CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD

Cambridgeshire County Council

Date:Friday, 08 September 2017

Democratic and Members' Services
Quentin Baker
LGSS Director: Lawand Governance

09:30hr

Shire Hall
Castle Hill
Cambridge
CB3 0AP

Kreis Viersen Room
Shire Hall, Castle Hill, Cambridge, CB3 0AP

AGENDA

Open to Public and Press

1. Notification of the appointment of the Chairman

2. Notification of Changes of Membership of the Board

3. Apologies for absence and declarations of interest

Guidance on declaring interests is available at http://tinyurl.com/ccc-conduct-code

4. Better Care Fund Plan 2017 **3 - 368**

5. Date of Next Meeting

To note that the Board will meet next at 10.00am on Thursday 21 September 2017 in the Civic Suite, Pathfinder House, Huntingdon.

The Cambridgeshire Health and Wellbeing Board comprises the following members:

Councillor Peter Topping (Chairman)

Councillor Margery Abbott Jessica Bawden Councillor Mike Cornwell Councillor Angie Dickinson Jonathan Dunk Councillor Sue Ellington Stephen Graves Chris Malyon Val Moore Wendi Ogle-Welbourn Dr Sripat Pai Stephen Posey Liz Robin Councillor Joshua Schumann Vivienne Stimpson Aidan Thomas and Matthew Winn Councillor Samantha Hoy Councillor Claire Richards Councillor Susan van de Ven and Councillor David Wells

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

Clerk Name: Richenda Greenhill

Clerk Telephone: 01223 699171

Clerk Email: Richenda.Greenhill@cambridgeshire.gov.uk

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Public speaking on the agenda items above is encouraged. Speakers must register their intention to speak by contacting the Democratic Services Officer no later than 12.00 noon three working days before the meeting. Full details of arrangements for public speaking are set out in Part 4, Part 4.4 of the Council's Constitutionhttps://tinyurl.com/CCCprocedure.

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Agenda Item No:4

Better Care Fund Plan 2017

To: **Health and Wellbeing Board**

Meeting Date: **8 September 2017**

From: **Will Patten, Director of Commissioning – Cambridgeshire County Council**

Recommendations: **The Board is asked to:**

a) **consider and approve the Better Care Fund Plan for 2017/19 subject to final amendments;**

b) **delegate authority to the Director of Public Health in consultation with the Chairman of the Board for any final amendments to be made to the Plan before submission.**

	Officer contact:	***Member contact:***
Name:	Geoff Hinkins	Name: Councillor Peter Topping
Post:	Transformation Manager	Post: Chairman
Email:	Geoff.hinkins@cambridgeshire.gov.uk	Email: peterwwtopping@gmail.com
Tel:	01223 699679	Tel: 01223 706398

1. BACKGROUND

1.1 The Better Care Fund (BCF) creates a joint budget to help health and social care services to work more closely together in each Health & Wellbeing Board Area. The BCF came into effect in April 2015. The 2017/19 plan is the third Cambridgeshire BCF Plan. Following previous discussions with the Health and Wellbeing Board, a joint plan has been developed between Cambridgeshire and Peterborough for 2017-19; however, two separate pooled budgets will be maintained in line with statutory requirements.

1.2 The Cambridgeshire & Peterborough BCF plan for 2017/19 must be submitted by 11th September, and Health and Wellbeing Board approval is required for the plan. The current draft of the plan is attached in the Appendices to this report. Please note that work will continue on the Plan until the date of the meeting and further papers may be tabled at the meeting. A verbal presentation will be provided to give an overview of the 2017/19 plan and explain any significant changes made since the version circulated.

2. MAIN ISSUES

2.1 Policy Requirements

New guidance for the 2017 BCF plans were issued in late July and contained two key changes to policy framework. First, plans are now required to be developed for a two year period. Secondly, the number of national conditions has been reduced from eight to four. The national conditions require:

- A locally agreed plan, signed off by the health and wellbeing board, local authority and Clinical Commissioning Group (CCG)
- Maintenance of adult social care spending from the CCG minimum contribution in line with inflation
- Investment in NHS commissioned out of hospital services
- Areas to implement the high impact change model for managing transfers of care

Local areas are asked to continue to consider the previous national conditions, namely:

- Develop delivery of seven day services across health and social care
- Improve data sharing between health and social care; and
- Ensure a joint approach to assessments and care planning

Plans should also set out the joint vision and approach for integration, including how the BCF complements the Next Steps on the NHS Five Year Forward View, STP, Care Act 2014 requirements and wider local government transformation.

2.3 Approach

The narrative plan attached as Appendix A describes our overall approach to the Better Care Fund (BCF) in 2017/19. The plan describes local delivery priorities; the approach to the budget; and how our work will meet the BCF national conditions. This approach has been agreed with the Clinical Commissioning Group and will allow the plan to adapt to the local environment over the period of the plan.

Timescales

Milestone	Date
BCF planning submission (with HWB approval)	11 September 2017
Regional assurance	12-25 Sept 2017
Regional moderation	w/c 25 Sept 2017
Cross regional calibration	2 Oct 2017
Approval letters issued	From 6 Oct 2017
Escalation panels for plans rated as not approved	w/c 10th Oct 2017
Deadline for areas with plans rated approved with conditions to submit updated plans	31 Oct 2017
All section 75 agreements to be signed and in place	30 Nov 2017

2.3 Financials

The Better Care Fund will see some changes in the financial arrangements for 2017/19, the main being the addition of the Improved Better Care Fund (iBCF) funding stream. Appendix B1-5 contains the expenditure plan for the BCF.

Spending contained within the BCF broadly falls into three areas: spending in mainstream services; transformation; and the new iBCF grant.

Mainstream Priorities

Mainstream funding will retain the broad categories established in the Cambridgeshire's 2016/17 plan, namely:

- Intermediate Care and Reablement
- Promoting Independence
- Neighbourhood Teams
- Carers Support
- Voluntary Sector Joint Commissioning

- Discharge planning and Delayed Transfers of Care (DTOCs)

Transformation priorities

Due to the delay in the publication of national guidance there will not be detailed spending plans relating to the transformation priorities in the BCF plan. Instead, the funding will be allocated internally by each organisation to best meet the overall 4 priorities; with a particular focus on reablement.

Improved Better Care Fund

The new 'Improved Better Care Fund grant' is paid directly to local authorities, and amounts to £8,339k in Cambridgeshire in 2017/18. It is important to note that a proportion of the iBCF, announced in the Spring Budget 2017, is non-recurring and reduces over three years. Councils are required to balance use of the Improved Better Care Fund against three areas: Meeting adult social care needs generally; Reducing pressures on the NHS (including DTOC) and Stabilising the Care Market. A list of initiatives being supported by the IBCF is included in the BCF Plan. The CCG and local authorities will flex the investment over the period of the plan by reviewing performance through the Integrated Commissioning Board (ICB), and then adjusting the investment into schemes to meet the BCF Metrics.

3. BCF PLAN SUBMISSION

3.1 The BCF Plan must be submitted to NHS England by 11 September 2017, and should be signed by the Chair of the Health and Wellbeing Board. The Board are invited to comment on the draft plan attached and the verbal update to be provided at the meeting in order to inform the final plan. To allow final amendments to be made following the meeting, delegated authority is requested to the Director of Public Health in association with the Chair of the Board to make any final amendments to the plan before submission.

4. ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

The BCF is relevant to priorities 2, 3, 4 and 6 of the Health and Wellbeing Strategy:

- 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 6: Work together effectively.

Integration and Better Care Fund

Narrative Plan Template 2017/19

DRAFT – VERSION 5.7

Area	**Cambridgeshire & Peterborough**
Constituent Health and Wellbeing Boards	**Cambridgeshire & Peterborough Health and Wellbeing Boards**
Constituent CCGs	**Cambridgeshire & Peterborough Clinical Commissioning Group**

Contents

Introduction

This document forms part one of Cambridgeshire and Peterborough's (C&P) Better Care Fund (BCF) Plans for 2017-19 - a joint narrative, highlighting the integrated approach to BCF plans across the Cambridgeshire and Peterborough Health and Wellbeing Board areas. The purpose is to:

- Outline our 2020 vision for integration
- Set out priorities for delivery of further integrated working
- Establish the context
- Provide an overview of the changes and progress against 2016/17 BCF plans...
- Describe the budget setting approach
- Describe how we will meet each of the national BCF conditions.

Local vision and approach for health and social care integration

Our vision across C&P remains consistent since 2015/16 – expressed in previous BCF plans:

"Over the next five years in Cambridgeshire and Peterborough we want to move to a system in which health and social care help people to help themselves, and the majority of people's needs are met through family and community support where appropriate. This support will focus on returning people to independence as far as possible with more intensive and longer term support available to those that need it.

This shift is ambitious. It means moving money away from acute health services, typically provided in hospital, and from ongoing social care support. This cannot be achieved immediately – such services are usually funded on a demand-led basis and provided as they are needed in order to avoid people being left untreated or unsupported when they have had a crisis. Therefore reducing spending is only possible if fewer people have crises. However, this is required if services are to be sustainable in the medium and long term."

This vision remains relevant in 2017/ 19 translating into our key transformation plans and strategies:

- ***Transforming Lives***[1], Cambridgeshire's approach to social work, which emphasises

[1] https://ccc-live.storage.googleapis.com/upload/www.cambridgeshire.gov.uk/residents/working-together-

the need to support people to stay well – and the importance of providing support that is focused on returning them as far as possible to independence.

- ***Peterborough's vision for Social Care***[2], to ensure that people in Peterborough can live in a strong and vibrant community that works in partnership with the council to protect the most vulnerable people and communities; maximise the health and wellbeing opportunities for individuals; provide the right level of information and support to individuals so they can make informed choices on the services they need; redesign services with community organisations to be more responsive and better meet the needs of individuals.
- ***Fit for the Future***[3], Cambridgeshire and Peterborough's Sustainability & Transformation Plan (STP) which emphasises three key messages: 'At Home is Best'; 'Safe and effective hospital care, when needed'; and 'We're only sustainable together'.

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

Priorities for Change	10-Point Plan
At home is best	**1.**People powered health and wellbeing **2.**Neighbourhood care hubs
Safe and effective hospital care, when needed	**3.**Responsive urgent and expert emergency care **4.**Systematic and standardised care **5**.Continued world-famous research and services
We're only sustainable together	**6.**Partnership working supported delivery
Supported delivery	**7.**A culture of learning as a system **8.**Workforce: growing our own **9.**Using our land and buildings better **10.**Using technology to modernise health

Some of our solutions are common across the NHS. Other aspects are specific to our local

children-families-and-adults/Transforming%20Lives%20strategy.pdf?inline=true

[2] https://www.peterborough.gov.uk/council/strategies-polices-and-plans/council-strategies/strategic-priorities/

[3] http://www.fitforfuture.org.uk/documents/cambridgeshire-peterborough-sustainability-transformation-plan-october-2016/

system as follows:

- **Improving outcomes for older people:** We are building on the Older People's and Adult Community Services (OPACS) outcomes and we are implementing components of the care model which harnesses the benefits of social capital, integrated neighbourhood teams, and a community-based rapid response to deteriorating patients/ service users in the community.
- **Care networks:** Our approach is to move knowledge and not patients wherever possible and appropriate.
- **Chief Executive Officers (CEOs) delivering together:** Through collective leadership at system level, we will implement the changes required.
- **Exploiting the benefits of new developments:** We are inputting into the development of new homes to optimise the health of our new residents and employees.

In last year's plans we set out how we wanted the 'system' that supports older people, people with long term conditions including disabilities, carers and families to work in future. We also set out a plan for delivery – across the NHS, Social Care, District Councils, Housing, Voluntary and Community Sector (VCS) and independent sector organisations providing services for people.

These priorities have formed the basis for Cambridgeshire and Peterborough's Better Care Fund Plans for 2016/17 onwards; and have informed the work planned for the 'Primary Care and Integrated Neighbourhoods' work-stream of the NHS Sustainability and Transformation Plan. They remain the drivers for integrated working across the system in Cambridgeshire and Peterborough. The 'BCF Plan' section of this document describes the specific areas of work we will progress through the Better Care Fund budgets in Cambridgeshire and Peterborough from 2017-19.

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 are focusing our response across both cohorts.

Further information on our joint vision can be found at ***Appendix 1.***

Background & Context to C&P 2017/19 BCF Plans

The vision outlined above has been the guiding principle for the work undertaken in previous years and local progress is reflective of the strong commitment to integration from senior leaders across the local system.

During the last 12 months, there have been a number of external changes which have impacted on the approach to BCF in Cambridgeshire and Peterborough, including the creation of a Cambridgeshire and Peterborough NHS Sustainability and Transformation Plan; establishment of new governance arrangements across the Cambridgeshire and Peterborough health and care system; greater joint working between Cambridgeshire and Peterborough local authorities and the development of local devolution plans[4]. These offer an opportunity to review the current approach to BCF across Cambridgeshire and Peterborough, to ensure it is better aligned with other initiatives, whilst still meeting its core aims.

Plans for 2017-19 build on current progress and the lessons learnt to date. They recognise the changing landscape locally and the need to move forward in a dynamic way. The number of agencies involved in different elements of the above programmes, and the lack of alignment across geographic and organisational boundaries would, left unchecked, create a delivery risk for our BCF Plans. We want the BCF to drive closer alignment across our system to support better outcomes for patients and citizens. Below outlines some of the key learning points and plans for progressing into next year, which have been incorporated into our approach for 2017-19.

Greater Joint Governance & STP Linkages

2017/19 is the third year of BCF plans. Over time the Cambridgeshire and Peterborough BCF Plans have developed from two separate plans and governance systems into one joint narrative plan, as set out here.

Three years ago the BCF maintained a separate project structure to the rest of the system for many of its transformation projects. There were also separate BCF commissioning boards within C&P for each of the BCF plans. There is now greater joint working between C&P local authorities and local devolution plans are being developed[5]. A joint 'Integrated Commissioning Board' (ICB) now replaces the two separate Boards. This is designed to support better integration, closer co-ordination, and streamlined reporting into the two C&P Health and Wellbeing Boards. This will help to strengthen our BCF Delivery Plans.
The C&P STP was established through 2016/17 and as such new STP structures have been created. The key decision making forum for the STP is the Health Care Executive (HCE) comprising all health and Local Authority CEOs. The HCE has committed to a Memorandum of Understanding[6] which sets out the jointly agreed approach to effective system transformational change. In addition, an agreed approach through the STP to measuring

[4] https://www.peterborough.gov.uk/council/strategies-polices-and-plans/council-strategies/devolution/
[5] https://www.peterborough.gov.uk/council/strategies-polices-and-plans/council-strategies/devolution/
[6] http://www.fitforfuture.org.uk/wp-content/uploads/2016/06/Cambridgeshire-and-Peterborough-STP-Memorandum-of-Understanding-October-2016.pdf

whole system outcomes, of which the BCF forms a part, is now being developed. This will enable closer alignment with the objectives and deliverables of the Health Care Executive, as well as local devolution plans.

The ICB is now working closely with the STP and as such has already agreed to joint fund STP Business Cases during 2017/18. Plan implementation has equally become increasingly integrated, resulting in stronger and more efficient delivery.

During 2016/17 we have strengthened the Vision and Approach to Social Care Integration as outlined in the Local Vision and Approach section and **Appendix 1**. This has now been successfully adopted within the STP as part of the 'Primary Care and Integrated Neighbourhoods' (PCIN) Workstream. Although PCIN is the main STP link with BCF, we also established stronger links with the STP's Urgent Emergency Care (UEC) Workstream, vital for successful integrated working to reduce demand on urgent and emergency care services and to reduce delayed transfers of care (DTOCs).

Challenges

Our key challenges, which have informed the evidence base for our 2017/19 BCF plans, are as follows:

- **Financial:** Cambridgeshire and Peterborough collectively is one of the most 'challenged health economies'; this means that if we change nothing, then by 2021 local health services would need an extra £504 million[7], with local social care services facing similar challenges.

- **Population Growth:** Both Cambridgeshire and Peterborough have a rapidly 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. For further demographic information, see **Appendix 2.**

- **Over-reliance on emergency health and long term social care:** People are living longer with a greater number of co-morbidities or disabilities, resulting in increased demand on our health and care services, in common with the rest of the country. This creates particular challenges for planning and managing health and social care services. 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. Our acute hospitals are under severe operational pressure. Supporting people earlier, in their own homes, in order to prevent emergencies will achieve better outcomes.

- **Lack of alignment:** The number of agencies involved in different elements of the above programmes, and the lack of alignment across geographic and organisational boundaries would, left unchecked, create a delivery risk for our BCF Plans.

[7] Cambridgeshire and Peterborough Sustainability and Transformation Plan (http://dev.speed.agency/fitforfuture/wp-content/uploads/2016/11/Cambridgeshire-and-Peterborough-Sustainability-and-Transformation-Plan-October-2016.pdf)

- **Delayed transfers of care:** in this area C&P has been an outlier. As well as system capacity issues with the support of the Emergency Care Intensive Support Team a number if process issues have been identified across the system which are causing blocks and delays in patient flow across the system.

Progress to date

Cambridgeshire and Peterborough have now reached the end of the second financial year of the Better Care Fund and the below outlines key progress made in 2016/17.

BCF Expenditure

The majority of funding included within the BCF budget was used in Cambridgeshire and Peterborough to support local health and social care services; including community based health services, protection of adult social care and funding VCS activities.

The approach taken to financial allocations in the BCF, in both Cambridgeshire and Peterborough has minimised financial risks to partners, whilst also continuing to protect existing social care and health services. This decision to limit risk to existing services has meant that lower amounts for transformation were released than in some health and wellbeing board areas, but was felt to be the most appropriate approach for the local area. This approach has ensured that we continue to maintain existing statutory community health and social care services. Without this support community capacity would be diminished and outcomes would worsen, with more people ending up in more expensive or longer term health and social care services. A smaller pot of money was made available to support transformation projects and progress during 2016/17 on these is outlined below.

Broadly speaking, BCF budgets were spent as planned in both Cambridgeshire and Peterborough, with a small underspend in Cambridgeshire; in Peterborough budgets were balanced at year end. Further information on the 2016/17 BCF budgets can be found in **Appendix 3**.

BCF Metrics Performance

Whilst performance against some indicators has been positive, performance against non-elective admissions and delayed transfers of care have notably failed to meet targets. The 2016/17 actual year performance and 2017-19 targets are detailed in the 'BCF Planning Template' spreadsheet. This is in the context of significant increased activity across the system; and in particular increased attendances of 85 plus year olds at hospital. Whilst BCF-funded activities, particularly the community based neighbourhood teams, undoubtedly impacted on preventing non-elective admissions and reducing DTOCs, this was clearly insufficient to mitigate against the increasing system demand. The CCG engaged the support of the Emergency Care Intensive Support Team (ECIST) to look at the root causes and develop DTOC plans – which are aligned where appropriate with the 2017/19 DTOC and 8 High Impact Change (8HIC) plans.

Reablement performance also showed a slight decline in performance from 2015/16 as a result of capacity issues in the care market and winter pressures, as well as increased higher level need hospital discharges into reablement.

Successful delivery against the BCF metrics is reliant on a significantly wider range of factors than activity contained solely within the BCF Plan.
The specific performance metrics for 2016/17 are included at **Appendix 4.**

BCF metrics for 2017/19 have been set, with the detail outlined in the attached planning spreadsheet. Below provides a high level overview of the approach to setting targets for 2017/19, factoring in previous year performance and forecast local challenges.

- **Non Elective Admissions:** BCF trajectories are aligned to the CCG operational plan trajectory to ensure alignment. The CCG non-elective activity plan for 2017/18 represents a system wide target of 75,940, with the STP growth assumption of 3.4% applied to give a Do Nothing plan of 83,583 non-elective admissions. In addition to BCF planned activity, there are a number of QIPP projects in place that aim to reduce the number of non-elective admissions during 2017/18, including:

QIPP Project	*Non Elective Admissions avoided*
• Ambulatory Care	-2,476
• Joint Emergency Team	-2,303
• Mental Health	-1,785
• Other small projects	-1,529
• Total QIPP reductions	-8,093

- **DTOCs:** DTOC targets have been aligned with system plans to deliver the 3.5% national target by November 2017. This represents a challenging target, but the system is confident regarding delivery, with a robust DTOC plan established which is fully aligned with winter planning initiatives and the 8 High Impact Changes Plans. Further information on the DTOC plan can be found in the DTOC section.

- **Residential Admissions:** Residential admissions have continued to be at a relatively low rate during 2017/18, successfully delivering against target for another year. However, based on demographic and self-funder pressures the local authorities were predicting a significant increase in residential admissions in 2017-19. The BCF plans and iBCF investment will mitigate these pressures through investment in prevention and early intervention, reducing the predicted trajectory to a smaller increase on 2016/17 activity.

- **Effectiveness of reablement:** Reablement targets for 2017-19 have been set to offer a small, but challenging, improvement on 2016/17 performance and the baseline target. This will be supported by increased investment in reablement capacity and a strong focus on early intervention to support discharge to assess pathways.

Progress in areas of major investment

The following transformation work has been supported by the BCF over the past two years:

- ***Strengthened Community services Capacity:*** The majority of health funding from the CCG's minimum allocation was used to contribute towards NHS commissioned out of hospital services. A new system of community based health services has now been established through the development of Neighbourhood Teams (NTs). These provide an integrated multi-disciplinary approach to person-centred care across health and social care. Care is personalised and coordinated around people, promoting community resilience, self-management and choice. The integrated approach delivers flexible, tailored care based upon the integration of multi-disciplinary staff across NTs, supported via proactive case management and care coordination of people with complex needs. The alignment of Social Care with NTs, alongside integration with the VCS and Primary Care, will support proactive case management and care coordination of people with complex needs, with 'Trailblazer' pilot sites established throughout 2016/17 to refine the multi-disciplinary team (MDT) proactive case management model. These sites have seen joint work in MDTs across health, social care and the voluntary sector, and development of an approach to case management for vulnerable people across the County. Lessons from the Trailblazer teams are now being rolled out to other neighbourhood teams across Cambridgeshire and Peterborough. This continues to embed across the system and requires further development to encompass case finding and case management. This will assist in identifying and managing people at risk of hospital admission, thus helping to mitigate against all the health and care demands. STP funding is also being used to support the roll out of case management.

- ***Disabled Facilities Grant (DFG), Integrated Community Equipment Services and Assistive Technology:*** In Cambridgeshire, DFG funding is passed via the BCF to the District Councils, who have statutory responsibility for DFG. Peterborough is a unitary authority. In 2016/17, the District Councils, County Council, Peterborough City Council and the CCG collaborated on the DFG Review, a multi-agency partnership approach in order to:

  - review the performance of the three home improvement agencies (HIAs);
  - consider the need for earlier intervention; and
  - scrutinise both capital and revenue funding in light of the uplift in the DFG.

  Outcomes include a phased redirection of revenue funding into early help and housing options advice; support for the HIAs to introduce a fast track system for smaller grants to improve efficiency; and the adoption of a Joint Adaptations Agreement across all partners committing to more flexible spend of the DFG Allocation in order to meet Better Care Fund outcomes. The System Partners are also exploring alternative funding options for 2018/19

  The Integrated Community Equipment Service and Assistive Technology plays an important role in diverting demand away from long-term care and support. As more projects and interventions are funded that focus on keeping people at home, this has had implications for community equipment budgets. BCF partners have collaborated

to find more sustainable solutions for Community Equipment funding, ensuring that where savings are achieved elsewhere in the system, the cost of community equipment is factored in appropriately.

We have also sought to expand the impact of assistive technology in Cambridgeshire and Peterborough – making further steps to embed equipment as a core part of care pathways and a key element of the support we offer at every stage of a service users' journey.

- ***Data Sharing***: During 2016/17, the project has provided advice and guidance to the Trailblazers; and has brought together Information Governance leads to reach agreement across agencies on how data can be shared appropriately. It also supported development of a 'proof of concept' system that allowed sharing of data between organisations to support the case management process. There have been challenges in bringing this work into 'business as usual', as work in this area relies on reaching complex and detailed agreements between a number of partners. From 2017-18 it has been agreed to incorporate this work into the 'Digital' work-stream of the Sustainability and Transformation Plan, recognising the need for system-wide ownership of these issues.

- ***Information, Communication and Advice:*** The Information and Communication project has focused on development of a 'local information platform' or LIP. During this year the project has had three key outputs:

  - A piece of research, analysing customers of older people's services provided by Cambridgeshire County Council and Peterborough City Council, to understand their communication and information needs and preferences.
  - A set of data standards that allow the collation of data from multiple databases into one place.
  - A system that demonstrates an automatic way of passing data from local authority and voluntary sector databases about services to a central point, and then on to the NHS 111 service to be used with customers (the Local Information Platform).

  The goal is that information given to the public can be consistent, wherever people seek advice – and that it only needs to be updated once. At the time of writing the research and data standards are complete, and work is nearing completion which will make the Local Information Platform available as a proof of concept.

- ***Healthy Ageing and Prevention:*** During 2016/17, a falls prevention pilot project in St Ives was implemented, to ensure implementation of NICE guidelines for falls and integrating falls prevention within Neighbourhood Teams. The aim of the pilot was to reduce falls and fall-related injuries in the community through improving the identification, multifactorial assessment, uptake and compliance of evidence based interventions in people aged 65+ who have reported a fall or are at risk of falling. Fundamental to achieving this aim was the delivery of falls prevention training and support to staff in Neighbourhood Teams, GP practices and other community

organisations to enable them to screen, assess and refer those at risk or those reporting a fall to multifactorial, evidence based support. An evaluation report was published in April 2017 and a joint STP and BCF funded business case has been developed for standardised falls prevention provision across the county, which it is anticipated will generate significant savings for the whole system and has now moved into the implementation stage..

- ***Joint Commissioning:*** Work to develop an integrated approach to joint commissioning has been a focus in 2016/17, with an agreed set of Joint Commissioning Principles to guide joint commissioning of wellbeing services through the VCS and through strengthening community resilience. These were shared with around 100 key stakeholders at a Wellbeing Commissioning Summit in October 2016 and these now form an agreed basis for wellbeing services joint commissioning between the Local Authorities and CCG, which will be developed through 2017/19.

  There is an emerging evidence base that Social Prescribing systems have the potential to divert people with non-clinical needs away from GPs, A&Es and hospital in-patient beds to more appropriate community based sources of support. During 16/17 different models of social prescribing were explored and this has informed our thinking on the development of Social Prescribing in 2017/19. We have two separate Wellbeing Networks across C&P. The purpose of each is to help navigate people towards appropriate community based support / services through a single point of access. Progress towards establishing a single CCG wide Wellbeing Network was made during the year and work on both areas will be further progressed through the 2017/19 BCF plans.

A summary of the 2016-17 BCF transformation theme progress can be found at **Appendix 5.** The full detail of BCF plan progress can be found in C&P BCF Plans' respective annual reports. Peterborough's report can be found in **Appendix 6** and Cambridgeshire's report can be found here.

Lessons learnt for 2017/19

There were three key lessons learnt which have been incorporated into 2017-19 plans to support stronger BCF Delivery and integration:

- build on the alignment between BCF, STP and the rest of the system and maximise opportunities to achieve the sustainable transformation necessary across the whole system which will involve the Devolution Plan
- greater alignment of Cambridgeshire and Peterborough BCF Plans, including establishment of a joint commissioning board to oversee delivery of the BCF
- provide a more integrated focus on reducing DTOCs, through joint implementation of the 8 HIC Model.

Evidence base and local priorities to support plan for integration

The evidence base and priorities have been informed by:

- Current context – Governance & challenges – See Background and Context Section.
- BCF progress over previous years – See Progress to Date Section
- Lessons learned from previous BCF Plans – See Progress to Date Section

Evidence base for issues to be addressed in the 2017/19 BCF plan
• Continued growth of over 65 year old population who have more co-morbidities
• Continued rising demand on acute health and social care services
• Insufficient primary and community based health and social care capacity to provide adequate alternatives to hospital and long term social care
• Sub optimal system-wide systems and processes leading to delayed transfers of care (DTOCs)
• Under-utilisation / inefficient use of VCS & weak community resilience
• Financial Challenges

BCF Plans for 2017-19 are based on the local context, challenges, progress to date and lessons learned which all inform the evidence base for 2017/19. Our aim is that the BCF will drive closer alignment and integration where appropriate across our system to support better outcomes for patients and citizens.

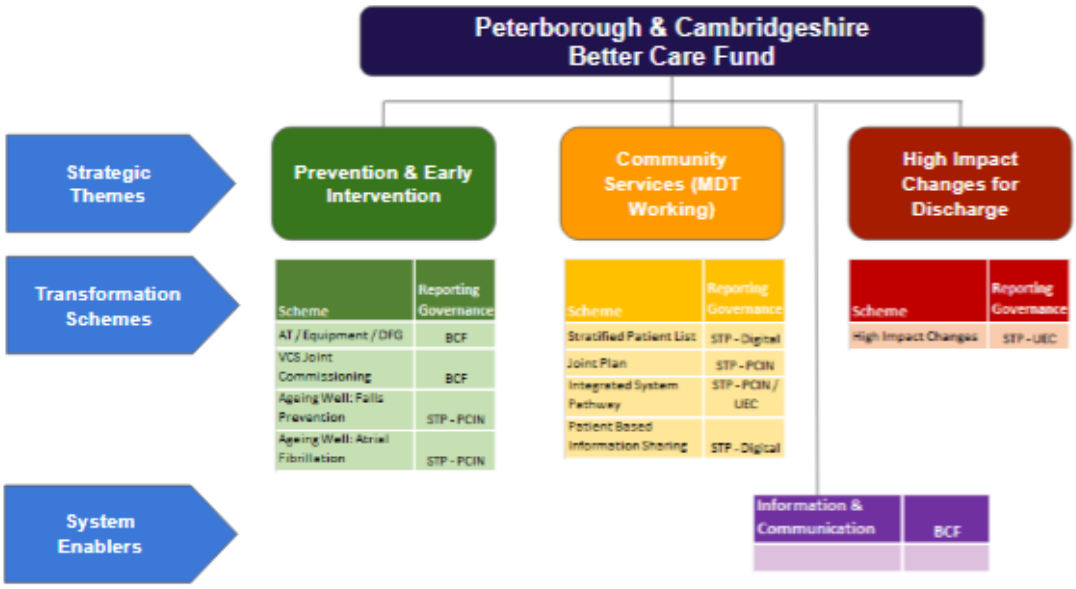
Better Care Fund plan 2017-19

Our ultimate aim is to shift away from long term social care, or care that is provided in the acute hospital setting, and towards preventive services that focus on keeping people well. Our plans therefore focus on the following four strategic theme areas:

- Prevention & early intervention
- Community services (MDT working)
- High Impact Changes to reduce DTOCs and support patient flow through pathways
- Information & communication

This section describes each of the overarching strategic theme areas and sets out the underpinning BCF plans. Further detail on individual plans is at **Appendix 7.**

Figure 1: C&P 2017/19 BCF Plans Strategic Themes



Focus area one: Prevention and early intervention

This area focuses on establishing and implementing approaches that prevent or delay the need for more intensive health (specifically admissions and re-admissions to hospital) and social care services, or, proactively promote the independence of people with long-term conditions and older people and their engagement with the community.
This area includes specific and planned evidence based public health programmes with an emphasis on falls, social isolation, malnutrition, dementia and end of life care. It also includes interventions to enhance independence for people with increasing levels of need.

The 2017/19 BCF Plans will build on the huge amount of work already undertaken in this area.as follows:

- Ageing Well
- Falls Prevention
- Atrial Fibrillation
- Joint approaches to Voluntary Sector Commissioning & social prescribing
- Assistive Technology, Equipment, Environmental Controls and DFG

- ***Ageing Well:*** Age increases the risk of many health disorders and these can have significant impacts on an older person's independence and ability to function day-to-day. Different sources of data (mortality, admissions, GP diagnoses, medications) provide an insight into the diseases that are important in older age. As people age, they are more likely to experience multimorbidity – the presence of multiple long-term conditions at the same time. Older age is also characterised by the emergence of several complex health states that tend to occur only later in life, such as falls, cognitive decline and dementia, incontinence, malnutrition and social isolation. Because most of the disease burden in older age is due to non-communicable diseases, risk factors for these conditions are important targets for health promotion – including physical activity, nutrition, alcohol, smoking and continued education. strategies to reduce the burden of disability and mortality in older age by enabling

healthy behaviours can therefore start early in life and should continue across the life course. Strategies to reduce their impact continue to be effective in older age, particularly for reducing hypertension, improving nutrition and stopping smoking.

Cambridgeshire and Peterborough's first BCF plans established the Healthy Ageing and Prevention programme. Recognising the importance of this agenda not just to the BCF agenda but to the wider STP as a whole, it has been incorporated into the STP as a new 'Ageing Well Strategy Board'. We will continue to engage with the programme through the BCF and consider new areas of activity to support an approach to Healthy Ageing.

- ***Falls prevention:*** Falls are the commonest cause of accidental injury in older people and the commonest cause of accidental death in the population aged 75 and over in the UK. A significant number of falls result in death or severe or moderate injury, at an estimated cost of £15 million per annum for immediate healthcare treatment alone.[8] This is a significant underestimation of the overall burden from falls once the costs of rehabilitation and social care are taken into account, as up to 90% of older patients who fracture their neck of femur fail to recover their previous level of mobility or independence.[9] In addition to these financial costs, there are additional costs that are more difficult to quantify. The intangible human costs of falling includes distress, pain, injury, loss of confidence and loss of independence, as well as the anxiety caused to patients, relatives, carers, and hospital staff.[10]

  The aim of this project is thus to implement a comprehensive, standardised, and integrated falls prevention pathway across the CCG area of Cambridgeshire and Peterborough. See **Appendix 7** for project detail.

- ***Atrial Fibrillation:*** Evidence shows us that Atrial Fibrillation (AF) is one of the risk factors for stroke. The yearly risk of stroke for a person with AF ranges from 1% to 15%. This risk is cumulative over time. AF-related strokes are preventable and for every 25 patients treated with anticoagulants, one AF-related stroke is prevented each year. Currently in Greater Peterborough and Wisbech:

  - 25% of high-risk AF patients do not receive anticoagulation therapy (826 patients).
  - 38% of AF patients remain undiagnosed.

  These areas account for the largest proportion of untreated and undiagnosed AF across the CCG. Our AF pilot therefore targets 3 GP Practices in Greater Peterborough and Wisbech by working with GPs (using a quality improvement approach) to:
  - Improve the management of patients diagnosed with AF not currently receiving Oral Anticoagulants (OACs).
  - Identify and treat asymptomatic cases of AF.

[8] NPSA 2007 Slips, trips and falls in hospitals www.npsa.nhs.uk.

[9] Murray GR, Cameron ID, Cumming RG. The consequences of falls in acute and subacute hospitals in Australia that result in proximal femoral fracture. Journal of the American Geriatrics Society. 2007; 55(4): 577-82.

[10] Patient Safety First Campaign 2010. Reducing Harm from Falls.

Through treatment both health and social outcomes will improve for patients as well as reducing costs to the health and social care system through avoided hospital admissions and care costs relating to strokes as well as reducing DTOCs as stroke patients typically have complex ongoing needs. This project has joint STP and BCF funding. See **Appendix 7** for project detail.

- ***Community Equipment, Disabled Facilities Grants and Assistive Technology***
- ***Community Equipment:*** The Integrated Community Equipment Service (ICES) provides short- and long-term loans of equipment, ranging from simple walking aids, through to larger and more complex items, such as pressure relieving mattresses and hoists. Equipment may also be designed to help carers with the safer delivery of care. The service can also include installation, servicing and maintenance, depending on the type of equipment specified. For people with complex needs, a multi system approach may be required from DFG, ICES and AT teams to assess people for a package of support to optimise their outcomes.

  This equipment plays an important role in diverting demand away from long-term care and support. As more projects and interventions are funded that focus on keeping people at home, this has implications for community equipment budgets. These costs have not always been factored into business cases. The first impact of increasing demand for community equipment is now being felt, with overspends in budgets in both Cambridgeshire and Peterborough during 2016/17.

  BCF partners will therefore collaborate to find a more sustainable solution for ICES funding during 2017/19 and will also ensuring that the cost of community equipment is factored into future business cases that focus on transferring care from the acute to community settings.

- ***Assistive Technology (AT):*** Through the BCF we will seek to expand the impact of AT in C&P – moving to the point where it is a core part of care pathways and a key element of the support we offer at every stage of a service users' journey. We will build upon and expand the existing joint health and social care funding in this area and have identified a number of specific opportunities to use AT.

- ***DFG:*** In 2017/18, the District Council partners have committed to developing a Joint Grants Policy over the coming year in order to deliver a consistent approach to appropriate conversations (re suitability of an adaptation or alternative options) and adaptations for residents across the county. We are working with the Elderly Accommodation Council to develop a bespoke Cambridgeshire Housing Options for Older People tool and are also considering services that can provide support for people to move.

  The results of this work will provide significantly better outcomes for people in need of housing support across Cambridgeshire and Peterborough.
  See **Appendix 7** for further detail.

- ***Joint approaches to Voluntary Sector Commissioning:*** Building on the Joint Commissioning Principles established during 2016/17, in 2017/19 existing arrangements will be reviewed and opportunities to jointly recommission will be identified.

  Across the CCG, there are pockets of social prescribing within GP Practices / District Council areas. Further, many elements of a 'social prescribing system' are already commissioned through the VCS contracts – e.g. the Cambridgeshire Community Navigators contract. Under the BCF, the approach planned is to explore how a more 'bottom up' organic approach to social prescribing can be supported by the whole system, which incorporates the aspiration of the GP and Mental Health Forward View's.. Further, as the wellbeing commissioning principles are adopted and joint commissioning of VCS services proceeds, there will be further opportunities to strengthen the necessary community infrastructure to support social prescribing.

  The two separate C&P Wellbeing Networks will merge into one in September 2017 which will strengthen the co-ordination of and support for wellbeing services and VCS activity across C&P. In this way more support will be provided vulnerable adults before they require the support of statutory services.

Focus Area Two: Community Services / MDT Working

Case management within the Neighbourhood Teams is key to reducing increasing demand on the acute and statutory care services. This area is supported by BCF funding as per above and in 2017/18 the STP supported a business case to develop case management in order to identify and support more people who are frail than current services allow. This builds on the work already undertaken to establish an extended MDT case management approach in four trailblazer sites across C&P. The ongoing focus will be to refine, embed and expand the approach across the whole system. Key elements include the following:

- **Stratified patient list**: to identify the top 5-15% of people most at risk of hospital admission
- **Joint care and support plans:** to support the further development of multi-disciplinary working, a new assessment of need is being developed, which will cut across health and social care (GP services, district nurse services, physiotherapist services, occupational therapy, social care), including acute and community-based care, and make the process of assessing service users with multiple needs more joined up and efficient. This area is also being supported by NAVCA, the Coalition for Collaborative Care and Patient Voices who are working with local partners to support the development of co-produced plans in conjunction with patients, users, carers to ensure individuals identify their own health and care goals and agree plans to meet those needs.
- **Integrated system pathway to admission and discharge:** This will focus on an integrated pathway from early identification of need, through intermediate care provision to long term care support and supported early discharge.
- **Patient based information sharing:** The focus will be on supporting the practical elements of data sharing to support effective MDT working on a day-to-day basis.

This area has received dual investment from the STP and BCF funding during 2017/18. Further project detail can be found in **Appendix 7.**

Focus Area Three: High Impact Changes for managing transfers of care

The Integration and Better Care Fund (iBCF) planning requirements require BCF plans to have a DTOC metric set consistent with the targets set by the CCG to meet the 3.5% DTOC target by 2 November 2017. The target is to include planned reductions for NHS and social care DTOCs. Each of the C&P Health & Wellbeing Boards submitted their agreed DTOC metrics to the NHSE on 21 July 2017 for Quarters 2-4 of 2017/18.

Health and social care partners are mandated to jointly assess the current status against each of the 8 HIC and determine a joint implementation plan as part of the BCF Plan in order to improve the management of transfers of care.

8 High Impact Change (8HIC) Plan

The following joint process was put in place across C&P in order to agree the joint baseline assessment and plan development with involvement from the following boards:

- Integrated Commissioning Board (ICB)
- North West Anglia Foundation Trust (NWAFT) A&E Delivery Board (incorporating Peterborough and Stamford Hospitals NHS Trust (PSHFT) and Hinchingbrooke Hospitals NHS Trust (HHT))
- Cambridge University Hospitals NHS Trust (CUHFT) A&E Delivery Board
- Urgent and Emergency Care (UEC) Delivery Group (part of the STP structure).

The HIC plans build upon existing system DTOC plans to avoid duplication and ensure cohesion. The completed 8HIC self-assessments can be found at **Appendix 8**.

Further to the completion of the individual hospital system self-assessment plans a C&P wide whole system workshop was held to ensure consistency of application of assessment criteria against the 8HICs and to agree the top three HIC priorities across the whole system that would have the maximum impact on DTOCs in the short term to support achievement of the 3.5% DTOC target by November 2017.

The 8 HIC assessments and DTOC plans were then costed, which fed into the iBCF costed plan development process. The costed DTOC Plan is attached at **Appendix 9**.

The agreed immediate system priorities for implementation of the 8HIC Model are:

- Discharge to Assess
- Continuing Health Care Hospital Discharge Process
- Trusted Assessor

In order to support these initiatives, the following enablers were also agreed as priorities:

- Implementation of the Choice Policy
- Enhancements to SHREWD and patient flow monitoring systems

Further information on project plans can be found at **Appendix 7.**

Strategic Theme Area Four: Information and Communication (Enabler)

The short term vision is to support the immediate need of dependent projects (e.g. MiDOS, 111/Out of Hours, PCC and CCC Front Door redesigns, the C&P wide Wellbeing Network and Social Prescribing) through maximising the quality and consistency of information currently held across Directories of Services. This comprises of:

- Personas (insight research of the 'shared' customer): research and understand the needs of customers via the use of 'customer journeys' / personas. This will inform the development of a customer focused solution.
- Information Standards: gain a better understanding of the current DOS landscape, including mapping of information and ownership. The development of a consistent approach to updating and maintaining information held on DOS in collaboration with local system partners.
- Development of the platform service: development of a technical solution that is able to curate, search, share and improve information that is held in DOS and pass this information to a variety of website front ends.

The medium term vision of the project is to widen the scope of information that can be provided, through the development of a platform service to dovetail with existing search tools (e.g. MiDOS). This could, for example, include information on local events or self-management focused health information. This comprises of:

- Further development of the platform service and roll out across the whole partnership: development of a technical solution that is able to curate, search, share and improve information that is held in Directories.
- Front End: support the development of partner websites and front door tools to enable access to the platform service.
- Embedding approach to ensure ongoing management of information and advice in line with best practice approaches.

Further project detail can be found at **Appendix 7.**

Project Delivery

A flexible and agile approach, enabling collaborative planning to be undertaken should problems be encountered and the delivery of agreed outcomes be at risk. The following table summarises how our proposed method and approach will deliver the BCF plans:

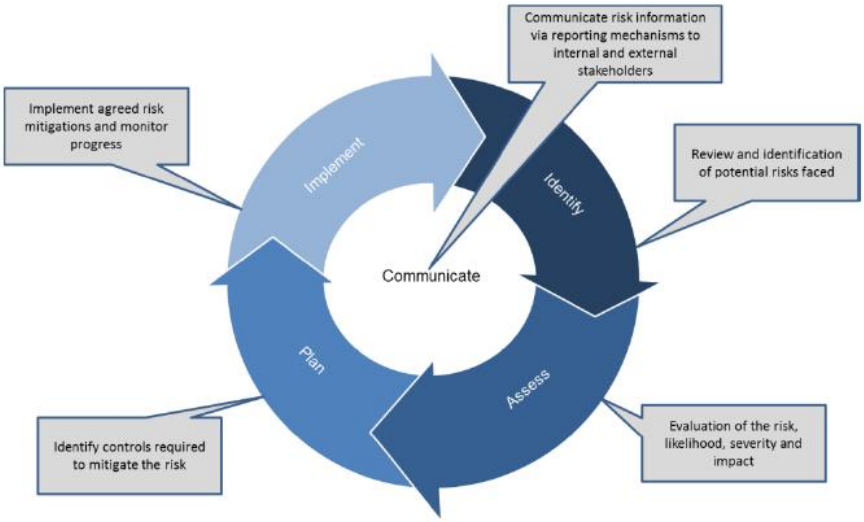
Requirement:	How our method/approach will deliver:
Establish a clear articulated and prioritised plan to steer the BCF streams development	Our right to left approach to planning will ensure that the plan is prioritised and will deliver expected outcomes in the right order. We will produce "plans on a page" for each work stream to provide clear articulation to key stakeholders. Our proposed approach includes early stage "doing" activity in addition to mobilising and planning.

alongside doing the early stages	
Produce comprehensive documentation of processes and create programme and project documentation	We will work to ensure comprehensively documented processes, applying our structured process development and management. We will deploy an experienced PMO team equipped with a comprehensive set of configurable documentation templates and PMO processes.
Establish governance structure and clear lines of reporting	We will work to socialise and establish the emerging governance structure for implementing the BCF streams. The governance structure and reporting lines will be informed by the stakeholder engagement activity, which is a key aspect of our approach in all stages.
Establish implementation plans, which will enable key work streams of activity that will be crucial to the success of the BCF streams.	Our approach to planning will ensure that all the necessary enabler-focussed outputs are planned within work streams to deliver the required outcomes. We will incorporate an approach to change management and enable the plans to be adjusted based on learning from any pilots. We will ensure that in designing the detailed plans all relevant factors are addressed including for example an assessment of change readiness; appetite for risks and probability of failures. The implementation plans will be supported by: a targeted communication plan; detailed work breakdown structures; Gantt charts with tasks/milestones/dependencies; resource plans and skill requirements; risk mitigation strategy.

Further detail on project plans can be found at **Appendix 7.**

Assessment of Risk and Risk Management

Cambridgeshire and Peterborough have 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 below diagram highlights the processes that will be applied to support effective identification and analysis of programme risks and issues.



CCG Approach to Risk Management: The CCG's Assurance Framework and risk register (CAF) 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 2017-2018 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 is 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. A copy of the current CAF is attached at **Appendix 10.**

STP Approach to Risk Management: The risk management process for the STP is overseen by the System Delivery Unit, an independent programme management office which has been set up to have oversight of STP delivery. The STP uses the NHS National Patient Safety Agency's Model Risk Matrix to evaluate and score its programme risks. In short this involves identifying and scoring the potential consequence(s) of a risk and assessing and scoring the likelihood of that risk occurring. Risk registers are maintained for all projects and there is a robust escalation process which aligns with the STP governance arrangements. Further information on the STP risk management approach can be found in **Appendix 11**.

Councils' Approach to Risk Management: All departments within Peterborough City Council and Cambridgeshire County Council hold departmental risk registers which report into a monthly Corporate Risk Group. All risks are reviewed at this meeting, which is chaired by the Corporate Risk Manager. Identified risks are transferred to the Corporate Risk Register which is fed into the executive Corporate Management Team for review on a quarterly basis. In addition, the local authority project management teams support project risks and issues, which are reviewed on an ongoing basis. Identified risks are escalated to the Peterborough and Cambridgeshire Commissioning Board, who review those identified as high risk. Any risks transferred to the Commissioning Board risk register also report into the quarterly Corporate Management Team.

Approach to establishing BCF Risks and management: A detailed BCF risk log, which is managed by the Integrated Commissioning Board, can be found attached at **Appendix 12.**

Financial Risk Management

A Risk Share Fund has been established for both Cambridgeshire and Peterborough for 2017/19. For the avoidance of doubt, the Risk Share Fund is incorporated within the CCG's minimum BCF allocation, i.e. it is not in addition to the CCG minimum contribution to the BCF.

The CCG will protect the Risk Share Fund within the CCG budget and it will only be released into the BCF pooled budget at the end of the financial year based on evidence that there has been the full reduction in non-elective admissions over the full year equal to or above the target agreed as part of the 2017-19 plan.
In the event that non-elective admissions target is not achieved, the Risk Share Fund will be used by the CCG to contribute towards the reimbursement of acute hospital providers for the excess non-elective admissions incurred.

Reporting on risk share spend will be to the Integrated Commissioning Board quarterly and in turn through to NHS England through the quarterly reporting mechanism.
A section 75 agreement is in place between both Councils and the CCG, with provision for the risk sharing agreement being reviewed in line with these arrangements.

National Conditions

The following section outlines how we have addressed the national conditions.

National condition 1: jointly agreed plan

The plan has been developed in conjunction with all health and Local Authority partners and the VCS. All key partners are signatories to the plan. Detailed discussions and engagement with system partners were undertaken over a period of months at the following meetings, which have representation across councils, districts, public health, the CCG, NHS providers and voluntary sector:

- Health and Wellbeing Boards for Peterborough and Cambridgeshire
- Integrated Commissioning Board
- CCG Clinical Executive Committee
- Health and care Executive incorporating LA and all health organisations CEOs
- STP Investment Committee for approval of joint BCF/STP business cases
- Three Area Executive Partnership Boards
- Two A&E Delivery Boards

National condition 2: social care maintenance

Protection of social care provision is integral to the delivery of an effective integrated care model and this is reflected in the inclusion of social care provision within the BCF plan

schemes. There are no proposals to reduce social care services within the plan and a real term BCF financial uplift has been included to support adult social care. There are no proposals to reduce social care services within the plan.

We and our partners have recognised that meeting the demand for social care services is not sustainable in the current financial climate, and the continued increase in population brings further pressures. While the BCF will enable us to improve many of our processes and develop new ways of providing services, the increase in demographic and financial demands being placed on the social care system will require a complete change to how social care is provided in order to ensure sustainability in the medium to long term. The BCF funding allocated to protecting social care will therefore provide a bridging mechanism in the transition from current to future working practices.

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

National condition 3: NHS commissioned out-of-hospital services

The majority of health funding from the CCG's minimum allocation for 2017/19 is set against NHS commissioned out of hospital services to fund the new system of community based health services – the fourteen Neighbourhood Teams. These provide an integrated multi-disciplinary approach to person-centred care across health and social care. The approach is being further developed in 2017/19 through use of a risk stratification methodology to identify the top 5-15% or people at risk of hospital admission and to proactively case manage and co-ordinate care for those people who have very complex needs.

The alignment of Social Care with NTs, alongside integration with the VCS and Primary Care, will support proactive case management and care coordination of people with complex needs. See BCF Plan section above for further detail.

National Condition 4: Managing Transfers of Care

The approach to implementing the high impact changes across Cambridgeshire and Peterborough is outlined above in the Project Delivery section.

Overview of funding contributions

We confirm that the funding contributions for the BCF have been agreed and confirmed – including agreement on identification of funds for Care Act duties, re-ablement and carers breaks from the CCG Minimum Allocation. These are confirmed in the excel Planning Template and an overview of funding is contained at **Appendix 13.**

Carer's Breaks

The BCF will continue to fund carers support in 2017/19. Work includes commissioning Carers Trust and support from the Alzheimer's Society. Carers Trust provide a Family

Carers' Prescription. This will give the carer access to a specialist worker at Carers Trust, who will discuss options and provide information to access the appropriate support. A Family Carers' Prescription will also help design a short break that works for the carer and they will also provide support for this break to happen. The worker will help the carer decide what type of break is suitable. The Prescription can be offered via the carer's GP Practice who will record the family carer so that they can support the carer appropriately in the future.

Maintenance of Adult Social Care

The CCG minimum allocation includes a 1.79% uplift based on the 16/17 August BCF Plan baseline for the protection of adult social care in 2017/18 and a 1.9% uplift in 2018/19. Further information on the maintenance of adult social care can be found in the National Conditions Section.

Reablement

Continued additional investment is planned for reablement across Cambridgeshire and Peterborough to support increasing demand and the effective implementation of Discharge to Assess pathways. Investment in reablement supports at home is best and early intervention/prevention approaches to preventing individuals' needs escalating to long term care options.

Care Act Duties

The delivery of an integrated health and social care system supported through the Better Care Fund will enable the social care and health community to be better placed to deliver requirements of the Care Act through the provision of a more efficient and better coordinated system of provision. A major objective is to simplify access to and navigation through the Health and Social Care system, ensuring that citizens and carers are able to access the right support at the right time including community based preventative provision. The BCF Plan contains specific funding to support delivering minimum eligibility standards and better support for carers.

Disabled Facilities Grant

In Cambridgeshire the DFG monies are passed to the District Councils. In Peterborough, As a unitary authority, responsibility for the DFG sits with Peterborough City Council. DFG funds will support home adaptations and support to better support people to remain in their homes for longer. Engagement and integration of housing is a crucial element in supporting the outcomes of the BCF and housing colleagues have been actively involved in the development of the 2017/19 plans.

Improved Better Care Fund (iBCF)

The Improved Better Care Fund (iBCF) is a new introduction to BCF plans this financial year and plans have been developed to comply with the following national conditions:

- Monies must be pooled into the Better Care Fund (BCF) Section 75 budget
- Monies must only be used for the following purposes:
    - Meeting Adult Social Care (ASC) needs,
    - Reducing pressures on the NHS, including supporting more people to be discharged from hospital when ready; and

- Ensuring the local social care provider market is supported.

The following areas of funding have been agreed for 2017-19:

Initiative	Description
Investment in care and support, including housing, for Vulnerable People	Provision of suitable long term care and support, including housing, to support individuals to maintain greater independence within their own homes. This will manage and prevent escalation of need to more complex long term packages of care, including care home placements. Further information on this can be found at **Appendix 14.**
Social Care Capacity and Investment	Address demand pressures through investment in prevention and early intervention transformation initiatives. This includes investment in the redesign and integration of enhanced reablement, therapy and housing adaptation services, as well as improvements in adult social care access points.
Prevention Initiatives	An investment in public health targeted prevention initiatives, including falls prevention, social isolation and atrial fibrillation. Focusing on early prevention in key trigger areas for older people will prevent or reduce the escalation of health and care needs for these individuals.
Delivery of 3.5% DTOC target, including implementation of the 8 High Impact Changes	Targeted implementation of identified priority high impact changes to support a reduction in DTOCs and reduce financial pressures to health and social care as result of managing discharges more effectively.

DTOC Plan

The Local Authorities have worked with health partners to develop and agree a costed plan to support delivery of the 3.5% national DTOC target by November 2017. This builds on the gaps identified as part of the High Impact Changes self-assessments and workshops were held to agree the system priorities, as outlined in the 8 High Impact Change Section. Investment requirements were also considered to inform local plans. The CCG and Local

Authorities will flex the investment over the period of the plan by reviewing performance through the ICB and then adjusting the investment into schemes to meet the BCF metrics.

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 STP Urgent and Emergency Care Delivery Group. The DTOC plan is a consistent plan across the CCG footprint and takes into account cross-border pressures on the local system.
- Our A&E Delivery Groups have agreed plans in place for reducing DTOCs, which are aligned to other existing system plans, e.g. winter planning.
- Each acute 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.

A detailed costed system DTOC Plan is attached at **Appendix 9.**

Programme Governance

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

The BCF governance has been reviewed to ensure alignment with the newly established STP governance structure. This is to ensure a consistent approach across the system. In its first two years, the BCF has maintained a separate PMO structure. This has seen project boards established for a number of pieces of work, and officers dedicated to BCF and integration work employed in each local authority and the CCG. In some areas, this structure has helped to move things on effectively. However, in a number of areas, this structure has led to insufficient integration with other programmes of work, and a risk of duplication. In general the projects that have developed most effectively have been those where one or two organisations have been commissioned to develop and deliver a piece of work.

It is important that we ensure alignment as much as possible with the STP and devolution plans, whilst recognising the need to ensure the protection of social care, drive local delivery and ensure oversight of progress. Where appropriate, we would propose that the STP is effectively commissioned by the BCF to deliver specific work packages; this would enable a whole-system approach whilst retaining clear oversight.

In some instances, there are areas of work that remain priorities for the local authorities and do not naturally fall within the STP work streams. In these instances it would be more appropriate for these projects to be managed at a local authority level, feeding into the Joint Integrated Commissioning Board for governance oversight and reporting on delivery

progress into the local Area Executive Partnerships where appropriate.

The local structures are about to further align to merge the Local Health Partnerships at District level with the AEPBs to join up the District Delivery and Public Health on a place based arrangement. This will create four Living Well Partnerships instead of the current 5 Local Health Partnerships and the three AEPs.

The Diagram in **Appendix 15** outlines the revised BCF governance structure for 2017/18 onwards.

The Diagram in **Appendix 16** outlines the STP governance structure, which shows the relationship with the Integrated Commissioning Board.

In order to ensure effective establishment and delivery of the BCF moving forwards, the following has been established:

- A single county-wide Integrated Commissioning Board across Peterborough and Cambridgeshire has been established, which supersedes the existing Cambridgeshire BCF Delivery Board and Greater Peterborough Executive Partnership Commissioning Board.
- Projects commissioned from the STP will feed into the STP Governance structure, with reporting to the BCF for monitoring purposes.
- Governance arrangements for Local Authority led programmes of work will be managed by local project boards, feeding into the Joint Integrated Commissioning Board for system governance oversight. Reporting lines are established to the Living Well Partnerships for monitoring of delivery progress where appropriate.

Approval and Sign Off

Signature:	
Signed on behalf of:	*Peterborough Health and Wellbeing Board*
By:	*Councillor John Holdich*
Position:	*Chair of Health and Wellbeing Board*

Date:	

Signature:	
Signed on behalf of:	*Cambridgeshire Health and Wellbeing Board*
By:	*Councillor Peter Topping*
Position:	*Chair of Health and Wellbeing Board*
Date:	

Signature:	
Signed on behalf of:	*Peterborough City Council & Cambridgeshire County Council*
By:	*Gillian Beasley*
Position:	*Chief Executive*
Date:	

Signature:	
Signed on behalf of:	*NHS Cambridgeshire and Peterborough Clinical Commissioning Group*
By:	*Jonathan Dunk*

Position:	*Acting Chief Operating Officer*
Date:	

Signature:	
Signed on behalf of:	*North West Anglia NHS Foundation Trust*
By:	*Stephen Graves*
Position:	*Chief Executive*
Date:	

Signature:	
Signed on behalf of:	*Cambridgeshire University Hospital NHS Foundation Trust*
By:	*Roland Sinker*
Position:	*Chief Executive*
Date:	

Signature:	
Signed on behalf of:	*Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)*

By:	*Tracy Dowling*
Position:	*Chief Executive*
Date:	

Signature:	
Signed on behalf of:	*Primary Care Representation*
By:	*Gary Howsam*
Position:	*Clinical Chair, Cambridgeshire and Peterborough Clinical Commissioning Group*
Date:	

Cambridgeshire & Peterborough

Better Care Fund Narrative Plan 2017-19

Appendices

Contents

Appendix 1 - Local Vision for Integration

Before people have significant ongoing needs

Ageing well

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

Eyes and ears – indicators of vulnerability

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

Clear and joint sources of information

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

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

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

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

Holistic identification of need with a coordinated response

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

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

Support for people with significant ongoing needs

Clear, coordinated pathways and hand overs

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

Neighbourhood teams and Multi-Disciplinary Team (MDT) working

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

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

Case finding and case management

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

Working with Care Homes

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

Working with housing providers

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

Enablers – support for delivery

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

Joint outcomes

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

Information and data sharing

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

A common language

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

Workforce development

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

Property co-location

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

Joint commissioning of the voluntary and community sector

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

Appendix 2 - Cambridgeshire & Peterborough Demographics

Cambridgeshire Demographics

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

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

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

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

Peterborough Demographics

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

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

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

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

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

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

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

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

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

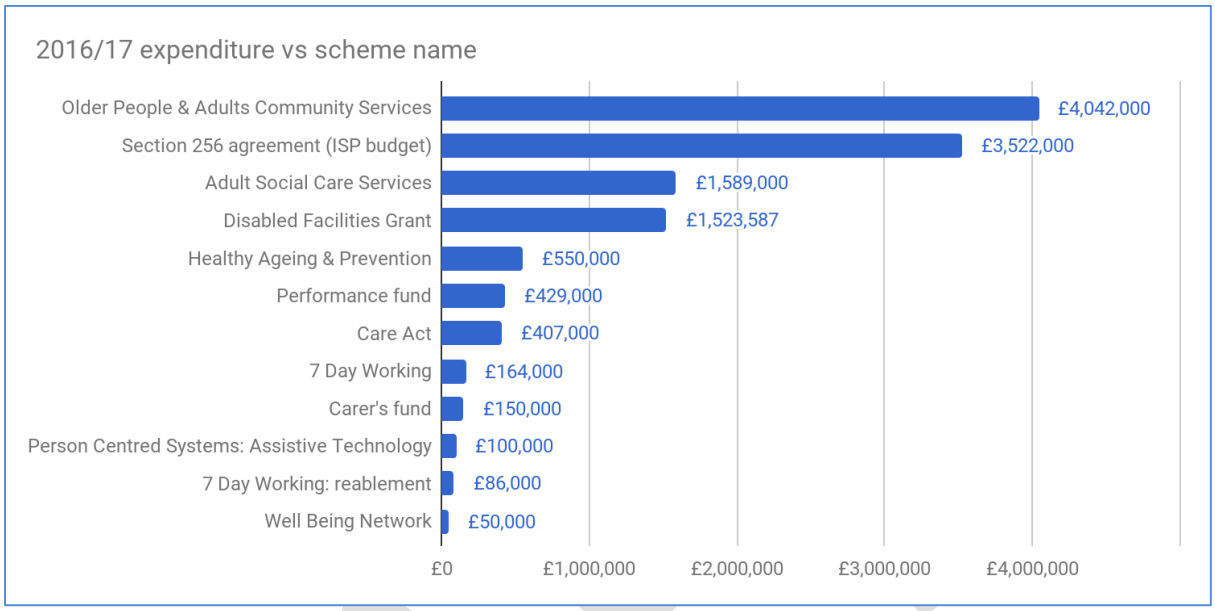
Further reading

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

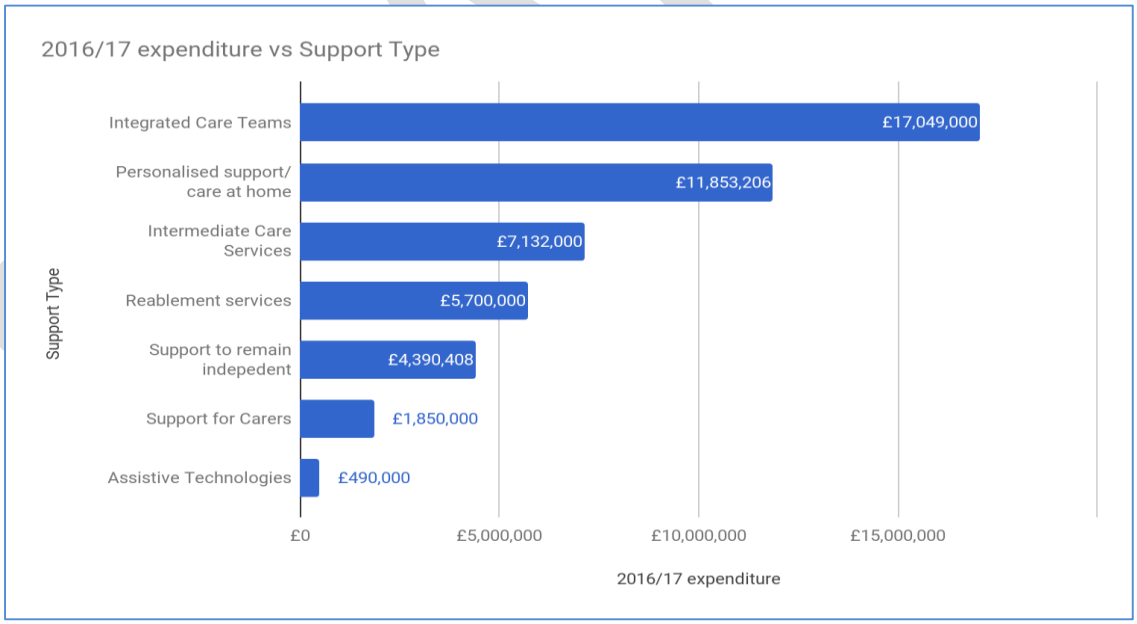
Peterborough JSNA Core Dataset 2016 refresh
Peterborough Health and Wellbeing Strategy 2016-19
Cambridgeshire Health and Wellbeing Strategy 2012-17
Peterborough Diverse Ethnic Communities JSNA
Peterborough Mental Health and Mental Illness of Adults of Working Age JSNA
Peterborough Cardiovascular Disease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

Appendix 3 - BCF Expenditure Plans 2016/17

Cambridgeshire



Peterborough:



Appendix 4 - BCF Progress against Performance Metrics 2016/17

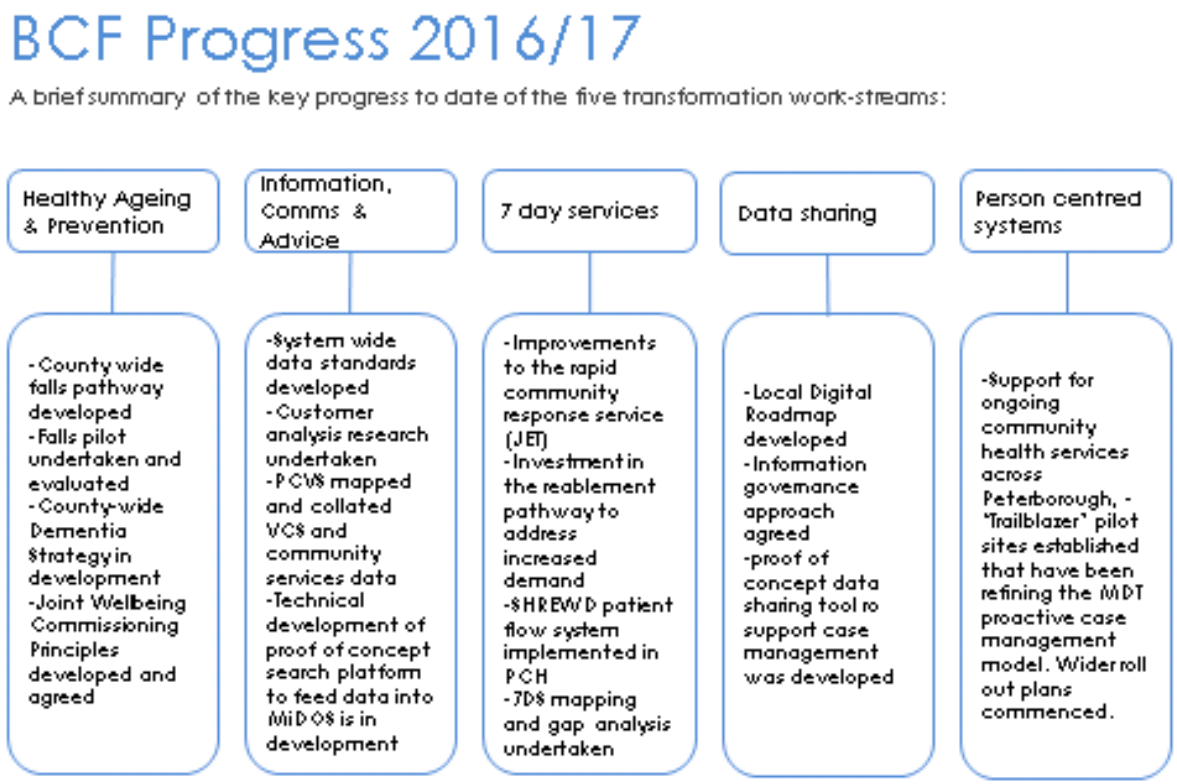
BCF Progress against performance metrics - Cambridgeshire

Metric	2016/17 Actual Performance	2016/17 Planned Threshold Target
Non-elective admissions to hospital	15,625	15,665
Delayed Transfers of Care (DTOCs) from hospital	35,732	10,336
Admissions to long term residential and nursing homes (per 100,000)	345	435.6
Effectiveness of reablement services	61.20%	81.20%
Maintained satisfaction with NHS Services (Friends and Family Test)	97%	93%
Proportion of adults receiving long term social care (per 100,000)	1,962	1600

BCF Progress against performance metrics - Peterborough

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

Appendix 5 - BCF Progress against Transformation Themes 2016/17



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

App 6 - Pet S75 Annual Report 16-17

Appendix 7 - Better Care Fund Project Plan Detail

App 8 - BCF PLan.xlsx

Appendix 8 - 8 High Impact Changes Self-Assessments

App 8 - HIC assessment plan.xlsx

Appendix 9 - Costed DTOC Plan

Costed DTOC Plan v6.xlsx

Appendix 10 - CAF Risk Register

App 10 - CAF Risks Summary.xlsx

Appendix 11 – STP Risk Management Approach

App 11 - STP risk approach.pdf

Appendix 12 - BCF Risk Register

App 12 - BCF 17_19 Risk Log.xlsx

Appendix 13 - Overview of 2017/19 Funding

App 13 - Cambs finances.docx

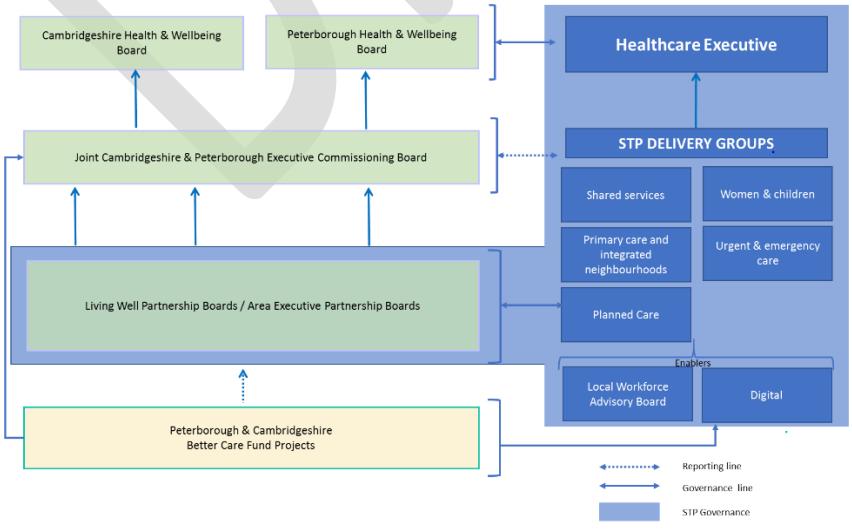
App 13 - Peterborough finan

Appendix 14 – Support and Housing for Vulnerable People Business Cases

PCC IBCF Housing Business Case.doc

CCC IBCF Housing Business Case.doc

Appendix 15 - BCF Governance Structure



Appendix 16 - STP Governance Structure

STP governance.pdf

Peterborough
Better Care Fund
Section 75 Agreement Annual Report 2016-17

Introduction

During the financial year of 2016/17, a Section 75 pooled budget was established in relation to the Better Care Fund (BCF) between Peterborough City Council (PCC) and Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). The sum of £12,612,587 was invested into the pooled fund to deliver the outcomes of the BCF. This financial contribution was redirected from existing budgets within PCC and the CCG and did not comprise a new pot of money. In 2017, Peterborough will be required to submit a new, jointly agreed BCF Plan, covering a two year period (April 2017 to March 2019). This report provides an update on the 2016/17 financial position, progress on delivery and lessons learnt for future planning.

Background

Peterborough is approaching the end of its second financial year of the BCF. The vision for Peterborough's BCF plan has remained the same over its first two years:

Over the next five years in Peterborough we want to move to a system in which health , housing support 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 desire to shift activity across the system has informed the budget-setting, performance management and transformation activity contained within the BCF. The vision is system-wide and has remained relevant; similar aims are expressed through the NHS Sustainability and Transformation Plan and the Council's Transformation approach to social care.

The '10 aspects of an integrated system' principles, which were developed jointly with Cambridgeshire, continued to form the basis of local plans for health, housing support and social care integration. These principles incorporate:

- A series of community based programmes and support that help people to age healthily
- A recognised set of triggers of vulnerability which generate a planned response across the system
- A universal network helping citizens to find high quality information and advice
- An aligned set of outcomes
- An integrated front door with an agreed principle of 'no wrong front door'
- Shared assessment process, information sharing between health, social care and other partners
- A shared tool that describes levels of vulnerability
- A locality based Integrated Neighbourhood Team approach working with Primary Care

- Co-located staff
- Joint commissioning and aligned financial incentives

In addition, the following five transformation themes were identified within the plan, to be progressed jointly with Cambridgeshire:

1. Data Sharing
2. 7 Day Services
3. Person Centred Systems
4. Information, Communication and Advice
5. Healthy Ageing and Prevention

Financial Position

Nearly all of the funding included within the BCF budget was already being used in Peterborough to support local health and social care services. Local areas were required to move specific budgets into the Better Care Fund, including:

- Funding that was already providing community health services
- 'Section 256' funding that was already transferred from the NHS to social care to support social care services which benefitted the health and Care system
- Funding for delivery of new social care duties under the Care Act 2014
- Funding received by the NHS for funding local re-ablement provision
- Capital funding used by District Councils for provision of Disabled Facilities Grant
- The Adult Social Care Capital Grant used for capital requirements in Adult Social Care.

This has limited Peterborough's ability to use BCF funding flexibly and has limited the proportion of the budget that could be freed up in the short term to support transformation.

The Section 75 agreement outlined the breakdown of budgeted financial allocations for the BCF in 2016/17and at the end of the financial year the budget was balanced. The breakdown of actual financial spend is attached at **Appendix 1**.

There was a performance fund element to the BCF allocation that was held back by the CCG, only to be released into the pooled fund on delivery of a successful 2.1% net reduction in non-elective admissions. At the time of writing, performance was only available up to and including Quarter 3, which indicates that non-elective admissions are not on track to meet target. If the target is not met, then this funding will be directed to cover acute costs as a result of the increased activity.

Progress in 2016/17

The vision expressed in our submission has been the guiding principle for the work undertaken over the last financial year and local progress is reflective of the strong commitment to integration from senior leaders across the local system. The transformation projects have progressed at varying speeds and the below offers a brief summary of the key progress to date and future plans for each of the five transformation work-streams:

Data Sharing

Data sharing has been identified as a crucial enabler to the provision of integrated care and underpins our whole model of person centred care. A multi-agency data sharing project was established in 2015, with the following aims:

1. To enable decision makers within health and wellbeing pathways to be well informed.
2. To complement and facilitate delivery of 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.

In the first year, the project focused on expanding a data sharing solution being developed by UnitingCare into social care; development of this system ceased with the ending of the contract. Therefore the focus of the work shifted in 2016/17 to support the development of Neighbourhood Teams, via enabling data sharing in the 'trailblazer' sites; ensuring that professionals can access each other's 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. During 2016/17, the project has provided advice and guidance to the Trailblazers; and has brought together Information Governance leads to reach agreement across agencies on how data can be shared appropriately. It also supported development of a 'proof of concept' system that allowed sharing of data between organisations to support the case management process. It has however been challenging to bring this work into 'business as usual'; whilst all organisations are willing to work together, there has not always been sufficient capacity in the system to progress this work, which relies on reaching complex and detailed agreements between a number of partners.

An acute patient pathway live monitoring system (SHREWD) was launched in the autumn and incorporates key hospital, community health, mental health and social care activity metrics for the acute pathway.

Local Authorities were actively involved in the development of the Cambridgeshire and Peterborough Local Digital Roadmap (LDR) during 2016/17. The data sharing BCF workstream programmes have been incorporated into the LDR. From 2017-18 it has been resolved to incorporate this work into the 'Digital' workstream of the Sustainability and Transformation Plan, recognising the need for system-wide ownership of these issues.

In addition, Peterborough City Council is progressing procurement of a new adult social care system, which will incorporate open APIs, supporting the longer term objectives of this work-stream. The decision has been made to align the system to that used in Cambridgeshire to facilitate information sharing and interoperability for health and care records across the STP footprint.

7 Day Services

Some areas of investment intended through the BCF in 2016/17 in relation to 7 Day Services did not progress to plan. Governance of this work-stream was originally overseen by the Systems Resilience Group. However, this became the Operational Group in December 2016 and reports to the A&E Delivery Board, which has a very focused remit on admissions/Dtoc targets. Further, there is an inter-relation with work being established under the NHS Sustainability and Transformation Plan programme, which has operated to separate governance and delivery arrangements to the BCF. It is recognised that this has created the potential for a lack of joined up delivery across transformation initiatives. One of the lessons learned for future planning is the need to better align BCF activity with the STP.

Despite these challenges, progress has been made against some of the key areas of 7 day services; e.g. improvements to the rapid community response service (JET), continued investment in the reablement pathway to address increased demand and the ongoing commissioning of the Red Cross 'Home from Hospital' service to support discharge to assess. The SHREWD patient flow system was implemented in Peterborough City Hospital, with daily social care metrics uploaded to enable system wide oversight of key blockages.

PCC is undertaking a redesign of 'Home Services' which encompasses the integration of Care and Repair, assistive technology, reablement and therapy teams. This will strengthen and enable closer alignment of the intermediate care tier. Further work is planned for 2017/18 to embed this new model of delivery. The local system is also committed to implementing the High Impact Changes for Discharge, which is a national requirement for 2017/18.

Person Centred Systems

In 2015/16, the most significant investment in transformation through the 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 following cessation of the contract was on securing a safe transition of all service contracts to the CCG; and service continuity for patients and assurance for staff.

In 2016/17, despite the ending of the contract, Neighbourhood Teams in Peterborough have continued to develop with Better Care Fund investment. As well as support for ongoing community health services across Peterborough, four 'Trailblazer' pilot sites were supported that have been refining the multi-disciplinary team (MDT) proactive case management model. These sites have seen joint work in MDTs across health, social care,Primary Care and the voluntary sector, and development of an approach to case management for vulnerable people. Lessons from the Trailblazer teams are now being rolled out to other neighbourhood teams across Cambridgeshire and Peterborough. Further work is being undertaken to develop patient pathways and training plans for the consistent use of the Rockwood Frailty Tool across the system.

Information, Communication and Advice

Work to develop a new Digital Front Door for the council and an enhancement of the Adult Social Care First Point of Contact services is underway, with the first phases of implementation planned for September 2017. Workshops have been held with health partners to develop a model for an integrated MDT Urgent and Emergency Care hub and further work to refine and agree this continues.

The Information and Communication project has also focused on development of a 'local information platform' or LIP. During this year the project has had three key outputs:

1) A piece of research, analysing customers of older people's services provided by Cambridgeshire County Council and Peterborough City Council, to understand their communication and information needs and preferences. This research has been completed and personas developed.
2) A set of data standards that allow the collation of data from multiple databases into one place. This is complete and the data standards have been agreed.
3) A system that demonstrates an automatic way of passing data from local authority and voluntary sector databases about services to a central point, and then on to MiDOS and the NHS 111 service to be used with customers (the Local Information Platform). This has been developed and is being tested by MiDOS.

Further work is planned in 2017/18 to enhance the platform, enabling connectivity with the range of front doors across the system. The goal is that information given to the public can be consistent, wherever people seek advice – and that it only needs to be updated once, so that *'if a customer calls NHS 111, the practitioner on the other end of the phone searches MiDOS [the local NHS database], and finds information about local authority or voluntary sector services that is of good enough quality to ensure that customers can get the support they need; and is consistent with what that customer would find if they looked online themselves.'*

PCC has also undertaken a review of Directory of Services and is planning a consolidation of the DOS structure and development of further content in 2017/18.

Healthy Ageing and Prevention

The Healthy Ageing and Prevention Project has been exploring how best to 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. A clear set of early triggers were identified in 2015/16 and the areas of focus have been; falls prevention, social isolation, malnutrition, dementia and continence/UTIs.

During 2016/17, a falls prevention pilot project was implemented, jointly with Cambridgeshire, in St Ives, with a view to wider rolling out of learning to Peterborough after the 12 month pilot evaluation. The aim of the pilot was to reduce falls and fall-related injuries in the community through improving the identification, multifactorial assessment, uptake and compliance of evidence based interventions in people aged 65+ who have reported a fall or are at risk of falling. Fundamental to achieving this aim is the delivery of falls prevention training and support to staff in Neighbourhood Teams, Primary Care and other community organisations to enable them to screen, assess and refer those at risk or those reporting a fall to multifactorial, evidence based support. An evaluation report will be published in April 2017. A business case has been developed for standardised falls prevention provision across the county, which it is anticipated will generate significant savings for the whole system.

A strong focus on community development is being taken forward through Peterborough City Council's Community Serve project. The project is underway to build community resilience and improve health and wellbeing. 'Meet and eat' social dining sessions are running regularly across all three pilot areas (Can-Do area, Westwood & Ravensthorpe and the Ortons). Community hubs have been established and area coordinators are in place. A volunteer time-bank pilot is being explored. Further work is planned in 2017/18 to expand provision to include health and wellbeing advice, skills development and community access.

Other areas of financial investment in 2015/16

Care Act monies

PCC is now legally compliant with the requirements of the Care Act and 2016/17 investment funded additional costs due to the increased responsibilities of PCC as a result of the Care Act changes, e.g. Carer's assessments. Further investment in 2017-19 is identified to continue to support the costs of these additional responsibilities.

Ex. Section 256 monies

In 2016/17 money was invested in providing independent sector placements and care packages for service users with eligible needs. 2016/17 funding has been budgeted to continue to support this.

Protection of Adult Social Care

This investment has been allocated to core service budgets to ensure that the level of provision of Adult Social Care is protected. This has allowed us to continue to maintain the existing thresholds, as well as ensuring that we can meet demand and respond to demographic pressures and increasing levels of need.

Integrated Adults Community Services Contract

In 2016/17, despite the ending of the UnitingCare contract, Neighbourhood Teams in Peterborough have continued to develop with Better Care Fund investment and a commitment has remained to continue to deliver the integrated community service model.

Carer's Prescription

Investment was made in the Carer's Prescription in 2016/17, which has facilitated support to Carer's. This investment has facilitated the GP Family Carers Prescription service, supporting GP commissioning by offering GPs and surgeries a proactive way to support carers.

Disabled Facilities Grant

Capital allocation was invested in this area to support minor and major adaptations for eligible adults and children via the Care and Repair service to enable people to stay in their homes. More innovative models of utilising the DFG were also implemented, including preventative small grants to aid hospital discharges.

