APPENDIX A

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 7th January 2015. Agreement has

	been reached for the HWB board to review proposals for the BCF, and sign off the templates prior to this 9th January submission.
Date submitted:	**Friday 9th January 2015**
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:	Peterborough Health and Wellbeing Board and Peterborough City Council
By Chair of Health and Wellbeing Board	Councillor Marco Cereste
Date	Friday 9th January 2015

Signed on behalf of:	Peterborough City Council
By	Gillian Beasley
Position	Chief Executive
Date	Friday 9th January 2015

Signed on behalf of:	NHS Cambridgeshire and Peterborough Clinical Commissioning Group
By	Andy Vowles
Position	Chief Strategy Officer
Date	Friday 9th January 2015

Signed on behalf of:	Peterborough & Stamford Hospitals NHS Foundation Trust
By	Stephen Graves
Position	Chief Executive
Date	Friday 9th January 2015

Signed on behalf of:	UnitingCare Partnership
By	Keith Spencer
Position	Chief Executive Officer (Interim)

Date	Friday 9th January 2015

Signed on behalf of:	Peterborough Council for Voluntary Service
By	Leonie McCarthy
Position	Chief Executive Officer
Date	Friday 9th January 2015

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

Document or information title	Synopsis and links
Health and Wellbeing Strategy: Peterborough	Sets out the key priorities on which the Health and Wellbeing Boards will focus on in the next five years. The NHS and Local Authority plans are informed by the Health and Wellbeing Strategies.
Cambridgeshire and Peterborough Joint Strategic Needs Assessment (JSNA) - Summary Report 2013/14	The JSNA Summary Report for 2013/14 provided an overview and update on the entire breadth of the JSNA work in Cambridgeshire to date. It was designed to identify and flag key pieces of information about the health and wellbeing needs of the community, and local inequalities in health for specific population groups.
Joint Strategic Needs Assessment for Cambridgeshire and Peterborough	JSNA analysed the health needs of population to inform and guide commissioning of health, well-being and social care services within the area. The JSNA underpinned the health and well-being strategies and the CCG commissioning plans.
Peterborough Adult Social Care - Older People's Accommodation Strategy	This strategy outlines our plans for the accommodation needs of older people in Peterborough who require support from social care to live their lives.
Cambridgeshire and Peterborough Health and Care System Transformation Programme - System Blueprint	Blueprint for the Cambridgeshire and Peterborough health system for the years 2014 to 2019. This health system exists to serve the people of Cambridgeshire and Peterborough and its overall aims are to empower people to stay healthy, improve the quality of care, improved outcomes and to continually develop a sustainable health and social care system.
NHS Cambridgeshire and Peterborough CCG 2 Year Operational Plan	The document sets out how C&P CCG intended to implement the national and local planning priorities for the next two years and achieve sustainable financial balance. It sets out the medium term financial plan for the period 2013/14 to 2016/17 which showed how the financial metrics requested by NHS England by 2014/15 will be delivered 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.

Governance structure chart and draft terms of reference for BCF Executive Partnership Group	The Borderline and Peterborough Transformation Board is accountable to the Health & Wellbeing Board for the development of the BCF which also ensures the engagement of all parties. This is currently the equivalent of the Cambridgeshire Eexecutive Ppartnership Board. The CEPB also includes includes PCC and Borderline & Peterborough LCG membership to ensure alignment across the two Local Authorities. It should be noted that the governance arrangements within and between Peterborough and Cambridgeshire will be revisited as part of the Section 75 Agreement and this will also seek to ensure greater alignment between the two Local Authorities,

2) VISION FOR HEALTH AND CARE SERVICES

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

The BCF is one part of our overall transformational activity but is not the solution in itself. Implementing interventions to deliver the BCF outcome will require a system wide integrated approach across the Health and Social Care, alongside other important work around the Care Act (part 4 integration). Impacting upon the matrix set out in the BCF requires transformation at scale and is about ways of working rather than a piece meal approach to commissioning and intervention in isolation. The greatest impact will be realised through the cumulative effect of joined up interventions over a sustained period of time. This will include investment in the right service areas and skilled service redesign and process reengineering, evaluation of new initiatives, a closer more integrated relationship with the voluntary sector and an IT infrastructure that is fit for purpose and enables data sharing across organisational boundaries. This transformational change will be an ever evolving picture to support continuous development and improvement- decision makers will be realistic about the pace of change and appreciate the complexity of sourcing evidence on any impact on financial savings (this could be between 3 to 5 years).

Our vision is to enable people living in Peterborough to live longer, be healthier and have a better quality of life, especially in the communities with the poorest health. We will achieve this by local people, commissioners and providers working together to transform the health and social care system. Our aim is to remove organisational barriers and ensure that teams from different sectors work together seamlessly. Citizens will receive care in their home or the community; by shifting resources from hospitals to primary and community care we will be able to reduce unnecessary hospital admissions and shorten hospital stays. Services will be high quality, accessible, sustainable and based on the real needs of the population.

The Health and Well-being Board has identified the Better Care Fund as an important enabler to support this transformation of the overall local health and social care system for patients, service users and carers. In developing its strategy, partners on the Health and Wellbeing Board have agreed a number of principles that helped to shape our priorities for the local health and social care system.

Developing Our Priorities

Data available from the local JSNA, Public Health team and Projecting Older People Population Information (POPPI) dataset reveals the following information about our increasingly ageing population in Peterborough with a higher prevalence of long term conditions:

- The percentage of the Peterborough populated age 65+ is expected to increase from 13.9% to 18.0% by 2035 and the percentage of the population aged 85+ from 1.7% to 3.3% in the same time period.[1]
- By 2020, it is estimated that there will an increase of 0.9%, from 7.4% to 8.3% of population, of Peterborough residents with diabetes[2].
- The modelled estimates of prevalence of cardiovascular disease amongst city

[1] http://www.poppi.org.uk/

[2] http://www.yhpho.org.uk/diabetesprevtable/pdfs/E06000031_Diabetes_Prevalence_profile.pdf

residents show a 10 year increase (from 2010-2020) of 0.7%, from 6.5% to 7.2% of population.[3]

- It is estimated that dementia affects 5% of all people over the age of 65[4] and this would represent an increase in Peterborough from 25,800 to 39,400 sufferers between 2012 and 2031 based on these projections.
- Patients with long-term conditions accounted for 18.9% of non-elective hospital admissions in 2013/14.
- Attendances at Accident and Emergency rose by over 5% during 2013/14.

Our Priorities
The Health and Wellbeing Strategy set five priorities for Peterborough, which have informed the development of our BCF plan:

- Priority 1 - Securing the foundations of good health
- Priority 2 – Preventing and Treating Avoidable Illness
- Priority 3 – Healthier Older People who maintain their independence for longer
- Priority 4 – Supporting Good Mental Health
- Priority 5 – Better health and well-being outcomes for people with lifelong disabilities and complex needs.

The prime focus is on preventative and early intervention community support resulting in a shift away from acute health services, typically provided in hospital, and from emergency social care services. This plan addresses this rebalance and has taken a whole system approach. We recognise the development of preventative and early intervention community based services (as an alternative to reactive, crisis based services) requires significant changes to our thinking and arrangements. Our plan over the next five years is to work towards a fundamental shift of emphasis.

The scale of this transformation is significant; it is as much about reducing admissions to hospital as about changing the whole system. The aim of these changes will be a system that is focused on supporting people wherever required with person-centred and professionally-led primary care, community care, social care and whole system community resources, in an integrated manner. We will be guided by the goal of people living as independently as possible, for as long as possible.

We are committed to achieving this, because it achieves better outcomes for our citizens as well as creating a sustainable integrated health and care system.

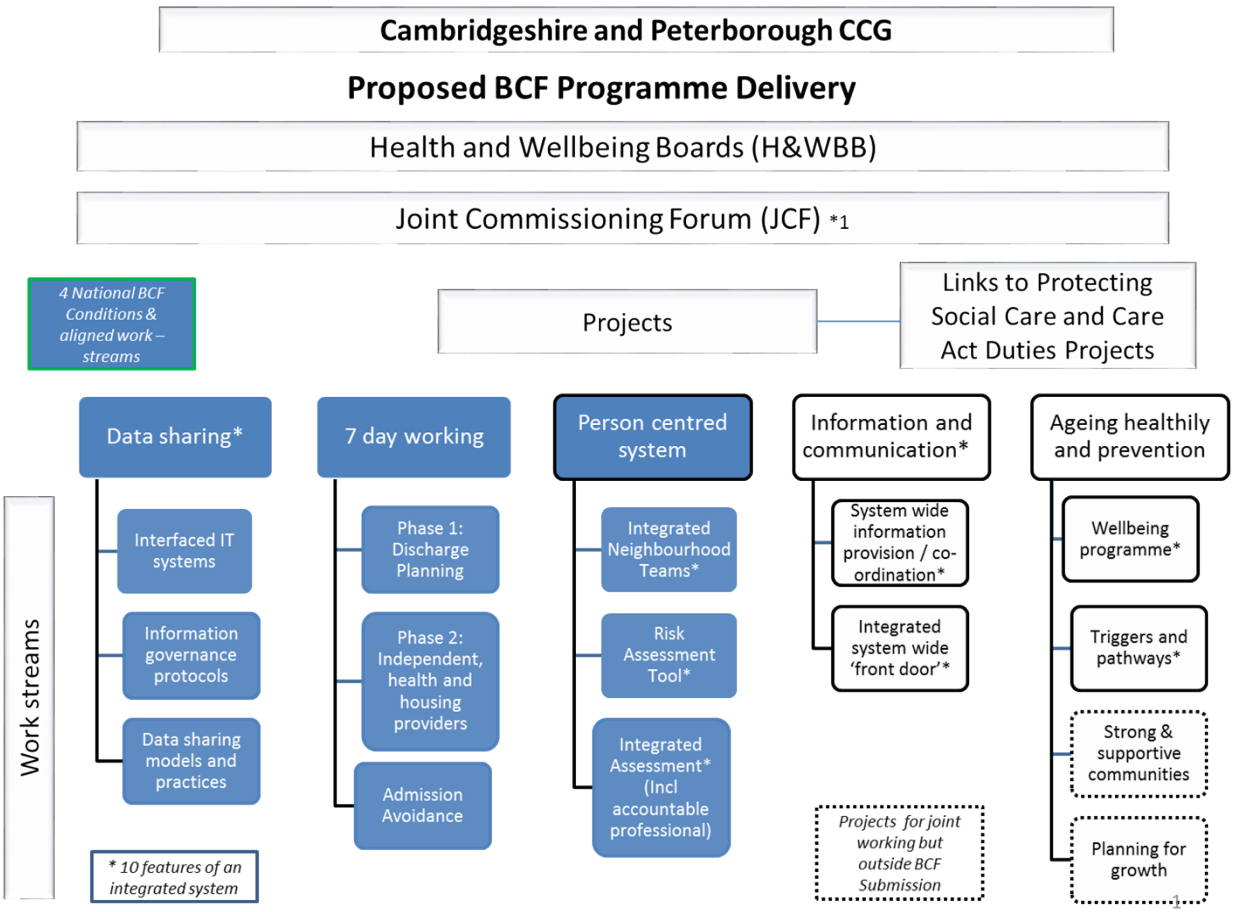
Delivery approach:
There have been detailed discussions and workshops with system partners to create the vision, goal and objectives contained within this submission, led by Peterborough City Council, the CCG and Cambridgeshire County Council in conjunction with Partners. These included the voluntary sector, GPs, Acute, UCP (the new community services health provider), Patient Representatives and Healthwatch.

The Partners have agreed the priority focus areas (outlined within this plan) and have aligned these with an outcomes based performance framework.

[3] http://www.apho.org.uk/resource/item.aspx
[4] http://www.mentalhealth.org.uk/help-information/mental-health-statistics/older-people/

The jointly agreed priority work streams are as follows:

- Data Sharing;
- 7 day working;
- Person Centred System;
- Information, Communication and Advice
- Ageing Healthily and Prevention



*1 For detailed arrangements see section 4b.

1. Data Sharing

To establish and implement an effective and secure approach to data sharing across the whole system. In order that the provision of all services will be better co-ordinated and integrated, and support the delivery of person centred care in the most beneficial setting. This will include a risk stratification model.

2. 7 Day Working

The expansion and development of community capacity and services linked to primary care and secondary care operational delivery plans will enable citizens to remain at or return home wherever and whenever possible.

3. Person Centred System

Multi-disciplinary integrated neighbourhood teams consisting of GPs, Community Matrons, Social Workers, lead professional, voluntary sector staff and Geriatricians on a sessional basis will be operational across the city. Each recipient of a service will have a named lead

professional.

The integrated neighbourhood teams will be supported by Risk Stratification tools and process, along with a common assessment framework, to ensure appropriate timely interventions are made.

Intermediate care services, crisis response and Local Authority reablement and emergency home care services will be reconfigured and processes aligned to support the independence pathway. This is complemented by expanding the use of assistive technology and tele-health including for citizens within residential and nursing homes and a 24/7 rapid response service JET (Joint Emergency Team). JET will consist of paramedics, health and social care staff working in and with the community to avoid referrals to secondary care wherever possible.

4. Information, Communication and Advice

The integration of information and advice services to simplify access to services for citizens through an integrated front door.
This will include formalising links with the development of a community service model, to reduce the demand for acute services. This will be complemented with ongoing integrated multi-agency teams based within neighbourhoods.

5. Ageing Healthily and Prevention

Implementation of new pathways to support early intervention will be delivered by a new target operating model. These pathways will be built using core customer segmentation and customer insight provided by a dedicated knowledge and improvement hub.

The Partners have agreed the following objectives will be achieved by 2019.

- Access to services will be less complex, with the provision of web based information and guidance allowing self-access;
- People will only tell their story once as assessment functions are joined up and Information is shared across health and social care;
- Citizens will have greater choice and control over their lives and greater support in self-care;
- People will have greater self-awareness of how to improve their own health and wellbeing through prevention of illness and healthy lifestyles;
- Local communities and individuals will be healthier, live longer and more independently;
- Hospitals and long term care will be last resorts and used only when there is an absolute need that cannot be met outside of these environments; and
- Organisations will be joined up and will work together to share resources and learning.
- Provision of services at a more level through improved engagement with the voluntary sector and the community.

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

The overarching objective of our Programme is to transform our resident's experience of Health and Social Care provision in Peterborough.

In five years' time, our aspiration is:

- **People will be living longer, be more independent and have a improved quality of life, remaining at home, feeling safe and part of the community for as long as possible;**
- **Reduced social isolation and fully developed responses to identified risks**, such as falls;
- **Reduced demand on secondary health care**, people will only be admitted to hospital if that is deemed to be the best place to meet their Clinical needs;
- A range of **alternatives to acute care** will be available
- **Services will be delivered within the local community**, enabling patients to be discharged from hospital in a timely manner;
- **New technologies will assist people to self-care and people will take responsibility for their own health and wellbeing**;
- **Staff and whole organisations will be joined up and integrated**, trained to offer more flexible care; and
- **People in our City will understand and be able to access the services at the right time and place**.

The focus is to make an individual's journey through the health and social care systems as simple as possible and based on creating and/or maintaining independence.

Their perspective will become the key organising principle of our service delivery – they will receive the care that they need, at the time that they need it, driven by their requirements and not by the suppliers. Care will become so well integrated that the patient will have no visibility of the organisations/different parts of the system delivering it.

This will all lead to a range of positive outcomes for patients and service users alike, 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;
- Effective information sharing and IT systems will be in place; and
- An organisational culture that supports staff to learn, improve and feel empowered.

Independent evaluation of the Adult Social Care Programme will focus upon addressing the following key questions, which are relevant to BCF schemes of Care Coordination, Independence Pathway, Assistive Technology, Access and Navigation, and Carers:

- Do our citizens find it easier to access and navigate our health and social care services?
- Do our citizens have improved choice which has led to greater preservation of

independence?
- Do our citizens feel our services have become more cohesive and joined up?
- Have our citizens' experiences of our health and social care services improved?
- Are our citizens satisfied with our health and social care service?

The data will be used to develop the patient experience metric and enable us to measure the benefits realised through the BCF Plan in 2016 and 2019 against the 2014 baseline.

The case study below is an illustration of what will be different for Peter.

1. Supporting older people to stay independent

Peter is 90 years old and lives alone. He is becoming increasing frail and reliant on the support of his daughter Jane. Jane lives fifty miles away, has her own family to care for and is finding it increasingly difficult to visit her father on a regular basis. Jane is worried about his safety and his loneliness. Peter lives in the family home and is still able of drive, however, he does not like to go far or travel at night. He has had several strokes and has just been diagnosed with diabetes. Peter wants to remain at home but understands that he needs support. Jane calls Adult Social Care to see what they can do to support Peter so that he can remain at home. A social worker visits Peter and assesses his needs. Peter then receives a visit from an Occupational Therapist who again assesses his needs. Peter is told that he is not eligible for statutory services but is supported with the installation and use of Lifeline.

By 2019, the integrated health and care system will offer Peter a very different experience. Peter will be offered a single integrated assessment which will look away from dependency and deficit towards independence and well-being. The assessment will be conducted by a relevant lead professional identified from a multidisciplinary team. The assessment will focus on what Peter can do and not on what he cannot do to ensure he can maintain his independence. Peter will be involved in the decision making process and the solution will be a shared decision not only with Peter but with all relevant organisations. The solution will look at how enablement, i.e. therapy services including reablement, assistive technology and other aids and adaptations can support independence, and how current relationships and networks and community resources can be strengthened to support Peter to live alone happily and safely. Peter will also have access to a comprehensive information service which will support him to keep well, e.g. advice and information on healthy eating and exercise opportunities. The Council and its partner commissioners will continue to stimulate a thriving and viable third sector which has a key role in relation to prevention and independent living.

2. Improved community services: reducing emergency admissions and re-admissions to hospital.

Peter had a fall coming down stairs and was admitted to hospital. Peter had various diagnostic tests to ensure he had no fractures and he was then deemed medically fit to be discharged home. Peter was still badly bruised and lacked confidence using the stairs and therefore decided to sleep in the chair downstairs. His daughter contacted Adult Social Care and asked if her father could be

assessed as he was having difficulty with the stairs and was, therefore, not sleeping in his bed or able to use the bathroom to wash himself. A social worker visits and assesses Peter, and sets up a programme of reablement to enable him to use the stairs in safety.

By 2019, the integrated health and care system will offer Peter a very different experience. On planning discharge from the hospital there will be three possible pathways for professionals to consider with Peter as follows: 1. Urgent Community Response Service aligned to ambulatory care and/or frailty pathway to support Peter to return home 2. MDT/reablement support to support Peter to return home. 3. Enhanced reablement/rehabilitation (intermediate or interim care bed) for 4 to 6 weeks prior to Peter returning home. This will mean that Peter will have the support required when he is ready to be discharged.

3. Reduction in excess bed days/delayed transfers of care.

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This will mean that Peter will have the appropriate support required to ensure he is ready to be discharged.

4. Reduction in excess bed days/delayed transfers of care.

Peter had another stroke and was admitted to hospital and transferred to the Stroke Unit. Peter's conditioned stabilised and he had active rehabilitation on the Unit and then was deemed medically fit to leave the hospital and return home. The Stroke Unit referred Peter to Adult Social Care for an assessment to consider what support he may require when he returns home. Adult Social Care contacted Peter's daughter Jane, who did not believe he is well enough to return home as his mobility was limited and she believed he was at risk of further falls and that he would not be able to use the stairs to get to his bedroom or bathroom.

Adult Social Care contacted the therapist who was working with Peter on the stroke unit who arranged to discuss possible options with Peter and his daughter, including moving Peter's bed downstairs and providing a commode. Peter was not happy with

this suggestion and his daughter supports him in his decision not to have his bed moved downstairs. Jane and Peter also believe he should be offered further therapy input to help improve his mobility. Peter is referred to Intermediate Care who come and assess him and agreed that his needs would best be met in an intermediate care bed however there are no beds available and Peter's discharge was delayed for several days.

By 2019, the integrated health and care system will offer Peter a very different experience. When he is medically fit to be discharged from hospital, a single referral process will be embedded and the appropriate lead professional of the MDT will assess Peter and co-ordinate both his health and social care in the appropriate setting, whether this is at home or in an intermediate bed.

5. End of Life Care

Peter has been diagnosed with end stage emphysema and his daughter, Jane, is told by the doctor treating her father that there is unlikely to be an improvement in his condition and he will deteriorate quite rapidly. Peter wishes to die at home and Jane makes the arrangements. Jane has to arrange the health and social care separately, discussing her father's case with the professionals from two organisations.

By 2019, the integrated health and care system will offer Peter an End of Life Care which will give him the choice to remain at home during the end stages of his life. Prior to discharge, the MDT will have conducted an integrated and comprehensive assessment resulting in an individual support plan. On arrival home, Peter will start to receive support from primary care, community health, social care and third sector staff who are trained to support Peter at this stage of his life. Any equipment, aids or adaptions will have been delivered or installed prior to Peter's arrival home.

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

Integrated services across health and social care will be delivered in a community setting and in citizens' homes wherever possible. A renewed focus on early intervention and prevention will ensure that citizens' needs are met at an earlier stage and that they are supported to be as independent as possible for as long as possible.

Developing our integrated system
Over the next five years, 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 where appropriate. This might be through all organisations better 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 timely support without waiting for needs to escalate. This support will focus on returning people to independence as far as possible. More intensive and longer term support will be available to those that need it.

This section describes our planned approach to integration in the following sections:

a. Features of an integrated system;
b. The Older People's and Adult Community Services (OPACS) contract; and
c. How the BCF will contribute to our vision for integration.

a. Features of our Integrated System

1. A series of community based programmes and support that help people to age healthily.

   This would include specific and planned evidence based public health programmes to prevent falls, promote physical activity and promote mental health and emotional wellbeing, drawn from Joint Strategic Needs Assessments (JSNAs). These programmes would be community based and delivered jointly with the local community in collaboration Public Service partners.

   Discussions are currently underway with;
   - Cambridgeshire Fire and Rescue about work they could do to carry out safety checks in homes,
   - A consortium of voluntary and community sector providers to help reduce isolation, increase community support in the home and provide local activities information
   - With Libraries to develop their role as hubs for older people, seeing libraries as assets that can be used flexibly to help prevent loneliness and isolation.

