APPENDIX 1

PETERBOROUGH – 14th February 2014 Submission

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	Peterborough City 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 that of Cambridgeshire County Council and with 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:	The Peterborough Health and Wellbeing Board met on 16 January, and discussed the emerging plans for the BCF; given that they will not meet again until April, the Board agreed to delegate the sign off of the drafts to the Joint Commissioning Forum, with a virtual sign off of the final draft prior to submission in April.
Date submitted:	Friday 14 February 2014
Minimum required value of BCF pooled budget: 2014/15	£661,000
2015/16	£11, 643,000
Total agreed value of pooled budget: 2014/15	£TBC
2015/16	£TBC

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	14 February 2014

Signed on behalf of the Council	Peterborough City Council
By	Jana Burton

Position	Executive Director of Adult Social Care, Health and Wellbeing
Date	14 February 2014

Signed on behalf of the Health and Wellbeing Board	Peterborough Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Marco Celeste
Date	14 February 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.

We have endeavoured to involve as many health and social care providers as possible during the drafting of this 'first cut' plan. Provider involvement has been achieved through:

- Participation in the work of the Peterborough Health and Wellbeing Board
- Discussion at the Chief Executive Officers Group (comprising all NHS Trust / Foundation Trust) providers in Cambridgeshire and Peterborough
- Active engagement in the Borderline and Peterborough Joint Commissioning Forum, with delegated oversight for the BCF from the PCC HWB between its meeting dates
- Active engagement in the Borderline and Peterborough Transformation Board (on which provider organisations, Patient Participation Groups and Healthwatch are represented)
- Development of two planning and engagement workshops to which a wide range of provider organisations (including housing, third sector, and NHS providers have been invited).
- Meetings with individual NHS Trust and NHS Foundation Trusts at Chief Executive and Director level
- Discussion and generation of ideas at the Urgent Care Networks
- Joint Local Authority / CCG-led working group, including PCC social care leads
- Ongoing engagement through a range of local meetings (e.g. Older People's Partnership Board, Carers Partnership Board) – for a full list, please refer to the Engagement Plan.
- Presentation of BCF material on both the PCC and CCG websites, with a dedicated email address for comments and suggestions, plus engagement in the BCF groups for Northants
- Discussion with Northamptonshire County Council.

This has proved to be a positive experience and it has contributed materially to the generation of ideas around the approach we should take in constructing the BCF joint commissioning fund and to the range and scope of potential individual initiatives.

Arising from this 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 Better Care Fund and the potential to achieve greater synergy of transformation
- 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 at 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 joint commissioning fund without achieving a tangible and measureable return on this investment e.g. through performance metrics

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

Our approach throughout has been to:

- secure 'buy-in' to the use of the Better Care joint commissioning Fund through the active engagement of all key stakeholders
- conduct consultation on draft proposals prior to discussions at the Health and Wellbeing Boards and sign off and submission to government
- be proportionate given the time and resource constraints. Where ever 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 Better Care joint commissioning Fund once plans have been accepted by government i.e. at the more detailed planning stage

To date, the scope of engagement in Cambridgeshire and Peterborough has been comprehensive including:

- Health and Well-being Board meetings (development and formal meetings)
- Older People Programme Board
- Integrated Mental Health Governance Group
- Chairs of the Local Health Partnership Boards
- City and Northants County Council, District Council representatives
- The CCG Patient Reference Group
- Local Commissioning Group Patient Reference Groups on request

- Presentation of BCF material on both the PCC and CCG websites, with a dedicated email address for comments and suggestions
- Promotion of the BCF Themes by Healthwatch via their Newsletter.

In addition, several of the items in Section (c) above, formally include patient representatives (e.g. Borderline and Peterborough Joint Commissioning Forum, Borderline and Peterborough Transformation Board, Stakeholder Workshops).

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 our 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.

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

- There is agreement on the Vision and Principles
- The importance of putting our Vision and Principles effectively into practice was underlined by several key stakeholders
- The need to avoid 're-inventing the wheel' and to ensure that we optimise care pathways
- Greater understanding of social care is needed generally and, in particular, how the social care elements of the plan inter-link with health services on the ground
- The need for Health to receive the equivalent benefit to the value of funding to be transferred to social care. It was 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

Joint working with the voluntary service sector is in place but we need to learn from examples elsewhere where voluntary and statutory sector services work particularly closely to deliver a range of services targeted at those in most need

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 Better Care Fund. 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.
The King's Fund Evidence summary: Making best use of the Better Care Fund	This document provides a summary of the requirements of the BCF with supporting evidence and suggested approaches,
NHS Cambridgeshire and Peterborough CCG Medium Term Financial Plan	This document sets out our medium term financial plan for the period 2013/14 to 2016/17 which shows how we will deliver the financial metrics requested by NHS England by 2014/15 and gives an overview of plans for future years.
NHS Cambridgeshire and Peterborough CCG Older People Services programme leaflet	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, Peterborough, Hertfordshire and Northamptonshire	These documents set out the key priorities on 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	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 authority and the CCG commissioning plans
Peterborough City Council Medium Term Financial Plan	This plan sets out the Cabinet's proposals for meeting the challenges of the Government's Spending Review (October 2010) and following Government announcements that impact local government funding.