Progress against BCF performance metrics

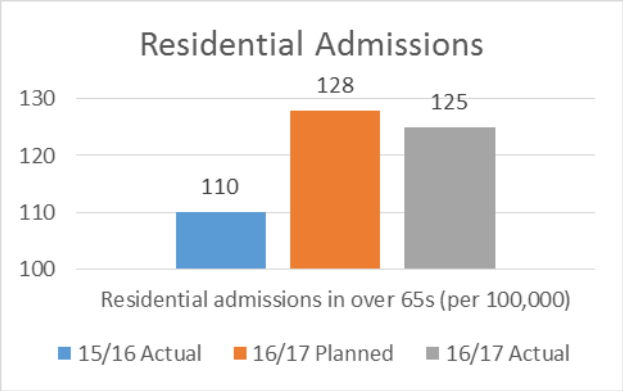
Performance metrics included within the BCF are largely set at a national level and relate to national policy goals for health and social care. The national metrics in Peterborough's Plan are:

- A reduction in non-elective admissions to acute hospital
- A reduction in admissions to long-term residential and nursing care homes
- An increase in the effectiveness of re-ablement services
- A reduction in Delayed Transfers of Care (DTOC) from hospital

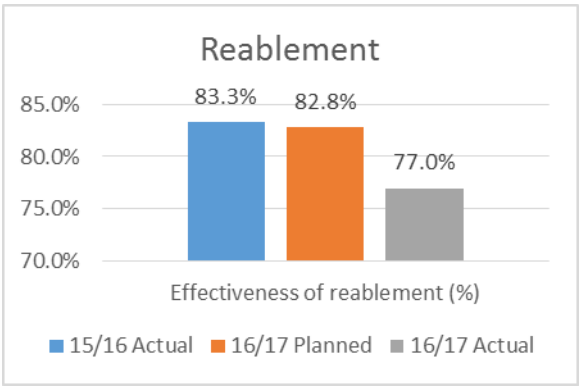
In addition, each area is asked to choose a local metric, and to choose their own measure of patient experience. In Peterborough, these measures are:

- Injuries due to falls in 65+ year olds
- Maintained patient satisfaction with local NHS services.

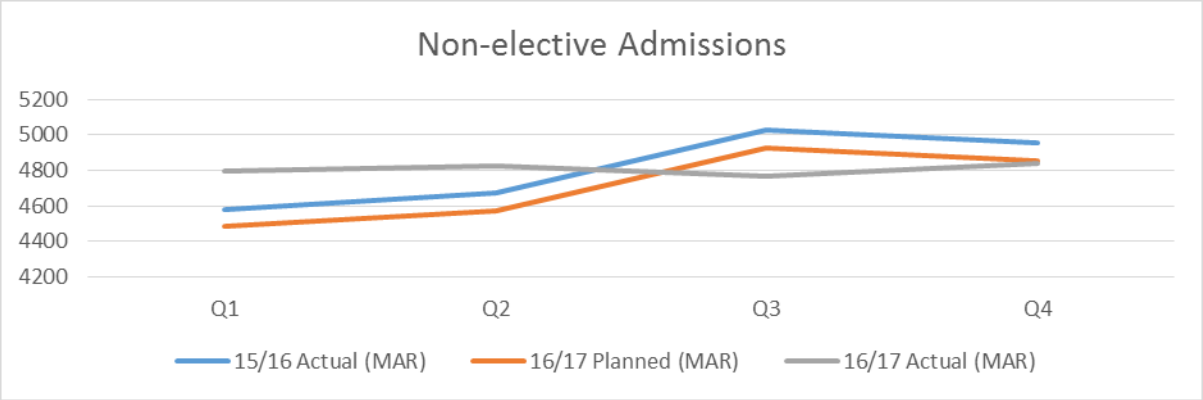
Residential admissions: The residential admissions 2016/17 target reflected the need to maintain the significant reduction achieved in 2015/16. Performance in 2016/17 exceeded the threshold target. Residential admissions for older people continued to be low in number due to the range of alternatives on offer. We had 125 admissions against a threshold target of 128. The table below shows a breakdown of year to date forecast activity for 2016/17 against planned year to date target and 2015/16 baseline.



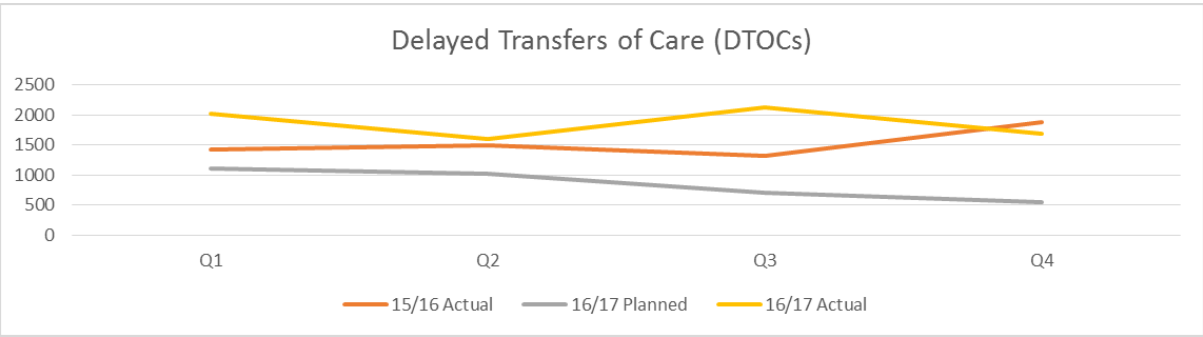
Reablement: Reablement performance showed a slight decline in performance from 2015/16 at. The target for 2016/17 was 82.8% of patients still at home 91 days after hospital discharge. Performance was strong in Q1 and Q2, but a dip in performance was experienced in Q3 and Q4. This was impacted by reduced performance due to capacity issues in the care market and winter pressures. Higher numbers were discharged to reablement servcies from hospital during the year and the service was expanded to meet a higher range of need. This also impacted slightly on the 91 day outcomes - which stands at 77%. The table below shows a breakdown of activity for 2016/17 against the planned target and 2015/16 baseline.



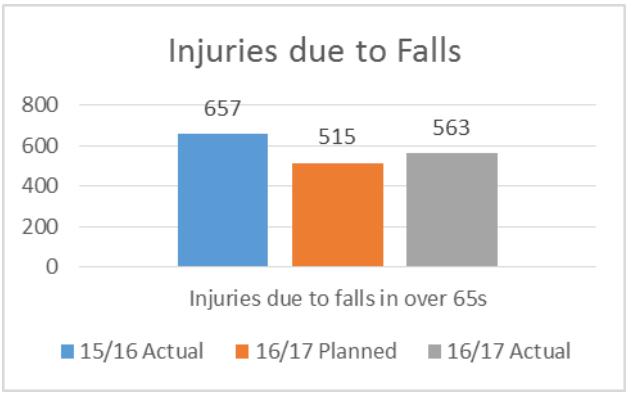
Non-elective admissions: The target 2.1% net reduction in non-elective admissions was not met in 2016/17. Increases in non-elective admissions were seen in Q1 and Q2, as a result of many increasing pressures on the system, including a rapidly growing population. Q3 and Q4 experienced a reduction in non-elective admissions, but progress at year end (0.05% reduction) underperformed against the planned year to date target of a 2.1% reduction. The table below shows a breakdown of activity for 2016/17 against the planned target and 2015/16 baseline.



Delayed Transfers of Care: Despite a slight downward trend in DTOCs in 2016/17 Q1 and Q2, a steep increase was experienced in Q3. The roll out of Discharge to Assess in Q4 had a positive impact towards the latter part of the year, however final year performance underperformed against target. Overall, DTOCs were still higher than levels seen in 2015/16. 2016/17 performance (7,456 occupied bed days) significantly underperformed against plan for 2016/17 (3,366 occupied bed days). A strong focus on discharge planning and DTOCs is a condition of national guidance for 2017/18 and will be incorporated in local system plans. The table below shows a breakdown of activity for 2016/17 against the planned target and 2015/16 baseline.



Injuries due to falls: During the course of 2016/17 there has been a consistent downward trend in injuries due to falls. The planned threshold target for 2016/17 (515) was ambitious based on previous year's performance. Despite a 2016/17 significant decrease of 21.6% against 2015/16 basline (563), the full year target was not fully met. The table below shows a breakdown of activity for 2016/17 against the planned target and 2015/16 baseline.



Friends and Family test: We exceeded the target for this metric, running consistently over the set target of 93%. Performance for 2016/17 at end of year was 97%.

Performance summary

Whilst performance against some indicators has been positive, performance against non-elective admissions and delayed transfers of care have notably continued to worsen. The below table summarises performance against metrics on a green (met target), amber (improved performance but didn't meet target) red (no improvement) basis:

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

However, it is important to note that success in these indicators is reliant on a significantly wider range of factors than activity contained within the BCF Plan. Whilst BCF-funded activity will have successfully had an impact on preventing non-elective admissions and reducing DTOCs, this has not been sufficient to mitigate all underlying demand and increased pressures across the system. This highlights the challenge of maintaining the BCF as a separate programme of activity in delivering reductions in these indicators.

Additional priorities for 2017-19

Plans for 2017-19 build on current progress and the lessons learnt to date. They recognise the changing landscape locally and the need to move forward in a dynamic way. Below outlines some of the key learning points and plans for progressing into next year.

National comparisons

In February 2017, the National Audit Office published a summary of progress in health and social care integration, which allows for some limited national comparisons of progress in delivery of Better Care Fund aims. Most notably, achievement against performance indicators in Peterborough matches the national picture. National results have seen a reduction in permanent admissions of older people to residential/nursing homes; and an increase in proportion of older people at home 91 days after discharge from hospital. However, delayed transfers of care and non-elective admissions have continued to increase significantly between 2014 and 2016. It was found that financial directors in the majority of areas did not believe it was possible to deliver on both financial and performance targets assigned to their local areas.

The report notes that progress in integration has been slow in many areas, particularly due to financial constraints and continuing short term financial pressures.

Nationally, the NAO found that the BCF process has created significant bureaucracy around integration; and that barriers remain in place through legislation and accountability frameworks that discourage greater integration. Despite these findings, 76% of local areas agreed that implementation of a pooled budget had led to more joined up health and social care provision; and 91% felt that the BCF had improved joint working.

The report concludes that the BCF has significant potential to join up health and social care services, but that better national guidance is needed on standards of integration and associated indicators to measure the effectiveness of local integration.

Local issues and lessons learned

In addition to the summary above, there are two further challenges that have been faced in developing a Better Care Fund plan in Peterborough – a lack of alignment of planning timescales; and a lack of alignment of boundaries.

Lack of alignment: timescales: Planning for the first year of BCF took place over an extended period of over 12 months; however during that time the guidance, financial allocations and requirements changed significantly. In the following years, time available for BCF planning has been considerably compressed. For 2016/17, the guidance was published in February 2016; the plan for the 2016/17 financial year was not then approved until late August. At the time of writing in March 2017, guidance for the financial year beginning 1 April 2017 has not yet been published. This has led to organisations agreeing their budgets before financial allocations have been published, based on assumptions about funding to be included in the BCF. This creates a barrier to effective alignment and planning of the pooled budget. The compressed timescales also significantly impedes wider engagement with a range of partners on the content of the BCF plan.

Lack of alignment: boundaries: Whilst the BCF covers the Peterborough Health and Wellbeing Board area, different organisations represented on the Board cover different areas. The CCG area covers local authority areas of Cambridgeshire and Peterborough, alongside small elements of Hertfordshire and Northamptonshire. The STP footprint covers Cambridgeshire and Peterborough; whilst many NHS providers cover a wider area again, serving patients from parts of Norfolk, Lincolnshire, Essex, Hertfordshire and Bedfordshire. Whilst there has been some linking of BCF plans across Cambridgeshire and Peterborough, slight differences in approach have led to delays at times and created the potential for confusion. It also creates the need for multiple reports to be generated covering different geographical areas. This disconnect is emphasised now that the NHS STP has been established as the main vehicle for NHS Transformation in the area. It is proposed that greater alignment is needed to ensure that partners can work together effectively on their approach to transformation.

Lessons learned for 2017 – 19

The following recommendations have been made for BCF planning in 2017-19:

Greater alignment of BCF activity with the STP and local authority transformation plans: In its first two years, the BCF has maintained a separate project structure for many of its transformation projects. Given the fact that many BCF performance targets are dependent on activity across the STP Delivery Boards, further alignment is necessary. From 2017, the BCF will shift to commissioning activity either from the STP or local authority transformation programmes as appropriate, to reduce duplication and ensure that all partners can be engaged with the correct pieces of work. The BCF

plan will describe activity to be commissioned, and responsibility for implementation would be passed to the most appropriate group. It will include specific targets in relation to performance indicators for BCF commissioned activity as well as clarity on the primary governance.

Greater alignment of Cambridgeshire and Peterborough BCF Plans: BCF transformation activity has always been aligned to some extent between Cambridgeshire and Peterborough. As most health and social care service transformation activity is now system wide in Cambridgeshire and Peterborough, it has been agreed that there should be further alignment of the two plans, with a single set of activity and common budget categories across the two areas wherever possible. Separate BCF budgets will still be maintained in line with statutory requirements, and each Health and Wellbeing Board will still be responsible for agreeing plans.

A single commissioning Board for Cambridgeshire and Peterborough: Previously there were two separate boards in Cambridgeshire and Peterborough overseeing BCF activity – the Cambridgeshire BCF Delivery Board and Greater Peterborough Area Executive Partnership Commissioning Board. To support more effective joint commissioning these are being replaced by a single board across Cambridgeshire and Peterborough. This will support a more joined up approach to planning and allow a more coordinated approach between the two areas and enable streamlined reporting into the two Health and Wellbeing Boards.

Appendix 1 - Better Care Fund - Peterborough Pool

2016/17 Budget - Year End Position

As at 31/03/17

					2016/17	
					Budget	**Actuals**
					£	**£**
		Revenue				
		Care Act			407,000	407,000
		Ex section 256 agreement			3,522,000	3,522,000
		Protecting Adult Social Care Services, including transformation			1,589,000	1,589,000
		7 Day working: reablement			86,000	86,000
		7 Day Working: reshaping bed based market			164,000	164,000
		Person Centred Systems: Assistive Technology			100,000	100,000
		Healthy Ageing and Prevention: Quality Assurance/Quality Improvement			550,000	550,000
			Sub-Total		**6,418,000**	**6,418,000**
		Older People and Adults Community Services (OPACS)			4,042,000	4,042,000
		Carer's Fund			150,000	150,000
		Wellbeing Network			50,000	50,000
		Performance Fund			429,000	429,000
			Sub-Total		**4,671,000**	**4,671,000**
		Capital				
		Disabled Facilities Grant: Adults			1,523,587	1,523,587
			Sub-total		**1,523,587**	**1,523,587**
			TOTAL		**12,612,587**	**12,612,587**
		Financed by				
		CCG	Revenue		11,089,000	11,089,000
		PCC	Capital		1,523,587	1,523,587
			TOTAL		**12,612,587**	**12,612,587**

1 16/17 Financial Position

1.1 The pool finished in balance

1.2 Care Act included packages of care for carers in line with increased Care Act responsibilities. It also included continued investment in wellbeing and prevention, safeguarding, advocacy, triage tool, Continuing Health Care pathways and shaping the market.

1.3 Ex section 256 agreement included investment in independent sector placements.

1.4 Protecting Adult Social Care included investment in core service budgets to maintain the level of provision.

1.5 Reablement included continued investment in commissoning additional reablement support in line with need.

1.6 Reshaping the bed based market included continued investment in Friary Court.

1.7 Assisitve Technology included investment in expanding the local AT offering, ongoing upskilling of therapy teams and commissioning provision e.g. Cross Keys and pilots e.g. Alcove.

1.8 Quality Assurance and Quality Improvement includedconitnued investment in market development, domiciliary care, quality improvement work and DTOCs

1.9 Performance Fund was not released by the CCG into the pooled budget as the non-elective admissions target was not reached. This was invested in acute provision.

Name
Paul Martin, Senior Accountant
Peterborough City Council
30/03/2017

Peterborough & Cambridgeshire 2017 - 2019 BCF Project Plan

Key area	Aim	Activities	Benefits	Accountability	Timescale	Supporting Documentation
FOCUS AREA 1: PREVENTION & EARLY INTERVENTION						
Community Equipment, DFG, Assistive Technology	Expand the impact of assistive technology in Cambridgeshire and Peterborough – moving to the point where it is a core part of care pathways and a key element of the support we offer at every stage of a service users' journey.	Developing the links between assistive technology services and neighbourhood teams – expanding the use of telehealth to monitor health indicators and ensure we can intervene with people who may be liable to a health crisis and hospital admission before they reach that point Developing the links between assistive technology services and primary care – using the test beds initiative to explore the impact of technology on managing demand for primary care or assist GPs in managing high-risk cases. Deploying monitoring equipment (such as Just Checking) to more accurately assess the need for social care – helping manage demand and freeing up capacity in the care system – in turn easing pressure on health services In Cambridgeshire, we will expand and build on the newly established Enhanced response service which will ease the pressure on Ambulance call outs and give us a response to alarms which is swifter and more fully linked into the range of preventative and intermediate tier health and social care services Exploring how we could unify the network of different call centres and monitoring hubs responding to community alarms and other technology. As well as achieving efficiency for the system this approach would allow us to gather and use the live information from assistive technology, telecare and alarms to target our responses across public services. Maximising the potential of technology to enhance resilience in communities by ensuring as many people as possible are linked to a support network which knows when they are deteriorating and is able to respond.	A more sustainable solution for Community Equipment funding, ensuring that where savings are achieved elsewhere in the system, the cost of community equipment is factored in appropriately diverting demand away from long-term care and support. As more projects and interventions are funded that focus on keeping people at home	Integrated Commissioning Board	Approach fully scoped and implementation plan developed - December 2017 Implementation of new approaches: March 2018	N/A
Ageing Well: Falls Prevention	Implement a comprehensive, standardised, and integrated falls prevention pathway across the CCG area of Cambridgeshire and Peterborough. This will include: •Increased provision and improved quality of evidence-based targeted interventions eg strength and balance classes, future development of fracture liaison services •Proactive identification of those at risk of falls •Comprehensive multifactorial assessment offered to those at risk of falling with appropriate intervention plan to address risks identified •Strengthened system-wide integration and co-ordination.	The following projects, programmes and services are proposed: 1. Developing and implementing a falls prevention mass media campaign 2. Enhancement and expansion of strength and balance exercise provision 3. Enhancement of the existing specialist Falls Prevention Health Trainer Service across Cambridgeshire and Peterborough 4. Strengthening Falls Prevention Delivery and Integration in the Community 5. Development and implementation of Fracture Liaison Services (FLS) across all acute Trust areas 6. Employment of Public Health Falls Prevention Coordinator	5%-10% reduction in injurious falls admissions 1.5%-3.6% reduction in hip fractures Gross savings of £1.05M (acute health care costs only) on a full year of operation in year one on the low estimate and gross savings of £2.12M (acute health care costs only) on the higher estimate of 10%/3.6% reduction in admissions.	STP: PCIN Delivery Group	**1. Falls primary prevention campaign** Scoping/Design: 1/4/17 – 13/10/17 Practical Completion/"Go Live": 13/10/17 – 3/11/17 Post-Project Evaluation: 3/11/17 - 15/12/17 **2. Enhancement and expansion of strength and balance training provision** Scoping/Design: 1/4/17 – 28/4/17 Contracting/Advertising: 28/4/17 – 7/7/17 Delivery Lead-Time: 7/7/17 – 11/8/17 Practical Completion/"Go Live": 11/8/17 – 31/3/22 Post-Project Evaluation: 31/3/22 – 28/4/22 **3a. Enhancement of Falls Prevention Health Trainer Service - Peterborough** Scoping/Design: 1/4/17 – 12/5/17 Contracting/Advertising: 12/5/17 – 4/8/17 Delivery Lead-Time: 4/8/17 – 29/9/17 Practical Completion/"Go Live": 29/9/17 – 31/3/22 Post-Project Evaluation: 31/3/22 – 28/4/22 **3b. Enhancement of Falls Prevention Health Trainer Service - Cambridgeshire** Contracting/Advertising: 1/4/17 – 21/7/17 Delivery Lead-Time: 21/7/17 – 15/9/17 Practical Completion/"Go Live": 15/9/17 – 31/3/22 Post-Project Evaluation: 31/3/22 – 28/4/22	Appendix 7a
Ageing Well: Atrial Fibrillation	To reduce the number of preventable Atrial Fibrillation (AF) associated strokes in Peterborough & Cambridgeshire by working with GPs (using quality improvement approach). Improve the management of patients diagnosed with AF not currently receiving Oral Anticoagulants (OACs). Identify and treat asymptomatic cases of AF.	The focus of the project is twofold: 1. Initiating treatment for patients currently on the AF register not receiving anticoagulation by reviewing records, undertaking assessments and where appropriate treating high-risk AF patients (CHA2DS2-VASc score of 2 or more) on GP registers who are currently not being optimally treated. 2. Targeted opportunistic case finding - Undertake targeted opportunistic case finding for AF in the over 65's population.	Reduce Non-Elective Hospital admissions. The savings would be accrued by the CCG through reduced acute hospital admissions (tariff based) and reduced stroke rehabilitation in the community. Overall the investment would lead to 381 additional patients being anticoagulated in year 1 and 476 in year 2 (this is in addition to the 2495 being anticoagulated in 2015/16). This will lead to 10 fewer strokes in year 1 and 19 in year 2 (based on 1 stroke prevented for every 25 patient's anticoagulated). The potential savings to the NHS from avoiding one stroke event is £11,693 (£3693 admission and £8000 rehabilitation costs). The potential savings to social care system from avoiding one stroke is estimated to be £7,604 in year 1 and £3,966 per year for years 2-5.	STP: PCIN Delivery Group	Scoping/Design: 06/03/17 – 17/04/17 Delivery Lead-Time: April to end June 2017 Works/Installation/Commissioning: April to end of June 2017 Practical Completion/"Go Live": End of June 2017 Post-Project Evaluation: January 2018	Appendix 7b
VCS Joint Commissioning	Develop approach to joint commissioning to: 1. improve the way we jointly commission VCS wellbeing services and community resilience building 2. achieve better outcomes for our residents 3. reduce duplication and waste 4. secure better value for our money	**Alignment of existing commissioners, allocating particular activity to each commiss**	1. Improved access to and uptake of VCS services / activities by residents 2. VCS organisations are promoting wellbeing 3. Greater sense of wellbeing in those accessing the VCS services 4. Reduced / delayed demand on statutory health and social care services by residents accessing the most relevant services / support for their presenting needs 5. Sustainable VCS wellbeing services 6. Vibrant VCS and stronger resilience through community groups 7. Financial savings	Integrated Commissioning Board	1st phase Joint Commissioning Plan to include: March 2018 1. Process for co-production agreed and people identified 2. Set up VCSreference group 3. commissioners' total VCS & community resilience building spend, activity & contracts mapped 4. joint outcomes framework developed & agreed 5. return on investment assessment tool / process developed 6. develop costed plans to achieve outcomes - building on H&WB Strategies and informed by Wellbeing Summit outputs 7. incorporation into other plans system wide plans as relevant e.g. BCF, Council, STP 8. Agree governance to oversee plan timplementation 9. Identify further investment opportunities Single Wellbeing Network commenced: December 2017 Social prescribing pilots commenced: December 2017	Appendic 7c
FOCUS AREA 2: COMMUNITY SERVICES / MDT WORKING						
MDT Case Management	Effective case finding and case management is a key enabler for the STP priority of 'at home is best'. Coordinated and effective management of people who are elderly, frail and have complex needs will promote independence and allow people to stay at home in a supported environment for longer. Supporting these people through a broader MDT model that include voluntary sector gives the system an integrated structure to make the best use of services and resources (STP priority: 'we're only sustainable together').	**Stratified Patient List**: Developing effective interventions to support frail older people and adults with long term conditions/disability is establishing a robust mechanism to identify these patients who are at risk (case finding). **Joint Care Plan:** co-produce a shared care plan, which will quickly inform professionals of agreed care plans **Integrated System Pathway to admission and discharge:** Ensure an integrated pathway from early identification of need, through intermediate care provision to long term care support and supported early discharge **Patient Based Information Sharing:** MDT working systems to share patient data and appropriate information governance will be developed to ensure seamless care and reducing the need for the patient to tell their story more than once	Once fully established, the service will identify and support the 7.5% most frail patients of the over 65 population and improve their quality of life as evidenced by the EQ-5D measure. It will provide better outcomes for those people and reduce the burden and cost to the health and social care system over the next 5 years. In year 2 the service aims to expand and provide case management to 15% of the most frail patients over 65. **Patient experience outcomes:** •Better patient involvement in decision making on interventions •Named care co-ordinator and identified contact point for the patient to approach with queries or concerns •Written care plan including crisis plan and agreed personal goals for patients •Signposting and utilisation of the public health prevention services available to tackle any health issues related to diet, exercise, drinking, smoking and taking drugs •Ensuring positive patient experience and enhancement of service provision from patient feedback **Clinical outcomes:** •Improvement in EQ-5D scores – a measure of general health and well-being, this covers the following 5 key domains: Mobility, Self-care, Activities, Pain and Mood/anxiety **System outcomes:** •Decrease in healthcare utilisation after one year for case managed	STP: PCIN Delivery Group	Phased roll out of case management to non-Trailblazer sites: to commence April//May 17. Pseudonymised tool for case finding rolled out: to commence August 2017. Joint Care Plan developed: January 2018. Frailty tool training implemented: to commence September 2017. Patient held record/information sharing approach implemented: March 2018.	Appendicx 7d
FOCUS AREA 3: 8 HIGH IMPACT CHANGES FOR MANAGING TRANSFERS OF CARE						
1. Early discharge planning	In elective care: planning should begin before admission. In emergency/ unscheduled care, robust systems need to be in place to develop plans for management and discharge and to allow an expected date of discharge to be set within 48 hours.	**Elective Care:** 1. Develop joint health & social careplans for early discharge planning for planned admissions. **Emergency / Unscheduled:** 1. CCG/Acute Hospital need to do further work to improve systems in respect of Health D2A including Continuing Health Care . 2. Need to develop one D2A model inline with the guidance	Reduction in DTOCs	STP: UEC Delivery Group	**Elective Care:** Baseline assessment completed March 2018 Comprehensively in place by March 2019. **Emergency / Unscheduled:** Improve health D2A, including Continuing Health Care: October 2017. Implement single D2A model: March 2018	appendix 7e,f,g
2. Systems to monitor patient flow	Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.	1.Synchronisation of health & social care systems to monitor patient flow in joined up way across fulll spectrum of services. 2.Move from paper based systems largely held by individual services to electronic real time systems (SHREWD) across Cambridgeshire. 3.Review of current metrics, and data feeds	Reduction in DTOCs		December 2017	
3. Multi-Disciplinary / Multi-Agency Discharge Teams, including the voluntary and community sector	Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients	1. The SPA needs to be developed further to include a Social Care strategic Lead. 2. Develop more integrated community workforce as part in IC Tier and D2A. 3. Joint policy and proecedure for discharge. 4. VCS Needs to be involved earlier and backed by the hospital system in order that the staff on the ground see the benefit of referrals	Reduction in DTOCs		Single D2A Pathway implemented: March 2018	
4. Home First / Discharge to Assess	Providing short-term care and reablement in people's homes or using 'stepdown' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.	1. Expansion of intermediate care service. Business case approved July 17. 2. Capacity of Independent sector and trusted assessor to reduce waits 3. Review of discharge planning pathway, and multi-agency white boards 4. Cambridgeshire: Review community capacity for interim beds, residential and nursing homes by end August 17.	Reduction in DTOCs		1 July 2017. 2 March 2019. 3. Ocotber 2018 4. August 2018	
5. 7 Day Services	Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs	1. Development of equal 7-day service in NHS , social and independent providers. (plans in place within organisations)	Reduction in DTOCs		March 2019	
6. Trusted Asessors	Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way	1. System wide working group to be established to agree gaps/priorities and implementation plans. 2. Pilot a trusted assessor model starting with patients returning to care home patients in Peterborough initially and develop roll out to Cambridgeshire in 2018. 3. Development and roll out of the trusted professional role across all acutes and continued discussions with independent provider network to eventually move to trusted assessor at least with the main care providers	Reduction in DTOCs		System wide approach to Trusted Assessors fully implemented - March 2019.	
7. Focus on Choice	Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.	1. Voluntary sector provision integrated in discharge teams 2. Training / support staff to implement choice policy - August 17 3. Leadership Review group for exception reporting and oversee cultural changes.	Reduction in DTOCs		Choice Policy agreed - July 2017 Training – August 2017 Implementation - September 2017 Mature system - December 2017	
8. Enhanced health in care homes	Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.	1. Continue with Care Home Educators project - linked with JET and neighburhood teams. 2. GP alignment/further development of the offer from care home educators, and community services 3. Provide intensive support to high referring homes	Reduction in DTOCs		September 2017	
FOCUS AREA 4: INFORMATION & COMMUNICATION						
Information & Communication	Deliver a trusted source of 'one version of the truth', enabling information and advice provided to customers to be consistent, accurate and comprehensive; regardless of the point of access.	**Phase 1 Approach** The short term vision is to support the immediate need of dependent projects (e.g. MiDOS, 111/Out of Hours, PCC and CCC Front Door redesigns, Wellbeing Network and Social Prescribing) through maximising the quality and consistency of information currently held across directories. This comprises of: ● Personas (insight research of the 'shared' customer): research and understand the needs of customers via the use of 'customer journeys' / personas. This will inform the development of a customer focused solution. ● Information Standards: gain a better understanding of the current DOS landscape, including mapping of information and ownership. The development of a consistent approach to updating and maintaining information held on Directories in collaboration with local system partners. ● Development of the platform service: development of a technical solution that is able to curate, search, share and improve information that is held in Directories and pass this information to a variety of website front ends. **Phase 2 Approach** The longer term vision of the project is to widen the scope of information that can be provided, through the development of a platform service to dovetail with existing search tools (e.g. MiDOS). This could, for example, include information on local events or self-management focused health information. This comprises of: ● Further development of the platform service and roll out across the whole partnership: development of a technical solution that is able to curate, search, share and improve information that is held in Directories. ● Front End: support the development of partner websites and front door tools to enable access to the search platform service.	●Demand Management – a reduction in first contacts with Adult Social Care and health. ●Greater confidence in information for professionals and the public. ●Increased opportunities for self-management. ●Increased accessibility of information and advice to the public. ●Diversion of customers away from statutory and high cost services. ●Efficiency savings, through improved access to information for professionals in order to provide advice and support to customers. ●Efficiency savings, through a more streamlined approach to maintenance of directory of services. ●Enabling full benefits realisation for dependent projects; e.g. 111/OOH, PCC/CCC Front Door, PCC Digital Front Door, VCS Wellbeing Network and social prescribing pilots.	Integrated Commissioning Board	**1 Stage 1 - LGA Funded Demonstrator / Proof of C**oncept	LIP Vision LIP Project Plan - embed in Word

SYSTEM WIDE BUSINESS CASE				Fit for the Future Working together to keep people well
Reference Number:				
Date:	08/03/2017	**Version:**	3.2	
Business Case Title:	**CCG Wide Falls Prevention Programme**			
Organisation(s) submitting business case:	System Wide – Health & Local Authority (Public Health)			
STP Work Stream / Directorate	PCIN – Healthy Ageing			
Author:	Helen Tunster, Jill Eastment, Karen Hurst, Jackie Riglin, Angelique Mavrodaris			
SRO:	Cath Mitchell			
Executive Sponsor:	Dr Liz Robin			
Senior Finance Manager Comments:	*This is to be completed by the Senior Finance representative responsible for reviewing bids prior to submission to the Exec Team / relevant committee for approval*			
Executive Team / Committee Meeting Comments:	*This is to be completed by the Exec Team / relevant committee reviewing the Business Case to capture the outcome of the review.*			

Guide to complete (and submit) your business case:

This document provides a template for all Business Cases. Please complete every section using the guidance as highlighted.

Be clear and concise.

Where relevant, try to articulate the case in terms of three core areas; Clinical effectiveness, Patient Experience and Safety.

Where necessary, involve specialists e.g. from finance, and proposed project work-streams to provide business case information including costs, risks, benefits and assumptions.

Include a paragraph in the Conclusion and Recommendations section explaining the decisions the committee are being asked to make.

Once completed, arrange for the business case to be reviewed by a peer and agreed by the Executive Sponsor before submission to the relevant board. Allow enough time for key people to review drafts, to support getting the business case right before it goes through the formal approval process.

Section Guidance is given in italics

[A] EXECUTIVE SUMMARY:

A1 – Purpose:

A fall is defined as an unplanned descent to the floor with or without injury to the patient.[1] Falls are the commonest cause of accidental injury in older people and the commonest cause of accidental death in the population aged 75 and over in the UK. A significant number of falls result in death or severe or moderate injury, at an estimated cost of £15 million per annum for immediate healthcare treatment alone.[2] This is a significant underestimation of the overall burden from falls once the costs of rehabilitation and social care are taken into account, as up to 90% of older patients who fracture their neck of femur fail to recover their previous level of mobility or independence.[3] In addition to these financial costs, there are additional costs that are more difficult to quantify. The intangible human costs of falling includes distress, pain, injury, loss of confidence and loss of independence, as well as the anxiety caused to patients, relatives, carers, and hospital staff.[4]

The project seeks to implement an integrated CCG-wide Falls Prevention programme across Cambridgeshire & Peterborough and is seeking revenue investment of £501k in year one rising to £638k in year two. It is proposed that the project will be part-funded by Public Health (CCC and PCC) pump priming for the first two years, so the NHS funding required will be £261k in year one rising to £398k in year 2 and £511k recurrent after this. Based on experience elsewhere, the annual savings once the programme is fully implemented will be between £1.05M - £2.2M annually for acute healthcare costs resulting from falls related admissions, plus additional cost avoidance for community services post discharge.

The aim of the project is to implement a comprehensive, standardised, and integrated falls prevention pathway across the CCG area of Cambridgeshire and Peterborough. This will include:

- Increased provision and improved quality of evidence-based targeted interventions eg strength and balance classes, future development of fracture liaison services
- Proactive identification of those at risk of falls
- Comprehensive multifactorial assessment offered to those at risk of falling with appropriate intervention plan to address risks identified
- Strengthened system-wide integration and co-ordination.

Multi-faceted interventions such as proposed here can prevent falls in the general community, in those at greater risk of falls, and in acute care settings. Well organised services, based on national standards and evidence-based guidelines can prevent future falls, and reduce death and disability from fractures. Recognition of the substantial burden and cost of falls, and the identification of consistent and modifiable risk factors for these injuries demands a pro-active approach to falls prevention. An action-oriented systems perspective is needed to address the challenges inherent in preventing falls. Many sectors have a role to play, all need to be engaged in this process.

[1] National Database of Nursing Quality Indicators (2011).
[2] NPSA 2007 Slips, trips and falls in hospitals www.npsa.nhs.uk
[3] Murray GR, Cameron ID, Cumming RG. The consequences of falls in acute and subacute hospitals in Australia that result in proximal femoral fracture. Journal of the American Geriatrics Society. 2007; 55(4): 577-82
[4] Patient Safety First Campaign 2010. Reducing Harm from Falls.

A2 – Driver for Change

Risk

The project responds to risk in that:

- the population is ageing and rapidly increasing in numbers;
- falls and fracture risk increases substantially with age;
- costs to the health and social care system are substantial and will increase over time;
- the intangible human costs of falling include distress, pain, injury, loss of confidence and loss of independence with up to 90% of older people who fracture their neck of femur failing to recover their previous level of mobility and independence, as well as the anxiety caused to patients, relatives, carers and staff.[1]

Opportunity

Building on strong foundations which include established evidence framework, local pathways developed, local application insights from the St Ives Pilot and the multi-agency working that has been built through the Cambridgeshire and Peterborough Working Group – the business case is in a strong position for effective implementation. The evidence base for falls prevention is strong but it is apparent that implementation needs to be at sufficient scale to reach the appropriate number and type of people across the population. Locally, an evidence based framework has been produced in conjunction with the Falls Working Group – and this is in the process of being tested by the Falls Pilot (Vanguard) in St Ives. This project therefore also represents an opportunity to further develop the implementation of the local framework, to increase the 'scale' of current interventions and 'reach' amongst the population and by monitoring and evaluation to generate data to ensure that interventions and resources are targeted appropriately.

A3 – Alignment with Organisation or System Priorities:

The investment supports the following **system priorities:**

- Cambridgeshire and Peterborough STP – in particular key priorities inherent in both Primary Care and Integrated Neighbourhoods (PCIN) and Urgent and Emergency Care (UEC) workstreams
- Cambridgeshire Better Care Fund (BCF) Plan
- Cambridgeshire Health and Wellbeing Strategy 2012-2017
- Cambridgeshire Older People Strategy
- CUH/CCG Care Homes protocl

The investment aligns to the following **provider objectives:**

- CPFT Operation Plan 2016-17
- CPFT Management and Prevention of Falls Strategy (awaiting ratification)
- CPFT Falls Prevention and Management Policy (awaiting ratification)
- CPFT contract with CCG
- CUH Harm Free Care strategy
- Everyone Health Falls Prevention Health Trainer Service

The investment supports the **CCG Improvement and Assessment Framework**:

- Better Health – Injuries from Falls in 65+

A4 – Brief Outline of Proposal:

To achieve its aim, the current programme of falls prevention activities across Cambridgeshire and Peterborough CCG area will need to be strengthened and expanded by applying the evidence base to the local infrastructure and by utilising existing models. The following projects, programmes and services are proposed:

1. **Developing and implementing a falls prevention mass media campaign (£10K)**
   To develop a social marketing campaign targeting those entering retirement and beyond to improve awareness of key falls prevention messages for maintaining and improving strength and balance as we age.
2. **Enhancement and expansion of strength and balance exercise provision (£124K)**
   Increase the number of frailer older people (75+) who successfully complete the recommended 50 hours of strength and balance training by recruiting four band 4 therapy assistants as part of the four rehabilitation falls units in each locality.
3. **Enhancement of the existing specialist Falls Prevention Health Trainer Service across Cambridgeshire and Peterborough (£58K)**
   Proposal is to fund two additional Falls Prevention Health Trainers, one to cover the inequity in provision observed in Peterborough and one additional Falls Prevention Health Trainer in Cambridgeshire.
4. **Strengthening Falls Prevention Delivery and Integration in the Community (£261K)**
   To strengthen the delivery of falls prevention and integration in the community by establishing the necessary staff roles, expertise and falls pathways. Three new band 7 falls champions are proposed as well as changes to existing staff roles including a band 8a uplift, band 7 backfill and a band 6 uplift.
5. **Development and implementation of Fracture Liaison Services (FLS) across all acute Trust areas (£137K)** proposed for year 2. Public Health England (PHE) have that identified that the implementation of a fracture liaison service in secondary care has potential to deliver savings to the NHS within five years. PHE have commissioned York Health Economics Consortium to produce a tool and model which will determine ROI (due June 2017). The aim of FLS is to reduce repeat fractures by identifying and treating people at risk – including by referrals to services described in this proposal.
6. **Employment of Public Health Falls Prevention Coordinator (£59K) (2 years fixed term)**
   The reduction of falls and fractures admission rates is dependent on system-wide leadership, coordination and integration. The proposal is to appoint a Band 8 (equivalent) falls coordinator to coordinate, monitor and evaluate the implementation of a comprehensive, standardised preventative programme, including wider inputs from district council leisure services, home improvement agencies, and other partners not directly included in this STP bid.

A5 – Financial Impact and Outcomes:

The workstream is seeking gross revenue investment of £500,617 in year one increasing to £637,770 year two onwards. This investment covers the six elements which contribute to an integrated falls prevention programme across Cambridgeshire & Peterborough CCG area. This is a request for recurrent funding for the four year period 2017/18 – 2020/21 with the first two years including pump priming investment from Cambridgeshire/Peterborough Public Health.

Cambridgeshire and Peterborough Public Health will offer pump priming of £240k annually for the first two years to cover the costs of (1) Mass media campaigns (2) Enhancement of strength and balance exercise provision (3) Enhancement of specialist falls health trainer service and (6) public health falls prevention co-ordinator. Therefore the NHS investment will be £260,617k for year one and £397,770 for year two. From year three, recurrent NHS investment of approx. £511k annually will be required to maintain the services, while public health will continue to fund media campaigns, health trainer services, and public health co-ordination.

Based on modelled estimates of the costs of falls (£85.5M to health and social care in 2017) £32.1M is direct costs to the NHS for acute health care treatment of hip fractures and injurious falls resulting in emergency hospital admissions. We have modelled the financial impact of modest reduction in admissions (5% reduction in injurious falls admissions and 1.5% reduction in hip fractures) and a reduction based on other areas that have implemented similar complex intervention (10% reduction in injurious falls admissions and 3.6% reduction in hip fractures). The results suggest gross savings of £1.05M (acute health care costs only) on a full year of operation in year one on the low estimate and gross savings of £2.12M (acute health care costs only) on the higher estimate of 10%/3.6% reduction in admissions. We have considered the effect of implementation on year one (and the falls liaison service being introduced in year two) so recognise that there will be part year effects for both investment and savings.

The key outcomes to be achieved are a reduction in injurious falls (65+) and reduction in hip fracture admissions.

A6 – Sponsorship:

The project has engaged with the following internal and external stakeholders:

- Formal STP process
- Falls Prevention Working Group
    - Cambridgeshire & Peterborough Foundation Trust (CPFT)
    - Cambridgeshire County Council (CCC)
    - Peterborough City Council (PCC)
    - Cambridgeshire & Peterborough CCG
    - Peterborough VCS
    - Institute of Public Health, University of Cambridge (evaluation)
    - Cambridgeshire Fire and Rescue Service,
    - RightStart
    - All five District Councils in Cambridgeshire
- St Ives Falls Prevention Pilot Operational Group
    - CPFT, CCC, CCG, Institute of Public Health, Everyone Health, RightStart, Local Pharmaceutical Committee

A7 – Quality Outcomes:

Injurious Falls

The key quality outcomes relating to injurious falls and fractures are expressed in terms of inpatient hospital admissions. It should be noted that falls are events rather than conditions or diseases thus coding of falls-related health data can be potentially problematic. Hip fractures are generally seen as a proxy for a serious fall.

Hip fractures

This indicator is based on the NICE quality standard 16 relating to hip fracture in adults.[1] Meeting the overall quality standard should contribute to improving the effectiveness, safety and experience of care for people with hip fracture. This would include preventing people from dying prematurely and protecting them from avoidable harm. The National Hip Fracture Database records specialist falls assessment criteria based on standard 4 in the 2007 British Orthopaedic Association and British Geriatrics Society Care of patients with fragility fracture ('blue book'):[2] All patients presenting with a fragility fracture following a fall should be offered multidisciplinary assessment and intervention to prevent future falls.[3] This indicator reflects both the incidence of falls and bone strength (osteoporosis prevention and treatment). CG146 Osteoporosis fragility fracture: NICE guideline[4] includes guidance on targeting risk assessment:

- Based on Public Health Outcomes Framework (PHOF) 4.14 – Hip fractures in people aged 65 and over
- Links to NHS OF Domain 1 - Preventing people from dying prematurely
- NICE recommended indicator (HFra24)[1] – Hip fracture: incidence

1 NICE Quality Standard 16.. Quality Standards for hip fracture. Available at: www.nice.org.uk/qs16
2 Royal Orthopaedic Society (2007) 'The care of patients with fragility fractures (The Blue Book)'. Available at: http://www.nhfd.co.uk/003/hipfractureR.nsf/resourceDisplay
3 National Collaborating Centre for Nursing and Supportive Care. (2004) 'Clinical practice guideline for the assessment and prevention of falls in older people.' Available at: http://www.nice.org.uk/nicemedia/pdf/CG021fullguideline.pdf
4 NICE Clinical Guideline 161. (2013). Falls: assessment and prevention of falls in older people. Available at: www.nice.org.uk/nicemedia/live/14181/64088/64088.pdf.

A8 – Recommendation:

The Falls Prevention Workstream seeks approval to invest the following STP NHS funding:

Year 1: £260,617
Year 2: £397,770
Year 3 and recurrent: £511,000
In this proposal for a CCG wide falls prevention programme.

NOTE: In years 1 and 2 this will be pump primed by an additional £240k investment from Cambridgeshire County Council and Peterborough City Council public health funds, over and above the STP NHS funding requested.

The Committee is asked to approve the STP NHS investment in this proposal and to commit to integrated and joint working to implement this proposal.

[B] DRIVER(S) FOR CHANGE:

B1 – Risk & Opportunity:

Risk

The project responds to risk in that:

- the population is ageing and rapidly increasing in numbers;
- falls and fracture risk increases substantially with age;
- costs to the health and social care system are substantial and will increase over time;
- the intangible human costs of falling include distress, pain, injury, loss of confidence and loss of independence with up to 90% of older people who fracture their neck of femur failing to recover their previous level of mobility and independence, as well as the anxiety caused to patients, relatives, carers and staff.[1]

Opportunity

The evidence base for falls prevention is strong but it is apparent that implementation needs to be at sufficient scale to reach the appropriate number and type of people across the population. Locally, an evidence based framework has been produced in conjunction with the Falls Working Group – and this is in the process of being tested by the Falls Pilot (Vanguard) in St Ives. This project therefore also represents an opportunity to further develop the implementation of the local framework, to increase the 'scale' of current interventions and 'reach' amongst the population and by monitoring and evaluation to generate data to ensure that interventions and resources are targeted appropriately.

Drivers for change

Population change

The number of older people aged 65 and over is forecast to increase significantly across the CCG population, with an increase of 42% in Peterborough and 48% in Cambridgeshire by 2031. In Cambridgeshire, amongst the oldest old, the number of people aged 90 years and over is forecast to nearly double in the next 15 years. In addition, a more than doubling of numbers in the 75-84 year age band who have an increased risk of injurious falls is anticipated across both Cambridgeshire and Peterborough.

Falls and fractures

Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK.[2] The average age of a person with hip fracture is 84 years for men and 83 for women, with 76% of fractures occurring in women. About 10% of people with a hip fracture die within one month and about one-third within 12 months.[3] Most of the deaths are due to associated conditions and not to the fracture itself, reflecting the high prevalence of comorbidity in this older group of people.[4] There is emerging evidence that people with dementia and neurological disorders have an increased risk of falling.[5]

Falls are the leading cause of injury-related hospitalisation in older people and are a common reason for older people requiring long-term care in their home or a residential facility. Falls often lead to reduced functional ability and thus increased dependency on families, carers and services. They can often be a turning point or trigger for a deterioration in health or wellbeing, reducing independence and mobility and may lead to increased needs for both formal and informal support. Well organised services, based on national standards and evidence-based guidelines can prevent future falls, and reduce death and disability from fractures.[6]

1 Patient Safety First Campaign 2010. Reducing Harm from Falls.

2 See Falls prevention chapter in the JSNA for the Prevention of Ill Health in Older People. Available at: http://www.cambridgeshirejsna.org.uk/prevention-ill-health-older-people-2013

3 Available at: http://www.wmpho.org.uk/resources/APHO_OP.pdf.

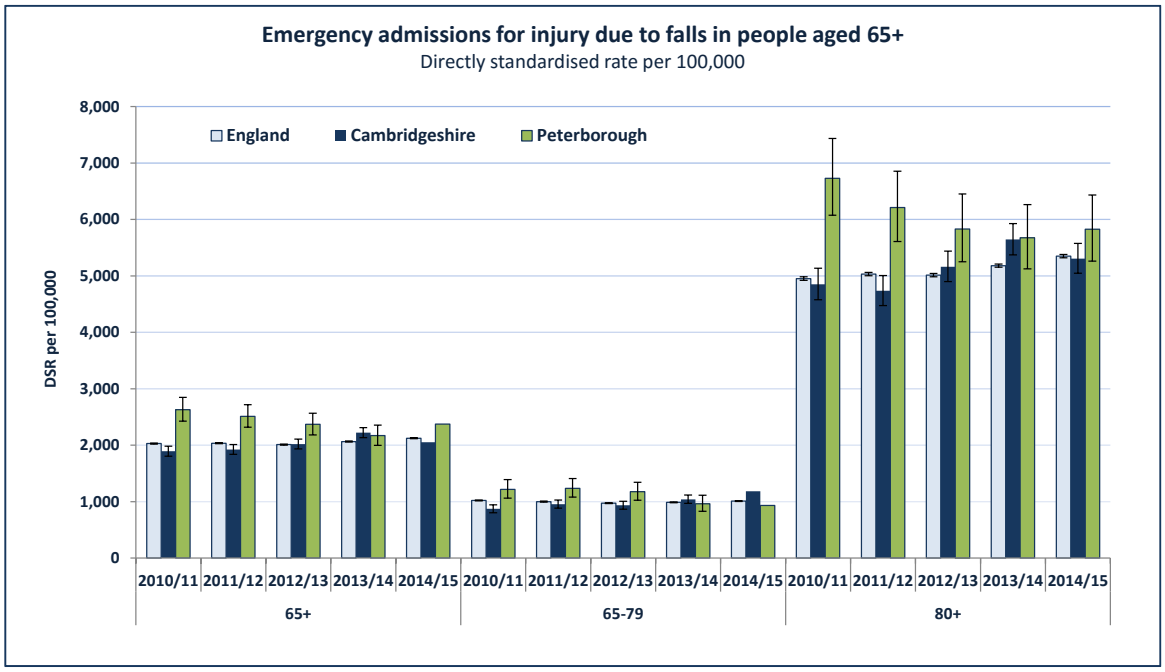
4 NICE Clinical Guideline 124 (2011): Hip Fractures – The Management of Hip Fractures in Adults. Available at: http://www.nice.org.uk/CG124

5 Allan LM, Ballard CG, Rowan EN, Kenny RA (2009) Incidence and Prediction of Falls in Dementia: A Prospective Study in Older People. *PLoS ONE* 4(5): e5521. doi:10.1371/journal.pone.0005521.

6 Royal College of Physicians.(2011) 'Falling standards, broken promises. Report of the national audit of falls and bone health in older people 2010'. Available at: http://www.rcplondon.ac.uk/sites/default/files/national_report.pdf

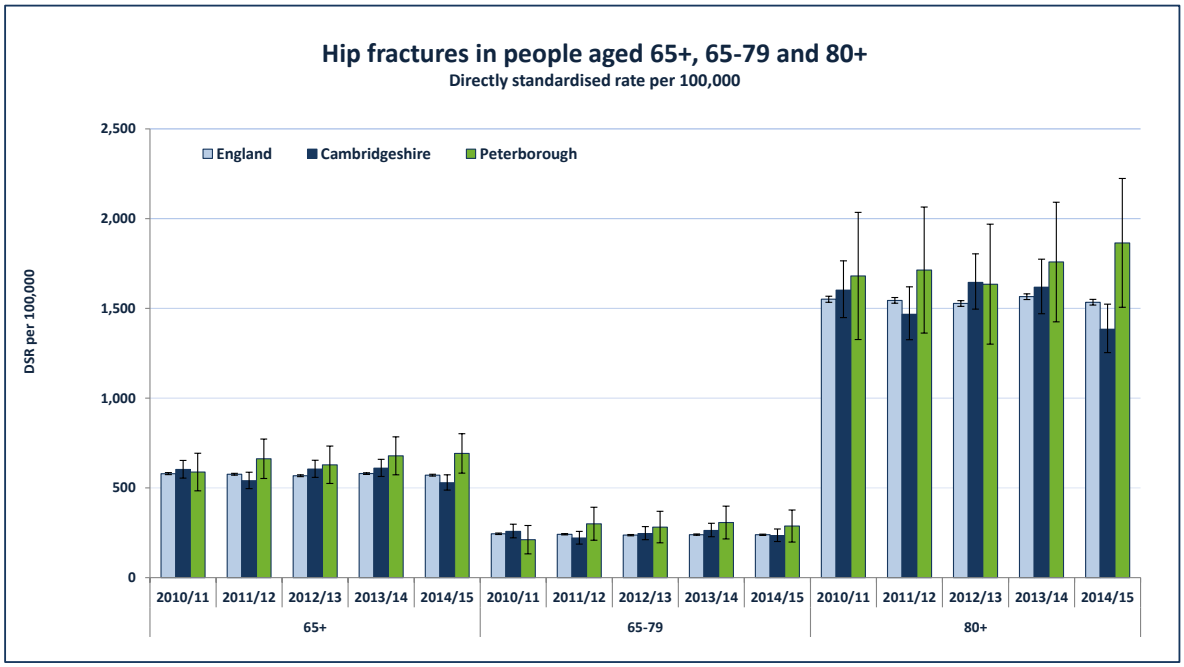
Figures 1 and 2, demonstrate rates of emergency admission for injuries due to falls, and for fracture of the hip between 2010/11 and 2014/15 in Cambridgeshire and Peterborough. Rates for emergency admissions in Cambridgeshire as a whole are similar to the national average whilst rates in Peterborough have been higher than the national average. It is clear that the impact of falls is disproportionately greater in those aged 80 years and above. This pattern accentuates the case for a dual approach to falls prevention. Services will target the over 65s who precede the age of high risk of hip fractures and frailty. Secondly, they will emphasise on effective approaches tailored to those aged over 75 years who are older and frailer, and have increasing risk of injurious falls and associated poor outcomes.

Figure 1: Emergency admissions for injury due to falls in people aged 65+



Source: Public Health England (PHE) Fingertips http://www.phoutcomes.info/ Primary diagnosis code for Injury (ICD 10 S00-T19) with falls code (WOO-W19) anywhere in diagnostic string.

Figure 2: Hip fractures in people aged 65+, 65-79 and 80+



Source: Public Health England (PHE) Fingertips http://www.phoutcomes.info/ Primary diagnosis ICD 10 S72.0, S72.1, S72.2.

Costs of falls to health and social care system

In 2013, results were published from a Scottish study which aimed to estimate the costs to health and social care services in managing older people who fall in the community.[7] The study used predominantly national databases and cost of illness methodologies and the authors noted that costs, while specific to Scotland, were generalisable to other parts of the UK. The study demonstrated that 34% of people aged 65 years and over living in the community fall at least once a year, of which 20% contacted a medical service for assistance. Applying the results from the Scottish study to local population figures for Cambridgeshire & Peterborough CCG, we can estimate the costs of falls across health and social care.

It is estimated that in 2017, falls will result in over 6,000 GP attendances, over 7,200 ambulance call outs, and more than 9,500 A&E attendances resulting in over 3,300 inpatient admissions across the CCG (numbers per year). The associated costs are high and estimated to be over £85 million. Costs at discharge are predominantly associated with social care but not from the funder perspective.

Table 1 - Estimated number and cost of fall related events, Cambridgeshire & Peterborough CCG 2017, based on study estimates applied to local population figures.

Clinical event			Number	Cost per event	Total cost (2017)	Total percentage
Population aged 65+			170,117			
Total people falling	34%	of population	57,840			
Of whom serious	7%	of population	11,908			
GP attendances	51%	of serious falls	6,073	£36	£218,635	0.3
Ambulance callouts	61%	of serious falls	7,264	£257	£1,866,849	2.2
A&E attendances	80%	of serious falls	9,527	£101	£962,183	1.1
Inpatient admissions	35%	of A&E attendances	3,334			
Falls (non hip fractures)	69%	of admissions	2,301	£7,406	£17,038,720	20.1
Hip fracture	31%	of admissions	1,034	£14,528	£15,016,603	17.7
Discharge falls						
Home	64%		1,475	£1,776	£2,619,118	3.1
Residential: short term	21%		492	£8,406	£4,132,703	4.9
Long term	15%		334	£65,942	£22,044,323	25.9
Discharge fractures						
Home	34%		353	£1,776	£627,362	0.7
Residential: short term	47%		482	£8,406	£4,049,368	4.8
Long term	19%		199	£65,942	£13,100,289	15.4
Re-admissions	7%	of admissions	400	£7,406	£2,963,256	2.1
Mortality at one year	12%	of admissions	233	£3,703	£864,283	1.8
Total cost					**£85,503,691**	**100**

Source: CCC PHI. ONS population projections applied to FHS Registration System (Exeter) January 2017 (Costs and estimates modelled using Craig et al.).

[7] Craig J, Murray A, Mitchell S et al. The high cost to health and social care of managing falls in older adults living in the community in Scotland. Scottish Medical Journal 2013;58(4):198-203. Available at: http://scm.sagepub.com/content/58/4/198.

Evidence based interventions

To achieve savings to the health and care system as modelled above, and improvement in health and QOL outcomes for our older population, a multi-faceted falls prevention approach is fundamental. The approach will need to address varying phases of need across the population, ranging from older people who are well and mobile with no risks identified; those complaining of unsteadiness; those who have fallen and injured themselves; and those with significant frailty and multi-morbidities that may have already had interventions related to falls.

There is a large body of research literature, including several systematic reviews of robust clinical trials completed, and meta-analyses to provide pooled estimates of the effect sizes for the interventions. Overall, the trialled interventions demonstrate clinical effectiveness and the outcomes include reduced rate of falls, and reduced risk of serious falls.

To achieve impact, an array of evidence-based interventions is necessary, targeted to specific population groups and needs and delivered in an integrated manner by a range of sectors and partners across the system (Table 2).

Table 2: Effective interventions to reduce the rate of falls and risk of serious falls

Effective Interventions[8]	**Target Group**
Strength and Balance (community)	All population >65
Tai chi (community)	Low/medium risk of falling
Home improvements (hazard assessments)	Medium/high risk of falling
Multi-factorial risk screening and intervention	Medium/high risk of falling
Medication review (withdrawal of psychotropic medication)	Taking multiple medications
Expedited cataract surgery	Patients with cataracts
Vision and eye exam	All population >65
Vitamin D and calcium	All population >65
Cardiac pacing	Patients with carotid hypersensitivity

The prevention and management of falls in community dwelling older people is only one element of a system wide falls prevention programme. NICE clinical guideline 161[9] centres on the delivery of multi-factorial assessment of risk of falling in all older people in contact with healthcare professionals (therefore representing the majority of the population aged 75 years and over), and the implementation of multifactorial interventions addressing for example:

- Strength and balance training
- Home hazard assessment and intervention
- Vision assessment and referral
- Medication review with modification/withdrawal

In addition, those who are discharged from acute care following medical intervention for a serious fall (estimated as 3,250 people locally) are an important population group known to be at very high risk of injurious falls. Approximately a third of patients admitted for a fall and two thirds of those admitted for a fracture from the community are discharged to a residential care setting. For those returning to living in a community setting, key interventions as identified in the local framework include the assessments of home hazards by an Occupational Therapist.

[8] Interventions drawn from Day et al., (2009) Modelling the impact, costs and benefits of falls prevention measures to support policy-makers and program planners. MONASH University Accident Reduction Centre; Church J, Goodall S. Norman R. Haas M. An economic evaluation of community and residential aged care falls prevention strategies in NSW. Sydney. NSW Ministry of Health 2011.

[9] Clinical Guideline 161 on Falls: Older People living in the community, 2013. Available at: http://www.nice.org.uk/guidance/cg161/resources

Local evidence based framework

In light of the evidence, a framework has been developed locally to describe evidence-based interventions across the population which are demonstrably effective in preventing falls (and therefore may incur cost savings for the NHS). This framework is summarised below:

Figure 3: Cambridgeshire and Peterborough Falls Prevention Framework

Primary prevention in the community (untargeted interventions) 60+	Identification & Assessment	Targeted interventions At risk/frail 75+	Preventing falls in hospitals & LTCF	Post-discharge (towards independence)
P.1 Exercise • gait, strength, balance, or functional training • Otago • Tai Chi	IA.1 Routinely ask older people whether they have fallen in the past year	TI.1 multidisciplinary assessment	PS.1 Groups at risk of falling in hospital: • All patients aged 65+ • Patients aged 50 to 64 years judged by a clinician to be at higher risk	PD.1 home hazard assessment and safety intervention/ modifications by suitably trained healthcare professional.
P.2 Vitamin D supplementation (+ Calcium)	IA.2 Observe for balance and gait deficits and consider for strength and balance.	TI.2 individualised multifactorial intervention: • strength and balance training • home hazard assessment and intervention • vision assessment and referral • medication review	PS.2 multifactorial assessment	PD.2 Multiple programs (eg Otago, Matter of Balance)
P.3 Environmental & home safety interventions	IA.3 healthcare professionals' professional competence in falls assessment and prevention.	TI.3 Strength and balance training	PS.3 Multifactorial interventions (include individual risk assessment and tailored interventions)	
P.4 Multifactorial interventions	IA.4 multifactorial falls risk assessment	TI.4 psychotropic medications reviewed, and discontinued if possible	PS.4 Multifactorial interventions with an exercise component older people in extended care settings	
	IA.5 strength and balance training	TI.5 Cardiac pacing considered for cardioinhibitory carotid sinus hypersensitivity	PS.5 Exercise for more than 6 months (2–3 times a week)	
		TI.6 falls prevention programmes (includes behaviour change & addressing barriers)	PS.6 Vitamin D supplementation	
		TI.7 Education & information.	PS.7 Early anticipation of discharge needs	
			PS.8 Information & support	
			PS.9 share relevant information across services.	

The framework also provides a foundation for potential roles and leadership actions across sectors. Further information can also be gleaned from examples of falls services delivered elsewhere in the UK. 'Gold standard' falls preventions packages typically include strong pathways between the relevant agencies. The Greater Glasgow and Clyde model,[10] which has evidence of actual realised savings, includes the following key components:[11]

- Single point of referral in each locality for triage and onward referral
- Multi-factorial falls assessments (all assessments in the home)
- Data recording of patients using the service
- Programme of exercise classes run in community centres by trained specialist therapists (held immediately after rehabilitation classes)
- Integration: Close partnership-working between the NHS and local council
- Falls service widely promoted in GP practices, libraries, and other public settings

Falls Pilot (Vanguard) St Ives

The local framework has been tested in the St Ives Falls Pilot (Vanguard). Learning from the pilot will be incorporated into strengthening community provision in this proposal. Full evaluation is due in June 2017.

[10] This programme is the only UK model to have evidence of realised savings, finding over a 10 year period the service has achieved a reduction in falls in the home of 32%, a reduction of falls in residential institutions of 27% and a reduction of falls in the street of almost 40%. However there may be some concerns about the analysis, and the ability to extrapolate for local models.

[11] Greater Glasgow and Clyde Falls Prevention and Osteoporosis Services. Available at: http://www.nhsggc.org.uk/CONTENT/default.asp?page=s1361

B2 – Strategic Context:

PHE Consensus Statement (January 2017)
This guidance was produced by the National Falls Prevention Coordination Group (NFPCG). The NFPCG is made up of organisations involved in the prevention of falls, care for falls-related injuries and the promotion of healthy ageing.
https://www.gov.uk/government/publications/falls-and-fractures-consensus-statement

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This proposal supports the system STP priorities of 'at home is best' and 'we're only sustainable together'.

Guidance documents, best practice and research:
NICE Clinical Guidance CG 161 & Quality Standard QS 86 Falls
NICE Clinical Guidance CG 81 & Quality Standard QS 16 Hip Fracture
NICE Clinical Guideline 21. Falls: The Assessment and Prevention of Falls in Older People. London, UK: National Institute for Clinical Excellence, 2004.
NICE Guidance NG5 Medicines Optimisation
NICE Technology Assessments TA 204, TA160 & TA161 osteoporosis medications
Commissioning for Quality and Innovation CQUINs. Fracture prevention & dementia
Best Practice Tariff Hip Fracture
Commissioning Toolkit Falls & Fracture Prevention
Royal College of Physicians National Falls & Fragility Fractures Audit Programme
British Geriatrics Society/American Geriatrics Society Falls Guideline
British Orthopaedics Association/ British Geriatrics Society Blue Book - hip fracture care
Silver Book - Quality Care for Older people with Urgent & Emergency Care Needs

Gillespie LD, Gillespie WJ, Robertson MC et al. Interventions for preventing falls in elderly people. Cochrane Database Syst Rev 2003;Issue 4.

Clemson L, Mackenzie L, Ballinger C, Close JC, Cumming RG. (2008) Environmental interventions to prevent falls in community-dwelling older people: a meta-analysis of randomized trials. J Aging Health. 2008;20(8):954-71. doi: 10.1177/0898264308324672.

Key resources:
National Patient Safety Association Slips, Trips & Falls in Hospital
National Patient Safety Association Rapid Response Report Essential care after in-patient fall
National Patient Safety Association How To Guide - Reducing Harm from Falls
Royal College of Nursing Let's Talk about Restraint
College of Occupational Therapists Practice Guideline Falls
Chartered Society of Physiotherapy/AGILE - Falls guidelines

B3 – Risk Assessment (only applicable if responding to a risk as identified in B1):

N/A

[C] ALIGNMENT WITH ORGANISATION or SYSTEM PRIORITIES:

C1 - The proposed investment aligns to the following elements of the organisational or system priorities:

CCG Framework Element / Provider Strategic Objective / STP Strategic Objectives (delete as applicable)	Evidenced By:
1. Change Priority 1 'At home is best'. Falls prevention is highlighted as a key action to enable the delivery of this priority under the 10 point plan 'People powered health and wellbeing'.	Cambridgeshire and Peterborough STP
2 PCIN – aims to enhancing quality of integrated care closer to home, improving outcomes, strengthening communities and support available to individuals and empowering people to live independently (leading to reduced demands on statutory health and care services)	PCIN Delivery Plan
3 'Prevention' priority - emphasises the need to address falls in older people	Cambridgeshire Better Care Fund (BCF) Plan
4. 'Support older people to be independent, safe and well' priority	Cambridgeshire Health and Wellbeing Strategy 2012-2017
5. 'Older people are more independent, more active and more engaged in their communities for as long as possible; knowing that if they need them, they can rely on services which are flexible, creative, coordinated and focused on keeping them well'.	Cambridgeshire Older People Strategy
6. 'To reduce avoidable harm through improved falls prevention and reduction in harm from falls'.	CPFT Operation Plan 2016-17
7. Admission avoidance priority (falls are a cause of hospital admission and therefore are a focus for CPFT)	CPFT contract with CCG
8. 'To reduce avoidable harm through improved falls prevention and reduction in harm from falls'.	CPFT Management and Prevention of Falls Strategy (awaiting ratification)
9. 'To reduce avoidable harm through improved falls prevention and reduction in harm from falls'.	CPFT Falls Prevention and Management Policy (awaiting ratification)
10. 'To reduce emergency admissions due to falls from care home residents'	CUH/CCG Care Home protocol
11. To reduce the no of avoidable harm falls (inpatient)	CUH Harm Free Care Strategy
12. To improve the identification and assessment of clients at increased risk of falling and implement evidence based interventions to contribute to a reduction in falls and injurious falls.	Everyone Health Falls Prevention Health Trainer Service Specification
13. Better Health – Indicator – Injurious Falls in people aged 65+	CCG Outcomes Framework
14. Hip fractures in people aged 65+; Injurious falls in people aged 65+	Public Health Outcomes Framework (PHOF)

OUTLINE PROPOSAL

D1 - The Preferred Option:

This is a summary of the Full Business Case. Please see attachment for further details.

The aim is to implement a comprehensive, standardised, and integrated falls prevention programme across the Cambridgeshire and Peterborough CCG area. To achieve this, the current programme of falls prevention activities will need to be strengthened and expanded by applying the evidence base to the local infrastructure and by utilising existing models. The preferred option is to invest in five schemes for 2017/18 and six from 2018/19:

1. **Develop and implement a Falls primary prevention campaign: £ 10,000**

A falls prevention communication campaign is a central tenet of a multi-faceted and comprehensive approach to reducing falls, as depicted in the locally developed falls prevention framework. The proposal is to develop a social marketing campaign targeting those entering retirement and beyond to improve their awareness of key falls prevention messages around maintaining and improving strength and balance as they age. The campaign strapline, graphics and communication routes will be developed and targeted to specific segments of the older people population based on behavioural insights and engagement with the target group to ensure the messages are well received. The campaign design will be underpinned by major principals for developing effective mass media campaigns previously identified from the evidence base (Appendix 1) and by key findings derived from qualitative research exploring appropriate falls prevention messages to communicate to older people. The campaign will be evaluated by calculating the number of people reached by the campaign, number of people aware of the campaign, and number intending to implement the behaviour.

2. **Enhancement and expansion of strength and balance exercise provision: £ 123,754**

Strength and balance training, based on the Otago programme, has been evidenced to reduce falls. Economic modelling undertaken locally indicates that significantly higher numbers of older people are needed to undertake and complete the recommended 50 hours of strength and balance exercise training to achieve a reduction in the number of falls on an individual level and to contribute to a reduction in injurious falls on a population level. The aim of the proposal is to increase the number of frailer older people (75+ years) who successfully complete the recommended 50 hours of strength and balance training which will reduce their risk of falls. This will be achieved by recruiting four band 4 Therapy Assistants to deliver NHS strength and balance classes and set up home exercise programmes with 6 monthly follow ups. The 4 Therapy Assistants will provide additional capacity as part of the 4 rehabilitation falls units in each locality and their role will embed in the local falls prevention infrastructure, linking with the 16 Neighbourhood Teams as appropriate.

3. **Enhance existing Falls Prevention Health Trainer Service: £58,333**

The identification and assessment section of the evidence based Cambridgeshire and Peterborough Falls Prevention Framework highlights the need for timely identification of those who have fallen or at risk of falling, multifactorial risk assessment, and implementation of evidence based intervention such as strength and balance exercises. The Falls Prevention Health Trainer service builds capacity in the local falls prevention system and enables a more upstream, preventative focus by identifying those at risk. It is a key component of a community level falls prevention pathway that is being implemented in a local falls prevention pilot, aligning and complementing the existing NHS falls prevention service and Neighbourhood Team provision. The proposal is to fund 2 additional Falls Prevention Health Trainers to cover the inequity of provision observed in Peterborough and to increase capacity and provision in Cambridgeshire. The Falls Prevention Health Trainers will complete falls assessments and implement an appropriate intervention plan, including setting up and progressing a home based strength and balance exercise programme to complement those attending a community class in order to ensure the correct exercise dose for preventing falls. 6 monthly follow up appointments will be implemented to provide valuable motivational support and to enable progression and compliance with the home exercise programme and other evidence based interventions. The aim is to increase the number of older people receiving multifactorial assessments and evidence based intervention plans, particularly those at risk of falling.

4. **Strengthen the delivery of falls prevention and integration in the community: £ 260,900**

Multi-faceted interventions can prevent falls in the general community in those at greater risk of falls. Well organised services, based on national standards and evidence-based guidelines can prevent future falls, and reduce death and disability from fractures.

The proposal is to strengthen the delivery of falls prevention and integration in the community by establishing and embedding the necessary staff roles, expertise and pathway. Three new band 7 falls champions roles are proposed, as well as changes to existing staff roles. These changes include: a band 8a uplift for the band 7 Falls Clinical Lead (their new role will include Falls Champion (see below) as well as falls leadership across CPFT and wider system); concomitant backfilling of their band 7 clinical role; and a band 6 uplift to consolidate the Exercise trainer post and ensure accredited training is delivered, monitored and evaluated.

It is proposed that three new band 7 falls champions (2 nurses and 1 therapist) are employed and that a complementary skill mix comprising a therapist and a nurse work collaboratively in each of the north and south localities (East Cambridgeshire/Fenland/Peterborough and Huntingdonshire/Greater Cambridgeshire). The third therapist role will be covered by the band 8a uplift mentioned above. The falls champions will be based around a rehab and falls hub in each locality which would become a centre of excellence for falls prevention and management training. The falls champions will be responsible for offering training, complex clinical intervention and support to falls link workers identified in each Neighbourhood Team and in Specialist Services to ensure all staff have falls prevention knowledge and follow the agreed falls prevention pathway. Furthermore, the nurse falls champion will have a specific role concentrating on MDT working and training around admission avoidance. The nurses will lead on proactive and timely management of patients with exacerbations of long term conditions who have an increased risk of falls and subsequent hospital admissions.

5. **Development and implementation of Fracture Liaison Service (FLS)**

Public Health England have identified at least six areas where interventions have the potential to deliver savings to the NHS within 5 years and the implementation of a fracture liaison service in secondary care is one. The aim of an FLS is to reduce repeat fractures from falls by identifying people at risk of future fractures and falls and offering bone strengthening medicines and referrals to services that can reduce this risk (for example, strength and balance programmes). There is strong evidence to demonstrate that investment in fracture liaison services results in improved quality of care for patients as well as financial savings for commissioners of health and social care[1,1].

The proposal is to plan, develop, and implement a Fracture Liaison Service (FLS) across acute trusts over a five year period. The first year will be dedicated to the planning and development of the service with implementation in years 2-5. The FLS will be a key part of the Falls Prevention Pathway. Currently the costing is for 3 Band 7 nurses.

6. **Public Health Falls Co-ordinator: £58,800**

A reduction in falls and fracture admission rates is dependent on system-wide leadership, co-ordination and integration. Evidence indicates that the success of multicomponent falls prevention interventions depends on strong co-ordination at a system-level. The proposal is to appoint a band 8 (equivalent) Falls Co-ordinator to co-ordinate, monitor and evaluate a comprehensive, standardised and falls prevention programme ensuring join-up across falls activities such as fracture liaison services, falls health services and community provision in line with the Falls Prevention Pathway. The co-ordinator would work with partners to develop a Primary Prevention Campaign and facilitate data collection. This will include wider inputs from district council leisure services, home improvement agencies, and other partners not directly included in this STP bid.

Note that Interdependencies/ Communication with other services will be important for referrals to the service and onward referrals from the Falls Service will be addressed through a Communication and Engagement Plan.

This Business Case is a standalone case for Falls Prevention and is not dependent on other PCIN and UEC business cases.

D2 - 'Do Nothing' Option:

The cost implications of falls and fractures for the health and care system are evident and a 'do nothing' approach incurs increasing costs to all components and partners of the health and care system over time in addition to the devastating impacts on quality of life and independence of our growing older populations.

The table below provides an additional breakdown of NHS costs associated with falls and fractures and indicates the financial impact assuming no change in prevention up until 2020. This is a conservative estimate as numbers have been applied on the risk across the 65+ age group and not specifically adjusted for the increased risk inherent in the oldest old (greatest falls burden). Note that these tables do not include the costs incurred post hospital discharge (60% of total described above). There is some distribution of these costs between health and social care though the majority will be to social care.

Table 3: Estimated number and NHS costs of fall related events, Cambridgeshire & Peterborough CCG 2016 - 2020, based on study estimates applied to local population figures.

Breakdown of costs to NHS - Cambridgeshire & Peterborough CCG - no change in prevention

	2016	2020	2016	2017	2018	2019	2020
Population 65+	166,039	181,667					
Estimated falls in the community	56,453	61,767					
of which serious	11,623	12,717					
GP attendances	5,928	6,486	£.2M	£.2M	£.2M	£.2M	£.2M
Ambulance callouts	7,090	7,757	£1.8M	£1.9M	£1.9M	£2.M	£2.M
A&E attendances	9,298	10,173	£.9M	£1.M	£1.M	£1.M	£1.M
Costs GP/Amb/A&E			**£3.M**	**£3.M**	**£3.1M**	**£3.19M**	**£3.25M**
Inpatient admissions	3,254	3,561					
Of which non hip fx	2,246	2,457	£16.6M	£17.M	£17.4M	£17.8M	£18.2M
Of which hip fractures	1,009	1,104	£14.7M	£15.M	£15.4M	£15.7M	£16.04M
Costs of admission			**£31.3M**	**£32.1M**	**£32.8M**	**£33.5M**	**£34.2M**
Readmissions	228	249	**£.8M**	**£.9M**	**£.9M**	**£.9M**	**£.9M**
Total			**£35.1M**	**£36.M**	**£36.8M**	**£37.6M**	**£38.4M**

Source: (Costs and estimates modelled using Craig et al)

D3 - Alternative Option(s) Considered:

In terms of strengthening the delivery of falls prevention and integration in the community, three options were considered:

1. The training of therapy staff and district nurses in the 16 Neighbourhood Teams could be continued by the current band 7 Falls Clinical Lead once the St Ives Falls Prevention pilot (and the Falls Nurse role), comes to an end at the end of June 2017. This was discounted because:
    a. The workload is unfeasible for one staff member preventing the timely implementation of evidence based practice, potentially leading to an increase in falls and injurious falls
    b. The falls prevention pilot has identified that therapy staff have specific clinical training needs that need to be met to enable them to more effectively identify and manage patients at risk of falls. These training needs are not met during their foundation training and a nurse would be required to deliver these elements of training and to provide ongoing support.
    c. The pilot has identified that district nurses are key players in identifying patients at risk of falling in the context of the patient's wider health needs and, in order to continue to embed falls within the role of the nurse, ongoing support and development is required from a falls specialist nurse
2. A falls nurse or therapist is employed in each of the Neighbourhood Teams. This was discounted because:
    a. Cost prohibitive
    b. Query over value for money
    c. Cheaper alternative was to uplift the current band 7 to band 8a and for their role to cover the therapist falls champion role as well as wider leadership roles and responsibilities.
3. The preferred option described in D1 – one nurse and one therapist working collaboratively in a locality (total of two nurses and two therapists across the two localities).

[E] FINANCIAL IMPACT:

E1 – Investment Required for Proposed Option:

The work stream is seeking gross revenue investment of £500,617 in year one increasing to £637,770 year two onwards. This investment covers the six elements which contribute to an integrated falls prevention programme across Cambridgeshire & Peterborough CCG area.

Cambridgeshire and Peterborough Public Health will offer pump priming of £240k annually for the first two years to cover the costs of (1) Mass media campaigns (2) Enhancement of strength and balance exercise provision (3) Enhancement of specialist falls health trainer service and (6) public health falls prevention co-ordinator. Therefore the NHS investment will be £260,617k for year one and £397,770 for year two. From year three, recurrent NHS investment of approx. £511k annually will be required to maintain the service, with the remainder of the programme covered by public health funds.

Implementation of an integrated CCG-wide Falls Prevention programme in Cambridgeshire & Peterborough 2017/1			Y1	Y2	Y3	Y4	Y5
Primary prevention campaign	Primary Prevention campaign (Cambs & Peterborough)	See business case	£10,000	£10,000			
Physical activity Strength & Balance	**Band 4 x 4 wte @ £28,126 per person per annum** (based on top of band 4 Agenda for Change Payband 2016, plus 24% on costs and expected 1% uplift for 2017)	To provide strength and balance home exercise programmes and classes for frailer older people (75+ years)	£112,504	£112,504	£112,504	£112,504	£112,504
Falls prevention Health Trainer	**x2 wte @ £26,667 per trainer per annum**	To conduct multifactorial assessments, implement intervention plan (including strength and balance home exercise programmes) and provide motivational support for up to 6 months for older people independent of activities of daily living, in Peterborough and in Cambridgeshire	£53,333	£53,333			
	Non pay costs		£5,000	£5,000			
	Total costs		£58,333	£58,333			
Strengthening falls prevention delivery and integration in the community	**Band 8a uplift**	Co-ordinate Falls prevention and management in CPFT and maintain wider links with other stakeholders.	£15,000				
		To enable service to have locality champions that will training and support identified link workers in all 1 community teams to ensure Falls prevention/management becomes everyone's responsibility. Develop consistent pathways	£137,700				
	Band 6 x 1 wte	To backfill clinical work that JR is currently doing	£38,350				
	Band 6 uplift for Exercise Trainer	Need to support development of this role as the postholder offers accredited training courses to internal and external staff to ensure consistency of Strength and Balance exercise training.	£6,500				
	Total		£197,550				
	Non pay costs		£27,700				
	Overheads @ 18%		£35,600				
	Total costs		£260,900	£260,900	£260,900	£260,900	£260,900
Fracture Liaison Service		Uncosted - assume Band 7 staffing across Acute Trusts	0	£137,700	£137,700	£137,700	£137,700
Public Health Falls Coordinator	**X1 wte Band 8a equivalent**		£53,880	£53,333			
	Non pay costs		£5,000	£5,000			
	Total costs		£58,880	£58,333			
	Grand Total	**Falls Prevention Programme across Cambridgeshire and Peterborough**	£500,617	£637,770	£511,104	£511,104	£511,104

This Business Case is a standalone case for Falls Prevention and is not dependent on other PCIN and UEC business cases.

E2 – Savings Delivered in the Proposed Option:

Method

Potential gross savings have been calculated by estimating the financial impact of reducing hospital admissions for injurious falls and hip fractures under two scenarios – a conservative estimate of 5% reduction in injurious falls and 1.5% reduction in hip fracture, and a more average reduction based on areas that have implemented similar complex interventions (10% reduction in injurious falls admissions and 3.6% reduction in hip fractures). Note that gross savings shown are for CCG acute health care costs only. Other health service costs pre hospital admission (GP attendances, ambulance callouts, A&E attendances) are not included and represent an additional cost of £3.05M in 2017. Note that these are modelled costs based on Craig et al (2013).

Estimate of savings to be delivered

Based on modelled estimates of the costs of falls (£85.5M to health and social care in 2017) of which £32.1M is direct costs to the NHS for acute health care treatment of hip fractures and injurious falls resulting in emergency hospital admissions. We have modelled the financial impact of modest reduction in admissions (5% reduction in injurious falls admissions and 1.5% reduction in hip fractures) and a reduction based on other areas that have implemented similar complex interventions (10% reduction in injurious falls admissions and 3.6% reduction in hip fractures).

The results suggest gross savings of £1.05M (acute health care costs only) on a full year of operation in year one on the low estimate and gross savings of £2.21M – (acute health care costs only) on the higher estimate of 10% /3.6% reduction in admissions.

We have considered the effect of implementation on year one (and the falls liaison service being introduced in year two) so recognise that there will be part year effects for both investment and savings.

We estimate that in 2017, the total costs of falls and fractures to the health and social care system in Cambridgeshire & Peterborough CCG will be £85.5M. Of this total, £32.1M is direct costs to the NHS for acute health care treatment of hip fractures (Table 3) and other injurious falls which result in hospital admission[1]. Costs post discharge amount to £46.6M and will be incurred predominantly by social care but also by community health care

- Achieving a modest 5% reduction in injurious falls admissions plus a modest 1.5% reduction in hip fractures results in acute healthcare gross savings of £1.05M.
- Achieving a 10% reduction in injurious falls admissions and a 3.5% reduction in hip fractures[2] results in acute healthcare gross savings of £2.18M.

Net savings on total investment (ie no split of funding determined between PH/STP/CCG etc)

Acute healthcare costs only		Y1	Y2	Y3	Y4	Y5
Savings from 5% reduction in falls admissions	5%	£0.83M	£0.85M	£0.87M	£0.89M	£0.91M
Savings from 1.5% reduction in hip fracture admissions	1.5%	£0.22M	£0.23M	£0.23M	£0.24M	£0.24M
Total (gross)		£1.05M	£1.08M	£1.10M	£1.13M	£1.15M
Net savings (acute healthcare NHS only)		**£0.55M**	**£0.44M**	**£0.46M**	**£0.49M**	**£0.51M**
Savings from 10% reduction in falls admissions	10%	£1.66M	£1.70M	£1.74M	£1.78M	£1.82M
Savings from 3.5% reduction in hip fracture admissions	3.5%	£0.51M	£0.53M	£0.54M	£0.55M	£0.56M
Total (gross)		£2.18M	£2.23M	£2.28M	£2.33M	£2.38M
Net savings (acute healthcare NHS only)		**£1.68M**	**£1.59M**	**£1.64M**	**£1.69M**	**£1.74M**

Cost avoidance post discharge is in addition to cost avoidance to acute healthcare. Neither summary includes health costs pre admission.	**Gross savings post discharge (community health and social care)**				
	Total - low	**£1.67M**	**£1.71M**	**£1.74M**	**£1.78M**	**£1.82M**
	Total - high	**£3.42M**	**£3.5M**	**£3.58M**	**£3.66M**	**£3.74M**

Please note: this table is based on 2012-based CCG population forecasts (CCC PHI) which will be updated.

