Appendix 3a

Better Care Fund 2021-22

Narrative Plan

Health and Wellbeing Board(s)

Cambridgeshire and Peterborough

Section 1 - Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

The following key stakeholders have been involved in the development of our local Better Care Fund (BCF) plans:

- Peterborough City Council
- Cambridgeshire County Council
- Cambridgeshire and Peterborough Clinical Commissioning Board (CCG)
- Public Health
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- North West Anglia Foundation Trust (NWAFT)
- Cambridgeshire University Hospital NHS Foundation Trust (CUHFT)
- Voluntary Sector
- District Councils
- Healthwatch

In the developing and drafting of the BCF plan there were discussions with partners, including discussion at the system wide Chief Operating Officers (COO) meeting, the Joint Cambridgeshire and Peterborough Integrated Commissioning Board, which has system wide health and care representation and has overseen the development and monitoring of local BCF plans in line with national requirements.

To ensure that local BCF plans align with wider strategic priorities around transition to being an Integrated Care System (ICS), engagement has happened with representatives from the North and South Integrated Care Partnerships (ICPs) and Health and Wellbeing Board chairs.

We are exploring how existing governance arrangements, such as the Health and Wellbeing Board (HWBB), can provide the opportunity to amalgamate and ensure effective and more joined-up decision-making with the ICP's and Integrated Care Board (ICB). An engagement document was released on 15 September to support Local Authorities, ICB and other key stakeholders to consider what arrangements might work best in their area when laying the foundations for establishing Integrated Care Partnerships (ICPs), this includes practical steps for implementation.

To complement this work, we are developing an ICS Partners Memorandum of Understanding (MOU) and are working with the System Governance Group to develop this.

The local BCF Plans have been approved by both the local CCG Governing Body and both Peterborough City Council and Cambridgeshire County Council. The plans have also been

approved by both the Cambridgeshire and Peterborough Health and Wellbeing Boards (HWBBs), via delegated authority to the HWBBs chairs following a meeting with chairs on the 11th November 2021. The plans will be presented at the next organised full HWBB meetings for full retrospective approval, but this will not be prior to submission of the BCF plans to NHSE.

Stretch targets have been agreed as part of this process for all the national metrics. This includes agreement with local partners, including the acute trusts; North West Anglia NHS Foundation Trust (NWAFT) and Cambridgeshire University Hospital NHS Foundation Trust (CUHFT), to ensure there is system ownership of stretch targets. Appendix 1 contains a more detailed overview and rationale associated with these targets).

In addition to the national metrics, we have agreed a number of additional prevention focused metrics, which we will monitor locally. We feel that this is an important indication to our commitment as a system to prevention and early intervention, recognising the need to monitor the effectiveness of preventative strategies on admissions avoidance and outcomes for people. Through effective management of disease, this has a positive impact on people's health and wellbeing, and ultimately delays or avoids unnecessary admissions. Locally, in in support of the system wide focus on our CVD prevention strategy, we will use the NICE Quality and Outcomes Framework Indicators (QOF) to measure this, focusing on key areas that recognise the local targeted approach we are adopting to prevention. Initially this will focus on the QOF metrics associated with Cardiovascular Disease (CVD), with a particular focus on hypertension. In addition we will monitor the admissions for heart attacks and strokes. We will continue to look at other local metrics around wider prevention initiatives as work progresses on local priorities, such as mental health, obesity and smoking,

Section 2- Executive Summary

This should include:

- ***Priorities for 2021-22***
- ***key changes since previous BCF plan***

This document forms part one of Cambridgeshire and Peterborough's BCF Plans for 2021-22, a joint narrative, highlighting the integrated approach to BCF plans across the Cambridgeshire and Peterborough Health and Wellbeing Board areas.

Our local BCF Plan continues to build on 2019-20 plans and the work undertaken to date. However, plans have been refreshed to ensure consistency and alignment with wider system plans, including local NHS recovery plans, Health and Wellbeing priorities and ICS plans, which represents a real shift to collaborative, integrated, place-based delivery.

Our plans take the approach of consistency, whilst building on learning and successes during the last year. Due to the onset of the pandemic in early 2020, we agreed locally to maintain provision of service capacity currently funded by the BCF pooled budget, so we continued provision in these areas. Wider integration plans were impacted by COVID, which meant that the system had to focus priorities on the local emergency response, meaning some work such as integrated neighbourhoods under the alliances was delayed. However, the pandemic strengthened community provision in other ways, e.g., our community hubs and joint working, which provides us with a strong base to progress our integration journey towards an Integrated Care System further.

The following table outlines some key integration successes and challenges we experienced as a system as outlined in our in BCF 2020-21-year end returns, which we aim to learn from:

Successes	**Challenges**
• In response to the Hospital Discharge policy, health and social care implemented jointly commissioned additional services during the pandemic to ensure appropriate capacity was in place to respond to the demands of the pandemic. Strong system leadership developed to jointly implement and redeploy resources to support existing D2A services. The system has worked jointly to support providers throughout the pandemic, ensuring we have consistent messaging and a central coordination point for management of issues. This has included development of a Care Home Cell providing support by Public Health, Infection control and Quality Team providing training and guidance. • A robust governance structure was developed to manage the central finance allocation across the system ensuring appropriate use of funds to support the emergency response. This governance structure included an effective and timely approval process allowing a rapid response to changes in demand and ensuring minimal delays to service delivery.	• The Hospital Discharge Guidance and speed of response to implement during the first wave often meant patient choice was not available. This was also compounded by numerous outbreaks in care homes limiting choice further. The system is undertaking a review of the D2A pathways reflecting on what went well and not so well to inform decision making on future service design. • Covid has caused the private provider market additional financial challenges due to implementing national guidance causing additional cost of PPE, reduced capacity available to adhere to infection prevention control measures and management of outbreaks. Whilst the system has provided a range of support to the market, both financial and practical, the implication of COVID has impacted on capacity, workforce morale and financial resilience.

We have continued to learn and adapt, but we still face a level of uncertainty re the full impact of COVID as we go forward. Whilst there have been many challenges, there have also been successes, with our local authority led Think Communities programme having thrived and developed in this time through the community hub, prevention and early intervention model, giving us an even stronger platform to develop further from, recognising that:

- We need to work together to make it simpler for residents and easier for communities to influence support and create opportunity relevant to their local needs
- Over the last 2 years the Think Communities Partnership approach has been building momentum across local councils, the public sector, health, and the voluntary, community and faith sector
- Through the last few months, the experience of COVID-19 has shown us practically how we can work together more closely to put our residents at the centre of what we do

- Whilst we are facing significant immediate challenge from the impact of COVID19 we believe that we need to continue to ensure we sustain more joined-up system working.

