CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD

Cambridgeshire County Council

Date:Thursday, 26 May 2016

10:00hr

Democratic and Members' Services
Quentin Baker
LGSS Director: Law, Procurementand Governance

Shire Hall
Castle Hill
Cambridge
CB3 0AP

South Cambridgeshire Council Chamber
South Cambridgeshire Hall, Cambourne Business Park, Cambourne, Cambridge, CB23 6EA

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1	**Election of Vice-Chairman/woman** *To be elected from the CCG representatives on the Board*	
2	**Apologies and Declarations of Interest** *Guidance for Councillors on declaring interests is available at http://tinyurl.com/ccc-dec-of-interests*	
3	**Minutes – 17th March and 21st April 2016**	**5 - 20**
4	**Minutes Action Log Update**	**21 - 24**
5	**Terms of Reference and Standing Orders**	**25 - 32**

THEME - PRIORITY 6 – Work together effectively – first meeting of municipal year

The Cambridgeshire Health and Wellbeing Board comprises the following members:

Councillor Daryl Brown (Chairman)Councillor Tony Orgee (Chairman)

Margaret Berry Councillor Mike Cornwell Councillor Sue Ellington Councillor Richard Johnson Dr John Jones Adrian Loades Chris Malyon Val Moore Dr Sripat Pai Liz Robin and Councillor Joshua Schumann Councillor Paul Clapp Councillor Mervyn Loynes Councillor Lucy Nethsingha and Councillor Joan Whitehead

For more information about this meeting, including access arrangements and facilities for people with disabilities, please contact

Clerk Name: Ruth Yule

Clerk Telephone: 01223 699184

Clerk Email: ruth.yule@cambridgeshire.gov.uk

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CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD: MINUTES

Date: **17th March 2016**

Time: **10.10 to 13.00**

Place: **Council Chamber, East Cambridgeshire District Council, Ely**

Present:

Cambridgeshire County Council (CCC)
Councillors P Clapp, L Nethsingha, T Orgee (Chairman) and J Whitehead
Adrian Loades, Executive Director: Children, Families and Adults Services (CFAS)
Chris Malyon, Section 151 Officer
Dr Liz Robin, Director of Public Health (PH)

District Councils
Councillors M Cornwell (Fenland) and R Johnson (Cambridge City),

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
Dr Sripat Pai

Healthwatch
Val Moore

Voluntary and Community Sector (co-opted)
Julie Farrow

Apologies: Councillors D Brown (Huntingdonshire), S Ellington (South Cambridgeshire) and J Schumann (East Cambridgeshire); Dr J Jones (CCG)

186. INTRODUCTION AND DECLARATIONS OF INTEREST

The Chairman welcomed all present. There were no declarations of interest.

187. MINUTES – 14th JANUARY 2016

The minutes of the meeting of 14th January 2016 were signed as a correct record.

188. MINUTES ACTION LOG UPDATE

The Board received and noted the Action Log.

189. UPDATE ON CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST – STRATEGIC IMPACT AND DIRECTION

The Board received a report outlining the Cambridge University Hospitals NHS Foundation Trust (the Trust, CUHFT) Improvement Plan for quality improvement. This had been drawn up in response to the Care Quality Commission's (CQC's) inspection report following an inspection in April and May 2015, which had led to CUHFT being placed in special measures. Members noted the structure of the plan, the supporting governance arrangements, and that the financial impact of the actions required under

each element of the plan had been taken into account. The Trust was confident that significant progress had already been made, and was awaiting the imminent publication of the report following CQC's mini-inspection in February 2016.

Discussing the report, Board members

- reported that Healthwatch Cambridgeshire had been able to support CUHFT in the post-inspection period, for example by Healthwatch volunteers helping in the gathering of feedback from a set of clinic patients; Healthwatch would be happy to continue to provide assistance

- welcomed the assurance that the Trust had confidence in the measures in place, and welcomed the improvements to date

- in response to a question about how the plan was dealing with the need to recruit sufficient nursing staff, were advised that
    - there was a welcome pause at national level in implementing a change in visa requirements for overseas nurses
    - the Trust would maintain larger banks of nurses, and rely less on agency staff, aiming to have the right nurse in the right place at the right time
    - there was a quality network through which all the local directors of nursing met regularly

- asked about progress with e-Hospital, and were advised that considerable improvements had been made; the Trust was monitoring to ensure that there were no issues obviously affecting patient safety, and was aware of a need to improve the quality of letters sent out to GPs

- reported that the CCC Health Committee had undertaken scrutiny of the quality of the Trust's services

- noted that, rather than each local NHS organisation putting its own plan to its own regulator, under the System Transformation Programme [see also agenda item 12, minute 197] all the providers would be submitting a joint plan, having agreed how to manage the financial resources as one system; it was expected that the system five-year plan would be put in to Monitor and NHS England (NHSE) by the end of June 2016

- noted that the Urgent and Emergency Care Vanguard would support CUHFT to build the necessary resilience in A&E services, though recruitment of A&E consultants was challenging locally

- requested an update on the availability of home births, following anecdotal reports that the shortage of midwives had made it difficult to accommodate requests for home births; the Deputy Director of Quality undertook to provide this

Action required

- sought reassurance that lessons had been learned from events at Addenbrooke's. Members were advised that plans were in place to address issues of finance, quality of care and leadership, and that Monitor was examining the Trust's finances daily; however, no certain assurance could be given that a similar situation would never happen again.

The Chairman reminded Board members that the Health Committee, in its Scrutiny function, was keeping events at CUHFT under review. A liaison group had been set up with Addenbrooke's and would be reporting back to the Health Committee.

The Board agreed unanimously to note the Trust's Improvement Plan for quality improvement, its progress to date, and continued commitment to addressing the issues raised by the CQC.

190. A PERSON'S STORY

The Board received a presentation from Dr Cornelia Guell of the Centre of Excellence for Diet and Activity Research (CEDAR). Dr Guell described the situations of three people: a child going alone to play in a park very close to home; a parent cycling as her regular means of transport round Cambridge; and a widow in her 70s who had recently lost her dog, but continued to keep active by walking round town. The stories aimed to show how people were using the environment for health and emotional wellbeing, and the problems that they encountered.

The Board noted the personal stories as context for the remainder of the meeting.

191. PROGRESS REPORT ON HEALTH AND WELLBEING STRATEGY PRIORITY 5

The Board received a report updating members on progress with the Health and Wellbeing Strategy Priority 5 – Create a sustainable environment in which communities can flourish. Members noted the progress that was being made with implementing the Transport and Health Joint Strategic Needs Assessment (JSNA) 2015, and with developing the New Housing Developments and the Built Environment JSNA 2016.

In the course of discussion, Board members

- reported that the Transport and Health JSNA was proving very useful, for example in successfully arguing the case to the Economy and Environment Committee for trial of a bus linking Barnwell to Addenbrooke's; the JSNA had shown that Barnwell was a very deprived area, where access to health was difficult for residents

- commented – in relation to the report and to the preceding Person's Story – that it was often external compulsion (such as the need to take the dog for a walk, or the cost of parking near the workplace) that spurred people into activity, and suggested that a question for the Board might be whether, as health advocates, members would be prepared to advocate unpopular policies as a way of encouraging healthy lifestyles and behaviours

- cited the example of children cycling daily to school in Cambridge because the alternative was spending time in traffic jams

- drew attention to the issue of safety in public spaces, with for example the reduction in the number of play rangers meant that there was less supervision of play areas, and asked how parents could be supported to feel more confident about letting their children play outside unsupervised

- speaking as a GP, commented on the importance of picking the time and motivation that was right for a patient who needed to be told, and act on, unwelcome information

- noted that work in Huntingdonshire to encourage more active lifestyles was being started; it would be necessary to work with CEDAR to map at ward level which the areas were that would require extra intervention. It was suggested that these findings should be supplied to the local weight management organisation as background information for when a resident sought its help

- reported that efforts were being made in Fenland to develop a Health and Wellbeing Strategy that would affect every officer of the council, encouraging them always to consider the wider wellbeing aspects of any subject. Every unit in the authority had been required to write a section of the strategy setting out how they would work to improve residents' health and wellbeing, an approach which was still at an early stage, but starting to be incorporated into officers' routine

- pointed out that adverse weather conditions and the condition of the roads, such as the prevalence of potholes, could act as disincentives to cycling

- drew attention to the need to change people's mindset and behaviour as well as the built infrastructure.

The Board noted the update.

192. CAMBRIDGESHIRE NEW HOUSING DEVELOPMENTS AND THE BUILT ENVIRONMENT JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

The Board received a report introducing, and seeking approval for, the New Housing Developments and the Built Environment JSNA for Cambridgeshire. Members noted that the JSNA focused on four aspects of new communities: the built environment, social cohesion and community development, assets and services, and NHS commissioning. The JSNA also looked at questions of current and future demography and the health needs of residents of new housing developments.

Discussing the draft JSNA, Board members

- welcomed the draft, describing it as an excellent JSNA and interesting to read

- commented on the frustration arising from the situation at several development sites where Section 106 monies had been allocated to primary healthcare but nothing had yet been spent

- noted that conditions for Community Infrastructure Levy and S106 funding were very strict, and that it could be difficult to bring all parties together to spend it; for example, it was up to a GP practice to decide whether it wished to expand

- suggested that it would be useful to have parts of the JSNA adopted as supplementary planning guidance to help local authorities in their negotiations with developers on the use of CIL and S106 funding

- pointed out that, as well as community centres, it was important that communities have spaces where people can come together, such a shops and open spaces

- noted that a county-wide health group had been established, originally for Northstowe but now extended to cover Cambridgeshire and Peterborough, and including membership drawn from CCC, CCG, NHSE, NHS estates, and developers; it would be very helpful if this group could work towards the development of links between the NHS and S106 funding

- commented on the apparently high figure (69% in Cambridgeshire and Peterborough) for the percentage of residents of new communities who had seen or spoken to a GP in the past six months; the Senior Health Improvement Specialist undertook to check this figure **Action required**

- drew attention to the influence of house design on family life, and the need to convey to developers that open plan accommodation was not always helpful, for example when children needed a quiet space for homework; space for a dining table was also important for families

- commented on the apparent beneficial effect on the longevity of people over the age of 75 of having walkable green spaces near their homes, pointing out that there was a correlation between poverty, deprivation, and ill-health, and suggesting that the beneficial effect of green spaces could be due at least in part to the greater disposable income of those who could afford to live near them. Officers advised that the statement in the JSNA was based on an American study

- reported that it appeared possible from recent announcements that proposals for a garden town development in Wisbech might be realised, and asked that they be taken into account when looking ahead

- drew attention to the lower levels of demand on children's services and of home ownership at Orchard Park than in other new settlements, and enquired whether this meant that there were fewer young families there than elsewhere

- suggested that it would be helpful if references to mental health could be brought together into a single section of the JSNA rather being scattered throughout it, and commented that social care services could be acting as a catch-net in new communities in the absence of other facilities.

- stressed the need to create a practical action plan, and to translate the JSNA into the Health and Wellbeing Strategy.

It was resolved unanimously to approve the JSNA, taking into account the comments made, and to note the findings and the areas which were highlighted for further work.

193. UPDATE ON TERMINATION OF OLDER PEOPLE AND ADULT COMMUNITY SERVICES CONTRACT

The Board received a report updating it on the independent internal investigation on the termination of the Older People's and Adult Community Services (OPACS) contract held between the CCG and UnitingCare LLP, which had been published on 10 March. Publication of the NHS England review was expected shortly, and the CCG was working with Healthwatch on a shared learning event to be held on 11 May 2016. The Chairman reported that the Health Committee, in its scrutiny function, had already considered the collapse of the contract on three occasions.

Members noted that the CCG review had highlighted a number of areas of difficulty. These included a fundamental mismatch between expectations of contract value and future funding; the number of questions of clarification outstanding at the point of signature; and a failure to identify the significance of the change of structure of UnitingCare from a consortium to a Limited Liability Partnership (LLP), or to obtain Parent Company Guarantees from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and CUHFT prior to the signing of the contract. The Health Committee had learned on 10 March that Monitor would have liked more time in which to review the business case before the contract started, but there had been local anxiety to have certainty for staff as to what their employment arrangements would be.

Discussing the report and review, one Board member said that, as an observer at the Health Committee, she had been struck by the fact of the 34 unresolved issues. Another member asked whether they had now been resolved. The Board was advised that the issues related to matters of concern to UnitingCare, and had been superseded by the ending of the contract. The learning point for the CCG was not so much the number of issues as the key nature of some of them. The CCG's Director of Corporate Affairs offered to circulate the list of 34 issues to Board members; these were not in the public domain, but had already been supplied to members of the Health Committee. **Action required**

Members noted that there would be a review of the various reports once they had all been published.

The Chair of Healthwatch said that she was impressed and encouraged by the way in which all parties were dealing with the consequences of the contract collapse. She confirmed that the CCG had acted promptly to reassure patients in that first week after the contract terminated, and to review workstreams. A well-attended meeting examining workstreams had been held three weeks previously: Healthwatch was keen to host the forthcoming learning event on 11 May.

The Board noted the report.

194. CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD DEVELOPMENT DAY – FEEDBACK FROM WORKING GROUP'S DISCUSSIONS

The Board received a report and presentation setting out initial proposals on changes to the Health and Wellbeing Board (HWB) membership. These had been developed by the working group established at the HWB meeting in November.

Speaking as Chair of the working group, Councillor Nethsingha said that there had been a remarkable degree of consensus in the group on both the problems and the potential solutions. The Board was seen as rather dominated by local government representatives and ways of conducting business, and would benefit from more NHS engagement. While the five District Councillors made a valuable contribution to the Board, because there was only one CCG for the whole county, there were fewer NHS representatives than was usual elsewhere. The working group's key proposal was therefore to reduce the number of elected Councillors on the HWB, and to allow representatives of NHS providers to become Board members.

Points made in the course of discussing the proposals included

- acknowledgement of the importance of improving the mix between Councillor and NHS representatives, and a welcome for the proposal that the Vice-Chair be a CCG representative

- while it was necessary to reduce the overall number of Councillor members, it would be difficult to achieve the right balance given the diverse nature of the various areas of the county; if the voice from the district authorities became inadequate, for example by reducing their representatives to one, then there was a risk that their voice in the district public health agenda would be undermined

- the links between Local Health Partnerships (LHPs) and the HWB were inadequate, and District members of the Board did not necessarily attend meetings of their LHP; it was necessary to clarify how LHPs should feed into the HWB

- given the developing importance of LHPs and that they were district-based and often chaired by District Councillors, consideration should be given to appointing the Chairs of the five LHPs to the Board. This would automatically ensure that each district of the county was represented

- another route for involving LHPs might be to encourage them to work together with the integrated care boards (which had been set up by UnitingCare)

- the report had not set out a clear rationale for why reorganising the Board would make it work better, or why the number of elected Councillors should be halved; a smaller reduction in their number should be considered

- for CCG officers, attending HWB meetings could feel like attending a scrutiny committee. Meetings had the potential to be a good forum for difficult and wide-ranging conversations; the main providers should be welcomed as HWB members

- the terms of reference for the HWB and for the Health Committee in its scrutiny function were very different; scrutiny had deliberately not been included in the functions of HWBs laid down by legislation

- attendance of NHS representatives at Board meetings under current arrangements had not always been good; changing HWB composition would not necessarily be sufficient on its own to increase Health participation in its meetings. It was noted however that NHS England was under considerable pressure nationally, and had stated that it would only attend meetings of Health and Wellbeing Boards for specific business that affected NHSE

- comments by Councillors on the working of the HWB had in the past included that the discussions had covered interesting and useful topics, but could feel completely irrelevant to current problems

- it had proved impossible to convene a meeting of the District Council Member Forum. The Senior Health Improvement Specialist undertook to send the presentation of the working group's recommendations to Forum members and seek their views. **Action required**

The Director of Public Health explained that the intention was to develop the working group proposals further, taking account of comments at the present meeting. It was

important both to consider potential changes thoroughly and to implement changes at the start of the municipal year, in May. The Constitution and Ethics Committee would be invited to consider suggested changes to the CCC Constitution at its next meeting on 5 April*, and the Public Service Board would consider them on 13 April. At its special meeting on 21 April, the HWB would then consider and approve the proposal to be submitted to CCC's Annual Council on 10 May 2016.

It was resolved

1) to endorse four of the five working group's recommendations for potential changes to the Cambridgeshire Health and Wellbeing Board set out in the appendix of the report before the Board, namely
    b) Invite 5 representatives for providers (mix of influential non-executive directors and executives)
    c) Co-chair or vice-chair arrangements with CCG
    d) Board-to-board meetings with Peterborough, explore joint programmes of work
    e) Strengthen links with Local Health Partnerships – Integrated Care Boards?

2) to mandate the working group to carry out further consultation and continue work on its recommendations, paying particular attention to the concerns expressed about recommendation a), Reduce from 5 County Councillors and 5 District Councillors to 5 elected Councillors (County and District) in total

3) to mandate the working group to develop one or more sets of proposals for the Board to consider at its meeting on 21 April.

The Chairman thanked the working group for its continuing efforts.

195. PLANNING FOR THE BETTER CARE FUND 2016-17

The Board received a report updating it on the Better Care Fund (BCF) planning process for the coming year. Officers apologised for the late circulation of the report and draft BCF Plan for 2016/17, and invited members to comment on the draft after the meeting. The draft plan was being submitted on 21 March, and would be subject to feedback from NHS regional organisations. This draft of the plan would then be circulated to members for comment, and the final draft of the BCF Plan would be discussed at a special meeting of the Board on 21 April 2016. **Action required**

The CCG's Integration Lead said that the CCG was keen to proceed with the delivery of the BCF Plan. She would be working with Local Authority colleagues in both Cambridgeshire and Peterborough; non-elective hospital admissions were continuing to increase, and it was essential that all parties work together in an integrated way, as would be set out in the Sustainability and Transformation Plan [minute 197 refers].

The Chairman thanked officers for their report, saying that the Board was well aware of the short timescales imposed by the BCF submission process; the Board had already drawn attention to this, as reported in the previous meeting's Action Log.

The Board noted the Better Care Fund plan and approach for 2016/17.

196. CLINICAL COMMISSIONING GROUP OPERATIONAL PLANNING FOR THE FINANCIAL YEAR 2016-17

The Board received a report briefing it on the changing context for planning, and progress being made with drafting an Operational Plan for 2016/17. Members noted that the CCG had received an increase in resource of 4.7% for the coming year, and had to plan for efficiency savings of 4.5%. The Plan was being developed in the context of transition to multi-year system planning, with the five-year Sustainability and Transformation Plan also under development. The CCG was required to submit the final version of its Operational Plan to NHS England by 11 April 2016.

The Board noted the content of the report.

197. UPDATE ON SYSTEM TRANSFORMATION PROGRAMME AND FIT FOR THE FUTURE, SUSTAINABILITY AND TRANSFORMATION PLAN

The Board received a report updating it on the progress of the System Transformation Programme. Members noted that national shared health and care planning guidance had been issued in December, which the local health system was already working to. This was reflected in the recently-published document *Fit for the Future* introducing the new clinically-led programme of work to transform the health and care system in Cambridgeshire and Peterborough. Attention was drawn to a diagram of the governance structure for Fit for the Future appended to the report, which showed all areas of work being brought together and reporting to the Clinical Advisory Board.

In the course of discussion, Members

- suggested that The Queen Elizabeth Hospital King's Lynn (QEH) might usefully be included in developing the programme because of the importance of QEH for the Wisbech area. CCG officers advised that a memorandum of understanding was being developed between Norfolk CCG and Cambridgeshire and Peterborough CCG, in recognition of the need to work together across county boundaries; Wisbech was acknowledged to be an area of high deprivation, where demand for primary care services had increased greatly

- asked whether it was possible to deliver the standard of health service sought, given the financial constraints under which the system was expected to work. In reply, the old saying 'we're short of nothing that we've got' was quoted, and it was pointed out that the overall health of the population continued to improve; looking at matters the other way round, the question should perhaps be how to get the best health value from the money available. It was necessary to think about how everybody saw their own health, and how they accessed health services

- drew attention to the national planning guidance that working together would bring value, improving both the quality of care and NHS finances; the local system had much to gain from working together to achieve synergy and improve care quality

- noted that local health planners were in conversation with NHS regional planners about anticipated changes in population numbers in Cambridgeshire and about the use of services in new communities.

The Director of Public Health reminded Members that the Health and Wellbeing Board under legislation was an executive partnership board, representing a partnership between the Local Authority (LA) and the NHS. Unlike some other parts of the region, where health system planning areas followed hospital boundaries, the local area coincided with LA boundaries, and so with those of the Cambridgeshire and Peterborough HWBs; this greatly enhanced the boards' opportunities to be involved in health planning.

Board members were reminded that submission of the Sustainability and Transformation Plan formed part of a process to bid for extra funding to further the work of transformation. The Plan would be assessed as a plan and as a demonstration of how the local health system was working; anything Board members could do to encourage good system working would help the bid for funding.

It was resolved unanimously to note the direction of Fit for the Future as well as the CCG's Sustainability and Transformation programme for 2016/17 and beyond.

198. FORWARD AGENDA PLAN

The Board noted the forward agenda plan. Members were invited to send any comments on the plan to the Democratic Services Officer.

199. DATE OF NEXT MEETING

Board members noted the date of the Board's next two meetings:

- 2pm on Thursday 21st April 2016, at Shire Hall, Cambridge CB3 0AP
- 10am on Thursday 26th May 2016, at Bargroves Centre, Cromwell Road St Neots PE19 2EY

Chairman

* Post-meeting note (minute 194): the date of the Constitution and Ethics Committee was subsequently changed from 5 April to 19 April 2016.

CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD: MINUTES

Date: **21st April 2016**

Time: **14.00 to 15.30**

Place: **Kreis Viersen Room, Shire Hall, Cambridge**

Present: Cambridgeshire County Council (CCC)
Councillors P Clapp, M Loynes, L Nethsingha, T Orgee (Chairman) and J Whitehead
Charlotte Black, Service Director: Older People's Services and Mental Health, Children, Families and Adults Services (CFAS) (substituting for Adrian Loades)
Dr Liz Robin, Director of Public Health (PH)

District Councils
Councillors D Brown (Huntingdonshire) and R Johnson (Cambridge City

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
Cath Mitchell (substituting for Dr Sripat Pai)

Healthwatch
Val Moore

Voluntary and Community Sector (co-opted)
Julie Farrow

Apologies: Councillors M Cornwell (Fenland), S Ellington (South Cambridgeshire) and J Schumann (East Cambridgeshire); Dr S Pai (CCG); M Berry (NHS England); A Loades (Executive Director, CFAS, CCC) and C Malyon (Section 151 Officer, CCC)

200. DECLARATIONS OF INTEREST

There were no declarations of interest.

201. MEMBERSHIP OF THE CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD

The Board received a report setting out options for change to the Health and Wellbeing Board (HWB) membership. These had been developed by the working group established at the HWB meeting in November, and discussed by the HWB in March and by the Cambridgeshire Public Services Board in April.

At its meeting on 17th March, the HWB had already agreed four of the five changes proposed:

b) Invite 5 representatives for providers (mix of influential non-executive directors and executives)
c) Co-chair or vice-chair arrangements with CCG
d) Board-to-board meetings with Peterborough, explore joint programmes of work
e) Strengthen links with Local Health Partnerships – Integrated Care Boards?.

The difficulty had lain with the first proposal, to reduce local authority HWB membership from 5 County Councillors and 5 District Councillors to 5 elected Councillors (County and District) in total.

Members noted that the CPSB, composed of experienced chief executives from public sector organisations, had confirmed that there was no easy answer. There had been a helpful discussion of HWB membership by the CCC Constitution and Ethics Committee at its meeting on 19th April; the Committee had concluded that the Board should discuss the options, and had delegated authority to the Monitoring Officer, in consultation with the Chairwoman and Vice-Chairman of the Constitution and Ethics Committee and Chairman and Vice-Chairman of the Cambridgeshire Health and Wellbeing Board, to recommend the final proposed membership changes to full Council on 10th May 2016.

Comments at the Constitution and Ethics Committee meeting had been generally supportive of making changes to Board membership, and of retaining five District Councillors. It had been suggested that it might be appropriate to appoint Chairs or Vice-Chairs of the relevant policy and service committees as CCC Board members, and perhaps the Leader and Deputy Leader of CCC; there was also support for appointing the chairs of Local Health Partnerships. It was also clarified that the HWB should not engage in scrutiny, because this was carried out by the Health Committee.

Members noted the proposed options for Councillor membership of the Board:

- Option 1: existing Councillor membership to remain, perhaps increasing CCG membership by one
- Option 2: reduce to four County Councillors and one District Councillor
- Option 3: reduce membership to three County Councillors, but remain with five District Councillors

and also noted the suggestion that the Board hold a development day in June to talk about new ways of working as a Board.

Emailed comments from Councillors Cornwell and Whitehead were read; the points they made included that

- having one District Councillor on the Board had been unsatisfactory in the past; one District representative could not speak for five very different districts, and Option 2 was therefore unacceptable
- even if Integrated Care Boards were to come into existence locally, it was not certain that they would adequately reflect the whole spectrum of health and care
- having a slightly larger Board would not be a problem; District members had been diligent and useful attenders, and their number should not be reduced, neither should the number of County members, where it was important to have a political balance of members under a hung Council
- if Option 3 were to be adopted, the three County members should be either the chairs of the three relevant committees (Adults; Children and Young People; Health) or members of and nominated by those committees.

It was noted that not all chairs of Local Health Partnerships were Councillors.

Speaking as both a member of the Constitution and Ethics Committee and chair of the HWB working group, Councillor Nethsingha said that she would not have any difficulty with maintaining the current number of Councillors on the Board. The starting point of the working group had been that conversations around the Board needed to be more robust and involve more people. Since the group had concluded its work, some strong feedback had been received, particularly from the NHS, about the value of

having all five districts represented on the Board, and following conversations after the Constitution and Ethics Committee, she had also come to agree with retaining five County Councillors.

Other comments in the course of discussion included that

- the CCG was very supportive of the proposal to widen Board membership

- Integrated Care Boards did not yet exist in Cambridgeshire; they were still under discussion, but would perhaps be known by a different name

- Option 1 was the best because it would retain representation from all the Districts, despite the resulting Board being perhaps rather large for difficult discussions

- It was very important to define how the Board functioned; because of the constant changes in the health and wellbeing environment, it was necessary to utilise the help available from such sources as the Local Government Association (LGA), and to look at best practice from other HWBs to see how they tackled the challenges, perhaps utilising peer review

- the development day in June could be a good time to invite somebody to attend from the LGA to attend in relation to best practice and peer support; the day would also provide an opportunity to look at the Board's work in relation to the new Health and Wellbeing Strategy.

The Chairman stated that the Districts each had their own characteristics and priorities, and he did not support reducing the number of their members on the Board. As the Board was a committee of the County Council, it was inappropriate for it to have fewer County than District Councillor members. He therefore supported retaining five County and five District Councillors. This view was supported by the Board by acclamation.

Members went on to consider whether they wished to indicate to Council a view on who those Councillors should be. Points made included that

- it would be useful if District members had a link into the Local Health Partnerships, and prudent to have a link into the County committees
- there was a requirement for HWBs to join up public health, NHS and social care functions, which were executive streams of work for which the three committees were responsible; despite the county officer membership of the Board, there was a lack of a clear Councillor link to the Adults Committee
- it would be better to leave matters as they were, and not be too prescriptive; under the Committee system of governance, the chair's function was to chair meetings, and he/she could not speak for the Committee
- perhaps the Board could offer a sentence supporting nomination of members to the Board who would contribute to its work.

The Chairman summed this up as wishing to offer Council gentle guidance as to whom it would be helpful to have as Board members.

The Board went on to consider a suggestion that it recommend amendment of its standing orders. This question had not been included in the report, but identified when it had been realised that the absence of the Vice-'Chairwoman meant that it would have been impossible, under the present standing orders, to hold a valid meeting of the Board had anything happened to prevent the Chairman's attendance. Members noted that under the current terms of reference, the quorum was five, to

include the Chairman/woman or Vice-Chairman/woman. A larger Board perhaps required a larger quorum, and usual practice for Council committees was that in the absence of Chair and Vice-Chair, those members present selected a temporary chairman/woman for the meeting.

The Chairman proposed, and the Board agreed, to recommend to Council that the quorum be amended to eight, and that Standing Orders be amended to remove the requirement that Chair or Vice-Chair be present and allow the nomination of a temporary Chair.

It was resolved:

a) to agree that the Board's preferred option was Option 1, as set out in section 3 of the report before the Board, under which the existing Councillor membership of the Board would remain at 5 County Councillors and 5 District Councillors

b) to agree the proposal to organise a development session in June 2016 to develop future ways of working, as set out in section 4 of the report.

202. BETTER CARE FUND PLAN 2016-17

The Board received a report setting out the background to the Better Care Fund (BCF) plan for 2016/17 and updating members on further areas for development in the plan. Attention was drawn to the requirement to submit the final BCF plan by 3rd May 2016, and the request for a delegation to the Director of Public Health in consultation with the Chair and Vice-Chair of the Health and Wellbeing Board for completion and approval of the templates.

Members noted that

- the BCF continued to involve creating a joint budget to help health and social care services to work more closely together in each Health and Wellbeing Board area
- the plan was being drawn up in a different environment from that of the previous year, largely as a result of the termination of the UnitingCare contract for the delivery of Older People and Adult Community Services (OPACS)
- the majority of the BCF spending remained within mainstream services, but efforts had been made to set out more clearly which service areas the BCF would be supporting in 2016/17
- for 2015/16, a target of 1% had been set, but not achieved, for the reduction of non-elective admissions, so a fresh look had been taken at what was being done to support the aim of keeping people out of hospital and not needing support from social care services
- a large part of the plan involved the creation of and effective working of integrated teams involving all local partners to offer home-based services and intensive rehabilitation services
- the target for 2016/17 was based on CCG operating plans; the final target figure was not yet known but due to be received from NHS England shortly
- feedback on the draft version submitted on 21 March had been relatively positive; the reason for the 'not assured' rating had been largely because the draft had been unable to include final figures and targets

- the plan for 2016/17 was to be assessed in the context of the local health and care economy, and the risks the local system was facing. The rating would reflect these local conditions.

The Board went on to consider the draft plan as presented in appendices to the report. Points raised and noted in the course of discussion included

- whatever was done to develop the best possible plan, local financial circumstances meant that it would be signed off 'with support' (rather than not being signed off, or being signed off as assured); regionally, no plans had been signed off as assured

- a 5% target for reducing non-elective admissions was ambitious, particularly by contrast with the previous year's unachieved 1% target, and in the light of reduced financial resources; setting such a target could be a recipe for failure

- unlike last year, there was one target across the whole system, and this ambitious target would be contained within other relevant plans; therefore the BCF plan would be likely to be rejected if it were to contain a different target

- the requirement to align figures across the health system was setting up the whole system for a budget deficit, because they appeared to reflect the amount of funding available rather than being aligned with actual need.

  The Director of Public Health raised and undertook to look into the questions of whether the figures used for the BCF applied to both Cambridgeshire and Peterborough together, as the Cambridgeshire and Peterborough CCG would have submitted one figure, and of whether the figures assumed inbuilt growth

- the BCF was not the only mechanism involved in delivering the target, there was also the Urgent and Emergency Care Vanguard, and the five-year Sustainability and Transformation Plan

- it was important fully to engage with primary care, and to encourage people to access primary and urgent care services appropriately, to reduce the number of people simply turning up at hospital emergency departments

- if somebody was actually admitted to hospital on a non-elective basis, it was because there was a problem that required admission

- efforts were being made to offer early intervention to as many people as possible, in order to avoid them reaching the point where admission was required; it was more cost-effective to invest in lower-end services than spend on hospital care

- the aim of making savings by diverting people to other services required prior investment in those services in order to be successful

- investment was being undertaken in the community, including in neighbourhood teams, which had been in place since October 2015. It had been decided to invest heavily in these teams through the BCF, realigning resource in health, social care and the voluntary sector to support the teams to work in a different, more proactive way. It was not a question of cutting services, but of intervening earlier so that people did not need to go into hospital

- the new teams in place needed workforce development. This included workforce development for voluntary organisations, which were vital to the success of these teams and plans; Care Act training for example had included the voluntary sector free of charge. The CCG's representative on the Board acknowledged the point and undertook to convey it to the CCG

- the content of the 2016/17 plan was very similar to that of the previous year's plan, because there had been considerable delay in implementing some of the targets following the end of the UnitingCare contract; anything the Board could do to keep up the momentum for progress would be very helpful

- it had emerged from the aftermath of the OPACS contract that some of the data sharing anticipated had not taken place, which raised the question whether the data sharing being sought by the BCF plan would in fact occur

- Oneview, part of the UnitingCare plans, was not now going ahead, so work was being done on how to link in with neighbourhood teams, including checking what consents would be required for elements of data it was proposed to share. The result arrived at would not be one big technical solution; there was much that could be done within existing systems

- it had been a CCG decision not to proceed with Oneview; GPs had judged that Oneview was not going to provide information that could be viewed by everybody and could give the outcome that had been sought

- a common information hub was being created for the public, which would provide consistent information by whatever route the hub was accessed; anything the Board could do to support the delivery and implementation of these changes would be helpful

- the Health and Wellbeing Board was responsible for the actual Better Care Fund plan, but the targets were system-wide and the responsibility of several bodies.

It was resolved to:

- delegate authority for completion and approval of the Better Care Fund templates to the Director for Public Health in association with the Chair and Vice-Chair of the Health and Wellbeing Board.

203. DATE OF NEXT MEETING*

Board members noted the date of the Board's next meeting:

- 10am on Thursday 26th May 2016, at Bargroves Centre, Cromwell Road St Neots PE19 2EY

Chairman

***POST-MEETING NOTE**
The venue for the next meeting (still at 10am on 26th May) has been changed to **South Cambridgeshire Hall, Cambourne.**

HEALTH & WELLBEING BOARD MINUTES ACTION LOG AND UPDATES FROM 17 MARCH AND 21 APRIL 2016

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
120. Better Care Fund	Updated Terms of Reference document for Cambridgeshire Executive Partnership Board to be brought to a future Health and Wellbeing Board meeting. **Action: G Hinkins / R Yule** **UPDATE:** On HWB Agenda Plan as to be scheduled.	**COMPLETED**
136. Addressing the Findings of the Transport and Health JSNA	This JSNA to be sent to the Leaders of the County Council, Cambridge City Council, and South Cambridgeshire District Council **Action: I Green** **UPDATE:** The JSNA has been raised at Cambridgeshire Public Service Board (CPSB); officers have worked with District Councils to arrange briefings to their management teams and/or members. The Director of Public Health has attended the Huntingdonshire District Council management team to provide a briefing on the JSNA and discuss next steps.	**COMPLETED**
149. Progress on HWB Priority 4	Circulate a briefing to HWB members on the work being done on universal credit and provision of support in benefits sanction cases in Children, Families and Adults Services (CFA) and in the District Councils **Action: A Loades/ I Green** **UPDATE:**	**ONGOING**
164. HWB Strategy – Priority 1	The Service Director undertook to find out more about FACET's (Fenland Area Community Enterprise Trust's) provision of courses for people with autism and convey the answer to the Member reporting that these courses had ceased. **Action: M Teasdale** **UPDATE:** Enquiries continue; the findings will be reported to the Member once a reply has been received from FACET.	**ONGOING**
180. Community Resilience Strategy	The Board's District Council support officer undertook to liaise with the Service Director on local planning in South Cambridgeshire, with the aim of avoiding duplication and identifying gaps in what was in place **Action: S Ferguson/I Green**	**ONGOING**

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
	UPDATE:	
181. Older People's and Adult Community Services (OPACS) Contract	The CCG Chief Strategy Officer and the Executive Director: CFAS were examining various issues including Doddington Court; Chief Strategy Officer to share his response to the Executive Director with Councillor Cornwell **Action: A Loades** **UPDATE:** Termination of OPACS contract on agenda for 26 May (agenda item 9)	**ONGOING**
189. Update on Cambridge University Hospitals NHS Foundation Trust – Strategic Impact and Direction	The Deputy Director of Quality, CCG, to provide an update on the availability of home births **Action: K Handscomb** **UPDATE:** The CCG Director of Quality; Nurse Member has confirmed that all the CCG's providers provide support for home births and the availability of home births is not a problem for Cambridgeshire residents	**COMPLETED**
192. Cambridgeshire New Housing Developments and the Built Environment JSNA	The Senior Health Improvement Specialist to check the apparently high figure (69% in Cambridgeshire and Peterborough) for the percentage of residents of new communities who had seen or spoken to a GP in the past six months **Action: / I Green** **UPDATE:**	**ONGOING**
193. Update on termination of OPACS Contract	The CCG's Director of Corporate Affairs to circulate the list of 34 issues to Board members **Action: J Bawden** **UPDATE:** List has been circulated	**COMPLETED**
194. HWB Development Day – feedback from working group's discussions	The Senior Health Improvement Specialist to send the presentation of the working group's recommendations to District Council Member Forum members and seek their views. **Action: I Green** **UPDATE:** Working group's recommendations refined in discussion at HWB on 21 April and revised terms of reference and standing orders agreed by Council on 10 May 2016.	**COMPLETED**

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
195. Planning for the Better Care Fund 2016-17	Draft of Plan to be circulated to members for comment and final draft of the BCF Plan to be discussed at a special meting of the Board on 21 April 2016 **Action: G Hinkins** **UPDATE:** Draft circulated and final plan signed off by the Director of Public Health in association with the Chair and Vice-Chair of the Health and Wellbeing Board, in accordance with delegated authority from HWB meeting on 21 April.	**COMPLETED**
201. Membership of the Cambridgeshire HWB	Recommend the Board's preferred option to Council **Action: A Lynes / R Yule** **UPDATE:** Council agreed the proposed changes to the HWB's terms of reference and standing orders at its meeting on 10 May 2016 – see Item 5 on HWB agenda for 26 May	**COMPLETED**
	Organise a development session in June 2016 to develop future ways of working **Action: A Lynes** **UPDATE:** Development session arranged, provisionally for Tuesday 14 June	**COMPLETED**

Agenda Item No. 5

TERMS OF REFERENCE AND STANDING ORDERS

To: Health and Wellbeing Board

Date: 26th May 2016

From: Ruth Yule, Democratic Services Officer

1.0 PURPOSE

1.1 To present its revised terms of reference and standing orders to the Health and Wellbeing Board (HWB).

2.0 BACKGROUND

2.1 On the recommendation of the County Council's Constitution and Ethics Committee, the County Council approved revisions to the Cambridgeshire HWB's terms of reference (Appendix A) and standing orders (Appendix B) at Annual Council on 10th May 2016.

