CAMBRIDGESHIRE BCF SUBMISSION WORKING DRAFT: 8 SEPTEMBER 2014

Better Care Fund planningtemplate – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.ukas well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Cambridgeshire County Council**
Clinical Commissioning Groups	**NHS Cambridgeshire and Peterborough Clinical Commissioning Group**
Boundary Differences	**For NHS Cambridgeshire and Peterborough CCG there are two differences to the boundary when compared with those of Cambridgeshire County Council and Peterborough City Council. From 1 April 2012, several practices from North Hertfordshire and Northamptonshire became part of NHS Cambridgeshire and Peterborough CCG:** ***North Hertfordshire – Royston*** **Three Royston practices provide care for a patient population of 24,142 residents in the town of Royston itself and the surrounding villages and they comprise Royston Medical Centre, Roysia Surgery and Barley Surgery**

	Northamptonshire **The Oundle and Wansford practices provide care for a patient population of 17,448 residents in the town of Oundle itself and the surrounding villages and they comprise Oundle Surgery, Wansford Surgery and Kings Cliffe (branch surgery).**
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of BCF pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	<Name of ccg>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	<Name of council>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

<Insert extra rows for additional Health and Wellbeing Boards as required>

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

The overall vision for health and social care services in Cambridgeshire is expressed in our 'BCF Vision and Principles' document issued in December 2013. It stated: 'our long-term shared vision is to bring together all of the public agencies that provide health and social care support, especially for older people, to co-ordinate services such as health, social care and housing, to maximise individuals' access to information, advice and support in their communities, helping them to live as independently as possible in the most appropriate setting'[1].

The whole health and social care system in the county has a shared ambition to improve health and wellbeing for local people, but is faced with the twin challenges of rising demand and reducing budgets. Furthermore, Cambridgeshire remains the fastest growing county in the country and, without change, our services will be unsustainable in the very near future. Consequently, the HWB Board, CCC and the CCG have already been planning to shift resources to invest in joined-up services that are focused on preventing deterioration and which support people to be independent, healthy and well in all aspects of their lives, thereby reducing demand for higher cost, more intensive services. This vision is ambitious, given the specific challenges that the system is facing in Cambridgeshire:

- Cambridgeshire is one of 11 'challenged health economies' that face particular difficulties in developing sustainable quality health services over the next five years. This is mirrored by challenging financial circumstances that affect our ability to ensure sustainable social care services.
- A reduction in acute activity runs counter to the current trend in the county. Existing CCG plans are based on a 1% reduction in A&E admissions, in the context of the current trend which is for an annual increase of around 2%. There is also a mismatch between the BCF vision of reduced acute activity and providers' 5-year plans which plan for increased acute activity and staffing. The scale of the challenge ahead is acknowledged in the CCG's Five Year System Blueprint which includes redesigning non-elective care.
- The local procurement of Older People and Community Services by the CCG (see section xxxx) means that Cambridgeshire faces particular challenges in achieving the flexibility required in budgets that are within scope of the procurement exercise. This is particularly true at present because the provider has not yet been appointed.

Focusing on preventative community support where possible means a shift away from acute health services, typically provided in hospital, and from emergency social care services. This cannot be achieved immediately – such services are usually funded on a demand-led basis and provided as they are needed in order to avoid people being left untreated or unsupported when they have had a crisis. Therefore reducing spending is only possible if fewer people have crises: something which experience suggests has never happened before.

[1] Adapted from 'Older People Community Budgeting: principles and project ideas' available from notes of item 3 of Health and Wellbeing Board, 17 October 2013.

We recognise that the development of preventative community based services (as an alternative to reactive, crisis based services) requires significant changes to our thinking and arrangements about how best to support the health and wellbeing of Cambridgeshire residents. Over five years we are working towards a fundamental shift in emphasis in the system – instead of needing to support people when they are in crisis with hospital or long-term social care support, personalised services provided in the community will wherever possible prevent crisis in the first place. Our collective ambition is to achieve this big change.

Nevertheless, collectively our organisations in Cambridgeshire are committed to achieving this, because the alternative is unsustainable services. In addition, preventing people from going into crisis is better for them and their families. This approach will also be supported by a clear focus on improving access to timely information, advice and guidance.

The BCF is one part of this transformation but is not a panacea for health and social care in itself. Firstly, we recognise that this is not new money – all of the money allocated to the BCF is already spent on health and social care services in Cambridgeshire. Secondly, compared to the overall spend in the system (more than £1bn per year in Cambridgeshire), it is a relatively small amount.

Therefore we will focus our use of the BCF on initiatives that help to prepare the system for a bigger change in the medium term, by protecting existing social care services; supporting the development of 7 day working and data sharing; and supporting the development of closer working, including development of joint assessments with an accountable lead professional.

b)What difference will this make to patient and service user outcomes?

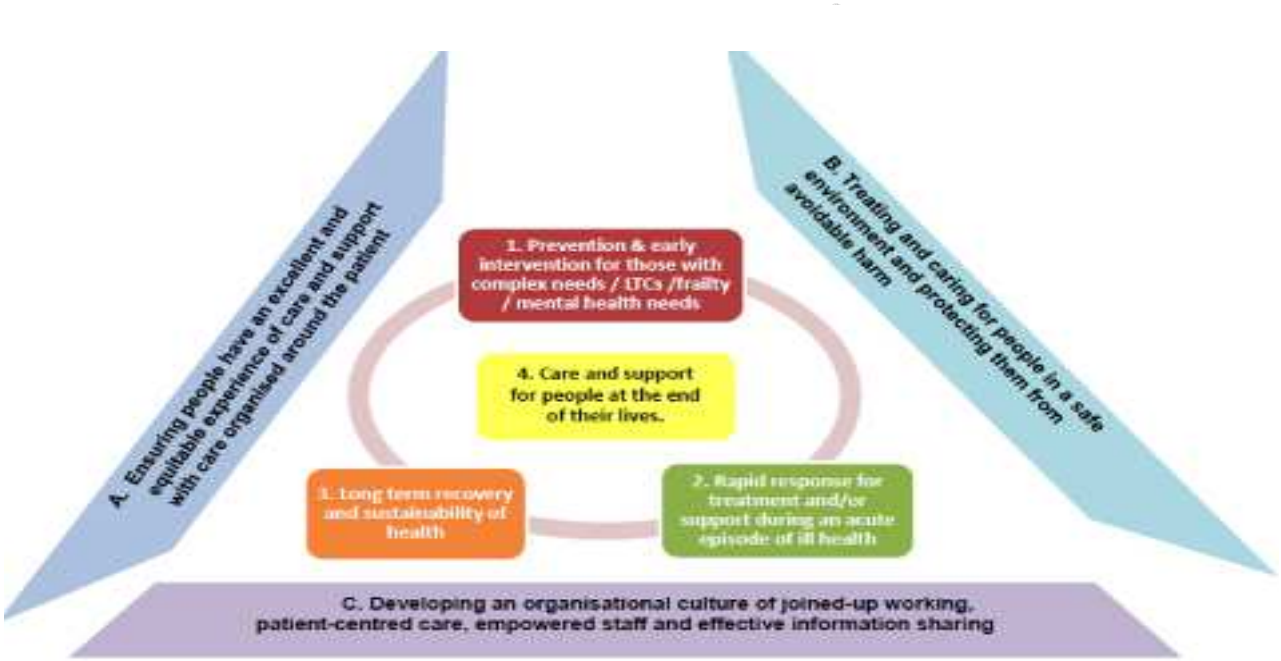
Our ambition is expressed in a number of top-level plans and strategies, which will drive the planning and commissioning of work and services funded through the BCF and more widely, and each include expressions of desired outcomes of the work they describe. They include:

