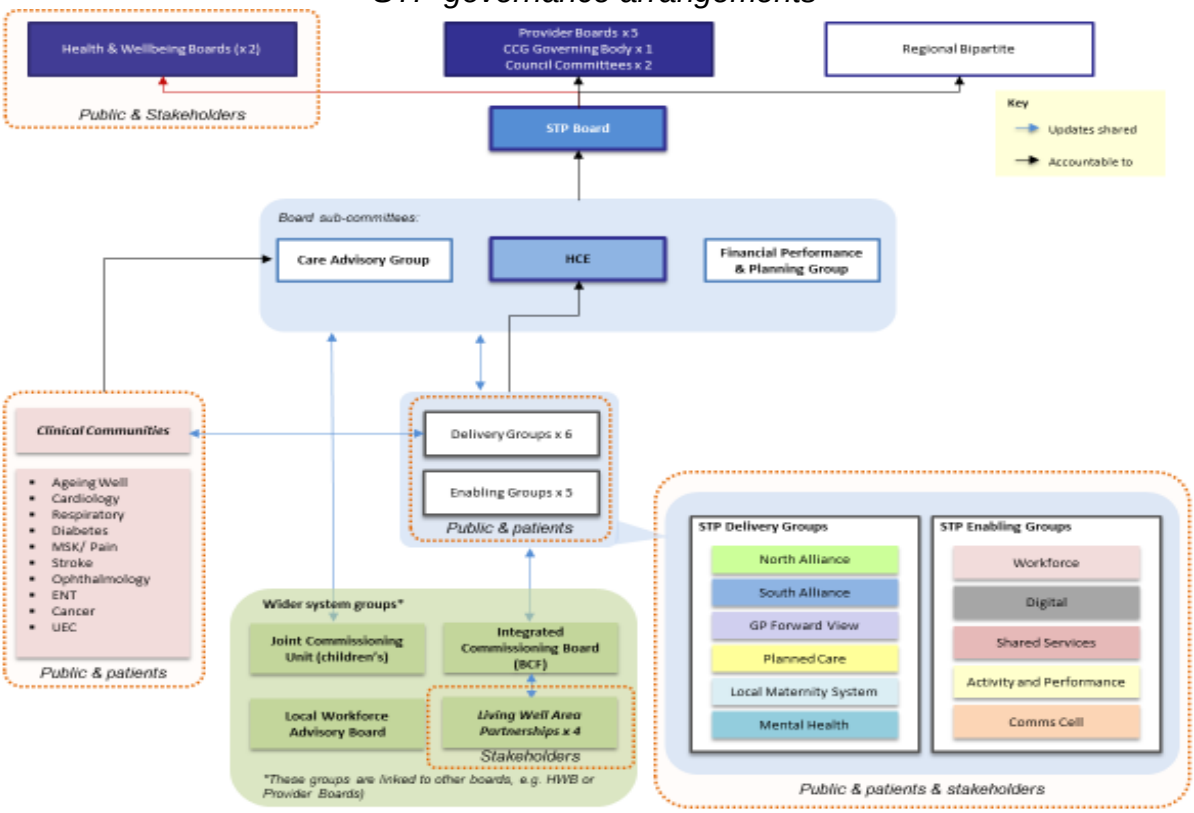
Peterborough and Cambridgeshire BCF strategic themes



2.3 Governance

Our shared strategic ambitions are delivered through longstanding and mature partnership arrangements. The Sustainability and Transformation Partnership (STP) has established a multi-agency multi-level governance structure to deliver our system priorities. The STP (please see governance diagram below) Board contains NHS partner Chairs and CEOs as well as elected members and directors of Cambridgeshire County Council and Peterborough City Council. STP governance also has the necessary structures and groups to ensure that senior executive leaders, operational directors, finance leaders, local clinicians and other stakeholders are driving forward the delivery of priorities.