2.2 The changes had been developed by the working group established at the HWB meeting in November, and discussed at subsequent HWB meetings. The Constitution and Ethics Committee had also considered the proposals because they involved changes to the Council's Constitution.

3.0 MAIN ISSUES

3.1 The revisions are to the membership of the HWB and to arrangements for chairing its meetings.

3.2 The membership has been increased by the addition of a third representative of the Clinical Commissioning Group (CCG) and of five representatives from NHS providers (see Appendix A). Other elements of the terms of reference are unchanged.

3.2 Instead of electing 'a Vice-Chairman/woman who will not represent the County Council', the HWB will now elect 'a Vice-Chairman/woman who will be drawn from the Clinical Commissioning Group representatives on the Board', and the requirement to have either the Chair or Vice-Chair present in order for a meeting to be quorate has been removed (see Appendix B paragraph 3). The quorum has been increased from five to eight, to reflect the increased number of Board members (Appendix B paragraph 4).

4.0 RECOMMENDATIONS

4.1 The Cambridgeshire HWB is asked to note its revised terms of reference and standing orders, as incorporated in the County Council's Constitution with effect from 10th May 2016.

Source Documents	Location
Reports to and minutes of: Health and Wellbeing Board November 2015 to April 2016 Constitution and Ethics Committee 19 April 2016 County Council 10 May 2016	 http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/Committee.aspx?committeeID=70 http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=13166 http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=13206

Appendix A

12. CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD

Introduction

The Cambridgeshire Health and Wellbeing Board (HWB) is established as a committee of the County Council under section 102 of the Local Government Act 1972. Its remit is to work to promote the health and wellbeing of Cambridgeshire's communities and its focus is on securing the best possible health outcomes for all residents.

Membership

- 5 County Councillors
- 5 nominated District Council representatives
  (supported by Senior District Council officer with Observer Status)
- 3 representatives of the Clinical Commissioning Group (CCG)*
  (nominated by the CCG Governing Body)
- 5 representatives for NHS providers (a mix of non-executive directors and executives, one each from Cambridge University Hospitals NHS Foundation Trust; Cambridgeshire and Peterborough NHS Foundation Trust; Cambridgeshire Community Services NHS Trust; Hinchingbrooke Health Care NHS Trust; Papworth Hospital NHS Foundation Trust)
- 1 representative of the local HealthWatch*
- Director of Public Health*
- Executive Director: Children, Families and Adults*
- Chief Finance Officer (Section 151 Officer)
- Representative of NHS Commissioning Board*

* Statutory members of the HWB. There is also a statutory requirement for at least one Local Authority Councillor, and at least one representative of the CCG, to be a member of the HWB.

Powers and functions

Delegated Authority	**Statutory Reference/ Condition**
Authority to respond to consultations about commissioning plans issued by clinical commissioning groups in connection with Section 26 of the Health and Social Care Act 2012	Section 26, Health and Social Care Act 2012
Authority to encourage persons who arrange for the provision of any health or social care services in the Council's area to work in an integrated manner	Section 195, Health and Social Care Act 2012
Authority to provide any advice, assistance and support it thinks appropriate for the purpose of encouraging the making of arrangements under Section 75 of the National Health Service Act 2006	Section 195, Health and Social Care Act 2012 Section 75, NHS Act 2006

Delegated Authority	**Statutory Reference/ Condition**
Authority to prepare the Joint Strategic Needs Assessment (JSNA)	Section 116, Local Government and Public Involvement in Health Act 2007 Section 196, Health and Social Care Act 2012
Authority to prepare the Joint Health and Wellbeing Strategy based on the need identified in the Joint Strategic Needs Assessment and overseeing the implementation of the Strategy	Section 116A, Local Government and Public Involvement in Health Act 2007. Section 196, Health and Social Care Act 2012
Authority to discharge any other functions specifically reserved to be undertaken by the Health and Wellbeing Boards as set out in legislation, guidance, circulars and directives received from national government.	

Appendix B

Cambridgeshire Health and Wellbeing Board (Standing Orders)

1. **Co-optees**

The Chairman/woman or the Board will be entitled to appoint, in consultation with the Board via e-mail, up to 3 people at any one time as non-voting co-opted members of the Board. The Board shall determine whether the co-options shall be for a specified period, for specific meetings or for specific items.

Co-options may only be made if the person co-opted has particular knowledge or elected expertise in the functions for which the Board is responsible, or knowledge/responsibility for a geographic or academic agenda issue.

2. **Notice of Meetings**

Meetings of the Board will be convened by the County Council, who will also arrange the clerking and recording of meetings (a member of the County Council's Democratic Services Team will act as Clerk).

3. **Chairmanship**

The appointment of the Chairman/woman will be determined by full Council at the annual general meeting, or at any subsequent meeting should the need arise; having regard to recommendations from the political Group Leaders.

The Cambridgeshire Health and Wellbeing Board will elect annually a Vice-Chairman/woman who will be drawn from the Clinical Commissioning Group representatives on the Board.

If the Chairman/woman and Vice-Chairman/woman are absent from a meeting, the Board members present will chose a person to preside for the meeting.

4. **Quorum**

The quorum for all meetings of the Board will be eight members.

5. **Appointment of Substitute Members**

Nominating groups may appoint a substitute member for each position. These members will receive electronic versions of agendas and minutes for all meetings. Notification of a named substitute member must be made in writing or by email to the Clerk. Substitute members may attend meetings after notifying the Clerk of the intended substitution before the start of the meeting either verbally or in writing. Substitute members will have full voting rights when taking the place of the ordinary member for whom they are designated substitute.

6. **Decision Making**

It is expected that decisions will be reached by consensus, however, if a vote is required it will be determined by a simple majority of those members present and voting. If there are equal numbers of votes for and against, the Chairman/woman will have a second or casting vote. There will be no restriction on how the Chairman/woman chooses to exercise a casting vote.

7. **Meeting Frequency**

The Board will meet ***at least*** four times a year.

In addition, extraordinary meetings may be called from time to time as and when appropriate. A Board meeting may be called by the Chairman/woman, by any three members of the Board or by the Director of Public Health if he/she considers it necessary or appropriate.

8. **Supply of information**

The Health and Wellbeing Board may, for the purpose of enabling or assisting it to perform its functions, request any of the following persons to supply it with such information as may be specified in the request—

(a) the local authority that established the Health and Wellbeing Board;
(b) any person who is represented on the Health and Wellbeing Board by virtue of section 194(2)(e) to (g) or (8) of the Health and Social Care Act 2012 ("the 2012 Act");
(c) any person who is a member of a Health and Wellbeing Board by virtue of section 194(2)(g) or (8) but is not acting as a representative.

A person who is requested to supply information under (a), (b) and (c) must comply with the request. Information supplied to a Health and Wellbeing Board under this section may be used by the Board only for the purpose of enabling or assisting it to perform its functions.

9. **Status of Reports**

Meetings of the Board shall be open to the press and public and the agenda, reports and minutes will be available for inspection at Cambridgeshire County Council's offices and on the County Council's website at least five working days in advance of each meeting. [This excludes items of business containing confidential information or information that is exempt from publication in accordance with Part 5A and Schedule 12A to the Local Government Act 1972 as amended.] Other participating organisations may make links from their website to the Board's papers on Cambridgeshire County Council's website.

10. **Press Strategy**

An electronic link to agendas for all meetings will be sent to the local media. Cambridgeshire County Council will be responsible for issuing press releases on behalf of the Board and dealing with any press enquiries. Press releases issued on behalf of the Board will be agreed with the Chairman/woman or Vice-Chairman/woman and circulated to all Board members.

11. **Members' Conduct**

Part 5 - Codes and Protocols of the County Council's Constitution applies to all elected and 'co-opted' members of the Board

http://www.cambridgeshire.gov.uk/info/20050/council_structure/288/councils_constitution

12. **Amendment of the Terms of Reference**

The Board may recommend variations to its Terms of Reference by a simple majority vote by the members provided that prior notice of the nature of the proposed variation is made and included on the agenda for the meeting.

13. **Governance and Accountability**

The Board will be accountable for its actions to its individual member organisations.

There will be sovereignty around decision making processes. Representatives will be accountable through their own organisations for the decisions they take. It is expected that Members of the Board will have delegated authority from their organisations to take decisions within the terms of reference.

Decisions within the terms of reference will be taken at meetings and will not normally be subject to ratification or a formal decision process by partner organisations. However, where decisions are not within the delegated authority of the Board members, these will be subject to ratification by constituent bodies.

It is expected that decisions will be reached by consensus.

Agenda Item No. 6

A PERSON'S STORY – THE HANDYPERSON SERVICE

To: Health and Wellbeing Board

Date: 26th May 2016

From: Liz Knox, Environmental Services Manager, East Cambridgeshire District Council

1.0 PURPOSE

1.1 To introduce the story being presented to the Health and Wellbeing Board.

2.0 BACKGROUND

2.1 The Cambridgeshire Health and Wellbeing Board have requested that a person's story be presented at the start of each meeting. The story being presented at this meeting will set out an individual's experience of accessing help through the Cambridgeshire Handyperson Service to carry out minor works to their home. The service is available to people aged over 65 years, or those with disability living in Cambridge City, South Cambridgeshire, East Cambridgeshire, Huntingdonshire and Fenland, and is the result of a countywide procurement process, which also included Cambridgeshire County Council.

2.2 The story is an illustration of how the Cambridgeshire Handyperson Service can help residents live safely at home. It aims to prevent falls and accidents by offering a free Personal Assessment, Home Safety Check and arranging for small jobs to be carried out. The Age UK Cambridgeshire and Peterborough Trusted Assessor provides relevant information about support services available, and where appropriate can recommend and arrange for improvements to be made to residents' homes by Age UK approved contractors.

3.0 SUPPORTING PARAGRAPHS

3.1 The Cambridgeshire Handyperson Service run by Age UK Cambridgeshire and Peterborough, started operating on 1st April and is the result of a joint procurement between Cambridgeshire County Council, the district and city Councils,

3.2 The aim of the service is to enable people to live in their own home more safely and securely. The handyperson service is an important resource to enable independent living creates a safe environment through early intervention by an accessible and appropriate service. This can range from prevention of falls, reducing admission to hospital or care homes, to maintenance of a decent housing stock

3.3 The following are the expected outcomes from the service:

- Enable people to maintain their independence in their home and improve their quality of life, health and wellbeing.
- Promote peace of mind and prevent dependence on health and social care services.
- Reduce the risk of falls, accidents, fire, emergencies and injuries in the home.
- Prevent delayed hospital discharge and repeat readmissions.
- Identify underlying social, relationship, environmental etc issues that may not have been recognised previously and signpost individuals to relevant support.
- Enable people to access other appropriate services.

4.0 LESSONS LEARNT

4.1 A report was brought to the Health and Wellbeing Board in April 2015, which outlined the learning from Handyperson task and finish group. This was 2 years after the group was originally set up. The key learning points were summarised as

- Do not underestimate the impact of other drivers on partners, but don't let that stop progress.
- Consider the process that will be required to secure funding and reflect this in a realistic timetable
- Consider what level of project management support is required and review this during the work
- When a process operated in one organisation is going to be used ensure that all partners understand all the stages of that process
- Make good use of materials from other local authority areas.
- Involve all partners in the design of all aspects of the work e.g. survey, specification, "method statements", partnership agreement, scoring bids.
- Involve people using who are or may use the service to inform what the service will deliver and how it will operate in the future.

4.2 Having worked through the issues that were encountered during the commissioning of the Handyperson Service, hopefully the outcomes will demonstrate that by working together there will be a more joined up service ensuring that the customer needs will be identified through the Home Safety Check assessment and they will be provided with the help and access to other services they need to enable them to remain in their own homes living independently.

5.0 OUTCOMES

5.1 The countywide Handyperson services were successfully commissioned and the service commenced on 1st April 2016, the core service is already making an impact, which can be demonstrated from the examples provided from the person's stories.

5.2 From 1st April to 2nd May a total of 59 Wellbeing and Home Check assessments have taken place, 51 of the assessments resulted in Handyperson works being completed, one third of the work completed was for grab rails.

5.3 In addition to the core service, a 7 day a week emergency service between the hours of 9am and 5pm to facilitate discharge from hospital has been introduced to date 7 emergency discharges have been completed. Four of these cases have also now had or will have the wellbeing and Home Check assessment.

6.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

6.1 This story relates to Priority Six of the Health and Wellbeing Board; Work together effectively

7.0 IMPLICATIONS

7.1 There are no direct implications arising from this report.

8.0 RECOMMENDATION/DECISION REQUIRED

8.1 The Person's Story is being told as context for the remainder of the meeting.

Source Documents	Location
Health and Wellbeing Strategy	http://www.cambridgeshire.gov.uk/info/20004/health_and_keeping_well/548/cambridgeshire_health_and_wellbeing_board

Agenda Item No. 7

APPROACH TO REFRESHING THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY 2012-17 AND REVIEW OF THEMED MEETINGS

To: Health and Wellbeing Board

Date: 26th May 2016

From: Dr Liz Robin, Director of Public Health

1.0 PURPOSE

1.1 To present options for refreshing the Cambridgeshire Health and Wellbeing Strategy 2012-17 and areas of focus.

1.2 To review the approach during 2015-16 of theming a section of each Health and Wellbeing Board meeting to one of the six priorities of the Cambridgeshire Health and Wellbeing Strategy.

2.0 BACKGROUND

2.1 The Cambridgeshire Health and Wellbeing Board (HWB) has a statutory duty to prepare a joint health and wellbeing strategy (JHWS), which meets the needs of the Joint Strategic Needs Assessments (JSNAs).

2.2 Section 116A of the Health and Social Care Act 2012 outlines the statutory function of joint health and wellbeing strategies:

(1) This section applies where an assessment of relevant needs is prepared under section 116 by a responsible local authority and each of its partner clinical commissioning groups (note: this means the JSNA)

(2) The responsible local authority and each of its partner clinical commissioning groups must prepare a strategy for meeting the needs included in the assessment by the exercise of functions of the authority, the national Health Service Commissioning Board, or the clinical commissioning groups ('a joint health and wellbeing strategy')

(3) In preparing a strategy under this section, the responsible local authority and each of its partner clinical commissioning groups must in particular consider the extent to which the needs could be met more effectively by the making of arrangements under section 75 of the National Health Service Act 2006 (rather than in any other way).

2.3 The Cambridgeshire Health and Wellbeing Strategy was approved by the Shadow Cambridgeshire Health and Wellbeing Board in October 2012. An interim update to the strategy was made and presented to the Cambridgeshire HWB in May 2015. The strategy will expire in September 2017.

2.4 The existing Cambridgeshire Health and Wellbeing Strategy focuses on the following six priorities:

- 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 while 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

3.0 POTENTIAL APPROACHES TO REFRESHING THE STRATEGY

3.1 A: Refresh the existing strategy

3.1.1 The existing Cambridgeshire Health and Wellbeing Strategy was widely consulted on during its development to ensure its focus and priorities were right for Cambridgeshire.

3.1.2 A light-touch refresh of the strategy took place in May 2015, to ensure the strategy took account of more recent JSNAs and delivery strategies in the health and care system.

3.1.3 A further refresh of the existing strategy could be an option for 2017 and beyond, ensuring demographics, contextual information, latest JSNAs and delivery strategies are updated and included. The focus and priorities of the 2012-17 strategy would however, remain.

3.1.4 A potential issue with this approach would be that the health and care system has changed significantly since 2012, and a light-touch refresh may not fully reflect this.

3.2 B: Rewrite the strategy using the same approach

3.2.1 A wide range of partners were engaged and consulted during the development of the existing strategy, including on the six priorities. However, the actual content of the strategy was largely written by Cambridgeshire County Council's Public Health team, in partnership with a small 'task and finish' group.

3.2.2 Although well received, one criticism of the existing strategy is that its six priorities are perhaps too broad and all encapsulating with less focus on planned actions.

3.3 C: the Peterborough approach

3.3.1 Peterborough's Health and Wellbeing Board has recently refreshed its joint health and wellbeing strategy.

3.3.2 The approach taken in Peterborough was for public health to propose the framework for the HWB Strategy based on needs identified in the JSNA and for the HWB to approve this framework. For each chapter a senior officer from the local authority, a senior officer from the NHS and a public health consultant was identified to co-write the chapter to an outline

template, which constrained the text to a one page summary. This enabled a brief, up to date description of current joint plans and priorities to be included in each chapter by senior officers working in that field, and therefore a more action focussed draft strategy to be agreed by the Health and Wellbeing Board for consultation with stakeholders and the public.

3.3.3 In Cambridgeshire, to ensure district council input, a senior district council officer could be tasked with building districts' perspectives into each chapter.

3.3.4 This co-authoring approach could ensure greater ownership of the strategy by key partners on the HWB.

4.0 EMERGING QUESTIONS

4.1 Focus of the strategy and JSNAs

4.1.1 The HWB has regularly acknowledged the high quality of Cambridgeshire's JSNAs.

4.1.2 At previous HWB meetings, and at development days, there has sometimes been a suggestion that the HWB's business does not always focus on the most pressing issues in the health and care system, such as the system pressures on health and social care services.

4.1.3 The focus of the JHWS should be on meeting the needs identified by the JSNAs. This refresh of the strategy presents an opportunity to review the focus of future JSNAs.

4.1.4 The HWB is asked to consider whether it recommends a future JSNA should focus on the pressures on the health and care system, therefore ensuring the refreshed strategy is focused on addressing this issue.

4.2 Sustainability and Transformation Plan

4.2.1 The leading national health and care bodies in England have come together to publish 'Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21', setting out the steps to help local organisations deliver a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances.

4.2.2 As part of this all NHS organisations are asked to produce a local health and care system 'Sustainability and Transformation Plan', which will cover the period October 2016 to March 2021.

4.2.3 The Cambridgeshire and Peterborough Sustainability and Transformation Plan will incorporate the work of its Urgent and Emergency Care (UEC) Vanguard Programme.

4.2.4 The Sustainability and Transformation Plan will be published before the end of the lifetime of the existing Cambridgeshire Health and Wellbeing Strategy 2012-2017. Therefore, the Sustainability and Transformation Plan must take into account the priorities of the existing strategy.

4.3 Focus for the HWB

4.3.1 The Cambridgeshire HWB has recently undergone changes to its membership. The HWB may wish to consider if the development of a refreshed joint health and wellbeing strategy should be a key focus for the HWB for the year ahead.

4.4 Local authority elections

4.4.1 Whichever approach to refreshing the strategy is taken, it will be important to ensure joint ownership of its aims and priorities.

4.4.2 As the current strategy was approved by the Cambridgeshire HWB in October 2012, the refreshed joint health and wellbeing strategy should be in place for October 2017.

4.4.3 It should be noted that county council elections will take place in May 2017, meaning county councillor membership of the HWB may change whilst work to refresh the joint health and wellbeing strategy is underway.

4.5 Next steps

4.5.1 It is suggested that these emerging questions, amongst others relating to ways of working as a board, are explored at a development day for the HWB in June 2016 (date TBC).

5.0 REVIEW OF THEMED MEETINGS

5.1 Background

5.1.1 At its meeting of 30 April 2015, the Cambridgeshire Health and Wellbeing Board (HWB) agreed to a proposal to theme a section of each HWB meeting to one of the six priorities of the Cambridgeshire Health and Wellbeing Strategy. The strategy's priorities are outlined at section 2.4 of this report.

5.1.2 The aim of focusing on each of these priorities in more detail was to ensure the HWB could explore the issues in each of these areas in more depth, whilst being kept up to date on delivery progress against each priority.

5.2 Format of themed meetings

5.2.1 The approach to themed meetings included:

- A person's story item at the beginning of each meeting, relevant to the meeting's theme, to set the context for the rest of the meeting
- Presentation of a standard template outlining contextual information around each priority, such as relevant Joint Strategic Needs Assessments (JSNAs) and key delivery strategies in the health and care system
- A more detailed report and discussion on relevant work in the system relating to each priority
- Grouping other relevant items on the HWB's forward agenda plan by theme/priority
- Inviting key partners to attend particular HWB meetings of interest, such as the Police and Crime Commissioner to the HWB meeting focusing on Priority 4

6.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

6.1 This paper relates to the refresh of the Cambridgeshire Health and Wellbeing Strategy.

7.0 IMPLICATIONS

7.1 There are no significant implications.

8.0 RECOMMENDATIONS

8.1 The Cambridgeshire HWB is asked to:

a) Consider approaches to refreshing the Cambridgeshire Health and Wellbeing Strategy, at the development day in June and report back to the next public meeting of the HWB in July.

b) Comment on the approach taken during 2015-16 of aligning a section of each meeting's agenda to one of the priorities of the Cambridgeshire Health and Wellbeing Strategy and agree if this approach should be continued for 2016/17.

c) Explore the emerging questions outlined in section 4, and other related issues, at the HWB's June development day (date TBC).

Source Documents	Location
Cambridgeshire Health and Wellbeing Strategy 2012-17	http://www.cambridgeshire.gov.uk/download/downloads/id/359/cambridgeshire_health_wellbeing_strategy_2012-2017
17 March HWB paper: Fit for the Future, Sustainability and Transformation Plan	http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=13064

SUSTAINABILITY AND TRANSFORMATION PROGRAMME UPDATE

To: Health and Wellbeing Board

Date: 26 May 2016

From: Catherine Pollard, Programme Director, NHS Improvement; Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough CCG

1.0 PURPOSE

1.1 To update the Board on the progress of the *Fit for the Future*, Sustainability and Transformation programme for the Cambridgeshire and Peterborough area, since the last report on 17 March 2016.

1.2 The work of the Fit for the Future programme supports the following JSNA priorities:
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 while 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

2.0 BACKGROUND

2.1 Cambridgeshire and Peterborough has reinvigorated its system-wide work to develop a shared strategy for a sustainable health and care system by 2020. The first major output of this work will be the Sustainability and Transformation Plan submission to NHS England and NHS Improvement on 29 June. The Plan will set out how each organisation in the system will need to work differently, and increasingly as if a single entity, in order to return the system to financial balance. The system's Boards have a key role to play in guiding this process towards the best set of system solutions.

2.2 This work will now be carried forward by the Sustainability and Transformation programme, overseen by the Health and Care Executive, whose membership includes the Cambridgeshire and Peterborough local councils' Chief Executive, Gillian Beasley, their Director of Public Health, Dr Liz Robin and Chief Executives of local NHS organisations. A clear governance framework has been developed and incorporates feedback from council colleagues (see appendix A).

3.0 SUMMARY OF PROGRAMME DEVELOPMENTS SINCE LAST MEETING

3.1 Sustainability and Transformation interim NHS England 'Check Point' report submitted 14 April

All NHS organisations are required to contribute to the development of a local Sustainability and Transformation Plan. This is a place-based, multi-year plan built around the needs of local populations. The Cambridgeshire and Peterborough system submitted an interim 'Check Point' report on 14 April 2016. This set out:

- How we would work together as a system to develop and deliver our Plan
- Our major areas of focus, and the decisions we need to make as a system
- Key local priorities for transformation through the remainder of the process.

Initial feedback received following the submission of Cambridgeshire and Peterborough's Check Point report has been positive.

3.2 **Key Priorities described within the Plan** (as described in the April Check Point)

The Health and Care Executive have made progress in describing a shared local vision to meet the health and wellbeing, care and quality, and financial challenges we face. A number of interdependent themes have emerged that will maximise our local population's health and user experience within a fixed budget. The emergent themes under consideration that could address the c. £250 million financial gap we will face by 2020/21 are:

1. **Empowered People and Engaged Communities.** Most factors and activity which determine health happens outside of the NHS direct sphere of influence. We will look to implement our local Prevention Strategy, adopt best practice for supporting self-care (e.g. peer support, health coaching) and use new housing developments and Healthy New Towns to build communities that promote activity in young people, and prolong independent living for the elderly.

2. **Primary Care.** As much care as possible will be primary care led. To achieve this, our GPs will need to work more closely with neighbourhood teams, including nurses, therapists, psychiatrists, social workers and pharmacists, to manage proactively the care for those with long-term conditions, the dying, care home residents or mental health service users. Patients identified as in need of this intensive support will receive tailored care packages aligned with their personalised care and support needs.

3. **Community Care Hubs.** To better use our limited resources we need modern, family and frailty friendly facilities where GPs and community staff work side by side to deliver care to larger populations, perhaps 30-50k, over time replacing much of outpatient care. The hubs could provide direct access to local diagnostics and specialist advice so they can diagnose more patients without the need to refer on.

4. **Responsive Urgent and Expert Emergency Care.** Acute care is an important but costly resource, so we must make sure those patients in an acute bed really need to be there and that they wait the minimum time for the next step on their care plan to be completed. To make this happen, we need to better coordinate urgent care using GPs, NHS 111, Neighbourhood Teams, Care Homes, Mental Health workers and empowering those individuals with long term conditions and their carers to self manage with support

from a case manager. A hub could coordinate the clinical responses from out-of-hours GPs, the admissions avoidance team (JET), mental health crisis teams, overnight sitting services, community IV antibiotic services and "Hospital@Home" services.

5. **Systematic and standardised planned care.** Evidence tells us that standardised care is higher quality and lower cost. As such, we have asked our clinicians to work together to develop a single set of care and treatment protocols that they can all use as the basis of care, including:
    - **Referral thresholds.** We need one set of clinical standards and referral criteria for all elective care services.
    - **Clinical scale.** We need services that are clinically safe and supported through clinical networks' 24/7 standards. The emergency centres we maintain will need to meet the government's 7 day services standards and the standards set out in the Keogh review.

6. **Partnership working**. None of us can be sustainable if we act alone – our financial challenge is too great. Collaboration will include:
    - **General Practice @ scale**. Our general practices are exploring how federations or partnerships might support long-term viability.
    - **Back office**. Rationalising overheads and support services, starting with HR, then procurement, will maximise potential savings.

    This plan will be underpinned by 4 key enablers:
    - **Workforce** – a new offer to staff so that they benefit from the new care models by acquiring new skills, having more flexibility or new opportunities
    - **Estates** – a review of estates to ensure any benefits are maximised
    - **QI** – a single system-wide capability for Quality Intelligence (QI) which supports an iterative approach to design/implementation/evaluation
    - **Digital and Health Informatics –** adopting of new technology to support self-care, remote care, paperless care and population analytics.

3.3 Update on Workstream activity

All clinical working groups have met to identify short-term opportunities for implementation during 2016/17. These opportunities have been discussed by the Clinical Advisory Group (18 April 2016) and recommendations have been signed off by the Health and Care Executive. Priorities include the falls prevention pilot, making most effective use of services such as the Joint Emergency Team (JET), and offering a multi-disciplinary response to those people who attend A&E frequently, potentially including case management.

A clinical working group focused on Sustainable Primary Care is being established, with support from the LMC. Dr David Roberts has been confirmed as the Clinical Chair. The first task of the group is to identify immediate opportunities that benefit GPs, local people and the system – a local response to the issues set out in the General Practice Forward View.

Over the next month, the clinical working groups will finalise the clinical standards and evaluation criteria to enable them to rank the options they've developed, ready to the Health and Care Executive for submission of our proposed plan at the end of June. We will be further updating the Health and Wellbeing Board at a development session in June. From July we have planned early engagement with the public from July 2016.

3.4 **Programme Governance**

Initial drafts of a Sustainability and Transformation Programme Governance Framework have generated comments from the Health and Care Executive, Provider Chairs, Local Authority Leads and the CCG Governing Body – see appendix A for the current framework. The Framework describes Cambridgeshire County and Peterborough City Councils as partners in this work, committed to planning health and social care in an integrated way, while simultaneously recognising the role of local authority councillors in scrutinising proposals for NHS service changes. The role of District Councils regarding housing and local planning is also recognised, especially since there is so much building development locally.

3.5 **Communication and Engagement Activities**

Cambridgeshire & Peterborough System Leadership Event 16 May. This was an opportunity for system leaders to learn more about the work underpinning the STP, including ideas emerging from the working groups. The aim was to ensure shared understanding among the senior leaders of the changes to care delivery and support services required to return the Cambridgeshire and Peterborough system to balance.

Following the recent round of Public Involvement Assemblies in March 2016, we are establishing a series of **focus group activities** over the next few weeks. More details will follow on the themes being covered and how to get involved.

A programme of **staff engagement** is being established across the system using a range of media including staff briefings, newsletters and web-based platforms. There are approximately 25,000 staff employed across health and care in Cambridgeshire and Peterborough and it will be through changes they make to their daily practice that this programme will be turned from a set of good ideas into reality. Their support becomes increasingly essential as we approach implementation.

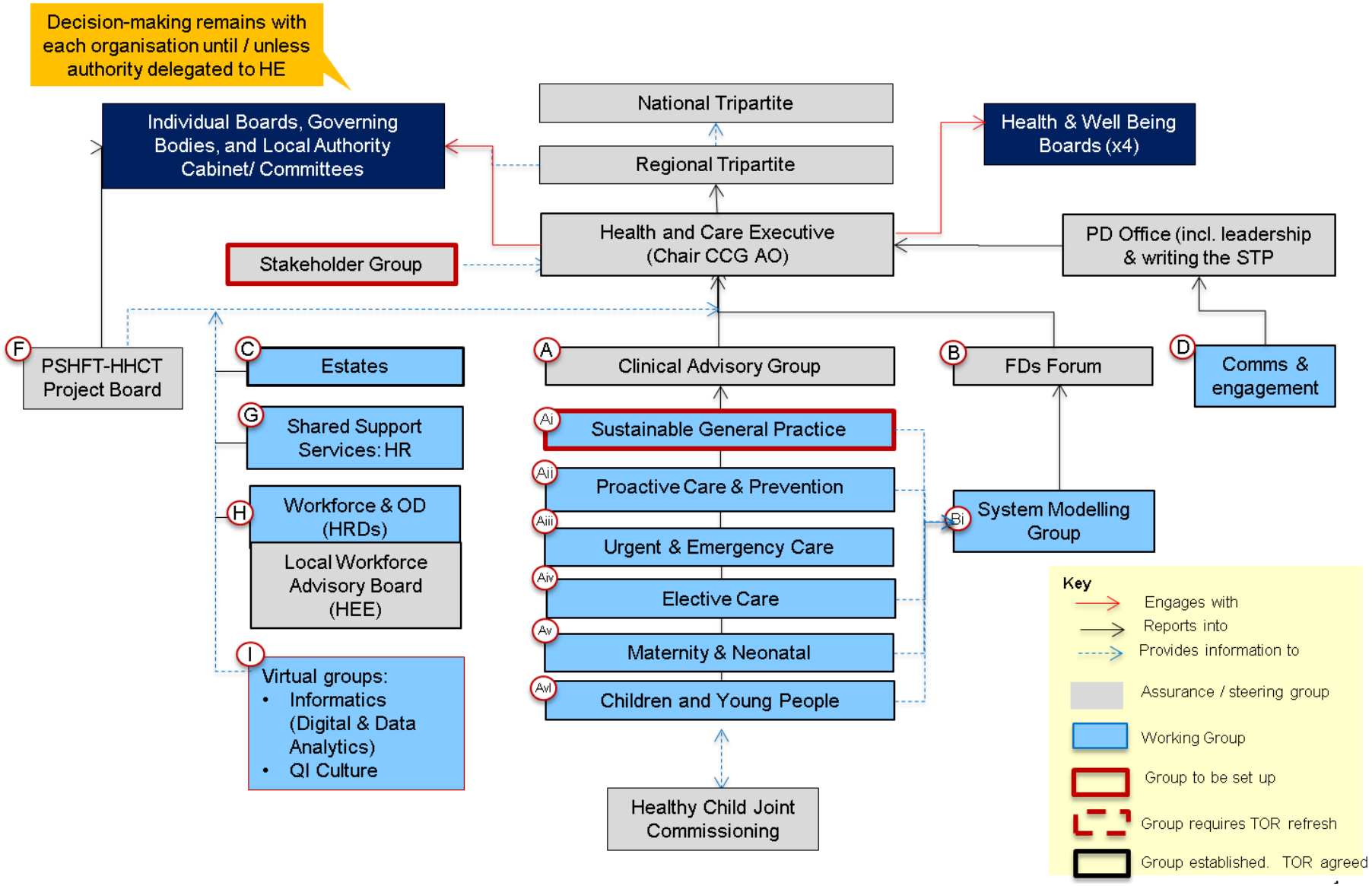
4.0 RECOMMENDATION/DECISION REQUIRED

4.1 The Board is asked to comment upon and note the progress made to date by the *Fit for the Future* programme.

Source Documents	Location
General Practice Forward View	https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

Fit for the Future
Working together to keep people well

Appendix A: Sustainability & Transformation Programme Governance Structure



OLDER PEOPLE AND ADULT COMMUNITY SERVICES (OPACS) CONTRACT UPDATE

Older peoples and adult community services workstreams review and Healthwatch learning event

To: Health and Wellbeing Board

Date: 26 May 2016

From: Matthew Smith, Assistant Director of Improving Outcomes, Cambridgeshire and Peterborough Clinical Commissioning Group

Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group

Contact Officer(s) – Cambridgeshire and Peterborough CCG Communications and Engagement Team
Contact Details – 01223 725304, capccg.contact@nhs.net

1. PURPOSE

1.1 The purpose of this report is to update the Health and Wellbeing Board for Health Issues on the work to review the Older People's and Adult Community Services (OPACS) model and workstreams. This paper also updates on the Healthwatch learning event, held on 11 May 2016.

2. BACKGROUND

2.1 On 3 December 2015 it was announced that the contract between Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) and UnitingCare had ended because it was financially unsustainable for all involved.

2.2 Although the contract was only in place a short time (eight months) the CCG believes it had started to show the green shoots of improvement. The procurement led to the creation of an innovative Outcomes Framework, improvements in integrating services, and extensive stakeholder engagement.

2.3 Two independent investigations have been carried out (by the CCG and NHS England) into the collapse of the contract. Further reports are expected from NHS England, the National Audit Office and Cambridgeshire and Peterborough NHS Foundation Trust.