2. A recognised set of triggers of vulnerability which generate a planned response across the system.

   An agreed set of triggers that organisations will respond to that are a strong indicator that vulnerability is about to or has increased and all partners would work together to both identify and respond to. Evidence suggests that there is clear evidence about what these might be. The more formal medical type triggers (falls, continence, malnutrition, mental health) could be complemented by other softer signals that partners would be able to identify, e.g. someone asking for assistance with their wheelie bin, a request for a personal alarm/life line, a concern raised when a housing provider carries out a routine visit, a death is registered or a blue badge is requested. It will be important for consent to be sought for information sharing across organisations and clear explanation given about the potential benefits.

   Peterborough benefits from a diverse and well established voluntary and community sector varying from volunteer based organisations to organisations such as Age UK, the Carers Trust and British Red Cross that provide direct services. These services already play a key role and could become a more explicit part of this planned system to prevent the need for involvement by specialist or statutory services. It is important to recognise how much of this happens already.

3. A universal network helping older people and their families to find high quality information and advice.

   The development of a high quality source of advice and information that is not

based on organisational boundaries. The way in which this information is delivered would need to go beyond online delivery but having one system wide web site would be a good starting point.

4. An aligned set of outcomes.

   We will commission work to develop a clear set of outcomes for older people that we can then deliver against, building on the OPACS outcomes framework. These could be drawn from the City Council's existing 'must dos' and supplemented by indicators that are developed locally, linked to the key elements of the integrated system. Part of this might include the development of some joint data sets or 'dashboards'.

5. An integrated front door with an agreed principle of 'no wrong door'.

   Work needs to take place to agree how we can develop an integrated 'front door' for older people and their carers who do not have a clear point of contact or lead professional, but do not differentiate between whether their needs are health, housing, social care or a combination of these. This could be based upon co-located staff or virtual links to, for example, housing providers, voluntary sector and Peterborough Plus.

   In addition a key feature of an integrated system could be the principle of 'no wrong door', recognising that support will be accessed via a wide variety of routes. We need a system which is able to help older people and their partners to navigate the system rather than just sign post.

6. Shared assessment process, information sharing between health, social care and other key partners.

   Whilst recognising that there may be a point at which a detailed specialist or statutory assessment is needed, it has been agreed that having a shared and joint approach to identifying the primary need for someone who may present as vulnerable or frail would be valuable, without them being drawn into a statutory assessment process. This would require a consent based approach along similar lines to the Common Assessment Framework (CAF) for children.

7. A shared tool that describes levels of vulnerability.

   A shared tool that will be used by all professional and providers working with an older person to describe levels of need, stratify risk and be used as a basis for MDT decision making. Some work has already been carried out to bring together existing tools that are used in the voluntary and community sector and in the acute sector (Rockwood Frailty Index) and by primary care based Multidisciplinary Teams. This could also be used to inform intelligence led commissioning.

8. A locality based Integrated Neighbourhood Team approach (MDT).

   Building on the learning from the CCG MDT pilot and exploring how this approach could develop to include the cohort of patients who are vulnerable or at risk of becoming frail or needing high cost services. We would see the development of shared record and identification of a lead professional as critical to success.

The Integrated Neighbourhood Team approach would include an expectation of multidisciplinary working between individual staff or practitioners from a range of organisations, working on the model of the 'team around the person' which can be formally escalated to a multidisciplinary team linked to a GP practice if needed. High risk would result in frequent, regular proactive Integrated Neighbourhood Team approach whereas low risk would require a lower level intervention that would be taking place in the community and involve a range on partners in the voluntary and statutory sector. There would be local flexibility to manage local circumstances and needs.

9. Co-located staff.

   Where possible, staff would be co-located or able to share working space in a variety of settings. As partner organisations move towards more mobile working and reduced office space, there will need to be a better join up in relation to planning use of estates to achieve functional integration. In addition, it will be important to make use of existing assets such as libraries and other community buildings to act as a point of information and advice.

10. Joint commissioning and aligned financial incentives.

    There are a number of areas where we think there would be benefit from more joint commissioning by commissioners who may be dealing with the same organisations and there would be benefit in a joint approach. This would be part of the work to align financial incentives across the system to deliver on outcomes. Commissioning could also be more informed by what we know about the experiences that older people have of the services that organisations provide.

Many of these features are already being taken forward and align closely to new statutory duties within the Care Act. Others link to the Older People's and Adult Community Services contract with UnitingCare Partnership, which was awarded in October 2014 and will be operational in April 2015. This is a ground breaking contract adopting an integrated pathway approach. The new provider is a consortium between an acute and mental health provider.

As referenced within our vision above, in recognition of the fact that many health partners in the local system operate across both Cambridgeshire and Peterborough, and that many of the challenges facing health and social care are common between the two areas, we plan to align and have one programme for integration and transformation with our Cambridgeshire colleagues. As a result, Cambridgeshire and Peterborough have agreed to collaborate on five key areas of project work that have been developed from the features of an integrated system:

1. Data Sharing;
2. 7 day working;
3. Person Centred System;
4. Information, Communication and Advice
5. Ageing Healthily and Prevention

Project 1: Data Sharing

The Data Sharing Project will deliver an effective and secure joint approach to data sharing across the whole system, enabling improved co-ordination and integration of services for adults and older people. It is a critical element of the overall transformation programme in Peterborough because the delivery of all other schemes will rely, at least in part, on effective and secure data sharing mechanisms being in place, particularly the Person-Centred Care project and the UnitingCare Partnership delivery model. This will include work-streams that will deliver the technical, procedural and cultural improvements required to enable effective data sharing as well as addressing the issue of consent.

At the heart of our approach to data sharing will be 'single-view of the patient record'. This will enable all care-staff to access a single-view of the patient record at the point-of-contact through a clinical portal using mobile technology. The portal will also host a shared care plan, accessible to all and updated after each patient interaction. Patients will be able to access the same information as clinicians through their own 'Patient-Portal', so that they are informed and involved in their own care. The portal will enable professional staff to allocate self-management tasks for patients/carers, whilst patients/carers will be able to interact with professional staff, amend their care plan, and ensure all information held is accurate. We will also invest in Telehealth / Telecare to promote self-management, remote monitoring and prevention.

This 'single-view' protocol is being rolled out as part of the UnitingCare Partnership's contract and a key aim to the expansion of this approach through the BCF will be to ensure that social care services can contribute to, and access, relevant data in the patient record, with appropriate patient and service user consents in place.

Effective and secure data sharing arrangements will improve customer experience. Patients will not have to re-tell their story to different agencies and will have increased confidence in the system and staff will be able to collaborate with each other and share information easily. Improved access to information will enable frontline staff to make better quality, well informed decisions about patient pathways and there will be a reduced risk of gaps in service, both of which will lead to better outcomes for patients. Through improved integrated working there will be a range of efficiency gains because information and provision of services will be better targeted and co-ordinated, and there will be enhanced opportunities for a whole-system intelligence led response to prevention, demand management and strategic planning.

Project 2: 7 day Working

The 7 Day Working project aims to expand 7 day working to ensure discharge planning is undertaken according to patient need, not organisational availability. Our approach will include expansion of a range of services involved in the hospital discharge process including health, social care and the residential and nursing home sector and will directly contribute to the admission avoidance agenda and align a significant number of the OPACS outcomes.

Reablement, intermediate care, district nursing and commissioned home care services already operate 7 days a week in Peterborough and in its first phase this project will focus on formal expansion of 7 day working within the local authority discharge planning teams (this includes social workers and discharge planning nurses). The

teams will work alongside independent providers to enable commissioned residential and nursing services to assess and receive residents at weekends. Following completion of this work, the focus will shift to expansion of the broader services required to enable successful 7 day working across the whole system including health and housing providers. This project will address the significant cultural change that will be required across the system to move to this new way of working.

The improved integration of discharge planning processes and practice will enable patients to be discharged from hospital as soon as they are medically fit. The support required to aid recovery will be available at the point of discharge; services based on need as opposed to availability will invariably lead to improved outcomes for patients. 7 day working will reduce the discharge peaks currently experienced within the system because discharge will take place 7 days a week, including weekends and Bank Holidays. The project will contribute to a reduction in the number of Delayed Transfers of Care, a reduction in the number of days patients spend in hospital and emergency bed days and in the long-term a reduction in the length of acute hospital stays.

Project 3: Person Centred System

The Person Centred system project aims to enhance and improve person centred care across the entire system. By ensuring that care and support is planned and co-ordinated by primary multi-disciplinary teams of professionals who will work closely with primary care agencies alongside those individuals who are identified as at risk of becoming frail or requiring high cost services in the future. In addition to the multi-disciplinary approach, Integrated Neighbourhood Teams will be linked to GP surgeries. This will identify gaps in service and facilitate the delivery of flexible, co-ordinated and creative long term support for those at high risk of requiring intervention or that require intensive or long-term support to enable them to remain within their communities wherever possible.

Multi-disciplinary working will be facilitated by a range of integrated practices co-location at a local level and the provision of an Accountable Lead Professional. Integrated decision making will be aided by the use of a consistent non age specific frailty tool that will be used to describe levels of need and stratify risk and which will also provide a broader picture of frailty within communities to enhance strategic planning. Whilst recognising that there may be a point at which a detailed specialist or statutory assessment is needed, an integrated joint assessment process for non-statutory assessment of the primary health and social care needs of individuals with complex needs will be implemented, facilitated by an accountable lead professional.

It is recognised that there are many potential as yet unidentified benefits that could be produced as a result of closer integration of frontline practice and it is, therefore, important that focus on these areas is maintained and explored as the project progresses. In order to do this, individual case studies and people's experiences of their journey through the system will be routinely analysed in order to inform the future project scope and identify any further opportunities or areas for financial or efficiency savings or service improvements.

The work of the Person Centred System project will contribute to a reduction in non-elective hospital admissions for adults over 18, a reduction in the overall length of unavoidable hospital stays and a reduction in residential care admissions. The most

vulnerable, frail and at risk of hospital admission will be identified and resources will be more efficiently and effectively targeted through a multi-disciplinary team approach which will enable a common understanding of a person's holistic needs and through an integrated approach to meeting those needs. Through the use of consistent tools and approaches it is envisaged the system will not only be more efficient but that multi-agency working will also be improved, including the development a consistent language which can very often be a barrier to delivery of effective outcomes. Through delivery of services within the community, there are better opportunities to make best use of existing community resources, and individuals in receipt or need of services will have a single point of contact, which will reduce the risk of critical information being missed, and will be empowered to remain independent and safe within their community.

To re-enforce this further, we will put in place a system that nominates a 'lead professional' who will undertake an assessment on behalf of health, social care and other agencies to assess risk and plan care for the patient. This is integral to person-centred care planning, and decision making about the person's care being undertaken in a timely manner, including telling their story once. The project will consider the impact for people with Dementia, and will set out how GPs could be supported in being accountable for co-ordinating patient-centred care for older people and those with complex needs.

Project 4: Information, Communication and Advice

The Information, Communication and Advice project will develop and deliver high quality sources of information and advice based on the individual needs of the population, not on organisational boundaries. This work will include the establishment of the principle of an integrated, system wide 'front door' for people that require information and advice about any part of the system irrespective of their presenting need(s). There is recognition that support and information will invariably be accessed via a broad range of routes, therefore, part of this work may involve embedding a principle of 'no wrong front door' and focusing efforts on supporting people to navigate the system in a way that best suits them, including exploration of self-service opportunities. This work will be as much around cultural change as it will be about procedural or technological change.

The Older People's and Adult Community Services (OPACS) Framework which will be delivered by UnitingCare Partnership (UCP) outlines some clearly related outcomes in respect of Information and Communication and these will also be integrated into the project scope as it continues to evolve and as UCP work towards full mobilisation.

The Information, Communication and Advice Project will enable people to access information and advice. In a way that works best for them and they will be helped to navigate the system successfully, irrespective of their needs or where they go for advice or information; through improving public and professional access to good quality information and advice about preventative and community based services. This will contribute to a reduction in non-elective hospital admission and inappropriate referral or admissions to residential care homes.

Project 5: Ageing healthily and prevention

This project will focus on the development of community based preventative services to support and enable older people, in particular, to enjoy long and healthy lives and to feel safe within their communities; this will promote independence and prevent people from requiring long-term health and social care needs leading to the delivery of improved outcomes.

A key deliverable of this project will be an agreed set of triggers of vulnerability which can be used to generate a planned response across the system; this will include formal medical triggers and will be complimented by softer data that could indicate potential escalation of need such as requests for blue badges or concerns identified by housing providers. There is a substantial amount of business intelligence data and information available across the system and the integration programme will offer partners an opportunity to align this information to inform future business planning and strategic commissioning and enable more effective targeting of resources.

The project will seek to build community resilience and deliver on an ongoing basis a series of planned, evidence based public health programmes to support falls prevention, promote physical activity and promote mental health and physical and emotional wellbeing. Public sector will work with the local voluntary and community sector to ensure activities will be co-ordinated to reduce the risk of social isolation for vulnerable people. The provision of accessible services within communities will support people to retain or regain the skills and confidence to remain living in their communities for as long as possible and maintain their independence, thus reducing demand on primary and secondary care and social care services. The project will also be responsible for ensuring clear and effective links are established with economic growth and development programmes to ensure that factors that have a positive impact on healthy ageing and prevention of acute need are integrated into long-term plans for new communities.

Key enabler: The Older People and Adult Community Services Contract (OPACS) Contract

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 Contract.

In October 2014, it was announced that UnitingCare Partnership (UCP) had been awarded the contract for the OPACS procurement. UCP is an NHS partnership that will deliver a distinctive, integrated, seamless and affordable service in partnership with patients and carers. The partnership will work closely with organisations to transform community services to deliver person-centred care.

The UCP service model has six distinctive components:

Component 1: Integrated neighbourhood and integrated care teams
18 neighbourhood teams, each supporting up to six GP practices, will form the hub of community-based activity. Services will be joined up around the patient and their GP practice where professionals talk to each other and work as a team. In the new integrated care, teams will be a combined workforce of community nurses, psychiatric

nurses, allied health professionals, specialist hospital doctors and support workers managed by community matrons and include aligned and co-located social workers. Neighbourhood teams will also have access to support from specialist professionals within four integrated care teams in Huntingdon, Peterborough, Cambridge and Fenland/Ely. These teams will include a housing link-worker to ensure accommodation and welfare issues are addressed as well as consultants, geriatricians, psychiatrists, cardiologists, respiratory physicians and palliative care consultants for advice and consultation.

Component 2: UnitingCare Centre - Single-point-of-co-ordination with clinical support
Services will be accessible via a single telephone number available to GPs, out of hour's services, community and mental health teams, hospitals, social care, third sector as well as patients and carers. Staffed by professionals with telephone links to expert clinical advice, the centre will manage people in the most appropriate way and support their independence and choice.

Component 3: Integrated case management – Co-ordinated care for those most at risk
UCP, supported and working with GPs and their teams, will identify the 5-15% of patients at greatest risk of future hospital admission. For these patients, coordinated case management through regular meetings and the provision of an Accountable Lead Professional, that include various different professionals structured to include health, mental health, social care and housing provision.

Component 4: Joint Emergency Team (JET) - Rapid response team
24/7 emergency service involving health and social care staff. The aim is to prevent costly referrals to hospital by providing emergency care for people in their homes.

Component 5: Wellbeing and prevention
Focus on prevention and wellbeing to support self-management, choice and to enable people to maintain independence. Working closely with the voluntary sector and social care to support prevention at every level.

Component 6: Technology
Using technology to allow health professionals to view an integrated electronic patient care record. Currently different organisations use different electronic record systems which means, for example, GPs cannot see what hospital staff have added and vice versa. The new technology will collate all records for that one patient making it easier to view and make decisions.

b. How the BCF will contribute to our vision for integration

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.

Specifically, the BCF will be used to fund the following schemes in Peterborough:

- A contribution towards the OPACS Older People and Adult Community Services contract to establish the UnitingCare Partnership model;
- The information and data sharing project;
- The establishment of joint assessments and an accountable lead professional, to support other elements of the system (particularly social care) to align with the UCP integrated neighbourhood team model and fulfil Care Act requirements; and
- The establishment of a multi-agency team to lead our approach to integration and transformation in Peterborough, and the creation of an ideas bank to assist in piloting small-scale integration projects

In addition, BCF will be used in the following areas of work in order to support the system as it works towards further integration and transformation:

- Implementation of the Care Act;
- Protection of social care services;
- Continuation of section 256 arrangements; and
- Continued CCG support for carers and reablement services

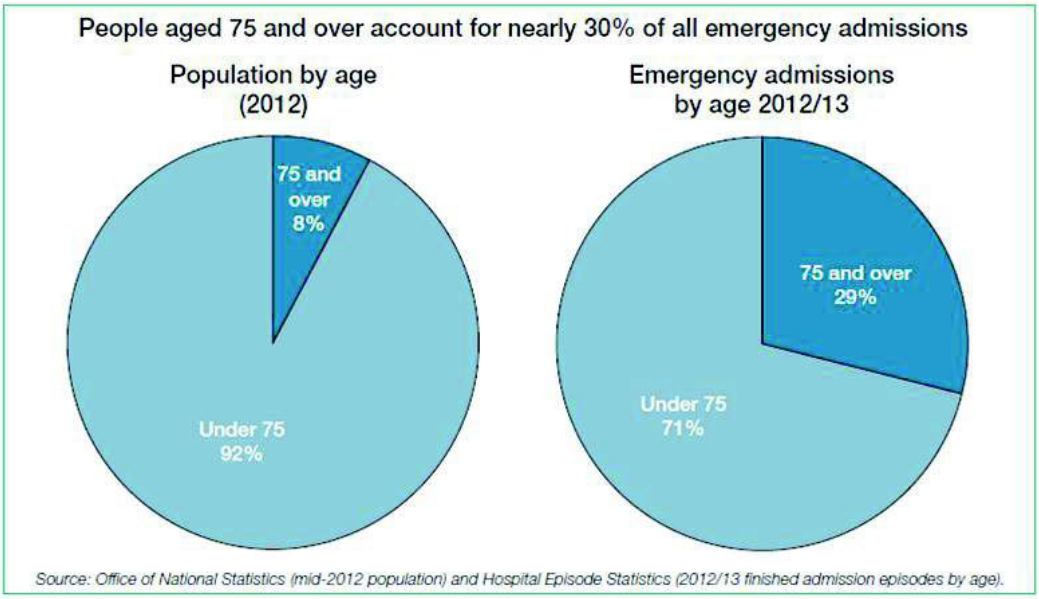
3) CASE FOR CHANGE

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

THE NATIONAL CASE FOR CHANGE

A recent Department of Health publication, *Transforming Primary Care* (April 2014), outlined the changes which need to occur across primary care (including community services) to ensure that care is safe, proactive and personalised for those who need it most. Pressures on both health and social care budgets, coupled with demographic and social pressures, necessitate the need to affect transformative change in the way in which we meet the needs of some of the most vulnerable members in our community. There is a clear need to transform health and care services based on an increasing ageing population with more chronic conditions, a system which is reacting to increasing emergency admissions and an increasingly complex health and social care landscape where patients feel their conditions are managed in isolation.

People aged over 75 currently account for nearly 30% of all emergency admissions (Figure.1 below), and by 2024 it is expected that people aged 75 and over will make up more than 10% of the population (Office of National Statistics). Taking into account this increasing ageing population alongside increasing budgetary pressures it is clear to see why there are so many calls nationally for care to be transformed.



The health and social care system have historically focussed on measuring service 'inputs' (such as attendances and admissions to hospital and admissions to residential care homes) and processes (such as waiting times). These have some value but do not tell us if the experience of health or social care was good or bad, or whether interventions were effective, which is why we are placing a particular focus upon information, communication and a person centred system in the priority work streams.

THE LOCAL CASE FOR CHANGE

a. The Peterborough context;
b. Life expectancy;
c. Healthy life expectancy;
d. Older people;
e. Health care resources;
f. Local challenges:
    i. Deprivation;
    ii. Rising demand;
    iii. Reduction in budget; and
    iv. Fragmentation.
g. Risk Stratification; and
h. Conclusion of the evidence - the case for change in Peterborough.

a. The Peterborough context

Peterborough currently has a population of approximately 185,000, which is predicted to grow by 11% by 2021. The majority of this population growth will be seen in the following age groups:

- 26% increase in the 65-74 age group;
- 21% increase in the 75-84 age group; and
- 52% increase in the 85+ age group.

This demographic change has been reflected within the new OPACS Outcomes Framework to inform the BCF implementation. This older population is increasingly likely to have multiple health conditions which impact on their quality of life and independence. The table below shows growth projections for key health conditions amongst the population aged 65 and over in the City, which have informed our vision.

Condition	2014	2020	% Growth
Dementia	1,935	2,226	15%
Heart Attack	1,335	1,512	13%
Stroke	629	714	14%
Bronchitus and Emphysema	460	521	13%
Falls	7251	8314	15%
Bladder Continence	4,461	5,097	14%
Diabetes	3,402	3,851	13%

This equates to an annual growth of 2.5% for dementia and falls, 2.3% for heart attack and bladder continence, and 2.2% for heart attack, bronchitis and diabetes.
Source – POPPI Health projections

Many older people will have more than one life limiting long term condition. In addition there is an increasing prevalence of mental illness amongst older people, in particular relating to depression. The table below gives projections for increases in depression.

Condition	2014	2020	% Growth
Depression	2,351	2,675	14%
Severe Depression	751	841	12%

This equates to an increase in depression of 2.3% each year and a 2% increase in severe depression.

Source – POPPI Health projections

Peterborough's rates of recorded disease/condition prevalence appear lower than the national average, the estimated prevalence rates (which are considered more accurate) show that they are lower than expected (as shown in the table below). The difference between recorded and estimated prevalence may, therefore, be indicative of undiagnosed cases who are likely to present at an acute healthcare provider such as Peterborough City Hospital. This could potentially be avoided through interventions provided at primary care level if adequate recording of prevalence and subsequent treatment were undertaken throughout the CCG.

