Cambridgeshire & Peterborough

Better Care Fund Narrative Plan 2017-19

Appendices

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Appendix 1 - Local Vision for Integration

Before people have significant ongoing needs

Ageing well

We are increasingly focused on establishing and implementing approaches that prevent or delay the need for more intensive health (specifically admissions and re-admissions to hospital) and social care services, or, proactively promote the independence of people with long-term conditions and older people and their engagement with the community. This includes specific and planned evidence based public health programmes with an emphasis on falls, social isolation, malnutrition, dementia and promoting continence.

Eyes and ears – indicators of vulnerability

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

Clear and joint sources of information

People will be able to access a consistent library of health, social care and wider information from a number of places - including web sites, libraries, community hubs or their GP surgery. Information will be available in print, digitally or through trusted sources. Consistent and up-

to-date digital information will be available, as each source will call on a shared information hub so that organisations offering support only have to update their information in one place – and it is available across all sources. From accessing this information it will be easy for people to find out how to make contact if they need further support.

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

Identification of these triggers, or a member of the public making contact, will result in a referral to a co-located or virtual single point of access where advice can be sought. Those who take the call can check existing levels of involvement with our agencies across different information systems via appropriate look-up access to records. There will be joint single point of access based on the assumption that 'there is no wrong door'. This will be based on the different referral points for health, social care and the Voluntary and Community Sector (VCS) operating as one virtual front door.

Holistic identification of need with a coordinated response

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

As well as that simple tool, a more in-depth holistic needs assessment process will be available that could be used to assess the full range of needs (physical, mental, social); and identify what support could prevent further escalation. A virtual 'team around the older person' would be established with all involved in this team (e.g. GP, District Nurse, Social Care practitioner Housing provider, home care agency, local voluntary organisation, neighbour) being able to work to a shared care plan based on shared information. A lead person or professional would be identified for as long as was needed as a key point of contact, to coordinate support and to simplify a complex system for people requiring support.

Support for people with significant ongoing needs

Clear, coordinated pathways and hand overs

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

Neighbourhood teams and Multi-Disciplinary Team (MDT) working

Neighbourhood teams will be embedded and operating effectively. Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) have restructured and established a number of integrated mental and physical health Neighbourhood Teams, each of which has a Neighbourhood Team Manager. An 'extended' Neighbourhood Team will be established which includes a range of other organisations that will work with the Neighbourhood Team to

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

Case finding and case management

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

Working with Care Homes

Although our focus is on supporting people to live independently we recognise that residential care is the most appropriate choice for people that need it. We will continue to support care homes to ensure that their residents continue to receive high quality support that is focused on preventing their needs from escalating. We will continue to invest in training for care homes. We will expand older people's Crisis Resolution and Home Treatment with new resources to support people with dementia and complex needs in care homes.

Working with housing providers

Supporting people to live independently requires that they have access to homes that are appropriate to their needs. We will work together with housing agencies to co-ordinate health, housing and social care to ensure that people with long-term conditions have access to accommodation that they want to live in, that enables them to remain independent within their community wherever possible. We will work to explore a range of opportunities linked to use of the Disabled Facilities Grant; and support for equipment and adaptations that enable people to remain at home for longer. People will also have early access to advice on the housing options available to them, to ensure that they can make choices and plan for their future.

Enablers – support for delivery

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

Joint outcomes

The Outcomes Framework was developed as part of the Older People and Adult Community Services (OPACS) procurement process, with input from a wide range of stakeholders and a review of scientific evidence. The Framework contains a number of agreed outcomes for measuring quality of care. Each outcome and metric was tested against a range of criteria to ensure that they would add value; and be feasible to implement. The framework is already being used in reporting on delivery of integrated services locally; and we will maintain the benefits of an integrated, outcomes-based model. We will look to include relevant outcomes framework measures in 2017-19 NHS contracts (and other contracts where relevant), joint programmes of work across the health and social care system including the Sustainability and Transformation Plan (STP) and BCF plans.

