Agenda Item No: 9

BETTER CARE FUND UPDATE

To: Health and Wellbeing Board

Date: 2 July 2015

From: Adrian Loades, Executive Director: Children Families and Adults, Cambridgeshire County Council
Andy Vowles, Chief Strategy Officer, Cambridgeshire and Peterborough Clinical Commissioning Group

1.0 PURPOSE

To provide an update on Cambridgeshire's Better Care Fund (BCF) plan, monitoring of the BCF and on the associated projects.

2.0 BACKGROUND

2.1 As previously reported, Cambridgeshire's Better Care Fund (BCF) has created a single pooled budget to support health and social care services (for all adults with social care needs) to work more closely together in the county. The BCF was announced in June 2013 and established in April 2015. The £37.7 million budget is not new money; it is a reorganisation of funding currently used predominantly by Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) and the County Council to provide health and social care services in the county. In order to receive approval for the BCF, Cambridgeshire had to show how it would meet a number of statutory conditions, including the protection of social care services; a reduction in non-elective admissions to hospital; greater seven day working across health and social care services to support discharge; and support for information sharing between social care and health to improve coordination of people's care.

3.0 BCF PLAN MONITORING

3.1 At its previous meeting, the Board received a verbal update on the national monitoring of Cambridgeshire's BCF Plan. The Health and Wellbeing Board agreed to delegate responsibility for completing the return to the Cambridgeshire Executive Partnership Board (CEPB). The process and templates for reporting of local areas' BCF progress were issued following the meeting by NHS England and the Local Government Association.

3.2 The first quarterly monitoring return is attached as Appendix A. This was shared with CEPB for comments and approved by the co-chairs of CEPB, Adrian Loades (for Cambridgeshire County Council) and Andy Vowles (for Cambridgeshire and Peterborough CCG). Given the significant joint working across Cambridgeshire and Peterborough, the returns between the two health and wellbeing board areas were closely aligned with one another.

3.3 The first return covers the fourth quarter of 2014/15 and so largely relates to the setting up of arrangements for the BCF. The return notes the progress by UnitingCare in setting up the new service model for older people and adult

community services, and briefly outlines the project areas being pursued. New templates are likely to be issued for the second quarter of 2015/16; these will again be discussed with the CEPB.

3.4 Separately to this return, the CCG – in line with other CCGs - has also had an opportunity to revise the BCF targets for a 1% reduction in non-elective admissions, in line with actual performance – or outturn - for 14/15. The plan in the fourth quarter of 2014/15 was to achieve a steady state when compared to 2013/14 Q4 – a 0% reduction. The system actually saw a marginal reduction of 0.2% in non- elective admissions (26 admissions) and therefore achieved the planned levels. There was no performance payment attached to this quarter. The agreed BCF target for non-elective admissions in 2015/16 will therefore be a cumulative total of 56,310 admissions across Cambridgeshire – this represents a reduction of 594 non-elective admissions.

4.0 CEPB PROJECTS

4.1 As previously reported, five projects have been established reporting to the CEPB, to be taken forward as part of the work funded by BCF; these project areas were aligned across Cambridgeshire and Peterborough. The five projects are intended to support the delivery of the 'ten features of an integrated system' linked to the Joint Older People's Strategy and agreed by the CEPB as the foundation of the Board's work programme.

4.2 Project 1: Data Sharing

4.2.1 The Data Sharing Project will deliver an effective and secure joint approach to data sharing across the whole system, enabling improved co-ordination and integration of services for adults and older people. It is a critical element of the overall transformation programme in Cambridgeshire because the delivery of all other schemes will rely at least in part on effective and secure data sharing mechanisms being in place, particularly the Person-Centred Care project and the UnitingCare delivery model and solution. The project will focus on four areas of delivery:

1. Ensuring practitioners and professionals have access to holistic information when making decisions related to adults and older people's care needs.
2. Enabling information to be shared at the earliest possible stage to prevent people developing care needs where possible.
3. Ensuring data and information is shared in order to inform strategic planning.
4. Data sharing as an enabler for delivery of the broader Cambridgeshire Executive Partnership Board Programme.