Table: GP recorded and estimated prevalence, Cambridgeshire & Peterborough CCG, 2012/13 and 2011[5]

Condition	CCG QOF recorded prevalence 2012/13 (%)	Estimated Prevalence (%), 2011	England average recorded prevalence, 2012/13	England Estimated Prevalence (%), 2011
Stroke / TIA (All Ages)	1.5	1.77	1.7	2.07
CHD	3.0	8.9	3.3	9.5
Hypertension	12.9	23.2	13.7	24.9
COPD	1.6	2.15	1.7	2.91
Diabetes Mellitus (17+)	5.5	6.7 (2012)[1]	6.0	7.6 (2012)[1]
Mental Health	0.75	N/A	0.84	N/A
Dementia	0.5	N/A	0.6	N/A
Depression (18+)	5.6	N/A	5.8	N/A

SAR = Standardised Admission Ratio. 100.0 is the adjusted admission rate for England; a ratio below 100.0 suggests the number of admissions is lower than would be expected, above 100.0 suggests the number of admissions is higher than would be expected.

b. Life expectancy:

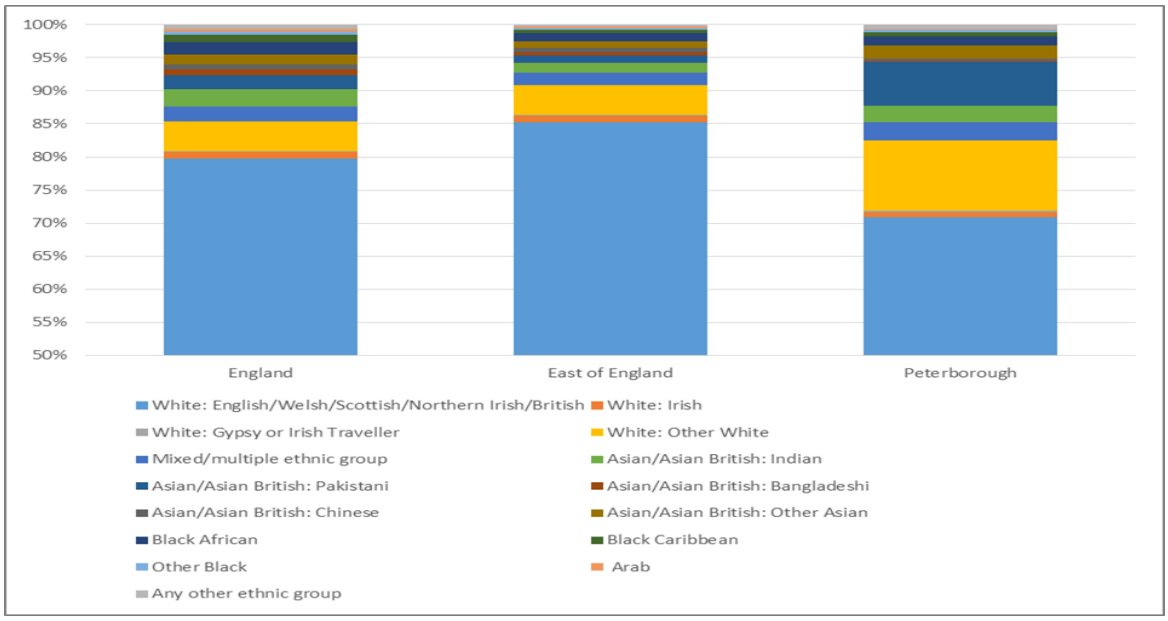
Peterborough has a significantly lower male life expectancy at birth (77.9) than the national average (78.9). Seven out of the 24 wards in Peterborough have significantly lower male life expectancies at birth than the national average. In addition, the disparity in life expectancy between the best and worst wards in Peterborough is substantial. Males born in Ravensthorpe (the ward with the lowest life expectancy for males – 74.2 years) are expected to live 8.9 years less than those born in Stanground East (the ward with the highest life expectancy for males – 83.1 years). Among females, those born in Park (the ward with the lowest life expectancy for females – 78.8 years) are expected to live 8.8 years less than those born in Werrington South (the ward with the highest life expectancy for females – 87.6 years). The wards with low life expectancy at birth are also the most deprived.

c. Healthy life expectancy:

Peterborough has a significantly lower healthy life expectancy for both males (59.9 years) and females (59.8 years) as compared to the national average (63.4 and 64.1 years respectively). These figures are also the lowest in the region. This indicates that a large proportion of Peterborough's population develops long term health problems at a relatively early age, often resulting in a high demand for health and social care services. This is a key factor for consideration in the development of the new service delivery model, facilitated by the BCF.

Peterborough has a higher percentage of people living in the 20% most deprived areas in England as compared to the national average. It also has a higher percentage of children and older people living in deprivation. Evidence shows that populations in deprived localities often experience poor health outcomes including lower life expectancy, higher burden of ill health, low uptake of health protection services such as screening and vaccinations and often seek medical attention late. The analysis by ward in Peterborough has revealed a similar pattern where the most deprived wards such as Central, Dogsthorpe, Orton Longueville, North and Ravensthorpe are associated with relatively poor health outcomes.

Peterborough is predominantly white but has a relatively higher proportion of black and minority ethnic groups as compared to other authorities in the region. It also has a higher proportion of non-British white population mainly made up of immigrants from Eastern Europe. Evidence suggests that people from black and minority ethnic groups (BME) suffer from poorer health, have reduced life expectancy and have greater problems with access to health care than the majority of the white population. Some minority ethnic groups are more predisposed to certain long term conditions e.g. diabetes (Asians).



Source 2011 Census

d. Older people

Dashboard 1 shows percentages of older people in deprivation and pensioners living alone by Peterborough wards compared to the England average. Red indicates a statistically significantly worse outcome than the England average, while green indicates a better than England average outcome. Yellow indicates that the observed difference is not statistically significant.

There are approximately 6,753 older people living in deprivation in Peterborough. This is an equivalent to 20.6% which is significantly higher than the national average (18.1%). Eleven out of the 24 wards in Peterborough have significantly higher percentages of older people living in deprivation than the national average.

[5] http://fingertips.phe.org.uk/profile/general-practice/data

About a third (8,093) of pensioners in Peterborough live alone. This is significantly higher than the national average (31.5%). Eleven out of the 24 wards in Peterborough have significantly higher percentages of pensioners living alone than the national average. North ward has the highest percentage (42.7%).

Area Name	*Number of Older People in Deprivation*	*% Older People in Deprivation*	*Number of Pensioners Living Alone*	*% of Pensioners Living Alone*
Barnack	97	11.2	174	26.5
Bretton North	435	25.6	408	35.5
Bretton South	75	12.5	115	28.1
Central	380	35.3	385	40.6
Dogsthorpe	590	32.5	478	34.7
East	533	30.9	530	39.2
Eye and Thorney	266	17.8	323	29.9
Fletton and Woodston	347	24.9	386	36.1
Glinton and Wittering	121	9.8	223	24.8
Newborough	61	10.1	103	23.8
North	393	31.7	404	42.7
Northborough	86	10.2	136	22.5
Orton Longueville	375	23.4	384	32.1
Orton Waterville	219	11.8	446	31.5
Orton with Hampton	122	12.0	251	28.7
Park	407	26.1	386	31.9
Paston	393	32.8	390	42.5
Ravensthorpe	336	30.9	283	35.4
Stanground Central	414	19.2	552	34.3
Stanground East	105	16.5	168	32.6
Walton	203	17.5	325	36.6
Werrington North	217	18.5	334	40.1
Werrington South	296	13.0	489	26.8
West	282	11.6	420	22.5
Peterborough UA	**6,753**	**20.6**	**8,093**	**32.5**
England	**2,094,588**	**18.1**	**2,725,596**	**31.5**

Dashboard 1: Percentage of older people in deprivation and pensioners living alone, IMD 2010

Source: Public Health England: Local Health

- **Key**

Statistically significantly better than the England average
The difference is not statistically significant
Statistically significantly worse than the England average

Currently frail older people are frequently admitted to hospital through Accident and Emergency departments (A&E), particularly in the evenings and at weekends. Hospitals beds become full and patients often stay longer than they should, which can make it difficult for them to regain independence.

The evidence indicates that a strategy focused on reducing emergency admissions of people aged 65 and over would achieve the greatest benefit in a reduction in emergency admissions. However, there are still a significant proportion of emergency admissions from people of other ages and so it should be considered how many of these admissions are preventable.

e. Health care resources:

Data from Peterborough & Stamford NHS Foundation Trust shows a total of 21,876 non-elective admission in 2013/14. The primary diagnoses with the highest number of admissions were urinary tract infection (site not specified), pneumonia (unspecified) and unspecified acute lower respiratory infection. Sorted by ICD10 Chapter, 30% of non-elective admissions were for diseases of the respiratory system, substantially higher than the next highest chapter, symptoms, signs and abnormal clinical and laboratory findings.

Emergency admissions by ID10 Chapter

ICD10-Chapter	Grand Total 2013/14	% Of All
Diseases of the respiratory system	2221	30.5
Symptoms, signs and abnormal clinical and laboratory findings	1055	14.5
Primary Diagnosis Blank	847	11.6
Injury, poisoning and certain other consequences of external causes	794	10.9
Diseases of the circulatory system	739	10.1
Certain infectious and parasitic diseases	644	8.8
Diseases of the genitourinary system	627	8.6
Diseases not elsewhere classified	346	4.7
Grand Total of top 20	-	**7273**
Grand Total of all admissions	-	**21876**

Peterborough has higher than expected emergency admissions for all causes, Coronary Heart Disease (CHD) and alcohol related harm. Some wards also have high emergency admissions for Stroke and Chronic Obstructive Pulmonary Disease (COPD).

The increasing demands on the Cambridgeshire and Peterborough health system are driven by a population that is increasing and ageing – see Section 1 above. Although work has and is being done across the health system to manage this pressure, if demand continues to rise at a rate that is proportionately greater than the achievement of efficiency savings there will be insufficient resources. To illustrate this, figure 13 below considers emergency admissions between 2012/13 and 2013/14. It shows how the emergency bed days per weighted population have stayed the same but there has been an absolute increase in emergency bed days across the CCG. One possible reason for this is that the health system is working more efficiently but that the absolute level of demand has risen as a result of change in demographics.

Cambridgeshire and Peterborough CCG Emergency Bed Days 2012/13 and 2013/14

	Emergency bed days			Emergency bed days per 1000 weighted population		
Locality group	**2012/13**	**2013/14**	**% change**	**2012/13**	**2013/14**	**% change**
Peterborough	50,591	53,197	5%	429.80	410.74	-4%
CCG overall	**331,441**	**349,183**	**5%**	**455.74**	**457.93**	**0**

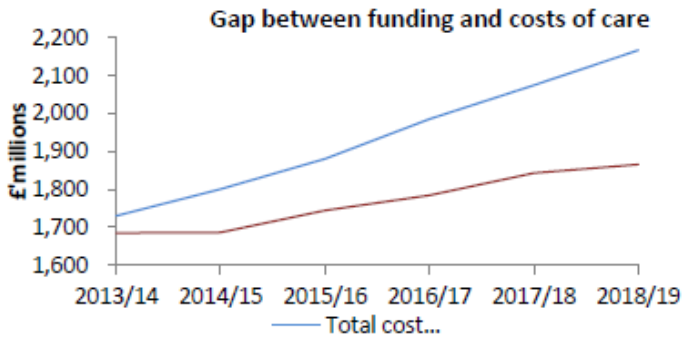
Source: CCG Business Intelligence Team

With these facts in mind, PwC were asked to model a number of financial scenarios for the whole of the Cambridgeshire and Peterborough health system for 2014-2019. All of these models include the BCF. The total for the health system included funding for adult social care, children's social care and public health but these services are assumed in each case to be in neither deficit nor surplus. In other words the gap shown relates to gaps in funding of direct healthcare provision only.

The initial scenario shows the depth of the financial concern regarding reducing budgets. It assumes that no provider savings are achieved i.e. there are no savings from cost improvement plans or commissioning efficiencies. The financial gap across the health system widens to over £300m by 2018/19.

Scenario 1: gap between funding and the cost of care

Year	Health care gap £'m *(total income less total cost)*
2013/14	(46,043)
2014/15	(114,256)
2015/16	(136,199)
2016/17	(201,223)
2017/18	(231,912)
2018/19	(301,793)



Source: PwC

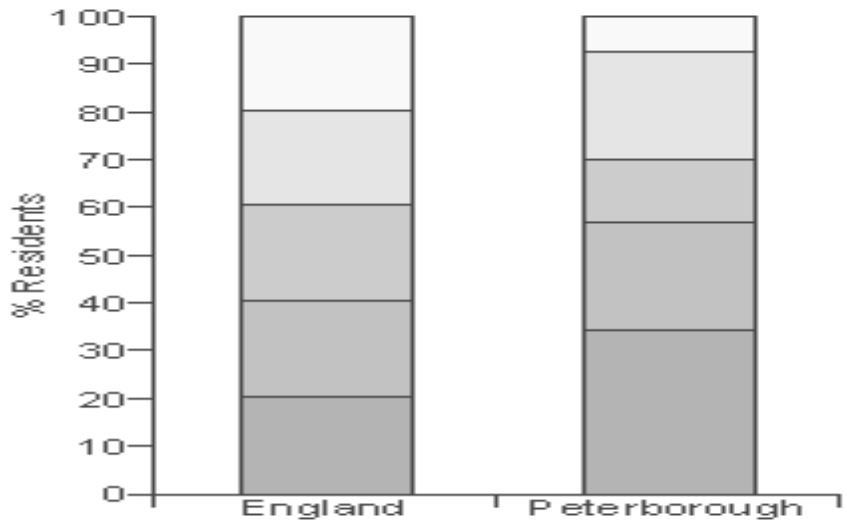
f. Local challenges:

The whole health and social care system in Peterborough and Cambridgeshire has a shared ambition to improve health and wellbeing for local people, but is faced with a number of specific challenges:

- High levels of deprivation;
- Rising demand;
- Reducing budgets; and
- Fragmentation

i. Deprivation

The overall level of economic deprivation is higher for Peterborough Unitary Authority than for that of England overall, with a higher percentage of residents than of England overall within the most deprived economic quintile and a lower percentage in the most affluent quintile.



Map: Deprivation levels in Peterborough by lower super output areas, IMD 2010[6]

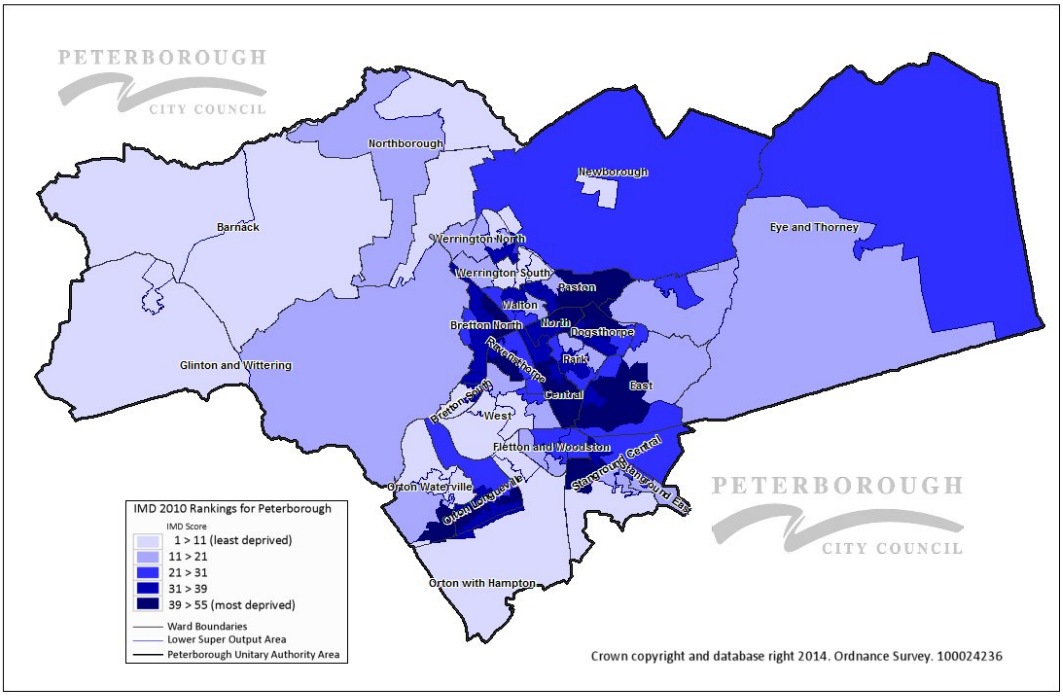


Table: Deprivation Indicators

Indicator	Peterborough Number	Peterborough %	England %
% people in this area living in 20% most deprived areas in England, 2010	63,633	34.1	20.4
% children (under 16) in families receiving means-tested benefits & low income, 2011 (Children in poverty)	9715	23.6	20.6
Statutory homelessness – crude rate per 1000, 2012/13	263	3.5	2.4
Long term unemployment (16-64), 2013	1567	13	9.9

Recorded violence against the person crimes, crude rate per 1,000 population, 2012/13	2401	13	10.6

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	62988	34.1	20.3	83.7		0.0
	2 Proportion of children in poverty	9470	23.5	21.1	45.9		6.2
	3 Statutory homelessness	267	3.7	2.3	9.7		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1097	49.3	59.0	31.9		81.0
	5 Violent crime	3403	19.6	13.6	32.7		4.2
	6 Long term unemployment	1398	11.6	9.5	31.3		1.2
Children's and young people's health	7 Smoking in pregnancy ‡	476	16.8	13.3	30.0		2.9
	8 Starting breast feeding ‡	2109	74.5	74.8	41.8		96.0
	9 Obese Children (Year 6) ‡	391	19.2	19.2	28.5		10.3
	10 Alcohol-specific hospital stays (under 18)	14	35.5	61.8	154.9		12.5
	11 Teenage pregnancy (under 18) ‡	153	44.5	34.0	58.5		11.7
Adults' health and lifestyle	12 Adults smoking	n/a	23.7	20.0	29.4		8.2
	13 Increasing and higher risk drinking	n/a	21.0	22.3	25.1		15.7
	14 Healthy eating adults	n/a	28.0	28.7	19.3		47.8
	15 Physically active adults	n/a	56.6	56.0	43.8		68.5
	16 Obese adults ‡	n/a	24.9	24.2	30.7		13.9
Disease and poor health	17 Incidence of malignant melanoma	26	16.2	14.5	28.8		3.2
	18 Hospital stays for self-harm	551	297.4	207.9	542.4		51.2
	19 Hospital stays for alcohol related harm ‡	4310	2302	1895	3276		910
	20 Drug misuse	1445	12.0	8.6	26.3		0.8
	21 People diagnosed with diabetes	8413	5.9	5.8	8.4		3.4
	22 New cases of tuberculosis	45	25.9	15.4	137.0		0.0
	23 Acute sexually transmitted infections	1463	793	804	3210		162
	24 Hip fracture in 65s and over	180	538	457	621		327
Life expectancy and causes of death	25 Excess winter deaths ‡	98	22.3	19.1	35.3		-0.4
	26 Life expectancy – male	n/a	77.7	78.9	73.8		83.0
	27 Life expectancy – female	n/a	82.6	82.9	79.3		86.4
	28 Infant deaths	13	4.3	4.3	8.0		1.1
	29 Smoking related deaths	238	208	201	356		122
	30 Early deaths: heart disease and stroke	133	77.7	60.9	113.3		29.2
	31 Early deaths: cancer	179	106.1	108.1	153.2		77.7
	32 Road injuries and deaths	90	49.3	41.9	125.1		13.1

‡ For comparison with PHOF Indicators, please go to the following link: www.healthprofiles.info/PHOF

ii. Rising Demand

Peterborough was listed by the 2014 Centres for Cities report 'Cities Outlook 2014[7]' as the fastest growing city in the UK

The table below shows Office for National Statistics predictions of population growth over the years 2010-2031[8] and highlights a predicted population growth of 20.5% by 2031, with growth rates of 23.6% and 27.3% for the age groups 5-9 and 10-14 respectively.

Table: Peterborough predicted growth rate 2010-2031 (Office for National Statistics)

[6] *Department of Communities and Local Government, 2010*
[7] http://www.centreforcities.org/assets/files/2014/Cities_Outlook_2014.pdf
[8] http://www.peterborough.gov.uk/pdf/CommunityInformation-About-PopulationEstimates-PopulationForecast.pdf

Age Group	2010	2011	2016	2021	2026	2031	% change 2010-2031
0-4	13.0	13.2	13.4	13.7	13.7	13.9	6.9%
5-9	10.6	10.9	12.7	12.8	13.1	13.1	23.6%
10-14	9.9	9.9	10.6	12.2	12.3	12.6	27.3%
15-19	10.7	10.5	9.8	10.4	11.9	12.0	12.1%
20-24	11.5	11.6	11.2	10.6	10.9	12.1	5.2%
25-29	13.5	13.8	15.0	14.5	13.8	14.1	4.4%
30-34	12.7	13.0	14.3	15.4	15.0	14.3	12.6%
35-39	13.1	12.9	13.0	14.2	15.3	14.8	13.0%
40-44	13.3	13.3	12.5	12.6	13.8	14.8	11.3%
45-49	12.0	12.2	12.9	12.1	12.1	13.3	10.8%
50-54	10.2	10.5	11.9	12.4	11.6	11.6	13.7%
55-59	9.2	9.2	10.1	11.4	11.9	11.1	20.7%
60-64	9.1	9.2	8.6	9.5	10.7	11.2	23.1%
65-69	6.8	7.2	8.5	8.0	8.8	10.0	47.1%
70-74	5.8	5.7	6.6	7.9	7.4	8.3	43.1%
75-79	4.8	5.0	5.1	6.0	7.1	6.8	41.7%
80-84	3.7	3.7	4.0	4.3	5.1	6.1	64.9%
85-89	2.1	2.2	2.5	2.9	3.3	4.0	90.5%
90+	0.8	0.9	1.2	1.5	2.0	2.5	212.5%
All ages	171.3	174.9	183.8	192.3	199.8	206.4	20.5%

SOURCE: ONS 2008-based sub-national population projections.
NOTE: Totals may not sum due to rounding.

However, ONS population predictions are based on trends of previous population growth. Research undertaken by the Cambridgeshire Research Group takes in to account the ambitious plans for growth within the city and revised growth predictions upwards based on the Council's current policy and planning decisions. The revised predictions show an overall predicted population growth between 2012 and 2031 of 29.7% rather than the 20.5% predicted by the ONS between 2010 and 2031. This would represent an increase in population from 187,100 in 2012 to 242,600 in 2031. Predicted growth is particularly high in the 85+ age group at 79.4% but also above 40.0% for the age bands 75-84 (50.0%), 65-74 (47.8%), 5-10 (47.1%) and 11-15 (40.4%). This increase in population will necessarily increase the demand on services within the Unitary Authority.

iii. Reduction in Budget

Peterborough's health, social care and housing system faces a number of additional specific challenges to budget:

- Cambridgeshire and Peterborough collectively is one of 11 'challenged health economies' that face particular difficulties in developing sustainable quality health services over the next five years. This is mirrored by challenging financial circumstances that affect our ability to ensure sustainable social care services.
- A reduction in acute activity runs counter to the current trend in the county. Existing CCG plans are based on a 1% reduction in A&E admissions, in the context of the current trend which is for an annual increase of around 2%. The scale of the challenge ahead is acknowledged in the CCG's Five Year System Blueprint which includes redesigning non-elective care.

iv. Fragmentation

We know that staff work hard to provide the best possible care, but the collective quality of the current services can be significantly improved. This is partly because so many different organisations are involved, but also because the way services are organised (the 'system') means that care is not always joined up and does not always deliver the outcomes we would like.