- The **Health and Wellbeing Strategy**, which focuses on the health and wellbeing needs of everyone living in Cambridgeshire, considers the wider determinants of health, and was signed off as a top-level strategy for services by the HWB Board
- The **CCG Older People's Services Programme**, which includes a new approach to improving outcomes for patients, and procurement for a provider that will take on all health services for older people in Cambridgeshire, with a remit to transform services so that they are preventative and joined up
- **Transforming Lives -** a new and markedly different social work model for adult services by CCC, focusing on professional social work at all levels of need, using community knowledge and resource to support people. The model requires social work to be more proactive, preventative and personalised and aims to enable residents to exert choice and control and ultimately to live health, fulfilled, socially engaged and independent lives.
- The **5-year plan for the CCG**, detailing the strategic plan for health services in

Cambridgeshire
- The development of a joint health and social care strategy for older people developed by CCC, the CCG, and district and city councils. This is accompanied by an 'operating model' for older people's services

A joint outcomes framework will be developed using the following as a starting point (shared with providers, the public, stakeholders, and the voluntary and community sector as part of our consultation and engagement processes associated with the Vision and Principles document):

CCG Older People's Procurement Programme – Outcome Domains



CCC Older People's Strategy – Outcomes

- Older people remain living at home and in their own communities for as long as possible into later life
- Older people are supported to retain or regain the skills and confidence to look after themselves into older age
- Carers of older people are supported to cope with and sustain their caring role
- The number of people requiring complex or intensive support packages is minimised through successful early intervention
- Older people who need ongoing care and support feel in control of their support plan and are able to choose the support which is right for them
- Older people are supported to live with dignity throughout their later lives
- Older people are protected from harm and isolation.

A New Approach to Partnership Working

We are committed to establishing a new approach to partnership working, not only for the Better Care Fund but for the services we collectively commission for a total value of over

£1bn.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Our plan is to move to a system which will support an operating model for the health and social care system that helps people to help themselves – where the majority of people's needs are met through family and community support. This might be through all organisations understanding the first signs that someone may need more support, or be developing greater support needs, and highlighting this to other organisations who can arrange any necessary support. This support will focus on returning them to independence as far as possible; but more intensive and longer term support will be available to those that need it.

Our key areas for investment are as follows:

1. **Older People and Community Services (OPACS) Procurement**
2. **7 day services in health and social care**
3. **Joint assessments including accountable professional**
4. **Data Sharing**

OPACS Procurement

The CCG has embarked on an ambitious Older People and Adult Community Services (OPACS) procurement which is designed to achieve transformation across the health and social care system. This procurement was established prior to announcement of the BCF and will happen independently; however, the scope of the procurement means that some of the BCF investment will inevitably be used on the services in scope. The main components of the OPACS procurement are

- An innovative Framework for improving outcomes which goes beyond traditional organisational boundaries
- A new contracting approach which combines a capitated budget with Payment By Outcomes to enable a population approach to service delivery, align incentives in a better way than current funding mechanisms allow, in a way which is consistent with the CCG's long term financial plan
- A 5 + 2 year contract term to enable investment and transformation
- A Lead Provider responsible for the whole pathway, providing leadership and operational coordination

The core scope of services is acute unplanned hospital care for older people (65 and over), older people's mental health services and older people and adult community services. The entire range of services relevant to the care of older people is shown in Figure 1: Service range. The underlying principle is to create an integrated care pathway between all of these services including the Services which are the subject matter of this Procurement.

Whilst the full range of social care services and funding is not in the scope of the procurement, the CCG is working closely with Local Authority partners on the procurement and wider Older People Programme. Cambridgeshire County Council,

Peterborough City Council and District Council representatives have been integrally involved in steering the programme and also in the detailed dialogue and evaluation associated with the procurement. There is a strong alignment and synergy between the OPACS work and the aims of the Better Care Fund which will enable and support it.

Services in scope of the procurement will become the responsibility of a 'Lead Provider' which will directly provide community services and hold the budget for the other services, so that the whole 'pathway' of care is more joined up and better o-ordinated. The Lead Provider may be a single organisation or a consortium made up of several partners. They will not just be responsible for providing and co-ordinating care, but also for supporting the health of the whole older population. This will include working with GPs and others to identify people who are at higher risk of becoming seriously ill and offering advice and support which reduce the risk of crises or hospital admissions. The Lead Provider will employ the community services staff and be responsible for ensuring that they are well supported.

The OPACS provider will be incentivised to work to reduce emergency admissions – one of the key aims of the Better Care Fund. BCF Partners will work closely alongside the provider to agree how these services will relate to other strands of Better Care Fund activity. As the provider is not yet appointed, it is not possible to outline in full what projects will be established; however, areas of interest include:

- **Falls reduction**
  A falls reduction programme that would seek to transform the falls and contributory pathways to put in place effective prevention and crisis management services which help maintain independence and reduce admission to hospital.

  Falling can precipitate a loss of confidence, the need for regular social care support at home, or even admission to a care home. Fractures of the hip require major surgery and inpatient care in acute and often rehabilitation settings, ongoing recuperation and support at home from NHS community health and social care teams. In addition, hip fractures are the event that prompts entry to a care home in around 15% of cases. Indeed, fractures of any kind can require a care package for most older people to support them at home.

  We will seek to establish a multifactorial intervention programme to include strength and balance training; home hazard assessment and intervention; vision assessment and referral; and medication review with modification/withdrawal. Following treatment for an injurious fall, older people should be offered a multidisciplinary assessment to identify and address future risk, and individualised intervention aimed at promoting independence and improving physical and psychological function.

  CCC analysis suggests that approx. 1/3 of admissions to long-term intensive social care support for older people were preceded by an unplanned hospital episode, with about half of those explicitly recording a fall as the reason for the hospital stay. Health service analysis shows that across the CCG around 3,500 admissions to hospital for older people include falls as one of the causes. These figures need to be treated with some caution, because in most cases a fall is only one of the reasons for the admission (which may therefore have been necessary irrespective of the fall). Nevertheless reducing falls is an important area of focus.

- **Intermediate care**
  We will seek to deliver better coordination across a wide range of intermediate care services, including night care, nursing, sitting services, rapid response, admission avoidance, step up and support for hospital discharge. We will seek to establish a focus on the services and pathways needed to enable people to be supported in the community to prevent hospital admission or allow timely discharge from hospital, including . Intermediate care services are already operating in Cambridgeshire and have been successful in reducing avoidable admissions to hospital, but capacity is often stretched and services have not always been coordinated across organisations. This work stream wouldbring together:
  - Intermediate care beds. The purpose and use of beds commissioned by health and social services and opportunities to reshape commissioning based on the needs of clients and patients and alternative pathways
  - Discharge to assess. An initiative to discharge patients from hospital as soon as they are medically fit. This has implications for community support services (and links to intermediate care bed requirements)
  - 7 day working. Ensuring services are able to support 7 day discharge from hospital, therefore reducing delayed transfers of care and improving patient outcomes
  - Reablement services which assist in helping people to live independently again, provided in the person's own home by a team of mainly social care professionals.