STP governance arrangements



2.3.1 **Health and Well-being Boards (HWB):** Provide the formal strategic leadership for health and social care services through two Boards – one for Cambridgeshire and for Peterborough. HWBs routinely meet jointly and include County Council/Unitary Authority (elected and Lead Officers), District Council representation, NHS provider representation, the CCG, the Police and Crime Commissioner, Healthwatch, with the voluntary sector co-opted.

2.3.2 The **Health Scrutiny Committees** review key areas of priority, for example, Delayed Transfers of Care. In addition, Scrutiny can effectively drill down via its 'topic' process into key issues where Members require greater levels of assurance. Most recently, Scrutiny examined issues such as workforce, patient transport and pressures on primary care services. Cambridgeshire and Peterborough Councils have an Adults Committee and a Communities and Adults Committee respectively that provide oversight of adult social care and a lead Portfolio holder for adults.

2.3.3 **Living Well Area Partnerships:** Four geographical Partnerships have recently been developed to provide operational leadership of a "whole system" partnership approach to the local delivery and implementation of "living well" health and wellbeing improvements, care model designs, service improvements and savings opportunities identified at a local and system level in the Health & Wellbeing Strategies, Public Health Priorities, Sustainability & Transformation Plan, and Better Care Fund. The Partnerships represent

a wider community of stakeholders including patient representatives, Healthwatch, Local GP representatives, Primary Care Management Leads, NHS Trusts, District Councils, Public Health, the community & voluntary sector.

2.3.4 **Cambridgeshire and Peterborough Safeguarding Adults Board**: The Safeguarding Adults Board is made up of strategic leaders from a wide range of partner agencies whose activity is key in safeguarding adults. They have the responsibility for developing and authorising the strategic framework for safeguarding, including the policies and strategies needed to meet the core functions of the Board and the priorities in the Business Plan. The Board report to a Safeguarding Executive Group, made up of the three statutory partners (Local Authority, Police and CCG representing Health) at the highest Executive level. It holds the responsibility for ensuring there is an effective arrangement in place to safeguard children, young people and the adults who come under Section 42 of the Care Act. In doing so they are joined by senior leaders from Healthwatch and Public Health. They approve the Business Plan and ultimate accountability lies with them.

2.3.5 **North and South Alliances:** Two, recently developed, Alliance Delivery Groups ensure providers of services for health and social care work together in partnership to better plan and deliver a wider range of services across a geographical area that are more proactive, person-centred and holistic, sometimes pooling resources and budgets. By working together at a neighbourhood level, and around our acute hospital footprints, these Alliances aim to improve population health outcomes, manage demand for services, reduce the unacceptable delays and barriers to people's care and, in particular, reduce the number of days people spend in a hospital bed as an emergency.

2.3.6 **A&E Delivery Boards:** These two Boards compliment the above Alliances and address operational performance issues and ensure urgent care needs are dealt with in the most appropriate setting by the most appropriate services (which in many cases should not be in A&E departments or acute hospital beds). They deliver nationally mandated improvement initiatives and core responsibilities to lead to A&E recovery, as well as oversee improvement projects that require locality tailoring for successful implementation. Our A&E Delivery Boards also provide a vehicle for strong and visible front-line clinical leadership and resident/patient involvement, as well as promote a culture of continuous quality improvement.

2.3.7 **Integrated Commissioning Board:** The Board's primary focus is to provide oversight and governance of the Better Care Fund for Cambridgeshire and Peterborough.

2.4 Current Priorities for Joint Working with Health

There are a number of current key priorities for joint working with health, including:

- System working to address DTOCs
  - Improved Better Care Fund (iBCF) investment to support DTOCs
  - Joint Discharge Programme
  - Market management of capacity for home care, residential and nursing care
- Admission Avoidance initiatives
  - Neighbourhood Place Based Care
  - Supporting care homes to reduce avoidable hospital admissions
  - Joint Commissioning to support prevention and early intervention

2.4.1 *System Working to Address DTOCs*

NHS partners and both councils have worked in close partnership, at a strategic level through the Sustainability and Transformation Partnership (STP) and through our Joint Better Care Fund Plans, resulting in significant investment to reduce current challenges. A range of operational forums have been established to co-ordinate our system wide activities to enable timely hospital discharge. That said it needs to be recognised that there are a number of major challenges, including a growing older population, greater acuity of need, workforce recruitment and retention and significant funding issues across the health and care system.