2) 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?

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] To be successful, this transformation will require the contribution of a range of health and social care providers as well the greater involvement of the community and voluntary sectors.

Cambridgeshire County Council, Peterborough City Council and the Clinical Commissioning Group believe that the Better Care Fund offers an important opportunity to transform the health and social care system and delivery in Cambridgeshire and Peterborough to meet the needs of a rapidly ageing population better, and by doing so, ease the pressure on the system more generally, enabling it to provide better services to the whole population of the county / City. The Better Care Fund offers a unique opportunity to re-think how a significant amount of public money could be more efficiently and effectively spent.

Fundamentally, we believe that the Better Care Fund should be used for genuine transformation of the health and social care system in Cambridgeshire and Peterborough; through creating greater synergy and hence efficiencies in the provision of social care and health services, these can better be protected from pressures brought about by increasing demand and reducing budgets. The scale of this transformation opportunity is significant; it is much more than just reducing admissions to hospital. Rather, it is about changing the whole system so that it is focused on supporting people wherever possible with person-centred and professionally-led primary care / community / social care, guided by the goal of living as independently as possible, for as long as possible.

This approach aligns with the principles set out by Government, NHS England and Local Government Association, is consistent with the priorities set out in Cambridgeshire's and Peterborough's Health and Wellbeing Strategies 2012-17. It is also well-supported by evidence that clinical and service integration delivers better outcomes for people, particularly if groups of patients or service users are clearly identified and services for them are joined up around their needs.[2]

[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

[2] See 'Clinical and service integration' Curry, N and Ham, C; King's Fund 2010; available from http://www.kingsfund.org.uk/sites/files/kf/Clinical-and-service-integration-Natasha-Curry-Chris-Ham-22-November-2010.pdf

Over the next five years we would anticipate, amongst other things, the following changes:

- A transformational shift from what has tended to be an acute hospital-centric system to one which provides timely and appropriate care and support along the whole care pathway, delivered through a variety of service providers and care givers
- Greater emphasis on multi-disciplinary working across health and social care leading to more effective care planning, early recognition of impending crisis and better co-ordination and targeting of resources tailored to the service user's needs
- A transition to 7 day working to enable all agencies to respond in a timely and effective manner
- A more holistic approach to commissioning health and social care recognising the importance of taking into account social, mental health and physical conditions

We anticipate a range of positive outcomes for patient and service users including:

- Greater personalisation of service response to users' needs
- Enhanced support and guidance to carers
- Services which are responsive, timely and pro-active

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?

Aims and Objectives of the Integrated System

The integrated system planned for Cambridgeshire and Peterborough through deployment of the Better Care Fund joint commissioning will have the following over-arching aims and objectives:

Coordinated and intelligence-led early identification and early intervention.

For example, this could include:

- professionals being proactive in identifying need rather than waiting for it to be presented as a formal referral
- ensuring that the workforce are able to feed back as much intelligence as possible as to the needs of the service users they are supporting and how service delivery and deployment of available resources can be improved
- further improving information sharing between the range of organisations in contact with older people about individuals at risk of requiring more support in future
- Social Workers having greater identification with a community and working with other

agencies to identify those at risk and interventions available

Investment in community capacity to enable people to meet their needs with support in their local community.

For example, this could include:

- further development and investment in community capacity-building to prevent some people from entering a crisis
- improving access to a range of specialist services with the potential to reduce long-term care costs
- helping people to stay where they want to be, that is, at home

An improved approach to crisis management and recovery.

For example, this could include:

- a process for rapid escalation and action when a crisis occurs in the life of an older person
- a coordinated response from all agencies working in or operating as multi-disciplinary teams to provide intensive support in the short term and encompassing services such as respite care
- ensuring that when the crisis is over, older people and their carers remain as independent as possible and avoid short term crises triggering a deterioration which inevitably leads to long term health or social care need

A united approach to advice and information on community and public sector services.

