CAMBRIDGESHIRE BCF SUBMISSION WORKING DRAFT: 19 SEPTEMBER 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.ukas well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

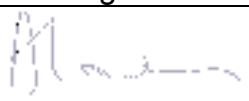
a) Summary of Plan

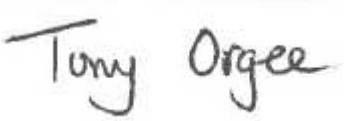
Local Authority	**Cambridgeshire County Council**
Clinical Commissioning Groups	**NHS Cambridgeshire and Peterborough Clinical Commissioning Group**
Boundary Differences	For NHS Cambridgeshire and Peterborough CCG there are two differences to the boundary when compared with those of Cambridgeshire County Council and Peterborough City Council. From 1 April 2012, several practices from North Hertfordshire and Northamptonshire became part of NHS Cambridgeshire and Peterborough CCG: *North Hertfordshire – Royston* Three Royston practices provide care for a patient population of 24,142 residents in the town of Royston itself and the surrounding villages and they comprise Royston Medical Centre, Roysia Surgery

	and Barley Surgery *Northamptonshire* The Oundle and Wansford practices provide care for a patient population of 17,448 residents in the town of Oundle itself and the surrounding villages and they comprise Oundle Surgery, Wansford Surgery and Kings Cliffe (branch surgery).
Date agreed at Health and Well-Being Board:	**11/09/2014**
Date submitted:	**19/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£0.00**
2015/16	**£34,451,000**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£34,451,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Cambridgeshire and Peterborough Clinical Commissioning Group
By	 Andy Vowles
Position	Chief Strategy Officer
Date	19 September 2014

Signed on behalf of the Council	Cambridgeshire County Council
By	 Adrian Loades
Position	Executive Director: Children, Families and Adults Services
Date	19 September 2014

Signed on behalf of the Health and Wellbeing Board	Cambridgeshire Health and Wellbeing Board
By Chair of Health and Wellbeing Board	 Councillor Tony Orgee
Date	19 September 2014

c) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Better Care Fund Consultation and Engagement Plan	Sets out a suggested approach for consulting on Cambridgeshire and Peterborough's Better Care Fund plans and how engagement with key stakeholders will be managed.
Review of Evidence to support Better Care Fund (BCF) Spend	This review assesses and qualifies the evidence of the effectiveness of social care and health interventions that impact on the outcome measures required by the BCF. Both integrated health and social care, and non-integrated interventions are considered. The review assesses interventions across a spectrum from primary prevention of social care to interventions aimed at reducing hospital admissions.
NHS Cambridgeshire and Peterborough CCG Two Year Operational Plan	This document sets out how C&P CCG intends to implement the national and local planning priorities for the next two years and achieve sustainable financial balance.
NHS Cambridgeshire and Peterborough CCG Older People Services programme leaflet http://tinyurl.com/oqqryw4	Sets out an overview of the CCGs vision and plans for older people's services.
Better Care Fund Performance Metrics (Cambridgeshire)	Provides an overview of the national and local metrics required to track progress towards the conditions attached to the Better Care Fund.
Health and Wellbeing Strategies: Cambridgeshire HWB Strategy Cambridgeshire: http://tinyurl.com/ofss2bx	These documents set out the key priorities which the Health and Wellbeing Boards will focus on in the next five years. NHS and Local Authority plans need to be informed by the Health and Wellbeing Strategies.
Joint Strategic Needs Assessments for Cambridgeshire and Peterborough Cambridgeshire: http://www.cambridgeshireinsight.org.uk/jsna	JSNAs analyse the health needs of populations to inform and guide commissioning of health, wellbeing and social care services within local authority areas. The JSNAs underpin the health

Peterborough: http://tinyurl.com/pbak2pf	and wellbeing strategies of each local authority and the CCG commissioning plans.
Draft Joint Older People's Straetgy for Cambridgeshire	A joint older people strategy for the county
Summary list of BCF proposals	This document summarises the list of proposals submitted and by whom.
Transforming Lives - Cambridgeshire's New Model of Social Work http://tinyurl.com/peybm2y	This document sets out Cambridgeshire's new model for ASC social work based on social work needing to be more pro-active, preventative and personalised.
NHS Services, Seven Days a Week Forum	There are a range of information sources on 7 day working since the publication of the NHS Services Seven Days a Week Forum in December 2013. The following hyperlink provides a point of entry: http://www.england.nhs.uk/ourwork/qual-clin-lead/7-day-week/7ds/
Governance structure chart and draft terms of reference for BCF Executive Partnership Group	This document sets out the terms of reference for a new executive partnership group that will report to the HWB Board to oversee the development and implementation of the BCF plan.

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Cambridgeshire Health and Wellbeing Strategy
Cambridgeshire's Health and Wellbeing Strategy takes as its starting point the fact that all aspects of our everyday life have an impact on our health and wellbeing – from health services through to our environment, housing, employment, education, transport and our involvement in local communities. This means that working to improve community health and wellbeing, whilst respecting people's personal lifestyle choices, is everybody's business and in everybody's interest.

The strategy was informed by national and local evidence of health needs as measured, analysed and reported in the Cambridgeshire Joint Strategic Needs Assessment (JSNA); existing local strategies and plans; consultation with the public and key stakeholders; and our Community Impact Assessment. . Recent JSNA work relevant to our vision for health and care services includes:

- Older people services and financial review (2012)
- Prevention of ill health in older people (2013)
- Housing and health (2013)
- Physical disabilities and learning disabilities through the life course (2013)
- Health and wellbeing needs of Carers (2014)
- Older people's mental health (2014)
- Primary prevention of ill health in older people (2014)

These JSNA documents are available on
www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports

In developing the strategy, partners on the Health and Wellbeing Board agreed a number of principles that helped to shape our priorities for the local health and social care system:

- Reducing inequalities by improving fastest the health of the worst off
- Focusing on prevention
- Using evidence-based practice and responding to local information
- Developing cost-effective solutions and improving efficiency
- Emphasising local action and responsibility
- Sustainability

In addition, our local approach focuses on the wider determinants of health – recognising that maintaining health and wellbeing is important for individuals to maximise their potential, enable them to lead active, fulfilled lives and participate fully in their local community. Physical health and mental health are closely linked and both are important for wellbeing. The diagram below illustrates how many different aspects of our environment and community have a significant impact on our health and wellbeing and influence our behaviour:

Figure 1: Model of wider determinants of health & wellbeing

Source: Modified from Dahlgren & Whitehead's rainbow of determinants of health (G Dahlgren and M Whitehead, Policies and strategies to promote social equity in health, Institute of Futures Studies, Stockholm, 1991) and the LGA circle of social determinants (Available at: http://www.local.gov.uk/web/guest/health/-/journal_content/56/10171/3511260/ARTICLE-TEMPLATE)

The Health and Wellbeing Strategy sets six priorities for Cambridgeshire, which have informed the development of our BCF plan:

- Priority 1: Ensure a positive start to life for children, young people and their families
- Priority 2: Support older people to be independent, safe and well
- Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities whilst respecting people's personal choices
- Priority 4: Create a safe environment and help to build strong communities, wellbeing and mental health
- Priority 5: Create a sustainable environment in which communities can flourish
- Priority 6: Work together effectively

Cambridgeshire's BCF Vision

In preparation for BCF we worked with partners to develop our 'BCF Vision and Principles' document issued in December 2013. It stated: 'our long-term shared vision is to bring together all of the public agencies that provide health and social care support, especially for older people, to co-ordinate services such as health, social care and housing, to maximise individuals' access to information, advice and support in their communities, helping them to live as independently as possible in the most appropriate setting'[1].

[1] Adapted from 'Older People Community Budgeting: principles and project ideas' available from notes of item 3 of Health and Wellbeing Board, 17 October 2013.

The whole health and social care system in the county has a shared ambition to improve health and wellbeing for local people, but is faced with the twin challenges of rising demand and reducing budgets. Cambridgeshire remains the fastest growing county in the country and, without change, our services will be unsustainable in the very near future. Consequently, the HWB Board, Cambridgeshire County Council (CCC) and the Clinical Commissioning Group (CCG) have already been planning to shift resources to invest in joined-up services that are focused on preventing deterioration and which support people to be independent, healthy and well in all aspects of their lives, thereby reducing demand for higher cost, more intensive services. This vision is ambitious, given the specific challenges that the system is facing in Cambridgeshire:

- Cambridgeshire is one of 11 'challenged health economies' that face particular difficulties in developing sustainable quality health services over the next five years. This is mirrored by challenging financial circumstances that affect our ability to ensure sustainable social care services.
- A reduction in acute activity runs counter to the current trend in the county. Existing CCG plans are based on a 1% reduction in A&E admissions, in the context of the current trend which is for an annual increase of around 2%. There is also a mismatch between the BCF vision of reduced acute activity and providers' 5-year plans which plan for increased acute activity and staffing. The scale of the challenge ahead is acknowledged in the CCG's Five Year System Blueprint which includes redesigning non-elective care.
- The local procurement of Older People and Community Services by the CCG (see section 2c) means that Cambridgeshire faces particular challenges in achieving the flexibility required in budgets that are within scope of the procurement exercise. This is particularly true at the time of this submission because the provider has not yet been appointed.
- Cambridgeshire has a growing and changing population. There will be large increases in the number of older people, children and people from different backgrounds living in the county in the next 10 years and beyond. This creates particular challenges for planning health and social care services

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

We recognise that the development of preventative community based services (as an alternative to reactive, crisis based services) requires significant changes to our thinking and arrangements about how best to support the health and wellbeing of Cambridgeshire residents. Over five years we are working towards a fundamental shift in emphasis in the system – instead of needing to support people when they are in crisis with hospital or long-term social care support, personalised services provided in the community will wherever possible prevent crisis in the first place. Our collective ambition is to achieve this big change.

At the heart of our plans is the obvious point that preventing people from going into crisis

is better for them and their families.

This approach will be supported by a clear focus on improving access to timely information, advice and guidance.

The BCF is one part of our transformation but is not a panacea for health and social care in itself. Firstly, we recognise that this is not new money – all of the money allocated to the BCF is already spent on health and social care services in Cambridgeshire, which are under significant financial pressures. Secondly, compared to the overall spend in the system (more than £1bn per year in Cambridgeshire), it is a relatively small amount.

Therefore we will focus our use of the BCF on initiatives that help to prepare the system for a bigger change in the medium term, by protecting existing social care services; supporting the development of 7 day working and data sharing; and supporting the development of closer working, including development of joint assessments with an accountable lead professional.

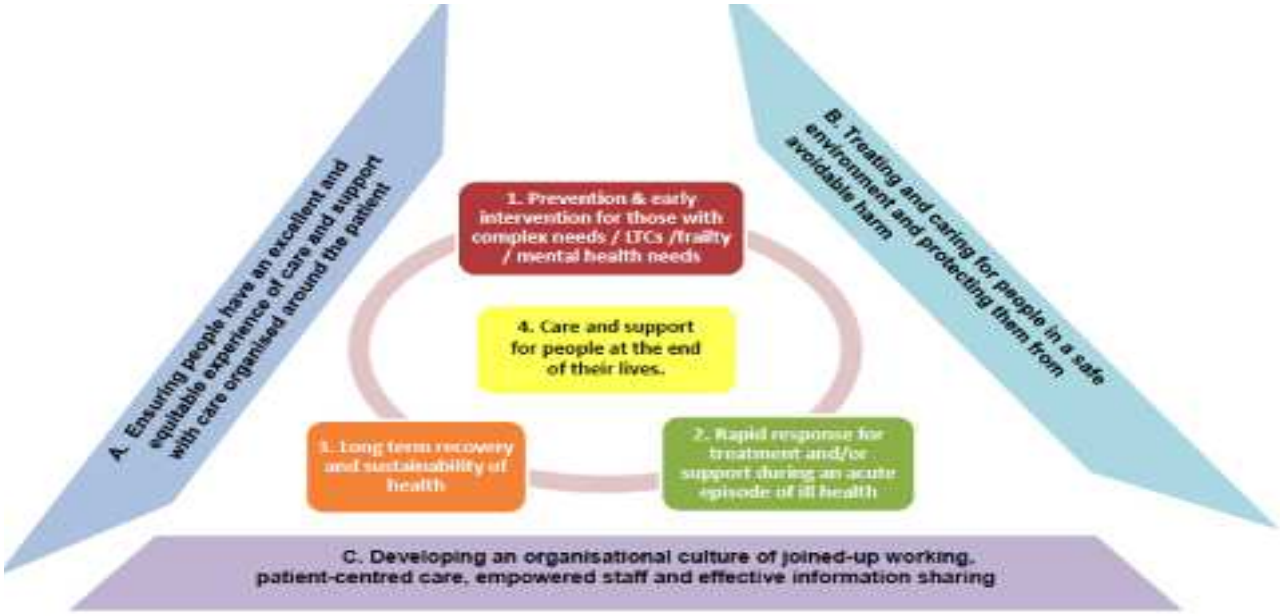
b) What difference will this make to patient and service user outcomes?

Our ambition is expressed in a number of top-level plans and strategies, which will drive the planning and commissioning of work and services funded through the BCF and more widely, and each include expressions of desired outcomes of the work they describe. They include:

- The **Health and Wellbeing Strategy**, which focuses on the health and wellbeing needs of everyone living in Cambridgeshire, considers the wider determinants of health, and was signed off as a top-level strategy for services by the HWB Board
- The **CCG Older People's Services Programme**, which includes a new approach to improving outcomes for patients, and procurement of a provider that will take on all health services for older people in Cambridgeshire, with a remit to transform services so that they are preventative and joined up
- **Transforming Lives -** a new and markedly different social work model for adult services by CCC, focusing on professional social work at all levels of need, using community knowledge and resource to support people. The model requires social work to be more proactive, preventative and personalised and aims to enable residents to exert choice and control and ultimately to live healthy, fulfilled, socially engaged and independent lives.
- The **5-year plan for the CCG**, detailing the strategic plan for health services in Cambridgeshire
- The development of a joint health and social care strategy for older people developed by CCC, the CCG, and district and city councils. This is accompanied by an 'operating model' for older people's services

A joint outcomes framework will be developed using the following as a starting point (shared with providers, the public, stakeholders, and the voluntary and community sector as part of our consultation and engagement processes associated with the Vision and Principles document):

CCG Older People's Procurement Programme – Outcome Domains



CCC Older People's Strategy – Outcomes

- Older people remain living at home and in their own communities for as long as possible into later life
- Older people are supported to retain or regain the skills and confidence to look after themselves into older age
- Carers of older people are supported to cope with and sustain their caring role
- The number of people requiring complex or intensive support packages is minimised through successful early intervention
- Older people who need ongoing care and support feel in control of their support plan and are able to choose the support which is right for them
- Older people are supported to live with dignity throughout their later lives
- Older people are protected from harm and isolation.

Measuring our impact on local outcomes

We believe that our BCF plan will have a strong impact on the following outcomes:

- **Total non-elective admissions to hospital (general and acute), all-age, per 100,000 population**

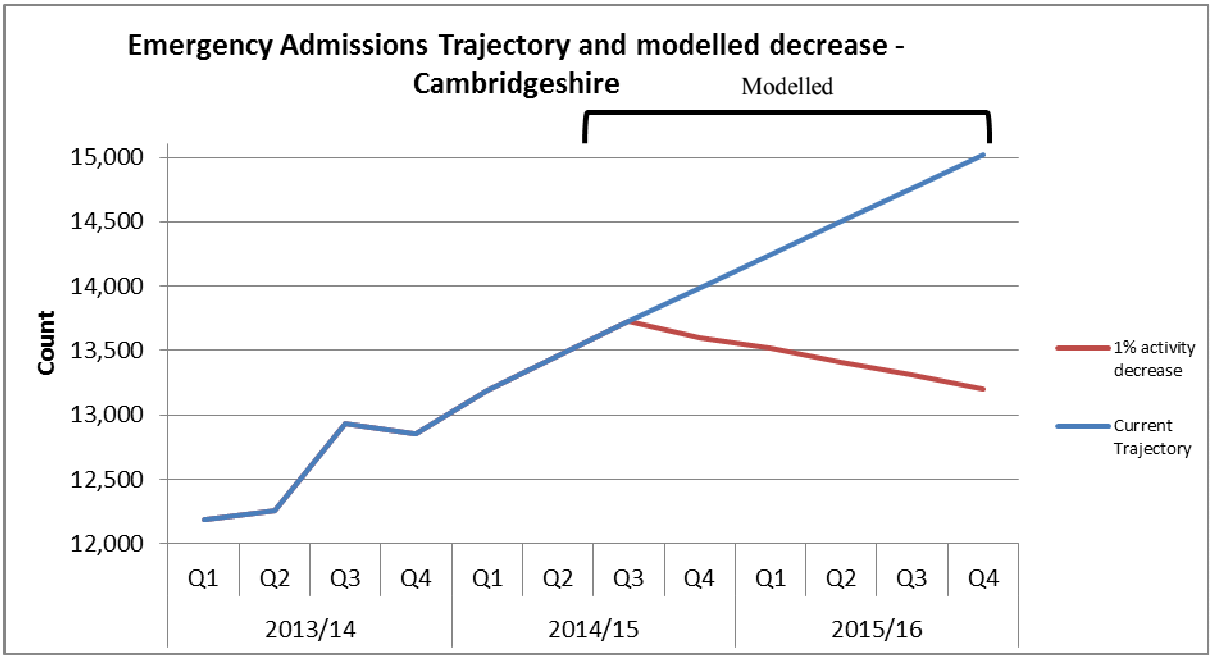
Our aim is to see a reduction of 1% against this indicator each year. This is lower than the suggested minimum of 3.5% set out in the BCF guidance. We know that a shift from acute to community services is essential to deliver on our vision for health and social care and we are ambitious – we must be stretching but we must also be realistic if we are to achieve real and lasting change. Our Health and Wellbeing Board has set a stretching target of a 1.0% reduction in emergency admissions in 2015/16, against a current trend

of significant growth. This therefore represents a reduction of over 8% in real terms.

