HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 7(a)
18 JUNE 2015		PUBLIC REPORT
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ADULT SOCIAL CARE, BETTER CARE FUND UPDATE

RECOMMENDATIONS	
FROM : Directors	**Deadline date :** N/A

The Board is requested to:

1. Note the update on the Better Care Fund monitoring and non-elective admissions targets; and
2. Comment on the development of the projects.

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing at the request of the Corporate Director for People and Communities.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide information for the Board; it sets out an update on delivery and monitoring following Peterborough's successful re-submission to the Better Care Fund (BCF) and the start of BCF funding on 01st April 2015.

2.2 This report is for Board to consider under its Terms of Reference No. 3.6, 'To identify areas where joined up or integrated commissioning, including the establishment of pooled budget arrangements would benefit improving health and wellbeing and reducing health inequalities.'

3. BCF BACKGROUND, GOVERNANCE, MONITORING AND WORKSTREAM UPDATES

3.1 Background

3.1.1 As previously reported, Peterborough's Better Care Fund (BCF) has created a single pooled budget to support health and social care services (for all adults with social care needs) to work more closely together in the city. The BCF was announced in June 2013 and established in April 2015. The £11.9 million budget is not new money; it is a reorganisation of funding currently used predominantly by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and the City Council to provide health and social care services in the city.

3.1.2 In order to receive approval for the BCF, Peterborough had to show how it would meet a number of statutory conditions, including the protection of social care services; a reduction in non-elective admissions to hospital; greater seven day working across health and social care services to support discharge; and support for information sharing between social care and health to improve coordination of people's care. Peterborough worked collaboratively with Cambridgeshire County Council (CCC), Peterborough & Stamford Hospitals NHS Foundation Trust (PSHFT), CCG, UnitingCare (UC) and the voluntary sector to develop its BCF submission.

3.2 Governance

3.2.1 At the previous meeting, the Health and Wellbeing Board confirmed that the Joint Commissioning Forum, now the Borderline & Peterborough Executive Partnership Board, Commissioning (BPEPB), will oversee the delivery of the BCF Plan and management of the pooled budget on behalf of the Peterborough H&WB Board.

3.2.2 Following approval by this Board in March 2015 of the draft Section 75 Agreement between Peterborough City Council and the CCG, the Agreement was in place by 01st April 2015 when BCF funding began.

3.2.3 Therefore, all necessary formal governance arrangements for the BCF were in place by April 2015.

3.3 Monitoring

3.3.1 The Health and Wellbeing Board agreed to delegate responsibility for reporting to the BPEPB. The process and templates for reporting of local areas' BCF progress were issued following the meeting by NHS England and the Local Government Association.

3.3.2 The first quarterly monitoring return for NHS England was submitted on the 29 May 2015. This was approved by the BPEPB. Given the significant joint working across Cambridgeshire and Peterborough, the returns between the two health and wellbeing board areas were closely aligned with one another. This first return covered the fourth quarter of 2014/15 and so largely related to the setting up of arrangements for the BCF.

3.3.3 Separately to the return to NHS England, the CCG – in line with other CCGs - has also had an opportunity to revise the BCF targets for a 1% reduction in non-elective admissions, in line with actual performance – or outturn - for 14/15. The Q4 2014/15 plan was to achieve a 1% reduction when compared to 2013/14 Q4. The system actually saw a marginal reduction of 0.3% (reduction in 14 admissions). Therefore the planned levels were not reached prior to the BCF coming into effect.

3.4 Workstream Updates

3.4.1 As previously reported, five projects have been established reporting to the BPEPB, to be taken forward as part of the work funded by BCF; these project areas were aligned across Cambridgeshire and Peterborough.

3.4.2 Initiation workshops took place on each of the five schemes detailed in our BCF submission. These workshops were jointly hosted with CCC, the CCG and attendees included representation from other relevant (existing and potential) delivery partners. Following the initial workshops, each scheme is moving forward as follows:

3.4.3 Data Sharing

<u>Background</u>

This workstream 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 workstream (see below) and the UnitingCare delivery model and solution.

The workstream will focus on four areas of delivery:

- Ensuring practitioners and professionals have access to holistic information when making decisions related to adults and older people's care needs;
- Enabling information to be shared at the earliest possible stage to prevent people developing care needs where possible;
- Ensuring data and information is shared in order to inform strategic planning; and
- Data sharing as an enabler for delivery of the broader Borderline & Peterborough Executive Partnership Board's objectives.

Next steps

The Project Scope outlines the priority areas for delivery over the next 3 years; this is based on current requirements and will be revised in order to reflect changing priorities. It has been agreed that in the first 12 months, a specific workstream of the project should focus on improving data sharing for the 5% cohort of patients identified by UnitingCare to be supported by the multi disciplinary teams (MDTs). A tiered approach to identifying subsequent patient cohorts for data sharing improvements will also be developed during this time. This approach was developed in recognition of the fact that specific changes to data sharing mechanisms will take some time to develop. By focusing on a smaller cohort of people, professionals can share data about those people through whatever means are possible in the shorter term, before processes are streamlined. This will help to ensure that the project can have an impact on patient outcomes even in its early stages.

A second strand of the project will focus on delivery of the BCF requirements within the next 12 months, and work will commence on the standardisation of relevant data sharing systems and processes across Cambridgeshire, Peterborough and the CCG – and potentially beyond where possible.

A project scope has been developed, a project board has been established and progress will continue to be reported to BPEPB.