2. 7 day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

Reablement services in Cambridgeshire already operate 7 days a week, able to accept and support patients on discharge from hospital at any time of the week. District Nurses are also able to support patients discharged from hospital at weekends. However, for a comprehensive 7 day per week discharge service, other services also need to operate 7 days a week. To meet this national condition our local plans need to deliver the following:

- To negotiate with local authority staff, including making amendments to terms and conditions, to allow for 7 day working in discharge. To be completed by April 2015.
- To negotiate with hospital based staff, including pharmacy, transport, medical staff necessary to approve discharge, including making amendments to terms and conditions, to allow for 7 day working in discharge. To be completed by April 2016.
- To negotiate with independent sector providers egg: residential and nursing care homes, to establish working practices to allow for 7 day working in intake and assessment processes particularly. To be completed by April 2016

3. Joint assessments including accountable professional

So that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care

and allocate a lead professional. Which demonstrates person-centred care planning e.g. who to contact, so that person can facilitate decision making about the person's care in a timely manner, including telling their story once. The project needs to adequately consider the impact for people with Dementia; and the project needs to sets out how GPs will be supported in being accountable for co-ordinating patient-centred care for older people and those with complex needs

4. Data Sharing

For health and social care staff to work together, they must be able to share information about a person's assessments, treatment and care using systems that are secure. This project needs to deliver systems that enable that and:

- Use the NHS Number as the primary identifier for correspondence across all health and care services
- Use systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))
- Have Information Governance Controls in place

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

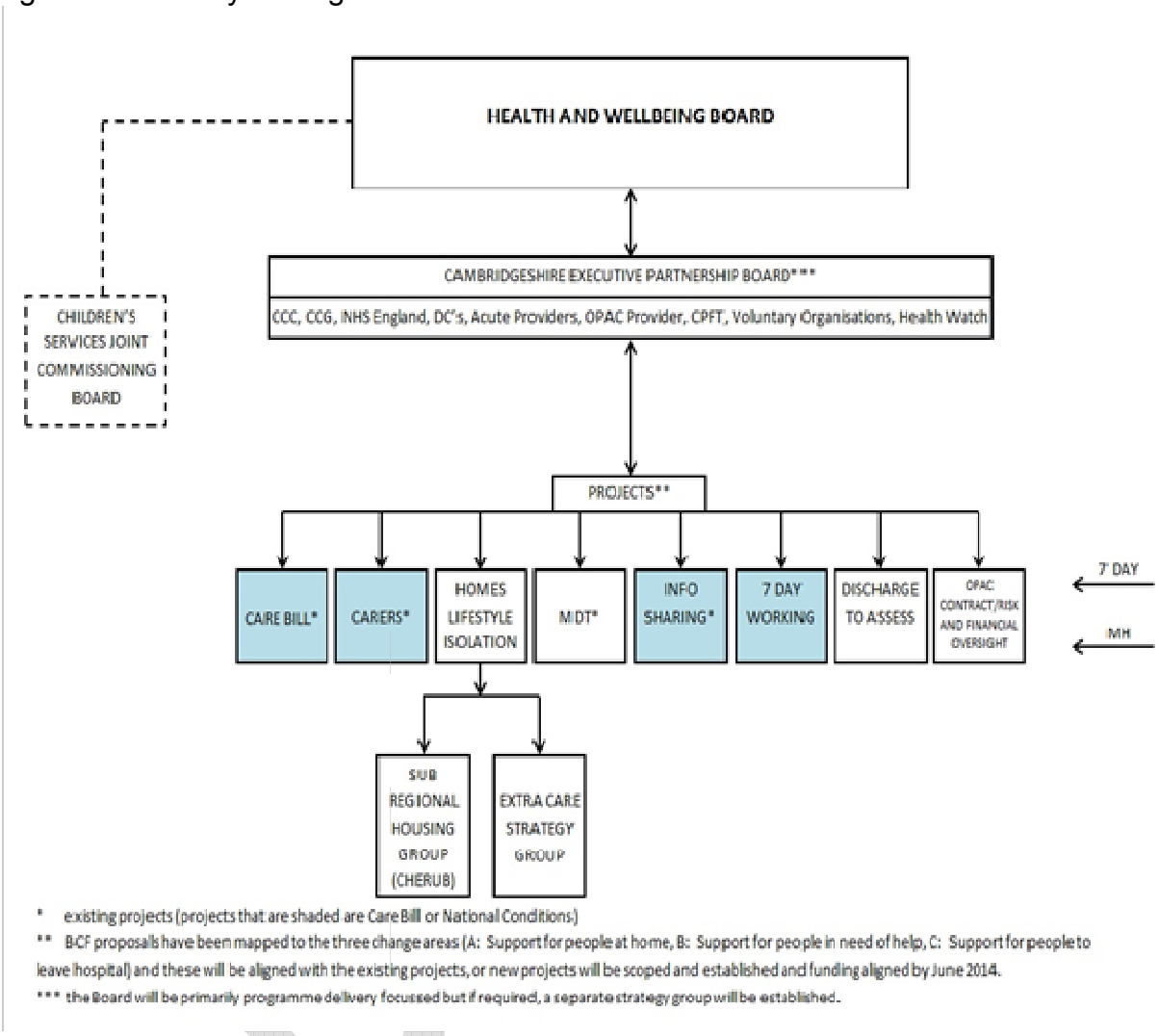
b) Please articulate the overarching governance arrangements for integrated care locally

Oversight and governance of our BCF Plan will continue to be provided by the HWB Board who will sign off the plan on behalf of its constituent councils and the CCG. The CCG Governing Body and the County Council's Committees still remain engaged in the development and sign off the BCF.

Weare in the process of creating a single Cambridgeshire Executive Partnership Board for Older People and Vulnerable Adults which will bring together all key partners across the County to provide a joint strategic approach to service transformation and delivery of the Better Care Fund. This executive-level partnership board will report directly to the Health and Wellbeing Board.The purpose of the Board is to provide whole system leadership and coordinated multi-agency oversight of health and social care service transformation for older people and vulnerable adults in Cambridgeshire.

The Partnership Board held its first meeting in shadow form in September 2014. The Board will be formally established as part of the Section 75 arrangement for the BCF and

will be responsible for the development of a joint strategy and joint transformation programme as agreed by the organisations represented on it. The Board will be accountable to its constituent member organisations for delivery of the joint strategy and joint transformation programme. It will work to deliver relevant Health and Wellbeing Board strategic priorities as well as provide regular reports on its Programme to the HWB Board.The Officers on the Board will be responsible for ensuring effective governance of the Better Care Fund pooled budgetand securing member organisation and HWB Board agreement to any strategic investment decisions.



* existing projects (projects that are shaded are Care Bill or National Conditions)

** BCF proposals have been mapped to the three change areas (A: Support for people at home, B: Support for people in need of help, C: Support for people to leave hospital) and these will be aligned with the existing projects, or new projects will be scoped and established and funding aligned by June 2014.

*** the Board will be primarily programme delivery focussed but if required, a separate strategy group will be established.

The objectives of the partnership board comprise:

- To oversee joint planning and a programme of transformation for older people and adults including mental health (16-64, 65 years +) in line with a jointly developed Strategy for older people and related service strategies
- To provide effective leadership, management and governance of the Better Care Fund Section 75 pool
- To provide a forum for multi-agency oversight of the Older People and Adult Community Services (OPAC) contract, risk and financial management including development of annual plans and outcome framework revision.
- To develop and oversee a joint action plan to deliver the transformation programme, and guide the work of joint integration staff.