High and low estimates of % reductions in admissions have been made. The Glasgow model that we use to assume the 3.5% (high) reduction in hip fractures is the model that most resembles our proposed complex intervention. The cautionary (low level) estimate is presented to account for the application of the intervention in local setting and context. This is what is currently being tested in the pilot and will continue to be monitored as the intervention is rolled-out to ensure local responsiveness.

If the 'low' ROI figure for the first year is halved to allow for the implementation process and the later introduction of the fracture liaison service in year two, the gross saving is still over £0.5M.

What has not been included in the summary analysis is the considerable cost of falls and fractures post hospital discharge. For 2017 this is estimated to be £45.5M. Proportions are borne by both community health care and social care (nursing and residential care post discharge for a hip fracture); depending on the local model of care. Gross savings shown in the table above therefore indicate considerable additional savings to both the health and social care system if the falls prevention programme aligns with other initiatives and projects – this is considered critical to the success of the programme.

E3 – Source of Funding:

It is proposed that funding is split between Cambridgeshire & Peterborough CCG/STP and Cambridgeshire/Peterborough Public Health as follows:

Year	NHS funding	CCC and PCC public health funding
Year 1	£261k	£240k
Year 2	£398k	£240k
Year 3 and recurrent	£511k	Mass media campaigns, health trainers and public health falls prevention coordination mainstreamed within local authority public health services.

E4 – Financial Model: See separate Excel spreadsheet – please complete for all options outlined in section D

E5 – Contractual Considerations:

The existing Health Trainer contract is currently undergoing a contract variation.
The remainder of the proposals consist of new posts (with two exceptions where existing posts include uplift). With the exception of the PH Falls Coordinator who will be employed within CCC (Public Health), all other posts will be employed by CPFT. SDU to further advise.

E6 – Capital Risk (Capital Cases only):

N/A

[F] PATIENT EXPERIENCE:

In terms of the preferred option:

F1 – Impact on Patient Care:

- Through strength and balance exercise provision, people identified as at risk of falls, are less likely to fall, and will maintain confidence and independence through training
- More people will be aware of falls prevention through the social marketing campaign
- Through the extension of the Falls Specialist health trainer role, more health professionals will be able to identify patients at risk of falls and conduct falls assessments, putting appropriate interventions in place.
- Patient satisfaction through strengthening the Falls Prevention Delivery and Integration in the Community
- Patients maintaining stability in balance through support, education and knowledge
- Patients being maintained in the community leading to fewer referrals and admissions to acute hospitals
- Patients who experience fragility fractures being identified and treated early once FLS operational leading to less severe fractures in the future

[G] OPERATIONAL IMPACT:

In terms of the preferred option:

G1 – Capacity: post change, during implementation; Other areas:

Primary prevention campaign	Currently little capacity is available within the falls prevention programme for this activity. The employment of the Falls Coordinator supported by existing public health staff will create the capacity to develop and implement the campaign.
Strength & Balance	The four new therapy assistants will increase capacity to support frailer older people to increase their strength and balance. The new staff will improve the number of people taking up the exercise programmes by reducing the waiting time for intervention enabling the patient to be seen sooner after the referral and when they are still motivated and more likely to make the behavioural change.
Falls Prevention Health Trainer	Two new posts: 1. One in Peterborough into the new service. Capacity unavailable in Peterborough currently. No impact during implementation as the lifestyle service is being commissioned and set up. 2. One in Cambridgeshire. The new post will increase capacity. Service will be able to continue during implementation.
Falls prevention delivery and integration	Three new posts will create capacity which is currently unavailable. Band 8a uplift will create capacity by enabling this post to cover one of the four falls champions in the 2 localities. The substantive band 7 post will need to be backfilled during the implementation and this is costed for in the business case. There will be an operational impact on this role whilst the backfilling takes place. Band 6 uplift of exercise specialist. Capacity available to some extent. The upgrade will create additional capacity in terms of responsibility and leadership.
FLS	This needs to be scoped and planned and implemented across the system. This is proposed for year 2.
PH Falls Prevention Coordinator	Currently the falls prevention programme is supported by the Senior Public Health Manager – Older People (Cambridgeshire County Council). However, the increasing demands of this programme have limited their capacity, prohibiting the ability to plan and implement new programmes of work such as UTIs/incontinence, malnutrition etc. The new 2 year fixed term post will release capacity of the manager to work on these other priority areas defined by STP and BCF and increase the capacity to implement the falls prevention programme. It is proposed that the PH Falls Prevention Coordinator will plan for the implementation of FLS across the acute trusts.

G2 – Support Services, Physical and Equipment Capacity, IT and IG Compliant:

Primary prevention campaign	n/a
Strength & Balance	The capacity is not currently available. Yes there are plans which could accommodate the additional therapy assistants within falls rehabilitation units.
Falls prevention Health Trainer	The capacity is not currently available. Yes additional staff could be accommodated within Cambridgeshire. Peterborough will be a new service (with falls health trainers recruited alongside general health trainers)
Falls prevention delivery and integration	Capacity not currently available.
FLS	n/a
PH Falls Coordinator	Capacity not currently available within public health team. Yes an additional staff member can be accommodated within existing structures.

G3 – Impact Assessment:

Cambridgeshire County Council (CCC)
An impact assessment was carried out in 2015 for Cambridgeshire County Council Public Health Directorate for the previous PH Business Plan regarding falls prevention. This will be updated to inform the current proposal across all project elements. This is likely to be when PH Falls Prevention Coordinator is in post.

[H] WORKFORCE/HR:

We have considered the ability to recruit to the small number of posts and there is no foreseen barrier to filling the posts. The more difficult posts for the Fracture Liaison service will have a lead in of 12 months as they are required in Year 2.

H1 – Staffing Numbers:

The Organisation's headcount will increase as shown in table as a consequence of this proposal.

	Organisation	WTE
Primary prevention campaign	n/a	n/a
Strength & Balance	CPFT	4 wte
Falls prevention Health Trainer	Everyone Health Solutions for Health	1 wte 1 wte incorporated within new contract implementation
Falls prevention delivery and integration	CPFT	4 wte (3 new posts, 2 uplifts and 1 backfill)
FLS	Acute Trusts	1 wte per Trust
PH Falls Coordinator	CCC	1 wte

H2 – Staff Consultation:

The Falls Pilot (Vanguard) has provided insight into the key staff groups who will be involved with developing and implementing key elements of this proposal. This has given useful feedback and engagement with different staff groups.

A consultation process involving staff side will not be required for this proposal.

H3 – Training:

Primary prevention campaign	n/a
Strength & Balance	Tbc
Falls prevention Health Trainers	Yes – Falls awareness training (internal); Falls prevention training (internal), Ongoing supervision by new band 7 therapists.
Falls prevention delivery and integration	Yes for the band 7 nurses and therapists – it will depend on the skill set of the staff recruited but as a minimum will include: Falls prevention training (internal), Falls pathways and internal IT systems training (Internal), Ongoing supervision by band 8a. Specialist nurses will need the following training: Holistic clinical assessment skills; mentorship; SystmOne training; Phlebotomy; Otago training.
FLS	Yes probably (Year 2) but also bone health, primary care staff,
PH Falls Coordinator	n/a – depending on appointee, some training may be required

H4 – Recruitment Considerations:

Primary prevention campaign	n/a
Strength & Balance	The Clinical Falls Lead has indicated that she is unaware of any difficulties and issues recruiting therapy assistants.
Falls Prevention Health Trainer	Recruitment of falls health trainers has been relatively straightforward and the role appears to be attractive to people interested in the health trainer role (physical activity backgrounds). No special considerations.
Falls prevention delivery and integration	It is not known whether there will be difficulties recruiting from an external pool. Internally, it is anticipated that there may not be the staff with the knowledge and skills currently employed by CPFT, however, successfully appointed individuals will be trained up to deliver the role.
FLS	Specialist nurses – there is likely to be interest within each acute trust and people with relevant experience and expertise. It may be wise to accelerate recruitment if national guidance is likely to make this a priority for each region/CCG.
PH Falls Prevention Coordinator	This is a new post which should attract a wide field of candidates from varying backgrounds. Recruitment should be straightforward.

H5 – Tenure:

New Posts will be fixed term.

H6 – Job Plans:

Primary prevention campaign	n/a
Strength & Balance	CPFT therapy assistant job descriptions exist.
Falls prevention Health Trainer	n/a Three successful appointments have been made. Employer is an external provider.
Falls prevention delivery and integration	One new band 7 therapist role based in CPFT. Job description exists and could be adapted for new role. One backfill of band 7 therapist role. Job description exists. Two new band 7 falls nurse roles based in CPFT. Job description exists for district nurses which could be adapted for falls nurse.
FLS	Comprehensive support is available from National Osteoporosis Society (NOS). This includes template job descriptions.
PH Falls Coordinator	Postholder will be employed by CCC (Public Health) and job description/person specification will be evaluated (Hay) by CCC HR and quality assured to ensure parity across the organisation.

[I] IMPLEMENTATION:

I1 – Timescales:

Following business case approval the project will take between 24-60 months to implement (depending on the project), with the earliest project anticipated 'go live' from August 2017.

1. **Falls primary prevention campaign**

Activity	No. Weeks	Dates Start - Finish
Scoping/Design	28	1/4/17 – 13/10/17
Planning Consent	0	n/a
Contracting/Advertising	0	n/a
Delivery Lead-Time	0	n/a
Works/Installation/Commissioning	6 (included in design phase)	n/a
Practical Completion/"Go Live"	3	13/10/17 – 3/11/17
Post-Project Evaluation	6	3/11/17 - 15/12/17
TOTAL	37	1/4/17 – 15/12/17

2. **Enhancement and expansion of strength and balance training provision**

Activity	No. Weeks	Dates Start – Finish
Scoping/Design	4	1/4/17 – 28/4/17
Planning Consent	0	n/a
Contracting/Advertising	12	28/4/17 – 7/7/17
Delivery Lead-Time	5	7/7/17 – 11/8/17
Works/Installation/Commissioning	0	n/a
Practical Completion/"Go Live"	239	11/8/17 – 31/3/22
Post-Project Evaluation	4	31/3/22 – 28/4/22
TOTAL	264	1/4/17 – 28/4/22

3a. Enhancement of Falls Prevention Health Trainer Service - Peterborough

Activity	No. Weeks	Dates Start - Finish
Scoping/Design	6	1/4/17 – 12/5/17
Planning Consent	0	n/a
Contracting/Advertising	12	12/5/17 – 4/8/17
Delivery Lead-Time	8	4/8/17 – 29/9/17
Works/Installation/Commissioning	0	n/a
Practical Completion/"Go Live"	234	29/9/17 – 31/3/22
Post-Project Evaluation	4	31/3/22 – 28/4/22
TOTAL	264	1/4/17 – 28/4/22

3b. Enhancement of Falls Prevention Health Trainer Service - Cambridgeshire

Activity	No. Weeks	Dates Start - Finish
Scoping/Design	0	n/a
Planning Consent	0	n/a
Contracting/Advertising	16	1/4/17 – 21/7/17
Delivery Lead-Time	8	21/7/17 – 15/9/17
Works/Installation/Commissioning	0	n/a
Practical Completion/"Go Live"	236	15/9/17 – 31/3/22
Post-Project Evaluation	4	31/3/22 – 28/4/22
TOTAL	264	1/4/17 – 28/4/22

4. Strengthening falls prevention delivery and integration in the community

Activity	No. Weeks	Dates Start - Finish
Scoping/Design	4	1/4/17 – 28/4/17
Planning Consent	0	n/a
Contracting/Advertising	12	28/4/17 – 21/7/17
Delivery Lead-Time	16	21/7/17 – 10/11/17
Works/Installation/Commissioning	0	n/a
Practical Completion/"Go Live"	228	10/11/17 – 31/3/22
Post-Project Evaluation	4	31/3/22 - 28/4/22
TOTAL	264	1/4/17 – 28/4/22

5. Development and implementation of Fracture Liaison Service

Activity	No. Weeks	Dates Start - Finish
Scoping/Design	42	1/4/17 – 19/1/18
Planning Consent	0	n/a
Contracting/Advertising	12	19/1/18 – 13/4/18
Delivery Lead-Time	0	n/a
Works/Installation/Commissioning	0	n/a
Practical Completion/"Go Live"	206	13/4/18-31/3/22
Post-Project Evaluation	4	31/3/22 – 28/4/22
TOTAL	264	1/4/17 – 28/4/22

6. Public Health Falls Prevention Co-ordinator

Activity	No. Weeks	Dates Start - Finish
Scoping/Design	4	1/4/17 – 28/4/17
Planning Consent	0	n/a
Contracting/Advertising	12	28/4/17 – 21/7/17
Delivery Lead-Time	6	21/7/17 – 8/9/17
Works/Installation/Commissioning	0	n/a
Practical Completion/"Go Live"	82	8/9/17- 31/3/19
Post-Project Evaluation	4	31/3/19 – 26/4/19
TOTAL	108	1/4/17 – 26/4/19

I2 – Implementation Governance Arrangements:

SRO	Catherine Mitchell
Clinical Lead	Dr Angelique Mavrodaris
Project Manager	Public Health Falls Coordinator – with support to be identified within each organisation involved

The project will be overseen by the Cambridgeshire and Peterborough Falls Working Group which currently reports through and is accountable to STP channels (via PCIN and CAG) as well as local Area Executive Partnership Boards and the Ageing Well Strategy Board (HWB).

I3 – Support Services Resources:

The project will benefit from support from Finance and HR functions within each organisation (ie CPFT, CCC) in drawing up the detailed implementation plans. In addition, project support will be welcomed to ensure smooth running pre recruitment. No funding requests have been included in E4 for these elements. SDU to advise.

I4 – Post-Project Evaluation (PPE):

Evaluation and monitoring is a key part of the implementation of this project and the St Ives pilot (Falls Vanguard) has been developing and implementing some of the key components which will lead to the success of this element. An example would be the development of key SystmOne modules to record and report on multifactorial falls assessments. This project has been carried out by pilot staff working with CPFT and CCG informatics leads. The result will be that any county-wide expansion will reap the benefits and monitoring should begin from start of project. In addition, a Falls Dashboard is in development as part of the current evaluation funded separately by PPHES with University of Cambridge staff. This will have identified and refined key data sources eg ambulance callouts and consequences. All training carried out by current specialist nurse has been evaluated in order to inform future expansion. A key element has been the learning logs (lessons learnt) and this approach will be continued to ensure learning is embedded during expansion with University of Cambridge staff.

Timescale for PPE: (Please tick one box below)

3 months	☐	**6 months**	☐	**9 months**	☒

I5 – Deliverables: KPIs/Outcomes and systems for measuring performance of the scheme:

Measure	Definition	Source/ method of collection	Reporting	Comment
Hospital admissions				
Hospital admissions for Injury due to Falls (65-79, 80+)	Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65+ per 100,000 population	PHOF, local SUS	PHOF Annual, local monitoring more frequent as required (quarterly)	
Hip fractures in people aged 65 and over (65=79, 80+)	Age-sex standardised rate of emergency admissions for fractured neck of femur in those aged 65+ per 100,000 population	PHOF, local SUS	PHOF Annual, local monitoring more frequent as required (quarterly)	
Hip fracture including fragility fractures (experimental)	As above with inclusion of codes for fragility fractures (ref OP Outcomes Framework)	Local SUS	As required (quarterly)	
Measure of repeat hospital admissions following an admission for an injurious fall	See Older People Outcomes Framework for definition	Local SUS	As required (quarterly)	Development: Linked data could indicate interventions
Ambulance service				
Number of ambulance callouts for fall by locality				
Number and % of conveyances				Development: Linked data could indicate admissions

A&E attendances

Number and rate of A&E attendance by acute Trust where a fall is identified as being cause of admission		*Placeholder		Explore whether coding in A&E sufficient to identify falls

Neighbourhood Teams

Multifactorial assessments	Definition	Source/ method of collection	Reporting	Comment
No. of referrals for multifactorial falls assessments received by Neighbourhood Team (broken down by	No. of referrals in to health for falls management and prevention	*Placeholder		Explore possibility
No. of multifactorial assessments completed by Neighbourhood Team (broken down by staff group)	No. of assessments completed	*Placeholder	Monthly	Beginning Feb 2017

Multifactorial intervention signposting and referral (by sour	Definition	Source/ method of collection	Reporting	Comment
No. of referrals for:				
Strength and balance training and motivational support from Falls Prevention Health Trainers		*Placeholder		Explore possibility
Medication Review		*Placeholder		Explore possibility
Home Safety Assessment		*Placeholder		Explore possibility
Vision assessment		*Placeholder		Explore possibility
Cardiac assessment		*Placeholder		Explore possibility
Urinary incontinence		*Placeholder		Explore possibility
Osteoporosis		*Placeholder		Explore possibility
Assistive Technology?		*Placeholder		Explore possibility

GP Practices

Multifactorial intervention signposting and referral (by	Definition	Source/ method of collection	Reporting	Comment
No. of referrals for:				
Strength and balance training and motivational support from Falls Prevention Health Trainers		*Placeholder		Explore possibility to monitor via read codes
Medication Review		*Placeholder		Data development agenda
Home Safety Assessment		*Placeholder		Data development agenda
Vision assessment		*Placeholder		Data development agenda
Cardiac assessment		*Placeholder		Data development agenda
Urinary incontinence		*Placeholder		Data development agenda
Osteoporosis		*Placeholder		Data development agenda
Assistive Technology		*Placeholder		Data development agenda

Health Trainers

Measure	Data collection in place?	Source/Method of collection	If no, when?	Reporting
No. of referrals from NT to Falls Prevention Health Trainers for falls multifactorial assessment	n	Placeholder	Explore possibility	n/a
No. of referrals received by Falls Prevention Health Trainers	y	Everyone Health KPI	n/a	monthly
No. of multifactorial assessments completed by Falls Prever	y	Everyone Health KPI		monthly
No. of personal health plans written with falls prevention go	y	Everyone Health KPI		monthly
No and % of clients achieving the falls prevention goals	n	Placeholder	Explore possibility	n/a
No and % of clients who attend strength and balance classes	n	Placeholder	Explore possibility	n/a
No. and % of people completing 6 weeks of strength and bal	n	Placeholder	Explore possibility	n/a
No. of people referred to RightStart to continue strength an	n	Placeholder	Explore possibility	n/a
No. of people engaged in RightStart strength and balance cla	n	Placeholder	Explore possibility	n/a
No and % of clients who demonstrate an increase in strength after participation in the Falls Prevention Health	n	Placeholder	Explore possibility	n/a

Measure	Definition	Method of collection		Reporting
Neighbourhood team training process measures				
No. and % of Neighbourhood staff receiving falls prevention training (by staff group)	No. neighbourhood team staff trained as % of Total no. of neighbourhood staff in NT	After each training session		Monthly
	As above: Occupational Therapists	After each training session		Monthly
	As above: Physiotherapists in NT	After each training session		Monthly
	As above: District Nurses in NT	After each training session		Monthly
	As above: CPNs in NT	After each training session		Monthly
No. and % of participants rating the training as good or excel	No. of participants rating as good or excellent as % of Total no. of evaluation forms completed	Post training evaluation form after each training session		Quarterly
No. and % of participants reporting that the training improved their knowledge, skills and confidence to screen and identify those who have fallen or at risk of falling (by	No. of participants reporting improvement as % of total evaluation forms	Post training evaluation form after each training session		Formative/at end of pilot
No. and % of participants reporting that the training improved their knowledge, skills and confidence to conduct multifactorial falls risk assessments (by staff	No. reporting improvement as % of total evaluation forms	Post training evaluation form after each training session		Formative/at end of pilot
No. and % of participants reporting that the training improved their knowledge, skills and confidence to refer/signpost patients to sources of help as detailed in the	No. of participants reporting increased K,S &C to signpost on as % of total evaluation forms	Post training evaluation form after each training session		Formative/at end of pilot

[J] RISKS & OPPORTUNITIES:

J1 – Implementation Risks & Opportunities:

Opportunities:

- To deliver an integrated falls service to achieve better outcomes for patients and a saving to the system
- To ensure that we are in a good position in 2018/19 to implement a Fracture Liaison Service which will again improve patients that have experienced a fall to have a better service provision and prevent repeated fractures which will also lead to a saving to the system
- To use falls and fractures as one of the key conditions to test joined up data and information across the system.

Risks:

- Falls prevention efforts are unlikely to be successful unless they are sustained at a systems level. The opportunities identified to deliver cost-effective interventions and outcomes among our older populations at risk of falling are not simply stand-alone strategies. Rather, they comprise component parts that ideally, interact synergistically to create an effective falls prevention system that will make a real difference in an area that causes pain and distress to many people every day.
- Communication channels does not reach targeted audience
- Patient engagement
- Recruitment and retention of staff
- Information systems do not currently lend themselves to analyses that contribute to better understanding of the whole patient journey across the system and the trigger events at which point an intervention could be made. There are many elements in this proposal which would benefit from such an approach.
- One of the difficulties with this proposal and separate components in the intervention is the ongoing need to establish and review at what scale the intervention needs to be operating in order to achieve the desired outcomes (and savings). The Falls Pilot has begun to generate information and this needs to continue in order to contribute towards estimating the scale required (eg training; multifactorial assessments; other)
- The Falls Pilot (Vanguard) has highlighted a risk if therapy teams do not take on the new systems and processes. Learning from the pilot will be applied in wider implementation.

[K] STAKEHOLDER ENGAGEMENT:

K1 –Stakeholders Engaged During Business Case Development:

Name	Title	Representing	Internal / External
Karen Hurst	AHP Lead for Integrated Care Services Directorate	CPFT	
Jackie Riglin	Falls Prevention Clinical Lead	CPFT	
Val Thomas	Consultant in Public Health	Public Health, Commissioner of Everyone Health	

All of the above stakeholders have received and reviewed the latest version of this business case and have consented to its submission.

The project has engaged with the following internal and external stakeholders

- Formal STP process

- Falls Prevention Working Group
    - Cambridgeshire & Peterborough Foundation Trust (CPFT)
    - Cambridgeshire County Council (CCC)
    - Peterborough City Council (PCC)
    - Cambridgeshire & Peterborough CCG
    - Peterborough VCS
    - Institute of Public Health, University of Cambridge (evaluation)
    - Cambridgeshire Fire and Rescue Service,
    - RightStart
    - All five District Councils in Cambridgeshire
- St Ives Falls Prevention Pilot Operational Group
    - CPFT, CCC, CCG, Institute of Public Health, Everyone Health, RightStart, Local Pharmaceutical Committee

In addition feedback on the proposals has been sought and received from the following stakeholders:

- Area Executive Partnerships
- Healthwatch
- District council providers
- Falls Working Group (see below) and St Ives Pilot Implementation Group (see below)

[L] RECOMMENDATION:

The Falls Prevention Workstream seeks approval to invest the following STP NHS funding:

Year 1: £260,617
Year 2: £397,770
Year 3 and recurrent: £511,000
In this proposal for a CCG wide falls prevention programme.

In years 1 and 2 this will be pump primed by an additional £240k investment from Cambridgeshire County Council and Peterborough City Council public health funds

The Committee is asked to approve the investment in this proposal and to commit to integrated and joint working to implement this proposal.

[M] DUE REGARD SCREENING:

Please note this will be reviewed as part of the update to the 2015 assessment (CCC). It is currently covered by the 2015 assessment and will be revised into STP format following SDU advice,

Impact (please indicate Yes or No for each question)	Race/Ethnicity	Sex	Religion or Belief	Gender Reassignment	Sexual Orientation	Age	Marriage & Civil Partnership	Pregnancy & Maternity	Disability
Do different groups have different needs, experiences, issues and priorities in relation to the proposed change?	N	N	N	N	N	Y	N	N	N
Is there potential for or evidence that the proposed change will not promote equality of opportunity for all and promote good relations between different groups?	N	N	N	N	N	N	N	N	N
Is there potential for or evidence that the proposed change will affect different population groups differently (including possibly discriminating against certain groups)?	N	N	N	N	N	N	N	N	N
Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular group or groups?	N	N	N	N	N	N	N	N	N

Note that if any box contains a 'Yes' then a full DUE REGARD assessment is required to be undertaken. (see note above)

[N] REVISION HISTORY:

Version	Date	Amendments	Authored/Approved By
1	3/3/17		Jodie Hills
2.1	6/3/17	Yes	Helen Tunster/Jill Eastment
2.2	7/3/17	Yes	Helen Tunster/Jill Eastment (Joanne Fallon reviewed)
2.3	8/3/17	Yes	HT/JE/Angelique Mavrodaris
2.4	8/3/17	Yes	As above and incorporating Liz Robin comments
2.6	9/3/17	Yes	Edits and comments from LR and Angelique Mavrodaris incorporated. SRO comments.
3.0	9/3/17	Yes	SRO and Executive Sponsor signed off and sending to SDU
3.1	9/3/17	Yes	Final comment incorporated (LR)
3.2	9/3/18	Yes	Table 1 corrected (JE) and resubmitted

This template should be used for all investment bids (both Capital and Revenue), in accordance with relevant Organisation's SFIs.

[O] SIGN-OFF TEMPLATE

BUSINESS CASE SIGN-OFF

Business Case Title:

Author:

Date:

Function	Name	Title	Approved	Rejected	Approved "subject to"	Comments (please explain reasons for approval, rejection and "subject to")	Signature	Date
Business Case Lead		Manager						
Clinical Lead		Clinical Lead						
Executive/ SRO Lead		Director						
Finance		Finance Lead						
HR/ Medical Staffing		HR/ Medical Staffing Lead						
Contracting		Contracting Lead						
Estates		Estates Lead						
IT		Head of IT						
Impact Assessment		Impact Assessment Lead						

SYSTEM WIDE BUSINESS CASE				Fit for the Future Working together to keep people well
Reference Number:				
Date:		**Version:**		
Business Case Title:	**Intermediate Care Tier including Discharge to Assess**			
Organisation(s) submitting business case:	Cambridgeshire and Peterborough CCG			
STP Work Stream / Directorate	Urgent and Emergency Care			
Authors:	Sara Rodriguez-Jimenez			
SRO:	Ruth Derrett			
Executive Sponsor:	Roland Sinker			
Senior Finance Manager Comments:	*This is to be completed by the Senior Finance representative responsible for reviewing bids prior to submission to the Exec Team / relevant committee for approval*			
Executive Team / Committee Meeting Comments:	*This is to be completed by the Exec Team / relevant committee reviewing the Business Case to capture the outcome of the review.*			

Guide to complete (and submit) your business case:

This document provides a template for all Business Cases. Please complete every section using the guidance as highlighted.

Be clear and concise.

Where relevant, try to articulate the case in terms of three core areas; Clinical effectiveness, Patient Experience and Safety.

Where necessary, involve specialists e.g. from finance, and proposed project work-streams to provide business case information including costs, risks, benefits and assumptions.

Include a paragraph in the Conclusion and Recommendations section explaining the decisions the committee are being asked to make.

Once completed, arrange for the business case to be reviewed by a peer and agreed by the Executive Sponsor before submission to the relevant board. Allow enough time for key people to review drafts, to support getting the business case right before it goes through the formal approval process.

Section Guidance is given in italics

[A] EXECUTIVE SUMMARY:

A1 – Purpose

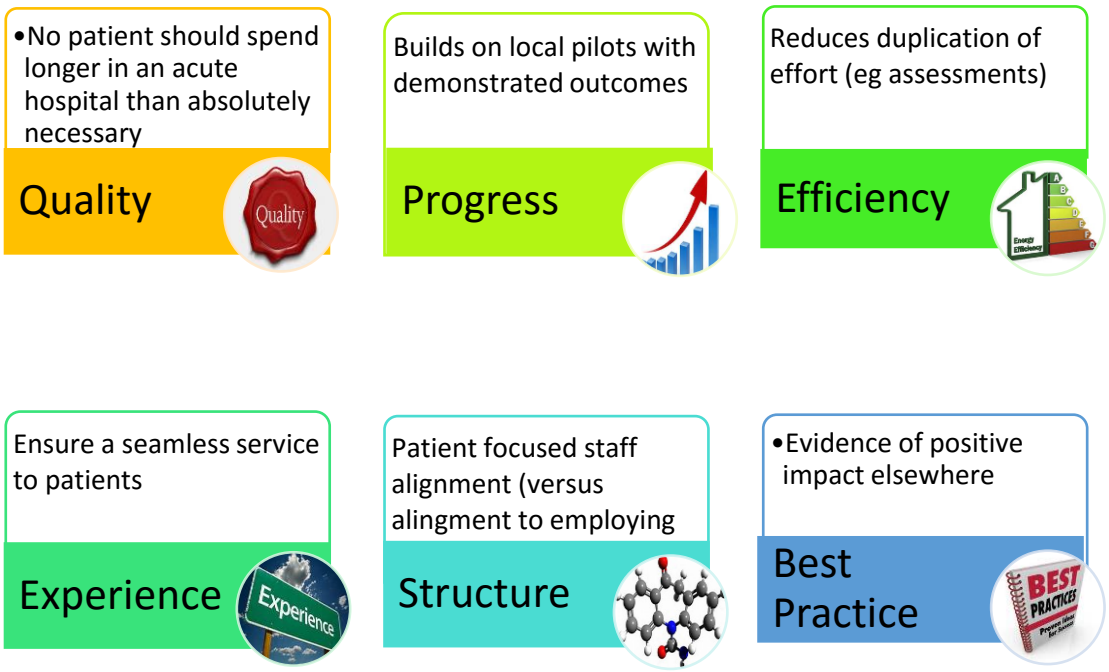
This proposal sets out how the local system can address the mismatch between patient need and demand and provision of community intermediate care services, with a particular emphasis on home support services.

Intermediate care comprises a number of services that is wider than solely community inpatient beds. Intermediate care was initially introduced to target elderly people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long-term residential care or continuing in-patient care. It is understood as being time-limited.

The local system is currently heavily dependent on acute and community bed based solutions and therefore there are missed opportunities to meet the needs of patients with home support to the levels required, resulting in unnecessary delayed transfers of care, and subsequent impact on patients' potential for deconditioning further while waiting.

This imbalance can only be reduced by investing and developing a comprehensive intermediate care tier offer, strengthening home based services. The preference is for patients to go back to their own home, however it is recognised sometimes this may not be possible for a number of reasons and therefore it is key that going forward community pathways are simplified into three main care pathways that provide the right mix of home based services, community rehabilitation beds, and residential / nursing home care for more complex patients.

This is also an opportunity for the system to establish a more integrated discharge support service in community that delivers the following ambitions:



To achieve this, the work stream is seeking investment to allow for the establishment of an Intermediate care workforce which would support the delivery of Discharge to Assess pathways for patients that are medically fit. The benefits to the system are inclusive of:

- Reduction in Delayed Transfers of Care
- Improved Patient Flow.
- Improved clinical outcomes
- Improved Patient outcomes and experience
- Reduced hospital falls and Hospital born infections
- Reduction in elective sourcing in the private sector
- Reduction in elective cancellations and improved RTT

A2 – Driver for Change

The Starting Point

- **Population Growth:** Cambridgeshire and Peterborough is facing increasing demand for local health and care services. It has a rapidly growing and ethnically diverse population that will be 20% higher by 2031.

- **Insufficient community capacity:** there is insufficient resource in community for the system to support complex discharges from hospital at the rate that it should, with demand for health and social care services (including long term placements) currently outstripping supply.

- **Clinical evidence:** There is much evidence of the benefits of delivering care at or closer to home. A recent national audit (2014) reported that the average waiting time for a place in an intermediate care service is currently 6.5 days – higher than in previous years. A wait of more than two days negates the additional benefit of intermediate care, and seven days is associated with a 10% decline in muscle strength which is a disadvantage for people with frailty for whom muscle weakness is a defining characteristic.

- **Pressures on patient flow and performance:** Acute hospitals in Cambridgeshire and Peterborough are under considerable and continuing pressure to meet the demands of unplanned care. The hospitals are regularly prone to black alert without available beds, long A&E waits, high outliers, and high average lengths of stay (ALOS). The system is failing to meet national standards and at times the quality of patient care is at risk.

- **The current approach leads to duplication and pathway delays:** the system doesn't have a single point of exit for complex discharges. The current system is not working effectively, often consumed by paperwork and process of "transfer of care", facing many obstacles and barriers as patients transfer through different services and teams.

Evidence from Case Studies / Pilots

Discharge to Assess has been successfully implemented across the country in a number of sites and has also been successfully trialled locally to support discharges from hospital. A summary of findings from national and local pilots is included in **Appendix A.**

National Direction of Travel

In May 2016 the National Audit office (NAO) reported its findings on discharging older patients from hospital. It reported nearly two thirds of hospital bed days being occupied by people over 65 with an 18% rise in emergency admission for older people in the last four years. The NAO also reported 1.75 million hospital bed days being lost due to delays in transfer of care in 2015, with an estimated 4.2 million bed days occupied by people no longer in need of acute hospital care.

The NAO described older people stranded in hospital when they no longer need to be there. It has been estimated that 10 days of bed rest for healthy older people can equate to 10 years of muscle ageing with attendant loss of function.

Staying in hospital has negative consequences for patients, especially the frail elderly who will experience physical decline, loss of mobility, their ability to function as they did before admission as well as a loss in confidence. It also impacts on patients who are unable to access beds occupied by those medically fit for discharge. Therefore, we need to ensure people are in hospital only for as long as they need acute medical and nursing care. Assessment for longer -term care and support needs should be undertaken in the person's own home (where possible) or another community setting.

This means patients no longer wait in hospital for these assessments, which reduces delayed discharges and improves patient flow. This challenges the current model of OT and PT assessment within the acute hospital, which has traditionally been based around the 'Assess to Discharge' model.

A3 – Alignment with Organisation or System Priorities

Priorities for change	10-point plan
At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs
Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care
Together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 10. Using technology to modernise health

A4 – Brief Outline of Proposal

Our ambition is to provide a comprehensive suite of services that provide truly integrated intermediate care in community for patients in Cambridgeshire and Peterborough. In doing this we need to embed pathways that focus on supporting discharges from hospital to the patients' home when clinically appropriate. The proposed model of care therefore needs to encompass the full range of intermediate care services. It is widely understood that long stays in hospital for older people once they are medically fit can result in significant muscle loss, deconditioning, loss of independence and confidence, and increased risk of infection. The evidence points to the significant benefits to patients returning to the life they had before through a shorter stay in hospital followed by discharge to their own home when appropriate with the right support package to meet their needs.

At present the capacity to provide home based health services is not formally commissioned. It has grown ad hoc to build system resilience over the winter and respond to increases in demand to support discharges of older and frail patients. Home capacity is provided mainly by the independent sector which - although responsive and a good alternative to bridge gaps in provision- can be expensive. It is also harder to achieve effective integration across services if the provider landscape is too diverse, and capacity taken from the independent sector for intermediate care puts further pressure on the pool of capacity available to the system for long term placements.

There are also variations as to how Discharge to Assess is being applied in different localities, and hospitals often find the large plethora of services and community pathways confusing and difficult to navigate effectively.

Our aim is to move the system from the current set up to a more effective and consistent approach, with a simplified number of community pathways to facilitate supported discharges from hospital. The figures below show a graphic representation of the current and proposed set ups:

Figure A: current pathways

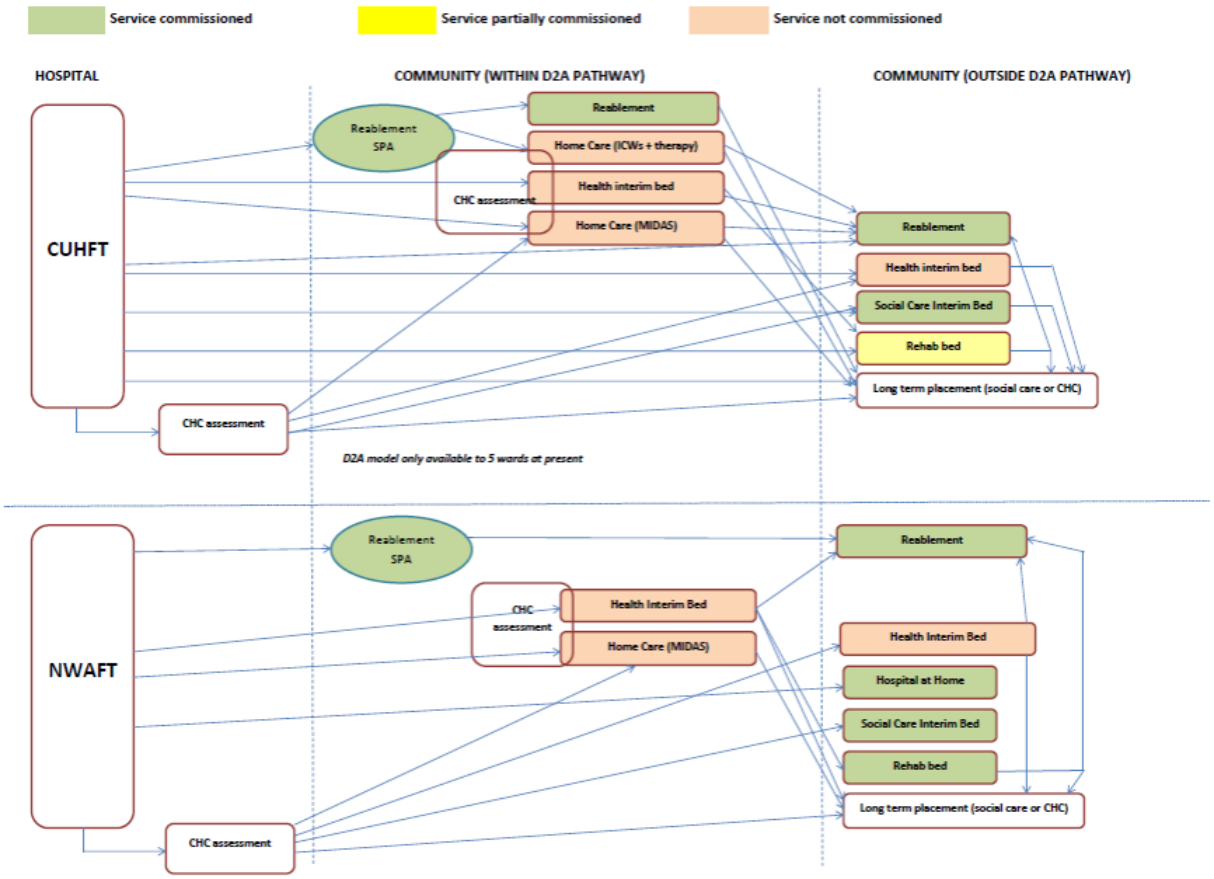
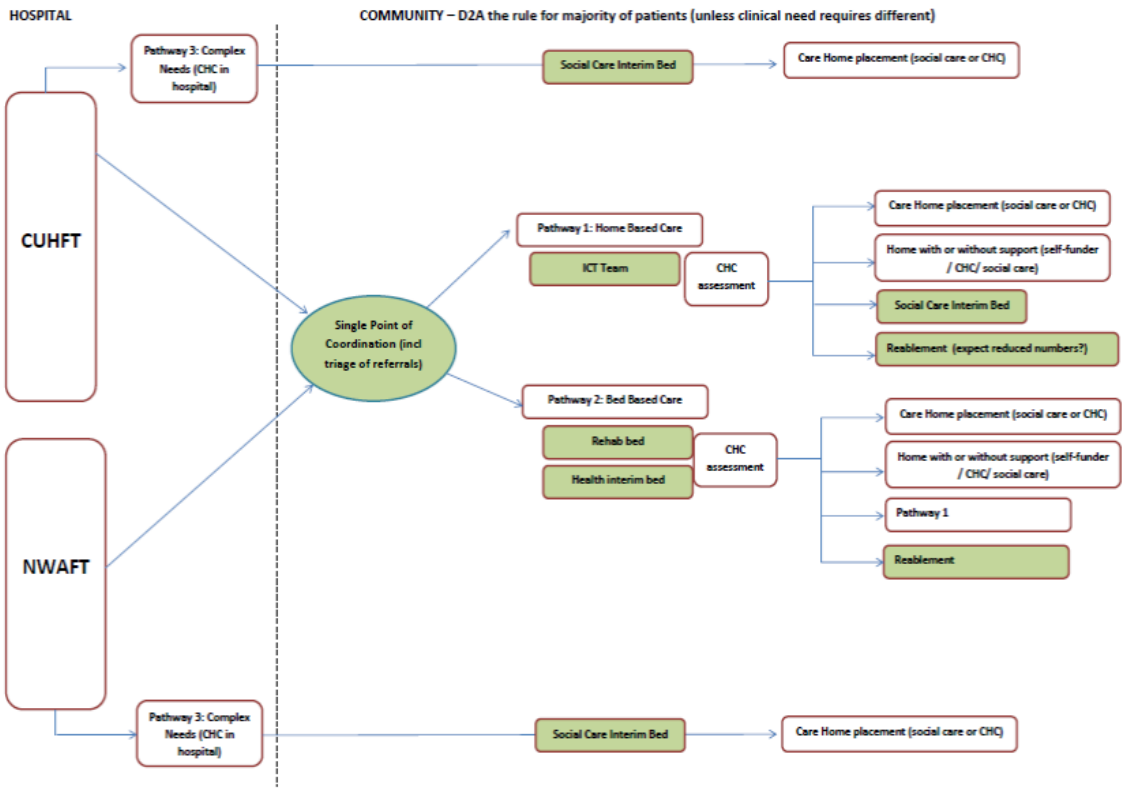


Figure B: Proposed Pathways



To make the transition from A to B as set out above, we need to deliver the following key elements:

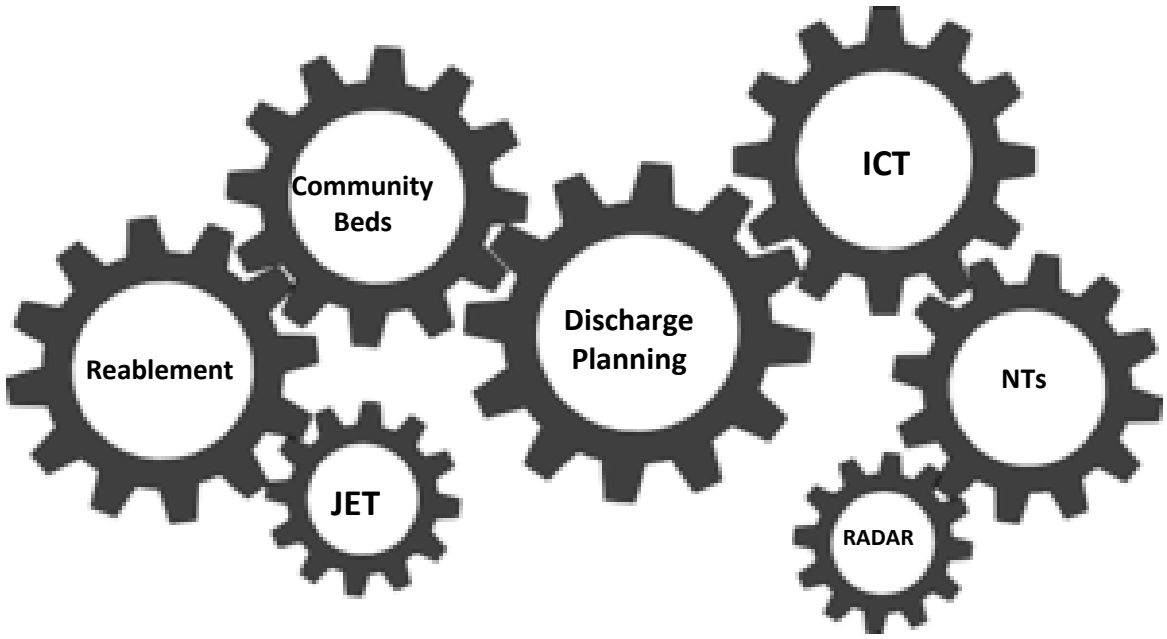
1. Development and implementation of a Single Point of Coordination (SPOC) to coordinate referrals into appropriate community services;
2. Development of a home based Intermediate Care Tier;
3. Improved utilisation and patient flow through existing bed based services;
4. Simplifying discharge pathways and implementing the full roll out of the Discharge to Assess approach across Cambridgeshire and Peterborough; and
5. Achieving greater integration across community services.

Services in Scope

- SPOC
- Intermediate Care Home Based Support (therapy & Integrated Care Workers)
- A proportion of reablement capacity (as part of the work in developing an integrated workforce)
- Community inpatient beds

Dependencies with other services – the full patient pathway

Intermediate care should be seen as a stage in overall care, not as an isolated service. It can help patients to stay independent for as long as possible and help identify the long term support needed after an accident or illness. It is a "cog" in a complex system of interconnected services in and out of hospital:



Recent work has been undertaken to reconfigure existing community services to develop multidisciplinary, locally-based community health and social care services, working closely with primary care. In addition a number of business cases have been put forth to expand capacity in other services with a particular focus in admission avoidance. We now need to take this to the next stage to establish a resilient intermediate care tier that can provide home-based services through Integrated Care Workers (ICW), and intensive rehabilitation services (therapy) better integrated to the robust reablement service provided by the local authorities to form the intermediate tier.

It is recognised that a number of health and care professionals are key to a number of services whether focused on admission avoidance or supported discharge (e.g. HCAs / Integrated Care Workers, therapists, OTs, nurses). Integrating teams around disciplines will enable the system to get greater economies of scale, and will support the provider of community services to manage workforce in a most effective manner. It will also avoid any potential duplication or double counting of workforce when developing proposals for future investment.

What will be different as a result?

Successful implementation of this proposal will deliver:

- Integrated ways of working in the community across health and social care
- Economies of scale through sharing workforce to support patient needs more effectively and appropriately
- Capacity agility to enable the system to flex capacity to reflect the demand of service
- Ownership of a complete patient pathway outside hospital and an objective overview of that collectively represents the patient
- A true Single Point of Coordination to access community services with clinical input to ensure patients' needs are matched to capacity
- Long term benefits to help us address social care and health capacity challenges

A5 – Financial Impact and Outcomes

The development of an Intermediate Care service including a single point of access to enable better coordination between agencies / services in providing a comprehensive approach to complex discharges will reduce bed days and Delayed Transfer of Care. The proposal will support the system to reduce length of stay in hospital and provide a safer, clinically effective pathway for patients.

A breakdown of expected financial savings resulting from implementation of the preferred option is provided in section E2 of this business case.

A6 – Sponsorship

The project team has engaged with the following internal and external stakeholders to secure sponsorship of the proposal:

- Cambridgeshire and Peterborough Clinical Commissioning Group
- Cambridge University Hospitals NHS Trust
- Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridgeshire Community Services NHS Trust
- Hinchingbrooke Health Care NHS Trust
- Papworth Hospital NHS Foundation Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust
- Cambridgeshire County Council
- Peterborough City Council

In addition, representatives from local general practices, East of England Ambulance Service NHS Trust, Hunts Forum, Peterborough Voluntary organisations, NHS Improvement, Emergency Care Improvement Programme (ECIP) and patient representatives have actively participated in developing solutions and are key partners for implementation.

A7 – Quality Outcomes

The implementation of the model will improve the experience of patients and carers as follows:

- Putting patients first with decisions about their long term care made within an environment familiar to the patient, it is 'context specific' and the patient's immediate and longer term needs can be more appropriately evaluated.
- Patients will see faster response times to care needs, as well as wider choice of alternative services to cater to their needs.

- Seamless care provision. Patients will benefit from greater availability of assessment services in the community leading to reduced dependency over time.
- Services targeted at encouraging self-care, promoting healthier living and providing activities in a home or community setting will dramatically improve the wellbeing of patients.
- Patients' outcomes will improve as more people will be able to live at home for longer. Length of stay in hospital will decrease thus reducing risk of deconditioning

It will also deliver the following benefits:

- Facilitating better integration across teams and providers, and breaking-down demarcation lines between professionals and multi-skilling to improve care.
- Releasing time to care with less time spent by referrers navigating services in an urgent care situation.
- Common outcomes to referral eligibility criteria and access to care.
- Prompt and appropriate professional advice to referrals from healthcare professionals / clinicians within the community.
- Removal of unnecessary steps, processes and delays in the discharge process with consume valuable resources and do not add value to the patient.
- Reduction in length of stay and Delayed Transfers of Care.
- Improvement in patient flow through hospital, thus enabling other patients to access acute care at the time they need it.
- Sharing responsibility, risks and skills across partners will lead to innovative and creative solutions that deliver safe, effective care and support.

A8 – Recommendation

Partner organisations are asked to approve investment as set out in section E of this business case from 1st April 2017.

[B] DRIVER(S) FOR CHANGE:

B1 – Risk or Opportunity

Cambridgeshire and Peterborough system partners have an opportunity to redress the current imbalance between investment in community capacity (particularly home based support) and patient demand. This business case puts forth a proposal that will restore that balance whilst enabling the delivery of the vision set out in our Sustainability and Transformation Plan (STP). We can do this by:

1) Increasing the ability of community services to respond to demand for care and support for patients in their own home / place of residence;
2) Optimising the utilisation of our existing community inpatient bed stock; and
3) Improving the speed with which people are safely discharged from hospital.

B2 – Strategic Context

Background and Strategic Ambition

The demand for health and care services is growing, associated with the rising age profile of the population and the increasing number of people living with long term conditions. The number of people aged 85 and over is expected to double over the next two decades.

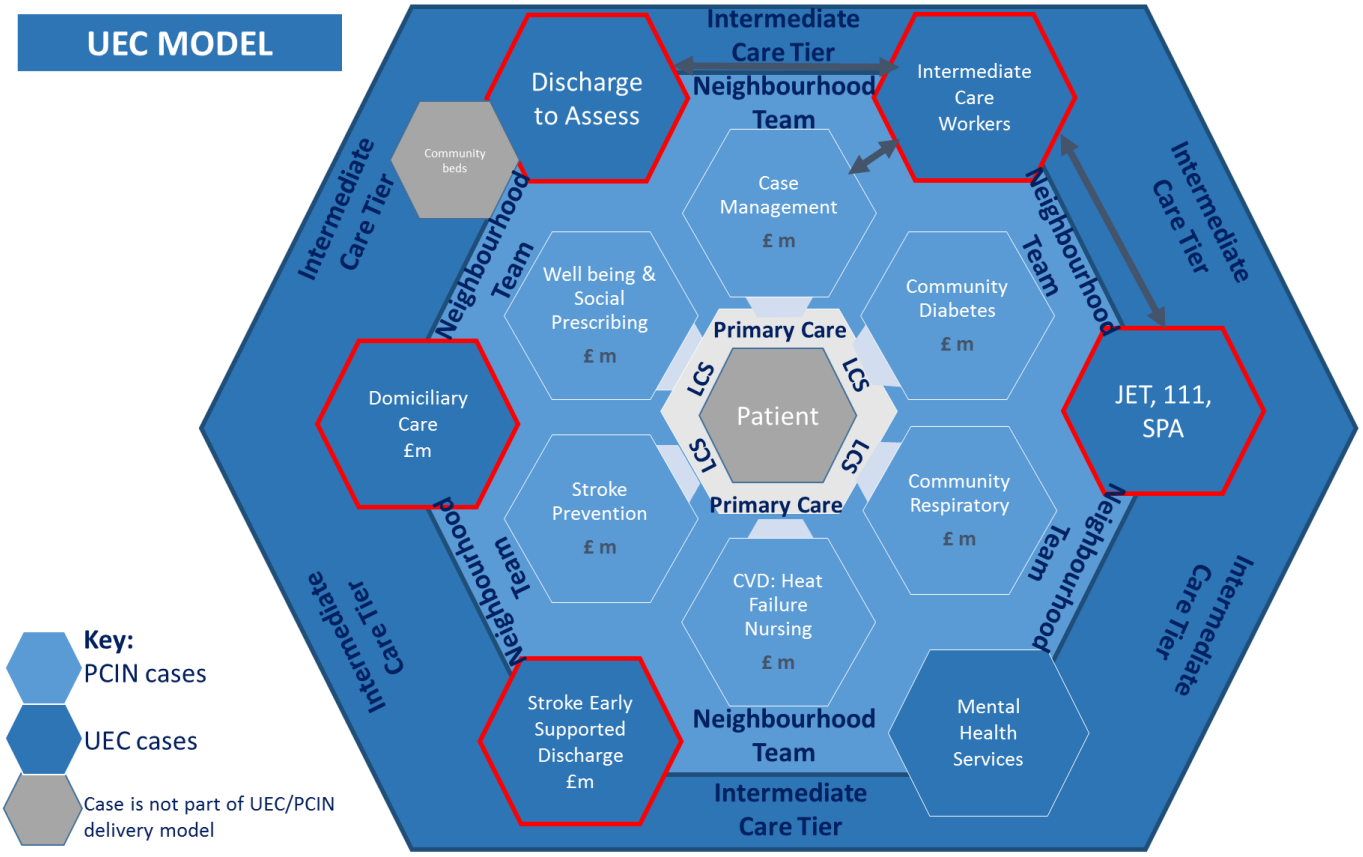
Between 2013 and 2031, the Cambridgeshire population is forecast to grow by 22.7% and Peterborough by 24.3%. In terms of the elderly population, there is expected to be substantially higher growth: 55.5% in Peterborough, and over 60% in Cambridgeshire. As elderly people are more likely to have chronic, long-term conditions, their needs from the services will change. It has been reported that older people with multiple

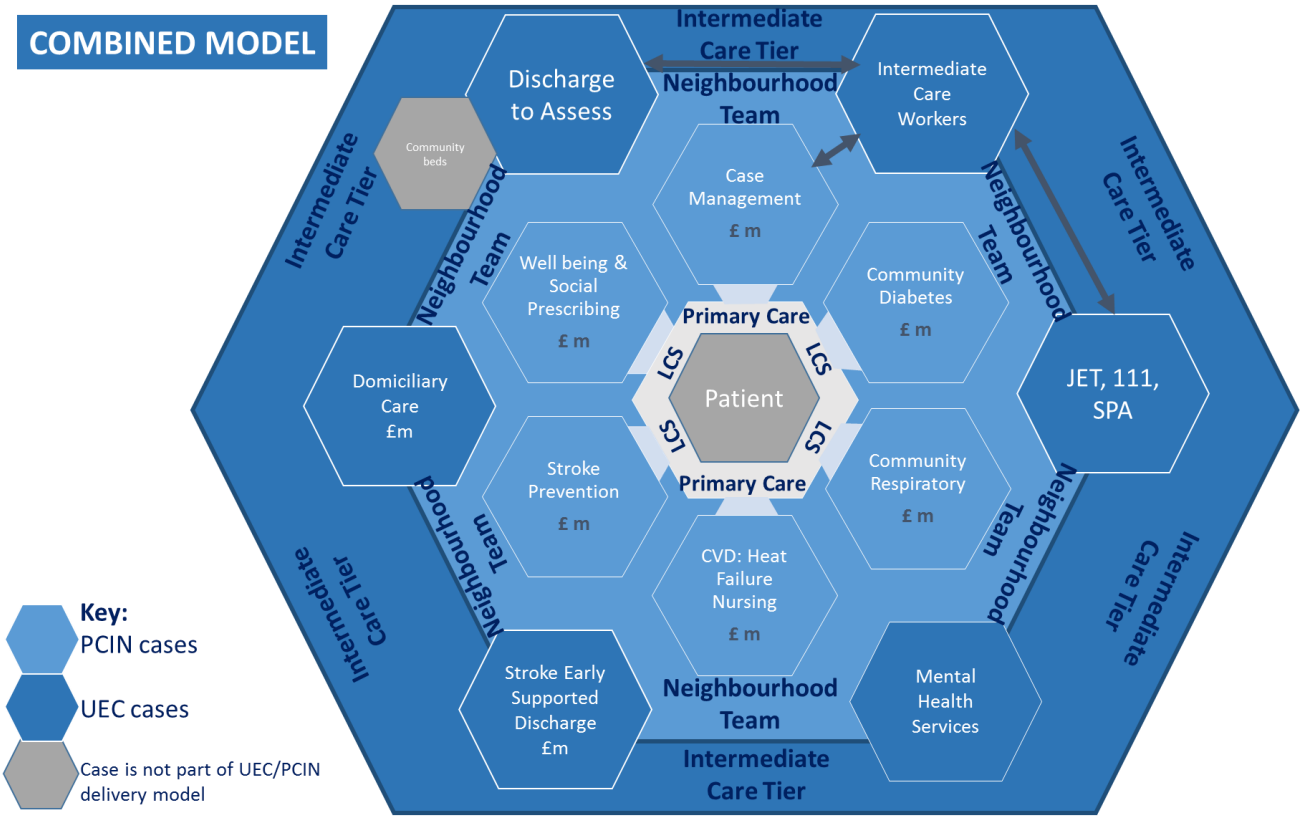
conditions, frailty or dementia, requiring complex and coordinated health and social care, currently account for 50% of NHS resources.

We need to transform our approach to providing intermediate care services in a community setting if we are to provide high quality services that are both clinically and financially sustainable. The system also faces significant financial challenges. Our ability to deal with the full scope of demand for health and social care services is limited and we need to radically change existing pathways of care to place a much stronger emphasis on:

1) Strengthening the capacity of our community services to support patients in their own place of residence;
2) Reducing the length of the stay patients spend in an acute setting when they no longer require acute care; and
3) Improving the outcomes for patients who can enjoy a longer period of independent living through front loaded rehabilitation and support interventions in their own home / place of residence whenever possible.

The system is already fully committed to greater integration as a key part of the future we envisage: which is for proactive, seamless care delivered through a person-centric care model, far from the disjointed, organisation-focused care which too many people currently receive. All the elements in the system are connected and rely on each other to operate successfully as an effective health and social care system.





B3 – Risk Assessment (only applicable if responding to a risk as identified in B1):

The proposal put forth is designed to redress the balance of community provision. The risk of not doing so is the system will continue to fail to meet levels of demand for support services outside an acute setting, potentially putting patient care at risk, putting further downward pressure on the performance of providers, and making it difficult for the system to maximise the outcomes and impact of investment in existing services.

[C] ALIGNMENT WITH ORGANISATION or SYSTEM PRIORITIES:

C1 - The proposed investment aligns to the following elements of the organisational or system priorities:

STP Priorities:

Priorities for change	Commitment
At home is best	• Community based rapid response to deteriorating patients • Introduction of home first discharge to assess model • Review of community bed-based and non bed-based provision.
Safe and effective hospital care, when needed	• Reduced delayed transfers of care • Consistent urgent and emergency care in right place

CCG Improvement and Assessment Framework:

Better Health	
Health inequalities	Inequality in avoidable emergency admissions
Better Care	
Urgent and emergency care	Achievement of milestones in the delivery of an

	integrated urgent care service
	% of patients admitted, transferred or discharged from A&E within 4 hours
	Delayed transfers of care attributable to the NHS per 100,000 population
	Population use of hospital beds following emergency admission
Sustainability	
Allocative efficiency	Outcomes in areas with identified scope for improvement
New models of care	Adoption of new models of care
Leadership	
Sustainability & Transformation Plan	Sustainability and Transformation Plan Delivery

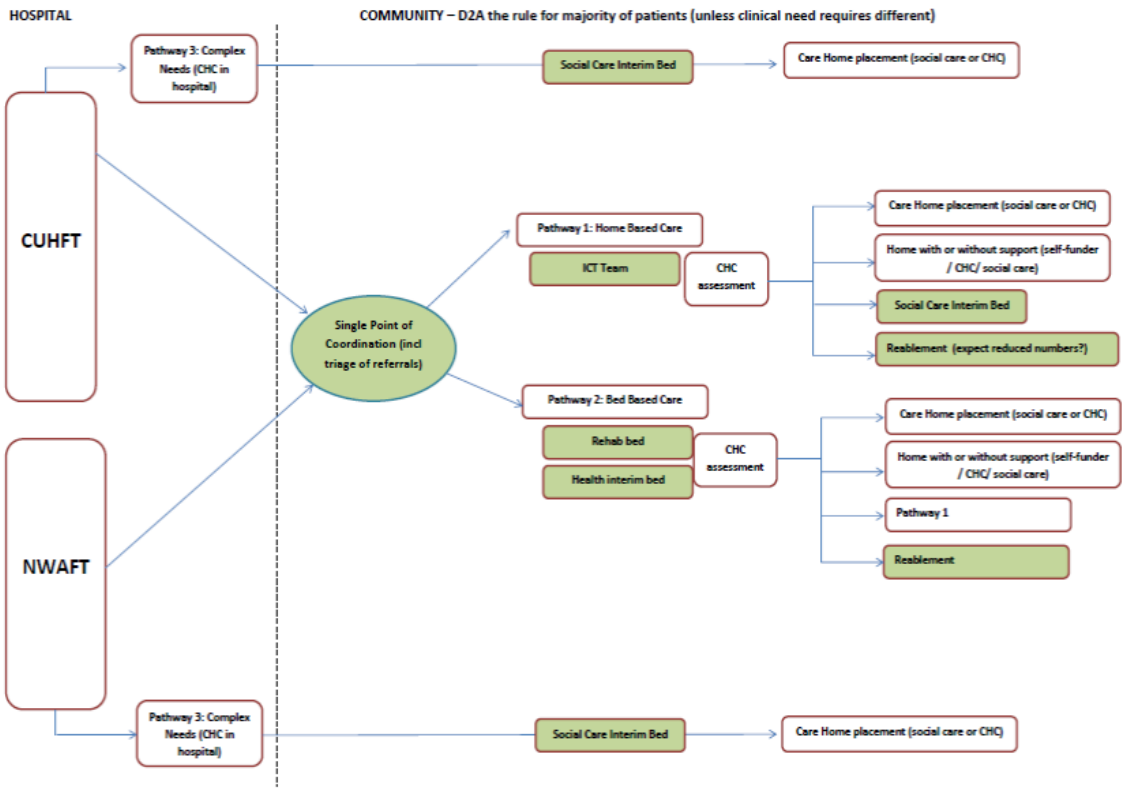
D] OUTLINE PROPOSAL

D1 - The Preferred Option

The preferred option is to set up a comprehensive and effective set of intermediate care services in the community, with effective overall coordination and pathway management. This requires the following:

- Development and implementation of a Single Point of Coordination (SPOC) to coordinate referrals into appropriate community services;
- Development of a home based Intermediate Care Tier;
- Improved utilisation and patient flow through existing bed based services;
- Simplifying discharge pathways and implementing the full roll out of the Discharge to Assess approach across Cambridgeshire and Peterborough;

Proposed Pathways



The Single Point of Coordination (SPOC)

To get economies of scale the proposal is to have a SPOC across the CCG, albeit some of the operational teams delivering intermediate care services will need to be split across the geography to be closely aligned to local services.

This SPOC will help professionals arrange the right care for referrals. It would operate as a "transfer of care bureau" supporting patients to receive appropriate care at home or as close as home as possible; and to prevent inappropriate hospital attendances and admissions through clinical navigation and integrated teams. The main functions will include:

- Act as the single point of access into the relevant community services;
- Triage referrals to the most appropriate service based on clinical review of information received from referrer;
- Respond to calls within clear and agreed timeframes working to agreed referral deadlines;
- Hold the knowledge of available community services and capacity levels;
- Hold and manage the overarching intermediate care tier patient flows and patient transfer list, proactively escalating delays in discharges from the relevant pathways;

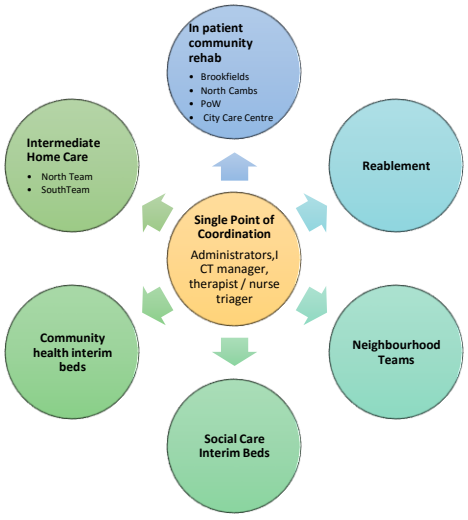
Referrals into the service will be accepted from a number of professionals as set out in the table below:

"Step Up" Care	**"Step Down" Care**
General Practitioners	Hospital Discharge Planning Teams
Community Matrons	A&E / Emergency Care Clinicians
Community Specialist Nurses / Teams*	
District Nurses*	
JET Practitioners*	
Social Care Services*	

**following consultation with GP or specialist consultant regarding patient condition and needs*

The SPOC will provide access into the following services[1]:

- Reablement
- Intermediate Home Care (ICWs and independent sector where appropriate)
- Community beds (rehabilitation, and interim)
- Social care interim beds
- Neighbourhood Teams



[1] Additional services can be added to the SPA if/where appropriate during future phases of service development if the system determines this to be the best approach

The Intermediate Care Tier

An effective model of care has to encompass a full range of intermediate care services to be able to support patients at home first but also offer alternatives for those patients for whom going back home is not an option right away. The proposed model of care for supported discharge will have three main community pathways supporting patients with different levels of dependency:

- Pathway 1: Home with support
- Pathway 2: Rehabilitation in a bedded facility
- Pathway 3 Long term care/ very complex care needs

The overarching principle of these pathways is that patients should always be cared for at home provided this pathway can meet their needs focusing on improving and maintaining their independence. All pathways should enable patients to rehabilitate fully (within their own potential) in the most appropriate setting. All assessments – including assessments for continuing health care needs - should be done in the community pathways rather than in hospital – with a very few exceptions. This would enable the system to have a consistent approach to **Discharge to Assess.**

Pathway 1: Home with Support

Patients that can go home with additional support are discharged home and receive ongoing support at home for a limited period. Support interventions can include nursing, therapy, care, or any service that will enable the patient's recovery to greater independence. The intensity of the service depends on the patients' needs.

Patients will be assessed at home following their discharge and will have therapy assessment within a 24 hour window to ensure the support package is tailored to the patient's needs.

This pathway is supported by therapies, social workers, integrated care workers (ICW's -Band 2/3) and discharge planning nurses, thus creating a rue intermediate care suite of health and/or social care services that can support early discharge from, or prevent unnecessarily prolonged stays in, hospital as well as supporting early discharge from community hospital rehabilitation units working alongside other community teams.

This service has to be integrated with the existing reablement services 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.

The voluntary sector will also have a key role to play in this pathway as they offer key complementary services to support patients at home.

Pathway 2: Rehabilitation in a bedded facility

Patients who cannot be discharged home directly but will benefit from additional rehabilitation and have clear rehabilitation goals set out by therapists in the receiving unit. Care will be provided in community hospitals and/ or care homes with rehabilitation support dependent on need for up to 3 weeks (expected average length of stay; we recognise for some patients with complex needs the length of stay will exceed 3 weeks, but we expect this cohort to be a discrete number). The purpose of rehabilitation in a bedded facility is to stabilise the patients so that they can be safely discharged home (with our without home based support).

With an expectation that most patients will reable / rehabilitate at home under pathway 1, the community beds become the appropriate setting for those patients that need rehabilitation and that cannot go home because of the degree of medical and nursing need.

The system will need to sustain the current community bed provision at least until the new model of care is fully implemented and the system is able to evaluate the impact of increasing home care support through investment in a number of community services. However, there are opportunities to improve the performance and patient throughput of the existing bed stock by continued focus on the reduction of community DTOC in these units.

The table below sets out potential bed days the system could gain (full year effect) if average LoS was reduced to 21 days across the 4 main community hospitals (21 day LoS applied to 75% of the patient

throughput in the understanding that 25% of patients going to a bed could have health interim needs and require a longer stay beyond 3 weeks):

	April 2016 to Jan 2017 Actuals			75% focus for reduction LoS to 21 days		New bed days used if 75% of patients average 21 day LoS	
	Bed Days	Patients discharged	Avg LoS	Bed Days	Patients	Bed Days	Discharges
Lord Byron Ward bed days	9873	336	29.38	7405	252	5292	252
Welney Ward bed days	3482	126	27.63	2612	95	1984.5	95
Trafford Ward bed days	4335	181	23.95	3251	136	2850.75	136
Intermediate Care Unit bed days	9573	500	19.15	N/A	N/A	N/A	N/A
Totals	27263	1143	23.85	13268	483	10127	483
Potential gain if average LoS reduced to 21 days for 75% of patient throughput - excluding ICU (full year effect)			***3141 bed days***				

Pathway 3: Long Term Care / Very Complex Care Needs

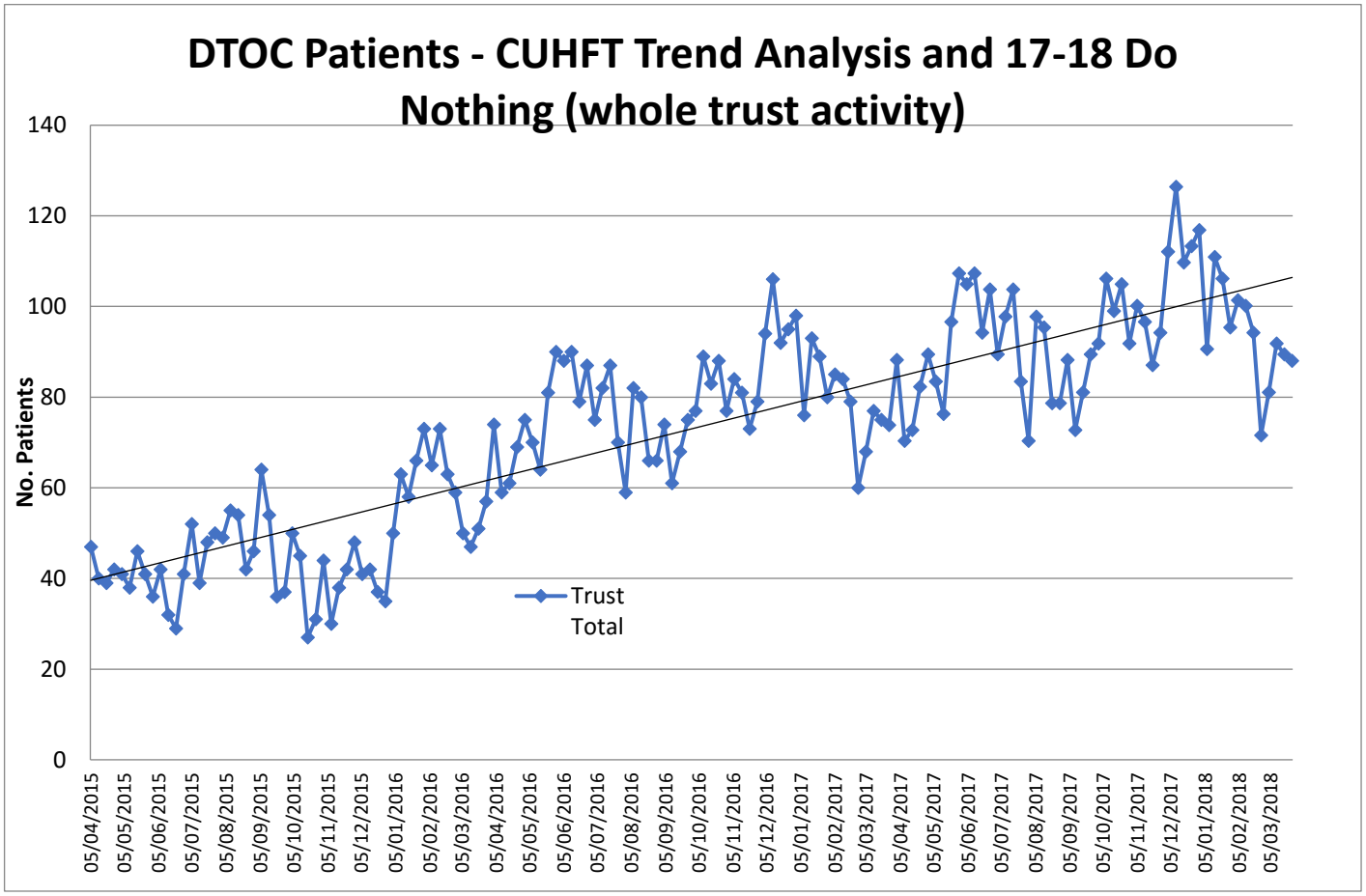
Patients that have likely long term care needs and require on going care in a residential setting. The hospital team would have identified these patients as having very complex care needs and are likely to require continued care in a care home setting for the rest of their lives. It is anticipated this will be a smaller cohort of patients for whom completing assessments in hospital will remain the best approach to provide the best quality of care.
Patients who can be discharged with a straight re-start of the care package in place before admission will be included under this pathway as they don't require new assessments if they can go home with same care package within 14 days of admission.

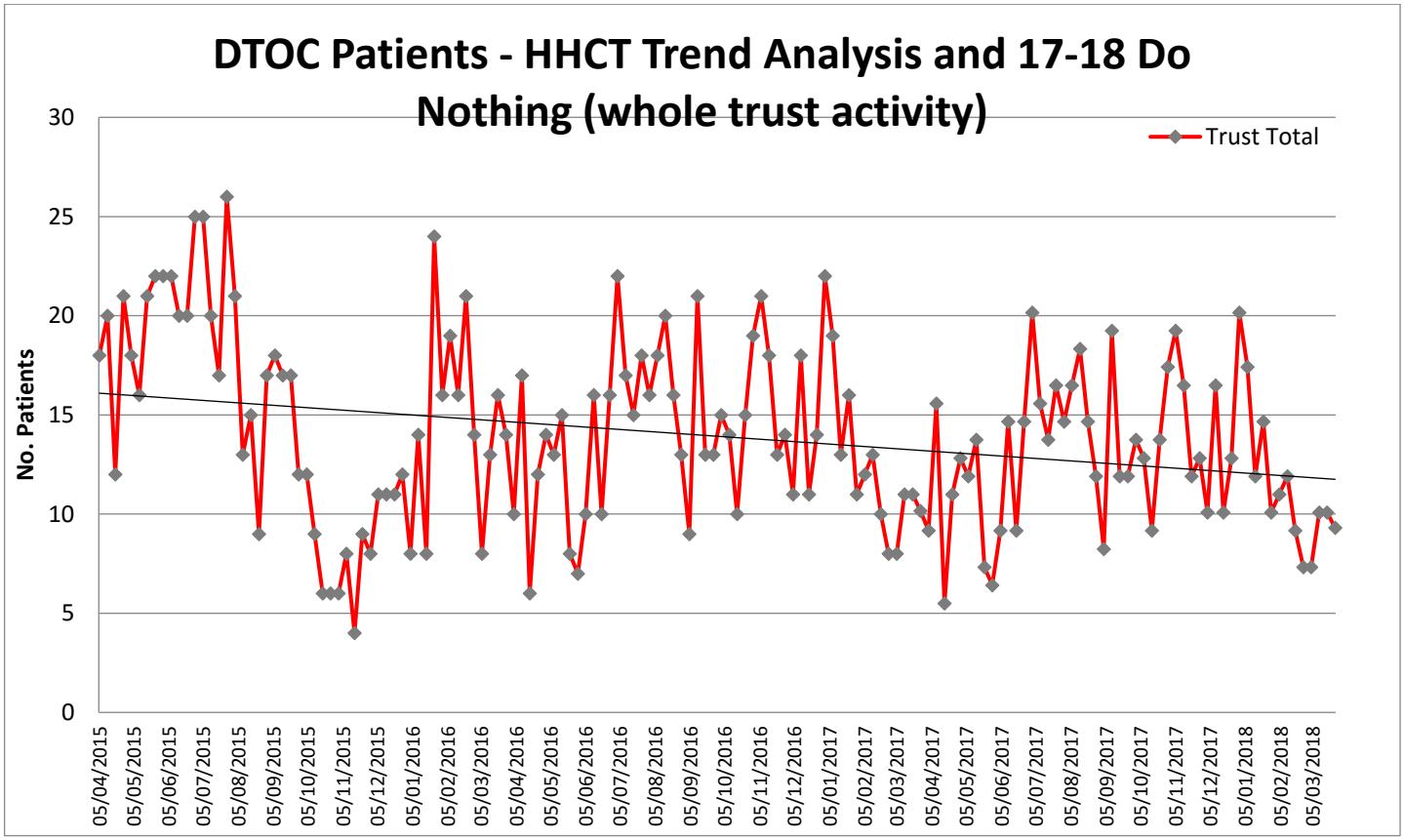
There can be movement between the 3 pathways if /when clinically appropriate; e.g. patient needs / abilities have changed (either improvement or deterioration)

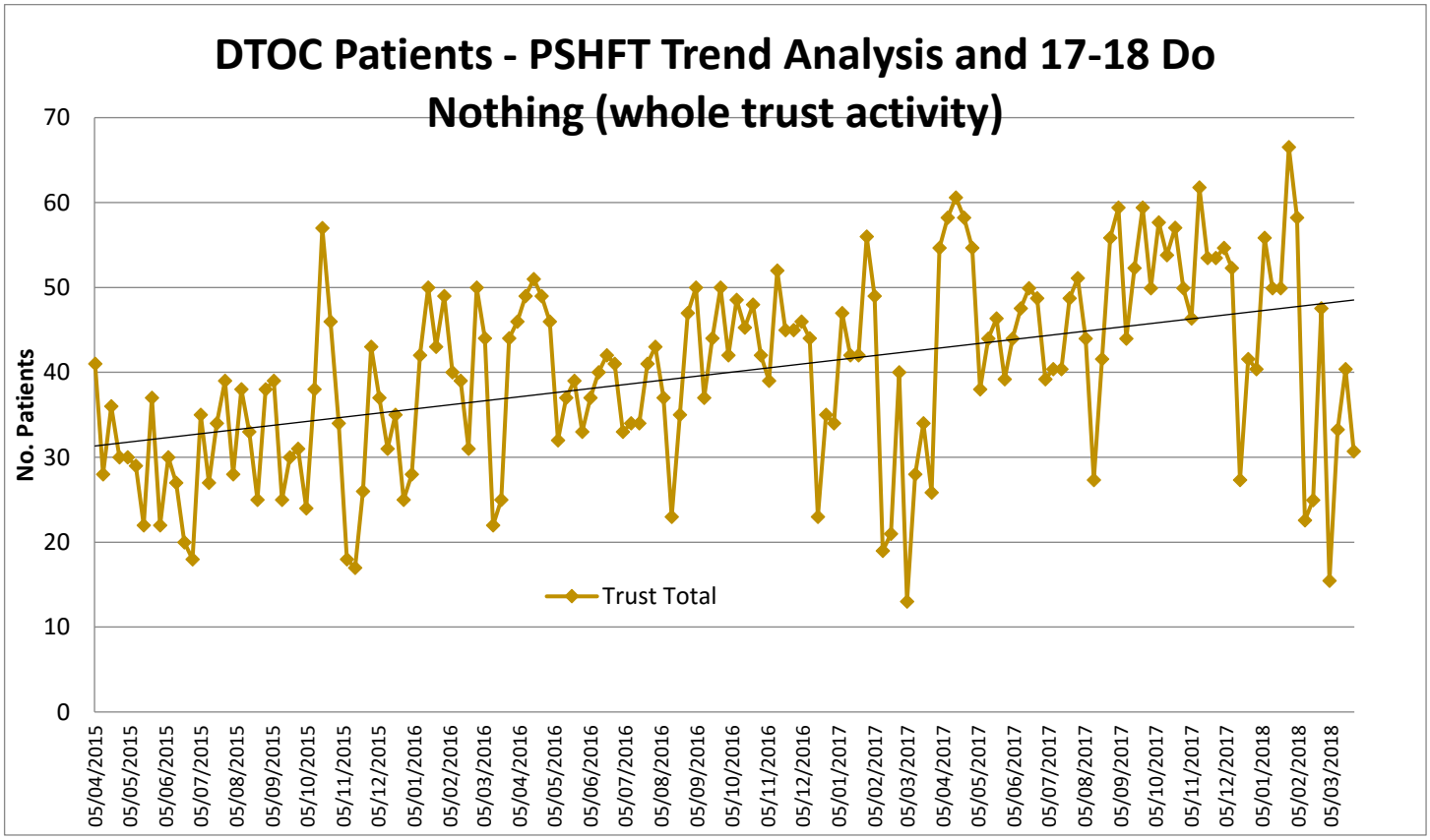
D2 - 'Do Nothing' Option

If the system doesn't make any changes and brings investment back to recurrent funding levels community capacity will be lost to include the existing intermediate care tier capacity (small number of ICWs and therapy to support existing pathways) and home care support for c.1200 patients per year delivered by the independent sector.

This would have a negative impact on the system's ability to facilitate supported discharges, increasing Delayed Transfers of Care. The tables below show the projected trend in DTOCs per Trust under this option:


DTOC Patients - CUHFT Trend Analysis and 17-18 Do Nothing (whole trust activity)
No. Patients
Trust Total


DTOC Patients - HHCT Trend Analysis and 17-18 Do Nothing (whole trust activity)
No. Patients
Trust Total



Data Source: Trust's SITREP reports

Most importantly, under the Do Nothing option patients in our system will not always have access to the best opportunities for a prompt discharge from hospital and speedy recovery at home, creating health and care inequalities and resulting in poorer patient experience. In the long term this would also be costly to the system through expected increased in long term dependency and high cost complex care packages for a greater number of people.

D3 - Alternative Option(s) Considered

In order to ensure there is capacity in community to deliver all three pathways under Discharge to Assess, the system could commission services with health home care provision delivered mainly by the independent sector. The current level of spend in home care (delivered by some ICW capacity plus independent sector packages) sits at circa £7.6m per year. This excludes comprehensive therapy input required to upscale D2A, nursing and social care support for assessments in community, and any clinical triage and pathway coordination (SPOC).

Under this option the system will not deliver an integrated care vision or realise full financial benefits as a more expensive and disjointed approach would be kept in place.

In addition, continued reliance on the independent sector to deliver home care will put further pressure on the pool of capacity available to the system for long term placements.

[E] FINANCIAL IMPACT:

E1 – Investment Required for Proposed Option

Different staffing scenarios have been modelled (see section H below on staffing). Of these, two preferred options have been highlighted and fully costed – options 4 and 6 - see attached below. The difference between them is whether patients stay in the pathway for 4 weeks or 3 weeks respectively. These two figures regarding length of stay are based on the current average length of stay for local reablement services

(average LoS of 3 weeks for Cambridgeshire and 4 weeks for Peterborough), which is the closest service model comparable to the proposed service. The system will need to determine which of the two is the preferred option.

D2A - Finance Schedule 6th April 17.

If the system is to continue to facilitate complex discharges from hospital until the new ICT team is in place, current levels of community capacity provided by the independent sector will have to be sustained as well as current levels of community in-patient beds. It is anticipated that the ICT tier builds proportionate independent sector capacity can be reduced in year.