Patients have also told us that they are often visited or cared for by many different professionals. Knowing who is responsible for them is confusing and can seem disjointed. The patient or their carer has to repeat information because it is not readily available to be shared within the NHS or with social care staff. Patients and carers have also told us they would like to be more involved in making decisions about their care.

g. Risk stratification

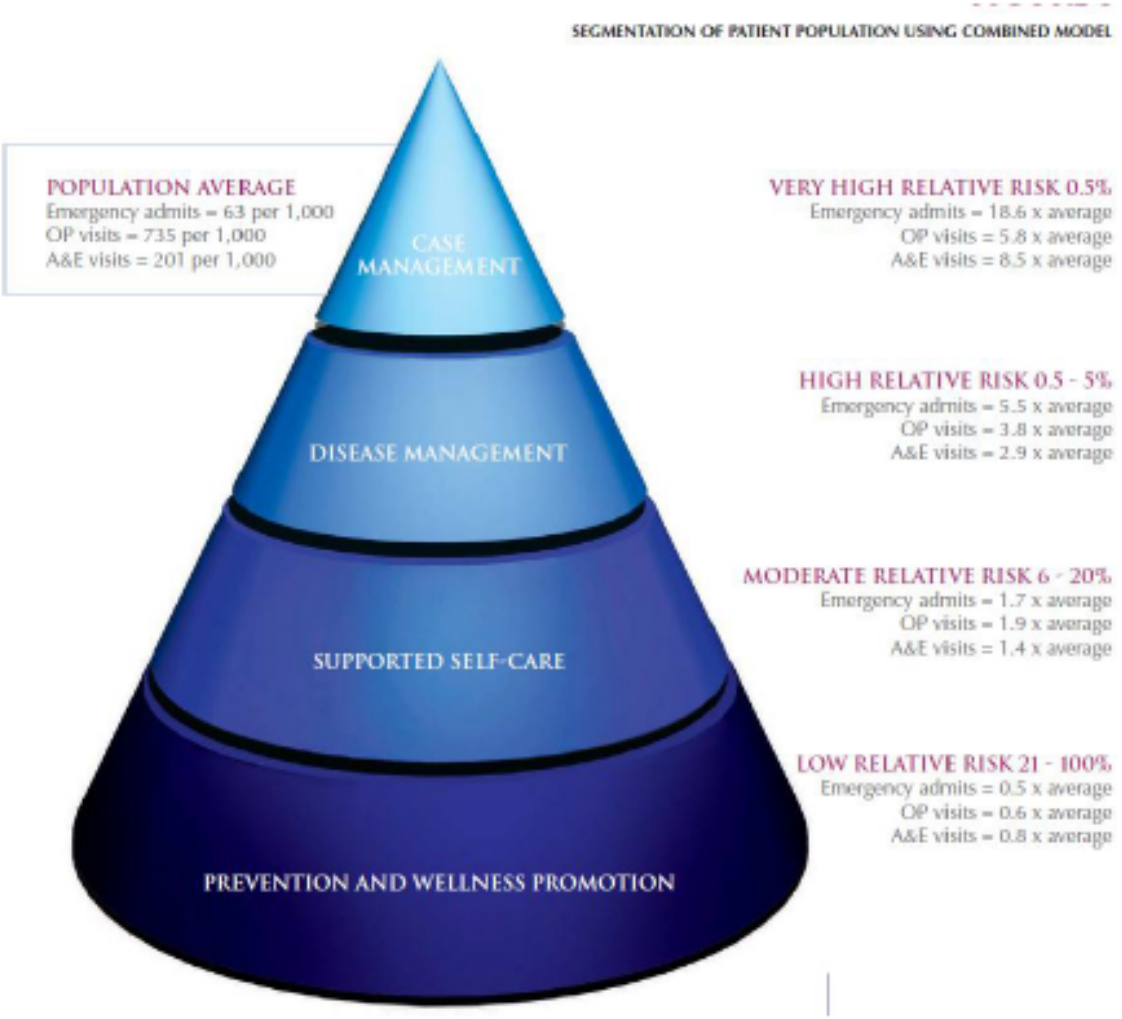
In order to change care from being reactive and disease oriented to proactive and patient oriented (integrated care) those who are frail must be identified. Key to developing effective interventions to support older people is establishing a robust mechanism to identify patients who are at risk (case finding). The assumption is that better upstream care (or case management) will improve health such that the risk of admission (and cost) 'downstream' will be reduced.

The accurate identification of those at risk is also crucial to ensure that care, and resources, are targeted at the correct people and do not exclude any vulnerable individuals. It is also important to conduct a health impact assessment to assess the risk of widening health and wellbeing inequalities through new models of care and support.

By reviewing the health and social care needs of Peterborough residents and the complexity of needs identified through risk stratification, a Data sharing project will be able to deliver key information for the delivery of timely interventions.

Therefore, the importance of Risk Stratification is recognised and as part of the BCF funding Peterborough will be investing in a tool to predict those aged 65 years and over at greatest risk of hospital admission. It is recognised that an accurate predictive risk model identifies those who are most at risk of unplanned admissions in the future (Duncan, 2011). The process will allow Integrated Neighbourhood Teams (MDT's) to target interventions according to need with intensive case management targeted at those most at risk.

Figure 2: Segmentation of population using Combined Predictive Model[33]



Risk	Population	Emergency Admissions			Outpatient visits			A&E visits		
		Admissions per '000	Average number	Total	OP visits per '000	Average number	Total	A&E visits per '000	Average number	Total
Very High Risk (< 0.5%)	935	63	18.6	1,096	735	5.8	3,986	201	8.5	1,597
High Risk (0.5% - 5%)	8,420	63	5.5	2,918	735	3.8	23,517	201	2.9	4,908
Moderate Risk (5% - 20%)	28,065	63	1.7	3,006	735	1.9	39,193	201	1.4	7,897
Low Risk (20% - 50%)	149,680	63	0.5	4,715	735	0.6	66,009	201	0.8	24,069
Very Low Risk (> 50%)										
Total	**187,100**			**11,735**			**132,705**			**38,471**
Average visits per '000				63			709			205
Average cost				£1,876			?			£111

This will be based on the Kaiser Permanente risk stratification pyramid and model for chronic disease management using four key approaches:

- Case management for the small minority of patients with highly complex and multiple conditions requiring high-intensity professional support.
- Disease management for people with a complex single or multiple conditions who would need to be managed proactively by responsive specialist services.
- Supported self-care for the majority of those living with – or at high risk of – long-term conditions.
- Targeted prevention pathways and risk triggers, and a generalist wellbeing programme.

The introduction of a risk stratification tool falls under the remit of the UnitingCare Partnership from April 2015, and the approach will be updated once this is implemented for the majority of those living with – or at high risk of – long-term conditions.

The risk stratification data will be used routinely by integrated neighbourhood teams which are multi-disciplinary during their monthly MDT meetings to identify and review patients at high risk of future admission as well as a review of patients on the current case load. The health and social care professionals at the MDTs are then able to plan a co-ordinated package of care in a targeted approach using either case management, disease management or providing supported self-care.

Risk Stratification	
Person Level	Population Level
Available on Integrator	Summarised on Integrator
Available to Patient	Not available to the Public
Available to chosen professionals	Summarised for professionals
Analytics to stratify	
Pop level comparison	Pop level detail

Currently, patients are identified based on age, Long Term Conditions, hospital admissions, or when they are known to more than one service/organisation. The specific areas developed to date includes Predictive Modelling, and this will be used to support proactive case management of patients using risk stratification of the Peterborough population and identifying patients who may be suitable for intervention. We will then stratify patients according to their risk score and produce an overview of the number of patients in each stratum. This allows for specific patient cohorts to be prioritised for proactive preventative care, with the ultimate aim of improving patient quality and outcomes and the efficient use of resources.

h. Conclusion of the evidence - the case for change in Peterborough

Pressures on both health and social care budgets, coupled with demographic and social pressures, necessitate the need to effect transformative change in the way in which we meet the needs of some of the most vulnerable members of our community because more of the same is financially unsustainable and will not improve older peoples quality of life. We need to increase the capacity of community services, specifically reablement services to prevent hospital admission and facilitate timely discharge, releasing costs within the system. This will ultimately improve patient choice as patients will be able to make decisions about their future in a stable environment, following a period of reablement. Unlike the current situation whereby long term

decisions are often made in a crisis situation.

Detailed analysis of the issues outline above has been fed into the BCF planning workshops that we have held with our Partners and has formed the evidence base for the development of our five key delivery streams:

1. Data Sharing
2. 7 Day Working
3. Person Centred Systems
4. Information, Communication and Advice
5. Ageing Healthily and Prevention

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

Strand:	Milestones:	Start:	Achieved by:	Notes/Key dependencies:
All	Establish Care Delivery Group (incorporating GP practices and Integrated Neighbourhood Teams (MDT's) and care coordinators)	01 February 2015	31 January 2016	Primary care vision
Ageing Healthily and Prevention:	Project lead and team established	01 February 2015	28 February 2015	
	Project Plan developed and approved by accountable bodies (CEPB / JCF / Transformation Board)	01 March 2015	30 April 2015	
	Identify up to three triggers including falls prevention	01 March 2015	30 April 2015	
	Agree data set and collect data on selected triggers			
	Initiate development of pathways – work across whole system to develop Scope wellbeing programme for development			
	Complete design pathway for identified triggers	1 May 2015	30 July 2015	
	Develop wellbeing programme			
	Implementation – review/modification –	1 November	31 January 2016	

	implement	2015		
	Evaluate and plan 2016/17	1 January 2016	1 March 2016	
Seven day working	Establish project: - Establish team; - Agree scope - Agree baseline data	26 January 15	28 February 2015	
	Desk based review of all existing plans for 7-day services, admission avoidance and discharge.	1 March 15	28 April 2015	
	Planning to ascertain and agree the feasibility of existing plans and whether they will they produce better outcomes for patients?	1 April 2015	31 July 2015	
	UCP contract commences with a system approach to integration	01 April 2015		
Data Sharing	Plan for the use of NHS Number	1 February 2015	September 2014	
	Project Initiation plan (Scope, risk register, communications strategy and plan)		30 May 2015	
	Options appraisal for procurement approach		31 March 2015	
	Detailed project plan		31 March 2015	
	Governance Arrangements		28 April 2015	
	Communications plan		30 May 2015	
	Information Governance Principles and roll-out plan		25 September 2015	
	Roll-out cycle commences		1 February 2016	
Information and communication advice	Peterborough City Council Universal Front Door Service in place (including	20 February 2015	28 April 2015	

	information and advice content, service directory, online assessment and carer assessment)			
	UnitingCare Partnerships Single Point of Access is operational	April 2015		
	Sharing of FAQS and Referral pathways between the two aligned front doors	1 May 2015	30 July 2015	
	Mapping of existing services completed	1 September 15	30 October 2015	
	FAQs and Referral pathways further updated	1 October 15	30 March 2016	
	Development of technology solutions, including on line assessment / self-referral	1 April 2015	Ongoing as integration develops	
	E-marketplace, 2015/16, re-referrals between PCVS, Council, Health, Private sector.	1 April 2015	Ongoing as more services are added	
	Communications and training	April 2015	June 2015	
	Development of information sharing protocols and agreement of sharing data sets and consent models	1 May 2015	30 September 2015	
Person centred system	Project lead and team established	01 March 2015	30 March 2015	
	Project Plan developed and approved	01 April 2015	30 May 2015	
	Initiate development of Integrated Neighbourhood Teams (MDT)	01 June 2015	15 July 2015	

	Complete design and validate	16 July 2015	30 August 2015	
	Implementation – review/modification – implement	1 November 2015	28 February 2016	
	Evaluate and plan 2016/17	1 April 2016	1 May 2016	

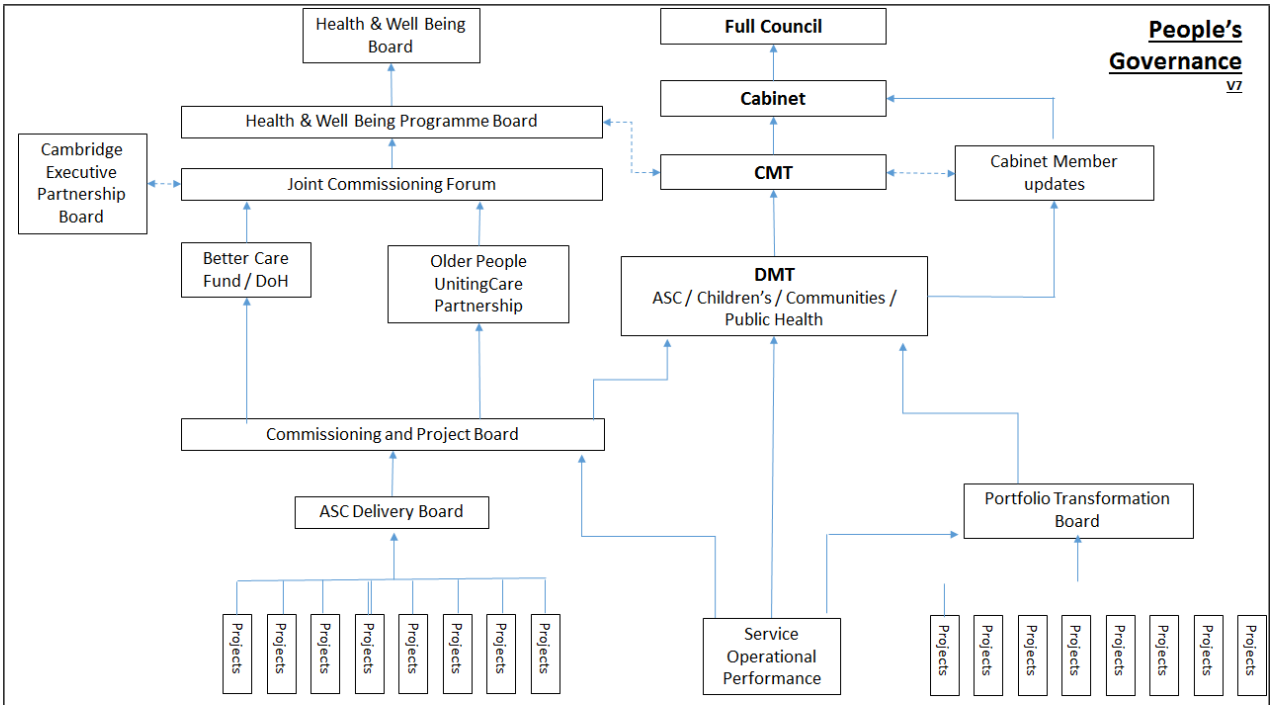
b) Please articulate the overarching governance arrangements for integrated care locally

Historically, whilst NHS commissioners and providers have operated county wide, the City Council and Cambridgeshire County Council have tended to have separate governance structures. There is now a commitment by both Councils', and indeed all parties, to create more joined up arrangements to maximise the benefits of whole system working. This work is in progress and will be accelerated.

Greater integration is underway at various levels in the system. As examples there are integrated governance arrangements through the Joint Commissioning Forum, and UnitingCare Partnership(UCP). All partners have made a commitment to Integrated Neighbourhood Teams (MDT's) working and joint assessments and to a united way of providing information and advice and this is underpinned by the governance arrangements. This is being developed further with a commitment from all agencies to join up implementation and governance arrangements with Cambridgeshire County Council. The opportunities for integration are being explored on an ongoing basis and will be driven through the integrated programme office for the BCF.

Oversight and governance of the BCF proposals are provided by the Peterborough Health and Wellbeing Board who have approved this plan. The implementation of the transformation programme 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 relates to funding transfers (and subsequent pooled funding arrangements) with the former, PCC. With this in mind, the following arrangements have been developed:

- The Director of Communities will be the Accountable Officer;
- The monthly Commissioning and Performance Board will engage stakeholders and drive forward the delivery of the core schemes, reporting to the Borderline and Peterborough Joint Commissioning Forum, which is the commissioning executive group of the Health and Well Being Board;
- Through monthly meetings the Joint Commissioning Forum will evaluate programme delivery and financial benefits realisation for the priority schemes. This will be assessed alongside a performance dashboard of integrated care metrics to ensure high levels of satisfaction from patients, carers and employees to ensure that the delivery of the programme remains on track;
- The accountability for performance, risk management, and remedial action will be managed through Joint Commissioning Forum. This will be overseen by the Health and Well Being governance structure, which will be responsible for the overall implementation of the transformation programme; and
- The following structures have been agreed for the implementation:



- In the above model the Joint Commissioning Forum provides a forum in which to develop a joint strategic approach to service transformation and delivery of the BCF, alongside local oversight of the UnitingCare Partnership; and
- The objectives for the JCF in relation to the BCF are to provide:

  a) Local, strong and visible clinical commissioning leadership combined with local patient engagement.
  b) Continuous improvement of quality and clinical outcomes within available resources.
  c) Greater integration of care achieved through more effective and innovative commissioning arrangements with partner organisations.

More detailed transformation planning, including management oversight of transformation and joint commissioning for each area of change, will be undertaken by the Commissioning and Performance Board. Along with commissioning leads, this group also includes provider representatives. This will be supported by a Delivery Board to ensure that the implementation of the priority schemes remains on track to meet the vision and required outcomes of the programme.

As stated at the outset (section b) it should be noted that although the existing governance arrangements are robust, the governance arrangements within and between Peterborough and Cambridgeshire will be revisited as part of the Section 75 Agreement development and this will also seek to ensure greater alignment between the two Local Authorities.

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

The management of the Better Care Fund will be the responsibility of the Assistant Director of Adult Social Care.

This role will be responsible for establishing the robust governance arrangements required to provide the oversight of the plan for the Health and Wellbeing Board. The projects will be reviewed by the Commissioning and Performance Board on a monthly basis and detailed action plans will be put in place where delivery is not on track.

The Assistant Director will have direct links with the commissioning leads in the CCG and the City Council and will escalate where any operational issues will affect the delivery of the plan.

Since our original BCF submission, the Council has made a significant investment in its project planning and management of Adult Social Care. Specifically, this investment has resulted in the following appointments:

1. Programme Manager for Transformation: a new post has been created and resourced to work across health and social care. This individual will be responsible for leading on the strategic direction of adult health and social care services to ensure delivery the BCF plan;
2. BCF Project Managers: these individuals will be responsible for achieving the success of the work steams and ensuring all the requirements of the specifications are satisfied on time, within budget and quality; and
3. Adult Social Care Programme Management Office (PMO): The establishment of a resourced PMO to co-ordinate, monitor and report on the delivery of activity related to BCF.

In bringing in programme and project professionals, the Council are ensuring that activities to deliver its BCF priorities, along with other key areas of focus (for example, those specifically related to ensuring compliance with the new Care Act), are drawn together into ‘one plan’.

In addition to this increased resource, a Delivery Board for the work in Adult Social Care has been established. The remit of this new Board is to ensure alignment of delivery activities with the key outcomes and a strategic programme level approach to risk and issue management.

As outlined in this document, Peterborough have designed our BCF programme around five strands and this section sets out our high-level plan for each of the strands and the approach we will follow to deliver a detailed set of implementation plans.

The PPM Methodology we are implementing:
The methodology for Project and Programme Management is fully aligned to, and compatible with, PRINCE2 and MSP. Our methodology provides a framework to enable project work streams, and their associated implementation plans, to focus on maximising programme value. It does so by utilising techniques and technologies to pro-actively drive results.

The approach adds value by applying a programme leadership philosophy focussed on outcome delivery. Therefore, this approach works to avoid the erosion of expected benefits by applying expertise in critical areas that include rapid mobilisation, effective planning, delivery, benefits management and embedding lasting change.

The methodology will enable us to ensure we are developing a robust and achievable implementation plan for the BCF streams, at pace, and with reduced risk to benefits delivery.

Approach Principles:
Our proposed approach has been tailored using the following principles:

1. Dual focus on both outcomes and outputs;
2. An approach, as follows, which maintains existing delivery momentum whilst ensuring that essential controls are put in place to:
    a. Mobilise and Plan;
    b. Implement; and
    c. Appraise and prepare for completing implementation
3. Clear deliverables defined for each stage, with checkpoints between each stage;
4. Leveraging of the Initial Review plan with an outcome-focussed planning approach to cross-check this and enhance where appropriate, particularly in the important areas of business change.

A flexible and agile approach, enabling collaborative re-planning to be undertaken should problems be encountered and the delivery of agreed outcomes be at risk.

