Better Care Fund Strategic Narrative
(2019-20 Plan)
Cambridgeshire & Peterborough

A) Person centred outcomes
Your approach to integrating care around the person, this may include (but is not limited to):
- **Prevention and self-care**
- **Promoting choice and independence**

(Word Count 1300/1500)

Our approach to integration in 2019-20 continues to build on the vision contained in the previous year's BCF plans:

"Over the next five years in Cambridgeshire and Peterborough we want to move to a system in which health and social care help people to help themselves, and the majority of people's needs are met through family and community support where appropriate. This support will focus on returning people to independence as far as possible with more intensive and longer term support available to those that need it. This shift is ambitious. It means moving money away from acute health services, typically provided in hospital, and from ongoing social care support. This cannot be achieved immediately – such services are usually funded on a demand-led basis and provided as they are needed in order to avoid people being left untreated or unsupported when they have had a crisis. Therefore reducing spending is only possible if fewer people have crises. However, this is required if services are to be sustainable in the medium and long term."

This vision translates into our key transformation plans and strategies throughout 2019-20:

● Prevention & Early Intervention: This area focuses on establishing and implementing approaches that prevent or delay the need for more intensive health (specifically admissions and re-admissions to hospital) and social care services, or, proactively promote the independence of people with long-term conditions and older people and their engagement with the community. The 2019-20 BCF Plans will build on the huge amount of work already undertaken in this area and will seek to reduce duplication across the system by working together with the CCG. Our system-wide Ageing Well Strategy Board, led by Public Health, is focusing on approaches to address falls prevention, dementia, social isolation and multi-morbidity and frailty. Other areas include information, advice and guidance, technology enabled care, dementia support, day opportunities and employment opportunities. Through our Better Care Fund programme of work we are developing ways of strengthening integrated approaches to commissioning from the voluntary sector. We have a number of jointly commissioned services, including community equipment, learning disabilities and mental health support. In addition we have developed system wide agreed principles to joint commissioning, which will continue to inform our approach for greater integration of voluntary sector commissioning and developing community resilience.

● Community services (MDT working): Case management within the Neighbourhood Teams is key to reducing increasing demand on the acute and statutory care services. Neighbourhood teams are well established across Cambridgeshire and Peterborough and MDT case management is an ongoing function which brings

together expertise from social care and health to support and manage complex patients in a holistic manner.

We have made good progress is development of an integrated discharge pathway, with the establishment of Integrated Discharge Services (IDS) across all three acute hospitals. This was set up to integrate the different services that support a patient's discharge from hospital to ensure that the patient journey is as seamless and timely as possible, and has the following objectives:

-To provide early input into discharge planning on the wards, from the point of admission, through attendance at board rounds and a single point of access for community services

-To bring together expertise from all agencies and challenge assumptions through specialist knowledge and high level decision making

-To collate information on patient health and social history across the system

-To act as a single point of access to community health and social care services on acute hospital wards

-To provide continuity of contact for patient and family and engage them to inform patient context, constraints and support preferences.

-To provide clinical challenge to discharge plans for complex patients

-To manage performance at the interface between acute and community against key indicators

-To reduce duplication in triage and assessment in the discharge process

The next step on our Community Services journey is to develop Place-Based Delivery, in which a wide range of organisations work together to govern the common resources available for improving health and care in their area. This builds on primary care networks, which are the cornerstone of delivery to populations of 30,000 to 50,000, delivering integrated neighbourhood delivery across health, social care and the voluntary sector. Maximising community assets to deliver sustainable health and wellbeing solutions to local communities.

