Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	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 Board:	The Peterborough Health and Wellbeing Board are next scheduled to meet on 25th September 2014. Agreement has been reached for the HwB board to review proposals for the BCF, and to virtually sign off the templates prior to

	this 19th September submission. Additionally the HwB have agreed to delegate ongoing oversight of implementation of the BCF during 2014/15 to the Joint Commissioning Forum.
Date submitted:	**Friday 19th September 2014**
Minimum required value of BCF pooled budget: 2014/15	£661,000
2015/16	£11, 999,000
Total agreed value of pooled budget: 2014/15	£661,000
2015/16	£11, 999,000

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	Friday 19th September 2014

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	Peterborough City Council
By	Jana Burton
Position	Executive Director of Adult Social Care, Health and Wellbeing
Date	Friday 19th September 2014

Signed on behalf of the Health and Wellbeing Board	Peterborough Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Marco Cereste
Date	Friday 19th September 2014

c) Related documentation

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 2 Year Operational 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 Peoples Pathway and Adult Community Services procurement information	A range of materials are available on the Older Peoples Programme pages of the CCG website relating to the scope, outcomes model, and proposed implementation for the CCG-wide procurement of community and older people's services.
Better Care Fund Performance Metrics (Peterborough)	Provides an overview of the national and local performance trends to support the targets associated with BCF metrics, and tracking 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.
Appendix 1 - Programme Portfolio – Care Services	Peterborough City Council Transformation programme, including detailed description of schemes relating to the Better Care Fund.
Appendix 2 - Programme Portfolio – Commissioning	Peterborough City Council Transformation programme, including detailed description of schemes relating to the Better Care Fund.
Appendix 3 – Learning Disabilities and Autism Strategy	Peterborough Strategy for People with a Learning Disability or Autism diagnosis.

2) VISION FOR HEALTH AND CARE SERVICES

The overall vision for health and social care services in Peterborough brings 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'

From out Joint Strategic Needs Assessment it is clear that Peterborough need to plan for a rapidly ageing population, with very specific mental health challenges and a diverse ethnic population. Peterborough falls under the ONS classification of 'new and growing towns' and comparisons are made within that group. Peterborough City Councils comparators, include; Swindon, Bedford, Thurrock, Milton Keynes, Harlow, Stevenage and Ipswich.

Some of the highlights from the JSNA are:

Population Profile and Growth

- The Population of Peterborough is 185,000
- Peterborough population is predicted to grow by 11% by 2021
- The largest growth in population will be seen in:
    - 65-74 age group 26%
    - 75-84 age group 21%
    - 85+ age group 52%
- Peterborough has a higher percentage of children than England average
- Peterborough has a higher percentage of adults 25 – 44 than England average

Ethnicity

- Peterborough has a diverse ethnic population, and is ranked the 40th most diverse of 152 Primary Care Trust's (PCT's) PCT[1] nationally for ethnic diversity. Peterborough is considered to be the second most diverse of the 14 PCTs in the Eastern Region, behind only Luton.
- People of the Pakistani ethnic group make up 6.6% of total population.
- 80% of migrant workers are from Europe of which 40% are from Lithuania and Latvia.

(Source: ONS mid-census population figures 2008)

Deprivation

- Peterborough is described as the most deprived Local Authority in the New and Growing Towns ONS Cluster.
- Peterborough is ranked 90th in England out of 354 Local Authorities.
- The deprived areas are densely populated and 26% of the population are living in the most deprived areas in the country[2]
- In 2010 there was an estimated 4,320 people unable to work
- The unemployment rate between July 2012 and June 2013 was 9.6% compared to the Great Britain average of 7.8%[3]

[1] PCT were replaced by Clinical Commissioning Groups in 2013
[2] The English Indices of Deprivation (2010)

- It is predicted that over 14,000 people in Peterborough have a limiting long term illness
- Peterborough is significantly worse than the national average for 16-18 year olds not in education, employment, or training
- Peterborough is significantly worse than the national average for violent crime and first time entrants into youth justice system[4].

Despite the local challenges relating to population growth as outlined above Peterborough has reducing financial resources, and without change, our services will be unsustainable in the very near future. Consequently, the HWB Board, PCC and the CCG have already been planning to move 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.

The Health and Well-being board have identified the better are fund as an important opportunity to transform the overall local health and social care system for patients, service users and carers'

This vision is ambitious, given the specific challenges that the system is facing in Peterborough:

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

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

[3] www.nomis.co.uk/reports/IMP/la/1946157202/report.aspx?town=peterborough#tabempunemp (downloaded 6 November 2013)
[4] Neighbourhood statistics 2010-2011
[5] Health Services Management Centre (2013); 'Turning the welfare state upside down?' Developing a new adult social care offer http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/PolicyPapers/policy-paper-fifteen.pdf Retrieved 6th November 2013

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

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.

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

The BCF is one part of our overall transformational activity but is not the solution in itself, other important work around the Care Act (part 4 integration) is closely aligned to the BCF.

Work is also underway locally improve our urgent care capabilities following the recent support provided by Emergency Care Intensive support Team ("ECIST") work with Peterborough and Stamford Hospitals NHS Foundation Trust work is underway to implement a 26 point plan which will make a series of improvement to urgent care. This will see changes to non-medical support in A&E in terms of physiotherapy and occupational therapy being made available at the point of contact to prevent admission in areas such as when an elderly patient may have had a fall or trip at home which does not result in a fracture, placing the emphasis on adequate pain relief and physiotherapy assessment as opposed to admission. Social care packages of care can be increased/ arranged if these people are seen early in the process.

We recognise that BCF is not new money – all of the money allocated to the BCF is already spent on health and social care services in Peterborough. The Better Care Fund does however offer a unique opportunity to re-think how a significant amount of public money will be more efficiently and effectively spent.

We will focus our use of the BCF on initiatives that help to prepare the system for a bigger change in the medium term, by protecting existing social care services; supporting the development of 7 day working and data sharing; and supporting the development of closer working, including development of joint assessments with an accountable lead professional. We aim therefore to ease the pressure on the system more generally, enabling it to provide better services to the whole population.

New Model of Care

Peterborough City Council and Peterborough and Borderline Locality Commissioning Group have developed a model of care that focuses on prevention promotion and early intervention. As commissioners we wish to see the development of a primary and

community care model, which reduces reliance on traditional secondary, care support and acute care services. This model will be based on Local Area Coordination, Asset Based Communities and further development of an integrated primary and community based service that seeks to build community resilience and minimise demand upon services.

The White Paper “Caring for our Futures; reforming care and support” (HM Govt 2012) and previous policy initiatives (A Vision for Adult Social Care, Think Local Act Personal, Putting People First etc.) have identified the need to move the balance of care and support from crisis and service driven to prevention, capacity building and stronger communities.

“Caring for our futures” now identifies Local Area Coordination and Asset Based Community Development (ABCD) as key approaches for strengthening communities and supporting vulnerable people to build non service solutions wherever possible.

The paper on building social capital by Think Local Act Personal (Volunteering: unlocking the real wealth of people and communities, Wilton, 2012) also cites Local Area Coordination as a key approach to supporting people to find local solutions, building capacity and strengthening communities (p.7). This concept is also central to the discussion paper, Policy Paper 15 - August 2013. (‘Turning the Welfare state upside down?’ Developing a new Adult Social Care Model) by the Health Services Management Centre and the importance of focusing on creative working with existing social capital and local community resources as the starting point for Adult Social Care.[5]

Table 1 below sets out Peterborough City Councils’ Target Operating Model and Customer Journey. This identifies Local Area Coordination as the Foundation of this model of care which will make available relevant, timely and appropriate information at the start of the customer journey.

Table 1: PCC Target Operating Model - Customer Journey

Our long-term shared vision is to bring together all of the public agencies that commission and 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.

To be successful, this transformation will require the contribution of a range of health, housing, and social care commissioners and providers, along with the greater involvement of the community and voluntary sectors. Peterborough has a strong commitment to coproduction, and will using the existing coproduction groups to share and develop designs and when they are available at an early stage.

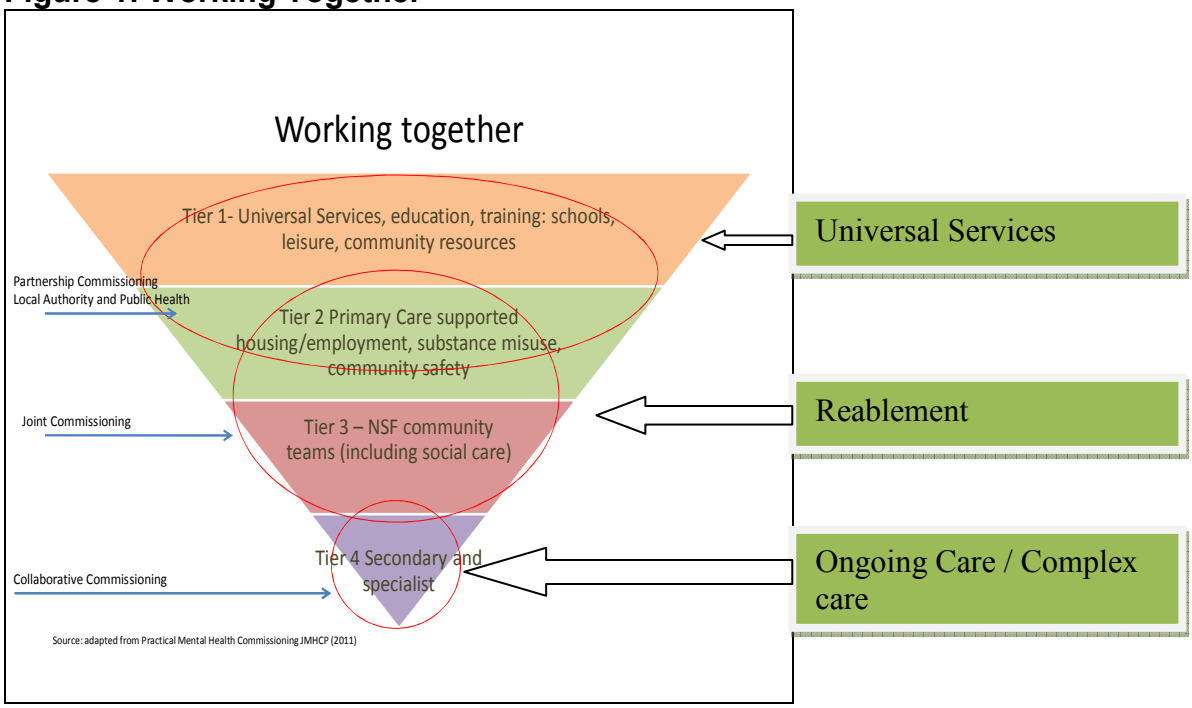
We want to ensure that Peterborough is an area with first class facilities and services for all its residents, local businesses, those who work in the area, and those who visit here. We see the Peterborough of the future as an area that will have a strong and well-defined positive image, confidence and sense of place.

Our vision is also about creating a place that is known - locally, regionally, nationally and internationally - as a 'modern city', a place offering the best balance of social, economic and environmental benefits - combining the best of urban and rural life.

Of course, communities are about people and our vision is of a 'safe, caring and healthy city' where local people will feel safe and secure in a strong community and have pride in the heritage, culture, environment, diversity, and achievements and success of the area.

Figure 1 below gives a pictorial view of how stakeholders will work together, understanding the key roles, responsibilities and accountabilities of the respective organisation. The figure also shows the key elements of Peterborough Customer Journey and how they fit with a 'whole systems commissioning strategy'

Figure 1: Working Together



Linked to the Better Care Fund programme in Peterborough are the many and various changes arising from the Care Act, and Peterborough's vision for Social Care and Health is in line with the general responsibilities in the Care Act with a focus on promoting wellbeing, developing community resilience and re-designing the whole system to deliver in ways which focus on early intervention, prevention, and proactive support. Specific examples include plans to enhance and align the offer to carers, enhance and integrate reablement and admission prevention services and to jointly develop tele health and tele care services.

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 Strategy 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.