Our plan is that as we achieve the transformation we are seeking across the system, that we will see growing reductions in emergency admissions

Please note, that the figures included within the Part 2 spreadsheet are pre-populated with the CCG's target figures for emergency admissions for 2014/15, and reductions are required to use these admissions as a starting point. However, the planned activity for 14/15 was produced based on the activity for 13/14 and assumed a similar activity level and pattern from quarter to quarter. Unfortunately given the available data for 14/15 this is not the case and emergency admission activity was nearly 1,000 higher than planned across the CCG in quarter 1.

With this extra quarter of data we have modelled the trend for emergency admissions and have estimated the activity for the remainder of 14/15 and 15/16. This is assuming a linear increase. Given that the quarter to quarter variation included in plan is based on only a single year of data and the trend has already been broken by a large margin we feel this is more appropriate than the CCG planned admissions activity.



To predict the Better Care Fund trajectory a total annual activity decrease of 1% in 15/16 has been modelled. A linear decrease has been assumed as this seems the most likely as projects and services start to affect emergency admissions and become more effective. As can be seen this is a significant swing from the predicted trajectory if it continues as it is, representing significantly larger savings than shown in the Part 2 spreadsheet.

- **Permanent admissions of older people to residential and nursing care homes, per 100,000 population**

A shift from supporting people in acute settings to supporting more people in their communities will result in people living more independently for longer. This is a key aim

of our Health and Wellbeing Strategy, Transforming Lives, our Older People Strategy and the Older People and Adult Community Services Procurement. This will result in a reduction in the number of people admitted permanently to residential and nursing care homes. Our target in 2015/16 will be for 60 fewer people admitted to permanent residential or nursing homes, resulting in a predicted saving of £1.7 million.

- **Proportion of older people who were still at home 91 days after discharge from hospital into reablement / rehabilitation services**

Reablement has been a real success story in Cambridgeshire for people being discharged from hospital. In 2013/14, over 83% of older people discharged into rehabilitation or reablement services were still independent after 91 days – before reablement, the majority of those older people would be receiving long term care support.

We have set a stretching target of 86.6% against this indicator for 2014/15. As our BCF plan is put into place we will develop reablement services, more often providing them in the community. As a result, we don't believe we will continue to see significant improvement against this specific indicator from 2015/16 onwards; but reablement will continue to be an increasingly important of our service offer.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Our plan is to move to a system which will support an operating model for the health and social care system that helps people to help themselves – where the majority of people's needs are met through family and community support where appropriate. This might be through all organisations better understanding the first signs that someone may need more support, or be developing greater support needs, and highlighting this to other organisations who can arrange timely support without waiting for needs to escalate. This support will focus on returning people to independence as far as possible. More intensive and longer term support will be available to those that need it.

We recognise that changes in the collective operating model for services and the configuration of services require change in our collective service infrastructure. So that our systems and ways of working reflect and support our vision for future services rather than hinder.

Our key areas for investment are as follows:

1. **Older People and Community Services (OPACS) Procurement**
2. **7 day services in health and social care**
3. **Joint assessments including accountable professional**

4. Data Sharing

OPACS Procurement

The CCG has embarked on an ambitious Older People and Adult Community Services (OPACS) procurement which is designed to achieve transformation across the health and social care system. This procurement was established prior to the announcement of the BCF and will happen independently. However, the scope of the procurement means that some of the BCF investment will inevitably be used on the services in scope. The procurement is extremely well aligned with the objectives and goals of the Better Care Fund. The main components of the OPACS procurement are:

- An innovative Framework for improving outcomes which goes beyond traditional organisational boundaries
- A new contracting approach which combines a capitated budget with Payment By Outcomes to enable a population approach to service delivery, align incentives in a better way than current funding mechanisms allow, in a way which is consistent with the CCG's long term financial plan
- A 5 + 2 year contract term to enable investment and transformation
- A Lead Provider responsible for the whole pathway, providing leadership and operational coordination

The core scope of services is acute unplanned hospital care for older people (65 and over), older people's mental health services and older people and adult community services. The entire range of services relevant to the care of older people is shown in Figure 1: Service range. The underlying principle is to create an integrated care pathway between all of these services including the Services which are the subject matter of this Procurement.

Whilst the full range of social care services and funding is not in the scope of the procurement, the CCG is working closely with Local Authority partners on the procurement and wider Older People Programme. Cambridgeshire County Council, Peterborough City Council and District Council representatives have been integrally involved in steering the programme and the detailed dialogue and evaluation associated with the procurement. There is a strong alignment and synergy between the OPACS work and the aims of the Better Care Fund which will enable and support it.

Services in scope of the procurement will become the responsibility of a 'Lead Provider' which will directly provide community services and hold the budget for the other services, so that the whole 'pathway' of care is more joined up and better o-ordinated. The Lead Provider may be a single organisation or a consortium made up of several partners. They will not just be responsible for providing and co-ordinating care, but also for supporting the health of the whole older population. This will include working with GPs and others to identify people who are at higher risk of becoming seriously ill and offering advice and support which reduce the risk of crises or hospital admissions. The Lead Provider will employ the community services staff and be responsible for ensuring that they are well supported.

The OPACS provider will be incentivised to work to reduce emergency admissions – one of the key aims of the Better Care Fund. BCF Partners will work closely alongside the provider to agree how these services will relate to other strands of Better Care Fund

activity. As the provider is not yet appointed, it is not possible to outline in full what projects will be established; however, areas of interest include:

- **Falls reduction**
  A falls reduction programme that would seek to transform the falls and contributory pathways to put in place effective prevention and crisis management services which help maintain independence and reduce admission to hospital.

  Falling can precipitate a loss of confidence, the need for regular social care support at home, or even admission to a care home. Fractures of the hip require major surgery and inpatient care in acute and often rehabilitation settings, ongoing recuperation and support at home from NHS community health and social care teams. In addition, hip fractures are the event that prompts entry to a care home in around 15% of cases. Indeed, fractures of any kind can require a care package for older people to support them at home.

  We will seek to establish a multifactorial intervention programme to include strength and balance training; home hazard assessment and intervention; vision assessment and referral; and medication review with modification/withdrawal. Following treatment for an injurious fall, older people should be offered a multidisciplinary assessment to identify and address future risk, and individualised intervention aimed at promoting independence and improving physical and psychological function.

  CCC analysis suggests that approx. 1/3 of admissions to long-term intensive social care support for older people were preceded by an unplanned hospital episode, with about half of those explicitly recording a fall as the reason for the hospital stay. Health service analysis shows that across the CCG around 3,500 admissions to hospital for older people include falls as one of the causes. These figures need to be treated with some caution, because in most cases a fall is only one of the reasons for the admission (which may therefore have been necessary irrespective of the fall). Nevertheless reducing falls is an important area of focus.

- **Intermediate care**
  We will seek to deliver better coordination across a wide range of intermediate care services, including night care, nursing, sitting services, rapid response, admission avoidance, step up and support for hospital discharge. We will seek to establish a focus on the services and pathways needed to enable people to be supported in the community to prevent hospital admission or allow timely discharge from hospital. Intermediate care services are already operating in Cambridgeshire and have been successful in reducing avoidable admissions to hospital, but capacity is often stretched and services have not always been coordinated across organisations. This work stream would bring together:
  - Intermediate care beds. The purpose and use of beds commissioned by health and social services and opportunities to reshape commissioning based on the needs of clients and patients and alternative pathways
  - Discharge to assess. An initiative to discharge patients from hospital as soon as they are medically fit. This has implications for community support services (and links to intermediate care bed requirements)

- 7 day working. Ensuring services are able to support 7 day discharge from hospital, therefore reducing delayed transfers of care and improving patient outcomes
- Reablement services which assist in helping people to live independently again, provided in the person's own home by a team of mainly social care professionals.

2. 7 day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

Reablement services in Cambridgeshire already operate 7 days a week, able to accept and support patients on discharge from hospital at any time of the week. District Nurses are also able to support patients discharged from hospital at weekends. However, for a comprehensive 7 day per week discharge service, other services also need to operate 7 days a week. To meet this national condition our local plans need to deliver the following:

- To negotiate with local authority staff, including making amendments to terms and conditions, to allow for 7 day working in discharge. To be completed by April 2015.
- To negotiate with hospital based staff, including pharmacy, transport, medical staff necessary to approve discharge, including making amendments to terms and conditions, to allow for 7 day working in discharge. To be completed by April 2016.
- To negotiate with independent sector providers e.g.: residential and nursing care homes, to establish working practices to allow for 7 day working in intake and assessment processes particularly. To be completed by April 2016

3. Joint assessments including accountable professional

We want local people at high risk of hospital admission to have an agreed accountable lead professional and health, social care and other partner agencies to use a joint process to assess risk, plan care and allocate a lead professional. This is integral to person-centred care planning, and decision making about the person's care being undertaken in a timely manner, including telling their story once. The project needs to adequately consider the impact for people with Dementia; and set out how GPs could be supported in being accountable for co-ordinating patient-centred care for older people and those with complex needs

More information on how we will deliver this project is contained within annex 2, and section 7d) of this submission.

4. Data Sharing

For health social care and other agencies to work together, they must be able to share information about a person's assessments, treatment and care using systems that are secure. This project will deliver systems that enable:

- Use of the NHS Number as the primary identifier for correspondence across all health and care services

- Use of systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))
- Have Information Governance Controls in place

5. Transformation Team and Ideas Bank

In December 2013, as we first prepared for BCF, we invited proposals from a wide range of organisations across the health and social care system, including from the public, private and voluntary sectors. The proposals and ideas received were wide-ranging in their scope and ambition and came from a diverse range of providers, including voluntary and statutory bodies of all size. The sheer volume and quality demonstrated a tremendous positive commitment in Cambridgeshire to the transformation of the health and social care system. The proposals helped to establish a sense of the most important areas for change, and have significantly shaped the BCF vision and plans.

Because of the nature of BCF, with no new investment it will not be possible to take all proposals forward. Some are not compatible with each other and many have some very similar features. The BCF plan must be driven by statutory requirements and the overall Health and Wellbeing Strategy as well as ideas contained in proposals that have been received. However, the proposals provide a wealth of ideas, many of which with a small investment could have a large impact on the shape of the local health and social care system.

We intend to establish a multi-agency transformation team to steer the BCF and coordinate the work of the Cambridgeshire Executive Partnership Board, as well as the contribution of each organisation, as we transform the system locally. Part of the role of that team will be to support organisations that submitted proposals to get their projects off the ground, where feasible. We will develop an ideas bank that can be called upon to identify project ideas that may have a real impact on our priority outcomes, or to safely test ideas on a small scale, where their impact is uncertain. Successful ideas will then be rolled out to a wider area in the medium term.

3) CASE FOR CHANGE

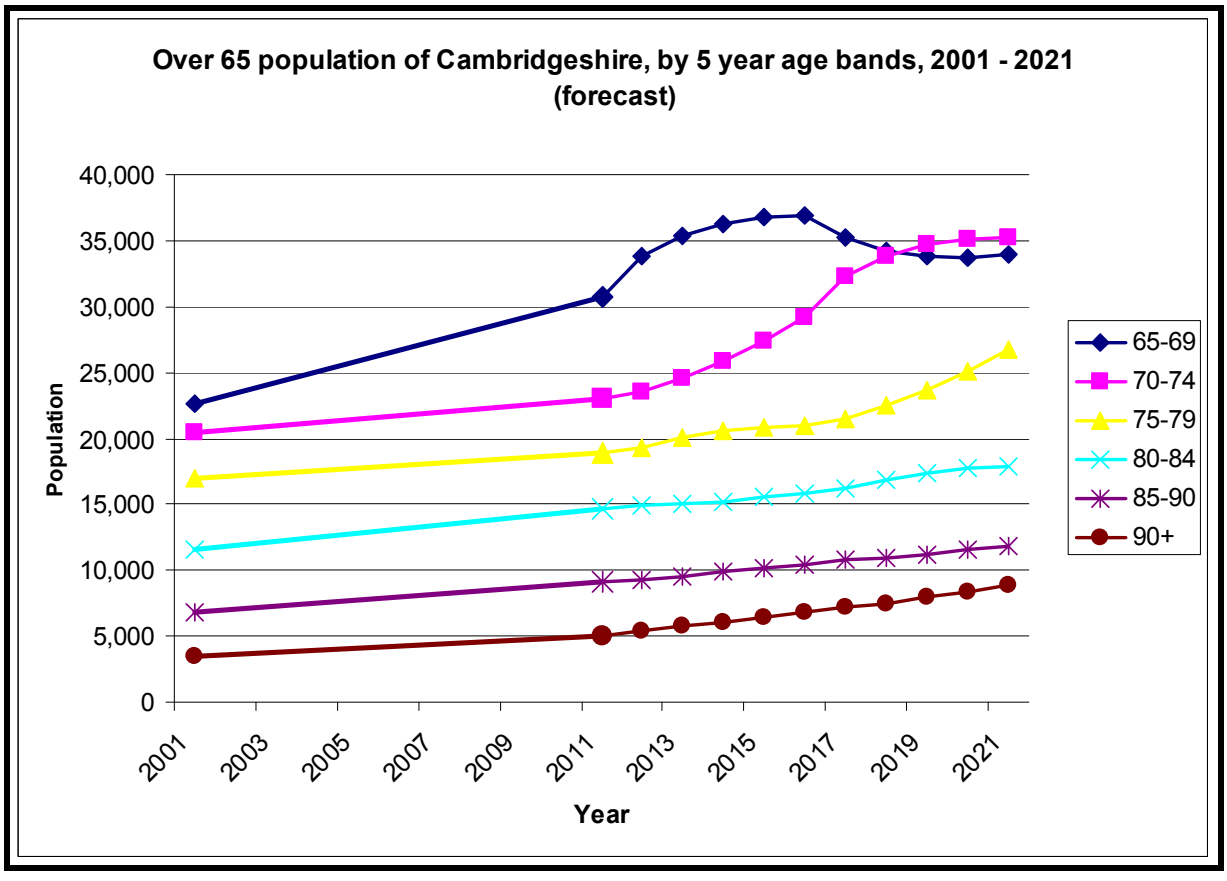
Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

The Case for change

Issues that the BCF will be seeking to address

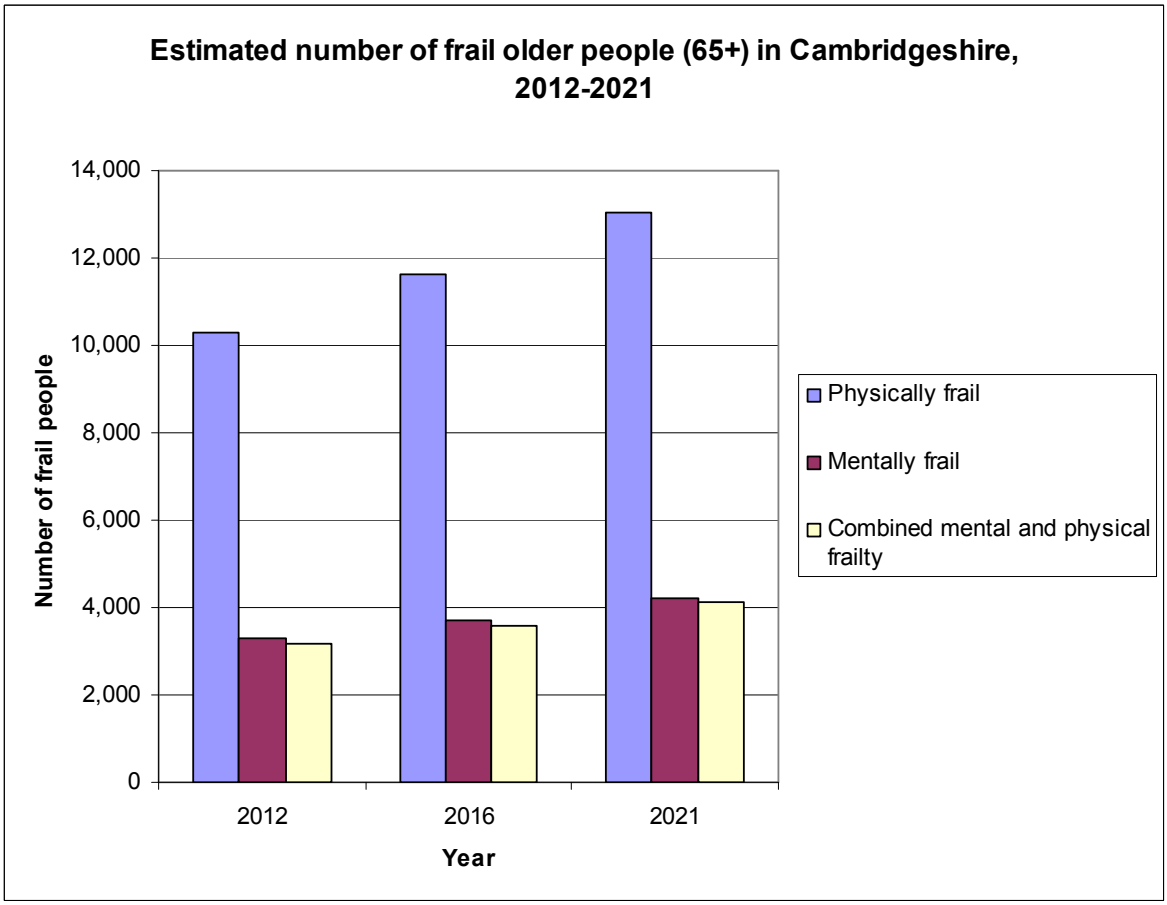
Our changing demography:

- **An ageing population**: In Cambridgeshire, we expect to see the number of people over 65 grow by around a third over the next ten years , with a clear expectation that this will put pressure on services. The number of older people will grow faster than the population as a whole.