2.4.2 <u>iBCF Investment to Support DTOC Pressures</u>

There was significant investment from the Improved Better Care Fund (iBCF) to support a range of initiatives to reduce DTOCs, as depicted below.

Key updates on these initiatives are outlined below:

- **Reablement Capacity:** Investment from the iBCF was made to increase reablement capacity by 20% and recruitment has established the teams at nearly full capacity.
- **Reablement Flats:** Additional capacity was commissioned across Eden Place, Ditchburn, Doddington Court and Clayburn Court to provide support to patients requiring a further period of recovery before returning home following hospital discharge.
- **Community Equipment:** additional investment to support the provision of equipment to enable people to manage as independently as possible in the home of their choice.
- **Dedicated Social Worker at Addenbrookes Hospital to support self-funders:** recruitment of a dedicated worker to support individuals who self-fund their care through the hospital discharge process.
- **Locality Review Backlog:** social worker capacity was recruited to address the backlog of reviews within the Cambridgeshire locality teams in order to avoid admission to hospital and ensure individuals are receiving the right level of care to meet their outcomes within the community.
- **Strategic Discharge Lead:** a coordinating social worker discharge lead has been established in Addenbrookes and Hinchingbrooke hospital. This has supported greater oversight of the system, including working with partner organisations to ensure the correct agencies are involved in discharge planning.
- **Trusted Assessor:** the service was commissioned from Lincolnshire Care Association (LINCA) and provides trusted assessments on behalf of care homes, to reduce unnecessary discharge delays in Addenbrookes.

A system-wide evaluation of iBCF funded DTOC initiatives is currently being undertaken to inform the future approach.

Joint Discharge Programme

2.4.2 A joint priority programme of work has been agreed with health and social care partners to support delivery of the 3.5% target. This comprises seven key enabling work streams of activity; Integrated discharge service (IDS), referral process for complex discharge support, robust operational management, discharge to assess, demand and capacity modelling, performance and reporting and effective partnership working. The key initiatives are set out below:

- An Integrated Discharge Service (IDS) has now been established in each acute site. The IDS is a team of health and social care discharge planning experts working together to support hospital wards with discharge planning for people with complex needs, and /or who need community support after discharge. In addition, a community hub has been established to manage capacity, demand and flow through key community pathways.
- Development of new Assessment and Discharge Notification forms that contain only information needed for the IDS to triage people effectively to the appropriate discharge pathway.

- Review and development of effective discharge to assess pathway to support hospital discharge and ensure people are getting the right care in the right setting:
    - Greater alignment of services offered under pathway 1 (services supporting people at home through an interim period of recovery);
    - Strengthening the commissioning arrangements for the community bed-based capacity required to support pathway 2 using evidence of need / demand for services;
    - Reviewing and simplifying the process for pathway 3 to ensure people with *not suitable for interim reabling care* are sent through the appropriate discharge pathway right out of hospital to plan their long-term care (including assessments for Continuing Health Care eligibility where appropriate);
- Understanding the growing needs for system- wide coordination of demand and capacity whilst fostering greater partnership working with independent sector providers; and
- Standardising data collection and reporting through joint health and social care governance structures in the system.

Market Management of Capacity

2.4.3

The Council is working intensively with the independent care home market to increase supply to home care provision. Homecare was recommissioned in Cambridgeshire, jointly with the CCG, by a Dynamic Purchasing Arrangement and came into effect in November 2017. The DPS framework re-opens every 3 months for new providers to apply. Since the launch of the new framework, home care providers have increased from 28 to 74. The Council engages with non-active providers on an ongoing basis to ensure available capacity is being maximised. In addition, a review of market capacity data and intelligence is being undertaken to address the geographical disparity of homecare provision across the county. Subsequent engagement with providers will inform the development of a strategy to increase capacity in areas of low supply in a sustainable way.

