Appendix A

Cambridgeshire Better Care Fund

DRAFT 2016/17 Narrative Plan

Version 0.7

Version control			
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0.7	Geoff Hinkins	14 April 2016	Updates and amendments – version for Health and Wellbeing Board

1. Introduction and approach

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

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

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

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

2. Vision, Priorities and Delivery Plan

Purpose of this section:

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

Our vision

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

> *Over the next five years in Cambridgeshire we want to move to a system in which health and social care help people to help themselves, and the majority of people's needs are met through family and community support where appropriate. This support will focus on returning people to independence as far as possible with more intensive and longer term support available to those that need it.*
>
> *This shift is ambitious. It means moving money away from acute health services, typically provided in hospital, and from ongoing social care support. This cannot be achieved immediately – such services are usually funded on a demand-led basis and provided as they are needed in order to avoid people being left untreated or unsupported when they have had a crisis. Therefore reducing spending is only possible if fewer people have crises: something which experience suggests has never happened before. However, this is required if services are to be sustainable in the medium and long term.*

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

Our priorities and delivery plan

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

We hope that in 12 months' time, implementation of many of these changes will be underway. This paper will form the basis for the Cambridgeshire and Peterborough Better Care Fund Plans for 2016/17 onwards; and builds on the work that has taken place so farand the '10 aspects of an integrated system' that have previously been agreed at the Cambridgeshire Executive Partnership Board (CEPB). The narrative set out here will underpin the ethos of the 2016 Urgent and Emergency Care Vanguard work. and the whole system Sustainability and Transformation Programme

Broadly speaking, these changes can be divided into support for people who do not have, or have not yet developed, significant ongoing health needs; and support for those people that have significant ongoing needs and receive support from a range of organisations. To achieve our ultimate aim of a shift away from long term social care or care that is provided in the acute setting to preventative services that are focused on keeping people well, we need to focus on our response across both cohorts.

Before people have significant ongoing needs

Healthy ageing and prevention

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

Eyes and ears – indicators of vulnerability

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

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

Clear and joint sources of information

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

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

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

health, social care and the VCS operating as one virtual front door. Ensuring that once a referrer or patient or carer has entered the system they are effectively directed to the right service quickly and are not aware of potentially moving between providers as part of that navigation process. This will be available for planned and unplanned care therefore ensuring all needs are met effectively.

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

Holistic identification of need with a coordinated response

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

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

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

Support for people with significant ongoing needs

Clear, coordinated pathways and hand overs

Services for people with significant ongoing needs will be well coordinated. Our health and social care teams will work in a different way with more of a focus on outcomes than process. We will work together in order to ensure a the whole pathway of care is delivered as an integrated set of providers, and therefore hand overs will be seamless. For example a call may come into JET, yet the

best response would be a social care response/ social care may already be involved. A hand over would take place, with the patient getting the timely response most appropriate to meet their needs and prevent escalation. Our staff will be co-located wherever possible, and if not will work as a virtual team to ensure there is a seamless joined up and coordinated response.

Neighbourhood teams and Multi Disciplinary Team (MDT) working

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

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

Case finding and case management

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

Working with Care Homes

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

Working with housing providers

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

Enablers – support for delivery

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

Joint outcomes

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

Information and data sharing

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

A common language

By January 2017, we will have established a common language, using the methods described previously, that will give us theassurance 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 shareworking 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 SPA this will be essential.

Joint commissioning of the voluntary and community sector

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

Specific priorities

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

Prevention

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

Joint planning and commissioning

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

Neighbourhood Team working/Local team around the person

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

Integrated pathways

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

3. Strategic context

Purpose of this section:

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

Reviewing the BCF in 2015/16

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

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

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

BCF Performance against metrics

Performance against the target metrics in the BCF has been mixed. The key indicator was for a reduction in non-elective admissions, for which the Health and Wellbeing Board agreed to set a target of a 1.0% reduction. However, non-elective admissions have continued to rise across the county, with performance at the end of quarter 3 showing an increase in non-elective admissions of 5%. Other indicators are either cumulative or only measured once a year; these factors have combined to make it difficult to demonstrate a link between BCF activity and performance at this stage of the financial year. This is an issue that we will address through the 2016/17 plan.

