Version 3 for HWB Meeting 3 April 2014

CAMBRIDGESHIRE County Council and Clinical Commissioning Group

Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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 Clinical Commissioning Group, there are two differences to the boundary when compared with those of Cambridgeshire County Council and Peterborough City Council. From 1st April 2012 several practices from North Hertfordshire and Northamptonshire became part of NHS Cambridgeshire and Peterborough Clinical Commissioning Group: *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 Boards:	Thursday 3 April 2014
Date submitted:	Friday 4 April 2014
Minimum required value of BCF pooled budget: 2014/15	**£2,334,000 [does not include existing s256 transfer]**
2015/16	**£37,668,000 [includes existing s256 transfer]**
Total agreed value of pooled budget: 2014/15	**£2,334,000 [does not include existing s256 transfer]**
2015/16	**£37,668,000 [includes existing s256 transfer]**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS Cambridgeshire and Peterborough Clinical Commissioning Group
By	Andy Vowles
Position	Chief Operating Officer
Date	3 April 2014

Signed on behalf of the Council	Cambridgeshire County Council
By	Adrian Loades
Position	Executive Director: Children, Families and Adult Services
Date	3 April 2014

Signed on behalf of the Health and Wellbeing Board	Cambridgeshire Health and Wellbeing Board
By	Councillor T Orgee
Date	3 April 2014

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

In Cambridgeshire we recognise that the whole system must be behind transformation in order for change to get traction and have a significant effect.

We have therefore endeavoured to involve as many health and social care providers as possible during the drafting of this version of the plan, building on the work already undertaken. We asked a wide range of stakeholders to submit their ideas and proposals for inclusion in the Better Care Fund (BCF) using a standard pro-forma and a set of criteria to guide respondents. We received over 120 responses from a wide range of providers and commissioners and we have used this to shape our initial thinking around the content of the plan and to further refine our areas for change.

We have also used existing forums to engage with providers wherever possible, and run ad-hoc new events where no other forum exists. This has included the following work:

Phase 1 (up until 14 February)

- Participation in the work of each Health and Wellbeing Board (HWB), for example, the Cambridgeshire HWB Board development meeting held before the Christmas break
- Attendance at, and participation in, Area Events in Cambridgeshire
- Discussion at the Cambridgeshire Public Sector Board
- Discussion at the Chief Executive Officers Group (comprising all NHS Trust / Foundation Trust providers in Cambridgeshire and Peterborough)
- Active participation in the Joint Commissioning Forum in Borderline and Peterborough
- Meetings with several Housing Providers (excluding City/District Councils' housing services)
- Meetings with individual NHS Trusts and NHS Foundation Trusts at Chief Executive and Director level
- Discussion and generation of ideas at the Urgent Care Networks
- Local Authority-led discussions with social care leads
- Discussions with Independent Sector Providers (Provider Forum and Strategic Provider group)
- Discussions with independent social care providers
- Discussions with voluntary and community sector providers

Phase 2 (up until 4 April)

- A further development session with the Health and Wellbeing Board (HWB)
- 2 workshops involving over 60 providers and strategic partners across the public, voluntary and community sectors covering health and social care
- Discussions with each provider as part of the 2014/15 contract round
- Regular updates by the CCG at the Chief Executive Group
- Further strategy session for all CEOs and Chairs is planned for 30 April

These further activities have again proved to be positive and have contributed further to the development and refinement of our ideas. They have materially contributed to the generation of ideas around the approach we should take in constructing the BCF, and to

the range and scope of potential individual initiatives. The process of calling for ideas yielded a wide variety of proposals from across the whole system. The number of responses and the relative similarity of the themes suggests that there is a significant amount of agreement about strategy and commitment to contribute to change amongst commissioners and providers in Cambridgeshire, which is very positive given the scale of the strategic ambition to transform the system.

One key recurrent theme arising from discussions is the need to ensure that we have a clear process for joint planning across commissioners and providers and to avoid viewing the BCF in isolation from the wider picture.

Providers have typically suggested specific initiatives and/or programmes of change and these have been taken into account in Section 2c below.

Arising from the first period of engagement, several common themes have been identified:

- The need to align the work associated with the Older People's Programme procurement with that of the BCF which has the potential to achieve greater synergy of transformation
- That it would be sensible for providers to design transformation proposals jointly instead of each organisation putting forward its own set of ideas. There is a clear recognition of the need for alignment of resources and change management effort
- A recognition that we need to think more strategically, moving away from a 'bids culture' to one of designing change programmes of sufficient scale to enable the health and care system to achieve the depth of transformation required to meet the significant challenge posed during the current strategic period
- The need for clarity around how the joint commissioning fund will be deployed, and specifically how to mitigate the risk of transferring CCG funding to the BCF fund without achieving a tangible and measureable return on this investment e.g. through performance metrics
- The need for Health to receive a benefit equivalent to the value of the funding to be transferred to social care. It has been noted that the money to be transferred has already been invested in services and that we would all need to be clear about what the impact could be of transferring it to a pooled budget
- A recognition that all adult social care client groups form part of the BCF plan, not just older people.

