NHS
Cumbria
Clinical Commissioning Group

| NHS Cumbria CCG Governing Body | Agenda Item |
|---|---|
| 17 April 2014 | 11 |

## Better Care Fund Plan

**Exec Summary/Purpose of report:**

The purpose of this report is to provide the Governing Body with an update on the Better Care Fund Plan which was submitted to NHS England and the Local Government Association on Friday 4th April 2014.

The Better Care Fund (BCF) is a single pooled budget, which begins in 2014/15, and is to be used to further encourage joint commissioning of integrated health and social care services. It brings together a portion of **existing** NHS and local government resources. In 2014/15 the fund in Cumbria amounts to £2.1m: this will rise to £40.183m in 2015/16.

The Cumbria plan has been developed by the BCF operational group made up of representatives of all partners. The work of this group is accountable to the CCG Governing Body and Cumbria County Council's Cabinet. The Health and Well Being Board were responsible for sign off prior to submission to confirm that the plan addressed the conditions of the fund and had been developed through a sensible, professional, process with appropriate engagement.

The plan describes the County Council and CCG's intention to manage integration in a way that delivers maximum benefits for the population while reducing the risk of destabilising the wider system. This will be the foundation for much more ambitious pooling of funds in the future.

In Cumbria the focus of the Better Care Fund plan will be to better utilise resources to deliver earlier identification, prevention and support services for frail elderly people, thus maximising the use and impact of resources to reduce costly and unnecessary acute interventions

National requirements of the fund are to:

- Protect adult social care services – but locally determine how this investment is best used.
- Deliver 7 day services to support hospital discharge and prevent unnecessary admissions at weekends
- Ensure data sharing using the NHS number as the unique identifier

- Provide a joint approach to assessment and care planning to frail older people and ensure that integrated packages of care are supported by an accountable professional.

The BCF plan is only a part of the planning process for Cumbria. it should be considered as an integral part of the 2 and 5 year strategic plans that have been produced by the CCG and NHS provider organisations and is therefore an enabler to achieving the transformation programmes identified in Better Care Together in south Cumbria and the equivalent in north Cumbria.

**Actions required by members:**

1. Receive the Better Care Fund Plan and consider in relation to the two year and draft five year CCG strategic plan.

| | |
|---|---|
| **Management Sponsor** | Peter Rooney, Director Planning & Performance |
| **Clinical Sponsor** | Hugh Reeve, Clinical Chair |
| **Presented By** | Judith Whittam, Cumbria County Council |
| **Contact Details** | Peter.rooney@cumbriaccg.nhs.uk |

# Better Care Fund planning template – Part 1

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

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

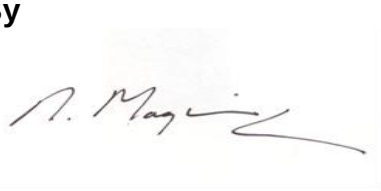
To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

## 1) PLAN DETAILS

### a) Summary of Plan

| | |
|---|---|
| **Local Authority** | Cumbria County Council |
| | |
| **Clinical Commissioning Groups** | NHS Cumbria Clinical Commissioning Group |
| | |
| **Boundary Differences** | The Cumbria Clinical Commissioning Group (CCG) and Cumbria County Council boundaries are co-terminus. The only exception to this is the area of Bentham in North Yorkshire which is part of Cumbria CCG but under the local authority jurisdiction of North Yorkshire County Council. |
| | |
| **Date agreed at Health and Well-Being Board:** | 24.1.14 |
| | |
| **Date submitted:** | 04.04.14 |
| | |
| **Minimum required value of BCF pooled budget:** | |
| **2014/15** | £2.1m |
| **2015/16** | £40.183m |
| | |
| **Total agreed value of pooled budget:** | |
| **2014/15** | £2.1m |
| **2015/16** | £40.183m |