In Peterborough we are developing a 'Model of Care' that has at its heart 'building

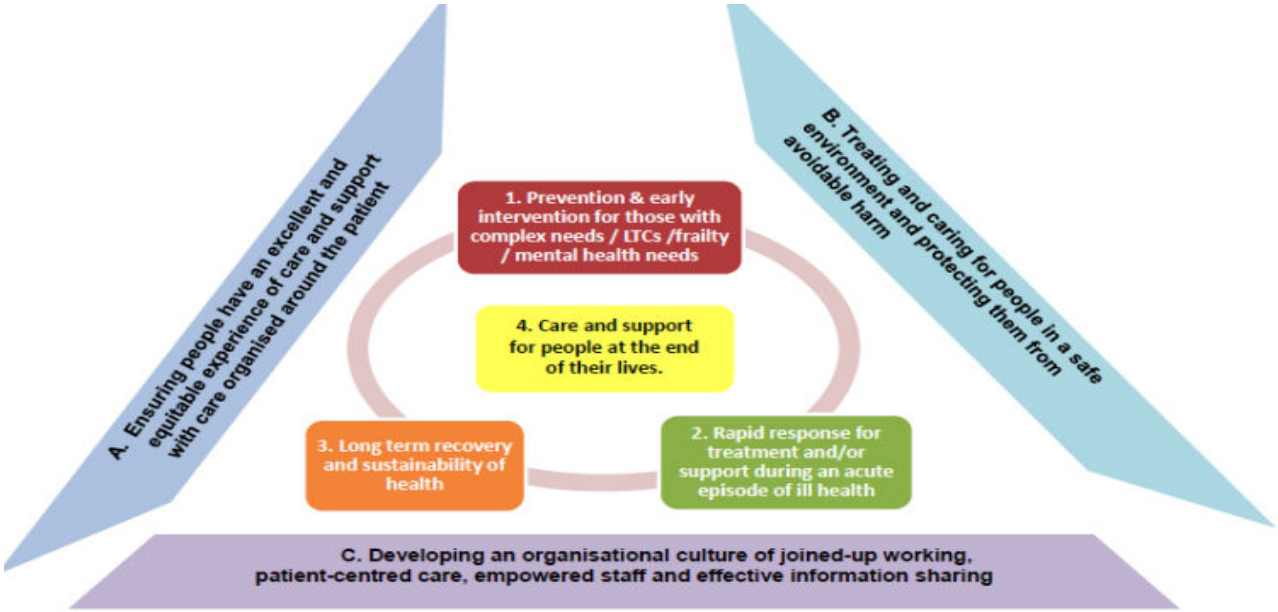
resilience' in the Community, with families and individuals. This has emphasis on the individual, family and communities emotional health alongside the care, support and interventions required. We recognise that mental health, wellbeing, and physical health are intrinsically linked and there is a need to accommodate a duality of approach. Closing the Gap priorities 13-15 focus on integrating physical and mental health care and a focus on wellbeing. To meet these priorities we will need to further define and develop how health and social care will work together.

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

We anticipate a range of positive outcomes for patients 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
- A greater emphasis on developing resilience and the emotional wellbeing of communities

Many of these are encapsulated within the Outcomes Framework being developed within the CCG OPPACS procurement (as summarised below), and it is hoped that this might form a good starting point for the development of a shared outcomes framework with providers, the public, stakeholders and the voluntary and community sector.



Supporting older people to stay independent

We would like to see care delivered to older patients, or for older patients to be able to access care, in ways that allow them to maintain their independence. Ways suggested

for doing this are:
• offering support at an earlier stage to a larger number of people than is the case now
• focusing on prevention - making sure those aged 65 plus have access to information and services that will help keep them well, for example diet advice and exercise opportunities
• with patient consent, offer a health/care review to identify and address issues, for example housing problems
• increased working with local voluntary organisations to direct patients to services and provide more informal support
• establishing healthcare contact points venues other than GP practices
• using technology such as Skype/Telehealth to provide support for people with long term conditions
• developing a record system that patients can access, so they can self-manage their care

Improved community services: reducing emergency hospital admissions, re-admissions and long stays in hospital.

Quite often during an episode of severe illness, hospital treatment is necessary. However a significant number of people are admitted to hospital who could have been safely treated at home, or discharged at an earlier point, if community services were organised in a different way.

We would like to see a healthcare system that reduces the number of older people being taken to hospital unnecessarily, or staying in hospital longer than needed.

Proposals received suggest this can be achieved by:

• improving information for, and engagement with patients, their relatives and carers to increase understanding of long term conditions, so they can better identify minor changes or serious deterioration and request help accordingly and earlier
• emphasis on personal case management to identify patients at risk of being admitted or re-admitted to hospital, managed through Multi-Disciplinary Teams (MDTs)
• having a 24/7 urgent care system that can send a community team to the patient to both assess and treat at home, without the need to go to A&E unless necessary

• good access to urgent hospital specialist advice and assessment
• much stronger links between the community and the hospital, from the A&E department to the wards, with teams based in the hospital supporting care and linking with community teams in-reaching into the hospital, supporting better arranged discharge
• better rehabilitation services to support people to recover from episodes of ill health. This could include the provision of ‘step down’ beds in community settings, or a hospital at home service giving help with personal hygiene such as bathing, shaving etc, as well as medical care.

End of Life Care

Alongside improving care for older people, the CCG has made improving End of Life Care across Cambridgeshire one of its priorities. The preferred provider(s) awarded the contract will be expected to work with the CCG on delivering improved End of Life Care.

Service users and carers will be directly involved in the commissioning, contracting and procurement of services, on a fully co-produced basis...

Service Users and Carers have confidence in the services they receive. Through the implementation of the new care model which is based on supporting natural communities regardless of client group we will build / develop the health and wellbeing of the community.

By developing our Asset Based Enterprise model alongside Local Area Coordination we will build on people's strengths and abilities. Developing innovative and bespoke responses to achieving an individual's 'good life'. Through the work on Local Area Coordination resilience will be built within Individuals, Families and Communities, and Statutory services are then seen as a last resort.

More people particularly those with Learning Disabilities, Mental Health challenges and autism will be in employment improving their self-esteem and general well-being. Through our initiatives relating to supported housing less people will be unnecessarily admitted to hospital or long term residential and nursing care.

Through our implementation of assistive technology more people particularly older people will be able to stay at home reducing the number of older people moving into residential care settings.

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

Our key areas for investment are as follows:

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

Through our transformation of services to Older People 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. Central to the pattern and configuration of services is the CCG led Older People and Adult Community Services (OPACS) Procurement which is summarised below:

OPACS Procurement

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

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

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

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

Whilst the full range of social care services and funding is not in the scope of the procurement, the CCG is working closely with Local Authority partners on the procurement and wider Older People Programme. Cambridgeshire County Council, Peterborough City Council and District Council representatives have been integrally involved in steering the programme and also in the detailed dialogue and evaluation associated with the procurement. There is a strong alignment and synergy between the OPACS work and the aims of the Better Care Fund which will enable and support it.

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

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

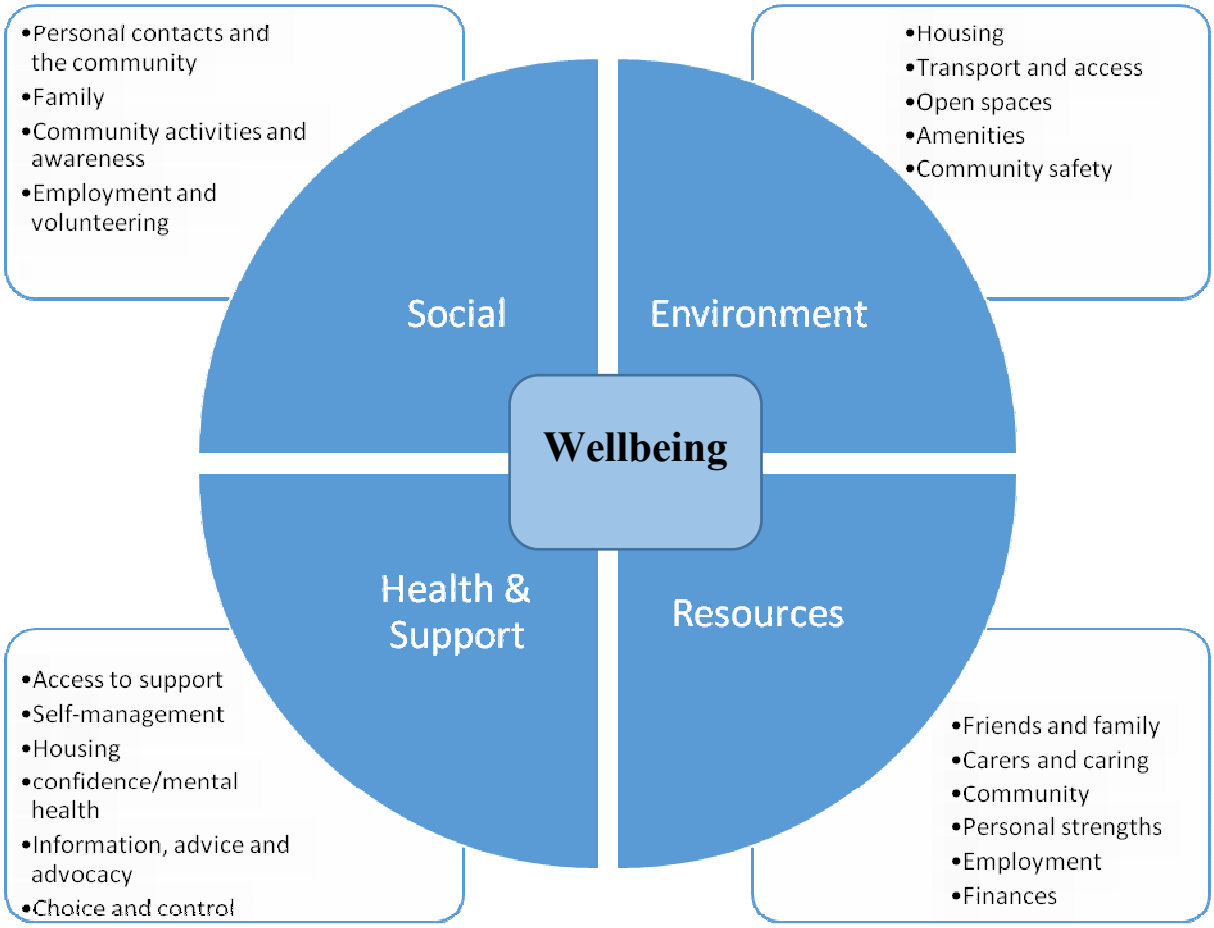
Vision

- People are able to manage the opportunities and challenges of life, to remain independent and to have the best health and wellbeing possible and People are able to make a positive and purposeful contribution and to maintain and develop connections with family, friends and their communities

We want to develop a model of wellbeing that focusses on removing or reducing the barriers that prevent people participating and that disable them and affect their quality of life. To do this we need to understand and support people's hopes and aspirations and enable, wherever possible, self-management of wellbeing. We need to move away from a default position of professionals providing support and care after a problem has arisen.

Central to wellbeing are the principles of safety and dignity: the Council will work with stakeholders to ensure that safety, dignity and human rights are paramount in all support, commissioning and development work.

The diagram below summarises the range of overlapping factors that can affect someone's wellbeing:



Key outcomes for these areas expressed as aspirational 'I statements' are:

- Social – I have a sense of purpose and good relationships; I live in my community and can play an active role
- Health, care and support – I am able to manage my health and wellbeing, get support when I need it and make choices about that support
- Environmental – I live in a place that is sensitive to my needs, healthy and enables active participation
- Personal resources – I can make of use my strengths and abilities; I can afford a good quality of life

How we will get there

The Council will work with other commissioners, providers and people using services to shape the range of support and opportunities that build on the strengths of people and their communities, to meet their needs and to benefit the wider community.