For example, this could include:

- developing robust and reliable sources of advice and support for older people before they become frail or need to access the statutory system
- providing universal information and advice about services from all partner agencies, which should be quick to access, clear, friendly and personalised

How we will measure our Aims and Objectives

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

- 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

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 reablement / 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

Support at Home (Early intervention, prevention, and proactive support)

This theme includes the following:

Carers services: to enhance the offer for carers, building on carers prescription, respite and other carers support, and working to align strategies for adults and children's services. Building on the future aspiration of the Joint Carers' Strategy, we wish to join up monies from the Council and the CCG to improve outcomes for carers, including young carers, and those adults who care for disabled or vulnerable children. It is envisaged that this work would include roll-out and implementation of Carers' Prescription Service, support at crisis, carers breaks, and better advice and upstream support for carers and communities.

Early intervention and prevention: to develop the upstream offer, to avoid future demands on health and care sector. We wish to develop a universally accessible and joined up first point of contact, with a view to avoiding escalation of demand (including admission to care or acute settings). Building on existing Third Sector provision, we will pro-actively develop community navigator schemes that improve access to advice and information (including for carers, and wider communities) and promote social and community capital with a particular aim to combat isolation, and the social causes of ill health. We will also promote empowerment and self-management, building on the philosophy of self-directed support, whether through development of personal health budgets, or associated planning mechanisms for those with long-term conditions.

End of Life: support the development of community resources alongside the Lead Integrator for Community Services. This includes enhanced home care support at end of life through specialist third sector provision, with aim of improved experience for patients and their families at the end of life as well as reduced unplanned care costs.

Support when People need Help and leave Hospital (Enhanced reablement services)

This theme includes the following:

Enhanced reablement team: Building on the provision successfully provided by the City

Council under present Section 256 transfer arrangements, with the proposed impact being reduced admissions, reduced length of stay, and reduced (or at least delayed) demand for long term care. This initiative includes closer alignment of community therapies to develop a structured and intensively supported discharge service (in particular for conditions such as stroke for which there is an evidence base as to the positive impact of e.g. Early Supported Discharge plus orthopaedic discharges following hip fracture). In addition, it will include a focused and preventative approach to (repeat) fallers, including close work with other initiatives including medication review, etc. We wish to improve waiting times and capacity by working in partnership with housing providers, to provide timely and preventative adaptations, as well as to enhance reablement services following admission etc. In future, we will consider whether local ICES contracts might be aligned or more closely integrated with this work.

The Firm / MDT: move to 7 day working, and enhanced level of service (including Adult Social Care input) to promote admission avoidance, and timely discharge from acute and intermediate care. We will increase investment in frontline care services targeted in areas of need which are presently under-provided by the health and care sector. This includes:

- building on existing intermediate care and admission avoidance schemes (including The Firm)
- further reducing the number of avoidable admissions and emergency bed days through enhanced MDT working with adults as well as older adults (e.g. to reduce admissions for patients with concurrent learning disability and epilepsy, or improved routine review of medications)
- increased social care input to all MDT working
- 7-day working through MDT (or similar) teams and inclusion of 7-day working in acute contracts, including The Firm (or equivalent)
- improved psychiatric liaison services or mental health presence in MDTs
- increased patient flow through intermediate care sector to ensure access to “step-up” as well as reablement beds.

Home adaptations, telehealth and telecare: better development and utilisation of emerging and existing technologies to support independence, and reduce demand on acute / long term care sectors. We will invest in areas for which assistive technologies are proven (e.g. for people with chronic heart-failure, COPD / asthma) with a view to maintaining independence, and reducing unnecessary hospital admissions.

Care sector review team: to support medication reviews, quality improvement, discharge from short-term care placements, market alignment, support, and development. We will develop enhanced services (alongside incoming Lead Integrator for Older Peoples Community Services, and with reference to the Primary Care Strategy, in partnership with Primary Care) to review the health and care needs of residents in the care sector (including those supported by Domiciliary Care Services, or in Extra Care or Sheltered Housing provision). We wish to review the quality of care and to support discharge (back to more independent living), increased independence (for those who require longer term care), and with a view to e.g. medication review.

Enhanced psychiatric liaison, and mental health community support

This theme includes the following:

Psychiatric Liaison: to support the ongoing development of psychiatric liaison services in PSHFT, to enhance discharge (and admission) planning, and develop timely care packages for discharge.

Dementia Resource Centre: to develop the centre as a resource for both "upstream" (preventative, community, and educational) interventions, as well as a "hub" to support discharge and care planning We wish to develop great community resource, building on the development of the Dementia Resource Centre, with a particular view to early diagnosis, and "upstream" interventions (e.g. psycho-educational, and including support to carers and wider communities) which may maintain independence and reduce (or delay) admission to long-term care settings.