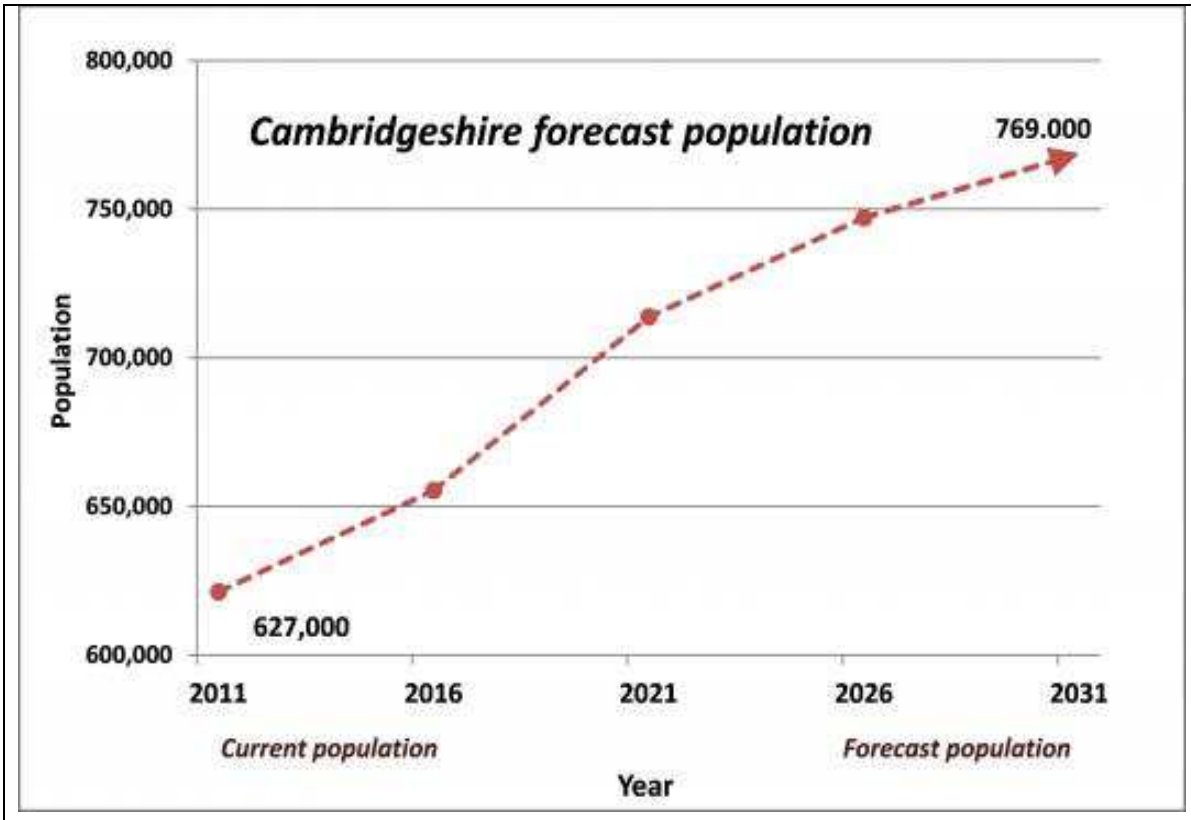


- **Increasing levels of need**: Most people in Cambridgeshire are in good health, but over a lifetime can expect to spend longer in poor health and with disability than previous generations. As the population ages, it is expected that more people will need more intensive support for longer. We will see a significant increase in the numbers of people aged over 85; older people tend to be at more risk of becoming

frail or developing conditions such as dementia. This increases, and is often linked to, vulnerability to crises like financial hardship, a fall, or bereavement.



- **A growing county**: At the same time, the county's population is set to grow significantly, with a number of new housing developments – creating opportunities for development, but also challenges in providing the facilities that people need and environments that will promote health and wellbeing and ensure that the local health and social care system can support people to remain healthy, well and independent in their communities for as long as possible



For social care, our demographic predictions show that without changes to our services, social care budgets would need to increase by £39.8 million by 2019/20 to meet increasing levels of need. Meanwhile, the Cambridgeshire and Peterborough health system faces a financial gap of £250-300m by 2019 if we 'do nothing'.

Challenges in funding
Although numbers of people are rising, funding is not increasing in line with the growing demand. Only minimal increases are expected in the coming years, so we need to find high quality ways of meeting the needs of a larger group of people within the budget made available to our area.

Fragmentation
We know that staff work hard to provide the best possible care, but the collective quality of the current services can be significantly improved. This is partly because so many different organisations are involved, but also because the way services are organised (the 'system') means that care is not always joined up and does not always deliver the outcomes we would like.

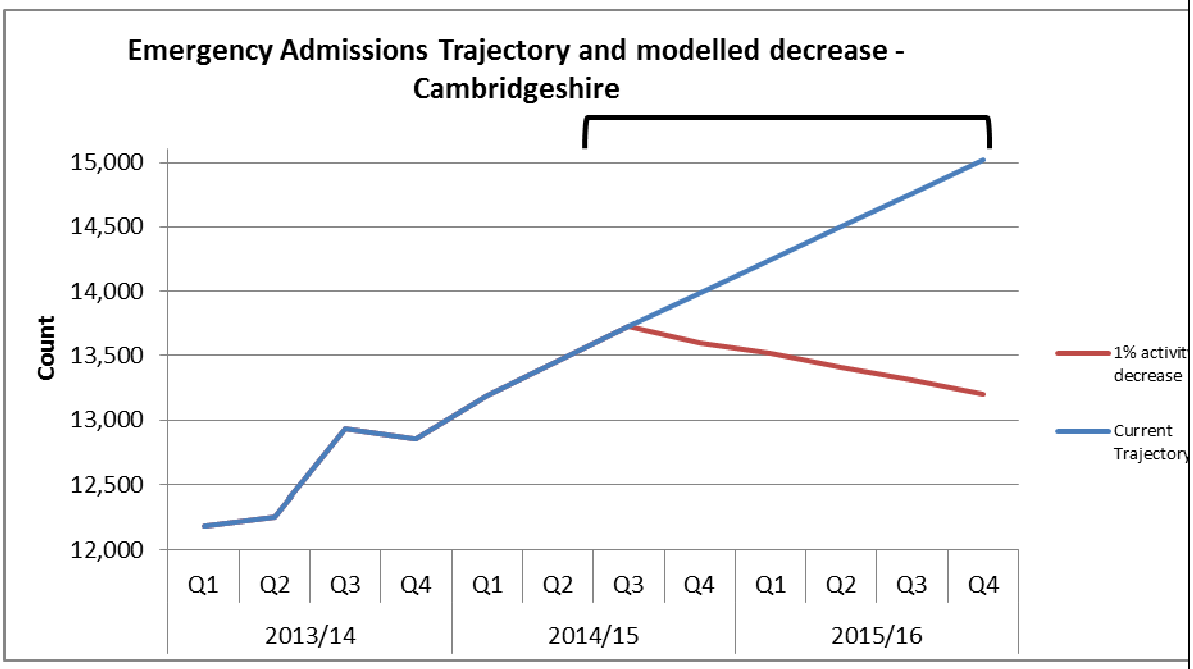
Patients have also told us that they are often visited or cared for by many different professionals. Knowing who is responsible for them is confusing and can seem disjointed. The patient or their carer has to repeat information because it is not readily available to be shared within the NHS or with social care staff. Patients and carers have also told us they would like to be more involved in making decisions about their care.

Over-reliance on acute services
Currently frail elderly people are frequently admitted to hospital through Accident and

Emergency departments (A&E), particularly in the evenings and at weekends. Hospitals beds become full and patients often stay longer than they should, which can make it difficult for them to regain independence.

Reducing reliance on emergency admissions

To understand how we can fulfil our vision of a shift away from acute health services and emergency social care in favour of greater community provision, we need to understand the reasons that people who present to acute settings are then admitted to hospital.



The graph above shows that our trajectory of emergency admissions is for a significant increase; over the past two years we have seen a significant increase. A decrease of 1%would require a 'swing' of over 8% from the current trajectory. Given the focus of the BCF on reducing emergency admissions, our case for change is based on work most likely to reduce emergency admissions.

Population stratification and segmentation

The incidence and reasons for emergency admissions vary significantly between age groups; age is the biggest known determinant factor in whether someone will be elected to hospital as an emergency:

Age	Population (2011 census)	% population (2011 census)	emergency admissions 13/14	% emergency admissions 13/14
0 – 14	105,300	17%	8,212	13.9%
15 – 64	415,681	67%	24,796	42.1%
65 +	100,229	16%	25,761	43.8%

Whilst people aged 65 and over make up 16% of the population, they constitute 43.8% of emergency admissions; people aged 15-64 represent 67% of the population but only 42.1% of emergency admissions; and people aged 0 – 14 make up 13.9% of emergency

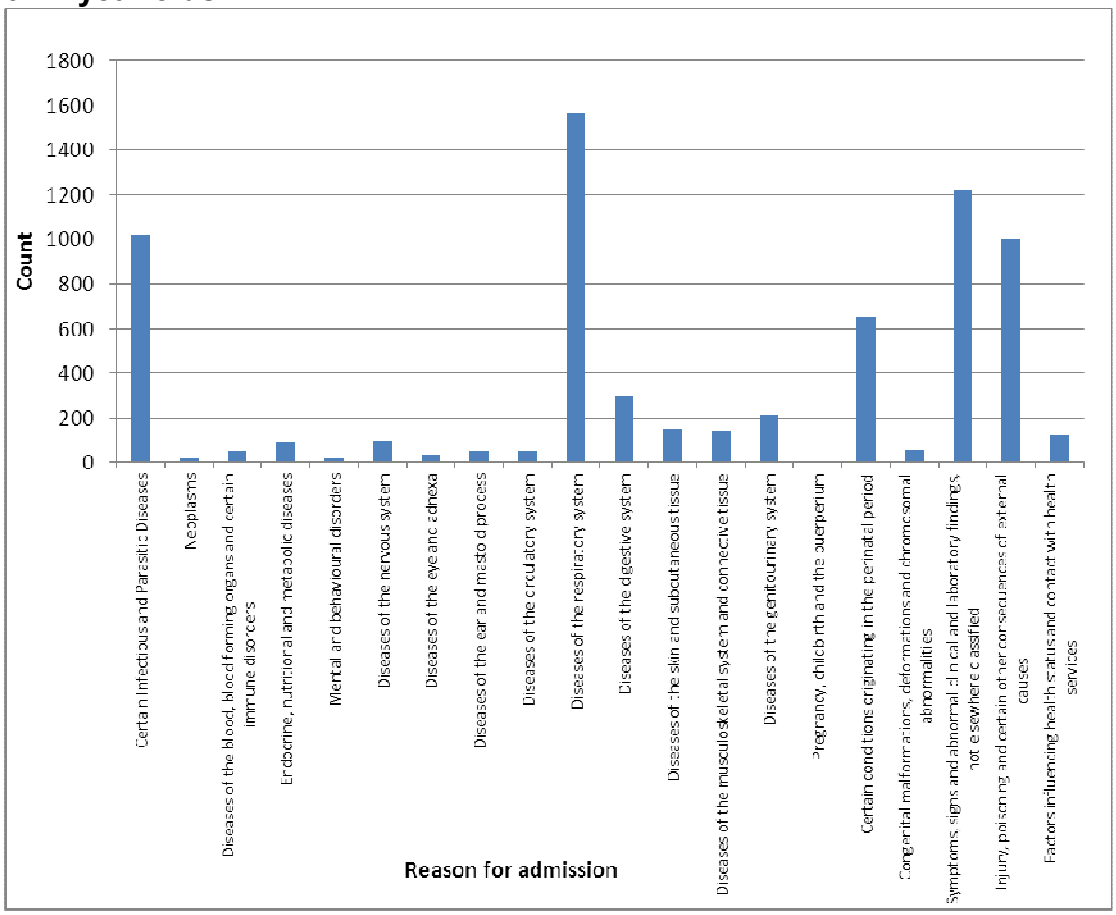
admissions whilst making up 17% of the population.

These figures strongly suggest that a strategy focused on reducing emergency admissions of people aged 65 and over would achieve the greatest benefit in a reduction in emergency admissions. However, there are still a significant proportion of emergency admissions from people of other ages and so it should be considered how many of these admissions are preventable.

Reasons for emergency admissions

Our research has demonstrated the most common reasons for emergency admissions; these vary significantly across different age groups. Assessing the reasons behind emergency admissions during 2013/14 provides an opportunity to review whether any emergency admissions could have been prevented.

0-14 year olds



For 0-14 year olds in Cambridgeshire the most likely reasons for emergency admissions are:

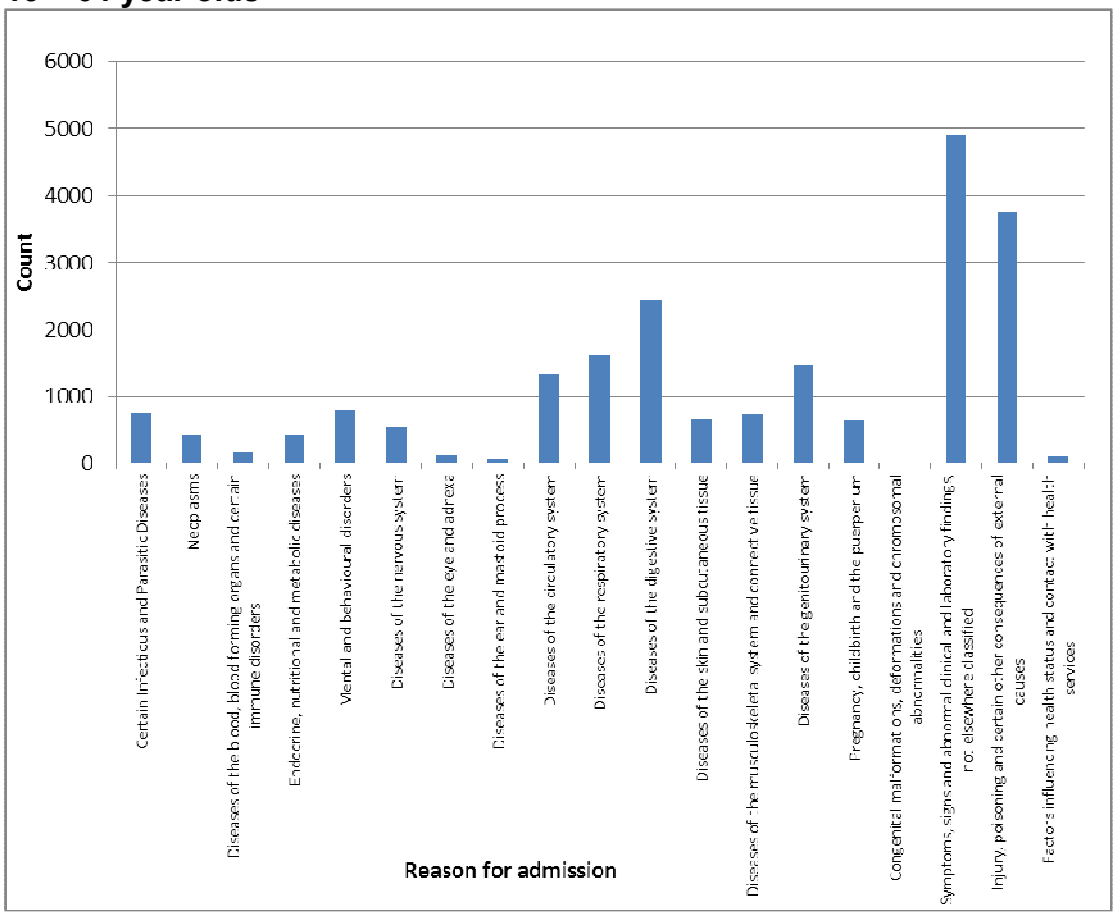
- Diseases of the respiratory system, with acute upper respiratory tract infection (374) and acute bronchiolitis (329) contributing the highest counts
- Symptoms, signs and abnormal clinical and laboratory findings NEC. Abdominal and pelvic pain (268)
- Injury, poisoning and other consequences of external causes. Fracture of forearm (183)

- Certain infectious and parasitic diseases. Viral and other specified intestinal infection (243), Viral infection of unspecified site (521)

- Certain conditions originating in the perinatal period. Neonatal jaundice from other and unspecified causes (337)

In this age group contagious viral diseases are the primary cause of admissions. Better assessment of which children need admitting and which can be returned home may have an impact on this.