Central to the Council's approach to commissioning for older people are the principles of:

- Equality and diversity including tackling discrimination
- Understanding better when support is required, what support is required and how that support should be made available
- Prevention and early intervention, wherever possible tackling issues before they arise
- Focussing on outcomes, not on services
- Enabling and empowering people to make choices and take control of support that is

tailored to the individual
- Working in partnership with people, their families and the communities they live in
- Mental health needs, physical health needs and social care needs are inter-related and equally important.

What this will mean in practice
There are some cross-cutting themes that the Council will be addressing including the development of clear care standards, training and support for workers across health and social care sectors and the promotion of safeguarding approaches and principles locally. In terms of more specific areas for development:

Universal services

- High quality information, advice available directly from the Council's Customer Service Team and from voluntary sector organisations
- Advice and information on benefits and financial matters through the council's Financial Assessment Officers and independent organisations
- Commissioning a new integrated advocacy service so people can understand their rights and have a voice
- Advice and support related to maximising well-being such as access to fitness activities, emotional support, family and social networks, smoking cessation and falls prevention through the voluntary sector, Vivacity, the Council's Live Healthy Team, GP surgeries and community health services
- Increased opportunities to access volunteering, education and employment opportunities including working with the voluntary sector, Vivacity, local employers, education and training providers
- Ensure transport provision meets the needs of people and supports community engagement by developing new opportunities with local transport providers

Prevention and enablement
- Increase access to aids, adaptations, equipment and assistive technology including for people funding their own support through the Council's Service Directory, the Integrated Community Equipment Service, the Reablement Service and independent partners
- Commissioning Community Catalysts to work with social entrepreneurs and innovators to develop sustainable, community based micro-enterprises that offer direct support to people
- Work with voluntary sector partners to develop the right range voluntary sector and not-for-profit support locally
- Increase Reablement Service capacity and develop new approaches to interim support that minimise reliance on residential and nursing care including the piloting of specialist reablement accommodation with local hosing providers

Longer term support
- Increase uptake of Direct Payments promoting the benefits to people and professionals, expansion of services that support people to manage a Direct Payment and increasing the number of people working as Personal Assistants locally. The development of a Personal Assistant register will make it easier to employ a Personal Assistant and provide assurance and confidence to people wanting to employ someone directly to provide support
- Work with housing providers to develop a range of options that provide integrated

accommodation and support including the development of extra care and more specialist dementia accommodation
- Develop the Council's Shared Lives service to include people over 65 to provide respite and longer term placements
- Develop a seven day specialist dementia day service at the Dementia Resource Centre and, longer term, in other community sites across Peterborough
- Develop a range of community based day opportunities that support inclusion
- All support to be developed and commissioned on a seven day and extended hours basis
- Develop approaches with health that take a whole family approach to assessing strengths and need and that consider the support needs of family carers
- Ensure that all health and care support works to maximise independence and self-management where possible
- The further development of the residential and nursing homes to ensure care is of the highest quality and opportunities for residential services to support people living nearby are developed with homes and communities
- Ensure a range of effective, coordinated and personalised support is available for people with multiple needs
- Establishment of quality improvement resources to support challenged providers to improve the quality of care and support they deliver.

From our Older Peoples strategy we intend to transform services to meet new outcomes as indicated in the table below.

	Issue	Activity	Who	When	Outputs and metrics
SOCIAL	Outcome **I have a sense of purpose and good relationships; I live in my community and can play an active role**				
	People are concerned about becoming isolated	Understand those groups most at risk of isolation to inform better targeting of resources. Map and develop social network opportunities locally and identify the range of support people need to access them. Complete a gap analysis to better inform commissioning plans. Raise awareness amongst communities and	PCC LACs VCS PCC LACs VCS PCC LACs PCC CCG Integrator PCC	Apr 15 Apr 15 Sep 15 Sep 15 Apr 16	• Comprehensive directory of opportunities developed • Numbers of people over 65 accessing • Opportunities are accessible (customer rating) • Number of opportunities available locally

		with professionals. Explore the development of a social prescribing model for Peterborough including identification of funding.			
	Older people want choices about how they take part in their communities	Work with PCVS, Community Catalysts and Local Area Coordinators to map and develop volunteering opportunities for older people. Support access to employment and training for older people. Raise awareness within communities of the resources that older people offer and ensure that older people are supported to offer their resources if they choose. Support the set-up of community groups including the development of intergenerational opportunities.	PCVS PCC PCC Training providers Local employers PCC LACs VCS PCC LACs VCS	Apr 15 Apr 16 Apr 15 Apr 16	• Number of people over 65 volunteering • Number of people over 65 supported as carers • Number of people over 65 in employment • Number of people over 65 accessing training and education opportunities
	Older people can lose confidence, this can be a barrier to getting involved in their communities and to getting the support they need.	Develop an awareness campaign using the Dementia Friendly cities model to raise awareness about the issues people over 65 face. Ensure community development,	PCC CCG PCC	Apr 15 Apr 16 and ongoing	• Number of awareness activities delivered • % of plans and strategies specifically including issues for people over 65 • Reablement

		community safety planning and environmental planning considers the needs of people over 65 and is co-produced with them. Develop reablement approaches that include supporting people to develop confidence and independence.	PCC	Apr 15	metrics • People over 65 accessing emotional support
		Ensure low-level psychological and emotional support is available locally including bereavement support.	PCC CCG	Apr 16	

In relation to mental health the key changes in delivery of care over the next five years are summarised below:

Area of Development	System Change	BCF
Public Health Communities	Local Area Coordination Delivering system change Formal care becomes a last resort Building resilience within Communities	Appointment of 6+ local Area coordinators Appointment of 3 CDW (BME) working as Local Area Coordinators (Peterborough)
	Suicide Prevention Clear Pathways across City Web based resource centre Training and awareness raising Peterborough Pledge	Sustainability funding Web maintenance and development Ongoing Training and awareness raising Anti –stigma national campaign Ongoing development and support for Peterborough Pledge
Area of Development	**System Change**	**BCF**
Public Health (cont.)	Bounce Project Delivering a programme of interactive workshops designed to promote well-being and resilience in general population. It	Sustainability funding

	explores individuals unique well-being and tailors individual solutions with the aim of increasing the ability to deal with life's challenges Building individual and community resilience	
Primary Care	Development of Primary Care Mental Health	Appointment of 3 Mental Health SWs in Peterborough
		IAPT step one plus There is significant unmet need amongst people with assessed low level MH need but complex social context such as people who hoard or who are leaving care transitioning into adulthood, if addressed this would reduce the use of inappropriate services and individual distress. IAPT step one would include, assessment, supported sign posting and engagement, brief psychological interventions with preventative social care interventions
		Integrated health and social care personal budgets. True personalisation and integration of health and social care is significantly achieved by the integration of personal budgets. This initiative would develop the infrastructure and piloting of integrated health and social care budgets.
Area of Development	System Change	**BCF**
Crisis Concordat	Development of capacity AMHPs - stronger connection with Police	Appointment of AMHPs (3 Peterborough) Police liaison Based in

	Development of Alternatives to Hospital Adm. / crisis intervention Protocol developed to respond to frequent attenders to Custody Suite and representations via S136	Police Control Centre Assessment and Custody Diversion AMHP based in Community Forensic Services (3 AMHPs Peterborough) Block contract for Alternatives to Hospital Admission
Integrated Health and Social Care	Enhancing S75 Agreements for the delivery of integrated care – • Health and Social care • Primary and Secondary Care • Physical and mental Health Care	Development of specialist reablement services to support Intermediate Care Services (alignment)Development of the Admissions Avoidance Team (health and Social Care) based in the Emergency Department Development of a single referral process for Health and Social Care for Transfer of Care from Secondary Care Development of a single assessment tool for Health and Social Care for the Admission Avoidance Team and Transfer of Care Development of the Discharge to Assess model from Secondary Care Development of the MDT model to support Secondary and Primary Care Development of Primary Care Mental Health Enhancing Acute Care Psychiatric Liaison
Care Act new responsibilities	Prisons; Assessment and Care Management;Carers;Self-Funders;Safeguarding;Health and Well Being,	Capacity Building Developing Integrated Care

	Personalisation; Preventing and Delaying through Self-Serve/Preventative Services	

Health and Wellbeing Strategy and Delivery Plan
Priority 4 of the above plan is:
Supporting good mental health
The aim of this priority is to:
Enable good child and adult mental health through effective, accessible mental health promotion and early intervention and rapid response services to impact upon early signs of mental ill health or deterioration

The system changes as identified above support the overarching aim of this priority.
The actions identified via the delivery plan are:

1. Review of operation of ARC single point-of-access
2. Re-establish local suicide prevention group
3. Universal settings support children and young people effectively and promote their resilience
4. Services are commissioned to support children and young people with developing additional mental or emotional health needs at tier 2, preventing need for accessing services at Tier 3
5. Tier 3 CAMH services are commissioned such that children and young people with more complex needs are able to access tier 3 services in a timely way with resultant improvements in their mental health and emotional wellbeing
6. Development of PCC/LCG MH Commissioning Strategy. This will include making links with:
    a. Suicide Strategy Development
    b. Public Health MH Strategy
    c. Police MH Strategy
    d. MH Employment Strategy
    e. Accommodation Strategy
    f. Joint CCG MH Strategy
7. Revising policy on parents and carers with mental health problems
8. Developing a specific and holistic re-ablement response within mental health services that incorporates BME and hard to reach communities. Services targets most deprived political wards

Progress has been made on the majority of actions identified above

Conclusion
A key priority for mental health services in the next few years is to address the underfunding issues that exist both within Health and Social Care and to rebalance the investment toward a prevention, promotion, early intervention and personalisation agenda.

3) CASE FOR CHANGE

Over the next five years we aim to deliver changes to services that:

- 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

Specific strategies are in place designed to improve services over the next 5 years:

Adult Social Care Adult social care strategic commissioning plans

Good housing and accommodation options are a key contributor to peoples overall wellbeing and across Peterborough a series of strategic plans are underway for people across the whole Social Care and Health system in the form of an overall accommodation strategy based on three priorities which are to:

- promote and support people to maintain their independence
- Deliver a personalised approach to care and to
- empower people to engage with their communities and have fulfilled lives

Where ever possible services are being commissioned on a joint basis across health, social care and housing. Work is underway to focus on commissioning a range of preventative services, which together will support the aims of the better care fund. High priority is being is being attached to enhanced reablement services, and the implementation of assistive technologies as examples.

During the course of 2014-15 to 2019 (and beyond) we will be further developing our commissioning strategies and plans and creating a market position statement that sets out the local authority's ambitions for working with care providers to encourage the development of a diverse range of care options. It will include statements about local demand for different care and support options, the local authority's vision for care and support, and commissioning policies and practices.

We will focus on delivering the various Strategies such as the transformation of Day services across all sectors with the City, we are reviewing and re-commissioning residential care and support service for people – including access to short breaks (respite), specialist services, support and personal assistants.

We will ensure that good quality information and advice is available for all people whether they fund social care themselves or it is funded by the council. We are now implementing new designs and technology in assistive technology which support people and carers to remain living and accessing community services.

From the Joint Strategic Needs Assessment we are reviewing the likely future demand for housing suitable for people in transitions, leaving residential care, people moving out from living with older carers including greater co-ordination between the planning authority and social and health care and housing providers, and working with the market and ensure that the needs of people can be met within general housing needs accommodation wherever possible.

An accommodation strategy for Adult Social Care services has recently been established and is in the process of consultation with housing partners to ensure a that there is clarity around the strategic needs of the Council and how these can best be met by partners and stakeholders within Peterborough across both Health and Social Care economies.

We are working with partners within the City Council and with RSLs to ensure effective use of existing housing and reviewing the use of Supporting People funding to ensure it is directed in the right places to maximise outcomes for older people. We are creating new investment in Specialist Housing following the Winterbourne enquiry

We are making a series of changes surrounding The Learning Disability Housing Strategy will be completed and we will commission long-term suitable housing that meets the needs of people with learning disabilities that are either living in the City already with family carers (transitions and adults) who will require accommodating and those people returning back to Peterborough from out of area placements. This work-stream is in partnership with Serco.