4.2.2 The Project Scope outlines the priority areas for delivery over the next 3 years; this is based on current requirements and will be revised in order to reflect changing priorities. It has been agreed that in the first 12 months the project will focus on delivery of two key strands of work: implementation of UnitingCare Partnership's 'Single View of the Patient Record'; and on the continued refinement and improvement of frontline data sharing practices, including the standardisation of systems and processes across Cambridgeshire, Peterborough and the CCG; this work will focus on areas

such as such as standardisation of secure email, consent and the full implementation of the NHS number as the primary identifier, and will be informed by patients, users and frontline staff. Links have been made with regional colleagues to ensure opportunities for cross-border improvements are pursued and best practice is shared.

4.2.3 In recognition of the fact that securing longer-term changes to systems and processes will take time, the group is maintaining a strong focus on work that will have a positive impact on patient outcomes in the shorter term, whilst providing learning for the systems work. Work has commenced on bringing together colleagues from across health, social care and the voluntary sector to identify what information should be shared in order to improve outcomes, with a workshop scheduled for July.

4.2.4 There are also longer term priorities identified within the scope for delivery in year two and three, and the work to prepare for future deliverables will commence before then in preparation for delivery. This will include exploration of the system wide options available for delivery of patient portal which are of particular importance to the personalisation agenda.

4.2.5 A project board has been established and will continue to report progress to CEPB.

4.3 **Project 2: 7 Day working**

4.3.1 7 day working is an enabler of better outcomes for patients; the model enables discharge planning to be undertaken in response to patient need as opposed to organisational availability and will improve outcomes for patients because they will be able to leave acute hospital as soon as they are clinically fit and it is safe to do so.The 7 Day Working project will deliver an integrated approach to discharge planning and non-elective admission avoidance by ensuring that appropriate services are operating 24 hours a day, 7 days a week. This will not mean that all services will operate in this way; it is about ensuring that appropriate services are available across the system when needed and will include expansion of health and social care services, and residential and nursing home services. In addition this project will focus on out of hours admission avoidance in order to ensure that the increased pace and capacity created by improved 7 day discharge planning is not filled by an increase in admissions.

4.3.2 A project team is being established for this work, and a draft scope has been developed based on the outcomes of workshops held both in Cambridgeshire and Peterborough. Within the first 12 months, the project will focus on three areas:

1. **Understanding the current state: mapping current service hours**

   A mapping of current service hours should be conducted across the system in order to understand what services are available at what times in different settings. This will inform an understanding of where there are gaps and identify opportunities to commission to fill these.

2. **Understanding current admissions and discharge data**
   Working closely with the System Resilience Groups (SRGs), and linking with existing work on the Eight High Impact Changes and actions resulting from 'Breaking the Cycle' further work will be undertaken to understand the specific areas where increased seven day working would impact on admissions and discharges in order to identify priority areas for action.

3. **Developing and implementing quick wins**
   Develop a series of smaller changes that could be implemented within the current financial year,based on the outputs of the above work.

4.3.3 Ownership and leadership by acute hospitals is particularly important to this project; and the approach to admission avoidance requires close involvement from UnitingCare. This has progressed in Peterborough and discussions are ongoing with acute providers about the best way for this work to be developed further in Cambridgeshire. It is proposed that this work should be developed in three distinct areas across Cambridgeshire and Peterborough, aligning to the broad catchment area of each acute setting. Work is therefore likely to be taken forward through each of the Systems Resilience Groups (SRGs) where possible. Early signs are that there are a number of common issues across the three local acute systems and so the Joint Integration Team will support and maintain an oversight of work at a countywide level. The CEPB will receive a further update at its meeting on 22 July 2015.

4.4 **Project three: Person-centred system**

4.4.1 The Person Centred System Project will deliver effective, holistic person centred health, social care and housing services for residents in Cambridgeshire and Peterborough. It will enhance and improve person-centred care across the whole system by supporting the delivery of flexible, coordinated and creative long term support for those that need it.

4.4.2 The project will work to align and support existing and new developments across the system, and add value to those arrangements by ensuring that they are aligned across the whole system – not just health and social care; and by providing capacity to test new ideas and ways of working in different parts of the system that will support person centred care.

4.4.3 In particular the project will support the development of the UnitingCare service model in Cambridgeshire, by ensuring that the changes enacted by UnitingCare are supported across the rest of the system. This will include immediate, more intensive work with people most at risk of developing serious health or care needs; as well as work to identify people's needs earlier and support them to plan based on their own choices.