The required investment for each option is put forth in the table below:

	Current Services	New Model	
		Option 4	Option 6
Expenditure	**£'000**	**£'000**	**£'000**
Home with Support			
Intermediate Care Tier (ICWs + Therapy already in place)	985	985	985
Independent Sector - Home Support	6,592	5,900	4,685
Non Recurrent transition costs		500	500
	7,577	**6,885**	**5,670**
Rehab in a bedded facility			
CPFT Lord Byron B	1,500	1,500	1,500
Independent sector - health interim beds	1,908	1,908	1,908
	3,408	**3,408**	**3,408**
Voluntary Sector	**248**	**248**	**248**
Total Cost	**11,233**	**11,041**	**9,826**
Funding Available			
CCG funding			
Operational Resilience	4,536	4,536	4,536
Better Care Fund	650	650	650
Re admissions	1,315	1,315	1,315
	6,501	**6,501**	**6,501**
Investment Committee			
MRET	935	935	935
Request from Invesptment pot	3,797	3,605	2,390
	4,732	**4,540**	**3,325**
Total Funding	**11,233**	**11,041**	**9,826**

E2 – Savings Delivered in the Proposed Option

There a number of benefits to the system from implementing the preferred option. Expected reduction in acute bed days has been modelled based on length of stay reductions achieved by other areas that have implemented this care model – see attached below. It is worth noting the potential benefits set out in the spreadsheet below will be realised by the providers:

E3 – Source of Funding

It is anticipated that funding for the scheme for 17/18 will be provided by the STP investment pot in the first instance. This would allow mobilisation of the enhanced service. It is anticipated that the enhanced service would reach full potential by March 2018.

E5 – Contractual Considerations

Further consideration might be required for the long term commissioning of any new services going forward and whether procurement rules will apply.

E6 – Capital Risk (Capital Cases only)

N/A

[F] PATIENT EXPERIENCE:

In terms of the preferred option:

F1 – Impact on Patient Care

The new model of care will ensure patients:

1. Have enough information and support to allow him to look after himself as much as possible without having to rely on others

2. Have their care planned so that when they becomes ill they knows that they can get help quickly to manage their illness and to keep them out of hospital where possible

3. Know who to call when they need help and services know about them

4. If they need to go to hospital, they know that care and support will be put in place to allow them to come home as soon as possible

5. They know that everyone providing their care is well supported and the system helps them to learn from each other and develop better care for others

The new model of care will ensure patients:

G] OPERATIONAL IMPACT

In terms of the preferred option:

G1 – Capacity: post change, during implementation; Other areas:

To ensure there is no change to the current system which is already at a point of sub-optimal care being delivered, the Business case has taken account therefore for the current bedded provision to be maintained during this community mobilisation. As there is current bedded capacity funded non- recurrently the business case requires the support of this investment for 17-18. The bedded provision will then be reviewed in year, as the new care model is implemented.

G2 – Support Services, Physical and Equipment Capacity, IT and IG Compliant

There will be a requirement to review support services to be scoped at early implementation. This would add to the ongoing progress from the BCF funded projects, and the digital technology work streams of STP.

H] WORKFORCE/HR:

H1 – Staffing Numbers

This proposal has taken into account the patient journey across the full pathway resulting in a number of possible scenarios regarding possible staffing numbers. Each scenario is further shaped by a number of variables to include estimated length of stay and caseload. Options 4, 5 and 6 also take into account the anticipated impact on the patient cohort of the additional investment in further capacity and support across other services such as JET. This means that the capacity highlighted on these options is to focused on supported discharges only as the eligible patient base has been reduced based on assumptions around reductions in NEL admissions.

In addition, new pathway assumes reablement patients will go through the D2A pathway for a period of up to 3 or 4 weeks. This therefore will reduce demand for reablement services and a proportion of extra reablement staff numbers initially put forth in a previous business case have been “rationalised” into the intermediate care tier model.

From these, the work stream leads have put forth two preferred options (**Option 4 and Option 6**) which the Investment Committee may wish to discuss in relation to the other alternatives set out in the document attached below:

D2A Modelling v4 LE edits.xlsx

H2 – Staff Consultation

Consultation with existing staff may not be required in the first phases of delivery. If during deployment and delivery of the new model the system made a joint decision to change the arrangements for existing services (eg SPA centres, community beds) staff consultation may be required at a later time. The SRO and Project Manager will keep oversight of any potential implications on this aspect and will ensure early cross organisational HR input and advice is sought if / when required

H3 – Training

The proposal requires a system response to the current therapy and social care pathways to support the system change to assessment in the community and not in an acute hospital. There are major considerations to the training required to support this pathway move.

There is an interdependency with the workforce work stream of the STP which needs to be scoped further should the system support the realignment of current workforce.

H4 – Recruitment Considerations

Modelling has shown that a gold standard intermediate care tier able to provide intensive therapy and support to patients in their own home to optimise their chances of reablement and rehabilitation requires a significant number of health and care professionals.

The system however must take into account the capacity already in place that should be aligned to this pathway as not all the staff put forth in either of the preferred models will imply these are new posts that need to be recruited for.

There will be however a need to recruit significant numbers of care workers in particular and this could prove a challenge to the system and has been highlighted as a risk with mitigation actions identified.

In order to ensure the system has access to a flexible workforce the following factors have been considered as critical for success:

- Development of a national Trailblazer bid will allow the system to design apprenticeship standards tailored to the needs of our local system. The standards will provide generalist competencies but with the expectation of rotation and experience in a range of clinical settings, particularly for those seeking advancement in their role. By creating a large workforce which is agile, flexible, and competent in a range of areas to support our specialist staff and deliver basic care to our patients, we should be better equipped to manage changes in demand for care.

- Education and training programmes will incentivise staff into roles. This supports the cycle of progression, provides career enhancement opportunities, and increases the competency and capability of our workforce. Programmes have been costed for MSc level, in house competency packages, and will maximise levy opportunities.

- Joint recruitment strategies across partner organisations resulting in a combined workforce plan that will mitigate against the current workforce shortages and the challenge and complexity associated with large scale workforce redesign and recruitment.

H5 – Tenure

To optimise recruitment opportunity and make the model sustainable staff should be recruited to posts on a substantive basis. We recognise however that until the full complement of staff is recruited across disciplines organisations may need to use agency / bank resources in the interim.

H6 – Job Plans

Should the system support the pathway move of therapy staff and discharge planning to the community, this will have a significant impact on Job plans for staff.

Should the system also support an integrated service as the preferred option to delivery an effective and efficient intermediate care tier then accountability structures will require significant realignment.

A full HR scoping of the agreed proposal will be central to the development of the model, to reduce efficient use of current resources in the system to support system change.

[I] IMPLEMENTATION:

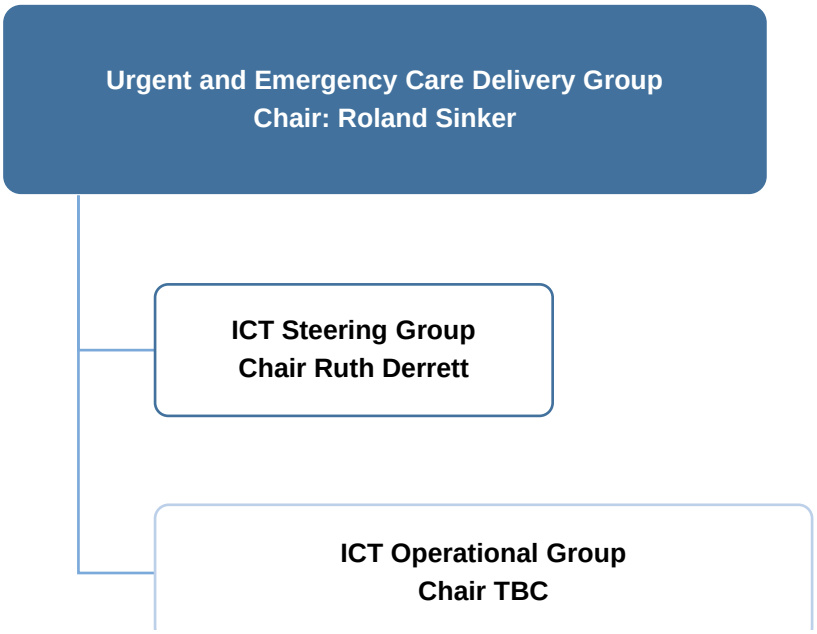
I1 – Timescales

Activity	No. Weeks	Dates Start - Finish
Scoping/Design		
Planning Consent		
Contracting/Advertising		
Delivery Lead-Time		
Works/Installation/Commissioning		
Practical Completion/"Go Live"		
Post-Project Evaluation		
TOTAL		

I2 – Implementation Governance Arrangements

SRO – Ruth Derrett

We will establish a programme management structure that reports formally to the UEC Delivery Group. There are project governance structures already in place with good clinical and senior management engagement and we wish to formalise these during the implementation phase. See figure below:



I3 – Support Services Resources

See E6

The delivery will require partnerships with all support services and support the STP priorities of change point 6 on use of services and estates.

I4 – Post-Project Evaluation (PPE)

Progress towards implementation will be continuously monitored by the ICT steering group; however it is proposed that a full evaluation of impact is also completed at 6 months and 12 months respectively

Timescale for PPE: (Please tick one box below)

3 months	☐	**6 months**	☒	**9 months**	☐

I5 – Deliverables: KPIs/Outcomes and systems for measuring performance of the scheme

KPIs/Outcomes	Target	Systems
Reduction in Non-Elective hospital Admissions (specified by CUHFT, HHCT and PSHFT respectively) – total and for over 65's	TBC	SUS data
NEL hospital admissions for falls for over 65's	TBC	SUS data
Reduction in Delayed Transfers of Care – total and specific categories (eg community rehab, reablement, assessment, patient choice)	TBC	Each Trust reporting for acutes CPFT reporting for community beds
Reduction in Length of Stay (acutes & community beds)	TBC	Each Trust reporting for acutes CPFT reporting for community beds
Reduction in excess bed days (acutes)	TBC	Each Trust reporting
Readmission to hospital following discharge into service (30 days)	TBC	Each relevant community service reporting
Patient & Carers satisfaction with care received	TBC	Patient surveys completed by each service
Reduction in dependency levels measured at admission to ICT service and discharge from ICT service	TBC	Community provider to establish mechanism to record and report on a regular basis
Staff satisfaction	TBC	Staff surveys by each provider organisation

(Please outline the specific KPIs that will be measured and the targets/outcomes this scheme is planned to meet. These should primarily align to improvements in Clinical Effectiveness, Patient Experience or Safety) Outline the systems in place that will monitor the respective KPI).

[J] RISKS & OPPORTUNITIES:

J1 – Implementation Risks & Opportunities

Risk Area	Mitigating Actions
Workforce: The new model requires the recruitment of a significant number of health care professionals and this may prove challenging	• Proactive recruitment campaign started early in the process pending approval of business case (end of February 2017) • Deployment of joint workforce strategies across provider organisations to increase appeal of roles to prospective applicants • Use of independent sector provider capacity in the interim to bridge gaps to provision during the recruitment process
Exit from the pathways might be affected by local market forces for domiciliary care and care home placements in particular	• Design processes (eg D2A) that enable system partners for early identification and planning of long term need to reduce risks of periods of excessive demand for long term assessment and care • Identify innovative solutions to delivery domiciliary care support (eg primary care support for patients at home, "grow your own workforce", etc) • Support the development of a "community pool" of capacity to support care for patients at home under the direct payment scheme (eg microbusinesses in community providing care in a given geography) • Promote use of direct payments as an alternative to social care support being arranged by the local authority

Financial implications to the system for the transition period	○ Ensure business case proposal takes account of the need to secure an interim period (up to 12 months maximum) of "double running" key community services until new models of care are sufficiently embedded and fully operational

J2 – Post-Implementation Risks & Opportunities:

All clinical safety and risks post Go Live will be managed by the relevant provider.

[K] STAKEHOLDER ENGAGEMENT:

K1 –Stakeholders Engaged During Business Case Development:

Name	Title	Representing	Internal / External
Roland Sinker			
Ruth Derrett			
Aidan Thomas			
Julie Frake Harris			
Ben Underwood			
Alex Gimson			
Charlotte Black			
Richard ODriscoll			
Phil Walmsley			
Neil Doverty			
Duncan Forsyth			

All of the above stakeholders have received and reviewed the latest version of this business case and have consented to its submission.

[L] RECOMMENDATION:

Partner organisations in the system across hospital, community and local authority sectors seek approval to invest a total of XXX from 1st April 2017. Of this total, XX is recurrent funding whilst XXX (for the community beds currently funded on a non-recurrent basis) could be reviewed at the 6 month evaluation point of the new service model.

[M] DUE REGARD SCREENING:

Impact (please indicate Yes or No for each question)	Race/Ethnicity	Sex	Religion or Belief	Gender Reassignment	Sexual Orientation	Age	Marriage & Civil Partnership	Pregnancy & Maternity	Disability
Do different groups have different	No	No	No	No	No	No	No	No	No

needs, experiences, issues and priorities in relation to the proposed change?									
Is there potential for or evidence that the proposed change will not promote equality of opportunity for all and promote good relations between different groups?	No	No	No	No	No	No	No	No	No
Is there potential for or evidence that the proposed change will affect different population groups differently (including possibly discriminating against certain groups)?	No	No	No	No	No	No	No	No	No
Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular group or groups?	No	No	No	No	No	No	No	No	No

Note that if any box contains a 'Yes' then a full DUE REGARD assessment is required to be undertaken.

[N] REVISION HISTORY:

Version	Date	Amendments	Authored/Approved by
1	18/03/2017	Draft document created	Sara Rodriguez-Jimenez
2	24/03/2017	Inclusion of staffing models	Chris Gillings
3	24/03/2017	Inclusion of financial impact / benefits	Greg Lane
4	31/03/2017	Revision of staffing model and financials following discussions with health and local authority providers	Chris G / Louisa E / Sara RJ / Greg L
5	04/04/2017	Further revision of staffing model and financials following discussions with health and local authority providers	Chris G / Louisa E / Sara RJ / Greg L
6	06/01/2017	Further revision following discussions with health and local authority providers and following further clinical input / comments	Sara RJ

This template should be used for all investment bids (both Capital and Revenue), in accordance with relevant Organisation's SFIs.

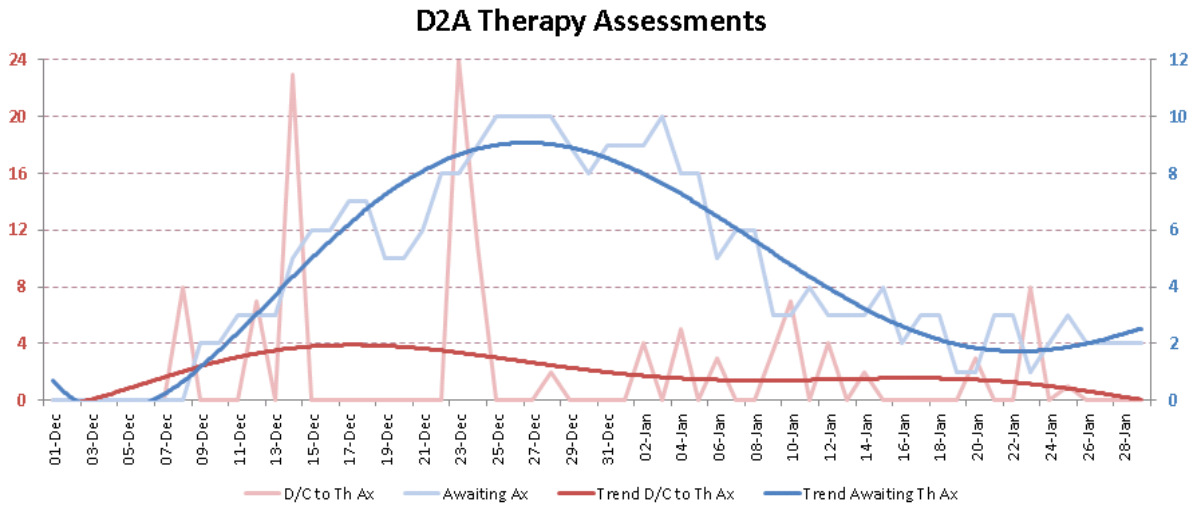
APPENDIX A

INTEGRATED CARE D2A PILOT: CAMBRIDGE SYSTEM (05/12/2016 TO PRESENT)

KEY SUCESSES

Clear improvements in patient outcomes:

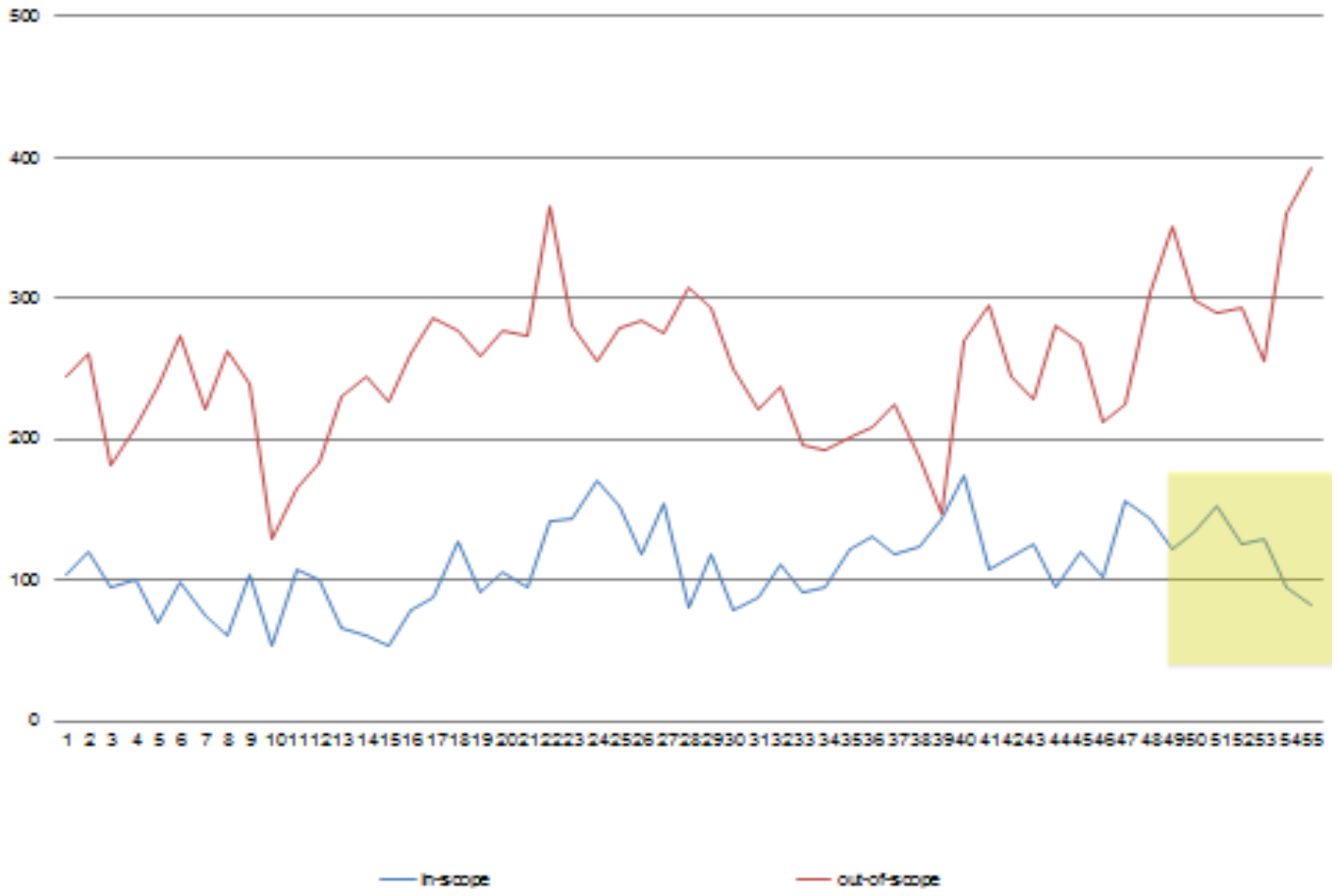
- A significant proportion of patients are going home and are remaining at home;
- Additional community therapy capacity has resulted in a significant reduction in wait times for patients to have a therapy assessment completed in the community (within 24 hours of discharge home). The table below shows the trend:



- Analysis of a sample of patients going through the pathway shows 7.5% of patients experienced functional improvement with need for therapy calls reducing by 75% from discharge into the pathway; a further 7.5% showed 100% reduction in need of therapy calls; and 14% showed 50% reduction.

- Readmission rates for patients in the 5 wards run at 10%, which is lower than the Trust average of 20%

- We have seen that for the 5 pilot wards the number of lost bed days has reduced whereas the rest of the hospital shows a general upward trend. Taking the week before the trial started as a baseline, there has been a reduction of 166 bed days in the first 7 weeks of the pathway since go live (compared to the LoS in the same five wards before the D2A pilot started). The figure below shows the Cambridgeshire validated lost bed days by ward for the last year. Blue is the line for the 5 wards in the pilot, and red is all other wards.



- Patient flow in reablement has improved, with a reduction in delays through the reablement pathway
- We have seen a clear commitment across teams to work differently, with high health and care professional buy in and engagement
- Improved communication between discharge planning, SPA, reablement, Intermediate Care teams
- 49% of patients have been discharged from CUH within 3 days of the Community Support Referral (CSR) being submitted; 44% of patients have been discharged within 3 days of their Clinically Fit Date (CFD).
- Released time to care for ward staff through reduction of phone calls to SPA /other services to facilitate discharge of individual patients

LEARNING POINTS TO TAKE FORWARD

- An overarching coordinating role to manage and “own” patient flow throughout the whole pathway is key to the success of this model.
- It is essential we continue to move forward the integration of pathways in the community and realise economies of scale through sharing of workforce to support patient needs more effectively (reablement / IC).
- Role of the SPA needs to be clearly defined to set out professional disciplines that need to be integrated / aligned into the single point of access / coordination (CPFT, reablement / social care, Discharge Planning teams); include clinical advice and expertise; and set out functions / responsibilities of the SPA going forward. All community pathways should also be routed through this single point – including community bed capacity

INTEGRATED D2A PILOT: NORTH BRISTOL NHS TRUST (began October 2015)

KEY SUCESSES

- There have been reductions in LoS for both the acute phase of treatment and the LHPD phase
- The total average stay is now 3.4 days shorter than the same period last year
- Stock (number of patients on LHPD at any time) has reduced due to the reduced LOS
- This has resulted in a reduction in bed days per annum which would equate to 29 beds across a full year
- As changes were not implemented as soon as demand & capacity model was completed the full saving has not been achieve during 2015/16
- Full saving could be achieved in 16/17

Measure	Impower Model (Jan 15)	Refreshed Model (Dec 15 to Feb 16)	Difference
Average LOS before LHPD	16	15.1	-0.9
Average LOS on LHPD	16.7	14.2	-2.5
Total LOS	32.7	29.3	-3.4
New Patients per Day subject to LHPD	13	13.4	0.4
LHPD Stock	218	190	-28
Bed days per annum	79242	69452	-9789.3
Equivalent beds at 92% occupancy			-29.2

INTEGRATED D2A PILOT: SHEFFIELD

KEY SUCESSES

- A study concluded from the Royal College of Physicians (2017) showed that two significant reductions in the weekly average wait for patients between hospital referral and being at home with community based support services (data from April 2012 to June 2015)
- The first reduction corresponds with the establishment of integrated community intermediate care service and demonstrates a reduction in average wait from 5.5 to 3.6 days. The second step change was driven by the more formal reconfiguration into a single service – Active Recovery (see figure below)

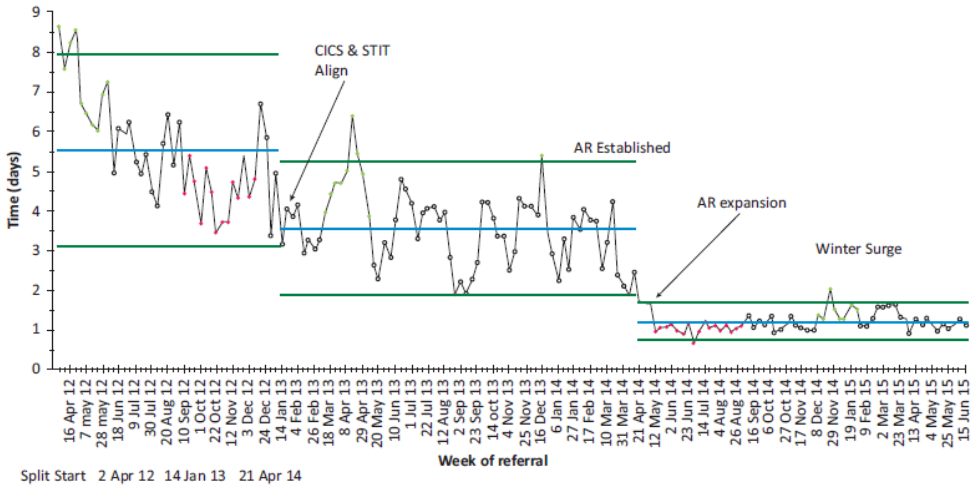


Fig 2. Reducing patient wait for active recovery from a hospital bed. AR = Active Recovery; CICS = Community Intermediate Care Service; STIT = Short Term Intervention Team

- Vertical integration between hospital and community healthcare systems further enabled and accelerated benefits.

- Further investment into the model in 2014 resulted in a more stable system with a mean transfer time from hospital to support at home of 1.2 days (therefore total reduction of average 4 hospital bed days per patient being saved as a result of implementing the new model of care at scale)

DISCHARGE TO ASSESS: SOUTH WARWICKSHIRE NHS FOUNDATION TRUST

KEY SUCESSES

- The Discharge to Assess service enables patient discharge from acute into nursing or residential homes, community hospitals, or their own homes with care and rehabilitation support for up to six weeks (average length of stay in the pathway is reported at 21 days)

- The patients' assessment for ongoing care needs are done outside of the hospital. Services are provided via three pathways for three distinct cohorts of patients. On average about 60% of patients a week are discharged home with support to reable/ rehabilitate.

- From 2011 to 2014 the trust reports that this work has supported improvements in A&E performance, reduction in length of stay for emergency inpatient adults, and reductions in length of stay for patients aged 75 and older with fewer emergency readmissions and fewer patients affected by several ward moves

- The Trust also reports that 2014/15 data shows the proportion of patients going to long term care home placements receiving CHC funds has fallen from 40% of eligible patients to 20% in year when compared to patients who refused to go on the D2A pathway.

A Whole System Approach To Wellbeing

Joint Commissioning Principles for Voluntary & Community Sector and Community Resilience Building

DRAFT

Cambridgeshire & Peterborough CCG
Cambridgeshire County Council
Peterborough City Council
Cambridge City & District Councils

21/11/16

Contents

Our Whole System Approach to Wellbeing

Joint Commissioning Principles for Voluntary & Community Sector and Community Resilience Building

1. Introduction

Both Peterborough and Cambridgeshire Councils have clear Health and Wellbeing (HWB) Strategies for our population, building on national guidance and informed by various local joint strategic needs assessments (JSNAs). The development and implementation of these strategies through work programmes is overseen by the Cambridgeshire and Peterborough HWB Boards. The work programmes are implemented through a variety of commissioning routes. These include arrangements with statutory health and local authority organisations as well as with the voluntary and community sector (VCS) organisations across Peterborough and Cambridgeshire.

The H&WB strategies make clear the need to work together more effectively, by improving the way in which we commission and deliver health and wellbeing services. Currently each commissioner (the CCG and seven Councils) has its own contractual arrangements with a range of VCS organisations for wellbeing services. This has led to a fragmented approach causing duplication, confusion, gaps, a lack of system-wide outcomes and inconsistent approaches to VCS capacity and community resilience building. The result is wasted time and resources and missed opportunities to better support our residents to maintain their own health and wellbeing in the community, to create a more vibrant VCS and to build community resilience.

In moving away from this position, all local authorities, and the CCG, are committed to improved joint working through the creation of a whole system approach to wellbeing. District Councils play a key role in relation to supporting independence at home and in vibrant communities. This means that health and social care commissioners *and* district councils commit to work together to take advantage of districts' :

- commitment to whole system partnership working
- core role in improving wider social determinants of health, wellbeing and quality of life
- close, established links with parishes, villages, local communities, neighbourhoods, and voluntary groups
- existing services (for example housing, tenant and neighbourhood support services, benefits, and community support and development work)
- willingness and ability to develop innovative solutions with health and social care partners, communities and the business sector e.g. the handy person scheme.

The purpose of this document is thus to propose Joint Commissioning Principles and next steps in order to:

- improve the way we jointly commission VCS wellbeing services and community resilience building
- achieve better outcomes for our residents
- reduce duplication and waste
- secure better value for our money

The document has been developed under the governance of the Better Care Fund (BCF) Healthy Ageing and Prevention Steering Group. It will be presented for comment and approval to Cambridgeshire County Council, Peterborough City Council, Cambridgeshire & Peterborough CCG,, Cambridge City and the four District Councils.

2. Definition of Wellbeing and Scope

2.1 Definition of Wellbeing

There is no consensus around a single definition of wellbeing. However, there is a general concensus that on a personal level wellbeing includes :- presence of positive emotions and moods (contentment, happiness), absence of negative emotions (depression, anxiety), satisfaction with life, fulfilment and positive functioning. Wellbeing is dependent upon good health , positive social relationships and access to basic resources. At broader levels, resources for health can include: peace, economic security, stable environments, safe housing etc, while at the individual level, resources for health can include physical activity, healthy diet, community connectedness, mental health and autonomy.

This in itself indicates how very broad the 'wellbeing' definition and agenda is. It is acknowledged here that 'wellbeing' in its broadest sense extends well beyond what Local Authorities and the CCG can achieve within current resources.

For the purposes of these Commissioning Principles, the focus will be more towards the individual level .

-

2.2 Scope

Within scope is the commissioning of VCS wellbeing and community resilience building services for all adults who live independently in the community, within Cambridgeshire and Peterborough, but are vulnerable to becoming frail or needing higher levels of support or intervention in future to maintain their physical, mental and / or emotional wellbeing and independence.

Commissioned services will need to be innovative with a clear focus towards delivery of services and support that enable residents to live independently for longer. These might include directly provided services that target specific needs or client groups, or services that support the capacity, resilience and abilities of communities to support each other.

There will need to be a strong focus towards prevention to help achieve our targets to reduce high cost services, and towards giving greater control and choice to residents over the support they need or want.

Commissioned service providers will need to engage and partner with statutory and private sector provision where appropriate, and to draw out maximum opportunity through cross-sectoral working for reducing demand, managing cost and building quality.

Consideration will need to be given to the needs of different communities – those with specific needs or those connected by geography, nationality, ethnicity etc.

3. Engagement & Governance

The development of these Principles has been overseen by the Healthy Ageing and Prevention Steering Group as part of the BCF Governance framework – see Annex A. Representatives from the voluntary & community sector (VCS), district councils, Peterborough City, Cambridgeshire County Council and C&PCCG were engaged in this work. The document has been further informed by a Wellbeing Summit held in October 2016 to which 92 participants from a wide range of organisations across the Peterborough & Cambridgeshire system met to discuss wellbeing plans

and challenges to be overcome. Further it has already been presented as a work in progress to the Cambs BCF Delivery Board, the Greater Peterborough Area Executive Partnership and the CCG's Clinical Management Executive Team (CMET).

4. National Guidance

The vision set out in the *Forward View*[1], is of a joint strategic approach to the prolongation of peoples' wellbeing and independence, based upon a more sustainable partnership approach to delivering care in new ways, empowering people and communities and committing to promoting emotional and physical wellbeing, preventing ill health and closing the health and wellbeing gap.

The social movement referred to in the *Forward View* alludes to a shared purpose, creating a sense of belonging for joining members, building momentum, and ultimately, shifting human behaviour through mechanisms of mass participation[2]. Social networks are increasingly recognised as more sustainable approaches to behaviour change with the potential to improve health and care through and by which people improve health outcomes.

5. Local Strategic Context

Each of the Peterborough (2016-19)[3] and Cambridgeshire (2012 – 2017)[4] Health & Wellbeing Strategies addresses the health needs analyses from the JSNAs. They look at health and wellbeing through the life course, creating a healthy environment, tackling health inequalities and working together effectively.

In terms of working together effectively, the H&WB strategies set out commissioning principles that support the development of a thriving, strong and diverse social and health care market to stimulate the development of new services, and promote competition and collaboration to ensure a varied care and support market to purchase from. There is a commitment to ensuring all the services commissioned are affordable and sustainable; evidence based; locally shaped, improve quality and the patient and user experience, address health inequalities and are appropriate in scale; reflect the user's views and are long term. Further, the role of the VCS and the part they have to play in implementing the H&WB strategies is recognised and supported.

6. Why do We Need to do Things Differently?

Our H&WB Strategies set out that we need to work together more effectively and commission services from the VCS in accordance with agreed commissioning principles. However, all eight commissioning organisations currently contract with the VCS independently. We therefore face the following issues:

- Fragmentation: due to the requirements of individual organisations driving service delivery leading to piecemeal and at times conflicting or confusing contractual and monitoring arrangements with the various VCS organisations

[1] Five Year Forward View DH 2014

[2] http://www.nesta.org.uk/blog/mobilising-communities-better-health-and-wellbeing#sthash.NDiQPpoR.dpuf

[3] Peterborough Health & Wellbeing Strategy 2016 – 19 - https://www.peterborough.gov.uk/healthcare/public-health/health-and-wellbeing-strategy/

[4] Cambridgeshire H&WB Strategy 2012 – 2017: http://www.cambridgeshire.gov.uk/info/20004/health_and_keeping_well/548/cambridgeshire_health_and_wellbeing_board

- Inequity: across Cambridgeshire and Peterborough in terms of investment in the VCS
- Focus on : transaction and process rather than partnerships, evidence and outcomes
- Patchy: attention to residents, carers and VCS voices in service planning and delivery
- Insufficient: intentional VCS capacity and community resilience building

Resulting in:

- Sub optimal services for our residents
- Wasted resources
- Unclear outcomes
- Lost opportunities for the VCS capacity and community resilience building

7. What Three Things Will We do Differently?

In order to progress in accordance with the direction of travel set out in the *Forward View* and our local H&WB Strategies we will:

i) Work in partnership with Cambridgeshire and Peterborough commissioners in accordance with the Joint Commissioning Principles, to develop joint plans and outcomes supported by pooled or aligned budgets for the VCS wellbeing and community resilience building services.

ii) Develop joint approaches and programmes to build community resilience and strengthen the VCS sector.

iii) Build on what is currently working well, learn from elsewhere, grasp opportunities to strengthen the VCS and build resilient communities, and listen to our VCS to make immediate improvements.

8. Guiding Principles

We will build on the commissioning principles already set out in our H&WB strategies. In commissioning wellbeing services from the VCS and in developing community resilience, we will ensure:

- **there is person-centred** guidance / support / services for residents and carers
- **we use co-production** in design and delivery of services in partnership with residents & carers
- a focus on **narrowing inequalities** by e.g. targeting investment in high demand communities
- **volunteering and social action** are recognised as key enablers
- support for the VCS to work in more **collaborative, co-ordinated ways** with each other
- we adopt a **learning and development** ethos guided by current research whereby our approach to wellbeing will encompass new approaches and opportunities but will also inform us when we need to stop services / initiatives that produce no or limited benefit
- we seek a **return on investment** to reduce unnecessary demand on high cost services and to ensure service sustainability
- we use the principles of a strength based approach we will seek ways to **empower** residents, carers and people to strengthen communities through helping themselves, helping each other and improving health outcomes.

9. Benefits of the Joint Commissioning Principles for a *Whole System Approach to Wellbeing*

to Individuals :

- Individuals become more empowered to increasingly take responsibility for their own health and wellbeing and on the basis of sought or provided information
- a greater sense of wellbeing and independence that maximizes the opportunities for people to live in the place they call home
- early intervention through practical and emotional l support for individuals to prevent and/or delay deterioration in their health and wellbeing

- carers are supported to sustain their caring role for as long as they wish to continue

to Communities :

- contributes to the strengthening of community resilience[5]
- a strong, vibrant, diverse, sustainable and coordinated voluntary sector across Cambridgeshire and Peterborough that works closely with all statutory and private sector partners as well as individuals.

  Seldom heard[6] groups will have access to more appropriate services

to the whole system:

- better wellbeing outcomes for our residents

- streamlined VCS commissioning systems and processes

- better value through elimination of waste in commissioning/delivery and reduced dependence on statutory services

- demonstration of savings achieved within the system through a positive return on investment in order to make the case for further investment in wellbeing services.

10. Outcomes

- Improved access to and uptake of VCS services / activities by residents
- VCS organisations are promoting wellbeing
- Greater sense of wellbeing in those accessing the VCS services
- Reduced / delayed demand on statutory health and social care services by residents accessing the most relevant services / support for their presenting needs
- Sustainable VCS wellbeing services
- Vibrant VCS and stronger resilience through community groups
- Financial savings

11. Next Steps

11.1 Commissioning Function Options

In order to ensure a jointly owned and sustainable way forward it is important that each commissioning organization invests the necessary resources into a joint commissioning function for wellbeing. This could be done ina number of ways e.g. :

[5] Insert definition -helping people to help themselves and others

[6] Seldom heard refers to people from different faiths, and or cultures, and deprivation .

- Development of a joint commissioning function with resources from all existing commissioners.
- Alignment of existing commissioners, allocating particular activity to each commissioner to prevent duplication

11.2 Governance

What will be important is to ensure that there is a Joint Commissioning Board that meets regularly to agree our strategy and activity, monitor performance and outcomes. This Board should include service users and providers.

These Commissioning Principles have been developed under the BCF governance. Once adopted by the CCG and all Councils and a planning team is in place the project will transition to ‘‘business as usual’.

11.3 Co-Production

The Commissioning Principles have been developed through co-production with a range of different organisations, Further, there was strong feedback from the Wellbeing Summit participants that co-production is crucial for the development of appropriate wellbeing and community resilience building services and approaches.

In order to continue the theme of co-production it will be important to ensure inputs from residents at the planning team level as well as more broadly.

In terms of broader inputs, consideration needs to be given to establishing a reference group, This could be a new group or could build upon an existing group . - e.g. the Cambridgeshire Compact. - adapted to incorporate wellbeing and with representation from the Wellbeing Summit attendees.

Further, securing input from an organization which facilitates the co-production process such as the Coalition for Collaborative Care should be considered.

11.4 Forward Plan

Year 1: April 2016 – October 2017

Action	Timescale	Status	Who
Workshop with key stakeholders to agree vision for wellbeing (Regional BCF funds)	April 16	Completed	C Mitchell/KPMG (BCF Support team)
Draft Commissioning Principles and workshop plan to HEAP, GP AEP, Cambs BCF Delivery Board & CMET	July - October	Completed	G Kelly
Commissioning Wellbeing Summit on *Approach to Wellbeing*	13/10/16	Completed	G Kelly
Summit feedback to invitees attendees & request further feedback / priorities	Mid November	Sent 18/11/16	G Kelly
Draft Commissioning Principles to Cambs BCF Delivery Board & GPAEP for comment	18/11/16	Sent 18/11/16	G Kelly
Present Draft Commissioning Principles to Peterborough City Council Commissioning	30/11/16	Booked	G Kelly/ P Carrington

Board			
Present to Cambs CC Commissioning Board	Dec / Jan	In progress	G Kelly / C Bruin
Schedule of District Council leads & meetings for presentation of Commisioning Principles to be arranged			G Kelly / T Cassidy/ M Hill
Map existing wellbeing service commissioning to ensure no duplication or gaps	Nov – December	In progress	G Kelly/ L Robin
Present to Public Health Reference Group for information	January	In progress	G Kelly/ L Robin
Extend contract for existing Wellbeing Networks till end March 2017	November	In progress	C Mitchell
Launch joint procurement process for Wellbeing Network and social prescribing pilots (C&P wide)	Nov – June 2017	Discussion & proposed timeline	G Kelly/ G Hinkins/B Pickburn
Identify quick wins from wellbeing summit proposals that can proceed now e.g.joint commissioning for carers support	November / December 16	In progress	Sign off by relevant budget holders
Incorporate cleansed VCS Activity onto MI DOS	December 16 onwards	check	J Farrow, L McCarthy, G Chambers
Present to District Councils for discussion / approval	Dec – Jan 17		G Kelly/M Hill/T Cassidy
Agree Joint Strategic Commissioning Principles for *Approach to Wellbeing*	January 17	In progress	PCC, CCC, CCG, Cambs City & 4 District Councils
Confirm VCS wellbeing and community resilience building investment within C&P BCF Plans	Jan / Feb 17		CCC, PCC, CCG
1st phase Joint Commissioning Plan to include: • Process for co-production agreed and people identified • Set up VCSreference group • commissioners' total VCS & community resilience building spend, activity & contracts mapped • joint outcomes framework developed & agreed • return on investment assessment tool / process developed • funding sources and levels identified for year 1 • develop costed plans to achieve outcomes - building on H&WB Strategies and informed by Wellbeing Summit outputs • incorporation into other plans system wide plans as relevant e.g. BCF, Council, STP • Agree governance to oversee plan timplementation • Identify further investment opportunities	March 17		Contingent upon identifying establishing a joint VCS commissioning team to support this see no 11.1

Single Wellbeing Network commenced	May / June 17		
Social prescribing pilots commenced	July 17		

12 Recommendations

Notwithstanding these Commissioning Principles still need to be submitted to Cambridgeshire County Council Commissioning Board, the District Councils and CCG Clinical Executive, Peterborough City Council Commissioning Board is asked to :

Comment on and approve in principle:

- Joint Commissioning Principles
- A preferred option for a Joint Commissioning Function
- Proposed governance arrangements
- Forward plan

Agree:

- next steps & who needs to do what

Cambridgeshire County Council Current VCS Wellbeing Investments – via the BCF

CCC: Older People VCS Contracts - VCS Joint Commissioning	Various support commissioned from VCS	Social Care	Local Authority	Charity/Voluntary Sector	CCG Minimum contribution	£300,000
CCC: Sensory Services VCS Contracts - VCS Joint Commissioning	Various support commissioned from VCS	Social Care	Local Authority	Charity/Voluntary Sector	CCG Minimum contribution	£250,000
CCC: Physical Disability VCS Contracts - VCS Joint Commissioning	Various support commissioned from VCS	Social Care	Local Authority	Charity/Voluntary Sector	CCG Minimum contribution	£50,000
Community Navigators - VCS Joint Commissioning	Various support commissioned from VCS	Social Care	Local Authority	Charity/Voluntary Sector	CCG Minimum contribution	£250,000

Community Resilience Building to be added

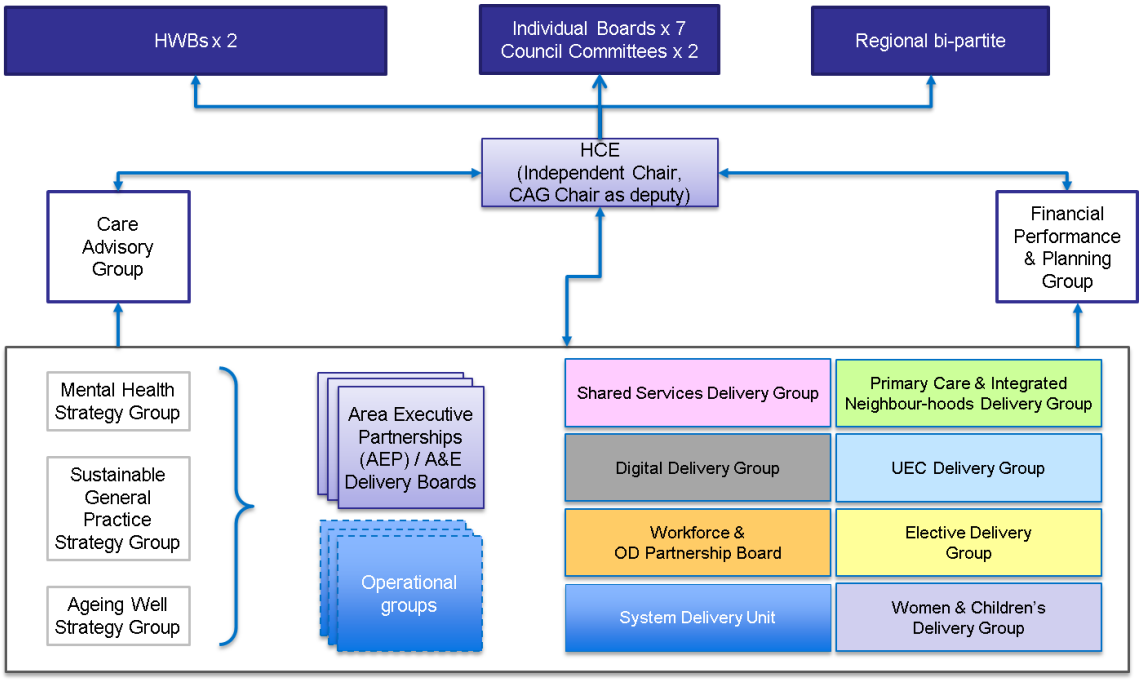
Peterborough City Council Current VCS Wellbeing Investments:

To be added

C&P CCG Current VCS Wellbeing Investments:

To be added

BCF Governance



The Ageing Well / Healthy Ageing and Prevention (HEAP) workstream, incorporates the Wellbeing Workstream, This sits within both the System Transformation Programme and the Better Care Fund (BCF) Programme.

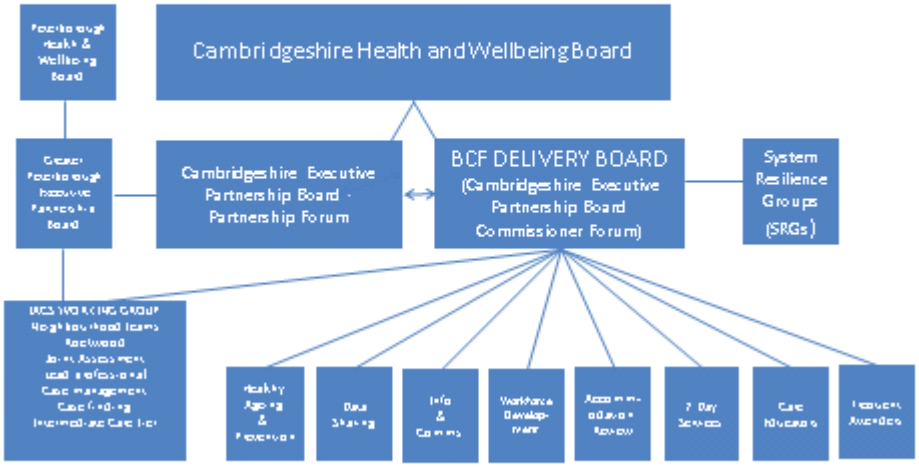
Accountability for this Area Executive project through to the Area Executive Partnerships to the Health Care Executive . In addition, the two Health and Wellbeing Boards hold the accountability for all BCF plans.

As the project transitions to 'business as usual' governance would be via a Council Joint Commissioning Board to include with District and CCG representation.

Annex Aiii

Cambridgeshire Better Care Fund Governance and Projects

Current arrangements



Annex C

Linkages With Other Services

The Cambridgeshire and Peterborough BCF plans' shared vision is rooted in '10 Aspects of an Integrated System for Older People'. This provides the context within which the 'Wellbeing' will be developed :

.. 'Over the next five years 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….'[7]

'Wellbeing' sits under the BCF driven 'Healthy Ageing and Prevention' (HEAP) work programme and as such will interface closely with its preventive work. Its work programme aims to prevent or delay the need for emergency health care and long term social care services and includes falls, social isolation, malnutrition, dementia and promoting continence. All outputs from the HEAP will feed into the 'Proactive Care and Prevention' Workstream which is part of the Sustainability and Transformation Programme (STP). See Organogram at Annex A.

It is important that 'Wellbeing' is linked to other related initiatives / services within the developing system. Some of the key interdependencies include:

The Communications and Information Project:

Under the BCF Plan this workstream is currently developing the Local Information Platform. This work includes the CCG, PCC and two CVS organisations. This will provide the means of sharing, maintaining and managing the data that can then be used by any partner. This information will also feed into the Health DOS.

CCVS and PCVS:

- Instrumental in gathering the information that will be needed by the Wellbeing Network
- Closest ties and links with smaller organisations (lunch clubs, walking clubs, etc)
- Key to some of the future work of the Wellbeing Approach

Cambridgeshire County Council:

- Early Help Team which has links with the H&WBN
- Community Resilience Strategy: *Stronger Together* [8] - articulates people finding the information and advice they need and being part of well-networked communities, and being helped to play an active role within their neighbourhoods.
- Community Hubs Project
- Community Navigators Scheme

[7] Cambridgeshire &Peterborough BCF Plans 2016-17

[8] *Stronger Together* Cambridgeshire County Council's Strategy for Building Resilient Communities October 2015

Cambridge City and District Councils

- Cambridge City and 4 Districts in Cambridgeshire offer a range of services which can contribute to health and well being:
    - Housing services and the built environment, including meeting housing needs, adapting homes, energy efficiency, condition, planning policy and development to meet the future needs of the area.
    - Maximising income through benefits
    - Environmental support including pollution, hoarding, pests, assisted bin collections, funeral services and food safety
    - Community Safety including tackling noise, anti social behaviour and licensing schemes e.g the alcohol and gambling
    - Community Development for example information , advice and guidance programmes for the community e.g Golden Age in Fenland
    - Accessible Leisure Services including exercise referral programmes , trained fitness instructors, tailored swimming classes and use of parks and open spaces

Peterborough City Council:

- People and Community Strategy
- Community Serve - Supporting the growth of adaptable and sustainable communities, looking at early help and prevention working with a focus on isolation, carers and life limitations.
- Home Service Delivery Model – a holistic service in peoples' homes preventing need for high cost services
- Integrated Neighourhood Teams and Social Care teams linked to Primary Care.
- Housing – which already has a number of existing initiatives that can be built upon

Town and Parish Councils in Cambridgeshire and Peterborough

- In many ways these have the closest connection to small communities and with enabling support from the broader public sector. They have the potential to support this agenda to build the community resilience in these communities and help identify seldom reached groups and individuals**.**

Across Cambridgeshire & Peterborough:

- Neighbourhood Teams & case management
- Communication and Information Group - to develop a common shared information platform built on a Directory of Services (DOS) and MI DOS and 111 system
- Data sharing Group – to facilitate information sharing between different organisations.
- Councils for Voluntary Service – to facilitate relationships with the VCS

Annex D

Project Scope: Whole System Approach to Wellbeing 2.0 8/8/16			
Business Leads / Sponsors	Cath Mitchell	**Task Lead**	Gill Kelly
Date raised	25/7/16	**Completion Date**	Presented to BCF Delivery Board 25/7/16 Amended to incorporate outcomes on 8/8/16

Objectives (aims)

To develop and implement an agreed Whole System Approach to Wellbeing across Cambridgeshire and Peterborough in order to reduce demand on primary care and long term social care and secondary and tertiary health interventions.

Background

The Forward View sets out a vision for a sustainable NHS which involves addressing three key gaps: the health and wellbeing gap, the care and quality gap, and the funding and efficiency gap. *The Forward View* vision is of a sustainable NHS that delivers care in new ways, underpinned by six principles for empowering people and communities which reflect the commitment to promoting wellbeing, preventing ill health and closing the health and wellbeing gap.

Post the UnitingCare Contract, there was a clear need to define what we mean by wellbeing across the system. To do this requires whole system engagement. This within a context of no new money for wellbeing and the need to reduce demand on acute health services / long term care through good preventive and wellbeing services.

A BCF supported workshop was held with KPMG on 19 April to which CCC, PCC, PH, PCVS, Health & Wellbeing Network and CCG were invited. The purpose of this workshop was to agree a strategy and vision for the Adult Wellbeing services being delivered across Cambridgeshire and Peterborough by achieving a common consensus of what the objectives should be for the service, what value is being derived currently, and how opportunities for improved value could be achieved across the patch. Several things were discussed and agreed including the benefits of and suggested role for a single 'co-ordinator' / network organisation across Cambridgeshire and Peterborough whereby the functions of the Peterborough CVS and Cambs Health and Wellbeing Network would combine to provide that single co-ordinator function; in addition to develop a single commissioning framework across Cambridgeshire and Peterborough and to develop a vision to inform the future direction of the wellbeing services. The report of that workshop is attached as Annex A.

Benefits and Outcomes

Benefits to:

Individuals:

- healthy lifestyles and positive attitudes to physical and mental wellbeing promoted
- a greater sense of wellbeing and independence that maximizes the opportunities for people to live in the place they call 'home'
- early intervention and practical support for individuals to prevent and/or delay deterioration in

their health and wellbeing

- carers of older people and adults with long-term conditions – supported to sustain their caring role for as long as they wish to continue.

- Wellbeing indicators

Communities:

- community resilience (helping people to help themselves and others) – strengthened

- seamless and efficient access to, and delivery of, community-based support and services provided by local third sector organisations – provided

The system:

12. a vibrant, diverse, sustainable and coordinated voluntary sector across Cambridgeshire and Peterborough that works closely with all statutory and private sector partners as well as individuals.

    - a more efficient and effective single Wellbeing Network across Peterborough and Cambridgeshire

13. reduced reliance on the statutory health and social care sectors by individuals and services

14. a system of social prescribing in place reducing demand on GPs and statutory services

Outcomes

15. Improved access to and uptake of VCS services / activities from population
16. Greater sense of wellbeing in those accessing the VCS services
17. Reduced demand on GP attends, A&E attends, non elective admissions, and long term residential care
18. Sustainable wellbeing services funded through return on investment
19. More efficiencies leading to increased investment in wellbeing services

Strategy (how to)

- Agree Whole System Approach to Wellbeing (via HEAP & BCF Delivery Board, GPEPB & PCP Steering Group)
- Engage key stakeholders – through HEAP subgroup: Wellbeing Steering Group and whole system workshop on 22/9/16 – see plan Annex B.
- Engage key stakeholders in planning and roll out
- Commission single wellbeing network (pan Cambridgeshire & Peterborough)
- Establish joint commissioning framework
- Set up two Social Prescribing pilots (in each of Cambridgeshire and Peterborough)
- Review wellbeing vanguards, best practice and evidence to continually consider refresh the local approach across Cambridgeshire & Peterborough.

Dependencies/ Linkages

CCVS and PCVS:

- Instrumental in gathering the information that will be needed by the Wellbeing Network
- Closest ties and links with smaller organisations (lunch clubs, walking clubs, etc.)
- Key to some of the future work of the Wellbeing Approach

Cambridgeshire County Council:

- Early Help Team which has links with the H&WBN
- Community Resilience Strategy: *Stronger Together* [9] - articulates people finding the information and advice they need and being part of well-networked communities, and being helped to play an active role within their neighbourhoods.
- Community Hubs Project
- Community Navigators Scheme

Cambridgeshire District Councils

- Housing services which already have a number of existing initiatives that can be built upon

Peterborough City Council:

- People and Community Strategy
- Community Serve - Supporting the growth of adaptable and sustainable communities, looking at early help and prevention working with a focus on isolation, carers and life limitations.
- Work with Parish Councils
- Home Service Delivery Model – a holistic service in peoples' homes preventing need for high cost services
- Housing – which already has a number of existing initiatives that can be built upon

Across Cambridgeshire & Peterborough:

- Neighbourhood Teams & case management
- Communication and Information Group - to develop a common shared information platform built on a Directory of Services (DOS) and MI DOS and 111 system
- Data sharing Group – to facilitate information sharing between different organisations.
- Councils for Voluntary Service – to facilitate relationships with the VCS

Governance			
There are a number of commissioning organisations involved:			
Single		**Multiple**	Yes
Primary Governance Body			
CCC, PCC CCG District Councils			

Team	Agencies	Names
Subject Matter Experts	• Primary Care • VCS • Peterborough City Council (PCC) • Cambridgeshire and Peterborough Clinical Group (CCG) • Public Health • Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)	

[9] *Stronger Together* Cambridgeshire County Council's Strategy for Building Resilient Communities October 2015

	• Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT)	
Project Manager	• CCG	Gill Kelly pro tem
Other resources		Requested from BCF

Status			
Stage	**Activity**	**Outputs**	**Status**
Stage 1	Establish programme, planning and preparation	• HEAP agree Approach to Wellbeing document 22/8/16 • Workshop 13/10/16 • Agreed plan 30/10/16	August 16
Stage 2	Design	• Agreed social prescribing scope • Agreed Social Prescribing Business Case • Engage GPs	Agreed BCF Del Board Present 25/7/ BCF Del Board August 16
Stage 3	Develop and test	• Start Social Prescribing project • Single Wellbeing Network	1 Sept Nov 16
Stage 4	Implementation	•	
Stage 5	Review	•	

Social Prescribing Cambridgeshire **Project Scope amended following the BCF Delivery Board Meeting – 25/7/16 v 3.0**			
Date Draft V1 completed & circulated to BCF Delivery Board to guide Business Case V2 comments incorporated	27/6/16	**Primary Governance : Cambs BCF Delivery Board** **Completion Date**	Sign off by BCF Delivery Board on 20 June 2016. Further amend 25/7/16 on outcomes

Objectives

To develop the design for a social prescribing programme in Cambridgeshire building on national good practice.

The objectives of the social prescribing programme will be to:

- enable individuals to feel more in control about their health and wellbeing choices, have improved self-esteem, independence and confidence, and to self-report an improvement in health and well-being
- ensure the service becomes self sustaining, providing a good return on investment
- focus on - but not be limited to - a reduction of social isolation, loneliness and malnutrition (workstreams within Healthy Ageing and Prevention) and demand management
- reduce demand on GP, hospital and statutory services
- help primary care teams, neighbourhood teams and social care staff to access community and voluntary sector activities
- provide support to residents and residents to access community and voluntary sector activities
- ensure referrals to alternative services as required
- identify ways in which social prescribing can contribute to the building of resilient communities and developing VCS capacity.

This design project will explore how to meet these objectives through the development of the most appropriate system of social prescribing for Cambridgeshire

Background

Data available from the local JSNA[10], Public Health team and Projecting Older People Population Information (POPPI) dataset reveals the following information about Cambridgeshire's increasingly ageing population; with a higher prevalence of adults living with long term conditions.
The prime focus of the Cambridgeshire Health and Wellbeing Strategy 2016–19 is on prevention and early intervention community support, resulting in a shift away from acute health services and towards a system that is focused on supporting people wherever required with person-centred and professionally-led primary care, community care, social care and whole system community resources, in an integrated manner. The goal is for people to live as independently as possible, for as long as possible because it achieves better

outcomes for people as well as creating a more sustainable and integrated health and care system. It is well evidenced that good health, and thus reduced dependence on health and care services, is a result of a complicated interaction of different factors including housing, education and employment. In 2008/09 the annual cost to the NHS of residents who frequently attend a GP with medically unexplained symptoms was £3.1 billion.
In 2007, the Department of Health set out proposals for introducing information prescriptions for those with long-term conditions, to enable people to access a wider provision of services. A range of different 'prescription' schemes, such as exercise-on-prescription projects, have been established in a number of areas. This is aimed at promoting good health and independence and ensuring people have easy access to a wide range of services, facilities and activities.
Social prescribing has since been established as a mechanism for linking residents, often through primary care, into social interventions to improve their health and wellbeing. This might include interventions such as exercise, art and creative opportunities, befriending and self-help, employment support or housing and debt advice and many other interventions.

There is a growing body of evidence for the effectiveness of social prescribing to act as a link between different sectors to address social need and wider health gain. Many socially isolated and marginalised groups, as well as black and minority ethnic communities, have often expressed a preference for support through the voluntary and community sector and social prescribing would provide a process to allow primary care teams to easily refer to those services.

The Cambridgeshire health and care system is thus keen to develop the design for social prescribing in order to establish its potential impact on the health and wellbeing of individuals, on the development of community capacity and capability., on community navigators and on health and care services within the local context.

Outcomes

Proximal Outcomes – the business case needs to demonstrate how these outcomes will be met over the initial 6 month period:

- an increase in knowledge of where to access local community activities amongst GPs, primary care teams, public and NT staff
- an increase in referrals by health and social care professionals into the organisation(s) mediating the social prescribing model
- An increase in numbers of people accessing community activities
- an increase in the number of people managing their LTCs optimally – including self-reported measures (GP patient survey and service collected data)
- an increase in the number of people reporting feeling healthier and happier (before and after prescription) [using both individual outcome measuresments such as the wellbeing STAR, and locally agreed validated tools across the cohort such as WEMWB(Warwick and Edinburgh Mental Wellbeing Score)]
- an increase in the number of people feeling less social isolated/lonely – well-being STAR or similar measures
- No of inappropriate GP referrals

Distal Outcomes – where possible the business case should demonstrate how these outcomes will be achieved. These are a contribution to a reduction in:

- No of OOH calls
- Unnecessary A&E attendances
- Non elective admissions.

- Reduction in need for Social Care Packages
- an increase in the number of people feeling less social isolated/lonely – Well-Being STAR or similar measures

Strategy

Business Case to be presented to BCF Delivery Board to include the following:

i) Target Population

- adults with long term conditions
- 50 + year old people scoring in the range of 4-6 in the Rockwood Frailty Scoring Tool

This may be refined further to specific focus groups, though should provide estimates of the number of people reached through the approach.

ii) Geographical Location

Through the Business Case two locations should be identified for testing the design for social prescribing. Criteria for selection need to include communities that are culturally, socially and ethnically stable and that have the potential for maximum impact on demand management

iii) Timeframe

August 2016 – Jan 2017: developing the design phase of social prescribing
February 2017: evaluation
February / March 2017 business case for further roll out of the social prescribing programme

iv) Funding

Up to £100k – BCF non recurrent funding one year only 2016-2017.

v) Referrals

Referral routes will be developed to include referrals from Early Help Team, Neighbourhood Teams, Community Navigators, as well as primary care teams and social workers as part of the business case

vi) Evaluation Process

To describe the baselines and measures against which the model will be evaluated and the process for evaluation.

vii) Options to be considered

At least three different models of implementing the design phase to be presented for consideration with recommendation for preferred option based on evidence of what is working elsewhere and Cambridgeshire's specific needs. The options also need to demonstrate what the funding will be used for – e.g. additional vol. org services, social prescribing infrastructure and demonstrate how value for money can be achieved through use of existing systems / networks.

viii) Preferred Option

Provide full description of preferred option to include:

- How decision will be made on what the 'menu' of social prescribing choices will be
- Specific target population including the numbers and rationale for selection
- Person / user / patient assessment / criteria process
- Patient / user information required
- Referral pathways & signposting routes (to include neighbourhood teams (NTs), social workers (SWs) and GPs)
- How the model will work in conjunction with the community navigators
- GP/SW and NT workers' roles and responsibilities for referral, and the plan for training / raising their awareness
- Role of Social Prescribing provider organisation(s) and function and how links will be made with

other services
- Provision of 'link workers' or similar capacity in the model
- Co-ordination of service
- Follow up
- Project plan
- Baselining, and evaluation questions and process including patient / user experience
- Funding flows including divestment to small voluntary and community
- Identification of Carers needs and referral to appropriate services
- Demonstration of the financial return on investment

Dependencies & Linkages
Community Navigators (CCC funded) Early help team in Cambs – a CCC funded service, A referral pathway between Early Help and the Cambs Health and Well Being Network is already established Links with the Cambs Community Resilience Strategy 'Stronger Together' Links with the Neighbourhood Teams and the 'Trailblazer' teams which are testing case management and the person centred system work which will all need to link into the social prescribing system Communication and information work and development of a shared platform Other linkages: VCS, Primary Care, Cambs County Council, CUHFT, HHT,CPFT,, C&PCCG

Team	Agencies	Names
Subject Matter Experts	• CCG • Primary Care • VCS • Cambs County Council (CCC) • Cambridgeshire and Peterborough NHS Foundation Trust (CPFT • Public Health • CUHFT • HHT • • Community Connectors? •	Gill Kelly GP Lead Julie Farrow R O'Driscoll& L Faulkener Sonnie ? tbc
Commissioning Project Manager Provider Lead:	• Tbd Tbd through business case	
Other resources	• tbd	

Status			
Stage	**Activity**	**Outputs**	**Status**
Stage 1	Establish programme, planning and preparation	• Agreement for project to proceed • Agreed scope and objectives • Agreed plan	• BCF Delivery Board as holds primary governance. Still to agree to proceed with scope in progress
Stage 2	Design	• Agreed service specification • Agreed solution • Agreed Business Case • ? Access and Diversity requirements	Stage 2 in progress – scope will inform the business case and business case in development Service specification to be developed following agreement of preferred option. Approvals: BCF Delivery Board
Stage 3	Develop and test	• Agreed design and delivery approach • Ready to receive the change • Approved implementation plan • Agreed commercial arrangements	
Stage 4	Implementation	• Approve implementation	
Stage 5	Review	• Solution implemented • Close project	

Peterborough Community Serve

Lead: Pat Carrington, Principal City College Peterborough and Assistant Director Skills and Employment, PCC.

City College Peterborough, Peterborough City Councils Adult and Community College, is leading on Community Serve with a brief to support the growth of adaptable, sustainable communities.
There are be three pilot initiatives in:

- Westwood & Ravensthorpe
- the Ortons
- the Can-Do area of the City.

The themes will be around early help and prevention working with adults as shown below.

Isolation
Carers
Life limitations
Communities

The initiatives will be based on need and co-designed by local residents. However, the initial framework that will be common across all the three pilot areas will be:

1. A physical hub
2. Local volunteering and a local timebank
3. Community Meet and Eat, a Super- Kitchen, community social dining
4. Delivery of Skills and Employment programmes
5. Classes to support Health and Well Being
6. Preventative and support work
7. Redevelopment of open space
8. Information, Advice and Guidance.
9. Setting up of community serve points

The approach will be from a positive stance, it will engage with and use local knowledge and skills, developing a sense of place, harnessing the goodwill of residents through a feeling of residentship and humanity and build on / or establish creative supportive networks. Integral to the delivery of this programme will be engagement and collaboration with schools, faith communities, GP's and local pharmacies, and in one area we will pilot a programme that supports the weekend discharge of older people from hospital. **Stage two** of the initiative will focus on developing the communities to set up and run social enterprises in order to run community networks and / or deliver local services.

The success will be measured initially on input measures and will include:

(a) the setting up of the community led steering group
(b) the number of people that engage in the hubs
(c) the number of carers engaged with
(d) the number of community serve points set up
(e) the number of hours in the time bank
(f) the amount of digital activity on the council website
(g) the number of initiatives implemented
(h) the number of social enterprises set up.
(i) the number of older people that have community friends and / or support

In addition to this there will be annual evaluation of impact including case studies.

SYSTEM WIDE BUSINESS CASE				Fit for the Future Working together to keep people well
Reference Number:				
Date:	09.03.17	**Version:**	6.6	
Business Case Title:	**Case Management**			
Organisation(s) submitting business case:	CPFT			
STP Work Stream / Directorate	PCIN			
Author:	John Hawkins			
SRO:	Cath Mitchell			
Executive Sponsor:	Aidan Thomas			
Senior Finance Manager Comments:	*This is to be completed by the Senior Finance representative responsible for reviewing bids prior to submission to the Exec Team / relevant committee for approval*			
Executive Team / Committee Meeting Comments:	*This is to be completed by the Exec Team / relevant committee reviewing the Business Case to capture the outcome of the review.*			

Guide to complete (and submit) your business case:

This document provides a template for all Business Cases. Please complete every section using the guidance as highlighted.

Be clear and concise.

Where relevant, try to articulate the case in terms of three core areas; Clinical effectiveness, Patient Experience and Safety.

Where necessary, involve specialists e.g. from finance, and proposed project work-streams to provide business case information including costs, risks, benefits and assumptions.

Include a paragraph in the Conclusion and Recommendations section explaining the decisions the committee are being asked to make.

Once completed, arrange for the business case to be reviewed by a peer and agreed by the Executive Sponsor before submission to the relevant board. Allow enough time for key people to review drafts, to support getting the business case right before it goes through the formal approval process.

Section Guidance is given in italics

[A] EXECUTIVE SUMMARY:

A1 – Purpose:

Managing people who are frail, who have complex needs and long term conditions is a growing and significant demand on primary care, acute hospitals and social care. It is one of the major challenges facing the health and social care economy over the next 5 years.

To help address this rising demand, the proposal is to implement a new model for case finding and case management across the Cambridgeshire and Peterborough health and social care system. It will identify the frailest and most complex elderly patients using a risk stratification tool, and will provide a consistent case management pathway with the aim of maximising independence and preventing avoidable unplanned care/ admissions. This approach was recommended as part of the strategy for integrated older people's services (Uniting Care contract) and has remained a key priority for health and social care partners. Significant work has already taken place over the past year, with involvement of all key stakeholders to develop the model, focusing on four Trailblazer Neighbourhood Teams (NTs).

Current MDT management of complex patients takes place via a direct enhanced service. This is ending 31/3/17 and is being replaced by the requirement to identify the most frail patients using a case finding tool and to undertake an annual review. The approach described in this paper complements the key role of the GP in MDT management, by ensuring there is a consistent approach to case finding, input from other agencies, and dedicated support in the community.

The case management pathway includes an initial assessment, care planning and stabilisation phase. Where appropriate, an MDT meeting will be used to review the patient's holistic needs and establish the input required from primary care, community services, social services and the voluntary sector. During the monitoring phase patients will be reviewed on a regular basis to identify a change in need. Every patient will have an up to date care plan and crisis plan to manage their long term health and social needs.

Comprehensive case finding and case management is critical to the system if we want to better manage the complex, frail and elderly population. When fully recruited this model will support the top 7.5% (11200 of over 65s) of older people who are most frail. This equates to an average of 800 patients per Neighbourhood Team (based on planned reduction of NTs from 16 to 14).

Diagram 1: Historical model (Appendix 1)

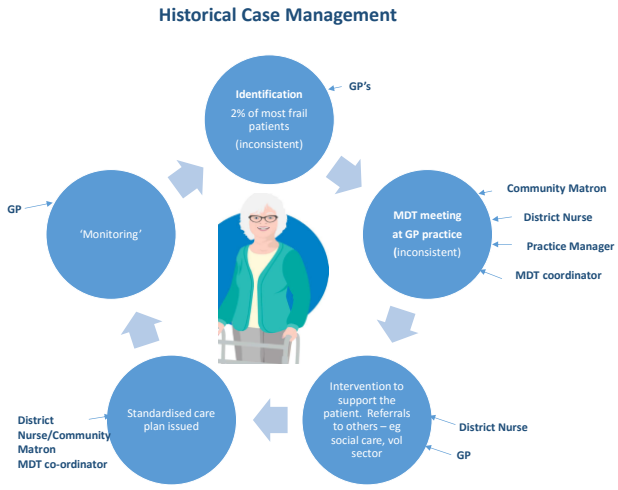
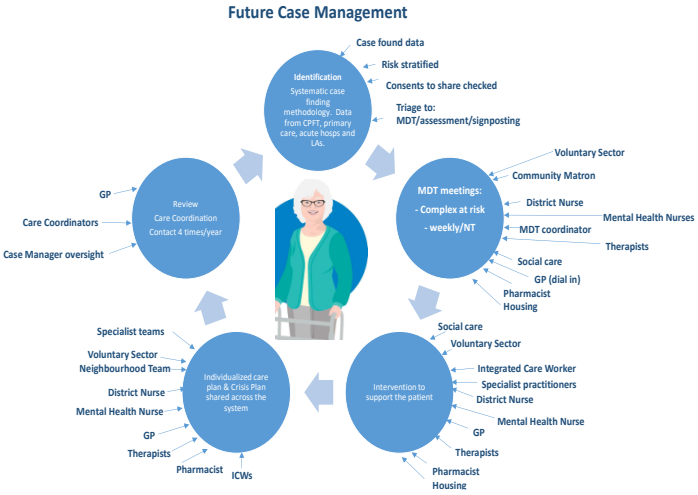


Diagram 2: Future model (Appendix 1)



A2 – Driver for Change:

Pressure on the system continues to grow, in particular acute hospital unplanned attendances and admissions. This requires key partners to work closer in a consistent and co-ordinated way as referenced in the STP.

The population of older people is rising rapidly and expected to grow by 34% for over 75s and 46% for over 85s by 2021.

Managing frailty is a huge challenge for health and social care. Where this can be achieved within a community setting there is both a patient and system benefit. It is well evidenced that hospital admissions within the elderly and frail lead to deconditioning, decreased cognitive function and decreased levels of independence which leads to needing greater levels of support.

Current MDT/case management models vary significantly across Cambridgeshire and Peterborough and do not sufficiently engage key partners, especially social care and the voluntary sector. This along with a lack of consistency in the case finding methodology will lead to future system pressures. Patients that are identified at an earlier point on a frailty pathway can be supported to self-manage their conditions with the minimum level of health and social care interventions and therefore reduce demand on statutory services.

The Trailblazer model:

- Brings together all MDT partners
- Identifies and ranks patients through a risk stratification tool to target the frailest people whilst also tackling those that are likely to become dependent of the services at a future date.
- Uses a consistent approach across all neighbourhoods and primary care (14 NTs, 105 practices, 2 local authorities and 2 overarching voluntary sector organisations)
- Makes the best use of the voluntary sector as a critical and expandable resource
- Integrates the key elements of an effective care and support system for frail people – i.e. primary care, case finding, case management, intermediate care, JET/urgent response services, reablement, specialist pathway teams

A3 – Alignment with Organisation or System Priorities:

Effective case finding and case management is a key enabler for the STP priority of **'at home is best'**. Coordinated and effective management of people who are elderly, frail and have complex needs will promote independence and allow people to stay at home in a supported environment for longer. Supporting these people through a broader MDT model that include voluntary sector gives the system an integrated structure to make the best use of services and resources (STP priority: **'we're only sustainable together'**).

Specific STP references are:

- **10-point plan, point 1:** People powered heath and well-being
- **10-point plan, point 2:** Neighbourhood care hubs
- **10-point plan, point 6:** Partnership working
- 100,000 people in Cambridgeshire and Peterborough with multiple long term conditions which lead to complex health needs
- People with long term conditions often experience a lack of coordination in the management of their condition. Too many people experience fragmented care
- Historic underfunding of the local health and social care system is reflected in the poor management of long term conditions
- We aim to deliver truly integrated health and social care
- We need to work more closely with district councils
- NTs, primary care and social care will work with the voluntary and community sector to identify those at risk or with deteriorating health

A4 – Brief Outline of Proposal:

This proposal seeks to implement a system wide case finding and risk stratification methodology to ensure that the top 7.5% frailest patients of the over 65 population of Cambridgeshire and Peterborough are identified and supported through an integrated case management approach. This will ensure that the correct people are identified no matter what GP practice they are aligned to.

The case management team embedded within each of the neighbourhood teams will support these patients to access the necessary assessment and interventions they need, working closely with primary care. For those patients who are most at risk with complex health and social care needs, an MDT approach that includes MDT co-ordinators, GPs, mental health specialists, social care, voluntary sector representatives, community nurses, community matrons and therapists will be used. The MDT will build an individualised care plan to implement the right interventions for each patient to be supported within their own home. In order for this approach to be successful, investment will be required to allow for VCS support, administration support and to build an MDT with appropriate breath of knowledge, skills and experience.

Where the case management capacity of NTs is expanded, patients can also be monitored to provide better outcomes for those people that reduces the burden and cost to the health and social care system over the next 5 years.

A typical case example that shows the case management model and how it links to other elements of the integrated STP model is:

Mrs Jones is 85, frail and lives alone. She has a number of health conditions including diabetes and hypertension that causes her to feel dizzy and fall which has led to 3 recent attendances at ED. Her husband died 5 months ago and since then she has felt low in mood and anxious about coping alone. She has become less socially active since her husband died.

An analysis of information from the acute hospital, primary care, CPFT and the Local Authority has indicated that Mrs Jones might be at risk of deterioration and avoidable admission. The team review her history and arrange an assessment by a band 6 community nurse. The nurse undertakes a comprehensive assessment that covers all areas of need for Mrs Jones including mental health, social care and her level of frailty.

Following this the nurse discusses Mrs Jones in the NT MDT meeting that includes mental health, community matrons, social care, primary care and the voluntary sector. Together they agree a plan that includes assessment by a MH nurse, review of her medication by her GP, a falls assessment by the NT OT, a visit by the voluntary sector co-ordinator and a regular check of her observations by a band 4 support worker.

The community nurse visits Mrs Jones again and provides her with a written copy of her care plan, that also includes who to contact in the event that she needs help urgently. Her first point of contact is her neighbour who has a key, but her "What if?" plan also includes her care co-ordinator (community nurse) and the JET team number.

Over time Mrs Jones feels better in herself. She has regular contact with a voluntary group and sees her band 4 support worker every month to check her observations and that all is well. However, one weekend she develops an infection, feels weak, unwell and takes to her bed. She calls the JET team who visit her. They arrange for anti-biotics and for intermediate care workers to call 3 times a day. The workers keep her hydrated, help her wash and ensure she takes her medications. Her community nurse calls to review her too. After 3-4 days she is feeling better and able to get up and do more for herself and only needs a call once a day from the intermediate care team. After 6 days she feels able to manage independently again.

This case example describes case management as one element of a model that integrates with primary care, intermediate care, voluntary sector, JET and other services.

A5 – Financial Impact and Outcomes:

The proposal aims to focus on the 7.5% most frail older people, case found through information sharing between CPFT, acute hospitals, local authorities and primary care practices. 7.5% of the total over-65 population (149000) equates to 11200. Risk stratification assumptions for the 11200 cohort are as follows:

Table 1

Highly Frail	20%	2238

Frail	60%	6714

Less Frail	20%	2238

Table 2 describes the resources necessary to increase NT capacity to support the 7.5% of the most frail O-65 population i.e. 11,200 people. WTE values are calculated from the average time spent by each practitioner in delivering each of the 3 "levels" of frailty pathway. The workforce modelling has been completed for the patient pathway and does not include the tasks required to establish and manage the service across each NT (e.g. co-ordination of MDT meetings, GP engagement, operational management and clinical leadership.) The actual resources requested have been adjusted accordingly. Please see appendix 2 for more details on the workforce modelling.

Table 2

	Workforce modelling				Additional resources required operationally for the 4 NTs
	HF	F	LF	Total	Required
MDT co-ordinator B5					*
Comm Matron B7	11.90	3.41	0.00	15.31	14 (1 per NT)
Nurse/OT B6	11.90	18.28	2.13	32.31	32.5
Nurse/OT B5	0.00	18.28	2.13	20.41	20.5
HCA B4	14.21	16.79	0.71	32.59	33
B3 Admin	0.18	0.53	0.18	0.89	4** (1 per locality)

** MDT co-ordinators are currently established and within CPFT baseline funding*

** Required to enable managers and clinicians to effectively operate the case management model*

The financial impact of this business case has built primarily on evidence from the Trailblazer pilot and a meta-analysis study of 48 papers looking at reducing hospital admission for older people (Philp et al 2013).

The paper referred to 3 case management studies one of which showed that recruited patients displayed a 20.8% reduction in ED presentations, a 27.9% reduction in hospital admissions, and a 19.2% reduction in bed-days. In comparison, the patients who declined recruitment displayed a 5.2% increase in ED presentations, a 4.4% reduction in hospital admissions, and a 15.33 increase in in-patient bed-days over a similar timeframe. The other 2 studies showed no significant savings from case management as a stand alone additional service.

Evidence on the impact of case management is 'promising but mixed' (Purdy 2010). This is mainly because of the difficulty in attributing any tangible impact (e.g. reduction in hospital utilisation) to the case management intervention when there are multiple factors at play. Nonetheless, there is widespread recognition of the model's validity. It is very similar to care co-ordination in mental health, which has successfully avoided admissions for the last two decades. Case management is also supported and recognised by both NHS England and the King's Fund as a key method of improving care for complex and frail individuals and avoiding unnecessary admission.

Positive outcomes have been reported from emerging models of integrated MDT care for frail people, which have case finding and case management at their heart, as described in the 2016 RCGP report "Innovative approaches to integrated care for older people with frailty" and in the Nuffield Trust 2017 report "Shifting the balance of care":

"… An evaluation of a number of large-scale integrated care pilots found that those that had case management at their heart reduce outpatient attendances and elective admissions by 22 per cent and 21 per cent respectively, and resulted in a significant 9 per cent reduction in overall secondary care costs in the six months following initiative (RAND, 2012). There is stronger evidence that case management improves satisfaction and quality of life (Hudon and others, 2016; Gravelle and others, 2007).

Case management is often one component of a wider initiative, which makes it difficult to attribute any impact. For case management to be effective, it relies upon other elements such as a functional multidisciplinary team and good data sharing. It is also important to have at its core a case manager who has an ability to negotiate and advocate on behalf of patients". Imison et al. (2017)

A6 – Sponsorship:

The case management project from day one has engaged with key partners to ensure a system-wide model is developed and tested. Senior leads from PCC, CCC, CCG, primary care, CPFT and both voluntary sectors have consistently attended, supported, undertaken development work – to redesign a new model.

The project was initially reported to the Integrated Adult and Community Joint Working Group CCG led – that included leads from: CCG: CPFT: CCC: PCC. Currently the project reports to PCIN and a joint CPFT: PCC: CCC operational group.

The Case Management Project Group includes:

- Older People's GP Lead, CCG
- Peterborough Voluntary Community Services Lead
- Health and Wellbeing Network Lead
- Transformation Lead – Urgent Care, CCG
- MH Lead, CPFT (Chair)
- Head of Operations, CCC
- NT TMs
- NT MDT co-coordinators
- NT community matrons

A7 – Quality Outcomes:

Patient experience outcomes:

- Better patient involvement in decision making on interventions
- Named care co-ordinator and identified contact point for the patient to approach with queries or concerns
- Written care plan including crisis plan and agreed personal goals for patients
- Signposting and utilisation of the public health prevention services available to tackle any health issues related to diet, exercise, drinking, smoking and taking drugs
- Ensuring positive patient experience and enhancement of service provision from patient feedback

Clinical outcomes:

- Improvement in EQ-5D scores – a measure of general health and well-being, this covers the following 5 key domains:
    - Mobility
    - Self-care
    - Activities
    - Pain
    - Mood/anxiety

System outcomes:

- Decrease in healthcare utilisation after one year for case managed patients compared to 12 months prior to case management intervention:
    - Unplanned admissions to acute hospital
    - ED attendances
    - Emergency call outs
- Improved utilisation of Pharmacy and review of medication.