How Our Method/Approach Will Deliver:
The following table summarises how our proposed method and approach will deliver the BCF stream plans:

Requirement	How our method/approach will deliver
Establish a clear articulated and prioritised plan to steer the BCF streams development alongside doing the early stages	Our right to left approach to planning will ensure that the plan is prioritised and will deliver expected outcomes in the right order. We will produce “plans on a page” for each work stream to provide clear articulation to key stakeholders. Our proposed approach includes early stage “doing” activity in addition to mobilising and planning.
Produce comprehensive documentation of processes and create programme and project documentation	We will work to ensure comprehensively documented processes, applying our structured process development and management. We will deploy an experienced PMO team equipped with a comprehensive set of configurable documentation templates and PMO processes.
Establish governance structure and clear lines of reporting	We will work to socialise and establish the emerging governance structure for implementing the BCF streams. The governance structure and reporting lines will be informed by the stakeholder engagement activity, which is a key aspect of our approach in all stages.
Establish implementation plans, which will enable key work streams of activity	Our approach to planning will ensure that all the necessary enabler-focussed outputs are planned within work streams to deliver the required outcomes. We will incorporate an approach to change management and enable the plans to be adjusted based on learning from any

that will be crucial to the success of the BCF streams.	pilots. We will ensure that in designing the detailed plans all relevant factors are addressed including for example an assessment of change readiness; appetite for risks and probability of failures. The implementation plans will be supported by: a targeted communication plan; detailed work breakdown structures; Gantt charts with tasks/milestones/dependencies; resource plans and skill requirements; risk mitigation strategy.

d) **Planned BCF schemes**

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

Ref no.	Scheme
1	Data Sharing
2	7 Day Working
3	Joint Assessments (Person Centred System)
4	Information, Communication and Advice (System Wide Information Provision / Co-ordination)
5	Ageing Healthily and Prevention

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
If there is no strategic vision, oversight or direction of travel, or if there is too much focus on small scale initiatives, opportunities to undertake critical and joined up transformation of services will not be maximised.	**3**	**3**	**9**	• Agreed vision and principles which are incorporated within service core planning documents. • Implementation of the 5 year strategic plan and other relevant strategic commissioning plans. • Re-visit governance to maximise opportunities for join up across Cambridgeshire and Peterborough and ensure proposals are mapped back to the agreed vision before approval, and to

				maintain oversight and monitor progress at all stages. • Client groups are identified and reflected in the future vision.
Lack of transformational change strategic leadership capacity across the system leading to inability / unwillingness of partner organisations to provide the sign up and required cultural shift to deliver the wholescale change, then the transformation will fail to achieve the necessary financial benefits and improvements for customers, staff and stakeholders.	**4**	**4**	**16**	• Develop / implement a Transformational System leadership capacity / capability building programme for all executive system leadership • Agreed vision and principles which are incorporated within service core planning documents. • Demonstrable leadership through the delivery of the engagement plan. • All organisations represented by the right people empowered to make decisions.
If the demand for social care services increases more rapidly than the profiled rate, the original plan will not be deliverable. Additional investment and transformation activity will, therefore, be required.	**3**	**5**	**15**	• Effective monitoring of demand for social care arising from the demographic change. • Effective monitoring of demand for social care arising from statutory duties under the Care Act. • Contingency plans prepared and in place for early intervention if anomalies or variations are identified. • Re-prioritisation of existing resources.
If investment in prevention fails to sufficiently reduce demand for acute services, this will increase the financial and resource challenges for acute and related services.	**3**	**3**	**9**	• Effective monitoring of demand for acute services arising from the demographic change. • Effective monitoring of demand for acute services arising from statutory duties under the Care Act. • Contingency plans prepared and in place

				for diversion of funding where necessary. • Continued review of whole system transformation to reduce demand for acute services.
If staff are not fully aware of, nor engaged with, the changes arising from the BCF Plan there may be a negative impact on staff attendance, retention and recruitment.	**3**	**4**	**12**	• Comprehensive engagement plan in place with clear and timely objectives and targets. • Profiling and management of workforce attendance and turnover. • Demonstrable leadership through the delivery of a comprehensive staff engagement plan. • Development of appropriate workforce and associated operational development plans.
If there is ineffective or insufficient engagement with stakeholders, including partners and customers, in developing and delivering the BCF then they may feel marginalised and excluded. Transformation may, therefore, be ineffective.	**3**	**3**	**9**	• Comprehensive engagement plan in place, developed with partners, which clearly segments the key stakeholder groups and the specific activities required to effectively reach them. • Clearly articulate the benefits and apportion to each partner organisation. • Ensure appropriate involvement of key staff in programme planning and implementation. • Clearly document the governance and ownership of the engagement plan and the relevant reporting and monitoring processes.
If evidence of improved outcomes in the short to medium term is not available, performance related funding which is dependent upon	**3**	**3**	**9**	• Clear alignment of BCF investment and change areas to key performance targets. • Robust performance management arrangements with data sharing

these outcomes may be withheld.				agreements. • Ensure new contracts link funding to outcomes to share the risk between commissioners and providers.
If there are multiple and/or uncoordinated changes to service delivery this could destabilise provision and performance.	**3**	**3**	**9**	• Ongoing review of strategy and vision. • Robust arrangements in place to coordinate delivery timetables across all change activities. • Appropriate investment in effective models and methods of communication with users and staff. • Develop and implement a whole system organisational development programme to work out delivery together.
If the data used to develop the BCF Plan is inadequate, delayed or unavailable, then there may be unforeseen and unplanned service delivery or financial impacts/demands.	**2**	**4**	**8**	• Ensure plan is updated regularly to reflect the emerging position and any agreements or changes which have been made. • Ensure effective coordination of the work of different project teams to allow timely update of assumptions. • Validation of data used and assumptions made are clearly evidenced and documented.
If there is insufficient project control, transparency and accountability, delivery of the BCF Plan and strategic vision may be compromised.	**1**	**3**	**3**	• Appoint programme management resources to deliver the plan to agreed milestones. • Agree strong governance and effective PMO processes to monitor and oversee delivery of the plan, milestones, risks and issues. • Strong and effective leadership from key stakeholders.

If there is a delay in developing the BCF Plan, it may not be finalised and approved by the due date for submission.	**2**	**5**	**10**	• Detailed plan to oversee development, taking into account all necessary requirements for adequate discussion, challenge and sign-off. • Early identification and engagement with officers and teams who will need to contribute and develop the plan.
If changes are made to national policy in respect of urgent and emergency care this could negatively impact the BCF Plan content and timetable.	**2**	**3**	**6**	• Effective links in place with local and national NHS policy makers.
If increased demand for carers' provision, as a direct result of the Care Act, exceeds that which has been profiled then there will be additional costs and demand on resources.	**3**	**3**	**9**	• Ongoing monitoring and profiling of demand. • Development of community capacity through commissioned activities and close working relationship with voluntary sector (PCVS). • Re-prioritisation of existing resources.
If the legacy systems are unable to record or match the NHS number, or staff fail to adopt new processes to record and use it, then data may be ineffective and unusable.	**2**	**3**	**6**	• Facility in place across all service areas/organisations to ensure NHS number can be populated either manually via process or automated. • New processes are embedded across all services areas/organisations. • Memorandum of understanding re sharing data is agreed.
If there is no clear agreement on data sharing and governance between partner organisations, this could compromise or delay progress in monitoring or delivering the BCF	**4**	**2**	**8**	• Data sharing agreements and protocols documented and signed off between all partners for the collection, storage and processing of data. • Agree strong joined up governance

Plan.				arrangements relating to data.

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b) Contingency plan and risk sharing

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

The funding relating to the Performance fund is £429k based on a targeted reduction in emergency admissions of 1%. The Council and CCG have agreed that this funding will remain under the control of Cambridgeshire and Peterborough CCG and used to support emergency admissions reduction. If the targeted reduction is achieved and expected to be sustained the funding will become available for wider BCF priorities in future years.

In relation to the BCF targets, the CCG has already put in place a planned 1% reduction in emergency admissions for 2014/15 as well as planned reductions in relation to on-going QIPP schemes with its main acute provider. The CCG is working together with the provider to ensure that these reductions are maintained and that the contract for 2015/16 includes a risk sharing arrangement to cover the continuation of the 1% target.

Concerted efforts are being made across the local health and social care economy in a number of ways to ensure that these reductions are achieved. For instance, senior leaders meet on a weekly basis through the System Resilience Group to escalate and resolve issues. In addition an Urgent Care Programme Director has recently been appointed on behalf of the City and County Council, the CCG leads on this agenda. However, given the challenging nature of our non-elective admissions target within the timeframe we consider the full £1.5 million to be at risk.

CCGs have historically managed activity variances and have a number of process and governance structures in place to identify these early and mitigate. In relation to the BCF schemes performance against all metrics, including the P4P non-elective admissions metric will be reported on and managed through the Commissioning Executive Group (CEG) which reports to the Health and Wellbeing Board, this will be overseen by the Assistant Director of Transformation.

CCGs hold both contingency and specific risk reserves based on calculated risk at plan stage, so these resources will be utilised should investment be needed for any mitigation or corrective action.

Mechanisms also exist and are built into provider contracts to manage and minimise the impact of any variation in the system. Furthermore, the whole focus of the schemes in the BCF plans are geared towards admissions avoidance and the implementation of these (and therefore the investment) will be done in a planned and managed way to allow flexibility to transfer resource should there be any slippage within the schemes.

In addition, it is important to note that the schemes currently being implemented that focus on admissions avoidance have been developed across the health and

social care community through the System Resilience work. This has involved full engagement with community and local authority colleagues. Each scheme has its own set of risks which have been identified within the risk log alongside mitigating actions.

There are numerous precedents for risk sharing in Peterborough. The Council and CCG have a Joint Funding protocol for high cost clients with health and social care needs. The Council and CCG have also worked closely on Winter Pressures to minimize the impact of pressures by a coordinated integrated approach and sharing of funding.

Furthermore, health and social care have an established history of managing risk through agreement of section 256 spending on mutually agreed priorities.

Another example would be the s75 agreement for Integrated Community Equipment Service (ICES). This is a risk sharing partnership between local authorities and health organisations, which is hosted by Peterborough City Council.

6) ALIGNMENT

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

The National planning guidance has signalled the closer alignment of NHS and local authority planning cycles. We have worked closely together to ensure that our service plans are in direct alignment, and that we have a shared understanding of the strategic direction needed to meet the health and social care needs of our population. Examples include working closely with our partners to agree a single shared strategy for Older People.

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

- Securing the foundations of good health
  - Enabled and supported by the provision of Information, Communication and Advice project and the Ageing Healthily and Prevention project
- Preventing and Treating Avoidable Illness
  - Enabled and supported by the Data Sharing project, implementing the Person Centred System project, the provision of the Information, Communication and Advice project and the Ageing Healthily and Prevention project
- Healthier Older People who maintain their independence for longer
  - Enabled and supported by the Data Sharing project, implementing the Person Centred System project, the 7 day working project, the provision of the Information, Communication and Advice project and the Ageing

Healthily and Prevention project
- Supporting Good Mental Health; and
  - Enabled and supported by implementing the Person Centred System project, the provision of the Information, Communication and Advice project and the Ageing Healthily and Prevention project
- Better health and well-being for outcomes with people with lifelong disabilities and complex needs.
  - Enabled and supported by the Data Sharing project, implementing the Person Centred System project, the 7 day working project and the provision of the Information, Communication and Advice project

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

We set out here the strategies and approaches closely linked with the delivery of this BCF plan:

i. Cambridgeshire and Peterborough health system Blueprint 2014-2019
The health system aims to empower people to stay healthy, improve the quality of care, improve outcomes and to continually develop a sustainable health and social care system. The work was led by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) supported by the City Council.

ii. The Health and Wellbeing Board Strategy for Peterborough
Building upon the implementation of personal budgets for health and social care, the BCF plan will assist with the further transformation of social care and health service delivery, including:

- The introduction of Integrated Neighbourhood Teams leading to effective and integrated co-ordination of care and a person centred planning approach that will inform all service delivery. The emphasis will be on preventative and early intervention community based provision; and
- Joint Commissioning of Health and Social Care that will enable the development of combined trusted reviewer and assessor functions. The focus will be on a service provision that delivers an integrated independence pathway.

iii. Older People's Accommodation Strategy for Peterborough
This strategy sets out how, through the use of appropriate accommodation, we will promote and support people to remain as independent as possible, with the emphasis being on the importance of independence in the community.

iv. **Older People's Strategy**
The Strategy has been developed to establish the following key delivery outcomes:

- Developing preventative approaches;
- Maximising health, wellbeing and independence;
- Personalised support through the use of carers, local communities and

local organisations; and
- Inclusion of older people within local communities, including digital inclusion.

The plans set out in the Strategy seek to:

- Reduce instances of isolation, prevent a deterioration of health and wellbeing and reduce dependency on health and social care interventions including hospital admissions (aligned with urgent care priorities);
- Develop community and voluntary sector resources including day opportunities (aligned with Neighbourhood Management and Peterborough Council for Voluntary Services (PVCS) infrastructure development);
- Better access to information and advice (aligned with Council's Digital Strategy and Customer Experience programme);
- Expansion of reablement and integration with intermediate community health services (aligned with OPACS and UCP mobilisation); and
- Increased access to assistive technology and telehealth.

Development of extra care and sheltered housing as an alternative to hospital Working with Registered Social Landlords 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 the risk of them being transferred in to a long term placement.

Advocacy
We are 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.

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.

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

The BCF aligns with the CCG's 5 year plan through an agreed set of principles by which PCC and the CCG 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 through a risk stratification process; and
- 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.

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

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

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.

The CCG has worked with GPs at Member Practice events, provider stakeholder events, through discussion at LCG Board meetings, discussions with the Area Team and through the elective and non-elective Care Design Groups to identify a set of critical success factors for primary care. These success factors are as follows:

- Generate a greater sense of individual responsibility to remain well and choose health lifestyle choices to avoid ill health;
- Reduce unwarranted variation and address inequalities (evidence shows that primary care can reduce inequalities and improve health outcomes1);
- Deliver quality improvement;
- Improve access to GPs; and
- Develop capability and capacity to meet the demands of a rapidly increasing and diverse population, and a greater number of older people with associated frailty and long term conditions.

To enable these changes to happen, the following are planned throughout our

approach to the delivery of this BCF plan:

- Closer working with Public Health England, the local authority public health team and the voluntary and community sector to promote self-care and healthy lifestyles;
- Exploration of options to deliver primary care at scale through, for example, increased collaboration between GP practices;
- Review of capacity within primary care including mapping against demand;
- Better signposting of services; and
- Improved communication between GPs and secondary care clinicians.

Primary care services will contribute significantly to the Cambridgeshire and Peterborough health system goal to produce a sustainable health system because primary care reduces demand on health services through its role in preventing illness. This is entirely consistent with the aims of our BCF plan. An example of alignment is our proposal for joint assessment. The CCG comprises 8 Local Commissioning Groups made up of groups of GP practices which provide local focus and engagement. Integrated Neighbourhood Teams (MDT's) are being piloted to provide better and more holistic support to frail elderly or other vulnerable people. 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 inform our BCF work programme.

7) NATIONAL CONDITIONS

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

a) Protecting social care services

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

The locally agreed definition of protecting social care services is maintaining the existing thresholds set under Fair Access to Care Services (FACS), which is based on meeting substantial and critical needs. This is in line with the new national eligibility provisions set out in the Care Act 2014.

In addition to maintaining the current eligibility criteria the local definition of protection for social care services includes the following:

- Ensuring that we can respond to demographic pressures and increasing levels of need in particular; dementia, long-term conditions and younger adults with complex care needs;
- Promoting innovation in social care and integration with health in line with transformation plans to improve social care outcomes and realise savings and efficiencies in both health and social care budgets;
- Future proofing – building in additional capacity for Care Act implementation; and
- Maintaining and improving the existing social care model – essential core services, enhancing personalisation, focus on support for carers, promoting independence through enablement and reablement, building community capacity to deliver preventative services.

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

Protection of social care provision is integral to the delivery of an effective integrated care model in Peterborough and this is reflected in the inclusion of social care provision within the BCF plan schemes. There are no proposals to reduce social care services within the plan, Peterborough plan to continue with the existing s256 allocations which provides funding for reablement, and we have no plans to reduce the amount of resources dedicated to supporting reablement.

We and our partners have recognised that meeting the demand for social care services is not sustainable in the current financial climate, and the continued increase in Peterborough's population brings further pressures. While the BCF will enable us to improve many of our processes and develop new ways of providing services, the increase in demographic and financial demands being placed on the

social care system will require a complete change to how social care is provided in Peterborough in order to ensure sustainability in the medium to long term. The BCF funding allocated to protecting social care will therefore provide a bridging mechanism in the transition from current to future working practices.

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

- Our response to the Care Act
- The development of a new Target Operating Model (TOM)
- A robust approach to demand management

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

Target Operating Model: The new Target Operating Model (TOM) introduced under the Transformation programme focusses on a preventative approach through the development of a self-care pathway accessed through a single point of access and removal of FACS eligibility considerations for enablement and reablement provision. The aim of this approach is to encourage and support citizens to manage their condition within a community setting as effectively as possible maximising the community resources available, thus reducing demand on more intensive health and care provision. This will run concurrently with Health Improvement initiatives to reduce health inequality and raise living standards to which the City is committed.

Demand Management; Partners are currently working on a number of measures to manage the demand on our services. These include:

- Releasing staff capacity by simplifying processes and procedures and enabling staff to work flexibly
- Enabling and encouraging the use of direct payments wherever possible to enable service users to exercise choice about how support needs are met within a clear budget
- Supporting the review of all requests for increases in packages and prioritise reviews according to need and cost of care package
- Moving away from spot purchasing of respite care to a more planned approach, which enables carers and service users to plan in a proactive way to prevent crises
- Reviewing our arrangements for interim beds and developing a joint approach with NHS partners
- Making good use of the Brokerage Unit to ensure best possible value for money when purchasing residential, nursing home, respite and interim beds and support ‘self-funders’ to make good decisions about quality and costs of care
- Further expansion of early intervention approaches including assistive

technology and promotion of self-care

Working with partners in the way that we manage the reduction in winter pressures funding and how we respond to unplanned surges in demand in the acute sector New strategic procurement policies within the CCG which will stimulate seven day working, whilst requiring providers to reduce admissions.

Additional specific social care services that will be protected through Better Care funding include:

- Support for Carers
- Telecare / Assistive Technology;
- Reablement and Residential Reablement; and
- Information and Advice

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

The 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. The social care service is 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.)

The total amount of funding within the BCF that has been allocated for protection of social care services is £6,011,000. The indicative local amount for implementation of Care Act Duties from the national £135m pot is £407,000. This funding is reflected in the BCF plan and will be combined with the national new burdens grant to meet the requirements arising from implementation of the Care Act.

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

The delivery of an integrated health and social care system supported through the Better Care Fund will enable the social care and health community to be better placed to deliver requirements of the Care Act through the provision of a more efficient and better coordinated system of provision. A major objective of

the Target Operating Model is to simplify access to and navigation through the Health and Social Care system ensuring that citizens and carers are able to access the right support at the right time including community based preventative provision. A programme board has been established to oversee implementation of the Care Act requirements, which reports through to the Health and Well-Being Board. The Peterborough BCF Plan contains specific proposals in relation to delivering minimum eligibility standards and better supporting carers. It should be noted, however, that the BCF Plan does not contain provision for the additional demand on social care budget suggested by the Care Act the extent of which is still being scoped. Peterborough is fully engaged in on-going national work to scope additional demand and the additional finance required to resource this.

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

An amount of £150k of BCF funding has been allocated to carer specific support in relation to carers prescriptions. In addition an element of the Care Act funding of £407k, will be used to provide support to carers as part of the Care Act requirements.

Our carers model of provision has been co-produced with carers, reflective of priorities within the Peterborough Joint Carers Strategy. It has been designed to provide a holistic integrated response to different levels of carer need. In doing this, the approach addresses the identified demographic pressures associated with an increase of those with long-term conditions and the Ageing population of the City. The Adult Social Care Delivery Board will continue modelling demand for provision in partnership with Peterborough carers' organisations.

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

There is no material difference between this submission and the original plan from a financial perspective.

b) 7 day services to support discharge

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

The shared commitment to 7 day working, by the Health and Wellbeing Board and the Joint Commissioning Forum, which underpins service delivery models supporting the BCF agenda.

Community based health and social care services such as Intermediate Care Services, Reablement and Community Nursing already deliver 7 day working. Services have been redesigned to deliver an integrated Urgent Community Response pathway to deliver rapid stabilisation and resilience in the system. The Urgent Care Response Service will avoid unnecessary admissions at the time of crisis and support discharge from the Frailty Unit at the acute trust. Community based services (in particular domiciliary care and care home services) will be engaged and working arrangements will 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 CQUIN 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 provision of Health and Social Care Domiciliary Services that can be commissioned by OOH's GP's to stay with patients overnight to prevent admissions, with the same team supporting patients in Ambulatory Care or the Frailty Unit to return home overnight to prevent people being admitted for low level health and social reasons;
- Care Homes will accept referrals and complete assessments on the same day, 7 days per week, step up and down, and Domiciliary Care Agencies accepting and starting new and existing care packages 7 days per week;
- 7 day assessments will be completed by Health and Social Care in the Acute Trust to support 7 day discharge;
- To implement the concept of Discharge to Assess for patient's determined as medically fit who require an assessment for Continuing Health Care to deliver capacity and resilience in the Acute Trust; and
- 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 criteria. Success will mean that people will be able to be discharged from hospital 7 days a week, because staff are there to medically approve discharge, plan their discharge and link up with an appropriate community based 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.

Details on the implementation of this work are available at section 2c and in Annex 1. Risks and mitigating actions are detailed in Annex 1. Milestones are set out in 4a.

c) Data sharing

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

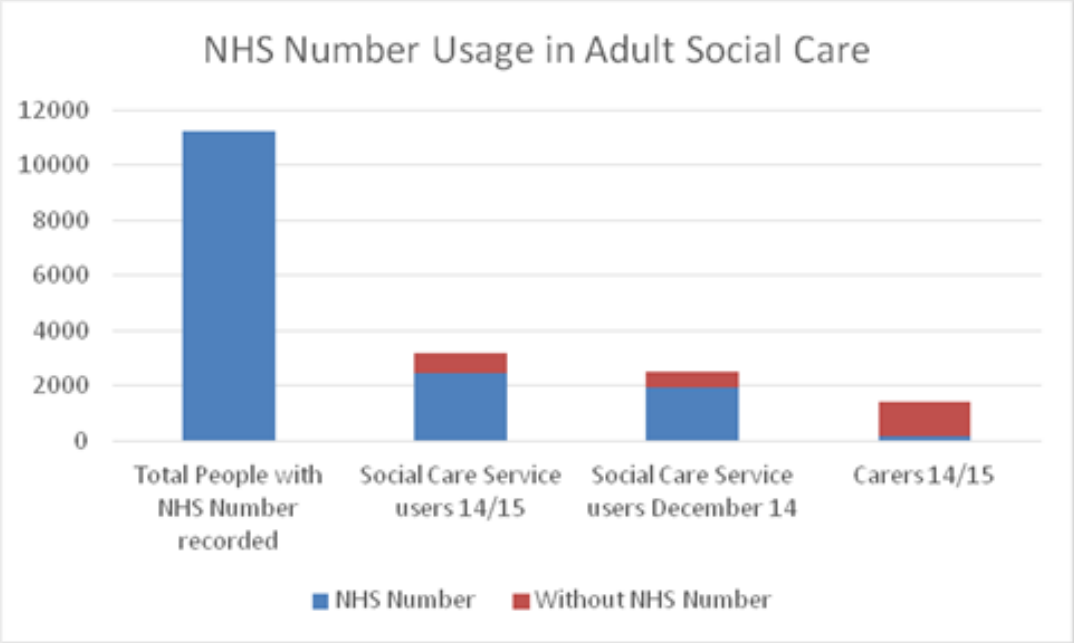
NHS Cambridgeshire and Peterborough CCG mandates the NHS Number as the primary identifier for correspondence through the NHS Standard Contract for providers, while at the same time ensuring compliance with the NHS Care Records Guarantee and Patient / Citizen privacy mandates.

