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