A8 – Recommendation:

This business case recommends the STP invests in providing case finding and case management via a comprehensive and coordinated MDT. The MDT will be part of the NTs and will involve the voluntary services and primary care.
Once fully established, the service will identify and support the 7.5% most frail patients of the over 65 population and improve their quality of life as evidenced by the EQ-5D measure. It will provide better outcomes for those people and reduce the burden and cost to the health and social care system over the next 5 years.
In year 2 the service aims to expand and provide case management to 15% of the most frail patients over 65.

[B] DRIVER(S) FOR CHANGE:

B1 – Risk or Opportunity:

This model provides opportunities for patients and the system

- Identify and better support more people who are frail
- Significantly impact on the health and social care system – in particular reduce acute hospital demand
- Implement an MDT approach that ensures system engagement
- Make fully use of the untapped assets within each NT/community
- Implement a consistent approach to case finding, case mgmt, measuring impact
- Develop the knowledge of frailty and how to assess and manage – across all partners, including use of the RFS
- Restructure S1 in CPFT to ensure consistency and improve the process of consent to share

Risks:

- Unable to resolve the challenge of primary care engagement
- Data sharing agreements (that allows case finding) not achieved
- Case found demand exceed system capacity

Mitigations:
Please see risk assessment below

B2 – Strategic Context:

Pressure on the system continues to grow, in particular acute hospital unplanned attendances and admissions. The populations for older people is rising rapidly and expected to grow by 34% for over 75s and 46% for over 85s by 2021.

Managing frailty is a huge challenge for health and social care. Where this can be achieved within a community setting there is both a patient and system benefit. It is well evidenced that hospital admissions within the elderly and frail lead to deconditioning, decreased cognitive function and decreased levels of independence which leads to needing greater levels of support.

Integration of services and blurring organisational boundaries is key to the success of the STP. This business case provides a multi-organisation, system wide solution to the pressure placed on the system by the increasing elderly and frail population

B3 – Risk Assessment (only applicable if responding to a risk as identified in B1):

Risk	Impact	Mitigating actions	Risk: Likelihood	Risk Impact	Score
Primary care engagement not achieved – because MDTs are NT rather than primary care hosted	MDT effectiveness compromised MDTs less efficient	1. Iterate the Trailblazer model – e.g. N City TB NT holding MDTs in practices on rotating basis or 6/52 to show value of broader MDT model. 2. Case finding data demonstrates need for broader MDT model	3	3	9
Data sharing agreements (that allows case finding) not achieved	MDTs not able to target key population Impact to system significantly less	1. Data sharing agreements being developed between CPFT (as data processor) and: Acute hospitals LAs Primary care practices 2. CPFT providing business information resource to process data 3. Data Sharing Board working towards system model for processing case found data	2	3	6
Case found demand exceeds system capacity – significant risk without investment	Case found people unable to access support they need. Impact on the system significantly compromised	Broader MDT approach – utilise all available resources Coordinated approach – reduces waste STP investment – the most impactful mitigating action	Without investment: 5 With investment: 2	4 4	20 8
Savings cannot be evidenced within 1 year	Continued funding at risk.	SMART outcomes measures identified, based on evidence of current hospital NEL activity.	3	3	9

[C] ALIGNMENT WITH ORGANISATION or SYSTEM PRIORITIES:

C1 - The proposed investment aligns to the following elements of the organisational or system priorities:

STP Strategic Objectives	Evidenced By:
1. At home is best	Case management aims to: - improve support to people at home - utilise neighbourhood care hubs
2 Sustainable together	- engages and utilises a broader range of partners

D] OUTLINE PROPOSAL

D1 - The Preferred Option:

The preferred options is for a system wide, comprehensive case finding and case management service which will case manage **7.5% of the frailest and elderly over 65 population**. The model includes:

Case finding – using data/information sharing agreements between partners and criteria that identifies those people at risk today and our future at risk people. The methodology allows CPFT to process primary care, acute hospital, social care and CPFT data to case find and risk stratify patients.

Initial case finding criteria comprises:

- 3 or more unplanned admissions in the last 3 months
- 3 or more ED attendances in the last 3 months
- eFI>0.36
- FRS>3
- People with bereavement in past 12 months
- People O-65 who have been assessed as meeting national EC under the Care Act
- People with dementia dx
- JET referrals
- People with RFS>3

Patient list - NTs will be provided with a list of case found patients which will highlight new patients to the list and those who have a trigger for potential deterioration e.g. unplanned admission. Patients can also be referred directly for case management. New patients are triaged by the MDT coordinator and triage outcomes include: signposting, referral for MDT, allocation for assessment.

Case management – Each patient will have a named case manager from the most appropriate professional group. They are responsible for coordinating a single care plan and crisis plan which will be held within the NT, on S1 and accessible by all partners (including the voluntary and social care sector). Care plans will be accessible by EDs, 111 services and ambulance services – based on consent being in place.

MDT reviews – a system wide, structured, MDT will be established involving social care, VSC, NTs and primary care. Weekly meetings will discuss: new case found patients, patients who are an increasing concern and patients who have complex needs. Outcomes of MDTs will be recorded on and shared with relevant professionals

SystmOne – restructuring S1 in CPFT to better support the case management function. This includes restructuring MDT units to more clearly hold triage, active and review lists. To revise templates to improve care planning, consent recording etc and that ensures consistency across all 14 NTs. To ensure shared care planning, risk and assessment tools which support multi-disciplinary integrated working.

Frailty - developing system-wide knowledge of frailty, how to identify, how to respond and manage. Providing an online frailty training tool that is open to all partners to access.

D2 - 'Do Nothing' Option:

If no investment is achieved through STP:

1. The current case finding process will identify patients however they will not access the services they need in a coordinated and collaborative manner
2. The trailblazer model will continue in a limited way without dedicated resources to deliver at scale
3. Elderly, frail and complex patients will continue to access GPs, ambulance services and acute trusts for their health needs which for many could have been avoided
4. Risk that MDT working becomes more disparate and eventually breaks down

D3 - Alternative Option(s) Considered:

The proposed case management model has been developed in partnership with primary care, voluntary sector and local authority partners, taking into account lessons learned from the different MDT approaches across the county as well as examples of good practice from elsewhere. Different options were considered as the model evolved over time (e.g. case finding methodology, function of MD co-ordinator, setting and frequency of MDT meeting, voluntary sector role).

Below we describe an option for a reduced scale case management model (2.5% of over 65 population with frailty and complex needs)

Additional resources required for NTs to case manage the top third of the 7.5% (i.e. 2.5% most frail > 65s):

	Based on workforce modelling				Additional resources required operationally for the 14 NTs
Staff group	Highly Frail	Frail	Less Frail	Total	Required
MDT co-ordinator B5					**
Community Matron B7	11.90	0.76	0.00	12.66	14 (1 per NT)
Nurse/OT B6	11.90	4.06	0.00	15.96	16
Nurse/OT B5	0.00	4.06	0.00	4.06	3
HCA B4	14.21	3.73	0.00	17.94	18
B3 Admin	0.18	0.12	0.00	0.30	4 (1 per locality, for additional tasks required for operational management)
					55

	AfC Banding	WTE	Cost (£)
District Nurse	5	4.00	£141,500
District Nurse	6	16.00	£683,300
Community Matron	7	14.00	£649,000
Administrator	3	4.00	£91,900
Therapy Assistants	4	18.00	£499,100
Casefinding Anayltics Post		1.00	£50,000
Recruitment Support		0.50	£15,351
Vol Sector MDT attendance			£31,200
Vol Sector Co-ordinator		1.00	£41,617
Total pay costs		**58.50**	**£2,202,968**
Travel expenses			£95,000
Mobile/VPN rental			£14,040
Stationery/office supplies			£15,000
MSE/Clinical supplies			£20,000
Staff uniforms			£8,500
Premises (assuming agile w orking)			£125,000
Total non pay costs			**£277,540**
Total direct cost			**£2,480,508**
Overheads @ 10%			**£248,051**
Total cost of service			**£2,728,559**

Set up costs		**WTE**	**Cost (£)**
Agile w orking equipment - Laptops/phone including			

Please see section E 1 below for details of how savings have been calculated. For this reduced cohort of patients the analysis is as follows;

The recurrent costs of the reduced model (2.5% case management) is £2,729k. To deliver a £1 for £1 return this level of investment would need to result in 1,522 avoided spells. To return a 1:1.3 return this would need to increase to 1979.

This funding would allow for 3,730 individuals to be case managed, which would mean that one admission would need to be avoided for 53% of this population. It would be more likely that as this cohort are the most frail, these individuals would have more than one admission per year, and because of this by keeping these individuals less frail this should avoid more than one admission per year.

[E] FINANCIAL IMPACT:
Please complete all sections other than E4 for the preferred option only

E1 – Investment Required for Proposed Option

	AfC Banding	WTE	Cost (£)
District Nurse	5	20.50	£729,700
District Nurse	6	32.50	£1,389,100
Community Matron	7	14.00	£649,000
Administrator	3	4.00	£91,900
Therapy Assistants	4	33.00	£915,900
Casefinding Analytics Post		1.00	£50,000
Vol Sector MDT attendance			£31,200
Vol Sector Co-ordinator		1.00	£41,617
Total pay costs		**105.00**	**£3,775,600**
Travel expenses			£215,000
Mobile/VPN rental			£25,200
Stationery/office supplies			£15,000
MSE/Clinical supplies			£20,000
Staff uniforms			£16,750
Premises (assuming agile working)			£125,000
Total non pay costs			**£416,950**
Total direct cost			**£4,192,550**
Overheads @ 10%			**£419,255**
Total cost of service			**£4,611,805**

Set up costs		**WTE**	**Cost (£)**
Agile working equipment - Laptops/phone including cost of configuration			£70,000
Office equipment, furniture & fittings			£23,500
Recruitment Support		1.00	£30,702
S1 Project Support 1yr FTC agency staff rates			£120,000
Total set up costs			**£244,202**

E2 – Savings Delivered in the Proposed Option:

CPFT currently have an active care episode with 5,600 patients who have a Rockwood Frailty Score of 5 or above, and are therefore assessed as no less than moderately frail. The true figure once all patients are assessed using this scale is likely to be much higher.

Emergency hospital admissions for patients registered in Cambridgeshire & Peterborough CCG area are currently running at an average of 96 per calendar day, or in excess of 35,000 per annum.

Additionally - Case found data on the 250 most frequently admitted patients to acute hospitals (CUH, HHCT and PSHFT) in 15/16 was provided to NTs to review and caser manage where necessary. A summary of this data showed that whilst many patients were already known to CPFT, some were not. Those patients not known were reviewed (subject to necessary consent). As at month 7, QIPP savings of £47k were identified (target £40K) and a planned savings trajectory of £612k in 2016/17 and £1,717k in 2017/18. However, it is important to note this is data based on a relatively small number of patients and 1 month of impact data.

Case Management is a hard area to quantify savings for, with previously reviewed schemes having varying levels of success. Another issue is that currently due to the lack of data sharing agreements we do not have a full understanding as a system as to who would be classed as 'highly frail', 'frail' or 'less frail' to be able to quantify the likely savings, as case finding can not be carried out properly without this. Therefore the following section sets out a sensitivity analysis of how many admissions would need to be avoided to pay back the investment to provide the committee with a sense of the achievability of this.

The table below shows the CCG NEL spend for over 65 yrs old in the four local providers for M1-10 of FY16/17;

HRG4	HRG Desc	2016/17 Spells	2016/17 Cost	2016/17 XSBD	XSBD Tariff	XS Bed Day Price	Tariff Price
DZ11A	Lobar, Atypical or Viral Pneumonia with Major CC	1,298	£4,193,326	930	£187	£173,910	£4,019,416
EB01Z	Non-Interventional Acquired Cardiac Conditions	1,224	£838,918	632	£204	£128,928	£709,990
LA04D	Kidney or Urinary Tract Infections with length of stay 2 days or more with Major CC	838	£3,292,635	233	£200	£46,600	£3,246,035
EB03H	Heart Failure or Shock with CC	557	£1,745,698	115	£204	£23,460	£1,722,238
AA26A	Muscular, Balance, Cranial or Peripheral Nerve Disorders; Epilepsy; Head Injury with CC	557	£925,877	1052	£200	£210,400	£715,477
AA22A	Non-Transient Stroke or Cerebrovascular Accident, Nervous System Infections or Encephalopathy with CC	550	£1,865,779	1108	£200	£221,600	£1,644,179
EB10Z	Actual or Suspected Myocardial Infarction	490	£1,587,747	426	£204	£86,904	£1,500,843
WA22V	Other Specified Admissions and Counselling with Major CC	459	£1,551,255	1	£198	£198	£1,551,057
DZ22A	Unspecified Acute Lower Respiratory Infection with Major CC	429	£1,053,410	97	£187	£18,139	£1,035,271
EB08H	Syncope or Collapse with CC	391	£584,267	76	£204	£15,504	£568,763
DZ21H	Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation with Major CC	387	£1,187,478	290	£187	£54,230	£1,133,248
WD11Z	All patients 70 years and older with a Mental Health Primary Diagnosis, treated by a Non-Specialist Mental Health Service Provider	380	£1,192,512	0	£0	£0	£1,192,512
EB07I	Arrhythmia or Conduction Disorders without CC	376	£301,689	81	£204	£16,524	£285,165
	TOTAL	**7,935**	**£20,320,591**	**5,041**		**£996,397**	**£19,324,194**

This gives an average spell of £2,561. However, if this was MRET adjusted a prudent cost would be £1,793 per spell.

The recurrent costs of the full model (7.5% case management) is £4,612k. To deliver a £1 for £1 return this level of investment would need to result in 2,572 avoided spells. To return a 1:1.3 return this would need to increase to 3,344

	2016/17 Spells	2016/17 Cost	2016/17 XSBD	XS Bed Spend	Tariff Price
Mt 1-10 Actual	25,971	£64,821,001	15,362	£3,013,717	£61,738,895
FOT	31,165	£77,785,201	18,434	£3,616,460	£74,086,674

To put this into context, the below table shows the total NEL admissions of over 65s from month 1-10 this year, and grossed up to full year;

	2016/17 Spells	2016/17 Cost	2016/17 XSBD	XS Bed Spend	Tariff Price
Mt 1-10 Actual	25,971	£64,821,001	15,362	£3,013,717	£61,738,895
FOT	31,165	£77,785,201	18,434	£3,616,460	£74,086,674

The percentage reduction of the two models is reflected below;

	Reduction in spells	% Reduction in spells	Number of Admissions avoided per NT per Month	Number of clinical staff to deliver this per NT (average)
£1 for £1 full model	2,572	8.25%	15.3	7
£1.30 for £1 full model	3,344	10.7%	19.9	7

However, this assumes that the whole saving needs to be delivered from admissions avoidance. There are a number of other savings that will be delivered by case management;

- Reduced GP attendances/OOH calls
- Ambulance Call outs
- Medicines savings
- Reduction in Nursing home places required (Kings Fund 2011)

Additionally, freeing up Acute beds gives the opportunity to repatriate elective income into the Trusts. This is predominantly for PSHFT and CUH, but for all providers a further saving will be the removal of excess bed days, and the fact that these cost more than the tariff paid for them.

Acute providers have quoted the missed opportunity of having to outsource elective activity rather than provide it in house at £500 per bed day. The CCG also outsourced £7.3m of activity to Independent Sector Providers in 16/17 (based on FOT). The average LOS for the top 10 NEL admissions is 8.5 and therefore each admission avoided would allow the Trusts to make £4,250 in additional margin from elective activity.

Therefore the saving per admissions is actually the average CCG tariff avoided £2,561 plus the additional margin to the provider per admission avoided of £4,250, so £6,811. This therefore makes the revised admissions required;

	Reduction in spells	% Reduction in spells	Number of Admissions avoided per NT per Month	Number of clinical staff available to deliver this per NT (average)
£1 for £1 full model	677	2.2%	4	7
£1.30 for £1 full model	880	2.8%	5.24	7

E3 – Source of Funding:

Funding is requested through the STP investment pot

E4 – Financial Model: See separate Excel spreadsheet – please complete for all options outlined in section D

E5 – Contractual Considerations:

STP agreement to fund will be reflected in CPFT:CCG contract.
OJEU does not apply as this is an expansion of an existing service

E6 – Capital Risk (Capital Cases only):

N/A

[F] PATIENT EXPERIENCE:

In terms of the preferred option:

F1 – Impact on Patient Care:

Patient experience outcomes:

- Better patient involvement in decision making on interventions
- Named care co-ordinator and identified contact point for the patient to approach with queries or concerns
- Written care plan including crisis plan and agreed personal goals for patients
- Signposting and utilisation of the public health prevention services available to tackle any health issues related to diet, exercise, drinking, smoking and taking drugs
- Ensuring positive patient experience and enhancement of service provision from patient feedback

[G] OPERATIONAL IMPACT:

In terms of the preferred option:

G1 – Capacity: post change, during implementation; Other areas:

The new model of case management enables capacity for 6,000 – 7,000 patients per year to have an active period of case management and then go on to have care coordination as a monitoring tool.

The activity assumptions are detailed further in Appendix 2. Broadly, the case management pathway consists of 3 phases:

Pathway stage	Activities	Staff roles
Triage and referral management	Review of patient notes, liaison with agencies and patient, obtaining consent	Mainly MDT co-ordinator, admin
Active case management	Holistic assessment, frailty score, EQ-5D, development of care plan, liaison with agencies, discussion at MDT meeting, development of crisis plan, follow up visits, clinical record keeping	Mainly B5-7, depending on complexity
Review	Reassessment of needs, revision of plan, liaison with agencies	Mainly B4 with B6 undertaking annual reviews

Each NT requires a minimum level of resource for administration and operational management. MDT co-ordinators are already included in the CFPT baseline and are not included in this business case.

The Community Matrons will provide expect clinical assessment for the most complex of frail patients as well as advice and leadership within the NT on frailty and case management.

Additional capacity required to implement the case management model:

- Engagement of the voluntary sector in the MDT meetings and MDT care plans.
- SystmOne technical and training support to ensure that the configuration and templates on SystmOne support integrated working, in line with the new case management pathways.
- Analytics resource to support roll out and implementation of case finding tool

G2 – Support Services, Physical and Equipment Capacity, IT and IG Compliant:

By operating the described model, efficiencies will be realised. The MDT process in the TBs brings together a broader range of agencies than before. This reduces overlap and duplication. Work is underway to use a single care plan across agencies, for all staff to be able to identify frailty and undertake a generic assessment.

Additional staff will be NT based and equipped with agile devices that reduces the need to work from base. The project aims to enable all staff from which ever organisation to be able to access any base under any partner agency to touch down, liaise etc.

CPFTs work to expand agile working includes case management.

G3 – Impact Assessment:

A QIA will be completed, in accordance with CPFT requirements.

[H] WORKFORCE/HR:

H1 – Staffing Numbers:

	AfC Banding	WTE
District Nurse	5	20.50
District Nurse	6	32.50
Community Matron	7	14.00
Administrator	3	4.00
Therapy Assistants	4	33.00
Casefinding Analytics Post		1.00
Vol Sector Co-ordinator		1.00

H2 – Staff Consultation:

Formal staff consultation is not required.

H3 – Training:

The proposal includes the development of a Frailty/RFS training module. This is an online training tool for all partner agencies to access. E-learning frailty tool is currently being tested.

H4 – Recruitment Considerations:

Recruitment of most professions in Cambs and P'boro is challenging. CPFT are developing a STP recruitment strategy and trajectory that includes:

- Attracting clinical apprentices
- Developing associate practitioner posts
- Broadening the advertising and recruitment potential. CPFT have previously successfully run intense recruitment campaigns using a wide range of media than standard NHS Jobs or recruitment fairs.
- There is an opportunity for us to describe case management and associated posts as an element of a new and innovative system transformation.

H5 – Tenure:

All appointments will be substantive unless otherwise noted.

H6 – Job Plans:

Case management is a existing component of key NT staff job descriptions.
Roles and responsibilities for different staff in relation to the new case management model have been developed and will be included in relevant JDs.

[I] IMPLEMENTATION:

I1 – Timescales:

The Case Management Project Group has plans to begin to roll-out across NTs from April//May 17. Delivery plans for the different Workstreams are already in place. The roll-out implementation plan will be reviewed and updated depending on the success of this bid.

I2 – Implementation Governance Arrangements:

Once implemented, the governance responsibility for the neighbourhood teams lies with CPFT.

During the development and implementation phase the project reports to the PCIN delivery group, which in turn reports to the CAG, FFPG and HCE. Additionally, the group reports to the joint CPFT: PCC: CCC operational group.

The Case Management Project Group includes:

- OP GP Lead, CCG
- Peterborough Voluntary Community Services Lead
- Health and Wellbeing Network Lead
- Transformation Lead – Urgent Care, CCG
- Mental Health Lead, CPFT (Chair)
- Head of Operations, CCC
- NT TMs
- NT MDT co-coordinators
- NT community matrons

I3 – Support Services Resources:

CPFT have provided project support:
- SystmOne technical support
- IG leadership for data sharing agreements
- Business information for case finding methodology
- L&D for Frailty/RFS development
- Project lead

CCG have provided:
- Clinical/primary care leadership
- IG support

CCC have provided
- IG support

CCG, CCC, HWN, CPFT and PCVS have provided senior leads to the project group

I4 – Post-Project Evaluation (PPE):

Key system outcomes are:

- Numbers of unplanned admissions for case found patients
- Numbers of ED attendances for case found patients
- Patient experience outcomes

Timescale for PPE: (Please tick one box below)

3 months	☐	**6 months**	☐	**9 months**	☐

I5 – Deliverables: KPIs/Outcomes and systems for measuring performance of the scheme:

KPIs/Outcomes	Target	Systems
Number of MDT care plans completed	6,000 – 7,000	SystmOne
% of case managed patients showing Improvement in EQ5-D scores	N/A	SystmOne
Reduction in non-elective admissions	880	TBC*

*The methodology for measuring avoidable admissions requires an STP-wide approach e.g. via a review panel, as recommended by the King's Fund.

[J] RISKS & OPPORTUNITIES:

J1 – Implementation Risks & Opportunities:

The success of the project is dependent on access to other community services, in particular the expanded JET and intermediate care, expanded Psychological Wellbeing Service and expanded voluntary sector capacity.

J2 – Post-Implementation Risks & Opportunities:

Post-implementation opportunity to refine case finding criteria that better supports the system
To research the effectiveness of a case management model that is implemented as part of a wider integrated model

[K] STAKEHOLDER ENGAGEMENT:

K1 –Stakeholders Engaged During Business Case Development:
There has been significant engagement from stakeholders over the past 12 months, as part of the case management working group, to develop the operational model, case finding tool and data sharing agreements. Voluntary sector, Local authorities and primary care have been involved alongside NT clinicians and trailblazer staff. See section I2 for more details.

[L] RECOMMENDATION:

The PCIN delivery group seeks approval to invest £4,856,007 to implement case funding and case management within the Cambridgeshire and Peterborough system.

[M] DUE REGARD SCREENING:

Impact (please indicate Yes or No for each question)	Race/Ethnicity	Sex	Religion or Belief	Gender Reassignment	Sexual Orientation	Age	Marriage & Civil Partnership	Pregnancy & Maternity	Disability
Do different groups have different needs, experiences, issues and priorities in relation to the proposed change?	No	No	No	No	No	No	No	No	No
Is there potential for or evidence that the proposed change will not promote equality of opportunity for all and promote good relations between different groups?	No	No	No	No	No	No	No	No	No
Is there potential for or evidence that the proposed change will affect different population groups differently (including possibly discriminating against certain groups)?	No	No	No	No	No	No	No	No	No
Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular group or groups?	No	No	No	No	No	No	No	No	No

Note that if any box contains a 'Yes' then a full DUE REGARD assessment is required to be undertaken.

[N] REVISION HISTORY:

Version	Date	Amendments	Authored/Approved By

This template should be used for all investment bids (both Capital and Revenue), in accordance with relevant Organisation's SFIs.

[O] SIGN-OFF TEMPLATE

BUSINESS CASE SIGN-OFF

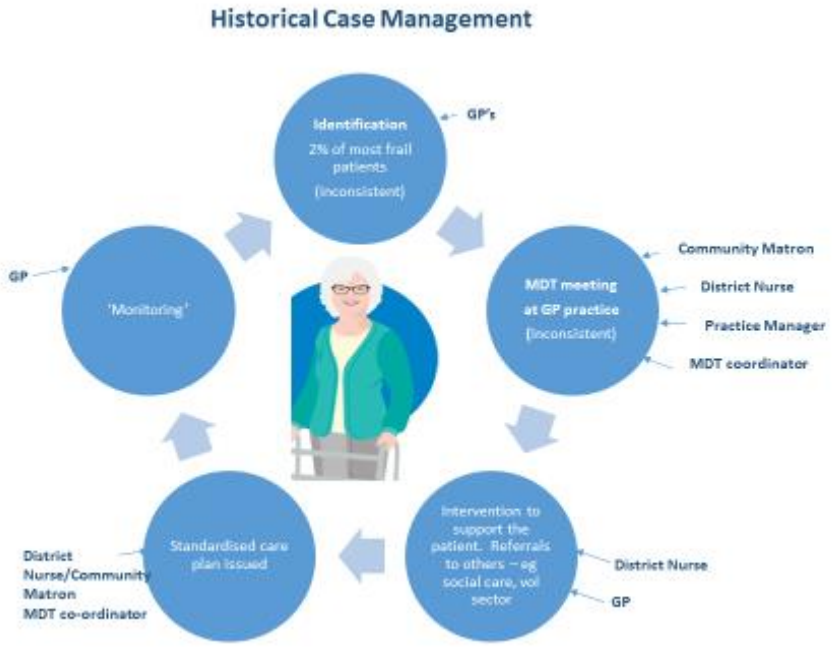
Business Case Title:

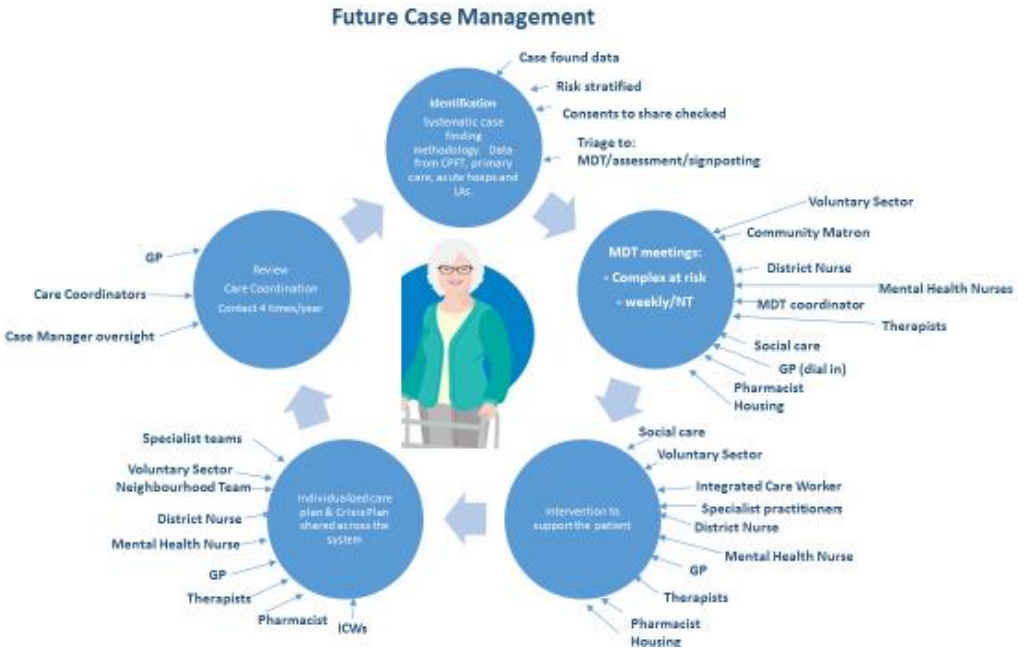
Author:

Date:

Function	Name	Title	Approved	Rejected	Approved "subject to"	Comments (please explain reasons for approval, rejection and "subject to")	Signature	Date
Business Case Lead	John Hawkins	Mental Health Lead						
Clinical Lead	Rhiannon Nally	Clinical Lead						
Executive/ SRO Lead	Cath Mitchell	Director						
Finance	Louisa Ellington	Finance Lead						
HR/ Medical Staffing		HR/ Medical Staffing Lead						
Contracting		Contracting Lead						
Estates		Estates Lead						
IT		Head of IT						
Impact Assessment		Impact Assessment Lead						

APPENDIX 1


Historical Case Management
Identification
2% of most frail patients
(inconsistent)
GP's
MDT meeting at GP practice
(inconsistent)
Community Matron
District Nurse
Practice Manager
MDT coordinator
Intervention to support the patient. Referrals to others – eg social care, vol sector
District Nurse
GP
Standardised care plan issued
District Nurse/Community Matron
MDT co-ordinator
'Monitoring'
GP


Future Case Management
Identification
Systematic case finding methodology. Data from CPFT, primary care, acute hosps and UAs
Case found data
Risk stratified
Consents to share checked
Triage to:
MDT/assessment/signposting
MDT meetings:
- Complex at risk
- weekly/MT
Voluntary Sector
Community Matron
District Nurse
Mental Health Nurses
MDT coordinator
Therapists
Social care
GP (dial in)
Pharmacist
Housing
Intervention to support the patient
Social care
Voluntary Sector
Integrated Care Worker
Specialist practitioners
District Nurse
Mental Health Nurse
GP
Therapists
Pharmacist
Housing
Individualised care plan & Crisis Plan shared across the system
Specialist teams
Voluntary Sector
Neighbourhood Team
District Nurse
Mental Health Nurse
GP
Therapists
Pharmacist
ICWs
Review Care Coordination Contact 4 times/year
GP
Care Coordinators
Case Manager oversight

APPENDIX 2: Workforce modelling

2a: Highly Frail Pathway Assumptions

Total population 65+	149201
7.5% MDT coverage	11190

Pathway stages:	Triage and referral management
	Active case management
	Review

			per NT (/14)
Highly frail	20%	2238	160
Frail	60%	6714	480
Less frail	20%	2238	160

Highly Frail pathway (estimated 12 month pathway with 6 weeks active case management)

What	Time estimate per patient	Who	Total hours
Triage and referral management	30 min, all patients	Mainly MDT co-ordinator, some admin	0.5
Clinical assessment	120 min, majority of patients	Mainly B7/6	2
Liaison follow up	60 min *2, majority of patients	Mainly B7/6	2
Stabilisation	60 min *2, majority of patients	B7/6 and B4	2
Follow up reviews (monthly)	60 min *9, majority of patients	Mainly B7/6	9
Additional support	60 min *9, majority of patients	Mainly B4	9
			24.5

2b: Frail Pathway Assumptions

Total population 65+	149201
7.5% MDT coverage	11190

Pathway stages:	Triage and referral management
	Active case management
	Review

			per NT (/14)
Highly frail	20%	2238	160
Frail	60%	6714	480
Less frail	20%	2238	160

Frail pathway (estimated 12 month pathway with 5 weeks active case management)

What	Time estimate per patient	Who	Total hours
Triage and referral management	30 min, all patients	Mainly MDT co-ordinator, some admin	0.5
Clinical assessment	120 min, majority of patients	Mainly B5/6	2
Liaison follow up	60 min *2, majority of patients	Mainly B5/6	2
Stabilisation	60 min *2, majority of patients	B5/6 and B4	2
Follow up reviews	90 min *3, some patients	Mainly B4	4.5
One year follow up	120 min, all patients	Mainly B5/6	2
			13

2c: Less Frail Pathway Assumptions

Total population 65+	149201
7.5% MDT coverage	11190

Pathway stages:	Triage and referral management
	Active case management
	Review

			per NT (/14)
Highly frail	20%	2238	160
Frail	60%	6714	480
Less frail	20%	2238	160

Less Frail pathway

What	Time estimate per patient	Who	Total hours
Triage and referral management	30 min, all patients	Mainly MDT co-ordinator, some admin	0.5
Clinical assessment	120 min, half of the patients	Mainly B5/6	2
Liaison follow up	60 min, majority of the patients	Mainly MDT co-ordinator, B5/6	1
Stabilisation	Not required		0
Follow up reviews (annually)	60 min, some patients	Mainly B4	1
			4.5

2d: Workforce modelling summary options

For 20/60/20 split and 7.5%
Based on workforce modelling

	HF	F	LF	Total
MDT co-ordinator B5	0.71	2.13	0.71	3.55
Comm Matron B7	11.90	3.41	0.00	15.31
Nurse/OT B6	11.90	18.28	2.13	32.31
Nurse/OT B5	0.00	18.28	2.13	20.41
HCA B4	14.21	16.79	0.71	32.59
B3 Admin	0.18	0.53	0.18	0.89
	38.90	59.41	5.86	105.06

For 7.5% most frail over 65s:

Total population 65+	149201
7.5% MDT coverage	11190

			per NT (/14)
Highly frail	20%	2238	160
Frail	60%	6714	480
Less frail	20%	2238	160

For top third of 7.5% (i.e. 0.33*0.075= 2.5%).
For 2.5% and 60/40/0 split

	HF	F	LF	Total
MDT co-ordinator B5	0.71	0.47	0.00	1.18
Comm Matron B7	11.90	0.76	0.00	12.66
Nurse/OT B6	11.90	4.06	0.00	15.96
Nurse/OT B5	0.00	4.06	0.00	4.06
HCA B4	14.21	3.73	0.00	17.94
B3 Admin	0.18	0.12	0.00	0.30
	38.90	13.20	0.00	52.10

For 2.5% most frail over 65s:

Total population 65+	149201
2.5% MDT coverage	3730

			per NT (/14)
Highly frail	60%	2238	160
Frail	40%	1492	107
Less frail	0%	0	0

NB:

- **Over 65 population data based on CCG extract April 2016 for GP registered patients**
- **20/60/20 Frailty split are estimates, consistent with CPFT patient profile (for patients who have a Rockwood Frailty Score)**
- **Modelling covers clinical roles in relation to patient pathway. Admin, leadership and operational management, co-ordination, case finding analytics and set up costs not included.**
- **Based on estimates and assumptions, not validated by data.**

APPENDIX 3

Summary Options Table

	Option A Full model 7.5% of >65s	Option B Reduced model 2.5% of >65s
Case managed patients	11,,190	3,730
Additional staff WTE	105	58.50
Recurrent cost	£4,611,805	£2,728,559
Total NEL target for 1:1.3 ROI	880	521
Total savings target	£5,993,680	£3,547,127

APPENDIX 4

References

Baker M, Olver D, Burns E, Paynton D, Bullard E and Cooke C. Integrated care for older people with frailty: Innovative approaches in practice. Royal College of General Practitioners and British Geriatrics Society. November 2016

Bird SR, Kurowski W, Dickman GK and Kronborg I (2007). Integrated care facilitation for older patients with complex health care needs reduces hospital demand. Australian Health Review 31(3): 451–61.

Huntley AL, Thomas R, Mann M, Huws D, Elwyn G, Paranjothy S, Purdy S (2013). Is case management effective in reducing the risk of unplanned hospital admissions for older people? A systematic review and meta-analysis. Family Practice 2013; 30(3): 266-275

Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, Appleby J, Thorlby R and Lombardo S (2017), Shifting the balance of care: great expectations. Research report. Nuffield Trust.

Philp I, Mills K, Thanvi B, Ghosh K and Long J (2013) Reducing hospital use by frail older people: results from a systematic review of the literature, Int J Integr Care 2013; Oct–Dec; URN:NBN:NL:UI:10-1-114756

Purdy S (2010) Avoiding hospital admissions: what does the research evidence say? The King's Fund, December 2010

Appendix 5

Actual patient case study from Trailblazer NT

Mr X is a 66 year old gentleman.

Current Health needs – COPD managed with antibiotics and steroids. Lymphoedema with leg circumference of a metre each which leak constantly. Abdomen also leaks. Housebound and at high risk of pressure ulcers. Mr X is very low in mood and feels there isn't much point to life. He has been let down by healthcare professional and says "they cannot manage the level of need that he presents with".

Social History – Lives with son in privately rented accommodation. Unable to go upstairs and not allowed to attach any equipment to walls etc. due to the house being privately rented. Mr X has the use of a downstairs toilet which he struggles to get into due to size. Mr X sleeps in his chair which is a leather recliner which is collapsing under his weight. The chair is soaked due to leakage from abdomen and legs which is causing an infection control risk to his health. Mr X has to sleep upright due to his COPD as cannot breathe when lying down. Current recliner chair tips forward if legs are reclined due to weight. Not being able to elevate legs causes the lymphoedema to get worse. Mr X is unable to have a hospital bed as he cannot get in and out of the bed due to not being able to get his legs on and off. Mr X is socially isolated due to immobility. Unable to access relevant clinics as hospital transport cannot support his size and he cannot sit in waiting rooms at the hospital.

The District Nurses attend for daily dressings but are struggling with the weight of the legs when bandaging. They cannot provide adequate pressure relieving equipment as the chair doesn't support it. They cannot manage the leakage within the dressings and need the legs to be elevated to support improvement.

Matron and MDT co-ordinator – Co-ordinated all of the relevant clinicians and kept Mr X involved with his care. We sourced a bariatric chair that was able to meet his complex needs. It provided pressure relief, was able to tilt adequately to enable him to lie down at an angle to sleep and have legs elevated at same time. It was cleanable to reduce the risk of infection. It provided a good elevation of the legs so that the District Nurses weren't bending. It was electric so Mr X could use it independently and safely. We sourced the funding for the chair from a charity as we were not able to get one through our current equipment provisions. MDT co-ordinator ensured the servicing of the chair was provided and liaised with the legal team regarding responsibilities. MDT co-ordinator documented minutes of the meeting on SystmOne. Mr X was educated to recognise signs of deterioration and which relevant person to contact if he needed further support. We brought Mr X's case to MDT every week to move it along quickly.

District Nurses – work with Mr X to develop care plans for the leg dressings that Mr X could tolerate. Linked in with lymphoedema service for advice and explained the importance of a home visit from them. District nurses attend MDT meetings to share their good knowledge of Mr X with others.

Occupational Therapist - They carried out a risk assessment of the environment and established that without being able to make adaptations to the house, they would struggle to meet his needs. They gave advice and supported with the de-cluttering of the house to make the environment safer. They supported the District Nurses with carrying out moving and handling of the legs at dressing change to prevent unnecessary risk to backs etc. OT liaised with matron to research pieces of equipment that couldn't be sourced within current provisions. OT also formed part of MDT discussion at meetings.

Physiotherapy – Mr X was suffering with backache from the current chair and the pressure the weight of the legs and abdomen and physiotherapy provided support for exercises that were manageable which reduced the pain which subsequently meant reducing pain relief medications that were having other side effects such as constipation.. MDT input with current progress.

Social Services – Offered a care package to help with washing and dressing and housework and washing. Offered to support with rehousing urgently so Mr X could remain living independently with the adaptations he needed.

Mental Health – Offered CBT and counselling to help him cope with his current long term conditions.

Voluntary – Provided a befriending service to reduce the risk of social isolation. They helped him fill out all the forms required for rehousing and did a benefits check to make sure he was receiving his entitlements.

GP and nurse practitioner reviewed medication to reduce polypharmacy. They also rang in to MDT to discuss their input.

Outcome – Mr X has accessed GP and 999 much less since neighbourhood team input. He is feeling much better emotionally and physically. District Nurse visits have reduced substantially. Mr X now has a good support network in place and knows what his options are for the future. He now feels more in control of his health and wellbeing.

SYSTEM WIDE BUSINESS CASE				Fit for the Future Working together to keep people well
Reference Number:				
Date:		**Version:**		
Business Case Title:	**Intermediate Care Tier including Discharge to Assess**			
Organisation(s) submitting business case:	Cambridgeshire and Peterborough CCG			
STP Work Stream / Directorate	Urgent and Emergency Care			
Authors:	Sara Rodriguez-Jimenez			
SRO:	Ruth Derrett			
Executive Sponsor:	Roland Sinker			
Senior Finance Manager Comments:	*This is to be completed by the Senior Finance representative responsible for reviewing bids prior to submission to the Exec Team / relevant committee for approval*			
Executive Team / Committee Meeting Comments:	*This is to be completed by the Exec Team / relevant committee reviewing the Business Case to capture the outcome of the review.*			

Guide to complete (and submit) your business case:

This document provides a template for all Business Cases. Please complete every section using the guidance as highlighted.

Be clear and concise.

Where relevant, try to articulate the case in terms of three core areas; Clinical effectiveness, Patient Experience and Safety.

Where necessary, involve specialists e.g. from finance, and proposed project work-streams to provide business case information including costs, risks, benefits and assumptions.

Include a paragraph in the Conclusion and Recommendations section explaining the decisions the committee are being asked to make.

Once completed, arrange for the business case to be reviewed by a peer and agreed by the Executive Sponsor before submission to the relevant board. Allow enough time for key people to review drafts, to support getting the business case right before it goes through the formal approval process.

Section Guidance is given in italics

[A] EXECUTIVE SUMMARY:

A1 – Purpose

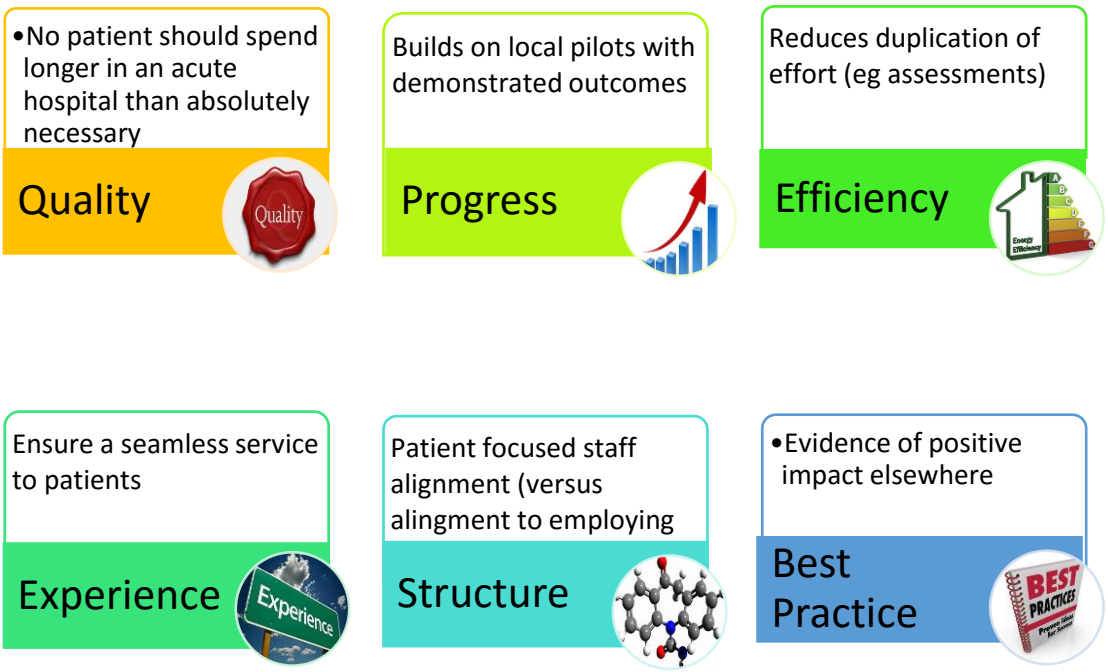
This proposal sets out how the local system can address the mismatch between patient need and demand and provision of community intermediate care services, with a particular emphasis on home support services.

Intermediate care comprises a number of services that is wider than solely community inpatient beds. Intermediate care was initially introduced to target elderly people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long-term residential care or continuing in-patient care. It is understood as being time-limited.

The local system is currently heavily dependent on acute and community bed based solutions and therefore there are missed opportunities to meet the needs of patients with home support to the levels required, resulting in unnecessary delayed transfers of care, and subsequent impact on patients' potential for deconditioning further while waiting.

This imbalance can only be reduced by investing and developing a comprehensive intermediate care tier offer, strengthening home based services. The preference is for patients to go back to their own home, however it is recognised sometimes this may not be possible for a number of reasons and therefore it is key that going forward community pathways are simplified into three main care pathways that provide the right mix of home based services, community rehabilitation beds, and residential / nursing home care for more complex patients.

This is also an opportunity for the system to establish a more integrated discharge support service in community that delivers the following ambitions:



To achieve this, the work stream is seeking investment to allow for the establishment of an Intermediate care workforce which would support the delivery of Discharge to Assess pathways for patients that are medically fit. The benefits to the system are inclusive of:

- Reduction in Delayed Transfers of Care
- Improved Patient Flow.
- Improved clinical outcomes
- Improved Patient outcomes and experience
- Reduced hospital falls and Hospital born infections
- Reduction in elective sourcing in the private sector
- Reduction in elective cancellations and improved RTT

A2 – Driver for Change

The Starting Point

- **Population Growth:** Cambridgeshire and Peterborough is facing increasing demand for local health and care services. It has a rapidly growing and ethnically diverse population that will be 20% higher by 2031.

- **Insufficient community capacity:** there is insufficient resource in community for the system to support complex discharges from hospital at the rate that it should, with demand for health and social care services (including long term placements) currently outstripping supply.

- **Clinical evidence:** There is much evidence of the benefits of delivering care at or closer to home. A recent national audit (2014) reported that the average waiting time for a place in an intermediate care service is currently 6.5 days – higher than in previous years. A wait of more than two days negates the additional benefit of intermediate care, and seven days is associated with a 10% decline in muscle strength which is a disadvantage for people with frailty for whom muscle weakness is a defining characteristic.

- **Pressures on patient flow and performance:** Acute hospitals in Cambridgeshire and Peterborough are under considerable and continuing pressure to meet the demands of unplanned care. The hospitals are regularly prone to black alert without available beds, long A&E waits, high outliers, and high average lengths of stay (ALOS). The system is failing to meet national standards and at times the quality of patient care is at risk.

- **The current approach leads to duplication and pathway delays:** the system doesn't have a single point of exit for complex discharges. The current system is not working effectively, often consumed by paperwork and process of "transfer of care", facing many obstacles and barriers as patients transfer through different services and teams.

Evidence from Case Studies / Pilots

Discharge to Assess has been successfully implemented across the country in a number of sites and has also been successfully trialled locally to support discharges from hospital. A summary of findings from national and local pilots is included in **Appendix A.**

National Direction of Travel

In May 2016 the National Audit office (NAO) reported its findings on discharging older patients from hospital. It reported nearly two thirds of hospital bed days being occupied by people over 65 with an 18% rise in emergency admission for older people in the last four years. The NAO also reported 1.75 million hospital bed days being lost due to delays in transfer of care in 2015, with an estimated 4.2 million bed days occupied by people no longer in need of acute hospital care.

The NAO described older people stranded in hospital when they no longer need to be there. It has been estimated that 10 days of bed rest for healthy older people can equate to 10 years of muscle ageing with attendant loss of function.

Staying in hospital has negative consequences for patients, especially the frail elderly who will experience physical decline, loss of mobility, their ability to function as they did before admission as well as a loss in confidence. It also impacts on patients who are unable to access beds occupied by those medically fit for discharge. Therefore, we need to ensure people are in hospital only for as long as they need acute medical and nursing care. Assessment for longer -term care and support needs should be undertaken in the person's own home (where possible) or another community setting.

This means patients no longer wait in hospital for these assessments, which reduces delayed discharges and improves patient flow. This challenges the current model of OT and PT assessment within the acute hospital, which has traditionally been based around the 'Assess to Discharge' model.

A3 – Alignment with Organisation or System Priorities

Priorities for change	10-point plan
At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs
Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care
Together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 10. Using technology to modernise health

A4 – Brief Outline of Proposal

Our ambition is to provide a comprehensive suite of services that provide truly integrated intermediate care in community for patients in Cambridgeshire and Peterborough. In doing this we need to embed pathways that focus on supporting discharges from hospital to the patients' home when clinically appropriate. The proposed model of care therefore needs to encompass the full range of intermediate care services. It is widely understood that long stays in hospital for older people once they are medically fit can result in significant muscle loss, deconditioning, loss of independence and confidence, and increased risk of infection. The evidence points to the significant benefits to patients returning to the life they had before through a shorter stay in hospital followed by discharge to their own home when appropriate with the right support package to meet their needs.

At present the capacity to provide home based health services is not formally commissioned. It has grown ad hoc to build system resilience over the winter and respond to increases in demand to support discharges of older and frail patients. Home capacity is provided mainly by the independent sector which - although responsive and a good alternative to bridge gaps in provision- can be expensive. It is also harder to achieve effective integration across services if the provider landscape is too diverse, and capacity taken from the independent sector for intermediate care puts further pressure on the pool of capacity available to the system for long term placements.

There are also variations as to how Discharge to Assess is being applied in different localities, and hospitals often find the large plethora of services and community pathways confusing and difficult to navigate effectively.

Our aim is to move the system from the current set up to a more effective and consistent approach, with a simplified number of community pathways to facilitate supported discharges from hospital. The figures below show a graphic representation of the current and proposed set ups:

Figure A: current pathways

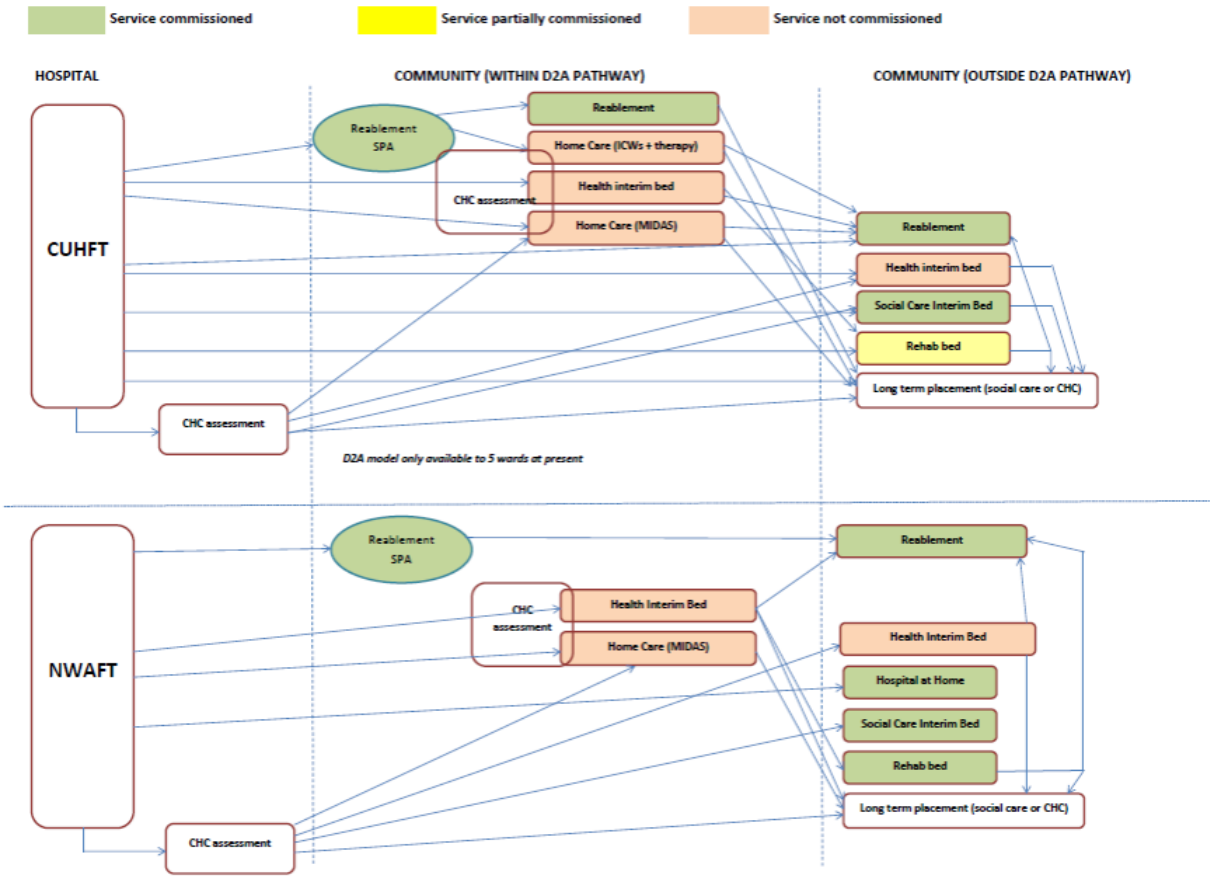
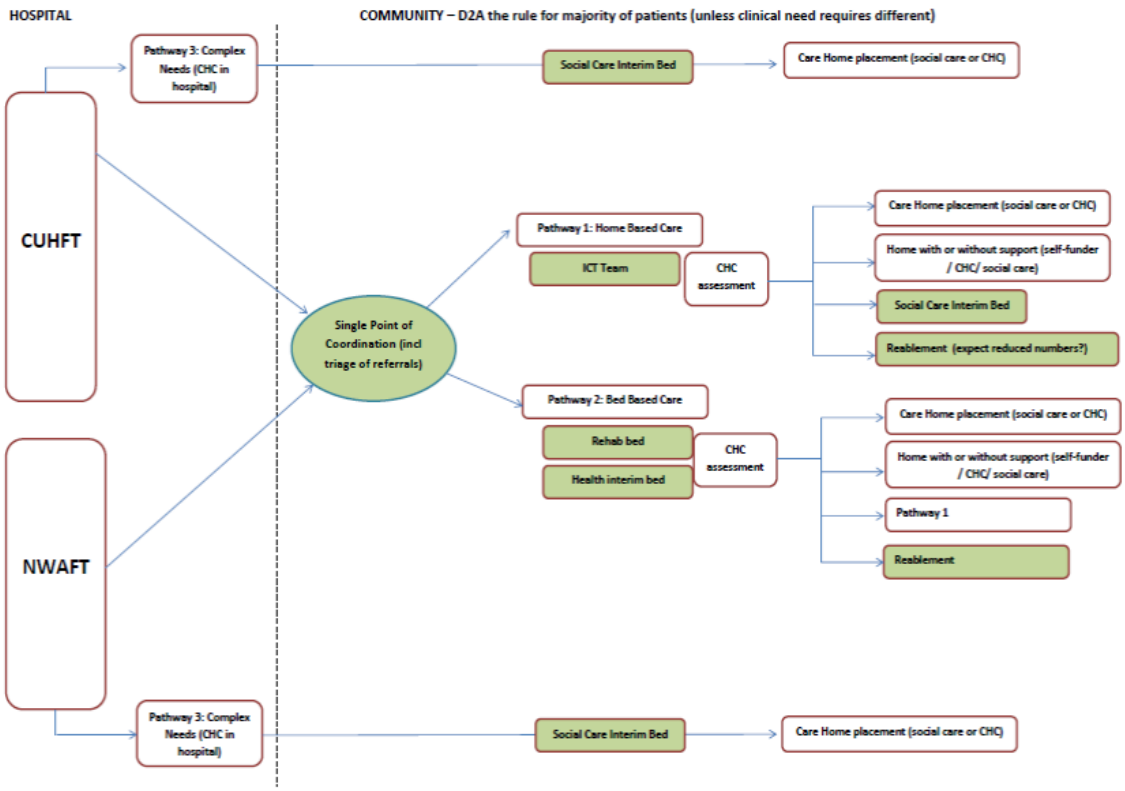


Figure B: Proposed Pathways



To make the transition from A to B as set out above, we need to deliver the following key elements:

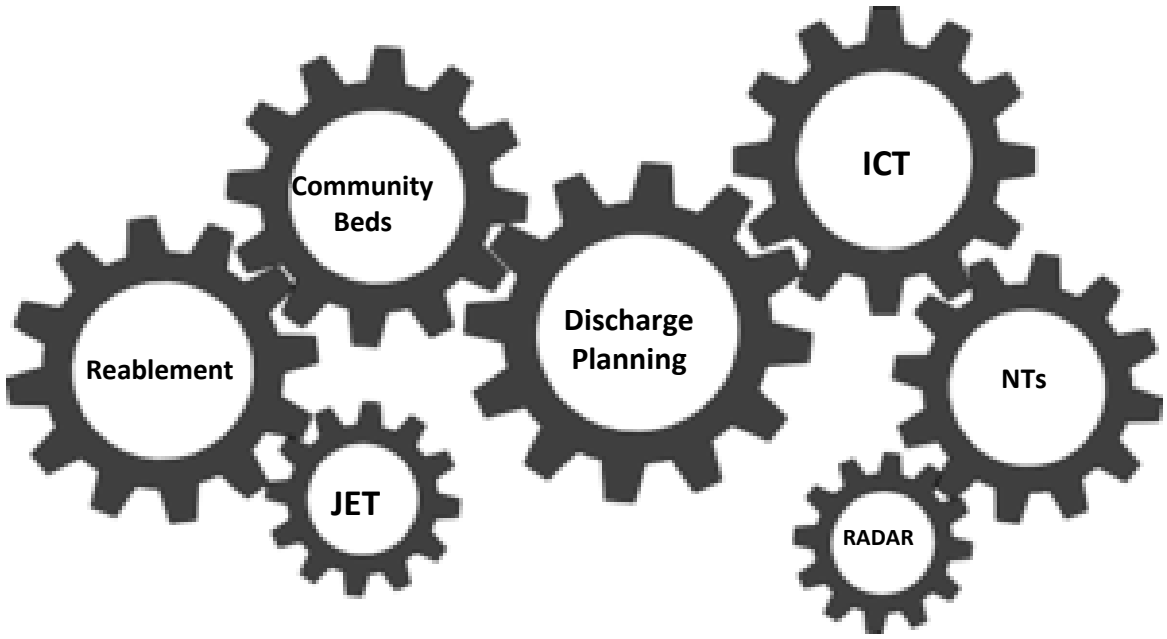
1. Development and implementation of a Single Point of Coordination (SPOC) to coordinate referrals into appropriate community services;
2. Development of a home based Intermediate Care Tier;
3. Improved utilisation and patient flow through existing bed based services;
4. Simplifying discharge pathways and implementing the full roll out of the Discharge to Assess approach across Cambridgeshire and Peterborough; and
5. Achieving greater integration across community services.

Services in Scope

- SPOC
- Intermediate Care Home Based Support (therapy & Integrated Care Workers)
- A proportion of reablement capacity (as part of the work in developing an integrated workforce)
- Community inpatient beds

Dependencies with other services – the full patient pathway

Intermediate care should be seen as a stage in overall care, not as an isolated service. It can help patients to stay independent for as long as possible and help identify the long term support needed after an accident or illness. It is a "cog" in a complex system of interconnected services in and out of hospital:



Recent work has been undertaken to reconfigure existing community services to develop multidisciplinary, locally-based community health and social care services, working closely with primary care. In addition a number of business cases have been put forth to expand capacity in other services with a particular focus in admission avoidance. We now need to take this to the next stage to establish a resilient intermediate care tier that can provide home-based services through Integrated Care Workers (ICW), and intensive rehabilitation services (therapy) better integrated to the robust reablement service provided by the local authorities to form the intermediate tier.

It is recognised that a number of health and care professionals are key to a number of services whether focused on admission avoidance or supported discharge (e.g. HCAs / Integrated Care Workers, therapists, OTs, nurses). Integrating teams around disciplines will enable the system to get greater economies of scale, and will support the provider of community services to manage workforce in a most effective manner. It will also avoid any potential duplication or double counting of workforce when developing proposals for future investment.

What will be different as a result?

Successful implementation of this proposal will deliver:

- Integrated ways of working in the community across health and social care
- Economies of scale through sharing workforce to support patient needs more effectively and appropriately
- Capacity agility to enable the system to flex capacity to reflect the demand of service
- Ownership of a complete patient pathway outside hospital and an objective overview of that collectively represents the patient
- A true Single Point of Coordination to access community services with clinical input to ensure patients' needs are matched to capacity
- Long term benefits to help us address social care and health capacity challenges

A5 – Financial Impact and Outcomes

The development of an Intermediate Care service including a single point of access to enable better coordination between agencies / services in providing a comprehensive approach to complex discharges will reduce bed days and Delayed Transfer of Care. The proposal will support the system to reduce length of stay in hospital and provide a safer, clinically effective pathway for patients.

A breakdown of expected financial savings resulting from implementation of the preferred option is provided in section E2 of this business case.

A6 – Sponsorship

The project team has engaged with the following internal and external stakeholders to secure sponsorship of the proposal:

- Cambridgeshire and Peterborough Clinical Commissioning Group
- Cambridge University Hospitals NHS Trust
- Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridgeshire Community Services NHS Trust
- Hinchingbrooke Health Care NHS Trust
- Papworth Hospital NHS Foundation Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust
- Cambridgeshire County Council
- Peterborough City Council

In addition, representatives from local general practices, East of England Ambulance Service NHS Trust, Hunts Forum, Peterborough Voluntary organisations, NHS Improvement, Emergency Care Improvement Programme (ECIP) and patient representatives have actively participated in developing solutions and are key partners for implementation.

A7 – Quality Outcomes

The implementation of the model will improve the experience of patients and carers as follows:

- Putting patients first with decisions about their long term care made within an environment familiar to the patient, it is 'context specific' and the patient's immediate and longer term needs can be more appropriately evaluated.
- Patients will see faster response times to care needs, as well as wider choice of alternative services to cater to their needs.

- Seamless care provision. Patients will benefit from greater availability of assessment services in the community leading to reduced dependency over time.
- Services targeted at encouraging self-care, promoting healthier living and providing activities in a home or community setting will dramatically improve the wellbeing of patients.
- Patients' outcomes will improve as more people will be able to live at home for longer. Length of stay in hospital will decrease thus reducing risk of deconditioning

It will also deliver the following benefits:

- Facilitating better integration across teams and providers, and breaking-down demarcation lines between professionals and multi-skilling to improve care.
- Releasing time to care with less time spent by referrers navigating services in an urgent care situation.
- Common outcomes to referral eligibility criteria and access to care.
- Prompt and appropriate professional advice to referrals from healthcare professionals / clinicians within the community.
- Removal of unnecessary steps, processes and delays in the discharge process with consume valuable resources and do not add value to the patient.
- Reduction in length of stay and Delayed Transfers of Care.
- Improvement in patient flow through hospital, thus enabling other patients to access acute care at the time they need it.
- Sharing responsibility, risks and skills across partners will lead to innovative and creative solutions that deliver safe, effective care and support.

A8 – Recommendation

Partner organisations are asked to approve investment as set out in section E of this business case from 1st April 2017.

[B] DRIVER(S) FOR CHANGE:

B1 – Risk or Opportunity

Cambridgeshire and Peterborough system partners have an opportunity to redress the current imbalance between investment in community capacity (particularly home based support) and patient demand. This business case puts forth a proposal that will restore that balance whilst enabling the delivery of the vision set out in our Sustainability and Transformation Plan (STP). We can do this by:

1) Increasing the ability of community services to respond to demand for care and support for patients in their own home / place of residence;
2) Optimising the utilisation of our existing community inpatient bed stock; and
3) Improving the speed with which people are safely discharged from hospital.

B2 – Strategic Context

Background and Strategic Ambition

The demand for health and care services is growing, associated with the rising age profile of the population and the increasing number of people living with long term conditions. The number of people aged 85 and over is expected to double over the next two decades.

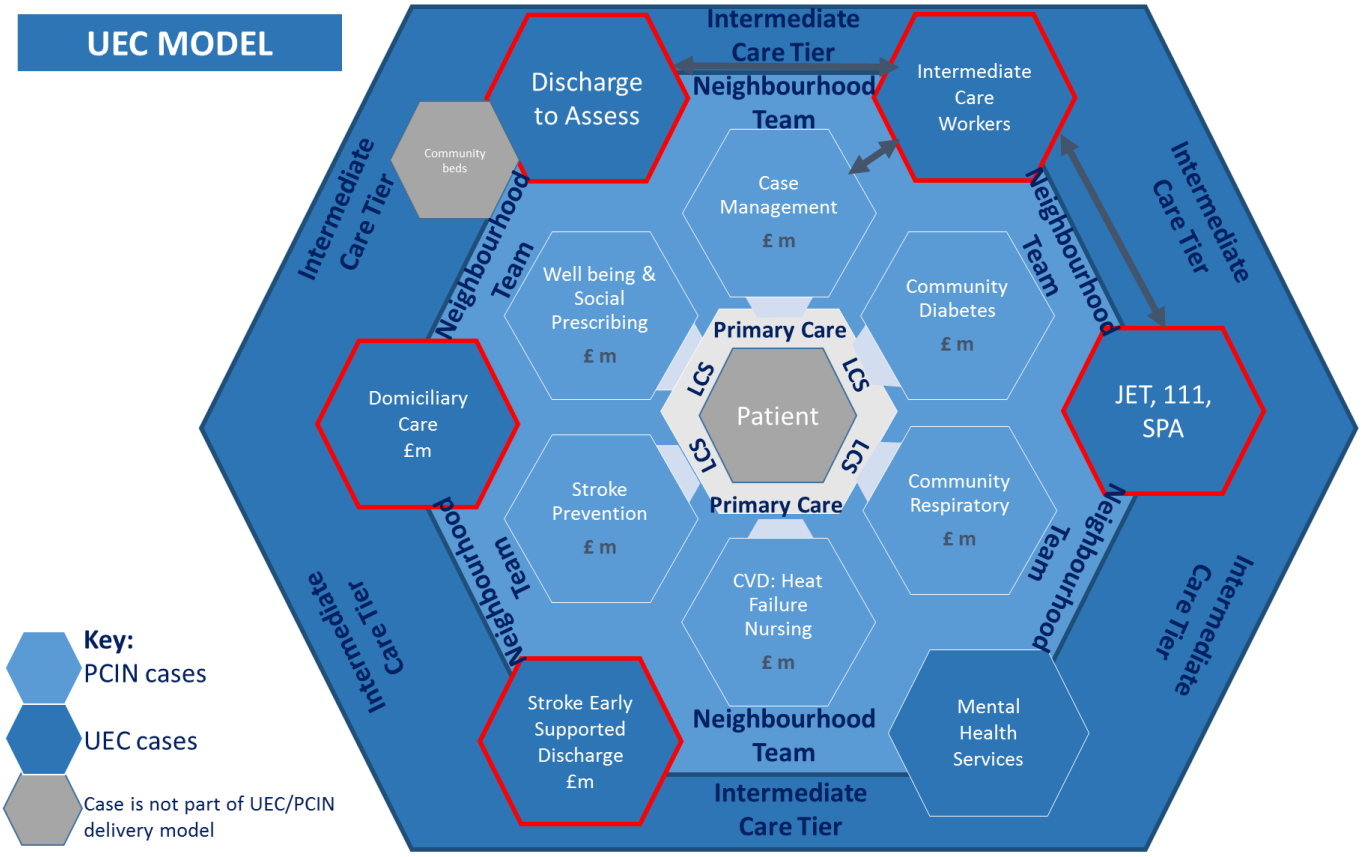
Between 2013 and 2031, the Cambridgeshire population is forecast to grow by 22.7% and Peterborough by 24.3%. In terms of the elderly population, there is expected to be substantially higher growth: 55.5% in Peterborough, and over 60% in Cambridgeshire. As elderly people are more likely to have chronic, long-term conditions, their needs from the services will change. It has been reported that older people with multiple

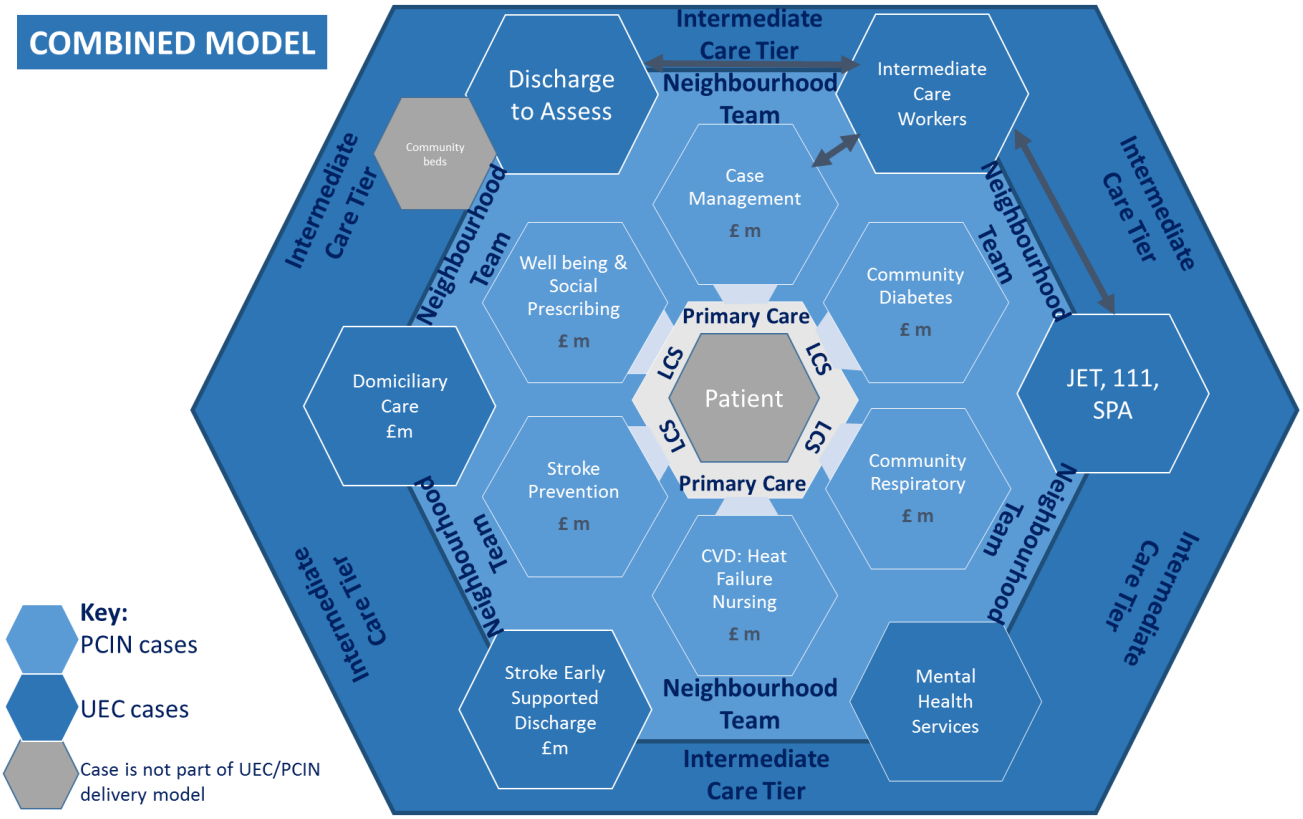
conditions, frailty or dementia, requiring complex and coordinated health and social care, currently account for 50% of NHS resources.

We need to transform our approach to providing intermediate care services in a community setting if we are to provide high quality services that are both clinically and financially sustainable. The system also faces significant financial challenges. Our ability to deal with the full scope of demand for health and social care services is limited and we need to radically change existing pathways of care to place a much stronger emphasis on:

1) Strengthening the capacity of our community services to support patients in their own place of residence;
2) Reducing the length of the stay patients spend in an acute setting when they no longer require acute care; and
3) Improving the outcomes for patients who can enjoy a longer period of independent living through front loaded rehabilitation and support interventions in their own home / place of residence whenever possible.

The system is already fully committed to greater integration as a key part of the future we envisage: which is for proactive, seamless care delivered through a person-centric care model, far from the disjointed, organisation-focused care which too many people currently receive. All the elements in the system are connected and rely on each other to operate successfully as an effective health and social care system.





B3 – Risk Assessment (only applicable if responding to a risk as identified in B1):

The proposal put forth is designed to redress the balance of community provision. The risk of not doing so is the system will continue to fail to meet levels of demand for support services outside an acute setting, potentially putting patient care at risk, putting further downward pressure on the performance of providers, and making it difficult for the system to maximise the outcomes and impact of investment in existing services.

[C] ALIGNMENT WITH ORGANISATION or SYSTEM PRIORITIES:

C1 - The proposed investment aligns to the following elements of the organisational or system priorities:

STP Priorities:

Priorities for change	**Commitment**
At home is best	• Community based rapid response to deteriorating patients • Introduction of home first discharge to assess model • Review of community bed-based and non bed-based provision.
Safe and effective hospital care, when needed	• Reduced delayed transfers of care • Consistent urgent and emergency care in right place

CCG Improvement and Assessment Framework:

Better Health	
Health inequalities	Inequality in avoidable emergency admissions
Better Care	
Urgent and emergency care	Achievement of milestones in the delivery of an

	integrated urgent care service
	% of patients admitted, transferred or discharged from A&E within 4 hours
	Delayed transfers of care attributable to the NHS per 100,000 population
	Population use of hospital beds following emergency admission
Sustainability	
Allocative efficiency	Outcomes in areas with identified scope for improvement
New models of care	Adoption of new models of care
Leadership	
Sustainability & Transformation Plan	Sustainability and Transformation Plan Delivery

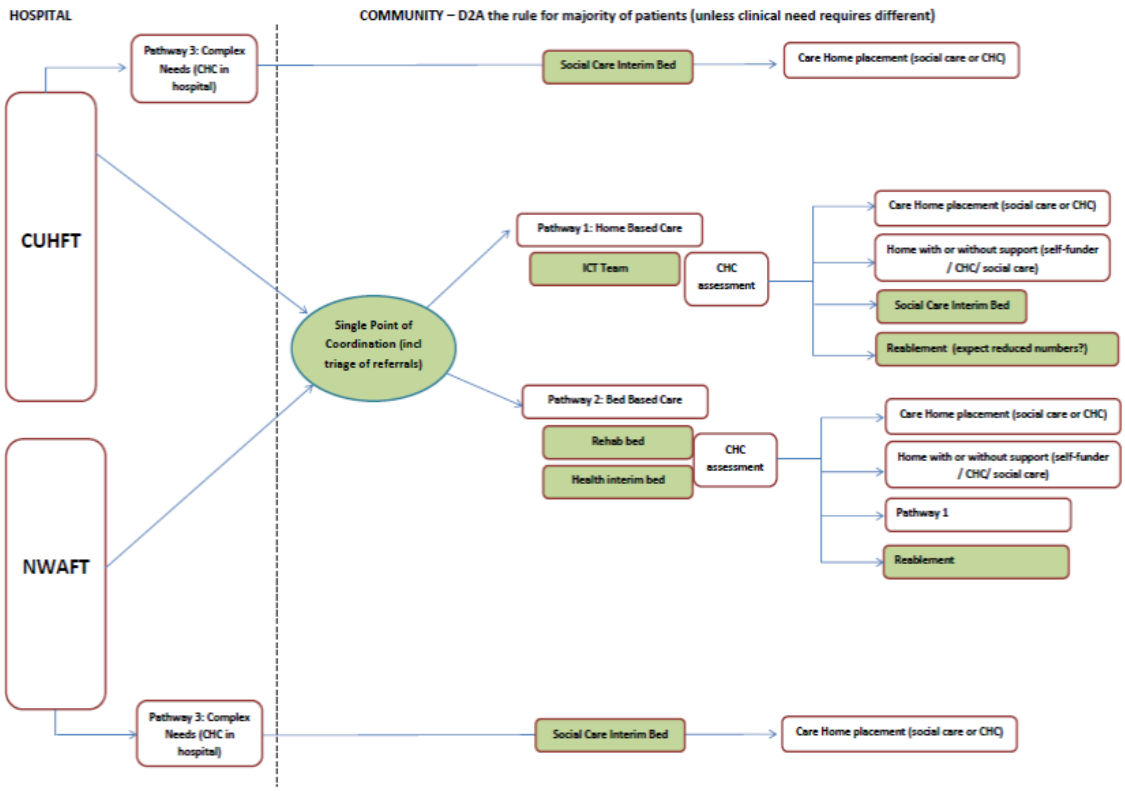
D] OUTLINE PROPOSAL

D1 - The Preferred Option

The preferred option is to set up a comprehensive and effective set of intermediate care services in the community, with effective overall coordination and pathway management. This requires the following:

- Development and implementation of a Single Point of Coordination (SPOC) to coordinate referrals into appropriate community services;
- Development of a home based Intermediate Care Tier;
- Improved utilisation and patient flow through existing bed based services;
- Simplifying discharge pathways and implementing the full roll out of the Discharge to Assess approach across Cambridgeshire and Peterborough;

Proposed Pathways



The Single Point of Coordination (SPOC)

To get economies of scale the proposal is to have a SPOC across the CCG, albeit some of the operational teams delivering intermediate care services will need to be split across the geography to be closely aligned to local services.

This SPOC will help professionals arrange the right care for referrals. It would operate as a "transfer of care bureau" supporting patients to receive appropriate care at home or as close as home as possible; and to prevent inappropriate hospital attendances and admissions through clinical navigation and integrated teams. The main functions will include:

- Act as the single point of access into the relevant community services;
- Triage referrals to the most appropriate service based on clinical review of information received from referrer;
- Respond to calls within clear and agreed timeframes working to agreed referral deadlines;
- Hold the knowledge of available community services and capacity levels;
- Hold and manage the overarching intermediate care tier patient flows and patient transfer list, proactively escalating delays in discharges from the relevant pathways;

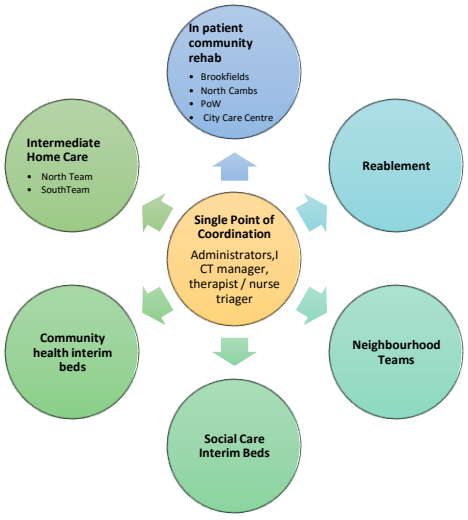
Referrals into the service will be accepted from a number of professionals as set out in the table below:

"Step Up" Care	**"Step Down" Care**
General Practitioners	Hospital Discharge Planning Teams
Community Matrons	A&E / Emergency Care Clinicians
Community Specialist Nurses / Teams*	
District Nurses*	
JET Practitioners*	
Social Care Services*	

**following consultation with GP or specialist consultant regarding patient condition and needs*

The SPOC will provide access into the following services[1]:

- Reablement
- Intermediate Home Care (ICWs and independent sector where appropriate)
- Community beds (rehabilitation, and interim)
- Social care interim beds
- Neighbourhood Teams



[1] Additional services can be added to the SPA if/where appropriate during future phases of service development if the system determines this to be the best approach

The Intermediate Care Tier

An effective model of care has to encompass a full range of intermediate care services to be able to support patients at home first but also offer alternatives for those patients for whom going back home is not an option right away. The proposed model of care for supported discharge will have three main community pathways supporting patients with different levels of dependency:

- Pathway 1: Home with support
- Pathway 2: Rehabilitation in a bedded facility
- Pathway 3 Long term care/ very complex care needs

The overarching principle of these pathways is that patients should always be cared for at home provided this pathway can meet their needs focusing on improving and maintaining their independence. All pathways should enable patients to rehabilitate fully (within their own potential) in the most appropriate setting. All assessments – including assessments for continuing health care needs - should be done in the community pathways rather than in hospital – with a very few exceptions. This would enable the system to have a consistent approach to **Discharge to Assess.**

Pathway 1: Home with Support

Patients that can go home with additional support are discharged home and receive ongoing support at home for a limited period. Support interventions can include nursing, therapy, care, or any service that will enable the patient's recovery to greater independence. The intensity of the service depends on the patients' needs.

Patients will be assessed at home following their discharge and will have therapy assessment within a 24 hour window to ensure the support package is tailored to the patient's needs.

This pathway is supported by therapies, social workers, integrated care workers (ICW's -Band 2/3) and discharge planning nurses, thus creating a rue intermediate care suite of health and/or social care services that can support early discharge from, or prevent unnecessarily prolonged stays in, hospital as well as supporting early discharge from community hospital rehabilitation units working alongside other community teams.

This service has to be integrated with the existing reablement services 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.

The voluntary sector will also have a key role to play in this pathway as they offer key complementary services to support patients at home.

Pathway 2: Rehabilitation in a bedded facility

Patients who cannot be discharged home directly but will benefit from additional rehabilitation and have clear rehabilitation goals set out by therapists in the receiving unit. Care will be provided in community hospitals and/ or care homes with rehabilitation support dependent on need for up to 3 weeks (expected average length of stay; we recognise for some patients with complex needs the length of stay will exceed 3 weeks, but we expect this cohort to be a discrete number). The purpose of rehabilitation in a bedded facility is to stabilise the patients so that they can be safely discharged home (with our without home based support).

With an expectation that most patients will reable / rehabilitate at home under pathway 1, the community beds become the appropriate setting for those patients that need rehabilitation and that cannot go home because of the degree of medical and nursing need.

The system will need to sustain the current community bed provision at least until the new model of care is fully implemented and the system is able to evaluate the impact of increasing home care support through investment in a number of community services. However, there are opportunities to improve the performance and patient throughput of the existing bed stock by continued focus on the reduction of community DTOC in these units.