Our local BCF plans recognise that we are still in a significant period of change, emerging from the pandemic, alongside moving to a local Integrated Care System, and therefore reflect the need to flex and adapt to the changing landscape to ensure amalgamation across wider local system plans. This is against a continued backdrop of significant financial challenge for both our local authorities and Clinical Commissioning Group (CCG). The implication of COVID on demand means we are starting to see more demand coming through, with higher levels of need. This is alongside significant impacts on wider social care providers, impacting on capacity and costs of care. Workforce challenges present a very real pressure to us locally, with challenges in recruitment and retention of staff across both health and social care providers as a result of:

- Staff health and wellbeing is challenged due to the extreme pressures the pandemic has presented
- Low rates of pay for social care staff which are not competitive with other sectors, e.g. retail and leisure.
- Impact of sickness, isolation and recruitment challenges.
- Increased agency costs to offset shortages in staff.
- Impact of mandatory vaccinations in care homes, which is also now due to be extended to frontline NHS staff.
- Compound effect of the pandemic and EU Exit, with people returning home due to economic viability, and the impact of immigration regulations on recruitment for a workforce where there is a high dependency on non-British nationals.

Having good quality capacity is predicated on a suitable skilled workforce which can be retained and new skills recruited to meet the ongoing demand. Working with the market to develop a workforce strategy with the care sector at a national, regional and local level, as well as supporting providers to manage associated cost pressures is a key priority in how we continue to support the market to be sustainable and this is being embedded across local plans.

Our local priorities for 2021/22 continue to reflect the key strategic themes we outlined in previous plans, but these have been refreshed to focus on current workstreams and priorities as outlined below:

- Prevention and Early Intervention:
    - Focus on prevention and early intervention to support people to remain independent in their own communities for as long as possible
- Community Services / Place Based Delivery: Progress integrated place-based delivery models (including integrated neighbourhoods) through the ICPs and Think Communities programme. Key areas of focus include:
    - Our work with community catalysts to support the development of local micro-enterprises to deliver new models of local care, delivered by local people within local communities, reducing travel costs and duplication in existing arrangements, enhancing continuity of care and connecting people with their local communities.
    - Community navigators helping people to find and access localised solutions. Supporting older people, people affected by disability and /or their carers to

maintain and improve their health, wellbeing and independence. The Community Navigators support people by:

- Informing people about, and referring them to, relevant activities and services
- Helping people to use information to answer questions and enable them to do things for themselves
- Helping people overcome barriers to make use of relevant activities and services
- Supporting people to access activities that enable them to remain independent, safe and well.
- Identifying where more activities and services are needed and working with local people to develop these
- Targeting people at risk of poor health and wellbeing
- Reaching out to communities to engage with people

- Hospital Discharge Flow:
    - Refinement and improvement of Discharge to Assess and 'Home First' model, embedding the outcomes from NESTA and ECIST improvement work
- System Enablers:
    - Population health management approach to address health inequalities. Cambridgeshire County Council has committed to embedding a 'health in all' policy approach across all aspects of local authority delivery
    - System approach underpinned by strong joint commissioning principles
    - Shared Care Record Implemented across health and social care
    - Establishment of ICS system governance, ensuring amalgamation of Health and Wellbeing Board priorities

Section 3 - Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

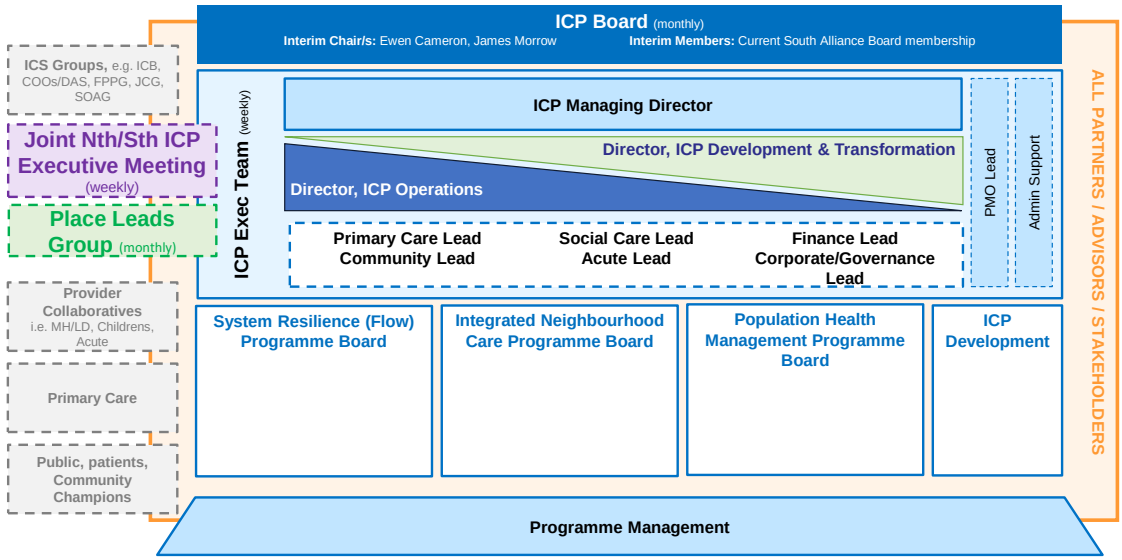
The existing governance oversight for the BCF sits with the Health and Wellbeing Boards (HWBBs) for Cambridgeshire and Peterborough, who have delegated responsibility down to the joint Integrated Commissioning Board.

It is important that we ensure amalgamation with the ICS governance, whilst recognising the need to ensure the protection of social care, drive local delivery and ensure oversight of progress.

We are working through the detail of the guidance related to ICS functions and governance and have scoped out via a governance diagnostic what we need to develop by when, to ensure that we meet the milestones set out in the latest ICS Establishment Timeline and are able to operate as an ICS from 1 April 2022. This will include developing the interface between Integrated Care Partnerships (ICPs) and Collaboratives.

We are exploring how existing governance arrangements, such as the Health and Wellbeing Board (HWBB), can provide the opportunity to build greater amalgamation and ensure effective and more joined-up decision-making with the ICP and Integrated Care Board (ICB). System wide workshops are being held throughout October and November to inform this arrangement. The below diagram outlines the interim ICP structure at this stage for further information.

Phase 1: Interim ICP Structure



Oversight of performance of BCF metrics
The oversight of performance against local targets sits with the North and South System Resilience Groups. These meetings have senior system wide leadership representation. The SRGs have routine oversight of system wide data on performance, alongside responsibility for programme oversight of wider flow and acute UEC transformation and improvement work. Discharge flow in relation to Queen Elizabeth Hospital NHS Foundation Trust (QEH) in relation to Cambridgeshire and Peterborough patients sits within the remit of the North ICP, which is establishing links with the QEH SRG.