An integrated brokerage function is being developed across health and social care, providing a single point of managed access to the market across Cambridgeshire and Peterborough for Adults, including older people and physical disabilities. This will enable a managed response to demand, removing competitive agency behaviours, ensuring better control of market fees and maximising opportunities for optimising provider capacity through a dedicated route to market.

Admissions Avoidance Initiatives

A number of admission avoidance interventions have been implemented, including joint iBCF/STP investment in falls prevention and stroke prevention projects. Both Councils have established Adult Early Help services and continue to work with primary care and CPFT's neighbourhood Teams to identify people whose needs may be escalating or may be vulnerable to hospital admission.

Neighbourhood Place Based Care

CCC is currently piloting two pilot 'Neighbourhood Care Teams' in Soham and St Ives, where new ways of working with system partners are being developed to prevent needs escalating and enable timely discharge. The pilots are based on the principles of the Buurtzorg model of care and aims to test a community model that supports customised care. The new model will be driven by a neighbourhood, 'place based' approach, and success will mean that citizens have greater independence and better outcomes with reduced state intervention by:

- addressing needs early to prevent them from escalating - working in partnership with communities and health partners, to share information, act as one care workforce & be proactive;
- empowering individuals to do more for themselves - providing them with the resources, tools and local support network to make it a reality; and
- building self-sufficient and resilient communities - devolving more preventative care & support resources at a neighbourhood level and enabling individuals to spend their long term care budget within their community.

An external evaluator, York Consulting Ltd, has been appointed to provide ongoing evaluation of the pilot and the findings will support system partners in defining and developing an agreed model of neighbourhood delivery.

Supporting Care Homes to Reduce Avoidable Admissions
The need to improve the quality of life, healthcare and planning for people living in care homes is essential as we move from reactive models of care delivery towards proactive care that is centred on the needs of residents, their families and staff working in care homes. It is recognised that many people living in care homes do not have their needs appropriately assessed and acted on in a holistic manner. This frequently leads to people experiencing unnecessary, unplanned and avoidable admissions to hospital, and inappropriate prescribing of medication which can lead to adverse health outcomes. Key system priorities are focused on co-producing solutions to support implementation of the Enhanced Health in Care Home model and maximise opportunities for aligning health and social care resources to improve the support offer to care homes. This includes how we support discharge planning through coordinated multi-disciplinary support to care homes, closer alignment of quality assurance, contract management and care home support resources to maximise impact and upskilling the care home workforce to support effective management of residents, preventing unnecessary hospital admissions.

Joint Commissioning to Support Prevention and Early Intervention
Integrated commissioning approaches support us to increase consistency in service provision and enable better engagement and market management. The following are a number of existing integrated commissioning arrangements that we already have in place:

- BCF pooled budget: commissions a range of integrated initiatives, including: community multidisciplinary neighbourhood teams, prevention and early intervention initiatives such as falls prevention, interventions to support the management of DTOCs;
- Support for people with mental health issues;

- Learning Disability Partnership;
- Community Occupational Therapy Services; and
- Community Equipment Services and Technology Enabled Care Services.

As a system, we continue to work across Adult Social Care and health to develop joint up commissioning strategies, for example the development of our local Dementia Strategy.

Commissioning intentions are focused on supporting people across the following key areas:

- Early Intervention;
- Medium level, reablement and rehabilitative support; and
- High level, ongoing support.

Early Intervention and Prevention: There is a focus on services to support people to remain independent and healthy for longer. Our, system-wide, Ageing Well Strategy Board, led by Public Health, is focusing on approaches to address falls prevention, dementia, social isolation and multi-morbidity and frailty. Other areas include information, advice and guidance, technology enabled care, dementia support, day opportunities and employment opportunities. Through our Better Care Fund programme of work we are developing ways of strengthening integrated approaches to commissioning from the voluntary sector. We have a jointly commissioned 'Wellbeing Network', which is a single access and coordination point to the voluntary sector. Additionally, we have developed system-wide agreed principles to joint commissioning which will continue to inform our approach for greater integration of voluntary sector commissioning and developing community resilience.