The table below sets out potential bed days the system could gain (full year effect) if average LoS was reduced to 21 days across the 4 main community hospitals (21 day LoS applied to 75% of the patient

throughput in the understanding that 25% of patients going to a bed could have health interim needs and require a longer stay beyond 3 weeks):

	April 2016 to Jan 2017 Actuals			75% focus for reduction LoS to 21 days		New bed days used if 75% of patients average 21 day LoS	
	Bed Days	Patients discharged	Avg LoS	Bed Days	Patients	Bed Days	Discharges
Lord Byron Ward bed days	9873	336	29.38	7405	252	5292	252
Welney Ward bed days	3482	126	27.63	2612	95	1984.5	95
Trafford Ward bed days	4335	181	23.95	3251	136	2850.75	136
Intermediate Care Unit bed days	9573	500	19.15	N/A	N/A	N/A	N/A
Totals	27263	1143	23.85	13268	483	10127	483
Potential gain if average LoS reduced to 21 days for 75% of patient throughput - excluding ICU (full year effect)			***3141 bed days***				

Pathway 3: Long Term Care / Very Complex Care Needs

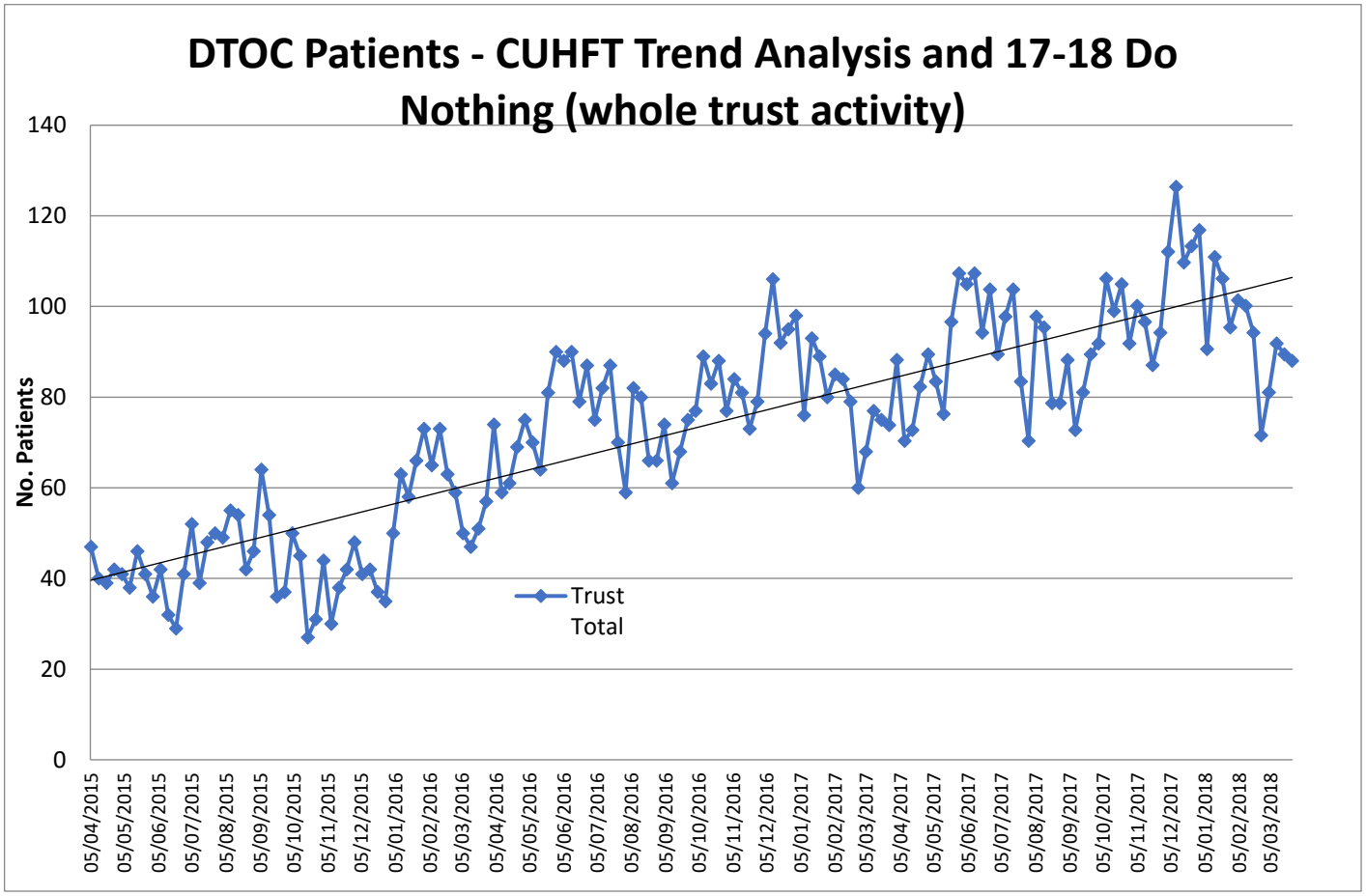
Patients that have likely long term care needs and require on going care in a residential setting. The hospital team would have identified these patients as having very complex care needs and are likely to require continued care in a care home setting for the rest of their lives. It is anticipated this will be a smaller cohort of patients for whom completing assessments in hospital will remain the best approach to provide the best quality of care.
Patients who can be discharged with a straight re-start of the care package in place before admission will be included under this pathway as they don't require new assessments if they can go home with same care package within 14 days of admission.

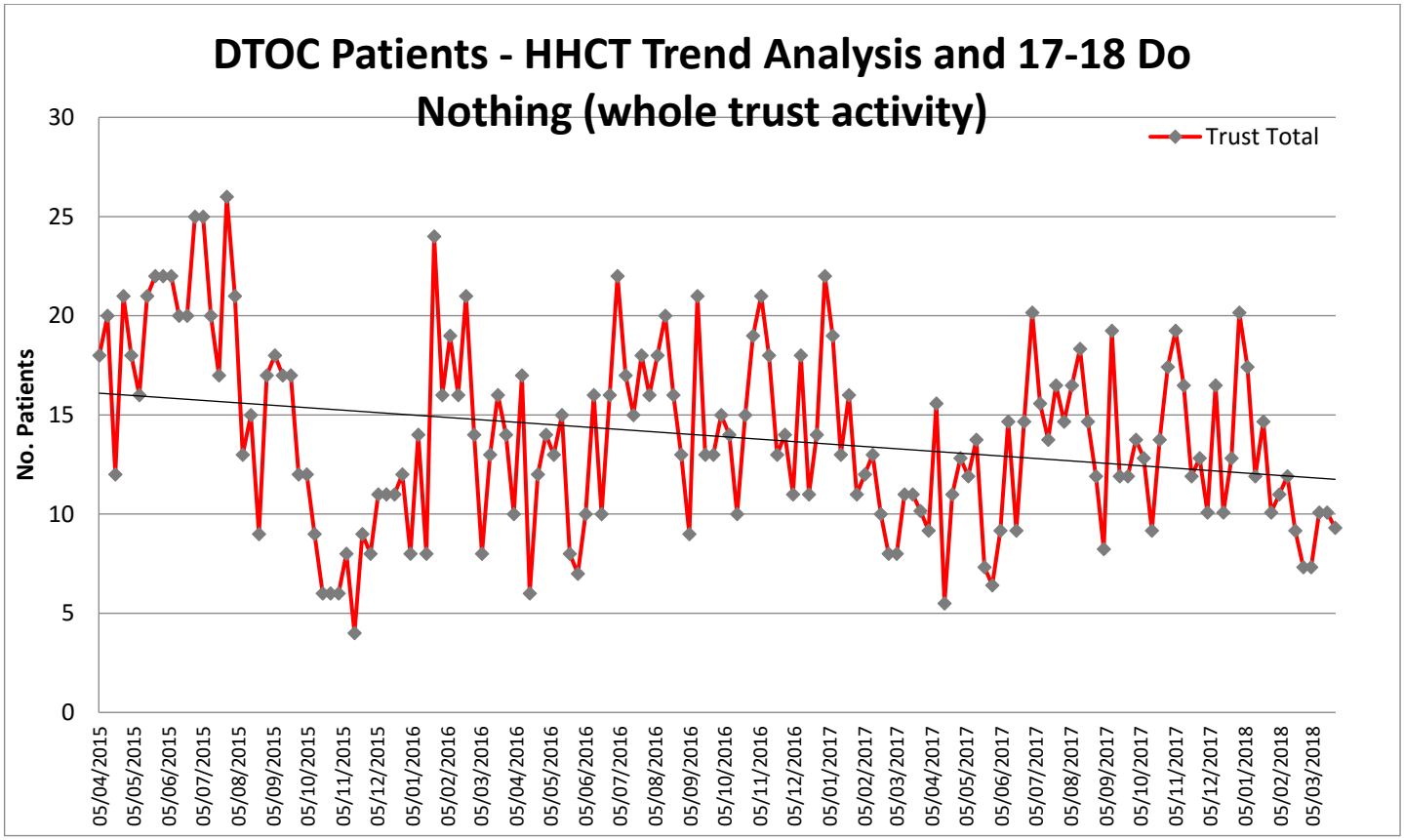
There can be movement between the 3 pathways if /when clinically appropriate; e.g. patient needs / abilities have changed (either improvement or deterioration)

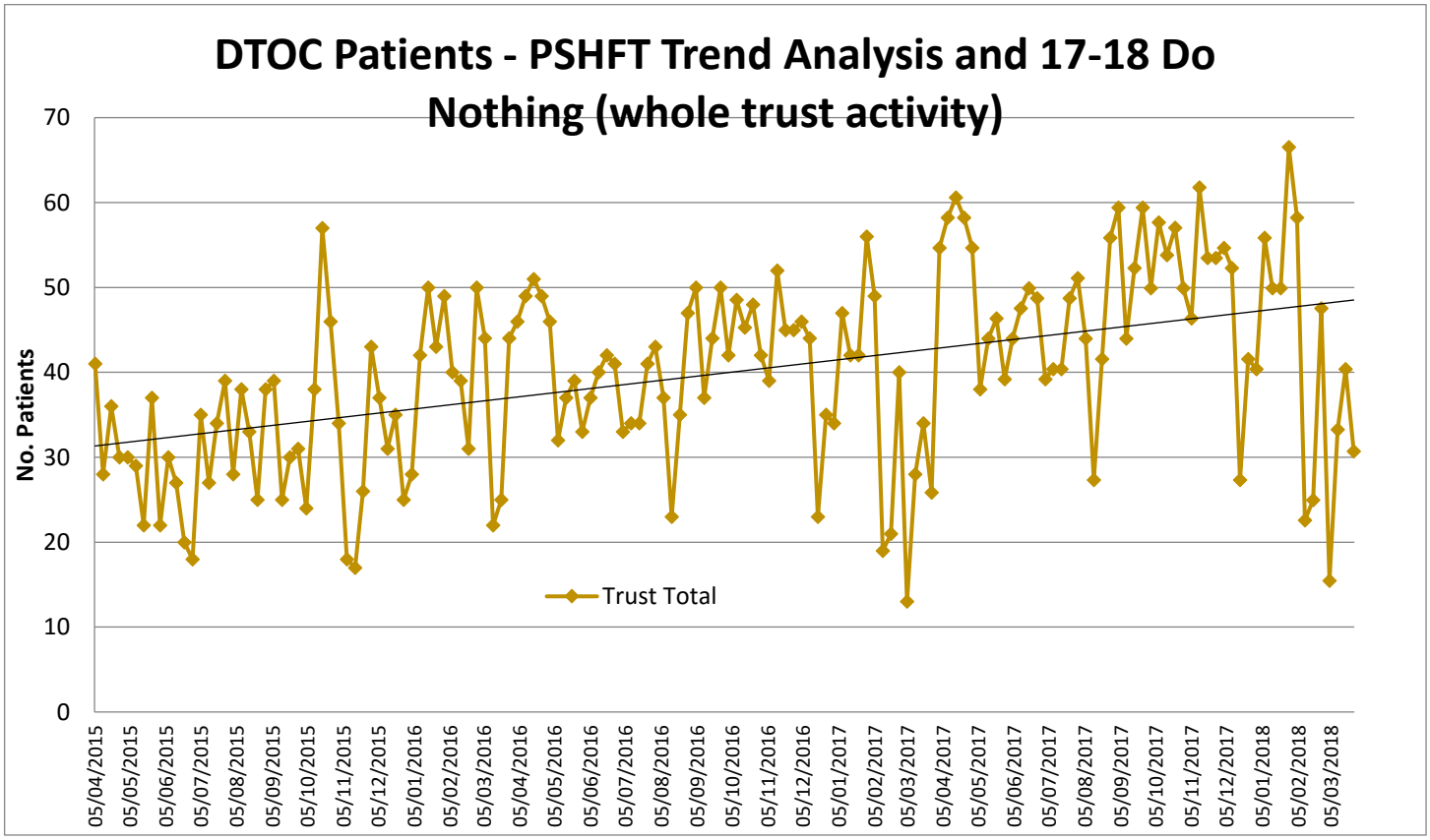
D2 - 'Do Nothing' Option

If the system doesn't make any changes and brings investment back to recurrent funding levels community capacity will be lost to include the existing intermediate care tier capacity (small number of ICWs and therapy to support existing pathways) and home care support for c.1200 patients per year delivered by the independent sector.

This would have a negative impact on the system's ability to facilitate supported discharges, increasing Delayed Transfers of Care. The tables below show the projected trend in DTOCs per Trust under this option:


DTOC Patients - CUHFT Trend Analysis and 17-18 Do Nothing (whole trust activity)
No. Patients
Trust Total


DTOC Patients - HHCT Trend Analysis and 17-18 Do Nothing (whole trust activity)
No. Patients
Trust Total



Data Source: Trust's SITREP reports

Most importantly, under the Do Nothing option patients in our system will not always have access to the best opportunities for a prompt discharge from hospital and speedy recovery at home, creating health and care inequalities and resulting in poorer patient experience. In the long term this would also be costly to the system through expected increased in long term dependency and high cost complex care packages for a greater number of people.

D3 - Alternative Option(s) Considered

In order to ensure there is capacity in community to deliver all three pathways under Discharge to Assess, the system could commission services with health home care provision delivered mainly by the independent sector. The current level of spend in home care (delivered by some ICW capacity plus independent sector packages) sits at circa £7.6m per year. This excludes comprehensive therapy input required to upscale D2A, nursing and social care support for assessments in community, and any clinical triage and pathway coordination (SPOC).

Under this option the system will not deliver an integrated care vision or realise full financial benefits as a more expensive and disjointed approach would be kept in place.

In addition, continued reliance on the independent sector to deliver home care will put further pressure on the pool of capacity available to the system for long term placements.

[E] FINANCIAL IMPACT:

E1 – Investment Required for Proposed Option

Different staffing scenarios have been modelled (see section H below on staffing). Of these, two preferred options have been highlighted and fully costed – options 4 and 6 - see attached below. The difference between them is whether patients stay in the pathway for 4 weeks or 3 weeks respectively. These two figures regarding length of stay are based on the current average length of stay for local reablement services

(average LoS of 3 weeks for Cambridgeshire and 4 weeks for Peterborough), which is the closest service model comparable to the proposed service. The system will need to determine which of the two is the preferred option.

D2A - Finance Schedule 6th April 17.

If the system is to continue to facilitate complex discharges from hospital until the new ICT team is in place, current levels of community capacity provided by the independent sector will have to be sustained as well as current levels of community in-patient beds. It is anticipated that the ICT tier builds proportionate independent sector capacity can be reduced in year.

The required investment for each option is put forth in the table below:

	Current Services	New Model	
		Option 4	Option 6
Expenditure	**£'000**	**£'000**	**£'000**
Home with Support			
Intermediate Care Tier (ICWs + Therapy already in place)	985	985	985
Independent Sector - Home Support	6,592	5,900	4,685
Non Recurrent transition costs		500	500
	7,577	**6,885**	**5,670**
Rehab in a bedded facility			
CPFT Lord Byron B	1,500	1,500	1,500
Independent sector - health interim beds	1,908	1,908	1,908
	3,408	**3,408**	**3,408**
Voluntary Sector	**248**	**248**	**248**
Total Cost	**11,233**	**11,041**	**9,826**

Funding Available			
CCG funding			
Operational Resilience	4,536	4,536	4,536
Better Care Fund	650	650	650
Re admissions	1,315	1,315	1,315
	6,501	**6,501**	**6,501**
Investment Committee			
MRET	935	935	935
Request from Invesptment pot	3,797	3,605	2,390
	4,732	**4,540**	**3,325**
Total Funding	**11,233**	**11,041**	**9,826**

E2 – Savings Delivered in the Proposed Option

There a number of benefits to the system from implementing the preferred option. Expected reduction in acute bed days has been modelled based on length of stay reductions achieved by other areas that have implemented this care model – see attached below. It is worth noting the potential benefits set out in the spreadsheet below will be realised by the providers:

E3 – Source of Funding

It is anticipated that funding for the scheme for 17/18 will be provided by the STP investment pot in the first instance. This would allow mobilisation of the enhanced service. It is anticipated that the enhanced service would reach full potential by March 2018.

E5 – Contractual Considerations

Further consideration might be required for the long term commissioning of any new services going forward and whether procurement rules will apply.

E6 – Capital Risk (Capital Cases only)

N/A

[F] PATIENT EXPERIENCE:

In terms of the preferred option:

F1 – Impact on Patient Care

The new model of care will ensure patients:

1. Have enough information and support to allow him to look after himself as much as possible without having to rely on others

2. Have their care planned so that when they becomes ill they knows that they can get help quickly to manage their illness and to keep them out of hospital where possible

3. Know who to call when they need help and services know about them

4. If they need to go to hospital, they know that care and support will be put in place to allow them to come home as soon as possible

5. They know that everyone providing their care is well supported and the system helps them to learn from each other and develop better care for others

The new model of care will ensure patients:

G] OPERATIONAL IMPACT

In terms of the preferred option:

G1 – Capacity: post change, during implementation; Other areas:

To ensure there is no change to the current system which is already at a point of sub-optimal care being delivered, the Business case has taken account therefore for the current bedded provision to be maintained during this community mobilisation. As there is current bedded capacity funded non- recurrently the business case requires the support of this investment for 17-18. The bedded provision will then be reviewed in year, as the new care model is implemented.

G2 – Support Services, Physical and Equipment Capacity, IT and IG Compliant

There will be a requirement to review support services to be scoped at early implementation. This would add to the ongoing progress from the BCF funded projects, and the digital technology work streams of STP.

H] WORKFORCE/HR:

H1 – Staffing Numbers

This proposal has taken into account the patient journey across the full pathway resulting in a number of possible scenarios regarding possible staffing numbers. Each scenario is further shaped by a number of variables to include estimated length of stay and caseload. Options 4, 5 and 6 also take into account the anticipated impact on the patient cohort of the additional investment in further capacity and support across other services such as JET. This means that the capacity highlighted on these options is to focused on supported discharges only as the eligible patient base has been reduced based on assumptions around reductions in NEL admissions.

In addition, new pathway assumes reablement patients will go through the D2A pathway for a period of up to 3 or 4 weeks. This therefore will reduce demand for reablement services and a proportion of extra reablement staff numbers initially put forth in a previous business case have been "rationalised" into the intermediate care tier model.

From these, the work stream leads have put forth two preferred options (**Option 4 and Option 6**) which the Investment Committee may wish to discuss in relation to the other alternatives set out in the document attached below:

D2A Modelling v4 LE edits.xlsx

H2 – Staff Consultation

Consultation with existing staff may not be required in the first phases of delivery. If during deployment and delivery of the new model the system made a joint decision to change the arrangements for existing services (eg SPA centres, community beds) staff consultation may be required at a later time. The SRO and Project Manager will keep oversight of any potential implications on this aspect and will ensure early cross organisational HR input and advice is sought if / when required

H3 – Training

The proposal requires a system response to the current therapy and social care pathways to support the system change to assessment in the community and not in an acute hospital. There are major considerations to the training required to support this pathway move.

There is an interdependency with the workforce work stream of the STP which needs to be scoped further should the system support the realignment of current workforce.

H4 – Recruitment Considerations

Modelling has shown that a gold standard intermediate care tier able to provide intensive therapy and support to patients in their own home to optimise their chances of reablement and rehabilitation requires a significant number of health and care professionals.

The system however must take into account the capacity already in place that should be aligned to this pathway as not all the staff put forth in either of the preferred models will imply these are new posts that need to be recruited for.

There will be however a need to recruit significant numbers of care workers in particular and this could prove a challenge to the system and has been highlighted as a risk with mitigation actions identified.

In order to ensure the system has access to a flexible workforce the following factors have been considered as critical for success:

- Development of a national Trailblazer bid will allow the system to design apprenticeship standards tailored to the needs of our local system. The standards will provide generalist competencies but with the expectation of rotation and experience in a range of clinical settings, particularly for those seeking advancement in their role. By creating a large workforce which is agile, flexible, and competent in a range of areas to support our specialist staff and deliver basic care to our patients, we should be better equipped to manage changes in demand for care.

- Education and training programmes will incentivise staff into roles. This supports the cycle of progression, provides career enhancement opportunities, and increases the competency and capability of our workforce. Programmes have been costed for MSc level, in house competency packages, and will maximise levy opportunities.

- Joint recruitment strategies across partner organisations resulting in a combined workforce plan that will mitigate against the current workforce shortages and the challenge and complexity associated with large scale workforce redesign and recruitment.

H5 – Tenure

To optimise recruitment opportunity and make the model sustainable staff should be recruited to posts on a substantive basis. We recognise however that until the full complement of staff is recruited across disciplines organisations may need to use agency / bank resources in the interim.

H6 – Job Plans

Should the system support the pathway move of therapy staff and discharge planning to the community, this will have a significant impact on Job plans for staff.

Should the system also support an integrated service as the preferred option to delivery an effective and efficient intermediate care tier then accountability structures will require significant realignment.

A full HR scoping of the agreed proposal will be central to the development of the model, to reduce efficient use of current resources in the system to support system change.

[I] IMPLEMENTATION:

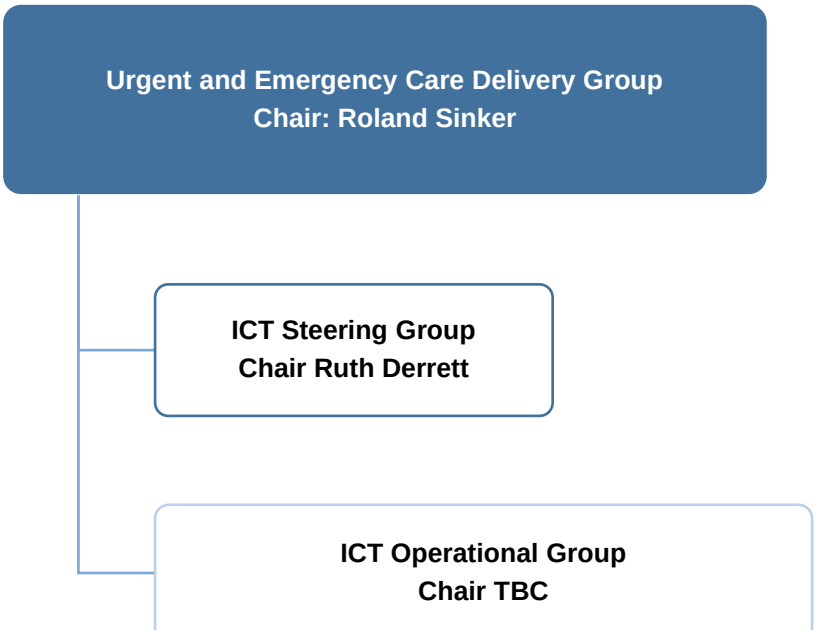
I1 – Timescales

Activity	No. Weeks	Dates Start - Finish
Scoping/Design		
Planning Consent		
Contracting/Advertising		
Delivery Lead-Time		
Works/Installation/Commissioning		
Practical Completion/"Go Live"		
Post-Project Evaluation		
TOTAL		

I2 – Implementation Governance Arrangements

SRO – Ruth Derrett

We will establish a programme management structure that reports formally to the UEC Delivery Group. There are project governance structures already in place with good clinical and senior management engagement and we wish to formalise these during the implementation phase. See figure below:



I3 – Support Services Resources

See E6

The delivery will require partnerships with all support services and support the STP priorities of change point 6 on use of services and estates.

I4 – Post-Project Evaluation (PPE)

Progress towards implementation will be continuously monitored by the ICT steering group; however it is proposed that a full evaluation of impact is also completed at 6 months and 12 months respectively

Timescale for PPE: (Please tick one box below)

3 months	☐	**6 months**	☒	**9 months**	☐

I5 – Deliverables: KPIs/Outcomes and systems for measuring performance of the scheme

KPIs/Outcomes	Target	Systems
Reduction in Non-Elective hospital Admissions (specified by CUHFT, HHCT and PSHFT respectively) – total and for over 65's	TBC	SUS data
NEL hospital admissions for falls for over 65's	TBC	SUS data
Reduction in Delayed Transfers of Care – total and specific categories (eg community rehab, reablement, assessment, patient choice)	TBC	Each Trust reporting for acutes CPFT reporting for community beds
Reduction in Length of Stay (acutes & community beds)	TBC	Each Trust reporting for acutes CPFT reporting for community beds
Reduction in excess bed days (acutes)	TBC	Each Trust reporting
Readmission to hospital following discharge into service (30 days)	TBC	Each relevant community service reporting
Patient & Carers satisfaction with care received	TBC	Patient surveys completed by each service
Reduction in dependency levels measured at admission to ICT service and discharge from ICT service	TBC	Community provider to establish mechanism to record and report on a regular basis
Staff satisfaction	TBC	Staff surveys by each provider organisation

(Please outline the specific KPIs that will be measured and the targets/outcomes this scheme is planned to meet. These should primarily align to improvements in Clinical Effectiveness, Patient Experience or Safety) Outline the systems in place that will monitor the respective KPI).

[J] RISKS & OPPORTUNITIES:

J1 – Implementation Risks & Opportunities

Risk Area	Mitigating Actions
Workforce: The new model requires the recruitment of a significant number of health care professionals and this may prove challenging	• Proactive recruitment campaign started early in the process pending approval of business case (end of February 2017) • Deployment of joint workforce strategies across provider organisations to increase appeal of roles to prospective applicants • Use of independent sector provider capacity in the interim to bridge gaps to provision during the recruitment process
Exit from the pathways might be affected by local market forces for domiciliary care and care home placements in particular	• Design processes (eg D2A) that enable system partners for early identification and planning of long term need to reduce risks of periods of excessive demand for long term assessment and care • Identify innovative solutions to delivery domiciliary care support (eg primary care support for patients at home, "grow your own workforce", etc) • Support the development of a "community pool" of capacity to support care for patients at home under the direct payment scheme (eg microbusinesses in community providing care in a given geography) • Promote use of direct payments as an alternative to social care support being arranged by the local authority

Financial implications to the system for the transition period	○ Ensure business case proposal takes account of the need to secure an interim period (up to 12 months maximum) of "double running" key community services until new models of care are sufficiently embedded and fully operational

J2 – Post-Implementation Risks & Opportunities:

All clinical safety and risks post Go Live will be managed by the relevant provider.

[K] STAKEHOLDER ENGAGEMENT:

K1 –Stakeholders Engaged During Business Case Development:

Name	Title	Representing	Internal / External
Roland Sinker			
Ruth Derrett			
Aidan Thomas			
Julie Frake Harris			
Ben Underwood			
Alex Gimson			
Charlotte Black			
Richard ODriscoll			
Phil Walmsley			
Neil Doverty			
Duncan Forsyth			

All of the above stakeholders have received and reviewed the latest version of this business case and have consented to its submission.

[L] RECOMMENDATION:

Partner organisations in the system across hospital, community and local authority sectors seek approval to invest a total of XXX from 1st April 2017. Of this total, XX is recurrent funding whilst XXX (for the community beds currently funded on a non-recurrent basis) could be reviewed at the 6 month evaluation point of the new service model.

[M] DUE REGARD SCREENING:

Impact (please indicate Yes or No for each question)	Race/Ethnicity	Sex	Religion or Belief	Gender Reassignment	Sexual Orientation	Age	Marriage & Civil Partnership	Pregnancy & Maternity	Disability
Do different groups have different	No	No	No	No	No	No	No	No	No

needs, experiences, issues and priorities in relation to the proposed change?									
Is there potential for or evidence that the proposed change will not promote equality of opportunity for all and promote good relations between different groups?	No	No	No	No	No	No	No	No	No
Is there potential for or evidence that the proposed change will affect different population groups differently (including possibly discriminating against certain groups)?	No	No	No	No	No	No	No	No	No
Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular group or groups?	No	No	No	No	No	No	No	No	No

Note that if any box contains a 'Yes' then a full DUE REGARD assessment is required to be undertaken.

[N] REVISION HISTORY:

Version	Date	Amendments	Authored/Approved by
1	18/03/2017	Draft document created	Sara Rodriguez-Jimenez
2	24/03/2017	Inclusion of staffing models	Chris Gillings
3	24/03/2017	Inclusion of financial impact / benefits	Greg Lane
4	31/03/2017	Revision of staffing model and financials following discussions with health and local authority providers	Chris G / Louisa E / Sara RJ / Greg L
5	04/04/2017	Further revision of staffing model and financials following discussions with health and local authority providers	Chris G / Louisa E / Sara RJ / Greg L
6	06/01/2017	Further revision following discussions with health and local authority providers and following further clinical input / comments	Sara RJ

This template should be used for all investment bids (both Capital and Revenue), in accordance with relevant Organisation's SFIs.

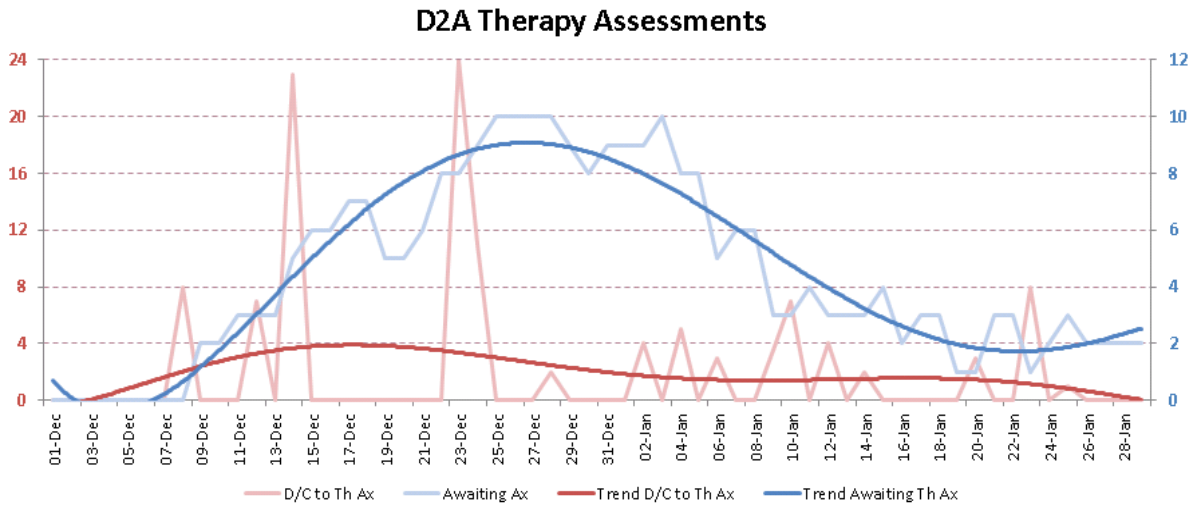
APPENDIX A

INTEGRATED CARE D2A PILOT: CAMBRIDGE SYSTEM (05/12/2016 TO PRESENT)

KEY SUCESSES

Clear improvements in patient outcomes:

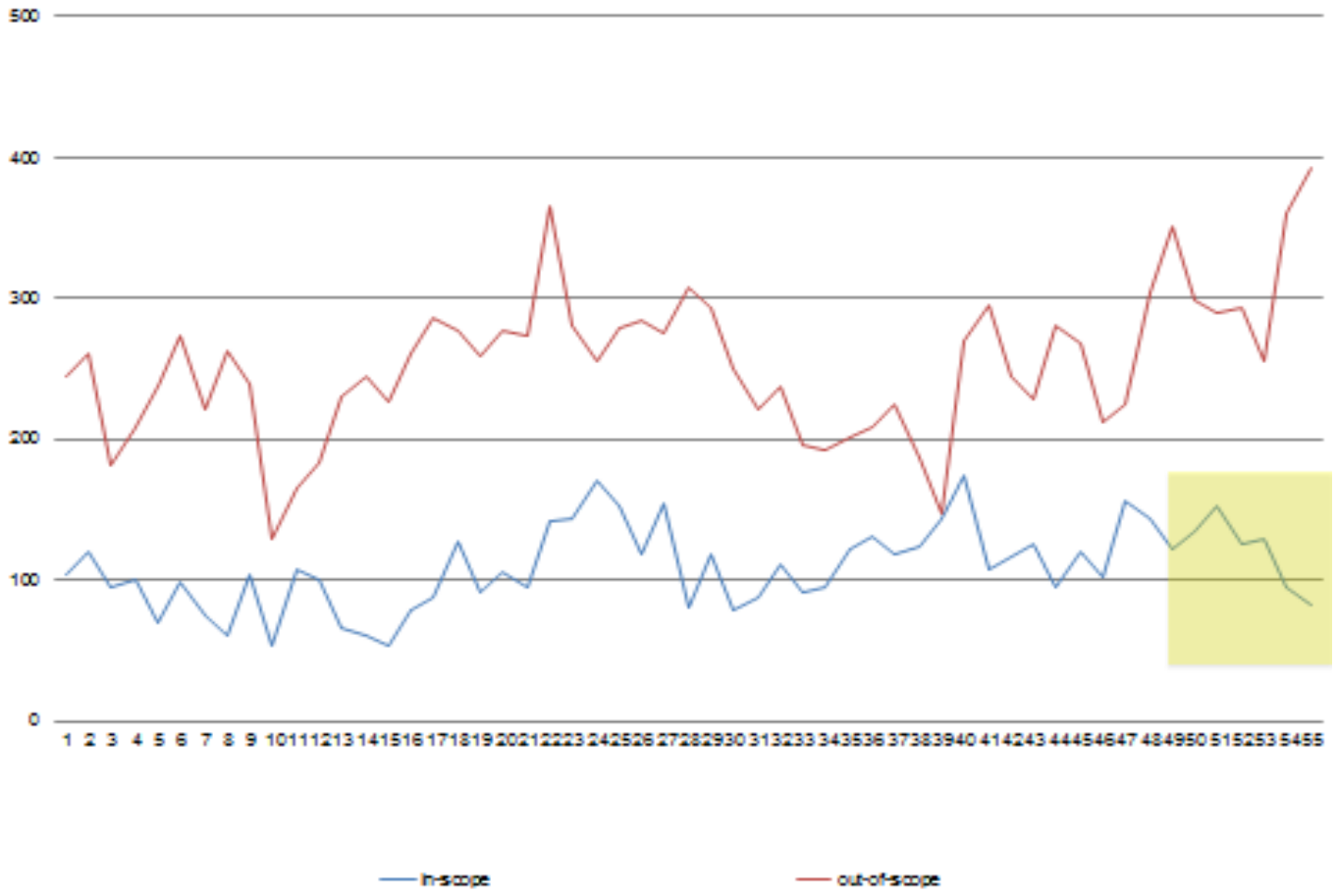
- A significant proportion of patients are going home and are remaining at home;
- Additional community therapy capacity has resulted in a significant reduction in wait times for patients to have a therapy assessment completed in the community (within 24 hours of discharge home). The table below shows the trend:



- Analysis of a sample of patients going through the pathway shows 7.5% of patients experienced functional improvement with need for therapy calls reducing by 75% from discharge into the pathway; a further 7.5% showed 100% reduction in need of therapy calls; and 14% showed 50% reduction.

- Readmission rates for patients in the 5 wards run at 10%, which is lower than the Trust average of 20%

- We have seen that for the 5 pilot wards the number of lost bed days has reduced whereas the rest of the hospital shows a general upward trend. Taking the week before the trial started as a baseline, there has been a reduction of 166 bed days in the first 7 weeks of the pathway since go live (compared to the LoS in the same five wards before the D2A pilot started). The figure below shows the Cambridgeshire validated lost bed days by ward for the last year. Blue is the line for the 5 wards in the pilot, and red is all other wards.



- Patient flow in reablement has improved, with a reduction in delays through the reablement pathway
- We have seen a clear commitment across teams to work differently, with high health and care professional buy in and engagement
- Improved communication between discharge planning, SPA, reablement, Intermediate Care teams
- 49% of patients have been discharged from CUH within 3 days of the Community Support Referral (CSR) being submitted; 44% of patients have been discharged within 3 days of their Clinically Fit Date (CFD).
- Released time to care for ward staff through reduction of phone calls to SPA /other services to facilitate discharge of individual patients

LEARNING POINTS TO TAKE FORWARD

- An overarching coordinating role to manage and “own” patient flow throughout the whole pathway is key to the success of this model.
- It is essential we continue to move forward the integration of pathways in the community and realise economies of scale through sharing of workforce to support patient needs more effectively (reablement / IC).
- Role of the SPA needs to be clearly defined to set out professional disciplines that need to be integrated / aligned into the single point of access / coordination (CPFT, reablement / social care, Discharge Planning teams); include clinical advice and expertise; and set out functions / responsibilities of the SPA going forward. All community pathways should also be routed through this single point – including community bed capacity

INTEGRATED D2A PILOT: NORTH BRISTOL NHS TRUST (began October 2015)

KEY SUCESSES

- There have been reductions in LoS for both the acute phase of treatment and the LHPD phase
- The total average stay is now 3.4 days shorter than the same period last year
- Stock (number of patients on LHPD at any time) has reduced due to the reduced LOS
- This has resulted in a reduction in bed days per annum which would equate to 29 beds across a full year
- As changes were not implemented as soon as demand & capacity model was completed the full saving has not been achieve during 2015/16
- Full saving could be achieved in 16/17

Measure	Impower Model (Jan 15)	Refreshed Model (Dec 15 to Feb 16)	Difference
Average LOS before LHPD	16	15.1	-0.9
Average LOS on LHPD	16.7	14.2	-2.5
Total LOS	32.7	29.3	-3.4
New Patients per Day subject to LHPD	13	13.4	0.4
LHPD Stock	218	190	-28
Bed days per annum	79242	69452	-9789.3
Equivalent beds at 92% occupancy			-29.2

INTEGRATED D2A PILOT: SHEFFIELD

KEY SUCESSES

- A study concluded from the Royal College of Physicians (2017) showed that two significant reductions in the weekly average wait for patients between hospital referral and being at home with community based support services (data from April 2012 to June 2015)
- The first reduction corresponds with the establishment of integrated community intermediate care service and demonstrates a reduction in average wait from 5.5 to 3.6 days. The second step change was driven by the more formal reconfiguration into a single service – Active Recovery (see figure below)

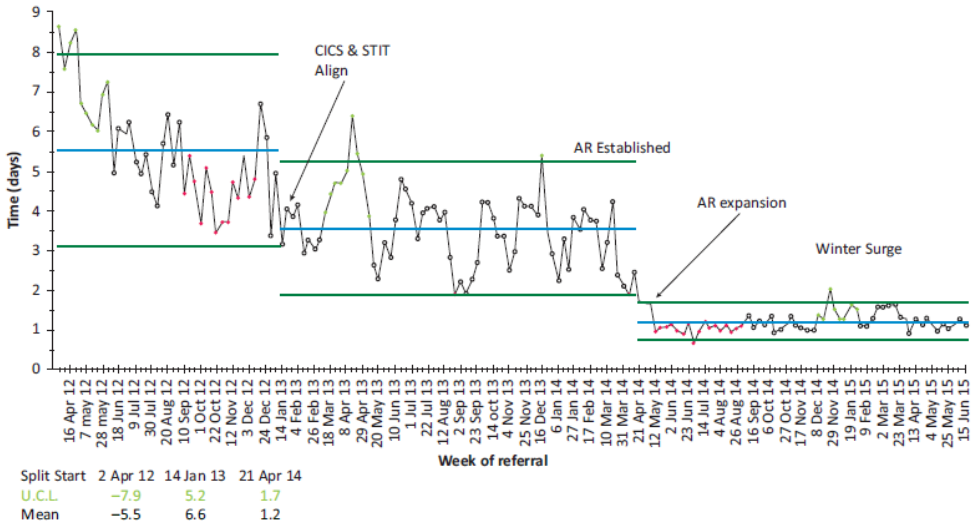


Fig 2. Reducing patient wait for active recovery from a hospital bed. AR = Active Recovery; CICS = Community Intermediate Care Service; STIT = Short Term Intervention Team

- Vertical integration between hospital and community healthcare systems further enabled and accelerated benefits.

- Further investment into the model in 2014 resulted in a more stable system with a mean transfer time from hospital to support at home of 1.2 days (therefore total reduction of average 4 hospital bed days per patient being saved as a result of implementing the new model of care at scale)

DISCHARGE TO ASSESS: SOUTH WARWICKSHIRE NHS FOUNDATION TRUST

KEY SUCESSES

- The Discharge to Assess service enables patient discharge from acute into nursing or residential homes, community hospitals, or their own homes with care and rehabilitation support for up to six weeks (average length of stay in the pathway is reported at 21 days)

- The patients' assessment for ongoing care needs are done outside of the hospital. Services are provided via three pathways for three distinct cohorts of patients. On average about 60% of patients a week are discharged home with support to reable/ rehabilitate.

- From 2011 to 2014 the trust reports that this work has supported improvements in A&E performance, reduction in length of stay for emergency inpatient adults, and reductions in length of stay for patients aged 75 and older with fewer emergency readmissions and fewer patients affected by several ward moves

- The Trust also reports that 2014/15 data shows the proportion of patients going to long term care home placements receiving CHC funds has fallen from 40% of eligible patients to 20% in year when compared to patients who refused to go on the D2A pathway.

Continuing Healthcare (CHC) Pathway Re-design Workshop

Pathway Proposal

Monday 17th July 2017

Introduction

Health and social care partners across Cambridgeshire and Peterborough are currently working together to address CHC assessment related delays in the hospital discharge pathway. The primary recorded cause for delayed transfers of care (DTOCs) across all three acute systems are health related assessment delays. A priority need has been highlighted to address the CHC hospital pathway to support the Discharge to Assess model, improve patient experience and contribute to a reduction in unacceptable levels of DTOCs across the system.

In meeting this challenge, a system wide workshop was held on the 17th July 2017 with the aim of engaging all partners in the development of a more effective CHC pathway for hospital discharges.

The key objectives of the workshop were to:

- Agree the Terms of Reference for the work that needs to be undertaken (Appendix 1)
- Develop a proposal for the redesign of the CHC acute pathway
- Develop a set of clearly defined actions for implementation of the pathway

Key Outcomes and Scope

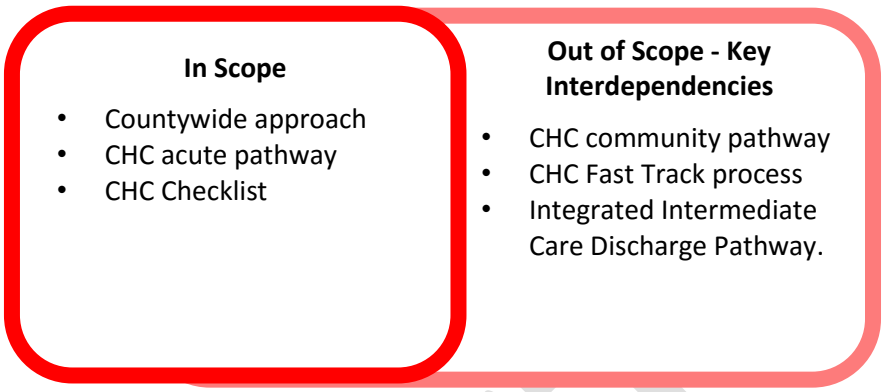
As part of this process, representatives attending the workshop were asked to come to a joint understanding of the key outcomes and also specify the scope for this area of development while acknowledging the key interdependencies with other service areas and initiatives.

The following key outcomes were jointly agreed:

- To review CHC patient flow and the impact on DTOCs
- Review and re-design the CHC acute pathway to support the discharge to assess model
- Explore and develop an alternative solution to CHC checklists in the acute
- Review resourcing and community capacity to support the new pathway

In delivering against the outcomes outlined above, the workshop scope was discussed. It is clear that there is currently a significant amount of work taking place across the system which aims to manage demand and the needs of individuals in a more joined up and coordinated way. Although all participants strongly agreed there was a need to identify and proactively manage key interdependencies between these initiatives, representatives equally recognised the importance of defining a clear scope in evidencing outcomes.

The following scope and key interdependencies were outlined:



Current Pathways – Key Challenges Identified

To inform development of a future, more effective CHC acute pathway, representatives were asked to review existing pathways used across the three Cambridgeshire and Peterborough acute trusts. In identifying challenges associated with the use of current pathways, a number of key themes emerged:

- **There are currently different CHC assessment pathways across the three acute trusts, which results in a lack of consistency and coordination.**
- **There are extremely high rates of CHC Decision Support Tools (DST) assessments happening in hospital (circa. 90% of patients), impacting on capacity and patient flow.**
- **There are low rates of conversion from checklist to CHC eligibility (circa 25%):**
    - CHC checklists are being completed in hospital when the patient's health is not optimum.
    - Checklists are completed by different professionals in different systems. E.g. in Peterborough they are completed by the Social Worker, Addenbrookes by the ward nurses and in Hinchingbrook by the Discharge planning team.
- **There is a lack of a jointly agreed and documented dispute policy and process, which results in unnecessary delays:**
    - Dispute related delays currently happening at three potential points in the pathway – checklist, DST and CHC panel decision.
- **Staff training and knowledge varies across different organisations as there is a lack of joint up approach to training.**
- **There are delays due to a lack of sufficient resource in CCG brokerage to locate suitable placements.**
- **Inconsistent levels of CHC specialist nurse resource across the system to undertake DSTs, including differences in employing organisations, contract arrangements and flexibility.**

- **Non-compliance with national framework timelines and a lack of locally agreed timeframes for each stage of the pathway.**
- **There is a lack of capacity in the community intermediate bed provision to support discharge to assess models.**
- **Delays in implementing the choice policy effectively, including misalignment of target timeframes across CHC and acute discharge pathways.**

Development of a Future Integrated Discharge Pathway

The feedback outlined above was used by representatives to commence development of a future, more efficient CHC acute pathway. A number of decisions were made in relation to key elements of the pathway and these have been included within the table below:

Key Area	Key Decisions
CHC Screening Tool	**1. Introduction of a Screening Tool** It was unanimously agreed that development of a CHC pre-screening tool should be introduced within the acute. The Screening Tool will comprise of the following four questions (see Appendix 2 for Decision Flowchart) and supporting guidance will be developed to sit alongside the tool: 1. *Can the patient's care needs be met within their existing care and support plan/package?* 2. *Is the care required over and above what the local authority can provide?* 3. *Is the patient considered to have significant physical health needs?* 4. *Is the patient considered to have significant psychological or emotional needs?* **Key Functions of the Screening Tool** • Apply more appropriate criteria for early screening for potential CHC eligibility, recognising that the Checklist threshold is currently very low. • Support discharge to assess, by quickly identify the most appropriate pathway for discharge: o Where patients have the potential to improve they should be diverted into a reablement pathway. o Patients whose care needs can be met within their existing care package arrangements restart their package arrangements (e.g. care home placement or care at home).

	○ Patients who have no potential to improve are discharged into intermediate bed based nursing care or appropriate care at home. • Support patients to be at their optimum health at the point of checklist, by delaying the checklist until no later than day 28 after discharge, improving the conversion rate of positive checklists to CHC eligibility. • Ensure consistency in the use of the screening tool: ○ Consistent screening pathway across all three acutes. ○ Screening tool to be completed by Discharge Planning Nurses. ○ Joint approach to cross-organisational training and- development of staff.
CHC Checklists	**2. CHC Checklist applied once the patient has had an opportunity to return to their optimum health** It was agreed that CHC checklists need to happen in the community wherever possible, once the patient has had an opportunity to return to their optimum health. **Key Functions of CHC Checklist** • Identify the most appropriate patients for potential CHC eligibility by undertaking the CHC Checklist when the patient is at their optimum health; to improve the conversion rate of positive checklists to CHC eligibility: ○ 90% of CHC Checklists to happen in the community. ○ CHC Checklist delayed until Day 28 after the Screening Tool has been undertaken. • The date for the CHC Checklist should be booked at the point of hospital discharge. • There should be a review planned for day 14 to assess patient progress. If optimum health is reached earlier, then the checklist date can be moved forward to sooner than day 28. • CHC checklists should be undertaken by a centralised pool of CHC Specialist Nurses (to be hosted by the CCG) to enable consistency of practice and ensure resource can be flexed across the county dependent on demand need.
CHC Decision Support Tool and eligibility	**3. DSTs should happen immediately for patients who have had a positive checklist.** It was agreed that DSTs for patients with positive checklists should be undertaken immediately. **Key Functions of DST** • To comply with national framework timelines and avoid further delay, DST assessments should be completed at the same appointment when a positive checklist has been completed.

	• DSTs should be undertaken with representation from the social care worker and CHC Specialist Nurse. • CCG brokerage resources need to be sufficient to ensure that appropriate placements are sourced within suitable timeframes.

Other areas of consideration	Further consideration needs to be given to the following:
	• **Locally agree and embed appropriate timeframes for each stage of the CHC pathway:**
	  ○ Ensure compliance with the National Framework.
	  ○ Ensure consistency of target timelines across CHC pathway and wider discharge pathways.
	• **Centrally hosted resource established:**
	  ○ Review resource requirements to effectively address CHC demand, including CHC Specialist Nurses and CCG Brokerage capacity.
	  ○ Review contract and staffing implications to move to a centralised pool of CHC Specialist Nurses to be hosted by the CCG and agree a phased approach to pooling resource.
	• **Develop a jointly agreed CHC Dispute Policy and Process.**
	• **Apply the Choice Policy consistently:**
	  ○ Align target timeframes across CHC pathway and acute discharge pathway.
	  ○ Enhance staff skills and confidence in applying the choice policy in practice.
	• **Ensure alignment with the Integrated Intermediate Care Discharge Pathway implementation.**
	• **Develop a standardised contact and triage tool for use across all acutes.**

Proposed CHC Pathway

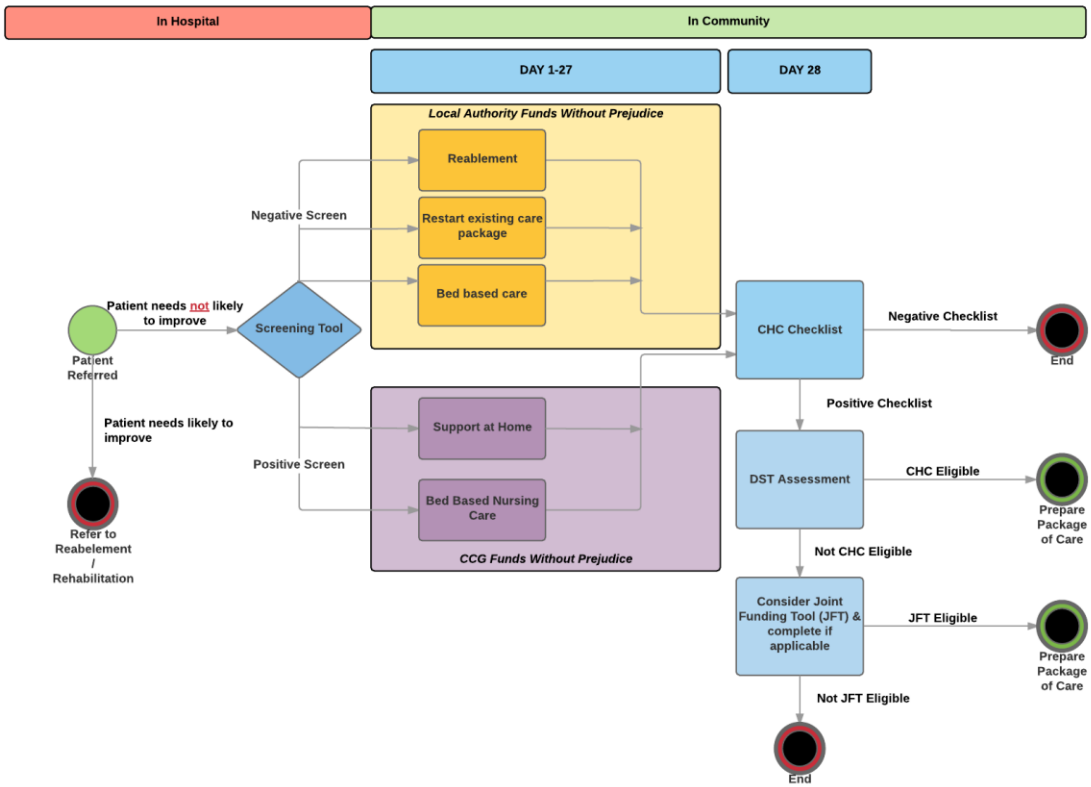
Recognising the importance of incorporating the above key elements, the below diagram outlines the proposed standardised Cambridgeshire and Peterborough acute pathway for CHC.

During discussion, the benefits and risks of various options and approaches were assessed including the utilisation of good practice examples in other localities (e.g. Norfolk, Essex, Basildon and Thurrock), financial risks for health and social care partners, the use of a consistent and flexible workforce.

Importantly, it was confirmed that although there was a close dependency to the Integrated Intermediate Care Discharge to Assess Pathway (led by the UEC Delivery Group) to ensure sufficient

community capacity, the implementation needed to progress in a phased way to ensure priority maximisation of benefits.

The below diagram outlines the proposed new CHC Pathway to be implemented.



It was unanimously agreed that the new pathway structure should be underpinned by a robust Memorandum of Understanding which empowers organisations to work effectively together, but also to ensure joint ownership of risk and ongoing performance against agreed Key Performance Indicators.

Management of CHC Specialist Nurses

In developing the pathway, participants made a key decision that the local system would best maximise the use of resource through development of a central pool of CHC Specialist Nurses to support the consistent delivery of the CHC pathway. In assessing how this could be delivered in practice, the following option was considered at length:

- **The CCG centrally host all CHC Specialist Nurses:** Discussion indicated general agreement that the CCG would be well placed to host all CHC Specialist Nurses.
    - This would enable clarity over responsibility for completing assessments and ensure a consistent approach to delivery. Currently CHC Specialist Nurses are hosted by a range of organisations across Cambridgeshire and Peterborough:

Acute Trust Area	Organisation who currently undertakes Acute based DST	Organisation who currently undertakes Community Based DST
Peterborough	CPFT	NWAFT
Addenbrookes	CUH	CUH
Hinchingbrook	CPFT	CPFT

    - It would support the new CHC pathway design of shifting 90% of CHC assessments outside of the acute, as staff will need to shift to community delivery to support this model.
    - This would allow flexibility of resource deployment across Cambridgeshire and Peterborough based on demand and will offset current resourcing inconsistencies across the county.
    - It would maximise efficiencies and reduce duplication across the county.

Next Steps

A number of key actions were agreed:

Action	Owner	Timeline
Approvals		
Summarise CHC Pathway Proposal for comment and agreement	Debbie McQuade / Caroline Townsend	21st July 2017
Approvals for new pathway in place with CCG and Local Authorities	Debbie McQuade / Vicki Main / Jill Houghton	31st July 2017
Documentation		
Develop and agree MOU	Debbie McQuade / Jill Houghton	31st July 2017
Develop Screening Tool Pro-Forma and associated Guidance	Debbie McQuade / Kimberley O'Leary	31st July 2017
Develop standardised contract and triage tool	Katie Wilson / Catherine Paterson	31st August 2017
Finalise and agree Dispute Policy	Kimberley O'Leary	27th July 2017
Review and finalise Choice Policy	Gill Bennett	31st July 2017
Resources		

Review staffing model	Simon Pitts / Debbie McQuade / Linda Chibuzor	31st July 2017
Review resourcing implications and develop CCG Business Case for additional resourcing	Simon Pitts	15th August 2017
Training and Communications		
Develop staff training plan	Kimberley O'Leary / Elizabeth Pitt / Linda Chibuzor	15th August 2017
Develop patient letters to explain how CHC assessments work	Katie Wilson	15th August 2017
Community CHC Pathway Development		
Review CHC Community Pathway, with a view to adopting the new pathway proposal	Debbie McQuade / Jill Houghton	After 3 months pilot in acute

A follow on workshop is planned for the 3rd August, to review progress of actions and agree a detailed implementation plan for roll out of the new pathway.

Appendix 1:

Cambridgeshire and Peterborough

Continuing Healthcare (CHC) Pathway Review

Terms of Reference

Objectives

- Reduce CHC DTOCs and delays in hospital discharges for patients awaiting CHC assessments, supporting delivery of the 3.5% DTOC target
- Reduce CHC DTOC's and excess days in Community Health beds including rehabilitation and interim.
- Reduce backlog of CHC assessments
- Improve patient experience
- Understand the consequence of the current system processes and practice for people
- Faster processing of CHC cases
- Reducing duplication and effort across the system
- Relieve financial pressures as a result of delays in CHC assessments
- Compliance with National Framework recommended timelines
- Compliance with Care Act

Deliverables

- Review CHC hospital discharge and community pathways to improve efficiency and effectiveness of process.
- Ensure CHC Fast Track process is effective and there if effective monitoring of process and early resolution of issues
- Ensure compliance with National Framework timelines, including completion of DST within 28 days.
- Improve conversion rate of positive checklists to confirmed CHC eligibility, by reducing unnecessary and inappropriate check listing, including exploring alternative options to checklists.
- Ensure a robust audit trail from start to finish of pathway.
- Review best practice models in other areas, e.g. Basildon & Thurrock, Norfolk and Essex, to incorporate best practice learning.
- Review funding without prejudice arrangements for 28 day period, to support discharge to assess models and early discharge.
- Integration and alignment with Discharge to Assess model.
- Address backlog of CHC assessments.

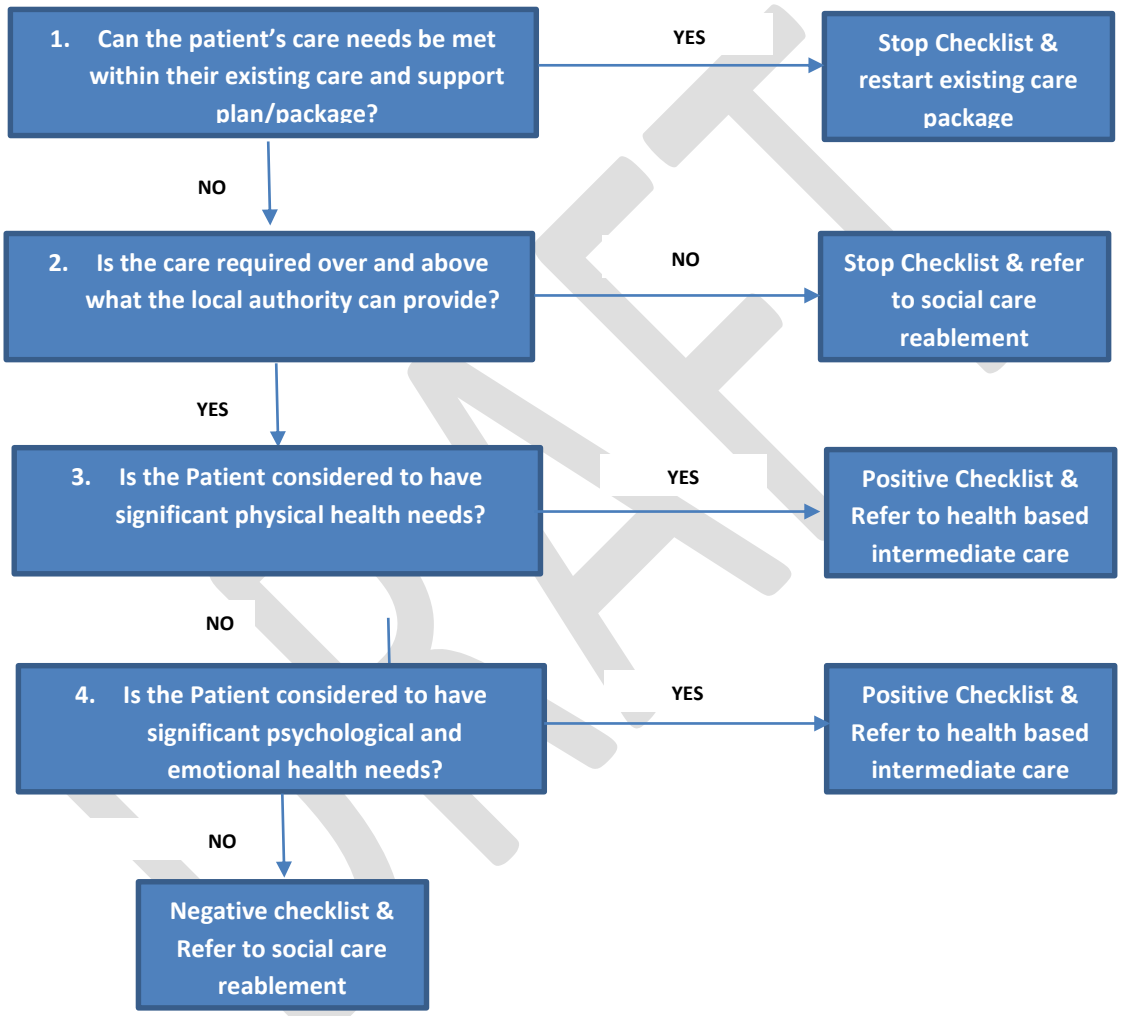
- Address the issue of Joint Funding, where no eligibility for CHC
- Establishment of key success criteria including agreed timelines and key performance indicators e.g. % out of hospital, % within 28 days, % reduction of excess bed days, % verified within 24 hrs (10% sampling), % brokered within 48 hrs, %challenge/dispute etc.
- Review resource requirements to support effective CHC pathway implementation and ongoing delivery including commissioning and brokerage functions.
- Clarity on roles and responsibilities.
- Review of dispute process to ensure it is efficient and effective.
- Finalise and agree proposals for the revised CHC Pathway by 21st July 2017.

Appendix 2:

Cambridgeshire and Peterborough

Continuing Healthcare (CHC)

Screening Tool



BCF Action Plan for Managing Transfers of Care
(8 High Impact Change Model)

Local Authority	Cambridgeshire
Date	03/08/2017 System Wide HIC workshop - G Bennett (CUH), S Pitts (CCG), M Smith (CCG), R O'Driscoll (CCC), D McQuade (PCC), N Sheperd (PCC), C Townsend (CT), L Chibuzor (CCG), L Hurren (Care Network), A Howard (CCC), M Donaldson (NWAFT), J Fallon (CCG), C Mitchell (CCG) 24th July workshop - completed by Gill Kelly(CCG), J Fallon(CCG), C Townsend (PCC), Alison Edwards (CPFT), Phil Vinning (CUH), Gill Bennett (CUH), Richard O'Driscoll (CCC), Lynette Hurren (Care Network), Sandra Myers (CUH), Sara Rodriguez-Jimenez (C&P CCG)

Impact Change		Current Position	Where are you?	What do you need to do?	When will it be done by?	By Who? (one lead)	How will you know it is successful?	Key milestones	Reference to existing plan	Cost	Funding source
1a	**Early Discharge Planning**. **In elective care**, planning should begin before admission.	Established	1. Joint pre admission discharge plannin place in primary care . Early discharge planning project in place - as part of the PRIME process in CUH but not joined up across the system. 2. Joint pre admission discharge planning is in place in primary care	Expand early d/c planning project to include whole system including community services, primary care and VCS.	Self assessment of individual organisations by Dec 2017.Joint planning for cross organisational planning by Mar 2018	Sandra Myers	Patients seen in the PRIME clinic will have a joint assessment that follows them to the clinic and back to the community post hospital admission.Patient better prepared for discharge and less likely to have related re admission. Reduction in elective DTOC	Joint task and fininsh group CUH/CPFT	Link to CUH Improvement project	Nil	
1b	**Early Discharge Planning. In emergency/ unscheduled care**, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.	Mature	1. Emergency admissions have discharge dates set within 48 hrs - and which whole hospital is committed to delivering	1. CCG/Acute Hospital need to do further work to improve systems in respect of Health D2A including Continuing Health Care . 2. Need to develop one D2A model inline with the guidance. 3.Define a the role the 3rd sector cwill play	1. October 2017. 2. March 2018	Katie Wilson/SaraRJ	1.4Qs process agreed.2.Business case agreed. 3.VCS able to fully contribute to discharge pathway. All partners using same system and pathway	work with VCS to develop pathway/	Review current contracts withh CCG/partners with the VCS	Nil	
2	**Systems to Monitor Patient Flow**. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.	Plans in place	1. Good systems in place with individual organisations - but NOT shared across the system. Cant flex capacity across the system. 2. Some relationships between demand and capacity in care pathways 3. Staff understand the relationship between poor patient flow and senior clinical decision making and support 4. Bottlenecks occur 5. No ability to increase capacity when capacity increases. 7. Staff training in place to ensure understanding of senior clinical capacity.	1.Join up information systems for demand and capacity into one system. 2. Improve involement with voluntary sector earlier 3. Agreed escalation process 4. Senior leaders summitin 18 August 2017 to agree set priniciples in information sharing across organisations for North / South SPOC 5. Detailed project plan for schemes in place/pipeline including:Homecare contract, shared brokerage(residential/nursing homes, domicilllary care, and CHC), Intermediate care STD business case. 6. Develop OD Programme	Timeline to be agreed by system partners at the Intermediate Care Tier Operational Group with focus on D2A on 18/08/17. This will inform on development of a detailed project plan with milestones and deliverables which are designed to monitor and deliver patient flow.	Julie Frake-Harris	Project plan in place and milestones achieved. Shared information system in place and demonstrating reduction in delays due to information flow	as per project plan	BCF Business Plan		
3	**Multi-disciplinary/Multi-Agency Discharge Teams,** including the Voluntary and Community Sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients	Plans in place	1. separate planning processes in place. 2. CHC assessments carried out in hospital and taking too long. 3. discussions re creation of integrated ASC and health d/c teams. 4. Discussions on introduction of MDTs on all wards 5. Discussions in place to establish D2A arrangements. 6. There are plans in place to create a single mulit disciplinary hub for services to work together formally (part of Intermediate Care business case SDU)	1. Implement the plans that are in place with clear timescales and leads. 2. Engage voluntary sector earlier 3. Ensure organisations are aware of voluntary sector opportunities 4. Plans to address CHC assesemnts carried out in hospital earlier 5. Implement plans to establish the disciplinary hub	SPOC as part of the D2A process will have an MDT approach. Discussion at DToC Operational Group Meeting on 16/08/17 regarding establishment of MDT for CUH area to focus on reducing DToCs to 3.5 with traction. Team to comprise of CUH, Social Care, CPFT, CHC etc. This would entail redeployment of staff to CUH for 6/52. BD MDTs	Julie Frake-Harris	CHC pathway in place and implemented	Workshop on 06/09/17 to agree ICT process with inclusion of CHC.	CHC Task and Finish Project		
4	**Home First/Discharge to Assess**. Providing short-term care and reablement in people's homes or using 'stepdown' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.	Plans in place	1. Strong reablement service - people return home with re-ablement in place 2. CC care homes assess people within 24 hours (not all care homes contracted by CC) 3. People only enter care home when needs cannot be met at home.	1. Linked to the ICT business case and Action On Care Homes and implementation of the same 2. Ensure Multi disciplinary response for people when they go home 3. Strengthen relationships with care homes 3.. Review community capacity for interim beds, residential and nursing homes by end August 17.	Timeline to be agreed by the Intermediate Care Tier Operational Group. First meeting 18/08/17. This will inform on development of a detailed project plan with milestones and deliverables.	Julie Frake-Harris	Reduction in DTOC and incremental increases in numbers of assessments in the community	Staff recruited, reviised discharge policies and SOP implemented, CHC model reviewed and implemented.	BCF Business Plan		
5	**Seven-Day Service**. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs	Plans in place	1. Discharges are planned 5 days a week 2. Support and help not readily availble at weekends 3. Brokerage service not avaialble at wekends for SC to access 4. VCS Support is available at weekends if planned	1. Get HIC change systems in place for Monday - Fridays in first instance - then build on this. 2. Review in 18/19 for opportunities in 7 day working with each element	Mar-19	SM/JF-H/RO'D L H	1. Weekend discharges are the same as weekdays. 2. Number of new dtocs doesn't increase after weekends. 3. 7 day consultant led ward rounds on all wards	This work will follow on from the implementation of the key changes to our D2A pathways and and changes to workforce .	This work will follow on from the implementation of the key changes to our D2A pathways and and changes to workforce .	?	?
6	**Trusted Assessor**. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way	Not yet established	1. Plans are in place for training of health and social care staff 2. Joint assessment form shared with care home providers 3. Care Homes not yet discussing joint approach of assessing on each others behalf.	1. CHC: test form in August & agree principles with vol sector. One document (SPOC) between professionals 2. Care Homes - a longet term piece of work look at Herts model of independent provider organisation / Lincs model	Sara RJ to complete	R Derrett/ R O'Driscoll/ Jill Houghton	1. Trusted assessors in place. 2. Number of assessments undertaken by trusted assessors with incremental increases	Reduction in DTOC	Sara RJ to complete	Sara RJ to complete	Sara RJ to complete
7	**Focus on Choice**. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.	Plans in place	1. Pre admision leaflet and information available 2. Choice protocol in place	1. work with voluntary sector to co-design contracts. 2. Agree updated polic - end July. 3.Training / support staff to implement choice policy - August 17 4. Leadership Review group for exception reporting and oversee cultural changes.	Policy agreed by 31/07/2017, training 30/08/2017, September implementation, December - aim for 'mature'	SM	Policy implemeneted, staff familiar with the policy and using it effectively.patients and carers understand what is their responsibility.	Policy signed off by end July 17.In use from August and review by Oct/Nov	All other choice policies are de commissioned	Design and print cost	
8	**Enhancing Health in Care Homes.** Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.	Established	1. Care home educator project - fully resourced across the system working with care homes to reduce admissions .2. community & primary care support to care hoes. 3 Dedicated intensive support to high referring hokes in place. 4. quality & safeguarding plans in plce to support care homes.	1. Continue with Care Home Educators project - linked with JET and neighburhood teams. 2.Develop implementation plan and deliverables.	Sara RJ to complete	Care team recruited	Number of care home attendances and emergency admissions from care home reduced	Sara RJ to complete	Care Home business case	Sara RJ to complete	Sara RJ to complete

BCF Action Plan for Managing Transfers of Care
(8 High Impact Change Model)

Local Authority	Cambridgeshire
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		Peterborough			Cambridgeshire			
Project	Detail of funding required	Cost	Funding stream	Impact on DTOCs per month	Cost	Funding stream	Impact on DTOCs	Notes
High Impact Changes Implementation								
Discharge to Assess Implementation	Integrated Discharge Pathway and ICWs		STP	105.78		STP		
	Reablement capacity - general	191,000	iBCF		1,000,000	iBCF		Expand Reablement by 20%
	Reablement Capacity - Flats Ditchburn				140,000	iBCF		
	Reablement capacity - Doddington CT (plus required continuation of NHS contribution)				80,000	iBCF		
	Admission Avoidance SW in ED x 1	40,000						
	CHC 4Q x 1 DPN x 1SW and utilise existing resource	80,000	iBCF					x 1 CPFT DPN and 1 x SW to be redeployed
	Equipment Budget Pressures (Cambs: plus the continued requireme	80,000	iBCF		140,000	iBCF		ICES pressure
	Moving and Handling Coordinator	50,000	iBCF					
	Increased low level reablement support (VCS provision)	100,000	iBCF					
	CHC 4Q x 3 DPN and utilise existing resource				120,000	iBCF		x 2 DPN (x1 CUH x1CPFT) to be redeployed
	Discharge Cars Pressure				140,000	iBCF		
	Dedicated social work capacity to support self-funders (CUH)				41,000	iBCF	878.015	
Continuing Healthcare	Social Care Lead (1 per acute) to support D2A 4Q Pathway	50,000	iBCF	98.03	100,000	iBCF		4Q D2A resource
	Brokerage Capacity	40,000	iBCF					
	CHC Nurse resource to address CHC backlog	150,000	iBCF		250,000	iBCF		Reliant on CCG paying L.A. aged debt.
	Social Worker Capacity to address CHC backlog	50,000	iBCF		125,000	iBCF	156.165	
Trusted Assessor	Trusted Assessor	50,000	iBCF	8.56	75,000	BCF		PCC - funded pilot 50/50 with South Lincs CCC - CCG funding from ICW funding.
	Market Management Review	50,000	iBCF				89.61	
Reduction of Admissions to reduce DTOCs								
Public Health Initiatives	Stay Well in Winter	50,000	iBCF	10	50,000	iBCF		
	Keep Your Head Website	4,000	iBCF		4,000	iBCF		
	Dementia Alliance Coordinator	15,000	iBCF		15,000	CCC		
Admissions Avoidance	Adult Early Help				30,000	iBCF		
	Admissions Avoidance (Locality Teams)				80,000	iBCF	36.54	
	Actual DTOC reduction planned			**220.37**			1160.33	
	Target reduction of DTOCs to hit 3.5% national target			**214**			1160	
	iBCF Total	**1,000,000**			**2,375,000**			

Raising Cost Residential Care (4% Inflation on residential Nursing Care)		1,200,000	this is currently not allocated but needst to be acknowledged

Health and Well-Being Board Better Care Fund DToC Metric Planning

Selected Health and Well Being Board:

Peterborough

Data Submission Period:

2017-18

DToC Metric Plans

<< Link to the Guidance tab

Delayed Transfers of Care

	17-18 plans											
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
NHS attributed delayed days	0.0	0.0	0.0	546.0	546.0	339.0	312.0	264.0	273.0	273.0	246.0	273.0
				546.0	546.0	339.0	312.0	264.0	273.0	273.0	246.0	273.0
				0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Select any additional CCGs

Social Care attributed delayed				2.0	2.0	2.0	1.0	0.0	0.0	0.0	0.0	0.0
Jointly attributed delayed days				4.0	4.0	4.0	3.5	3.0	3.1	3.1	2.8	3.1
Total Delayed Days	0.0	0.0	0.0	552.0	552.0	345.0	316.5	267.0	276.1	276.1	248.8	276.1
Population Projection (SNPP	148,565	148,565	148,565	148,565	148,565	148,565	148,565	148,565	148,565	149,988	149,988	149,988
Delayed Transfers of Care	0.0	0.0	0.0	371.6	371.6	232.2	213.0	179.7	185.8	184.1	165.9	184.1

Delayed Transfers of Care numerator includes the delayed days attributable to the NHS, those to Social Care, and those which are jointly attributable to the NHS & Social Care.
Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+) population projections are based on a calendar year using the 2014 based Sub-National Population

30	31	30	31	31	30	31	30	31	31	28	31

Comments	
	The trajectory has been aligned to the revised system trajectory to deliver the NHSE 3.5% DTOC target by November 2017. The social care DTOC target is reducing to 0, which aligns to maintaining previous levels of DTOC performance and is corresponds with the prescribed recommended social care DTOC target for Peterborough.

Provisional BCF DToC Metric Plans: due on 21/07/2017

Health and Well-Being Board Better Care Fund DToC Metric Planning

Selected Health and Well Being Board:
Cambridgeshire

Data Submission Period:
2017-18

DToC Metric Plans

<< Link to the Guidance tab

Delayed Transfers of Care

	17-18 plans											
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
NHS attributed delayed days	0.0	0.0	0.0	1579.0	1579.0	1218.0	837.0	545.0	565.0	565.0	509.0	565.0
				1,547.0	1,547.0	1,194.0	820.0	534.0	554.0	554.0	499.0	554.0
				32.0	32.0	24.0	17.0	11.0	11.0	11.0	10.0	11.0

Select any additional CCGs (if

<Please Select>												

Social Care attributed delayed days				1,193.0	1,193.0	903.0	619.0	405.0	417.0	417.0	378.0	417.0
Jointly attributed delayed days				1,010.0	1,010.0	762.0	524.0	340.0	351.0	351.0	317.0	351.0
Total Delayed Days	0.0	0.0	0.0	3782.0	3782.0	2883.0	1980.0	1290.0	1333.0	1333.0	1204.0	1333.0
Population Projection (SNPP 2014)	524,010	524,010	524,010	524,010	524,010	524,010	524,010	524,010	524,010	528,478	528,478	528,478
Delayed Transfers of Care (delayed	0.0	0.0	0.0	721.7	721.7	550.2	377.9	246.2	254.4	252.2	227.8	252.2

Delayed Transfers of Care numerator includes the delayed days attributable to the NHS, those to Social Care, and those which are jointly attributable to the NHS & Social Care.
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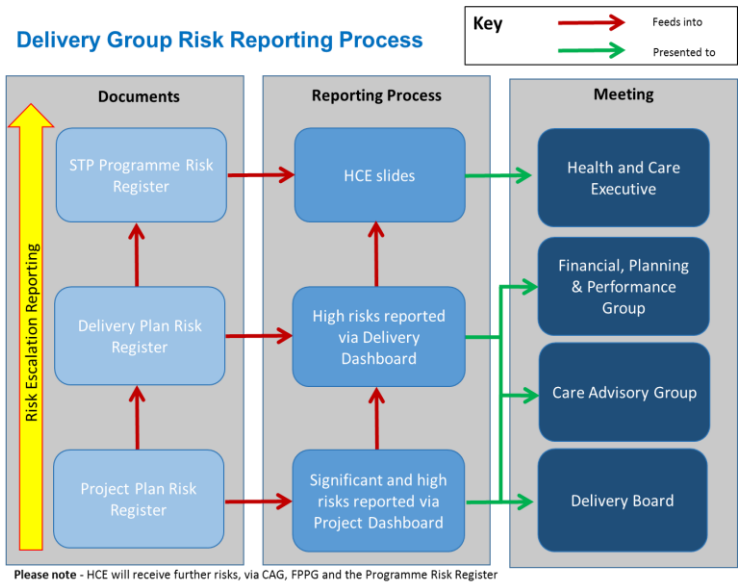
Comments	
	The trajectory has been aligned with revised NHSE system DTOC returns, which commit the delivery of the 3.5% national target by November 2017.

C&P CCG - ASSURANCE FRAMEWORK & RISK REGISTER - SUMMARY: 2017-18

Ref	Risk	Year Start Risk Score (Apr 17)	Current Risk Score (Aug 17)	Target Risk Score	Movement since last review
CC1	Failure to engage with Member Practices and wider stakeholders	**12 Amber**	**16 Red**	**6 Yellow**	→
CC2	Failure to deliver service transformation due to pressures and challenges facing primary care, and insufficient or uncoordinated resources for commissioning primary care.	**12 Amber**	**12 Amber**	**12 Amber**	→
CC3	Failure to deliver commissioning of primary care in line with the Delegation Agreement with NHS England	**12 Amber**	**3 Green**	**3 Green**	→
CC4	Risk to delivery of the Cambridgeshire and Peterborough Sustainability and Transformation Plan	**12 Amber**	**12 Amber**	**9 Amber**	→
QOP1	Failure to Safeguard Children	**12 Amber**	**9 Amber**	**6 Yellow**	→
QOP2	Failure to Safeguard Adults	**12 Amber**	**6 Yellow**	**6 Yellow**	→
QOP3	Overarching Risk - Potential for the poor quality in the services which the CCG commissions *(Risk re-instated following CCG Governing Body - 04.07.17)*	**12 Amber**	**12 Amber**	**6 Yellow**	Re-instated (Aug 17)
QOP3a	Potential for poor quality in the services which the CCG commissions from the East of England Ambulance Trust.	**16 Red**	**12 Amber**	**12 Amber**	↓
QOP3b	Potential for poor quality in the services which the CCG commissions: Smaller contracts	**16 Red**	**12 Amber**	**12 Amber**	↓
QOP3c	Failure to deliver the Integrated Out of Hours Service (QOP 10 and CMP 3 now merged and moved to QOP 3c to discuss the merging of this	**16 Red**	**16 Red**	**9 Amber**	Revised Risk
QOP4	Risk of poor quality care being delivered to patients in residential and nursing care homes and domiciliary care providers	**16 Red**	**16 Red**	**9 Amber**	→
QOP5	Failure to meet National Framework for NHS Continuing Healthcare and NHS funded Nursing Care compliance	**16 Red**	**16 Red**	**12 Amber**	→
QOP6	Failure to address quality improvement in Primary Care	**16 Red**	**16 Red**	**12 Amber**	↑
QOP7	Impact on quality as a result of workforce capacity within all providers	**16 Red**	**16 Red**	**12 Amber**	→
QOP7a	Impact on quality as a result of workforce capacity in relation to lack of paediatricians	**16 Red**	**16 Red**	**8 Amber**	→
QOP8	Risk around medication safety, including Controlled Drugs	**16 Red**	**12 Amber**	**9 Amber**	↓
QOP9	Risk that the merger between HCT and PSHFT to form North West Anglia NHS Foundation Trust impacts negatively on patient safety, patient experience & patient outcomes at one or both locations - Proposed that this risk be **Archived**	16 Red	9 Amber	9 Amber	→
QOP10	Failure to deliver the Integrated Out of Hours Service *(Risk merged with CMP 3 and moved to QOP3c above)*	16 Red	16 Red	9 Amber	→
QOP11	Financial Risk to complete Care Budgets due to there being a backlog of S117 disputes with the Local Authorities and no agreed Joint Funding Tool in place	**16 Red**	**20 Red**	**6 Yellow**	↑
QOP12	Failure to improve the CCG's Clinical Priority Ratings	**12 Amber**	**12 Amber**	**6 Yellow**	→
F1	Failure to achieve the Financial Control total agreed with NHS England	**20 Red**	**20 Red**	**12 Amber**	→
F2	Failure to provide accurate data on activity and finance for complex cases	**16 Red**	**20 Red**	**12 Amber**	↑
F3	Impact of Termination of the Older Peoples and Adult Social Care Contract on the CCGs Financial Control Total and QIPP Programme	**9 Amber**	**9 Amber**	**9 Amber**	→
CMT1	Risk to delivery of QIPP Plan 2017-18	**20 Red**	**20 Red**	**12 Amber**	→
CMT1a	*Impact of Capped Expenditure Process on delivery of QIPP and Financial Control Total wording of risk to be confirmed). Additional sub-risk identified for inclusion by at Finance Committee - 04.07.17: To be populated*	**TBC**	**TBC**	**TBC**	
CMT2	Failure to deliver 2017-18 Operational Plan Objectives (Excluding QIPP & Finance)	**12 Amber**	**12 Amber**	**3 Green**	→
CMT3	Impact of reduction in social care funding / capacity	**20 Red**	**16 Red**	**12 Amber**	↓
CMP1	Failure to deliver key NHS Constitution Targets	**20 Red**	**16 Red**	**3 Green**	↑
CMP2	Risk to procuring new support services contract - Failure to procure a new provider including corporate and primary care ICT service	**16 Red**	**16 Red**	**3 Green**	→
CMP3	Risk to the delivery of service standards of the Integrated Out of Hours Services Contract *(Risk to merged with QOP 10 and moved to QOP 3c)*	20 Red	20 Red	3 Green	→
ODW1	Insufficient capacity within the CCG to deliver all goals	**12 Amber**	**12 Amber**	**6 Yellow**	→
ODW2	Failure to deliver a robust Organisational Development Plan	**12 Amber**	**6 Yellow**	**3 Green**	↓
G1	Risk to maintaining robust CCG Governance Arrangements	**12 Amber**	**12 Amber**	**6 Yellow**	→
G2	Risk of poor information governance including non-compliance with the DPA, FOIA and other legislation relevant to the CCG and the services it commissions	**12 Amber**	**12 Amber**	**6 Yellow**	→
G3	Risk to robust incident and business continuity planning	**6 Yellow**	**6 Yellow**	**3 Green**	→
G4	Risk to data services following proposed move to health and Social care Information Centre	**12 Amber**	**12 Amber**	**6 Yellow**	→
G5	Failure to comply with public sector Equality Duties	**6 Yellow**	**6 Yellow**	**3 Green**	→
G6	Risk to the CCG meeting Section 5.2.1 of the Constitution - Make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements	**12 Amber**	**12 Amber**	**6 Yellow**	→

RISK MATRIX

	Risk Register
1	Further details on risk scoring is on the 'Risk Matrix Tab'
2	Project Manager captures all risks within Project Plan
3	Project Manager to submit Project Dashboard with all significant and high risks (scoring between 15-25).
4	All significant and high risks (scoring between 8-25) which have been escalated via Project Dashboard to be populated within the Delivery Plan Risk register tab
5	Delivery Plan Risk Register to be submitted alongside all other risk registers monthly.
6	Project dashboard and Delivery dashboard to be presented to Delivery Board monthly.
7	Any discussions at the Delivery Board should then be updated on the Delivery Plan Risk Register
8	Any high risks (scoring between 15 - 25) are then escalated via the Delivery Dashboard to the HCE.