Transformation supported by BCF

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

Since then, the CCG has been reviewing all UnitingCare services and workstreams in order to maintain the benefits and improvements the model has been able to deliver to date. However, some significant parts of the model had already been delivered, including:

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

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

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

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

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

New initiatives

Urgent and Emergency Care Vanguard

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

Sustainability and Transformation Plan

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

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

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

The case for change

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

- Population Growth: Cambridgeshire has a growing and changing population. There will be large increases in the number of older people, children and people from different backgrounds living in the county in the next 10 years and beyond. This creates particular challenges for planning and managing health and social care services.
- Financial: Cambridgeshire and Peterborough collectively is one of 11 'challenged health economies'; this means that if we change nothing, then in five years' time local health

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

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

The population of Cambridgeshire has continued to grow and the estimated population in 2014 was 639,800 with 17.7% of the population (113,500 people) aged 65 and over, which is the same as the England average.[1]The population is more ethnically diverse in Cambridge, with just 66% white: British compared with 87-90% elsewhere.[2]

The population of Cambridgeshire is forecast to grow by 23% between 2016 and 2036, an additional 147,700 people; the areas forecast to see the biggest growth are South Cambridgeshire (34%) and East Cambridgeshire (29%).[3]This makes Cambridgeshire the fastest growing shire county in the UK. Cambridgeshire's population is also ageing: the population aged 65+ in Cambridgeshire is expected to increase by 64% between 2016 and 2036, an additional 76,300 people; the area forecast to see the biggest increase in people aged 65+ is Huntingdonshire (67%).[3]

Levels of deprivation are low for the county as a whole but this varies by district; the most deprived district in the county is Fenland, the 80th most deprived local authority district out of 326 in England. The least deprived district is South Cambridgeshire (ranked 316).[4]Compared to 2010, Fenland and East Cambridgeshire now rank as more deprived in national terms than previously; Cambridge City ranks as less deprived. Cambridgeshire now has 16 LSOAs in the 20% most deprived nationally – this is compared to 9 in 2010.

Average life expectancies for men and women in Cambridgeshire are higher than the national averages at 81.2 years and 84.5 years respectively.[5] Average life expectancy varies by district: for both men and women, the lowest life expectancies are found in Fenland (79.4 and 82.6 years respectively) and the highest in South Cambridgeshire (82.7 and 85.6 years respectively).[5]Age-standardised all-age all-cause mortality rates are lower in Cambridgeshire compared with the England average.[6]By district, age-standardised all-age all-cause mortality rates were highest in Fenland for men and women; premature mortality (deaths before the age of 75) follow the same pattern.[6]

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

>> Further reading:

BCF Plan 2015/16, page 27

4. Delivering the Better Care Fund

Purpose of this section:

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

Setting a Better Care Fund budget

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

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

Please note that these budget figures are provisional pending further discussions in Cambridgeshire; final totals will be confirmed for the final plan on April 25 2016.

BCF Funding 2016/17

	CCG (k)	County Council (k)	Other (k)	TOTAL (k)
Revenue	£35,655	£956	£700*	**£37,311**
Capital	£0	£4,773	£0	**£4,773**
TOTAL	**£35,655**	**£5,729**	**£700**	**£42,085**

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

BCF Budget categories, 2016/17

Scheme	Amount (k)	Type	Lead	Notes
Integrated Adults Community Health Services (IACHS)	£17,012	Revenue	CCG	

CCG Re-ablement funding	£2,000	Revenue	CCG	
Risk share	£836	Revenue	CCG	
CCG Carers Funding	£350	Revenue	CCG	
Protecting social care	£2,500	Revenue	LA	
Former s256	£10,652	Revenue	LA	
Care Act Implementation	£1,367	Revenue	LA	
Additional Council contribution (revenue)	£956	Revenue	LA	
Transformation team	£300	Revenue	Joint	
Transformation projects	£1,338	Revenue	Joint	Includes 15/16 underspend of £700k
Disabled Facilities Grant	£3,479	Capital	LA	
CCC Capital	£1,294	Capital	LA	Funding removal of ASC Capital Grant
Total	**£42,085**	Combined		
Figures have been rounded –see Planning Template for precise figures				