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

- First draft submission to NHSE 14 February 2014, to await and respond to any comments as part of ongoing development of the plans, prior to sign off through local governance arrangements (including through HWB, CCG Governing Body).
- Final submission of BCF proposals will be made on 4/4/2014, but it is expected that these will be the subject of ongoing transformational planning through 2014/15 in preparation to implementation in 2015/16.
- The CCG will continue between the 14 February and 4 April submissions actively to work with the four Health and Wellbeing Boards by whom BCF proposals will be authorised to ensure that synergies relating to schemes and proposals for the use of the fund (in the different LA areas) can be maximised, and that any duplications or inconsistencies of approach avoided.
- Further discussion with stakeholders and providers will be ongoing throughout, with two stakeholder workshops already planned to further develop the details of proposals, and a shared vision of transformational (rather than project based) change.
- The final plan will include an outline 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 / emergency / long-term services, including reductions in DTOCs (where applicable), reductions in avoidable emergency admissions, and reductions in long-term care placements.
- It will also include: commitment to named lead professional for integrated packages of care, use of the NHS number as the primary identifier, and development of increased 7-day working.
- Stakeholder involvement and commitment to transformation

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 to meet the health and social care needs of our population. As an example, in terms of strategic

direction and priorities for Older People, Cambridgeshire County Council and NHS Cambridgeshire and Peterborough 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 Health and Wellbeing 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 five priorities set by the Board, that is:

- Preventing and treating avoidable illness
- Healthier older people who maintain their independence for longer
- Supporting good mental health
- Better health and well-being outcomes for people with life-long disabilities and complex needs

We have used the intelligence available in the JSNA to identify the key target areas of focus and 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

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

- Implementation of the Integrated Older People's Pathway and Adult Community Services Procurement led by NHS Cambridgeshire and Peterborough CCG
- Aligned to this, implementation of the initiatives set out in the Better Care Fund 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 acute 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 Boards are engaged in this 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 not actually being achieved
- A requirement that, as a whole system, we jointly align the work and objectives of the Older People Programme with that of the Better Care Fund to avoid 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

Realisation of NHS Savings

National planning guidance[3] sees the BCF as having the potential to improve sustainability, raise quality and reduce emergency admissions; the latter will have to reduce by around 15%. Within Peterborough, 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, for example, the older people's programme. It will also form a part of the CCG five year strategic plan. The Better Care Fund 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 the initial stage of preparing the BCF plan and, as a result of our engagement activities, we have received a large number of proposals for transformation from a wide range of stakeholders. Having grouped those proposals into key themes, our next task is to evaluate the proposals in detail, in order to assess the potential scale and scope of NHS savings which could be

[3] Everyone Counts: Planning for Patients 2014/15 to 2018/19; issued by NHS England on 20 December 2013; gateway reference 01000

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 link the BCF initiatives back to the delivery plans set out in the two year operational plan both to ensure consistency of approach and to eliminate the risk of duplication. The results of this work will be set out in the second 'cut' plan submission in April 2014.

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 are working jointly to conduct a risk assessment which will be informed by the evaluation of the proposals mentioned in the section above.

e) **Governance**
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Oversight and governance of the Better Care Fund Plan are provided by the Peterborough Health and Wellbeing Board who will sign off the plan. The development of plans for the Better Care Fund in the Borderline and Peterborough LCGs is undertaken jointly with Peterborough City Council (PCC), Cambridgeshire County Council, and Northamptonshire County Council. The majority of the agreement will relate to funding transfers (and subsequent pooled funding arrangements) with the former, PCC.

With this in mind, the following arrangements have been developed:

- the PCC Health and Wellbeing Board has delegated a small working group (the BCF group) to take forward the planning work. This group meets regularly to coordinate the work
- the BCF Group will report to the monthly Joint Commissioning Forum from February to April. The Forum has been delegated responsibility for the sign-off of drafts of the plan (in advance of the next Health and Wellbeing Board meeting in April)
- the PCC Health and Wellbeing Board will be asked to sign off virtually the final plan before submission on 4th April 2014
- the monthly Transformation Board will be used to engage more widely on the plans as they develop; in addition however, two workshops are being planned (mid-February and mid-March) to more widely engage with local stakeholders]

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

Within NHS Cambridgeshire and Peterborough CCG, leadership from the top is provided by the Chief Clinical Officer, supported by the Chief Operating Officer, who generate the drive, focus and performance management ethos within the organisation on behalf of the Governing Body. The Chief Clinical Officer works particularly closely with Local Commissioning Group Chairs to ensure that service transformation is shaped and steered through clinically-led commissioning. Local commissioning group engagement is steered and overseen by Local Chief Officers who work closely with their respective Local Commissioning Group Boards.