CALCULATING RISK SCORES FOR THE STP ASSURANCE FRAMEWORK AND RISK REGISTERS

The STP uses the NHS National Patient Safety Agency's Model Risk Matrix to evaluate and score its programme risks. In short this involves identifying and scoring the potential consequence(s) of a risk and assessing and scoring the likelihood of that risk occurring. These two figures are then multiplied to provide an overall risk score. For reference the guidance that is used to calculate these scores is set out below.

TABLE 1 – IDENTIFYING THE CONSEQUENCE SCORE

The most appropriate domain that an identified risk may fall under is chosen from the first column on the left-hand side of the table. Then by working along the columns in the relevant row the severity of the risk is assessed on a scale of 1 to 5 to determine the consequence score. This is the number at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
Domains Please note: These are examples used in the national model and can be tailored to individual organizations')	**1**	**2**	**3**	**4**	**5**
	Insignificant	**Minor - GREEN**	**Moderate - YELLOW**	**Major - AMBER**	**Catastrophic - RED**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

				No staff attending mandatory/ key training	
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

TABLE 2 – IDENTIFYING THE LIKELIHOOD SCORE

The table used to determine the likelihood score(s) (L) for those adverse outcomes to a risk is shown below. If possible, the likelihood is scored by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, a probability to the adverse outcome occurring within a given time frame is assigned, such as the lifetime of a project. If it is not possible to determine a numerical probability the probability descriptions set out in the table can be used to determine the most appropriate score.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely - GREEN**	**Possible - YELLOW**	**Likely - AMBER**	**Almost certain - RED**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

TABLE 3 – CALCULATING THE OVERALL RISK SCORE

The overall risk score is calculated by multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

Likelihood	**X**	**Consequence**				
		Insignificant = 1	**Minor = 2**	**Moderate = 3**	**Major = 4**	**Catastrophic = 5**
Rare – 1		**1**	**2**	**3**	**4**	**5**
Unlikely – 2		**2**	**4**	**6**	**8**	**10**
Possible – 3		**3**	**6**	**9**	**12**	**15**
Likely – 4		**4**	**8**	**12**	**16**	**20**
Almost Certain – 5		**5**	**10**	**15**	**20**	**25**

Low risk **Score (1 – 3)**	Normal risks which can be managed by routine procedures
Moderate risk **Score (4 – 6)**	Risks requiring assessment and action planning allocated to Delivery Group
Significant risk **Score (8 - 12)**	Risks requiring urgent Delivery Group action
High Risk **Score (15 – 25)**	Risks requiring immediate action by Accountable Officer/Health and Care Executive

There is a risk that:	How likely is the risk to materialise? Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely	Potential impact Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact And if there is some financial impact please specify in £000s, also specify who the impact of the	Overall risk factor (likelihood *potential impact)	Risk Owner	Mitigating Actions
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.	3	3	9	ICB	Agreed vision and principles which are incorporated within BCF Plan and service core planning documents. Alignment of vision with other system plans - e.g. STP, devolution, Health and Wellbeing Strategies, Council's visions. Reviewed 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.
Lack of transformational change strategic leadership capacity across the system 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.	3	4	12	CCG/PCC/CCC	Continue development of a Transformational System leadership capacity / capability building programme 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.
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	PCC/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. Focus on prevention and early intervention transformation initiatives to manage demand.
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.
If staff are not fully aware of, nor engaged with, the changes arising from the BCF Plan there may be a negative impact on staff attendance, retention and recruitment.	3	3	9	PCC/CCC/CCG/NHS Partners/VCS	Comprehensive engagement plan in place with clear and timely objectives and targets. Profiling and management of workforce attendance and turnover. Demonstrable leadership through the delivery of a comprehensive staff engagement plan. Development of appropriate workforce and associated operational development plans.
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 excluded. Transformation may, therefore, be ineffective.	2	3	6	PCC/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. 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.
If there are multiple and/or uncoordinated changes to service delivery this could destabilise provision and performance.	4	4	16	PCC/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.
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	PCC/CCC/CCG	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.
If there is insufficient project control, transparency and accountability, delivery of the BCF Plan and strategic vision may be compromised.	3	3	9	PCC/CCC/CCG	Programme management resources in place to deliver the plan to agreed milestones. 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.
If there is a delay in developing the BCF Plan, it may not be finalised and approved by the due date for submission.	1	2	2	PCC/CCC	Build on the agreed vision and development of work within 2016/17. 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. Clear governance agreed for final approval.
If changes are made to national policy in respect of urgent and emergency care this could negatively impact the BCF Plan content and timetable.	3	3	9	CCG	Effective links in place with local and national NHS policy makers.
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.	2	3	6	PCC/CCC	Ongoing monitoring and profiling of demand. Development of community capacity through commissioned activities and close working relationship with voluntary sector (PCVS). Re-prioritisation of existing resources.

There is a risk that:	How likely is the risk to materialise? Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely	Potential impact Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact And if there is some	Overall risk factor (likelihood *potential impact)	Risk Owner	Mitigating Actions
Equipment / Assistive Technology / DFG					
If effective planning for equipment requirements is not sufficiently factored in, then associated equipmentfinancial pressures may impact on system wide benefits.	4	3	12	ICB	System business cases to include equipment requirements in modelling. Financial budget pressures for equipment planned for in BCF expenditure plans for 17/18 and 18/19. Reviewing options for more integrated use of equipment/AT and DFG. Preventative uses of DFG being utilised. Close monitoring of equipment budget pressures and ongoing review of approaches.
If approaches to equipment are not fully embedded in business as usual practices, then early intervention and prevention impacts will not be maximised.	3	3	9	PCC/CCC/CCG	New service models to include equipment considerations and training in implementation plans. Strategic system wide working group established to review approaches. Workforce development requirements considered and implemented.
VCS Joint Commissioning					
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**	PCC/CCC/CCG	Joint commissioning approach established to support best use of resources Ensure best practice and guidance from Ageing Well adopted by local commissioners. Review of Wellbeing Network to ensure appropriate community provision Specific investment allocated to key areas of work Community resilience key strand of work for both Councils.
Ageing Well - Falls Prevention					
If the populatuon and demand predictions are underestimated then there will be increased costs to the health and social care system, reducing the full impact of benefits	3	3	9	CCG	Public health trajectories utilised to model predictions working group overseeing implementation oversight of project by STP PCIN to review effectiveness
If communications are not effective at reaching the targeted audience, then the service will not target the required number of people.	3	3	9	CCG	Communications plan and Comms team engagement Training and workforce development learning from pilot rolled out
If there is a hgh staff turnover rate, this will impact on the necessary resources being deployed to deliver the project activities and will reduce consistency of delivery	3	2	6	CPFT	Working group overseeing implementation to ensure consistent approach implementation plan established with clear responsibilities review and monitoring of implmementation progress
If there are inadequate information systems to support whole system patient journey analyses, then interventions will not be targetted to maximise effective patient outcomes	2	3	6	CCG	public health input into ongoing project implementation and evaluation system wide STP owenership to project system partner represnetation on working group ongoing review and monitoring of effectiveness of project
If Therapy Teams do not adopt the new systems and processes then the new service will not be implemented to full effect.	2	4	8	CPFT	Learning from the falls pilot to be rolled out Workforce training and development plan established
Ageing Well - Atrial Fibrillation					
If GPs do not engage with the project fully, then it will impact on the ability to implement the project	3	4	12	CCG	Project responsibility to be shared with LMC Comms Team to engage with GP practices Comms plan established and agreed
If suitable patients are not identified, then the intended benefits will not be realised.	3	2	6	CCG/GPs	GP education Clinical decision on suitability/risk Monitoring of effectiveness of project
If suitable patients do not want to take anticoagulants, then this will impact on the ability to deliver the nefits	3	2	6	GPs	GP to educate patient on the risks of not taking anticoagulants. All responses should be documented to understand issues GP communications

There is a risk that:	How likely is the risk to materialise? Please rate on a scale of 1-5 with 1 being very	Potential impact Please rate on a scale of 1-5 with 1 being a relatively small impact	Overall risk factor (likelihood *potential impact)	Risk Owner	Mitigating Actions
Technological: delivery of the Person Centred System deliverables is reliant on effective data sharing systems and information governance protocols being in place and utilised by professionals across the system.	**3**	**3**	**9**	CPFT/STP	Pseudonymisation tool developed and being tested. Data Sharing agreements signed and in place with system partners. Close integration with STP Digital Delivery Group projects and alignment of organisational leads Immediate solutions to practical data sharing options being explored Alignment with local digital roadmap Clear expectations of information governance and consent
Inadequate co-location and integration of staff across health and social care will not enable effective MDT working	**2**	**3**	**6**	PCC/CCC/CPFT	PCC/CCC commitment to alignment with neighbourhood teams Centralised 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
If Primary care engagement is not achieved because MDTs are NT rather than primary care hosted then MDT effectiveness will be compromised.	3	3	9	CCG/CPFT	1. Iterate the Trailblazer model – e.g. N City TB NT holding MDTs in practices on rotating basis or 6/52 to show value of broader MDT model. 2. Case finding data demonstrates need for broader MDT model
If data sharing agreements are not established with all relevant system partners, then MDTs will not be able to target gthe key population which will impact on delivery of benefits	2	3	6	CPFT/STP	Data sharing agreements developed between CPFT (as data processor) andAcute hospitals LAs, Primary care practices CPFT providing business information resource to process data Data Sharing Board working towards system model for processing case found data
If case found demand exceeds system capacity then there is a significant risk, that without additional investment, there will be insufficient capacity to deliver the system benefits	5	4	20	CPFT/CCG	Broader MDT approach – utilise all available resources Coordinated approach – reduces waste STP investment – the most impactful mitigating action
If savings cannot be evidenced within year 1, then there is a risk that the project will not deliver on the projected benefits	3	3	9	STP	SMART outcomes measures identified, based on evidence of current hospital NEL activity.
If there is a lack of availability of other community services, in particular the expanded JET and intermediate care, expanded Psychological Wellbeing Service and expanded voluntary sector capacity, then there will be insufficient support to deliver the full patient benefits	3	3	9	CCG/CCC/PCC/ CPFT	STP buy in to business case system wide involvement in implementation of case management clear roles and responsibilities ongoing review of effectiveness

There is a risk that:	How likely is the risk to materialise? Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely	Potential impact Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)	Overall risk factor (likelihood *potential impact)	Risk Owner	Mitigating Actions
Inadequate engagement with Care Homes impacts on ability to effectively discharge patients	**4**	**4**	**16**	PCC/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 in place Trusted Assessor models being explored
If significant culture change is not implemented across all providers then this will impact ont he ability to manage DTOCs effectively	**4**	**4**	**16**	CCG/PCC/CCC/Providers	Workforce and development plans Commitment to joint workforce development approaches Change management support Communications and engagement plan D2A pathway being implemented
If there in insufficient intermediate care provision in the community to manage appropriate discharges, then reablement effectiveness may be impacted.	**3**	**3**	**9**	PCC/CCC/CCG	D2A business case being implemented. Additional investment in reablement agreed. iBCF funding additional capacity to pick up briding packages at periods of high demand, i.e. winter period as short term response. Alignment of intermediate care provision to maximise and flex resources more effectively.
If the recruitment of new workforce requirements are not succeeful then there will not be sufficient capcity to implement the new model	4	4	16	CCG/CPFT	Proactive recruitment campaign started early in the process Deployment of joint workforce strategies across provider organisations to increase appeal of roles to prospective applicants Use of independent sector provider capacity in the interim to bridge gaps to provision during the recruitment process
If there is insufficient domiciliary care and care home capacity then this will impact on effective pathway exits.	3	4	12	CCG/PCC/CCC/Providers	Design processes (eg D2A) that enable system partners for early identification and planning of long term need to reduce risks of periods of excessive demand for long term assessment and care Identify innovative solutions to delivery domiciliary care support (eg primary care support for patients at home, “grow your own workforce”, etc) Support the development of a “community pool” of capacity to support care for patients at home under the direct payment scheme (eg microbusinesses in community providing care in a given geography) Promote use of direct payments as an alternative to social care support being arranged by the local authority

There is a risk that:	How likely is the risk to materialise? Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely	Potential impact Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact And if there is some financial impact please specify in £000s, also specify who the impact of the	Overall risk factor (likelihood *potential impact)	Risk Owner	Mitigating Actions
If the cost of IT solution that meets the requirements of the specification is overly prohibitive, then this will impact on the ability to deliver a system wide solution.	3	3	9	ICB	LGA funding proof of concept test pilot. Partner wide agreement to spread costs where appropriate. Ongoing review to ensure cost effective approaches developed. Contractual requirements included in relevant contracts. e.g. VCS maintenance of data within Wellbeing Network contract. System wide steering group to oversee.
If all partners across the system do not agree with the solution and implement individual options then this will impact on delivery of the vision and associated benefits.	3	3	9	ICB	Local providers engaged in steering group Organisational leads establish working group Review of local issues and gap analysis to ensure clear scope User reference group established to ensure system wide input into design.
If data on information in sources becomes unreliable and inaccurate, then the benefits of the project will not be realised.	3	3	9	PCC/CCC/CCG	Dedicated resource for management of platform established Contracts/SLAs for the maintenance of information sources
If the customer interface is not effective – the information on sources are reliant on the way data is presented to the customer - then the customer will not utilise and benefit from the information.	2	4	8	Steering Group	Understand customer and best practice on information presentation Investment in research into customer needs from LGA bid User refence group established to inform desing requirements Ongoing review and oversight via the steering group to ensure effectiveness

There is a risk that:	How likely is the risk to materialise? Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely	Potential impact Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact And if there is some financial impact please specify in £000s,	Overall risk factor (likelihood *potential impact)	Risk Owner	Mitigating Actions
Non-elective admissions					
Failure to deliver 2017-19 CCG Operational Plan objectives	**4**	**4**	**16**	CCG	Monthly reporting to CMET and Finance and Performance sub-committee PMO in place Accountability reviews Standard agenda item on COG Action plan in place overseen by COO and Head of Planning NHSE quarterly assurance meetings Performance dashboard
Risk to delivery of Urgent and Emergency Care Plans	**4**	**4**	**16**	CCG	Monthly reporting to CMET and Patient Safety and Quality Committee COO leading and chairing Action plan in place for acute systems, including winter planning approved Monthly and quarterly reviews with NHS England UEC STP delivery group oversight to ensure system wide buy in. A&E Delivery Groups responsible for delivery of dependent targets
DTOCS					
Ward staff in acute don't implement the learning from training/development	**4**	**4**	**16**	NWAFT / CUH	Workforce development plan to support culture change Closer working and integration with the voluntary sector Development of joint workforce initiatives (e.g. training, rotations, recruitment processes) Social Care Discharge Lead being implemented to support
High numbers of new DTOCs on a daily basis prevent reduction to trajectory	**4**	**4**	**16**	NWAFT /CUH	Agreement from all system partners to proactively assess and plan discharge for patients Closer alignment of intermediate care teams to aid discharge Costed DTOC plan established 8HIC implementation plan in place Implementation and refinement of patient flow management software SHREWD for early escalation of issues.
Care provider market can't meet need within certain geographical areas	**3**	**3**	**9**	PCC / CCC	PCC/CCC and CCG to work to develop market in areas known to have poor provision Joint commissioning approaches 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**	PCC/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 health/long term conditions, impacting on target	**3**	**3**	**9**	PCC/CCC	Widened scope of JET to offer intermediate care and emergency response from 65 to 50 year olds Scope of age for the Wellbeing Service been widened to all adults over 18, enabling stronger community support provision - 24/7 mental health service in place
Effectiveness of Reablement					
Discharge from acute into reablement happens before medically fit resulting in readmissions to hospital	**3**	**3**	**9**	PCC/CCC/NWAFT/	Discharge protocol agreed D2A pathway being implemented Alignment of intermediate care tier New CHC process being implemented
If there in insufficient intermediate care provision in the community to manage appropriate discharges, then reablement effectiveness may be impacted.	**3**	**3**	**9**	PCC/CCC/CCG	D2A business case being implemented. Additional investment in reablement agreed. iBCF funding additional capacity to pick up briding packages at periods of high demand, i.e. winter period as short term response. Alignment of intermediate care provision to maximise and flex resources more effectively.

CAMBRIDGESHIRE BCF
Summary of Proposed Financial Arrangements

The following elements, must be included in the BCF pooled budget for 2017-19: CCG minimum revenue contribution, Disabled Facilities Grant & Improved Better Care Fund, which comprises:

- Local Government Financial Settlement (LGA): IBCF funding was announced as part of the 'Core Spending Power: Provisional Local Government Finance Settlement'[1] in December 2016. The funding is recurring, on-going and increasing.
- Spring Budget 2017: in the Government's Spring Budget of March 2017[2] additional funding was announced for Adult Social Care. The funding is non-recurring, over 3 years and decreasing.

Income

The below tables outlines the BCF revenue and capital income for 2017-19 for Cambridgeshire.

Cambridgeshire[2]	2017/18	2018/19
CCG Minimum revenue contribution	£36,294,733	£36,983,314
Disabled Facilities Grant	3,809,721	£4,140,576
Improved Better Care Fund	£8,339,311	£10,658,272
TOTAL	**£48,443,765**	**£51,782,162**

Expenditure

It is agreed that historically committed spend remains the same for 2017-19 (a full breakdown is included in **Appendix 1**). The additional monies (CCG minimum contribution uplift) and iBCF monies, following discussions between the Local Authorities and CCG, are proposed to be utilised in the following areas:

CCG Minimum Contribution – Uplift

Cambridgeshire	2017/18 Amunt	2018/19 Amount	Description of spend
CCC – Social Care Uplift[3] (Protection of ASC)	£266, 048	£287,452	Additional funds used to cover increased contract costs, price uplifts & increases related to National Living Wage changes. Not used to fund additional provision
CCG – Uplift[4]	£638,968	£688,294	Additional funds used to cover:

[1]

[2] BCF 2017/19 planning template

[3] 2017/18 = 1.79%, 2018/19 = 1.9% Social care allocation: 2016/17 £14,863,000 2017/18 £15,129,048 2018/19 £15,416,500

[4] 2017/18 = 1.79% 2018/19 = 1.9% CCG allocation: 2016/17 £20,792,499 2017/18 £21,165,685 2018/19 £21,566,814

			- CPFT contract increase (Neighbourhood teams - £221k) - ICES Equipment and Assistive Technology increases - £129.7k - Carer's Prescription uplift - £9.3k

Improved Better Care Fund

	2017/18 Amount	2018/19 Amount	Description of Spend
Spring Budget monies: (£8,339k in 2017/18 and £6,567 in 2018/19)			
Investment in Adult Social Care and Social Work	£2,889,000	£4,000,000	- See Appendix 2
Investment into housing options for vulnerable people	£3,000,000	£517,000	Business Case Attached
Commitment to joint fund with the STP Falls Prevention & Atrial Fibrillation	£150,000	£150,000	STP Business cases fully approved
Costed plan to support delivery of the 3.5% national DTOC target	£2,300,000	£1,900,000	Costed DTOC Plan
Local Government Financial Settlement monies			
Local Government Financial Settlement monies – protection of ASC in line with original intentions of the national grant	£0	£4,100,000	Allocated to investment in Social Care
Deducted ending social care support grant		--£2,561,000	
Subtotal Improved Better Care Fund	***£8,339,000***	***£8,106,000***	

Appendix 1 – Full Expenditure Breakdown Cambridgeshire

The NHSE issued BCF planning template has outlined the below minimum spend areas must be complied with:

	2016/17 - benchmark	2017/18	2018/19
BCF Expenditure on social care from minimum CCG contribution	14,863,000	15,129,048	15,416,500
NHS Commissioned Out of Hospital ringfence		10,313,650	10,509,609

The below outlines the full expenditure breakdown:

CCG Minimum Contribution	2017/18 Amount	2018/19

		Amount
CCC – Promoting Independence	1,525,000	1,525,000
CCC – Intermediate Care & reablement	8,600,000	8,600,000
CCC – Carers Support	1,500,000	1,500,000
CCC – VCS Joint Commissioning	1,950,000	1,950,000
CCC – Discharge Planning & DTOC	944,000	944,000
CCC – Social Care uplift (Protection of ASC)	272,048	559,500
CCC – Social Care commissioning and protection. (To fund CCC commissioning, Social care transformation and protection of social care)	338,000	338,000
Subtotal (total CCG contribution to CCC)	15,129,048	15,416,500
CCG – Intermediate care & reablement	£1,994,916	£2,032,819
CCG – Carer's Support	£350,000	£356,650
CCG – Neighbourhood teams	£17,333,769	£17,663,833
CCG – Commissioning and Transformation	£485,000	£494,215
Risk Share	£836,000	£852,112
Wellbeing	£50,000	£50,000
CCG – Commissioning & Transformation	£115,000	£117,185
Subtotal (Out of Hospital Commissioned Services)	*£21,164,685*	*£21,566,814*
Subtotal CCG Minimum Contribution	***£36,293,733***	***£36,983,314***
CCC – Disabled Facilities Grant	£3,809,721	£4,140,576
Subtotal Disabled Facilities Grant	***3,809,721***	
Improved Better Care Fund		
Spring Budget monies: (2018/19 spending TBC)		
Supporting Adult Social Care pressures and investment	£2,889,000	£4,000,000

Investment into housing options for vulnerable people	£3,000,000	£517,000
Commitment to joint fund with the STP Falls Prevention & Atrial Fibrillation	£150,000	£150,000
Costed plan to support delivery of the 3.5% national DTOC target	£2,300,000	£1,900,000
Local Government Financial Settlement monies – protection of ASC in line with original intentions of the national grant	£0	£4,100,000
Adult Social Care Support grant ending		-£2,561,000
Subtotal Improved Better Care Fund	***8,339,000***	***8,106,000***
Total Pooled Budget		

Appendix 2 – Cambridgeshire iBCF funding for Social Care & Social Work

Category/Project	Allocation
Additional Capacity in : ● Multi-agency safeguarding hub (MASH) ● Early Adult Help ● Social work following Reablement ● Care planning & reviews ● Peterborough city Hospital Capacity ● Dedicated CHC team ● Centralised Brokerage of homecare to improve prioritisation ● Dedicated capacity for focus on recruitment	£600,000
Specialist support for Adults with Autism to increase their independence	£50,000
Using Assistive technology to help people with learning disabilities be safe and without need for 24hr care	£186,000
Using Assistive technology to support Older People be safe and remain independent	£110,000
Neighbourhood Cares transformation pilot	£656,000
Enhanced occupational therapy support to reduce the need for double-handed care	£90,000
Enhanced response service - Falls and telecare	£393,000
Sub-total investment	£2,085,000
External consultancy support, developing a transformation programme & longer term demand response	£500,000

iBCF monies needed to meet gap in BCF savings ask (cf. unavailability of previous uplifts/share)[5]	£513,000
Total Commitment	£3,098,000
Allocation available in this category	-£2,889,000

[5] As part of the Council's response to a £17m cut in unringfenced grants a planning assumption has been made about protection of social care budges using ring-fenced BCF monies. The Council's view was that the long-standing contribution to social care through the BCF is relatively low compared to national norms and so it had assumed that this would be addressed through the original BCF. As this has not been fully possible to the expected level a top-slice is required via the iBCF.

Peterborough BCF

Summary of proposed financial arrangements

The following elements, must be included in the BCF pooled budget for 2017-19:

- CCG minimum revenue contribution
- Disabled Facilities Grant
- Improved Better Care Fund, which comprises:
    - Local Government Financial Settlement (LGA): IBCF funding was announced as part of the 'Core Spending Power: Provisional Local Government Finance Settlement'[1] in December 2016. The funding is recurring, on-going and increasing.
    - Spring Budget 2017: in the Government's Spring Budget of March 2017[2] additional funding was announced for Adult Social Care. The funding is non-recurring, over 3 years and decreasing.

Income

The below table outlines the BCF revenue and capital income for 2017-19.

	2017/18	2018/19
CCG Minimum revenue contribution	£11,287,227	£11,501,684
Disabled Facilities Grant	£1,675,081	£1,826,575
Improved Better Care Fund	£3,876,686	£5,245,865
TOTAL	**£16,838,994**	**£18,574,125**

Expenditure

It is agreed that historically committed spend remains the same for 2017-19 (a full breakdown is included in **Appendix 1**). Expenditure for 2017/18 Q1 for these areas are currently spending in line with budget. The additional monies (CCG minimum contribution uplift) and iBCF monies, following discussions between the Local Authorities and CCG, are proposed to be utilised in the following areas:

CCG Minimum Contribution - Uplift

	Further detail	2017/18 Amount	2018/19 Amount
PCC – Social Care uplift (Protection of ASC)	cover the cost of the national Living Wage -	£116,673	£242,732

	£350k		
CCG – Uplift	Cover the CPFT contract increase (Neighbourhood teams)	£81,554	£169,952

Improved Better Care Fund

	Further details	2017/18 Amount	2018/19 Amount
Spring Budget monies: (2018/19 £2,260k spending TBC)			
Social Care Capacity and Investment - Repayment to corporate against previous investment in transformation	Repay investment in the following areas: 2017/18 investment: - Transfer of Care Team - £302k - Respite - £372k - Reablement - £312k	£350,000	Nil
Investment into housing options for vulnerable people		£2,000,000	£1,110,000
Commitment to joint fund with the STP Falls Prevention & Atrial Fibrillation	STP Business Cases fully approved	£150,000	£150,000
Costed plan to support delivery of the 3.5% national DTOC target		£1,000,000	£1,000,000
Local Government Financial Settlement monies			
Local Government Financial Settlement monies – protection of ASC in line with original intentions of the national grant	Cover identified cost pressures. 2017/18 identified cost pressures of £3.3m: - Self Funders - £408k - Homecare (cost, demand and complexity) - £936k - Direct Payments (rate increase) - £173k - National Living Wage - £350k - ISP budget deficit at year start - £1.1m - Demographic pressures - £86k - Nursing Care - £57k - Mental Health and LD - £200k	£376,686	£2,995,866
Subtotal Improved Better Care Fund		***£3,876,686***	***£5,245,865***

Appendix 1 – Full Expenditure Breakdown

The NHSE issued BCF planning template has outlined the below minimum spend areas must be complied with:

	2016/17 - benchmark	2017/18	2018/19
BCF Expenditure on social care from minimum CCG contribution	£6,518,000	£6,634,672	£6,760,731
NHS Commissioned Out of Hospital ringfence		£3,207,510	£3,268,452

The below outlines the full expenditure breakdown (highlighted:

CCG Minimum Contribution	2017/18 Amount	2018/19 Amount
PCC – Section 256 (Independent Sector Placements)	£3,522,000	£3,522,000
PCC – Protection of ASC (Core service budgets to maintain provision)	£1,589,000	£1,589,000
PCC – Reduction of DTOCs / 7DS (reablement and bed based market/Friary Court(	£250,000	£250,000
PCC - Person Centred Services (Assistive Technology)	£100,000	£100,000
PCC - Ageing healthily and prevention (QA/QI, market development)	£550,000	£550,000
PCC – Care Act (Carers packages)	£407,000	£407,000
PCC – Social Care uplift (Protection of ASC)	£116,672	£242,731
PCC – Carer's Support (50/50 with CCG)*	£75,000	£75,000
PCC – Wellbeing (50/50 with CCG)*	£25,000	£25,000
Subtotal (total CCG contribution to PCC)	*£6,634,672*	*£6,760,731*
CCG – Integrated Adult Community Services	£4,042,000	£4,042,000
CCG – Carer's Support (50/50 with PCC)*	£75,000	£75,000
CCG – Wellbeing (50/50 with PCC)*	£25,000	£25,000
CCG – Uplift	£81,555	£169,953
Risk Share	£429,000	£429,000

Subtotal (Out of Hospital Commissioned Services)	*£4,652,555*	*£4,740,953*
Subtotal CCG Minimum Contribution	***£11,287,227***	***£11,501,684***
Disabled Facilities Grant		
PCC – Disabled Facilities Grant	£1,675,081	£1,826,575
Subtotal Disabled Facilities Grant	***£1,675,081***	***£1,826,575***
Improved Better Care Fund		
Spring Budget monies: (2018/19 £2,260k spending TBC)		
Repayment to corporate against previous investment in transformation	£350,000	TBC
Investment into housing options for vulnerable people	£2,000,000	TBC
Commitment to joint fund with the STP Falls Prevention & Atrial Fibrillation	£150,000	£150,000
Costed plan to support delivery of the 3.5% national DTOC target	£1,000,000	TBC
Local Government Financial Settlement monies		
Local Government Financial Settlement monies – protection of ASC in line with original intentions of the national grant	£354,000	£3,000,000
Subtotal Improved Better Care Fund	***£3,924,000***	***£5,260,000***
Total Pooled Budget	**£16,838,994**	**£18,574,125**

***Monies held by CCG and not transferred to PCC.** In the 2016/17 submitted plan, £6,518,000 was identified as 'social care' spending. However, £100k of this was retained by the CCG to fund the Carer's Prescription and Wellbeing Network. Therefore the sum of £6,418,000 was pass-ported to PCC. Last year's uplift (£100k) should remain with the CCG, as this has been incorporated in the CCG base budgets.

CAMBRIDGESHIRE COUNTY COUNCIL

Outline Business Case

Investment in housing options for vulnerable people

Version 11

Draft

August 2017

Prepared by

B Pickbourn

Document Control

Authorisation		
Name	Richard O'Driscoll	
Position	Head Of Commissioning (Adults)	
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Distribution		
Name		Organisation
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Contents

1 Executive Summary

Cambridgeshire is required to submit a new, jointly agreed Better Care Fund (BCF) Plan, covering a two year period to NHS England on 11th September 2017. The Improved Better Care Fund (iBCF) is a new introduction to BCF plans this financial year and is considered to be part of the ongoing BCF programme.

In line with the national conditions, discussions are taking place with the Clinical Commissioning Group (CCG) to reach agreement on the use of the IBCF funds. There are a number of areas being discussed for 2017/18, these are subject to final agreement and approval. One of these areas is;

- **Investment in housing options for vulnerable people**

The recommendation is to invest £3m of the IBCF Funds and provide accommodation to this group of people in Cambridgeshire.

This scheme meets the conditions of the IBCF and would offer a **sustainable investment** and an **annual return**. This proposal will

- contribute to **reducing pressures on National Health Service (NHS)**
- directly meet current adult social care needs and priorities
- supports the Council's Prevention and Early Intervention Strategy
- provide a lasting benefit to the people of Cambridgeshire

There is **robust financial case** - For investing the £3m of IBCF Funds, Cambridgeshire's CCG and Council get a **return of £2.17m** over five years.

- This will be a joint financial benefit of 2.17m over five years to the Learning Disabilities Partnership Pool Budget.

The **health and social care benefits** of providing this accommodation include:

- Housing with support can reduce the risk of inpatient admission
- Housing with support can delay or avoid the need for registered care
- Facilitate the delivery of personalised care and support
- Provide a local higher quality solution for the client that it is easier to oversee by the social and health professionals because it is local
- People can receive more suitable accommodation and support whilst maintaining links with their local communities
- Offers better value for money than existing options, i.e. out of area placements

2 Background

2.1 The Better Care Fund

The Better Care Fund was established in 2015/16, to create a pooled budget in each local authority area supporting closer integration of health and social care services, in order to improve outcomes for service users and ensure the sustainability of services.

Cambridgeshire is required to submit a new, jointly agreed Better Care Fund (BCF) Plan, covering a two year period to NHS England on 11th September 2017. The Improved Better Care Fund (iBCF) is a new part of the BCF plans this financial year and is considered to be part of the ongoing BCF programme.

In line with the national conditions, discussions are taking place with the CCG to reach agreement on the use of the IBCF funds. There are a number of areas being discussed for 2017/18, these are subject to final agreement and approval.

For more information on BCF see Appendix One.

2.2 BCF Vision

The vision for Cambridgeshire is expressed 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.

It means moving money away from acute health services, typically provided in hospital, and from ongoing social care support. This cannot be achieved immediately – such services are usually funded on a demand-led basis and provided as they are needed in order to avoid people being left untreated or unsupported when they have had a crisis. Therefore reducing spending is only possible if fewer people have crises. However, this is required if services are to be sustainable in the medium and long term."

2.3 IBCF Programme

The Improved Better Care Fund (iBCF) is a new part of BCF plans this financial year. The monies are paid direct to the Local Authority from the Department of Communities and Local Government (DCLG) and the following national conditions apply:

- Monies must be pooled into the Better Care Fund (BCF) Section 75 budget between Cambridgeshire County Council (CCC) and Cambridgeshire and Peterborough Clinical Commissioning Group (CCG).
- Monies must only be used for the following purposes:
    - Meeting Adult Social Care (ASC) needs,
    - Reducing pressures on the NHS, including supporting more people to be discharged from hospital when ready; and
    - Ensuring the local social care provider market is supported.

2.4 Conditions of the grant

Non-recurrent social care grant allocation, i.e. the funding is for a single year only and does not form part of an on-going arrangement.

To be used for:

- Stabilising the social care market
- Meeting adult social care needs
- Reducing pressures on NHS
- Making Progress in theHigh Impact Change model

Quarterly reporting to the Department of Communities and Local Government (DCLG)

2.5 The proposal

Discussions are taking place with the CCG to reach agreement on the use of the IBCF funds. There are a number of areas being discussed for 2017/18, these are subject to final agreement and approval. One of these areas is;

- **Investment in housing options for vulnerable people**

It was felt that this met the conditions of the IBCF and would offer a sustainable investment and an annual return.

3 Drivers and Objectives

3.1 The case for the investment

As the funding is currently short-term and non-recurring, it was important to use the grant for an activity or area that;

- did not create an on-going financial commitment that couldn't be sustained
- would provide a lasting benefit to the people of Cambridgeshire
- would directly meet current adult social care needs and priorities
- would contribute to reducing pressures on NHS
- supports the Council's Prevention and Early Intervention Strategy

3.2 Inequalities in life expectancy

A person's health is determined by a complex mix of factors including income, housing and employment, lifestyles and access to health care and other services. There are significant inequalities in health between individuals and different groups in society.

These inequalities are not random. In particular, there is a 'social gradient' in health; neighbourhood areas with higher levels of income deprivation typically have lower life expectancy and disability-free life expectancy. This relationship (known as the 'Marmot curve') formed an important part of the independent and influential report on health inequalities, Fair society, healthy lives (the Marmot Review).

3.3 The opportunity

CCC is committed to providing a range of independent housing options for adults with a learning disability and/or autism . The Council is working with local Registered Social Landlords and Private Landlords to secure single tenancies and supported living services for people with these conditions and effectively manage the accommodation available.

Supporting people with learning disabilities and/or autism to be active citizens in their communities is a key priority for the Council, as part of its Prevention and Early Intervention Strategy.

The supply of specialist housing is critical to achieving the objectives of prevention and progression. Specialist housing includes accommodation that has been designed and built to meet the needs of the vulnerable adult and may include some elements of care and support for everyone who lives there. This support can either be on-site or off-site.

This will promote best outcomes for local people and minimise the risk of out of area placements.

As at August 2016 there were circa 1570 adults (18+) with a learning disability in Cambridgeshire. (source LDP Market Position Statement)

3.4 Benefits

The health and social care benefits of providing local specialist housing include:

- Specialist housing with support can reduce the risk of inpatient admission
- Specialist housing with support can delay or avoid the need for registered care
- Appropriate accommodation can facilitate the delivery of personalised care and support
- Provides a local higher quality solution for the client that is more manageable by the professionals
- People can receive more suitable accommodation and support whilst maintaining links with their local communities
- Offers better value for money than existing options, i.e. out of area placements and can maintain and utilise existing local networks including family and friends who may offer "natural support" as part of the package
- The accommodation would be closer to home, as some of the clients are out of area, and wish to move closer.
- Appropriate accommodation can enable people to maintain and develop independent living skills
- People are able to receive welfare benefits that they would not be entitled to if they were living in a registered care environment
- Bringing people back from out of area placements to their localities, where this is appropriate.
- Professionals are better able to monitor/review progress of clients and manage emerging risks when people are in area

3.5 Assumptions

- The proposed scheme is acceptable to DCLG criteria.
    - Discussions have been had with the local BCF Lead for the Eastern Region and he is supportive.
- CCG and Council agree to the investment
    - Discussions are on-going and in principle the concept is acceptable
- Suitable accommodation can be sourced and acquired to meet the timescales.
    - Property has already been identified that meets a large proportion of the requirement. The provider has commitment to identify sites for the remained.
- Suitable group of Clients who will benefit can be identified
    - 25 Clients have been identified to-date and the exercise continues. The Council has 130 Clients placed out of county that it is reviewing. Some of these people are now well connected in the community where they are living and it would not be appropriate to return and some people are placed out of county for their safety linked to safeguarding concerns that could not

be managed locally. The cohort of clients will be reviewed jointly with health colleagues to ensure best investment value is realised.

- Council agree to the financial commitment prior to funds being available from IBCF Fund. To enable the timescales to be met.
    - Proposal has been discussed and agreed in principle with CMT.

4 Approach

4.1 Analysis

CCC's Commissioners have carried out an analysis of the Clients placed out of county or in inpatient settings who the Council currently supports by providing or is trying to provide specialist housing accommodation. There are 130 people on the list so far of which a high number will have complex needs including some challenging behaviours.

We have done some initial analysis on the 130 people with the LDP and the PAT SW Teams and come to the supposition that 25 people could be repatriated with further work to be done on the remainder of 130 people. In order to make this happen two additional social workers are being appointed now as part of this initiative to strengthen capacity which this will inevitably impact on. Appendix 4 details which providers the 25 people are currently with. This number may fluctuate however as there is the pool of 130 people there is confidence that the repatriation will succeed.

Of the 130 clients that are currently living out of area. Of these, the split between those where repatriation may or may not be appropriate is shown below.

	clients	value
Desktop analysis indicates repatriation could be beneficial	25	c5M
Desktop analysis shows that repatriation may not be appropriate – more work to follow with new capacity	68	c4M
Desktop analysis was inconclusive, further investigation including meeting the service user and provider needed to determine if repatriation could be beneficial	37	c1.5M
Total	130	10.5M

Work is underway with Local Authority and CCG commissioners and CPFT to ensure we have the 'Principles' of support and care that providers need to deliver now and have the sufficient capacity to do so. A market testing exercise was undertaken recently which identified a number of providers want to work with complex needs people and a firmer arrangement will be put in place to support this going forward. This work is happening now and will also be embedded in all future Frameworks and Tenders for complex needs and TCP cohort.

It is important to recognise it will not be appropriate in every case to repatriate people back to Cambridgeshire. In particular where service users have made a deliberate choice to move away or have formed close friendships and links to the local community out of area they will not want to return. Equally there are some people living only just over the border and not far from their local community.

As well as the positive impact on outcomes, there is the potential for new care arrangements in Cambridgeshire to be better value for money than out of area provision. Efficiencies can be delivered through reassessment and reducing or refining the care

package and through brokerage/negotiation process to ensure the placement is offering best value for money.

In some instances where an out of area placement was identified as the only viable provision to meet a more specialist need (at the point it was needed) the price may well have been artificially high. In those cases if we can successfully identify or create new provision then there is every opportunity we will be able to agree a model with the new provider which meet needs at lower costs.

From the review we can make the following observations (excluding clients who are part of the Transforming Care Programme Cohort)

- That 16-45 year olds make up the most popular age band on our current accommodation list – a further analysis of the 12 TCP clients will be undertaken and the model of care will range from supporting living services to more intensive residential care. For those TCP clients identified to be suitable the supported living services this initiative will play an important building block for repatriation.
- From 'Current Address' field people family homes are across Cambridgeshire. A further analysis being undertaken of the 12 clients in the TCP group shortly.
- Learning Disability is the most common 'Primary Care Need' of those where Social Workers are requesting support from CCC Commissioning for accommodation (other than Residential or Nursing home categories);
- Of this group clients with a 'Physical Disability' or are aged over 65 years age form less than 5%. The next most popular category of client need based on information provided at this time is those with a 'Learning Disability' and 'Mental Health' need
- The most common reason for seeking accommodation is to offer the client greater 'independence'
- Referral waits for accommodation are long and need attention
- Mobility issues are reported in in less than 10% of the group
- Compatibility' issues and matching service user wants is a delicate process but needs careful attention in offering any shared house arrangement

See Appendix Two for detail

4.2 Selection of clients

The CCC Commissioners carried out an analysis of the clients know to the Council using the information in the ASC Case Management system.

Key to the selection criteria was based on which clients and client groups would get the maximum benefit. The Commissioner's considered all ages, client groups, the client's current accommodation and reasons for seeking alternative accommodation. They then considered compatibility factors, type of support required, type of accommodation that would be most suitable, etc. In total more than 10 different aspects.

They concluded that the following group would get the maximum benefit;

- Age group – No restriction
- Primary Client Group - Learning Disability

There are circa 25 clients who are in this group. Further detailed analysis will be done to confirm the selection and to consider people within the county that require accommodation based services either living with elderly carers or preparing for adulthood. .

4.3 Care Package Review - objective

The objective is to achieve savings through re-design, re-evaluation and price renegotiation of package costs, reviewing and reducing the hours of support where there is no rationale for the differential charging and minimise staff intervention where it is not necessary or through other means of support and interventions.

Both the LA and CCG have at their disposal established means by which they can quality assure provision; additionally those service users who fall within the transforming care programme are subject to additional reporting requirements (for the DoH) and therefore we are confident that we ensue that any provision we invest in, be that 'care' or 'buildings' elements for the programme are of a high standard.

4.4 Review method

An experienced and competent Social Work team will review each care package using a proven methodology used on the High Cost Placements Review programme. This process uses existing market value products such as the care funding calculator to drive down costs and support. The approach is used by a number of councils.

Step 1 – Package evaluation

Basic details of these service user and their existing packages is downloaded from the Council's Case Management System (AFM). A Senior Social Worker will review these, initially at a high level looking at basic core information and data, this includes the Client's age, length of time on the package and in the current placement number of different disabilities and services provided. This indicates whether the existing package has potential to provide efficiencies.

This may include if

- the assessed hours of care provided appears excessive to the need
- a range of services were to be replaced with e.g. reablement, assistive technology (AT) etc.

Those assessed as having potential go to the next phase.

Step 2 – Package review

Data will include details of the care package, length of time each element of the package has been in place including start/stops, assessed hours of need (including when the last assessment took place), current provider of care and costs of the package and how the package is financed (ASC, Continuing Health Care, etc.). Any specific reasons for being in the current placement e.g. religious beliefs, safeguarding issues; and how connected the person is to Cambridgeshire and the community in which they are currently living.

These will be reviewed by a different senior care professional with appropriate competence in a range of services such as AT, reablement, etc. The review will establish whether, if that service user were to present for the first time today, in their new setting, what package would be provided. Each package will be checked for the following:

1. Assessment of need in line with The Care Act 2014 – requires full involvement of person being assessed and, where they need assistance to understand the assessment process, anyone that is acting as their advocate. This could be a family member or, if not, this will require referral to advocacy. There is also the process of agreeing and signing off the assessment with the person and within the Council.
2. Determination of eligibility for services (this is separate to the assessment but part of the process – listed separately to be clear on all stages).
3. Calculation of indicative budget based on assessment of need.
4. Discussion with the person and their family as part of the support planning process around potential to move back to County seeking their views and wishes and taking into account their community networks and other variables.
5. Support plan revised as required and signed by the Council and person.
6. Placement finding process – looking at all available vacancies to determine if needs could be met or deciding if a new service needs to be commissioned.
7. Accommodation needs to be considered and identified. This may mean existing vacancies, acquisition of new properties or even new build in some circumstances.
8. Mental Capacity Act 2015 (MCA) assessment and, if needed, a best interest process which has to look at all of the available options which may meet a person's needs (including staying in existing provision). There is potential for court of protection proceedings which are complex with timeframes agreed through the court.
9. Using a comprehensive user profile we will establish compatibility requirements for shared accommodation.

The difference in size and complexity of package would be defined between that existing and that which should be provided. Our working assumption, based upon work with similar requirements ('Out of area repatriation' 2017' project in Cambridgeshire) suggest that there is confidence in securing a 10% reduction in package costs (before and after new placement) assuming we adopt the approach outlined above. This saving figure is corroborated by selecting clients from the existing Cambridgeshire cohort for the total cost (ie the LDP Pooled Budget will benefit)

Step 3 – Package check

For those packages where there may be savings, further opportunities are then considered. These include applying the Just Checking (JC) Assistive Technology tool. This will be installed for a minimum of 2 weeks (however, dependent upon the service user's disability, it may be used for up to 8 weeks). The analysis of the JC data will be supported by a specialist OT in JC. This analysis will provide objective data to enable the Step 2 Package review estimate to be confirmed or updated.

The re-assessment can then be planned in advance of the visit. Note: there may be a requirement for support from OT services or JC to discuss the installation of JC in the service user's home to:

- deal with questions the client / carer / family may have
- to position the sensors in the most appropriate place to achieve quality data

Before the final analysis is complete, there will be a sense of the new services required. These should be organised in good time e.g. ensuring that the AT provider (either OT services or external) have the appropriate AT equipment and installation / integration capacity / capability in place to provide a service within the SLA.

Step 4 – Re-assessment

A re-assessment will then be arranged. The team will include care and health professionals with appropriate competence in a range of services depending on the planned re-assessment. The re-assessment will produce a change in the package and this change, including step-down cost savings need to be calculated. It should be noted that not all re-assessments will lead to a reduced cost but a return to Cambridgeshire may still be in the best interests of the person.

Step 5 – Record and report outcomes

The re-assessment may produce a change in the package in terms of services to be delivered and the hours of each element of those services; this change will be clearly identified and recorded. It is at this point that a Broker will negotiate with the care provider on costs for each element of the care package; outcomes will be shared with the Social Care Worker for the case to be agreed by the Team Manager and taken forward for approval by CCC's Countywide Panel..

Withdrawal of duplicate Day care funding

The care packages of clients who are in receipt of both residential & 24/7 supported living and day services should be examined.

It may be possible to achieve significant savings within a short timeframe by reviewing clients who are funded for both a residential placement and a day care placement. In most schemes providing meaningful day activities is included in the cost of the residential placement.

The social worker will ensure all documentation is complete correctly on AFM and communication to the correct person within each provider organisation is made pre and post review with the outcome.

If there are any disputes or the provider is not willing to engage this will be recorded on the risk register of the project and managed through this arrangement. All savings will have to be certified by the finance officer before reported in the high light report.

4.4.1 Opportunities

Expected opportunities will be achieved through the review and reduction in care packages and the way in which the project is undertaken. Lessons Learnt from previous projects has been applied. All savings will be validated by finance before being reported and the source of these savings entered on the finance system

- Financial (cashable) benefit – reduction in care package placement costs covering residential/nursing placements, direct payments and supported living services
- Financial (cashable) benefit – saving through Direct Payment Clawback
- Non-financial benefit placement rationale, stronger relationships – better placement rationale, stronger relationships with suppliers, a universal and fair pricing model.

4.5 The accommodation

CCC will work with PCC. PCC have an existing joint venture with Meacham Homes. The plan is to source the accommodation through Meacham Homes.

The Council will then loan the joint venture the funds to acquire the property. This will then turn a one year short term funding into ongoing opportunity.

Where-ever possible the accommodation will be within Cambridgeshire.

One of the options is to review the Council's property disposal stock, this may offer an opportunity to re-use an existing asset.

4.5.1 Type of accommodation

The plan is to commission a mix of property, i.e. a number of "self contained units" and a number of "Homes of Multiple Occupancy" (HMOs) and "Supported Living Schemes"

- This would cater for the different needs of the clients and be able to best match care plans.
- To meet the very complex needs of some of the people that will be included in this cohort the accommodation may need to be clustered so that there is a robust enough staff team and management infrastructure to manage the challenging behaviours of the people. This will also need to be reflected in the build of the accommodation and robust design and layout access points etc.
-

Looking at HMOs that accommodate four people – 3 clients and carers

HMOs have the additional benefit of offering a cost effective care option, i.e. a single live-in carer could support a number of clients.

The accommodation could be a conversion or a new build.

Most importantly it is a normal build, i.e. not specialist unit however may need to design building to suit challenging behaviour and/or physical disabilities.

For Supported Living Services this would be for the more complex clients that require a robust staffing model subject to the compatibility of the people sharing the scheme. More

work is to be done with the pool of people identified and following that the appropriate route for housing.

4.5.2 Cost of accommodation

From discussions with the Corporate Property Team, Housing Associations and Meacham Homes, for budgetary and planning purposes, to acquire the property;

- "Homes of Multiple Occupancy" (HMO) – circa £400,000 per scheme
- "Supported Living Schemes' (SLS) – Circa £400,000 per scheme
- "Self contained unit" – circa £200,00 per unit

Therefore for an investment of £3m, plan is to acquire;

- "Homes of Multiple Occupancy" (HMO) – 2 off x £400,000 = £800,000
- "Supported Living Schemes' (SLS) – 5 off x £400,000 = £2,000,000
- "Self contained unit" – 1 off x £200,000 = £200,000

5 Financial case

Following consultation with the CCG, the Council is proposing to invest £3m in housing options for vulnerable people.

5.1 Types of financial benefit

1. **Care Packages**

   The Council and Health can make savings on the Care Packages from;

   - The clients being more appropriately housed, which will result in a reduction in care packages required. These savings would continue whilst the client remained with the scheme.
   - Review of Care Packages - will follow a similar method to the current High Cost Placements initiative, each Client's Care Package would be reviewed by Care Team and Commissioning.
   - Bring Clients back - some of the Clients are in "out of area" arrangements, which attract a premium.
   - Designing in the use of appropriate Assistive Technology, this will save money and avoid costs. Following similar methods to the current AT initiative.

2. **Financing**

   - Council could earn a commercial loan rate of interest paid by Meacham Homes - with the risk of the loan covered by the property.
   - Return of the loan value of a period of time to CCC - which would allow future investment opportunities in the scheme and provide further returns

3. **Property Value**

   - The property will be an asset to the JV and probably the value will appreciate.

4. **Joint Venture**

   - As the Council is a shareholder in the JV, benefit from a share in the profits.

5. **Housing Benefit**

   - Many of these Clients will quality for a Housing Benefit - Local Housing Allowance (LHA). This will go towards paying their rent for the new accommodation.
   - The LHA is paid to the Client from the District Housing Benefit.
   - CCC can claim back this money from Department of Works and Pensions (DWP)

6. **Health Service Efficiencies**

   There might be other efficiencies that the Health Teams could realise including;

   - Reduce travel times as there are a group patients at the same address.
   - GPs may realise a small benefit. From the increase in the Quality and Outcomes Framework (QOF), i.e. the system for the performance management and payment of

general practitioners. From an increase of a number of service users with a similar category within their practice

5.2 Summary of financial benefits

- LDP Pool Budget Annual cost of current care packages for the 25 Clients – circa £2.9M
- Estimated annual financial benefit per year - circa £433k
- £143k + £290k = £433k

	Benefit type	Description	Amount
1.	Financing	• Commercial loan rate of interest paid by Meacham Homes – This could attract a commercial loan rate of circa 4.78%	£143,400
2.	Care Packages	• The Council and Health can make savings on the Care Packages	£290,000p.a.
3.	Property Value	• The property will be an asset to the JV and value will appreciate.	Nil
4.	Joint Venture	• As the Council is a shareholder in the JV, will benefit from a share in the profits.	TBC
5.	Housing Benefit	• Local Housing Allowance will go towards rent, paid to JV. Will not cover rent.	Nil
6.	Health Service Efficiencies	• Other efficiencies that the Health Teams could realise	TBC

5.3 Care packages

Based on the 25 Clients selected by the Commissioners.

- They receive Care Packages that total c£2.9Mm per year from the LDP Pool Budget per year.

See Appendix Four for the detail

5.4 Scenarios

We have chosen several Clients at random from the list to project the savings from the care packages are possible.

This analysis indicates we should achieve efficiencies between 10% and 20% from a reduction in care package costs.

5.5 Benefits from review of care packages

If through the re-housing them it reduces the cost of care from LDP Pool Budget by

- 10% - it saves £290K per year
- 20% - it saves £540K per year

5.6 Phasing of care package savings

In year one, Health and Social Care will only see part year savings.

See Appendix Five for timescales

Assuming the Clients start moving in progressively from March 2018 onwards.

Following a review of their Care Packages, the first savings will be realised 3 months later.

This will be progressive in the first year – See Appendix Six for details.

Year one (part year) - £178k

First complete full year benefit will be in the second year - £290k

5.7 Costs

5.7.1 Establishment costs

- Legal
  - Covered by CCC Legal as business as usual
- Property Advice
  - Covered by CCC Property Services as business as usual
- Property acquisition costs
  - To be borne by provider – Meacham Homes

5.7.2 On-going operational costs

- Social Care activities
  - Covered by business as usual ASC operations
- Property Management costs
  - Covered by provider – Meacham Homes

5.8 Risks

5.8.1 In-compatibility

- Compatibility' issues and matching clients in particular in HMO settings. This is a delicate and sensitive process and needs careful attention in offering any shared housing arrangement.
- Mitigation
  - Very careful analysis of the information and selection of the clients, i.e. following the review process outline in section 4.4. Meeting and discussions with the client, their carer or family and social care and health professionals involved within the LDP..

5.8.2 Rents

We need to understand the rents Meacham Homes will be charging

- HMO
  - For supported accommodation in Cambridgeshire it is typically £200 per week.
  - Each Client will qualify for LHA of £57.15 per week (in HMO setting)
  - Leaves a gap of circa £143
  - This would have to be met by the Client or the Council, it is believe that these clients would qualify for support to bridge the gap but this needs confirming and is on a case by case basis. Cambridgeshire County Council will work with District Councils to utilise the Discretionary Housing Grant to mitigate this financial risk where appropriate. In the event that a District Council does not support the use of the Discretionary Housing Grant in this way, then the approach will be to not purchase property within that District.
  - Worst case - £143 x 52 weeks = £7,436 per client in HMO.
- Self Contained Units
  - For SCUs in Cambridgeshire it is typically £200 per week.
  - Each Client will qualify for LHA of £92.05 per week (one bedroom setting)
  - Leaves a gap of circa £108
  - This would have to be met by the Client or the Council, it is believe that these clients would qualify for support to bridge the gap but this needs confirming and is on a case by case basis.
  - Worst case - £108 x 52 weeks = £5616 per client in SCU.
- Total cost for rent gap
  - £95,160
- Mitigation
  - Council receives an annual Discretionary Housing Payments (Grant) of £600k
  - This could be used to mitigate this risk

5.8.3 Modifications / Repairs

- The intention is to acquire industry standard properties that are not be-spoke. That provides maximum flexibility when clients change. However there is a risk that the properties may need modifying or maintenance.
  - The budget required is not known.
- Mitigation
  - Disabled Facilities Grant
  - The Council receives a grant that is used to support minor and major adaptations for eligible adults and children via the Care and Repair service to enable people to stay in their homes.

5.8.4 Voids

- There will be times that a property or unit will be empty, i.e. not earning rent. This is the risk of the provider – Meacham Homes. However they will cost this risk into their financial model and pass on the risk to the Client or the Council.
  - The void days per year allowance is not known
- Mitigation
  - To agree a lower void days per year with the provider – Meacham Homes. E.g. the Council under-rights anything above 30 days.
  - Council then takes out Void Days insurance to protect against the potential cost. The cost of the insurance is not known but it is standard industry practice and offers good value for money.

5.8.5 Change in Government Policy

- There is a risk that the IBCF Scheme could be cancelled.
  - Council has made the financial commitment to the Property Provider to meet the timescales
- Mitigation
  - Risk is considered very low, this is a central policy to Government Strategy.

6 Options

There are a number of options and variables considered.

6.1 Option 1

To decide to use the funds for this purpose or not.

The Council and CCG are investing their funds in a range of areas in line with the IBCF principles of meeting Adult Social Care (ASC) needs and reducing pressures on the NHS. In particular the investment of £1m to improve the discharge from hospital process.

It was felt that this proposal met the conditions of the IBCF and would offer a sustainable investment and provide an on-going annual return.

- For more detail see Section 3 above and in particular 3.1 the case for the investment.

6.2 Option 2

Which Client Group – to offer maximum benefit

Following extensive discussions and analysis it is recommended the opportunity is targeted at

- Age group – 16 to 45 year olds
- Primary Client Group - Learning Disability, Mental Health and Chronically Excluded Adults condition

Supporting people with learning disabilities and/or autism to be active citizens in their communities is a key priority for the Council, as part of its Prevention and Early Intervention Strategy – as outlined in Section 3.3.

The supply of housing is critical to achieving the objectives of prevention and progression. Specialist housing includes accommodation that has been designed and built to meet the needs of the vulnerable adult and may include some elements of care and support for everyone who lives there. This support can either be on-site or off-site.

6.3 Option 3

Type of accommodation – this is influenced by the Client Group and their needs and to get good value for money.

As outlined in section 4.5.1 above, the plan is to commission a mix of property, i.e. a number of “self contained units” and a number of “Homes of Multiple Occupancy” (HMOs) and “Supported Living Schemes”.

- This would cater for the different needs of the clients and be able to best match care plans.
- HMOs have the additional benefit of offering a cost effective care option, i.e. a single live-in carer could support a number of clients.

- For people with complex needs the Supported Living Model would be the best fit to ensure right level of staff can be deployed to support needs.

6.4 Option 4

Financial Case – as outlined in section 5.

There will be financial savings to both the CCG and the Council. The numbers are prudent and there are certain details to be confirmed. The savings would be

- This will be a joint benefit to health and the council of £290K pa £1.45M over five years to the Learning Disabilities Partnership Pool Budget.

For use of the £3m investment, Health and Social Care get a return of £1.45M over five years.

Plus valuable assets providing on-going benefits.

The health and social care financial return on investment will be re-invested to support delivery of the ongoing iBCF 3.5% DTOC plan.

Governance and review of performance will sit with the Integrated Commissioning Board to ensure benefits are maximised.

7 Recommended Option

To proceed with the scheme to invest £3m of the IBCF Funds and provide accommodation to this group of vulnerable people of Cambridgeshire.

1. This scheme **meets the conditions of the IBCF** and would offer a **sustainable investment** and an **annual return**. This proposal will
    - contribute to reducing pressures on NHS
    - directly meet current adult social care needs and priorities
    - supports the Council's Prevention and Early Intervention Strategy
    - provide a lasting benefit to the people of Cambridgeshire
    - not create an on-going financial commitment

2. **Robust financial case** - For a £3m investment, Health and Social Care get a return of £2.17m over 5 years.
    - Joint benefit to health and the council of £433k pa £2.17m over five years to the Learning Disabilities Partnership Pool Budget.

3. The **health and social care benefits** of providing this accommodation include:
    - Specialist housing with support can reduce the risk of in patient admission
    - Specialist housing with support can delay or avoid the need for registered care
    - Appropriate accommodation can facilitate the delivery of personalised care and support
    - Provides a local higher quality solution for the client that is more manageable by the professionals
    - People can receive more suitable accommodation and support whilst maintaining links with their local communities
    - Offers better value for money than existing options, i.e. out of area placements

8 Timescale & Implementation

8.1 Indicative Timescales

No	Milestones	Dates
1.	Agree principles / prepare Business Case	Mid August 2017
2.	Start to source property (to meet time-line)	August 2017 onwards
3.	Approval of Business Case by CCG and Council	Mid August 2017
4.	Commit to plan in principle by CCG and Council	End August 2017
5.	Submit BCF Plan	September 2017
6.	Approval of BCF Plan	October 2017
7.	Review Learning Disability Section 75 Agreements to enable transfer of financial benefits	October 2017
8.	Funding released / drawn down	October2017
9.	Commit funds to JV to enable acquisition of property – sign contracts	October 2017
10.	Property available	Early January 2018
11.	Property prepared	End January 2018
12.	Property (accommodation) available	Mid February 2018
13.	Clients move in and benefits start to be realised.	Mid March 2018

8.2 Dependencies

There is a dependency on the out of area project and 2 Social Workers. This business case has been to the JCB and is now to go to GPC and is waiting for approval.

9 Reference Documents

Please list any reference material or information sources and maintain a bibliography.

10 Glossary

Include any terms or acronyms used in the document and provide an explanation.

11 Appendices

11.1 Appendix One – Better Care Fund (BCF)

The BCF was announced in June 2013 and introduced in April 2015. The £48.5 million is largely a reorganisation of funding currently used predominantly by Cambridgeshire and Cambridgeshire Clinical Commissioning Group (CCG) and Cambridgeshire County Council (CCC) to provide health and social care services in the County.

Cambridgeshire's BCF has created a single pooled budget to support health and social care services (for all adults with social care needs) to work more closely together in the County.

Cambridgeshire is required to submit a new, jointly agreed BCF Plan, covering a two year period to NHS England on 11th September 2017.

The BCF plan builds on the following agreed principles:

- Greater alignment across Cambridgeshire and Cambridgeshire
- A single commissioning board (the ICB)
- Greater alignment with the STP and local authority transformation plans
- Using the BCF to 'get the basics right' and coordinate our approach, focusing on a smaller number of system-wide changes

There is a focus on building on the work undertaken to date, with the following areas identified as continued priorities:

Prevention and Early Intervention: including a county wide falls prevention programme, further work to ensure a comprehensive approach to equipment and assistive technology, and development of joint VCS commissioning opportunities.

Community Services (MDT Working): including wider roll out and embedding of case management, to include data sharing to support risk stratification and pro-active identification of service users. Development of integrated hospital discharge and admission pathways and enhancement of intermediate care and reablement provision.

Enablers: continued development of consistent, accurate and reliable information and advice to support the concept of 'no wrong front door'.

High Impact Changes for Discharge: A new national BCF condition, requires the local system to implement the high impact change (HIC) model for managing transfers of care. The HIC areas are: early discharge planning; systems to monitor patient flow; MDT/multi-agency discharge teams; home first / discharge to assess; 7 day services; trusted assessor; focus on choice; and enhancing care in care homes. An initial system wide self-assessment has been completed against the high impact changes and existing system plans.

The Improved Better Care Fund (iBCF) is a new introduction to BCF plans this financial year and is considered to be part of the ongoing BCF programme.

11.2 Appendix Two – Data analysis

- Personal data
  - Surname
  - Date of birth
  - Age
  - AFM ID
  - Primary Client Group
  - Current Address
- Status
  - Current Accommodation
  - Reasons for seeking alternative accommodation
  - Date of Referral
  - Priority Ratings - H/M/L
  - RAG Rating - Timescale requested (Days)
- Considerations

1. What property features are required? (e.g. ground floor, wide corridors etc)
2. Can the client live in shared accommodation with on-site support, including sleeping provision?
3. If yes, are there any compatibility issues? (e.g. must be female, young, communicative)
4. Can the client live in self-contained accommodation within a supported living setting with low level on-site support including sleeping in provision?
5. Can the client require a single service with staff available 24/7?
6. Can the client live in independent accommodation in the community with visiting support?
7. Is accommodation & support being sourced through framework tender?
8. Are there current housing plans/proposals for service user?
9. If Yes, please provide details - Referrers Email
10. Status Notes - Supporting Documents

11.3 Appendix Three - Types of Welfare Benefit

1. Local housing allowance (Housing Benefit)

This benefit is paid to Clients by the District Housing Benefit, but can be fully claimed back from the Department of Works and Pensions.

- Local housing allowance (LHA) is the way payments are calculated for people receiving housing benefit. A flat rate is used based on the size of the tenant's household and the area in which they are renting the property. This amount is not directly related to the rent being charged.
- The rate of LHA that a claimant receives is reviewed on an annual basis. Other circumstances, such as money that the tenant has coming in or other people living in the household will still affect the amount of benefit paid, so the tenant may not always receive the full rate of LHA.
- The weekly rate (April 2017) for
    - Shared Accommodation is £57.15
    - 1 Bedroom is £92.05

In most cases this will not cover rental costs.

2. Disability Living Allowance (DLA)

This benefit is paid to Clients by DWP. This benefit is being phased out and is being replaced by PIP for new claimants. Existing claimants remain on the existing DLA arrangements

- DLA is ending for people aged 16 to 64.It is being replaced with the Personal Independence Payment (PIP). A Client will continue receiving the DLA until DWP invites them to apply for PIP.
- The rate a person receives is made up of 2 components. How much depends on how the disability or health condition affects the individual
    - Care component – ranges from £22 to £83.10 per week (This group are likely to be the higher rate – i.e. £83.10)
    - Mobility component – ranges from £22 to £58 per week

3. Personal Independence Payment (PIP)

This benefit is paid to Clients by DWP. This is the new scheme replacing DLA for new claiments.

- If the Client is aged 16 to 64 they could get between £22 and £141.10 a week by claiming Personal Independence Payment (PIP).
- The amount a person gets depends on how their condition affects them, not the condition itself.
- For this group of Clients it is believed they will receive £83.10 per week.

4. Employment and Support Allowance (ESA)

- If the Client is ill or disabled, they may qualify for Employment and Support Allowance (ESA). It offers:
  - financial support if the person is unable to work
  - personalised help so that you can work if you're able to

- How much ESA a person gets depends on:
  - Their circumstances, such as income
  - the type of ESA they qualify for
  - where they are in the assessment process

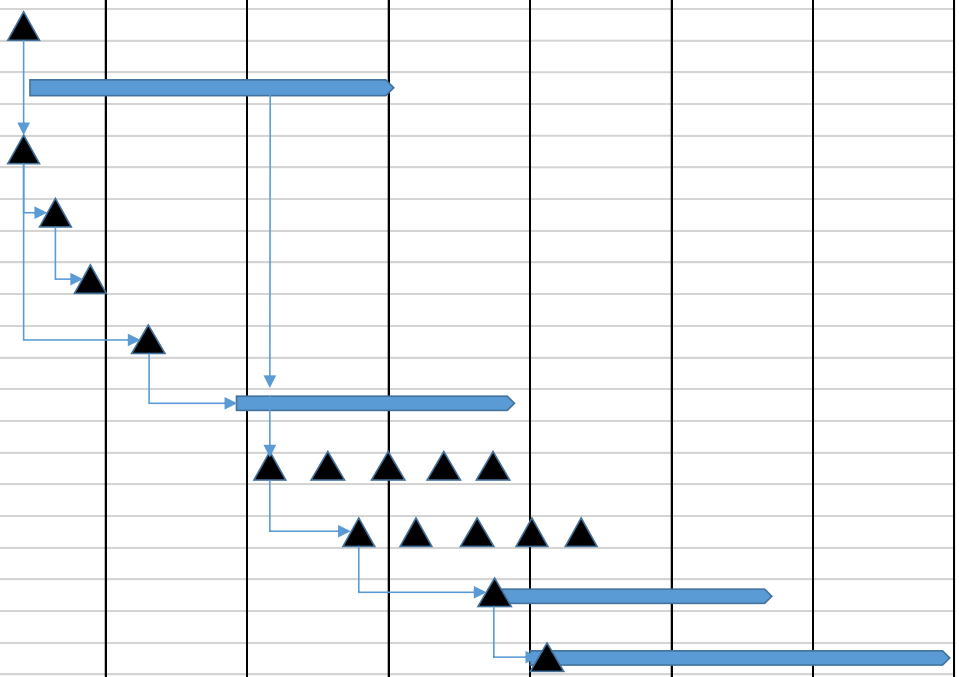
- Following assessment, if a person is entitled to ESA, they will be placed in one of 2 groups and will receive:
  - up to £73.10 a week if you're in the work-related activity group
  - up to £109.65 a week if you're in the support group (i.e. this group of Clients)

11.4 Appendix Four - Cost of Care Packages (25 Clients)

Current Provider	Current Annual Cost	Future Provider	Case Worker	Case Status
Tigh Naveen	£113,835.16			Repatriate
Community Integrated Care	£106,798.48			Repatriate
Decoy Farm	£158,949.16			Repatriate
Churchfields(Active Care Part)	£63,918.80			Repatriate
Heathers (Jeesal Res. Care)	£159,718.26			Repatriate
Alderwood	£276,626.72			Repatriate
Decoy Farm	£162,253.97			Repatriate
The Coppice	£81,406.47			Repatriate
Bright Futures Care Ltd	£193,450.00			Repatriate
Decoy Farm	£155,252.23			Repatriate
Jeesal Akeman Care Ltd				Repatriate
St Elizabeth'S Ld	£86,035.19			Repatriate
Redmond House (Voyage)				Repatriate
Zero Three Care	£129,597.42			Repatriate
An Darach Hse (Kisimul Gp)	£108,909.22			Repatriate
Gretton Homes	£103,034.00			Repatriate
Oaklands - Ld (Ccs)	£69,749.41			Repatriate
An Darach Hse (Kisimul Gp)	£132,583.64			Repatriate
Oaklands - Ld (Ccs)	£118,284.51			Repatriate
Suillean House	£122,121.70			Repatriate
Griffin Lodge	£99,192.92			Repatriate
Regard (Mill House)	£71,136.94			Repatriate
Craegmoor	£186,390.38			Repatriate
Pinetrees	£91,041.43			Repatriate
Byards Keep	£111,591.97			Repatriate

11.5 Appendix Five - Timescales

Activity	Dates	2017 / 18 Apr - Jun Qtr 01	2017 / 18 Jul - Sept Qtr 02	2017 / 18 Oct - Dec Qtr 03	2017 / 18 Jan - Mar Qtr 04	2018 / 19 Apr - Jun Qtr 01	2018 / 19 Jul - Sept Qtr 02	2018 / 19 Oct - Dec Qtr 03	2018 / 19 Jan - Mar Qtr 04
Agree principles / prepare Business Case	Mid Aug 17								
Source property	Aug 17 onwards								
Approval of Business Case	Mid Aug 17								
Commit to plan by CCG and Council	End Aug 17								
Submit BCF Plan	Mid Sept 17								
Commit funds to enable acquisition of property	Oct-17								
Property purchase complete	Early Jan 18 onwards								
Property (accommodation) available	Mid Feb 18								
Clients move in	Mid Mar 18								
Care Plans Reviewed	Jun 18 onwards								
Savings realised	July onwards								



11.6 Appendix Six – Savings Benefits realisation plan

	2018													2019 onwards
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Health and Social Care Package saving														
Client 1				892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 2				892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 3				892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 4				892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 5				892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 6					892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 7					892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 8					892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 9					892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 10					892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 11						892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 12						892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 13						892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 14						892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 15						892.28	892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 16							892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 17							892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 18							892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 19							892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 20							892.28	892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 21								892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 22								892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 23								892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 24								892.28	892.28	892.28	892.28	892.28	892.28	11599.64
Client 25								892.28	892.28	892.28	892.28	892.28	892.28	13999.96
				£4,461	£8,923	£13,384	£17,846	£22,307	£22,307	£22,307	£22,307	£22,307	£22,307	£292,391
													£178,456	£113,935

PETERBOROUGH CITY COUNCIL

Outline Business Case

Investment in housing options for vulnerable people

Version 08

Draft

August 2017

Prepared by

B Pickbourn

Document Control

Authorisation		
Name	Oliver Hayward	
Position	Assistant Director Commissioning	
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Distribution		
Name		Organisation
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Contents

1 Executive Summary

Peterborough is required to submit a new, jointly agreed Better Care Fund (BCF) Plan, covering a two year period to NHS England on 11th September 2017. The Improved Better Care Fund (iBCF) is a new introduction to BCF plans this financial year and is considered to be part of the ongoing BCF programme.

In line with the national conditions, discussions are taking place with the Clinical Commissioning Group (CCG) to reach agreement on the use of the IBCF funds. There are a number of areas being discussed for 2017/18, these are subject to final agreement and approval. One of these areas is;

- **Investment in housing options for vulnerable people**

The recommendation is to invest £2m of the IBCF Funds and provide accommodation to this group of people in Peterborough.

This scheme meets the conditions of the IBCF and would offer a **sustainable investment** and an **annual return**. This proposal will

- contribute to **reducing pressures on National Health Service (NHS)**
- directly meet current adult social care needs and priorities
- supports the Council's Prevention and Early Intervention Strategy
- provide a lasting benefit to the people of Peterborough

There is **robust financial case** - For investing the £2m of IBCF Funds, Peterborough's CCG and Council get a **return of £1.4m** over 5 years. The savings would be

- Health – circa £95k per year or almost £0.5m over 5 years
- PCC – circa £179k or almost £0.9m over 5 years

The **health and social care benefits** of providing this accommodation include:

- Housing with support can reduce the risk of hospital admission
- Housing with support can delay or avoid the need for registered care
- Facilitate the delivery of personalised care and support
- Provide a local higher quality solution for the client that is more manageable by the professionals
- People can receive more suitable accommodation and support whilst maintaining links with their local communities
- Offers better value for money than existing options, i.e. out of area placements

2 Background

2.1 The Better Care Fund

The Better Care Fund was established in 2015/16, to create a pooled budget in each local authority area supporting closer integration of health and social care services, in order to improve outcomes for service users and ensure the sustainability of services.

Peterborough is required to submit a new, jointly agreed Better Care Fund (BCF) Plan, covering a two year period to NHS England on 11th September 2017. The Improved Better Care Fund (iBCF) is a new part of the BCF plans this financial year and is considered to be part of the ongoing BCF programme.

In line with the national conditions, discussions are taking place with the CCG to reach agreement on the use of the IBCF funds. There are a number of areas being discussed for 2017/18, these are subject to final agreement and approval.

For more information on BCF see Appendix One.

2.2 BCF Vision

The vision for Peterborough is expressed as follows:

"Over the next five years in Peterborough we want to move to a system in which health and social care help people to help themselves, and the majority of people's needs are met through family and community support where appropriate. This support will focus on returning people to independence as far as possible with more intensive and longer term support available to those that need it.

It means moving money away from acute health services, typically provided in hospital, and from ongoing social care support. This cannot be achieved immediately – such services are usually funded on a demand-led basis and provided as they are needed in order to avoid people being left untreated or unsupported when they have had a crisis. Therefore reducing spending is only possible if fewer people have crises. However, this is required if services are to be sustainable in the medium and long term."

2.3 IBCF Programme

The Improved Better Care Fund (iBCF) is a new part of BCF plans this financial year. The monies are paid direct to the Local Authority from the Department of Communities and Local Government (DCLG) and the following national conditions apply:

- Monies must be pooled into the Better Care Fund (BCF) Section 75 budget between Peterborough City Council (PCC) and Cambridgeshire and Peterborough Clinical Commissioning Group (CCG).
- Monies must only be used for the following purposes:
    - Meeting Adult Social Care (ASC) needs,
    - Reducing pressures on the NHS, including supporting more people to be discharged from hospital when ready; and
    - Ensuring the local social care provider market is supported.

2.4 Conditions of the grant

Non-recurrent social care grant allocation, i.e. the funding is for a single year only and does not form part of an on-going arrangement.

To be used for:

- Stabilising the social care market
- Meeting adult social care needs
- Reducing pressures on NHS
- Meeting High Impact Change model

Quarterly reporting to the Department of Communities and Local Government (DCLG)

2.5 The proposal

Discussions are taking place with the CCG to reach agreement on the use of the IBCF funds. There are a number of areas being discussed for 2017/18, these are subject to final agreement and approval. One of these areas is;

- **Investment in housing options for vulnerable people**

It was felt that this met the conditions of the IBCF and would offer a sustainable investment and an annual return.

3 Drivers and Objectives

3.1 The case for the investment

As the funding is currently short-term and non-recurring, it was important to use the grant for an activity or area that;

- did not create an on-going financial commitment that couldn't be sustained
- would provide a lasting benefit to the people of Peterborough
- would directly meet both health and adult social care needs and priorities
- would contribute to reducing pressures on NHS
- supports the Council's Prevention and Early Intervention Strategy

3.2 Inequalities in life expectancy

A person's health is determined by a complex mix of factors including income, housing and employment, lifestyles and access to health care and other services. There are significant inequalities in health between individuals and different groups in society.

These inequalities are not random. In particular, there is a 'social gradient' in health; neighbourhood areas with higher levels of income deprivation typically have lower life expectancy and disability-free life expectancy. This relationship (known as the 'Marmot curve') formed an important part of the independent and influential report on health inequalities, Fair society, healthy lives (the Marmot Review).

3.3 The opportunity

PCC is committed to providing a range of independent housing options for adults with a learning disability and/or autism spectrum condition. The Council is working with local Registered Social Landlords and Private Landlords to secure single tenancies and supported living services for people with these conditions and effectively manage the accommodation available.

Supporting people with learning disabilities and/or autism spectrum condition to be active citizens in their communities is a key priority for the Council, as part of its Prevention and Early Intervention Strategy.

The supply of specialist housing is critical to achieving the objectives of prevention and progression. Specialist housing includes accommodation that has been designed and built to meet the needs of the vulnerable adult and may include some elements of care and support for everyone who lives there. This support can either be on-site or off-site.

This will promote best outcomes for local people and minimise the risk of out of area placements.

As at April 2014 there were 656 adults with a learning disability of working age in Peterborough.

3.4 Benefits

The health and social care benefits of providing local specialist housing include:

- Specialist housing with support can reduce the risk of hospital admission
- Specialist housing with support can delay or avoid the need for registered care
- Appropriate accommodation can facilitate the delivery of personalised care and support
- Provides a local higher quality solution for the client that is more manageable by the professionals
- People can receive more suitable accommodation and support whilst maintaining links with their local communities
- Offers better value for money than existing options, i.e. out of area placements
- The accommodation would be closer to home, as some of the clients are out of area.
- Appropriate accommodation can enable people to maintain and develop independent living skills
- People are able to receive welfare benefits that they would not be entitled to if they were living in a registered care environment
- Bringing people back from out of area placements to their localities.
- Professionals are able to monitor/review progress of clients when people are in area

3.5 Assumptions

- The proposed scheme is acceptable to DCLG criteria.
    - Discussions have been had with the local BCF Lead for the Eastern Region and he is supportive.
- CCG and Council agree to the investment
    - Discussions are on-going and in principle the concept is acceptable
- Suitable accommodation can be sourced and acquired to meet the timescales.
    - Property has already been identified that meets a large proportion of the requirement. The provider has commitment to identify sites for the remained.
- Suitable group of Clients who will benefit can be identified
    - 22 Clients have been identified to-date and the exercise continues. The Council has 96 Clients that it is reviewing. The cohort of clients will be reviewed jointly with health colleagues to ensure best investment value is realised.
    - There are only 15 accommodation places available, i.e. the actual savings depends on the actual 15 clients chosen.
- Council agree to the financial commitment prior to funds being available from IBCF Fund. To enable the timescales to be met.

- Proposal has been discussed and agreed in principle with CMT.

4 Approach

4.1 Analysis

PCC's Commissioners have carried out an analysis of the Clients who the Council currently supports by providing or is trying to provide specialist housing accommodation. There are 96 people on the list.

From the review we can make the following observations (excluding clients who are part of the Transforming Care Programme Cohort)

- That 16-24 year olds make up the most popular age band on our current accommodation list – a further analysis of the 12 TCP clients will be undertaken shortly
- From 'Current Address' field the vast majority are currently live within Peterborough post codes PE1 to PE4. A further analysis being undertaken of the 12 clients in the TCP group shortly.
- From 'Current Address' field the vast majority are currently live within Peterborough post codes PE1 to PE4; and equal number of user either live with parents or currently live in supported accommodation
- A further analysis being undertaken of the 12 clients in the TCP group shortly which will be included in this opportunity.
- Learning Disability is the most common 'Primary Care Need' of those where Social Workers are requesting support from PCC Commissioning for accommodation (other than Residential or Nursing home categories); of this group clients with a 'Physical
- Disability' or are aged over 65 years age form less than 5%. The next most popular category of client need based on information provided at this time is those with a 'Learning Disability' and 'Mental Health' need
- The most common reason for seeking accommodation is to offer the client greater 'independence'
- The majority of clients in the current cohort have both health and social care needs
- Referral waits for accommodation are long and need attention
- Mobility issues are reported in in less than 10% of the group
- Compatibility' issues and matching service user wants is a delicate process but needs careful attention in offering any shared house arrangement

See Appendix Two for detail

4.2 Selection of clients

The PCC Commissioners carried out an analysis of the clients know to the Council using the information in the ASC Case Management system.

Key to the selection criteria was based on which clients and client groups would get the maximum benefit. The Commissioner's considered all ages, client groups, the client's current accommodation and reasons for seeking alternative accommodation. They then considered compatibility factors, type of support required, type of accommodation that would be most suitable, etc. In total more than 10 different aspects.

They concluded that the following group would get the maximum benefit;

- Age group – 16 to 24 year olds
- Primary Client Group - Learning Disability and / or Autism spectrum condition

There are circa 22 clients who are in this group. Further detailed analysis will be done to confirm the selection.

4.3 Care Package Review - objective

The objective is to achieve savings through re-design, re-evaluation and price renegotiation of package costs, reviewing and reducing the hours of support where there is no rationale for the differential charging and minimise staff intervention where it is not necessary or through other means of support and interventions. The review also includes looking for CHC savings.

Both the LA and CCG have at their disposal established means by which they can quality assure provision; additionally those service users who fall within the transforming care programme are subject to additional reporting requirements (for the DoH) and therefore we are confident that we ensue that any provision we invest in, be that 'care' or 'buildings' elements for the programme are of a high standard.

4.4 Review method

An experienced and competent Social Work team will review each care package using a proven methodology used on the High Cost Placements Review programme. This process uses existing market value products such as the care funding calculator to drive down costs and support. The approach is used by number of councils.

Step 1 – Package evaluation

Basic details of these service user and their existing packages is downloaded from the Council's Case Management System (Frameworki). A Senior Social Worker will review these, initially at a high level looking at basic core information and data, this includes the Client's age, length of time on the package, number of different disabilities and services provided. This indicates whether the existing package has potential to provide efficiencies.

This may include if

- the assessed hours of care provided appears excessive to the need
- a range of services were to be replaced with e.g. reablement, assistive technology (AT) etc.

Those assessed as having potential go to the next phase.

Step 2 – Package review

Data will include details of the care package, length of time each element of the package has been in place including start/stops, assessed hours of need (including when the last assessment took place), current provider of care and costs of the package and how the package is financed (ASC, Continuing Health Care, etc.).