Information and data sharing

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

A common language

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

Workforce development

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

Property co-location

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

Joint commissioning of the voluntary and community sector

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

Appendix 2 - Cambridgeshire & Peterborough Demographics

Cambridgeshire Demographics

Cambridgeshire was the fastest growing county authority between 2001 and 2011 and is expected to continue to grow. The estimated population in 2014 was 639,800 with 17.7% of the population (113,500 people) aged 65 and over, which is the same as the England average[1]. The population is more ethnically diverse in Cambridge, with just 66% white: British compared with 87-90% elsewhere. The population of Cambridgeshire is forecast to grow by 23% between 2016 and 2036, an additional 147,700 people; the areas forecast to see the biggest growth are South Cambridgeshire (34%) and East Cambridgeshire (29%). Cambridgeshire's population is also ageing: the population aged 65+ in Cambridgeshire is expected to increase by 64% between 2016 and 2036, an additional 76,300 people; the area forecast to see the biggest increase in people aged 65+ is Huntingdonshire (67%).

Cambridgeshire is a relatively affluent county, but significant pockets of deprivation exist across the area, most notably in Fenland, north Huntingdon and north of Cambridge City. Life expectancy for both males and females is significantly higher in Cambridgeshire when compared to England. However, life expectancy is 6.8 years lower for men and 5.0 years lower for women in the most deprived areas of Cambridgeshire than in the least deprived areas.

For the adult population, 9.8% of people reported two or more longstanding illnesses which equates to over 39,000 people in Cambridgeshire. 0 people report two or more LTCs, with limitation and with mental ill health. 45% of people aged 65 and over with two or more LTCs experience limitation. Over 51% of those with multiple (three or more) LTCs experience limitation.

By 2026 the number of people aged over 90 years is forecast to more than double, with the number of people in their 80s rising by more than 50%. Over this time it is expected that the number of older people with depression will increase by 12% and the number with dementia will increase by 64%. Increases of this size over a short period will put severe strain on existing services

Peterborough Demographics

Peterborough is one of the fastest growing cities in the UK, with predicted population growth of 34.9% between the 21 years spanning 2010-2031. The city is ethnically diverse, with 29.1% of residents not self-identifying as White English/Welsh/Scottish/Northern Irish/British. The next most common ethnicities declared in the 2011 census were Asian/Asian British: Pakistani or British Pakistani (6.6%), White Polish (3.1%) and Asian/Asian British: Indian or British Indian (2.5%).

Based on 2014 population estimates the population of Peterborough is estimated to be 190,461, with 17.6% of the population over 65 years of age[2].

Peterborough was listed by the 2016 Centres for Cities report 'Cities Outlook 2016' as the third-fastest growing city in the UK (behind Slough and Milton Keynes) and this presents

[1] http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/mid-2014/stb---mid-2014-uk-population-estimates.html
[2] http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/mid-2014/stb---mid-2014-uk-population-estimates.html

unique opportunities and challenges for us as a Unitary Authority, particularly considering the number of people over the age of 65 within the city is expected to grow substantially over the next few years. The over 65 population in Peterborough is predicted to grow to 31,000 by 2020, just under half will be over 75, which is an 11% increase since 2015. Between 2016 and 2036 the 85+ population is forecasted to double. Such high growth presents both the obvious risks associated with increasing service demand but also the opportunity to ensure the health of our residents improves through the design and commissioning of appropriate services, particularly preventative services, to enable people to stay healthier for longer.

The overall level of economic deprivation is higher for Peterborough Unitary Authority (UA) than for that of England overall, with a higher percentage (37.5%) of residents than England overall (20.2%) within the most deprived economic quintile. The current priorities of our Health & Wellbeing Board (insert footnote to health and wellbeing strategy) remain focused on narrowing inequalities and providing the best levels of opportunities in life and care when needed to residents ranging from children and young people to our older residents.

A feature of adult health in Peterborough is a relatively high rate of premature death and disability, with life expectancy and healthy life expectancy being below national averages. Premature deaths from cardiovascular disease including in particular coronary heart disease, and from respiratory disease are higher than average – and these high rates of cardiovascular disease are focussed in electoral wards with the highest levels of socio-economic deprivation. Rates of premature death from cancer and liver disease are similar to the national average. Standardised hospital admission rates follow the pattern of premature mortality, with high admission rates for cardiovascular disease (and for all causes) from the more deprived wards.

There are lifestyle and health behaviour issues with longer term implications for public health – adult smoking rates are similar to the national average at 18.6%, however smoking attributable hospital admissions and smoking attributable mortality rates are both higher than the national average, emergency hospital admissions for COPD are higher than the national average, hospital admissions specific to alcohol use are higher than average, and about two thirds of adults are overweight or obese (similar to the national average). It is known that smoking, excess alcohol and obesity all cause long term medical conditions which require treatment and that high prevalence of these behaviours will result in additional demand on health and social care services.