From the second period of engagement some themes have emerged more strongly alongside the development of more specific ideas:

- Better co-ordination between providers, including local authorities and voluntary groups;
- Creating a team around the family and taking a whole family approach to users of health and social care;
- Empowering people, through providing them with more options and more points into social care;
- Improving and transforming commissioning and procurement so that processes are more joined up and services represent value for money;
- Improved information sharing; and
- Better signposting towards services

We have again committed to working closely with partners as we further refine our plans

in April and May and remain convinced that investing in engaging partners at length, although time consuming, will yield positive results as we start to integrate services across Cambridgeshire.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

During Phase 1 (up until 14 February), the HWB Board gave a clear steer that proposals for BCF should be developed in the context of a thorough and wide-reaching patient, service user and public engagement programme. Therefore, our approach was to:

- Secure 'buy-in' to the use of the BCF through the active engagement of all key stakeholders
- Conduct consultation on draft proposals prior to discussions at the HWB Boards and sign-off and submission to government
- Be proportionate, given the time and resource constraints. Wherever possible, we have achieved this by using existing meetings/forums and communication channels e.g. consultation pages on the CCG and the Local Authority websites to facilitate the process, formal presentations to meetings, organising Area Events to ensure that we reach a broad audience directly
- Ensure there will be further opportunities to shape and influence use of the BCF at the more detailed planning stage.

The scope of engagement during Phase 1 was comprehensive including:

- The CCG Patient Reference Group
- Local Commissioning Group (LCG) Patient Reference Groups on request
- ASC user groups
- Healthwatch
- Health and Well-being Board meetings (development and formal meetings)
- Public consultation run by Cambridgeshire County Council (CCC)
- Older People Programme Board
- Integrated Mental Health Governance Group
- Chairs of the Local Health Partnership Boards
- Delayed Transfers of Care meeting with Hinchingbrooke Healthcare NHS Trust
- Cambridgeshire Voluntary Services
- City and District Council representatives.

During Phase 1 we undertook two areas of work:

Area 1: Stakeholder Engagement

In Area 1, we developed a shared Vision and Principles with stakeholders, in particular with Health and Social Care providers, public sector bodies and the community and voluntary sectors. The aim was to seek 'buy-in' to the overall proposition, clarify issues (e.g. funding, scope) and to manage expectations.

Area 2: User, Patient and Wider Public Consultation

In Area 2, we published a document setting out our shared Vision and Principles and sought views from patients and service users across the health and social care system. This consultation was underway until 8 February 2014.

During Phase 2 (up until end of march) we concentrated our effort on holding two public meetings in Cambridge and Wisbech with the support of Healthwatch. These meetings explored our current ideas around the BCF and discussing the emerging detail about the likely 'areas of change.'

Overall, the response from stakeholders has been positive with a wide range of views expressed, for example:

- The strong support for the Vision and Principles
- The need to build on our existing commitment to transformation
- The need to ensure that we optimise care pathways, in particular, how the social care elements of the plan inter-link with health services on the ground
- Joint working with the voluntary service sector is in place but we need to learn from examples elsewhere where the voluntary and statutory sector services work particularly closely to deliver a range of services targeted at those in most need
- The BCF should take into account service users themselves, their families and their carers - both formal and informal. One service user suggested that formal carers ought to be supported to be as flexible as possible: for example, she found it difficult to arrange for a carer just for the weeks when her husband was away. Another member of the public felt that the vision and principles of the programme ought to mention individuals and families
- Efforts should be made to ensure that duplication is avoided, particularly during the assessment stages. Service users have expressed the view that the services they are referred to rarely seem to share information between each other
- The language of the consultation paper and the programme was mentioned by some members of the public, who were concerned that older people in particular were being framed as 'problematic'. There should be a recognition that some people do need to be in hospital
- Making sure that the BCF focuses on the *quality* of care and not just trying to save money
- Impact of changes on services, particularly increased fragmentation of services, loss of health services and duplication of administrative costs
- The development of specific services e.g. stroke services, hospital discharge, social worker attitudes and end of life
- The importance of being able to access information that is relevant to your particular circumstances from one place
- The need for frontline services to be integrated and focused on people not structures
- The challenge of releasing money from NHS providers to pass into the BCF
- The important role of GPs in reducing demand on acute hospitals

Throughout the planning process, we have endeavoured to engage with stakeholders as widely as possible and to ensure that the views obtained through dialogue and feedback from our stakeholders are played appropriately into the plan as it develops.

We envisage that engagement will continue as an on-going activity throughout the duration of the BCF plan so that we can assure ourselves that the initiatives we implement reflect, as far as possible, the opportunities identified as a result of engagement.

e) 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
Better Care Fund Consultation and Engagement Plan	Sets out a suggested approach for consulting on Cambridgeshire and Peterborough's Better Care Fund plans and how engagement with key stakeholders will be managed.
Review of Evidence to support Better Care Fund (BCF) Spend	This review assesses and qualifies the evidence of the effectiveness of social care and health interventions that impact on the outcome measures required by the BCF. Both integrated health and social care, and non-integrated interventions are considered. The review assesses interventions across a spectrum from primary prevention of social care to interventions aimed at reducing hospital admissions.
NHS Cambridgeshire and Peterborough CCG Two Year Operational Plan	This document sets out how C&P CCG intends to implement the national and local planning priorities for the next two years and achieve sustainable financial balance.
NHS Cambridgeshire and Peterborough CCG Older People Services programme leaflet http://tinyurl.com/oqqryw4	Sets out an overview of the CCGs vision and plans for older people's services.
Better Care Fund Performance Metrics (Cambridgeshire)	Provides an overview of the national and local metrics required to track progress towards the conditions attached to the Better Care Fund.
Health and Wellbeing Strategies: Cambridgeshire HWB Strategy Cambridgeshire: http://tinyurl.com/ofss2bx	These documents set out the key priorities which the Health and Wellbeing Boards will focus on in the next five years. NHS and Local Authority plans need to be informed by the Health and Wellbeing Strategies.
Joint Strategic Needs Assessments for Cambridgeshire and Peterborough Cambridgeshire: http://www.cambridgeshireinsight.org.uk/jsna	JSNAs analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas. The JSNAs underpin the health and well-being strategies of each local