At Peterborough we understand that housing is a key enabler to independent living and that an effective and appropriate housing strategy can act as a preventative strategy enabling people to build worthwhile and sustainable lives.

A transformation of available Housing options for those people with a learning disability/autism diagnosis is in place so that people will have greater choice and control and greater flexibility in being part of a wider community. People and in particular young people transitioning from children into adult services as part of ‘mid-life transitions’ will be able to identify shared/group living options to support independent living. This will enable People and their families to choose where they live and who they live with wherever this is practicable and affordable.

Work is underway to improve the management and utilisation of the existing supported housing portfolio, particularly shared/group living, through the introduction a central void management system and compatibility assessments, to increase the capacity available across Peterborough.

We are improving the management of the adult social care CBL reserved allocations to ensure they are used efficiently and effectively. We will continue to improve the support offered to people with learning disability who bid for social housing through CBL where they have low needs or shared living is deemed not suitable.

At the same time Peterborough intend to maintain and improve partnerships and knowledge sharing with private sector and social landlords through the establishment of a landlord' forum. The forum will be particularly important in engaging landlords in the future planning and provision of housing.

We are developing our commissioning processes for transitions covering both Learning Disability (children to adult transitions) and older people (older people with older carers). We will develop an accommodation planning process which provides a pathway to source accommodation in a collective yet personalised manner.

We are also developing our long-term suitable housing that meets the needs of people with mental ill health that are living in the City already and those people returning back to Peterborough from out of area placements. We continue to review and refresh our Transport Strategy and commission transport services that meet the needs of our customers.

Stakeholders have identified accommodation for people with mental health care needs in Peterborough as a key concern. There is a lack of a clear pathway to access appropriate housing. This together with very limited resources results in people receiving their care outside of Peterborough boundaries.

Settled accommodation for those people in receipt of secondary care mental health services is a key performance management target for the Local Authority. Peterborough is recorded as having 33.6% of those in receipt of secondary mental health care in settled accommodation. This compares to 59.3% England average and 63.2% Comparator Authorities average.

Working continues to recognise the vital role that Carers play and Peterborough Carers Strategy, will commissioning a range of services to support carers in their role.

For people with a Learning Disability or Autism diagnosis:

Employment

We understand the importance of employment for people with a learning disability and aim to support people to fulfil their aspiration of obtaining work experience or paid work, including those with more complex needs. We are working to promote personal budgets for employment support, develop current micro-enterprises into social enterprises as a means to promote employment and self-employment for people with a learning disability, encourage more supported employment organisations to operate in Peterborough and to link employment support more closely with day services, both in-house and external,

We also aim to promote joint working and work experience/placements and paid work for people with a learning disability. We will encourage public sector organisations and their contractors to offer work experience/placements and paid work to people with a learning disability.

Partnerships with large scale retail businesses in the city will be developed so that they can offer work experience/placements and paid work to people with a learning disability, and we will improve referral pathways into the supported employment service from care management teams for people with a learning disability.

We will promote joint working and co-ordination of supported employment opportunities with organisations in the city through the establishment of an employment co-ordination group.

Employment for those people in receipt of secondary care mental health services is a key performance management target for the Local Authority.
Peterborough is recorded as having 4.0% of those in receipt of secondary mental health care in employment. This compares to 7.7% England average and 7.0% Comparator Authorities average.[6]

Day Opportunities/Activity

All people with a learning disability should be able to access day services/opportunities that support them to have an independent and inclusive life of their own. This includes employment, study, leisure and social activities and a range of community based experiences.

We will promote the use of personal budgets within day opportunities to meet individuals needs and choices, and ensure all support provided within day services/activities is outcome focused and support is provided in a way to meet these outcomes for each individual. We also intend to maintain day services/activities wherever possible in community based settings to promote independence and choice.

Health

Access to good healthcare is really important to people with a learning disability and their families. People with a learning disability have the right to good quality healthcare that meets their needs. The local authority in partnership with its NHS partners will work to reduce the inequalities in health outcomes between people with a learning disability and the general population “adding life to years and years to life”.

We have a programme in place to ensure that we proactively monitor people’s health. Specifically the work will address Annual health checks, Summary Care Records, Hospital E-Track system, Health Events, Eye Care Campaign, Pharmacy awareness, Public Health Programmes, National Screening Programmes, Dental Access Centre

We also want to put in place more “Easy Read” health information

Preparing for Adulthood

The transition of young people with learning disabilities into adulthood requires lots of planning and preparation. All services need to ensure the young person and their family carers are fully engaged in the process and are informed of all the options available early so planning can take place. Adult Social Care should have good intelligence of the needs of young people from the age of 0/25 onwards therefore able to plan the services required when they reach 18 years of age which is a critical life milestone. Links with housing, employment and education services should also feed in to their development plans as well as the take up and deployment of personal budgets across the commissioned responsibilities of Health, Social Care and Education.

[6] ASCOF Comparator Report 2012-13

In Peterborough work is advanced to ensure that we operating to Department of Health's guidance on the transition from children's to adult services and the SEND Agenda, we are work closely together with children's services and other stakeholders to plan and develop a multi-agency Transitions Strategy. A robust database of all known young people from the age of 0/14 and 25 onwards is to be further developed.

We are also making available a transitions information pack for young people entering adult services.

We are improving our management information so that we are bettered prepared to provide intelligence to housing and other departments and agencies of the type of services required for the next 3 to 5 years which is fit for purpose and meets the needs of the individuals.

We also aim to put in place Person Centred Services that reflect the needs and aspirations of young people which can be met within the boundaries of Peterborough, avoiding unnecessary travel for people and reducing the cost and demand for statutory services.

Mental Health Services

In 2014 Peterborough City Council and Peterborough and Borderline LCG approved their Mental Health Commissioning Strategy. This describes their vision for mental health care and their priorities for the next 5 years. This strategy has been coproduced with the Peterborough Mental Health Stakeholder Group which is jointly Chaired by the LCG lead GP 3rd Sector CEO and supported by Local Authority officers.

The purpose of this Strategy is to support the Clinical Commissioning Group's Mental Health Strategy as part of its 5 year plan, and to articulate the needs of Peterborough and its priorities.

Our vision for Mental Health Services

Our vision in the Peterborough Strategic Partnership is to:

- Ensure a whole systems approach to the commissioning of mental health care.
- This is to include Promotion, Prevention Early Intervention Mental Wellbeing and where necessary ongoing care
- To facilitate an individual's recovery by making most use of their strengths and existing community resources.
- Where possible we will offer help and support early to ensure that individuals receive advice and support that will prevent the need for ongoing care

Mental health and an overall sense of wellbeing is a key requirement of how people define wellness. It is central to confidence, independence, self-esteem, and inclusion. It is central to how people and communities perceive their quality of life.

Our Mental Health Commissioning strategy is about repositioning services, so people can get access to services that help them more quickly and easily, without having to negotiate a system that seems to present obstacles to obtaining help, or that defines them by their mental health problem. It is also about getting high quality and effective

help in the most appropriate place, within a system that empowers people and promotes recovery.

Peterborough City Council Adult Social Care and Peterborough Locality Commissioning Group has three priorities:

1. is to ensure there are effective local providers of mental health services that are responsive to the needs of local commissioners and actively engages local people

2. is to ensure a model of care that has a focus on promotion, prevention, early intervention and support. Personalisation must be a key feature of this model

3. a greater degree of plurality in the market is required. This plurality needs to be established within the community infrastructure. The motivation for plurality is that it will achieve higher quality services, greater efficiency and improve value for money and choice for the consumer in line with the personalization agenda

Our Approach to Commissioning

Mental health commissioning according to the Joint Commissioning Panel for Mental Health (JCPMH) (2011) will in the future be freed from the traditional, activity –focussed specialist service orientated model. The norm will become a multi-agency approach commissioning for mental health and wellbeing. It is expected that a much wider range of organisations will deliver a broad spectrum of services. Investment will be channelled into new areas of development beyond the boundaries of traditional 'mental illness' treatment and care, recognising that positive well-being is not simply the absence of mental ill health.

These new areas, according to JCPMH, will include:

- Social capital, building community networks and resources
- Citizen pathways – creating opportunities for people's active participation in local government
- Mechanisms to ensure people have a voice at strategic, community and individual levels.

Offender Mental Health Care

It is estimated that 40% of the most serious offending in the county is concentrated in the Peterborough area. Peterborough city is in the 'worst' third of local authority areas regarding crimes per head of population, only being exceeded by inner city boroughs in London and other large conurbations. There are relatively high levels of acquisitive crime, underpinned by a group of offenders with high incidence of repeat offending. In Peterborough – as in many other inner cities – there are also significant levels of violent crime, some of which is drug and alcohol related and high levels of domestic violence.

The relatively high levels of criminal behaviour in Peterborough are reflected in the case mix of the existing mental health teams and there is substantial co-morbidity of mental illness and substance misuse problems.

Peterborough also has the only prison in the country that houses both male and female prisoners, with respective populations of approximately 600 males and 400 females. It houses both remand and sentenced prisoners, with an annual turnover of approximately 10,000 prisoners a year. The Government's improvement plan in

January 2013 to update Britain's prisons identified HMP Peterborough to convert to a 'House block' status will increase the total prison population from 1000 to 1300. This will take effect in 2015. The majority of prisoners are resettled locally, including a significant proportion of women offenders and offenders from ethnic minority groups (increasingly from Eastern Europe).

Between April 2011 and March 2012, 54 adults with mental health needs and who were receiving treatment from the HMP Peterborough Mental Health In-Reach Team were released to the locality of Peterborough.

The community forensic mental health service aims to meet the needs of mental health services in Peterborough and Fenland with forensic histories or high risk behaviours. Taking account of high-risk mentally-disordered offenders not currently engaged with mental health services, it is estimated there are at least 80 individuals whose needs would appropriately be met by the specialist forensic community team.

Over the last year much work has been done to take forward mental health care across Cambridgeshire and Peterborough. The Strategic Partners of Peterborough City Council NHS Cambridgeshire and Peterborough Clinical Commissioning Group, Cambridge County Council and Cambridge and Peterborough Foundation Trust have worked together to address a series of challenges.

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 whole systems integrated approach which focuses on promoting wellbeing, early identification of need, and early intervention to address this.

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

- Frontline practitioners being mental health aware and understanding the impact of anxiety and depression on a person's physical health and social functioning. Change to workforce development activities will support these cultural changes

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 and resilience -

building to prevent some people from entering statutory services or 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, clearly this will incorporate changes included in our Carers Strategy.

Current work in these areas includes the development of our Dementia Resource Centre. This development sees the integration of health, and social care which includes third sector providers. More recently we have begun a review of our mental health single point of access. This review is seeking to improve the integration of health and social care and the aspiration to achieve a single assessment process.

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
- develop information sharing and referral systems between respective organisations in the Statutory and non-statutory sector

How we will measure our Aims and Objectives

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

- setting and monitoring performance against agreed outcomes and metrics
- continuing engagement with service users, patients, carers and other 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 integrated 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

4) PLAN OF ACTION

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

In support of the Peterborough vision and our case for change above Peterborough have designed our BCF programme around the three broad themes of Protecting Social Care, 7 Day Working and Data Sharing. When viewed as part of Peterborough's overall transformation programme these themes, along with CCG's OPACS Procurement will deliver the BCF outcomes. In summary

Protecting Social Care

Will implement a revised information & advice strategy for ASC health, social care and wellbeing; make improvements to how health and social care is accessed, and how assessments are undertaken on a joint basis. This theme will also to ensure that services are compliant with the Care Act. Here we will also develop quality of care provision via the Care Sector Quality Improvement Team, improve asset Based Community Development to deliver health & social care support / community resilience, implement an enhanced offer for Carers (all age), implement Tele care/Tele health/ AT, and reshape the housing market, minor & major adaptations,

We will also re-shape the 24 hour bed-based care market - residential care, nursing care, reablement/rehab bed based, implement an enhanced offer for Dementia, develop a market position statement for health and social care in Peterborough, and put in place Employment First – which will develop Employment opportunities for our service users. We will also develop our 3rd sector VCS and advocacy arrangements.