These will be reviewed by a different senior care professional with appropriate competence in a range of services such as AT, reablement, etc. The review will establish whether, if that service user were to present for the first time today, in their new setting, what package would be provided. Each package will be checked for the following:

1. Assessment of need in line with The Care Act 2014 – requires full involvement of person being assessed and, where they need assistance to understand the assessment process, anyone that is acting as their advocate. This could be a family member or, if not, this will require referral to advocacy. There is also the process of agreeing and signing off the assessment with the person and within the Council.
2. Determination of eligibility for services (this is separate to the assessment but part of the process – listed separately to be clear on all stages).
3. Calculation of indicative budget based on assessment of need.
4. Discussion with the person and their family as part of the support planning process around potential to move back to County seeking their views and wishes and taking into account their community networks and other variables.
5. Support plan revised as required and signed by the Council and person.
6. Placement finding process – looking at all available vacancies to determine if needs could be met or deciding if a new service needs to be commissioned.
7. Accommodation needs to be considered and identified. This may mean existing vacancies, acquisition of new properties or even new build in some circumstances.
8. Mental Capacity Act 2015 (MCA) assessment and, if needed, a best interest process which has to look at all of the available options which may meet a person's needs (including staying in existing provision). There is potential for court of protection proceedings which are complex with timeframes agreed through the court.
9. Using a comprehensive user profile we will establish compatibility requirements for shared accommodation.

The difference in size and complexity of package would be defined between that existing and that which should be provided. Our working assumption, based upon work with similar requirements ('Out of area repatriation' 2017' project in Cambridgeshire) suggest that there is confidence in securing a 10% reduction in package costs (before and after new placement) assuming we adopt the approach outlined above. This saving figure is corroborated by selecting clients from the existing Peterborough cohort for the total cost (ie for both health and social care funders).

Step 3 – Package check

For those packages where there may be savings, further opportunities are then considered. These include applying the Just Checking (JC) Assistive Technology tool. This will be installed for a minimum of 2 weeks (however, dependent upon the service user's disability, it may be

used for up to 8 weeks). The analysis of the JC data will be supported by a specialist OT in JC. This analysis will provide objective data to enable the Step 2 Package review estimate to be confirmed or updated.

The re-assessment can then be planned in advance of the visit. Note: there may be a requirement for support from OT services or JC to discuss the installation of JC in the service user's home to:

- deal with questions the client / carer / family may have
- to position the sensors in the most appropriate place to achieve quality data

Before the final analysis is complete, there will be a sense of the new services required. These should be organised in good time e.g. ensuring that the AT provider (either OT services or external) have the appropriate AT equipment and installation / integration capacity / capability in place to provide a service within the SLA.

Step 4 – Re-assessment

A re-assessment will then be arranged. The team will include care professionals with appropriate competence in a range of services depending on the planned re-assessment. The re-assessment will produce a change in the package and this change, including step-down cost savings need to be calculated.

Step 5 – Record and report outcomes

The re-assessment may produce a change in the package in terms of services to be delivered and the hours of each element of those services; this change will be clearly identified and recorded. It is at this point that a Broker will negotiate with the care provider on costs for each element of the care package; outcomes will be shared with the Social Care Worker for the case to be agreed by the Team Manager and taken forward for approval by PCC's Quality Assurance and Expenditure Panel.

Withdrawal of duplicate Day care funding

The care packages of clients who are in receipt of both residential and day services should be examined.

It may be possible to achieve significant savings within a short timeframe by reviewing clients who are funded for both a residential placement and a day care placement. In most schemes providing meaningful day activities is included in the cost of the residential placement.

The social worker will ensure all documentation is complete correctly on FWi and communication to the correct person within each provider organisation is made pre and post review with the outcome.

If there are any disputes or the provider is not willing to engage this will be recorded on the risk register of the project and managed through this arrangement. All savings will have to be certified by the finance officer before reported in the high light report.

4.4.1 Opportunities

Expected opportunities will be achieved through the review and reduction in care packages and the way in which the project is undertaken. Lessons Learnt from previous projects has

been applied. All savings will be validated by finance before reported and the source of these savings is Frameworki

- Financial (cashable) benefit – reduction in care package placement costs covering residential/nursing placements, direct payments and supported living services
- Financial (non-cashable) benefit – cost avoidance saving through Direct Payment Clawback
- Non-financial benefit placement rationale, stronger relationships – better placement rationale, stronger relationships with suppliers, a universal and fair pricing model.

4.5 The accommodation

The Council has an existing joint venture with Meacham Homes. The plan is to source the accommodation through Meacham Homes.

The Council will then loan the joint venture the funds to acquire the property. This will then turn a one year short term funding into ongoing opportunity.

Where-ever possible the accommodation will be in or close to Peterborough, preferably central.

One of the options is to review the Council's property disposal stock, this may offer an opportunity to re-use an existing asset.

4.5.1 Type of accommodation

The plan is to commission a mix of property, i.e. a number of "self contained units" and a number of "Homes of Multiple Occupancy" (HMOs).

- This would cater for the different needs of the clients and be able to best match care plans.

Looking at HMOs that accommodate four people – 3 clients and 1 carer

HMOs have the additional benefit of offering a cost effective care option, i.e. a single live-in carer could support a number of clients.

The accommodation could be a conversion or a new build.

Most importantly it is a normal build, i.e. not specialist unit.

It is likely that we will have to provide bespoke accommodation for those referrals within the Transferring Care Programme cohort.

We recognise that we will need to continue to keep fully appraised of potential accommodation solutions and recognise that the cohort list may be subject to change

4.5.2 Cost of accommodation

From discussions with the Corporate Property Team and Meacham Homes, for budgetary and planning purposes, to acquire the property;

- "Homes of Multiple Occupancy" (HMO) – circa £350,000 per
- "Self contained unit" – circa £150,000 per

Therefore for an investment of £2m, plan is to acquire;

- "Homes of Multiple Occupancy" (HMO) – 2 off x £350,000 = £700,000
- "Self contained unit" – 9 off x £150,000 = £1,350,000

5 Financial case

The Council and the CCG are proposing to invest £2m in housing options for vulnerable people.

5.1 Types of financial benefit

1. **Care Packages**

   The Council and Health can make savings on the Care Packages from;

   - The clients being more appropriately housed, which will result in a reduction in care packages required. These savings would continue whilst the client remained with the scheme.
   - Review of Care Packages - will follow a similar method to the current High Cost Placements initiative, each Client's Care Package would be reviewed by Care Team and Commissioning.
   - Bring Clients back - some of the Clients are in "out of area" arrangements, which attract a premium.
   - Designing in the use of appropriate Assistive Technology, this will save money and avoid costs. Following similar methods to the current AT initiative.

2. **Financing**

   - Council could earn a commercial loan rate of interest paid by Meacham Homes - with the risk of the loan covered by the property.
   - Return of the loan value of a period of time to PCC - which would allow future investment opportunities in the scheme and provide further returns

3. **Property Value**

   - The property will be an asset to the JV and value will appreciate.

4. **Joint Venture**

   - As the Council is a shareholder in the JV, will benefit from a share in the profits.

5. **Housing Benefit**

   - Many of these Clients will quality for a Housing Benefit - Local Housing Allowance (LHA). This will go towards paying their rent for the new accommodation.
   - The LHA is paid to the Client from PCC.
   - PCC can claim back this money from Department of Works and Pensions (DWP)

6. **Health Service Efficiencies**

   There might other efficiencies that the Health Teams could realise including;

   - Reduce travel times as there are a group patients at the same address.
   - GPs may realise a small benefit. From the increase in the Quality and Outcomes Framework (QOF), i.e. the system for the performance management and payment of general practitioners. From an increase of a number of service users with a similar category within their practice

5.2 Summary of financial benefits

Health –

- Annual cost of current care packages for the 22 Clients - £947,818
- Annual savings per year up to a maximum - circa £94,781 (10%)
  - Depending on if the Clients are currently eligible for CHC funding

PCC –

- Annual Net cost of current care packages for the 22 Clients - £1,226,219
- Annual savings per year for the 22 clients - circa £122,622 (10%)
- Note based on average for 15 clients, saving – circa £83,600

	Benefit type	Description	Amount
1.	Financing	• Commercial loan rate of interest paid by Meacham Homes – This could attract a commercial market loan rate of circa 4.78%	£95,600
2.	Care Packages	• The Council and Health can make savings on the Care Packages (average)	£148,223 p.a.
3.	Property Value	• The property will be an asset to the JV and value will appreciate.	Nil
4.	Joint Venture	• As the Council is a shareholder in the JV, will benefit from a share in the profits.	TBC
5.	Housing Benefit	• Local Housing Allowance will go towards rent, paid to JV. Will not cover rent.	Nil
6.	Health Service Efficiencies	• Other efficiencies that the Health Teams could realise	TBC

5.3 Care packages

Based on the 22 Clients selected by the Commissioners.

- They receive Care Packages that total £1.23m per year from PCC per year.
- In addition they receive Care Packages that total £948k from the NHS per year.
- However we have only 15 places available, so the figures have been adjusted.

See Appendix Four for the detail

5.4 Scenarios

We have chosen two Clients at random from the list to confirm the savings from the care packages are possible.

This analysis indicates we should achieve between 5% and 10% from a reduction in Carer's costs, i.e. in a shared facility so can share a Carer at certain times of the day.

See Appendix Five for the detail

5.5 Benefits from review of care packages

Based on the 22 Clients if through the re-housing them it reduces the cost of care from PCC by

- 10% - it saves £123k per year
- 20% - it saves £245k per year

If through the re-housing them it reduces the cost of care from NHS by

- 10% - it saves £95k per year
- 20% - it saves £189k per year

Total savings to health and social care

- **10% - it saves £217k per year**
- **20% - it saves £435k per year**

We don't know which specific Clients will be involved.

5.6 Costs

5.6.1 Establishment costs

- Legal
  - Covered by PCC Legal as business as usual
- Property Advice
  - Covered by PCC Property Services as business as usual
- Property acquisition costs
  - To be borne by provider – Meacham Homes

5.6.2 On-going operational costs

- Social Care activities
  - Covered by business as usual ASC operations
- Property Management costs
  - Covered by provider – Meacham Homes

5.7 Risks

5.7.1 In-compatibility

- Compatibility' issues and matching clients in particular in HMO settings. This is a delicate and sensitive process and needs careful attention in offering any shared housing arrangement.
- Mitigation
  - Very careful analysis of the information and selection of the clients, i.e. following the review process outline in section 4.4. Meeting and discussions with the client, their carer or family.

5.7.2 Rents

We need to understand the rents Meacham Homes will be charging

- HMO
  - For supported accommodation in Peterborough it is typically £200 per week.
  - Each Client will qualify for LHA of £57.15 per week (in HMO setting)
  - Leaves a gap of circa £143
  - This would have to be met by the Client or the Council, it is believe that these clients would qualify for support to bridge the gap but this needs confirming and is on a case by case basis. Peterborough City Council undertakes to utilise the Discretionary Housing Grant to mitigate this financial risk where appropriate.
  - Worst case - £143 x 52 weeks = £7,436 per client in HMO.

- Self Contained Units
  - For SCUs in Peterborough it is typically £200 per week.
  - Each Client will qualify for LHA of £92.05 per week (one bedroom setting)
  - Leaves a gap of circa £108
  - This would have to be met by the Client or the Council, it is believe that these clients would qualify for support to bridge the gap but this needs confirming and is on a case by case basis.
  - Worst case - £108 x 52 weeks = £5616 per client in SCU.
- Total cost for rent gap
  - £95,160
- Mitigation
  - Council receives an annual Discretionary Housing Payments (Grant) of £600k
  - This could be used to mitigate this risk

5.7.3 Modifications / Repairs

- The intention is to acquire industry standard properties that are not be-spoke. That provides maximum flexibility when clients change. However there is a risk that the properties may need modifying or maintenance.
  - The budget required is not known.
- Mitigation
  - Disabled Facilities Grant
  - The Council receives a grant that is used to support minor and major adaptations for eligible adults and children via the Care and Repair service to enable people to stay in their homes.

5.7.4 Voids

- There will be times that a property or unit will be empty, i.e. not earning rent. This is the risk of the provider – Meacham Homes. However they will cost this risk into their financial model and pass on the risk to the Client or the Council.
  - The void days per year allowance is not known
- Mitigation
  - To agree a lower void days per year with the provider – Meacham Homes. E.g. the Council under-rights anything above 30 days.
  - Council then takes out Void Days insurance to protect against the potential cost. The cost of the insurance is not known but it is standard industry practice and offers good value for money.

5.7.5 Change in Government Policy

- There is a risk that the IBCF Scheme could be cancelled.
  - Council has made the financial commitment to the Property Provider to meet the timescales
- Mitigation

- Risk is considered very low, this is a central policy to Government Strategy.

6 Options

There are a number of options and variables considered.

6.1 Option 1

To decide to use the funds for this purpose or not.

The Council and CCG are investing their funds in a range of areas in line with the IBCF principles of meeting Adult Social Care (ASC) needs and reducing pressures on the NHS. In particular the investment of £1m to improve the discharge from hospital process.

It was felt that this proposal met the conditions of the IBCF and would offer a sustainable investment and provide an on-going annual return.

- For more detail see Section 3 above and in particular 3.1 the case for the investment.

6.2 Option 2

Which Client Group – to offer maximum benefit

Following extensive discussions and analysis it is recommended the opportunity is targeted at

- Age group – 16 to 24 year olds
- Primary Client Group - Learning Disability and / or Autism spectrum condition

Supporting people with learning disabilities and/or autism spectrum condition to be active citizens in their communities is a key priority for the Council, as part of its Prevention and Early Intervention Strategy – as outlined in Section 3.3.

The supply of housing is critical to achieving the objectives of prevention and progression. Specialist housing includes accommodation that has been designed and built to meet the needs of the vulnerable adult and may include some elements of care and support for everyone who lives there. This support can either be on-site or off-site.

6.3 Option 3

Type of accommodation – this is influenced by the Client Group and their needs and to get good value for money.

As outlined in section 4.5.1 above, the plan is to commission a mix of property, i.e. a number of “self contained units” and a number of “Homes of Multiple Occupancy” (HMOs). HMOs that accommodate four people – 3 clients and 1 carer

- This would cater for the different needs of the clients and be able to best match care plans.
- HMOs have the additional benefit of offering a cost effective care option, i.e. a single live-in carer could support a number of clients.

6.4 Option 4

Financial Case – as outlined in section 5.

The will be financial benefits to both the CCG and the Council. The numbers are prudent and there are certain details to be confirmed. The benefits would be

- Health – circa £94,781 or almost £0.5m over 5 years
- PCC – circa £179,200 or almost £0.9m over 5 years

For use of the £2m investment, Health and Social Care get a return of £1.4m over first full 5 years.

Plus valuable assets providing on-going benefits.

The health and social care financial return on investment will be re-invested to support delivery of the ongoing iBCF 3.5% DTOC plan.

Governance and review of performance will sit with the Integrated Commissioning Board to ensure benefits are maximised.

7 Recommended Option

To proceed with the scheme to invest £2m of the IBCF Funds and provide accommodation to this group of vulnerable people of Peterborough.

1. This scheme **meets the conditions of the IBCF** and would offer a **sustainable investment** and an **annual return**. This proposal will
   - contribute to reducing pressures on NHS
   - directly meet current adult social care needs and priorities
   - supports the Council's Prevention and Early Intervention Strategy
   - provide a lasting benefit to the people of Peterborough
   - not create an on-going financial commitment

2. **Robust financial case** - For a £2m investment, Health and Social Care get a return of £1.4m over 5 years. The financial benefit would be
   - Health – circa £95k per year or almost £0.5m over 5 years
   - PCC – circa £179k or almost £0.9m over 5 years

3. The **health and social care benefits** of providing this accommodation include:
   - Specialist housing with support can reduce the risk of hospital admission
   - Specialist housing with support can delay or avoid the need for registered care
   - Appropriate accommodation can facilitate the delivery of personalised care and support
   - Provides a local higher quality solution for the client that is more manageable by the professionals
   - People can receive more suitable accommodation and support whilst maintaining links with their local communities
   - Offers better value for money than existing options, i.e. out of area placements

8 Timescale & Implementation

8.1 Indicative Timescales

No	Milestones	Dates
1.	Agree principles / prepare Business Case	Mid August 2017
2.	Start to source property (to meet time-line)	August 2017 onwards
3.	Approval of Business Case by CCG and Council	Mid August 2017
4.	Commit to plan in principle by CCG and Council	End August 2017
5.	Submit BCF Plan	September 2017
6.	Approval of BCF Plan	October 2017
7.	Review Learning Disability Section 75 Agreements to enable transfer of financial benefits	October 2017
8.	Funding released / drawn down	October2017
9.	Commit funds to JV to enable acquisition of property – sign contracts	October 2017
10.	Property available	Early January 2018
11.	Property prepared	End January 2018
12.	Property (accommodation) available	Mid February 2018
13.	Clients move in and benefits start to be realised.	Mid March 2018

For the plan see Appendix Five.

8.2 Dependencies

Identify any projects which are dependent on this project and any projects which this project is dependent on.

- None

9 Reference Documents

Please list any reference material or information sources and maintain a bibliography.

10 Glossary

Include any terms or acronyms used in the document and provide an explanation.

11 Appendices

11.1 Appendix One – Better Care Fund (BCF)

The BCF was announced in June 2013 and introduced in April 2015. The £16.8 million is largely a reorganisation of funding currently used predominantly by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and Peterborough City Council (PCC) to provide health and social care services in the city.

Peterborough's BCF has created a single pooled budget to support health and social care services (for all adults with social care needs) to work more closely together in the city.

Peterborough is required to submit a new, jointly agreed BCF Plan, covering a two year period to NHS England on 11th September 2017.

The BCF plan builds on the following agreed principles:

- Greater alignment across Cambridgeshire and Peterborough
- A single commissioning board (the ICB)
- Greater alignment with the STP and local authority transformation plans
- Using the BCF to 'get the basics right' and coordinate our approach, focusing on a smaller number of system-wide changes

There is a focus on building on the work undertaken to date, with the following areas identified as continued priorities:

Prevention and Early Intervention: including a county wide falls prevention programme, further work to ensure a comprehensive approach to equipment and assistive technology, and development of joint VCS commissioning opportunities.

Community Services (MDT Working): including wider roll out and embedding of case management, to include data sharing to support risk stratification and pro-active identification of service users. Development of integrated hospital discharge and admission pathways and enhancement of intermediate care and reablement provision.

Enablers: continued development of consistent, accurate and reliable information and advice to support the concept of 'no wrong front door'.

High Impact Changes for Discharge: A new national BCF condition, requires the local system to implement the high impact change (HIC) model for managing transfers of care. The HIC areas are: early discharge planning; systems to monitor patient flow; MDT/multi-agency discharge teams; home first / discharge to assess; 7 day services; trusted assessor; focus on choice; and enhancing care in care homes. An initial system wide self-assessment has been completed against the high impact changes and existing system plans.

The Improved Better Care Fund (iBCF) is a new introduction to BCF plans this financial year and is considered to be part of the ongoing BCF programme.

11.2 Appendix Two – Data analysis

- Personal data
  - Surname
  - Date of birth
  - Age
  - Frameworki ID
  - Primary Client Group
  - Current Address
- Status
  - Current Accommodation
  - Reasons for seeking alternative accommodation
  - Date of Referral
  - Priority Ratings - H/M/L
  - RAG Rating - Timescale requested (Days)
- Considerations

1. What property features are required? (e.g. ground floor, wide corridors etc)
2. Can the client live in shared accommodation with on-site support, including sleeping provision?
3. If yes, are there any compatibility issues? (e.g. must be female, young, communicative)
4. Can the client live in self-contained accommodation within a supported living setting with low level on-site support including sleeping in provision?
5. Can the client require a single service with staff available 24/7?
6. Can the client live in independent accommodation in the community with visiting support?
7. Is accommodation & support being sourced through framework tender?
8. Are there current housing plans/proposals for service user?
9. If Yes, please provide details - Referrers Email
10. Status Notes - Supporting Documents

11.3 Appendix 3 - Types of Welfare Benefit

1. Local housing allowance (Housing Benefit)

This benefit is paid to Clients by PCC, but can be fully claimed back from the Department of Works and Pensions.

- Local housing allowance (LHA) is the way payments are calculated for people receiving housing benefit. A flat rate is used based on the size of the tenant's household and the area in which they are renting the property. This amount is not directly related to the rent being charged.
- The rate of LHA that a claimant receives is reviewed on an annual basis. Other circumstances, such as money that the tenant has coming in or other people living in the household will still affect the amount of benefit paid, so the tenant may not always receive the full rate of LHA.
- The weekly rate (April 2017) for
    - Shared Accommodation is £57.15
    - 1 Bedroom is £92.05

In most cases this will not cover rental costs.

Care Support or Supervision is provided to Tenant

If Landlord is also responsible for providing care and it is a RSL (not for profit organisation) the amount that can claimed is higher, e.g. full cost of the provision of the accommodation. E.g. Cross Keys King Fisher Court

In 2019, there is a new grant being proposed, which is designed for replacing the additional costs of supported care e.g. the £140 per week gap.The only requirement is a minimal care provision

2. Disability Living Allowance (DLA)

This benefit is paid to Clients by DWP. This benefit is being phased out and is being replaced by PIP for new claimants. Existing claimants remain on the existing DLA arrangements

- DLA is ending for people aged 16 to 64.It is being replaced with the Personal Independence Payment (PIP). A Client will continue receiving the DLA until DWP invites them to apply for PIP.
- The rate a person receives is made up of 2 components. How much depends on how the disability or health condition affects the individual
    - Care component – ranges from £22 to £83.10 per week (This group are likely to be the higher rate – i.e. £83.10)
    - Mobility component – ranges from £22 to £58 per week

3. Personal Independence Payment (PIP)

This benefit is paid to Clients by DWP. This is the new scheme replacing DLA for new claiments.

- If the Client is aged 16 to 64 they could get between £22 and £141.10 a week by claiming Personal Independence Payment (PIP).
- The amount a person gets depends on how their condition affects them, not the condition itself.
- For this group of Clients it is believed they will receive £83.10 per week.

4. Employment and Support Allowance (ESA)

- If the Client is ill or disabled, they may qualify for Employment and Support Allowance (ESA). It offers:
  - financial support if the person is unable to work
  - personalised help so that you can work if you're able to

- How much ESA a person gets depends on:
  - Their circumstances, such as income
  - the type of ESA they qualify for
  - where they are in the assessment process

- Following assessment, if a person is entitled to ESA, they will be placed in one of 2 groups and will receive:
  - up to £73.10 a week if you're in the work-related activity group
  - up to £109.65 a week if you're in the support group (i.e. this group of Clients)

11.4 Appendix Four - Cost of Care Packages (22 Clients)

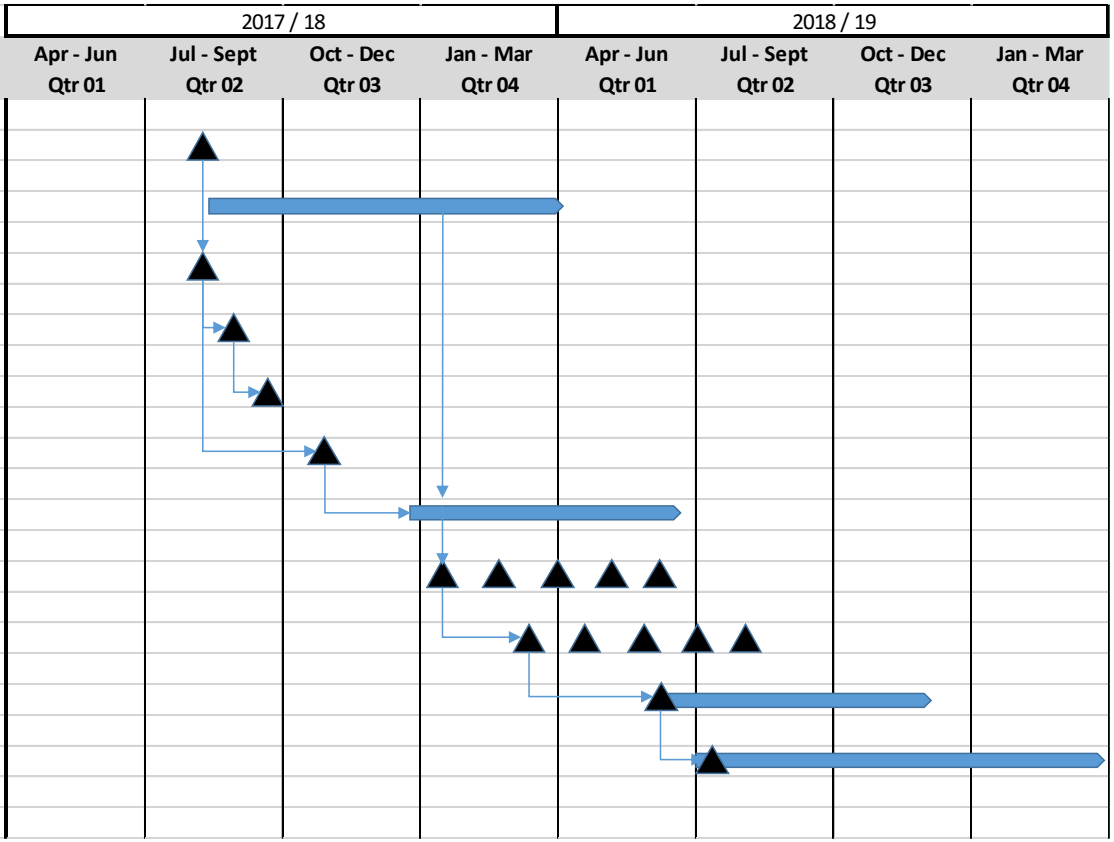
Clients	Weekly Expenditure Costs	Weekly Client Income Cont	Weekly NHS Income Cont	Total Weekly Net Costs	FY Annual Gross Expenditure Costs	FY Annual Client Income Cont	FY Annual NHS Income Cont	FY Annual Weekly Net Costs
1	401.15	-19.99		**381.16**	20,860	-460		**20,400**
2	1000.00		-422.00	**578.00**	52,143		-22,004	**30,139**
3	1506.44	-111.75		**1394.69**	79,841		-5,923	**73,919**
4	2700.00	-100.00	-1300.00	**1300.00**	140,786	-5,214	-67,786	**67,786**
5	5213.06	-84.75		**5128.31**	276,292	-4,492		**271,800**
6	1700.47		-680.18	**1020.29**	88,424		-35,369	**53,055**
7	2164.58		-490.20	**1674.38**	114,723		-25,981	**88,742**
8	2222.22	-92.75	-1155.55	**973.92**	117,778	-4,916	-61,244	**51,618**
9	435.63			**435.63**	23,088			**23,088**
10	6500.00		-6350.00	**150.00**	338,929		-331,107	**7,821**
11	2759.40	-124.18	-997.50	**1637.72**	143,883	-6,582	-52,868	**84,434**
12	750.00		-750.00	**0.00**	39,107		-39,107	**0**
13	800.00			**800.00**	41,714			**41,714**
14	2500.00	0.00	-1500.00	**1000.00**	130,357	0	-78,214	**52,143**
15	800.00			**800.00**	41,714			**41,714**
16	950.00	-100.00		**850.00**	49,536	-5,214		**44,321**
17	925.50			**925.50**	48,975			**48,975**
18	1500.00		-750.00	**750.00**	78,214		-39,107	**39,107**
19	1936.60	-92.75	-1059.32	**784.53**	102,640	-4,916	-56,144	**41,580**
20	1500.00		-1500.00	**0.00**	78,214		-78,214	**0**
21	2500.00		-1050.00	**1450.00**	130,357		-54,750	**75,607**
22	1309.00			**1309.00**	68,255			**68,255**
						Total	**-£947,818**	**£1,226,219**

11.5 Appendix Four – Two scenarios from list of clients

Service User ID	NOTES	Weekly	Current Supplier	Notes	Weeks	2 to 1 Hours			1 to 1 Hours	Rate	Costs	1 to 2 Hours	Rate	Costs	1 to 3 Hours	Rate	Costs	Total Weekly Costs	Annual	TOTAL COSTS
2000435	CURRENT	£1,506	Turning Point	College	36				£55	£15	£818	£42	£8	£315				£1,133	£40,770	
				Holiday	16				£70	£15	£1,050	£42	£8	£315				£1,365	£21,840	
				Evening	52				£14	£15	£210							£210	£10,920	
				Sleep	52										£56	£2	£117	£117	£6,067	
																				£79,597
	COULD BE		TBA	College	36				£55	£15	£818	£42	£8	£315				£1,133	£40,770	
				Holiday	16				£50	£15	£750	£20	£8	£150				£900	£14,400	
				Evening	52							£14	£8	£105				£105	£5,460	
				Sleep	52										£56	£5	£280	£280	£14,560	
																				£75,190
	POTENTIAL EFFICIENCY																			£4,407
																				5.5%
29547	CURRENT	£1,937	Affinity	Home	52				£79	£14	£1,090							£1,090	£39,247	
				Doing	52	38.00	13.80	524.40										£524	£18,878	
				Sleep	52										£56	£6	£322	£322	£11,592	
																				£69,718
	COULD BE	£1,670	TBA	Home	52				£52	£14	£718	£27	£7	£186				£904	£32,540	
				Doing	52	38.00	13.80	524.40										£524	£18,878	
				Sleep	52										£56	£6	£322	£322	£11,592	
																				£63,011
	POTENTIAL EFFICIENCY																			£6,707
																				9.6%

11.6 Appendix Five – Timescales

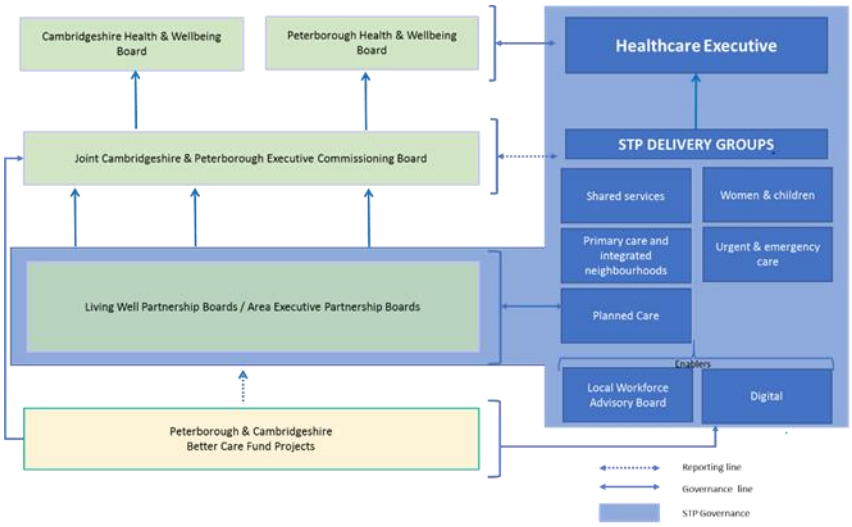
Activity	Dates
Agree principles / prepare Business Case	Mid Aug 17
Source property	Aug 17 onwards
Approval of Business Case	Mid Aug 17
Commit to plan by CCG and Council	End Aug 17
Submit BCF Plan	Mid Sept 17
Commit funds to enable acquisition of property	Oct-17
Property purchase complete	Early Jan 18 onwards
Property (accommodation) available	Mid Feb 18
Clients move in	Mid Mar 18
Care Plans Reviewed	Jun 18 onwards
Savings realised	July onwards



11.7 Appendix Five – Savings Benefits realisation plan

	2018													2019 onwa
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
PCC Care Package saving														
Client 1				428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	5573.36
Client 2				428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	5573.36
Client 3				428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	5573.36
Client 4				428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	5573.36
Client 5				428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	5573.36
Client 6					428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	5573.36
Client 7					428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	5573.36
Client 8					428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	5573.36
Client 9					428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	5573.36
Client 10					428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	5573.36
Client 11						428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	5573.36
Client 12						428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	5573.36
Client 13						428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	5573.36
Client 14						428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	5573.36
Client 15						428.72	428.72	428.72	428.72	428.72	428.72	428.72	428.72	5573.36
				£2,144	£4,287	£6,431	£6,431	£6,431	£6,431	£6,431	£6,431	£6,431	£6,431	£83,600
													£57,877	£25,723
Health Care Package saving														
Client 1				331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	4308.2
Client 2				331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	4308.2
Client 3				331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	4308.2
Client 4				331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	4308.2
Client 5				331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	4308.2
Client 6					331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	4308.2
Client 7					331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	4308.2
Client 8					331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	4308.2
Client 9					331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	4308.2
Client 10					331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	4308.2
Client 11						331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	4308.2
Client 12						331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	4308.2
Client 13						331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	4308.2
Client 14						331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	4308.2
Client 15						331.4	331.4	331.4	331.4	331.4	331.4	331.4	331.4	4308.2
				1657	3314	4971	4971	4971	4971	4971	4971	4971	4971	64623
													44739	19884
Total	£0	£0	£0	£3,801	£7,601	£11,402	£11,402	£11,402	£11,402	£11,402	£11,402	£11,402	£11,402	£148,223
													£102,616	£45,607

Appendix 15 - BCF Governance Structure



NHS England

Fit for the Future
Working together to keep people well

NHS Improvement

Cambridgeshire & Peterborough

STP Review Meeting

27 July 2017

Cambridgeshire and Peterborough NHS Clinical Commissioning Group
Cambridgeshire and Peterborough NHS Foundation Trust
Cambridgeshire Community Services NHS Trust
Cambridge University Hospitals NHS Foundation Trust
North West Anglia NHS Foundation Trust
Papworth Hospital NHS Foundation Trust
Cambridgeshire County Council
Peterborough City Council
East of England Ambulance Service NHS Trust

Agenda

	Item
1.	**Capped Expenditure Process**
2.	**STP governance and infrastructure for delivery:** • STP Leadership • STP Governance • Infrastructure for Delivery
3.	**Programme Management Approach and Key Milestones**
4.	**Service Changes Proposed**
5.	**Practical Support NHSE can provide STPs**
6.	**Aligning oversight processes**
7.	**STP Engagement**

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Capped Expenditure Process - Update

Progress since 30 May Capped Expenditure Process Panel Meeting:

1. *Closing the operational planning and contracting gap*
   - Over the last month there has been focused engagement between CCG and Provider colleagues, including CEO escalation, to continue to work through the QIPP schemes and agree the most effective way to ensure and monitor delivery.
   - We have discussed at length the request of bipartite colleagues to implement:
     1. A set of aligned activity and financial plans between providers and commissioners
     2. Enact contract variations as appropriate to reflect the activity on a financial planning basis, i.e. financial plans to align to activity plans
   - All parties have repeatedly stated their desire to focus on the delivery of schemes and the desire for this to be monitored at a system level. However, the difference is whether this process sits outside of or is reflected in revised contracts and financial plans.
   - Collectively, there is a consensus we have sufficient transparency and cooperation between organisations to focus and monitor delivery without repeatedly revisiting the IAPs at this point in time but rather, to focus on delivery. Until the QIPP schemes start to impact and joint clinical work on £3m demand restriction is complete providers are not willing to amend IAPs.
   - Through this mechanism, the commitment is to collectively deliver a balanced financial plan and to support each organisation across the system to deliver their individual control totals. By the reviews at the HCE we will continue to develop our QIPP/ CIP to respond to variances and challenges through the year.
   - We remain committed to managing activity levels through the year within the expected financial envelopes.

2. *Implementation of additional initiatives to mitigate delivery risk*
   - *Details overleaf*

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Capped Expenditure Process - Update

Opportunities to close the STP Planning Gap	Value £m	Updated on progress since CEP Panel – 30 May
Additional benefits from expansion of the JET service	£0.7	• Significant ICW recruitment campaign launched through multiple avenues including secondments from EAST • Widespread GP engagement programme underway with focused education sessions and programme of visits to all practices by Sept • Recruitment of additional project resource to support delivery • Widened criteria to enhance range of conditions which JET can accept to increase impact
Extend waiting times to 12 week minimum wait	£0.6	• Speciality by speciality review of waiting lists to identify specific opportunities initially focused on areas with the highest opportunity, i.e. T&O. • The CCG has written to formally notify providers of the position with a start date of 1st Sept 2017
Opportunities in primary care prescribing	£1.9	• High Level implementation plans created. Self Care Plus list drafted and Local 'stop' prescribing list created. Implementation was discussed with the CCG Prescribing Leads at the MO Quality & Engagement Meetings in July. Proposals to be formally reviewed at the Joint Prescribing Group on the 26 July with CEC sign off on 8th August. Implement in full from Sept.
Implementation of a new multidisciplinary foot care service	£0.2	• Confirmation of national funding received. Implementation plan developed ahead of planned roll out in Q3
Vary NICE TAs where there are lower cost alternatives which we can implement without affecting patient outcomes – On hold	£0.7	• Still awaiting national feedback on this. Views of anti-coags complex and therefore will be difficult to implement - additional schemes will be pursued in meantime. Will not progress without national permissions
Restriction of referral and elective treatment thresholds for secondary care activity	£3.0	• Strong piece of clinical engagement/leadership supported by the systems' Medical Directors. Clinical leads and project support have been identified for MSK, Ophthalmology, Cardiology and ENT. Dates for initial meetings agreed per specialty in July / early August. 2nd phase of specialties in process of finalisation re: leads and dates in August. System finance colleagues have been engaged to undertake detailed review of national and local data to identify areas with greatest opportunity ahead of implementation in Q3. LMC engaged
Opportunities to improve the system position	**Value £m**	**Updated on progress since CEP Panel – 30 May**
Debt Restructure	£6.5 - £13.0	• The system, is aiming to gain agreement to convert all of its loans to equity in the form of PDC. The system will engage with NHSI in July in order to discuss the full detail of this proposal and advance the negotiations. It may then be necessary to take this to the Department of Health for their view and final agreement

Fit for the Future
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STP Leadership

Independent Chair

The current interim chair is Alex Gimson, following the recent departure of our previous Chair in April. The HCE and Chairs agreed to the appointment of an STP Independent Chair, however to ensure there is momentum a Chair with understanding of the local system and the strategic plan; and with the skills to ensure decisions are made for the benefit of the system overall, with the inclusion of all of the organisations boards – is what we are looking for.

The Chairs are each proposing non exec / lay members for secondment to the Chair role to fill the vacant position by September. A selection process will follow nominations.

Accountable Officer

The HCE and Chairs have agreed the STP AO responsibility remains with Tracy Dowling for the medium term.

Executive Programme Director

In order to ensure that the STP has sufficient day to day leadership of both the current delivery programme, and the transition route to an ACS, it was agreed to advertise the Executive Programme Director post externally as a full time executive level role. The closing date for the post was 16 July and we received twenty applications. Interviews were held on Monday 24 July and a verbal update on the outcome of the interviews will be provided at the meeting.

The leadership structures will be reviewed again in twelve months as part of the transition to an Accountable Care System, where there may be a need for additional/alternative roles to support the Accountable Care transition.

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STP AO Role

Organisation of 2 days per week time commitment

The Board of CPFT have approved the continuation of Tracy Dowling as AO for the STP. This is with the understanding that the commitment required is two days per week.

This will be organised as follows:

- 1 day - formal STP corporate business to include STP exec meeting with Chair, Programme Director, Clinical Lead, Finance Director and System Strategy Director; oversight of programme development, ACS development and STP OD.

- 1 day flexed across the week to be able to respond to requests for STP leads meetings, HCE, meetings with local authority partners, progression of work programmes critical to STP delivery, communications and engagement activities.

Many of the STP work programmes are delivered by CPFT, therefore there is significant overlap of agendas for strategic development. These will be the workstreams led at AO level by Tracy.

The STP has a well resourced SDU and with the appointment of a full time Programme Director to lead the team day to day will enable the STP AO to undertake both roles.

CPFT has a stable and experienced executive team, and associate directors so through effective delegation and a programme delivery approach in CPFT too – it should be possible to undertake both roles.

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STP Governance (1/2)

Our ambition: for the Cambridgeshire and Peterborough health and care system is to develop the beneficial behaviours of an **Accountable Care System** on the way to becoming a value-based system which is jointly accountable for improving our population's health and wellbeing, outcomes, and experiences, within a defined financial envelope.

Currently the STP has the following governance arrangements in place:

Health and Care Executive (HCE)

- A cross Health and Social Care Chief Executive group which meets monthly and currently acts akin to the STP Board as outlined in the recent Five Year Forward View Next Steps publication, with the exception that at present we do not have any Non Executive or lay members.
- It has recently been agreed that we will set up a new STP Board with Non Executive representation from each of the STP partners including Local Authority Members, to ensure Board and lay members are more directly involved in the work of the STP. In addition, we are also setting up a new STP Stakeholder Group which will include representation from partner's Council of Governors and equivalent members from CCG and Local Authorities. Further details on the STP Board on slide 8.

Memorandum of Understanding for partnership working:

- NHS partners have signed a Memorandum of Understanding (MOU).
- This sets out the behaviours we expect of each other and how we will work together, including formal strategic decision making arrangements, the sharing of budgets (e.g. STP investment pot) and our commitments around clinical and financial sustainable health and care services.
- Cambridgeshire County Council and Peterborough City Council have signed an appendix supporting partnership working.

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STP Governance (2/2)

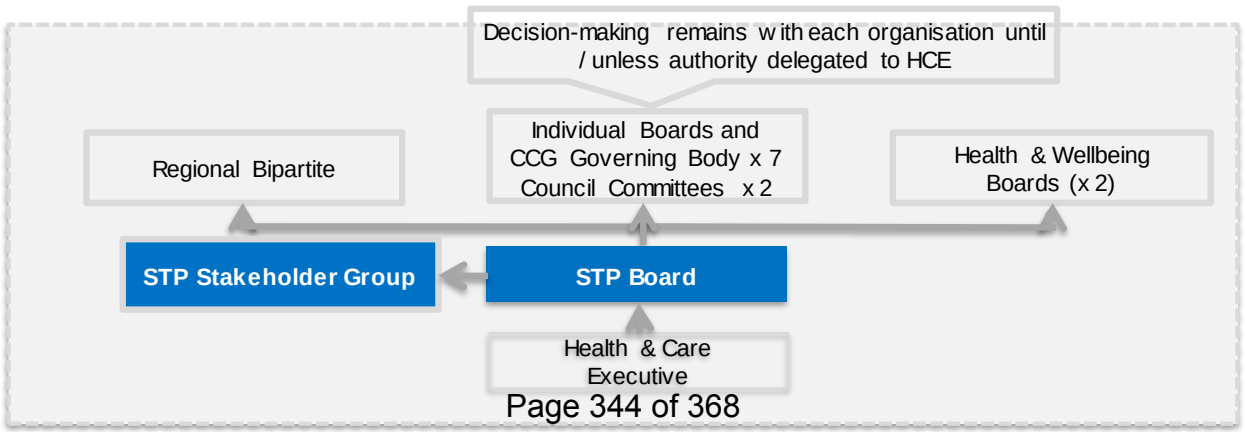
STP Board

There has been universal support from both the Chairs and Health & Care Executive for the formation of an STP Board which will have Non-Executive Director (NED) membership from across the system (nominated from existing pool of NEDs within provider boards and CCG governing body and appropriate representation from the LAs), all Chief Executives. Other key stakeholders are being considered such as EAHSN, GP provider representation/LMC and Healthwatch. The Board will be chaired by the substantive STP Independent Chair.

The first meeting will be in September with STP Board development taking place over the Summer with support from East of England Academic Health Science Network. The meetings will be held bimonthly and meet with HCE quarterly and the newly formed Stakeholder Group twice a year.

Stakeholder Group

Support from both the Chairs and Health & Care Executive for the formation of an STP Stakeholder Group which will Include nominated members from the provider's Council of Governors and appropriate representation from the CCG and LAs (such as Health and Wellbeing Boards), wider stakeholders including patient, carer and voluntary group representation and Staff Partnership Forum.



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Infrastructure for Delivery

- The STP has a system-wide delivery programme which is managed through five delivery work streams and two enabling work streams.

- Each work stream is led by a system CEO acting as Accountable Officer, supported by relevant system Executives/Directors as Senior Responsible Officers, together with dedicated clinical, finance, local authority colleagues (where relevant), HR, and project management resourced by the system, and assisted by a small co-ordinating STP team (the SDU).

- It should be noted that this structure supports the STP work programme, which is mostly focused on 'enabling' work streams that support the system partners achieve their performance standards and deliver the 'national asks' (e.g. expanding JET should support the acute providers achieve the relevant UEC standards).

- Where a 'national ask' is being delivered and monitored locally through individual organisations (e.g. CCG, providers), these are aligned to the STP work but not all are embedded within the relevant STP delivery group's work programme. e.g. the UEC delivery group is not responsible for all UEC actions, only those highlighted as such in the template.

- As a system we have architecture in place to underpin the programme management and reporting arrangements to help support delivery of the STP, which are outlined on slides 10-12.

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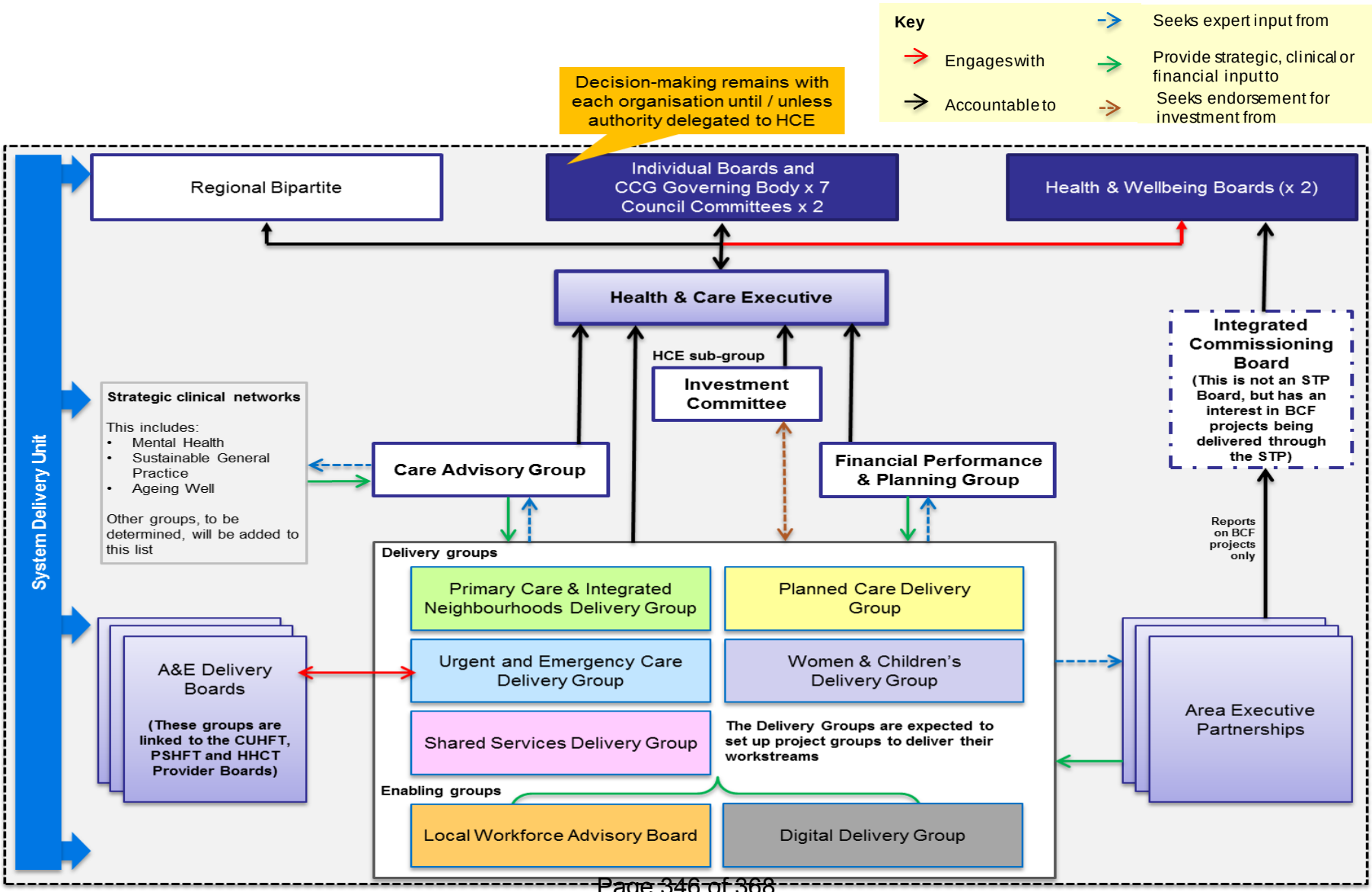
Infrastructure for Delivery: Organogram



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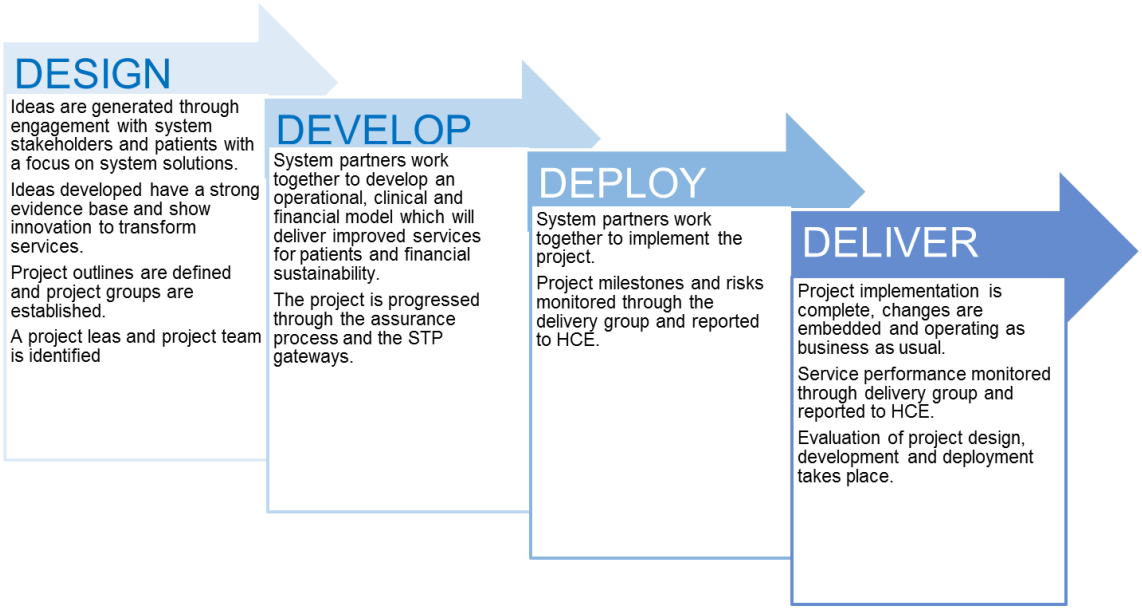
STP Programme Management Approach (1/2)

STP Programme Cycle

As the STP moves from planning into implementation and delivery it became apparent that we needed a clear and consistent structure to frame the various processes across the STP to reduce confusion and ensure appropriate accountability across the 'lifecycle' of the STP improvement projects.



To support this the SDU developed a suite of guidance documents and tools which will assist all parties understand at each stage in the improvement project's life (design, develop, deploy and deliver):

1. Their respective roles and responsibilities
2. The reporting requirements
3. The governance requirements
4. The comms and engagement requirements

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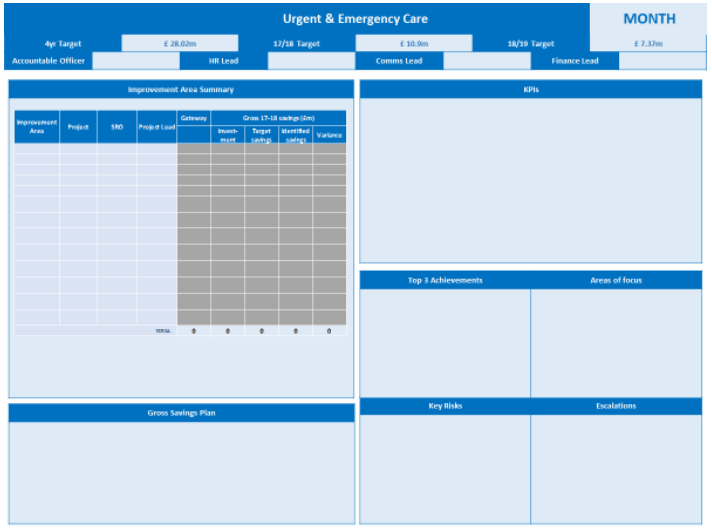
STP Programme Management Approach (2/2)

Health and Care Executive (HCE)

At the May HCE meeting we implemented a new monitoring and reporting framework which provides HCE with essentially a 'performance' report for the STP programme which includes a dashboard from each STP delivery group as well as a system wide KPIs report. These dashboards provide both finance and non financial performance information for the improvement projects (i.e. service change) under the responsibility of the delivery group.



STP Delivery Groups

Underneath HCE, each STP delivery group will receive a dashboard for each improvement project, in addition to the summary delivery group dashboard submitted to HCE. There are four types of improvement project dashboards, reflecting the different type of monitoring information required at design, develop, deploy and delivery stages. Dashboards are fed by PMO style workbooks which include project plans, actions, owners, milestones, risk registers, coms etc.

The SDU supports the system in the management of these dashboards.

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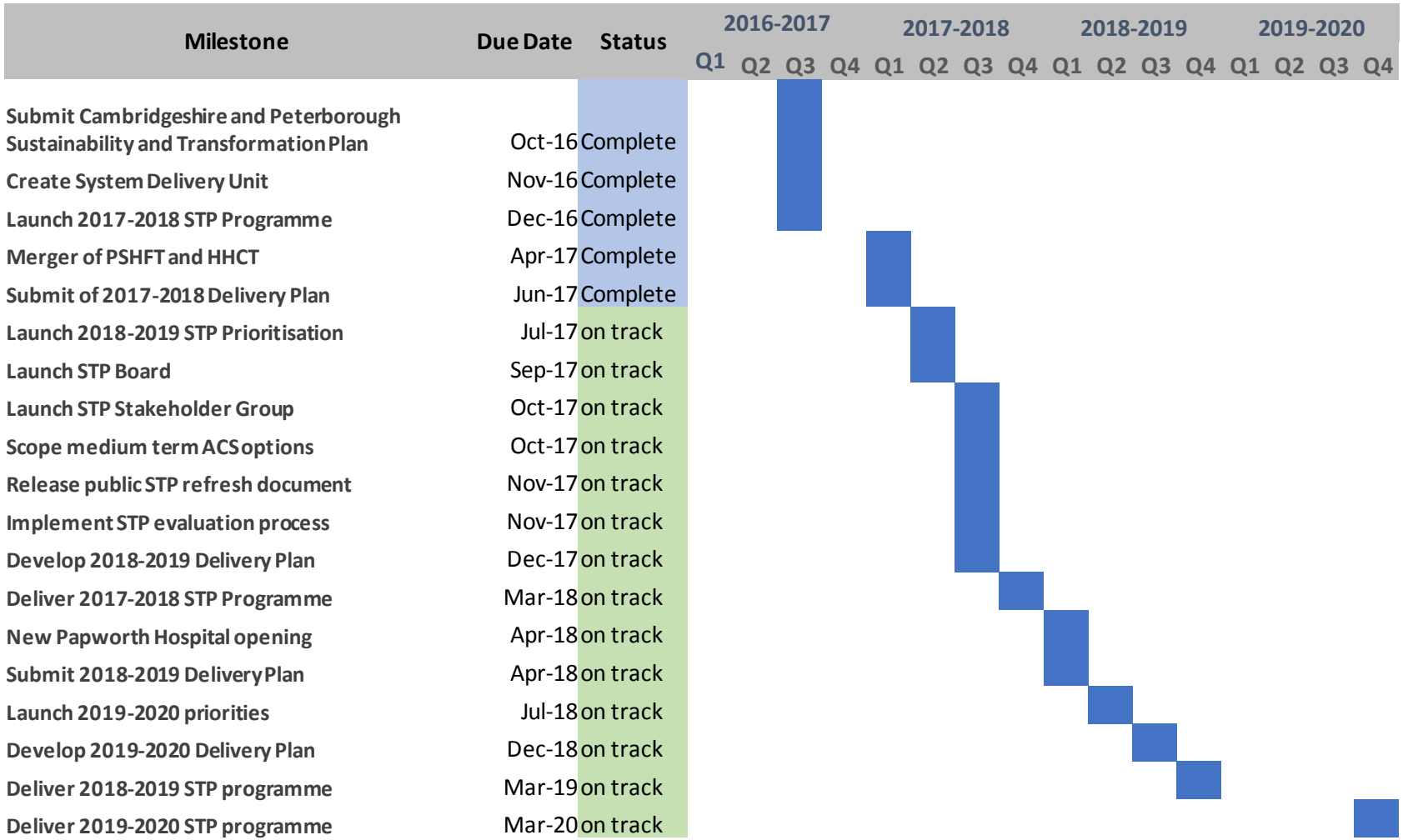
STP Programme Milestones

In addition to the monthly reporting arrangements we have a number of programme milestones

Milestone	Due Date	Status
Submit Cambridgeshire and Peterborough Sustainability and Transformation Plan	Oct-16	Complete
Create System Delivery Unit	Nov-16	Complete
Launch 2017-2018 STP Programme	Dec-16	Complete
Merger of PSHFT and HHCT	Apr-17	Complete
Submit of 2017-2018 Delivery Plan	Jun-17	Complete
Launch 2018-2019 STP Prioritisation	Jul-17	on track
Launch STP Board	Sep-17	on track
Launch STP Stakeholder Group	Oct-17	on track
Scope medium term ACS options	Oct-17	on track
Release public STP refresh document	Nov-17	on track
Implement STP evaluation process	Nov-17	on track
Develop 2018-2019 Delivery Plan	Dec-17	on track
Deliver 2017-2018 STP Programme	Mar-18	on track
New Papworth Hospital opening	Apr-18	on track
Submit 2018-2019 Delivery Plan	Apr-18	on track
Launch 2019-2020 priorities	Jul-18	on track
Develop 2019-2020 Delivery Plan	Dec-18	on track
Deliver 2018-2019 STP programme	Mar-19	on track
Deliver 2019-2020 STP programme	Mar-20	on track



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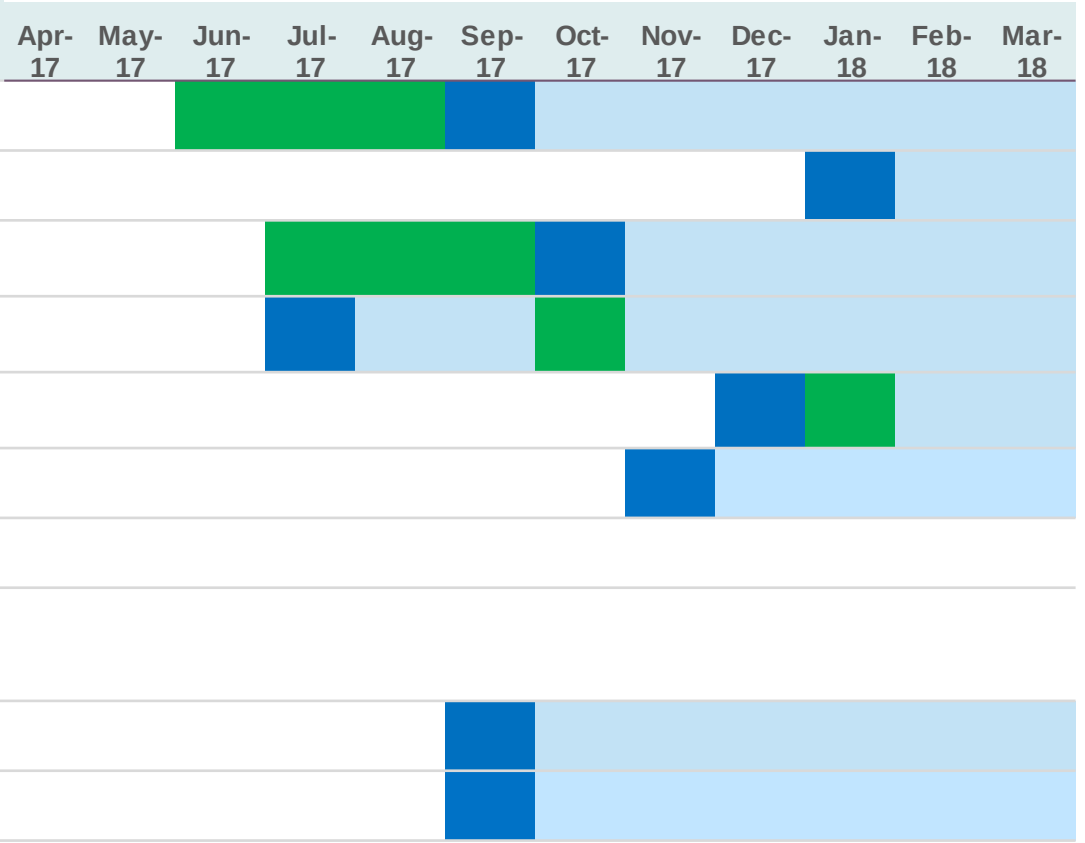
Approved Service Changes

ACTIVITY	17/18 INVESTMENT £M	PLAN START	REVISED GO LIVE DATE
JET	1.9	Sep-17	Jun-17
Stroke ESD	0.5	Jan-18	
Enhanced Provider Referral Triage	0.3	Oct-17	Jul-17
Community Respiratory	0.4	Jul-17	Oct-17
Community Heart Failure	0.4	Dec-17	Jan-18
Falls Prevention	0.2	Nov -17	
Case Management	1.4	**Pending**	
Discharge to Assess - Reablement/Dom Care	3.6	**Pending**	
AF Stroke Prevention	0.3	Sep-17	
Suicide Prevention	0.07	Sep-17	
Liaison Psychiatry	1.5	**April -18**	
Diabetes	1.5		



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Schemes in design/development for 2017-2018

Phase	Current Delivery Group	Project	Activity	Periods 2017-2018											
				Q1			Q2			Q3			Q4		
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Design	UEC	Regional Thrombectomy Service	Design regional Thrombectomy Service			■	■	■	■						
Design	UEC	High Impact Change Model	Baseline assessment against each of the 8 High Impact Change areas at each of the acute sites (PSHFT, CUHFT and HHT)				■	■	■						
Develop	UEC	High Impact Change Model	Phased and prioritised implementation of local High Impact Change plan							■	■	■			

Phase	Current Delivery Group	Project	Activity	Periods 2017-2018											
				Q1			Q2			Q3			Q4		
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Design	PCIN	End of Life Dashboard	Review End of Life Care				■	■	■						
Develop	PCIN	End of Life Dashboard	End of Life Care Dashboard Development												
Develop	PCIN	Social Prescribing	Develop Social Prescribing strategy				■	■	■						
Develop	PCIN	Primary Care LCS	Develop scheme to proactively manage patients with long term conditions within general practice	■	■	■	■	■	■						

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Schemes in design/development for 2017-2018

Phase	Current Delivery Group	Project	Activity	Periods 2017-2018											
				Q1			Q2			Q3			Q4		
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Design	Planned Care	Cardiology	Design improved clinical pathways and service changes for Cardiology	■	■	■									
Design	Planned Care	Pain	Design improved clinical pathways and service changes for Pain							■	■	■			
Design	Planned Care	Ophthalmology	Design improved clinical pathways and service changes for Ophthalmology				■	■	■						
Design	Planned Care	ENT	Design improved clinical pathways and service changes for ENT				■	■	■						
Design	Planned Care	MSK Orthopaedics	Design improved clinical pathways and service changes for MSK				■	■	■						

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Schemes in design/development for 2017-2018

Phase	Current Delivery Group	Project	Activity	Periods 2017-2018											
				Q1			Q2			Q3			Q4		
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Design	Planned Care	Cancer	Design local Cancer strategy		■	■	■								
Design	Planned Care	Cancer	Review Best Practice pathways (BPP) to reduce variation and inequalities across C&P (Focus on Urology, Upper GI and Lung – including impacts on tertiary centres(s))							■	■	■			
Design	Planned Care	Cancer	Develop and implement Inter Trust Transfer (ITT) Policy to reduce unnecessary delays in treatment / diagnostics							■	■	■			
Design	Planned Care	Cancer	Support Public Health England (PHE) to improve screening uptake for bowel, breast and cervical screening including: Finish assessment of local factors Support PHE in implementation of task and finish group recommendations Assess impact of bowel, breast and cervical screening pilots and implement accordingly										■	■	■
Develop	Planned Care	Cancer	MDC - agree next steps and develop business case (if revelant to C&P STP)												

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Schemes in design/development for 2017-2018

Phase	Current Delivery Group	Project	Activity	Periods											
				2017-2018											
				Q1			Q2			Q3			Q4		
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Design	Planned Care	Cancer	Expand access to the latest molecular diagnostics capability across England - Work with Specialised Commissioning to understand local impact and agree next steps for C&P												
Design	Planned Care	Cancer	Design cancer Risk Stratified follow up pathways (Breast, Prostate, Colorectal, Gynae and Haematology) and Recovery Package							■	■	■			
Design	Planned Care	Cancer	Design and agree funding for delivery of Transforming Community Cancer Care across C&P										■	■	■

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Schemes in design/development for 2017-2018

Phase	Current Delivery Group	Project	Activity	Periods											
				2017-2018											
				Q1			Q2			Q3			Q4		
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Design	CYPM	Asthma	Design Asthma education and support programme for paediatrics							■	■	■			
Design	CYPM	Perinatal Mental Health	Design and obtain funding for an integrated, system-wide Perinatal Mental Health service				■	■	■						
Design	CYPM	0-19 Universal Services	Re-design paediatric non-elective pathways										■	■	■
Design	CYPM	Continence	Design improved clinical pathways and service changes for Continence in paediatrics										■	■	■
Design	CYPM	Better Births	Design clinical pathways and service changes for in line with Better Births guidance for maternity										■	■	■

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Schemes in design/development for 2017-2018

Phase	Current Delivery Group	Project	Activity	Periods											
				2017-2018											
				Q1			Q2			Q3			Q4		
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17			Mar-18
Develop	Digital		Development of Business Intelligence technology- Datalytics												
Develop	Digital		Widening Digital Participation of residents												
Develop	Digital		Expansion of Environmental Control Systems												
Develop	Digital		Develop Health Analytics strategy												
Develop	Digital		111 Symptom checker integration between symptom checker and MyHealth App.												
Develop	Digital		Develop plan for Implementing Digital Innovation Roadmap												
Deploy	Digital		Implement data sharing across health economy												
Deploy	Digital		Deployment of Child Protection Information System (CPIS)												

Milestones dependant on national funding confirmation

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Schemes in design/development for 2017-2018

Phase	Current Delivery Group	Project	Activity	Periods 2017-2018											
				Q1			Q2			Q3			Q4		
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Develop	LWAB	System OD plan	Develop System OD plan				■	■	■	■	■	■			
Develop	LWAB	Long Term workforce strategy	Develop long term workforce strategy										■	■	■
Develop	LWAB	Workforce Plan	Develop system workforce plan to support implementation of service changes approved to date funded by the System Investment Fund.	■	■	■	■	■	■						
Develop	LWAB	Agency, sickness and turnover	Develop system plan to reduce agency, sickness and turnover										■	■	■

Phase	Current Delivery Group	Project	Activity	Periods 2017-2018											
				Q1			Q2			Q3			Q4		
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Develop	Shared Services	Procurement	Identify procurement opportunities to reduce costs to align with peers.				■	■	■						
Develop	Shared Services	Back Office	Develop back office strategy to reduce costs to align with peers.				■	■	■						
Develop	Shared Services	Clinical Support Services	Identify clinical support services opportunities to reduce overall cost to the system.							■	■	■			
Develop	Shared Services	Estates	Develop Estates management strategy				■	■	■						

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Practical Support NHSE can provide STPs

We would welcome the following practical support to progress the STP;

- Subject matter experts and resource to support key enabling work streams, specifically workforce and digital.
- Clarification of reporting requirements at STP level and an articulation of how this overlaps with organisational reporting requirements, for example, Urgent Care deliverables.
- Support in securing capital monies in the next phase following recent announcement on national allocations

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Aligning oversight processes

Our vision is to have a streamlined reporting process that provides clarity and assurance to national partners over delivery of national priorities.
We propose two options to achieve this;

Option 1:
Full system wide reporting:

One system wide reporting process for all national priorities, for example UEC, Cancer, GPFV, coordinated by the SDU.

Option 2:
Aligned STP and organisational reporting:

Agreement on what is organisational versus system reporting requirements, for example STP to report on UEC, CCG to report on GPFV.

The benefits of a streamlined reporting process include;

- Removes duplication
- Creates capacity to support delivery
- Provides a consistent message
- Provides a consistent point of contact for colleagues within the system and nationally
- Aligns national reporting requirements to STP programme delivery

We would welcome a discussion and are happy to work with you to develop either

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STP Engagement

MP engagement

- No significant MP concerns currently
- HCE met with County MPs in January 2017 to provide STP briefing and raise specific issues e.g. system funding. Follow-up meeting agreed, at that time, however planning affected by June election. Currently being planned.
- AO continues to meet with specific MPs regarding specific issues e.g. MIU, CEP

Local Authority engagement

- Strong and on-going engagement with both politicians and officers at Social Services LA's and District Councils with systems in place to pro-actively manage engagement
- Regular formal (public session) and informal STP briefings to OSC and HWB of both Social Services LA's including bespoke briefings on specific areas of political interest e.g. Workforce, Primary Care and engagement
- AO attends CPSB CEOs meeting which focusses on priorities of combined Authority
- HCE and Cambridgeshire Public Services Board (SSLA's/DC, Fire, Police) meetings quarterly with jointly agreed priorities
- STP Board being established and will include LA politicians to strengthen accountability

General

- STP-wide Communications & Engagement Plan in place across all partners incorporating pro-active engagement with politicians, LAs, etc.
- 'Comms cell', incorporating all partners, jointly agree and manage messaging
- Media management protocol in place to manage STP interest/enquiries. Statements/releases pro-actively prepared regarding key STP issues e.g. progress assessment.
- Ongoing and pro-active engagement with key stakeholders and partners including HWBs, OSCs, District councils, partner boards, FT council of members, patient groups, voluntary sector, Healthwatch.
- Policy of active patient involvement in delivery programmes as well as comms & engagement plans for all 'live' improvement projects.

Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 2. Health and Well-Being Board Funding Sources

Selected Health and Well Being Board:
Cambridgeshire

Data Submission Period:
2017-19

2. HWB Funding Sources

<< Link to the Guidance tab

Local Authority Contributions exc iBCF		
Disabled Facilities Grant (DFG)	2017/18 Gross Contribution	2018/19 Gross Contribution
Cambridgeshire	£3,809,721	£4,140,576
Lower Tier DFG Breakdown (for applicable two tier authorities)		
Cambridge	£634,216	£692,159
East Cambridgeshire	£518,287	£563,624
Fenland	£918,527	£992,173
Huntingdonshire	£1,118,716	£1,218,680
South Cambridgeshire	£619,976	£673,939
Total Minimum LA Contribution exc iBCF	**£3,809,721**	**£4,140,576**

Are any additional LA Contributions being made in 2017/18 or 2018/19? If yes please detail below	No	No

Local Authority Additional Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
Total Local Authority Contribution	**£3,809,721**	**£4,140,576**	

iBCF Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Cambridgeshire	£8,339,311	£10,658,272
Total iBCF Contribution	**£8,339,311**	**£10,658,272**

CCG Minimum Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
NHS Cambridgeshire and Peterborough CCG	£36,293,733	£36,983,314
Total Minimum CCG Contribution	**£36,293,733**	**£36,983,314**

Are any additional CCG Contributions being made in 2017/18 or 2018/19? If yes please detail below	No	No

Additional CCG Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	**£0**	

	2017/18	2018/19
Total BCF pooled budget	**£48,442,765**	**£51,782,161**

Funding Contributions Narrative
The funding contributions to the BCF meet the national minimum allocation requirements. No additional voluntary contributions have been made into the pooled budget over and above this.

Specific funding requirements for 2017-19	**Response**	**Response**	**If the selected response for either year is 'No', please detail in the comments box**
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority?	Yes	Yes	
2. In areas with two tiers of local government:			
i) Are there plans to pass down the full amount of Disabled Facilities Grant from the county to each of the district authorities?	No	No	Formal agreement with District Councils for the County Council to retain approximately 4% of DFG for it to spend directly on housing-related capital purposes. It is likely a similar approach will apply in 2018/19 although there is no formal agreement as yet
ii) If a portion of the DFG funding has been retained by the county, have the relevant district councils agreed to this approach? If applicable, please detail in the comments box how the retained portion of DFG will be spent to support integrated approaches to health, social care and housing.	Yes	Yes	
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes	Yes	
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes	Yes	
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	Yes	
6. Is the iBCF grant included in the pooled BCF fund?	Yes	Yes	

Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 3. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:
Cambridgeshire

Data Submission Period:
2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to Summary sheet

Running Balances	**2017/18**	**2018/19**
BCF Pooled Total balance	£311	£4,091,271
Local Authority Contribution balance exc iBCF	£0	£0
CCG Minimum Contribution balance	£0	£0
Additional CCG Contribution balance	£0	£0
iBCF	£311	£4,091,272
Running Totals	**2017/18**	**2018/19**
Planned Social Care spend from the CCG minimum	£15,129,048	£15,416,500
Ringfenced NHS Commissioned OOH spend	£21,164,685	£21,566,814

Expenditure

Scheme Descriptions Link >>

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
	CCC - Promoting independence	13. Primary prevention / Early Intervention	4. Other	Social Care-related support to maintain independence	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,525,000	£1,525,000	Existing
	CCC - Intermediate Care and Reablement	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£8,600,000	£8,600,000	Existing
	CCC - Carers Support	3. Carers services	4. Other	Various carers support	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,500,000	£1,500,000	Existing
	CCC - VCS Joint Commissioning	2. Care navigation / coordination	3. Other	Various support commissioned from the VCS by the local authority	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,950,000	£1,950,000	Existing
	CCC - Discharge Planning and DTOC	9. High Impact Change Model for Managing Transfer of Care	9. Other	Discharge Planning services	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£944,000	£944,000	Existing
	CCC - Social Care Uplift (protection of Adult Social Care)	16. Other		Support for core service budgets to maintain ASC services	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£272,048	£559,500	Existing
	CCC - Social Care commissioning and protection	16. Other		CCC Commissioning,social care transformation	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£338,000	£338,000	Existing
	CCG - Intermediate Care and Reablement	11. Intermediate care services	5. Other	Various intermediate care services	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,994,916	£2,032,819	Existing
	CCG - Carers' Support	3. Carers services	4. Other	CCG-commissioned support for carers	Other	Carer support	CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£350,000	£356,650	Existing
	CCG - Neighbourhood Teams	10. Integrated care planning	4. Other	Support for Neighbourhood Teams who coordinate	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£17,333,769	£17,663,833	Existing
	CCG Commissioning and Transformation	16. Other		Discharge to Assess project	Community Health		CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£485,000	£494,215	Existing
	Risk Share	16. Other		Risk Share	Other	Risk Share	CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£836,000	£852,112	Existing
	Wellbeing	13. Primary prevention / Early Intervention	4. Other	VCS Advice and Support	Primary Care		CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£50,000	£50,000	Existing
	CCG Commissioning and Transformation	16. Other		Care Home Educators	Other	CCG Commissioning	CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£115,000	£117,185	Existing
	Social Care Capacity and Investment	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Local Authority	Improved Better Care Fund	2017/18 Only	£2,889,000		New
	Investment into housing options for vulnerable people	16. Other		Housing	Other	Health and Social Care	Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£3,000,000	£517,000	New
	Prevention Initiatives: Falls Prevention & Atrial Fibrillation	13. Primary prevention / Early Intervention	3. Other - Physical health/wellbeing		Community Health		Local Authority			NHS Community Provider	Improved Better Care Fund	Both 2017/18 and 2018/19	£150,000	£150,000	New
	DTOC Plan	16. Other		DTOC Plan	Other	Health and Social Care	Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£2,300,000	£1,900,000	New
	Adult Social Care Cost Pressures	16. Other		Social Care Cost Pressures	Social Care		Local Authority			Local Authority	Improved Better Care Fund	2018/19 Only		£4,000,000	New
	Disabled Facilities Grant	4. DFG - Adaptations			Other	DFG	Local Authority			Local Authority	Local Authority Contribution	Both 2017/18 and 2018/19	£3,809,721	£4,140,576	Existing

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Scheme Type	Description	Sub type
1. Assistive Technologies	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Digital participation services).	1. Telecare 2. Wellness services 3. Digital participation services 4. Other
2. Care navigation / coordination	A service to help people find their way to appropriate services and support and thus also support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. This is often as part of a multi-agency team which can be on line or use face to face care navigators for frail elderly, or dementia navigators etc. . This includes approaches like Single Point of Access (SPoA) and linking people to community assets.	1. Care coordination 2. Single Point of Access 3. Other
3. Carers services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. This also includes the implementation of the Care Act as a sub-type.	1. Carer advice and support 2. Implementation of Care Act 3. Respite services 4. Other
4. DFG - Adaptations	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.	
5. DFG - Other Housing	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.	
6. Domiciliary care at home	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.	1. Dom care packages 2. Dom care workforce development 3. Other
7. Enablers for integration	Schemes that build and develop the enabling foundations of health and social care integration encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commisisioning infrastructure includes any personnel or teams that enable joint commissioning.	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Other
8. Healthcare services to Care Homes	Improve the availability and quality of primary and community health services delivered to care home residents. Support the Care Home workers to improve the delivery of non-essential healthcare skills. This includes provider led interventions in care homes and commissioning activities eg. joint commissioning/quality assurance for residential and nursing homes.	1. Other - Mental health / wellbeing 2. Other - Physical health / wellbeing 3. Other
9. High Impact Change Model for Managing Transfer of Care	The 8 changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system.	1. Early Discharge Planning 2. Systems to Monitor Patient Flow 3. Multi-Disciplinary/Multi-Agency Discharge Teams 4. Home First/Discharge to Access 5. Seven-Day Services 6. Trusted Assessors 7. Focus on Choice 8. Enhancing Health in Care Homes 9. Other
10. Integrated care planning	A co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. For Multi-Disciplinary Discharge Teams and the HICM for managing discharges, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.	1. Care planning 2. Integrated care packages 3. Review teams (reviewing placements/packages) 4. Other
11. Intermediate care services	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and delivered by a combination of professional groups. Services could include Step up/down, Reablement (restorative of self-care), Rapid response or crisis response including that for falls.	1. Step down 2. Step up 3. Rapid/Crisis Response 4. Reablement/Rehabilitation services 5. Other
12. Personalised healthcare at home	Schemes specifically designed to ensure that a person can continue to live at home through the provision of health related support at home. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term and end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in the Personalised Healthcare at Home scheme type.	1. Other - Mental health /wellbeing 2. Other - Physical health/wellbeing 3. Other
13. Primary prevention / Early Intervention	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.	1. Social Prescribing 2. Other - Mental health /wellbeing 3. Other - Physical health/wellbeing 4. Other
14. Residential placements	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.	1. Supported living 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Other
15. Wellbeing centres	Wellbeing centres provide a space to offer a range of support and activities that promote holistic wellbeing or to help people to access them elsewhere in the community or local area. They can typically be commissioned jointly and provided by the third sector.	
16. Other	Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.	

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Sheet: 4. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board:
Cambridgeshire

Data Submission Period:
2017-19

4. HWB Metrics

<< Link to the Guidance tab

4.1 HWB NEA Activity Plan

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	**Total 17/18**	**Total 18/19**
HWB Non-Elective Admission Plan* Totals	**13,858**	**14,185**	**15,142**	**14,517**	**13,860**	**14,184**	**15,135**	**14,521**	**57,702**	**57,700**

Are you planning on any additional quarterly reductions?	No

Please only record reductions where these are over and above existing or future CCG plans. HWBs are not required to attempt to align to changing CCG plans by recording reductions.

If yes, please complete HWB Quarterly Additional Reduction Figures

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 17/18	Total 18/19
HWB Quarterly Additional Reduction										
HWB NEA Plan (after reduction)										
HWB Quarterly Plan Reduction %										

Are you putting in place a local contingency fund agreement on NEA?	Yes

	2017/18	2018/19
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/contingency fund **	£10,313,650	£10,509,609

Cost of NEA as used during 16/17***	£1,565	Please add the reason, for any adjustments to the cost of NEA for 17/18 or 18/19 in the cells below
Cost of NEA for 17/18 ***	£1,565	
Cost of NEA for 18/19 ***	£1,565	

		Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	**Total 17/18**
Additional NEA reduction delivered through BCF (2017/18)	£0					£0
		Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	**Total 18/19**
Additional NEA reduction delivered through BCF (2018/19)	£0					£0
HWB Plan Reduction % (2017/18)	0.00%					
HWB Plan Reduction % (2018/19)	0.00%					

The CCG Total Non-Elective Admission Plans are taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level, extracted on 10/07/2017
* This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)
** Within the sum subject to the condition on NHS out of hospital commissioned services/contingency fund, for any local area putting in place a contingency fund for 2017/18 or 2018/19 as part of its BCF
*** Please use the following document and amend the cost if necessary: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577083/Reference_Costs_2015-16.pdf

4.2 Residential Admissions

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	561.0	486.6	475.2	464.8	Plans aim to maintain the absolute number of admissions at a constant level, representing a small fall in the overall rate despite continued demographic pressure
	Numerator	652	581	581	581	
	Denominator	116,225	119,392	122,260	124,994	

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2014 based Sub-National Population Projections for Local Authorities in England;
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a Residential Admissions rate for these two Health and Well-Being Boards.

4.3 Reablement

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	71.8%	82.1%	82.0%	82.0%	82.8% target for 2017/18 and possibly 83% for 2018/19
	Numerator	392	82	82	82	
	Denominator	546	100	100	100	

4.4 Delayed Transfers of Care

		16-17 Actuals				17-18 plans				18-19 plans				
		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Comments
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	1718.5	1707.6	1893.7	1549.0	1393.7	1993.7	878.4	732.3	740.4	748.6	748.6	726.5	Targets align with the previously submitted DTOC return to NHSE and align with system plans to hit the national 3.5% target by November 2017.
	Numerator (total)	8,921	8,864	9,830	8,117	7,303	10,447	4,603	3,870	3,913	3,956	3,956	3,870	
	Denominator	519,103	519,103	519,103	524,010	524,010	524,010	524,010	528,478	528,478	528,478	528,478	532,722	

Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+) population projections are based on a calendar year using the 2014 based Sub-National Population Projections for Local Authorities in England;
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a DTOC rate for these two Health and Well-Being Boards.

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Sheet: 5. National Conditions

Selected Health and Well Being Board:

Cambridgeshire

Data Submission Period:

2017-19

5. National Conditions

<< Link to the Guidance tab

National Conditions For The Better Care Fund 2017-19	Does your BCF plan for 2017/18 set out a clear plan to meet this condition?	Does your BCF plan for 2018/19 set out a clear plan to meet this condition?	If the selected response for either year is 'No', please detail in the comments box issues and/or actions that are being taken to meet the condition.
1) Plans to be jointly agreed	Yes	Yes	
2) NHS contribution to adult social care is maintained in line with inflation	Yes	Yes	
3) Agreement to invest in NHS commissioned out of hospital services	Yes	Yes	
4) Managing transfers of care	Yes	Yes	