Budget categories

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

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

For "contribution" funds, a lead commissioner is identified for each spending line. That lead commissioner is authorised to arrange services or service contracts up to the approved expenditure from the Better Care Fund. To avoid unnecessary financial transactions, 'Contribution' funding for which the Lead Commissioner will be the CCG will not be physically transferred into the pooled fund. Contribution funds will be the sole responsibility of the lead commissioner identified within the Section 75; but the lead commissioner will report progress on spending and performance metrics to the Cambridgeshire Executive Partnership Board as part of the overall reporting on the BCF.

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

Risk share funding will be held by the CCG, subject to meeting targets for non-elective admissions. The CCG will only release the full value of the risk share fund into the Pooled Fund if the non-elective admissions reduction target is met. If the target is not met, the CCG shall only release into the Pooled Fund a part of that funding proportionate to the partial achievement of the target. The

Partnership Board shall determine how any risk share funding which is released into the Pooled Fund is spent.

Budget management

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

Key spending areas

Contribution funds:

Contribution budgets will support the following core services:

Intermediate Care and Reablement
Reablement services
Rehabilitation and therapy
Occupational Therapy
Interim Beds
Community beds
JET
Respite, central contract and block beds
Promoting independence
Integrated Community Equipment Service
Handyperson scheme
Home Improvement Agency
Assistive Technology (revenue, CCC share)
Sensory Services
Disabled Facilities Grant
Neighbourhood Teams
Community Nursing
Carers support
CCC Carers Support
CCG Carers Support
Voluntary sector joint commissioning
County Council Older People VCS contracts
Sensory Services VCS contracts
Physical Disability VCS Contracts
Community Navigators
Day Opportunities for Older People
CCG VCS contracts
Discharge planning and DTOCs

Discharge to Assess (CUH)
Discharge planning teams

Full details are contained within the BCF Planning Template (appendix 1)

Project budgets

The following budgets have been agreed to support the areas of transformation that we want to develop through the BCF:

- **Transformation Team:**£300k to support a transformation team made up of staff providing project management capacity to the different project areas established under the BCF.
- **Transformation fund:** £1,338k to support delivery of transformation through the BCF.

The following projects are expected to receive financial support from the Transformation fund:

- **Intermediate Care Teams (non-bed based provision)**

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

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

Options include the recruitment of integrated care workers; intermediate care technicians and therapists; and delegated health tasks.

- **Care home educators**

The educator scheme, already operational in Peterborough, provides clinical review, support, and training to care home staff. The educator provides a link between care homes and other health services to embed alternative pathways to prevent avoidable admissions, and, between the acute trust and care homes, to improve discharge pathways. The role supports medication reviews, improved care quality to reduce incidences of pressure sores, deep vein thrombosis (DVT), urinary tract infection (UTI), and falls. The care home educators will support a system-wide approach to reduce the number of hospital admissions relating to UTI or blocked catheters. An analysis of UTI (ICD10: N39) recorded over 2,600 emergency admissions and over 32,500 bed days at a total cost of £8.6m. Whilst not all these admissions are from care homes, it is realised that care homes are having a significant impact on UTI and catheter care for patients at risk of UTIs.

- **Developing social prescribing**

The BCF could further support the development of a model of social prescribing, building on the work undertaken in Luton and Rotherham. The evidence base for social prescribing is robust with increasing rates of return on investment for health, social care, patients, and the third sector.