15 – 64 year olds



For adults aged 15 – 64, the picture is quite different with most admissions coming from these categories:

- Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified. Chest pain(1267), Abdominal and pelvic pain (1491)

- Injury, poisoning and certain other consequences of external causes. Poisoning by nonopioid analgesic, antipyretics and antirheumatics (527).

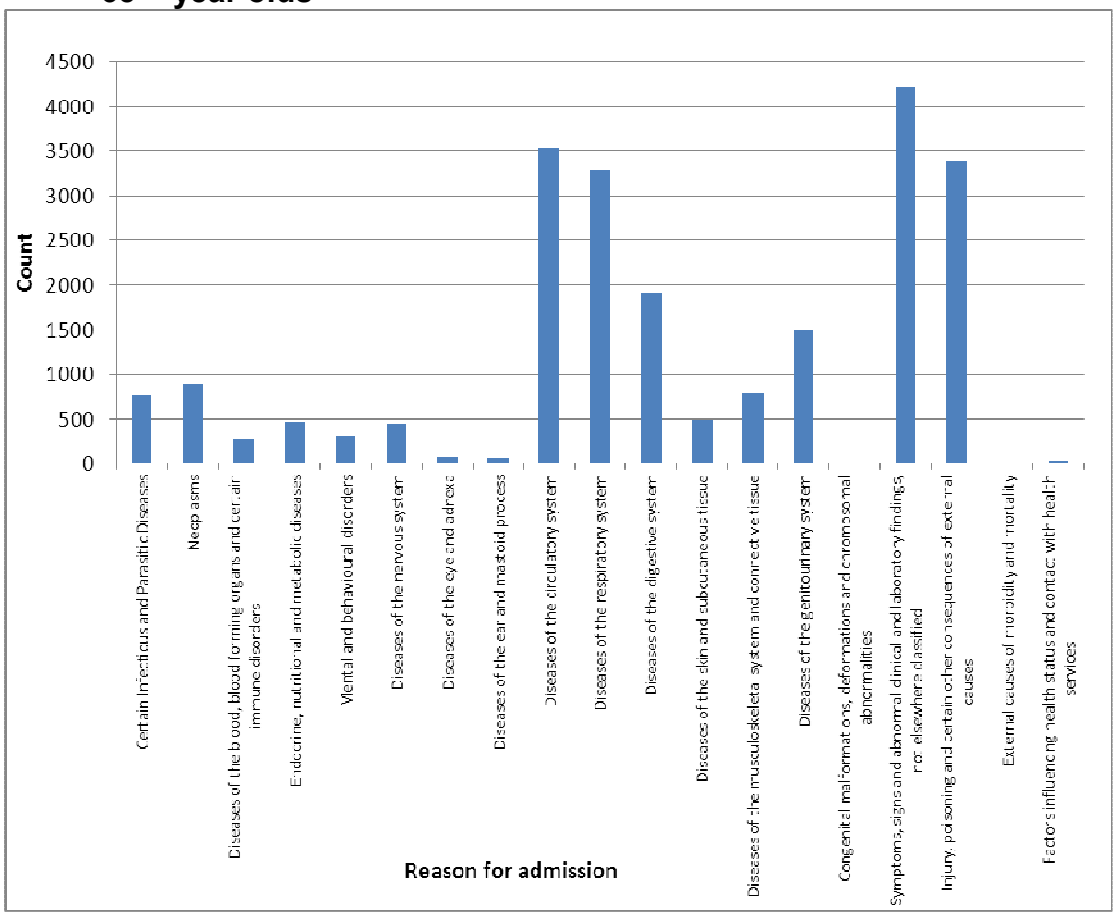
- Diseases of the digestive system. Acute appendicitis (344), Cholelithiasis (311).

There are few admissions related to long term conditions.

Many of these admissions are related to conditions that can be assessed at a GP

level. Chest pain and abdominal pain do not necessarily require an admission if properly assessed and treated in outpatient clinics. The rate of emergency admissions for circulatory conditions is quite low, which suggests many of these chest pain codes are not related to an underlying condition which would require emergency treatment. ECGs before admission or in primary care could help reduce this discrepancy. Abdominal pain attendances could possibly be assessed in a similar manner and admission prevented.

65 + year olds



In the 65+ age range long term conditions contribute much more to emergency admissions than the younger age groups:

- Diseases of the circulatory system. Angina pectoris (398), Acute myocardial infarction (444), Atrial fibrillation and flutter (467) Heart Failure (558), Cerebral Infarction (443).
- Diseases of the respiratory system. Pneumonia, organism unspecified (1283), Other chronic obstructive pulmonary disease (804)
- Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified. Chest pain (883). Other symptoms and signs involving the nervous and musculoskeletal systems (458), Syncope and collapse (539)
- Injury, poisoning and certain other consequences of external causes. Fracture of

femur (767).

In the CCG's older population there are many admissions related to long term conditions. Better community based management and care plans could address these admissions. There are many projects currently underway in the CCG to look at this method of admission prevention. Pro-active assessment and on-going management within these projects should also prevent patients deteriorating to the point where an emergency admission cannot be avoided.

Conclusions

This analysis of emergency admissions suggests that targeting people over the age of 65 will be most successful in reducing emergency admissions. Proportionally, people over the age of 65 constitute significantly more emergency admissions than other age groups whilst making up only 16% of the population.

Whilst people aged 15 – 64 make up fewer overall emergency admissions and are statistically underrepresented, they are still a significant proportion of emergency admissions, and so it will be important to also target initiatives at 15-64 year olds. However, it would not make sense to use broad communications to reduce emergency admissions from 15 – 64 year olds – any interventions would need to be targeted for maximum benefit.

Therefore it is proposed that priorities for reducing acute admissions should be focused on people aged 65 and over, who are over-represented in emergency admission statistics. However, there is also a case for work particularly with GPs to ensure that conditions are adequately assessed at a GP level.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Date	Task / Milestone	Notes
19/09/14	Submission of BCF plan	
30/09/14	Appointment of new OPACS Provider	This provider will have a significant impact on the shape of our BCF plan
2/10/14	Health and Wellbeing Board	To discuss the submission and plans for working with the new provider

Mid October 2014	Meetings with new provider to discuss taking forward BCF proposals	This will begin a process of joint working to identify detailed schemes within the remit of the OPACS contract
Mid October 2014	Interim Integration and Transformation team established	
22 October 2014	Second meeting of the CEPB	Feedback on BCF assurance process and further activity
October – mid November 2014	Development of detailed schemes	
Mid November 2014	CEPB	CEPB comments on and agrees OPACS schemes for sign-off at Health and Wellbeing Board
December 2014 – March 2015	Detailed preparation of BCF schemes in advance of 2015/16; establishment of monitoring arrangements; recruitment	
April 2015	BCF schemes operational; Integration and Transformation Team fully established	
July 2015	Quarterly monitoring and reporting of BCF progress	
October 2015	Interim Year 1 BCF report	To cover outcomes, evaluation of schemes and plans for Year 2
January 2016	Finalise Year 2 plans	

b) Please articulate the overarching governance arrangements for integrated care locally

Oversight and governance of our BCF Plan will continue to be provided by the HWB Board who will sign off the plan on behalf of its constituent councils and the CCG. The CCG Governing Body and the County Council's Committees still remain engaged in the development and sign off the BCF.

A comprehensive Governance plan has been put in place which ensures adequate governance across the BCF; our Older People's Procurement contract; and ensures

robust governance where our work overlaps with Peterborough. A diagram is attached as Annex 3. The key parts of the system are:

- **Cambridgeshire Health and Wellbeing Board** which will provide effective leadership, management and governance of the BCF including agreement of strategic investment decisions, agreement of the joint strategy and joint transformation programme
- **Cambridgeshire Executive Partnership Board** which will provide whole system leadership and coordinated multi-agency oversight of health and social care service transformation for older people and vulnerable adults in Cambridgeshire
- **Cambridgeshire and Peterborough Integration Forum** which will promote, develop and coordinate joint planning, transformation and delivery for Older People and vulnerable adults across the Cambridgeshire and Peterborough Health and Social Care Economies

Cambridgeshire Executive Partnership Board
We are in the process of creating a single Cambridgeshire Executive Partnership Board for Older People and Vulnerable Adults which will bring together all key partners across the County to provide a joint strategic approach to service transformation and delivery of the Better Care Fund. This executive-level partnership board will also report to the Health and Wellbeing Board. The purpose of the Board is to provide whole system leadership and coordinated multi-agency oversight of health and social care service transformation for older people and vulnerable adults in Cambridgeshire.

The Partnership Board held its first meeting in shadow form in September 2014. The Board will be formally established as part of the Section 75 arrangement for the BCF and will be responsible for the development of a joint strategy and joint transformation programme as agreed by the organisations represented on it, to be agreed by the Cambridgeshire Health and Wellbeing Board. The Board will be accountable to its constituent member organisations for delivery of the joint strategy and joint transformation programme. It will work to deliver relevant Health and Wellbeing Board strategic priorities as well as provide regular reports on its Programme to the HWB Board. The Officers on the Board will be responsible for ensuring effective governance of the Better Care Fund pooled budget and securing member organisation and HWB Board agreement to any strategic investment decisions.

The objectives of the partnership board comprise:

- To oversee joint planning and a programme of transformation for older people and adults including mental health (16-64, 65 years +) in line with a jointly developed Strategy for older people and related service strategies
- To provide effective leadership, management and governance of the Better Care Fund Section 75 pool
- To provide a forum for multi-agency oversight of the Older People and Adult Community Services (OPAC) contract, risk and financial management including development of annual plans and outcome framework revision.
- To develop and oversee a joint action plan to deliver the transformation programme, and guide the work of joint integration staff.

The next tier of governance will provide management oversight of all transformation and joint commissioning for each area of change, together with an enabling project to

complete the procurement and then provide multi-agency contract oversight. These transformational groups will be multi-agency and work to the Partnership Board/joint commissioning board. The projects will cover our areas for change as well the national conditions. Terms of reference for these groups have been agreed.

Regular formal and informal reporting is undertaken to each organisation's board or governing body.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

The Cambridgeshire Executive Partnership Board (CEPB) will maintain oversight of BCF outcomes; regular reports will be made to the Cambridgeshire Health and Wellbeing Board, offering the opportunity for democratic oversight of progress. In addition, the County Council and CCG's own management information and governance mechanisms will ensure that there is appropriate oversight and decision making; and arrangements will be held to account through the local authority's health scrutiny function. The CEPB will be coordinated by the multi-agency Transformation Team.

Given the importance of the older people's procurement exercise, it has been agreed that the CEPB will also oversee the OPACS contract; this will ensure effective integration between different partners in the system.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Older People and Community Services (OPACS) Procurement
2	7-day services in health and social care
3	Joint assessments including accountable professional
4	Data Sharing
5	Transformation Team and Ideas Bank

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Financial disinvestment in acute providers without adequate measures in place to relieve pressure on acute providers	4	5 This would impact on the £836,000 performance fund included within our BCF plan. Therefore the financial risk would fall primarily on the CCG and County Council; if rises in acute admissions continue, the impact would also be felt significantly by acute providers.	20	• Performance related pay • Clarity around financial planning and monitoring • Understanding financial impact of disinvesting in services and financial impact of 'new' services/configurations • Financial accountabilities are clear across organisations • Critically appraise proposals for new investment against evidence base

				• New initiatives will be asked to articulate clear mitigation measures if they do not deliver planned savings
Failure to protect social care services: Demand for social care increases at a rate that outstrips the increased investment and transformation	4	4 The financial risk would fall largely on the County Council; although any resulting reduction in care services would also have an impact across the system.	16	• Closely monitor demand for social care arising from demographic change and the new statutory duties under the Care Act • Early implementation of the Care Account and assessment of private funders
Loss of Strategic Perspective and Scale: The plan focusses on many small scale initiatives leading to lost opportunity to undertake strategic transformation of services	3	3	9	• Refer back as needed to the 5 year strategic plan context and over-arching priorities and other relevant strategic and commissioning plans • Consistently map the initiatives and proposals back to the agreed End State to check for right scale and scope Agree a set of categories for strategic change, and group ideas and proposals around these
Destabilising 'the system:' Making changes to the current patterns and models of service delivery in advance of implementing new ways of working de-stabilising current levels	3	3	9	• On-going review of strategy and vision • Robust arrangements for reviewing progress across all change activities • Appropriate investment in communication to users and staff • Development of appropriate workforce and OD

of demand and performance				plans
Clinical Commissioner engagement: Localities and member practices feel disenfranchised and alienated by the planning process	3	3	9	• Regular briefing and discussion at CCG Governing Body and at Clinical Management and Executive Team meetings • Local Chief Officers to keep their Local Commissioning Group (LCG) Boards fully informed and ensure they have the opportunity to contribute • Nominate clinical champions from LCGs / local health systems who would co-lead with SROs the priority change programmes • LCGs to engage regularly with their practices / localities and ensure that they are kept informed and aware of the wider context • CCG Members' Events to give opportunity for wider discussion and opportunity to address concerns raised by the membership
Provider engagement: Lack of engagement and support from Providers	3	3	9	• Use the Chief Executive Officer Group to identify and obtain consensus on the key strategic priorities • Invite providers to submit their ideas and proposals for

				transformation and use these to inform on-going discussions • Use selected provider clinical forums to keep clinicians aware and engaged • Incorporate specific change initiatives into the mainstream commissioning and contracting cycle to ensure that the BCF plans are part and parcel of everyday business • Discussions with each provider as part of the 14/15 contract round • Regular updates by the CCG at the Chief Executive Group • Further strategy session for all CEOs and Chairs planned for 30 April • Rather than look at the BCF in isolation, use the fund as a catalyst to look at improved joint planning across commissioners and providers.
Staff engagement: Staff are not fully aware of and engaged with the changes set out in the Better Care Fund plan	3	3	9	• Hold regular staff briefings • Post updates to organisations' websites • Use the organisations' newsletters to promote better understanding and flag examples of excellent performance and innovation

Strategic Vision / End State: Lack of clarity around the 'end state' resulting in loss of delivery	3	3	9	• Link to the 5 year Strategic Plan – move to single Older People's Plan for Cambridgeshire • Ensure all clients groups are reflected in the vision • Agree vision and principles and set them out clearly in the BCF plan (and reflect this in each organisation's core planning documents) • Set out in the plan each initiative and how it will contribute towards realisation of the bigger picture
Stakeholder Engagement: Key stakeholders do not have the opportunity to contribute to and shape the Better Care Fund plan	2	2	4	• Ensure that key stakeholders are identified • Build time into the BCF Fund planning timetable to brief and discuss stakeholders • Maximise the opportunity to brief and debate through attending existing meetings • Organise bespoke events e.g. HWB Board development days, Area Events etc. • Keep stakeholders up to date with progress in drafting the plan e.g. through regular written briefings, use of websites etc. • Reflect back to stakeholders the key outcomes of the engagement

				discussions
Financial Information: Lack of clarity around the funding to be transferred from the CCG to the Better Care Fund joint commissioning pools	2	2	4	• CCG and Local Authority Finance leads agree the methodology for calculating the funding to be transferred and the process for transfer • Financial information to be set out explicitly in core planning documents e.g. CCG 5 Year Strategy
Planning Assumptions: Early planning assumptions may prove to be incorrect.	2	2	4	• Ensure that the BCF plan is updated regularly to reflect the emerging position and any agreements and/or changes made • Ensure effective co-ordination of the work of the different local authority project teams to allow timely update of assumptions
Governance: Insufficient project control, transparency and accountability.	2	2	4	• Appoint a Senior Responsible Officer in each organisation who will be accountable for progress with developing and implementing the plan • Appoint joint CCG/CCC project team(s) to implement the process and to meet the key milestones for delivery • Maintain the opportunity for scrutiny through regular formal

				reporting to boards responsible for decision-making • Through regular communication and briefing, ensure sufficient transparency and openness with regard to the Better Care Fund Plan • Maintain a detailed project timetable to ensure that key board meeting dates are identified and met
Sign-Off: Lack of agreement between partners and at the HWB Board means that an agreed plan cannot be signed off	2	2	4	• All partners to be involved in discussions and represented at the Executive Group • All partners signed up to Vision and Principles • Special meeting of the HWB Board to allow sufficient time for discussion
Government Approval: Delay in government signing- off use of the Better Care Fund, leading to loss of the funding	2	2	4	• All partners working to ensure that proposals address the national criteria • It is likely that the Government will allow time to refine proposals rather than rejecting immediately

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The outcome based Older People and Adult Community Services contract mitigates risk for commissioners. The provider is responsible for managing demand within a capitated budget and is incentivised to work with providers to ensure the highest quality health care in the most appropriate setting. The Section 75 for the pooled budget will also mitigate financial risk and ensure agreed outcomes are established for joint projects from the

outset.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

The national planning guidance has signalled the closer alignment of NHS and local authority planning cycles and this is welcomed. Historically, we have worked closely together to ensure that our service plans are in direct alignment, where appropriate, and that we have a shared understanding of the strategic direction needed to meet the health and social care needs of our population. As an example, in terms of strategic direction and priorities for Older People, CCC and the CCG are working closely to agree a single, shared strategy for Older People this year. As a Challenged Health Economy, the local health system is receiving significant support in order to improve alignment between organisations.