● High Impact Changes to reduce Delayed Transfers Of Care (DTOCs) and support patient flow through pathways. As a system we have established processes in place which support the eight high impact changes, as outlined below:

- Early Discharge Planning: Patients are allocated an estimated / predicted date of discharge at the point of admission.
- Patient Flow Systems: To collate information on patient health and social history across the system. These include system-wide DTOC reporting and DTOC KPIs, implementation of a bed state tracking system and plans to implement SHREWD (Single Health Resilience Early Warning Database)
- Multi-Disciplinary Teams including voluntary sector: To act as a single point of access to community health and social care services on acute hospital wards. These are the Integrated Discharge Services (IDS) across all three acute hospitals, mentioned above.
- Home First / Discharge to Assess (D2A): We have implemented a D2A pathway across Cambridgeshire and Peterborough. This included a review of commissioned capacity and alignment of reablement and intermediate care as well as ensuring D2A is a key element of all training programmes.
- 7 day services: The system is fully committed to delivering 7 day discharges and has already implemented 7-day working in some areas e.g. Reablement, Social Work etc. We will continue working towards better coordination as part of winter planning work.

- Trusted Assessor: Delivered trusted assessor in all three acutes to expedite the discharge process for patients that require a discharge to a care home. We are also expanding this concept to other community pathways including the D2A pathway.
- Choice: We have an agreed system wide choice policy which has been implemented across all acutes. The embedding of this has been supported by a staff training programme which had choice as a key learning module and has been very successful in training staff in having “difficult” conversations with patients and families about ongoing care needs and options earlier on following admission.
- Health in Care Homes: The Care Home Support Team is implementing Enhanced Health in Care Homes (EHCH), by (i) Supporting the PCNs to provide enhanced primary care and MDTs within the Care Homes; (ii) Supporting the system and Care Homes to use reablement and rehabilitation to promote independence; (iii) Ensuring Care Homes provide high quality end of life and dementia care; (iv) Working with the Local Authorities and Care Homes for commissioning and collaboration; (v) Offering Workforce Development; (vi) Introducing NHS Mail for care homes, supporting people in care homes to benefit from assistive technology, implementing bed state tracker and establishing robust data collection and evaluation methods.

● Information & communication: The overall vision is to have consistent and accurate information that supports self care and management across the sector. Peterborough City Council has already developed the Peterborough Information Network and work is in place towards a similar solution in Cambridgeshire County Council. This will mean revision of websites and publications as part of the Adults Positive Challenge Programme (APC), adopting a strengths-based and assets-based focus. There is scope for exploring wider linkages with Midos/health platforms etc. as well as placed-based partnerships with the Voluntary and Community Sector, through the work of our Think Communities team. An example of this kind of work is Community Navigators. We will also soon be able to count on the social prescribing link workers that will be coming on board in Primary Care Networks. Community asset mapping is being used to identify gaps and how we strengthen these and also to look at coordinated place based data areas profiles.

B) HWB level

(i) Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):
- Joint commissioning arrangements
- Alignment with primary care services (including PCNs (Primary Care Networks))
- Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)

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There is a strong commitment across the system to developing place based services which provide proactive, integrated and person centred care to people, keeping them well and independent in their own communities for as long as possible. This work is being led at a system wide level by the STP, through the north and south alliance boards through the development of integrated neighbourhoods. Primary Care Networks (PCNs) are the cornerstone of the integrated neighbourhood model, which aims to keep local people well and out of hospital, bringing all parts of the workforce together and putting people at the centre of the care they receive. The cornerstone of each Integrated Neighbourhood is a Primary Care Network (PCN). ambridgeshire and Peterborough's population of almost one million patients will be covered by 21 PCNs.

This is the foundation on which we plan to move towards an accountable care system in the future, possible through a number of large scale programmes which are currently being invested in across health and social care:

- Think Communities – Here the Local Authority aims to bring multiple stakeholders together to work in a structured manner across a locality, to solve complex issues and reduce demand for the future. Stakeholders include including Top tier Local Authorities, District Councils, Police, Voluntary Sector and Health.

- Adults Positive Challenge (APC) - Local Authority Programme supporting transition to a demand management system of service delivery for Adult Social Care; a model that is based on promoting independence and putting choice directly into the hands of individuals and communities.

- Integrated Neighbourhoods - South & North Alliance Programme which will develop local models of integrated care with primary care networks as their cornerstone, bringing together community, social, secondary care, mental health and voluntary services. Integrated Neighbourhoods provide proactive and integrated care to communities of 30,000-50,000. They build on the base of primary care networks, bring all parts of the workforce together and put the patient at the centre of the care they receive.