Suicide rates in Peterborough are currently similar to the national average, but admissions to hospital for mental health causes are higher than average. The predicted increase in the number of older people in the population means that the numbers of people with dementia in Peterborough, as well as older people suffering from depression is forecast to increase significantly over the next ten years, which will increase demand on health and social care services. Prevalence estimates were obtained from the Dementia UK Report (Alzheimer's Society, 2007) and applied to the official ONS population estimates, predict the number of people with dementia (including early onset) living in Peterborough, is predicted to increase from 2,011 in 2015 to 2,274 in 2020 and 2,655 in 2025 – an increase of 32% over the next ten years.

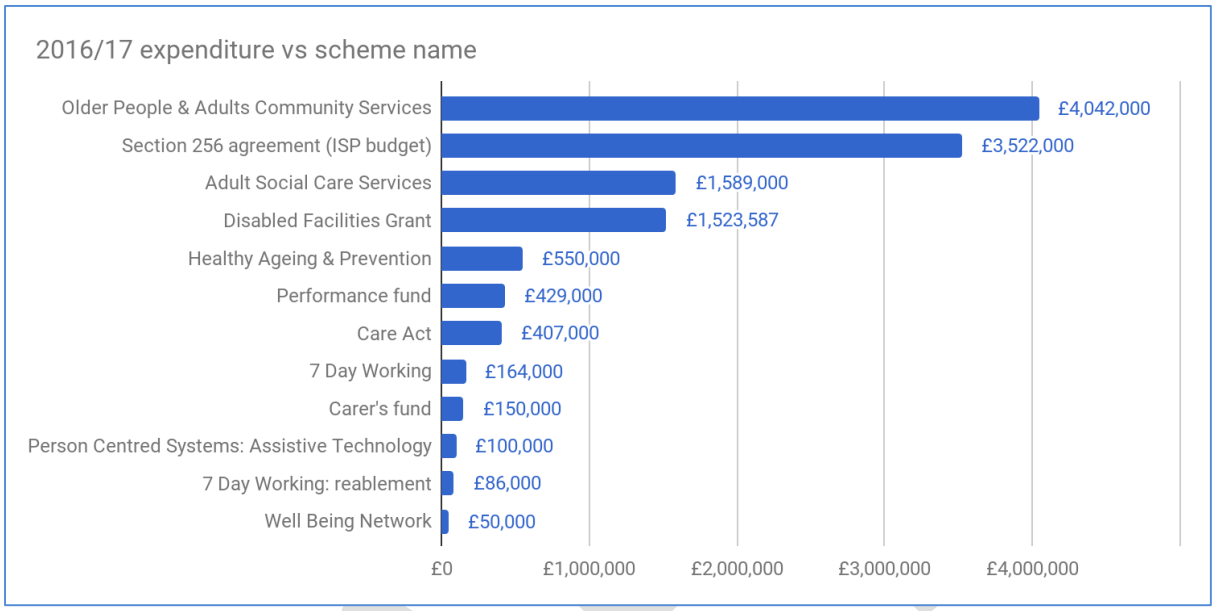
Further reading

Peterborough Better Care Fund Plan 2016/17, Case for Change
Cambridgeshire Better Care Fund 2016/17, Case for Change
Cambridgeshire and Peterborough Sustainability and Transformation Plan