## b) Authorisation and signoff

| Signed on behalf of the Clinical Commissioning Group | |
|---|---|
| **By**  | Nigel Maguire |
| **Position** | Chief Operating Officer |
| **Date** | 04.04.14 |

| Signed on behalf of Cumbria County Council | |
|---|---|
| **By**  | Richard Parry |
| **Position** | Director of Health and Care |
| **Date** | 04.04.14 |

| Signed on behalf of the Cumbria Health and Wellbeing Board | |
|---|---|
| **By Chair of Health and Wellbeing Board**  | Councillor Patricia Bell |
| **Date** | 04.04.14 |

## c) Service provider engagement

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

Extensive engagement has taken place with NHS providers through regular development sessions with the NHS Cumbria Clinical Commissioning Group and Cumbria County Council.

An engagement event has also taken place with NHS providers, the Cumbria Health and Wellbeing Board Chair, a representative from NHS England, the county council and the CCG to inform the final iteration of the Cumbria Better Care Fund plan.

A working group, including representation from District Councils, the third sector, and Healthwatch Cumbria, has been established to work with Cumbria County Council and NHS Cumbria CCG on a collaborative basis. This group includes two members of the Cumbria Health and Wellbeing Board.

The Cumbria Better Care Fund plan reflects Cumbria County Council's broad commissioning principles which have been developed through extensive engagement with social care providers. Cumbria County Council and NHS Cumbria CCG have engaged with provider organisations in developing the Better Care Fund.
This has been taken forward through the Cumbria Health and care Alliance, which is comprised of:

- Cumbria County Council: Chief Executive and Corporate Director, Health and Care.
- Cumbria Partnership NHS FT: Chief Executive and Medical Director.
- Healthwatch Cumbria: Chief Executive.
- NHS Cumbria CCG: Chief Officer and Clinical Chair.
- NHS England CNTW Area Team: Director and Medical Director.
- North Cumbria University Hospitals NHS Trust: Chief Executive and Medical Director.
- University Hospitals of Morecambe bay NHS Foundation Trust: Chief Executive and Medical Director.

The Cumbria Health and Care Alliance was instituted in Autumn 2013 to enable the whole system to address the following challenges:

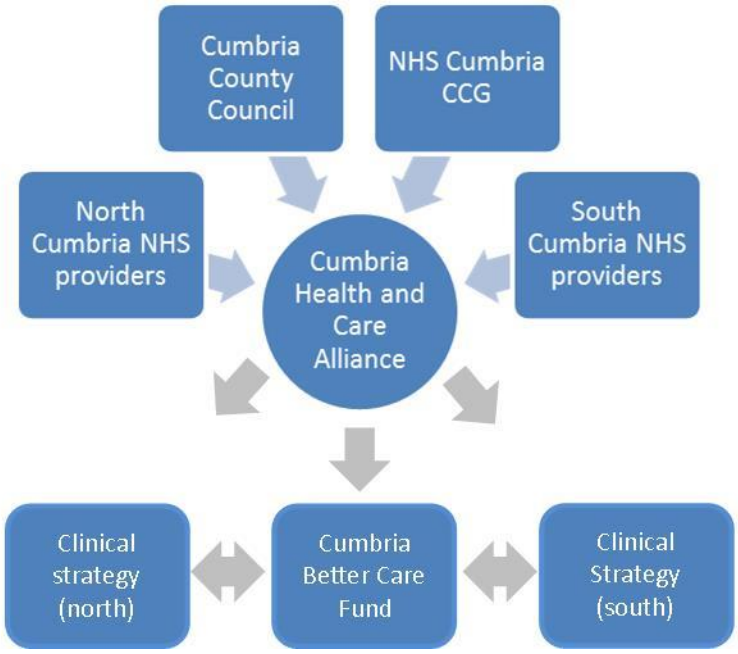
- The health system needs to improve across the three quality domains of
    - Patient safety
    - Patient experience
    - Clinical effectiveness

- The health system currently costs more money than it is allocated. Although the CCG itself will achieve financial balance in 2013/14, some of Cumbria's main providers have had to access external financial support, and will continue to need to do so in 2014/15. Cumbria needs to develop a clear plan to live within its means. This challenge is very much shared with the county council across social care.