- **Falls Pilot**

Pilot of a new falls prevention pathway, with learning rolled out wider across Cambridgeshire

- **Older People Accommodation Review Programme**

Our Older People Accommodation Programme brings together partners from across the system to co-ordinate health, housing and social care agencies so our work supports older people's access to accommodation that they want to live in, that enables them to remain independent within their community wherever possible. By co-ordinating activity, we hope to help older people to have a choice about where they live, even if their health and social care needs are high or escalating. The Programme will be supported in order to make use of specialist technical expertise during 2016/17 to inform planning for future accommodation needs

- **Data Sharing**

Financial support to develop new methods of data sharing in order to improve patient experience; improve professionals' decision making; improve strategic planning; and meet BCF requirements

- **Workforce and Organisational Development in Integrated Teams**

Support for training and development of an integrated workforce and an organisational development programme

- **Frequent attenders at acute settings**

Developing approaches to identify and coordinate support for people who frequently attend acute settings, in order to improve their lives and reduce overall costs to the system

Governance

At the time of writing, the governance arrangements remain the same as in our existing Better Care Fund Plan. The Cambridgeshire Health and Wellbeing Board has overall responsibility for the Better Care Fund plan, whilst the regular monitoring of the Plan and budget is delegated to the Cambridgeshire Executive Partnership Board (CEPB), which brings together all key partners across the county to provide a joint strategic approach to service transformation and delivery of the Better Care Fund. This executive-level partnership board reports to the Health and Wellbeing Board. The purpose of CEPB is to provide whole system leadership and coordinated multi-agency oversight of health and social care service transformation for older people and vulnerable adults in Cambridgeshire.

Given the termination of the OPACS contract; and the creation of the new UEC Vanguard and STP programmes, a review of governance and delivery arrangements is due to be undertaken by the Cambridgeshire Executive Partnership Board in the current months. The goal will be to rationalise the governance and delivery arrangements surrounding each of these initiatives, whilst also ensuring alignment across Cambridgeshire and Peterborough where possible.

In the interim a BCF Delivery Board will be established to ensure there is the appropriate level of drive and focus on programme delivery in 2016/17. Engagement with relevant key health, care and voluntary sector partners, clear objectives for the year based on the above vision/ delivery plan and realistic project plans will be key to the successful implementation.

>> Further reading:

BCF Plan 2015/16, page 47

Programme Management

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

5. National Conditions

Purpose of this section:

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

Plans to be jointly agreed

The Cambridgeshire BCF plan has been jointly agreed by local partners in the health and social care system. The transformation priorities have been discussed widely across the system, and build on the Joint Older People Strategy agreed by our system in 2014. The draft plan has been circulated to members of the Cambridgeshire Executive Partnership Board (CEPB) for comment as well as all Health and Wellbeing Board Members. The draft plan will be informed by discussion at the Health and Wellbeing Board; and at the CEPB. The final plan will be discussed in detail at the Health and Wellbeing Board and signed off by the Health and Wellbeing Board, County Council and CCG Governing Body.

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

>> Further reading:

BCF Plan 2015/16, page 80

Maintaining provision of social care services

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

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

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

>> Further reading:

BCF Plan 2015/16, page 66

Care Act requirements

£1,367,000 has been allocated to support our local response to the Care Act, including meeting the new duties placed on local authorities. As a result of part 2 of the Care Act being delayed to 2017, the programme set up to deliver the requirements of the Care Act was merged with the Transforming Lives project in July 2016. Governance arrangements were reviewed and projects

were re-scoped to deliver by April 2016. The Transforming Lives/Care Act programme portfolio of projects is as follows:

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

The programme will be reviewed again in April 2016.

Support for Carers

Our 2015/16 BCF contained £350k as the minimum amount of carer specific support included within the BCF, which is used within CCG budgets for their support for carers. The total £350k was transferred to the UnitingCare contract for the purposes of commissioning carers' support from the Carers Trust. This responsibility has now returned to the CCG who are using it to support the Carers' Prescription (£278k); along with other carer liaison and support and other posts within the voluntary sector. More detail is contained within our 2015/16 plan.