Peterborough: http://tinyurl.com/pbak2pf	authority and the CCG commissioning plans.
Cambridgeshire County Council Older People's Strategy	Sets out the council's strategy for older people.
Summary list of BCF proposals	This document summarises the list of proposals submitted and by whom.
Transforming Lives - Cambridgeshire's New Model of Social Work http://tinyurl.com/peybm2y	This document sets out Cambridgeshire's new model for ASC social work based on social work needing to be more pro-active, preventative and personalised.
NHS Services, Seven Days a Week Forum	There are a range of information sources on 7 day working since the publication of the NHS Services Seven Days a Week Forum in December 2013. The following hyperlink provides a point of entry: http://www.england.nhs.uk/ourwork/qual-clin-lead/7-day-week/7ds/

VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Shared Vision and Approach

The overall vision for health and social care services in Cambridgeshire is expressed in the '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 well-being for local people, but is faced with the twin challenges of rising

[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, at http://www.cambridgeshire.gov.uk/CMSWebsite/Apps/Committees/Meeting.aspx?meetingID=636

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.

Focusing on preventative community support, wherever possible, means a shift away from acute health services, typically provided in hospital, and from emergency social care services. This is an ambitious and risky strategy – 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. Nevertheless, collectively the 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 £37.7m allocated by Government to the BCF offers an opportunity to improve the co-ordination and delivery of health and social care services in Cambridgeshire to support this goal. We regard the BCF as an exciting enabler to help our organisations work together, but not as 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 on the system (more than £1bn per year in Cambridgeshire), it is a relatively small amount and therefore it must be a lever for much bigger change in the mainstream of health, social care and community services, including housing. 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. There has to be 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.

We are organising our planning for BCF into three areas:

- Things that we are statutorily obliged to do. For example, Government has told us that we must meet the requirements of the new Care and Support Bill by changing the way we carry out social care assessments and by supporting the introduction of the cap on social care spending
- Transformation of existing services. For example, CCC and the CCG already fund services to support carers. One of the requirements of the Care and Support Bill is to change the way that carers are assessed. We will use the opportunity of the new Bill, and the thinking prompted by the BCF, to consider more radically how our collective support to carers is provided and not just 'bolt on' an extension to existing services funded by the BCF. This will maximise the opportunity afforded by the BCF to undertake better and more joined-up planning and commissioning in support of our big change
- Stimulating innovation. Some of the ideas we have received from a wide range of organisations, both big and small, are genuinely new and offer a lot of promise.

We want to support innovative ways of making our big change, and take calculated risks where we can.

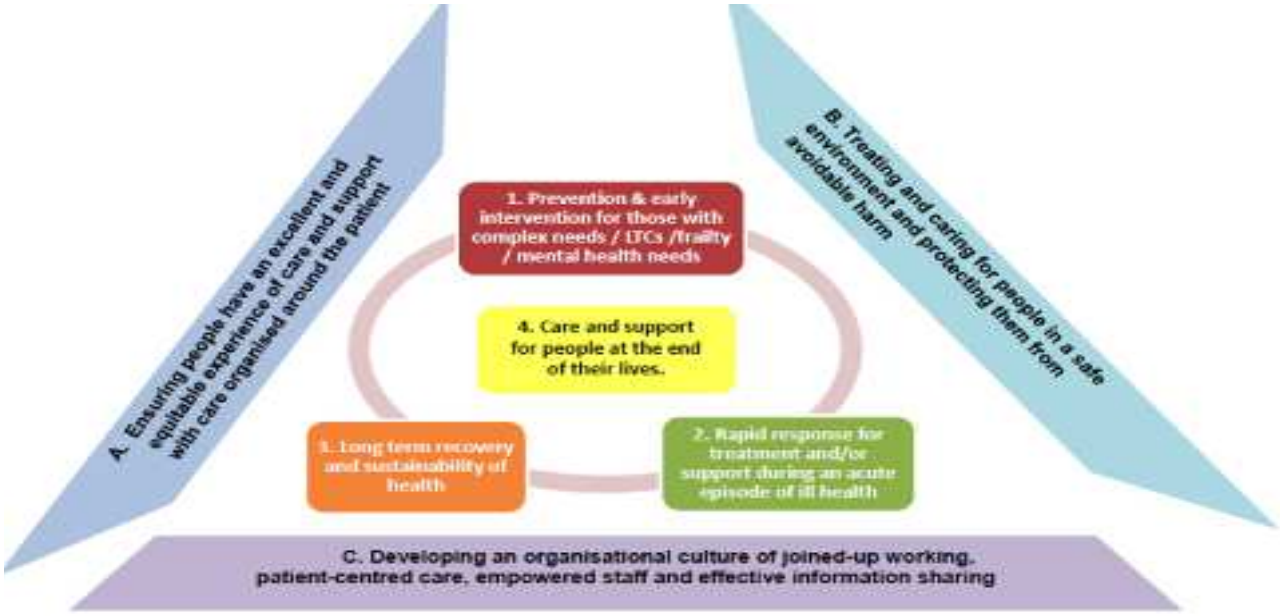
Outcomes

Our ambition for the big change 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 they are preventative and joined-up
- The development of 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 healthy, 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