The next tier of governance will provide management oversight of all transformation and

joint commissioning for each area of change, together with an enabling project to complete the procurement and then provide multi-agency contract oversight. These transformational groups will be multi-agency and work to the Partnership Board/joint commissioning board. The projects will cover our areas for change as well the national conditions. Terms of reference for these groups have been agreed.

Regular formal and informal reporting is undertaken to each organisation's board or governing body.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, includingmanagement of any remedial actions should plans go off track

To be agreed

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Older People and Community Services (OPACS) Procurement
2	7-day services in health and social care
3	Joint assessments including accountable professional
4	Data Sharing

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Financial disinvestment in acute providers	4	5	20	• Clarity around financial planning and monitoring • Understanding financial impact of disinvesting in services and financial impact of 'new' services/configurations • Financial accountabilities are clear across organisations • Critically appraise proposals for new investment against evidence base • New initiatives will be asked to articulate clear mitigation measures if they

				do not deliver planned savings
Failure to protect social care services: Demand for social care increases at a rate that outstrips the increased investment and transformation	4	4	16	• Closely monitor demand for social care arising from demographic change and the new statutory duties under the Care and Support Bill
Failure to protect acute services: Investment in prevention fails to sufficiently reduce demand for acute services, creating financial challenges for the acute sector	4	4	16	• Closely monitor demand for acute services and ensure that contingency plans are in place for diversion of funding if necessary • Close and continuing liaison with key groups such as the Chief Executives Group to ensure joint awareness and ownership of the issues
Failure to meet performance targets: Results in loss of up to £9m	4	3	12	• Effective negotiation of targets with government • Clear alignment of BCF investment and change areas to key performance targets • Robust performance management arrangements are put in place
Loss of Strategic Perspective and Scale: The plan focusses on many small	3	3	9	• Refer back as needed to the 5 year strategic plan context and over-arching priorities and other relevant strategic and commissioning

scale initiatives leading to lost opportunity to undertake strategic transformation of services				plans • Consistently map the initiatives and proposals back to the agreed EndState to check for right scale and scope Agree a set of categories for strategic change, and group ideas and proposals around these
Destabilising 'the system:' Making changes to the current patterns and models of service delivery in advance of implementing new ways of working de-stabilising current levels of demand and performance	3	3	9	• On-going review of strategy and vision • Robust arrangements for reviewing progress across all change activities • Appropriate investment in communication to users and staff • Development of appropriate workforce and OD plans
Clinical Commissioner engagement: Localities and member practices feel disenfranchised and alienated by the planning process	3	3	9	• Regular briefing and discussion at CCG Governing Body and at Clinical Management and Executive Team meetings • Local Chief Officers to keep their Local Commissioning Group (LCG) Boards fully informed and ensure they have the opportunity to contribute • Nominate clinical champions from LCGs / local health systems who would co-lead with SROs the priority change programmes • LCGs to engage

				regularly with their practices / localities and ensure that they are kept informed and aware of the wider context • CCG Members' Events to give opportunity for wider discussion and opportunity to address concerns raised by the membership
Provider engagement: Lack of engagement and support from Providers	3	3	9	• Use the Chief Executive Officer Group to identify and obtain consensus on the key strategic priorities • Invite providers to submit their ideas and proposals for transformation and use these to inform on-going discussions • Use selected provider clinical forums to keep clinicians aware and engaged • Incorporate specific change initiatives into the mainstream commissioning and contracting cycle to ensure that the BCF plans are part and parcel of everyday business • Discussions with each provider as part of the 14/15 contract round • Regular updates by the CCG at the Chief Executive Group • Further strategy session for all CEOs and Chairs

				planned for 30 April • Rather than look at the BCF in isolation, use the fund as a catalyst to look at improved joint planning across commissioners and providers.
Staff engagement: Staff are not fully aware of and engaged with the changes set out in the Better Care Fund plan	3	3	9	• Hold regular staff briefings • Post updates to organisations' websites • Use the organisations' newsletters to promote better understanding and flag examples of excellent performance and innovation
Strategic Vision / EndState: Lack of clarity around the 'end state' resulting in loss of delivery	3	3	9	• Link to the 5 year Strategic Plan – move to single Older People's Plan for Cambridgeshire • Ensure all clients groups are reflected in the vision • Agree vision and principles and set them out clearly in the BCF plan (and reflect this in each organisation's core planning documents) • Set out in the plan each initiative and how it will contribute towards realisation of the bigger picture
Stakeholder Engagement: Key stakeholders do not have the opportunity to contribute to	2	2	4	• Ensure that key stakeholders are identified • Build time into the BCF Fund planning timetable to brief and discuss

and shape the Better Care Fund plan				stakeholders • Maximise the opportunity to brief and debate through attending existing meetings • Organise bespoke events e.g. HWB Board development days, Area Events etc. • Keep stakeholders up to date with progress in drafting the plan e.g. through regular written briefings, use of websites etc. • Reflect back to stakeholders the key outcomes of the engagement discussions
Financial Information: Lack of clarity around the funding to be transferred from the CCG to the Better Care Fund joint commissioning pools	2	2	4	• CCG and Local Authority Finance leads agree the methodology for calculating the funding to be transferred and the process for transfer • Financial information to be set out explicitly in core planning documents e.g. CCG 5 Year Strategy
Planning Assumptions: Early planning assumptions may prove to be incorrect.	2	2	4	• Ensure that the BCF plan is updated regularly to reflect the emerging position and any agreements and/or changes made • Ensure effective co-ordination of the work of the different local authority project teams to allow timely update of

				assumptions
Governance: Insufficient project control, transparency and accountability.	2	2	4	• Appoint a Senior Responsible Officer in each organisation who will be accountable for progress with developing and implementing the plan • Appoint joint CCG/CCC project team(s) to implement the process and to meet the key milestones for delivery • Maintain the opportunity for scrutiny through regular formal reporting to boards responsible for decision-making • Through regular communication and briefing, ensure sufficient transparency and openness with regard to the Better Care Fund Plan • Maintain a detailed project timetable to ensure that key board meeting dates are identified and met
Sign-Off: Lack of agreement between partners and at the HWB Board means that an agreed plan cannot be signed off	2	2	4	• All partners to be involved in discussions and represented at the Executive Group • All partners signed up to Vision and Principles • Special meeting of the HWB Board to allow sufficient time for discussion
Government Approval: Delay in	2	2	4	• All partners working to ensure that proposals address the

government signing- off use of the Better Care Fund, leading to loss of the funding				national criteria • It is likely that the Government will allow time to refine proposals rather than rejecting immediately

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

The national planning guidance has signalled the closer alignment of NHS and local authority planning cycles and this is welcomed. Historically, we have worked closely together to ensure that our service plans are in direct alignment, where appropriate, and that we have a shared understanding of the strategic direction needed to meet the health and social care needs of our population. As an example, in terms of strategic direction and priorities for Older People, CCC and the CCG are working closely to agree a single, shared strategy for Older People this year.

In drawing up our plans and activities for the Better Care Fund, we have worked closely with members of the HWB Board who have provided the required strategic direction and advice, grounded in the priorities set out in the Health and Wellbeing Strategy. As a result, we believe that our plans and activities will contribute directly towards four of the six priorities set by the Board. These are:

- Support older people to be independent, safe and well
- Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices
- Create a safe environment and help to build strong communities, wellbeing and mental health
- Work together effectively.