Section 4 - Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- ***Joint priorities for 2021-22***
- ***Approaches to joint/collaborative commissioning***
- ***Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.***
- ***How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.***

Our approach in 2021-22 continues to build on the vision contained in the previous year's BCF plans:

"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 translates into a number of key joint priorities throughout 2021-22:

- Integrated, person centred, place-based delivery, with prevention and early intervention at its core (also see section 6)
- Addressing health inequalities through a population health management approach (also see section 7)
- Supporting Hospital Discharge flow (see section 5)
- Implementation of a local shared care record
- Working collaboratively as a system to deliver these priorities.

Currently, in line with our system wide Joint Commissioning Principles, the local authorities jointly commission c. £200m of services in conjunction with the NHS in addition to the Better Care Fund, including:

- Section 75 agreement with CPFT for the delivery of mental health support
- Section 75 agreement with CPFT for the delivery of Occupational Therapy (OT) services
- Learning Disabilities Partnership
- Integrated Community Equipment Service (ICES) and Technology Enabled Care (TEC)
- Prevention and Early Intervention Framework

In addition to the formal arrangements and delegated models, there are a number of teams and services delivering an integrated pathway or approach alongside NHS staff, including:

- Discharge to assess pathway 1: this includes CCC reablement and CPFT intermediate care staff working in a complimentary way.
- Transfer of care team: the council has staff based in our local acute hospitals working with clinicians to plan discharge.
- Care home support team and Brokerage: work closely with the CCG's Quality Team and Public Health supporting independent providers with quality, staffing or infection control issues.
- Multi-disciplinary teams (MDTs) with primary care – named social workers have been identified to work with Primary Care Network MDTs and advise and support decision making, sharing information and planning together how to prevent need from escalating.

The next step in our community journey is to develop place-based delivery, across the County, in which a wide range of organisations work together to govern the common resources available to them to deliver place base services which provide proactive, integrated and person-centred care to people, keeping them well and independent in their own communities for as long we possible.

Personalisation and a strengths-based approach is central to our model of delivery. 'Changing the Conversation' continues to focus on having the right conversations at the right time. This approach has been rolled out an embedded across adult social care via the

Council's Adults Positive Challenge transformation programme. The focus now is widening the scope to partners and providers, such as occupational therapists, place-based co-ordinators and commissioned providers, to widen the number of strengths-based conversations taking place across the whole system. There will be a pilot of changing the conversation with the block car providers for domiciliary care, with a view to rolling this out more widely to other providers based on the learning and impact evidenced.

"Community power is an inherently preventative way of thinking about public services"

Community power starts with the principle that people have the best insight into their own situation. As an ethos for public services, it entails a shift of power away from bureaucratic centres towards people on the ground, building on values such as collaboration and participation. Due to its focus on communities and places, community power is an inherently preventative way of thinking about public services. It understands, in its DNA, the importance of social determinants of health, as its focus is on the things that create ill-health at the level of populations and groups of people.

- This all works to counter spiralling demand. Instead of dealing with the issues of individuals at the point at which they become 'problems', community power means addressing things upstream – and, as a result, preventing problems from occurring in the first place. This reduces pressure on acute services.
- Community power also involves shifting the internal character of public sector institutions. For the NHS, this would mean becoming more outward looking, and forging closer relationships with other key place-making institutions, not least local government, local communities, voluntary and community groups to better intervened upstream and address local issues and challenges.
- This integration agenda, and the imminent national roll-out of Integrated Care Systems will help with this on a structural level. However, for real change to happen, culture needs to mirror and reinforce the new strategy. Health needs to be understood as being something bigger than the NHS – something that is created through the environment, through housing, through education, and through society itself. In recognition of the impact that social and wellbeing preventative measures can have in reducing long-term health and social care needs. This means recognising the importance of policy levers held outside the NHS, and for much deeper and more meaningful engagement with communities, as well as other public sector institutions.
- It also means system-wide targeted approaches to tackling health inequalities that recognises the impact of social determinants of health on health and wellbeing outcomes for individuals, for example the work on anti-poverty, which supports the Health and Wellbeing Board priority of 'preventing people falling into debt'. Cambridgeshire County Council and Public Health are leading on the development of a system-wide anti-poverty strategy that supports health outcomes.

Decentralisation is key to tackling inequalities, deprivation, poverty, unlocking the power in communities and providing opportunities rather than focusing on managing demand or saving money. To do this:

- we will work with district/city councils to understand what already exists by means of local governance, and seek to align ourselves to that rather than creating anything new
- we will bring our resources to the table up front – data and intelligence, skills service, libraries, youth services, budgets etc - but also get to a shared understanding quickly

of the challenges and issues so we can identify other resources that can be devolved or delivered differently
- if a district/city wants or needs to focus on smaller geographies (e.g. Wisbech, North Hunts, Abbey) we will focus resources there too and work on agreed boundaries that make most sense to our residents
- We will adapt our Adult Skills and Think Communities service offer to support the nurturing and development of new community leaders

Prevention and Early intervention is a continued focus for local BCF plans, with the continued embedding of approaches that prevent or delay the need for more intensive health and social care services. Our 2021-22 plans will build on the huge amount of work already undertaken in this area, e.g.:

- Public health led falls prevention programme
- Investment in Voluntary sector provision
- Carers Support and respite
- Day Opportunities
- Technology Enabled Care (TEC) and Community Equipment (ICES) and the embedding of a TEC first approach
- Information and advice, including community navigator service and social prescribing
- Reablement as default pathway for hospital discharge across Peterborough and Cambridgeshire

Joint commissioning across health and social care underpins the approach, and we will move towards commissioning at a place-based level, based on outcomes and supporting social value. This includes evolving options for devolving commissioning budgets to local ICP footprints where appropriate and developing new models of commissioning care.

Some options being explored include:

- **New model of home care:** A shift away from the Home Care model to develop a place-based approach, which comprises:
    - A community based, case management approach
    - Carers who live and work in their own community, including care micro-entrepreneurs, supported by Community Catalysts
    - Part of, and integrated into local health and care teams and resources
    - Investment in carers, reduces travel time, reduces attrition and improves career prospects and outcomes

  Given the scale of transformation, the first phase will be the development of a single early adopter pilot in East Cambridgeshire. Following successful evaluation, it is proposed to apply the learning from the early adopter site across the county.

- **Build more care and support around peoples' homes:** Alongside supporting older people to remain living independently through community-based care, commissioners are seeking to evolve the local residential and nursing care to develop tenancy-based models of care as alternatives to the traditional residential and nursing care home. Stimulating development of new capacity in this way will generate the much-needed provision to meet population growth forecasts and do so at an affordable cost. It will also offer greater choice, control and care flexibility for those older people no longer able to remain living safely at home.

- **Personalisation of Care and expansion of Self-Directed Support:** Individual Service Funds are being rolled-out in both Cambridgeshire (initially in East Cambridgeshire, under the Care Together project) and Peterborough. These will enable more people to gain choice, control and flexibility of the services they access with more support from providers who will link up with community assets to ensure individual agreed outcomes are achieved.