Within Protecting Social Care we have identified (Early intervention, prevention, and proactive support as a sub theme which is includes:

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 and 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. Ensuring the new responsibilities of the Care Act are met as carers will have the right to an assessment and services.

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, as detailed in the new target operating model with a view to avoiding escalation of demand (including admission to care or acute settings, which in mental health care will mean the development of 'alternatives to hospital admission' and further development of appropriate supported housing). 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.

Dementia Resource Centre: By recognising that Older Adults and those with a physical health problems are more likely to experience anxiety and depression, and how this will impact on their overall quality of life, and by ensuring we treat emotional and physical health together, we will achieve better outcomes for the individual. 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.

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

Within Protecting Social Care we have identified Enhanced reablement and admission prevention as a second sub-theme

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. . Enhanced reablement will have direct referral/access to The Firm and Intermediate Care to avoid unnecessary admissions or re admissions to Secondary Care.

Enhanced reablement within mental health care will aim to prevent individuals entering secondary care services and giving people the coping strategies to deal with future crisis and life events without the need to access statutory services

Home adaptations, tele health and tele care: the inclusion of Disabled Facilities Grant

(DFG) funding within the BCF envelope offers a huge opportunity to develop integrated support for people in and through their own homes. Although this can be captured under the heading of home adaptations, it should essentially be seen as running in an integrated way throughout both of the overarching work programmes, as an enabler for early intervention and maintaining and reabling independence. In addition, the 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 Quality Improvement Team: Establishment of central team with virtual members across the health and social care economy To support medication reviews, quality improvement, and 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.

7 Day working theme

We will build on the existing arrangements for 7 Day working to further improve transfer of care on a 7 Day basis integration with health to improve hospital admission / hospital avoidance

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 developing the Admission Avoidance Team in the Emergency Department to continue to reduce the number of unnecessary admissions to the Acute Trust.
- Development of the Domiciliary Care and Care Home Market to respond to 7 day working
- further reducing the number of avoidable admissions and emergency bed days through enhanced MDT (including mental health, alcohol and substance misuse) 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 , Intermediate Care, Enhanced Reablement and Admission Avoidance Team
- improved psychiatric liaison services and mental health presence in MDTs (GP practices) to enhance discharge (and admission) planning, and develop timely

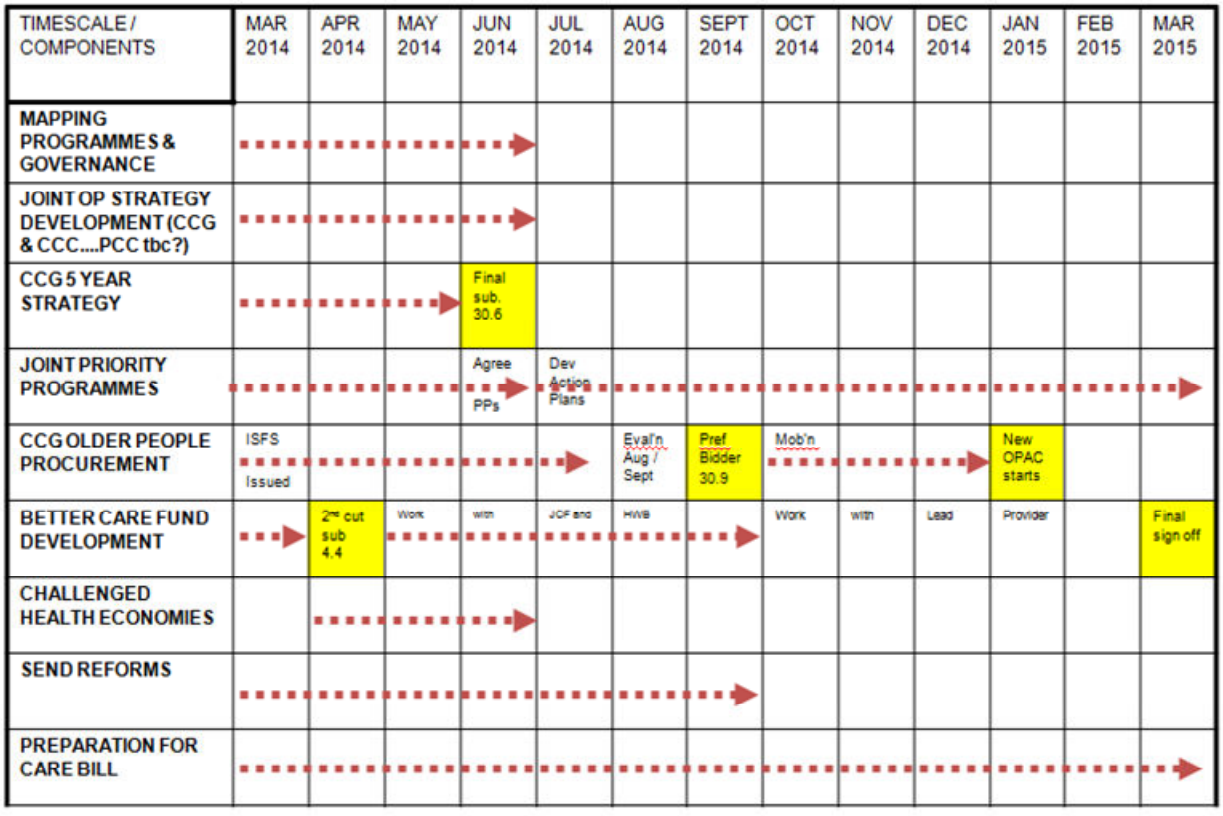
care packages for discharge

- Increased patient flow through intermediate care sector to ensure access to "step-up" and "step down" as well as reablement beds.

Data Sharing

We will continue to work on the readiness of ICT systems, and processes to monitor and respond to the impact of the Care Act (including use of NHS number)

A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough system response to the ECIST review is under development and will be completed in November 2014. The overall transformation plan will ensure the delivery of the BCF outcomes commencing April 2015. This is indicated in the outline plan below:



Key BCF Milestones are therefore as follows:

<u>October</u>

- Map all change activity already underway including; existing governance arrangements, use of resources, identify interdependencies, expected delivery dates, expected benefits (financial and non-financial).
- Confirm priorities and re-align change activity accordingly (including streamlining governance, making best use of resources, re-planning delivery dates taking into account interdependencies).
- Complete and agree detailed BCF proposals and consult with stakeholders

<u>November</u>

- Establish the BCF Programme with phased projects to deliver changes (developing phased implementation plans, risks and issues, communications plans) and cross

cutting delivery work streams (EG ICT, HR, Finance and benefits realisation, contracts and procurement, engagement and communication etc.).
- HWB sign off of detailed BCF proposals and planning

November - December
- Work with Providers, including OPPACS Lead Integrator when appointed to align / finalise implementation plans.

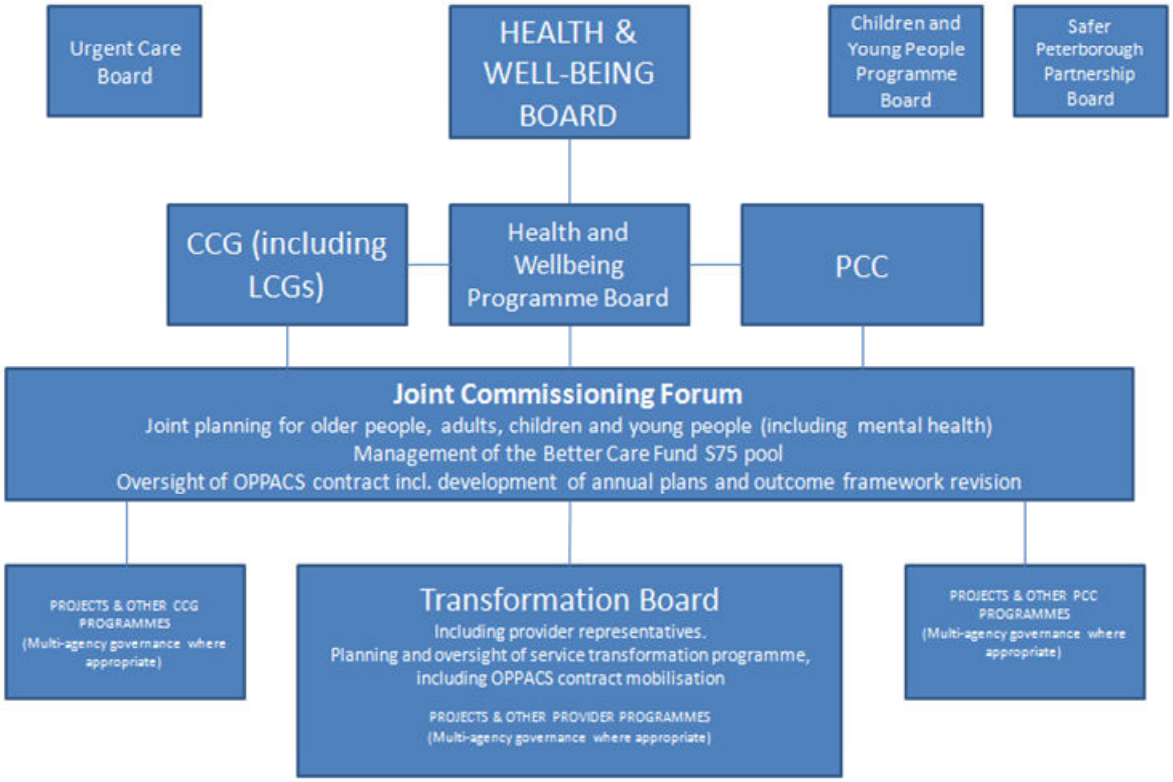
Jan-March
- Begin implementation in phased/controlled way January 2014 onwards

The detailed planning for the BCF has been severely constrained by an extremely onerous and demanding series of checkpoints by the BCF programme office/NHS England which have caused significant management time pressure through the main holiday period, which in turn has made it extremely difficult to complete the work to fully base-line the BCF programme, however following submission on the 19th September the programme will be prepared, and consultation will take place with key stakeholders.

The move to greater integration is underway at various levels in the system. As examples there are integrated governance arrangements through the Joint Commissioning Forum. All partners have made a commitment to multi- disciplinary working and joint assessments and to a united way of providing information and advice.

Oversight and governance of the Better Care Fund proposals 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 Working Group) to take forward the planning work. This group meets regularly to coordinate the work
- The BCF Working Group has reported monthly to the 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 monthly Transformation Board has been used to engage stakeholders
- For 2014/15 the HWB have delegated the Borderline and Peterborough Joint Commissioning Forum to act as a formal sub-group of the Board for the purposes of further developing the BCF, with the Transformation Board used to monitor the implementation of the proposals with partners.
- Joint Governance arrangements for 2015/16 will be further developed and finalised as part of this ongoing work, however, the following model is in place.



- In the above model the JCF provides a forum in which to develop a joint strategic approach to service transformation and delivery of the Better Care Fund, alongside local oversight of the OPPACS contract once established.
- The objectives for the JCF in relation to the BCF are likely to include:
  - To provide effective leadership, management and governance of the Better Care Fund Section 75 pool
  - To provide a forum for multi-agency oversight of the OPPACS 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.
  - To ensure safeguarding is mainstreamed into commissioning and service delivery.

More detailed transformation planning, including management oversight of transformation and joint commissioning for each area of change, and interrelatedness with the mobilisation and subsequent transformation based on the OPPACS contract, would be undertaken by the Transformation Board. Along with commissioning leads, this group also includes provider representatives. It would be envisaged that a number of working groups would report into this Board on key areas of transformational work. 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.