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 as part of 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.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Our aims and objectives for work funded through BCF are the same as our aims and objectives for the system overall, as expressed in the HWB Strategy, the CCG Older

People's Services Programme, the new social work model under development by CCC, the development of a joint Older People's Services strategy by CCG and CCC, and the CCG's 5 year plan.

They are as follows:

1. Improve and integrate advice and information services so that people know what to do or where to get help.
2. Develop integrated processes, systems and services that ensure the right support is provided at an early stage so that people (especially those with long-term illness or disability) can live as independently as possible – 'the right services, at the right time, in the right way'. This implies a flexible service model of support from services depending on the individual's need (which might involve support from social services, health services, housing services or the voluntary sector) and over which service users or patients have choice and control.
3. Develop services and arrangements which will provide specialised reactive support to people when they have a crisis in order to help them back to independence as quickly as possible, and to avoid high intensity hospital-based treatment or long-term institutional or home-based care. These services will be provided by a combination of agencies working together, and will often involve alternatives to hospital treatment or a long-term paid carer.
4. Expand support in communities to prevent people from needing help from acute or long-term services in the first place, and to help people manage long-term illness or disability. This shift will mean that longer-term patterns of demand for acute, emergency or long-term services, on which the system is currently focused, will change, and that formal health and social care treatment and support will build on a base of community-provided support and be primarily focused on short-term interventions.

How we will measure our Aims and Objectives

We will measure how well we achieve our aims and objectives through a variety of methods by:

- Setting and monitoring performance against agreed outcomes and metrics
- Continuing engagement with key stakeholders and service providers, which will provide feedback on how successful the initiatives we have commissioned are 'on the ground' and where the key gaps in service are
- Formal reviews and evidence-building as we make progress with implementing our joint commissioning approach
- Regular reviews of progress through a newly developed governance and commissioning framework for the BCF

Applying Measures of Health Gain

We wish to ensure that the Better Care Fund plan initiatives form an integral part of joint plans and are not viewed as something separate. We will monitor the health gains achieved via the Better Care Fund using the following measures of health gain:

- EQ5D as a marker of health related quality of life for people with long-term conditions
- Emergency admissions from causes considered amenable to healthcare as a marker of the ability of integrated care to keep people out of hospital

We will consider how we can monitor, understand and improve the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Overview of the Schemes and Changes covered by our Joint Work Programme

Our key areas for change have been developed with contributions from organisations across the health and social care system, including contributions from the housing and voluntary sectors. Partner organisations were invited to submit proposals to support the development of the BCF. Further discussions of these areas of change were held across 'the system' on 12 and 13 March. Refinement of these and the allocation of funding for 2015/16 is still required.

<u>(A) Support for people at home – to help people to live independently at home, either preventing them needing acute or long-term health and social care or minimising their needs</u>

- Integrating carers' services and meeting the requirements of the Care and Support Bill, so carer breakdown is avoided
- Integrating Disabled Facilities Grant, occupational therapy, home improvement, advice and guidance in order to provide comprehensive housing service for vulnerable groups, possibly countywide, so housing is safe
- Developing community-based services providing relatively informal support for people with low-level conditions or who are coping with changes in circumstances- for example, peer-coaching for people with disabilities- so low-level conditions do not deteriorate
- Extending community medicine by, for example, supporting community pharmacies to do more medication management, developing occupational therapy and physiotherapy to be more accessible and to support people to be more independent, so long-term support services are minimised
- Creating a small grants pot to provide broader primary prevention activities or other patient-group specific interventions, so people are more resilient and can cope independently.

<u>(B) Support for people in need of help – to help people who have had a crisis (or who are at the most risk of crisis) to get back to living independently so they don't need long-term or acute health and social care services</u>

- Development of support or recovery programmes for people with long-term conditions, at a variety of levels of need – for example a support service for people with mental health issues who are very vulnerable and for whom a further crisis would result in breakdown, or telehealth remote monitoring for people at risk of hospital admission, so long-term support services are minimised

- Develop a common risk stratification tool and scale up multi-disciplinary teams (MDTs) across the county to respond to the results; develop a shared health and social care database, so we can identify people most at risk of crisis and respond with a joined-up proactive package of support to prevent crisis
- Develop and extend integrated intermediate care and rapid response services across the county for hospital and social care admission avoidance, including developing community step-up beds for use by GPs / MDTs and for hospital discharge, so we can avoid wherever possible someone in crisis being admitted to hospital.

(C) Support for people to leave hospital – to help people be discharged from hospital as quickly as is safe so they can recover at home (or another appropriate place)

- Expand teams to provide 7 day discharge planning and discharge so that at the weekends people do not have to wait for staff to become available to be discharged
- Develop more comprehensive 'return home' support, delivered by voluntary or private sector provider(s), to help people to be discharged from hospital safely and speedily and with support to help them back to independence.