We have used the intelligence available in the JSNAs to identify the key target areas of focus, and we have complemented this through the collation of an evidence base led by the Public Health Team.

b)Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

To be completed

c)Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

To be completed

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

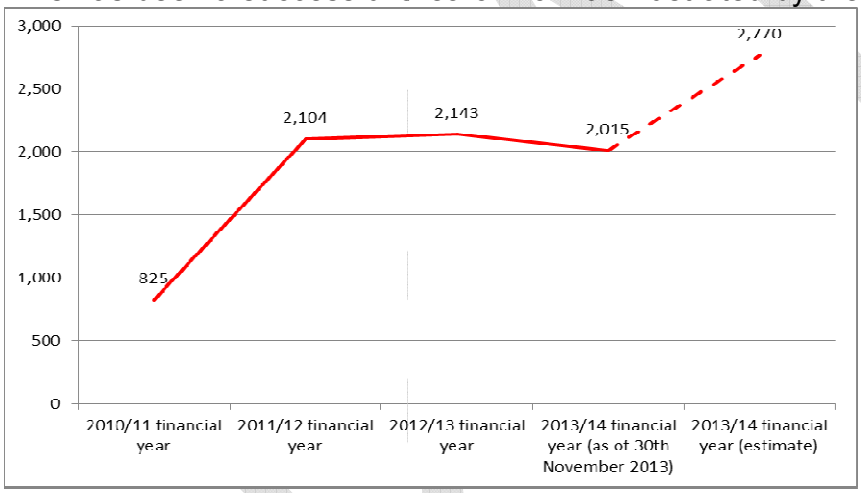
a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The locally agreed definition of protecting social care services is maintaining the existing thresholds set under Fair Access to Care Services or, following the introduction of national eligibility criteria, ensuring that social care services are able to meet the new criteria.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

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



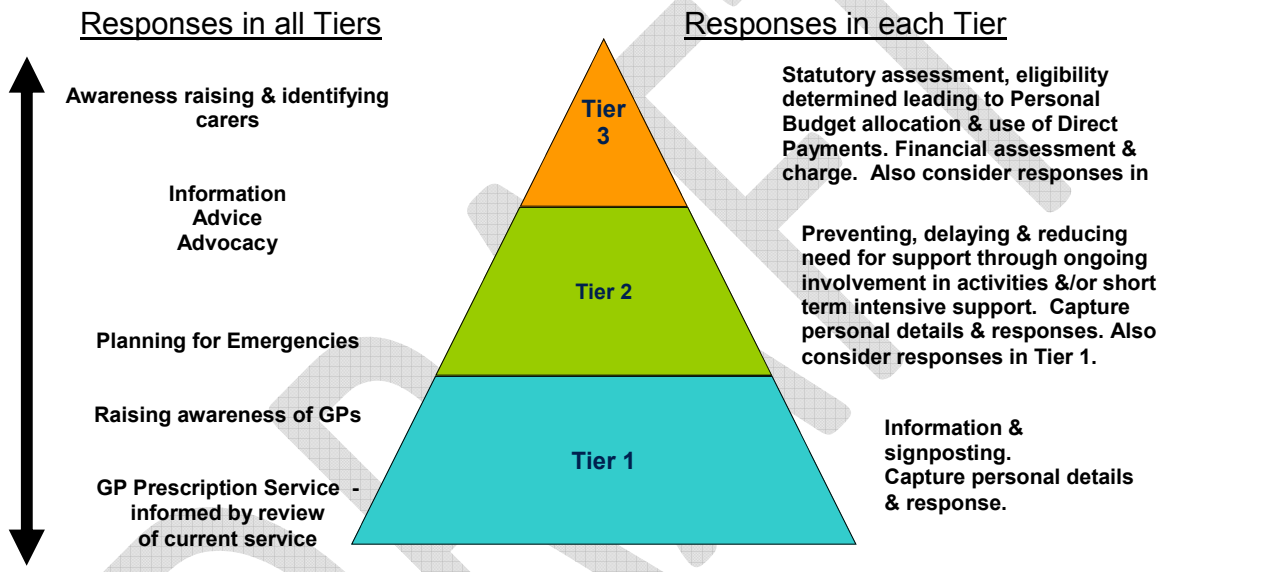
However, all partners have recognised that meeting the demand for social care services is not sustainable in the current financial climate, and the rapid expansion in Cambridgeshire's overall population brings further pressures. While the BCF will enable us to improve many of our processes and develop 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 Cambridgeshire, in order to ensure sustainability in the medium to long term. The £2.5million of 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 will be 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. More specifically social care services will be protected by:

- Our response to the Care Bill
- The development of a new social work model (Transforming Lives)
- A clear workforce development programme
- A robust approach to demand management

The close alignment of our intentions within the BCF and the Care Act means that other expenditure from the BCF will also contribute to delivering the requirements of the Act, in particular preventative activities, assessment and crisis intervention.

Support for Carers: The Council is currently leading a project to develop a new model of support for carers, taking into account the new duties arising from the Draft Care Bill. The project is taking an inclusive and collaborative approach with statutory partners, family carers, the community and the voluntary sector to consider how best to deploy the funding transferred through the BCF and the investment in carers by the Council.



The emerging model is based on 3 tiers of need, with some responses being available to all 3 Tiers and some responses that are specific to each Tier.

Responses to all 3 Tiers

- To reach out to carers it will be necessary to raise awareness about being a carer and provide information that is relevant for a wide range of circumstances.
- Advice and advocacy may be required at different times by carers across all tiers.
- GPs have a significant role in identifying carers and further work is needed to continue to promote their recognition of carers within their patient groups.
- Currently GPs have a “prescription service” through which they can prescribe a number of hours of support, delivered through Carers Trust. This is available to any carer whom the GP judges has a need for support. This service model will need to be reviewed to see if and how it could be enhanced in the new model.
- Building on the experience of the current Individual Carer Emergency Respite (ICER) scheme through which the carer can develop a plan for emergencies, we will develop a wider concept of emergency planning, including plans that clarify informal networks of support that can be called upon in an emergency, with a view to encouraging all carers to develop a plan.

Tier 1 represents lower levels of need where the provision of information and signposting will be very important. Capturing personal data will help to build up a picture of the carers across the County.

Tier 2 focuses on interventions that will prevent, delay and reduce the need for support including ways to maintain or develop informal networks. This may also include short term intensive support where that would prevent further deterioration of the situation.

Tier 3 represents the higher levels of need that meet the eligibility criteria for social care support, following an assessment. The assessment should use and build on the information captured within Tiers 1 and 2. The support to meet eligible needs will be personalised, with the identification of the personal budget available and the option of taking this as a Direct Payment. Consideration should still be given as to how to support the carer within informal networks as a way of reducing the need for support.

Transforming Lives: A new strategic framework for adult social work and social care in Cambridgeshire, which will fundamentally change how we deliver services to better meet the demands that we face. It is based on a proactive, preventative and personalised approach and enabling residents to exert choice and control and ultimately continue to live, to the fullest extent possible, healthy, fulfilled, socially engaged and independent lives. This new way of working will embed social care staff in local communities, playing a strong role in multi-disciplinary teams alongside health and voluntary sector colleagues.

The new model is based on 3 levels of intervention: Help to Help Yourself; Help When You Need It; and On-going Support.