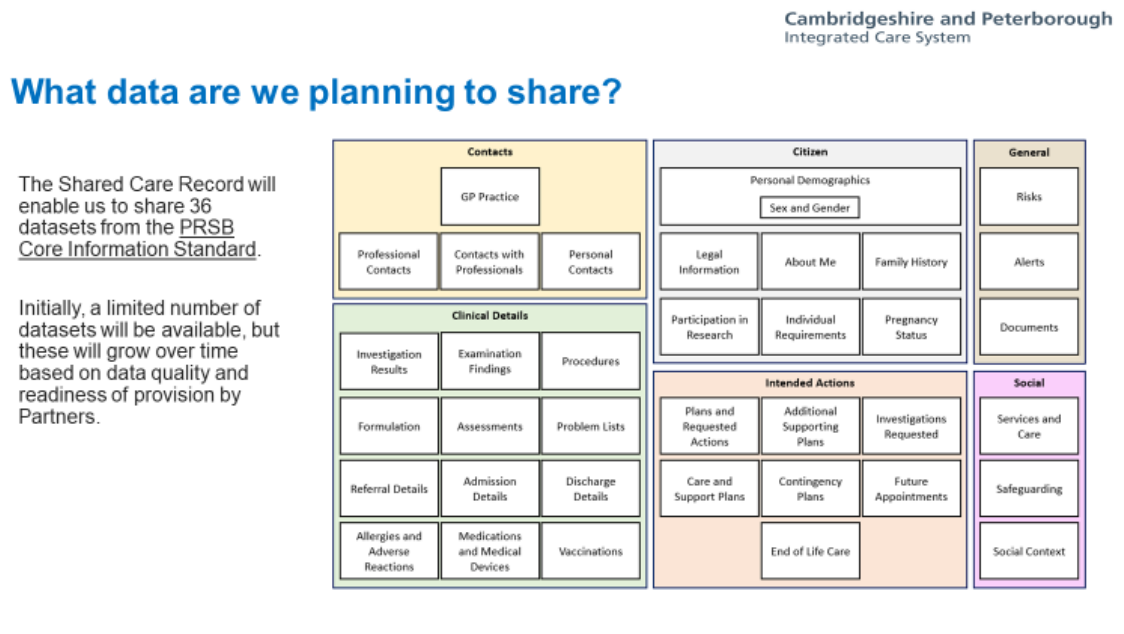
Shared Care Record

We want to bring together patient data currently held by our partners across our health and care system, into one single patient record view for direct care purposes.

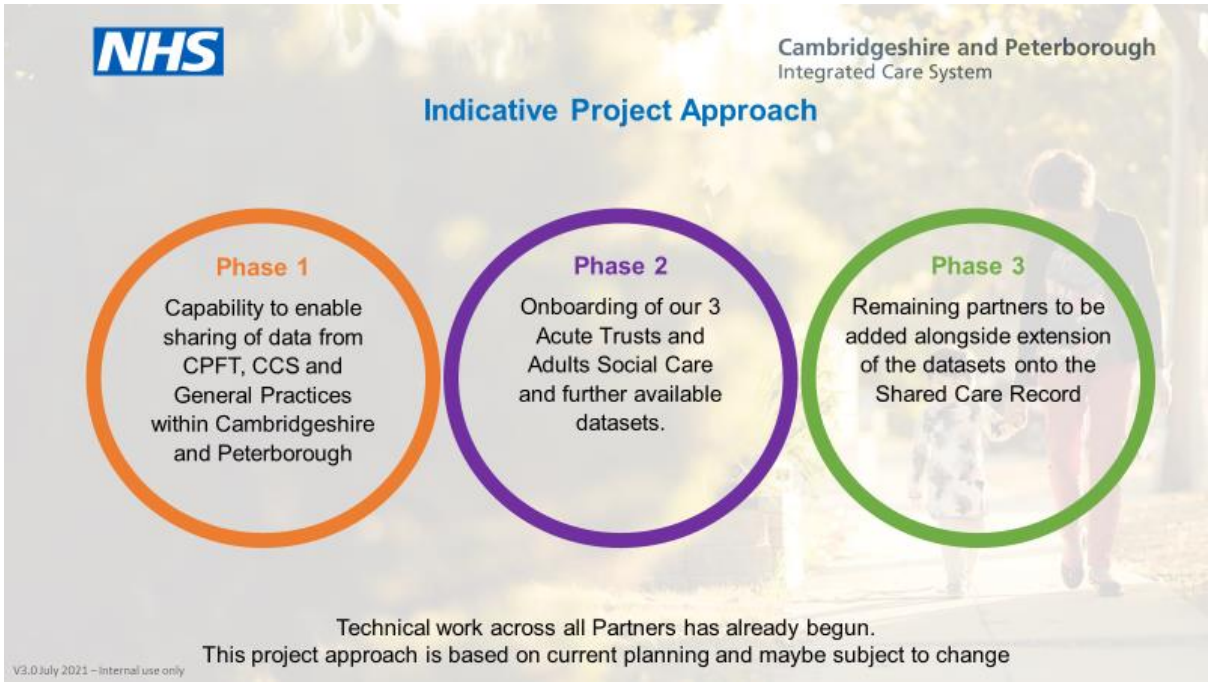
What will this involve:

- Data sharing capability between our core Partners
- Data will be shared in near real-time across Partners and presented, on-demand, in one of two ways:
    - In context presentation through existing Partner systems e.g. EMIS, SystmOne, MOSAIC etc
    - A standalone web browser
- Single sign on to the Shared Care Record, through Partner systems.
- Adopting a national common information standard to ensure sharing of consistent data quality and integrity using compliant interoperability standards.
- Compliance with NHS information governance framework and Cyber Essentials Plus

The type of data we are aiming to share is as per the below.