3.4.4 7 Day Working:

Background

7 Day Working is an enabler of better outcomes for patients; the model enables discharge planning to be undertaken in response to patient need as opposed to organisational availability and will improve outcomes for patients because they will be able to leave acute hospital as soon as they are clinically fit and it is safe to do so. The 7 Day Working workstream will deliver an integrated approach to discharge planning and non-elective admission avoidance by ensuring that appropriate services are operating 24 hours a day, 7 days a week. This will not mean that all services will operate in this way; it is about ensuring that appropriate services are available across the system when needed and will include expansion of health and social care services, and residential and nursing home services. In addition this project will focus on out of hours admission avoidance in order to ensure that the increased pace and capacity created by improved 7 day discharge planning is not filled by an increase in admissions.

Next steps

Following the initial joint workshop jointly hosted with CCC, a workshop for system partners in Peterborough took place in May 2015. Principles and activities of work were identified and a delivery approach and plan is being prepared. Attendees at the workshop included representatives from: Peterborough City Council's ASC Commissioning and Operations Teams; Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), Peterborough & Stamford Hospitals NHS Foundation Trust (PSHFT); GP community; Cambridgeshire and Peterborough Clinical Commissioning Group (CCG); UnitingCare (UC); The Ambulance Service; patient and carer groups; and the voluntary sector. A project team is being established for this work, and a draft scope has been developed based on the outcomes of workshops held both in Cambridgeshire and Peterborough. Within the first 12 months, at a high-level, the workstream will focus on three areas:

1. Understanding the current state: mapping current service hours

A mapping of current service hours should be conducted across the system in order to understand what services are available at what times in different settings. This will inform an understanding of where there are gaps and identify opportunities to commission to fill these;

2. Joint working with SRGs

Working closely with the System Resilience Groups (SRGs), and linking with existing work on the Eight High Impact Changes and actions resulting from 'Breaking the Cycle'. Further

work will be undertaken to understand the specific areas where increased seven day working would impact on admissions and discharges in order to identify priority areas for action .An aligned plan will be presented the July BPEPB;

3. Developing and implementing quick wins
Develop a series of quick changes that will be implemented within the current financial year, based on the outputs of the above work.

3.4.5 Information and Communication:

Background
The Information and Communication workstream will develop and deliver high quality sources of information and advice based on individuals' needs as opposed to organisational boundaries. Part of 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 self-service opportunities. This work will require all of our organisations, and residents to think differently about how they pass on or receive information.

Next Steps
Scoping work to understand the synergies and differences across Cambridgeshire and Peterborough is underway. The next step is for a core group to scope the work in detail; this will be informed by conversations regarding the broader programme that have taken place to date. The scope will be presented to the BPEPB for consideration in July.

3.4.6 Ageing Healthily & Prevention:

Background
This project was envisaged as having a focus on the development of community based preventive services to support and enable older people in particular to enjoy long and healthy lives and feel safe within their communities. Three project proposals emerged from the first discussion. These were:

1. **Triggers and Pathways:** to jointly develop a recognised set of triggers of vulnerability which generate a planned response across the system;
2. **Planning for growth**: which would support the growing numbers of older people in future through a coordinated approach to primary prevention; and
3. **Strong and supportive communities**: linking to a number of existing initiatives across the system to ensure that people were linked in to appropriate support in their community wherever possible

Next Steps
Further work is required to define the scope of this project and the deliverables. It has been agreed that Public Health will lead this project across Cambridgeshire and Peterborough and a Project Sponsor from within Public Health has been nominated. Given the broad potential scope of the work, it has been agreed that an effective approach would be an overarching prevention framework with targeted projects and areas of delivery that sit underneath, focused around frailty and reducing avoidable admissions. This work will develop alongside existing initiatives that are already underway. Public Health have been tasked with developing a more detaied scope for presenation to the July BPEPB

3.4.7 Person Centred Care:

Background
This workstream 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.

Next steps

Following a workshop held on 05th May 2015 with a range of partners (including UC, CCG and the voluntary sector), further work is being undertaken in the following areas:

- **Integrated Neighbourhood Teams (MDTs):** Scoping activity is underway on a review of social care involvement in current MDTs and how this might feed into a new model;
- **Risk assessment tool:** Planning how UC's use of the Rockwood Frailty Score can be supplemented/ adapted for wider use (given the currently exclusive medical context) and how this would be implemented/delivered;
- **A 'Pre statutory assessment':** A process to promote health and wellbeing in older people.

4. CONSULTATION

4.1 As previously reported, in the developing and drafting of the BCF Plan there were detailed discussions and workshops with system partners. The purpose of these discussions and workshops was to create the vision, goal, objectives and scope of the Strategic level Plan for BCF and the specific delivery projects/schemes. The Board is asked to note the necessary balance between consultation and development of robust project scopes and the need for delivery in recognition that the BCF is currently time limited.

5. ANTICIPATED OUTCOMES

5.1 The Board:

- Notes the update on the Better Care Fund monitoring and non-elective admissions targets; and
- Comments on the development of the projects.

6. REASONS FOR RECOMMENDATIONS

6.1 To inform the delivery of the BCF Plan.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 Do nothing – this option is discounted as the Council would not be able to access the BCF.

8. IMPLICATIONS

Financial

8.1 Delivery assurance through the Board will enable the Council and the CCG to continue to meet NHS England's conditions for receiving £11.9m BCF.

8.2 The BCF funding is in-line with the Council's MTFS (Medium Term Financial Strategy).

9. BACKGROUND DOCUMENTS

i) Peterborough City Council's BCF Submission, January 2015
ii) Borderline & Peterborough Executive Partnership Board's Terms of Reference
iii) Section 75 Agreement, final version

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