In drawing up our plans and activities for the Better Care Fund, we have worked closely with members of the HWB Board who have provided the required strategic direction and advice, grounded in the priorities set out in the Health and Wellbeing Strategy. As a result, we believe that our plans and activities will contribute directly towards four of the six priorities set by the Board. These are:

- Support older people to be independent, safe and well
- Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices
- Create a safe environment and help to build strong communities, wellbeing and mental health
- Work together effectively.

We have used the intelligence available in the JSNAs to identify the key target areas of focus, and we have complemented this through the collation of an evidence base led by the Public Health Team.

b)Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

BCF is integral to the two year operational plan and BCF principles underpin the 5 year strategic plan.

Service Transformation and Innovation objectives expressed in the two year plan focus on integration and joint commissioning. These objectives are:

- Achieving national outcome measures
- Enhancing integration and joint commissioning through the Better Care Fund
- Older People Programme
- Implementing 7 day working
- Encouraging innovation
- Mental Health, Parity of Esteem and IAPT

Achieving sustainable services and finances is another key component with the majority of underpinning QIPP schemes focusing on urgent care and aiming to reduce A&E attendance and emergency admission. BCF proposals link to these objectives and draw from our learning. For example BCF proposals for falls reduction will include an element of crisis intervention services piloted as part of our two year plan, but will go much further to include the entire pathway, starting with prevention in the community.

The plan is underpinned by work steams including partners. Key work streams linked to our BCF plan are:

- Older people
- Urgent care

Our 5 year plan assesses a potential funding gap of between £250 and £300 million if we do nothing. The plan is clear that prevention and integrated service delivery is critical to close this gap and ensure a sustainable health and social care economy. The strategic aims, which also reflect our BCF objectives are:

- Empowering people to stay healthy
- Developing a sustainable health and social care system
- Improving quality and improving outcomes

These goals are underpinned by system programmes, with one of the key aims being to reduce emergency bed days and avoidable emergency admissions.

c)Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The CCG has worked with GPs at Member Practice events, provider stakeholder events, through discussion at LCG Board meetings, discussions with the Area Team and through the elective and non-elective Care Design Groups to identify a set of critical success factors for primary care. These success factors are as follows:

- Generate a greater sense of individual responsibility to remain well and choose health lifestyle choices to avoid ill health
- Reduce unwarranted variation and address inequalities (evidence shows that primary care can reduce inequalities and improve health outcomes1)
- Deliver quality improvement
- Improve access to GPs
- Develop capability and capacity to meet the demands of a rapidly increasing population, and a greater number of older people with associated frailty and long term conditions

To enable these changes to happen the following enablers need to be considered:

· Closer working with Public Health England and the local authority public health team to promote self-care and healthy lifestyles
· Exploration of options to deliver primary care at scale through, for example, increased collaboration between GP practices
· Review of capacity within primary care including mapping against demand
· Better signposting of services
· Improved communication between GPs and secondary care clinicians

Primary care services have the potential to contribute significantly to the Cambridgeshire and Peterborough health system goal to produce a sustainable health system because primary care reduces demand on health services through its role in preventing illness. This is entirely consistent with the aims of our BCF plan. An example of alignment is our proposal for joint assessment. The CCG comprises 8 Local Commissioning Groups made up of groups of GP practices which provide local focus and engagement. Multi-disciplinary teams (MDTs) are being piloted to provide better and more holistic support to frail elderly or other vulnerable people. They bring together social, medical and community care plans involving GPs, hospital doctors, nurses, physiotherapy, social workers and voluntary or community groups. Learning from these pilots about the role of lead professionals and the application of risk stratification tools will inform our BCF work programme.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

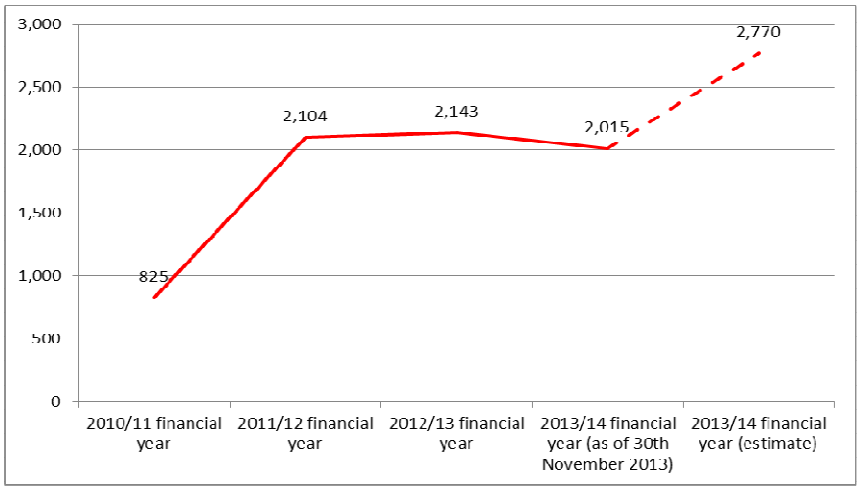
a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The locally agreed definition of protecting social care services is maintaining the existing thresholds set under Fair Access to Care Services or, following the introduction of national eligibility criteria, ensuring that social care services are able to meet the new criteria.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

There are no proposals to reduce social care services within the plan, in the sense of changing the eligibility criteria as per the definition above. £2.5m of the BCF has been allocated in the CCC budget to ensure that services can be protected, along with the continuation of existing s256 allocations which provides funding for reablement, and we have no plans to reduce the amount of resources dedicated to supporting reablement. The graph below demonstrates the increase in reablement over the past three years.



Reablement has been increasingly successful, with 83.7% of older people still at home 91 days after discharge in 2013/14 – we are now stretching ourselves further with a target of 86.6% for 2014/15.

However, all partners have recognised that meeting the demand for social care services is not sustainable in the current financial climate, and the rapid expansion in Cambridgeshire's overall population brings further pressures. While the BCF will enable us to improve many of our processes and develop new ways of providing services, the increase in demographic and financial demands being placed on the social care system will require a complete change to how social care is provided in Cambridgeshire, in order to ensure sustainability in the medium to long term. The £2.5million of BCF funding

allocated to protecting social care will therefore provide a bridging mechanism in the transition from current to future working practices.

Our overall approach to protecting social care services will be through developing a more integrated working arrangement with health, housing and community based sectors predicated on improved information, advice and guidance and effective earlier preventative and intervention measures. More specifically social care services will be protected by:

- Our response to the Care Act
- The development of a new social work model (Transforming Lives)
- A clear workforce development programme
- A robust approach to demand management

The close alignment of our intentions within the BCF and the Care Act means that other expenditure from the BCF will also contribute to delivering the requirements of the Act, in particular preventative activities, assessment and crisis intervention.

Transforming Lives: A new strategic framework for adult social work and social care in Cambridgeshire, which will fundamentally change how we deliver services to better meet the demands that we face. It is based on a proactive, preventative and personalised approach and enabling residents to exert choice and control and ultimately continue to live, to the fullest extent possible, healthy, fulfilled, socially engaged and independent lives. This new way of working will embed social care staff in local communities, playing a strong role in multi-disciplinary teams alongside health and voluntary sector colleagues.

The new model is based on 3 levels of intervention: Help to Help Yourself; Help When You Need It; and On-going Support.

Help to Help Yourself: Information, advice, prevention, early identification and early intervention are inextricably linked. Information and advice would help people to find out about local voluntary and community activities and the model will include the concept of 'supported introductions' to activities where people are reticent to attend alone. Strong, independent communities and supportive families and carers are crucial to the success of this model. Families and carers are often best placed to support individuals to achieve their aspirations.

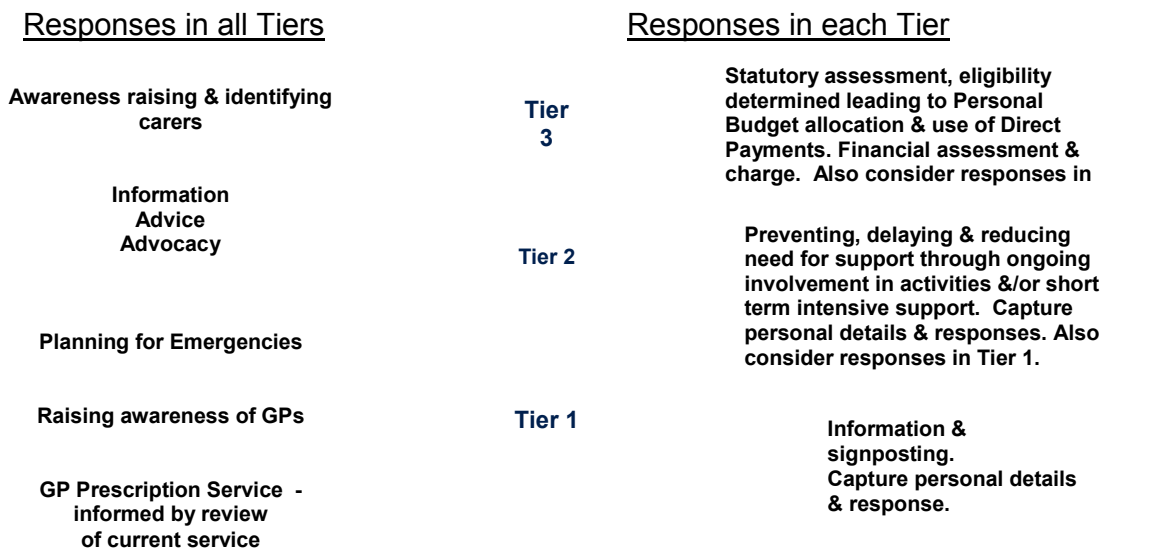
Help When You Need It: Crisis resolution provides a local, rapid response immediately following a crisis, at which the individual is put at the centre of this intensive work. It focuses on the needs of the individual at that point in time, and very short term planning will take place with support designed around the needs and circumstances of the individual. The adult social care professional would then provide support to the individual for the duration of the crisis, checking with them regularly to ensure that they are coping and feel well supported. The aim of the rapid response is to support individuals through crisis to help them to maintain their independence, prevent further deterioration and the need for longer term adult social care. One of the key aims of crisis resolution is therefore to support people to remain independent of statutory services. Alongside crisis response are reablement, visual impairment and occupational therapy rehabilitation, assistive technology and deaf services equipment, which play a fundamental role in supporting, encouraging and enabling individuals to regain their independence. Where possible, they will be able to continue to live active, fulfilled lives independently in their own homes and

maintain their role within the local community. This model suggests that an increased investment in professionals to assess for Assistive Technology and the technology itself which could prevent or delay access to more costly and longer term social care packages.

On-going Support: The longer term support for individuals would be planned through the use of holistic, integrated assessments, and would be self-directed, based upon personal budgets and the principle of choice and control. The nature of the strengths based conversations that professionals will have with the individual would change. Planning would take place with the individual to ensure that we are continually building upon their strengths, families, networks and resources to achieve their aims. At this level, it is anticipated that deeper conversations may be required, for example into individual's personal financial circumstances. It will be acknowledged that the individual, their carers and their families are the experts on their own lives. Individuals in receipt of on-going support from adult social care services would be encouraged to utilise assistive technology and rehabilitation services and encouraged to be active participants within their local community. Should any additional issues be raised, the individual would be signposted to information and advice, enabling them to find a local solution that meets their needs.

With the transfer of funding from the NHS through the Better Care Fund there is a real opportunity to develop these two models collaboratively with NHS colleagues, to maintain good health and wellbeing of people and carers and support them to have fulfilling lives. The time is right to make radical changes to the traditional ways of working that these work streams are designed to deliver.

Support for Carers: The Council is currently leading a project to develop a new model of support for carers, taking into account the new duties arising from the Care Act. The project is taking an inclusive and collaborative approach with statutory partners, family carers, the community and the voluntary sector to consider how best to deploy the funding transferred through the BCF and the investment in carers by the Council.



The emerging model is based on 3 tiers of need, with some responses being available to all 3 Tiers and some responses that are specific to each Tier.

Responses to all 3 Tiers

- To reach out to carers it will be necessary to raise awareness about being a carer and provide information that is relevant for a wide range of circumstances.
- Advice and advocacy may be required at different times by carers across all tiers.
- GPs have a significant role in identifying carers and further work is needed to continue to promote their recognition of carers within their patient groups.
- Currently GPs have a "prescription service" through which they can prescribe a number of hours of support, delivered through Carers Trust. This is available to any carer whom the GP judges has a need for support. This service model will need to be reviewed to see if and how it could be enhanced in the new model.
- Building on the experience of the current Individual Carer Emergency Respite (ICER) scheme through which the carer can develop a plan for emergencies, we will develop a wider concept of emergency planning, including plans that clarify informal networks of support that can be called upon in an emergency, with a view to encouraging all carers to develop a plan.

Tier 1 represents lower levels of need where the provision of information and signposting will be very important. Capturing personal data will help to build up a picture of the carers across the County.

Tier 2 focuses on interventions that will prevent, delay and reduce the need for support including ways to maintain or develop informal networks. This may also include short term intensive support where that would prevent further deterioration of the situation.

Tier 3 represents the higher levels of need that meet the eligibility criteria for social care support, following an assessment. The assessment should use and build on the information captured within Tiers 1 and 2. The support to meet eligible needs will be personalised, with the identification of the personal budget available and the option of taking this as a Direct Payment. Consideration should still be given as to how to support the carer within informal networks as a way of reducing the need for support.

<u>Workforce Development</u>

Ahead of the need to assess the impact of the Better Care Fund on the workforce, Cambridgeshire County Council has already been carrying out a review into the workforce capabilities within health and social care particularly to support its Transforming Lives initiative.

Workforce planning and development will be addressed across the board, from front line workers to senior managers. The development programme is focused on three tiers.

The first tier will focus on level 3 vocational qualifications, setting a benchmark for our social care staff and giving them a transferable qualification which will allow them to work in other settings. Between 100 and 130 learners are enrolled on level 3 courses at any one time, and the vast majority complete their courses within 12 months.

Cambridgeshire County Council trainers already have a strong track record of delivering training to staff members, and are confident that they will be able to expand their

programme in the near future. Cambridgeshire will have its own vocational qualification centre from the 1st of April 2014, which will give the County much more flexibility in the vocational qualifications it will be able to deliver to staff. In addition, a bespoke training qualification in reablement is already being developed, which will soon be available to all staff at level 3.

The second tier ties in to Cambridgeshire County Council's Transforming Lives agenda by moving to strengths-based assessments, making assessments more conversational and motivating social care staff to work in a fundamentally different way. Public health officers will also provide training on motivational interviewing as part of this tier, to boost the confidence of health and social care workers in persuading service users to make positive changes to their own lives. Around 100 officers each year are expected to take on this second tier of training.

The third and final tier will focus on attachment-based working. Helping service users to strengthen their family attachments can prevent social isolation, which has been proved to be a factor in a range of health problems including depression. Again, it is expected that around 100 council officers each year will undergo training in this area.

These tiers are not an exhaustive list: other work-streams are being considered to ensure that there is sufficient workforce capacity at all levels of the organisation. One potential area of workforce development is the senior management team, where a short- to medium- term programme could be developed to encourage culture change and facilitate cross-organisational working at the highest levels. The workforce implications of multi-disciplinary teams could also come under the Transforming Lives project.

Within the NHS, Health Education East of England has been co-ordinating the development of workforce planning and seeking to introduce a strategic framework within which manpower development can take place. A common approach to workforce development has been adopted across the East of England with the aim of developing a workforce fit for the future reflecting the following:

- Increased demand for GPs and Practice Nurses
- Staff with skills to support integrated care closer to home
- Staff with skills to care for frail elderly / people with dementia
- Multi-professional approach to delivery of care across settings
- Opportunities for new roles, e.g. urgent care
- Smarter ways of working through the use of technology
- Use of evidence based staffing tools
- Workforce and service transformation in response to use of staffing tools

Around 70% of the future workforce are employed by the NHS now. Health Education East of England trains 3,000 students per annum in order to secure future NHS supply (representing 17% of the future workforce); it expects to recruit up to 12% new employees by 2020 in addition to newly qualified recruits. The Cambridgeshire and Peterborough providers are facing an unprecedented efficiency savings gap, estimated at 5.6% p.a. by 2020, higher than the average for East of England. In the period between 2000 and 2010, the NHS workforce in Cambridgeshire and Peterborough grew by 60%, faster than in other areas of East of England and in 2010.

Healthcare is entering a new era that needs flexible and trained workforce for the future.