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

>> Further reading:

BCF Plan 2015/16, page 80

7 day services

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

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

Better Data Sharing, based on the NHS Number

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

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

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

Original plans for 2015/16 focused around the development of the UnitingCare system 'OneView', which would offer a single view of the patient record. In light of the contract changes a decision was taken to not proceed with OneView, so further scoping is underway to determine alternative options. A focus on immediate practical data sharing options are being progressed to facilitate better data flow and integrated working practices (e.g. Local data sharing agreements, cross-organisational access to existing systems). In addition, Cambridgeshire County Council has recently procured a new adult social care system, which will incorporate open APIs. This system is expected to be operational in Autumn 2016. This work is aligned with the CCG's local digital roadmap and digital maturity work.

Joint approach to assessments and care planning

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

>> Further reading:

BCF Plan 2015/16, page 77

Impact on providers

Our 2015/16 plan described engagement that had been carried out with providers in development of our plan. Since then, providers and commissioners have continued to collaborate on the projects

and development work established under the Better Care Fund; notably through representation of both commissioners and providers at the Cambridgeshire Executive Partnership Board.

Between our first submission on 21 March and our final submission on 25 April, conversations will continue with providers through meetings of the Cambridgeshire Executive Partnership Board; Cambridgeshire Health and Wellbeing Board; and attendance at local System Resilience Groups.

>> Further reading:

BCF Plan 2015/16, page 82

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

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

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

Integrated Adult Community Health Services (IACHS)

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

Local plan to reduce Delayed Transfers of Care

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

or in discharge from NHS care) will vary according to the needs of each patient but can be complex and sometimes lead to delays.

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

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

Our overall strategic approach to DTOCs is being coordinated through the Urgent and Emergency Care Vanguard, under its 'post-hospital discharge' workstream. In addition, each System Resilience Group (SRG) has its own plan to reduce Delayed Transfers of Care. Our overall aim is to reduce Delayed Transfers of Care by 2.5% during 2016/17.

UEC admissions for >65 year olds account for 47% of all UEC admissions and 62% of spend in acutes. Elderly patients are more likely to stay longer as inpatients even after their acute medical problems have been resolved. Prolonged hospitalisation not only increases costs, it is also associated with other complications like infections, immobility, pressure sores, DVT, and deconditioning, thus worsening the patient's quality of life. The elderly are most susceptible to developing complications associated with hospital stay including medical problems not related to their primary diagnosis.

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

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

Discharge Planning Protocol

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

Intermediate Care Teams (non-bed based provision)

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

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

Discharge Home to Assess pathway

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

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

Early evidence suggests that 15 patients have already been discharged from Addenbrooke's hospital over a seven week period with an average length of stay in the pathway of nine days. Of the 15 patients, two were self-funders (13%) and 13 were Fast Tracks (87%). A previous audit of CHC Fast Track patients in hospital before the pilot started showed average length of stay from fast track referral to discharge to be 5.4 days. Of the 13 patients in the pilot, 30% were discharged within 24 hours, 54% were discharged within 48 hours, and 92% within 72 hours, with 100% of patients discharged within four days. In addition, there are invaluable benefits to patients by going through this pathway as 46% of them passed away at home in line with their wishes. The feedback from carers has also been extremely positive.

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

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

Community Based Intermediate Care Beds

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

The latter will also support greater patient flow within community beds increasing throughput and reducing LoS. We are aiming to reduce LoS in community beds to an average of 14 days.

Overall Impact in 2016/17

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

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

Approach to DTOC fines

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

>> Further reading:

UEC Vanguard Value Proposition 2, page 22

Annex 1: Milestone plan

Healthy ageing and prevention

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

	model	2016	
Social Isolation:	Early trigger action plan developed and approved	01 April 2016	01 June 2016
	Develop joint pathway across the system to improve service join up and coordination	01 June 2016	01 October 2016
	Develop strategic evaluation tool to aid local commissioning of high quality social isolation services	1st October 2016	01 March 2016
	Implementation plan and operational readiness	01 February 2017	01 April 2017
	Evaluation tool being practically used to support local commissioning	01 April 2016	-
The Wellbeing Service:	Finalise revised delivery model	01 March 2016	01 July 2016
	Action plan developed and approved	01 May 2016	01 June 2016
	Pilot new 'Wellbeing Service', including social prescribing element (in collaboration with Vanguard)	01 July 2016	01 January 2017
	Review and evaluation	01 January 2017	01 March 2017
Overall:	Evaluate and plan 2017/18	01 January 2017	01 March 2017