4.4.4 <u>Targeted, co-ordinated support for those most at risk</u>
This work will include:
- Risk stratification of the population
- Establishment of Integrated Neighbourhood Teams (INTs)
- Establishment of Integrated Care Teams (ICTs)
- Multi-disciplinary team (MDT) working
- A shared plan with a named lead professional for the 5% most vulnerable (increasing over time to 15%)

This strand of work is defined by the establishment of the UnitingCare service model, and in particular, will focus on interfaces between UnitingCare and those parts of the system linked to, but not included in, the UnitingCare contract. These include statutory services such as social care and housing; and a range of services across the voluntary and community sector. The Joint Integration Team will work with UnitingCare to support their engagement with the rest of the system on this work as appropriate.

4.4.5 Identifying and addressing needs earlier and building a plan based on people's needs and choices

Whilst recognising that there may be a point at which a detailed specialist or statutory assessment is needed, it has been agreed that having a shared and joint approach to identifying the primary need for someone who may present as vulnerable or frail would be valuable, without them being drawn into a statutory assessment process. This would require a consent based approach along similar lines to the Common Assessment Framework (CAF) for children. This would include:

- A shared tool that describes levels of vulnerability – be they social, community based or physical. The Rockwood Frailty Index is useful in describing physical frailty, but consideration should be given to whether a similar tool exists that can identify social or community needs
- A shared questionnaire or assessment tool that can identify an individual's needs at an earlier stage and record their priorities and wishes, as a means to linking them into appropriate support. This tool must be consent-based and could either be patient-held and/or shared between agencies.
- A co-ordinated approach to identifying the appropriate population to conduct such a questionnaire / assessment with.

A range of initiatives are already underway in Cambridgeshire and Peterborough, and have also been conducted in other areas of the country. Local initiatives include the Health and Wellbeing Network's pilot work through GP surgeries; and early work between Cambridgeshire CC and the Fire and Rescue Service. National initiatives include Essex's Information About Me approach; the 'Outcome Star' model; and the South Warwick model. It is proposed that a task-and-finish group be established to review the development of a single CAF-type approach in Cambridgeshire, learning from work in Cambridgeshire and other areas. Leadership from the voluntary sector and from front-line staff in both health and social care will be essential.

4.5 **Project four: Information and Communication**

The Information and Communication Project will develop and deliver high quality sources of information and advice based on individuals' needs as opposed to organisational boundaries. Part of this work will include the establishment of the principle of an integrated system wide 'front door' for people that require information and advice about any part of the system irrespective of their presenting need(s). There is recognition that support and information will invariably be accessed via a broad range of routes. Therefore part of this work may involve embedding a principle of 'no wrong front door' and focusing efforts on supporting people to navigate the system in a way that best suits them, including self-service opportunities. This work will require all of our organisations, and residents to think differently about how they pass on or receive information.

Scoping work to understand the synergies and differences across Cambridgeshire and Peterborough is underway. The next step is for a core group to scope the work in detail; this will be informed by conversations regarding the broader programme that have taken place to date. The scope will be presented to the next CEPB meeting for consideration

4.6 Project five: Ageing healthily and prevention

4.6.1 This project was envisaged as having a focus on the development of community based preventive services to support and enable older people in particular to enjoy long and healthy lives and feel safe within their communities. Three project proposals emerged from the first discussion. These were **Triggers and Pathways,** to jointly develop a recognised set of triggers of vulnerability which generate a planned response across the system; **Planning for growth**, whichwould support the growing numbers of older people in future through a coordinated approach to primary prevention; and **Strong and supportive communities**, linking to a number of existing initiatives across the system to ensure that people were linked in to appropriate support in their community wherever possible.

4.6.2 Further work is required to define the scope of this project and the deliverables. It has been agreed that Public Health will lead this project across Cambridgeshire and Peterborough and a Project Sponsor has been nominated. Given the broad potential scope of the work CEPB has agreed that an effective approach would be an overarching prevention framework with targeted projects and areas of delivery that sit underneath, focused around frailty and reducing avoidable admissions. This work will develop alongside existing initiatives that are already underway – and in particular will need to link to discussions at the System Transformation Board. An update will be presented to CEPB for discussion in July.

5.0 RECOMMENDATIONS

The Cambridgeshire Health and Wellbeing Board is invited to:

- Note the update on the Better Care Fund monitoring and non-elective admissions targets; and
- Comment on the development of the projects.

6.0 SOURCE DOCUMENTS

None