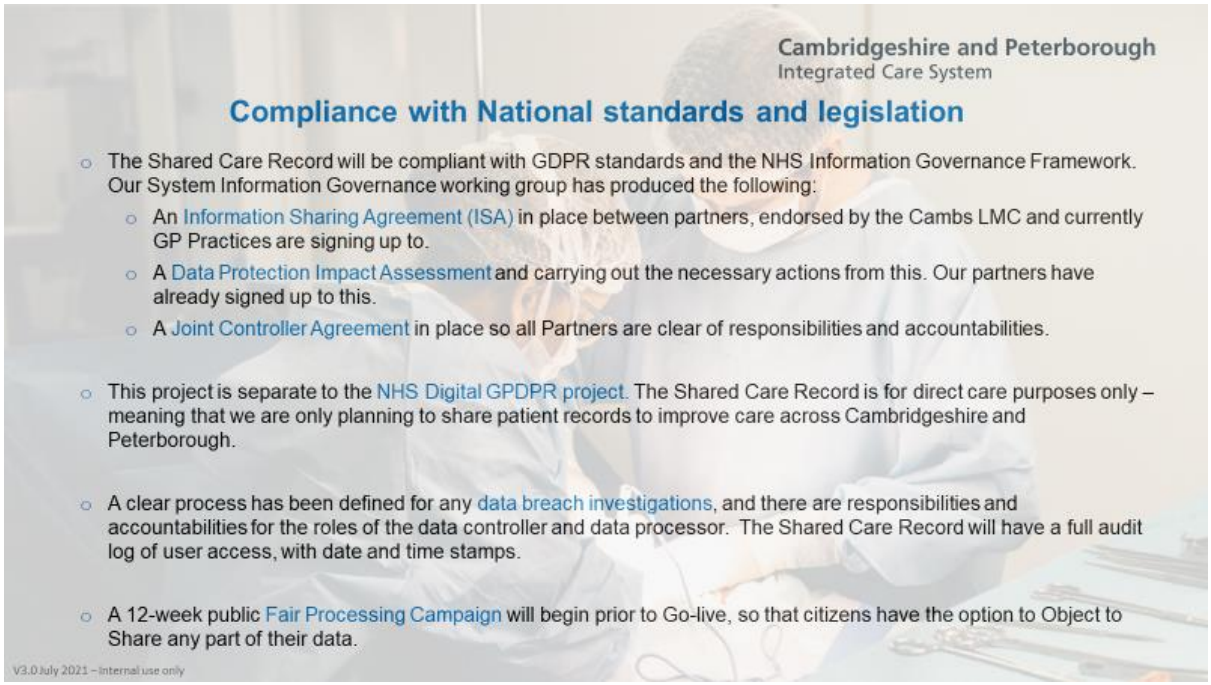


The roll out will happen in a phased way, as outlined below.



In relation to integration of social care records, we are looking to prioritise access for the older peoples community referral pathway (including reablement and OT) and LDP first with January 22 go live - with a view to full integration by September 2022.

The below provides an overview in terms of compliance with National standards and legislation and the local approach.



Working Collaboratively as a system to deliver these priorities

The reforms set out in the White Paper 'Integration and Innovation' published in February 2021 and the creation of an integrated care system (ICS), offer an opportunity to transform health and social care at a national and local level.

Integrated Care System (ICS) development is being driven nationally and all systems are required to have an ICS established by April 2022. Locally the proposals for an Integrated Care System for Cambridgeshire and Peterborough have been approved. The proposed ICS covers a footprint of nearly 1 million people.

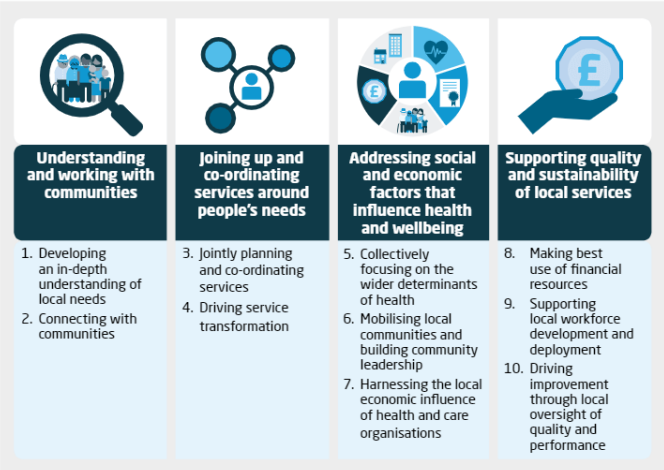
Integrated Care Boards (ICB) will be established to replace the Clinical Commissioning Group (CCG) which are being abolished.

The ICS in Cambridgeshire and Peterborough will include two ***Integrated Care Partnerships (ICPs)*** in the North and South building on the existing North and South Alliances:

- North: covers Peterborough, Fenland and parts of Huntingdonshire; and
- South: covers Cambridge City, South Cambridgeshire and East Cambridgeshire.

The ICPs will be a strategic body bringing together the ICB and local authorities within the ICS to facilitate the local integrated care strategy. Local decision-making, local knowledge and local democratic accountability are essential components of the ICS. Giving a meaningful voice to local people is at the heart of our vision for health and social care. The mechanism for local democratic accountability is through elected politicians and thus the ICS will be a partnership of equals across the NHS and local government, ensuring that local politicians share responsibility for the integration of health and social care through local democratic structures.

Locally, we are considering how we can streamline strategy and governance to amalgamate the ICPs with the Health and Wellbeing Boards. The role of the Integrated Commissioning Board, which has delegated responsibilities from the HWBs will also be reviewed as part of this. The key functions of ICPs is outlined in the below diagram.



The below diagrams show an overview of the ICP key workstreams, which reinforces the alignment between local BCF plans and the work that the ICPs will be progressing to take place-based delivery and priorities to the next level.

South ICP Roadmap

System Resilience (Flow) Programme Board (monthly)
Chair/SRO
Clinical/Professional Leads
Members

- NEL pathway management – daily rhythm and process improvement
- D2A Nesta 100 Day Challenge
- Surge/winter planning
- Community Care Coordination Hub
- *Virtual ward and virtual hospital models (with Acute Provider Collaborative)*

Integrated Neighbourhood Care Programme Board (monthly)
Chair/SRO
Clinical/Professional Leads
Members

- Co-develop refresh of IN Framework / Primary Care Strategy (incl. LMC)
- Building PCN and IN capability, capacity & infrastructure, incl OD
- Co-design Early Adopter INT model
- Community/Patient engagement
- *Link SR and PHM programmes to design and implement new OOH pathways*

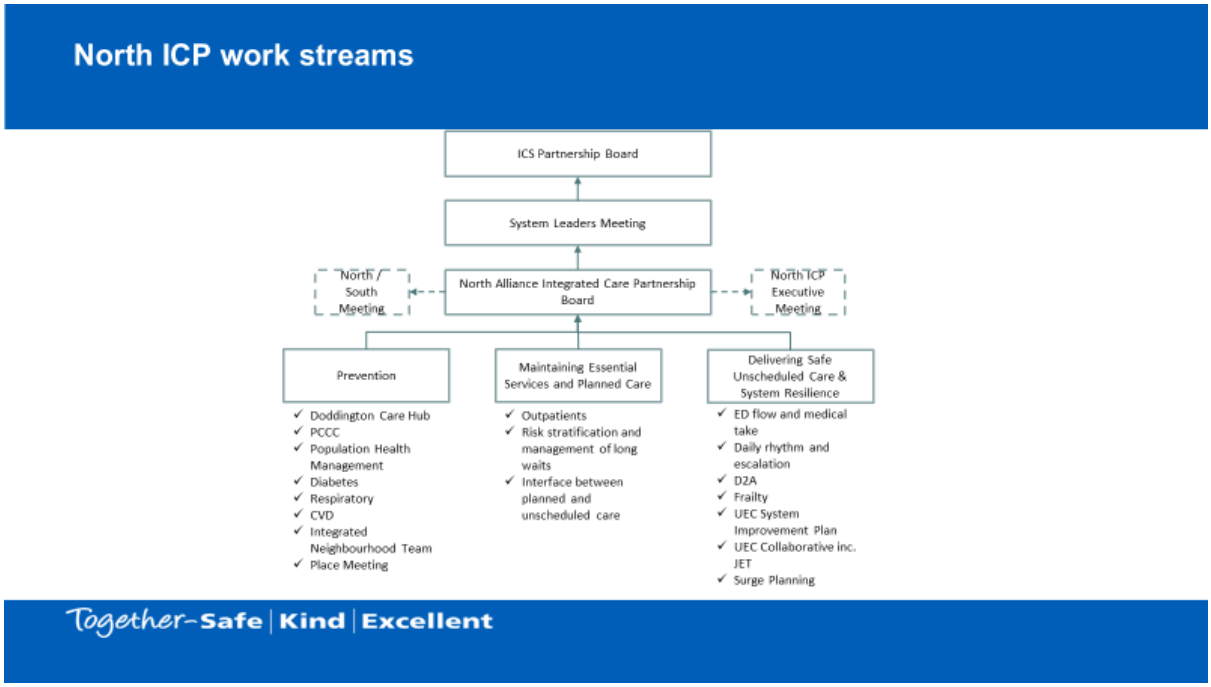
Population Health Management Programme Board (monthly)
Chair/SRO
Clinical/Professional Leads
Members