- Neighbourhood Teams (NTs) – Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) Programme involving 14 NTs. These are the physical and mental health care hub of the local community for over 65-year olds and adults requiring community services. They work closely with GPs, primary care, social care and the third and independent sector to provide joined-up responsive, expert care and treatment.

These programmes are driving a move towards Place-Based Commissioning and partners have developed two area-based STP delivery groups (North and South Alliance Delivery Groups) which have representation from health and social care

commissioners, providers, patients and the voluntary and community sector. Six placed-based Delivery Boards will lead on local development of neighbourhood-based care and will link with district councils, local communities, multi-agency neighbourhood teams, primary care networks and locality wellbeing initiatives, such as support for carers and promoting physical activity. The aim is to develop an integrated neighbourhood model across populations of 30,000 to 60,000 people – currently being piloted in two areas of Cambridgeshire. All community-based services will deliver preventative and holistic care that enables people to live healthier, longer and more independently.

Underpinning integration is a continued move to integrated models of commissioning across Cambridgeshire and Peterborough which seeks to:
• Increase choice and control
• Build strong partnership working
• Strengthen community capacity
• Deliver outcome based commissioning

Integrated commissioning approaches support us to increase consistency in service provision and enable better engagement and market management. The following are a number of existing integrated commissioning arrangements that we have in place:
• Better Care Fund pooled budget: commissions a range of integrated initiatives, including community multidisciplinary neighbourhood teams, prevention and early intervention initiatives such as falls prevention, interventions to support the management of DTOCs.
• Support for people with mental health issues
• Learning Disability Partnership
• Community Occupational Therapy Services
• Community Equipment Services and Technology Enabled Care Services

Commissioning intentions are focused on supporting people across the following key areas:
• Early Intervention
• Medium level, reablement and rehabilitative support
• High level, ongoing support

During development of the joint Health & Wellbeing Board sub-committees, the HWBs have used interim joint arrangements to agree several measures to support future joint working:
•establishing a system-wide joint strategic needs assessment core dataset, so that data for the STP footprint appears together;
•agreeing to develop a system-wide joint health and wellbeing strategy (until now there have been two separate strategies);
•inviting the LGA to conduct a peer review of the local health and care system.

The joint HWB will work with the Integrated Care System (ICS) to help oversee these developments, along with wider issues such as how to make the best use of the ‘local pound’ and whether resources are in the right place in the longer term.

(ii) Your approach to integration with wider services (e.g. Housing), this should include your approach to using the DFG to support the housing needs of people with disabilities or care needs and any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the (Regulatory Reform Order 2002)

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Housing and adaptations are crucial elements in maintaining independence within the home. Both Cambridgeshire and Peterborough systems are committed to joined-up working and more proactive use of the Disabled Facilities Grant (DFG), Technology Enabled Care (TEC), Community Equipment (ICES) etc. to support greater independence.

Peterborough City Council's Housing Renewals Policy 2017 - 2019 was adopted in January 2017 and introduced discretionary funding in addition to the Mandatory DFG funding already covered within legislation. Two types of discretionary funding were introduced. The first was a Top Up grant to the Mandatory DFG which allowed ground floor extensions to provide bedroom and bathing facilities (particularly for disabled children) to progress which had stalled due to rising building costs and insufficient grant funding.