Help to Help Yourself: Information, advice, prevention, early identification and early intervention are inextricably linked. Information and advice would help people to find out about local voluntary and community activities and the model will include the concept of 'supported introductions' to activities where people are reticent to attend alone. Strong, independent communities and supportive families and carers are crucial to the success of this model. Families and carers are often best placed to support individuals to achieve their aspirations.

Help When You Need It: Crisis resolution provides a local, rapid response immediately following a crisis, at which the individual is put at the centre of this intensive work. It focuses on the needs of the individual at that point in time, and very short term planning will take place with support designed around the needs and circumstances of the individual. The adult social care professional would then provide support to the individual for the duration of the crisis, checking with them regularly to ensure that they are coping and feel well supported. The aim of the rapid response is to support individuals through crisis to help them to maintain their independence, prevent further deterioration and the need for longer term adult social care. One of the key aims of crisis resolution is therefore to support people to remain independent of statutory services. Alongside crisis response are reablement, visual impairment and occupational therapy rehabilitation, assistive technology and deaf services equipment, which play a fundamental role in supporting, encouraging and enabling individuals to regain their independence. Where possible, they will be able to continue to live active, fulfilled lives independently in their own homes and maintain their role within the local community. This model suggests that an increased investment in professionals to assess for Assistive Technology and the technology itself which could prevent or delay access to more costly and longer term social care

packages.

On-going Support: The longer term support for individuals would be planned through the use of holistic, integrated assessments, and would be self-directed, based upon personal budgets and the principle of choice and control. The nature of the strengths based conversations that professionals will have with the individual would change. Planning would take place with the individual to ensure that we are continually building upon their strengths, families, networks and resources to achieve their aims. At this level, it is anticipated that deeper conversations may be required, for example into individual's personal financial circumstances. It will be acknowledged that the individual, their carers and their families are the experts on their own lives. Individuals in receipt of on-going support from adult social care services would be encouraged to utilise assistive technology and rehabilitation services and encouraged to be active participants within their local community. Should any additional issues be raised, the individual would be signposted to information and advice, enabling them to find a local solution that meets their needs.

With the transfer of funding from the NHS through the Better Care Fund there is a real opportunity to develop these two models collaboratively with NHS colleagues, to maintain good health and wellbeing of people and carers and support them to have fulfilling lives. The time is right to make radical changes to the traditional ways of working that these work streams are designed to deliver.

Workforce Development

Ahead of the need to assess the impact of the Better Care Fund on the workforce, Cambridgeshire County Council has already been carrying out a review into the workforce capabilities within health and social care particularly to support its Transforming Lives initiative.

Workforce planning and development will be addressed across the board, from front line workers to senior managers. The development programme is focused on three tiers.

The first tier will focus on level 3 vocational qualifications, setting a benchmark for our social care staff and giving them a transferable qualification which will allow them to work in other settings. Between 100 and 130 learners are enrolled on level 3 courses at any one time, and the vast majority complete their courses within 12 months.

Cambridgeshire County Council trainers already have a strong track record of delivering training to staff members, and are confident that they will be able to expand their programme in the near future. Cambridgeshire will have its own vocational qualification centre from the 1st of April 2014, which will give the County much more flexibility in the vocational qualifications it will be able to deliver to staff. In addition, a bespoke training qualification in reablement is already being developed, which will soon be available to all staff at level 3.

The second tier ties in to Cambridgeshire County Council's Transforming Lives agenda by moving to strengths-based assessments, making assessments more conversational and motivating social care staff to work in a fundamentally different way. Public health officers will also provide training on motivational interviewing as part of this tier, to boost the confidence of health and social care workers in persuading service users to make positive changes to their own lives. Around 100 officers each year are expected to take

on this second tier of training.

The third and final tier will focus on attachment-based working. Helping service users to strengthen their family attachments can prevent social isolation, which has been proved to be a factor in a range of health problems including depression. Again, it is expected that around 100 council officers each year will undergo training in this area.

These tiers are not an exhaustive list: other work-streams are being considered to ensure that there is sufficient workforce capacity at all levels of the organisation. One potential area of workforce development is the senior management team, where a short- to medium- term programme could be developed to encourage culture change and facilitate cross-organisational working at the highest levels. The workforce implications of multi-disciplinary teams could also come under the Transforming Lives project.

Within the NHS, Health Education East of England has been co-ordinating the development of workforce planning and seeking to introduce a strategic framework within which manpower development can take place. A common approach to workforce development has been adopted across the East of England with the aim of developing a workforce fit for the future reflecting the following:

- Increased demand for GPs and Practice Nurses
- Staff with skills to support integrated care closer to home
- Staff with skills to care for frail elderly / people with dementia
- Multi-professional approach to delivery of care across settings
- Opportunities for new roles, e.g. urgent care
- Smarter ways of working through the use of technology
- Use of evidence based staffing tools
- Workforce and service transformation in response to use of staffing tools

Around 70% of the future workforce are employed by the NHS now. Health Education East of England trains 3,000 students per annum in order to secure future NHS supply (representing 17% of the future workforce); it expects to recruit up to 12% new employees by 2020 in addition to newly qualified recruits.The Cambridgeshire and Peterborough providers are facing an unprecedented efficiency savings gap, estimated at 5.6% p.a. by 2020, higher than the average for East of England. In the period between 2000 and 2010, the NHS workforce in Cambridgeshire and Peterborough grew by 60%, faster than in other areas of East of England and in 2010.

Healthcare is entering a new era that needs flexible and trained workforce for the future. Some of the challenges for redesign include:

- Greater use of technology on the front line
- New roles that cross the boundaries between hospital and community services
- A much stronger emphasis on joined-up personalised care

To date, Cambridge and Peterborough's Workforce Partnership local priority is to improve urgent and emergency care services; reducing avoidable admissions and preventing unnecessary hospital stays – enabling integrated care pathways and the development of community-based services. Cambridge and Peterborough Workforce Partnership have created workforce transformation programmes during 2013/14 which will focus on the following:

- Values based recruitment focusing on Bands 1-4 across all NHS Providers in Cambridge and Peterborough
- A review to ensure better support for the workforce in the care home sector
- A redesign of the workforce needs for urgent care access system for people not using A&E - with a major focus on support of frail elderly people living at home
- Workforce re-design to support the acute care delivery linked to the workstream for developing the workforce to respond to urgent care access system outside of A&E

Health Education East of England will continue to promote staff progression as well as the labour market with a view to increasing the number of people in professional careers. This is particularly important for professions such as nursing where a significant proportion of nurses are approaching retirement over the next 10 years. Health Education East of England will also focus on developing opportunities for staff within band 1-4 roles that typically include healthcare assistants, technical support staff and office staff. A consultation on a national strategy to develop these staff has been completed and the results will be made known soon.

Work will focus on ensuring that the training and skillset development needs required to implement the plans arising from the Better Care Fund initiative are identified at the earliest opportunity and that an action plan is put into place to ensure that the sector is prepared and ready to support the significant service transformation opportunities available.