- Population Health Management Development Programme
- Risk Stratification – high intensity users [link to SR Programme]
- Anticipatory Care (Ageing Well and LTCs), including OOH pathway/model of care redesign
- *Prevention and early intervention*

ICP Development Group (weekly?)
Members

- Organisational Development
- Development Plan & Operational Plan
- Due Diligence requirements

North ICP Roadmap



Integrated Neighbourhoods have been established in a number of specific areas. These are still in their early stages and provide a test bed for innovation and integration to reflect local needs and demand.

There is also work underway to develop a number of ***'Provider Collaboratives'***, including one focused on mental health and learning disabilities and another in relation to maternity and children's services.

Section 5 - Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

Over the past year our well-established system Discharge to Assess (D2A) group has worked together to increase acute admission capacity and improve flow across our health and care system.

What we have achieved so far:

- We have begun implementation of the criteria to reside in our acute and community hospitals
- We have increased community and social care capacity through re-deployment, increased ICT to enhance our home support offer, recruitment of Integrated Care Workers (ICWs) and rapid commissioning of community bedded capacity
- We have implemented a multi-partner single point of access and multi-disciplinary decision-making process that has enabled us to commit to no assessments taking place in hospital (only exception being MCAs for safeguarding purposes) and manage patient flow as a system
- We have simplified processes under D2A pathway 1 to eradicate unnecessary 'hand offs' between services and ensure patients get continuity of care from hospital discharge to long term care arrangements where appropriate regardless of whether the lead commissioner of their care is health or local authority
- We have reinstated clinical criteria led admission to inpatient rehabilitation and health interim beds to ensure proactive rehabilitation of patients that are appropriate for this pathway
- We have ensured daily discharges are maximised and continued to pro-actively troubleshoot system issues through our steering group
- We have agreed a Memorandum of Understanding (MoU) across system partners outlining the processes required to manage any potential delays in the 6-week D2A period ensuring all patients are clearly allocated to a case manager to support them through to discharge home or into long term care
- Our dedicated ward pharmacy services have demonstrated reductions in patient length of stay and the Discharge Medicines Service will soon be implemented across our system
- We have continued to develop our integrated care home medicines optimisation service reviewing those at greatest risk, to support early discharge and prevent readmission for those residents in care homes or assisted living
- We have recruited two pharmacy technicians in our community services pharmacy team to work with people in their usual place of residence to feel confident to manage their medication, in turn reducing the need for care packages and possible admission to hospital
- Implementation of discretionary DFGs to facilitate quick hospital discharge for clients who need minor adaptations to be able to be independent at home, as well as for hoarders that require a deep clean to enable them to be discharged back home.

The local D2A model aims to achieve the following outcomes:

- Avoiding unnecessary hospital admissions;
- Improving patient flow through the system and particularly on discharge;
- Improving outcomes for individuals, with the right care and support being offered in the right setting at the right time, with long term care needs being determined once patients recovery and health has been maximised;
- Maximising opportunities for reablement and rehabilitation to promote independence and recovery, promoting the 'home first' model;
- Resources and capacity are commissioned based on flow and utilised effectively

The implementation of this model has resulted in simplified processes and the configuration of health and social care staff to support D2A in the community.

The provision of 7 flow has improved since D2A commenced with brokerage, acute discharge planning and social care transfer of care teams all now working 7 days, building on 7 flow from intermediate care and reablement. The JET service also supports Out of Hours provision, particularly at weekends, which also helps with admission

avoidance. NHS Hospital Discharge funding, which has been varied into the BCF section 75 has enabled capacity to be increased to support a number of identified areas, including:

- Brokerage capacity
- Social worker capacity
- Therapy capacity
- Intermediate care capacity
- Spot purchasing of bed capacity
- Voluntary sector
- Community IV service
- Additional nursing and residential bed capacity
- Additional home care capacity to support discharge

The Voluntary and Community Sector (VCS) offers dedicated support for older people and adults aged 18+ (with physical disabilities, sensory impairments, learning disabilities and/or autism, mental health issues, and/or their carers) when coming home from hospital, which is fundamental to support Pathway 0. Age UK, Care Network and British Red Cross offer discharge support services with the aim of helping people to return home from hospital in a safe and timely manner and to prevent readmission through a range of practical support and information and advice activities such as:

- One-to-one support
- Telephone support/welfare check-ins
- Collecting prescriptions and shopping
- Installing grab rails and key safes
- Food parcels
- Information and advice
- Support for discharge planning
- Wellbeing activities
- Triage into other local voluntary sector support

Examples of triage into other local voluntary and community sector services could include:

- Carers support offered by Caring Together and Making Space (who support people looking after someone with mental illness)
- Support for people with sensory impairments, for example Cambridgeshire Hearing Help, Camsight, etc.
- Homes support services (offering help with general domestic tasks including cleaning) and shopping services (such as those provided by Age UK Cambridgeshire and Peterborough)
- Referrals into local strength and balance exercise classes (promoted by Public Health's 'Stay Stronger for Longer' campaign) to reduce people's risk of falls
- Putting people in touch with local community groups and schemes where they live, such as Timebanks, Good Neighbour Schemes, etc.

These services, many of which are funded by BCF funding, complement our existing Reablement offer and provide localised support to people, enabling them to rebuild networks and establish support within their communities.