A project has commenced to establish and implement an effective and secure approach to data sharing across the whole system in order that the provision of all services will be better co-ordinated and integrated, and support the delivery of person centred care in the most beneficial setting. The project will ensure the use of the NHS number as primary identifier. It will include the delivery of an overarching IT solution that will make available data from several systems across Peterborough with the provision of Application Programming Interfaces (API's) for each core system. This will be aligned with the production of Information Sharing protocols and a phased roll-out plan for Data Sharing. The scope of the project will initially focus on Peterborough, but could be extended in later phases to include neighbouring authority areas such as Cambridgeshire and Lincolnshire.

Further advantages that will be achieved through data sharing:

- The Risk Stratification, triggers and preventative planning projects all rely on the ability to track people's outcomes across the system and not just within a single database;
- As part of delivering the Council's personalisation programme and the requirements of the Care Act, a single point of contact for the Council's Social Care enquiries is being launched; and
- A new Customer Relationship Management (CRM) system is being implemented from January 2015 onwards with improved data capture elements from the initial contact. This means as a minimum all referrals from the healthcare system into social care will capture the NHS number. The CRM will also be built on Open API's to allow it to connect to the system wide integrator once Minimum Data Sets have been agreed upon.

Within Adult Social Care, a combination of real time collection of the numbers in the front door and judicious batch processing has been introduced, with improvements to the process for collecting going live early in 2015.



Source: Framework Peterborough City Council Social Care Case Management System 15 Dec 2014

The collection of NHS number and core data set as a standard across all systems will smooth referral pathways and improve administrative tasks. The data sharing project is an enabling project for partnership working that will support:

- Successful implementation of Integrated Neighbourhood Teams (MDT's) (Project 3);
- Delivery of the UnitingCare Partnership Service model; and
- Delivery partners working seamlessly together.

Key Outcomes

- Integrated system(s) to be in place to record and access patient data, governed by robust protocols.
    - The patient NHS Number becomes the primary identifier for users of health and care services;
- Patients will not have to 'tell their story' to a number of agencies involved in delivery of services to them; the relevant information will be accessible to all agencies across the system as required;
- Improved information sharing between organisations leading to the provision of support for people at an earlier stage, thus preventing their condition from worsening and reducing demand for acute services; this will include the independent sector;
- Staff report they collaborate with each other and can share information easily (as per C.3.2 OPACS Outcomes Framework); and
- The range and quality of performance information across the system will be improved and contribute to the continued long-term system wide service planning; this may include the development of joint data sets

The project milestones are set out in section 4a.

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))

The CCG and PCC are committed to adopting systems that are based upon Open APIs and Open Standards, wherever possible, and encourAgeing existing supplier to adopt Open APIs and Open Standards in future releases of software. The CCG is often directed to use specific software suppliers by NHS England and/or the Health and Social Care Information Centre.

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

A further project is under way to identify the key information which should be shared between professionals: this includes the NHS numbers. The project is being supported by the Health and Social Care Information Centre, and includes learning from the pan London experience on the best ways to find and share data across organisations.

Peterborough City Council has developed a digital strategy, part of which is designed around interfaces between core records and a number of applications that support social care practice. Based on the principle that data will be collected at the first point of contact and shared with relevant parties. Our preferred models of assessment are those which can be accessed on line as a self-assessment tool and could be completed by service users in their own home. At the time of collection, this model allows for the recording of consent to be shared. 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.

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.

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

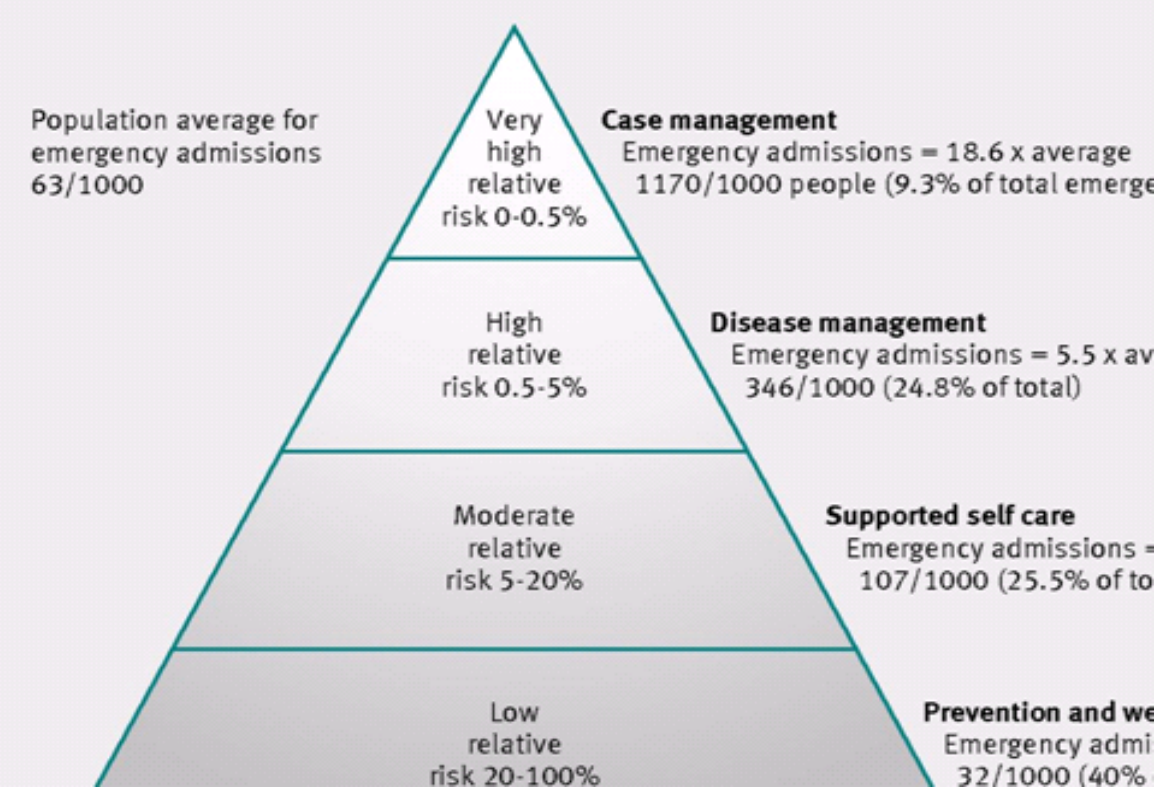
i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Across Peterborough we will be introducing Integrated Neighbourhood Teams (MDTs) to provide better and more holistic support to frail elderly or other vulnerable people. Integrated Neighbourhood Team (MDTs) assessments will become the norm. They bring together social, medical and community care plans involving GPs, hospital doctors, nurses, physiotherapy, social workers and voluntary or community groups. Learning from 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 MDTs will also use risk stratification tools and processes to create personalised care plans for the most vulnerable, and ensure that this group has a named and accountable Lead Professional. The Lead Professional will ensure the Integrated Neighbourhood Team (MDTs) has all of the relevant information, organise appropriate co-ordination meetings, record the decisions and outcomes and produce the agreed the plans

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 and the most important age group for the intensive institutional services that we are trying to reduce the need for. Risk stratification will form a key component of the solutions being implemented by Uniting Care Partnership 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 team around the person will have a common understanding of a person's holistic needs to ensure integrated assessment and working is facilitated and resources are efficiently and effectively targeted to the most vulnerable to reduce emergency bed days and reduce unnecessary admissions to care homes.

Roll out is expected to begin in April 2015, to allow for time for change management and to set up new governance procedures. This work will link closely to the governance of the information sharing work.

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.

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

The deployment of a risk stratification tool will be key in the accurate identification of those at risk in ensuring that care and resources, are targeted at the correct people and do not exclude any vulnerable individuals.

Furthermore, our approach outlined in this Plan includes further activities that will drive and/or support the assessment of risk, plan care and allocate a lead professional. These include:

- commitment to named lead professional for integrated packages of care;
- use of the NHS number as the primary identifier;
- development of increased 7-day working; and
- development, agreement and usage of a frailty assessment tool across the health and social care system.

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

Through our MDT Pilot which we have applied Risk Stratification, we have got approximately 8000 patients across Cambridgeshire and Peterborough area.

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

The Joint Commissioning Forum, which includes patient representatives, and a range of patient forums have had presentations on the BCF process and involvement in the development of high level plans.

During the development of the UnitingCare Partnership, which forms a key element of the BCF transformation programme, 12 engagement events were held covering every Local Commissioning Group area where local people guided the vision, values and service model. This was supported by a formal consultation exercise and questionnaire to capture views about the proposed changes. This has been incorporated into the overall vision and the 5 priority work streams.

The consultation events were completed between 17 March and 16 June 2014, with 80% of respondents saying they were supportive of the reasons for change. The respondents also showed strong support for vision for delivering more joined-up older people's healthcare and adult community services. As an illustration of the views:

- 87% supported the vision for improved community and out of hospital services
- 88% agreed the vision will be successful in achieving more patients being supported to remain independent

Work has also been completed with social services, housing stakeholders, the Third-sector (through the UK's leading charity network ACEVO2), general practitioners (covering 25% of the local population), the Local Medical Committee, Urgent Care Cambridgeshire, Herts Urgent Care (NHS 111), the Cambridgeshire Pharmaceutical Committee, all local NHS acute trusts and NHS England to discuss the proposals. This has ensured that the new model reflects the views of local people and commands the support of local NHS organisations. Further details are provided below.

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 Hospitals Foundation Trust (PSHFT) were involved with potential providers of the OPAC service in developing models of care to

deliver the outcomes required and have been consulted regarding the vision for the BCF. They have been involved in the workshops to develop the vision for the programme and the priority work streams. A formal submission has been presented by the Trust and has contributed directly to the resubmission document ensure that the views of the Trust are taken into account.

A paper produced by PSHFT which identified the key priorities and actions that influence the design and approach of the plan have been incorporated including:

- assistive technology;
- carers support services;
- early intervention and prevention;
- falls management;
- risk stratification predictive modelling;
- care co-ordination and intensive case management;
- Geriatrician community service; and
- Telephony consultation in residential homes.

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 is embedded within the BCF.

ii) primary care providers

Primary care have been represented on the original working group of the Better Care Fund in Peterborough, and through the Joint Commissioning Forums, and Local Commissioning Group Boards of the CCG. They have been involved in the development of the vision, planning, proposals and priority themes through these governance arrangements.

Specifically, the development of the BCF has been discussed with the Older Peoples Programme Board, which is GP led, to ensure that they have had an opportunity to contribute to the vision and priority work streams. GP representatives have also been involved within the workshops to determine the vision and the priority work streams.

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 with providers, particularly where they are seen to be able to offer services which will 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.

The General Secretary of Peterborough Council for Voluntary Services (PCVS)

and colleagues attended a number of design workshops planning Peterborough's response to the BCF.

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. 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.

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?

Peterborough Hospital is an active partner in the development of short, medium and longer term plans and has engaged in the leadership of the strategic priorities for integration.

The identification of schemes has been based on the use of benchmarking information, evidence from other health communities and an inherent knowledge of existing pathways as well as an understanding of the health needs of the local populations.

The scale of the transformational and financial challenge that the BCF process presents to the Trust is accepted along with the part it must play in delivering changes to its own services and ways of working, including reducing the size of the acute footprint.

The Cambridgeshire Executive Partnership (which includes acute providers) and HWB agreed a 2015/16 BCF target reduction in emergency admissions of one percent. Given the current trajectory of growth (which exceeds 2014/15 plan) reversing the trend of growth and delivering a one percent reduction for 2015/16 will be very stretching.

The ambition across the system including Peterborough & Stamford Hospitals NHS Foundation Trust is for greater reduction over the subsequent four years as transformation programmes are fully operational and deliver outcomes. For 2015/16 the one percent reduction provides alignment with provider plans on the basis of a stretching and achievable target.

For further detail of a key proposed BCF, see Scheme Number 2 - 7 Day working. 7 day working is vital to supporting the NHS acute service delivery targets as well as enabling better outcomes for patients because it will enable discharge planning

to be undertaken in response to patient need as opposed to organisational availability.

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.

Key enabler to Peterborough's BSF Schemes:

The Older People and Adult Community Services Contract (OPACS) Contract

In October 2014, it was announced that UnitingCare Partnership (UCP) had been awarded the contract for the Older People and Adult Community Services procurement. UCP is an NHS partnership that will deliver an integrated, seamless and affordable service in partnership with patients and carers. The partnership will work closely with organisations to transform community services to deliver person-centred care.

The UCP service model has six distinctive components:

- Integrated neighbourhood and integrated care teams
- UnitingCare Centre - Single-point-of-co-ordination with clinical support
- Integrated case management – Co-ordinated care for those most at risk
- Joint Emergency Team (JET) - Rapid response team
- Wellbeing and prevention
- Technology

The OPACS Contract is a key enabler of and / or directly supports our five BSF Schemes;

1. Data Sharing
2. 7 Day Working
3. Person Centred Systems
4. Information, Communication and Advice
5. Ageing Healthily and Prevention

ANNEX 1 – Detailed Scheme Description

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

Scheme ref no. 1
Scheme name: Data Sharing – Data Sharing Across the Whole System
What is the strategic objective of this scheme?
The Data Sharing Project will establish and implement an effective and secure set of approaches and protocols for sharing data across the whole system, to enable the provision of services to be better co-ordinated and integrated, and to facilitate the delivery of the person-centred system (see scheme 5) in the most beneficial setting. This will allow information to be shared across organisations so that intelligence and data about the needs of the individual can be accessed as and where required to ensure the support and treatment they need can be effectively provided and enable seamless joint working. The scope of the work links to the Care Act and includes public, private and third sector provider requirements and links to Primary Care and Integrated Neighbourhood Teams.
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?
Work-streams will be established to deliver the technical, procedural and practice related and cultural improvements required in the area of data sharing including addressing the issues of consent. **The key elements of the scheme are as follows:** **Information Sharing Processes** • Undertake desk top research into single Assessment models, drawing from a variety of sources (internal and external) to identify what “best practice” looks like • Engage with key stakeholders to identify the core elements of information needed to inform the dialogue with service users • Capture and map information needs to identify any thematic areas • Identify success factors, risks and issues • Use identified “Best Practice” models as starting point for development of new/revised forms that meets the need of the stakeholders. • Produce and test design • Produce first draft model for verification and approval • Agree pilot scope and timescales

- Implement pilot and evaluate
- Implementation and review

Information Sharing [Technical Solutions]
- Produce specification for data exchange
- Produce options based on identified requirements and facilitate delivery of preferred options
- Produce high level design
- Identify any implications for existing user access devices and connectivity
- Produce detailed design and test
- Establish terms of reference for pilot
- Conduct a pilot and complete operational readiness
- Facilitate adaption of relevant databases to record data sharing consent against each service user and carer record
- Implementation of solution

Information Sharing / Security [Protocols / practice]
- Desk-top research into adult social care data sharing “best practice”; to include guidance on anonymisation, and data protection and data security
- Review existing data sharing protocols for adult social care and produce an information sharing protocol (including how consent will be obtained and when sharing without consent can take place)
- Assist partner organisations where possible to obtain relevant data sharing consent from service users and implement data sharing policy and agreements
- Assist in identifying information governance/security requirements for technical systems e.g. using iPads to share information
- Confirm legal and information governance requirements for data sharing egg: developing information sharing agreements / personal commitment statements for MDT Coordinators and other key staff outside of CCC who we want to be able to share information with about vulnerable older people in line with established CCC processes

Information Sharing [Workforce Development]
- Establish training needs and needs analysis
- Produce checklists and guidance
- Design and implement appropriate training solutions, including any changes to existing training programmes
- Implement training plans
- Support partners with any training needs [3rd sector may need support with training]

Network Connectivity
- Produce a requirements specification including a mapping exercise to identify what connectivity is in place now
- Produce a short report (which can be included in the final project report) outlining any opportunities/constraints together with details of what can be improved in the short/medium/longer term
- Develop high level design and plan
- Produce detailed design and test

- Confirm operational readiness
- Implement solution

Risk Tools
- Produce requirements specification for new tool
- Conduct options appraisal and produce business case
- Procure application
- Development and testing of Risk Tools
- Implementation

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

UnitingCare Partnership have been commissioned by the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) to deliver the entire care pathway for older people. UnitingCare Partnership is a provider vehicle with commissioning capability and will deliver a single view of the patient record which will facilitate and enable effective data sharing.

The multi-agency project board will be reviewed in January 2015 to lead delivery of the redefined Data Sharing project scope. This project will be one of a programme of interdependent projects aimed to enhance integrated working. Peterborough City Council and Cambridgeshire County Council will establish an appropriate governance structure to be responsible for oversight and ensuring the delivery of this programme within timescale.

The project will work across the health and social care system, with key partners being:

- CCC, CCG, LCGs, GPs
- Acute Trusts (Addenbrooke's, Hinchingbrooke, Peterborough and Queen Elizabeth Hospital)
- Cambridgeshire Community Services
- CPFT
- UnitingCare Partnership
- Private Sector Providers
- Voluntary Sector via the Peterborough Plus

The key joint commissioners of this work will be the City Council and Clinical Commissioning Group; engagement will take place with all partners to determine the precise model for service delivery.

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

Difficulties in information sharing is commonly a challenge for integrated approaches to health and social care but can also be improved through effective integration (**http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/Research/IPC-ER4---Integrated-**

Health-and-Social-Care-Report-100613-FINAL.pdf).

Good communication improves the ability of teams to work together successfully (Howarth, Holland and Grant, 2006). Clear communication structures are needed to keep all staff aware of, and involved in, the processes surrounding integrated care, design and implementation. Complex documentation, poor record keeping, incompatible IT systems and differences in referral arrangements cause problems (Cameron and Lart, 2003). Robust information systems for rapid communication between sectors/organisations and within teams including using a single record gathered from shared assessments (Reed et al, 2005). See: http://www.wales.nhs.uk/sitesplus/documents/888/The%20Determinants%20of%20Effective%20Integration%20of%20Health%20and%20Social%20Care%20FINAL.pdf

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 Data Sharing project will create new data sharing capabilities and opportunities to enable the successful delivery of the broader transformation agenda; the impact and benefits of this project will predominantly be realised through the success of the other projects within the programme.

It is expected that this project will deliver a broad range of benefits across the system. Effective and secure data sharing arrangements will improve customer experience and the quality of practice. Patients will not have to re-tell their story to different agencies and will have increased confidence in the system, staff will be able to collaborate with each other and share information easily and the use of the NHS number as the unique identifier will facilitate the delivery of smooth care pathways and enable more effective joint strategic planning. Improved access to information will enable frontline staff to report that they can collaborate with one another and share information, and as a result can make high quality, well informed decisions about patient pathways in a more efficient and timely manner than at present. There will be a reduced risk of gaps in service and efficiency gains will be achieved across the workforce as a result of more efficient use of contacts with customers.

Through improved integrated working there will be a range of efficiency gains because information and provision of services will be better co-ordinated, and there will be enhanced opportunities for a whole-system intelligence led response to prevention, demand management and strategic planning.
In addition the expected impact of the measures put in place by the project includes:

- Better information sharing between organisations leading to earlier support for older people, and providing timely access to information, advice and support
- By providing scheme will be signposting or support earlier, this will prevent

people's condition from worsening
- This will promote independence and reduce calls on acute services

Benefits which data sharing will enable delivery of across the health and social care system include
- Reductions in admissions to permanent residential care
- Reductions in delayed transfers of care
- Reduction on non-elective admissions
- Efficiency gains across the workforce as a result of more efficient and effective contacts with service users, patients, carers and their families.
- Provision of self-service interfaces will lead to reduced contacts with services.

The scheme is linked to the following I statements for our target population.

"My privacy will be respected, however the professionals that need to know about my situation will be able to access my information if and when they need to."

"I won't have to keep telling my story to different professionals from different places"

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?

Improved data sharing will lead to the following benefits:
- Improved customer satisfaction – through the customer only having to tell us once
- Quality of care – the information about the customer is available to all professionals as and when they require it
- Efficiency – the professionals will have access to the data they require when they need it
- Improved performance – the timeliness and volume of customers' being seen by the professionals should increase
- Improved controls – better management information and performance metrics
- Behavioural change – improved partnership working as professionals increase their confidence from using and relying on information and data provided by other partners

What are the key success factors for implementation of this scheme?

- Agreed set of protocols and procedures including agreement of the NHS Number is the primary identifier for health and social care services.
- Integrated systems are in place to record and access patient data, governed by robust practice standards.
- Agreement of a core data set
- An effective system of risk stratification based on shared intelligence is in operation and having an impact of the identified metrics.
- Patient confidence in the service
- 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.
- All professionals and partner organisations have easy access to summary information they need in order to inform support options provided to individuals, including Integrated Neighbourhood Teams (MDT's)
- Provides UnitingCare Partnership with a single view of the patient record which will facilitate and enable effective provision of service
- Joint data sets inform joint commissioning plans and support further alignment of services.

Scheme ref no 2

Scheme name 7 Day working –
Service redesign to support an Integrated approach for health and social care to avoid unnecessary admissions to hospital and reduce the number of excess bed days and delayed transfers of care.
Re-shaping the housing market, minor & major adaptations
Re-shaping the 24 hour bed-based care market - residential care, nursing care, reablement / rehabilitation bed based
Telecare/Telehealth/Assistive Technology

What is the strategic objective of this scheme?

To deliver an integrated approach to discharge planning and admission avoidance to ensure that appropriate services are operating 24 hours a day 7 days a week to enable better outcomes for service users and patients. The services provided will be based on need and not availability and a redesign of services will create capacity within the system. This does not mean that all services will operate 24 hours a day, 7 days a week – it is about ensuring that across the system, whatever time or day, there are appropriate services available.

- All patients will leave acute hospital as soon as clinically fit and safe to do so; and that complex assessment will be undertaken at home or within interim provision such as a nursing home.
- Provide a responsive equipment and adaptations offer supporting people to be discharged from hospital and enabling people to maintain their independence, have more control of their life and supporting them to remain at home for longer.
- Provide an integrated health and social response for people in ambulatory care or on the frailty unit to return home and to reduce the number of excess bed days through enhanced reablement or the urgent community response service.
- Ensure Extra Care, Residential and Nursing homes are supported through appropriate channels to avoid unnecessary admission to hospital through direct links with primary care and/or secondary care (Skype).
- Put in place better capacity to enable "step up" and "step down" options and better alignment and agree pathways for reablement and intermediate care services.