3. CCG STAKEHOLDER WORKSHOP, 24 FEBRUARY 2016

3.1 On 24 February 2016 the CCG held a workshop for commissioners and providers involved in delivering older people's and adult community services which showed strong support for the model that had been developed by UnitingCare. The workshop was attended by delegates from a range of organisations including local NHS, local Councils, voluntary organisations and patient groups. The aim of the workshop was to discuss the CCG's emerging thinking. The speakers were from the CCG, Healthwatch Cambridgeshire, Healthwatch Peterborough, Care Network, Cambridgeshire County Council, Peterborough City Council and Cambridgeshire and

Peterborough NHS Foundation Trust. The workshop had an external facilitator who asked groups of attendees to share their priorities. The discussions were split into two rounds; the first focusing on *'Well-Being Prevention and Integrated Working'*; and the second focusing on *'Urgent and Emergency Care'*. Across both discussions a number of common themes emerged which are described in Appendix A.

4. HEALTHWATCH LEARNING EVENT, 11 MAY 2016

4.1 Healthwatch Cambridgeshire and Healthwatch Peterborough, working with Healthwatch Hertfordshire and Healthwatch Northamptonshire organised a Community Stakeholder Learning Event which was held on Wednesday 11 May 2016. The event had two purposes: firstly to share learning from the early termination of the UnitingCare contract, and secondly to consider the future of patient services based on the conclusions of the CCG Service Review. It was a collaborative event organised by Healthwatch and supported by Cambridgeshire and Peterborough Clinical Commissioning Group, Cambridgeshire County Council and Peterborough City Council.

4.2 The purpose of the event was to demonstrate transparency, learning and integration through a day of information sharing and discussion. The objectives were:

- To involve all local stakeholders, and understand together, what the enquiries into the failure of the UnitingCare contract for older peoples services in Peterborough and Cambridgeshire tell us
- To listen to peoples experience of care, and the roles and contribution of all stakeholders in achieving excellence
- To challenge and support the emerging plans for future service organisation and development, and ways that stakeholders can be involved and consulted
- To raise awareness of the local and national implications

4.3 We understand that Healthwatch will publish the outcomes from the learning event in due course.

5. WORK TO THE REVIEW THE WORKSTREAMS

5.1 Since December 2015 the CCG has been working with a wide range of stakeholders, including CPFT, Local Authorities, Healthwatch, providers and other stakeholders to review the current model, taking into account experience to date and the views of stakeholders to determine the best solution on how to deliver the benefits of the model within the resources available.

5.2 This work links to Cambridgeshire's JSNA priority 2 'Support older people to be independent, safe and well' and JSNA priority 4 'Create a safe environment and help to build strong communities, wellbeing and mental health'. The CCG's original drivers for integrating older people's and adult community services are also still applicable.

5.3 The review of the workstreams has taken into account the work of the Better Care Fund, the new Sustainability and Transformation programme and links to the joint vision and delivery plan with Local Authorities for improving outcomes for older people and those with long term conditions through effective integration.

5.4 The CCG and Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) remain committed to the outcomes and service model which was developed through the OPACS work. The CCG has commissioned services for 2016/17 from CPFT and other providers which reflects the conclusions of this review, and are aligned to both the Better Care Fund and the

new Sustainability and Transformation Programme (STP). The new contract will allow the delivery of all existing services provided by CPFT. We are making significant investment in progressing the service model. In summary, we intend to build on the Neighbourhood Team approach, continue funding the Joint Emergency Team (JET), the Dementia Intensive Support Service (DIST) and to make additional investment in community intermediate care capacity.

5.5 Although we remain fully committed to the model, the financial constraints we face mean that it is not possible to match the level of additional funding in services originally intended by UnitingCare for 2016/17. It is important that the CCG works with CPFT and other partners to manage expectations by being transparent about what we are not in a position to develop in 2016/17.

5.6 A summary of the recommendations, approved by the CCG Governing Body on 10 May 2016, are set out below:

Early Intervention and Well-Being Service	• Better coordinated and understood 'Well-Being Service', supported by an electronic directory of services • Cover all adults who may be vulnerable or at risk of developing more acute health or social care needs • CCG works with partner Local Authorities to commission these services, including social prescribing • Work with partners towards the vision for joined up advice and support, via STP and BCF processes
Neighbourhood Teams	• The CCG builds on and supports development of the 16 Neighbourhood Teams • Focus on developing joined up team working with primary care, social care and third sector services • Seek opportunities for closer working between Neighbourhood Teams and emerging 'primary care at scale' groups, including selection of NTs as 'demonstrator sites'
Case Finding, Case Management and Multi-Disciplinary Working	• Shift to more proactive care and develop 'case finding' by building on existing work and tools • Test use of the 'Rockwood' Frailty Score across the system • Adopt the draft Operational Policy for case management • A consistent approach to effective MDT coordination.

Integrating Information	• Wider consultation on the proposed solution (maximising the benefits from existing systems) and detailed development of an agreed model • Progress work via the Better Care Fund Data Sharing Group to support engagement and change as well as providing governance for the project(s) • Aligning with the wider digital roadmap, as well as the wider programmes of work within the – Better Care Fund, Sustainability and Transformation
Primary Care, Prevention and Long Term Conditions	• Development of improved care pathways for Long Term Conditions is taken forward by the STP Proactive Care & Prevention programme • Development of primary care at scale is linked with the development of OPAC services, and also taken forward as part of the STP Proactive Care and Prevention programme • Identify demonstrator sites where partners are able and willing to accelerate local integrated working
Single Point of Access (OneCall)	• The 'new OneCall' service operated by CPFT is evaluated for 6 months • The option to integrate 'OneCall' functions with the new Integrated Urgent Care service from October 2016 is reviewed in the light of the 6 month evaluation
Joint Emergency Teams	• The CCG continues to invest in the JET in 2016/17 • That the CCG, CPFT and other partners work to deliver on a joint improvement plan to continue to improve the JET service in terms of effective operation, onward pathways, and also appropriate referral into the service
Discharge & Intermediate Care	• Develop the discharge planning protocol • Carry out the intermediate care beds review • Develop community intermediate care in line with the UEC Vanguard proposals, including Integrated Care Workers.

Working with Care Homes	• That the CCG rolls out the Care Educator approach in line with the UEC Vanguard proposals • That the CCG reviews the Care Home Local Enhanced Service with a view to offering a more comprehensive approach during 2016/17
Other Services	• Investment in the Dementia Intensive Support Service should continue • Further development of End of Life Care Services will be taken forward within the Urgent & Emergency Care workstream of the STP services
The Outcomes Framework	• Outcomes Framework metrics are built into Better Care Fund plan outcomes • The Outcomes Framework should be reviewed to take into account the new context in which it is operating, updated national outcomes guidance and experience to date • This review should if possible identify a small number of key outcome metrics which the whole health and social care system can sign up to and measure performance against
Integrator Function	• Further development of the OPAC Service model is taken forward through the relevant STP workstreams and Better Care Fund structures • The CCG should work with CPFT to produce localised performance reporting which supports both front-line staff and the commissioning process • Engagement work should be taken forward in future via the STP and BCF processes • Regular communications for staff and other stakeholders should be produced to update on progress and services.

Source Documents	**Location**
Cambridgeshire and Peterborough CCG Governing Body paper, 10 May 2016 (Agenda item 2).	http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/GB%20Meetings/2016-17/20160510/Agenda%20Item%2002.1a%20-%20OPAC%20Service%20Review%20v4.2.pdf

APPENDIX A: 24TH FEBRUARY 2016 STAKEHOLDER FEEDBACK SUMMARY

Summary outputs from the two open discussions at the OPACS workshop on the 24th of February 2016

1. Introduction and Executive Summary

Outlined below is a summary of the key outputs from a stakeholder workshop to agree our future priorities in Older People and Adult Care Services.

The discussions were split into two rounds; the first focusing on *'Well-Being Prevention and Integrated Working'*; and the second focusing on *'Urgent and Emergency Care'*. Across both discussions a number of common themes emerged including:

What's working:

- Clear, shared vision – there is a lot of buy in to the vision and model, and a strong feeling this must continue beyond UnitedCare
- The outcome based approach
- Integration – long way to still go, but have already seen a good results of agencies working together and the co-location of staff e.g. in neighbourhood teams etc.
- Connecting with the voluntary sector – this is seen as a vital area for further work, but there has been good progress in pilots of involving them in discharge teams etc.
- JET – although still need further work on skills mix and integration with other services

What we need to improve and rethink our approach to:

- Greater focus on implementation – need to move out of planning into action, with a view to learning as we move forward
- Data and information sharing, and a better Directory of Services
- Better engagement of / partnership with the voluntary sector

What we should STOP doing:

- People accessing expensive services they don't need – e.g. sending them to hospital when it is not the best place for them
- Duplication across the system – e.g. assessments
- Culturally, playing it safe – need to be more innovative, and open to learning from different approaches

Goals/priorities for the next 12 months:

- Continued focus on integration; improving handovers, putting a greater focus on prevention and improving sharing of learning across the system
- Better engagement and partnership with the voluntary sector
- Data sharing and universal access to it
- Single point of access needs further work
- Getting an accurate DOS
- Engagement and education of the public behind our vision

2. First Round – Focusing on Well-Being, Prevention and Integrated Working

Working Well

- Cohesive vision across the system
  - Everyone working towards the same objectives
  - Vision is bringing the right services together
  - Vision that GPs are bought into
- Outcomes focus
- Integration of Health and Social Care
  - Willingness of different organisations/agencies to work together (attitude shift)
  - Staff still enthusiastic about integration – need to capitalise on this
  - Joint working in neighbourhood teams – early stages of making it work, but some good 'green shoots' emerging which we need to maintain
  - CPFT and Social Care now working together well
  - Multi disciplinary teams around localities
- Broad engagement of multiple services that have a role to play in prevention
  - Engagement of Lead Professionals other than just GPs and Social Care
- Connecting with the 3rd/voluntary sector
  - Using voluntary organisations as our eyes and ears
  - Work with Voluntary Sector on Wellbeing Services
  - Discharge from hospital/handover from NHS to voluntary sector
- Efforts to share information
  - Moves towards data in one place – still long way to go
  - Directory of Services developing well in Peterborough
  - Single Point of Contact in Hunts for Community Teams
- Care Home Education
- District Nursing
- JET working well in HUNTS
- Health Watch
- Peterborough Partnership Board
- MDT meetings

Needs to improve; need to rethink our approach to:

- Communicating/selling the vision to all key stakeholders; including patients
  - i.e. Shared vision at top level not filtered all the way down to the coal face
  - Need a common language – still confusion amongst professionals on terminology (e.g. case management)

    - Better patient education regarding services – patients need to understand the model and feel engaged/empowered. More dialogue (time) in Primary Care with patients about choices
    - Link to Carers and empowering them
- Need clear communication around changes as a result of the end of the contract with Uniting Care
- Greater focus on implementation of the vision
    - Delivering what we said we would do in relation to JET, NT, MDT, Care home Education etc.
    - Focus on action and learning, rather than trying to figure out the perfect approach first
    - Need clear communication around what is replace Oneview
- Better feedback and evidence informed approaches
    - Single pathway for feedback (Health and Social Care)
    - Coordinated analysis of feedback
- Enabling better data sharing is absolutely critical
    - Data linking, not just sharing
    - Need to channel all work on Directory of Services though one process (connect to 111)
- Better partnership with the 3rd sector / Voluntary sector
    - They need more stability
    - 3rd sector have some issues around the contract
- Right response the first time
- JET
    - Need clearly defined aims within the organisation
    - Better understanding and trust driving referrals
- Intermediate Care
    - Need seamless transition between reablement and I.C.
    - And immediate access
- Scope for joint commissioning to improve
- How to make better use of our resources
    - Reducing duplication
    - Driving efficiencies
    - Capturing and making full use of community resources
- How we move to a greater focus of resources on prevention
- Continued focus on improving integration
    - Increasing trust between organisations

- Integration between Social Care and Acutes
- Co-location of OOH Services?
- NTs joined up with Primary Care
- Closer links with Housing in Las

- MDT working/access to MDT

Stop doing:

- Duplication in the system – e.g. in assessments
- People accessing expensive services they don't need – put more experienced people on Triage
- Repeat prescriptions
- Single Disease based schemes
- Funding patient/users with poor life style choices – need to be more brutal in promoting health

Goals/priorities for the next 12 months:

- Set out a clear set of unambiguous goals and milestones; improving our effectiveness in prioritising across the system
  - and reprioritise investment to align with these new priorities
  - Then get on with it! I.e. focus on action, and learning from doing it.
- Single point of access needs to work much better
- Data sharing; and universal access to it – absolutely critical
- Continuing drive towards prevention
  - GP engagement
  - E.g. Falls prevention; Dementia Awareness; clear pathway around Frailty
- Better engagement with voluntary sector
- Greater connection to JET – i.e. maximizing use of it
- Social Prescribing (don't reinvent the wheel)
- Workforce plan as a key enabler
  - Embed vision
  - Workforce recruitment
  - Empower staff – create a culture where mistakes are okay with a focus on learning from them
- Improving sharing of learning across the system

3. Second Round – Focusing on Urgent and Emergency Care

Working Well

- Our vision and model is the right approach – need to stick with it and hold our nerve

    - We have a clear view of what we want to do for older people, based on good insight into their needs and who is best placed to do what
- Outcome based approach
- Integration and co-location of staff (as an increasing part of this)
- Working across the whole system operationally
- Funding through the Vanguard
- Concept of Jet – when it works well it is brilliant, but still variable
- Voluntary organisations being embedded in the discharge teams
    - Doing ward rounds in Hunts
    - Community Warden
- GPs working at front door of A&E
    - And greater involvement in 111 and 999
- Ambulance response and Ambulatory Care – brilliant
- Amber Care Bundle – EOL
- Health watch works well
- Comms by UnitingCare worked well – need to retain this
- System 1 template – is it used though?

Needs to improve; need to rethink our approach to:

- Information sharing / Directory of Services
    - Improve the DOS
    - Knowledge of Health and Social Care Services
- Engage Volunteer sector more
    - Have capacity there which is not been taken up
    - Single point of access for voluntary sector
    - How are they engaging with key initiatives/schemes like neighborhood teams
- JET skill mix and integration with other services
- Escalation to the Community rather than Acute
    - Step change /shift in seeing ‘acute’ as the place of safety
    - Ambulance role in Community; rather than ‘scoop and run’
- Hospital discharge
    - Making sure patients opportunity to go home is not missed
- Alignment of Social Care and NTs
- EOL pathway
- Intermediate Care tier – Beds/home care

- Need to know how all the work streams fit together – i.e. Vanguard, BCF, CPFT programme, STP etc. – and what are the priorities

Stop doing:

- Sending people to hospital when it is not the best place for them
  - Stop promoting hospital care as always the best
  - Stop open door at A&E; put other services in front
  - Stop over medcalising people; frailty etc.
- Stop thinking we can make the transition without investment in alternatives to hospital
- Duplication across the system
  - E.g. Assessments
- Procurement and competition between providers – it gets in the way of collaboration
- Short term funding - need longer to make it work
- Culturally – stop risk aversion/playing it safe/playing by the rules

Goals/priorities for the next 12 months:

- Continuing our work on integration
  - Health and Social Care
  - Seamless handover between 111 / OOH's; JET etc.
  - NTs working with Councils – truly integrated, multi disciplinary NT's
  - Improve join up between voluntary sector and JET
- Discharge
  - Including roll out of voluntary sector involvement in discharge team
- Get an accurate DOS sorted – including for the voluntary sector
- Data sharing – to enable good data based decisions right across the system; including by the voluntary sector
- Change public behavior around what services they go to, by raising awareness of options and which is best for different needs; and increasing confidence in the system
- Sort EOLC
- Develop ICBs to ensure coordination and communication
- Make decisions on community beds
- Reduce variation through understanding what works

Agenda Item No. 10

ANNUAL PUBLIC HEALTH REPORT (2015-16)

To: Health and Wellbeing Board

Date: 26th May 2016

From: Dr Liz Robin, Director of Public Health

1.0 PURPOSE

1.1 To present the Annual Public Health Report (2015/16) to the Health and Wellbeing Board.

2.0 BACKGROUND

2.1 The Health and Social Care Act (2012) includes a requirement for Directors of Public Health to prepare an independent Annual Public Health Report (APHR) on the health of local people.

2.2 Last year the APHR (2014/15) focussed on the changes and trends in public health outcomes over recent years. It identified three new opportunities for public health action:

- A focus on promoting the health of school age children, including mental health
- A whole system approach to healthy diet and physical activity – reversing the trend in obesity
- Supporting a positive approach to healthy ageing

2.3 The Annual Public Health Report 2015/16 updates progress against the opportunities for action identified in the APHR (2013/14) and the APHR (2014/15). It is available on request as a printed booklet, and is on the Council's website both with other HWB papers at http://tinyurl.com/ccc-hwb-2016-05-16 and at the link in the source box below.

3.0 MAIN ISSUES

3.1 The Annual Public Health Report (2015/16) recognises that many of the factors which affect people's health exist at a very local level, based on the opportunities and lifestyles in the communities where we live. The report focusses on issues at this local level – providing health 'maps' of the County broken down into individual electoral wards. It also provides case studies of what is being done at the moment in communities in Cambridgeshire to support healthy lifestyles and wellbeing.

3.2 It is recommended that there should be a focus over the coming year on engagement with all three tiers of local government and with the voluntary and community sector, to understand how we can work with communities to improve health, building on activities and assets which already exist at local level.

3.3 The APHR (2015/16) has been laid out to be easily read by a range of audiences, and hard copies will be distributed to County Councillors, MPs, District Councils, GP surgeries, libraries and secondary schools. It will also be publicised internally and externally on the relevant websites.

3.4 Special thanks are due to Senior Public Health Analyst Helen Whyman and Public Health Analyst Elizabeth Wakefield for their work on the report.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 This Annual Public Health Report has some relevance to all six headline priorities of the Cambridgeshire Health and Wellbeing Strategy, linking most strongly with focus area 3.1 'Encourage individuals and communities to get involved and take more responsibility for their health and wellbeing', and focus area 5.4 'Seek the views of local people and build on the strengths of local communities, including the local voluntary sector, to enhance social cohesion and promote social inclusion of marginalised groups and individuals'.

5.0 RECOMMENDATIONS

5.1 The Cambridgeshire HWB is asked to:

- consider the information outlined in the Annual Public Health Report
- endorse the approach recommended in the Report of engaging with the three tiers of local government and the voluntary/community sector, to understand how we can best work with local communities to improve health, building on activities and assets which already exist at local level.
- consider how NHS commissioner and provider colleagues might want to support and/or engage with the recommendations of the Report.

Source Documents	Location
Cambridgeshire Annual Public Health Reports (2013/14, 2014/15 and 2015/16)	http://www.cambridgeshireinsight.org.uk/health/aphr

Agenda Item No. 11

QUALITY PREMIUM 2016-17 – CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP CHOICE OF LOCAL INDICATORS

To: Health and Wellbeing Board

Date: 26 May 2016

From: Sarah Shuttlewood, Director of Contracting, Performance and Delivery

1.0 PURPOSE

1.1 This report sets out for information the local Quality Premium indicators which have been selected by the Clinical Commissioning Group for implementation in 2016/17.

2.0 BACKGROUND

2.1 National planning guidance on the Quality Premium for the financial year 2016/17 was published by NHS England on 9 March 2016. Clinical Commissioning Groups (CCGs) are required to submit their local Quality Indicators which, when combined with the national set of Quality Indicators will form the basis of payment of the 2016/17 Quality Premium.

2.2 The purpose of the Quality Premium is to reward CCGs who improve the quality of services they commission and for any associated improvements in health outcomes and reductions in inequalities. Subject to achievement of all of the conditions, the maximum Quality Premium payment for the CCG is just over £4m.

2.3 The 2016/17 scheme has been designed to support delivery of the major priorities set out for the NHS in the Five Year Forward View and the NHS Constitution. The national indicator set has been designed with that in mind and it focuses on the following priorities which are worth 70% of the full Quality Premium payment:

- Cancer (20% of the quality premium)
- GP Patient Survey (20% of the quality premium)
- Electronic Referrals (20% of the quality premium)
- Improved antibiotic prescribing in primary care (10% of the quality premium)

2.4 CCGs can also select three local indicators through which they can drive improvements together with their local partner organisations; each measure is worth 10% of the Quality Premium. The approach to identifying local indicators for 2016/17 differs from that adopted in previous years, in that they must be based on the outputs of the Right Care Programme. The national Right Care Programme has been established to address the funding challenges in the NHS and tackle unwarranted variationthrough a strong focus on value.

2.5 Local indicators must be agreed with the NHS England local team and, for the 2016/17 Quality Premium, there are two submission deadlines comprising 11April 2016 (initial submission) and 29 April 2016 (final submission).

3.0 LOCAL INDICATORS

3.1 The national guidance sets out a process to be adopted based on the 'Where to look" phase of the Right Care Programme, which identifies areas of unwarranted local variation and a potential list of improvement programmes. The guidance document contains an assessment nationally of data availability and the extent of variation to assist CCGs in selecting the metrics.

3.2 We have conducted a local check of data availability and we have taken account of the following:

a) Mapping to one or more of the Sustainability and Transformation Programme Clinical Working Groups to ensure strategic alignment
b) Likelihood of being able to make a change in one year
c) Availability of local data for performance monitoring purposes
d) Alignment with the Cambridgeshire and the Peterborough Health and Wellbeing strategic priorities

3.3 The local indicators selected comprise:

3.3.1 **Mental health admissions to hospital: rate per 100k population**

This indicator is relevant to the work of the Proactive Care and Prevention Clinical Working Group, with mental health being one of the key national and local service transformation priorities. It is also relevant to the work of the Urgent and Emergency Care Vanguard programme which has a discrete mental health work stream focusing on ensuring a consistent, safe, high quality mental health crisis response service 24/7. We are seeking a 1.0% reduction in the rate, giving a rate of 269 per 100k population (as calculated locally) which is intended to reverse the trend.

3.3.2 **Mental Health: Improving Access to Psychological Therapy (IAPT) reliable recovery: percentage of people who have completed IAPT treatment who achieved "reliable improvement"**

This indicator will become a national standard in 2017/18 and its inclusion in the Quality Premium for 2016/17 is a good opportunity to prepare for its introduction. We are aiming for a target of 60% in 2016/17 which will be challenging, given increased complexity in caseload. However, in the light of best practice adopted at Cambridgeshire and Peterborough Foundation Trust, there is greater likelihood of the target being achieved.

3.3.3 **Cross cutting indicator: Percentage of the eligible population aged 40 – 74 years who have received an NHS Health Check since 1 April 2013**

As stated in the Health System Prevention Strategy for Cambridgeshire and Peterborough, the NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. People between the ages of 40 and 74, who have not already been diagnosed with one of these conditions or have certain risk factors, are invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and are given support and advice to help them reduce or manage that risk.

The service is commissioned by Cambridgeshire County Council as part of the drive to improve health. The health check quality premium indicator is relevant also to the work of the Proactive Care and Prevention Clinical Working Group who are setting the strategic direction for the range of services within their remit. The CCG wishes to work in partnership with the Local Authority commissioning team with the aim of achieving a cumulative percentage target of 28% by the end of 2016/17. Achievement of this aim will require careful joint planning between the CCG and the Local Authority commissioning team resulting in the creation of an agreed project plan. The targeting of the health checks programme will also be important to ensure that known health inequalities are taken into account as part of joint planning. Any associated resource implications will be identified and addressed to ensure a successful outcome.

3.3.4 The final submission of the local indicators was made with their agreement to NHS England on 29 April 2016.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

Number	Health and Wellbeing Strategy Priority
3.	Encourage healthy lifestyles andbehaviours in all actions and activitieswhile respecting people's personal choices.
4.	Create a safe environment and help tobuild strong communities, wellbeing and mental health.
6.	Work together effectively.

5.0 IMPLICATIONS

5.1 None identified.

6.0 RECOMMENDATION/DECISION REQUIRED

6.1 The CambridgeshireHealth and Wellbeing Board is requested to comment upon and note the CCG's selection of local Quality Premium indicators for the financial year 2016/17.

Source Documents	Location
Quality Premium: Guidance for 2016/17; Gateway Reference 04798; NHS England; published 9 March 2016	https://www.england.nhs.uk/resources/resources-for-ccgs/ccg-out-tool/ccg-ois/qual-prem/
NHS Right Care Programme	http://www.rightcare.nhs.uk/
Health System Prevention Strategy for Cambridgeshire and Peterborough [pdf]	http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/GB%20Meetings/2015-16/20160209/Agenda%20Item%2003.4a%20-%20Health%20Prevention%20Strategy.pdf
Health System Prevention Strategy for Cambridgeshire and Peterborough [alternative route to same document]	Agenda Item 03.4a for 9 February 2016 at http://www.cambridgeshireandpeterboroughccg.nhs.uk/governing-body-meetings-2015-16.htm

Agenda Item No. 12

ANNUAL HEALTH PROTECTION REPORT (2015)

To: Health and Wellbeing Board

Date: 26th May 2016

From: Dr Liz Robin, Director of Public Health

1.0 PURPOSE

1.1 To present the Annual Health Protection Report (2015/16) to the Health and Wellbeing Board

2.0 BACKGROUND

2.1 This is the third annual report on health protection produced in Cambridgeshire since the transfer of public health functions to local authorities.

2.2 The Health and Social Care Act 2012, from 1 April 2013, placed statutory responsibilities on the County Council, through the Director of Public Health (DPH), to advise on and promote local health protection plans across agencies, which complements the statutory responsibilities of Public Health England, NHS England, the Clinical Commissioning Group (CCG) and City and District Councils.

2.3 It was agreed that the DPH would deliver an annual health protection report to provide a summary of relevant partnership activity. This report would cover the multi-agency health protection plans in place which establish how the various responsibilities are discharged.

2.4 The services that fall within Health Protection include :-

- Communicable disease and environmental hazards;
- Public health emergency planning
- Immunisation
- Screening
- Sexual health

2.5 The multi-agency Cambridgeshire Health Protection Steering Group (HPSG) was established in April 2013, chaired by the DPH, to support the DPH in having oversight of health protection in Cambridgeshire. It meets quarterly in January, April, July and October. Starting in October 2015, the Cambridgeshire HPSG has joined with the Peterborough HPSG.

3.0 MAIN ISSUES

3.1 Items of particular interest in the Annual Health Protection Report (2015), attached as Annex A include:

- The ongoing use and updating of the Public Health England led Joint Communicable Disease Outbreak Management Plan and the Cambridgeshire Health Protection Memorandum of Understanding (AHPR para 2.5 and 2.6)
- Levels of notifiable infectious diseases have generally remained stable over the past three years in Cambridgeshire with the exception of scarlet fever, which has shown a significant rise in the number of cases in line with national trends (AHPR para 3.1 and 3.3)
- The work of the task groups on improving uptake of childhood immunisations (AHPR para 4.2), a low uptake of flu vaccination by people in risk groups aged under 65 including pregnant women, and uncertainty about uptake by adult social care staff (AHPR para 4.8 and 4.10)
- An improvement in breast screening uptake in Cambridgeshire, but ongoing concern about low uptake of cervical screening, which is being addressed through a task group implementation plan presented to Health Committee in March 2016 (AHPR para 5.2 and 5.3)
- Testing of the updated Cambridgeshire and Peterborough Local Resilience Forum Pandemic Influenza Plan, through the multi-agency Exercise Corvus (AHPR para 6.6)
- Lower rates of diagnosed sexually transmitted infections and of teenage pregnancies than national rates, but a higher proportion of HIV infections being diagnosed at a late stage (AHPR paras 8.1-8.4)
- Local East Anglia workshop recommendations for implementation of the national TB strategy (AHPR section 9.0).

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 The partnership work described on health protection reflects focus area 6.1 of the Health and Wellbeing Strategy: Commit to partnership working, joint commissioning, and combining resources in new ways to maximise cost-effectiveness and health and wellbeing benefits for individuals and communities.

5.0 RECOMMENDATIONS

5.1 The Cambridgeshire HWB is asked to note the information in the Annual Health Protection Report (2015).

Source Documents	Location
None	

Annex A

CAMBRIDGESHIRE HEALTH PROTECTION STEERING GROUP

ANNUAL HEALTH PROTECTION REPORT (2015/16)

1. INTRODUCTION

1.1 This is the third annual report on health protection produced in Cambridgeshire since the transfer of public health functions to local authorities.

1.2 The Health and Social Care Act 2012, from 1 April 2013, placed statutory responsibilities on the County Council, through the Director of Public Health (DPH), to advise on and promote local health protection plans across agencies, which complements the statutory responsibilities of Public Health England, NHS England, the Clinical Commissioning Group (CCG) and City and District Councils.

1.3 The delivery of the health protection functions of the County Council must be publicly reported so that members can assure themselves that statutory responsibilities are being fulfilled. Members of the public can also access this information for their own reassurance or research.

1.4 It was agreed that the DPH would deliver an annual health protection report to the Health Committee to provide a summary of relevant activity. This report would cover the multi-agency health protection plans in place which establish how the various responsibilities are discharged.

1.5 The services that fall within Health Protection include :-

- Communicable disease and environmental hazards;
- Public health emergency planning
- Immunisation
- Screening
- Sexual health

2.0 CAMBRIDGESHIRE HEALTH PROTECTION STEERING GROUP

2.1 The Cambridgeshire Health Protection Steering Group (HPSG) was established in April 2013, chaired by the DPH, to support the DPH in having oversight of health protection in Cambridgeshire.

2.2 The HPSG meets quarterly in January, April, July and October. Starting in October 2015, the Cambridgeshire HPSG has joined with the Peterborough HPSG. The meeting has separate sections for Cambridgeshire only and Peterborough only issues at beginning and end of the meeting and a middle section to discuss all those issues that

are relevant to both local authorities. The middle section receives reports on work across both areas on issues such as immunisation, screening, emergency planning and communicable diseases common to both authority areas.

2.3 Standing items have included:

- Immunisations – routine data as well as specific issues that have arisen – report from NHS England
- Screening – routine data and any specific issues that have arisen – report from NHS England
- Healthcare associated infection and antimicrobial resistance – reports from the CCG
- An update on health emergency planning and updates from the Local Health Resilience Partnership (LHRP)
- Tuberculosis including the new national strategy, BCG vaccination and incidents.

2.4 The three priority areas agreed by the HPSG to be standing agenda items are:

- Public communication to support uptake of immunisation and screening (e.g. cervical screening uptake is low in Cambridge City) and some other issues such as use of anti-microbial drugs.
- TB to include consideration of vulnerable people and the implementation of the national TB Strategy
- Pandemic flu planning including planning for excess deaths

2.5 Memorandum of Understanding

The 2014 Memorandum of Understanding (MOU) for health protection, developed to ensure agreement from all relevant organisations to provide reports and assurance to the Health Protection Steering group for Cambridgeshire and to collaborate with other partners in the response to any incident that affects public health in the county, has been reviewed and revised and is being re-issued to partner organisations for sign-off.

In practice this proved to be very helpful over the past two years during the response to public health incidents, as it clarified responsibilities, including financial responsibilities, in a number of public health incidents and meant that there were no delays while this clarification was sought.

2.6 Joint Communicable Disease Outbreak Management Plan

Development of this plan was led by Public Health England with support from the public health teams in local authorities. It has been in use since it was initially ratified in 2014 and has also been tested during exercises. Further to organisational and other changes, the plan was updated in April 2015.

3.0 SURVEILLANCE

3.1 Notifications of Infectious Diseases

Doctors in England and Wales have a statutory duty to notify suspected cases of certain infectious diseases. These notifications along with laboratory and other data is an important source of surveillance data. The table below shows the notifiable diseases reported to the HPT from 2013 - 2015.

Table 1: Notifiable Diseases in Cambridgeshire

Notifiable Disease*	2013†	2014†	2015†
Acute infectious hepatitis	27	20	25
Acute meningitis	17	8	8
Botulism	0	0	<5
Cholera	0	<5	0
Cryptosporidiosis		See below	
Enteric Fever	<5	<5	<5
Food poisoning	671	763	768
Infectious bloody diarrhoea	8	6	5
Invasive Group A streptococcal disease	13	23	18
Legionnaires' Disease	<5	0	<5
Malaria	11	10	9
Measles	53	23	13**
Meningococcal septicaemia	7	<5	9
Mumps	47	44	24**
Rubella	<5	11	5**
Scarlet fever	47	89	159
Whooping cough	84	108	80

SOURCE: East of England HPT (Thetford) HPZone

***** *Notifiable diseases with no reported cases during the three years are not listed here. These are notifications of infectious disease and are not necessarily laboratory confirmed.*

† *Because of the confidentiality risk associated with reporting very small numbers, where there are fewer than 5 cases they are reported as <5*

** *Single case of laboratory confirmed measles. Two laboratory confirmed cases of mumps and no laboratory confirmed cases of rubella*

3.2 It is particularly important to note the number of cases notified that are of illness which could have been prevented by immunisation, in particular mumps, measles, whooping cough, rubella (German measles), each of which can have serious long term health consequences, especially when also considering the childhood immunisation uptake data later in this report..

3.3 Scarlet fever

Scarlet fever is a common childhood infection caused by *Streptococcus pyogenes*, also known as group A streptococcus (GAS). It is most

common between the ages of 2 and 8 years, although children and adults of all ages can develop it.

Similar to the rest of the country, scarlet fever seasonal activity has remained elevated across Cambridgeshire, following the increase in notifications seen last year. Since the start of 2015 there has been a rapid and higher than expected increase in notifications compared to the previous year.

Although scarlet fever is usually a mild illness, patients can develop complications such as an ear infection, throat abscess, pneumonia, sinusitis or meningitis. Clinicians should also be mindful of a potential increase in invasive GAS (iGAS) infection which tends to follow trends in scarlet fever. Early recognition and prompt initiation of specific and supportive therapy for patients with iGAS infection can be lifesaving.

3.4 Cryptosporidiosis increase

Most human infections are caused by *Cryptosporidium hominis*, for which humans are the only natural host, and *C parvum*, which infects bovines as well as humans.

There has been an exceedance of cryptosporidiosis cases reported for Norfolk, Suffolk and Cambridgeshire throughout the autumn months of 2015, which has also been seen across the country. The three week rolling average for 2015 has followed a similar distribution to previous years, but at a higher level between September and December. The numbers of cases decreased to normal levels by the end of December. The largest number of cases was from Norfolk (39%), followed by Cambridgeshire (26%) and Suffolk (20%). Mapping the cases did not identify any geographical clustering. Routine questionnaires identified that 25% cases reported contact with at least one other confirmed or suspected case of cryptosporidiosis, although this question was left blank on half of the questionnaires. The main contextual settings (potential sources) for cases were household (30%) and unknown (25%), with foreign travel only indicated for 22 (11%) cases. The predominant species changed over the autumn with more *C. hominis* in September and more *C. parvum* in November and December.

A national case control study, which the HPT is participating in, was initiated in January 2016 to identify risk factors for the cryptosporidiosis increase.

3.5 Outbreaks and Incidents

Table 2: Cambridgeshire, January - December 2015

Gastroenteritis	Healthcare-associated infection	Respiratory virus	TB	Environmental/ Chemical	Scabies	Other infectious disease	Total
34[†]	4	4	3	4*	2	3	**54**

SOURCE: East of England HPT (Thetford) HPZone

† *32 care-home outbreaks, 6 confirmed as norovirus; 1 workplace gastroenteritis outbreak and 1 food poisoning outbreak*

* *3 fires, 1 mercury spill*

4.0 PREVENTION

The focus of this section is Immunisation and Screening programmes. NHS England East Anglia Team leads on commissioning of the following programmes for the population of Cambridgeshire;

- Cancer Screening: Breast, Cervical and Bowel Cancer,
- Adult and Young People Screening: Abdominal Aortic Aneurysm (AAA) and Diabetic Eye Screening(DES),
- Antenatal and Newborn Screening programmes,
- Immunisation Programmes: neonatal and childhood, school age and adult immunisations

The team provides regular updates on screening and immunisations to the Cambridgeshire HPSG.

4.1 IMMUNISATION PROGRAMMES

Uptake of childhood immunisations is low in Cambridgeshire. A Task & Finish Group was established in December 2015 to review detailed data on immunisation uptake across the county, including mapping to identify areas in which uptake is particularly low. This will enable a targeted approach to the development of plans to address issues identified with a view to improving coverage.