(D) Investment in infrastructure to support integration – to work between organisations to develop common approaches to assessment, treatment and support

- Establish a joint team to oversee integration activity, so that there is capacity to do the development work necessary for common assessments, joint services, and joined-up packages of care and support
- Ensure organisations have the necessary frameworks to enable comprehensive data sharing and fully accessible databases.

The key success factors including an outline of processes, end points and time frames for delivery

A review of the current projects that are contributing to emerging BCF work, the Care Bill and the national conditions has been completed and, as described above, we are proposing to establish a specific governance and programme arrangement to take this work forward. This board will commence in late April.

This review has shown that there are already projects and work streams e.g. developing multi-disciplinary teams, that exist to deliver our BCF plan so it is our intention to sharpen and consolidate these to ensure we have effective project plans in place by May and an overall programme to ensure we can step up the pace of change and implementation.

Further discussions will also take place with those services and organisations that submitted proposals in order to hone down on the specific 'projects' that will be taken forward as part of our final BCF plan (April-May). This work is likely to include:

- A series of whole systems workshops based on areas A-D outlined above, possibly broken down into further sub-areas if required;
- The further development of those proposals that are going to be taken forward. This will require specific information about cost, performance and impact; and
- Agreeing what other projects should be taken forward that are outside of the BCF 'umbrella' but that contribute to the overall transformation of services.
- Development of a BCF work programme and delivery plan setting out work

streams and projects, include those that will be progressed in advance of 2015/16.

By June we aim to have a final plan which will include a delivery plan focusing on resources, sequencing and risk issues.

Key success factors will be:

- Thorough alignment with overall strategy
- Achieving a reduction in demand for acute and emergency services
- Reduction in the need for long-term social care services
- Stakeholder involvement and commitment to transformation
- Increase in user and patient satisfaction
- Increased community capacity to support prevention and avoid dependence on key services
- Workforce development

The timeline below also highlights how the various elements of our transformation and strategy, linked to the BCF work will link together over the coming 12 months.

TIME-SCALE / COMPONENTS	MAR 2014	APR 2014	MAY 2014	JUN 2014	JUL 2014	AUG 2014	SEPT 2014	OCT 2014	NOV 2014	DEC 2014	JAN 2015	FEB 2015	MAR 2015
DEVELOPING PROGRAMMES & GOVERNANCE			Agree arr.								Recruit team		
JOINT OP STRATEGY DEVELOPMENT	OPPB												
CCG 5 YEAR STRATEGY				Final sub. 30.6									
JOINT PRIORITY PROGRAMMES		Agree PPs	Set up	Action plans									
CCG OLDER PEOPLE PROCUREMENT	ISFS Issued					Eval'n Aug / Sept	Pref Bidder 30.9	Mob'n			New OPAC starts		
BETTER CARE FUND DEVELOPMENT		2nd cut sub 4.4	1.Finalise 2.Progress projects	BCF Plan current	HWB Sign off 10.7	Develop implementation plans	full	Work with planning	Providers	on detail			Final sign off

Key BCF milestones are therefore as follows:

<u>April-May</u>

- Finalise the 'areas for change'
- Progress existing projects around Care Bill and the National Conditions
- Finalise governance arrangements

<u>June</u>

- Complete final BCF and consult on changes

<u>July</u>

- HWB sign off BCF

<u>Aug-Sept</u>

- Develop full implementation plan

<u>Oct-Dec</u>

- Work with Providers

<u>Jan-March</u>

- Gear up for full implementation

How we will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care?

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.

The development of the CCG Five-Year Strategic Plan is being shaped through a substantial amount of stakeholder engagement and through reference to key sources of shared intelligence such as the JSNA and other organisations' plans.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Overview and Main Implications

Since we started developing this plan, NHS Cambridgeshire and Peterborough CCG has been formally identified as one of eleven challenged economies nationally. Work has just begun to develop a shared 'system blueprint' as part of the 5 year planning process. This work will look in some detail at developing a pattern and configuration of health services that is sustainable in the long term, including considering emergency flows into each of the main hospitals locally. The first phase of this work will conclude in June 2014.

Discussions with providers are on-going as we shape and agree contracts for services in

2014/15 and beyond. A key element of those discussions is agreement of CQUINs to support the introduction of 7 day working (see section 2b).

The acute sector provider landscape will change appreciably over the next few years as a result of several factors:

- Implementation of the five-year plans, currently being developed by the CCG and all providers
- Implementation of the Integrated Older People's Pathway and Adult Community Services Procurement led by the CCG
- Implementation of the initiatives set out in the BCF plan
- Provider-led initiatives in response to the challenges and opportunities available during this strategic period.