7 day services

Integration of BCF into SRG Urgent Care Plans	Review and agree feasibility of existing SRG urgent care plans and whether they will produce better outcomes for patients	01 March 2016	01 May 2016
Mapping of current 7 Day Service provision	Review and mapping of existing whole system 7 day service provision	01 March 2016	01 May 2016
	Review and mapping of 7 day provision of national clinical standards within acute	01 April 2016	01 May 2016
	Project plans for 2016/17 updated and approved by each SRG	01 April 2016	01 June 2016

Overall:	Evaluate and plan 2017/18	01 January 2017	01 March 2017

Data sharing

Overall:	Project plan for 2016/17 updated and approved	01 April 2016	01 May 2016
Joint approach to consent and fair processing:	Joint approach to consent and fair processing agreed	01 April 2016	01 October 2016
Protocol for working with patient held records	Protocol developed as part of pilot project	01 May 2016	30 September 2016
	Protocol shared with all health and social care delivery staff	30 September 2016	31 March 2016
Summary care record content signed off and extracts / views created for all systems.	Social care summary content extracts developed	01 May 2016	30 August 2016
	Summary views made available to support dual record access by front line and front door workers	01 September 2016	30 December 2017
Development of longer term plan to demonstrate progress towards common APIs:	Development of 5 year data sharing plan and approval	01 April 2016	01 November 2016
Interim solutions for improved data sharing across existing systems	Implementation of interim solutions (e.g. cross-organisational log ins/access to existing systems)	01 April 2016	01 August 2016
Implementation of SHREWD activity planning tool	Confirm operational and IT leads from organisations and establish project team	01 March 2016	01 April 2016
	Develop Common set of high level triggers	01 April 2016	01 July 2016
	Implementation commenced	01 July 2016	
Overall:	Evaluate and plan 2017/18	01 January 2017	01 March 2017

Information and communications

	Project plan for 2016/17 updated and approved	01 April 2016	01 May 2016

Information hub:	Mapping of existing directories and services completed		01 June 2016
	Options appraisal and approval of technology solution		01 August 2016
	Development of information sharing protocols and agreement of sharing data sets and consent models	01 August 2016	01 December 2016
	Development of technology solution		
	Plan implementation and operational readiness	01 December 2016	01 April 2017
	Implementation commenced	01 April 2017	-
Front door:	Sharing of FAQS and referral pathways between PCC and BCF front doors	01 June 2016	01 September 2016
	Detailed design	01 September 2016	01 January 2017
	Plan implementation and operational readiness	01 January 2017	01 April 2017
	Implementation Commenced	01 April 2017	-
Change management:	Communications plan developed	01 March 2017	01 April 2017
Overall:	Evaluate and plan 2017/18	01 January 2017	01 March 2017

Integrated Adult Community Services

Overall:	Project lead and team established	01 March 2016	01 May 2016
	Project Plan for 2016/17 updated and approved	01 April 2016	01 June 2016
Population risk stratification and case management:	Develop case management approach	01 April 2016	01 June 2016
	Roll out and communication plan developed	01 June 2016	01 September 2017
	Phased roll out commenced	01 September 2017	-
Integrated Neighbourhood Teams:	Approach to alignment of Integrated	01 April 2016	01 July 2016

	Neighbourhood Teams with Adult Social Care		
	Roll out and communication plan developed	01 July 2016	01 October 2016
	Phased roll out commenced	01 October 2016	-
Joint early assessment framework:	Develop joint assessment approach – including joint framework and joint response, including lead professional	01 July 2016	01 January 2017
	Engagement and roll out plan	01 January 2017	-
Joint frailty assessment tool(e.g. Rockwood)	Finalise decision on frailty tool to use	01 March 2016	01 May 2016
	Engagement and roll out plan	01 May 2016	01 July 2016
	Phased roll out commenced, starting with Neighbourhood Teams	01 July 2016	-
Overall:	Evaluate and plan 2017/18	01 January 2017	01 March 2017