4.2 Childhood Primary Vaccinations

The table 4 below clearly shows that the target for uptake of childhood immunisations which is 95% is yet to be met for all childhood primary immunisation programmes. This is the uptake level that ensures herd immunity in the local population. When a high percentage of the population is vaccinated, it is difficult for infectious diseases to spread because there are not many people who can be infected. For example, if someone with measles is surrounded by people who are vaccinated against measles, the disease cannot easily be passed on to anyone, and it will quickly disappear again. This is called 'herd immunity', and it gives protection to vulnerable people such as newborn babies, elderly people and those who are too sick to be vaccinated and to those whose immune system is weakened and prevents them developing a good level of immunity when vaccinated.

Analysis of the data has shown that there are pockets of poor uptake in Cambridgeshire which has led to the Health Protection Steering Group

recommending that a Task & Finish Group undertake a piece of work to understand the causes of the declining uptake and start setting out actions to reverse this downward trend. The Task and Finish group, led by PHE/NHS England in collaboration with Cambridgeshire County Council and other partners, has agreed terms of reference to identify areas of lower immunisation uptake, understand the cause and make recommendations to reverse this trend.

Table 3: Childhood vaccination uptake in Cambridgeshire 2015/16

12 months DTaP/IPV/Hib [target 95%]				
	Q4 2014/5	Q1 2015/6	Q2 2015/6	Q3 2015/6 Data not yet available
Cambs	94.8	93.1	94.7	
East Anglia	95.6	95.6	95.6	
12 months PCV [target 95%]				
Cambs	94.6	92.9	94.4	
East Anglia	95.3	95.4	95.4	
24 months DTaP/IPV/Hib [target 95%]				
Cambs	94.4	95.6	93.3	
East Anglia	96.4	95.6	95.7	
24 months PCV Booster [target 95%]				
Cambs	91.6	91.3	90.0	
East Anglia	93.9	93.6	93.0	
24 months Hib/Men C [target 95%]				
Cambs	91.5	91.9	89.4	
East Anglia	94.0	93.8	92.5	
24 months MMR 1 [target 95%]				
Cambs	91.4	91.7	89.1	
East Anglia	93.5	93.4	92.3	
5 years DTaP Hib [target 95%]				
Cambs	94.2	94.7	93.8	
East Anglia	95.8	96.2	95.3	
5 years MMR 1 [target 95%]				
Cambs	91.3	92.3	90.9	
East Anglia	94.1	94.2	93.1	
5 years MMR 2 [target 95%]				
Cambs	85.6	89.8	84.7	
East Anglia	89.7	91.4	88.8	
5 years DTaP/IPV Booster [target 95%]				
Cambs	86.3	85.7	85.4	
East Anglia	90.7	90.7	89.5	
5 years Hib/Men C [target 95%]				
Cambs	91.2	91.3	90.0	
East Anglia	93.4	93.1	93.0	

4.3 Rotavirus Vaccination programme

Rotavirus, a highly contagious virus that has been the most common cause of gastroenteritis in infants and very young children has reduced markedly since the introduction of a vaccine against the disease in July 2013. Rotavirus infection previously led to high demand on GP consultations and frequently led to hospital admission.

Uptake, while not yet over 95% is consistently high. The effectiveness of the vaccine has been demonstrated by surveillance data provided by the PHE Eastern Field Epidemiology Unit (EFEU), showing rates of infection have dropped to 0 – 3 cases per week across Anglia (Cambridgeshire, Peterborough, Norfolk and Suffolk) in March 2016 compared to around 60 cases per week in the same period prior to introduction of the vaccine.

Table 4: Rotavirus vaccination uptake

	April 2014 %	May 2014 %	June 2014 %	July 2014 %	August 2014 %	Sept 2014 %	Oct 2014 %	Nov 2014 %	Dec 2014 %	Jan 2015 %	Feb 2015 %	Mar 2015 %
CCG	90.9	90.5	90.6	91.2	92.3	92.5	90.4	88.5	91.2	91.3	90.3	90.3
East Anglia	92.5	90.1	90.7	91.8	91.9	92.5	92.5	89.3	90.6	91.0	91.3	91.5
	April 2015	May 2015	June 2015	July 2015	August 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	March 2016
CCG	91.0	92.0	92.1	92.1	91.8	NA	91.3	88.5	90.9	91.4	NA	NA
East Anglia	90.4	92.2	91.7	91.6	91.7	NA	92.2	90.7	91.9	91.6	NA	NA

4.4 BCG Vaccination

BCG vaccination is for prevention of Tuberculosis (TB). It confers some immunity, and is recommended for newborn babies who:

- Are born in an area with a high incidence of TB – high incidence is defined by the World Health Organisation as 40 or more new cases per 100,000 population per year (Cambridgeshire rate is 5.6/100,000/year)
- Have one or more parents or grandparents who were born in countries with a high incidence of TB

Maternity units have been responsible for giving BCG vaccination to eligible babies since April 2015. The model of good practice is that the baby should be vaccinated before discharge home from the maternity unit. Implementation was delayed due to the need to train midwives to administer the vaccine and then by a shortage of the vaccine in 2015. However both issues have now been resolved and the Screening and Immunisation Team (NHSE / PHE) has agreed to report uptake to each meeting of Cambridgeshire HPSG.

4.5 School based immunisation programmes

There is good evidence that, for school age children, uptake of vaccinations is higher when they are given at school. Cambridgeshire school children previously received HPV vaccination at school, and all other school age vaccinations from their GP. In 2015 NHS England awarded the contract for the delivery of all school based immunisation

programmes in East Anglia to Cambridgeshire Community Services. This contract includes administration of the new flu vaccinations that are being gradually introduced for school age children.

CCS was also commissioned to deliver school leaving booster (Td/IPV), HPV and Men ACWY. Data is not available for uptake rates prior to introduction of the new contract for school based immunisations but in January 2016 uptake of the year 10 (age 14+) Diphtheria, Tetanus and Polio booster was 71%, a very good start to the new contract arrangements.

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4.6 Human Papilloma Virus (HPV) programme

The Human Papilloma Virus (HPV) programme of vaccination of girls aged 12 – 13 has been very successful. HPV is a causative factor in Viral Warts, Cervical Cancer and other forms of cell morphological changes in the human body. Up until September 2014, this vaccine was given as three doses over the course of a school year. Since then the programme has been changed to provide two doses over the course of 6 to 24 months, usually given early in year 8 and year 9. The data below is for the first year of this new schedule, hence the apparently very low uptake of the second dose, as most will not receive it until at least a year after the first dose.

Table 5: HPV vaccination uptake in school year

2014/15 up to 31.8.15 *	Dose 1	Dose 2
Cambridgeshire	85.5	2.3
East Anglia	89.4	5.0

*As this programme runs over a school year, complete data for 2014/5 will not be available for some time

4.7 Seasonal Influenza vaccination programme - Children

A programme that will eventually see all children aged 2 - 16 offered Influenza (flu) vaccination each year began three years ago and so far has been rolled out to pre-school children age 2 – 4 years, who are vaccinated by their GPs and from 2015 children in years 1 and 2, vaccinated as part of the school immunisation programme

The flu vaccine for children is given as a single dose of nasal spray squirted up each nostril. Not only is it needle-free (a big advantage for children), the nasal spray works even better than the injected flu vaccine with fewer side effects. In the case of some children in the at risk groups, two doses of the nasal spray will be needed. For many years prior to introduction of this universal programme, children aged from 2 years who are identified as having health conditions that cause them to be at greater risk of complications from Flu have been offered

vaccination by injection each year. Although this vaccination programme reduces the incidence of Flu among children, it is also known to break transmission of the disease from children to vulnerable adults.

Table 6: Flu vaccination uptake age 2 to 4

Cambridgeshire & Peterborough CCG						
	2yrs not in clinical risk groups %	2 yrs in clinical risk groups %	All 2 yrs %	3 yrs not in clinical risk groups %	3 yrs in clinical risk groups %	All 3yrs %
Period to Jan 2014	40.9	53.2	41.3	40.6	53.8	41.2
Period to Jan 2015	39.1	52.7	39.6	42.6	54.2	43.1
Period to Jan 2016	36.6	49.9	37.1	38.7	54.1	39.5
East Anglia to Jan 2016	38.6	49.9		40.1	53.2	40.8

Table 7: Flu vaccination uptake age 4 – added in 2014/5 season

Cambridgeshire & Peterborough CCG			
	4yrs not in clinical %	**4 yrs in clinical %**	**All 4 yrs %**
Period to Jan 2015	33.5	51.6	34.5
Period to Jan 2016	28.6	47.2	29.8
East Anglia to Jan 2016	30.8	48.8	32.0

Table 8: Flu vaccination uptake for year 2015/16 which introduced school year 1 and 2,

Cambridgeshire & Peterborough CCG						
Period to Jan 2016	5 yrs not in clinical %	5 yrs in clinical %	All 5 yrs %	6yrs not in clinical %	6 yrs in clinical %	All 6 yrs %
CCG	57.2	67.1	57.9	54.4	64.6	55.2
East Anglia	57.7	67.9	58.5	54.9	65.9	55.8

4.8 Influenza vaccination uptake in clinical risk groups

In addition to the childhood groups mentioned above, the following groups are eligible for free annual seasonal flu vaccination, using an injected vaccine:

- those aged 65 years and over
- people aged from six months to less than 65 years of age with a serious medical condition such as:
  - chronic (long-term) respiratory disease, such as severe asthma, chronic obstructive pulmonary disease (COPD) or bronchitis
  - chronic heart disease, such as heart failure
  - chronic kidney disease at stage three, four or five
  - chronic liver disease
  - chronic neurological disease, such as Parkinson's disease or motor neurone disease, or learning disability
  - diabetes
  - splenic dysfunction
  - a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment)
- pregnant women
- those in long-stay residential care homes
- carers

Table 9: Flu vaccination uptake in clinical risk groups

Cambridgeshire & Peterborough CCG			
	Influenza [target 75%]		
	Over 65yrs	Under 65yr at risk	Pregnant
Period to Jan 2014	74.1	50.3	43.4
Period to Jan 2015	70.6	48.7	43.3
Period to Jan 2016	72.4	42.7	32.2

It is of concern that those in the at risk groups and pregnant women have such low uptake, as flu can lead to serious long term complications and even death in these people. Each year detailed planning is undertaken to try to improve uptake and early planning for the 2016/17 vaccination season will soon commence

4.9 Influenza vaccination uptake in frontline healthcare workers

Flu vaccination has been recommended and provided free for many years to frontline health care workers as those who contract flu can put their patients at risk though cross transmission to patients whose health is already compromised by other medical conditions. The vaccination protects the staff who, in turn, can protect their patients and their families and friends by being immune to flu. This has the advantage of reducing the risk to vulnerable patients and also the risk

to the health services of losing staff to illness or family care responsibilities during the very busy winter season. Despite the many benefits of flu vaccination to healthcare staff and the huge efforts made by their employers, uptake is generally but remains disappointingly low in some organisations.

Table 10: Flu vaccination uptake – front line health care workers

Period to Jan 2015 [compared with 2012/13 and 2013/4]				
	Influenza Health Care Workers [target 75%]			
	2012/3	2013/4	2014/5	2015/6
CUHFT	45.6	49.3	47.5	53.5
CCS	37.0	51.5	52.6	59.2
Papworth	58.4	75.6	69.3	65.9
Hinchingbrooke	46.4	60.6	76.8	65.4
CPFT	23.7	54.2	51.2	61.9
PSHFT	71.5	75.3	69.5	62.9

4.10 Influenza vaccination uptake in frontline social care staff

The same arguments are made for vaccination of social care staff as for healthcare staff, as they are also in contact with very vulnerable groups. In 2014/5 flu season, Cambridgeshire County Council made flu vaccination available to employed staff who were identified as meeting the criteria for vaccination. The following groups of frontline staff were identified for vaccination:

- Older People front line staff
- Frontline LDP/PD staff
- Frontline Children's Disability staff
- Early years support frontline staff (children's centres)
- Staff in Children's residential homes

Table 11: Flu vaccination uptake, CCC employed front line social care staff

Service Area	No. eligible staff offered vaccine	No. staff vaccinated
LDP (3 teams) only one team responded (East)	No data provided	2
Physical Disability frontline staff	40	3
Frontline Children's Disability Staff	38	14
Early Support Frontline Staff (Children's Centres)	No data provided	No data provided
Staff in Children's Residential Homes	No data provided	*
Older People front line staff	approx. 190	17**

* only 1 of the 3 homes responded to request for data

** the 17 staff vaccinated received their vaccination while working in an acute clinical setting and not as part of the council programme

In 2014/5 season a decision was taken to offer financial reimbursement for the full cost of the vaccine to staff who obtained it independently through a local pharmacy. Information was distributed to staff, via their line manager, to promote awareness of the benefits of vaccination and to inform them of the process for reclaiming vaccine cost via their monthly expenses. When uptake was measured it was disappointingly low (table 12 above)

For 2015/6 season, a late agreement was reached with Cambridgeshire Community NHS Service trust that they give the vaccine to Cambridgeshire County Council employed front line staff. This was done as it had been reported that staff were less likely to have the vaccine when there was an up-front cost to them. Uptake data are awaited.

For front line social care staff not directly employed by the county council responsibility for funding and administering the seasonal flu vaccine to staff (other than those in clinical risk groups) lies with their employers. This has led to difficulty getting social care staff vaccinated, as there are no levers within contacts to require social care providers to offer flu vaccination to their front line staff. It was decided to take a different approach for staff employed by external, CCC commissioned, organisation, sending communication to employing organisations that:

- Requested that employers consider arrangements to offer flu vaccination to eligible staff
- Highlighted the responsibility of the employer in protecting the health of staff and vulnerable clients
- Highlighted the benefits of vaccination in improving organisational resilience
- Signposted employers to the resources available via the NHS Flu Fighters campaign site

There is no mechanism in place to assess whether this communication was successful by measuring uptake among these staff.

4.11 Shingles vaccination programme

Shingles is an infection of a nerve and the skin around it, caused by the varicella zoster virus, which also causes chickenpox. Shingles can occur at any age but is commoner after age 70 years. Its main symptom is a painful rash that develops into itchy blisters and lasts for two to four weeks. The main complication of shingles is post-herpetic neuralgia, a severe nerve pain that can last for several months after the rash has gone and is commoner in older people.

This vaccination programme was introduced in 2013, to protect elderly people who are at greatest risk of Shingles and its adverse consequences. Eventually everyone will be offered the vaccination at age 70, but in the early years a catch up programme is in place to cover as many of those aged over 70 but less than 80 years. In 2014/15 the

vaccine was routinely offered to those aged 70 and catch-up to those aged 78 years between 1st September 2014 and 31st August 2015. Uptake is fair, but could improve considerably.

Table 12: Shingles vaccination uptake to Feb 2016

Shingles Sentinel	Feb 2016 %	
	70 yrs	**78 yrs**
CCG	51.1	50.1
East Anglia	48.8	48.6

Source: Immform accessed 14.2.16

4.12 Pertussis vaccination in pregnancy

Following an outbreak among babies of Pertussis (Whooping cough) which led to a number of infant deaths, a programme to vaccinate pregnant women between 28 and 38 weeks of pregnancy was initiated in 2012/3. Evidence showed that immunity among women of child-bearing age had waned, and by vaccinating them, it would prevent them picking up whooping cough and passing it to their babies. Following introduction of this programme, there was a 79% drop in cases in 2013 and a decision was made to continue with this programme of vaccination in pregnancy.

The table below give data on uptake, data is reported for the Cambridgeshire and Peterborough CCG area, showing fair levels of coverage. However data capture for this programme has not been robust up to now but NHSE have introduced an improved data capture system.

Table 13: Pertussis vaccination uptake by pregnant women

	April 2014 %	May 2014 %	June 2014 %	July 2014 %	August 2014 %	Sept 2014 %	Oct 2014 %	Nov 2014 %	Dec 2014 %	Jan 2015 %	Feb 2015 %	Mar 2015 %
CCG	59.6	53.0	53.1	49.0	48.1	51.3	52.0	50.8	59.6	53.1	54.1	51.6
East Anglia	60.6	60.5	57.2	55.8	55.5	58.3	60.3	60.6	65.7	61.6	60.9	58.1
	April 2015	May 2015	June 2015	July 2015	August 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	March 2016
CCG	49.8	45.9	52.7	50.5	51.2	50.5	54.1	52.5	50.7	50.3	NA	NA
East Anglia	56.8	53.8	58.9	56.3	58.5	67.2	60.3	61.4	60.3	59.3	NA	NA

5. SCREENING PROGRAMMES

5.1 Cancer screening programmes

There are three cancer screening programmes in the UK for Breast, Cervical and Bowel cancer and the data for these programmes was provided by NHS England

Uptake of the two established cancer screening programmes in women for breast and cervical cancer has been low in Cambridgeshire and for cervical screening it is showing a worrying downward trend. A Task and finish Group was established in May 2015, and completed its work in September 2015. The group has continued to meet to plan implementation of a series of recommendations to encourage uptake. The most recent cancer screening data is given below.

5.2 Breast Screening

The breast screening service which nationally commenced operation in 1987 was designed to invite eligible women aged 50 to 70 (47-73 if enrolled onto the National Age extension study) every three years using the call and recall system and any self-referrals for women over 73 years. Recently a referral pathway for high risk breast screening was commissioned and must only be taken from specialised services such as Genetics and Oncology.

A number of measures or quality standards are reported to evaluate the success of the screening programme and all are reported to the HPSG. Uptake data is usually reported annually and has not yet been reported for 2015/16, so the most recent annual data is given in Table 15 below. Other data for the breast screening programme are given in the figures below.

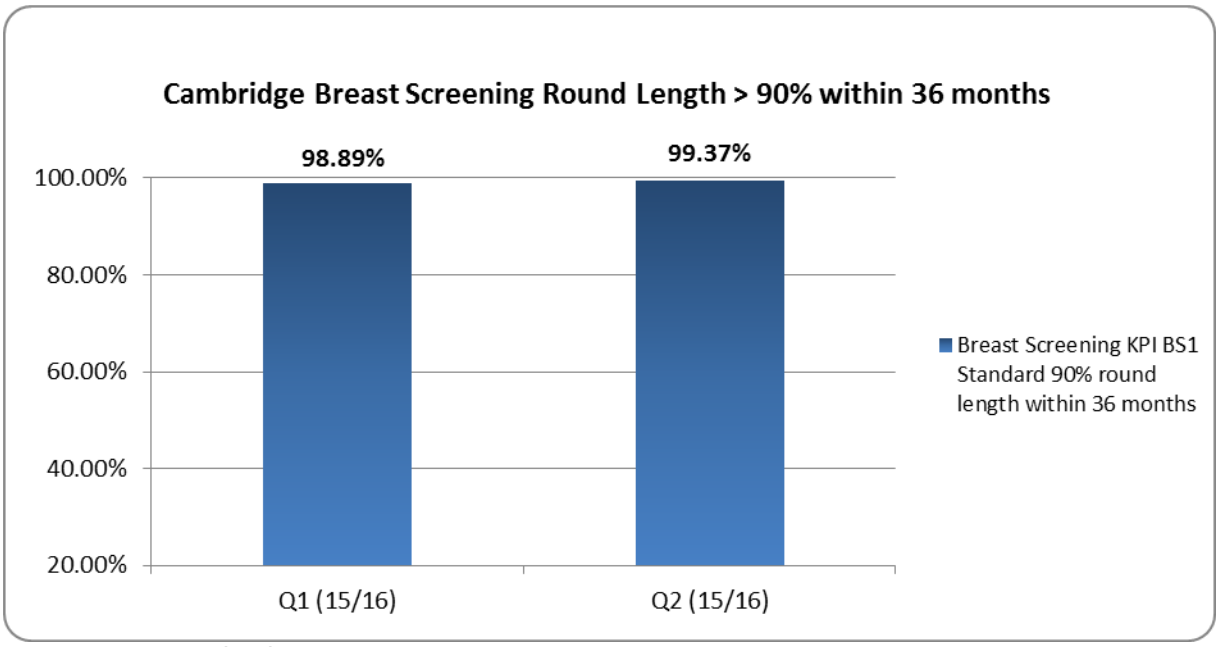
Table 14: Breast screening uptake in Cambridgeshire 2014/15

Age group	Uptake
50 – 70	74.6%
All ages	76.8%

Other important measures are the proportion of women who are screened within a 36 month period[1] and the time taken from screening to assessment if any abnormality is detected on the screening mammogram (The standard is to respectively achieve 90% within 36 months of previous screen and 90% of assessments within three weeks of being screened). The following two figures illustrate achievement in these two areas for Cambridgeshire women. The 36-month round length has significantly improved in 2015/16, with the standards now being met quarter on quarter. The proportion of women needing assessment who are seen within recommended timescales has improved but still below the 90% mark.

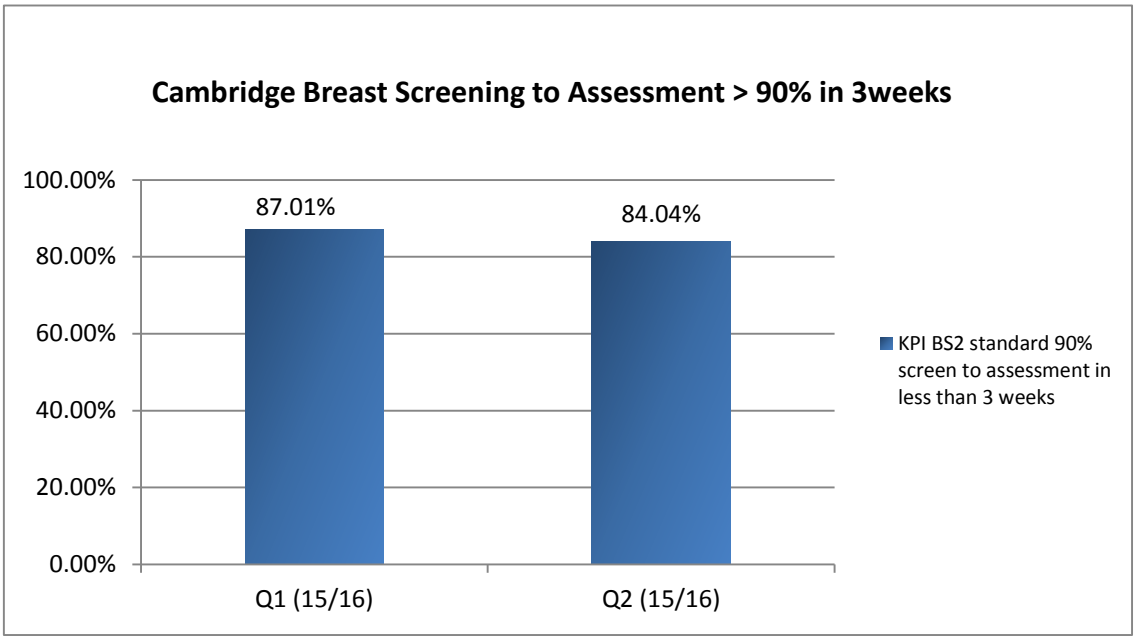
[1] The NHS Breast Screening programme aims to offer a first screening appointment to 90% or more women within 36 months of their previous screen.

Figure 1: Proportion of eligible women screened within 36 months



Source: NHS England

Figure 2: Proportion of women requiring assessment who are seen within 3 weeks of the screening test



Source: NHS England

The Breast screening uptake has seen an increase on the previous year's figure and is now similar to the national average. The issue of the difficulty with securing accessible venues in the Cambridge city and

Cambridge North areas and the shortage of trained radiographers have been a major challenge to effective service delivery. The screening service has worked collaboratively with the council and public health to identify suitably accessible sites to host the mobile screening van. The newly identified and agreed site is in the heart of Arbury and this site is now fully functional. It is expected that the introduction of the Arbury site, along with the additional capacity created through CUFHT putting on additional clinics on Saturdays, should support the improvement of uptake and coverage. Plans are underway to secure a further site North of Cambridge, in and around the Impington or Milton area.

5.3 Cervical Screening

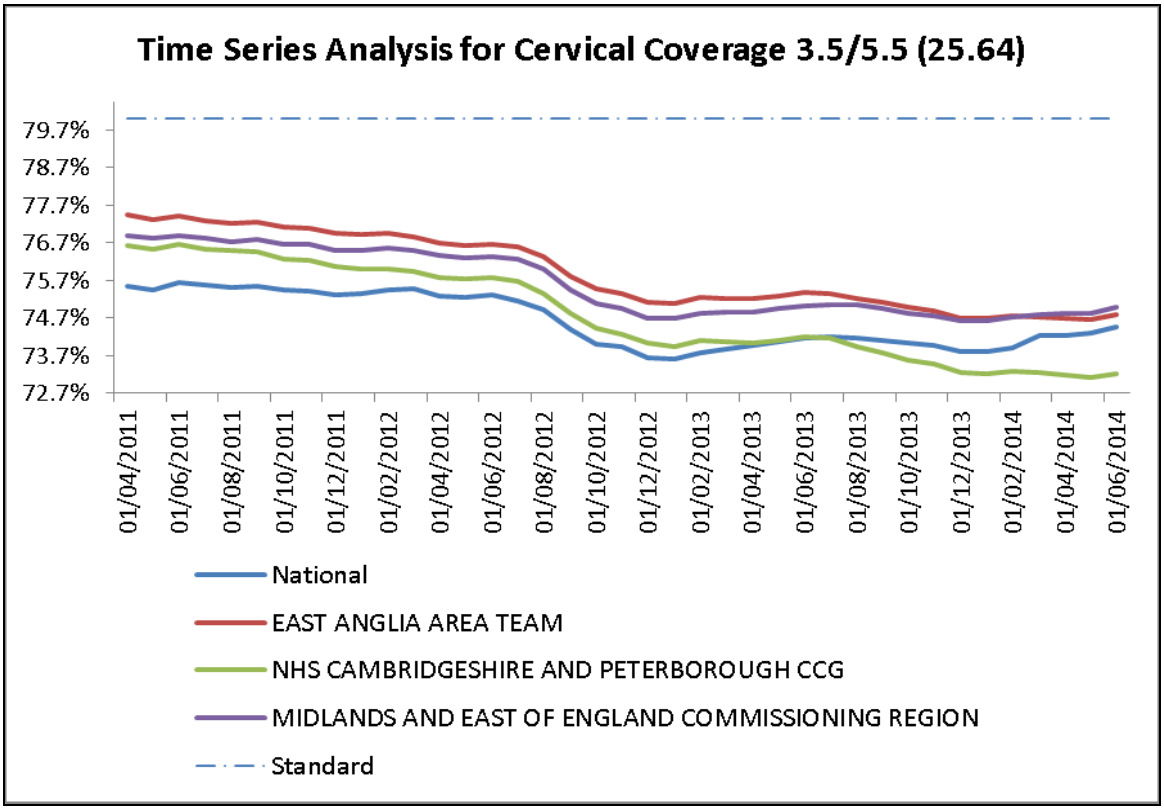
Cervical screening is offered to all women aged 25 to 49 years every three years and those aged 50 to 64 every five years. Screening takes place in GP practices and the samples are sent to the laboratories for testing. Upon testing, women are informed of the outcome of their screening episode and those with abnormal cervical screening tests are referred for colposcopy and possibly virology testing- a specialist test to further assess and treat the abnormalities detected. As with the other screening programmes aimed at early detection, the programme is monitored on uptake, coverage, the speed of getting results to service users who have been tested, as well as the timeliness of getting service users in for assessment and treatment.

From the most recent comparative data analysis available, the trend data below show a steady decline in coverage for the Cambridgeshire and Peterborough CCG area. (Coverage is a measure of the proportion of women aged 25 to 49 having an adequate sample taken in last 3 years, or in the last 5 years for those aged 50-64). The target for coverage is 80% and these trend data show that performance is now below the national (England) level. Coverage has fallen in all areas as shown in Figure 3 below; (England (national), Midlands and East Commissioning region, East Anglia Area Team (Norfolk, Suffolk, Cambridgeshire and Peterborough) and Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). Also of note, is the fact that coverage remains considerably lower in the younger cohort (25 – 49) than in the 50 – 64 age group, where coverage too is now below the target of 80%. (Table 15).

Table 15: Latest Cervical screening data

Cervical Screening	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
Coverage standard - % of women 25-64 yrs with adequate test in 5 years	68.9%	68.7%	2015/16 Q3 Data awaited	2015/16 Q4 Data awaited
standard 80% coverage for 25-49 yrs (3.5 yearly)	65.4%	65.2%	2015/16 Q3 Data awaited	2015/16 Q4 Data awaited
standard 80% coverage for 50-64 yrs. (5 Yearly)	76.8%	76.6%	2015/16 Q3 Data awaited	2015/16 Q4 Data awaited
Standard 98% 14 day turnaround time from date of test to receipt of result letter	90.47%	99. 47%	2015/16 Q3 Data awaited	2015/16 Q4 Data awaited

Figure 3: Cambridgeshire and Peterborough CCG Cervical Screening Coverage Trend 25 – 64 years



5.4 Cancer screening Task and Finish Group

This group established by NHS England at the request of the HPSG, met for the first time in May 2015. At the first meeting detailed analysis of the data for breast and cervical screening was presented that helped to identify pockets of poor uptake. Further analysis, evidence review and intelligence gathering have been undertaken; all of which have informed the recommendations for actions and interventions to address these issues. The group reported back to the HPSG and, with some change in membership has now become an Implementation Group with responsibility to oversee the delivery of the agreed recommendations, some of which include collaborative working with Cancer Research UK and Jo's Trust to deliver training to front line public health staff and primary care staff to ensure staff are confident and knowledgeable about discussing and promoting cancer screening and are able to appropriately signpost. Awareness campaigns on cancer screening and prevention have also been planned and agreed, with plans underway to work with specific practices in areas of poorer uptake to better understand the reasons for lack of engagement and high DNA rates.

5.5 Bowel Cancer screening

This national screening programme involves all those aged 60 and over receiving a testing kit by post in which they can return faecal samples for testing. The test looks for hidden (occult) blood which can indicate some problem in the bowels that is causing bleeding. The presence of Faecal Occult Blood (FOB) is not diagnostic of cancer but gives an indication that

further testing is needed. The further tests are by endoscopy (examination of the bowel with a specialised scope and camera apparatus). A number of measures are reported to evaluate the success of the screening programme and these are reported in the table below.

Table 16: Bowel Cancer data for Cambridge Programme

	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
Bowel Screening ***(standard 52% completion of FOBT kit)***	61.8%	59.2%	**Data awaited**	**Data awaited**
Assessment by specialist screening practitioner (SSP) ***(standard 100% seen by SSP in 2 weeks*)**	100%	100%	100%	**Data awaited**
SSP assessment to endoscopy time ***(standard 100% endoscopy within 2 weeks of seeing SSP)***	100%	100%	100%	**Data awaited**

5.6 Non-cancer screening programmes

There are two national screening programme for non-cancer conditions, Diabetes Eye Screening (DES) provides an annual retinal check for people with diabetes; and Abdominal Aortic Aneurysm Screening (AAA) for men aged 65 and over (self-referral for those who have not been screened once).

As the data in Table 18 below indicates, the DES programme is performing well. However, recent capacity issues have resulted in delays with referred patients being seen and treated within specified timescales at some Trusts. This issue is being addressed contractually and with the support of the Clinical Commissioning Group.

The AAA screening programme reported that the proportion of men eligible for AAA screening to whom an initial offer of screening was made was 100% in the 2014/15 fiscal year. This is an annually reported metric and the 2014/15 data is the most up to date data available. It has been noted that lack of attendance is a growing problem and an action plan is in place to address this.

Table 17: Diabetes Eye Screening data 2015/16

Diabetic Eye Screening				
	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
standard 70% uptake (% *screened out*	78.5%	77.6%	Data awaited	Data awaited

of the total offered)				
standard 70% results received issued within 3 weeks of screening	99.1%	99.4%	Data awaited	Data awaited
standard 80% treatment within 4 weeks and 60% within 2 weeks of significant positive screen	2wks: 66.7% 4wks: 83.3%	2wks: 40% 4wks: 80%	Data awaited	Data awaited

Table 18: Abdominal Aortic Aneurysm data

KPI AA1 standard 90% (acceptable level) and 100% (achievable level)		
	14/15	15/16
	100%	Data awaited

5.7 Antenatal and newborn screening

A large number of screening tests are offered during pregnancy to screen for certain conditions that may impact on the health of the Mother and baby, in order that action can be taken during the pregnancy to minimise the potential effect and optimise the outcome for both.

Details of uptake levels for a number of these tests are given below. Data is submitted quarterly in the form of National Key Performance Indicators (KPI's) by the Hospital Trust's.
(https://www.gov.uk/government/collections/nhs-screening-programmes-national-data-reporting)

Screening data for Quarter 3 will not be available until later this year.

Ante-natal screening includes the routine offer of screening for a number of conditions that can adversely affect the health of the baby as well as the mother including:

Infectious Diseases:	• HIV • Hepatitis B • Syphilis • Rubella susceptibility

Sickle Cell and Thalassemia	
Down's syndrome	

Newborn screening includes testing for a number of conditions that are not obvious at birth but would have serious consequences for the baby if not detected and treated early, including:

Newborn infant physical examination		
Newborn Hearing screening		
Newborn blood spot test which detects conditions such as:	congenital hypothyroidism	
	sickle cell disease;	
	cystic fibrosis; and	
	Inherited Metabolic Disorders including:	phenylketonuria;
		medium chain acetyl-CoA dehydrogenase deficiency
		Maple syrup urine disease
		Homocystinuria
		Glutaric acidaemia type 1
		Isovaleric acidaemia

(see http://www.newbornbloodspot.screening.nhs.uk/ for explanations of each of these conditions.

Table 19: Ante-natal screening coverage

	Q2 Jul-Sep 2014	Q3 Oct-Dec 2014	Q4 Jan –Mar 2015	Q1 Apr-Jun 2015	Q2 Jul-Sept 2015
HIV screening ID1 (standard is to achieve >90%)					
CUHFT	No data	97	98.4	98.3	97.8
HHT	99.3	99.7	99.7	99.5	99.3
Infectious disease Hepatitis B (Standard >70-90% timely referral of hep B + women for specialist treatment)ID2					

CUHFT	100	100	100	100	100
HHT	100	100	*100	No cases	100
Down's Screening (standard >97%) FA1					
CUHFT	98.5	99.2	99.7	99.8	99.5
HHT	98.5	97.6	98.1	98.9	97.6
Sickle Cell and Thalassaemia screening (standard >95%) ST1					
CUHFT	No data	98.2	98.2	97.3	98.0
HHT	98.2	98.3	98.8	98.5	98.5
KPI ST2 Standard 50-75% Sickle Cell and Thalassaemia Tested within 8-10 weeks					
CUHFT	38.9	34.9	46.3	29.6	31.6
HHT	47.5	No data	No data	No data	No data
KPI ST3 Standard 90-95% Sickle Cell and Thalassaemia Completion of FOQ					
CUHFT	96.5	93.7	96	89.8	80.2
HHT	98.1	No data**	No data**	No data**	No data**

**Transfer of pathology services caused issue with extracting accurate data for ST2 & ST3 at Trust level; resolution still being sought. KPI stipulates data source should be the laboratory. Release of new amalgamated pathology form should go some way to address and HHT are looking at their own database to collect data.

Table 20: Newborn screening

	Q2 Jul-Sept 142014	Q3 Oct-Dec 1	Q4 Jan-Mar 15	Q1 Apr-Jun 15	Q2 Jul-Sept 15
Newborn Bloodspot test (standard 95-99%)					
(CCS)	100	100	99.9	98	98.0
Newborn Bloodspot – avoidable repeat tests (standard <2%)					
CUHFT	2.2	3.1	3	3.8	2.7
HHT	No data	No data	No data	No data	**9.0
Newborn blood spot timeliness of result (Standard 95-98%)					
CCS	100	99.9	99.9	***cease	***cease
** Laboratory unable to extract Trust level data until Q2 due to a software issue. HHT have action plan to address high repeat rate.					
***NB3 ceases from Q1					
New KPI: Apr 15 KPI NB4: Newborn blood spot screening – coverage (Movers In)					
CCS	NA	NA	NA	80	78.6
KPI NP1 Standard 95-100% Newborn & Infant physical coverage					
CUHFT	No data	No data	99.4	93.2	94.0
HHT		96.3	97.2	95.9	95.4
KPI NP2 Standard 95-100% Newborn & Infant physical timely assessment					
CUHFT	No data	No data	No data	57.1	0.0
HHT	No data	No cases	100	No cases	100

HHT have implemented the use of the National failsafe NIPE SMART IT system. CUHFT have been using their own internal system, but are in on-going discussions with the national team regarding the use of the NIPE SMART following on from some of the data extraction issues they have experienced. NIPE SMART offers a national failsafe solution for this programme.					
Newborn hearing coverage (standard 100%)					
CUHFT	97.5	93.6	96.8	98.6	98.0
HHT	99.6	99.6	99.6	100	100
Newborn hearing timely referral (standard 100%)					
CUHFT	93	69.2	100	75	78.9
HHT	33.3	80	100	100	100

6.0 HEALTH EMERGENCY PLANNING

6.1 Cambridgeshire County Council has always been a Category 1 responder under the terms of the Civil Contingencies Act 2004, As a result the council has an emergency planning/Resilience team that works in partnership with other organisations to lead emergency planning and response for the council. Some additional responsibility for health emergency preparedness passed with the move of Public Health into local authorities. In their role within local authorities the DPH is expected to:

- Provide leadership to the public health system for health Emergency Preparedness, Resilience and Response (EPRR)
- Ensure that plans are in place to protect the health of their population and escalate concerns to the Local Health Resilience Partnership (LHRP) as appropriate
- Identify and agree a lead DPH within the Cambridgeshire and Peterborough Local Resilience Forum (CPLRF) area to co-Chair the LHRP
- Provide initial leadership with PHE for the response to public health incidents and emergencies. The DPH will maintain oversight of population health and ensure effective communication with local communities.