Medium level support: It is our intention to increase medium level, reablement and rehabilitation type provision to support more people to remain as independent for as long as possible. We continue to expand current and quality reablement support that promotes safer and quicker hospital discharge. Additionally, we will review and commission an appropriate supply of extra care housing, supported living, mental health support and interim bedded provision.

High Level, Ongoing Support: Support to live at home, care home provision for older people and residential care for people with learning disabilities are a continued focus to build the provision we need locally. Currently, across Cambridgeshire, the local authority and CCG have a jointly commissioned dynamic purchasing system in place for home care provision and we are procuring a new joint commissioned framework for home care in Peterborough. This is supported in Cambridgeshire by an integrated brokerage team that places home care and care home packages for both social care and Continuing HealthCare. We are planning to expand this integrated brokerage approach across Peterborough later this year.

Local Government Association (LGA) Peer Review

Following the budget announcement of additional funding for adult social care in 2017, the Care Quality Care Commission (CQC) was requested by the Secretary of State for Health to undertake a programme of local system area reviews. Twenty area reviews

were undertaken in 2017/18. The reviews were system wide and looked at the quality of the interface between health and social care and the arrangements and commitments in place to use the Better Care Fund to reduce delays in transfer of care. The scope also considered:

- How do people move through the system and what are the outcomes for people?
- What is the maturity of the local area to manage the interface between health and social care?
- How can this improve and what is the improvement offer?

Following local system wide discussion, support was sought from the LGA to undertake a peer review for the Cambridgeshire and Peterborough health and care system. Peer reviews are a constructive process with the central aim of helping areas to improve and also proved a valuable opportunity to prepare the system for a future CQC inspection if we are selected.

Following a scoping discussion with the Local Government Association (LGA), the following two questions and supporting key lines of enquiry were agreed by the Health Care Executive:

1. Is there a shared vision and system wide strategy developed and agreed by system leaders, understood by the workforce and co-produced with people who use services?

2. The people's journey: how does the system practically deliver support to people to stay at home, support when in crisis and support to get them back home?

The peer review was undertaken during 24-27 September 2018. The peer team interviewed system leaders, commissioners, service leads, operational staff, service users and carers. The peers will also reviewed written documents from strategic plans to randomly selected case files regarding service users.

The initial feedback from the peer review team has indicated that as a system we are in a strong position, with synergy and commitment at all levels of management and front line staff. There was a recognition that there were some excellent services and approaches already in place to support prevention, keeping people well, supporting independence and avoiding hospital admission, but there is a lack of consistency. In addition, when people do go into hospital, as a system we have a real issue getting them out.

Key recommendations from the initial peer review feedback are outlined below. A full report will be developed and fed back to system partners imminently, which will then inform a more detailed action plan for how we take the recommendations forward to improve as a system.

- Development of a single vision that is person focused and co-produced with people and stakeholders. With simple, visual, clear branding and communications strategy.
- Ensure strategic partnerships include Primary Care, voluntary sector and Social Care providers
- Establish Home first as a default position for the whole system