In discussions with acute providers we have identified the following implications for the sector:

- The need to jointly re-design and streamline admission and discharge processes to ensure that the planned developments in community capacity and expertise are complemented by the right capacity being available at the right time. Urgent Care Network Boards are engaged in this work but there is also a need for a more strategic approach to the whole system
- A risk of reducing capacity (and therefore income) related to emergency admissions in anticipation of the transformational changes to community-based capacity taking effect but before they are actually achieved
- A requirement that, as a whole system, we jointly align the work and objectives of the Older People Programme with that of the BCF to avoid the risk of a fragmented response by acute providers

Discussions have also identified opportunities for the acute sector to work in a more innovative and radical way with social care, clinical commissioners and others including the third sector to:

- Draw up a strategic vision of what a fully integrated health and social care system could look like and what would be needed to achieve it, using the BCF as one of the key enablers for change and transformation
- Create more efficient care pathways which are more responsive to individuals' needs and which support the role of carers
- Achieve sustainable and appreciable reductions in unnecessary emergency admissions to hospital
- Achieve more efficient and effective streamlining of discharge processes and 'handovers' to other care agencies
- Reduce/eliminate the number of delayed transfers of care
- Respond better overall to the personalisation agenda.

In addition to our discussions around acute hospital services, we recognise that mental health and wellbeing is as important as physical health in order to maintain good quality of life. Recent national planning guidance emphasised the need to maintain parity of esteem for mental health services. Since the establishment of the CCG, the greater involvement of GPs (for whom mental health issues form a major part of their workload) in the commissioning process has raised the profile of metal health locally and, in particular, highlighted the close link between physical and mental health problems. Recognising and anticipating the need for "parity of esteem", the CCG and its predecessor PCTs have for the past three years required local mental health services to

deliver only the national efficiency requirement of all service providers, and not sought any further efficiency savings. In addition to this, we need to maintain the pace of innovation in mental health services and to maximise the potential of the current investment. We believe that there is potential to help the wider health system via a range of schemes such as liaison psychiatry, psychological therapy for long-term conditions as well as the earlier identification and diagnosis of dementia in both primary care and hospital settings. Each of these elements of service should both improve patient outcomes and the efficiency of current "physical health" services. We will continue to identify opportunities where improved access to specialist mental health expertise would help the rest of the local health system.

Realisation of NHS Savings

National planning guidance sees the BCF as having the potential to improve sustainability, raise quality and reduce emergency admissions.
Within Cambridgeshire, there is a joint vision and a collective commitment to radical change. Unlike programmes which are funded from 'new' money, the BCF cannot operate in isolation. It has touch points with our main strategic work streams, which include the older people's programme. It will also form a part of the CCG five year strategic plan. The BCF is one of the essential elements of this wider strategic programme and we need to ensure that it supports our wider vision.

In terms of process, we are at a relatively early stage of planning though we are making steady progress. We have concentrated our focus, within the limited time available, on ensuring wider engagement with the BCF and wider change opportunities. As a result, we have received a large number of proposals for transformation from a broad range of stakeholders. We have grouped those proposals into key themes and are examining the proposals in detail, in order to assess the potential scale and scope of NHS savings which could be realised as a result of their implementation.

One of the key tasks ahead for the joint project team will be to map the potential impact against each of the health providers, so that we can see clearly the extent to which they would be affected. The CCG will also cross match the BCF initiatives with the Two Year Operational Plan, to ensure consistency of approach and to eliminate the risk of duplication.

Risk of Savings not being realised

We are aware of the risk that the required savings may not be realised, despite having implemented a wide range of transformational schemes. In the risk section of this template, we have described several areas of risk and, in particular, the risk of failing to protect acute services. We continue to are work jointly to conduct a risk assessment which is informed as required by the evaluation of the proposals mentioned in the section above.

d) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Oversight and governance of the 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 Board and the council's Cabinet still remain engaged in the development and sign off the BCF.

We now plan to create of a Cambridgeshire Executive Partnership Board or Older People and Vulnerable Adults Joint Commissioning Board (JCB), which will provide the opportunity to bring together existing Older People Programme Boards 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. Our initial thinking is set out in the diagram below:

INSERT SN's governnace diargram

The Partnership Board will be formally established as part of the Section 75 arrangement and will be responsible for the development of the 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 Well-Being 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 budget and securing member organisation and HWB Board agreement to any strategic investment decisions.

The draft 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 OPACS contract 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 would 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 contract oversight. These transformational groups would 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.

It is our intention to establish these new arrangements as quickly as possible but until that point the current Joint Executive Group and Joint Project Team will continue to drive the on-going development and early implementation of the BCF.

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

2) NATIONAL CONDITIONS

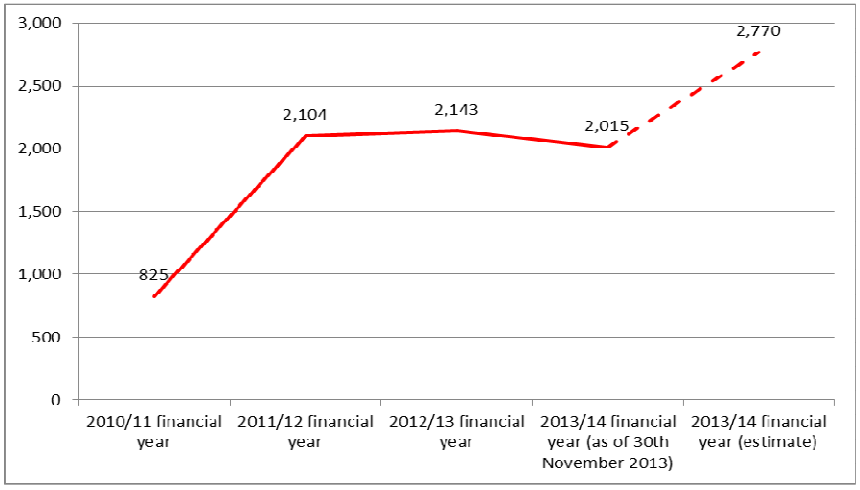
a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

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, being able to meet the new criteria.