Some of the challenges for redesign include:

- Greater use of technology on the front line
- New roles that cross the boundaries between hospital and community services
- A much stronger emphasis on joined-up personalised care

To date, Cambridge and Peterborough's Workforce Partnership local priority is to improve urgent and emergency care services; reducing avoidable admissions and preventing unnecessary hospital stays – enabling integrated care pathways and the development of community-based services. Cambridge and Peterborough Workforce Partnership have created workforce transformation programmes during 2013/14 which will focus on the following:

- Values based recruitment focusing on Bands 1-4 across all NHS Providers in Cambridge and Peterborough
- A review to ensure better support for the workforce in the care home sector
- A redesign of the workforce needs for urgent care access system for people not using A&E - with a major focus on support of frail elderly people living at home
- Workforce re-design to support the acute care delivery linked to the workstream for developing the workforce to respond to urgent care access system outside of A&E

Health Education East of England will continue to promote staff progression as well as the labour market with a view to increasing the number of people in professional careers. This is particularly important for professions such as nursing where a significant proportion of nurses are approaching retirement over the next 10 years. Health Education East of England will also focus on developing opportunities for staff within band 1-4 roles that typically include healthcare assistants, technical support staff and office staff. A consultation on a national strategy to develop these staff has been completed and the results will be made known soon.

Work will focus on ensuring that the training and skillset development needs required to implement the plans arising from the Better Care Fund initiative are identified at the earliest opportunity and that an action plan is put into place to ensure that the sector is prepared and ready to support the significant service transformation opportunities available.

<u>Demand Management</u>

Partners are currently working on a number of measures to manage the demand on our services especially for old people. These include:

- Releasing staff capacity by simplifying processes and procedures and enabling staff to work flexibly
- Enabling and encouraging the use of direct payments wherever possible to enable service users to exercise choice about how support needs are met within a clear budget
- Supporting the review of all requests for increases in packages and prioritise reviews according to need and cost of care package
- Moving away from spot purchasing of respite care to a more planned approach, which enables carers and service users to plan in a proactive way to prevent crises
- Refreshing the Council's 'Contributions Policy'
- Reviewing our arrangements for interim beds and developing a joint approach with NHS partners

- Making good use of the Brokerage Unit to ensure best possible value for money when purchasing residential, nursing home, respite and interim beds and support 'self-funders' to make good decisions about quality and costs of care
- Ensure that there is clarity about arrangements in relation to Continuing Health Care (CHC)
- Working with partners in the way that we manage the reduction in winter pressures funding and how we respond to unplanned surges in demand in the acute sector
- New strategic procurement policies within the CCG which will stimulate seven day working, whilst requiring providers to reduce admissions.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The following sums have been allocated to support the protection of social care:

- £10,652,000 – continued application of Section 256 monies into social care services which support healthcare objectives
- £2,500,000 – funding towards protecting social care and supporting its transformation
- £1,344,000 – allocation to support the Care Act to meet a range of new duties placed on councils.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Work is underway to deliver the requirements of the Care Act through an overarching programme board with activity focused on the following areas:

- Support for Carers (see above for details)
- Transforming Lives – a new model for social work/social care – including prevention (see above for details)
- Information and advice
- Identifying self-funders, assessments, eligibility criteria and workforce capacity
- Managing the market
- Statutory status of the Safeguarding Adults Board
- Financial systems for deferred payments and care accounts

Financial modelling on the impact of the Care Act has begun and the potential pressure areas are recognised as being:

- Additional staff required to undertake more assessments
- Demand from self-funders where demand could outstrip available funding
- meeting the increased duties in respect of carers being assessed and having a personal budget to meet eligible needs
- The changes to the eligibility criteria which we believe will draw in people who would currently fall into the category of moderate need
- Deferred payments impacting on cash flow
- Impact on prices in the care market

The inclusion of £130m revenue and £50m capital (national figures) in the BCF is

welcomed. The work of the programme board will determine exactly how to deploy this funding to address some of these pressures and to contribute to the delivery of the requirements of the Care Act.

v) Please specify the level of resource that will be dedicated to carer-specific support

£350,000 is the minimum amount of carer specific support included within the BCF; this is currently used within CCG budgets for their support for carers. The current CCG-funded work is set to continue with the same resource allocation; more carer-specific support will be included as we develop plans with the Older People's Procurement provider.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There has been no significant change in the agreed financial allocations to the Council for protection of social care. However, the refocusing of the BCF on emergency admissions has removed some of the potential for wider transformation which would have supported longer term sustainability of the local authority's budget position.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Strategic Commitment

Cambridgeshire County Council, working with acute partners and the CCG, have committed to operate a "discharge to assess" process i.e. all patients will leave the acute hospital as soon as clinically fit and safe to do so. Complex assessments will be undertaken at home or within interim provision such as a nursing home. A project has begun within the Cambridge University Hospitals NHS Foundation Trust system to implement this approach based on the model developed in South Warwickshire. A key requirement for the approach is 7 day working. Estimates suggest a potential cost of £600K investment in 10 additional interim community bed provision within-reach therapy support Similar proposals are being developed for Hinchingbrooke and Peterborough Hospital systems. To support this, a review of interim bed provision is currently taking place across the health and social care system. Other identified costs include a 30% increase in staffing of the Discharge Planning Teams in Cambridge and Huntingdon, amounting to an additional cost of £479k.

Our proposal for supporting people to leave hospital (see Section 2c) is based on a shared commitment to move to 7 day services to support discharge. This commitment will be signed off by the HWB Board, CCC and CCG as a key area for transformation. This reinforces the shared strategic commitment to 7 day working of the health and social care system in Cambridgeshire.

Details on the implementation of this work are available at section 2c) and in the detailed scheme description (Annex 1)

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

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

In November 2013, 97% of all social care records contained the NHS number: however,

it is not included on all correspondence currently. From February 2014, the NHS number has been included on all correspondence generated from AIS, the new social care information system that is currently being rolled out across all social care services. We are therefore committed to using NHS numbers as the primary identifier in all our work.

Cambridgeshire County Council is in the process of procuring a new IT system. A requirement of the service specification is the ability to link to NHS networks to facilitate better information and data sharing. The procurement team have taken learning from other local authorities where similar systems have been tried.

Details on the implementation of this work are available at section 2c) and in the detailed scheme description (Annex 1)

ii) Please explain your approach foradopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The CCG and CCC are committed to adopting systems that are based upon Open APIs and Open Standards, wherever possible, and encouraging existing supplier to adopt Open APIs and Open Standards in future releases of software. The CCG is often directed to use specific software suppliers by NHS England and/or the Health and Social Care Information Centre. The re-procurement of the council's social care information system has within its specification the need for API capacity.

As well as what is implied by work in other areas, our proposal to invest in infrastructure to support integration, (see Section 2c) highlights our commitment to develop further our work in the areas of data sharing agreements, shared databases and joint protocols that allow full and comprehensive data sharing, using the NHS number as the primary identifier.

A further project is under way to identify the key information which should be shared between professionals: this includes sharing emails over a secure system, use of shared documentation (e.g. Common Assessment Form), and NHS numbers. The project is being supported by the Health and Social Care Information Centre, and includes learning from the pan London experience on the best ways to find and share data across organisations.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott2.

Since 2009 there has been a shared IG protocol in place covering health and social care partners as well as other public sector bodies in Cambridgeshire.

The CCG submitted IG Toolkit Version 11 (2013/14) for publication at the end of October 2013. 'Satisfactory' assurance was attained for this early submission as required to enable Stage 1 Safe Haven status and the NHS Standard Contract was used. Caldicott2

recommendations are known and will be implemented. The CCG has a well-established IG and IM&T Group in place to ensure compliance with all aspects of information governance.

In addition to addressing the specific questions in relation to data sharing we have also established a project to look specifically at how data sharing needs to change to support a single assessment process. Meetings have taken place involving CCC, CCG, CUHFT and a representative from the Health and Social Care Information Centre to start this work. A project board will be established shortly incorporating strategic and technical leads from each organisation to:

- Agree a set of key priorities, including some parallel 'quick wins' using existing systems and processes. These will be agreed by the NHS Chief Executives Group
- To develop a better join up of information systems across health and social care that will move us to a single assessment process
- Scope the work needs to link to the Care Act and include independent sector provider requirements and links to primary care and MDTs.
- Roll out a pilot of iPads to team managers plus another member of each team and then undertake an evaluation
- Develop 'honorary contracts' for MDT coordinators and other key staff outside the county council who we want to be able to share information with about vulnerable older people

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Across Cambridgeshire, the Local Commissioning Groups (there are 8 LCGs, made up of groups of GP practices which provide local focus and engagement across the CCG) are currently introducing multi-disciplinary teams (MDTs) to provide better and more holistic support to frail elderly or other vulnerable people. MDT assessments will become the norm for people who fall into these categories. They bring together social, medical and community care plans involving GPs, hospital doctors, nurses, physiotherapy, social workers and voluntary or community groups. Learning from these pilots about the role of lead professionals and the application of risk stratification tools will be used in developing proposals to support people in need of help as described in Section 2c.

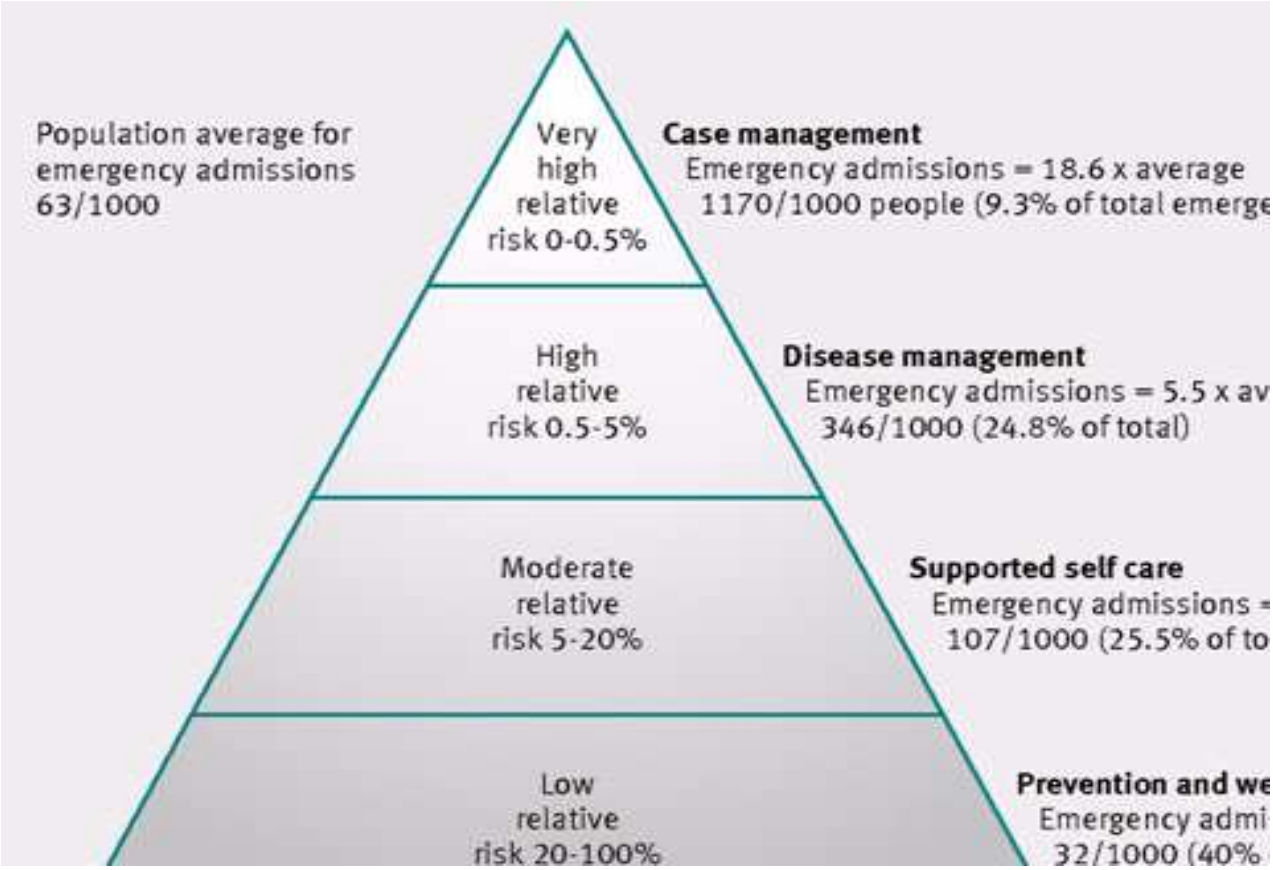
The Direct Enhanced Service for GPs will also require practices to risk stratify their service users, create personalised care plans for the most vulnerable, and ensure that this group has a named and accountable GP.

To support the development of multi-disciplinary working, a new assessment of need is being developed, which will cut across health and social care (GP services, District Nurse services, physiotherapist services, occupational therapy, social care), including acute and community-based care, and make the process of assessing service users with multiple needs more joined up and efficient.

The new assessment will be used in supporting everyone who is 80 or over- around

30,000 people, or 5% of the population, and the most important age group for the intensive institutional services that we are trying to reduce the need for. There will be a further development of this model through the CCG procurement exercise, where the successful bidder will be involved in developing further models of working both in relation to joint assessment and the notion of an 'accountable lead professional'.

Risk stratification will form a key component of the solutions being worked on by bidders as part of the CCG procurement for Integrated Older People Pathway and Adult Community Services. The illustration below emphasises the need to ensure that proactive care approaches extend beyond the most intensive service users, at the top of the pyramid, to cover those who are at moderate-to-high relative risk of admission to hospital.



The project to develop new assessment documentation and the accompanying process I is underway and expected to be complete by November 2014. Roll out is expected to begin in April 2015, to allow for time for change management and to set up new governance procedures. This work will link closely to the governance of the information sharing work.

Experience of joint case work leading to comprehensive health and social care assessments within the integrated Learning Disability Partnership can be drawn upon to inform the work to develop joint assessments for older people. This approach has ensured that health and social care interventions are cohesive and support the person as effectively as possible.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Our MDT programmes is described above. MDT co-ordinators ensure the most appropriate lead professional for each patient.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

Through our MDT pilot and which applies risk stratification we now have care plans for approximately 8 000 patients across the Cambridgeshire and Peterborough.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

In Cambridgeshire we recognise that the whole system must be behind transformation in order for change to get traction and have a significant effect. In developing our first BCF plans, the HWB Board gave a clear steer that proposals for BCF should be developed in the context of a thorough and wide-reaching patient, service user and public engagement programme. Therefore, our approach was to:

- Secure 'buy-in' to the use of the BCF through the active engagement of all key stakeholders
- Conduct consultation on draft proposals prior to discussions at the HWB Boards and sign-off and submission to government
- Be proportionate, given the time and resource constraints. Wherever possible, we have achieved this by using existing meetings/forums and communication channels e.g. consultation pages on the CCG and the Local Authority websites to facilitate the process, formal presentations to meetings, organising Area Events to ensure that we reach a broad audience directly
- Ensure there will be further opportunities to shape and influence use of the BCF at the more detailed planning stage.

The scope of engagement during Phase 1 was comprehensive including:

- The CCG Patient Reference Group
- Local Commissioning Group (LCG) Patient Reference Groups on request
- ASC user groups
- Healthwatch
- Health and Wellbeing Board meetings (development and formal meetings)
- Public consultation run by Cambridgeshire County Council (CCC)
- Older People Programme Board
- Integrated Mental Health Governance Group
- Chairs of the Local Health Partnership Boards
- Delayed Transfers of Care meeting with Hinchingbrooke Healthcare NHS Trust
- Cambridgeshire Voluntary Services
- City and District Council representatives.

During Phase 1 we undertook two areas of work:

Area 1: Stakeholder Engagement

In Area 1, we developed a shared Vision and Principles with stakeholders, in particular with Health and Social Care providers, public sector bodies and the community and voluntary sectors. The aim was to seek 'buy-in' to the overall proposition, clarify issues (e.g. funding, scope) and to manage expectations.

Area 2: User, Patient and Wider Public Consultation

In Area 2, we published a document setting out our shared Vision and Principles and sought views from patients and service users across the health and social care system. This consultation was underway until 8 February 2014.

During Phase 2 (up until 4 April) we held two public meetings in Cambridge and Wisbech with the support of Healthwatch. These meetings explored our current ideas around the BCF and discussing the emerging detail about the likely 'areas of change.'