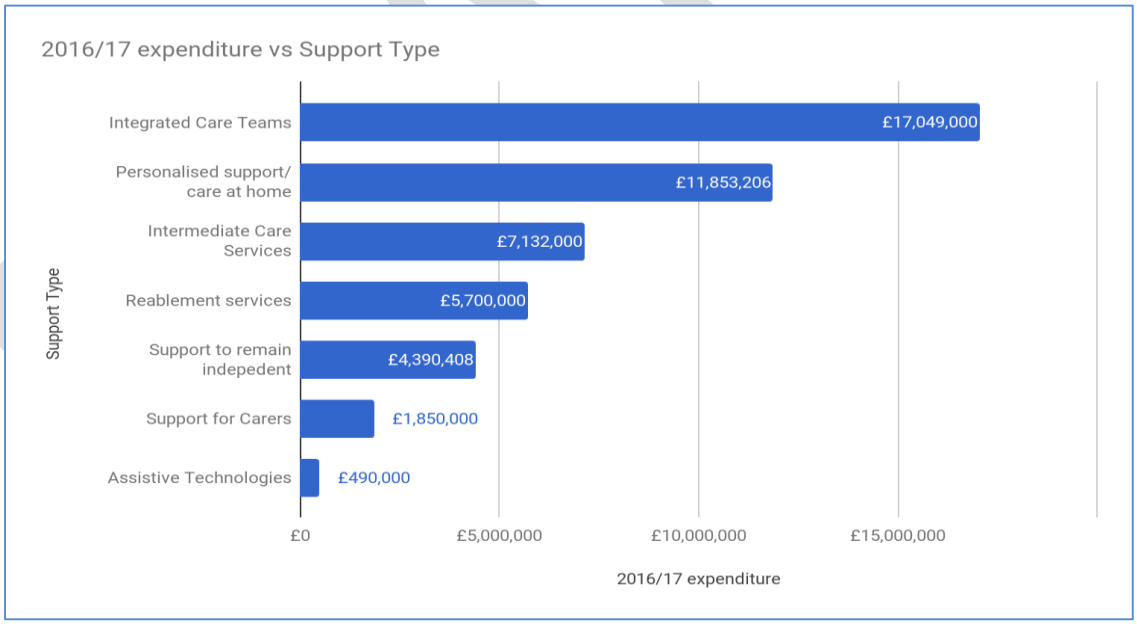
Peterborough JSNA Core Dataset 2016 refresh
Peterborough Health and Wellbeing Strategy 2016-19
Cambridgeshire Health and Wellbeing Strategy 2012-17
Peterborough Diverse Ethnic Communities JSNA
Peterborough Mental Health and Mental Illness of Adults of Working Age JSNA
Peterborough Cardiovascular Disease JSNA
Cambridgeshire JSNA Summary Report 2016
Peterborough Adult Social Care Market Position Statement 2016
Peterborough Older People's Primary Prevention JSNA 2017
Cambridgeshire Migrant and Refugee JSNA

Appendix 3 - BCF Expenditure Plans 2016/17

Cambridgeshire



Peterborough:



Appendix 4 - BCF Progress against Performance Metrics 2016/17

BCF Progress against performance metrics - Cambridgeshire

Metric	2016/17 Actual Performance	2016/17 Planned Threshold Target
Non-elective admissions to hospital	15,625	15,665
Delayed Transfers of Care (DTOCs) from hospital	35,732	10,336
Admissions to long term residential and nursing homes (per 100,000)	345	486.6
Effectiveness of reablement services	61.20%	81.20%
Maintained satisfaction with NHS Services (Friends and Family Test)	97%	93%
Proportion of adults receiving long term social care (per 100,000)	1,962	1600

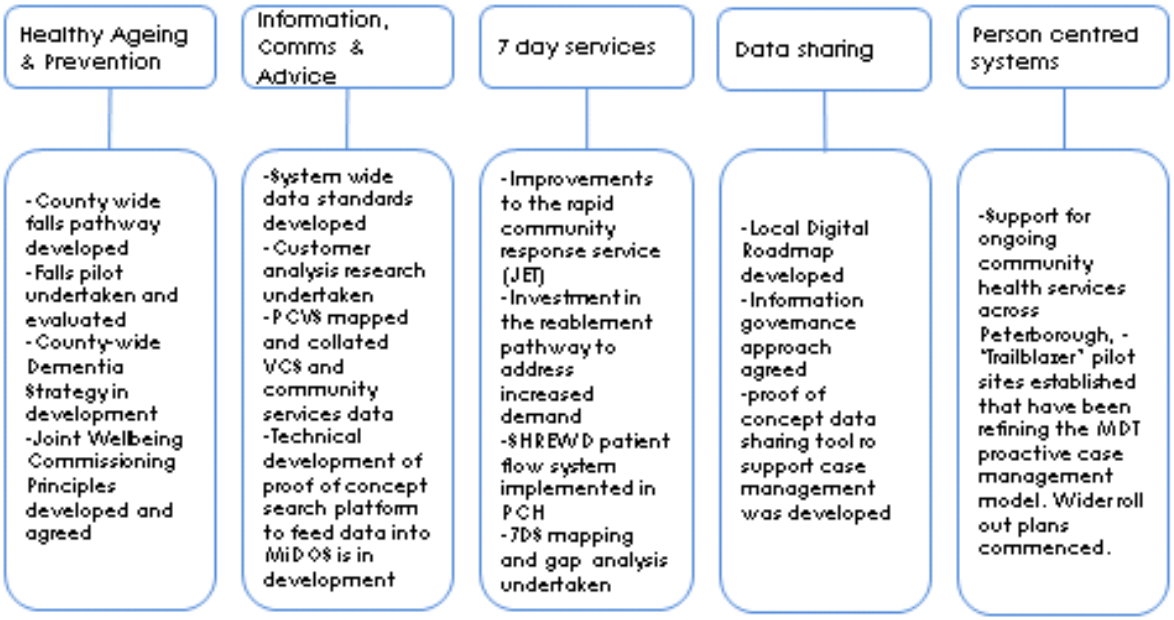
BCF Progress against performance metrics - Peterborough