<u>Demand Management</u>

Partners are currently working on a number of measures to manage the demand on our services especially for old people. These include:

- Releasing staff capacity by simplifying processes and procedures and enabling staff to work flexibly
- Enabling and encouraging the use of direct payments wherever possible to enable service users to exercise choice about how support needs are met within a clear budget
- Supporting the review of all requests for increases in packages and prioritise reviews according to need and cost of care package
- Moving away from spot purchasing of respite care to a more planned approach, which enables carers and service users to plan in a proactive way to prevent crises
- Refreshing the Council's 'Contributions Policy'
- Reviewing our arrangements for interim beds and developing a joint approach with NHS partners
- Making good use of the Brokerage Unit to ensure best possible value for money when purchasing residential, nursing home, respite and interim beds and support 'self-funders' to make good decisions about quality and costs of care
- Ensure that there is clarity about arrangements in relation to Continuing Health Care (CHC)
- Working with partners in the way that we manage the reduction in winter pressures funding and how we respond to unplanned surges in demand in the acute sector
- New strategic procurement policies within the CCG which will stimulate seven day working, whilst requiring providers to reduce admissions.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The following sums have been allocated to support the protection of social care:

- £10,652,000 – continued application of Section 256 monies into social care services which support healthcare objectives
- £2,500,00 – funding towards protecting social care and supporting its transformation
- £1,344,000 – allocation to support the Care Act to meet a range of new duties placed on councils.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Check with Sue Nix

Work is underway to deliver the requirements of the Care Act through an overarching programme board with activity focused on the following areas:

- Support for Carers (see above for details)
- Transforming Lives – a new model for social work/social care – including prevention (see above for details)
- Information and advice
- Identifying self-funders, assessments, eligibility criteria and workforce capacity
- Managing the market
- Statutory status of the Safeguarding Adults Board
- Financial systems for deferred payments and care accounts

Financial modelling on the impact of the Care Act has begun and the potential pressure areas are recognised as being:

- Additional staff required to undertake more assessments
- Demand from self-funders where demand could outstrip available funding
- meeting the increased duties in respect of carers being assessed and having a personal budget to meet eligible needs
- The changes to the eligibility criteria which we believe will draw in people who would currently fall into the category of moderate need
- Deferred payments impacting on cash flow
- Impact on prices in the care market

The inclusion of £130m revenue and £50m capital (national figures) in the BCF is welcomed. The work of the programme board will determine exactly how to deploy this funding to address some of these pressures and to contribute to the delivery of the requirements of the Care Act.

v) Please specify the level of resource that will be dedicated to carer-specific support

CCG

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

To discuss

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Strategic Commitment

Cambridgeshire County Council, working with acute partners and the CCG, have committed to operate a "discharge to assess" process i.e. all patients will leave the acute hospital as soon as clinically fit and safe to do so. Complex assessments will be undertaken at home or within interim provision such as a nursing home. A project has begun within the Cambridge University Hospitals NHS Foundation Trust system to implement this approach based on the model developed in South Warwickshire. A key requirement for the approach is 7 day working. Estimates suggest a potential cost of £600K investment in 10 additional interim community bed provision within-reach therapy support Similar proposals are being developed for Hinchingbrooke and Peterborough Hospital systems. To support this, a review of interim bed provision is currently taking place across the health and social care system. Other identified costs include a 30% increase in staffing of the Discharge Planning Teams in Cambridge and Huntingdon, amounting to an additional cost of £479k.

Our proposal for supporting people to leave hospital (see Section 2c) is based on a shared commitment to move to 7 day services to support discharge. This commitment will be signed off by the HWB Board, CCC and CCG as a key area for transformation. This reinforces the shared strategic commitment to 7 day working of the health and social care system in Cambridgeshire.

Local Implementation Plans

Cambridgeshire County Council and its partners in the NHS have already recognised the many benefits of 7 day working and have taken steps to enable this new working pattern in the most vital services. Reablement services, intermediate care and district nursing already operate 7 days a week, as do commissioned home care services. There is already an integrated health and social care Single Point of Access for community services. A phased programme is in place to look at other services. Specifically, for social care these will include the discharge planning teams - both social workers and discharge planning nurses -as well as building on the existing voluntary arrangement and ensuring that commissioned residential and nursing services are able to assess and receive residents at weekends. Leadership for the implementation of seven day working in the CCG rests with Local Chief Officers, who are responsible individually and collectively as a county-wide group for the development and on-going management of their local health systems.

In order for seven day working to be effective, it is recognised that the interdependency with other services must be managed. In hospitals specifically this includes patient transport and pharmacy services, which are scaled down at weekends. This results in unnecessary delays and can have a detrimental impact on hospital discharge.

The main challenges our implementation plans will address are:

- Identifying resources to support 7 day a week working
- Changing rotas and working patterns for social care and medical assessment and care planning staff necessary for safe appropriate discharge, including amending terms and conditions if necessary
- Ensuring independent sector providers can operate a 7 day a week intake and assessment service
- Working with health and social care partners in other areas (e.g. Peterborough hospital, Queen Elizabeth II Hospital in King's Lynn) to ensure compatible systems

Our current plans are:

- To negotiate with local authority staff, including making amendments to terms and conditions, to allow for 7 day working in discharge. To be completed by April 2015.
- To negotiate with hospital based staff, including pharmacy, transport, medical staff necessary to approve discharge, including making amendments to terms and conditions, to allow for 7 day working in discharge. To be completed by April 2016.
- To negotiate with independent sector providers, to establish working practices to allow for 7 day working in intake and assessment processes particularly. To be completed by April 2016

For 2014/15 provider contracts, the CCG is introducing a Commissioning for Quality and Innovation (CQUIN) agreement to ensure that:

- Following emergency admission to hospital all patients have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours (note this is in addition to normal clinical assessment by doctors and nurses)

- Hospital inpatients have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week.

- In addition, shortlisted bidders for the Older People Programme procurement have set out their intentions in the Outline Solutions summaries to provide services on a 7 day basis

The Urgent Care Boards are key forums to ensure effective co-ordination across providers and to offer the opportunity for wider stakeholder engagement and ownership of the plans and work streams in Cambridgeshire. This includes extending coverage of acute community nursing services and of GP services - both aimed at preventing unnecessary admission to acute hospitals. For example, in Isle of Ely and Wisbech, discharge planning is being developed as a key area for 7 day a week working covering elective and non-elective work. The creation of alternative community pathways including Rapid Response which operate over the weekend will be key to this.

Direct stakeholders in this work include Cambridgeshire County Council, NHS Cambridgeshire and Peterborough CCG, Cambridge University Hospitals NHS Foundation Trust, HinchingbrookeHealthcare NHS Trust, independent sector providers

and (from 2015) the provider of older people's services selected through the CCG Older People's procurement. Indirect, cross-border stakeholders will be hospitals and other health and social care agencies in Peterborough and in King's Lynn.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

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

In November 2013, 97% of all social care records contained the NHS number: however, it is not included on all correspondence currently. From February 2014, the NHS number has been included on all correspondence generated from AIS, the new social care information system that is currently being rolled out across all social care services. We are therefore committed to using NHS numbers as the primary identifier in all our work.

Cambridgeshire County Council is in the process of procuring a new IT system. A requirement of the service specification is the ability to link to NHS networks to facilitate better information and data sharing. The procurement team have taken learning from other local authorities where similar systems have been tried.

ii) Please explain your approach foradopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The CCG and CCC are committed to adopting systems that are based upon Open APIs and Open Standards, wherever possible, and encouraging existing supplier to adopt Open APIs and Open Standards in future releases of software. The CCG is often directed to use specific software suppliers by NHS England and/or the Health and Social Care Information Centre. The re-procurement of the council's social care information system has within its specification the need for API capacity.

As well as what is implied by work in other areas, our proposal to invest in infrastructure to support integration, (see Section 2c) highlights our commitment to develop further our work in the areas of data sharing agreements, shared databases and joint protocols that allow full and comprehensive data sharing, using the NHS number as the primary identifier.