Delayed Transfers of Care

Locally agreed DTOC plan:	Develop local DTOC action plan for 2016/17 and approval by each SRG	01 March 2016	01 June 2016
	Review and agree feasibility of existing SRG urgent care plans and whether they will produce better outcomes for patients	01 March 2016	01 May 2016
	Evaluate and plan 2017/18	01 January 2017	01 March 2017

Annex 2: Risk Log

There is a risk that:	Likelihood[1]	Potential impact[2]	Overall risk factor	Mitigating Actions
1. If there is no strategic vision, oversight or direction of travel, or if there is too much focus on small scale initiatives, opportunities to undertake critical and joined up transformation of services will not be maximised.	4	4	16	• Agreed vision and principles which are incorporated within service core planning documents. • Implementation of the 5 year strategic plan and other relevant strategic commissioning plans. • Re-visit governance to maximise opportunities for join up across Cambridgeshire and Peterborough and key areas of transformation (e.g. Cambridgeshire and Peterborough CCG Sustainability and Transformation Programme) to ensure proposals are mapped back to the agreed vision before approval, and to maintain oversight and monitor progress at all stages. • Client groups are identified and reflected in the future vision.
2. 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	• 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.

3. 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	• 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.
4. 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	• 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.
5. 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	4	12	• 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.
6. 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.	3	3	9	• Comprehensive engagement plan in place, developed with partners, which clearly segments the key stakeholder groups and the specific activities required to effectively reach them.

Transformation may, therefore, be ineffective.				• 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.
7. If there are multiple and/or uncoordinated changes to service delivery this could destabilise provision and performance.	4	4	16	• 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.
8. 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	• 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.
9. If there is insufficient project control, transparency and accountability, delivery of the BCF Plan and strategic vision may be compromised.	3	3	9	• 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.
10. If there is a delay in developing the BCF Plan, it may not be finalised and approved by the due date for submission.	1	5	5	• Build on the agreed vision and development of work within 2015/16 • Detailed plan to oversee development, taking into account all necessary requirements for adequate discussion, challenge and sign-off. • Early identification and engagement with officers and teams who will need to contribute and develop the plan.
11. If changes are made to national policy in respect of urgent and emergency care this could negatively impact the BCF Plan content and timetable.	2	3	6	• Effective links in place with local and national NHS policy makers.
12. If increased demand for carers' provision, as a direct result of the Care Act, exceeds that which has been profiled then there will be additional costs and demand on resources.	3	3	9	• 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.
13. If the legacy systems are unable to record or match the NHS number, or staff fail to adopt new processes to record and use it, then data may be ineffective and unusable.	2	3	6	• Facility in place across all service areas/organisations to ensure NHS number can be populated either manually via process or automated. • New processes are embedded across all services areas/organisations. • Memorandum of understanding re sharing data is agreed.
14. If there is no clear agreement on data sharing and governance between partner organisations, this could compromise or delay progress in monitoring or delivering the BCF Plan.	3	5	15	• Data sharing agreements and protocols documented and signed off between all partners for the collection, storage and processing of data. • Agree strong joined up governance arrangements

				relating to data.
15. Changes to the OPACS contract may delay projects or add complexity, as new arrangements are made to carry out the work previously undertaken by UnitingCare, the delivery provider	4	4	16	• Detailed and early discussions with CCG around key personnel who will lead on each of the areas of work. • Dedicated resource to oversee transfer of contractual responsibilities of UnitingCare to new lead personnel. • Strengthened focus on governance to oversee the change process and ensure the pace of change, project plan and delivery is maintained.

[1]Likelihood - How likely is the risk to materialise? Rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely.

[2]Potential Impact- Rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact. If there is some financial impact specify in £000s, also specify who the impact of the risk falls on.