Integration and Better Care Fund

Narrative Plan Template 2017/19

DRAFT – VERSION 5.7

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

Contents

Introduction

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

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

Local vision and approach for health and social care integration

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

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

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

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

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

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

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

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

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

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

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

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

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

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

system as follows:

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

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

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

Broadly speaking, these changes can be divided into:

- support for people who do not have, or have not yet developed, significant ongoing health needs; and
- support for those people that have significant ongoing needs and receive support from a range of organisations.

To achieve our ultimate aim of a shift away from long term social care, or care that is provided in the acute setting, to preventative services that are focused on keeping people well, we are focusing our response across both cohorts.

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

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

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

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

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

Greater Joint Governance & STP Linkages

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

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

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

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

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

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

Challenges

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

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

- **Population Growth:** Both Cambridgeshire and Peterborough have a rapidly growing and changing population. There will be large increases in the number of older people, children and people from different backgrounds living in the county in the next 10 years and beyond. For further demographic information, see **Appendix 2.**

- **Over-reliance on emergency health and long term social care:** People are living longer with a greater number of co-morbidities or disabilities, resulting in increased demand on our health and care services, in common with the rest of the country. This creates particular challenges for planning and managing health and social care services. Too many people are treated in our acute hospitals and numbers of people admitted to hospital as an emergency has been growing by around 2% each year. Our acute hospitals are under severe operational pressure. Supporting people earlier, in their own homes, in order to prevent emergencies will achieve better outcomes.

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

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

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

Progress to date

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

BCF Expenditure

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

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

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

BCF Metrics Performance

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

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

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

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

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

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

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

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

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

Progress in areas of major investment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Lessons learnt for 2017/19

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

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

Evidence base and local priorities to support plan for integration

The evidence base and priorities have been informed by:

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

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

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

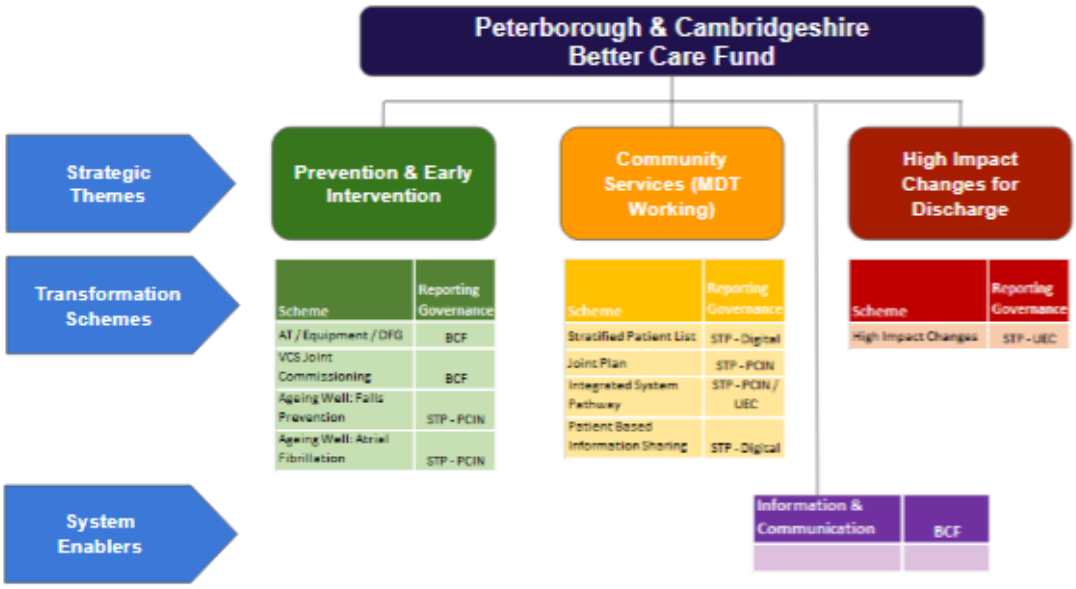
Better Care Fund plan 2017-19

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

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

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

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



Focus area one: Prevention and early intervention

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Focus Area Two: Community Services / MDT Working

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

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

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

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

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

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

8 High Impact Change (8HIC) Plan

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

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

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

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

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

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

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

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

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

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

Strategic Theme Area Four: Information and Communication (Enabler)