Peterborough will manage the BCF programme using best practice Office For Governance Commerce "Managing Successful Programmes" methodology, in recognition of the very high complexity of the programme. Individual projects will be managed using the PRINCE2 method. The whole change will be managed through a dedicated programme office. These change methodologies coupled with the governance arrangements above will Through the robust governance arrangements outlined above we will escalate any and all project activity that may begin to go off track through the Programme Management office function.

d) **Planned BCF schemes**

Ref no.	Scheme
1	**Protecting Social Care**
a	Implementing the information & advice strategy for ASC health, social care and wellbeing
b	Accessing health and social care
c	Care Act compliant care management (including joint assessments)
d	Development of Care Sector Quality Improvement Team
e	Asset Based Community Development to deliver health & social care support / community resilience
f	Enhanced offer for Carers (all age)
G	Tele care/Tele health/ AT
H	Re-shaping the housing market, minor & major adaptations
I	Re-shaping the 24 hour bed-based care market - residential care, nursing care, reablement/rehab bed based
J	Enhanced offer for Dementia
K	Market position statement for health and social care in Peterborough
L	Employment First - developing Employment opportunities for our service users
M	Development of 3rd sector VCS and advocacy
2	**7 Day working**
A	Integration with health to improve hospital admission / hospital avoidance
3	**Data Sharing**
3a	Monitoring and responding to the impact of the Care Act (including use of NHS number and shared view of patient / user records)
4	**OPACs Procurement**

5) RISKS AND CONTINGENCY

a) Risk log

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

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Loss of Strategic Perspective and Scale: The plan focuses on many small scale initiatives leading to lost opportunity to undertake strategic transformation of services	**3**	3	9	• 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	3	5	15	• Closely monitor

protect social care services: Demand for social care increases at a rate that outstrips the increased investment and transformation				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	**3**	3	9	• 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:	**3**	3	9	• 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	**3**	3	9	• On-going review of strategy and vision • Robust arrangements for reviewing progresses

service delivery in advance of implementing new ways of working de-stabilising current levels of demand and performance				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	**3**	3	9	• 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				• 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	**3**	3	9	• Hold regular staff briefings • Post updates to organisations' websites • Use the organisations' newsletters to promote better understanding and flag

				examples of excellent performance and innovation
Strategic Vision / End State: Lack of clarity around the 'end state' resulting in loss of delivery	**3**	3	9	• Link to the 5 year Strategic Plan – move to single 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	**1**	3	3	• 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	**1**	3	3	• 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.	**1**	3	3	• 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.	**1**	3	3	• 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				• All partners to be involved in discussions and

agreement between partners and at the Health and Wellbeing Board means that an agreed plan cannot be signed off				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				• 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

b) Contingency plan and risk sharing

Discussions between Peterborough City Council and the CCG are ongoing and agreement is not yet reached in terms of BCF funding and therefore risk sharing is unclear.

6) ALIGNMENT

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

A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST action plan is under development

- 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
- 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.
- **Care Sector Quality Improvement Team:** To support quality improvement in care and support services in the City, including medication reviews, 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).
- 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.

Specific works is aligned to the BCF as follows:

Dementia Resource Centre – co-locating health and social care under one roof. Delivering pre and post diagnostic support using a hub and spoke model. Delaying/ reducing the need for ASC intervention and reducing preventable hospital admissions for

people living with dementia.

Carers Hub – Commissioned a central resource to provide carers the support they need to sustain their caring role. Includes GP prescriptions for carer support – a CCG funded initiative to provide a one off break to the carer to avoid/ prevent the breakdown of the caring relationship.

Development of extra care and sheltered housing as an alternative to hospital- Working with RSL's to develop a number of units that can be used as intermediate / interim care as part of enablement package of support. Ensuring people do not stay in hospital longer than necessary and to support people back to independence, reducing risk of them being transferred in to a long term placement.

Advocacy- Designing an advocacy service that will serve adults with care and support needs, ensuring their rights are upheld and they are receiving the benefits and other available support they are entitled to. The intention being to signpost people to community based support services early on, preventing them from presenting in primary care / hospitals.

Residential Care Contracts – The City Council is transferring all residential homes to the regional ADASS standard contract. The specification for older people's care will include the condition that the home must take admissions 7 days a week to support the Hospitals to free up bed space and improving the discharge process.

British Red Cross Contract – The City Council has recently awarded a contract to British red Cross to provide volunteer led reablement support to citizens with support needs. The Manager of this service splits their time between being based with the hospital discharge team and the community social work team. The focus of the service is matching those individuals who require some practical and/or emotional support following a fall, life event or period of ill health with a volunteer who can help them regain their independence.

The BCF aligns with the CCG's 5 year plan through an agreed set of principles by which we will work together over the next five years:

•Organise services around the patient's clinical needs and not around organisational and professional specialties
•Integrate care to maximise continuity and safety for patients across separate facilities and organisations
•Expand the geographic and population reach for specialties to ensure clinical and financial sustainability
•Measure costs and outcomes for each patient and, where possible, develop local pricing to reflect local costs
•Build enabling information flows and IT platforms to maximise efficiency and continuity of care
•Work together effectively, openly and transparently in best interests of patients and

public
•Maximise focus on prevention and anticipatory care to avoid unnecessary admissions and costs
•Allocate resources across time, place and person in way that maximises sustainability and reduces inequalities

The programmes of work being developed within the five year plan encompass the BCF to deliver transformational, sustainable change.

The CCG is developing its approach to primary care co-commissioning with the Area Team. The CCG is seeking to develop an approach in co-commissioning for additional services beyond the scope of the standard contracting of Primary Care. The CCG has the desire to increase the capacity of primary care to deliver a greater range of services that support the local populations health needs

7) NATIONAL CONDITIONS

The locally agreed definition of protecting social care services is maintaining the existing thresholds set under Fair Access to Care Services or, following the introduction of national eligibility criteria, ensuring that social care services are able to meet the new criteria.
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 Act and in particular the need to assess self-funders and to assess and meet the needs of carer's, prisons and the principles enshrined with the Act of Well-being and personalisation. 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.

Funding for care act 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.

Funding will be used to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment. In addition we will also seek to establish whether existing support can be provided effectively by the third sector and/or commissioned social care rather than more expensive social workers or health care professionals, and whether the extended use of tele care/tele health can help us to change previous thinking

regards roles and expectations.

The Local Authority will expect to fund the implications of the 'Care Act' via the additional social care funds transferring from 1 April 2015 in respect of national eligibility criteria and carer assessments. Planning for local care services will prioritise the development of services that:

- Provide universal services intended to prevent, reduce or delay needs and Information, advice and guidance.
- For those whose need cannot solely be met through universal services, carry out an individual assessment or carer assessment considering benefit from Universal or local services.
- Development of integrated care and support plans to reflect personal choice and set up personal budget for those that meet eligibility criteria for social care Services.
- The emergent work on Peterborough's digital strategy will further protect social care

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.

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

£6.011 million has been allocated to protecting adult social care (including £3.522m existing s106 agreements) and £407K has been allocated to supporting the implementation of Care act duties. The Council is taking a transformational approach to the allocation for protecting social care, by investing it in programmes to deliver transformational change, quality improvements and system efficiencies.

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

The BCF allocation will be used to fund early assessments for self-funders, assessment and support for carers, resourcing of the new national eligibility criteria, additional advocacy support and information and advice for prevention. These are all area where new duties will impact on Social Care and where protection is important.
There are also some resources allocated to related ICT development and staff training

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

A specific allocation of £150K has been allocated to carer prescriptions. The remainder of carer specific funding is apportioned to schemes within the Care Act allocations (£407K) and the protecting adult social care allocations (£6,011K)

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

Funding agreement has been reached between the Council and its CCG partner as to the deployment of the BCF funding for 15/16. The agreement recognises the complexity of the CCG OPPACS initiative and its impact upon the attainment of BCF outcomes in seeking to develop and transform the commissioning of existing services to meet these. The Council and the CCG have therefore looked at the BCF funding allocation as a whole and apportioned funds to the OPPACS programme where those funds will be employed to meet the outcomes specified within the BCF submission, and apportioned equal unallocated funds to be spent on the transformation of Social Care services.
The latter will be employed to improve local services and generate efficiencies to be re-invested into BCF initiatives and the protection of Adult Social Care.
Both partners will exploit joint commissioning opportunities contained within the funding allocations to maximise the attainment of BCF outcomes and achieve the best return on investment.

a) 7 day services to support discharge

There is a shared commitment to 7 day working which has been accepted by the Health and Wellbeing Board and the Joint Commissioning Forum and which underpins service delivery models supporting the BCF agenda.

Community based health and social care services such as The Firm, Intermediate Care Services, Reablement and Community Nursing already deliver 7 day working. Community based services (in particular homecare and residential services) will be engaged and working arrangements be established to be able to deliver services 7 days per week from the 1st April 2015, including the acceptance of referrals to support discharge from, and prevent admission to, hospital based services. A CQIN relating to 7 day discharge has been in place with PSHFT during 2013/14 and has been built into the contract for 2014/15

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

The System will review its approach and expectations of the Market to deliver 7 day a week response to support people requiring care/ support services. 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 and care providers.

b) Data sharing

Within Peterborough social care services, the NHS Number is collected, but not currently used as the primary identifier for correspondence, care plans etc. The Council has commenced data completeness checks and currently holds NHS number for around 50% of client records. For referrals from Peterborough City Hospital the NHS Number is already routinely captured and used as the primary identifier for MDT discussions.

Peterborough City Council is developing a universal front door and e-referral portal, collection of NHS Number and consent to store and share will be embedded into our front door processes and assessment tools. We are also anticipating alignment with health front door once the new Countywide contract has been awarded. We will commence conversations on how this model might operate in earnest following the selection of the preferred bidder to act as the Integrator, scheduled for end September 2014.

As part of our wider transformation programme we will move towards use of the NHS number as the primary inter-agency identifier via the following means:

- Introduction of e-referral for all referrals for professionals, which capture NHS number and consent of patients to the referral and sharing of NHS number.
- Updating all forms within the social care system, including letters and care plans, to pull through NHS Number.
- Exploring options for bulk uploads of missing NHS numbers

These work streams will be overseen by the Adult Social Care Systems Project Board, feeding into the Transformation Programme Board.

We have also established a Health and Wellbeing Board Information Working Group where information leads from across the Council and Health system as looking to establish procedures for safe data sharing within the Caldecott guidelines, for the purpose of needs assessment, commissioning intelligence and risk stratification.

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

Peterborough City Council has a digital strategy which is designed around interfaces between core records and apps which support practice. We are committed to the principle of collecting data and once and sharing. Our preferred models of assessment are those which can be accessed on line as a self-assessment tool or be completed with service users in their own home, this model allows recording consent to share at the time of collection. This model allows for service user / patient owned shared records, delivered via an online portal and interfaced to clinical and social care systems as appropriate.

We are also currently in the process of moving from secure e-mail to cloud based file sharing systems to facilitate safe sharing of assessments and care plans across support networks, to limit use of e-mail transfer. This system in time could also allow for user set

permissions to personal records, thus supporting in reality the concept of the person held assessment and care plan.

Plans will be built on in more detail following the appointment of the system wide health integrator, as their role involves support of shared care plans.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practice and in particular requirements set out in Caldicott 2.

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

Peterborough City Council currently has certified PSN accreditation and therefore we must complete the I.G. Toolkit self-assessment to demonstrate our compliance with national standards. All organisations completing the IGT are expected to score a minimum of level 2 in all requirements or submit a comprehensive action plan detailing how they will reach level 2 during the following period. Whilst we have achieved 20 compliance requirements at level 2 to comply with PSN accreditation, we have five requirements at level 0 and 3 at level 1. These eight requirements are our priorities for improvement over the current year.

We have drawn up an IG Management Framework setting out all the roles, responsibilities and essential policies within the organisation. We are currently reviewing a draft overarching Information Governance policy, an improved and more robust data protection policy. We are ensuring that each contract not only contains the relevant information governance clauses but also that third parties have the appropriate IT and IG policies, strategies and procedures in place. Each requirement of the IG Toolkit will form our work plan for the coming year.

We have noted the recommendations of Caldicott 2 and the revised principles from September 2013. These principles are embedded in approach to IG and we have also begun to map the 26 recommendations accepted by the government to the IG Toolkit where possible to ensure our compliance with both. We have also engaged with the Caldicott Implementation Monitoring Group to provide evidence and feedback on our compliance.