- There has been a loss of public confidence, and a lack of clear engagement to enable the public to properly inform, and understand, the current service offer.

The Cumbria Better Care Fund planning has taken place in this broader context, and is entirely consistent with the collective aims of:

- An increased focus on supporting independent living and specialist support for self-management.
- Integrated services delivered to natural communities through a much expanded primary and community care service offer.
- Moving to sustainable bed-based services (hospitals and residential care).




**d) Patient, service user and public engagement**

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

**Health and care model principles**

The principles of community-based care were established through a public consultation undertaken by the NHS in Cumbria in 2008. This consultation, which was subject to gateway review and expert analysis by the University of Cumbria, involved widespread public and stakeholder involvement in the establishment of a strategic direction for health services based on the principle of care closer to home.

The next iterations of this strategic approach are being progressed through the development of refreshed clinical strategies for the University Hospitals of Morecambe Bay Hospitals NHS Foundation Trust (UHMBFT) area and the North Cumbria University Hospitals NHS Trust (NCUHT) area.

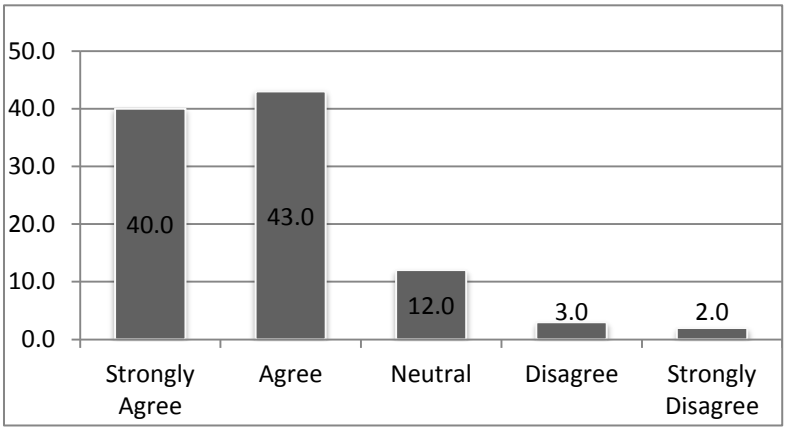
In the UHMBFT area, a major feature of this process has been large-scale public engagement undertaken in south Cumbria to support the development of a refreshed clinical strategy under the mantle 'Better Care Together.' A similar process will begin later this year (2014) in the NCUHT area. The focus of this engagement activity is across the whole health and care system, rather than the specific remit of the Better Care Fund. This is to enable consistent and coherent engagement - rather than specific engagement on individual programmes.

**Health and care integration principles**

In 2014, Cumbria County Council concluded its own consultation on the principles of greater integration between health and social care (and the themes outlined in the Cumbria Better Care Fund plan) as part of the organisation's 2014/15 budget consultation process. Members of the public, stakeholder and organisations were asked to state their level of agreement/disagreement for the use of NHS resources to enable closer integration between health and care services that support more people to remain independent for longer, reduce unnecessary hospital admissions and deliver better outcomes for patients and service users.

More than 1,500 responses were received during the consultation process. The quantitative results for the proposition of closer health and care integration are shown in figure 1 (below).

**Figure 1**




**Better Care Fund principles**

The NHS Cumbria Clinical Commissioning Group's commissioning priorities are reflected within the Cumbria Better Care Fund plan, and have in turn been influenced through patient and public locality engagement events.

For example, the development of the Copeland frail elderly project (referenced in section '2a' of this document) has involved workshops with the third sector, health and social care professionals, primary care, residential and nursing homes, patients and carers. A similar process will be replicated in other Cumbria localities.

The Third Sector in Cumbria has been engaged through the weekly Action for Health network bulletin, which is a Cumbria wide network of Voluntary and Community Sector organisations that work with adults and children on health, social care and engagement activities.