Please explain how local social care services will be protected within your plans

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 re-ablement. We have no plans to reduce the amount of resources dedicated to supporting re-ablement. 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 being sustainable in the current financial climate. The rapid explanation in Cambridgeshire's overall population brings further pressures.

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 and Support 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 Bill means that other expenditure from the BCF will also contribute to delivering the requirements of the Care Bill, in particular preventative activities and assessment and crisis intervention.

Care and Support Bill

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

- Support for Carers (see below for details)
- Transforming Lives – a new model for social work/social care – including

prevention (see below 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

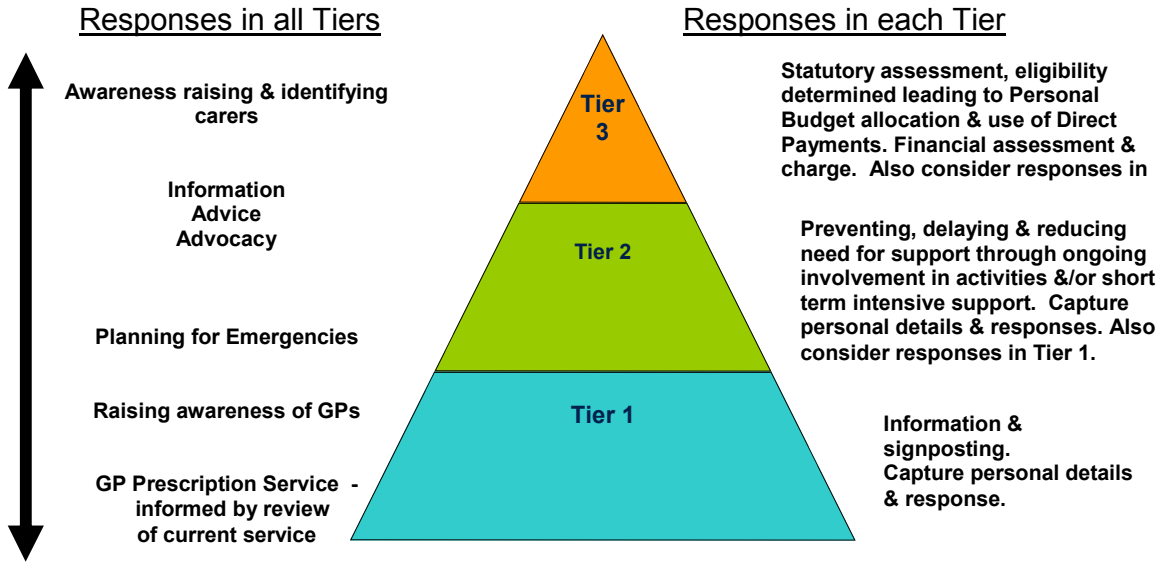
Financial modelling on the impact of the Care Bill has begun and the potential pressure areas are recognised as being:

- 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, and 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 Bill.

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

Support for Carers: The Council is currently leading a project developing a new model of support for carers that is taking into account the new duties arising from the Draft Care and Support Bill. The project is taking an inclusive and collaborative approach with statutory partners, family carers and the community and 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 that 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 described below.

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 individuals to maintain their independence and to 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 is 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 and where possible 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, and 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, for example into individual's personal financial circumstances, may be required. 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. When any additional issues might 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 2 models collaboratively with NHS colleagues, to maintain good health and wellbeing of people and carers and support them to have fulfilling lives. In line with the general approach of the Better Care Fund to deliver transformational change to the health and social care system, the time is right to make radical changes to the traditional ways of working that these work streams are designed to deliver.

Workforce Development (more to be added)

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 workers

with basic skills 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 workstreams 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.

While the workforce implications of the Better Care Fund are still being fully worked through, Cambridgeshire County Council's workforce development team are confident that the processes which are currently being developed will be sufficient to meet the challenge.

<u>Demand Management</u>

We 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 Continiung 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, by requiring providers to reduce admissions.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Strategic Commitment

Cambridgeshire County Council, working with Cambridge University Hospitals NHS Foundation Trust and the CCG, have committed to operate a "discharge to assess" process which will ensure that all patients will leave the acute hospital as soon as they are 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 is underway to implement this approach, which is 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.

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 demonstrates the 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, although operating, 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
-

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. For 2014/15 provider contracts, we are introducing a Commissioning for Quality and Innovation (CQUIN) agreement to ensure that:

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

    - All emergency admissions are seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital

    - 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, Hinchingbrooke Healthcare NHS Trust, independent sector providers and 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 (add more about strategic view)

Please confirm that you are 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.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

As mentioned above, the NHS number was included on the vast majority of correspondence in November 2013, and a new system has been implemented earlier this year which includes the NHS number on all correspondence.