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

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

Across Cambridgeshire and Peterborough CCG have introduced multi-disciplinary teams (MDTs) to provide better and more holistic support to frail elderly or other vulnerable people. MDT assessments will become the norm for people who fall into these categories. They bring together social, medical and community care plans involving GPs, hospital doctors, nurses, physiotherapy, social workers and voluntary or community groups. Learning from these pilots about the role of lead professionals and the application of risk stratification tools will be used in developing proposals to support people in need of help as described in Section 2c.

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

To support the development of multi-disciplinary working, a new assessment of need is being developed, which will cut across health and social care (GP services, District Nurse services, physiotherapist services, occupational therapy, social care), including acute and community-based care, and make the process of assessing service users with multiple needs more joined up and efficient.

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

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

The integrated model of delivery will be implemented across Peterborough on a phased basis targeting key clinical pathways, or groups of patients to ensure that inequalities are addressed, and impact in terms of health outcomes and financial savings are maximised. For the Living my Life programme to be effective we need to identify those people most at risk of escalating care needs who would benefit from a more coordinated response to enable them to live more independently. This might include CVD, completion of reablement or rehabilitation programmes, diabetes, etc. and this focus will be further developed through the detailed implementation planning during 2014/15.

We are building up an understanding of the health and social care needs of Peterborough's population and will employ the outcomes to target those people who will benefit from early intervention within an integrated model of assessment and care. As the Peterborough City Council revised Target Operating Model becomes established, and alongside the expected transformation of services which will be undertaken by the

incoming Lead Integrator for Older Peoples' and Community Services, commissioned activity arising will start to impact upon the key objectives identified within the BCF agenda.

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

- 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.

8) ENGAGEMENT

a) Patient, service user and public engagement

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

Patient representatives are on the Joint Commissioning Forum, that has delegated responsibility for the BCF from the HWB. Patient forums have had presentations on the BCF process and high level plans. Post submission a more detailed programme of engagement is planned on the schemes included within the submission

b) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

Peterborough and Stamford Foundation Trust (PSHFT) have been involved with potential providers of the OPAC service in developing models of care to deliver the outcomes required. The ECIST review of the Peterborough health and social care system recommendations and subsequent action plans to deliver the recommendations are aligned and intrinsic to the workstreams set out within the BCF submission In addition the Cambridgeshire and Peterborough System have a collaborative programme with all partner organisations under the challenged health economy work to deliver a sustainable health and social care system for the future. Delivery of the BCF is embedded within this work.

ii) primary care providers

Primary care have been represented on the steering group of the BCF in Peterborough, and through the Joint Commissioning Forums, and Local Commissioning group boards of the CCG

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

Peterborough commissioners meet regularly with provider networks in the independent and voluntary sectors. The BCF proposals have been discussed in with providers particularly where they are seen to be able to offer services which might meet BCF outcomes. More detailed work will take place through 2014/15 to offer clarity around particular delivery models where providers will be asked to submit proposals and engage in more formal procurement procedures for the identified initiatives, An example of this is the Day Opportunities for people with a Learning Disability exercise to re-shape services

through the creation of community resilience models, reablement and use of Assistive Technology solutions to create a whole systems approach to mitigating core service demand and addressing pressure points on the health and social care system. Strategic partners within the independent and voluntary sector as well as stakeholders have been involved in the design and co-production of the delivery model options and delivery vehicle. (Case for Change P.26)

c) Implications for acute providers

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

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

Work is underway through the ECIST to improve the discharge processes and to "right size" Intermediate Care capacity.

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

ANNEX 1 – Detailed Scheme Description

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

Scheme ref no.1a
Scheme name: Protecting Social Care (Implementing the information & advice strategy for ASC health, social care and wellbeing.)
What is the strategic objective of this scheme?
To create the environment whereby Peterborough residents are able to self-serve where-ever possible.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To put in place an information and advice website and care directory. To put in place community specific content (care directory) designed to promote self-service To agree and implement a process/mechanism to keep content up to date, involving commissioners, contracts, procurement, 3rd sector, and providers To enable any Peterborough resident or carer to create their own support plan The introduction of capability that enables residents to find, order and pay for items to support the self-funder/self-service model To put in place a training programme targeted at social care operational staff
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
Reduction in demand for Statutory Services through the reduced volume of Health and Social Care contacts from residents.

Scheme ref no.1b
Scheme name: Accessing health and social care
What is the strategic objective of this scheme?
To ensure that conceptual plans for the creation of a new “front door” to health and social care are implemented in a way in which change is thoroughly embedded.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To put in place a single point of initial contact, the new front door for social care - contact centre, telephony/IVR, electronic referrals, processing along with white mail / and fax referrals To create the single point of initial contact for health and social care including mental health To put in place triage/eligibility and initial demand management with reablement & assistive technology as the default To implement a new CRM system to support the new front door To create the ASC operating model to support the new front door
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough’s strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.

Scheme ref no.1c
Scheme name: Protecting Social Care(Care Act compliant care management (including joint assessments)
What is the strategic objective of this scheme?
To make adjustments to business as usual operations so that services are compliant with the incoming care act in April 2015.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To bring about changes to assessment & personalised support planning as a result of Care Act (e.g. eligibility, response to self-funders, carers) To implement a Care Act training programme changing care management culture To ensure that Case management system(framework) is compliant with the changes to the care act compliant Implementing changes to care management so that personalisation and direct payments are the default Making changes to care management processes so that Assistive technology is an intrinsic part of the assessment process.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

What are the key success factors for implementation of this scheme?
Service improvements made for Peterborough residents and new statutory duties implemented into "business as usual" operations

Scheme ref no. 1d
Scheme name Development of Care Sector Quality Improvement Team
What is the strategic objective of this scheme?
The creation of a multi-disciplinary team with a clear focus to support care providers to drive up standards, and improve the safeguarding of vulnerable people
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Development of multi-agency quality improvement / trouble-shooting function with health and social care input; The provision of targeted/practical support to improve the quality of all commissioned care – e.g. care homes, day-care, home care, PA's etc. The design of "kite mark" quality standards and processes to support links with commissioning/contracts/procurement/contract monitoring. To be published on the website & care directory
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
Service quality improvements made for Peterborough residents and improvements to safeguarding arrangements across the Peterborough Care Sector.

Scheme ref no.1e
Scheme name Protecting Social Care - Asset Based Community Development to deliver health & social care support / community resilience
What is the strategic objective of this scheme?
To put in place community based systems that can function to provide support at a local neighbourhood level
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To put in place arrangements for Local Area Coordinators To develop community assets into appropriate business models (e.g. groups, small enterprises, trading business etc.) To create a sustainable model of community development and resilience To put in place a culture change programme (training/engagement) on asset based community development for all staff and partners
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
Community based social enterprises formed and demand for statutory services is reduced.

Scheme ref no. 1f
Scheme name Protecting Social Care (Enhanced offer for Carers (all ages))
What is the strategic objective of this scheme?
To enhance the support that careers receive.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
carers integrated assessment & planning carers prescriptions respite for carers support for carers at crisis Improving info & advice for carers Developing the 3rd sector to support carers
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
New rights for Carers will be in place for April 2015 in line with the Care Act.

Scheme ref no.1g
Scheme name: Protecting Social Care (Tele care/Tele health/ AT)
What is the strategic objective of this scheme?
The AT project objective is to develop, implement and adopt an integrated approach, to achieve both Health and Social care outcomes, by the use of Assistive Technology, to improve the quality of care, enhance user lifestyle choice, promote independence and secure expedient benefits for the City of Peterborough and its citizens.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To produce a clear tele care and tele health offer; To make changes to the integrated assessment and planning pathway with AT becoming the default To put in place systems that can order/monitor/track benefits To put in place a culture change programme (training/engagement) on the use of tele care/tele health/AT to reduce care package costs and time spent on assessment & support planning (initially focusing on self-management for long term conditions and falls prevention)
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

Scheme ref no. 1h
Scheme name: Protecting Social Care (Re-shaping the housing market, minor & major adaptations)
What is the strategic objective of this scheme?
To put in place a better funded and much more responsive Equipment and adaptations offer making it easier for people to be discharged from hospital to home and for people to stay at home for longer.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Increase funding for Home adaptations Enhanced Care & repair / handyman service Improved provision and quality of sheltered accommodation
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
More of Peterborough's residents are able to live independently and safely reducing demand for hospital based services and expensive residential housing

options
Scheme ref no. 1i
Scheme name: Protecting Social Care - Re-shaping the 24 hour bed-based care market - residential care, nursing care, reablement/rehab bed based
What is the strategic objective of this scheme?
To put in place better capacity to enable "step up" and "step down" options
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To develop and implement a new service specification/contract to deliver improved provision and quality of residential and nursing care To develop and implement a new service specification/contract to deliver bed based reablement/rehabilitation at Friary Court"
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
Pressure on A&E and Acute beds reduced. More people are able to regain

independence reducing demand for statutory services and improving overall Well-Being.

Scheme ref no.1j
Scheme name Protecting Social Care - Enhanced offer for Dementia
What is the strategic objective of this scheme?
To put in place specifically tailored additional capacity and specifically for people living with dementia, their carer's and families
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Establish a specialist Dementia Resource Centre Development of AT specifically for dementia. Support for carers of dementia Development of domiciliary care specifically for dementia Development of residential and nursing care homes specifically for care homes Development of extra care housing specifically for dementia"
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

Overall improvement to the capability and capacity of Dementia based services in Peterborough

Scheme ref no.1k
Scheme name: Protecting Social Care - Market position statement for health and social care in Peterborough
What is the strategic objective of this scheme?
To create a clear strategic view of where and what type of services are required in line with the Joint Strategic Needs Assessment.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To map out all provision of health and social care against the JSNA needs assessment across Peterborough. Establish baseline. Analyse. Identify gaps. To develop commissioning intentions/strategies/refocus projects or initiate new ones to address these gaps
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
A clear market position statement which informs the detailed commissioning

plans across Peterborough in-line with demographic growth forecasts.

Scheme ref no.1l
Scheme name Protecting Social Care - Employment First - developing Employment opportunities for our service users
What is the strategic objective of this scheme?
To review and open up employment pathways across Peterborough.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Develop and deliver programme of job skills development to support clients to access employment; Raise awareness with employers Set up as micro enterprise Develop pathway to employment (including volunteering) for each service user group
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A detailed transformation programme for the Care Act, the BCF, and incorporating Peterborough's strategies for Mental Health, Older People, Learning Disability and Autism, along with the Peterborough and Borderline ECIST is under development at the time of this report which will be completed in October/November 2014. The detailed plan will provide details of the delivery chain for this scheme.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
Increased volume of younger adults obtaining paid employment. Increased independence and reduced demand for statutory services

Scheme ref no.1M
Scheme name Protecting Social Care - Development of 3rd sector VCS and advocacy
What is the strategic objective of this scheme?
To develop capacity within the 3rd sector to improve advocacy.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To design an integrated advocacy service To specifically review and redesign Older People's VCS day service To review and improve HIV support services To Develop Direct Payment and personalisation support in the 3rd sector To Develop support planning service in the 3rd sector To review and develop services that support Independent Mental Capacity Advocate (IMCA) services To review and put in place improvements to Community Support for stroke survivors To review Deaf, blind UK / about me Develop new focus for MIND (April 2015) Work with the voluntary sector to further develop reablement (e.g. British Red Cross)
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
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The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

What are the key success factors for implementation of this scheme?
Development of Voluntary services at the community level. Reduced demand for statutory services.