It is important to note the ongoing work with Queen Elizabeth Hospital NHS Foundation Trust (QEH) to support length of stay and discharge flow for Cambridgeshire and Peterborough resident patients. Social care and community provider discharge planning teams work actively with QEH, including regular attendance at long length of stay meetings, patient tracker meetings and escalation calls. We are supporting multi-disciplinary team discharge conversations for patients to ensure that their discharge is supported in a safe and timely manner. A virtual discharge room has been established across the system, which QEH, are part of. This enables staff to drop in at any time for updates and queries relating to patient discharges. In addition we have a dedicated social worker linked to the hospital who is based on site.

Discharge Improvement

Over the next 6 months we will build on this good work and lessons learned (locally, regionally and nationally) to develop a sustainable, equitable and resilient D2A pathway and intermediate care/reablement model that incorporates our patient and service user feedback, is outcomes focussed and financially sustainable. We will work together to:

- Continue to simplify the processes in acute and community hospitals to reduce bureaucracy and support patients' discharge when they no longer meet the criteria to reside
- Develop a pooled and flexible staffing model for therapy/OT staff across our system, with outreach from acutes and rotation of staff through acute and community settings
    - A gap in therapy resource has been identified and system discussions are taking place to address the funding gap
- Take forward recommendations for pathways 1 & 2 based on what worked well during Covid-19 and what is needed going forward for the next 6 months
- Continued use of the Care Home Trusted Assessor model for pathway 3, with potential for greater efficiencies through some remote working
- Continue to build on the Single Point of Access, multi-disciplinary working, whole system patient tracker and continue to manage patient flow as a system
- Continue to engage with and expand the use of the voluntary sector support
- Review our system capacity for intermediate care and home first, to include a comprehensive review of wrap around services, e.g. therapy, social care, DPSNs and primary care support. We have commissioned NESTA to lead a 100-day challenge in September to further refine this model. This will highlight any gaps in recurrent funding which require a system solution
- Review and improve the commissioning framework for D2A beds to ensure that the system has the flexibility to adjust what we commission in response to unplanned events
- Use data to inform our understanding of health inequalities across our services and pathways and ensure that any future model is proactively addressing this through delivery at place and monitoring population health outcomes
- Continue to work seamlessly with the community services pharmacy team to expedite the discharge process by providing medication administration training for the large number of new ICWs and advice and guidance
- Increase the availability of pharmacy technicians in the community service pharmacy team as it is currently only funded for half the county

A single programme structure has been established to ensure a consistent approach to the improvement programme of work.

Our local vision for Discharge to Assess – By November 2022, will ….

- Focus on people, keeping them at the heart of all our decisions
- Focus on outcomes, with the metrics we focus on created and agreed by the people the metrics relate to
- Do no harm (emotional or physical) to patients because of capacity constraints or process delays
- Have the right people, in the right place, at the right time
- Deliver smooth flow and exceptional experience through simple referrals done at the right time
- Enable patients to leave hospital within 24 hours of no longer needing to be an inpatient, going home wherever possible

This improvement work is being supported by NESTA who have tasked system leaders across the North and South ICPs with making improvements to current pathways and processes to get better outcomes.

- North – exploring how to develop both push and pull models to support people home quicker and safer from hospital into the right care setting
- South – looking at how to improve things for people who require care and support to leave hospital

NESTA's focus is less about discrete projects, but more about empowering multi-agency teams to make improvements over 100 days and then the progress and benefits from these will be used as a foundation for how we continue to progress

The ICPs are also taking responsibility for flow at Place level and are currently looking at how to develop initial arrangements for winter around:

- Triage
- Escalation
- Management of flow

How is BCF funded activity supporting safe, timely and effective discharge?

BCF funding supports a number of key areas that support discharge flow, including the below examples:

- Significant contribution towards reablement and intermediate care provision. This includes both care at home to support the 'Home First' model, as well as rehabilitation and reablement beds where bed-based rehabilitation is required.
- NHS Discharge money has been pooled into the local BCF and has been used to increase capacity to deliver the D2A model, as outlined previously.
- Improved Better Care Funding is utilised to fund additional provision, including nursing capacity in Peterborough and discharge capacity in Cambridgeshire.
- Significant Improved Better Care Funding in our local DTOC/Discharge plans, this includes funding of specific interventions such as our local care home trusted assessor model, discharge team social worker capacity, CHC assessment capacity and D2A leads.
- BCF funding of social care placements, to ensure sufficient capacity in the market to support discharge
- Funding of voluntary sector support, which aids discharge of patients with low level needs, e.g. Care Network, British Red Cross.

Section 6 - Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people.

In Cambridgeshire, DFG monies are passed to the District Council. In Peterborough, as a unitary authority, responsibility for the DFG sits with Peterborough City Council. DFG monies are used to support home adaptations and to better support people to remain in their homes for longer. There is a strong local commitment to ensure that we use adaptations, Technology Enabled Care (TEC) and Community Equipment (ICES) proactively to support independence.

The role of the District Councils across Cambridgeshire, Peterborough City Council as a unitary authority and the Home Improvement Agencies (HIAs) are fundamental to this approach and ensuring that people are supported to access the adaptations and assistance that they need. More information on the HIAs in Cambridgeshire and Peterborough can be found at:

- Cambridgeshire: Cambridgeshire HIA
- Peterborough: Care and Repair

Integration of housing with health and care services is a crucial element to supporting the outcomes of the BCF and housing colleagues are actively represented at the Integrated Commissioning Board, to ensure housing is integrated with strategic joint commissioning intentions across the system.

Both Cambridgeshire and Peterborough have Housing Renewal Policies which introduce discretionary funding in addition to the mandatory DFG funding already covered in legislation. This has enabled DFG funding to be used as 'top up grants' and to support physical works to homes to expedite hospital discharges or prevent hospital admissions, or to support relocation grants to enable applicants to move to a more suitable property that can be more easily adapted if necessary.

In line with the County-wide policy, we have also implemented the following which has aided speeding up hospital discharges and avoided unnecessary hospital admissions:

- Implemented the Community Warden pilot scheme as part of our Doddington Hub work.
- Addressed the significant delay in Occupational Therapist (OT) assessments by commissioning private OT capacity.

Alongside this, in 2020/21 we ran a boiler replacement programme for vulnerable households, making homes warmer and more efficient on cost to again benefit the health and well-being of the households and we are looking at the potential to run this again this financial year. Just looking at the spend profile to see if feasible to offer anything along those lines this year.

Community equipment (ICES) and TEC work hand in hand with the DFG to enable more innovative models of support and we continue to build on this to further enhance a holistic approach. The Integrated Community Equipment Service provides short- and long-term loans of equipment, ranging from simple walking aids, through to larger and more complex items, such as pressure relieving mattresses and hoists. Equipment may also be designed to

help carers with the safer delivery of care. The service can also include installation, servicing and maintenance, depending on the type of equipment specified. This equipment plays an important role in diverting demand away from long-term care and this is an area where BCF funding actively supports provision via a pooled integrated model of delivery.