6.2 Local Health Resilience Partnerships (LHRPs) provide strategic leadership for the health organisations of the LRF area and are expected to:

- Assess local health risks and priorities to ensure preparedness arrangements reflect current and emerging need
- Set an annual EPRR work plan using local and national risk assessments and planning assumptions and learning from previous incidents
- Facilitate the production and authorisation of local sector-wide health plans to respond to emergencies and contribute to multi-agency emergency planning
- Provide a forum to raise and address issues relating to health EPRR

- Provide strategic leadership to planning of responses to incidents likely to involve wider health economies e.g. winter capacity issues
- Ensure that health is represented on the LRF and similar EPRR planning groups
- Delegate tasks to operational representatives of member organisations in line with agreed terms of reference.

6.3 The Cambridgeshire and Peterborough Local Health Resilience Partnership (CP LHRP) is co-chaired by the NHS England Cambridgeshire & Peterborough Director and the Cambridgeshire and Peterborough DPH. Member agencies share responsibility for oversight of health emergency planning in this forum. It is for the CPLRF and/or the LHRP to decide whether LHRP plans should be tested through a multi-agency exercise as a main or contributory factor The DPH reports health protection emergency resilience issues to the LHRP on a regular basis. The DPH provides a brief update report on the activities of the LHRP to the HPSG to ensure sharing of cross cutting health sector resilience issues.

6.4 The DPH has been supported in this work by a consultant in public health who co-chairs the Health and Social Care Emergency Planning Group (HSCEPG) with the Head of EPRR from the NHS England Area Team and has oversight of all health protection issues. The function is supported by the shared Health Emergency Planning and a Resilience Officer (HEPRO) based within Public Health. The HEPRO reports into the LHRP and the LRF through the DPH.

6.5 The HSCEPG has membership from local acute hospitals, East of England ambulance service (EEAmb), community services, mental health services, social care services, other NHS funded providers, Public Health England and NHS England.

6.6 This year's deep dive for the EPRR core standards was planning for Pandemic Influenza. The working group delivered Exercise Corvus, a local adaptation of the PHE off-shelf exercise to test the arrangements for pandemic influenza. Follow up of the seven recommendations from this exercise forms part of the work plan for the working group this year. The other priorities for this group are to revise the local Mass Casualty Plan and put in place a plan for identifying vulnerable people in an emergency, both to be presented at the LHRP and CPLRF shortly.

6.7 Exercise Nimbus, a two day multiagency exercise to test eight CPLRF plans, was delivered on the 5th and 6th of November 2015. A total of 60 people from 27 agencies participated and a collated list of actions is being progressed by the CPLRF.

7.0 HEALTHCARE ASSOCIATED INFECTION (HCAI) AND ANTIMICROBIAL RESISTANCE (AMR)

7.1 MRSA bacteraemia

National mandatory reporting, in place since 2009, continues for Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia and Clostridium difficile (C Diff), to tackle the previous very high numbers of cases being reported that contributed to patient mortality.

Zero tolerance of MRSA bacteraemia remains the national and local objective.

The arbitration process acknowledges that a number of providers, including all community and social care services, may be involved in the care of a patient so that a case may not be attributable to any one care provider or that the infection occurred despite no lapse in care. These are referred to as Third Party assigned cases and do not appear on the local objectives for either the acute provider or CCG.

For the period of 2015/16 the following were reported in Cambridgeshire:
Acute providers – 7 cases of which one was assigned to an acute Trust.
CCG – 4 cases of which one was assigned to the CCG. A local commissioned community service was identified to have learning and an action plan will be monitored.

7.2 Clostridium difficile

Following some years of significant reduction, the number of C Diff cases nationally continues to fall but at a slower rate than when mandatory reporting initially commenced in 2009. Every effort is made to ensure continued reduction and to broaden our knowledge of this disease and the best means to reduce the associated risks. We have a clear understanding of what best practice looks like but complex patient pathways across all our health systems leading to many professional staff groups and specialties being involved in the care of individual patients. Each professional must share ownership of this risk. Co-coordinating this pathway and joining up communication is complex and challenging, but important especially between primary and acute care.

Every case of C Diff, whether community or hospital onset, has a root cause analysis completed and scrutiny meetings are held. Improvements have been made in antibiotic prescribing and the challenges reduced to prevent onward transmission to other patients.

For a second year the national process to remove cases from the local objective where no lapses in care have been identified was used, the Post Infection Review (PIR) process. Using strict criteria and standards the arbitration decision is made at scrutiny meetings which have high level

representation from Directors of Nursing, microbiologists, front line clinical staff and medical staff, infection control teams from provider services and the CCG. This process enables providers to review their practice and have an effective learning opportunity when cases occur. Providers are supported to achieve high standards of care providing a more positive patient experience. The aim is that providers do not become complacent with their achievements to date, ensuring that best practice continues to be embedded amongst staff. For the period of 2015/16, providers have slightly exceeded the actual number of cases against their national objectives and have also achieved to remain under this locally by the number of non-sanctioned cases. Approximately 53% of cases met this criterion as a result of the excellent work within provider services.

7.3 Antimicrobial Resistance

Antimicrobial resistance has been identified as a national and international risk to human health by the Chief Medical Officer, World Health Organisation and the Government as a whole. Antibiotics are widely used with many patients in the UK failing to complete the prescribed course or demanding antibiotics for viral or self- limiting conditions. These factors contribute to the development of antimicrobial resistance. In addition, no new class of antibiotics has been developed by the pharmaceutical industry in recent years. Each year on European Antibiotic Awareness day in November these problems are highlighted in the media, social media and posters.

The prescribing of antibiotics is monitored by the Medicines Management Team in the CCG for primary care and by hospital pharmacists for in-patients. Because antibiotic use is implicated in cases of C Diff, antibiotic prescribing is discussed at each scrutiny panel for C Diff, following completion of the root cause analysis. Concerns identified are either discussed with the GP or with the Medicines Management Team (MMT). High prescribing levels of two particular groups of antibiotics have been identified and a strategy is being developed to address the associated risks, one of which is an increased risk of C Diff infection. While general use of these groups of antibiotics should be limited, they must continue to be available and effective to treat infections caused by certain bacteria, which are sensitive to them.

This is an area under continual scrutiny and that will continue to be tackled by the CCG in collaboration with other local prescribers in acute, community and primary care

7.4 Other infections

Norovirus is a gastrointestinal infection that is self-limiting in nature but easily passes from person to person. The impact of outbreaks for hospitals is significant if ward closures are required to contain the situation. There have

been a number of small outbreaks within the Cambridgeshire hospitals, that were quickly identified and managed. The challenges remain for the public to understand the actions of staying away from hospitals if they are symptomatic. There has been minimal impact this season to date that has the potential to cancel surgery and admissions through lack of beds.

Flu has been occurring in slightly higher numbers of both A and B strains. The impact on hospitals has been slightly less, with cohorts nursed in smaller bedded areas where possible. The importance for patients, staff and the public to have the annual flu jab is stressed regularly. Trusts in Cambridgeshire have achieved well against national data in vaccinating members of staff.

8.0 SEXUAL HEALTH

8.1 Cambridgeshire has a favourable rate of diagnosis of new sexually transmitted infections (STIs) at 481 diagnoses of STIs per 100,000 residents (compared to 829 per 100,000 in England, and is lower than the East of England PHE Region average rate which is 669 per 100,000).

8.2 Rates of HIV late diagnosis

Between 2012 - 2014, 52.8% of HIV diagnoses were made at a late stage of infection, compared to 42.2% in England and is a slight increase when compared to 51.7% in 2011 – 2013. Earlier diagnosis leads to an improved outcome of treatment and reduced risk of onward transmission.

8.3 Chlamydia diagnoses

In 2014, the rate of chlamydia diagnoses per 100,000 young people aged 15-24 years in Cambridgeshire was 1557 which is below 2014 national average for England. In 2013, the rate was 1548 in Cambridgeshire and national rate of 2072, and in 2012 the rate was 1620 in Cambridgeshire and the national rate was 2074, all of which are below the Public Health Outcome Indicator of 2300 per 100,000 of young people aged 15-24 years. This positivity rate resulted from screening 24.9% of the eligible 15 – 24 year old population which is similar to 24.3% overall rate in England.

8.4 Teenage pregnancy

Rates of teenage pregnancy in Cambridgeshire continue to show the downward trend of recent years (2010 to 2014). In 2014 the under 18 conception rate was 16.2 per 1,000 which compares favourably with the England rate of 24.3 per 1,000.

8.5 PHE Eastern Region Work

PHE Eastern Region noticed an unusual increase in gonorrhoea cases across Milton Keynes, Luton, Central Bedfordshire and parts of Hertfordshire. Following a review of gonorrhoea case across the whole of the Eastern Region most areas including Cambridgeshire were

showing an increase in gonorrhoea case albeit not as significant as those in the areas mentioned previously.

PHE Eastern Region have organised a number of meetings with commissioners and providers in the area to develop an action plan to halt further increases in cases of gonorrhoea.

8.6 Sexual Health Service

In October 2014 an integrated sexual health service was launched with the aim of integrating the provision of sexual health and contraception services, increase accessibility, especially for hard to reach, high risk populations, and to address the inequity of service provision and the health inequalities between the north and the south of the county. Close monitoring of the new service shows it has been effective against these aims.

8.7 Cambridgeshire Sexual Health Network

To help maintain the momentum of the achievements of the integrated sexual health service we have reinstated the Cambridgeshire Sexual Health Network to act as a multi-agency network responsible for overseeing and implementing the Cambridgeshire Sexual Health Strategic Plan

The strategic plan identifies the following key themes for Cambridgeshire:

- Improved Chlamydia diagnosis for 15 to 24 year olds
- Improved early HIV diagnosis, reducing rates of late diagnosis
- Continued improvement in teenage pregnancy rates
- Improved access to sexual and reproductive health services for vulnerable groups
- All sectors of the population are informed about sexual health and how they can access services they require through an integrated sexual health communications plan.

9.0 LOOKING FORWARD

Commissioning TB services

A Collaborative TB Strategy for England was published in January 2015 and launched jointly by PHE and NHS England who are committed to working in partnership with the NHS, clinical commissioning groups (CCGs) and local authorities.

TB has major health and social impacts for those affected. In addition, it contributes to increasing health inequalities in already deprived populations. Each infectious case represents a risk of onward

transmission and the failure to protect communities from TB transmission should be regarded as a failure of public health systems.

The strategy ambition is to make significant advances in TB control. To achieve this, improvements are needed in the following key areas:

1. Access to services and ensure early diagnosis
2. Universal access to high quality diagnostics
3. Treatment and care services
4. Comprehensive contact tracing
5. BCG vaccination uptake
6. Reduce drug-resistant TB
7. Tackle TB in under-served populations
8. Systematically implement new entrant latent TB screening
9. Strengthen surveillance and monitoring
10. Ensure an appropriate workforce to deliver TB control

When the strategy was launched in East Anglia, workshop discussions generated 4 common recommendations to implement the 10 action areas, which are:

1. Establish intelligent, clear and consistent commissioning of local TB services
2. Improve links between key social and medical services
3. Raise the profile of TB amongst professionals, organisations and the general public
4. Empower and improve support mechanisms for healthcare workers

GLOSSARY

AAA	Abdominal Aortic Aneurysm
AT	Area Team (part of NHS England)
BCG	Bacillus Camille Guerin (vaccine for TB)
CCC	Cambridgeshire County Council
CCA	Civil Contingencies Act 2004
CCDC	Consultant in Communicable Disease Control
CCG(s)	Clinical Commissioning Group(s)
CCS	Cambridgeshire Community Services
CPLHRP	Cambridgeshire and Peterborough Local Health Resilience Partnership
CUHFT	Cambridge University Hospital Foundation Trust
DH	Department of Health
DPH	Director of Public Health
DsPH	Directors of Public Health
EH	Environmental Health
EHO	Environmental Health Officer
EPRR	Emergency Preparedness, Resilience and Response
GP	General Practitioner
GUM	Genito-urinary medicine (sexual health)
HIV	Human Immunodeficiency Virus
HHT	Hinchingbrooke Hospital Trust
HPN	Health Protection Nurse
HPSG	Health Protection Steering Group
HPT	Health Protection Team (part of Public Health England)
HPV	Human Papilloma Virus
HSE	Health and Safety Executive
HWB	Health and Well-being Board
IMT	Incident Management Team
JHWS	Joint Health and Well-being Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LGA	Local Government Association
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
MMR	Measles, Mumps and Rubella (vaccine)
MOU	Memorandum of Understanding
NHS	National Health Service
NHSE	NHS England
OIMT	Outbreak Incident Management Team
OOH	Out of Hours
NHS	National Health Service
NHSE	NHS England
PCT	Primary Care Trust
PHE	Public Health England
Q 1,2,3,4	Reporting quarters for each year
TB	Tuberculosis

Agenda Item No: 13

BETTER CARE FUND PLAN 2016-17

To: Health and Wellbeing Board

Date: 26 May 2016

From: Geoff Hinkins, Senior Integration Manager, Cambridgeshire County Council

Gill Kelly, Integration Lead, Cambridgeshire and Peterborough Clinical Commissioning Group

1.0 PURPOSE

1.1 The purpose of this report is to:

- provide Health and Wellbeing Board with the final Better Care Fund Plan, submitted in May 2016; and
- briefly outline the next steps for the Better Care Fund in Cambridgeshire.

2.0 BACKGROUND

2.1 The Better Care Fund (BCF) creates a pooled budget in each Health and Wellbeing Board area to support health, care and housing services to work more closely together. The BCF is designed to support better integration of health and social care to improve services for the most vulnerable people in the community; provide better support for carers and create efficiencies. The BCF also includes the Disabled Facilities Grant (DFG) which supports housing adaptations for people with disabilities.

2.2 Cambridgeshire's Better Care Fund plan was submitted to NHS England on 4 May 2016; at the time of writing, Cambridgeshire is awaiting feedback from NHS England and the Association of Directors of Adult Social Services (ADASS) who will decide whether the plan is 'assured' and can be put into action. A verbal update on the assurance process will be provided at the meeting

3.0 CAMBRIDGESHIRE'S BETTER CARE FUND PLAN 2016/17

3.1 The Cambridgeshire plan has four separate sections:

- Appendix A [attached]: Narrative Plan, which describes the overall approach and budgets that are included in the BCF and how they will be spent
- Appendix B [attached]: Annex E of the Narrative Plan (Huntingdonshire system Delayed Transfers of Care [DTOC] Plan)
- Appendix C [attached]: Annex F of the Narrative Plan (Cambridgeshire system DTOC Plan)
- Appendix D [not attached to the printed report, but on the Council's website at http://tinyurl.com/ccc-hwb-2016-05-16 and available on request]: The Submission Template, which provides financial and performance information to support the narrative plan, in the format required by NHS England.

3.2 Following approval of the Plan, the Council and CCG will agree a Section 75 agreement to make arrangements for the pooling of funds. These are agreements made under section 75 of National Health Services Act 2006 between a local authority and an NHS body in England, which allow for pooling of resources and delegating certain NHS and local authority health-related functions to the other partner(s). The Section 75 Agreement will be agreed before the end of June 2016.

3.3 Work on the transformation described in the BCF is underway; updates on progress will be brought to the Health and Wellbeing Board during the year.

4.0 RECOMMENDATIONS

4.1 It is recommended that the Health and Wellbeing Board note the report and the Better Care Fund Plan.

Source Documents	Location
Better Care Fund Technical Guidance	https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

Appendix A

Cambridgeshire Better Care Fund

2016/17 Narrative Plan

Version 1.1

Version control			
Version	**Author**	**Date**	**Notes**
1	Geoff Hinkins	4 May 2016	Version submitted to NHS England
1.1	Geoff Hinkins	4 May 2016	

Contents

Authorisation and sign-off

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:	**21 April 2016**
Date submitted:	**4 May 2016**
Minimum required value of BCF pooled	**£39,134,365**

budget: 2016/17	
Total agreed value of pooled budget: 2016/17	**£48,350,614**

a) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Cambridgeshire and Peterborough Clinical Commissioning Group
By	 Tracey Dowling
Position	Chief Operating Officer
Date	4 May 2016

Signed on behalf of the Council	Cambridgeshire County Council
By	 Adrian Loades
Position	Executive Director: Children, Families and Adults Services
Date	4 May 2016

Signed on behalf of the Health and Wellbeing Board	Cambridgeshire Health and Wellbeing Board
By	Tony Orgee Councillor Tony Orgee
Position	Chair of Health and Wellbeing Board
Date	3 May 2016

Signed on behalf of Cambridgeshire and Peterborough NHS Foundation Trust	Cambridgeshire and Peterborough NHS Foundation Trust
By	A. M. Thomas
Position	CEO
Date	03.05.16

Signed on behalf of Cambridge University Hospitals NHS Foundation Trust	Cambridge University Hospitals NHS Foundation Trust
By	
Position	AD CEO Director Workforce
Date	29/4/16.

Signed on behalf of Hinchingbrooke Health Care NHS Trust	Hinchingbrooke Health Care NHS Trust
By 	Cara Charles-Barks
Position Chief Operating Officer / Deputy CEO	

Date	3 May 2016

1. Introduction and approach

This document forms part one of Cambridgeshire's Better Care Fund (BCF) Plan for 2016/17. The other part is the 'template for BCF submission' spreadsheet, which contains financial and performance targets. This purpose of this submission is to:

- Outline our vision for integration across the Cambridgeshire system and how this has developed in the past year.
- Describe our specific priorities for delivery of further integrated working in Cambridgeshire in 2016/17
- Describe the context for the vision and priorities, including an overview of changes across the Cambridgeshire system and a brief overview of progress against the BCF plan for 2015/16
- Describe our approach to the Better Care Fund budget in 2016/17, including:
    - Use of the budget
    - Arrangements for risk sharing
- Describe how we will meet each of the national BCF conditions.

To avoid repetition, this document references last year's plan where applicable rather than repeating sections of it. The 2015/16 plan can be downloaded from:

http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=10965

2. Vision, Priorities and Delivery Plan

Purpose of this section:

- To describe our overall vision and the specific priorities that will set the framework for delivery of the BCF Plan during 2016/17.

Our vision

In our 2015/16 we expressed our vision as follows:

Over the next five years in Cambridgeshire 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: something which experience suggests has never happened before. However, this is required if services are to be sustainable in the medium and long term.

This vision has been the guiding principle for our work in developing our 2016/17 BCF Plan.

Our priorities and delivery plan

This section aims to set out in simple terms how we want the 'system' that supports older people, people with long term conditions including disabilities, carers and families to work in future and to set out set out a plan for delivery. By the 'system' we mean the NHS, Social Care, District Councils, Housing, Voluntary and Community sector and independent sector organisations providing services for people. This paper prioritises those people who are currently living independently but are vulnerable to becoming frail or needing higher levels of support or intervention in future. This paper is aspirational – it describes where we want to get to in the next 3 to 5 years, building on work that is developing across the health and wellbeing system in Cambridgeshire and Peterborough.

We hope that in 12 months' time, implementation of many of these changes will be underway. These priorities will form the basis for the Cambridgeshire and Peterborough Better Care Fund Plans for 2016/17 onwards; and builds on the work that has taken place so far and the '10 Aspects of an Integrated System' that have previously been agreed at the Cambridgeshire Executive Partnership Board (CEPB). The BCF plans will operate in conjunction with those of the 2016 /17 Urgent and Emergency Care Vanguard plans, the CCG's one year Operating Plan for 2016/17 and five year Sustainability and Transformation Plan (STP).

The narrative set out here will underpin the ethos of the 2016 Urgent and Emergency Care Vanguard work and the whole system Sustainability and Transformation Programme.

Broadly speaking, these changes can be divided into support for people who do not have, or have not yet developed, significant ongoing health needs; and support for those people that have

significant ongoing needs and receive support from a range of organisations. To achieve our ultimate aim of a shift away from long term social care or care that is provided in the acute setting to preventative services that are focused on keeping people well, we need to focus on our response across both cohorts.

Before people have significant ongoing needs

Healthy ageing and prevention

We are increasingly focused on establishing and implementing approaches that prevent or delay the need for more intensive health (specifically admissions and re-admissions to hospital) and social care services, or, proactively promote the independence of people with long-term conditions and older people and their engagement with the community. This includes specific and planned evidence based public health programmes with an emphasis on falls, social isolation, malnutrition, dementia and promoting continence. A lot of work is already happening in this area. It will remain a key priority across our organisations into 2016/17, informing the Proactive and Prevention workstream that has been set up as part of the NHS System Transformation Programme.

Eyes and ears – indicators of vulnerability

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

To support this, we will develop a list of 'triggers' which indicate that someone has, or may develop, increased vulnerability. Examples include someone asking for assistance with their wheeled bin, a request for a personal alarm/life line, a concern raised when a housing provider carries out a routine visit, a death is registered or a blue badge is requested. It will also include medical triggers such as low mood/depression, continence/ frequent Urinary Tract Infections (UTIs), injuries caused by falls, or frequent missed medical appointments. When these triggers are noticed the system will have a planned response to offer support, advice and information.

Clear and joint sources of information

People will be able to access a consistent library of health, social care and wider information from a number of places - including web sites, a library or community hub or their GP surgery. Information will be available in print, digitally or through trusted sources. Consistent and up-to-date digital information will be available, as each source will call on a shared information hub so that organisations offering support only have to update their information in one place – and it is available across all sources. From accessing this information it will be easy for people to find out how to make contact if they need further support.

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

Identification of these triggers, or a member of the public making contact, will result in a referral to a co-located or virtual single point of access where advice can be sought. Those who take the call can check existing levels of involvement with our agencies across different information systems via

appropriate look-up access to records. There will be joint single point of access based on the assumption that 'there is no wrong door'. This will be based on the different referral points for health, social care and the Voluntary and Community Sector (VCS) operating as one virtual front door. Ensuring that once a referrer or patient or carer has entered the system they are effectively directed to the right service quickly and are not aware of potentially moving between providers as part of that navigation process. This will be available for planned and unplanned care therefore ensuring all needs are met effectively.

If a follow-up appointment is needed there will be capacity for health and social care staff to make contact in person if a face to face conversation is needed with the individual or their carer, partner or relative. This could take place in someone's home or in the community.

Holistic identification of need with a coordinated response

Two types of 'assessment' tool will be available to support staff to identify levels of need and easily communicate that to people in other disciplines.

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

As well as that simple tool, a more in-depth holistic needs assessment process will be available that could be used to assess the full range of needs (physical, mental, social); and identify what support could prevent further escalation. A virtual 'team around the older person' would be established with all involved in this team (e.g. GP, District Nurse, Social Care practitioner Housing provider, home care agency, local voluntary organisation, neighbour) being able to work to a shared care plan based on shared information. A lead person or professional would be identified for as long as was needed as a key point of contact, to coordinate support and to simplify a complex system for people requiring support. This would most likely be the person who has most contact with the person and as circumstances change, the lead professional may also change. The purpose of this team would be to support the person and put measures in place which improve outcomes and avoid, as far as possible, escalation of need and admission to hospital or nursing/residential care.

Support for people with significant ongoing needs

Clear, coordinated pathways and hand overs

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

Neighbourhood teams and Multi-Disciplinary Team (MDT) working

Twelve neighbourhood teams will be embedded and operating effectively. Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) have restructured and established a number of integrated mental and physical health Neighbourhood Teams, each of which has a Neighbourhood Team Manager. An 'extended' Neighbourhood Team will be established which includes a range of other organisations that will work with the Neighbourhood Team to ensure integrated working. It is proposed that the next stages focus on integration with primary care, social care and the third sector. This will include social care staff who will be aligned to, or 'vertically integrated' with Neighbourhood Teams to ensure the appropriate person is identified as the lead professional. There is the potential to link this work with the move towards GP practices working much more closely together ('Primary Care at Scale'), and to consider designating some Neighbourhood Teams as 'demonstrator' or pilot sites where there is the potential to develop integrated working at a faster pace, providing valuable learning for other areas to accelerate local integrated working.

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

Case finding and case management

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

Working with Care Homes

Although our focus is on supporting people to live independently we recognise that residential care is the most appropriate choice for people that need it. We will continue to support care homes to ensure that their residents continue to receive high quality support that is focused on preventing their needs from escalating. We will continue to invest in training for care homes. We will expand older people's Crisis Resolution and Home Treatment with new resources to support people with dementia and complex needs in care homes. We will prioritise funding services to ensure that people are supported to live independently as long as possible. We will ensure that all residential home residents are known to the Neighbourhood Team , who will be notified as the patient deteriorates – in order to prevent a possible hospital admission as a patient's needs transition from residential to nursing care.

Working with housing providers

Supporting people to live independently requires that they have access to homes that are appropriate to their needs. We will work together with housing agencies to co-ordinate health, housing and social care to ensure that people with long-term conditions have access to accommodation that they want to live in, that enables them to remain independent within their community wherever possible. We hope that this will help people to have a choice about where they live, even if their health and social care needs are high or escalating. We will work to explore a range of opportunities linked to use of the Disabled Facilities Grant; and support for equipment and

adaptations that enable people to remain at home for longer. People will also have early access to advice on the housing options available to them, to ensure that they can make choices and plan for their future.

Enablers – support for delivery

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

Joint outcomes

The Outcomes Framework was developed as part of the Older People and Adult Community Services (OPACS) procurement process, with input from a wide range of stakeholders and a review of scientific evidence. The Framework contains a number of agreed outcomes for measuring quality of care. Each outcome and metric was tested against a range of criteria to ensure that they would add value; and be feasible to implement. The framework is already being used in reporting on delivery of integrated services locally; and we will maintain the benefits of an integrated, outcomes-based model. We will look to include relevant outcomes framework measures in 2016/17 NHS contracts (and other contracts where relevant), joint programmes of work across the health and social care system including the Sustainability and Transformation Plan (STP) and Better Care Fund plans.

Information and data sharing

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

A common language

By January 2017, we will have established a common language, using the methods described previously, that will give us the assurance we are able to work effectively and efficiently as a whole system, this will ensure that our well defined pathways can be navigated by any provider or user of the system.

Workforce development

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

Property co-location

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

Joint commissioning of the voluntary and community sector

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

Specific priorities

The specific components of this model that we will focus on in 2016/17 are:

Prevention

- An explicit prevention programme with an emphasis on falls, dementia and promoting continence; and on improving outcomes for people with long term conditions and their carers
- A joint set of standards for information making consistent information and advice available from a variety of different sources
- 'Eyes and ears' - a clear agreement about what the triggers for support should be and how the system will work

Joint planning and commissioning

- A joint approach to commissioning the voluntary and community sector between the Clinical Commissioning Group (CCG) and local authorities
- Reviewing our approach to housing adaptations and the Disabled Facilities Grant to ensure they are supporting as many people as possible to live independently
- Joint risk stratification of the population to inform Neighbourhood Team working
- Joint approach to the commissioning of beds and accommodation across the CCG area

Neighbourhood Team working/Local team around the person

- Aligned social care and community health staff
- Co-location at every opportunity
- The Rockwood tool used to quickly assess physical frailty; and investigation of alternative quick tools for social and community needs – with an agreed set of possible actions at each level.
- Information sharing – with staff able to access data held in different systems
- A joint holistic assessment tool, with information gathered from range of sources and the outcome of the assessment shared, with appropriate consent
- Lead professional identified where needed to avoid escalation

- Joint work force development programme for all staff working in this way

Integrated pathways

- Front doors operating as if one
- An integrated pathway for the intermediate care tier
- Delegated tasks and trusted assessor approach- carrying out tasks on behalf of each other within clear accountability framework
- Joint approach to care homes prioritising investment in training to prevent residents' needs from escalating

3. Strategic context

Purpose of this section:

- To review the approach to and performance of the BCF in 2015/16
- To describe the changes that have taken place across the system since 2015/16's plan
- To provide updates on the 'case for change'

Reviewing the Better Care Fund in 2015/16

In developing its approach to BCF for its first year, Cambridgeshire County Council and Cambridgeshire and Peterborough CCG jointly considered the distribution of the minimum NHS contribution towards the Better Care Fund. Overall, the approach recognised the responsibilities associated with the Care Act and new initiatives through the BCF balanced against the fact that the BCF involved no additional funding. There was also a need to maintain service delivery and contractual commitments in both health and social care.

This cautious and pragmatic approach meant that in broad terms the money in the BCF remained in the same area of the system as it was previously. In the first year of BCF most funding remained in existing budgets, and the small amount of repurposed spending was focused on areas that would begin to develop a transformation in services. The expectation was that in future years there would be more funding available to support different services as our work began to have an impact. In the first year of the BCF, our major areas of spending were:

- £18.1 million on community health services in the NHS, mainly on the CCG's Older People and Adult Community Services (OPACS) contract
- £14.5 million on social care services, with the majority spent on services that reduce demand for NHS services. This was mainly sourced from the previous section 256 agreement funding that supported social care services which delivered benefits to the health service.
- £0.9 million on transformation projects that were intended to help to shift demand away from emergency hospital services towards services provided in the community and helping people to stay more independent
- £1.9 million on Disabled Facilities Grants, awarded by District Councils to make changes to people's homes to support them to live independently – such as access ramps, internal modifications to make rooms easier to access, and improving heating and lighting controls to make them easier to use.

BCF Performance against metrics

Performance against the target metrics in the BCF has been mixed. The key indicator was for a reduction in non-elective admissions, for which the Health and Wellbeing Board agreed to set a target of a 1.0% reduction. However, non-elective admissions have continued to rise across the county, with performance at the end of quarter 3 showing an increase in non-elective admissions of 6.7%. Other indicators are either cumulative or only measured once a year; these factors have combined to make it difficult to demonstrate a link between BCF activity and performance at this stage of the financial year. This is an issue that we will address through the 2016/17 plan.

Transformation supported by BCF

The most significant investment through BCF was in the CCG's Older Peoples and Adults Community Services (OPACS) contract, awarded to UnitingCare Partnership. The five year contract was ended early on 3 December 2015, with the contract no longer financially viable. The immediate focus was on securing a safe transition of all service contracts to the CCG; and service continuity for patients and assurance for staff.

Although the contract with UnitingCare ended prematurely, the procurement process led to the creation of an innovative Outcomes Framework, a detailed service re-design process, comparison of alternative service options, extensive stakeholder engagement and public consultation and ultimately delivery of the first phase of the preferred service solution. Among the most significant achievements of OPACS under UnitingCare were:

- TUPE transfer of over 1300 staff into CPFT
- Set up of 16 neighbourhood teams
- Set up of Joint Emergency Team (JET)
- Set up of Onecall as single point of access

In addition to the UnitingCare contract, five BCF transformation projects were established, aimed at transformation over the medium term. Because many health partners in Cambridgeshire work across both Cambridgeshire and Peterborough, and recognising that many of the challenges faced by the system are common across both areas, these were established across Cambridgeshire and Peterborough:

- **Data sharing**: to ensure an effective and secure way to share data across health and social care, to help coordinate and join up services for adults and older people.
- **7-day services**: to expand 7 day working to ensure discharges from hospital and other services are planned around the needs of the patient, not when organisations are available.
- **Person Centred System**: to ensure services are focused around the needs of the patient, across health and social care. Care and support will be planned and coordinated by 'integrated care teams' made up of professionals from a range of organisations to ensure services are more joined up.
- **Information and Communication**: to develop and deliver high quality sources of information and advice based on individuals' needs, as opposed to organisational boundaries.
- **Healthy Ageing and Prevention**: to develop services in the community focused on preventing people falling unwell; in particular, to support older people to enjoy long and healthy lives and feel safe.

These projects have progressed at varying speeds this year. Many of the projects were closely integrated with work being undertaken by the UnitingCare Partnership; thus much of the work has been subject to review following the OPACS contract termination and the subsequent contract review. An example is the Data Sharing work, which was focused on extending the OneView system that UnitingCare were set to develop to improve sharing of information about patients and service users. Following the termination of the OPACS contract, the contract for this service has also been terminated for financial reasons, leading to delays in the work. As a result there are currently underspends in the project budgets, although in accordance with the section 75 financial agreement governing use of the BCF these will be carried forward into the 2016/17 BCF in Cambridgeshire.

Learning for 2016/17 and new initiatives

Lessons Learned from OPACS Contract

Since 3 December the CCG has discussed the OPACS services and workstreams with a wide range of stakeholders during December 2015 – March 2016 including Healthwatch organisations, Local Authorities, CPFT and other providers.

Since the termination of the contract there has been an internal (CCG led) review and an independent internal review as well as a further review. The CCG Governing Body agreed a process for reviewing the OPACS model and workstreams in January 2016, and the resulting draft Service Review was presented to the CCG Governing Body in April 2016. This review made recommendations on the way forward and further work required. It took into account the current position on the Sustainability and Transformation Programme (STP) work, the Better Care Fund and agreement of 2016/17 contracts. This Review is still confidential and in draft status at time of BCF submission and will be publicised later in May 2016.

An Internal Audit[1] was also undertaken in March, providing a crucial opportunity for reflection and identification of lessons learnt. The principle reason for the termination of the contract related to a mismatch in financial expectations of the CCG and provider and did not relate to service quality. The lessons learnt relate primarily to procurement and contract management and have shaped the approach to ongoing delivery. There has also been an external review conducted by the NHSE whose findings were very similar to the Internal Audit. Further, a third review is soon to be undertaken conducted by the National Audit Office. The CCG has assimilated all learning in relation to these reviews / Audits into its systems and processes moving forward.

Under the previous OPACS head contract, UnitingCare provided strategic oversight and programme management for the new delivery model. Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) were sub-contracted as a local delivery provider. The CCG does not plan to undertake a re-procurement of the OPACS contract. The subcontract that CPFT held has now passed directly to the CCG and the CCG will provide the programme management function in-house, to enable a more cost effective approach. CPFT will continue to be the local community delivery provider.

The CCG has therefore been – and will continue to - working with providers to directly commission what was the OPACS model. Now with the broadening of the programme to all adults it is known as the Integrated Adults Community Health Services (IACHS) model. The CCG will ensure this model progresses towards the agreed vision.

The CCG is committed to continuing with the service model developed through the contract, and this is reflected in the above priorities for delivery for 2016/17. The CCG is also committed to learning from the contract termination.

[1] Review of Procurement, Operation and Termination of the Older People and Adults Community Services (OPACS) Contract.
http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/Priority%20Older%20Peoples%20Programme/Internal-Audit-OPACS-Report-10-March-2016.pdf

Five Year Sustainability and Transformation Plan

In accordance with national guidance, Cambridgeshire and Peterborough Clinical Commissioning Group is also developing its five year Sustainability and Transformation Plan. The plan encompasses five key programme areas:

- Urgent and Emergency Care Vanguard
- Proactive Care and Prevention
- Elective Care Design Programme
- Maternity and Neonatal
- Children and young people

There is strong alignment between the BCF Programme, Proactive Care and Prevention and UEC Vanguard work-streams (particularly admissions avoidance, post hospital discharge and integrated urgent care clinical hub). In particular, there are strong links between the BCF 7 day services and person centred system schemes and Vanguard. In addition, close alignment with the Proactive Care and Prevention programme and the BCF Healthy Ageing and Prevention and Wellbeing schemes are being established.