**e) Related documentation**

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

| Document or information title | Synopsis and links |
|---|---|
| Cumbria Joint Strategic Needs Assessment 2012-15 | A summary of the health and social care needs in Cumbria: http://www.cumbriaobservatory.org.uk/elibrary/Content/Internet/536/671/4674/5359/5360/4123412228.pdf |
| Cumbria Joint Health and Wellbeing Strategy 2012-15 | Strategy agreed by the Cumbria Health and Wellbeing Board: http://councilportal.cumbria.gov.uk/documents/s1000009397/Master%20Final%20Draft%20HWB%20Strategy%2016th%20Oct%202012.pdf |
| NHS Cumbria Clinical Commissioning Strategic & Operational commissioning plan | NHS Cumbria Clinical Commissioning Group Governing Body meeting paper: http://www.cumbriaccg.nhs.uk/about-us/key-policies/cumbria-ccg-strategic-commissioning-plan.pdf |
| Growing Older in Cumbria | Cumbria Public Health lifecycle report: http://www.nwpho.org.uk/cumbria/GROWING%20OLDER%20IN%20CUMBRIA%20SUMMARY.pdf |
| Working together to Improve Life with Dementia in Cumbria | Cumbria Dementia Strategy: http://www.cumbria.gov.uk/elibrary/Content/Internet/327/6548/40704155936.pdf |
| Cumbria Commissioning Strategy for Older people and their Carers 2010-2019 – Cumbria County Council | Cumbria County Council commissioning strategy for older people and their carers: http://www.cumbria.gov.uk/elibrary/Content/Internet/327/6548/39505113242.pdf |
| Cumbria County Council budget consultation | Cumbria County Council budget consultation document: http://www.cumbria.gov.uk/elibrary/Content/Internet/536/652/41564103228.pdf<br><br>Consultation feedback report: http://councilportal.cumbria.gov.uk/documents/s25855/Appendix%20D%20-%20Summary%20of%20Consultation%20Responses.pdf |
| Council Plan | The county council's strategic priorities document for 2014/17: http://www.cumbria.gov.uk/elibrary/Content/Internet/536/41718123513.pdf |
| NHS Cumbria closer to home consultation | NHS Cumbria clinical strategy consultation document: http://www.cumbria.nhs.uk/YourLocality/consultationdocument.pdf |

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| | University of Cumbria consultation analysis: http://www.cumbria.nhs.uk/YourLocality/finalc2hreport.pdf |

# 2) VISION AND SCHEMES

### a) Vision for health and care services

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

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

**Outline vision**

We want to co-produce, with citizens and our partners, a system in Cumbria that delivers world-class outcomes and experiences of care for individuals and communities. We want people to experience on a daily basis the narrative developed by National Voices, in association with Making it Real.

*'I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.'*

We want to put people at the centre of their care and support them to make decisions that are right for them and their individuals care needs.

**Population context**

The Cumbria Better Care Fund is a staging post on the health and care system's journey to deliver this vision for the county's population with an initial emphasis on Cumbria's ageing population and the needs of frail elderly people.

We have the oldest population in the North West and the number of people in Cumbria aged over-85 is set to double in the next 20 years. This ageing population will bring large increases in the numbers of people with long term conditions. Long term conditions (LTCs) currently account for 70 per cent of health and social care spend, and this proportion is increasing.

The frailest people within our population need particular support, and it is this group that utilise a significant proportion of health and social care resource – with 1 per cent of the population utilising approximately a quarter of our resources. Integrated care is essential to meet the needs of Cumbria's ageing population, transform the way that care is provided for people with long-term conditions and enable people with complex needs to live healthy, fulfilling and independent lives.

The ageing population and increased prevalence of chronic diseases require a strong re-orientation towards, prevention, self-care, more 'up-stream' aspects of primary care, and care that is well coordinated and integrated.

This is a message recognised by the health and care system in Cumbria, which is seeking through different means to bring about a significant shift in the balance of where care is provided.