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

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

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

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

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

Project Delivery

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

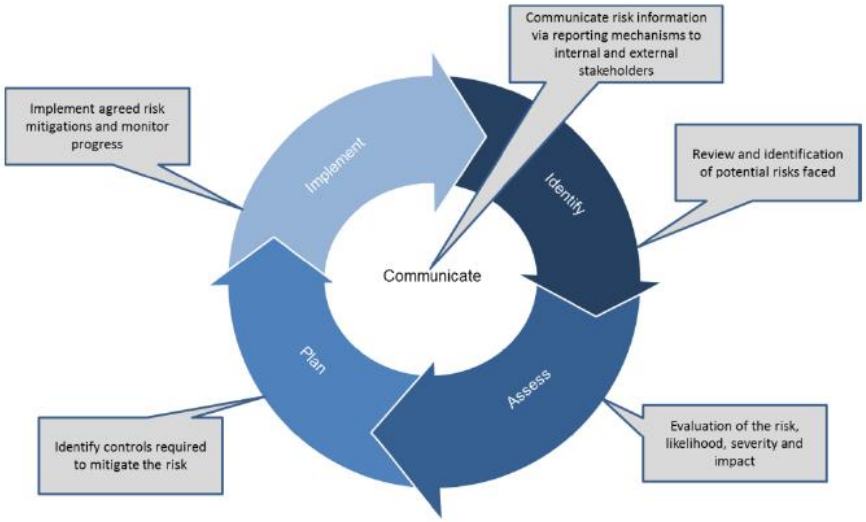
Requirement:	How our method/approach will deliver:
Establish a clear articulated and prioritised plan to steer the BCF streams development	Our right to left approach to planning will ensure that the plan is prioritised and will deliver expected outcomes in the right order. We will produce "plans on a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

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

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

Assessment of Risk and Risk Management

Cambridgeshire and Peterborough have adopted a proactive approach to risk and issue management, based on best practice methodologies. The risk and issue management pathway includes a sequence of activities to identify, assess, prioritise and mitigate the risks and issues. This incorporates robust engagement with local stakeholders. The below diagram highlights the processes that will be applied to support effective identification and analysis of programme risks and issues.



CCG Approach to Risk Management: The CCG's Assurance Framework and risk register (CAF) sets out the high level organisational risks that could potentially impact upon the CCG and its ability to deliver its responsibilities. The CAF brings together all of the evidence required to support the Annual Governance Statement. It clearly identifies the risks of failing to meet the CCG's Strategic Aims and also its agreed Values. The 2017-2018 CAF is also linked to the relevant domains within the DH Annual CCG authorisation process. The CAF clearly identifies the Strategic Risks to the organisation. It identifies the controls in place to mitigate the risks, the assurances on these controls and the action plans that have been established to address any gaps. The CAF is a living document which will be updated regularly by the Corporate Governance Team and reported to the CCG Governing Body and relevant sub-committees for monitoring purposes. A copy of the current CAF is attached at **Appendix 10.**

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

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

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

Financial Risk Management

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

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

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

National Conditions

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

National condition 1: jointly agreed plan

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

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

National condition 2: social care maintenance

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

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

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

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

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

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

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

National Condition 4: Managing Transfers of Care

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

Overview of funding contributions

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

Carer's Breaks

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

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

Maintenance of Adult Social Care

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

Reablement

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

Care Act Duties

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

Disabled Facilities Grant

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

Improved Better Care Fund (iBCF)

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

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

- Ensuring the local social care provider market is supported.

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

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

DTOC Plan

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

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

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

- Our strategic approach to DTOCs is being coordinated through the STP Urgent and Emergency Care Delivery Group. The DTOC plan is a consistent plan across the CCG footprint and takes into account cross-border pressures on the local system.
- Our A&E Delivery Groups have agreed plans in place for reducing DTOCs, which are aligned to other existing system plans, e.g. winter planning.
- Each acute system has operational arrangements to respond to short-term increasing pressures, which allow for quick escalation; improving use of capacity and procuring additional capacity where necessary; and establishes regular conference calls at times of significant pressure to ensure that the system is doing everything possible to alleviate the situation.

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

Programme Governance

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

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

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

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

progress into the local Area Executive Partnerships where appropriate.

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

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

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

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

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

Approval and Sign Off

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

Date:	

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

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

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

Position:	*Acting Chief Operating Officer*
Date:	

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

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

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

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

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