Urgent and Emergency Care (UEC) Vanguard

During 2015/16, Cambridgeshire and Peterborough was chosen as an Urgent and Emergency (UEC) Care Vanguard site. The Cambridgeshire and Peterborough UEC Vanguard (which is part of the STP Programme) is an ambitious and challenging programme. The vision is to accelerate the implementation of the Keogh Review to realise the quality, patient experience and financial sustainability benefits that transformation of urgent and emergency care across health system will realise. The aim is to provide clarity to patients regarding the most effective and efficient way to access UEC, and then to be clear on what to expect when the call or visit to UEC is made. This requires patients to understand what's available from a local UEC offer, why this might be different across the system's geography, and what this means regarding the future configuration of UEC services. In return, providers will be better able to manage and, in turn, plan their service capacity within a system which is less susceptible to huge variations in demand. The aim of this is to enable resources to be used in a more economical way, by reducing demand on expensive emergency hospital services and establishing better local services for patients. In this way it is envisaged that patient satisfaction will be improved and people's associated health outcomes, whilst supporting staff to be more fulfilled in their roles. In short, the Vanguard Programme will look to demonstrate how and where 'value' can be added across the UEC healthcare system.

The case for change

Overall the case for change remains the same at the start of 2016/17 as it did one year ago. Our key challenges include:

- Population Growth: 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 and managing health and social care services.
- Financial: Cambridgeshire and Peterborough collectively is one of 11 'challenged health economies'; this means that if we change nothing, then in five years' time local health services

would need an extra £250 million - £300 million, with local social care services facing similar challenges.

- Over-reliance on emergency care: too many people are treated in our acute hospitals and numbers of people admitted to hospital as an emergency has been growing by around 2% each year. Supporting people earlier, in their own homes, in order to prevent emergencies will achieve better outcomes.

The population of Cambridgeshire has continued to grow and the estimated population in 2014 was 639,800 with 17.7% of the population (113,500 people) aged 65 and over, which is the same as the England average.[1] The population is more ethnically diverse in Cambridge, with just 66% white: British compared with 87-90% elsewhere.[2] The population of Cambridgeshire is forecast to grow by 23% between 2016 and 2036, an additional 147,700 people; the areas forecast to see the biggest growth are South Cambridgeshire (34%) and East Cambridgeshire (29%).[3] This makes Cambridgeshire the fastest growing shire county in the UK. Cambridgeshire's population is also ageing: the population aged 65+ in Cambridgeshire is expected to increase by 64% between 2016 and 2036, an additional 76,300 people; the area forecast to see the biggest increase in people aged 65+ is Huntingdonshire (67%).[3]

Levels of deprivation are low for the county as a whole but this varies by district; the most deprived district in the county is Fenland, the 80th most deprived local authority district out of 326 in England. The least deprived district is South Cambridgeshire (ranked 316).[4] Compared to 2010, Fenland and East Cambridgeshire now rank as more deprived in national terms than previously; Cambridge City ranks as less deprived. Cambridgeshire now has 16 LSOAs in the 20% most deprived nationally – this is compared to 9 in 2010. Average life expectancies for men and women in Cambridgeshire are higher than the national averages at 81.2 years and 84.5 years respectively.[5] Average life expectancy varies by district: for both men and women, the lowest life expectancies are found in Fenland (79.4 and 82.6 years respectively) and the highest in South Cambridgeshire (82.7 and 85.6 years respectively).[5] Age-standardised all-age all-cause mortality rates are lower in Cambridgeshire compared with the England average.[6] By district, age-standardised all-age all-cause mortality rates were highest in Fenland for men and women; premature mortality (deaths before the age of 75) follow the same pattern.[6]

No single organisation can meet these challenges alone and there is the need to develop a system together in a way that is based upon the real experiences and needs of people, families and carers rather than on organisational arrangements.

>> Further reading:

BCF Plan 2015/16, page 27

4. Delivering the Better Care Fund

Purpose of this section:

- To describe the approach to setting a BCF budget for 2016/17 in Cambridgeshire
- To provide an overview of the major budget lines being supported
- To describe governance arrangements for the BCF budget
- To describe the approach to Programme Management of the transformation to be delivered through the BCF.

Setting a Better Care Fund budget

One limitation of the approach to the BCF budget in 2015/16 in Cambridgeshire is that it was difficult to monitor the impact of the BCF as a whole. The Council and CCG have agreed as guiding principle for the Better Care Fund in 2016/17 that there should be greater transparency over the budget lines in the BCF pool. By this we mean that wherever possible budget lines will have clear performance metrics attached; and that clear and realistic expectations should be set for the transformation projects undertaken through BCF. It is expected that this approach will assist all partner organisations, and the Cambridgeshire Health and Wellbeing Board, in better assessing the impact of the BCF. This will become increasingly important as we move towards longer-term, more integrated planning across the system beyond 2016/17.

As the BCF does not contain any new investment, a significant proportion of the fund will be supporting existing services. We have attempted to bring service budgets into the BCF where a clear benefit can be realised through aligning service budgets in health and social care. The expectation is that this will drive further joint commissioning and support an expansion of integrated working in future years. This has increased the overall size of the BCF in 2016/17, which will be made up as follows:

BCF Funding 2016/17

	CCG (k)	County Council (k)	Other (k)	TOTAL (k)
Revenue	££41,261	£1,352	£700	**£43,313**
Capital		£5,038		**£5,038**
TOTAL	**£41,261**	**£6,390**	**£700**	**£48,351**

'Other' line relates to project funding carried forward from 2015/16. Figures have been rounded – see BCF planning template for precise figures.

BCF Budget categories, 2016/17

The spend making up the BCF has been found from the following categories:

Scheme	Amount (k)	Type	Responsible Commissioner	Notes
Integrated Adults Community Health Services (IACHS)	£17,012	Revenue	CCG	
CCG Re-ablement funding	£2,000	Revenue	CCG	
Risk share	£836	Revenue	CCG	
CCG Carers Funding	£350	Revenue	CCG	
Protecting social care	£2,500	Revenue	LA	
Former s256	£10,652	Revenue	LA	
Care Act Implementation	£1,367	Revenue	LA	
Additional Local Authority contribution (revenue)	£1,352	Revenue	LA	
Additional CCG contribution	£5,605	Revenue	CCG	
Transformation team	£300	Revenue	Joint	
Transformation projects	£1,338	Revenue	Joint	Includes 15/16 underspend of £700k
Disabled Facilities Grant	£3,480	Capital	LA	
CCC Capital	£1,559	Capital	LA	Funding removal of ASC Capital Grant
Total	**£48,351**	Combined		
Figures have been rounded –see Planning Template for precise figures				

Budget categories

All of the areas of spend of the Better Care Fund are considered to be part of a single Pooled Budget for the purposes of the Better Care Fund. In recognition of the fact that significant portions of the budget are to be passported to other services, a principle has been agreed that partners will seek to limit physical transfers of funding, to reduce transaction costs. To achieve this, categories of spend have been created as follows:

- Contribution: for funds that are being contributed to an existing service budget or project from the Better Care Fund pool
- Project: for funds that are reserved for spend on transformation projects under the governance of the Better Care Fund
- Risk Share: funding previously used as the performance-related pay element of BCF and now reserved for the local risk share agreement in relation to achievement of non-elective admission targets

For “contribution” funds, a Responsible Commissioner is identified for each spending line. That Responsible Commissioner is authorised to arrange services or service contracts up to the approved expenditure from the Better Care Fund. To avoid unnecessary financial transactions, ‘Contribution’

funding for which the Responsible Commissioner will be the CCG will not be physically transferred into the pooled fund. Contribution funds will be the sole responsibility of the Responsible Commissioner identified within the Section 75; but the Responsible Commissioner will report progress on spending and performance as part of the overall reporting on the BCF. In particular this means:

- Responsibility for and control of the funding does not pass into the BCF pooled budget;
- No assumption is made by either party about this funding remaining in the BCF in future years;
- the Responsible Commissioner may make changes to, or reduce, or re-allocate the budget in year – but will advise the other partner that it is doing so; and
- any underspend will be retained by the Responsible Commissioner; and the Responsible Commissioner will be liable for any overspend; i.e. there will not be a call on the pooled budget for any overspend.

For "project" funds, the amount identified is available to joint commissioners for project spending towards the agreed BCF plans. Any underspends will be reinvested in the pooled budget.

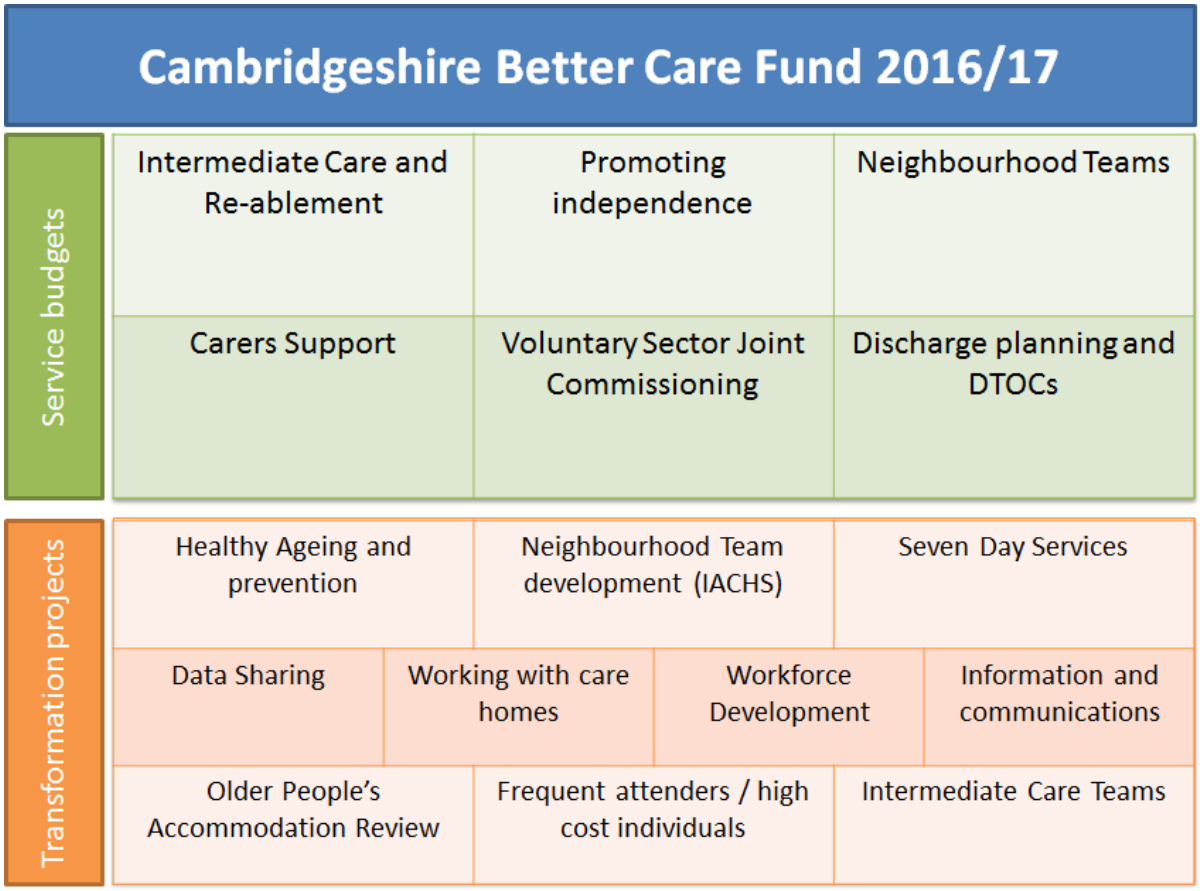
For 'Risk Share' funds the CCG will set the Risk Share aside within the CCG budget and it will only be released into the pooled budget at the beginning of the following financial year based on performance against the target for non-elective admissions. Any funding not released into the pool will be used to compensate acute providers. The methodology for the risk share will be agreed as part of the sign-off process for the section 75; the proposed risk share process is described at Annex A.

Budget management

The County Council will act as host partner for the pooled fund and will be responsible for holding the budgets transferred; administering the budgets; and nominating a 'pooled fund manager' to ensure that the Council complies with its obligations.

Key activity areas

The BCF is divided into 'service budgets' and 'transformation projects':



Service budget spending

As the BCF does not contain any new investment, a significant proportion of the fund will be used to support existing services. However, this year we have attempted to bring service budgets into the BCF where a clear benefit can be realised through aligning service budgets in health and social care. The expectation is that this will drive further joint commissioning and support an expansion of integrated working in future years. This will allow joint planning and monitoring of activity and outcomes in key areas across the system. Alongside existing service spending, we are also investing in key transformation projects that will support the shift that we want to see away from long-term and acute care towards care that is increasingly personalised and provided to people in their homes and communities.

Our BCF activity areas are as follows:

Service area	Amount	Description
Promoting independence	£9,343k	A wide range of services that provide support to people to enable them to remain living independently in their own homes. Services include the Integrated Community Equipment Service; Handyperson scheme; Home Improvement Agency; Assistive Technology and provision of the Disabled Facilities Grant.
Intermediate Care and Re-ablement (bed and non-bed based)	£12,832k	Short term interventions in both health and social care which support people to retain or

		regain their independence
Neighbourhood Teams	17,049k	Neighbourhood teams are integrated community-based physical and mental health care teams 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.
Carers support	£1,850k	Advice, information and direct support for carers
Voluntary sector joint commissioning	£2,902k	A variety of contracts held with the voluntary sector that support our goals
Discharge Planning and Delayed Transfers Of Care (DTOCs)	£1,900k	Services that promote effective and timely discharge from hospitals back into the community
Transformation team	£300k	Investment in transformation capacity to support the transformation projects contained within the BCF plan
Transformation projects	£1,338k	Investment in a range of transformation projects that will support our goals (see below)

Full spending plans are contained within the Submission 3 Template on Tab4 (HWB Expenditure Plan); for each budget line the relevant category is indicated at the end of the 'scheme name' field.

Transformation projects

Our service spending is complemented by a range of transformation projects that will support the aims of our joint delivery plan. Some of these projects continue from 2015/16, whilst others are newly established for 2016/17. A brief description of each project is below along with a summary of funding agreed in principle to support the project. Full business cases are in development for each project where funding is to be provided, which will include a summary of the benefits expected for both health and social care; these will be agreed between partners as part of the sign-off process for the section 75 agreement.

Healthy ageing and prevention

The Healthy Ageing and Prevention Project will establish and implement preventative 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 engagement with the community. Areas of focus will include falls prevention, older people's mental health, social isolation and loneliness, and promoting continence.

Two project areas are to be supported financially via the BCF in Cambridgeshire:

- Developing social prescribing

  Social Prescribing aims to increase the capacity of GPs, community health and Local Authorities to meet the non-clinical/non-service threshold of Adult Social Care needs of a variety of different people in need of non-medical services that aim to prevent worsening health for people with

long-term health conditions. In recent years locality-based social prescribing services have increasingly been developed by health and social care commissioners to provide a mechanism for linking patients in primary care with sources of social, therapeutic and practical support in the voluntary and community sector. Social prescribing is being promoted by the Department of Health and NHS England as a vital component in the transformation and integration of health and social care.

Funding of £100k will be made available through the BCF to support the development of a business case and initiate development of a service model for social prescribing.

- Falls Pilot

£42.5k of BCF funding will be used to support a pilot project in St Ives, to ensure implementation of NICE guidelines for falls and improve joined up working between different community teams. The pilot will include approaches to case identification; multifactorial falls risk assessment; and linking people to appropriate falls prevention provision in the community. The pilot will be used to establish approaches that will reduce the number of falls in the community; and will be used to inform the roll-out of a wider service across the county following evaluation.

Information and communication

This project is working to provide consistent, accurate and comprehensive health and social care information and advice regardless of the access channel used or partner organisation contacted. The project will develop access to consistent 'front doors' for information or advice. The project will develop shared information management standards across the partnership and a model for feeding data to a range of partners – a local information platform. The project will enable partners to collaborate better, by developing a deeper understanding of their shared customers and available community resources.

Data sharing

In order to support effective care, access to, and integration of, health and care information is a key enabler in ensuring patients receive the right care at the right place at the right time. These activities also need to be aligned with patient/ citizen sharing preferences as owners of their health and care information and that information where available is used to ensure the care they receive reflect their choices where possible to do so and alleviates the requirement for patients to tell their story multiple times to health and care professionals as they move through their health/ care pathway(s). The Data Sharing Project was established with four objectives for data sharing:

1. To enable decision makers within health and wellbeing pathways to be well informed.
2. To complement and facilitate delivery the preventative / admission avoidance agenda including, but not limited to, the risk stratification process, the person-centred system and the joint assessment process.
3. To improve people's experience of and confidence in the health and wellbeing system; patients will not have to 'tell their story' to a number of agencies involved in delivery of services to them; the relevant information will be accessible to all agencies across the system as required
4. To improve strategic commissioning, planning and delivery.

The focus of the work in 2016/17 is to support the joint delivery plan, via enabling data sharing in 'trailblazer' neighbourhood teams; ensuring that professionals can access each others' systems as appropriate; promoting early sharing of information about people whose needs are increasing; and

developing an approach to information governance that supports the above priorities. Work will also continue on development of the county's Digital Roadmap which will describe how we will move towards 'fully interoperable electronic health records so that patient's records are paperless'. £200k of BCF investment has been agreed to support development of the project in 2016/17.

Seven day services

The Seven Day Services project will enable discharge planning to be undertaken in response to patient need as opposed to organisational availability and will improve outcomes for patients because they will be able to leave hospital as soon as they are clinically fit and it is safe to do so. The Seven Day Services Project will deliver an integrated approach to discharge planning and admission avoidance ensuring that the right services are available across the system when needed and will include expansion of health and social care services, and residential and nursing home services. In addition this project will focus on out of hours admission avoidance in order to ensure that the increased pace and capacity created by improved 7 day discharge planning is not just filled by an increase in admissions. Priorities for 2016/17 include working with providers to achieve clinical standards, mapping of services to identify priority areas for further planning /investment and discharge planning. No funding is included within the BCF for seven day services; in the short term it is intended that each organisation will meet its own costs. Seven day services form an important part of the CCG contracts with its acute providers.

Neighbourhood Team Development, with links to the Integrated Adult Community Health Services (IACHS) Programme

The Neighbourhood Team (NT) is central to the Integrated Adults Health Services (IACHS) model, delivering care organised around the patient. NTs are the physical and mental health care hub of the local community, working in an integrated way with GPs, primary care, social care, housing and local community support services (voluntary and community sector and independent sector) to provide responsive expert care and treatment to local people. NTs are focused on admission avoidance and high quality care and management of patients with complex long term conditions. Multi-disciplinary integrated NTs consisting of Community Matrons, Community Nurses, Allied Health professionals, Mental Health Social Workers are operational across the county. The continued development of these teams will include Adult Social Care and each recipient of a service will have a named lead professional.

The NTs will be supported by case finding, case management, risk stratification and frailty tools and associated processes, along with a common assessment framework, to ensure appropriate timely interventions are made. These all form key parts of our Delivery Plan.

Working with care homes

This project will provide resource to recruit Care Home Educators. Building upon a successful recent pilot, the educator scheme is already operational in Peterborough, providing clinical review, support, and training to care home staff. The educator provides a link between care homes and other health services to embed alternative pathways to prevent avoidable admissions, and, between the acute trust and care homes, to improve discharge pathways. The role supports medication reviews, improved care quality to reduce incidences of pressure sores, deep vein thrombosis (DVT), urinary tract infection (UTI), and falls. The care home educators will support a system-wide approach to reduce the number of hospital admissions relating to urinary tract infection (UTI) or blocked

catheters. An analysis of UTI (ICD10: N39) recorded over 2,600 emergency admissions and over 32,500 bed days at a total cost of £8.6m. Whilst not all these admissions are from care homes, it is realised that care homes have a significant part to play in reducing UTIs and with regards to catheter care for patients at risk of UTIs. Investment of £113.5k has been agreed from the BCF transformation fund to support this work.

Workforce development

We are committed to the development of joint workforce development approaches. We will focus on developing capacity, capability and work to change attitudes and behaviour regarding integrated working across the health, social care, voluntary and private care system. To this end we are in the process of developing a BCF Integrated Workforce Group, which is aligned with the work of the Local Workforce Advisory Board. This Board will oversee the delivery of the Sustainability and Transformation Plan workforce requirements for health. Across the health and care system there are three main areas to be explored:

- Career pathways
  The sector as a whole is facing severe personnel shortages at all levels of health and care, and so we need to create attractive career pathways in the care and health sector as a whole; supporting people to develop their skills whilst staying within the sector. This will mean understanding people's current pathways; understanding the reasons that people join and leave the sector; and understanding where the gaps are that cause people to leave for a new career elsewhere. This will help us to identify opportunities for new training opportunities, support and new role types. If these pathways are not coordinated across health and care then any significant recruitment in one sector will lead to shortages in another, destabilising the whole system.

- Training and skills
  New or changed roles will require individuals to learn new skills. Practitioners will need training that supports them to develop through more integrated career pathways. Individuals will need training to become more flexible in providing care and health tasks; and will need longer term support to develop into their future career. This will require a mix of short term learning opportunities; informal courses and development; and longer-term vocational and professional qualifications. We will work with our own learning and development functions as well as other education providers to understand what new opportunities may be needed for the future - and work with them to design the right training mix to realise this.

- System culture
  Learning and Development interventions that are focused on practitioners' role as part of a wider system - instilling a culture that helps practitioners at all levels think about people's needs wider than their own organisation. helping them to understand how their role links with others in different organisations; and focused on giving people the common skills and common language to pull together for the benefit of residents, patients and service users.

Up to £100k funding will be made available from the BCF to support this work in 2016/17 and the plan is to match funding with other funding sources in year.

Older People's Accommodation Review

Our Older People Accommodation Programme brings together partners from across the system to co-ordinate health, housing and social care agencies so our work supports older people's access to accommodation that they want to live in, that enables them to remain independent within their

community wherever possible. By co-ordinating activity, we hope to help older people to have a choice about where they live, even if their health and social care needs are high or escalating. The Programme will be supported in order to make use of specialist technical expertise during 2016/17 to inform planning for future accommodation needs. £50k of BCF investment is available to support this work during 2016/17.

Frequent attenders / high cost individuals

Research has shown that small numbers of people can have a proportionately high impact on the system, whether this is through frequent attendances at Emergency Departments (ED), frequent visits to primary care, high levels of hospital admissions or because their needs mean that they receive significant care on an ongoing basis from a range of different organisations. Based on our local research to date, in many cases there will be opportunities to provide better care for those people more efficiently, in ways that are tailored to their individual needs and circumstances and closer to home.

This work is currently being scoped will explore three areas to better understand how we can identify and meet the needs of groups of patients more effectively:

- Frequent attenders/ frequent admissions – identifying patients who are frequently attending at or admitted from ED and seek to work with them to understand their needs. We will aimt to coordinate support for them more effectively in the expectation that this will reduce their attendances and admissions and ensure that they are getting the care that they need.
- Most expensive patients – identify the patients known to an acute setting that are most expensive over a period of time; explore whether they are known to other agencies and whether it would be possible to meet their needs in a different way
- Identifying patients at risk of becoming high users of health and social care services – Coordinating support through neighbourhood teams, identifying the patients that are receiving regular and intensive support from a range of different organisations to explore whether their support can be provided in a more joined up way.

The methodology for the work is to be developed, but in each of the three areas is likely to include elements of:

- Automated, data driven identification of individuals
- Holistic and collaborative assessment of their needs
- Development of a shared care plan that will coordinate their support across a number of agencies, with an identified lead professional
- Regular review of individual needs to ensure that they are receiving the support they require
- Evaluation to understand whether closer collaboration around those patients will reduce costs to the system and improve people's care.

Up to £70k of BCF transformation investment is available to support the development of this work during 2016/17.

Intermediate Care Teams (non-bed based provision)

Review the intermediate tier to ensure that neighbourhood teams are complemented by a resilient, integrated intermediate care tier offering home-based services and intensive rehabilitation services

(therapy). This will involve all local partners, including commissioners and providers. The aim is that there will be co-ordination, co-location, and co-operation between re-ablement, rehabilitation, neighbourhood teams, primary care, housing and the voluntary sector to make best use of the total resources available. This would result in the creation of a strengthened, integrated intermediate care suite of health / social care services to:

- prevent unnecessary admission to hospital
- support early discharge from, or prevent unnecessarily prolonged stays in, hospital as well as supporting early discharge from community hospital rehabilitation units
- prevent premature admission to long-term residential care
- maximise health and self-confidence and chances of living independently.

The service includes the recruitment of integrated care workers, intermediate care therapists and nurses. The best means of delivering this service is currently being explored with the community services provider CPFT.

Programme Management

As part of our 2015/16 plan, it was intended to establish a multi-agency transformation team to develop the BCF transformation projects. After further discussion this was established as a 'virtual team' comprising officers from Cambridgeshire County Council, Peterborough City Council, Cambridgeshire and Peterborough CCG, and (until December 2015) UnitingCare Partnership. Wherever possible, projects are being developed jointly across both Cambridgeshire and Peterborough Health and Wellbeing Board areas. Dedicated Programme Managers are based within each local authority, and project sponsors and leads are drawn from across the partnership as appropriate. This arrangement will continue for 2016/17. In 2016/17 wherever possible there will be system-wide design of the joint projects with consideration being given to local implementation where it makes sense to do so.

Risk Management

Below are details of our respective approaches to the most important risks and our plans to mitigate them.

Cambridgeshire has adopted a proactive approach to risk and issue management, based on best practice methodologies. The risk and issue management pathway includes a sequence of activities to identify, assess, prioritise and mitigate the risks and issues. This incorporates robust engagement with local stakeholders.

The CCG's Assurance Framework and risk register (CAF) was last reviewed and updated in March 2016. It sets out the high level organisational risks that could potentially impact upon the CCG and its ability to deliver its responsibilities. The CAF brings together all of the evidence required to support the Annual Governance Statement. It clearly identifies the risks of failing to meet the CCG's Strategic Aims and also its agreed Values. The 2015-2016 CAF is also linked to the relevant domains within the DH Annual CCG authorisation process. The CAF clearly identifies the strategic risks to the organisation. It identifies the controls in place to mitigate the risks, the assurances on these controls and the action plans that have been established to address any gaps. The CAF should be seen as a living document which will be updated regularly by the Corporate Governance Team and reported to the CCG Governing Body and relevant sub-committees for monitoring purposes. The 2015-2016 version of the CAF comprises risks that were transferred from the 2015-2016 CAF together with new risks identified following review at the end of 2015-2016. Following recommendations made by

Internal Audit, the design of CAF has included changes to include target risks scores and also reflect the organisation's risk appetite. This latter recommendation will continue to be developed as the current year is progressed. As set out in our Risk Management Policy the CAF is linked to the Local Commissioning Group (LCG) Board Risk Registers and also the individual directorate registers which have now been established. These Risk Registers are reviewed on a quarterly basis by the CCG Secretary and High Risks are reported through to the Clinical and Management Executive Team (CMET), and escalated to the CAF where appropriate. Risk Registers have been developed for each of the CCG's Programme Boards. These registers are monitored by the respective Programme Boards. Each Urgent Care Network has established risk registers which have been combined to form an Urgent Care Collaborative Board Risk register. The risks on the Assurance Framework have been evaluated and scored using the NHS Patient Safety Agency's Model Risk Matrix. The CAF design is based around the CCG's Strategic Aims agreed for 2014/15. The CCG's extensive risk plans incorporate those risks relating to the high risk areas within BCF plan delivery relating, for example, to QIPP, financial balance, increasing NEAs, DTOCs etc.

The County Council also has a robust risk management policy to identify, evaluate and manage risks. Major risks to the delivery of outcomes and services are identified and included within the risk register. For each risk, a risk owner is identified who is responsible for reviewing and monitoring the risk. All risks, including the effectiveness of mitigating actions, are reviewed on a quarterly basis. Directorates each have their own risk register. Where risks cannot be managed at a directorate level, they are escalated to the Corporate Risk Register for discussion by the Council's Strategic Management Team (SMT). SMT review all 'red residual' risks each quarter. A quarterly report detailing key changes to corporate risk and its profile is presented to Committee.

Governance and Programme Alignment

One of the lessons learned during 2015/16 was the need for much greater scrutiny across the system of BCF plan delivery and on the reduction of non-elective admissions (NEA). In order to achieve the level of shift from acute to community care the rapid but sustainable development of community health, Local Authority, and VCS systems and services as part of the integrated solution is necessary. This is of paramount importance during 2016/17 given the scale of the financial challenge facing both the CCG and Local Authority. The reduction of NEAs, and demand on long term social care services, are key components of the QIPP and Local Authority plans to move towards greater financial sustainability.

The governance landscape around the BCF Plan has changed this year, and is set out in a diagram at Annex G. The Sustainability and Transformation Programme (STP) leads on the development of the five year Sustainability and Transformation Plan, overseen by The Health and Care Executive, which is a Chief Executive Officer-level group comprising CCG, Providers, Local Authorities and NHS Improvement. Workstreams overseen by this group include the Urgent and Emergency Care (UEC) Vanguard, which reports locally to the Super-System resilience Group (SSRG) and through to the Health Executive. Another programme included as part of the STP is the Proactive Care and Prevention Programme (PCPP), which includes the BCF Healthy Ageing and Prevention workstreams.

The Programme is now referred to as the Integrated Adults Community Health Service (IACHS) in view of the fact that all adults and not just older people are incorporated within the way forward. The mechanisms / governance for IACHS will be as straight-forward as possible, recognising it is a

complex system. Most IACHS planning and service development work fits well with the new STP structures, and joint working associated with the Better Care Fund. As there are already a number of existing local system structures, there will be a CCG wide Integrated Adult Community Services Joint Clinical and Management Team responsible for continued operational delivery. It will also form part of the Urgent and Emergency Care Vanguard structure, but through its membership link strongly with Proactive Care and Prevention STP workstream, and Better Care Fund work. The value of this joint clinical and management team will be reviewed at 6 months, recognising the rapidly changing environment.

As the CCG area is comparatively large, it contains four Local Health Systems, with six Local Commissioning Group (LCG) Boards. The LCGs are responsible for driving the System Resilience Groups (SRGs). The role of the three local SRGs is to ensure systems are in place around each acute hospital to ensure patient flow across the system. SRGs comprise representation from the acute hospital, CCG, Local Authority, VCS, Ambulance Trust and member of the BCF team. The SRGs are responsible for developing and delivering the DTOC plans locally as well as monitoring the non-elective activity and implementing the new ways of working coming out of the Vanguard Programme.

The Cambridgeshire Health and Wellbeing Board has overall responsibility for BCF Plan delivery, whilst regular monitoring of the Plan and budget is delegated to the Cambridgeshire Executive Partnership Board (CEPB), which brings together all key partners across the county. As well as overseeing the BCF Plan delivery, the purpose of CEPB 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. In order to further strengthen BCF plan delivery during 16/17, a BCF Delivery Group has been established, reporting to the CEPB. This Group will ensure there is the appropriate level of drive and focus on programme delivery in 2016/17. The Group's core members are representatives from the County Council and CCG; the group will engage with other partners regularly as required.

With such close inter-relationship it is crucial that there is clarity on where the governance and thus decision point sits for each workstream. A review of governance and delivery arrangements is scheduled to take place during the first quarter. The aim will be to rationalise and integrate the governance and delivery arrangements of workstreams across the health and care system whilst also ensuring alignment across Cambridgeshire and Peterborough wherever possible.

>> Further reading:

BCF Plan 2015/16, page 47

5. National Conditions

Purpose of this section:

- To describe how each of the National Conditions for the BCF will be met in Cambridgeshire

Local plan to reduce Delayed Transfers of Care

A Delayed Transfer of Care (DTOC) is experienced by an inpatient in a hospital, who is ready to move on to the next stage of care but is prevented from doing so for one or more reasons. Timely transfer and discharge arrangements are important in ensuring that the NHS effectively manages emergency pressures. The arrangements for transfer to a more appropriate care setting (either within the NHS or in discharge from NHS care) will vary according to the needs of each patient but can be complex and sometimes lead to delays.

In Cambridgeshire, non-elective admissions for over 65 year olds account for 47% of all non-elective admissions and 62% of spend in acute hospital care. Older patients are more likely to have a longer length of stay, even after their acute medical problems have been resolved. Prolonged hospitalisation not only increases costs, it is also associated with other complications especially in older patients such as infections, immobility, pressure sores, Deep Vein Thrombosis and deconditioning, thus worsening the patient's quality of life and outcomes.

Recognising that patient flow has a significant impact on the effectiveness of emergency care, we have a robust approach to DTOCs which operates at three levels:

- Our strategic approach to DTOCs is being coordinated through the Urgent and Emergency Care Vanguard;
- Our System Resilience Groups (SRGs) have plans for reducing DTOCs
- Each system has operational arrangements to respond to short-term increasing pressures, which allow for quick escalation; improving use of capacity and procuring additional capacity where necessary; and establishes regular conference calls at times of significant pressure to ensure that the system is doing everything possible to alleviate the situation.

There are a number of factors that affect Length of Stay (LoS), some of which are associated with internal hospital processes such as waiting for tests, specialist review, or Occupational Therapist (OT) review. Issues associated with processes and behaviours within the acute hospitals are addressed within the Vanguard's 'In Hospital' workstream through embedding the SAFER Bundle of interventions as well as the standardisation of pathways for common conditions.

There is also a strong focus on discharge planning and DTOCs from each of the Hunts and Cambridgeshire SRGs and this work is in turn also supported by both the BCF and UEC Vanguard work streams. On this basis a gradual reduction in DTOCs has been seen as realistic, with the aim of reaching the nationally recommended target of 2.5% occupied bed days in by June 2016 for Cambridgeshire and July 2016 for Huntingdonshire. These slightly differential targets underpin the single Cambridgeshire-wide target set out in the Part 2 DTOC Plan metric.. The local Cambs and Hunts DTOC plans are attached. Both are undergoing significant revision by each SRG at time of BCF

plan submission in order to strengthen the delivery and risk sections of the plans. They will be signed off in June 2016.

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Key deliverables regarding discharge planning across the Cambridgeshire and Peterborough system in 2016/17 include:

Discharge Planning Protocol

We will develop and implement consistent discharge protocols across acute and community hospitals, with pathways for discharge well defined and streamlined. The protocol will bring consistency in the processes and definitions used to identify and act upon delayed transfers of care. The local system of notification will alert community and social services to the likely need for services post-acute discharge and will facilitate forward planning for discharge.

Intermediate Care Teams (non-bed based provision)

Recent work has been undertaken to reconfigure existing community services to develop multidisciplinary, locally-based community health and social care services, working with clusters of GP practices. These services, set out around Neighbourhood Teams (NTs), include integrated case management, community nursing, community therapy, and mental health support. We now need to take this to the next stage to establish a resilient intermediate care tier that can provide home-based services and intensive rehabilitation services (therapy).

This service will be aligned with the robust reablement service provided by Cambridgeshire County Council to form a truly integrated intermediate tier. It is envisaged that there will be co-ordination, co-location, and co-operation between the services to make the best use of the resources available.

These services will build the community service base necessary to enable safe and timely discharge.

Discharge Home to Assess pathway

Discharge home with 'live in' care support and wrap around care from community teams for complex patients. This is a time-limited intervention for patients that will benefit from a period of care and support at home before their final care needs are assessed. This will complement the intermediate care tier service for those patients that require more intensive support (e.g. 24 hour care) in the initial weeks of their recovery, or for those patients who are on the final stages of an End of Life pathway.

This service has already been piloted successfully in the Cambridge system focusing on Continuing Health Care (CHC) Fast Track patients and self-funders with very positive results. MIDAS care, an independent sector provider, provides support for six placements at any one time with either live-in care or two shifts of 12-hour care if the patient's home cannot accommodate a live-in carer.

Early evidence suggests that 15 patients have already been discharged from Addenbrooke's hospital over a seven week period with an average length of stay in the pathway of nine days. Of the 15 patients, two were self-funders (13%) and 13 were Fast Tracks (87%). A previous audit of CHC Fast Track patients in hospital before the pilot started showed average length of stay from fast track referral to discharge to be 5.4 days. Of the 13 patients in the pilot, 30% were discharged within 24 hours, 54% were discharged within 48 hours, and 92% within 72 hours, with 100% of patients discharged within four days. In addition, there are invaluable benefits to patients by going through

this pathway as 46% of them passed away at home in line with their wishes. The feedback from carers has also been extremely positive.