Overall, the response from stakeholders has been positive with a wide range of views expressed, for example:

- Strong support for the Vision and Principles
- The need to build on our existing commitment to transformation
- The need to ensure that we optimise care pathways, in particular, how the social care elements of the plan inter-link with health services on the ground
- Joint working with the voluntary service sector is in place but we need to learn from examples elsewhere where the voluntary and statutory sector services work particularly closely to deliver a range of services targeted at those in most need
- The BCF should take into account service users themselves, their families and their carers - both formal and informal. One service user suggested that formal carers ought to be supported to be as flexible as possible: for example, she found it difficult to arrange for a carer just for the weeks when her husband was away. Another member of the public felt that the vision and principles of the programme ought to mention individuals and families
- Efforts should be made to ensure that duplication is avoided, particularly during the assessment stages. Service users have expressed the view that the services they are referred to rarely seem to share information between each other
- The language of the consultation paper and the programme was mentioned by some members of the public, who were concerned that older people in particular were being framed as 'problematic'. There should be a recognition that some people do need to be in hospital
- Making sure that the BCF focuses on the *quality* of care and not just trying to save money
- Impact of changes on services, particularly increased fragmentation of services, loss of health services and duplication of administrative costs
- The development of specific services e.g. stroke services, hospital discharge, social worker attitudes and end of life
- The importance of being able to access information that is relevant to your particular circumstances from one place
- The need for frontline services to be integrated and focused on people not structures
- The challenge of releasing money from NHS providers to pass into the BCF
- The important role of GPs in reducing demand on acute hospitals

Throughout the planning process, we have endeavoured to engage with stakeholders as widely as possible and to ensure that the views obtained through dialogue and feedback from our stakeholders are played appropriately into the plan as it develops.

Recent engagement
In Phase 3, the speed at which we have had to work in order to develop submissions for BCF has necessarily limited the extent to which we could conduct significant engagement in advance of the 19 September deadline. However where possible, engagement across the sector has continued, through:

- Meetings with District Council Members
- Meetings of County Council Committees
- Workshops for Health and Wellbeing Board representatives
- A meeting with local Voluntary Sector Chief Executives
- Representation from the voluntary sector

We envisage that engagement will continue as an on-going activity throughout the duration of the BCF plan so that we can assure ourselves that the initiatives we implement reflect, as far as possible, the opportunities identified as a result of engagement.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

It is important that BCF is not compartmentalised and is viewed as a component of the transformation plan for our area.
Our work on developing a five year blue print for the system has been carried out alongside our providers. Providers are also integral to BCF development and as members of the Cambridgeshire Executive Partnership have developed and agreed this BCF Plan.

Our engagement with providers and this identified the following implications for the sector:

- The need to jointly re-design and streamline admission and discharge processes to ensure that the planned developments in community capacity and expertise are complemented by the right capacity being available at the right time. Urgent Care Network Boards are engaged in this work but there is also a need for a more strategic approach to the whole system
- A risk of reducing capacity (and therefore income) related to emergency admissions in anticipation of the transformational changes to community-based capacity taking effect before they are actually achieved. Our proposed emergency admission reduction target and BCF financial allocations recognise this issue
- A requirement that, as a whole system, we jointly align the work and objectives of the Older People Programme with that of the BCF to avoid the risk of a fragmented response by acute providers. The Executive Partnership Board is a partnership Board which includes providers and brings together the Older People Programme and BCF.

ii) primary care providers

The CCG has worked with GPs at Member Practice events, provider stakeholder events, and engaged more locally at Local Commissioning Group board and strategy meetings to develop our BCF proposals. The governance structure for BCF includes GP representation and the Executive Partnership Board is the forum for providers to engage in plan development, implementation, monitoring and review.

iii) social care and providers from the voluntary and community sector

We have endeavoured to involve as many social care providers as possible during the development of BCF. For our first plan, providers were included in We asked a wide range of stakeholders to submit their ideas and proposals for inclusion in the Better Care Fund (BCF) using a standard pro-forma and a set of criteria to guide respondents. We received over 120 responses from a wide range of providers and commissioners and we have used this to shape our initial thinking around the content of the plan and to further refine our areas for change.

We have also used existing forums to engage with providers wherever possible, and run ad-hoc new events where no other forum exists. Feedback from providers has informed the development of proposals; will continue to inform 'idea bank' projects; and will continue to be sought as we develop further proposals in partnership with the successful bidder under the OPACS contract.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The Cambridgeshire Executive Partnership (which includes acute providers) and HWB

agreed a 2015/16 BCF target reduction in emergency admissions of one percent. Given the current trajectory of growth (which exceeds 2014/15 plan) reversing the trend of growth and delivering a one percent reduction for 2015/16 will be very stretching.

The ambition across the system including Cambridge University Hospital FT and Hinchingbrooke Health Care Trust is for greater reduction over the subsequent four years as transformation programmes are fully operational and deliver outcomes. For 2015/16 the one percent reduction provides alignment with provider plans on the basis of a stretching and achievable target.

Provider comments are attached in Annex 2

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
1.
Scheme name:
Older People and Adult Community Services Outcome Based Procurement
What is the strategic objective of this scheme? In summary, the vision for Older People and Adult Community Services is: • for people to be proactively supported to maintain their health, well-being and independence for as long as possible, receiving care in their home and local community wherever possible; • for care to be provided in an integrated way with services organised around the patient; • to ensure that services are designed and implemented locally, building on best practice; • to provide the right contractual and financial incentives for good care and outcomes; and • to work with patients and representative groups to design how the CCG commissions services. The strategic objective is for older people's healthcare and adult community services to be better organised around needs of the patient. We want to see: • More joined-up care We want to make sure that the health and care professionals involved in the care of an older patient or adult with a Long Term Condition, work together in joined-up teams. We are proposing to have a "lead" organisation responsible for delivering and co-ordinating this care, no matter where is it delivered, in the hospital or the community. • Better planning and communication We want to ensure that patients and their carers are involved in creating their health and care plans, and with consent, for these plans to be available at all times (24/7) to the appropriate professionals. • More patients supported to remain independent We would like older people to have access to care in ways that allow them to maintain their independence.

• Improved community and "out of hospital" services and fewer patients admitted to hospital as an emergency, where it can be safely avoided.

We want to stop people going into hospital unnecessarily (where it can safely be avoided) and we want make sure our older patients and adults with long term conditions can access the right support either at home or in their local community, in a timely manner. We want people to feel confident about the care they receive at home.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The patient groups being targeted are those aged over 65 and adults who receive health commissioned community services.

The model of care will be developed in further detail from October 2014, when the provider is appointed and will include BCF objectives. At this stage proposals are:

- More joined up care: organising care around the patient

To improve both patients' and carers' experiences of the healthcare received by older people, along with the quality of services delivered, the CCG asked organisations taking part in the tendering process to put together proposals that showed care organised around a patient's need.

The proposals received suggest this can be achieved by:
• making sure that patients and carers are involved in making plans for their health and community care, so that services are delivered according to their need
• providing named care co-ordinators for patients
• the named care co-ordinators focussing on frail older patients, or those with complex problems, or those needing end of life care, will be supported by a team of doctors, nurses and therapists working together around the needs of each patient, and working better with voluntary organisations and social care
• if the patient is living with a long term condition such as dementia or diabetes or respiratory disease, the team would include a professional specialising in those fields
• providing specialist teams to provide support to the 'patient's team' when needed.

- Better planning & communication: delivering 'seamless' care

We want to see care delivered in ways the ensure people feel everyone is part of the same team and knows what each other is doing. We want both patients and their carers to feel that their care is 'seamless' not disjointed.
We want to see all staff involved in a patient's care to be communicating with one another and working in a co-ordinated way.

Proposals received suggest this can be achieved by:
• having a single point of access contact centre operating 24 hours a day, seven days a week - either nurse-led or staffed by professionals with links to expert advisors and all organisations involved in the care of older patients

• having a single electronic record system and shared protocols, so that all relevant health and social care professionals can access, with patient consent, information whenever necessary.
• the continuation and strengthening of the already established Multi-Disciplinary Team (MDT) models, with better links to hospital specialist advice
• ensuring all health and care professionals have an understanding of all the health and social care needs of people in their care, not just in the specific area that they are trained to deliver care in
• bringing mental health professionals into the wider team, so that frail older people with both physical and mental health problems receive better joined-up care
• solid partnership working with voluntary organisations providing everyday living support to older people for example with transport or providing respite for partners who are carers.

- Supporting older people to stay independent

We would like to see care delivered to older patients, or for older patients to be able to access care, in ways that allow them to maintain their independence. Ways suggested for doing this are:
• offering support at an earlier stage to a larger number of people than is the case now
• focusing on prevention - making sure those aged 65 plus have access to information and services that will help keep them well, for example diet advice and exercise opportunities
• with patient consent, offer a health/care review to identify and address issues, for example housing problems
• increased working with local voluntary organisations to direct patients to services and provide more informal support
• establishing healthcare contact points venues other than GP practices
• using technology such as Skype/Telehealth to provide support for people with long term conditions
• developing a record system that patients can access, so they can self-manage their care

- Improved community services: reducing emergency hospital admissions, re-admissions and long stays in hospital.

Quite often during an episode of severe illness, hospital treatment is necessary. However a significant number of people are admitted to hospital who could have been safely treated at home, or discharged at an earlier point, if community services were organised in a different way.

We would like to see a healthcare system that reduces the number of older people being taken to hospital unnecessarily, or staying in hospital longer than needed.

Proposals received suggest this can be achieved by:

• improving information for, and engagement with patients, their relatives and carers to increase understanding of long term conditions, so they can better identify minor changes or serious deterioration and request help accordingly and earlier
• emphasis on personal case management to identify patients at risk of being admitted or re-admitted to hospital, managed through Multi-Disciplinary Teams (MDTs)

• having a 24/7 urgent care system that can send a community team to the patient to both assess and treat at home, without the need to go to A&E unless necessary

• good access to urgent hospital specialist advice and assessment
• much stronger links between the community and the hospital, from the A&E department to the wards, with teams based in the hospital supporting care and linking with community teams in-reaching into the hospital, supporting better arranged discharge
• better rehabilitation services to support people to recover from episodes of ill health. This could include the provision of 'step down' beds in community settings, or a hospital at home service giving help with personal hygiene such as bathing, shaving etc., as well as medical care.

- End of Life Care

Alongside improving care for older people, the CCG has made improving End of Life Care across Cambridgeshire one of its priorities. The preferred provider(s) awarded the contract will be expected to work with the CCG on delivering improved End of Life Care.

Proposals put forward include:
• providing:
− local specialist nurses
− 24-hour support for patients and carers if needed, at home or in community bed settings
− well co-ordinated MDT working around the needs of the patient, as described above
• with patient consent, making sure information on a patient's needs and wishes regarding resuscitation and the place where they wish to be cared for at the end of their life, is available to all healthcare services, including the ambulance service
• ensuring that community services are able to meet the needs and wishes of patients and their carers.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Service	Current Delivery Chain
Community services for older people and adults	Cambridgeshire Community Services NHS Trust
Unplanned acute hospital care for patients aged 65 and over (A&E, non-specialist services admissions)	• Cambridge University Hospitals NHS Foundation Trust • Hinchingbrooke Health Care NHS Trust • Peterborough & Stamford Hospitals NHS Foundation Trust • Queen Elizabeth Hospital Kings Lynn NHS Trust The main impact for this BCF plan will be for CUH
Older People Mental Health Services	Cambridgeshire & Peterborough NHS Foundation Trust
Other services which support the care of	Specialist palliative care services

older people	providers; GP practices (local enhanced service for care homes/nursing homes); specific voluntary organisations; other acute Trusts (hospitals) providing unplanned acute care

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The CCG's programme is informed by a comprehensive assessment of the evidence available. This began with an assessment of need, and includes a detailed analysis of evidence on improving outcomes for patients. There is published evidence that better organised and joined-up care leads to better health outcomes. For example, in April 2013 the Kings Fund updated a report 'Transforming Our Health Care System: A Summary' where they published the evidence for the effectiveness for all aspects of care for older people. A separate summary of the clinical case for change can be found on our website

Specific JSNA s underpin the evidence base for our population. Bidders have been encouraged to use the local JSNAs to inform their commissioned services and development of integrated care pathways:

Primary Prevention for Older People JSNA

This JSNA provides important evidence and information to support the commissioning of preventative services and initiatives for Older People across health and social care and to encourage awareness and signposting of available public health improvement programmes and services available across Cambridgeshire. The successful lead provider will be expected to use this evidence and information to develop effective integrated pathways of prevention to support healthy behaviours in older people.

This JSNA focusses on modifiable lifestyle behaviours, for which there are clear associations with poor health outcomes and opportunities to take a preventative approach: active ageing and physical activity, maintaining a healthy diet (including preventing malnutrition), and stopping smoking. It provides evidence on health-related behaviours in older people, including local data where available and a description of local programmes or initiatives to support healthy behaviours or actions to reduce lifestyle risk

Carer's JSNA

The main question for the JSNA was 'What can we do to support carers to stay healthy and well?' In addition, to support the work around the Better Care Fund, the JSNA has also looked at the evidence for whether supporting carers reduces health and social care service use. The scope of the JSNA is carers across the whole life course

Older People's Mental Health JSNA

The Cambridgeshire HWB highlighted older people's mental health as a priority area for JSNA work.

In consultation with partners the scope of an Older People's Mental Health JSNA was narrowed to focus primarily on dementia and depression. The JSNA makes an important distinction between mental wellbeing or mental health and mental illness or disorder

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The scheme is supported by outcome domains underpinned by metrics.

The CCG has agreed the following success criteria:

- improve patient experience and service quality for patients and their carers through care organised around the patient;
- deliver services which are sensitive to local health and service need, as defined in the Local Requirements;
- move beyond traditional organisational and professional boundaries, so front-line staff can work effectively and flexibly together to deliver seamless care;
- support older people to maintain their independence and reduce avoidable emergency admissions, re-admissions and extended stays in acute hospitals (including delayed transfers of care);
- deliver an organisational solution for older people's care which can demonstrate strong leadership, sound governance, resilience, and the confidence of commissioners and provider partners;
- demonstrate credible approach to engaging patients and representative groups in design and delivery of services; and
- provide a sustainable financial model (see Financial Principles below).

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Outcomes Framework for Older People and Adult Community Services to improve health, wellbeing and maintain independence includes seven domains.

Each domain is supported by performance metrics. Delivery against metrics will be

managed by the CCG and partners through our joint governance arrangements
What are the key success factors for implementation of this scheme? This schemes is well advanced with the provider due to be appointed in October 2015 The procurement objectives are aligned with those for the Better Care Fund and this has featured in provider dialogue and the outcomes framework.

Scheme ref no.
2
Scheme name
Seven day working in health and social care
What is the strategic objective of this scheme?
Our aim is that all patients will leave acute hospital as soon as clinically fit and safe to do so; and that complex assessments will be undertaken at home or within interim provision such as a nursing home. In the short term this means that sufficient County Council staff will be available 7 days a week to ensure a smooth and timely discharge from hospital process in all acute settings. In the medium term, this will be extended across more of the health and social care system. This medium term transformation will assist in reducing the length of time that people stay in acute settings; and will support the aims of Transforming Lives in social care by ensuring that holistic support is available to people recovering from crisis who are not at a level of need at which they need long-term care services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Cambridgeshire County Council and its partners in the NHS have already recognised the many benefits of 7 day working and have taken steps to enable this new working pattern in the most vital services. Reablement services, intermediate care and district nursing already operate 7 days a week, as do commissioned home care services. There is already an integrated health and social care Single Point of Access for community services. A phased programme is in place to look at other services. Specifically, for social care these will include the discharge planning teams - both social workers and discharge planning nurses -as well as building on the existing voluntary arrangement and ensuring that commissioned residential and nursing services are able to assess and receive residents at weekends. Leadership for the implementation of seven day working in the CCG rests with Local Chief Officers, who are responsible individually and collectively as a county-wide group for the development and on-going management of their local health systems.

In order for seven day working to be effective, it is recognised that the interdependency with other services must be managed. In hospitals specifically this includes patient transport and pharmacy services, which are scaled down at weekends. This results in unnecessary delays and can have a detrimental impact on hospital discharge.

The main challenges our implementation plans will address are:

- Identifying resources to support 7 day a week working
- Changing rotas and working patterns for social care and medical assessment and care planning staff necessary for safe appropriate discharge, including amending terms and conditions if necessary
- Ensuring independent sector providers can operate a 7 day a week intake and assessment service
- Working with health and social care partners in other areas (e.g. Peterborough hospital, Queen Elizabeth II Hospital in King's Lynn) to ensure compatible systems

For 2014/15 provider contracts, the CCG has introduced a Commissioning for Quality and Innovation (CQUIN) agreement to ensure that:

- Following emergency admission to hospital all patients have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours (note this is in addition to normal clinical assessment by doctors and nurses)

- Hospital inpatients have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week.

- In addition, shortlisted bidders for the Older People Programme procurement have set out their intentions in the Outline Solutions summaries to provide services on a 7 day basis

The Urgent Care Boards are key forums to ensure effective co-ordination across providers and to offer the opportunity for wider stakeholder engagement and ownership of the plans and work streams in Cambridgeshire. This includes extending coverage of acute community nursing services and of GP services - both aimed at preventing unnecessary admission to acute hospitals. For example, in Isle of Ely and Wisbech, discharge planning is being developed as a key area for 7 day a week working covering elective and non-elective work. The creation of alternative community pathways including Rapid Response which operate over the weekend will be key to this.