The TEC service continues to deliver interventions which reduce, prevent and delay the need for long term social care support and avoidance of health needs. Through BCF we seek to expand the impact of TEC, with it embedded in care pathways as core element of the support we offer at every stage of the journey.

Throughout the pandemic the TEC first approach has continued to be the default. The Council has also focused on building up the lifeline provision through direct delivery of a lifeline service. TEC huddles continue as a means of keeping practitioners up to date with new TEC, which is constantly emerging. The pandemic emphasised more than ever, the need for digital resilience to go hand in hand with TEC and the need to address digital exclusion inequalities. For 2021/22, a joint TEC and digital resilience plan has been developed with Think Communities, incorporating a range of shared actions around the following four outcomes:

- Intervention and prevention to reduce demand on adult social care services
- Development of a consistent TEC model across Cambridgeshire and Peterborough
- Link with the existing digital resilience offer
- Establishing a place-based pilot in Fenland in collaboration with North Alliance

A good example of housing, social care and health integration is the recent implementation of our Out of Hospital Care Models for Homelessness pilot in Peterborough and Cambridge City, for which we received bid funding from the Home Office in 2020/21 – 2021/22. The funding has enabled the recruitment of Senior Housing officer posts to offer dedicated housing advice and support where housing needs or homelessness are identified as a barrier to hospital discharge. The posts have been embedded within the existing discharge to assess (D2A) pathway across the Cambridgeshire and Peterborough. This ensures that appropriate housing support and decision making is in place at the point of multi-disciplinary discharge triage. In addition, the funding has secured dedicated step-down accommodation for the project, with wraparound intermediate care and/or reablement support, to support rehabilitation and independence where there is an identified need.

Section 7 - Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- ***Changes from previous BCF plan.***
- ***How these inequalities are being addressed through the BCF plan and services funded through this.***
- ***Inequality of outcomes related to the BCF national metrics.***

In Cambridgeshire and Peterborough stark inequalities exist in the social determinants of health, risk factors, health care provision and clinical outcomes across socio-economic, disadvantaged and inclusion health groups. A 10-year life expectancy gap exists between men living in the poorest areas of Peterborough compared to the richest areas of Cambridge. The gap in life expectancy is driven by early deaths in cardiovascular disease, cancer and respiratory conditions. COVID-19 has increased the pre-existing inequalities.

Our local BCF Plan is aligned with our local Cambridgeshire and Peterborough 'Health Inequalities Strategy 2020' (https://www.cambridgeshireandpeterboroughccg.nhs.uk/about-us/health-inequalities/). The strategy has three objectives:

1. Develop Guiding Principles to tackle health inequalities
2. Agree health inequality indicators
3. Identify specific areas for priority action

Drawing on national and international recommendations we have developed seven Guiding Principles. These are:

- Explore the impact of decisions on health inequalities early in the decision-making process
- Value staff through parity of recruitment, promotion and employment
- Offer simple, hassle-free services
- Partner with other organisations to take a place-based approach to address social determinants of health
- Allocate health care resources proportionate to need
- Consider actions at different stages of life
- Harness the community benefits of the Social Value Act

A Health Inequalities Board has been established to monitor and drive action on health inequalities, promote awareness of the guiding principles and embed them in commissioning and delivering of services.

The Health Inequalities work is overseen at system level by a Health Inequalities Board with Executive Director level membership from all organisations in the ICS, the Communities Directorate of our Local Authorities, Public Health and Health Watch. This Board is working with distributed system leadership; it is chaired by a CEO from one provider, has NED support from another provider and an SRO from a third organisation. In this way we are ensuring that reducing Health Inequalities is a system-wide and system-owned priority.

The Health Inequalities Board will be underpinned by a newly formed Health Inequalities Operational Group.

Basic Population Health Management approaches are already in use in our system through the use of “Eclipse Vista”. Eclipse Vista uses primary and secondary care data to provide risk stratification, patient segmentation and patient alerts to maximise primary and secondary prevention. Additionally, the ICS is part of a project with Optum to use joined up data to carry our population health management.

Sentinel indicators for Health Inequalities were developed as part of the overall system strategy and are reviewed by the CCG monthly as part of integrated performance monitoring and will become part of the regular information reviewed by the Health Inequalities Operational group over 2021/22.

In December 2020 NHS Cambridgeshire and Peterborough's application was accepted for the wave 3 Population Health Management programme. This programme will be run through a blend of NHSE/I teams, external SME (Optum) and transformation partners. Phase 1 will work with one place (the North of the system was chosen by the HI Board and the decision has since been ratified by system leaders) and 3-4 PCNs from anywhere across the system, likely to be a mix of both North and South of the system, taking into consideration local deprivation and population needs. It aims to help us understand the challenges being faced by specific groups in the health and care system and identify actions to address these.

The PHM Wave 3 Development Programme is a 22-week supported action learning programme to facilitate:

- Working with each tier of the system to **link local data sets**
- **Build analytics skills** across the system
- Find rising risk cohorts
- Risk stratification of elective backlogs and explore alternative models of service delivery.
- Support the design and delivery of new models of care for impactable patients
- Costed segmentation to develop new population based blended payment models and evaluate impact of interventions.

The second phase of the program will look to roll out the datasets and learning to all PCNs across the system. This may be via QlikView, Eclipse or via the Cambridgeshire and Peterborough Shared Care Record.

Social Mobility Strategy Development

This strategy is being developed, working with system and community partners across county, city, district and parish councils; voluntary, community & faith sectors; in conjunction with the Health Alliances and Police.

- Focus is on levelling-up communities, and addressing the absolute root causes of inequality
- The approach is designed to create the right conditions for citizens to take greater control and to make informed choices about their own future

To achieve this, our aspiration is that:

- Place teams exist – multi-disciplinary, multi-organisational, multi-age range
- Holistic assessments, triage, conversations are standard across all services
- A whole-family, whole-person, whole-place approach is embedded into decision making
- Interdependencies are understood, and impacts of decisions are owned by the whole place team

- Barriers to improved social mobility are understood by all, involvement in services always leads to opportunity
- The most appropriate worker takes the lead - but the whole place team supports the worker
- When intervention is needed, this leads to the right level of support, but step down is planned well in advance with the community
- Local volunteering opportunities are linked to the place team to support a seamless experience
- Information sharing agreements are embedded – systems co-exist but share information and data which is analysed and interpreted looking forward and looking back
- The roles of community connectors and social prescribers are embedded into the place team to support community opportunities
- Clear and holistic menu of interventions and opportunities has been created and is understood

Our Health Inequalities Strategy and Population Health Management approach is a core element to embed within our BCF Plans, particularly in support of place based Integrated Neighbourhood development, ensuring that local commissioning and provision of services is targeted to address health inequalities and meet local identified needs in an integrated manner. It will also support the risk stratification of patients, to enable targeted multi-disciplinary early interventions, preventing the unnecessary escalation of need and delivering the best outcomes for people.