The second discretionary grant introduced was to carry out physical works in clients' homes to expedite hospital discharge and preventative works to avoid or reduce hospital admissions and readmissions.The type of work that will be considered for hospital discharge/delayed transfer of care and for hospital admission avoidance includes:

- Clearance and a one-off deep clean of hoarded and filthy properties
- Ceiling Track Hoists to facilitate care in order to return home quickly
- Level access showers to facilitate care
- Heating and energy efficiency measures
- Sensory Equipment
- Ramps and door widening to facilitate access
- Telephone land line (installation only) to facilitate Assistive Technology/TEC
- Fixed Safety equipment – alarms, safety locks, specialised lighting, fire/radiator guards
- Physical changes to the property in order to eliminate/reduce the risk of falls which are outside the remit of the Council's Handyperson Service
- Changing flooring to facilitate safe moving & handling
- Any other request for physical property changes/adaptations deemed reasonable and practicable, necessary and appropriate to facilitate hospital discharge to a safe environment and to enable the elimination or reduction of care packages

In Cambridgeshire, work is under way to develop a similar housing adaptations policy in conjunction with districts and this will be adopted by districts so there is a consistent approach to application of DFG across the county. The kinds of discretionary funding already happening in Peterborough will become part of the Cambridgeshire approach moving forward.

DFG funding in Cambs is passed via the BCF to the District Councils, who have statutory responsibility for DFG. A new, joint county-wide adaptation and repairs policy has now been agreed and adopted by the five Cambridgeshire district

councils, starting to be implemented from April 2019. This allows for Disabled Facilities Grant (DFG) monies received through the Better Care Fund to be spent more creatively on wider partnership projects or other services, outside of mandatory DFGs, to help meet BCF objectives. Cambridgeshire Home Improvement Agency has significantly reduced the time taken to install new adaptations and to further develop this. A new pilot scheme to employ and locate an Occupational Therapist within the Cambridgeshire Home Improvement Agency (Cambs HIA) in being undertaken.

Community equipment (ICES) and TEC work hand in hand with DFG to enable more innovative models of support.

The Integrated Community Equipment Service provides short- and long-term loans of equipment, ranging from simple walking aids, through to larger and more complex items, such as pressure relieving mattresses and hoists. Equipment may also be designed to help carers with the safer delivery of care. The service can also include installation, servicing and maintenance, depending on the type of equipment specified. This equipment plays an important role in diverting demand away from long-term care and support therefore more spend in this area is required in 2019-20. BCF partners will therefore collaborate to find a more sustainable solution for ICES funding and will also ensure that the cost of community equipment is factored into future business cases that focus on transferring care from the acute to community settings. The service continues to deliver health and social care equipment service to all age groups across Cambs & Peterborough and is a positive example of joint working between CCG and both local authorities. The provision of essential equipment can avoid the need for expensive packages of care and support – e.g. equipment to support single-handed care to avoid double-up packages of care.

The Technology Enabled Care (TEC) service continues to deliver interventions which reduce, prevent and delay the need for long term social care support and avoidance of health needs – e.g. prevention of admission to hospital, falls prevention, medication management etc. Through the BCF we will seek to expand the impact of TEC, moving to the point where it is a core part of care pathways and a key element of the support we offer at every stage of a service users' journey.

C) System level alignment, for example this may include (but is not limited to):

- **How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans;**
- **A brief description of joint governance arrangements for the BCF plan.**

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Our approach to integration under the BCF underpins the local vision and is aligned with local STP plans and health and wellbeing priorities. As a system we have a strong vision and leadership commitment to integration.

The 5-year Sustainability & Transformation Project (STP), *Fit For the Future*, sets out a single overall vision for health and care for Cambridgeshire and Peterborough, including:

•Supporting people to keep themselves healthy
•Primary care (GP services)
•Urgent and emergency care
•Planned care for adults and children, including maternity services
•Care and support for people with long term conditions or specialised needs, including mental ill health.

The STP seeks to improve the health and care of our local population and bring the system back into financial balance. To enable us to deliver the best care we can, we have agreed a unifying ambition for health and care in Cambridgeshire and Peterborough. This is to develop the beneficial behaviours of an 'Accountable Care System' (ACS) by acting as one system, jointly accountable for improving our population's health and wellbeing, outcomes, and experience, within a defined financial envelope. Through engagement with staff, patients, carers, and partners, we identified four priorities for change and underpinned by a 10-point plan to deliver these priorities.