The service will be rolled out incrementally across the full CCG geography to enable providers to deploy additional resources without destabilising the existing capacity. The cohort of patients will be expanded beyond those selected for the initial pilot to include patients with other complex needs that are often difficult to place in interim health settings while they recover, such as patients presenting with slow-resolving delirium.

The final complement of 30 placements or "virtual beds" with an average length of stay of four weeks in the pathway would provide support for approximately 500 patients in a year.

Community Based Intermediate Care Beds

A review of community based intermediate care beds, covering community hospitals and care home settings, will be undertaken during 2016/17 to ensure that commissioned capacity is aligned to reduced demand levels expected as a result of developing and investing in community intermediate care teams and home based services resulting in a need for fewer beds. Investment in the development of community intermediate care capacity, as stated in the points above, has the potential to enable care at home for over 3000 patients per year.

More home care will also support greater patient flow within community beds increasing throughput and reducing Length of Stay (LoS). We are aiming to reduce LoS in community beds to an average of 14 days.

Overall Impact in 2016/17

We have agreed the following targets / objectives at present for the post-hospital discharge workstream:

- Achieving the nationally recommended target of a reduction of 2.5% occupied bed days by June 2016
- 20% reduction in spend on excess bed days (based on spend across the three main acute hospitals, all Health Resource Group (HRG) codes)
- 20% reduction in NE readmissions in acute hospitals
- 20% reduction in the use of escalation/contingency beds within the three acute hospitals
- Improved staff satisfaction and reduced sickness absences, staff turnover/vacancy levels, and spend on agency staff. This will be monitored during 2016/17 with a view to gathering evidence/baseline data of the impact proposed schemes have on the staff satisfaction and related metrics)
- Improved patient and carer experience of care and support at home/in the community
- In addition to the benefits already received through reablement it is expected that there will be a further reduction in demand for long-term social care packages. This is estimated to be 20% of the total patient throughput supported by the Intermediate Care Tier and expected reduction in local authority spend on long-term care packages
- Reduction in LoS down to an average of 14 days in community hospital beds to improve throughput

Approach to DTOC fines

In line with Care Act guidance and practice across the Eastern Region, the County Council has stated that it does not expect to be paying DTOC fines to acute hospitals on the assumption that it is doing everything within its power to effect a timely transfer from hospital of people CCC is responsible for supporting. The effective delivery and implementation of the Better Care Fund Plan will ensure that the health and social care system is working to maximum effect to prevent admissions where appropriate and enable appropriate discharge.

>> Further reading:

UEC Vanguard Value Proposition 2, page 22

Plans to be jointly agreed and Impact on providers

Provider engagement and sign off of the BCF plans is an intrinsic part of the process in Cambridgeshire – to ensure that plans are jointly agreed and that the impact of our proposals on providers is considered. The Cambridgeshire BCF plan is closely aligned with the CCG-wide Sustainability and Transformation Programme; particularly through its Proactive Care and Prevention and UEC Vanguard workstreams, both of which involve partners from across the system.

The BCF Plan is a standing item on the agenda for the Cambridgeshire and Huntingdonshire monthly System Resilience Group (SRG) meetings, which include health and social care commissioners and providers alongside members of the VCS. Further the plan is the subject of ongoing discussion at the Cambridgeshire Executive Partnership Board (CEPB) which includes District Council representatives and is accountable to the Health and Wellbeing Board for the BCF Plan development. Comments and input from CEPB means that the plan has been commented on by commissioners and providers in social care and health. The final plan has been approved by the Health and Wellbeing Board and signed off by the County Council and CCG Governing Body and also Hinchingbrooke Hospitals NHS Trust, Cambridge United Hospitals NHS Trust (CUHFT) and Cambridge and Peterborough NHS Foundation Trust (CPFT), our community and mental health services provider.

The plan has thus been discussed throughout its development and jointly agreed by local partners across health, local authorities and the VCS. The transformation priorities have been discussed widely across the system, and build on the Joint Older People Strategy agreed by our system in 2014.

The CCG will also include the Cambridgeshire BCF Plan as part of the Cambridge University Hospitals Foundation Trust (CUH), Hinchingbrooke Healthcare NHS Trust (HHT) and CPFT contracts as a document to be relied upon. The detail of the plan will be incorporated within the post contract agreement in the next routine contract meeting.

Our 2015/16 Plan (page 80) describes our approach to engagement in developing the first year's BCF Plan. Cambridgeshire Executive Partnership Board Members have continued to be engaged in development of the plan and the projects which sit underneath it; and continue to take responsibility for engaging with their own organisations and sectors.

>> Further reading:

Annex D to this submission is our high level communications plan – this is being further developed. **BCF Plan 2015/16, pages 80, 82**

Maintaining provision of social care services

The locally agreed definition of protecting social care services is maintaining the existing thresholds for social care eligibility criteria, ensuring that social care services are able to meet the national minimum eligibility criteria.

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 to the CCC budget to ensure that services can be protected, alongside the continuation of the funding that was previously in section 256 allocations, and there are no plans to reduce the amount of resources dedicated to supporting reablement.

Our overall level of support specifically identified to maintain provision of social care services has remained the same in 2016/17 as in 2015/16. More information on our overall approach is contained within our 2015/16 BCF Plan.

>> Further reading:

BCF Plan 2015/16, page 66

Care Act requirements

£1,367,000 has been allocated to support our local response to the Care Act, including meeting the new duties placed on local authorities. As a result of Part 2 of the Care Act being delayed to 2017, the programme set up to deliver the requirements of the Care Act was merged with the Transforming Lives project in July 2016. Governance arrangements were reviewed and projects were re-scoped to deliver by April 2016. The Transforming Lives/Care Act programme portfolio of projects is as follows:

- Transforming Lives (including Workforce Development) – a new model of social work for Adult Social Care
- Adult Early Help – a new model of front door access to Adult Social Care
- Communication and information
- Care markets – managing the market to meet Care Act requirements
- Safeguarding – set up to deliver 'making safeguarding personal', transferring safeguarding referrals to the Multi-Agency Safeguarding Hub (MASH) and to meet Care Act requirements
- Advocacy – set up to commission and procure a new advocacy service
- Supporting Systems – to deliver the changes to the contributions policy to meet the Care Act requirements
- Community Navigators - set up to commission and procure a new contract for community navigators

The programme will be reviewed again in April 2016.

Support for Carers

Our 2015/16 BCF contained £350k as the minimum amount of carer specific support included within the BCF, which is used within CCG budgets for their support for carers. The total £350k was transferred to the UnitingCare contract for the purposes of commissioning carers' support from the Carers Trust. This responsibility has now returned to the CCG who are using it to support the Carers'

Prescription (£278k); along with other carer liaison and support and other posts within the voluntary sector. More detail is contained within our 2015/16 plan.

To support a more joined up service for Carers in future, the County Council has brought some of its own services for carers within the scope of the BCF budget in Cambridgeshire, alongside the services already included.

>> Further reading:

BCF Plan 2015/16, page 80

7 day services

All partners maintain a strategic commitment to 7 day working where appropriate. Many services are already operating seven days a week; our focus locally is ensuring that the right services are available at the right time to ensure that patients are kept safe, and that patient flow is maintained.

During 2015/16 whole system workshops were held in each of Cambridgeshire and Huntingdonshire System Resilience Groups (SRGs). These took a whole system pathway approach to ensuring the development of seven day services in addition to working on the imperative to deliver the ten clinical standards. A common set of principles has been agreed, predicated on the need to ensure patients flow through the system irrespective of day of week. The resulting delivery plans are owned and being driven by each SRG and service mapping and communication of service availability via the Directory of Service as well as delivery against the ten clinical standards and discharge planning will be a key part of the delivery plan for 2016/17 BCF.

Better Data Sharing, based on the NHS Number

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.

The County Council has completed a procurement for a new social care management information system, which will be implemented during 2016/17. The new system will allow easier sharing with partner organisations based on open Application Programming Interfaces (APIs).

A project is underway to establish and implement an effective and secure approach to data sharing across the whole system in order that the provision of all services will be better co-ordinated and integrated, and support the delivery of person centred care in the most beneficial setting. The project will ensure the use of the NHS number as primary identifier. It will include the delivery of an overarching solution that will make available data from several systems across Cambridgeshire with the provision of APIs for each core system. This will be aligned with the production of Information Sharing protocols and a phased roll-out plan for Data Sharing.

Original plans for 2015/16 focused around the development of the UnitingCare system 'OneView', which would offer a single view of the patient record. In light of the UnitingCare contract changes a decision was taken to not proceed with OneView, so further scoping is underway to determine

alternative options. A focus on immediate practical data sharing options are being progressed to facilitate better data flow and integrated working practices (e.g. local data sharing agreements, cross-organisational access to existing systems). In addition, Cambridgeshire County Council has recently procured a new adult social care system, which will incorporate open APIs. This system is expected to be operational in Autumn 2016. This work is aligned with the CCG's local digital roadmap and digital maturity work.

Joint approach to assessments and care planning

Our approach to joint assessments and care planning is described in our 2015/16 BCF Plan. The plan described how the contract delivered by the UnitingCare contract would support a step change in our efforts around multi-disciplinary working and joint case management. During 2015/16, Neighbourhood Teams have been established to provide better and more holistic support for older people and people with long-term conditions. Further development of risk stratification, proactive case management and identification of a lead professional are priorities for 2016/17.

>> Further reading:

BCF Plan 2015/16, page 77

Reduction in non-elective admissions

The target 1% reduction in non-elective admissions (NEA) was not met in 2015/16, resulting in many increasing pressures on the system.

During 15/16, the BCF non elective target of 1% was based on Monthly Activity Returns (MAR) data, which includes all CCGs and is not hospital specific. As the CCG Operating Plan was based on SUS data the alignment between the two plans was not easily understandable.

For 2016/17 the BCF non elective data will instead be based on SUS data and will be directly extrapolated from the CCG's Operating Plan's non elective trajectory plus the non elective QIPP plans. The NEA target is thus based on 2015/16 outturn, which has growth built in. The impact of the non elective QIPP plans – those plans required to reduce NEA down to a sustainable and affordable level has then been added which gives a challenging 6.6% reduction in NEA during 2016/17. . This level of reduction is necessary in view of the deficit the CCG faces during 16/17 largely as a result of the OPACS contract and in order to move the system towards greater financial sustainability as discussed above. Partners acknowledge that this is a very challenging target and will require even greater collaboration, partnership working and scrutiny this year to enable this target to be achieved.

The achievement of the NEA target will therefore need to be achieved through composite activity from the UEC Vanguard, Proactive Care and Prevention Programme and the BCF Plans working closely together. It is not possible to ascribe targets to each individual part of the system, as they are interdependent.

One of the lessons learned from 2015/16 is the requirement for more detailed scrutiny by provider, GP practice and by neighbourhood teams on a monthly basis during 2016/17. The fact that the target is this year derived from SUS activity will make it much easier to understand what is

happening and where in order to ensure appropriate mitigating actions can be put in place. Therefore monitoring will not only be from the BCF Delivery Group but also the local SRGs and the Super SRG which governs the non-elective care Vanguard so that mitigating actions can be put in place across the whole system from primary care, community services, through to District Councils and voluntary sector as required.

Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Cambridgeshire has committed £20,866,310 of funding for 2016/17 to NHS Commissioned out-of-hospital services. This exceeds the minimum local BCF ring-fenced amount of £10,132,282. This is comprised of the following elements:

- £836,000 allocated to a local risk sharing agreement (described above)
- £19,680,310 allocated to the commissioning of providers to deliver local integrated adult community health services
- £350,000 dedicated to services for carers commissioned by the CCG.

Integrated Adult Community Health Services (IACHS)

The level of funding for IACHS in 2016/17 has provisionally increased to £19,012,000 from £17,808,000 in 2015/16. In 2015/16 this funding was invested in the OPACS contract, which was a key enabler for health and social care integration across the local system. Despite the provider UnitingCare no longer holding the contract, the local system partners remain committed to the integrated community model of delivery going forward. Cambridgeshire and Peterborough Clinical Commissioning Group have taken on direct responsibility for direct commissioning of the IACHS model and continued work to further develop the model is planned in 2016/17. This increase in funding allocation for provision of the IACHS model is necessary as the CCG has inherited an £8.4m deficit as a direct result of the transfer of the OPACS contract from UnitingCare to the CCG. This contract was specifically designed to develop community based services to enable people to be cared for closer to home, thus reducing the level of non-elective demand on acute hospitals. Within this context, the CCG has a duty to ensure that the appropriate level of health investment continues to be made in community services in order manage the health aspects of the urgent care demand in the system so that patient flow is maintained.

Use of the Disabled Facilities Grant

For 2016/17 there has been a significant uplift in the Disabled Facilities Grant (DFG), from £1.9 million in 2015/16 to £3.4 million in 2016/17. The full budget is included within the scope of the BCF. This uplift recognises the important part that housing adaptations play in supporting people to live more independently in their communities.

Social Care and district council partners have a good track record of partnership working and have previously worked collectively to review and establish the best model to deliver disabled facilities grants. This was partially achieved with the development of the shared service home improvement agency covering Cambridge, South Cambridgeshire and

Huntingdonshire in 2012. However, we do still have inconsistent arrangements across the county.

Cambridgeshire Executive Partnership Board (CEPB) members believe that the uplift in BCF presents an opportunity to take a more strategic approach to housing adaptations, encompassing both capital and revenue funds contributed by a range of partners countywide. We have locally established a DFG Review project, reporting to our Older People Accommodation Board.

We recognise that we need to take a planned approach. For 2016/17, the new DFG allocation will be passed in full to District Councils from the County Council; whilst the DFG Review project examines our overall approach and develops any changes to budgets through its work over the course of 2016/17. We will aim to make any changes to budgets from the 2017/18 financial year. Each District will use the increased allocation to meet the local need for housing adaptations. DFG allocations for each district are included within the BCF Spending Plan as part of the BCF submission template.

The focus of the DFG Review is on three key areas:

1. Review of current delivery model and time taken to deliver adaptations

- Desktop analysis of quarterly monitoring information including: Time taken to deliver DFGs, analysis of types of adaptation, location, etc.
- Research models of delivery in other areas including Peterborough
- Consider fast tracking standard works i.e. Level access showers, outside of DFG
- Consult with home improvement agency providers on possible options going forward.

2. Review early intervention and Occupational Therapy referrals

- Consider options for providing early housing options advice before an OT assessment is requested, including potential use of the Early Help team, Reablement, Handyperson Service, Home Visiting Service, etc.
- Explore use of Trusted Assessors for standard works i.e. level access showers and whether this would meet the duty to consult Social services
- Review OT practices in relation to DFGs in child, physical disability and older people cases
- Ensure adapted homes are considered as part of developing new communities/large sites
- Look at OT waiting times and whether these could be reduced through alternative ways of working or redeployment of resources.
- Consider how this work links with the new multi-disciplinary teams

3. Making best use of both capital and revenue funding

- Review the need/demand for DFGs by district and by household type.
- Identify any gaps/surplus in capital funding following new BCF allocations.
- Review current DFG ‘top up’ policies in districts and at the County to identify possible alternative options/mechanisms.

- Consider current discretionary grant/loan policies at district level and possible use of DFG capital for relocation, etc.
- Consider current revenue funding for HIAs from both CCC and Health and assess the impact of any reduction.
- Consider the use of a Memorandum of Understanding in relation to the use of both capital and revenue funding.
- Agree recommendations for best use of capital and revenue funding for 2017/18 onwards

The review group will report back to the Cambridgeshire Executive Partnership Board in summer 2016; and any proposals will be agreed by respective partner organisations and discussed at the Health and Wellbeing Board.

Annexes

Annex A	Proposed Risk Share Agreement
Annex B	Milestone Plan
Annex C	Risk Log
Annex D	Communications plan
Annex E	Huntingdonshire System DTOC Plan
Annex F	Cambridgeshire system DTOC Plan
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Annex A: Proposed Risk share agreement

This risk share approach will be finalised and included within the Section 75 Agreement

1. Context

During 2015/16, the BCF non elective admissions (NEA) target of 1% reduction against 14/15 outturn was based on Monthly Activity Returns (MAR) data which includes all CCGs and is not hospital specific. Further as the CCG Operating Plan was based on SUS data, the alignment between the two plans was not easily comparable. For 2016/17 the BCF non elective data will instead be based on SUS data.

2. BCF Guidance

The performance element of the Better Care Fund has been replaced in 2016/17 by 2 national conditions:

- Local areas to fund NHS commissioned out-of-hospital services
- Develop an action plan for managing Delayed Transfers of Care

The local risk sharing agreement refers to the first of those conditions. BCF Guidance states that local areas can choose to put an appropriate proportion of the performance element into a local risk-sharing agreement, as part of contingency planning in the event of excess NEA in year. Given the upward trajectory of NEA in 2015/16 and the financial position of the CCG, it has been agreed to establish a Risk Share Agreement between the CCG and Cambridgeshire City Council.

3. Risk Share Fund

The Fund comprises 100% of what was the 'performance fund' in the 2015/16 BCF Plan. The risk share value for Cambridgeshire is £836k. For clarity, this is the figure used when referring to the Risk Share Fund. The Risk Share Fund will be part of the CCG's minimum BCF allocation, and not in addition to it.

4. 2016/17 NEA Target

The 2016/17 NEA target aligns with the CCG Operating Plan 2016/17 NEA target plus the impact of NEA QIPP plans. This forms the BCF NEA target in Part 2 of the 2016/17 BCF Plan.

5. Ownership of the Risk

It is acknowledged that the risk sits with the CCG as the CCG is liable for payment to its acute providers in the event of over performance of NEA.

6. Risk Management

The risk will be monitored, managed and mitigated through the Strategic Systems Resilience Group (SRG), which governs the Vanguard Programme and oversees transformation

projects to reduce NEA, as well through the Cambridgeshire and Huntingdonshire SRGs which meet monthly, the BCF Delivery Group and the Cambridgeshire Executive Partnership Board (CEPB) which meets bi-monthly. NEA at Cambridgeshire University Hospitals NHS Trust (CUHFT) and Hinchingbrooke Hospital Trust (HHT) will be scrutinised on an ongoing basis. Where increases in NEA are identified, the reasons for this will be established and mitigating actions taken at the earliest opportunity. The SSRG and each SRG incorporate representation from primary care, local providers and Local Authority. The work of the SSRG, SRGs and CEPB will be overseen by the Health Executive and Health & Wellbeing Board.

7. Operation of the Risk Share

The CCG will set the Risk Share aside within the CCG budget and it will only be released into the pooled budget at the beginning of the new financial year (2017/18) based on year end performance against the BCF NEA target as shown in the below scenarios:

Scenario 1

If there is evidence that the BCF NEA target is met in full, or exceeded, at the end of the financial year (2016/17) then the Risk Share Fund will be paid in full into the pool for 2017/18.

Scenario 2:

If there is evidence that there is over-performance against BCF NEA target (i.e. that there is more-non elective spend due to increased activity than planned) but that the cost of that over-performance is below £836k the CCG will pay the balancing sum into the pool in 2017/18. The remaining element of the risk share will be retained by the CCG in order to compensate acute providers; thus that proportion of the sum will not be available for investment into the pool in 2017/18.

Scenario 3:

If there is evidence that there is over-performance against the BCF NEA target (i.e. that there is equal to or greater than £836k additional spend on NEA than planned) the CCG will retain the £836k in order to compensate acute providers thus this sum will not be available for investment into the pool in 2017/18.

Any funding released into the pool under Scenarios 1 and 2 will be made available for spending on joint transformation projects during 2017/18 as part of the BCF plan; the Council and CCG will collectively decide how the payment would be spent, in consultation with CEPB member organisations and the Health and Wellbeing Board.

Reporting on Risk Share Spend

This will be reported to the BCF Delivery Group through to the CEPB and NHS England through the quarterly reporting mechanism

Annex B: Milestone plan

Healthy ageing and prevention

Workstream	Milestone	Start date	End date
Overall:	Project plan for 2016/17 updated and approved	01 March 2016	01 May 2016
Falls prevention:	Early trigger action plan developed and approved	01 March 2016	01 May 2016
	Design whole system joint falls pathway		01 July 2016
	Agree data set and collect data		01 July 2016
	Falls pilot delivered in St Ives – to form basis for upscaling model across Cambridgeshire and Peterborough	01 July 2016	01 January 2017
	Plan implementation and confirm operational readiness	01 January 2016	01 April 2017
	Implementation commenced	01 April 2017	-
Dementia:	Early trigger action plan developed and approved	01 April 2016	01 June 2016
	Develop joint pathways and best practice guidance across the whole system		01 September 2016
	Agree data set and collect data		01 September 2016
	Pilot/test new pathway or model	01 October 2016	01 February 2017
	Plan implementation and operational readiness	01 February 2017	01 April 2017
	Implementation commenced	01 April 2017	-
UTIs/Continence:	Finalise project lead and project team members	01 March 2016	01 May 2016
	Develop clear vision and objectives	01 May 2016	01 July 2016
	Early trigger action plan developed	01 July 2016	01 September 2016

	and approved		
	Develop joint pathway across the system	01 September 2016	01December 2016
	Agree data set and collect data		01 December 2016
	Pilot/test new pathway model	01 December 2016	01 April 2017
Social Isolation:	Early trigger action plan developed and approved	01 April 2016	01 June 2016
	Develop joint pathway across the system to improve service join up and coordination	01 June 2016	01 October 2016
	Develop strategic evaluation tool to aid local commissioning of high quality social isolation services	1st October 2016	01 March 2016
	Implementation plan and operational readiness	01 February 2017	01 April 2017
	Evaluation tool being practically used to support local commissioning	01 April 2016	-
Wellbeing Service & Social prescribing	Develop Business case for social prescribing	01 May 2016	01 June 2016
	Action plan developed and approved	01 June 2016	01 July 2016
	Agree system wide commissioning model for 'Wellbeing Service'	01 April 2016	30 July 2016
	Implement delivery plans	01 August 2016	01 March 2017
Overall:	Evaluate and plan 2017/18	01 January 2017	01 March 2017

Information and communication

Workstream	Milestone	Start date	End date
	Project plan for 2016/17 updated and approved	01 April 2016	01 May 2016
Local Information Platform	Mapping of existing directories and services completed		01 June 2016
	Options appraisal and approval of technology solution		01 August 2016

	Development of information sharing protocols and agreement of sharing data sets and consent models	01 August 2016	01 December 2016
	Development of technology solution		
	Plan implementation and operational readiness	01 December 2016	01 April 2017
	Implementation commenced	01 April 2017	-
Front door:	Sharing of FAQS and referral pathways between CCC and health front doors Explore opportunities to align One call,111 and CCC SPA	01 June 2016	01 September 2016
	Detailed design	01 September 2016	01 January 2017
	Plan implementation and operational readiness	01 January 2017	01 April 2017
	Implementation Commenced	01 April 2017	-
Change management:	Communications plan developed	01 March 2017	01 April 2017
Overall:	Evaluate and plan 2017/18	01 January 2017	01 March 2017

Data sharing

Workstream	Milestone	Start date	End date
Overall:	Project plan for 2016/17 updated and approved	01 April 2016	01 May 2016
Joint approach to consent and fair processing:	Joint approach to consent and fair processing agreed	01 April 2016	01 October 2016
Protocol for working with patient held records	Protocol developed as part of pilot project	01 May 2016	30 September 2016
	Protocol shared with all health and social care delivery staff	30 September 2016	31 March 2016

Summary care record content signed off and extracts / views created for all systems.	Social care summary content extracts developed	01 May 2016	30 August 2016
	Summary views made available to support dual record access by front line and front door workers	01 September 2016	30 December 2017
Development of longer term plan to demonstrate progress towards common APIs:	Development of 5 year data sharing plan and approval	01 April 2016	01 November 2016
Interim solutions for improved data sharing across existing systems	Implementation of interim solutions (e.g. cross-organisational log ins/access to existing systems)	01 April 2016	01 August 2016
Overall:	Evaluate and plan 2017/18	01 January 2017	01 March 2017

7 day services

Workstream	Milestone	Start date	End date
Mapping of current 7 Day Service provision	Complete mapping of existing whole system 7 day service provision	01 March 2016	01 June 2016
	Review status of each clinical standard within each acute hospital	01 April 2016	30 ay 2016
	Prioritise areas for 7DS on basis of review	Ongoing	01 July 16
	Project plans for 2016/17 updated and approved by each SRG	01 April 2016	01 June 2016
Overall:	Evaluate and plan 2017/18	01 January 2017	01 March 2017

Neighbourhood Team development, linking to the Integrated Adult Community Health Services (IACHS) programme

Workstream	Milestone	Start date	End date
Overall:	Commissioning Project lead from Vanguard Team established	01 March 2016	01 May 2016
	Work plan for 2016/17 incorporated within work of Integrated Adults Community Services Joint Working Group.	01 April 2016	01 May 2016
Population risk stratification and case management:	Case finding approach agreed Test the 'Rockwood' Frailty Score across the system Refine Operational Policy for case management across the health and social care system for 2016/17; Agree a consistent approach to effective MDT coordination across Cambridgeshire and Peterborough,	01 April 2016	01 July 2016
Integrated Neighbourhood Teams:	1.Continued support of NT development 2.Plan for co-location / vertical integration / alignment of Integrated Neighbourhood Teams with Adult Social Care. 3.Develop closer working with Primary Care and the VCS 4. Greater co-working with Primary Care at Scale including selection of NT as demonstrator sites.	01 April 2016	Ongoing
Joint early assessment framework:	Develop joint assessment (pre statutory assessment) approach – including joint framework and joint	01 July 2016	01 January 2017

	response, including lead professional		
	Engagement and roll out plan	01 January 2017	-
	Engagement and roll out plan	01 May 2016	01 July 2016
	Phased roll out commenced, starting with Neighbourhood Teams	01 July 2016	-
Overall:	Evaluate and plan 2017/18	01 January 2017	01 March 2017

Working with care homes

Workstream	Milestone	Start date	End date
Working with Care Homes	Mobilisation plan agreed	2 May 2016	15 May 2016
	Recruitment	May 2016	Aug 2016
	Assessment of care homes	1 July 2016	31 July 2016
	Training in care homes where gaps are identified.	1 July 2016	31 July 2016
	Outcomes /impact report		1 Feb 2017

Workforce development

Workstream	Milestone	Start date	End date
Workforce Development	BCF Sub Group of Integrated Workforce Development Group established.	1 May 2016	31 May 2016
	Agree scope and workplan and opportunities to maximise funding through matched funding	1 May 2016	31 May 2016
	Implementation of plan	1 June 2016	30 March 2017

Older People's Accommodation Review

Workstream	Milestone	Start date	End date
Older People's Accommodation Review	Appointment of external consultancy support	April 2016	May 2016
	Review of DFG/ Home Improvement Agencies	May 16	October 2016
	Fully costed implementation Plan for Residential and nursing Care development		December 2016
	Extra Care Sheltered Housing Strategy and Market Position Statement		October 2016
	Hinchingbrooke Development plan		September 2016

Frequent attenders / high cost individuals

Workstream	Milestone	Start date	End date
Frequent attenders / high cost individuals	Lead identified in Hunts and Cambs Scoping work and project plan to be agreed	1 May 2016	1 July 2016

Intermediate care teams (non-bed based provision)

Workstream	Milestone	Start date	End date
Intermediate Care Teams (non-bed based provision)	Proposals signed off for new model with early implementation plan	1 April 2016	15 May 2016
	Recruitment	May 2016	June 2016
	Implementation	June 2016	August 2016
	Review and evaluation	Sept 2017	December 2017

Delayed Transfers of Care

Workstream	Milestone	Start date	End date
Locally agreed DTOC plan:	Re-develop DTOC delivery and risk plan for 2016/17 and approval by each SRG	01 March 2016	30 June 2016
	a) Complete development of discharge planning protocol	01 March 2016	01 May 2016
	Conduct intermediate care review (Vanguard)	April 16	Sept 16
	Community intermediate care tier is developed (see plan)	May	June onwards
	Evaluate and plan 2017/18	01 January 2017	March 2017

Annex C: Risk Log

There is a risk that:	How likely is the risk to materialise? [1]	Potential impact[2]	Overall risk factor	Risk Owner	Mitigating Actions
Overall BCF Programme					
1. If there is no strategic vision, oversight or direction of travel, or if there is too much focus on small scale initiatives, opportunities to undertake critical and joined up transformation of services will not be maximised.	**4**	**4**	**16**	Cambridgeshire Executive Partnership Board	· Agreed vision and principles which are incorporated within service core planning documents. · Implementation of the 5 year strategic plan and other relevant strategic commissioning plans. · Re-visit governance to maximise opportunities for join up across Cambridgeshire and Peterborough and key areas of transformation (e.g. Cambridgeshire and Peterborough CCG Sustainability and Transformation Programme) to ensure proposals are mapped back to the agreed vision before approval, and to maintain oversight and monitor progress at all stages. · Client groups are identified and reflected in the future vision. · Development of local delivery governance structure to oversee local project delivery
2. Lack of transformational change strategic leadership capacity across the system	**3**	**4**	**12**	CCG/CCC	· Continue development of a Transformational System leadership capacity / capability building programme

leading to inability / unwillingness of partner organisations to provide the sign up and required cultural shift to deliver the whole-scale change, then the transformation will fail to achieve the necessary financial benefits and improvements for customers, staff and stakeholders.					for all executive system leadership · Agreed vision and principles which are incorporated within service core planning documents. · Demonstrable leadership through the delivery of the engagement plan. · All organisations represented by the right people empowered to make decisions.
3. Complex governance arrangements and matrix working lead to confusion on point of decision making	**3**	**4**	**12**	Whole system	· Review whole system workstreams · Align / dovetail where possible · Create governance structures around these · Co-locate meetings wherever possible
4. Lack of organisational capacity and capability to deliver	**3**	**4**	**12**	Whole system	· Ensure alignment across Peterborough and Cambridgeshire wherever possible to maximise use of project resources · Single reports to different fora – e.g. falls reporting to both BCF Delivery Group and PCP Programme to Health Executive) · Strong programme management systems in place · Clarify design and delivery elemens of tasks ·

5.	If the demand for social care services increases more rapidly than the profiled rate, the original plan will not be deliverable. Additional investment and transformation activity will, therefore, be required.	**3**	**5**	**15**	CCC	· Effective monitoring of demand for social care arising from the demographic change. · Effective monitoring of demand for social care arising from statutory duties under the Care Act. · Contingency plans prepared and in place for early intervention if anomalies or variations are identified. · Re-prioritisation of existing resources.
6.	If investment in prevention fails to sufficiently reduce demand for acute services, this will increase the financial and resource challenges for acute and related services.	**5**	**3**	**15**	CCG	· Effective monitoring of demand for acute services arising from the demographic change. · Effective monitoring of demand for acute services arising from statutory duties under the Care Act. · Contingency plans prepared and in place for diversion of funding where necessary. · Continued review of whole system transformation to reduce demand for acute services.
7.	If staff are not fully aware of, nor engaged with, the changes arising from the BCF Plan there may be a negative impact on implementation of BCF plan	**3**	**4**	**12**	CCC/CPFT/CCG	· Comprehensive engagement plan in place with clear and timely objectives and targets. · Development of appropriate workforce and associated operational development plans.
8.	If there is ineffective or insufficient engagement with stakeholders, including partners and customers, in developing and delivering the BCF then they may feel marginalised and	**3**	**3**	**9**	CCC/CCG	· Comprehensive engagement plan in place, developed with partners, which clearly segments the key stakeholder groups and the specific activities required to effectively reach them. · Clearly articulate the benefits and apportion to each partner organisation.

excluded. Transformation may, therefore, be ineffective.					· Ensure appropriate involvement of key staff in programme planning and implementation. · Clearly document the governance and ownership of the engagement plan and the relevant reporting and monitoring processes.
9. If there are multiple and/or uncoordinated changes to service delivery this could destabilise provision and performance.	**4**	**4**	**16**	CCC/CCG	· Ongoing review of strategy and vision. · Robust arrangements in place to coordinate delivery timetables across all change activities. · Appropriate investment in effective models and methods of communication with users and staff. · Develop and implement a whole system organisational development programme to work out delivery together. · Development of integrated project governance and management structure to ensure integration across different programmes of work.
10. If the data used to develop the BCF Plan is inadequate, delayed or unavailable, then there may be unforeseen and unplanned service delivery or financial impacts/demands.	**2**	**4**	**8**	CCC	· Ensure plan is updated regularly to reflect the emerging position and any agreements or changes which have been made. · Ensure effective coordination of the work of different project teams to allow timely update of assumptions. · Validation of data used and assumptions made are clearly evidenced and documented.
11. If there is insufficient project control, transparency and accountability, delivery of the	**3**	**3**	**9**	CCC	· Programme management resources in place to deliver the plan to agreed milestones.

BCF Plan and strategic vision may be compromised.					· Strong governance and effective PMO processes in place to monitor and oversee delivery of the plan, milestones, risks and issues. · Strong and effective leadership from key stakeholders.
12. If there is a delay in developing the BCF Plan, it may not be finalised and approved by the due date for submission.	**1**	**5**	**5**	CCC	· Build on the agreed vision and development of work within 2015/16 · Detailed plan to oversee development, taking into account all necessary requirements for adequate discussion, challenge and sign-off. · Early identification and engagement with officers and teams who will need to contribute and develop the plan.
13. If changes are made to national policy in respect of urgent and emergency care this could negatively impact the BCF Plan content and timetable.	**2**	**3**	**6**	CCG	· Effective links in place with local and national NHS policy makers.
14. If increased demand for carers' provision, as a direct result of the Care Act, exceeds that which has been profiled then there will be additional costs and demand on resources.	**3**	**3**	**9**	CCC	· Ongoing monitoring and profiling of demand. · Development of community capacity through commissioned activities and close working relationship with voluntary sector . · Re-prioritisation of existing resources.
15. Changes to the OPACS contract may delay projects or add complexity, as new arrangements are made to carry out the work previously	**4**	**4**	**16**	CCG	· Detailed and early discussions with CCG around key personnel who will lead on each of the areas of work. · Dedicated resource to oversee transfer of contractual responsibilities of UnitingCare

undertaken by UnitingCare, the delivery provider					to new lead personnel within CCG. · Strengthened focus on governance to oversee the change process and ensure the pace of change, project plan and delivery is maintained. · Programme Review and lessons learned process · Contract review and negotiation with CPFT as local provider of delivery model to ensure financial and contractual risks agreed between parties and clear expectations in place.
16. Financial impact of termination of UnitingCare contract on CCG	**5**	**4**	**20**	CCG	· Exit agreement with UnitingCare agreed. · CCG in formal recovery · Service provision continued to deliver with no disruption · Finance and sub-committee ongoing review · Finance & Planning Programme Board · Internal and external audit undertaken · Contracts overview group · Weekly finance meetings and finance reports to Governing Body
Data Sharing					
If systems are unable to record or match the NHS number, or staff fail to adopt new processes to record and use it, then data may be ineffective and unusable.	**2**	**2**	**4**	CCC/CCG	· Facility in place across all service areas/organisations to ensure NHS number can be populated either manually via process or automated. · New processes are embedded across all services areas/organisations.