7 day working is an enabler for better outcomes for patients because it will enable discharge planning to be undertaken in response to patient need as opposed to organisational availability. The expansion of a range of services to facilitate discharge planning 7 days a week will include health, social care and the residential and nursing home sector.

In addition, a key strategic enabler is to maximise the use of Assistive Technology across social care and health to promote and maintain independence and health; to enable citizens to self-care where possible or to support citizens where needed. The Vision is to create an integrated Assistive Technology Service which encourages joined up equipment solutions dependent on a citizen's needs. This supports the Vision for Health and Care Services to realise the benefits of whole system model transformation including "further access to the assistive technology service". The scheme fits with the CCG Commissioning Strategy priorities around long term conditions and improving the health and wellbeing of the frail and elderly, and the local authority priority of Joint Working to drive collaboration, integration and efficiencies.

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?

Community based health and social care services such as Intermediate Care Services, Reablement and Community Nursing already deliver 7 day working. Services have been redesigned to deliver an integrated Urgent Community Response pathway to deliver rapid stabilisation and resilience in the system. The Urgent Care Response Service will avoid unnecessary admissions at the time of crisis and support discharge from the Frailty Unit at the Acute Trust.

Community based services (in particular domiciliary care and care home services) will be engaged and working arrangements will 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, we will focus on the following areas:

Domiciliary Services

- The provision of Health and Social care Domiciliary Services that can be commissioned by out of hours GP's to stay with patients overnight to prevent admissions, with the same team supporting patients in Ambulatory Care or the Frailty Unit to return home overnight to prevent people being admitted for low level health and social reasons;

Integrated Neighbourhood Teams (MDTs)

- Integrated Multi-Disciplinary Admission Avoidance Team aligned to Ambulatory Care and Frailty Unit.

Assessments

- Care Homes will accept referrals and complete assessments on the same day, 7 days per week, step up and down, and Domiciliary Care Agencies accepting and starting new and existing care packages 7 days per week;

- 7 day assessments will be completed by Health and Social Care in the Acute Trust to support 7 day discharge;
- To implement the concept of Discharge to Assess for patient's determined as medically fit who require an assessment for Continuing Health Care to deliver capacity and resilience in the Acute Trust; and

Third Sector

- 7 day support from Voluntary Sector Organisations to support people in the Community.

Community Response Team

- Urgent Community Response Team to support people in crisis and effectively manage acute health episodes minimising hospital admissions were medically appropriate.

Integrated Neighbourhood Teams (MDT's)

- Integrated Discharge Pathway - Single referral process, 7 day working, and strong alignment to MDT's in the community.

Reablement

- Integrated enhanced reablement/rehabilitation pathway aligned to Intermediate care pathway to avoid duplication - 7 day working, strong alignment to MDT's and accountable lead professional/coordinator named.
- Development of reablement offer for both LD and MH to reduce the need for long term care and support and proactively support individuals experience improved mental health and wellbeing.

Discharge to Assess

Implement the 3 pathways for Discharge to Assess:

- Able to return home with support to include MDT/Enhanced Reablement;
- Unable to return home, 2 to 6 weeks rehabilitation (interim/intermediate care bed model);
- Unable to return home, 4 to 6 weeks for Continuing Health Care Assessment/pathway - "funding without prejudice "

Accommodation

- Increase funding for Home adaptations
- Improved provision and quality of sheltered accommodation
- 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

Joint Emergency Team (JET)

- A 24/7 rapid response service JET (Joint Emergency Team). JET will consist of paramedics, health and social care staff working in and with the community to avoid referrals to secondary care wherever possible.

Telecare/Telehealth

This scheme will encourage an increased and more effective use of Assistive Technology (AT) across social care and health services and enable this to be done in an integrated way. The main forms of AT being:-

- Telecare – a range of equipment (alarms, sensors and detectors) to maintain independence, dignity and safety. Some of the equipment range is linked to a monitoring centre whereas some of the equipment range is stand alone. Service provision includes installation and maintenance of equipment and a 7 day monitoring and rapid response service;

- Telehealth – a range of equipment to support the remote monitoring of a patient long term condition through the measurement of vital signs and other condition specific information. Service provision includes installation and maintenance of equipment and 5 day monitoring of alerts;
- There is also Dispersed Alarm Provision: low intensity preventative service including 7 day monitoring and rapid response call out. Currently this low intensive support service a key feature of which is rapid response call out in order to reduce call out of emergency service provision.

Risk	**Mitigating Action**
Cambridgeshire and Peterborough currently have two different systems in place and therefore an integrated approach is not achieved	There will be one joint project group across the CCG area which will be tasked in ensuring the design of new services and systems aligns across both. Move to an integrated approach enabled by the BCF Model.
There is a lack of stakeholder engagement	Detailed stakeholder mapping and planning will be undertaken as part of the scheme to ensure all stakeholders are consulted and informed. An accountable and responsible owner for engagement with each stakeholder will be identified in the stakeholder plan. All organisations will be represented by the right people, who are empowered to make decisions
A significant cultural change is required for all stakeholders	A change management and communication plan will outline, by stakeholder, the changes and actions required to bring about the necessary new ways of working. This will be monitored closely by the project team through change readiness assessments. On-going regular engagement and communication with workforce.
Reductions are not achieved	The project team will closely monitor the impact of the new ways of working so that where reductions are not being achieved this are escalated through the governance structures and corrective actions deployed.
Recruitment, training and development requirements are not known	A needs analysis will be undertaken and from this a change management plan developed which will include an

	action plan to deliver the level of recruitment, training and development to ensure smooth transition.
Recruitment is currently a challenge and will be exacerbated if an expansion of the workforce is required	Close working with HR will be undertake to develop a recruitment and retention plan.
Financial resourcing to develop the project	Sufficient project support will be included as part of the whole transformation programme resource requirements.
There is a current lack of capacity and resource in the system to support five day working – spreading this over seven days creates risks of under-resourcing	Close working with HR to develop a recruitment and retention plan, alongside a review of existing and resources modelling forecast. The scheme will also look to identify duplication of effort and where this can be stopped.
Savings and benefits are likely to be medium term, whilst BCF expectations are short term	On-going monitoring of outcomes at a senior level with a robust approach to performance management. On-going monitoring and evaluation of programme to ensure that services/projects within the programme are fit for purpose and meeting expected outcomes within timescales.

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

A phased programme will be developed for the expansion of 7 day working across the system. Initially local authority discharge planning teams will formally expand to deliver services 7 days per week; this will include social workers and discharge planning nurses. Part of this initial phase of work will also focus on working with commissioned residential and nursing services to enable them to be able to assess and receive residents at weekends.

Requirement	Commissioner	Provider
Intermediate Care Service	Peterborough City Council	
Community Nursing	Peterborough City Council	
7 Day Assessments	Peterborough City Council / Out of Hours GP's Acute Trust	Care Homes Domiciliary Care Agencies Health & Social Care
Admission Management		Integrated Neighbourhood Teams
Continuing health care assessment	Acute Trust	

Personal in the community support	Peterborough City Council	Voluntary Sector Organisations
Integrated discharge pathway	Acute Trust / Peterborough City Council	Integrated Neighbourhood Teams
Reablement/rehabilitation pathway	Acute Trust / Peterborough City Council	Integrated Neighbourhood Teams / Accountable Lead Professional
Accommodation	Acute Trust / Peterborough City Council	Peterborough City Council Third Sector Private Sector
Assistive Technology / Telecare / Telehealth	Peterborough City Council	UCP Third Sector Private Sector

Peterborough is developing a joint Assistive Technology Strategy, the first phase of which has been implemented. The objectives identified through the Strategy were:-

- Improve Early Intervention / Prevention
- Sustain Independent Living
- Facilitate safe return home from hospital and other settings;
- Improve value for money;
- Improve service quality / efficiency of service providers.

These objectives were to be delivered by:-

- Integrated Adult Care;
- Embedded AT;
- Pooled resources;
- Effective procurement;
- Change management.

The aim is to develop a single AT service. The Better Care Fund will facilitate the pooling of resources to a more fully integrated and coordinated service.

The delivery of the AT Project and Strategy is overseen by the Adult Social Care Delivery Board to drive direction and ensure outcomes are met. This reports to the Joint Commissioning Forum and ultimately to the Health and Well Being Board.

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

Peterborough has considered the national evidence and policy initiatives in developing its local AT services as well as learning lessons from AT delivery in other areas. This includes evidence coming from the Whole System Demonstrator (WSD) pilots, polices within the 3 Million Lives initiative, and where use of AT is referred to in other policies e.g. National Dementia Strategy. Most of all however the key evidence base has been learning lessons from local

experience and listening to those who use or want to use the services. An example of national and local evidence affecting Telehealth delivery are the recent Journal of Advanced Nursing article on "The impact of Telehealth on community nursing" (http://onlinelibrary.wiley.com/doi/10.1111/jan.12480/pdf) along with a study of "nursing and community support workers experience of Telehealth (Brunel University study of Nottingham Telehealth (http://www.biomedcentral.com/1472-6963/14/164).

Effective use of AT services enable citizens to feel more confident and in control of their condition and enable professionals to provide the right of care and support without this being too intrusive. Effective use of AT has been evidenced to help citizens remain independent in their own homes for longer and thus realise savings in the costs of service delivery. There have been numerous studies published of Telehealth and Telecare services where cost savings have been evidenced through the avoidance of hospital admissions, reduced costs of nursing visits to patients and the delay or prevention of admission to residential care (on average use of Telecare realised £1,000 in avoided costs of social care and health delivery). There has been very positive feedback provided by users and carers of the Telecare Service with 96% of users feeling the equipment has given them more confidence / peace of mind and 86% of carers feeling Telecare has reduced any anxiety about the person they cared for. This is the evidence base driving the assumptions about impact and outcomes for increased use of AT across social care and health.

Here is an example of how the introduction of effective Telecare / Telehealth solution

- In Peterborough we have a population of 30,000 over 65s
- Currently 830 Beds (Nursing and Residential Care)
- With 71 admissions per month to hospital i.e. 852 admissions per year
- We believe we could get a reduction of 18% - 153 admissions
- Cost of an admission - £1876 per admission
- Therefore reducing by 18% will save £287,703

Rapid Response / Joint Emergency Team (JET)

- Currently 260 avoidable admissions to hospital per year
- Assume reduction of 12% - 31 per year
- Cost of an admission - £1,876 per admission
- Therefore a saving of £58,531

Discharge to Assessment Model

- Currently 1000 Excess Bed days per month in Peterborough
- 12,000 per year
- Assumed reduction of 20% - 2,400
- At a saving of £250 per day
- Therefore a saving of £600,000

Data from Peterborough & Stamford Hospitals NHS Foundation Trust shows a total of 3,535 non-elective admissions in 2013/14 for the below 10 primary diagnoses, considered relatable to the '7 day working' scheme. The scheme focuses on admission avoidance with emphasis on improved health management

by the individual and care system outside of hospital and these conditions and therefore the prevalence of these admissions may be reduced by this scheme, particularly in the case of related readmissions.

Primary Diagnosis Code	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14	Grand Total 2013/14
Urinary tract infection, site not specified	150	132	148	197	627
Unspecified acute lower respiratory infection	135	95	132	174	536
Chest pain, unspecified	96	102	141	116	455
Pain localized to other parts of lower abdomen	105	101	86	66	358
Other and unspecified abdominal pain	79	88	102	78	347
Syncope and collapse	85	96	88	77	346
Acute tonsillitis, unspecified	48	48	80	68	244
Fracture of neck of femur	57	54	52	59	222
Headache	39	43	57	65	204
Pain localized to upper abdomen	51	55	51	39	196
Total	**845**	**814**	**937**	**939**	**3535**

Assumptions have been made that citizens will embrace using AT to help them self-care and self-manage their long term condition. Assumptions have also been made that citizens will want to be able to purchase equipment where not eligible under local thresholds. An extension of the Telecare Service will provide an equipment selling service with reasonably priced items available backed up with support to enable citizens to use the equipment effectively. These assumptions have been based on an analysis of the population profile in Peterborough as well anecdotal evidence from citizens asking where they can purchase equipment.

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

Effective implementation and delivery of 7 day working will help maintain, increase and regain a citizen's level of independence in their own home, as well as supporting health, confidence, dignity and safety. Therefore anticipated outcomes include:

- Individuals with long term conditions experience improved outcomes and reduced complications or injury.
- Individuals with a long term condition, and their carers, are supported to manage their condition at home and maintain their independence.
- The health and independence of frail older people is maintained or improved through proactive assessment and care planning.

- Individuals experience improved mental health and wellbeing and quality of life through early support and diagnosis.
- Advice and signposting to local services and community support are made available to all people in contact with community services to support healthy lifestyles and independence.
- There is a reduction in the number of days spent in hospital (from emergency admissions) by people aged 65 and over.
- The community team effectively manages acute health episodes, minimising unplanned hospital admissions where medically appropriate.
- When referred to hospital as an emergency or presenting to A&E, frail older people are pro-actively managed along an integrated frailty pathway.
- The impact of the programme on planned care is assessed and not adversely impacted.
- The effective use of AT will help to:
    - maintain, increase or regain a citizens level of independence in their own home,
    - supporting health, confidence, dignity and safety.
    - reduce levels of anxiety in carers about the person they care for.

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?

In order to measure the outcomes of 7 day working combined with assistive technology initiative it is planned to carry out an external evaluation in Peterborough. The outcomes of this piece of work will capture lessons learnt, customer satisfaction and shape the delivery of future services. This evaluation will have the following factors:-

- a benchmark review of existing information, reports and statistics;
- interviews with key stakeholders as to their understanding and aspirations for the service – to be repeated one year later to note changes;
- a survey for frontline social care and health staff to be repeated one year later to note changes;
- questionnaires sent to 1,000 users and carers to gauge their views with a 10 – 20% return rate. Those returning questionnaires to be sent another one a year later to note changes;
- a cost effectiveness study of new AT users for a 6 month period (approx. 1,000) with consent being sought to obtain retrospective and future hospital, GP and social care data to view changes – a target 10% consent rate is expected;
- outcome focussed interviews with 20 users and carers to gauge their views on how AT supports them and how it impacts on their interaction with health and care services.

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.

- Reduction in admissions by 18% (153 pa)
- Reduction in avoidable admissions by 12% (31 pa)
- Reduction in excess beds by 20% (2,400 pa)

The scheme success factors outlined above have been set out to ensure ambitious but realistic delivery of the different services and AT to support the maximum number of people with a long term condition, support integrated health and care working as well as address priorities such as reducing unnecessary hospital admissions. This has been developed following local experience and consultation, local and national evaluation, learning lessons for other areas, consideration of priorities and a partnership approach to AT delivery.

Essentially, pressure on A&E and Acute beds are reduced. More people are able to regain independence reducing demand for statutory services and improving overall Well-Being.

Scheme ref no 3

Scheme name Person Centred System (Joint Assessments)
Protecting Social Care(Care Act compliant care management (including joint assessments)
Development of Care Sector Quality Improvement Team
Asset Based Community Development to deliver health & social care support / community resilience
Enhanced offer for Carers (all ages)

What is the strategic objective of this scheme?

The Person Centred Project will build upon the existing multi-disciplinary team (MDT) approach to the delivery of services to the cohort of service users who are vulnerable or at risk of becoming frail or requiring high cost services and to put in place community based solutions to provide support at a local neighbourhood level. The MDT approach enables effective integrated decision making and for the team around the person to have a common understanding of need and agree plans to address those needs. This project will deliver the tools required to facilitate and strengthen the MDT approach including an agreed risk stratification tool which will be used with all professionals and providers to describe the level of need, stratify risk and use as a basis for decision making, and an integrated joint assessment which will provide a common understanding of a persons need and agree an appropriate plan, facilitated by an accountable lead professional.

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?

Peterborough are currently introducing Integrated Neighbourhood Teams (MDTs) to provide better and more holistic support to frail elderly or other vulnerable people. Joint MDT assessments will become the norm for people who fall into

these categories and will bring together social, medical and community care plans involving GPs, hospital doctors, nurses, physiotherapy, social workers and voluntary or community groups as assess the pre-statutory need of people with complex needs and / or are at high risk of hospital admission. Whilst recognising that there may be a point at which detailed specialist or statutory assessment may be required, the consent based joint MDT assessment will provide a shared and joint approach to identifying primary need for someone who presents as vulnerable or frail without them being drawn into a statutory assessment process.

Feedback from the initial introduction of this approach about the role of lead professionals and the application of risk stratification and assessment tools will continue to be used in developing proposals about the future MDT model.

The MDT approach is closely aligned with the UnitingCare Partnership delivery model which will be based wherever possible within primary care services to enable effective relationships with GP's to be established and to work with primary services and to ensure activities meet the needs of people within their local community. The Integrated Neighbourhood Teams will comprise of:

- community nurses;
- mental health professionals;
- allied health professionals; and
- support workers.

They will be functionally integrated with existing rehabilitation and reablement services, including:

- social care;
- UnitingCare Partnership;
- local authorities; and
- the voluntary sector.

The Integrated Neighbourhood Teams will have access to support from specialist professionals, these teams will comprise of specialist staff including Geriatricians, Psychiatrists and named housing link-workers.

The Integrated Neighbourhood Teams will be the vehicle to assess risk, plan care and allocate an accountable lead professional. The UnitingCare Partnership Wellbeing Service will also implement preventative strategies to support self-management, choice and maintain independence and for people with long-term conditions, integrated clinical pathways will offer holistic review and assessment with specialists working closely with the Integrated Neighbourhood Teams. Crucially this will include reviews and consultations which will improve compliance and provide early-warning of possible deterioration in health to enable proactive admission avoidance.

The deployment of risk stratification is crucial to ensuring the people on the edge of frailty or at most risk of hospital admission are identified; a risk stratification tool will be devised for use by all professionals and providers that describe levels of need, stratify risk and is used as a basis for MDT decision making and joint working with local nursing and residential homes to identify areas of concern and reduce unnecessary acute admissions. GPs will be required 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.

The person centred model lends itself to provision of care and support to meet the need of the entire care spectrum, including people with mental health need and Dementia. The varying levels of need will inform and be considered as the work to develop the person centred approach and associated tools are developed.

In addition, the existing intermediate care services, crisis response and Local Authority reablement and emergency home care services will be reconfigured and processes aligned to support the independence pathway. This is complemented by expanding the use of assistive technology and tele-health including for citizens within residential and nursing homes and a 24/7 rapid response service JET (Joint Emergency Team).

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

UnitingCare Partnership have been commissioned by the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) to deliver the entire care pathway for older people. UnitingCare Partnership is a provider vehicle with commissioning capability.

A formal multi-agency project board will be established in January 2015 to lead on the delivery of the Person Centred Care Project including delivery of the joint assessment and lead professional practice and tool and the risk stratification tools. This project will be one of a programme of interdependent projects aimed to enhance integrated working and the Adult Social Care Delivery Board will be responsible for oversight and ensuring the delivery of this programme within timescale.

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 literature supporting the effectiveness of integration has been reviewed in detail by The Kings Fund (Curry and Ham, 2010). This review concludes that the evidence is supportive of the concept of integration and highlights the importance of integrating not just at the health system level, but also at individual patient's levels. The frequently cited example of Kaiser Permanente suggests that integrated care can result in fewer admissions (Feachem at al, 2002). Within the Kaiser system there is a view that patients who require hospital treatment that has not been planned have not received optimum care at an earlier stage in their illness; the proposed pre-statutory assessment will seek to redress this issue in Cambridgeshire.

Data from Peterborough & Stamford Hospitals NHS Foundation Trust shows a total of 1,920 non-elective admissions in 2013/14 for the below 10 primary diagnoses, considered relatable to the 'person centred system' scheme. This scheme focuses on the use of risk assessments and/or integrated assessment

from an accountable professional as well as input from wider integrated neighbourhood teams and therefore these diagnoses are selected on the basis of the benefit with regards to the patient and probability of lack of admission if an adequate assessment were undertaken through the proposed risk/integrated assessment models.

Primary Diagnosis Code	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14	Grand Total 2013/14
Septicaemia, unspecified	79	76	63	71	289
Acute tonsillitis, unspecified	48	48	80	68	244
Other chest pain	76	58	52	56	242
Poisoning by 4-Aminophenol derivatives	52	52	72	49	225
Atrial fibrillation and flutter	51	50	44	50	195
Cellulitis of other parts of limb	37	56	34	63	190
Constipation	30	40	50	51	171
Other symptoms and signs involving emotional state	30	37	36	29	132
Nausea and vomiting	24	41	26	29	120
Retention of urine	31	29	27	25	112
Grand Total	**458**	**487**	**484**	**491**	**1920**

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

Here is an example of how the introduction of a person centred system will reduce the number of non elective admissions:

- In Peterborough we have 17725 non- elective admissions in PSHFT
- Of these 16,113 would be influenced by Person Centred System approach.
- We would expect a 7.4% reduction in these admissions due to these interventions, which equates to 1,193 reduced admissions.
- Cost of an admission - £1876 per admission
- Therefore reducing the number of non elective admissions will save £2,238,818.

In addition, the introduction of a person centred system will reduce the number of A&E attendances:

- Of the 1,500 avoided non-elective admissions 80% of those will have an A&E attendance = 1,200 people
- Cost per A&E attendance is an additional £111
- Saving £133,200

Here is an example of how the introduction of a person centred system will reduce the number of people in permanent residential care:

- There are 150 admissions to permanent residential care per annum.
- This scheme would result in a reduction of 6% of these admissions = 9

- Each place saves £14,000 per annum, based on a net saving assuming a domiciliary care package would need to be put in place.
- Potential saving of £126,000

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 (OPACS) to improve health, wellbeing and maintain independence will be the key mechanism for measuring the anticipated outcomes of this project. Oversight of the contract will be the responsibility of the CCG.

In addition progress reports including outcomes will be reported to the Adult Social Care Delivery Board as commissioners of this project on a regular basis, and in turn progress updates including the impact of schemes will be reported to the Health and Wellbeing Board. The specificities of the progress reports are to be agreed by the Project Board once established, but one of the deliverables of the project will be to agree a methodology for measuring the impact of this project which aligns with the OPACS outcomes framework.