A further project is under way to identify the key information which should be shared

between professionals: this includes sharing emails over a secure system, use of shared documentation (e.g. Common Assessment Form), and NHS numbers. The project is being supported by the Health and Social Care Information Centre, and includes learning from the pan London experience on the best ways to find and share data across organisations.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott2.

Since 2009 there has been a shared IG protocol in place covering health and social care partners as well as other public sector bodies in Cambridgeshire.

The CCG submitted IG Toolkit Version 11 (2013/14) for publication at the end of October 2013. 'Satisfactory' assurance was attained for this early submission as required to enable Stage 1 Safe Haven status and the NHS Standard Contract was used. Caldicott2 recommendations are known and will be implemented. The CCG has a well-established IG and IM&T Group in place to ensure compliance with all aspects of information governance.

In addition to addressing the specific questions in relation to data sharing we have also established a project to look specifically at how data sharing needs to change to support a single assessment process. Meetings have taken place involving CCC, CCG, CUHFT and a representative from the Health and Social Care Information Centre to start this work. A project board will be established shortly incorporating strategic and technical leads from each organisation to:

- Agree a set of key priorities, including some parallel 'quick wins' using existing systems and processes. These will be agreed by the NHS Chief Executives Group
- To develop a better join up of information systems across health and social care that will move us to a single assessment process
- Scope the work needs to link to the Care and Support Bill and include independent sector provider requirements and links to primary care and MDTs.
- Roll out a pilot of iPads to team managers plus another member of each team and then undertake an evaluation
- Develop ‘honorary contracts’ for MDT coordinators and other key staff outside the county council who we want to be able to share information with about vulnerable older people

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Across Cambridgeshire, the Local Commissioning Groups (there are 8 LCGs, made up of groups of GP practices which provide local focus and engagement across the CCG) are currently introducing multi-disciplinary teams (MDTs) to provide better and more holistic

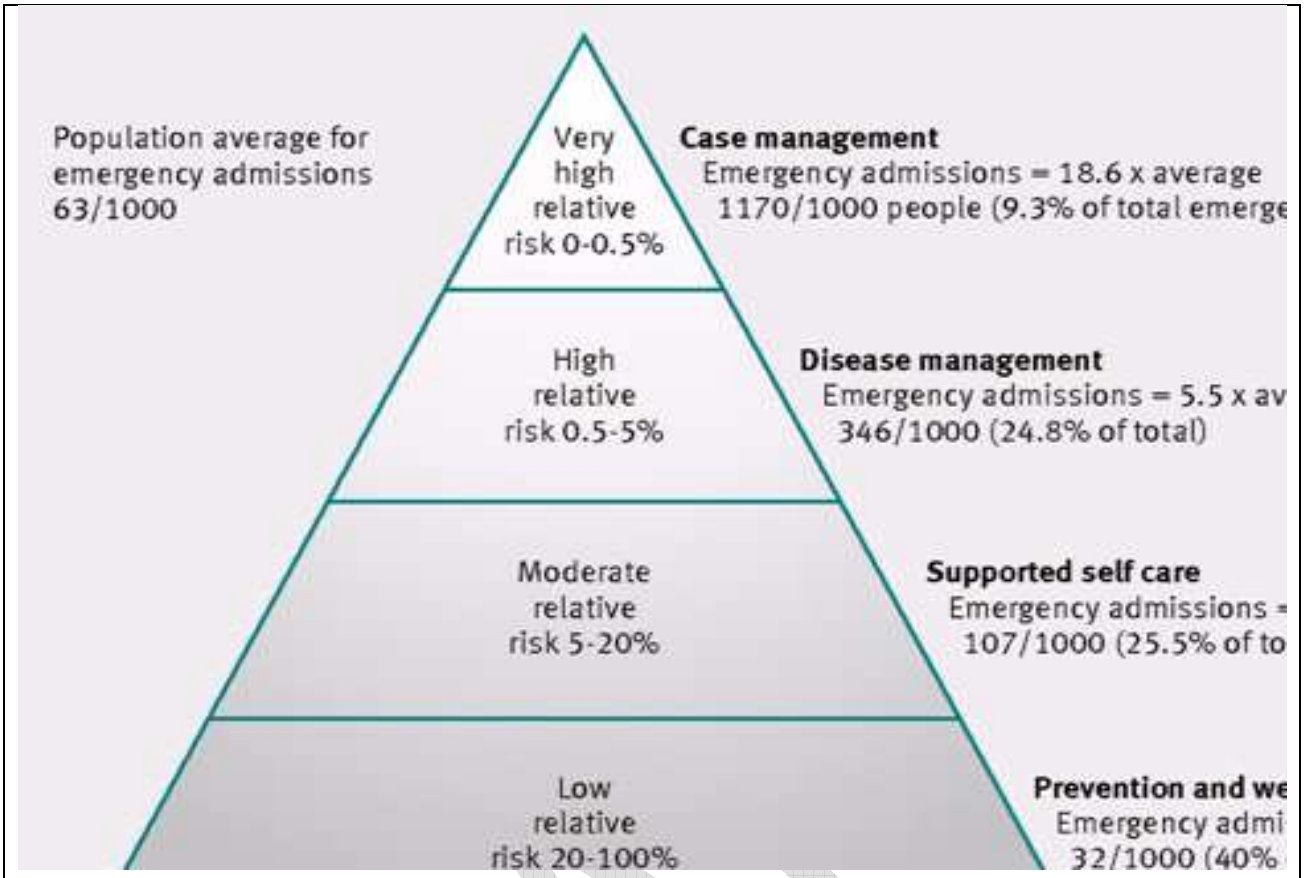
support to frail elderly or other vulnerable people. MDT assessments will become the norm for people who fall into these categories. They bring together social, medical and community care plans involving GPs, hospital doctors, nurses, physiotherapy, social workers and voluntary or community groups. Learning from these pilots about the role of lead professionals and the application of risk stratification tools will be used in developing proposals to support people in need of help as described in Section 2c.

The Direct Enhanced Service for GPs will also require practices to risk stratify their service users, create personalised care plans for the most vulnerable, and ensure that this group has a named and accountable GP.

To support the 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.

The new assessment will be used in supporting everyone who is 80 or over- around 30,000 people, or 5% of the population, and the most important age group for the intensive institutional services that we are trying to reduce the need for. There will be a further development of this model through the CCG procurement exercise, where the successful bidder will be involved in developing further models of working both in relation to joint assessment and the notion of an 'accountable lead professional'.

Risk stratification will form a key component of the solutions being worked on by bidders as part of the CCG procurement for Integrated Older People Pathway and Adult Community Services. The illustration below emphasises the need to ensure that proactive care approaches extend beyond the most intensive service users, at the top of the pyramid, to cover those who are at moderate-to-high relative risk of admission to hospital.



The project to develop new assessment documentation and the accompanying process will take place from April to October 2014. Roll out is expected a year later, in April 2015, to allow for time for change management and to set up new governance procedures. This work will link closely to the governance of the information sharing work.

Experience of joint case work leading to comprehensive health and social care assessments within the integrated Learning Disability Partnership can be drawn upon to inform the work to develop joint assessments for older people. This approach has ensured that health and social care interventions are cohesive and support the person as effectively as possible.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

ii) primary care providers

iii) social care and providers from the voluntary and community sector

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
What is the strategic objective of this scheme?
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	
Name of Provider organisation	
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agreewith the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	