Metric	2016/17 Actual Performance	2016/17 Planned Threshold Target
Non-elective admissions to hospital	0.05% net reduction (19,229)	2.1% net reduction (18,834)
Delayed Transfers of Care (DTOCs) from hospital	7,174	3.5% occupied bed days (3,366)
Admissions to long-term residential and nursing homes	125	128
Effectiveness of re-ablement services	77%	82.8%
Injuries due to falls in 65+ year olds	563	515
Maintained patient satisfaction with NHS services (Friends and Family Test)	97%	93%

Appendix 5 - BCF Progress against Transformation Themes 2016/17

BCF Progress 2016/17

A brief summary of the key progress to date of the five transformation work-streams:



Appendix 6 - Peterborough Better Care Fund Section 75 Annual Report 2016/17

App 6 - Pet S75 Annual Report 16-17

Appendix 7 - Better Care Fund Project Plan Detail

App 8 - BCF PLan.xlsx

Appendix 8 - 8 High Impact Changes Self-Assessments

App 8 - HIC assessment plan.xlsx

Appendix 9 - Costed DTOC Plan

Costed DTOC Plan v6.xlsx

Appendix 10 - CAF Risk Register

App 10 - CAF Risks Summary.xlsx

Appendix 11 – STP Risk Management Approach

App 11 - STP risk approach.pdf

Appendix 12 - BCF Risk Register

App 12 - BCF 17_19 Risk Log.xlsx

Appendix 13 - Overview of 2017/19 Funding

App 13 - Cambs finances.docx

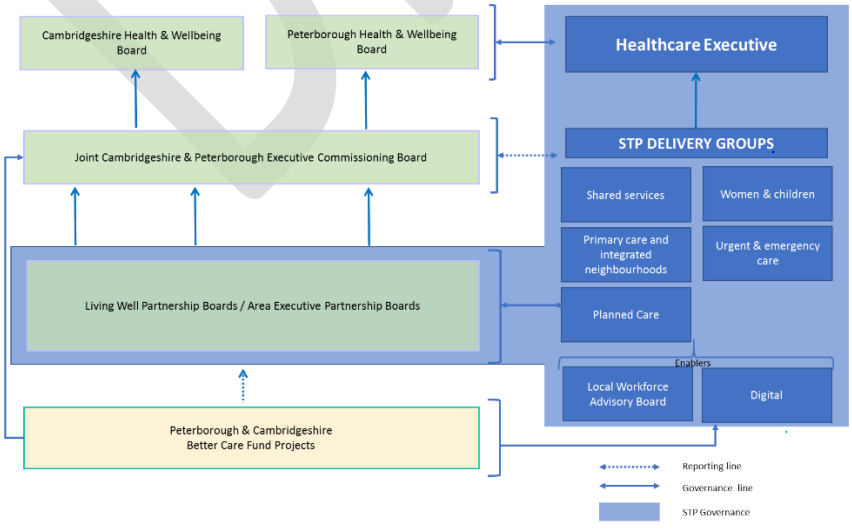
App 13 - Peterborough finan

Appendix 14 – Support and Housing for Vulnerable People Business Cases

PCC IBCF Housing Business Case.doc

CCC IBCF Housing Business Case.doc

Appendix 15 - BCF Governance Structure



Appendix 16 - STP Governance Structure

STP governance.pdf