In addition, in order to measure the outcomes of person centred system scheme it is planned to carry out an external evaluation in Peterborough. The outcomes of this piece of work will capture lessons learnt, customer satisfaction and shape the delivery of future services. This evaluation will have the following factors:-

- a benchmark review of existing information, reports and statistics;
- interviews with key stakeholders as to their understanding and aspirations for the service – to be repeated one year later to note changes;
- a survey for frontline social care and health staff to be repeated one year later to note changes;
- questionnaires sent to 1,000 users and carers to gauge their views with a 10 – 20% return rate. Those returning questionnaires to be sent another one a year later to note changes.

An analysis of the information will be carried out and the key lessons identified and the necessary improvements fed back into the operation.

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.

- Reduction in non elective admissions by 7.4%
- Saving achieved through the reduction in number of A&E attendances (£133,200)
- Saving achieved through the reduction in the number of people in permanent residential care (£126,000)

Essentially, pressure on A&E and Acute beds are reduced. More people are able to regain independence reducing demand for statutory services and improving

overall Well-Being.

Scheme ref no 4

- **Scheme name Information, Communication and Advice:**
  System Wide Information Provision / Co-ordination
  Integrated System Wide 'Front Door'

What is the strategic objective of this scheme?

The strategic objective of this scheme is to maximise the number of citizens being directed to the right services at the right time to meet their needs. This is through a single front door accessed irrespective as to whether the citizens needs are health or social care, whether a professional or citizen is making the referral / enquiry and whether the referral / enquiry is urgent or non-urgent.

This scheme is a key enabler of Peterborough's Health and Wellbeing Board's 5 priorities. Through this scheme citizens will find that "access to services will be less complex through single points of access and use of web-based information allowing self-access". In our Case for Change having a single point of access as well as streamlining referrals from acute to community are crucial for the delivery of our ambitions.

The development of a high quality source of advice and information that is not based on organisation boundaries.

Development of an integrated front door regardless of whether the presenting needs are health, housing or social care or a combination of these. The model will be based on a co-located service elements alongside virtual links between organisations, including Peterborough Plus, 111 service and the ARC.

A principle of the system is "no wrong door", recognising that support will be accessed via a variety of routes to help citizens navigate the system.

To create the environment whereby Peterborough residents are able to self-serve where-ever possible.

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?

This scheme will support the integration of front door access to social care and health services and navigation through to appropriate services delivery. The aim is to reduce the number of access options through the Peterborough Care System to simplify the process for citizens and professionals to get directed to services appropriate for their need and availability. This will be an integrated response to support citizens accessing the right level of support at the right time.

The project will establish a universal front door, one stop shop which includes social care, health, and voluntary sector and private sector services to all citizens of Peterborough.

The vision is for one single front door, beginning with the alignment of existing access points and sharing of online tools and directories. To include up to date information on public, private and voluntary sectors' services, including quality information, costings and access (e.g. e-marketplace).

Components:

- An information and advice website and care directory. A single website aligning and linking existing websites.
- Community specific content (care directory) designed to promote self-service
- A process/mechanism to keep content up to date, involving commissioners and providers
- The ability for 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
- Triage/eligibility and initial demand management with reablement & assistive technology as the default
- A new CRM system to support the new front door
- A shared knowledge system, with shared suite of frequently asked questions and decision making tool, such as the frailty scale.
- E-referrals between health, Council, private and voluntary sector.
- Publicity and training for public and professionals (including GPs, NHS and PVCS staff)

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

A formal multi-agency project board will be established in January 2015 to lead on the delivery of the Information, Communication and Advice scheme. This project will be one of a programme of interdependent projects aimed to enhance integrated working and the Adult Social Care Delivery Board will be responsible for oversight and ensuring the delivery of this programme within timescale.

UnitingCare Partnership have been commissioned by the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) to deliver the entire care pathway for older people including a suite of tools to support the provision of advice and guidance. UnitingCare Partnership is a provider vehicle with commissioning capability.

Peterborough City Council with its partner Serco will deliver the universal front door service in place by April 2015, including enhanced information and advice content, service directory, online assessment and carer assessment. This work stream will be under our wider customer experience programme, working closely with Uniting Care Partnerships and Peterborough Plus (the local voluntary sector consortium).

Milestones for this scheme are outlined in section 4a.

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

Navigation of the health and social care system in Peterborough is complex, and leads to poor public experience and a lack of take up of preventative services. The Older People's and Adult Community Services (OPACS) Framework which will be delivered by UnitingCare Partnership (UCP) outlines outcomes in respect of Information, Communication and Advice. The Information, Communication and Advice Project will enable people to access information and advice in a way that works best for them and they will be helped to navigate the system successfully irrespective of their needs or where they go for advice or information; through improving public and professional access to good quality information and advice about preventative and community based services this will contribute to a reduction in non-elective hospital admission and inappropriate referral or admissions to residential care homes.

The OPACS outcomes framework identifies the following outcome indicators that would be impacted by better, more co-ordinated information and advice services:
- Patients and carers experience effective and joined up working and co-ordinated care
- Patients have access to information in an appropriate way when they need it
- There is a reduction in the number of negative experiences from patients and carers
- Effective information systems are in place and valued by staff across all local provider organisations.
- Advice and signposting to local services and community support are made available to all people in contact with community services to support healthy lifestyles and independence.

Local intelligence evidences that frequently people opt to choose care in a residential home, when they are self-funding as this is recommended to them by a health professional as the only option. Improved provision of information about the wide range of community options available should limit the number of inappropriate self-funder admissions to residential settings.

Clearer referral pathways and information on services available, alongside the ability to book services via an e-marketplace will support effective discharge.

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 key focus of this scheme is to ensure people in Peterborough have access to

the right services at the right time to prevent inappropriate access to or avoidable use of high cost services such as acute admissions or residential care homes. The exact reductions in these activities will be impacted by the effectiveness of the preventative services available and therefore is reflected elsewhere in the BCF.

The outcomes of a universal front door for all customers will ensure they are directed to the right services for their needs. The outcomes for service provision will be stability by having a single referral source. This will also enable effective commissioning of services moving forwards based on need rather than historic provision and provide customers with choice.

We also expect that by directing customers to the right services for their needs we will alleviate pressures within the system, which in turn will contribute to the reduction in delays of the transfer of care from acute settings to the community.

There has been some scoping of existing service provision leading up to the design of this scheme. A specific benefits realisation group will be established that will include the financial impact and modelling to support the monitoring of the savings of this BCF scheme.

Savings are likely to arise though are not able to quantify with any precision.

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?

To measure the outcomes of information, communication and advice scheme it is planned to carry out an external evaluation in Peterborough. The outcomes of this piece of work will capture lessons learnt, customer satisfaction and shape the delivery of future services. This evaluation will have the following factors:

- a benchmark review of existing information, reports and statistics;
- interviews with key stakeholders as to their understanding and aspirations for the service – to be repeated one year later to note changes;
- a survey for frontline social care and health staff to be repeated one year later to note changes;
- questionnaires sent to 1,000 users and carers to gauge their views with a 10 – 20% return rate. Those returning questionnaires to be sent another one a year later to note changes.

An analysis of the information will be carried out and the key lessons identified and the necessary improvements fed back into the operation.

On-going feedback will also be sought from professionals and customers using the front door for referrals and enquiries as well as feedback from the services where customers are navigated to. One key measure of success will be to ensure that all referrals and enquiries are channelled through the 'front door' and that alternative / back door referral routes are not required.

The new 'front door' will be performance managed – recording levels of calls dealt with, waiting times and the level of lost calls. There will be analysis of enquiry and

referral types to aid continuous improvement.

Overall impact of aligned information and advice services will be measured via the OPACs outcomes

- Patients and carers experience effective and joined up working and co-ordinated care
- Patients have access to information in an appropriate way when they need it
- There is a reduction in the number of adverse experiences from patients and carers
- Staff and whole organisations are committed to working in a joined up and integrated way.
- Effective information systems are in place and valued by staff across all local provider organisations.
- Advice and signposting to local services and community support are made available to all people in contact with community services to support healthy lifestyles and independence.

What are the key success factors for implementation of this scheme?

Our success factors for delivery are:

- People can make informed choices about their health and wellbeing and self -care
- Escalating need is delayed by preventative information
- Decision makers access consistent high quality knowledge
- "Intelligent customers" are included in decision making
- A safe system that flags concerns and issues and links back to safeguarding
- System wide help for people to navigate the system rather than just sign-posting. This will include self-service opportunities.
- An integrated system wide "front door" with an embedded whole system principle of "no wrong point of contact"
- Provision of accessible, good quality information, advice and support and for the public and for staff across the system.
- Effective outreach engagement
- Health and social care commissioners understand where the gaps are and are able to respond to them.

For people in Peterborough the following "I" statement reflects success:

"I know how and where to get information on services and support. People who are helping me give me the same information, which is up to date and reliable."

Scheme ref no 5

Scheme name Ageing Healthily and Prevention
Enhanced offer for Dementia
Market position statement for health and social care in Peterborough
Employment First - developing Employment opportunities for our

service users
Development of 3rd sector PVCS and advocacy

What is the strategic objective of this scheme?

The Ageing Healthily and Prevention programme includes specific and planned evidence based, promotion of wellbeing through:

- healthy eating;
- physical activity;
- good mental health; and
- emotional wellbeing.

This will be coupled with triggers and pathways elements to develop responses to identified risks and deliver efficient responses to identified health and wellbeing needs.

The wellbeing programme will look to deliver long term improvements in the resilience and independence of communities and the wider health and social care system.

Initially this programme will focus on:

- falls prevention;
- carer breakdown; and
- social isolation.

The wellbeing programme will combine traditional public health communications with work to identify triggers and support the establishment of pathways to deal with need.

This scheme will:

- Put in place specifically tailored additional capacity and specifically for people living with dementia, their carer's and families.
- Create a clear strategic view of where and what type of services are required in line with the Joint Strategic Needs Assessment.
- Review and open up employment pathways across Peterborough.
- Develop capacity within the third 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?

This scheme will include:

Falls/UTI/Respiratory Services

- Deliver a series of planned evidence based health programmes to prevent falls, promote physical activity and promote mental health and emotional wellbeing.
- Prioritise a set of health and wellbeing programmes for development including falls prevention.
- Establish a falls prevention pilot
- Responses to UTI and respiratory conditions

Assistive Technology including Telecare / Telehealth

- Explore opportunities to maximise the use of telehealth and telecare

technology
- Produce a clear tele care and tele health offer;
- Make changes to the integrated assessment and planning pathway with AT becoming the default
- Put in place systems that can order/monitor/track benefits
- 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)
- Use of technology such as Skype to provide support for people with long term conditions
- 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.

<u>Establishment of Integrated Neighbourhood Teams</u>
- Care co-ordination and intensive case management as appropriate
- Use of risk assessment tools and stratification

<u>Expansion of Reablement and Residential Reablement</u>
- Review / strengthen reablement services, including residential reablement to ensure they are fit for purpose
- Establish clear pathways across the system for these trigger events
- Will aim to increase capacity and establish clarity around routes into and increasing the scope to those who are still in need of bed based support.

<u>Establishment of a specialist Dementia Resource Centre</u>

This centre will:
- Provide support for carers of dementia
- Develop domiciliary care specifically for dementia
- Develop residential and nursing care homes specifically for care homes
- Develop extra care housing specifically for dementia.

<u>Development of Information, Communication and Advice</u>
- Ensure the necessary information / communication with relevant parts of the system to ensure they are aware of the range services across the system.

<u>Setting up a Rapid Response Service</u>
- Agree a recognised set of triggers of vulnerability which generate a planned response across the system and within communities
- Identify response gaps.

<u>Introducing Geriatricians – working in the community</u>
- Working with GP's and other professionals to reduce the referral of people into hospitals

<u>Expansion of Carers Support Service</u>
- The establishment of a support service

<u>Engagement of the Voluntary Sector and Community Groups to:</u>
- Design an integrated advocacy service
- Specifically review and redesign Older People's PVCS day service
- Review and improve HIV support services
- Develop Direct Payment and personalisation support in the 3rd sector
- Develop support planning service in the 3rd sector

- Review and develop services that support Independent Mental Capacity Advocate (IMCA) services
- Review and put in place improvements to Community Support for stroke survivors
- 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)
- Co-produce outreach wellbeing programmes together with hard to reach local communities
- Establish local and joint initiatives to facilitate individuals and communities to self-help to stay active and well e.g. free swimming / badminton/table tennis /other for the over 60s, transport, coffee, library talks, lunch clubs etc.

<u>Expansion of Employment First - developing Employment opportunities for our service users</u>

- 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 formal multi-agency project board will be established in January 2015 to lead on the delivery of the Ageing Healthily and Prevention scheme. This project will be one of a programme of interdependent projects aimed to enhance integrated working and the Adult Social Care Delivery Board will be responsible for oversight and ensuring the delivery of this programme within timescale.

UnitingCare Partnership have been commissioned by the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) to deliver the entire care pathway for older people including a suite of tools to support the provision of advice and guidance. UnitingCare Partnership is a provider vehicle with commissioning capability.

Peterborough City Council working with UCP and PCVS, which includes Peterborough Plus, will deliver the Ageing Healthily and Prevention scheme.

- By targeting the key risk factors for Falls and Carer Breakdown such as continence management and medication all partners will work together to identify and respond to episodes preventing escalation and reducing the pressure on the rest of the system.
- For those without informal Carer support, local and joint initiatives will look to reduce social isolation and work closely with the voluntary sector to co-produce outcomes which improve resilience and ensure that people are not left without informal support.
- Over time the more formal triggers (falls, continence, malnutrition, mental

health issues) will be complemented by other softer signals that partners would be able to identify e.g. someone asking for assistance with their wheelie bin, a request for a personal alarm/life line, a concern raised when a housing provider carries out a routine visit, a death is registered or a blue badge is requested.

Drawn from Joint Strategic Needs Assessments (JSNAs) these programmes would be co-produced with local communities, based upon the principle of self-help and delivered jointly with the local community in collaboration with partners. In addition this will identify the areas needing increased capacity or improved working practices.

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

Peterborough has considered the national evidence and policy initiatives in developing its local Ageing Healthily and Prevention services as well as learning lessons from AT delivery in other areas. This includes evidence coming from the Whole System Demonstrator (WSD) pilots, polices within the 3 Million Lives initiative, and where use of AT is referred to in other policies e.g. National Dementia Strategy. Most of all however the key evidence base has been learning lessons from local experience and listening to those who use or want to use the services.

A recent paper co-authored by the Chief Executive of PSHFT identified that:

- British Red Cross volunteers have been shown to generate cost savings equivalent three and a half times their cost.
- Automated vital sign monitoring and telephone follow up by nurses are identified as most effective at reducing admissions
- One meta-analysis (of 11 randomised controlled trials) showed that telehealth is effective by demonstrating a 21% reduction in hospital admission in chronic heart failure patients
- Evidence from UK whole system demonstrator on the impact of telehealth showed
    - 5% fewer admissions to hospital in a 12 month period
    - Significantly shorter lengths of hospital stays by 0.64 days
    - Evaluation of Essex telecare provision showed that for every £1 spent £3.28 was saved in traditional care based on social worker report of next best case scenario. Where telecare is a direct replacement for traditional care for every £1 telecare saved £12.60 in traditional care
- Evaluation of handypersons services indicated that for every £1 spent there was £1.70 saved the majority to social services, health and the police
- Adaptations can reduce the need for daily visits and reduce or remove the cost of homecare (savings ranging from £1,200 to £29,000 annually). 90 adaptations help prevent related illness and injury thus reducing health service utilisation
- Meeting NICE guidelines on safely assessments and installing safely equipment in homes would cost £42,000 for an average local authority. If this prevented 10% of injuries it would save £80,000 in prevented hospital admissions and emergency visits, with further savings from reductions in

GP visits and utilisation of ambulance, police and fire services.

Data from Peterborough & Stamford Hospitals NHS Foundation Trust shows a total of 3,273 non-elective admissions in 2013/14 for the below 10 primary diagnoses, considered relatable to the 'ageing healthily and prevention' scheme through possible prevention via general improvements in public health and targeted interventions to improve individual health and associated wider determinants. The trend shows a substantial rise to 905 admissions in quarter 4 2013/14.

Primary Diagnosis Code	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14	Grand Total 2013/14
Pneumonia, unspecified	154	118	113	164	549
Unspecified acute lower respiratory infection	135	95	132	174	536
Viral infection, unspecified	78	73	108	96	355
Acute upper respiratory infection, unspecified	72	46	100	92	310
Chronic obstruct pulmonary dis with acute lower resp infec	74	54	94	85	307
Asthma, unspecified	54	58	95	68	275
Acute myocardial infarction, unspecified	69	70	63	64	266
Cerebral infarction, unspecified	72	59	58	53	242
Congestive heart failure	56	52	61	62	231
Acute renal failure, unspecified	47	61	47	47	202
Grand Total	**811**	**686**	**871**	**905**	**3273**

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

Wellbeing - falls prevention, carer breakdown and social isolation

Reduction in Emergency Admissions

- Improved focus on the key triggers for falls should also reduce admissions for UTI's and chest care

Reduction in GP appointments

- Improved resilience in the system should identify need earlier and reduce repeat GP appointments

Prescribing Savings

- Reductions in medication for UTI's and chest infections through improvements in chest care and continence management

Reduced Length of Stay in Hospital

- Earlier intervention should lead to shorter stays where they are still required

Reduced Admissions for falls

- Targeting the key factors for falls should have an impact on the level of admissions for falls

Reduced residential Respite (in crisis)

- Improved resilience of carers with better support should reduce the number of crisis respite interventions

Reduced Carer Breakdown

- Carer Breakdown often results in care for the cared for or the carer or both. This can be domiciliary or residential in nature and varies depending on the needs of the individual and the degree of carer breakdown

Greater Self Care inc carers

- Self-care by the cared for and carers for themselves and on behalf of the cared for person will have numerous benefits

Pathways and Triggers- Reablement, Residential Reablement and Telecare

Benefit type	Description	Cost	Benefit Range
Reduction in Long term residential care numbers	7% reduction in residential admissions based on increase in successful episodes of reablement equates to 10.5 people.	£100k	10 x £14K pa
Reduction in Short-term/Interim residential care numbers	Reduce Volume Reduce Cost collaboration		
Reduction in Long term Community Care packages	100 additional people through reablement, but with a reduced outcome rate down from 60%. For High expecting a 50% success rate and for Low 40%		Low 40 x £5K = £200k
Reduction in Emergency re-Admissions	In a year 15% (100) people were re-admitted prior to starting reablement. A reduction to 10%	<£200k	Low £45k
Reduction in Delayed Transfers of Care	If Reablement Beds were made available to deal with as little as 7 bed days a week this would be significant		Low 350 bed days pa
Reduced Length of Stay in Hospital			
Reduced A+E Attendance			
Reduced falls + Admissions for falls			

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?

To measure the outcomes of information, communication and advice scheme it is planned to carry out an external evaluation in Peterborough. The outcomes of this piece of work will capture lessons learnt, customer satisfaction and shape the delivery of future services. This evaluation will have the following factors:

- a benchmark review of existing information, reports and statistics;
- interviews with key stakeholders as to their understanding and aspirations for the service – to be repeated one year later to note changes;
- a survey for frontline social care and health staff to be repeated one year later to note changes;
- questionnaires sent to 1,000 users and carers to gauge their views with a 10 – 20% return rate. Those returning questionnaires to be sent another one a year later to note changes.

An analysis of the information will be carried out and the key lessons identified and the necessary improvements fed back into the operation.

Overall impact of the ageing healthily and prevention services will be measured via the OPACs outcomes:

- People and their carers feel supported to manage in the community and maintain their independence and wellbeing.
- Individuals experience improved mental health and wellbeing and quality of life through early support and diagnosis.
- Advice and signposting to local services and community support are made available to all people in contact with community services to support health lifestyles and independence.
- Patients are supported in the community following discharge and during their recovery period.
- Patients make a sustainable recovery after an acute episode with no avoidable deterioration in health.

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.

Essentially, pressure on A&E and Acute beds are reduced. More people are able to regain independence reducing demand for statutory services and improving overall Well-Being.

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

A clear market position statement which informs the detailed commissioning plans across Peterborough in-line with demographic growth forecasts.

Increased volume of younger adults obtaining paid employment. Increased independence and reduced demand for statutory services.

Development of Voluntary services at the community level. Reduced demand for

statutory services.

Falls/UTI/Respiratory Services

- Reduction in instances of falls, and UTI and respiratory being presented to accident and emergency

Assistive Technology including Telecare / Telehealth

More of Peterborough's residents are able to live independently and safely reducing demand for hospital based services and expensive residential housing options including:

- Reduction in admissions
- Reduction in avoidable admissions
- Reduction in excess beds
- Use of skype to reduce instances of residential and nursing home patients presented to accident and emergency
- Use technology such as Skype/Telehealth to provide support for people with long term conditions

Establishment of Integrated Neighbourhood Teams

- Better care co-ordination and intensive case management

Expansion of Reablement and Residential Reablement

Establishment of a specialist Dementia Resource Centre

- Establishment of specialist care
- The establishment of a support service

Development of Information, Communication and Advice

- Provision of information to customers to ensure they are aware of the range services across the system.

Introducing Geriatricians – working in the community

- Working with GP's and other professionals to reduce the referral of people into hospitals

Expansion of Carers Support Service

- The establishment of a support service

Engagement of the Voluntary Sector and Community Groups

- Provide a more tailored local community service
- Establish local and joint initiatives to facilitate individuals and communities to self-help to stay active and well e.g. free swimming / badminton/table tennis /other for the over 60s, transport, coffee, library talks, lunch clubs etc.
- A reduction in the number of people who were 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.

Expansion of Employment First - developing Employment opportunities for our service users

- Develop pathway to employment (including volunteering) for each service user group

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**	16,989
	2014/15 Plan	16,710
	2015/16 Plan	16,543
	14/15 Change compared to 13/14 outturn	1.6% decrease
	15/16 Change compared to planned 14/15 outturn	1.0% decrease
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	1378

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?**	The aim to reduce non elective admissions is challenging given the upward trend. . From our perspective we need the health and social care system to work together to achieve significant and lasting reductions in emergency admissions. We are sympathetic to the challenge and the inevitable time lag between design/implementation and impact which is the rationale behind the 1% target for 2015/16. Given the growth in our area and current trends this does represent a stretching target. Taking the projected increase based on current trend into account a 1% absolute decrease requires activity reduction of 9%. We and partners are ambitious to achieve step change improvement in the medium term. Providers and commissioners are working together through the challenged health economy programme to achieve sustainable health plans for the area. In particular work steams on urgent care and older people are focussed on reducing non elective admissions.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes, as part of the collective planning referred to above

Please see additional analysis document from the CCG attached at Annex 2a.

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