Priorities for Change:

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

The **NHS Long Term Plan** is a key enabler for further progressing the integration journey for the local system, and includes:

- supporting people to age well

- increasing funding for primary and community care by at least £4.5bn
- bringing together different professionals to coordinate care better
- helping more people to live independently at home for longer
- developing more rapid community response teams to prevent unnecessary hospital spells, and speed up discharges home.
- upgrading NHS staff support to people living in care homes.
- improving the recognition of carers and support they receive
- making further progress on care for people with dementia
- giving more people more say about the care they receive.

These strategies will set out how we intend to take the ambitions that the NHS Long Term Plan details, and work together to turn them into local action to improve services and the health and wellbeing of the communities they serve – building on the work they have already been doing.

Cambridgeshire health and wellbeing strategy priorities:

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

Peterborough health and wellbeing strategy priorities:

1. Ensure that children and young people have the best opportunities in life to enable them to become healthy adults and make the best of their life chances
2. Narrow the gap between those neighbourhoods and communities with the best and worst health outcomes
3. Enable older people to stay independent and safe and to enjoy the best possible quality of life
4. Enable good child and adult mental health through effective, accessible health promotion and early intervention services
5. Maximise the health and wellbeing and opportunities for independent living for people with life-long disabilities and complex needs.

Governance

The existing governance oversight for the BCF sits with the respective Health and Wellbeing Boards for Cambridgeshire and Peterborough, who have delegated responsibility down to the joint Integrated Commissioning Board. Furthermore, a joint Peterborough and Cambridgeshire Health and Wellbeing Boards Executive Sub-Committee has been created for the purpose of approving BCF Plans for 2019-20 and monitoring performance going forward.

The BCF governance is integrated with the local STP governance structure. This is to ensure a consistent approach across the system. Local monitoring of performance and financial spend is overseen by the Integrated Commissioning Board, which has delegated responsibility for the BCF and iBCF from the Health and Wellbeing Board. The Integrated Commissioning Board meets monthly. Initiatives which are jointly funded with the STP are also monitored through the STP North and South Alliance Boards, which have health and social care system wide representation in attendance.

In addition, a system-wide steering group has been set up, meeting 6-weekly, to monitor and assess iBCF interventions and to perform "deep dives" on specific areas that demand greater scrutiny in order to inform plans for 2019/20 and monitor performance.

Our shared strategic ambitions are delivered through longstanding and mature partnership arrangements. The Sustainability and Transformation Partnership (STP) has established a multi-agency multi-level governance structure to deliver our system priorities. The STP Board contains NHS partner Chairs and CEOs as well as elected members and directors of Cambridgeshire County Council and Peterborough City Council.

Health and Well-being Boards (HWBs) provide the formal strategic leadership for health and social care services through two Boards – one for Cambridgeshire and for Peterborough. HWBs routinely meet jointly and include County Council/Unitary Authority (elected and Lead Officers), District Council representation, NHS provider representation, the CCG, the Police and Crime Commissioner, Healthwatch, with the voluntary sector co-opted.
The Health Scrutiny Committees review key areas of priority, for example, Delayed Transfers of Care. In addition, Scrutiny can effectively drill down via its 'topic' process into key issues where Members require greater levels of assurance. Most recently, Scrutiny examined issues such as workforce, patient transport and pressures on primary care services. Cambridgeshire and Peterborough Councils have an Adults Committee and a Communities and Adults Committee respectively that provide oversight of adult social care and a lead Portfolio holder for adults.

Six Place-Based Delivery Boards have recently been developed to provide operational leadership of a "whole system" partnership approach to the local delivery and implementation of "living well" health and wellbeing improvements, care model designs, service improvements and savings opportunities identified at a local and system level in the Health & Wellbeing Strategies, Public Health Priorities, Sustainability & Transformation Plan, and Better Care Fund. The Partnerships represent a wider community of stakeholders including patient representatives, Healthwatch, Local GP representatives, Primary Care Management Leads, NHS Trusts, District Councils, Public Health, the community & voluntary sector.

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

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

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

Finally, an Integrated Commissioning Board has the primary focus of providing oversight and governance of the Better Care Fund for Cambridgeshire and Peterborough.