Scheme ref no.2a
Scheme name 7 Day working - Integration with health to improve hospital admission / hospital avoidance
What is the strategic objective of this scheme?
To put in place improvements to the hospital discharge pathway, and to create an enhanced reablement offer
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Integrated hospital discharge pathway & team - 7 day working, strong alignment to MDT's Integrated reablement/rehab/intermediate care pathway & team - 7 day working, strong alignment to MDT's CHC pathway - funding without prejudice" " Development of reablement offer for both LD and MH Accountable professional named for any integrated packages of care"
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
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The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

What are the key success factors for implementation of this scheme?
Reduce demand for acute services. Improved patient/service user experience.
Scheme ref no. 3a
Scheme name: Data Sharing - Monitoring and responding to the impact of the Care Act (including use of NHS number)
What is the strategic objective of this scheme?
Implementation of the NHS number
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Set up appropriate systems to monitor impact (e.g. self-funders, carers, wellbeing eligibility, safeguarding etc.) on budget, waiting lists, time spent by operational staff - align reporting function to Care Act Set up system to forecast demand and model operational impact e.g. the ASC TOM effort model Use of NHS number as prime identifier Identifying/coordinating response to risks & issues related to the Care Bill (including engagement with other local authorities, national developments, legal support)
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
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The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to

understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
Patients/Service users can quickly be identified by Health or social Care professionals avoiding delays in establishing identity and medication history leading to an improved patient/service user experience.

Scheme ref no. 4
Scheme name: Older People and Adult Community Services Outcome Based Procurement
What is the strategic objective of this scheme? In summary, the vision for Older People and Adult Community Services is: for people to be proactively supported to maintain their health, well-being and independence for as long as possible, receiving care in their home and local community wherever possible; for care to be provided in an integrated way with services organised around the patient; to ensure that services are designed and implemented locally, building on best practice; to provide the right contractual and financial incentives for good care and outcomes; and to work with patients and representative groups to design how the CCG commissions services. The strategic objective is for older people's healthcare and adult community services to be better organised around needs of the patient. We want to see: • More joined-up care We want to make sure that the health and care professionals involved in the care of an older patient or adult with a Long Term Condition, work together in joined-up teams. We are proposing to have a "lead" organisation responsible for delivering and co-ordinating this care, no matter where is it delivered, in the hospital or the community. • Better planning and communication We want to ensure that patients and their carers are involved in creating their health and care plans, and with consent, for these plans to be available at all times (24/7) to the appropriate professionals. • More patients supported to remain independent We would like older people to have access to care in ways that allow them to maintain their independence.

• Improved community and “out of hospital” services and fewer patients admitted to hospital as an emergency, where it can be safely avoided.

We want to stop people going into hospital unnecessarily (where it can safely be avoided) and we want make sure our older patients and adults with long term conditions can access the right support either at home or in their local community, in a timely manner. We want people to feel confident about the care they receive at home.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The patient groups being targeted are those aged over 65 and adults who receive health commissioned community services.

The model of care will be developed in further detail from October 2014, when the provider is appointed and will include BCF objectives. At this stage proposals are:

- More joined up care: organising care around the patient

To improve both patients’ and carers’ experiences of the healthcare received by older people, along with the quality of services delivered, the CCG asked organisations taking part in the tendering process to put together proposals that showed care organised around a patient’s need.

The proposals received suggest this can be achieved by:
• making sure that patients and carers are involved in making plans for their health and community care, so that services are delivered according to their need
• providing named care co-ordinators for patients
• the named care co-ordinators focussing on frail older patients, or those with complex problems, or those needing end of life care, will be supported by a team of doctors, nurses and therapists working together around the needs of each patient, and working better with voluntary organisations and social care
• if the patient is living with a long term condition such as dementia or diabetes or respiratory disease, the team would include a professional specialising in those fields
• providing specialist teams to provide support to the ‘patient’s team’ when needed.

- Better planning & communication: delivering ‘seamless’ care

We want to see care delivered in ways the ensure people feel everyone is part of the same team and knows what each other is doing. We want both patients and their carers to feel that their care is ‘seamless’ not disjointed.
We want to see all staff involved in a patient’s care to be communicating with one another and working in a co-ordinated way.

Proposals received suggest this can be achieved by:
• having a single point of access contact centre operating 24 hours a day, seven days a week - either nurse-led or staffed by professionals with links to expert advisors and all

organisations involved in the care of older patients
• having a single electronic record system and shared protocols, so that all relevant health and social care professionals can access, with patient consent, information whenever necessary.
• the continuation and strengthening of the already established Multi-Disciplinary Team (MDT) models, with better links to hospital specialist advice
• ensuring all health and care professionals have an understanding of all the health and social care needs of people in their care, not just in the specific area that they are trained
to deliver care in
• bringing mental health professionals into the wider team, so that frail older people with both physical and mental health problems receive better joined-up care
• solid partnership working with voluntary organisations providing everyday living support to older people for example with transport or providing respite for partners who are carers.

- Supporting older people to stay independent

We would like to see care delivered to older patients, or for older patients to be able to access care, in ways that allow them to maintain their independence. Ways suggested for doing this are:
• offering support at an earlier stage to a larger number of people than is the case now
• focusing on prevention - making sure those aged 65 plus have access to information and services that will help keep them well, for example diet advice and exercise opportunities
• with patient consent, offer a health/care review to identify and address issues, for example housing problems
• increased working with local voluntary organisations to direct patients to services and provide more informal support
• establishing healthcare contact points venues other than GP practices
• using technology such as Skype/Telehealth to provide support for people with long term
conditions
• developing a record system that patients can access, so they can self-manage their care

- Improved community services: reducing emergency hospital admissions, re-admissions and long stays in hospital.

Quite often during an episode of severe illness, hospital treatment is necessary. However a significant number of people are admitted to hospital who could have been safely treated at home, or discharged at an earlier point, if community services were organised in a different way.

We would like to see a healthcare system that reduces the number of older people being taken to hospital unnecessarily, or staying in hospital longer than needed.

Proposals received suggest this can be achieved by:

• improving information for, and engagement with patients, their relatives and carers to increase understanding of long term conditions, so they can better identify minor

changes
or serious deterioration and request help accordingly and earlier
• emphasis on personal case management to identify patients at risk of being admitted or
re-admitted to hospital, managed through Multi-Disciplinary Teams (MDTs)
• having a 24/7 urgent care system that can send a community team to the patient to both
assess and treat at home, without the need to go to A&E unless necessary

• good access to urgent hospital specialist advice and assessment
• much stronger links between the community and the hospital, from the A&E department
to the wards, with teams based in the hospital supporting care and linking with community teams in-reaching into the hospital, supporting better arranged discharge
• better rehabilitation services to support people to recover from episodes of ill health. This could include the provision of 'step down' beds in community settings, or a hospital at home service giving help with personal hygiene such as bathing, shaving etc, as well as medical care.

- End of Life Care

Alongside improving care for older people, the CCG has made improving End of Life Care across Cambridgeshire one of its priorities. The preferred provider(s) awarded the contract will be expected to work with the CCG on delivering improved End of Life Care.

Proposals put forward include:
• providing:
− local specialist nurses
− 24-hour support for patients and carers if needed, at home or in community bed settings
− well co-ordinated MDT working around the needs of the patient, as described above
• with patient consent, making sure information on a patient's needs and wishes regarding resuscitation and the place where they wish to be cared for at the end of their life, is available to all healthcare services, including the ambulance service
• ensuring that community services are able to meet the needs and wishes of patients and their carers.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Service	Current Delivery Chain
Community services for older people and adults	Cambridgeshire Community Services NHS Trust
Unplanned acute hospital care for patients aged 65 and over (A&E, non-specialist services admissions)	• Cambridge University Hospitals NHS Foundation Trust • Hinchingbrooke Health Care NHS Trust • Peterborough & Stamford Hospitals NHS Foundation Trust • Queen Elizabeth Hospital Kings Lynn

	NHS Trust The main impact for this BCF plan will be for Peterborough and Stamford FT
Older People Mental Health Services	Cambridgeshire & Peterborough NHS Foundation Trust
Other services which support the care of older people	Specialist palliative care services providers; GP practices (local enhanced service for care homes/nursing homes); specific voluntary organisations; other acute Trusts (hospitals) providing unplanned acute care

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes
-

The CCG's programme is informed by a comprehensive assessment of the evidence available. This began with an assessment of need, and includes a detailed analysis of evidence on improving outcomes for patients. There is published evidence that better organised and joined-up care leads to better health outcomes. For example, in April 2013 the Kings Fund updated a report 'Transforming Our Health Care System: A Summary' where they published the evidence for the effectiveness for all aspects of care for older people. A separate summary of the clinical case for change can be found on our website

Specific JSNA s underpin the evidence base for our population. Bidders have been encouraged to use the local JSNAs to inform their commissioned services and development of integrated care pathways:

Primary Prevention for Older People JSNA

This JSNA provides important evidence and information to support the commissioning of preventative services and initiatives for Older People across health and social care and to encourage awareness and signposting of available public health improvement programmes and services available across Cambridgeshire. The successful lead provider will be expected to use this evidence and information to develop effective integrated pathways of prevention to support healthy behaviours in older people.

This JSNA focusses on modifiable lifestyle behaviours, for which there are clear associations with poor health outcomes and opportunities to take a preventative approach: active ageing and physical activity, maintaining a healthy diet (including preventing malnutrition), and stopping smoking. It provides evidence on health-related behaviours in older people, including local data where available and a description of local programmes or initiatives to support healthy behaviours or actions to reduce lifestyle risk

Carer's JSNA

The main question for the JSNA was 'What can we do to support carers to stay healthy and well?' In addition, to support the work around the Better Care Fund, the JSNA has also looked at the evidence for whether supporting carers reduces health and social care service use. The scope of the JSNA is carers across the whole life course

Older People's Mental Health JSNA

The Cambridgeshire HWB highlighted older people's mental health as a priority area for JSNA work.

In consultation with partners the scope of an Older People's Mental Health JSNA was narrowed to focus primarily on dementia and depression. The JSNA makes an important distinction between mental wellbeing or mental health and mental illness or disorder

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The scheme is supported by outcome domains underpinned by metrics.

The CCG has agreed the following success criteria:

- improve patient experience and service quality for patients and their carers through care organised around the patient;
- deliver services which are sensitive to local health and service need, as defined in the Local Requirements;
- move beyond traditional organisational and professional boundaries, so front-line staff can work effectively and flexibly together to deliver seamless care;
- support older people to maintain their independence and reduce avoidable emergency admissions, re-admissions and extended stays in acute hospitals (including delayed transfers of care);
- deliver an organisational solution for older people's care which can demonstrate strong leadership, sound governance, resilience, and the confidence of commissioners and provider partners;
- demonstrate credible approach to engaging patients and representative groups in design and delivery of services; and
- Provide a sustainable financial model (see Financial Principles below).

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Outcomes Framework for Older People and Adult Community Services to improve health, wellbeing and maintain independence includes seven domains. Each domain is supported by performance metrics. Delivery against metrics will be managed by the CCG and partners through our joint governance arrangements
What are the key success factors for implementation of this scheme? This schemes is well advanced with the provider due to be appointed in October 2015 The procurement objectives are aligned with those for the Better Care Fund and this has featured in provider dialogue and the outcomes framework.

ANNEX 2 – Provider commentary

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

Name of Health & Wellbeing Board	The Peterborough Health and Wellbeing Board
Name of Provider organisation	Peterborough and Stamford Hospitals NHS Foundation Trust
Name of Provider CEO	Stephen Graves
Signature (electronic or typed)	Stephen Graves

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	23,296
	2014/15 Plan	24,729
	2015/16 Plan	24,479
	14/15 Change compared to 13/14 outturn	6.15% increase
	15/16 Change compared to planned 14/15 outturn	1.01% decrease
	How many non-elective admissions is the BCF planned to prevent in 14-15?	170
	How many non-elective admissions is the BCF planned to prevent in 15-16?	1,694

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	No. We believe that to deliver a sustainable health and social care system, we together need to be challenging in the reduction in emergency admissions and hence believe that we should continue with at least the 3.5% reduction, which is the proposed level of 3.5% BCF guidance
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	Our basis for not agreeing to the proposed percentage reduction is that as a Trust we believe that with the continuing trend in the growing demand for non-elective services is not sustainable. Hence the percentage levels set in the BCF will not provide the significant benefits required to the patients, the local health and social care system, including this Trust. As a minimum we would seek to have 3.5% reduction.

3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes

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