Please confirm that you are committed to adopting 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 confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

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. Caldicott 2 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.

d) Joint assessment and accountable lead professional

Please confirm 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. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Across Cambridgeshire, the Local Commissioning Groups (LCGs, made up of groups of GP practices) are currently introducing multi-disciplinary teams (MDTs) to provide better and more holistic support to frail elderly or other vulnerable people. MDT assessments

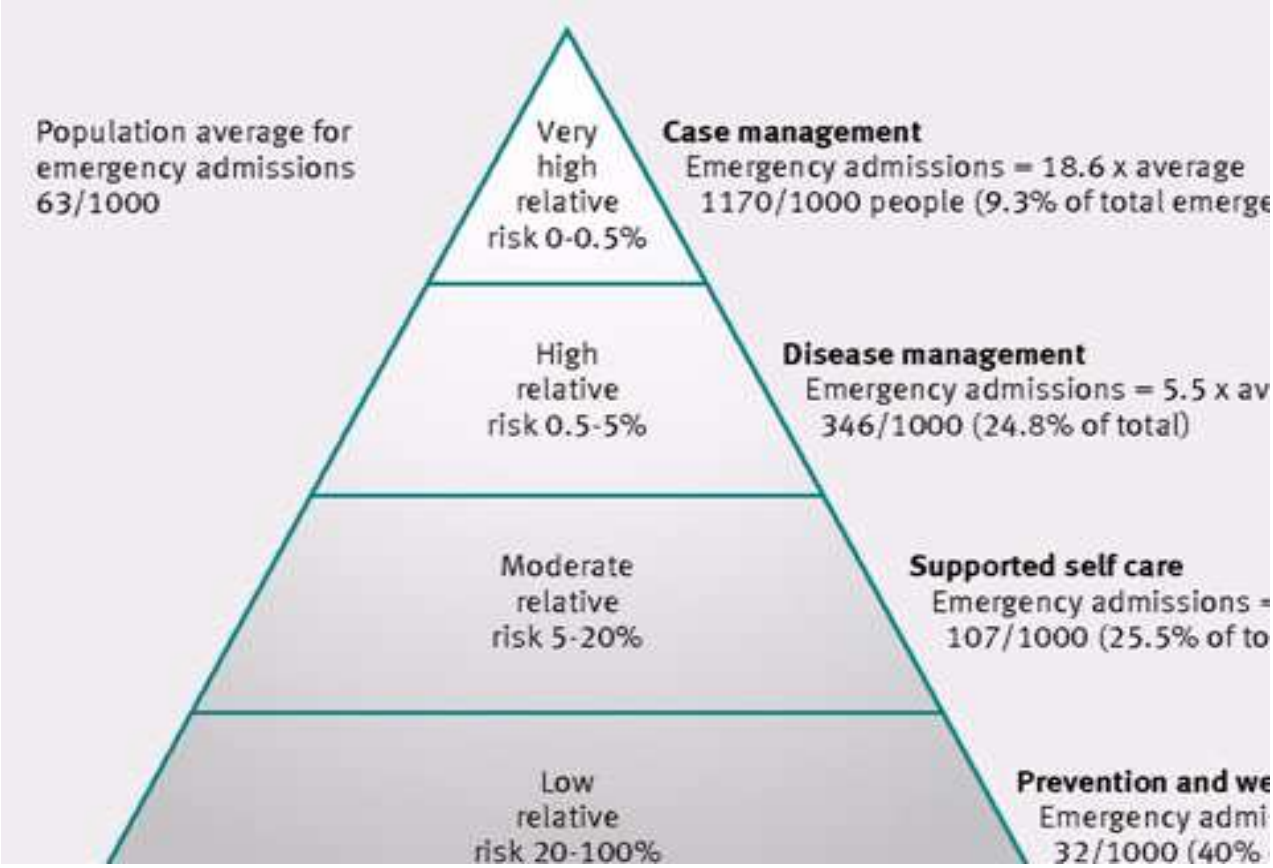
will become the norm for people who fall into these categories. They bring together social, medical and community care plans involving GPs, hospital doctors, nurses, physiotherapy, social workers and voluntary or community groups. Learning from these pilots about the role of lead professionals and the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

The Directly 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 is expected to 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.

3) RISKS

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

Risk	Risk Rating	Mitigating Actions
Financial Disinvestment	**High**	• 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
Loss of Strategic Perspective and Scale: The plan focusses on many small scale initiatives leading to lost opportunity to undertake strategic transformation of services	**Medium**	• Refer back as needed to the 5 year strategic plan context and over-arching priorities and other relevant strategic and commissioning plans • Consistently map the initiatives and proposals back to the agreed End State to check for right scale and scope • Agree a set of categories for strategic change, and group ideas and proposals around these
Failure to protect social care services: Demand for social care increases at a rate that outstrips the increased investment and transformation	**Medium**	• 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	**Medium**	• 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	**Medium**	• 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
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	**Medium**	• 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	**Medium**	• 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	**Medium**	• 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	**Medium**	• 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 / End State: Lack of clarity around the 'end state' resulting in loss of delivery	**Medium – needs further refinement**	• 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	**Low but needs to be maintained**	• Ensure that key stakeholders are identified • Build time into the BCF Fund planning timetable to brief and discuss stakeholders

the opportunity to contribute to and shape the Better Care Fund plan		• 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	**Low**	• 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.	**Low**	• 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.	**Low**	• 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	**Low**	• 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 government signing-off use of the Better Care Fund, leading to loss of the funding	**Low**	• All partners working to ensure that proposals address the national criteria • It is likely that the Government will allow time to refine proposals rather than rejecting immediately