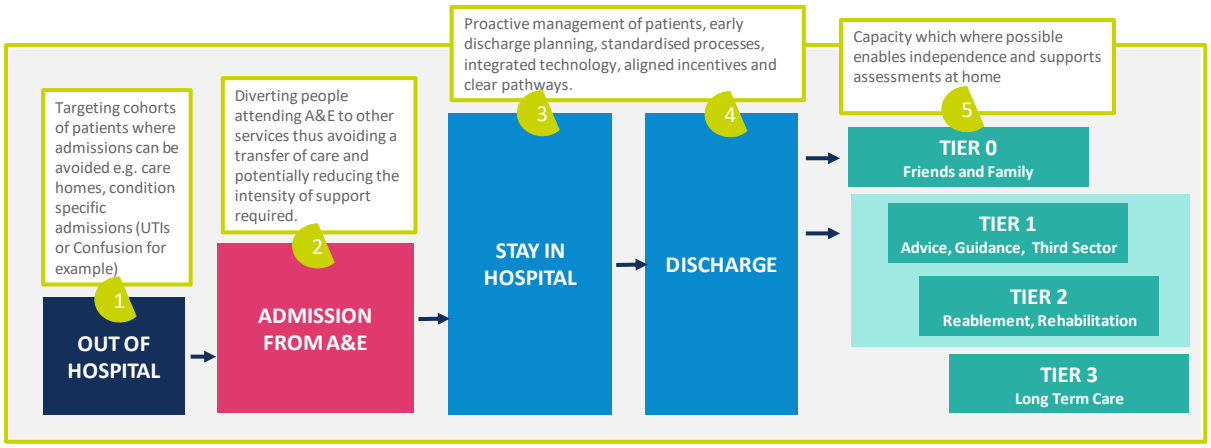
- Simplify processes and pathways – making it easier for staff to do the right thing
- Develop and implement a system wide commissioning strategy to deliver your vision. Look creatively at opportunities to shift or invest in community capacity to fully support a home first model.
- A significant piece of work to be done together to put Primary Care in the centre of models of care
- Build on strong relationship with Healthwatch to add more depth to co-production
- Develop a cross system workforce organisational development programme that reflects the whole system vision and supports staff in new ways of working
- Provide greater clinical leadership to support new processes and new ways of working across the system

2.5 Looking Ahead

Current schemes are focused on meeting demand at the 'back door' of the hospital and not managing demand across the system. Despite regional increases in NEL a sample of local authorities, showed:

- Only 8% of Improved Better Care Fund (iBCF) spend is currently focused on admission avoidance.
- Only 8.5% of schemes reviewed had an impact on admission avoidance.
- There are limited examples of schemes addressing cultural and behavioural issues across health and social care
- Very few examples of Discharge to Assess models are fully integrated

A more integrated approach to managing demand is needed to sustainably address system pressures, as outlined in the below model.



The key recommendations that will enable us as a system to deliver sustainable solutions to managing demand are:

- Widen the lens beyond the iBCF
- Invest in admissions avoidance
- Invest in disruptive innovation that tackles behaviours
- Address workforce issues jointly
- Change the narrative from coping with demand to maximising independence

3. ALIGNMENT WITH CORPORATE PRIORITIES

Report authors should evaluate the proposal(s) in light of their alignment with the following three Corporate Priorities.

3.1 Developing the local economy for the benefit of all

The following bullet points set out details of implications identified by officers:

- Improved provision of health and social care services that are more joined up, personalised and deliver care in the right setting at the right time.

3.2 Helping people live healthy and independent lives

The following bullet points set out details of implications identified by officers:

- Increased focus on prevention and early intervention to support people to remain as independent as possible for as long as possible.

3.3 Supporting and protecting vulnerable people

The following bullet points set out details of implications identified by officers:

- Better coordination of health and care support to prevent unnecessary escalations of need and enable services to be easier to navigate.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

There are no significant implications within this category.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications within this category.

4.3 Statutory, Legal and Risk Implications

There are no significant implications within this category.

4.4 Equality and Diversity Implications

There are no significant implications within this category.

4.5 Engagement and Communications Implications

There are no significant implications within this category.

4.6 Localism and Local Member Involvement

There are no significant implications within this category.

4.7 **Public Health Implications**

There are no significant implications within this category.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes or No Name of Financial Officer:
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes or No Name of Officer:
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes or No Name of Legal Officer:
Have the equality and diversity implications been cleared by your Service Contact?	Yes Name of Officer: Will Patten
Have any engagement and communication implications been cleared by Communications?	Yes or No Name of Officer:
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Name of Officer: Will Patten
Have any Public Health implications been cleared by Public Health	Yes or No Name of Officer:

Source Documents	Location
Cambridgeshire and Peterborough Sustainability and Transformation Plan	***https://www.fitforfuture.org.uk/what-were-doing/publications/***
Cambridgeshire Better Care Fund Plan 2017-19	***https://www.cambridgeshire.gov.uk/residents/working-together-children-families-and-adults/working-with-partners/cambridgeshire-better-care-fund-bcf/***