					· Memorandum of understanding re sharing data is agreed.
If there is no clear agreement on data sharing and governance between partner organisations, this could compromise or delay progress in monitoring or delivering the BCF Plan.	**3**	**5**	**15**	CCC	· Data sharing agreements and protocols documented and signed off between all partners for the collection, storage and processing of data. · Agree strong joined up governance arrangements relating to data.
7 Day Services					
Inadequate engagement with Care Homes impacts on 7 day discharges	**4**	**4**	**16**	CCC/CCG	· Care Home contract management robust · Close working and engagement with care homes to identify areas of issue and support · CCG reviewing approach to commissioning of GP support for care homes · Workforce development/training support of care home staff · Care home educators being recruited
Significant culture change required for all providers	**4**	**4**	**16**	CCG/CCC/Providers	· Workforce and development plans · Commitment to joint workforce development approaches · Change management support · Communications and engagement plan
Inadequate community provision impacts on discharges	**3**	**4**	**12**	CCC/CCG	· Engagement with the voluntary sector to utilise current resources · Review and alignment of intermediate care teams to support smoother discharge

Neighbourhood Teams					
Slow development of NTs and behaviour change impeding community capacity to provide admission alternatives	**3**	**4**	**12**	CPFT/CCC/CCG	· Review NT development framework · Consider team building / working · Workforce development plans to ensure sufficient capacity and capability
Inadequate co-location and integration of staff across health and social care will not enable effective MDT working	**3**	**4**	**12**	CPFT/CCC	· Co-location of neighbourhood teams to facilitate MDT working · Development of case management and joint assessment approaches, underpinned by data sharing · Implementation of Integrated Care Workers
Information and Communications					
Cost of IT solution that meets the requirements of the specification	**2**	**3**	**6**	CCC	· Commercial agreement with partners to spread of the cost · Investment from LGA bid to support development
All partners across the system do not agree with the solution and implement individual options	**3**	**3**	**9**	CCC	· Local providers engaged in steering group · Organisational leads establish working group · Review of local issues and gap analysis to ensure clear scope
Data on information in sources becomes unreliable and inaccurate	**3**	**3**	**9**	CCC	· Dedicated resource for management of platform established · Contracts/SLAs for the maintenance of information sources
Customer interface is not effective – the information on sources are reliant on the way data is	**3**	**4**	**12**	CCC	· Understand customer and best practice on information presentation · Investment in research into customer

presented to the customer					needs from LGA bid
Healthy Ageing and Prevention					
Financial and resource limitations may limit extent of activity and will need to be fully understood and considered by the appropriate organisation / governance structure.	**3**	**3**	**9**	CCC/CCG	· Joint commissioning approach established to support best use of resources · Ensure best practice and guidance from HEAP adopted by local commissioners · Specific investment allocated to key areas of work
Lack of GP engagement in falls pilot impacts on effectiveness	**3**	**4**	**12**	CCG	· CCG leading on GP engagement and communications · Clear scope of service and expectations · Local Falls Leads established to aid implementation on a local level

Performance Metrics – Risks and Issues

There is a risk that:	**How likely is the risk to materialise?**	**Potential impact**	**Overall risk factor**	**Risk Owner**	**Mitigating Actions**
Non-elective admissions					
Failure to deliver 2016-17 CCG Operational Plan objectives and Non elective QIPP	**4**	**4**	**16**	CCG	· SSRG and BCF Delivery Group scrutinise monthly returns on NEA and conduct analysis to identify root problems and where thesea are occurring.

					· Monthly reporting to CMET and Finance and Performance sub-committee · PMO in place · LCG accountability reviews · Standard agenda item on COG · Action plan in place overseen by COO and Head of Planning · NHSE quarterly assurance meetings · Performance dashboard
Failure to implement major service and contract change from 1st April 2016	**4**	**4**	**16**	CCG	· Plans developed as part of LCG Operational plans to deliver service changes and manage in line with contract changes · Monthly reporting to CMET and Finance and Performance sub-committee · LCG accountability review · Internal and external audit of UnitingCare contract impacts
Risk to delivery of Urgent Care Network Plans	**4**	**5**	**20**	CCG	· Monthly reporting to CMET and Patient Safety and Quality Committee · COO leading and chairing SRG · Monthly and quarterly reviews with NHS England
DTOCS					
Ward staff in acute don't implement the learning from training/development	**4**	**4**	**16**	Acutes	· Workforce development plan in place · Pathways Coordinator pilot to support culture change · Closer working and integration with the voluntary sector · Development of joint workforce initiatives (e.g. training, rotations, recruitment

					processes) across CCC, Acutes, and CPFT
High numbers of new DTOCs on a daily basis prevent reduction to trajectory	**4**	**4**	**16**	Acutes/CCC/CCG	· Agreement from all SRG partners to proactively assess and plan discharge for patients; · Daily calls, escalation and solving of current issues with organisations to reduce numbers and solve blockages · Monthly DTOC meetings for each acute setting to address issues and create new ideas · Closer alignment of intermediate care teams to aid discharge · Admissions avoidance team and JET to manage admissions to acute
Care provider market can't meet need within certain geographical areas	**3**	**3**	**9**	CCC/CCG	· CCC and CCG to work to develop market in areas known to have poor provision · Joint commissioning approaches being developed · Clear commissioning strategy in place · Investment in strengthening the local market · Monitoring of local performance and issues to identify early issues
Residential Admissions					
Increased provision of beds in the system impacts of admissions rate	**3**	**3**	**9**	CCC	· Close monitoring of self-funders to manage longer term ASC financial impact · Develop stronger relationships with providers for more integrated planning approaches · Close management of CHC delays and CCG step down bed purchasing in the system
Increase in under 65s accessing residential admissions due to mental	**3**	**3**	**9**	CCC	· Widened scope of JET to offer intermediate care and emergency response from 65 to 50

health/long term conditions, impacting on target					year olds · Scope of age for the Wellbeing Service been widened to all adults over 18, enabling stronger community support provision · UEC Vanguard 24/7 mental health service implementation planned
Effectiveness of Reablement					
Discharge from acute into reablement happens before medically fit resulting in readmissions to hospital	**3**	**3**	**9**	Acutes/CCC	· Discharge protocol agreed · Pathways coordinator pilot · Workforce development and training plan agreed · Review of discharge procedure in line with Care Act requirements
Reablement pathway redesign results in higher level of inappropriate referrals	**3**	**3**	**9**	Acutes / CCC	· Early discharge issues being addressed with further integrated working/workforce development · Refinement and embedding of pathway · Embedding of integrated assistive technology offering across health and social care · Pathway coordinator pilot · Monitoring and review of performance to identify and address issues early
Long-term users of social care					
Preventative interventions fail to reduce the number of longer-term social care users	**3**	**3**	**9**	CCC	• Continued monitoring of number of service users through CFA Performance Board • Discussion at BCF delivery group of performance and any mitigating actions required
Friends and Family Test					

Inadequate number of people complete the questionnaire, affecting the impact of the results	**2**	**3**	**6**	CUH/HHT	· Commitment from acute provider to undertake the F&F test with patients · Good uptake to date · Workforce and training to support · Monitoring of uptake for early identification of issues, through contract reporting to CCG
Friends and Family metric does not provide whole system customer satisfaction feedback	**4**	**5**	**20**	CCG	· Development of appropriate customer satisfaction metrics as part of outcome framework development · Provider contracts incorporate relevant metrics where relevant · Utilise other methods (e.g. CPFT feedback) to gather qualitative information to support wider system feedback

[1]Likelihood - How likely is the risk to materialise? Rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely.

[2]Potential Impact - Rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact. If there is some financial impact specify in £000s, also specify who the impact of the risk falls on.

Annex D: Communications Plan

Communications with key stakeholders across the local system is a crucial element of the success of the Better Care Fund plans for 2016/17. Cambridgeshire plans to develop a detailed communications strategy outlining the key objectives, underpinned by more detailed communication plans for implementation of local projects. Communication objectives are:

- Engagement and buy in from local providers and strategic partners
- Explain the benefits and strategic business reasons for new approaches to workforce
- Ensure consistency of messages through all communications
- Gain support from key influencers
- Manage expectations and overcome any potential resistance to the changes by proactively addressing negative reactions up front.

A high level overview of the key stakeholders and communications is outlined in the below table:

Target audience	**Deliverable / Description**	**Methods**
Strategic stakeholders: • Cambridgeshire & Peterborough Clinical Commissioning Group • Cambridgeshire County Council (Staff and Members) • Peterborough City Council • Cambridgeshire & Peterborough NHS Foundation Trust • Cambridge University Hospitals • Hinchingbrooke Health Care NHS Trust • Fenland District Council • Cambridge City Council • South Cambridgeshire District Council • East Cambridgeshire District Council • Huntingdonshire District Council	Consultation and engagement on key changes Updates and reports to governance meetings Active involvement in development of approaches	Workshops / consultation papers • Cambridgeshire Health & Wellbeing Board • Cambridgeshire Executive Partnership Board • Huntingdonshire System Resilience Group • Cambridge System Resilience Group Involvement in programme steering groups

• Public Health • VCS		
Local providers	Workforce training and development Embed change management	Briefing sessions / staff newsletters / workforce development plan Change management plans
Public / Service Users / Patients	Engagement in local system plans Communicate local approaches to delivering better services Promote new local services / projects	Consultation papers Health and Wellbeing Strategy / BCF information on website / link to local campaigns (e.g. National Dementia Awareness Week) Project communication plan developed with consistent information and messages
Programme / Project management teams	Regular updates on progress Staff knowledge and awareness of BCF work	Project highlight reports / reports to governance meetings Briefing sessions / staff newsletters / information on intranet

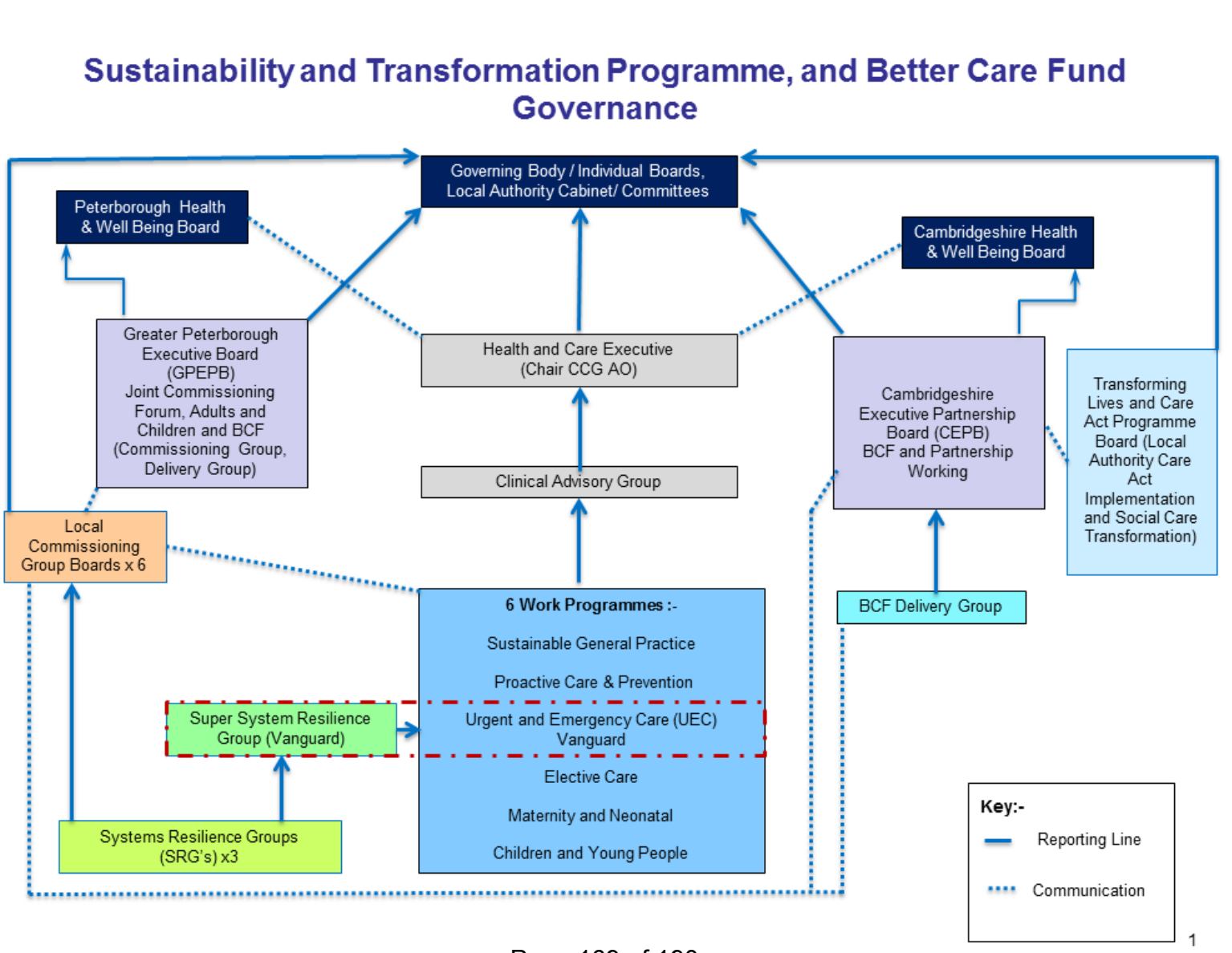
Annex E: Huntingdonshire System DTOC Plan

Attached as a separate file

Annex F: Cambridgeshire System DTOC Plan

Attached as a separate file

Annex G: Governance Diagram



Ref	Summary of action	Lead to report back	Measure and trajectory	Actions	By Whom	By When	Update on progress w/e 29/04/16	Tracking RAG
NEW DTOC PLAN V16 29/04/16 **Trajectories:** **May 2016 = 5% (12 DTOCs) review monthly** **June 2016 = 4% (9 DTOCs) review monthly** **July 2016 = 3% (7 DTOCs) review monthly** **Aug 2016 = 2.5% (6 DTOCs) review monthly**								
NO. 1 DTOC	DTOC guidance v 1.09 to be reviewed and implement with a standardised approach to DTOC process across the Cambridge and Peterborough system	NB/LCG	Delays to meet the stretch target of 2.5% = 4 patients	Continue to implement system wide approach via UECV Post Hospital work stream and ensure that HHCT is part of the process and devise measures through the working group to ensure that all areas are practising the same.	System wide discharge group LP/CH/PJ/NB	Ongoing NB/LP/CH	29/4/16 Awaiting update from SSRG discussions from Sara RJ	
				Review of readmissions	NB	31/03/2016	29/4/16 Initial reviewing of data and commencement of 'drilling down' in to detail of readmissions that may be linked to discharge and/or admission avoidance.	
				Review the 8 DTOC interventions (2 per meeting)	LP/SP	01/03/2016	29/4/16 4 interventions covered to date with a developing action plan	
				Continue to develop the face to face meetings to work together on the complex patient pathways.	PJ/AE/LD/NC/LP	On-going	29/04/16: Regular electronic updates. Face to face updates twice per week.	
				Validation meeting TOR to be revised by NB/PJ.	Nicky Brady	22/02/2016	29/4/16 NB and NC agreed to streamline attendance - trail for 1 month and update on progress at June meeting. Once agreed revise TOR.	

NO. 2 CHC	Routine & CHC fast tracks process to be simplified and standardised across the local system. Review of current timelines for a fast track.	HHCT Discharge lead (when in post)	Reduce delays in process	Continue to implement system wide approach and ensure HHCT is a key part of the process. Include training for all involved with discharge and engage with CHC team including medical staff for fast tracks.	Nicky Brady	31/03/2016	1/3/16 NB has made contact to commence discharge training within current training days at HHCT. DPAs have attended training and are sharing their knowledge with the MDT. 18/3/16 CHC training days valuable CCG system wide.	
				Review of current timelines for a fast track prior to DPSN referral contact by the wards.	Nicky Brady	31/03/2016	Agreed at meeting 21/02/16 and clarified at meeting 1/3/16 the requirement is to track the delays before the fast track is referred to the DPSN's. Case studies commenced; medical decision making and access to community decision making appear to be key.	
				Fast tracks - Collate data for choice of patients to die within hospital or an alternative choice outside of hospital. This requires a baseline and then ongoing monitoring for meeting the patients choice of where to die.	Marion Clarke	31/03/2016	Agreed at meeting 1/3/16 review progress 24/3/16	
NO.3 Discharge plans	Agree standardised discharge plans and implement	Nicky Brady/Paul Johnstone HHCT	95% of patients to have a plan on the two wards.	Build upon the yellow sheets and ensure hospital wide engagement and training with the new format. Snapshot audits of wards at white board meetings by matrons to ensure compliance . Ward sheet as well - yellow forms to be re-defined.	Paul Johnstone/Nicky Brady/Alison Edwards/Marion Clarke/Lucy Davies	30/04/2016	1/3/16 It was agreed to hold a meeting between HHCT, CCC, CPFT to plan linking the CRR to the my discharge plans and the reablement service user files. It was agreed to ensure EC&F are brought in to this to ensure there is one referral process within HHCT. It was agreed to have a prompt meeting with delivery by the end of April 2016. Yellow MDP now being rolled out over 6 weeks commencing 03/05/16 for all patients being referred into the Reablement service.	

				Front of house expansion of my discharge sheets	Marion Clarke	30/04/2016	1/3/16 The FOH team are completing my discharge forms on all over 85's and complex cases under 85 involving one or more agencies involved on discharge. The HHCT discharge planning assistants are to be trained in continued use of the plans on the wards.	
NO. 4 Voluntary services	Review of current arrangements (was to be undertaken by UnitingCare) Social services also undertaking a review	Clare Hawkins / Richard O'Driscoll		Care Network's data against KPI's to be reviewed. CH attending Vol Sector Commissioning meeting on 28/1. Need to undertake local mapping exercise - all agencies involved Business Case for 16/17 has been requested from Care Network	Clare Hawkins	31/03/16	1/3/16 Update to be provided at meeting on 24/3/16 by CH	
NO. 5 D2A	Agree new model for the replacement of beds	Clare Hawkins/ Alison Edwards/ Taneisha Scanlon	Increased use of D2A and number of patients returning to home/usual place of residence		CH/AE/TS	01/03/2016	29/4/16 We are currently reviewing interim capacity with the inclusion of MIDAS and a D2A option for 16/17.	
SAFER								
S - Senior Review	All patients will have a Consultant Review before midday.	Paul Johnstone HHCT		Data required to support progress or issues	Paul Johnstone/Ann Senior/Nicky Brady	31/05/2016	15/4/16 Weekly meeting reviewing SAFER implemented. Agreed metrics are at individual ward level informatics developing the automation of measures. Update to be divided at May meeting.	
A- All patients to have EDD	All patients will have an Expected Discharge Date	Paul Johnstone HHCT		Data required to support progress or issues	Paul Johnstone/Ann Senior/Nicky Brady	31/05/2016	15/4/16 Weekly meeting reviewing SAFER implemented. Agreed metrics are at individual ward level informatics developing the automation of measures. Update to be divided at May meeting.	

F - Flow	Flow of patients will commence at the earlier opportunity (by 10am) from assessment units to inpatient wards.	Paul Johnstone HHCT		Data required to support progress or issues	Paul Johnstone/Ann Senior/Nicky Brady	31/05/2016	15/4/16 Weekly meeting reviewing SAFER implemented. Agreed metrics are at individual ward level informatics developing the automation of measures. Update to be divided at May meeting.	
E - Early discharge	Early discharge, 33% of our patients will be discharged from base inpatient wards before midday. TTO's (medication to take home) for planned discharges should be prescribed and with pharmacy by 3pm the day prior to discharge wherever possible to do so.	Paul Johnstone HHCT		Data required to support progress or issues	Paul Johnstone/Ann Senior/Nicky Brady	31/05/2016	15/4/16 Weekly meeting reviewing SAFER implemented. Agreed metrics are at individual ward level informatics developing the automation of measures. Update to be divided at May meeting.	
R - Review - LOS	Review, a weekly systematic review of patients with extended lengths of stay (> 14 days) to identify the issues and actions required to facilitate discharge. This will be led by clinical leaders supported by operational managers who will help remove constraints that lead to unnecessary patient delays.	Paul Johnstone HHCT	Numbers to reduce to 95% with LOS <23 midnights. 24/11/15 = 72. Longest LOS 60 days.	Weekly meeting Tracking of numbers of LOS Review of longest length of stay patients in detail Engagement with system on current issues Trial commenced holding LOS meeting on the wards using white board 15/12/15	Paul Johnstone/Ann Senior/Nicola Brady	30/04/2016	15/4/16 Mon - Fri daily reviews of LOS plus red and green days implemented. NB to update with progress on 29/4/16 On-going review of current process and practices in line with ECIP quick guide. Update to be provided at each DTOC meeting (NB).	
Step down from interim beds	Produce a process for patients in interim beds to support stepping into social services	Carol Bargewell/ Nina Cosburn	Process to be agreed and monitored	Agreed by Vicky Main to develop the process to ensure rapid exit from interim nursing beds once nursing issues resolved.	Carol Bargewell/Nina Cosburn	21/03/2016	VB carries out validation on interim beds weekly. Agreed to change to green 21/04/16. Question: Has the process been formalised now?	
Delirium pathway		Liz Phillips		Review good practice with ECIP Agree pathway for in hospital and for discharge once reviewed and agreed	Liz Phillips/Marion Clarke/Vicky Main/Nicola Brady	30/06/2016	29/4/16 Report to be written reflect PDSA pathways in February to plan for future support. LP/Vanessa Bunn	

1. Complex Discharge Processes – UPDATED 12.4.16								
Overall Lead (s)	John Martin (CUHFT), Julie Frake-Harris, (CPFT)							
Key Performance Indicators	a. Total bed days lost to assessment or lack of choice policy b. Discharge notification sent 48 hours before CFD c. Number of patients with over 14 day LoS d. Average LOS in community beds reduced to 21 days by 1/8/15 & 19 days by 30/9/15 e. No. of readmissions to acute reduced f. No of DTOC g. Reduction in excess bed days							
Serial	**Project / Task**	**Due Date**	**Responsible Lead**	**Key Risks / Issues**	**Comments**	**RAG Rating**	**KPI**	**Impact Capacity**
5.1	Embed the Choice Policy within CUHFT							
5.1.1	Monitoring of choice policy use via PTL	01/11/2015	Jenny Abel	11/4/16 – not seen effect of Choice Policy – need to understand when families have declined more than 1 home.	16/10/2015 - New data analyst tasked to introduce two new codes to the PTL process to identify choice policy use and non-use where appropriate. 25/11/15 JM to chase Jenny for update, manual update currently - codes to be in place 01/01/15 15/01/2016 - Choice policy codes added to PTL and monitored daily 11/4/16 – To review CUH Choice Policy against ECIP national Policy. Confirmation that out of county trusts to hold interim beds for 5 days.		Code appearing in daily PTL output	Minimal – no impact from OOC.
5.1.2	Engage with clinical areas where choice policy has not been used	01/11/2015	John Martin	Staff engagement	16/10/2015 -Once report in action 4.2.4 is operational this will form the basis of discussions for this action. 27/11/15 - Individual wards are contacted following PTL, dependent		Decrease in number of times choice policy	

					on above action for automation. Only one code for choice on PTL currently, JM driving use of policy. 15/01/16 - Choice policy code now used and daily actions sent to ward managers. 11/4/16 – G6 codes don't always mean patient needs a choices letter.		not used where it should have been (via PTL)	
5.1.3	Introduce information booklet across the Trust early in patient pathway outlining discharge process	01/12/2015	Jenny Abel	Booklet not used by patients	16/10/2015 - booklet written by DME consultant, awaiting comments from reader panel 27/11/15 - JM chased Sharon McNally - still at reader panel. 15/01/16 - Booklet approved by reader panel and now being trialled within DME, F6 and Level 8 under guidance of Karen Kenwood 11/4/16 – Booklet piloted and approved by reader panel / document library. With procurement but discussions around printing costs.		Number of booklets produced	
5.2	Review DTOC process within organisations							
5.2.1	Process to review all patients staying over 14 days past CFD.	On-going.	John Martin	Engagement from other provider organisations in review	16/10/2015 weekly revi1`ew in place with system escalation call to resolve issues chaired by CCG. 27/11/15 - Process in place, JM to look at stats now we have a trend worth to establish position and report back to PFP 15/01/16 - Number of stranded patients on the weekly operational taskforce report		Number of pts over 14 days Length of Stay	11/4/16 – high impact when process carried out robustly

					11/4/16 – Now looking at patients over 7 days. DPSN team now fully staffed allowing more impact through case management.			
5.2.2	Maximise CFD accuracy	01/01/2016	John Martin	Clinical engagement	16/10/2015 ECIP review undertaken highlighting variability in CFD setting. Metric established within Epic. Next steps to be a clinical challenge event from ECIP. 27/11/15 - workshop delayed 15/1/16 - Clinical challenge events held by ECIP on the 11th December. 20/1/16 - CFD in the past highlighted and monitored with the operations centre 11.4.16 – Trust analysis shows CFDs are still moving. ECIP have challenged – review ECIP findings including CFD versus MFD.		CFD accuracy metric improvement	
5.2.3	Completion of discharge notification 48 hours prior to Clinically Fit Date	01/01/2016	John Martin	Clinical engagement	16/10/2015 Metric established and to be included in nursing and medical ward flow project. 15/01/16 - Update given to senior nurse briefing on XXX and weekly delays attributed to wards and circulated to management teams 15/01/16 - DPSN now attending PTL to coach named wards 11.4.16 – Info shared at nursing briefings. Need to look at how to use the data to show trends and impact. JA/KW to discuss notification process further to understand what		48hr notification metric improvement	Some impact

					is helpful and useful. Ensure CSR processes are timely and effective.			
5.2.4	Review of reablement referrals prior to discharge	01/04/16	Margi Fosh?		Agree process with reablement team to ensure regular review of reablement referrals to ensure correct package is provided on discharge.			
5.2.5	Develop use of equipment to support single handed care	1/4/16	Jenny Abel, Sharon McNally		Agree trust approach to assessment, prescription and use of moving and handling devices such as Molift to reduce double up care on wards and in community			
5.3	Develop Discharge planning Pathways on Epic and improve information provided on referral to community / discharge							
5.3.1	Revise training material for discharge planning and incorporate in rolling training programme.	01/12/2015	Jenny Abel	Availability for training	16/10/2015 New EPIC system live requires a refresh of training material. Increase in DPSN capacity allows more opportunity for clinical training 27/11/15 JM to chase JA for update (Katie Wilson) for an update on output and impact 20/01/16 - New guide to discharge in place 20/01/16 - Local ward training started by named DPSN 20/01/16 - New discharge planning manual in development 20/01/16 - Strategy for training from 1st April 11.4.16 – Training manual being prepared. Weekly rolling training programme being implemented around key topics. Some teaching		Number of training sessions delivered	

					for junior doctors. Discussed possibility of including discharge planning training in annual refresher course – already a packed programme so will not be possible.			
5.3.2	Ensure ward actions are completed	01/11/2015	Jenny Abel		16/10/2015 Virtual PTL in place on a daily basis which highlights ward actions to managers. Agreement with senior sisters that in-complete ward actions will be a metric monitored through the CNO. 27/11/15 - Process in place that highlights number of O/S ward actions that arrive on ward daily. Monthly the performance is a senior nursing metric. Some ward action remains incomplete, but handed over as business as usual to be picked up in Chief nurse office. and divisions. To be highlighted at the next PFP 20/01/16 - Monthly nursing metrics in place and ward manager briefing held (currently 43% of actions overdue by 1-3 days)		Decrease in number of outstanding ward actions	

Serial	Project / Task	Due Date	Responsible Lead	Key Risks / Issues	Comments	RAG Rating	KPI	Impact Capacity
5.3	Discharge Team							
5.3.3	DPSNs move from Long Road to	01/01/2016	Jenny Abel	Finance	16/10/2015 Awaiting costings		Move to long	Estimates

	CUH				from submitted specification 20/01/2016 County Council IT link being installed 20/01/2016 Awaiting final information from estates 11/4/16 – No IT in place and no funding to cover the move.		road	show that approx. 1 day per week is lost in time spent walking between sites.
5.3.4	Recruit additional DPSN	01/12/2015	Jenny Abel	Finance Recruitment process	16/10/2015 Additional post agreed at T3 and now with recruitment for advertising 27/11/15 - 4/5 in post, 5th position shortlisted and expected to be in post in next few months. 20/01/16 - Final position recruited to and due to start 20/2/2016 11/4/16 – DPSN team currently fully staffed but need to recruit to band 6 and 7 posts due to staff leaving – band 6, end April, band 7 end May/June.		Establishment	
5.3.5	Team development & role definition	30/11/2015	Jenny Abel	Away day impact on assessment Turnover of staff	16/10/2015 Team meetings instigated including a wider team meeting for SAFE and START. Full team building day for the DPSNs planned for November to establish team vision, shared goals and to set foundations on which to improve practice. Identification of individuals for specialist interest areas 27/11/15- Away day held, high	**Complete**	Attendance at team development sessions / team meetings	

					attendance. Clear objectives agreed, CLOSED. 20/01/16 - Evaluation of day completed			
5.3.6	Review capacity to support self-funder discharge following termination of CHS contract from 1st December	30/11/2015	Jenny Abel	Finance if new post required	16/10/2015 Scoping exercise started off number of patients impacted and alternative models of support 27/11/15 - pilot scheme developed with CCG and CCC for self-funders to be discharged home with care for assessment/placement - due to go live with pilot in Dec. Add milestone to consider pilot results Other option is to employ a home finder but awaiting pilot progress and development of business case (leave action open) 20/01/16 - Live-in care package live which is open to self-funders. Review in Feb 2016 11/4/16 – Number of self-funders has not increased following termination of CHS contract. Reduction in Midas capacity may cause self-funder delays to increase.	**in progress**	Number of delayed self-funders	
5.3.7	Review pilot for self-funders	30/03/2016	John Martin		20/01/16 - Full capacity used 11/4/16 – JM/JA/EH/SRJ to review Midas capacity to end March.			

5.4	Discharge summaries & Fast track patients							
5.4.1	Ensure that discharge processes (including discharge letters to GPs) for end of life patients are effective and delay free.	30/11/2015	Jenny Abel / Palliative Care	System wide dependencies for delays outside of C'shire	Q7.3 CQC response 25/11/15 - JM update- audit undertaken of previous fast track discharges and presented to Camb'shire IC board (Oct 15). Change in bleep holding provision for fast track. Issues highlighted in Minutes. Next steps - DPSN need to available 7 days a week (separate milestone) due March due to consultation period. Majority of delay is system delay. JM to revisit audit and chase actions via the IC meetings. Update due end December 2015. 20/01/2016 - ICB disbanded following UnitingCare closure 20/01/2016 - Further audit underway to monitor change 11/4/16 – JA/EH to review data for fast track patients who were discharged with Midas based on time stamps in the pathway.		Fast-track patient time to discharge	
5.4.2	Ensure that there is effective communication with community sources to ensure "fast track" discharge of patients.	30/11/2015	Jenny Abel		22/10/2015 Daily operational discharge call		Fast-track patient time to discharge	
5.4.3	Ensure that discharge summaries are well written and contain the right level of information.	31/10/2015 - moved milestone to 20/12/15 for	John Firth / Rosemary Wade / Afzal Chaudhary	Staff engagement	22/10/2015 Discharge summary monitoring by divisions in place 26/11/15 - JM writing report to summarise GP complaints and		Discharge summary completion	

		initial review of what well written looks like			EPIC, and then deliver a set of standards written with John Firth so CUH can audit. Actions are JF to agree standards for discharge summary (waiting response from e mail) TW to move milestone.		Discharge summary audit	
5.4.4	Develop 7 day working for discharge planning, starting with fast track patients	01/03/2016	Jenny Abel	Staff consultation Number of Staff	22/10/2015 Requirement for new starters 20/01/2016 - Consultation document in production 11/4/16 – internal discussions taking place regarding weekend cover (2 nurses working to hold the bleep) but needs reciprocal approval – Gill Kelly. Consultation documentation to be circulated to relevant staff. D Oades-Wells/CHC team to review – look at possibility of delegating commissioning authority to DPSN team over weekends – JA to take forward.		Rota cover for 7 days Fast-track time to discharge	
Serial	**Project / Task**	**Due Date**	**Responsible Lead**	**Key Risks / Issues**	**Comments**	**RAG Rating**	**KPI**	**Impact Capacity**
5.5	Community Based Bed Capacity							
5.5.1	Increase bed provision at Community Hospitals through reducing DTOCs and reducing lengths of stay leading to an increase in the equivalent of 50% additional spells	01/10/2015	CPFT	Availability of long term placements/care support	Monitoring systems in place and DTOCs reported	On track	d	100 bed equivalent across Cambridgeshire and Peterborough
5.5.2	Provide an additional 16 beds in	01/10/2015	CPFT		8 beds open, 4 additional beds	In	C / f	16

	Byron B				open mid-October, and a further 4 by end of October. Staff recruitment at 50% of posts required	progress		
5.5.3	Extend hours of admission, including at weekends	14/11/2015	CPFT		Develop admission protocol for OoHs to include clerking		c/ f	
5.6	Discharge planning							
5.6.1	Revise escalation process	01/11/2015	CCG		11.4.16 - Updated policy presented to Regional UECN meeting for comment and approval.	In progress	g	8 bed equivalent across Cambridgeshire and Peterborough
5.6.2	Create and implement Discharge protocol	01/11/2015	CCG		11.4.16 - Discharge protocol workshop held February 2016. Draft protocol circulated and comments received.	In progress	g	
5.6.3	Agree discharge pathways	16/11/2015	UCP		Process started and aimed to finish end November	In progress	g	
5.6.4	Developing and agreeing the dataset and performance monitoring framework	16/11/2015	UCP			In progress	g	
5.6.5	Recruitment of additional Care Manager for START	29/11/2015	Carol Bargewell		appointment successful, awaiting start date		f/g	
5.6.6	Minimum staffing during Winter set at 75% of team capacity	Immediate	Carol Bargewell			On track	f/g	
5.6.7	Transfer management of interim beds to Brokerage	30/10/2015	Richard O'Driscoll		Will improve flow and management oversight	On track	f/g	
5.6.8	Implement findings of reablement Review	31.03.16	Richard O'Driscoll		Will increase capacity and enable re-positioning of the service to focus on prevention and admission avoidance.	On track	f/g	
5.6.9	Re-commission 5 Reablement flats previously funded through the DTOC Grant	30.10.15	R.O'Driscoll	Fluctuation in demand	11/4/16 – Reablement flats commissioned until end September 2016.	On track	f/g	

5.6.10	Maintain 7 day working of the Discharge Planning team	On going	Carol Bargewell		Voluntary arrangement, planning for more robust arrangements underway. 11/4/16 – Consultation in progress and good response from staff to date. For final implementation 1/5/16.	On track	f/g	

HEALTH AND WELLBEING BOARD FORWARD AGENDA PLAN

MEETING DATE	ITEM	REPORT AUTHOR	TO DEMOCRATIC SERVICES R YULE BY
7 July 2016	*Priority to be confirmed*		
	Person's story	TBC	**Thursday 23 June**
	Joint Strategic Needs Assessment (JSNA) • JSNA Summary Report • Migrants and Refugees JSNA • JSNA on Long-Term Conditions – update on actions	I Green / A Mavrodaris A Mavrodaris	
	Update on implementation of the Community Resilience Strategy	Sarah Ferguson / Sue Nix	
	Cambridgeshire and Peterborough Health and Care System Transformation Programme [standing item]	Jessica Bawden	
	Better Care Fund Update [standing item]	Geoff Hinkins	
	Forward agenda plan	Ruth Yule	
15 September 2016	*Priority to be confirmed*		
	Person's story	TBC	**Thursday 1 September**
	Safeguarding Adults Board (SAB) Annual Report 2015/16	Claire Bruin / Ivan Molyneux	
	Cambridgeshire Local Safeguarding Children Board (LSCB) Annual Report 2015-16	Felicity Schofield / Andy Jarvis	
	Effective safeguarding during the transition into adults services	Andy Jarvis / Ivan Molyneux	
	Work in relation to safeguarding being undertaken with the universities	Claire Bruin	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme [standing item]	Jessica Bawden	

MEETING DATE	ITEM	REPORT AUTHOR	TO DEMOCRATIC SERVICES R YULE BY
	Better Care Fund Update [standing item]	Geoff Hinkins	
	Alcohol and Drugs JSNA report	Val Thomas	
	Forward agenda plan	Ruth Yule	
17 November 2016	*Priority to be confirmed*		
	Person's story	TBC	**Thursday 3 November**
	*Update on actions arising from the New Communities JSNA	Iain Green	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme [standing item]	Jessica Bawden	
	Better Care Fund Update [standing item]	Geoff Hinkins	
	Forward agenda plan	Ruth Yule	
19 January 2017	*Priority to be confirmed*		
	Person's story	TBC	**Thursday 5 January**
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme [standing item]	Jessica Bawden	
	Better Care Fund Update [standing item]	Geoff Hinkins	
	Forward agenda plan	Ruth Yule	
30 March 2017	*Priority to be confirmed*		
	Person's story	TBC	**Thursday 16 March**
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme [standing item]	Jessica Bawden	
	Better Care Fund Update [standing item]	Geoff Hinkins	
	Forward agenda plan	Ruth Yule	

MEETING DATE	ITEM	REPORT AUTHOR	TO DEMOCRATIC SERVICES R YULE BY
1 June 2017	***No theme: first meeting of municipal year***		
	Election of Vice-Chairman/woman	oral	**Wednesday 17 May**
	Person's story	TBC	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme [standing item]	Jessica Bawden	
	Better Care Fund Update [standing item]	Geoff Hinkins	
	Forward agenda plan	Ruth Yule	

Updated: RY 13 May 2016