Direct stakeholders in this work include Cambridgeshire County Council, NHS Cambridgeshire and Peterborough CCG, Cambridge University Hospitals NHS Foundation Trust, Hinchingbrooke Healthcare NHS Trust, independent sector providers and (from 2015) the provider of older people's services selected through the CCG Older People's procurement. Indirect, cross-border stakeholders will be hospitals and other health and social care agencies in Peterborough and in King's Lynn.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The Cambridgeshire Executive Partnership Board will oversee and coordinate commissioner discussions on the implementation of 7 day services; a project is to be established which will report to the CEPB. The CEPB will report back to the Health and Wellbeing Board. In phase 1, the Commissioners will be the Clinical Commissioning Group and the County Council; the providers will be the County Council and acute providers. As the project expands beyond statutory health and social care services, other providers will be brought in – notably independent service providers; voluntary and community sector support organisations.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
There is a strong evidence base for improving seven day working across health and social care: NHS Services, Seven Days a Week Forum Summary of Initial findings (December 2013) Centre for Workforce Intelligence (2013): Workforce Briefing. What does 24/6 working mean for the health and social care workforce?
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
This scheme will offer improved and streamlined clinical pathways with better outcomes for patients. Short term action will reduce the number of Delayed Transfers of Care. The medium term, wider transformation will assist in reducing the length of time that people stay in acute settings; and will support the aims of Transforming Lives in social care by ensuring that holistic support is available to people recovering from crisis who are not at a level of need at which they need long-term care services.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
7 day working is already a priority area for social care. Feedback and monitoring will be conducted by the Integration and Transformation Team and regularly reported to the Cambridgeshire Executive Partnership Board as the Programme Board.
What are the key success factors for implementation of this scheme?
Timescales Our current plans are:

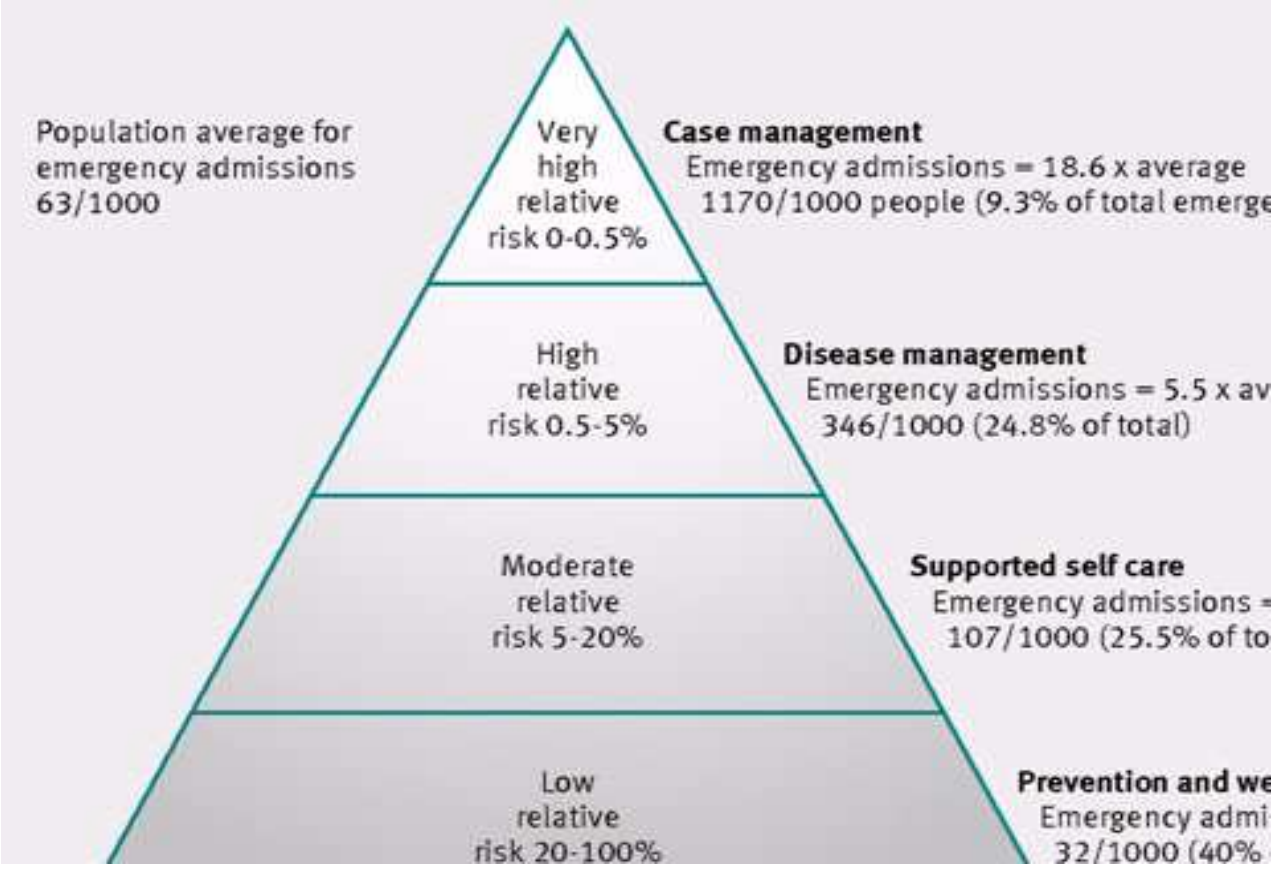
- To negotiate with local authority staff, including making amendments to terms and conditions, to allow for 7 day working in discharge. To be completed by April 2015.
- To negotiate with hospital based staff, including pharmacy, transport, medical staff necessary to approve discharge, including making amendments to terms and conditions, to allow for 7 day working in discharge. To be completed by April 2016.
- To negotiate with independent sector providers, to establish working practices to allow for 7 day working in intake and assessment processes particularly. To be completed by April 2016

Scheme ref no.
3
Scheme name
Joint assessments including accountable professional
What is the strategic objective of this scheme?
We want local people at high risk of hospital admission to have an agreed accountable lead professional and health, social care and other partner agencies to use a joint process to assess risk, plan care and allocate a lead professional. This is integral to person-centred care planning, and decision making about the person's care being undertaken in a timely manner, including telling their story once. The project needs to adequately consider the impact for people with Dementia; and set out how GPs could be supported in being accountable for co-ordinating patient-centred care for older people and those with complex needs
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Across Cambridgeshire, the Local Commissioning Groups (there are 8 LCGs, made up of groups of GP practices which provide local focus and engagement across the CCG) are currently introducing multi-disciplinary teams (MDTs) to provide better and more holistic support to frail elderly or other vulnerable people. MDT assessments will become the norm for people who fall into these categories. They bring together social, medical and community care plans involving GPs, hospital doctors, nurses, physiotherapy, social workers and voluntary or community groups. Learning from these pilots about the role of lead professionals and the application of risk stratification tools will be used in developing proposals to support people in need of help as described in Section 2c. The Direct Enhanced Service for GPs will also require practices to risk stratify their service users, create personalised care plans for the most vulnerable, and ensure that this group has a named and accountable GP. To support the development of multi-disciplinary working, a new assessment of need is being developed, which will cut across health and social care (GP services, District Nurse

services, physiotherapist services, occupational therapy, social care), including acute and community-based care, and make the process of assessing service users with multiple needs more joined up and efficient.

The new assessment will be used in supporting everyone who is 80 or over- around 30,000 people, or 5% of the population, and the most important age group for the intensive institutional services that we are trying to reduce the need for. There will be a further development of this model through the CCG procurement exercise, where the successful bidder will be involved in developing further models of working both in relation to joint assessment and the notion of an 'accountable lead professional'.

Risk stratification will form a key component of the solutions being worked on by bidders as part of the CCG procurement for Integrated Older People Pathway and Adult Community Services. The illustration below emphasises the need to ensure that proactive care approaches extend beyond the most intensive service users, at the top of the pyramid, to cover those who are at moderate-to-high relative risk of admission to hospital.



The project to develop new assessment documentation and the accompanying process is underway and will be complete by November 2014. Roll out will begin in April 2015, to allow for time for change management and to set up new governance procedures. This work will link closely to the governance of the information sharing work.

Experience of joint case work leading to comprehensive health and social care assessments within the integrated Learning Disability Partnership can be drawn upon to inform the work to develop joint assessments for older people. This approach has ensured that health and social care interventions are cohesive and support the person as

effectively as possible.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The delivery chain is under development and subject to discussion. Commissioners committed to this project include the CCG and County Council, with significant interest from GPs and District Councils.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Outcomes will be developed for this scheme as we continue to develop our proposals for joint assessments. Progress will be reported regularly to the Cambridgeshire Executive Partnership Board as commissioners of this project
What are the key success factors for implementation of this scheme?
• Development of proposals for shared assessments and lead professional • Sign up from phase 1 organisations • Agreement of process and schemes • Roll-out and evaluation of scheme in pilot areas • Develop proposals for expansion and receive sign-up from other organisations across the system.

Scheme ref no.
4
Scheme name
Information sharing

What is the strategic objective of this scheme?

This project will focus on the tools, processes and ways of working that will move us to a single assessment/discussion process (linked to scheme 3 above) across the Health and Social Care system for both Cambridgeshire and Peterborough. The focus will be on understanding who is communicating to who and what information they need to share.

This project will identify opportunities that will bring information sets together across organisations so that intelligence about the needs of older people and the support they receive can be used to facilitate joint working.

The scope of the work links to the Care Act and includes Independent Sector Provider requirements and links to Primary Care and Multi-Disciplinary Teams.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The key elements of the scheme are as follows:

Information Sharing Processes

- Undertake desk top research into single Assessment models, drawing from a variety of sources (internal and external) to identify what "best practice" looks like
- Engage with key stakeholders to identify the core elements of information needed to inform the dialogue with service users
- Capture and map information needs to identify any thematic areas
- Identify success factors, risks and issues
- Use identified "Best Practice" models as starting point for development of new/revised forms that meets the need of the stakeholders.
- Produce first draft model for approval and sign off
- Agree pilot scope and timescales
- Implement Pilot
- Evaluation and recommendation

Information Sharing [Technical Solutions]

- Produce options for secure data exchange based on identified requirements and facilitate delivery of preferred options
- Identify any implications for existing user access systems (PCs, tablets, mobile, connectivity) etc.
- Establish terms of reference for pilot of iPads for tam managers plus another member of each team, arrange fo0r pilot and evaluation
- Facilitate adaption of relevant databases to record data sharing consent against each service user and carer record

Information Sharing / Security [Protocols / practice]

- Desk-top research into adult social care data sharing "best practice"; to include

guidance on anonymisation, and data protection and data security
- Review existing data sharing protocols for adult social care and produce an information sharing protocol (including how consent will be obtained and when sharing without consent can take place)
- Assist partner organisations where possible to obtain relevant data sharing consent from service users and implement data sharing policy and agreements
- Assist in identifying information governance/security requirements for technical systems e.g. using iPads to share information
- Confirm legal and information governance requirements for data sharing egg: developing information sharing agreements / personal commitment statements for MDT Coordinators and other key staff outside of CCC who we want to be able to share information with about vulnerable older people in line with established CCC processes

Information Sharing [Workforce Development]
- Establish if there are any training needs
- Clarify if there are any changes needed to existing training programmes
- Support partners with any training needs [3rd sector may need support with training]

Network Connectivity
- Undertake a mapping exercise to identify what connectivity is in place now – to be completed by end of October 2014
- Produce a short report (which can be included in the final project report) outlining any opportunities/constraints together with details of what can be improved in the short/medium/longer term – to be produced in November 2014

Risk Tools
- Development of Risk Tools

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

It is not yet possible to provide a precise delivery chain for this project. The project will work across the health and social care system, with key partners being:

- CCC, CCG, LCGs, GPs
- Acute Trusts (Addenbrooke's, Hinchingbrooke, Peterborough and Queen Elizabeth Hospital)
- Cambridgeshire Community Services
- CPFT
- Independent Sector Providers
- Voluntary Sector via the Better Health Network

The key joint commissioners of this work will be the County Council and Clinical Commissioning Group; engagement will take place with all partners to determine the precise model for service delivery.

The evidence base

Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Difficulties in information sharing is commonly a challenge for integrated approaches to health and social care but can also be improved through effective integration (**http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/Research/IPC-ER4---Integrated-Health-and-Social-Care-Report-100613-FINAL.pdf**). Good communication improves the ability of teams to work together successfully (Howarth, Holland and Grant, 2006). Clear communication structures are needed to keep all staff aware of, and involved in, the processes surrounding integrated care, design and implementation. Complex documentation, poor record keeping, incompatible IT systems and differences in referral arrangements cause problems (Cameron and Lart, 2003). Robust information systems for rapid communication between sectors/organisations and within teams including using a single record gathered from shared assessments (Reed et al, 2005). See: **http://www.wales.nhs.uk/sitesplus/documents/888/The%20Determinants%20of%20Effective%20Integration%20of%20Health%20and%20Social%20Care%20FINAL.pdf**
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
The expected impact of the measures put in place by the scheme will be • Better information sharing between organisations leading to earlier support for older people, and providing timely access to information, advice and support • By providing signposting or support earlier, this will prevent people's condition from worsening • This will promote independence and reduce calls on acute services
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Outcomes will be developed for this scheme as we continue to develop our proposals for joint assessments. Progress will be reported regularly to the Cambridgeshire Executive Partnership Board as commissioners of this project
What are the key success factors for implementation of this scheme?
The key success factors are outlined in the scheme overview above.

Scheme ref no.
5
Scheme name
Transformation Team and Ideas Bank
What is the strategic objective of this scheme?
To form a multi-agency integration and transformation team to drive integration and transformation across the system.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
A small team will be established in order to deliver the following functions across our organisations: • oversee integration activity, so that there is capacity to do the development work necessary for common assessments, joint services, and joined-up packages of care and support • ensure organisations have the necessary frameworks to enable comprehensive data sharing and fully accessible databases • co-ordinate the CEPB to ensure adequate oversight and accountability of BCF scheme delivery • work with organisations to develop their Ideas Bank proposals; identify and support the establishment of pilot schemes; ensure learning is captured and shared; and support the rolling out of successful schemes
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The CCG and County Council will act as joint commissioners of the team. The team will work with a range of organisations and providers across the health and social care system.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
The team will draw on appropriate evidence for any schemes commissioned in conjunction with the commissioners.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The team will be accountable internally to the Children, Families and Adults Directorate in Cambridgeshire County Council; and the team's performance will be overseen by the Cambridgeshire Executive Partnership Board as part of the overall monitoring of BCF activity. A feedback mechanism will also be created for the CCG to have adequate oversight of this jointly commissioned team
What are the key success factors for implementation of this scheme?
Key success factors will vary across the projects undertaken by the scheme and will be developed during service planning for the team's work. However, one key success factor will be to ensure the smooth operation of other BCF schemes and facilitation of adequate governance of the Better Care Fund.

ANNEX 2 – Provider commentary

Name of Health & Wellbeing Board	Cambridgeshire
Name of Provider organisation	Cambridge University Hospitals NHS Foundation Trust
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	28,148
	2014/15 Plan	29,574
	2015/16 Plan	29,277
	14/15 Change compared to 13/14 outturn	5.07% increase
	15/16 Change compared to planned 14/15 outturn	1.01% decrease
	How many non-elective admissions is the BCF planned to prevent in 14-15?	111
	How many non-elective admissions is the BCF planned to prevent in 15-16?	2,020

For Provider to populate:

	Question	Response

1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	The aim to reduce non elective admissions is challenging given the upward trend. . From our perspective we need the health and social care system to work together to achieve significant and lasting reductions in emergency admissions. We are sympathetic to the challenge and the inevitable time lag between design/implementation and impact which is the rationale behind the 1% target for 2015/16. Given the growth in our area and current trends this does represent a stretching target. Taking the projected increase based on current trend into account a 1% absolute decrease requires activity reduction of over 8%. We and partners are ambitious to achieve step change improvement in the medium term. Providers and commissioners are working together through the challenged health economy programme to achieve sustainable health plans for the area. In particular work steams on urgent care and older people are focussed on reducing non elective admissions.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agreewith the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes, as part of the collective planning referred to above

Name of Health & Wellbeing Board	Cambridgeshire
Name of Provider organisation	Hinchingbrooke Health Care NHS Trust
Name of Provider CEO	HISHAM ABDEL-RAHMAN
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	11,263
	2014/15 Plan	11,822
	2015/16 Plan	11,704
	14/15 Change compared to 13/14 outturn	4.96% increase
	15/16 Change compared to planned 14/15 outturn	1.00% decrease
	How many non-elective admissions is the BCF planned to prevent in 14-15?	50

	How many non-elective admissions is the BCF planned to prevent in 15-16?	664

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	The aim to reduce non elective admissions is challenging given the upward trend. . From our perspective we need the health and social care system to work together to achieve significant and lasting reductions in emergency admissions. We are sympathetic to the challenge and the inevitable time lag between design/implementation and impact which is the rationale behind the 1% target for 2015/16. Given the growth in our area and current trends this does represent a stretching target. Taking the projected increase based on current trend into account a 1% absolute decrease requires activity reduction of over 8%. We and partners are ambitious to achieve step change improvement in the medium term. Providers and commissioners are working together through the challenged health economy programme to achieve sustainable health plans for the area. In particular work steams on urgent care and older people are focussed on reducing non elective admissions.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agreewith the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes, as part of the collective planning referred to above

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	
Name of Provider organisation	
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective	**2013/14 Outturn**	
	2014/15 Plan	

FFCEs in general & acute	**2015/16 Plan**	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agreewith the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	