3) NATIONAL CONDITIONS

a) Protecting social care services

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

The BCF working group have proposed that the funding and schemes behind the two s256 funding agreements which currently exist for the main DH funding allocation for Social Care and additional reablement funding, will form the basis of the amount of fund set aside for the protection of social care services. This funding is already embedded in agreed priorities and investment in social care and delivering benefits across the health and social care spectrum. The areas will be reviewed as part of the use of other BCF funding with a view to ensuring that maximum transformational change can be developed across the entire pool of funding and the services to which it relates.

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

Adult Social Care is facing increasing demographic pressures due to increased numbers of older people longevity and medical advances which mean people with disabilities are living longer. Pressure on services will be increased as a result of the implementation of the Care Bill and the need to meet the needs of self-funders. The funding allocated will need to be sustained and if necessary increased, to meet these pressures. The plans will be reviewed over the period of the BCF and amended as necessary to ensure that maximum transformational change can be developed across the entire pool of BCF funding and the services to which it relates, and that social care service are protected and in a position to deliver services which will give a whole system benefit across health and social care.

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 to 7 Day Services

There is a clear understanding and commitment to the importance of 7-day service delivery, and a CQIN relating to this has been in place with PSHFT during 2013/14. In addition:

- The offer of Health and Social care Domiciliary Services that can be called into stay with patients overnight by OOH's GP's to prevent admissions, with the same team supporting A&E Patients to return home overnight to prevent being admitted for Social Reasons.
- Care Homes accept referrals on the same day as assessment 7 days per week, step up and down, and Domiciliary Care Agencies accepting and

starting new care packages 7 days per week.
- 7 day assessments Health and Social Care in the Hospital to support 7 day discharging includes CHC needs
- 7 day support from Voluntary Sector Organisations to support people in the Community who don't meet Health and Social Care

Local Implementation Plans

Success will mean that people will be able to be discharged from hospital at the weekend, because staff are there to medically approve discharge, plan their discharge and link up with a suitable provider if they need ongoing care. This will mean service providers needing to change their staffing patterns to allow this, which might mean changes in terms and conditions or working hours for staff in hospitals, social services, housing or care providers.

Local implementation plans for introducing 7 day discharge have not yet been developed, and will form part of the next stage of planning.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

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. Within Peterborough social care services, the NHS Number is not currently used as the primary identifier for correspondence. The social care record system does have functionality to support the use and therefore, as part of our wider transformation programme, we will seek to build its collection and use as an identifier.

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

Peterborough City Council has a transformation programme with a timetable for delivery in 2014/15. Implementation of the NHS number as a primary / universal identifier will need to be introduced in a phased way across providers as part of the transformation programme.

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))

Cambridgeshire and Peterborough CCG is committed to adopting systems that are based upon Open API and Open Standard wherever possible and encouraging existing supplier to adopt Open API and Open Standards in future releases of software. NHS Cambridgeshire and Peterborough CCG is often directed to use

specific software suppliers by NHS England and or the Health and Social Care Information Centre. Peterborough City Council is committed to implementing the requirements of Caldicott2 and has recently reprocured software to allow secure sharing with the independent sector care providers. Use of GCSX - NHSnet e-mail when communicating between Council and Health professionals is well embedded.

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.

Cambridgeshire and Peterborough 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. NHS Standard Contract 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. Peterborough City Council has submitted the IG Toolkit assessment and established an action plan for key areas.

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.

Existing MDT arrangements (including the Firm for crisis support in the B&P system) provide a good foundation for ensuring that all those who are identified as at high risk of admission have an agreed lead professional. Present challenges around IG hamper formal approaches to risk stratification, but there is local agreement as to the benefit of taking this kind of approach.

4) 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
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 revenant 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 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
Failure to meet performance targets: Results in loss of up to £9m	**Medium**	• Effective negation 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		• On-going review of strategy and vision • Robust arrangements for reviewing progresses across all change activities • Appropriate investment in communication to users and staff • Development 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 & 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
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 OP's Plan for Cambridgeshire • Ensure all clients groups are reflected in the vision • Agree vision and principles and set them out clearly in the Better Care Fund 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 and shape the Better Care Fund plan	**Low but needs to be maintained**	• Ensure that key stakeholders are identified • Build time into the Better Care Fund planning timetable to brief and discuss stakeholders • Maximise the opportunity to brief and debate through attending existing meetings • Organise bespoke events e.g. Health and Well-being Board development days 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/PCC 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 Health and Wellbeing 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 Health and Wellbeing 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