**Organisational context**

The partner organisations in the Cumbria health and care system are all committed to delivering genuine transformational change. This will be predicated on placing the patient or service user at the centre and organising care around the needs of the users rather than the needs of the professionals.

This commitment presents a major challenge to organisational and professional sovereignty. In this context, the Better Care Fund will be used as catalyst to take forward positive change with greater urgency and scale over the next five years – with an initial focus on the care of frail elderly people.

Numerous reports have pointed to the need for significant improvements in care to frail older people that is better coordinated, of higher quality, and assures dignity and compassion.The current lack of joined-up care has been described as a huge frustration for patients, service users and carers.

There is recognition, across the health and care spectrum, that reform is needed to forge greater links with the third sector and housing; develop capacity in primary and community care; prioritise investment in social care to support rehabilitation and reablement; and, in doing so, enable acute hospitals to deliver improved services to the general population in areas including elective activity – thereby supporting the clinical and financial sustainability of our hospitals.

Cumbria has embraced this approach previously in its development of community-based health and social care teams, hospital-at-home services and other approaches that deliver measurable outcomes for patients, service users and carers.

In line with reductions in avoidable acute hospital admissions in Cumbria, this community-based approach has led also to a measurable decline in the proportion of people aged-65 and over in the county who require residential and nursing care.

Ensuring this approach delivers to scale and keeps pace with the county's ageing population is the challenge now before Cumbria health and social care system.

In order to meet this challenge, Cumbria's health and care partners want to develop an integrated frail elderly prevention model which will provide improved quality of life for older people through the provision of services tailored to meet individual needs and delivered in the most appropriate setting.

Achieving this outcome will see the use of the Cumbria Better Care Fund as a catalyst for the development of new system based on prevention and early intervention; joined-up reablement and rehabilitation across health and care; evidence-based identification of individuals at risk of crisis; personalised care planning; and seven-day working arrangements.

Such an approach has been identified as a strategic priority within the county council's Council Plan and is fully aligned to - and shaped by - the CCG strategic vision and commissioning strategy.

Discussions are taking place with health and care colleagues in North Yorkshire to ensure seamless delivery of the Cumbria Better Care Fund plan in conjunction for the Bentham area which is represented by the Cumbria CCG.

**Better Care Fund population**

The combined model provided through RAIDR has been used as the risk-stratification tool to identify the Better Care Fund population. The tool has a level of functionality that allows practitioners to identify those people with high-risk scores. This has led to the identification of approximately 5 per cent of the population as predominantly frail elderly people based on two or more of the following components:

- Adults living in residential or nursing homes
- Adults over 75 years
- Adults at a palliative stage using prognostic indicators or the 'the surprise question'
- People at risk of hospitalisation, defined and targeted within the local implementation of the 'Risk Profiling and Care Management' DES
- Adults with diagnosis of dementia
- Adults with long-term or complex conditions that are known and have an impact on daily living
- Adults who are housebound

For Cumbria this extrapolates to a total population of circa 25,000 frail elderly people (excluding those people who are not frail elderly but who are identified through this identification method and whose needs are met through existing models of service).

A frailty tool will be used to further stratify this population into levels of frailty. In Cumbria's Copeland locality this process is currently being piloted, using the Edmonton frailty score. This is based on active case management (as opposed to those patients for whom ongoing general practice support and management is appropriate) and a local multi-disciplinary team approach.

There is a nominated care coordinator attached to each GP practice in Copeland whose role is to provide a single point of contact for frail elderly patients (see figure 3).

A similar model is being piloted in the Allerdale locality but with a particular emphasis on the connectivity between social, primary, community and secondary care in order to effectively prevent avoidable admissions, delayed transfers of care, and deliver reduced length of stay.

In the South Lakeland locality, there are number of initiatives in South Lakes which are demonstrating capability to deliver key operational and strategic benefits. These have been captured in a benefits map and this in turns leads to the frail elderly vision for the locality. The current initiatives offered within South Lakes Locality are summarised in figure 3.

**Figure 2 – Copeland frail elderly pathway**

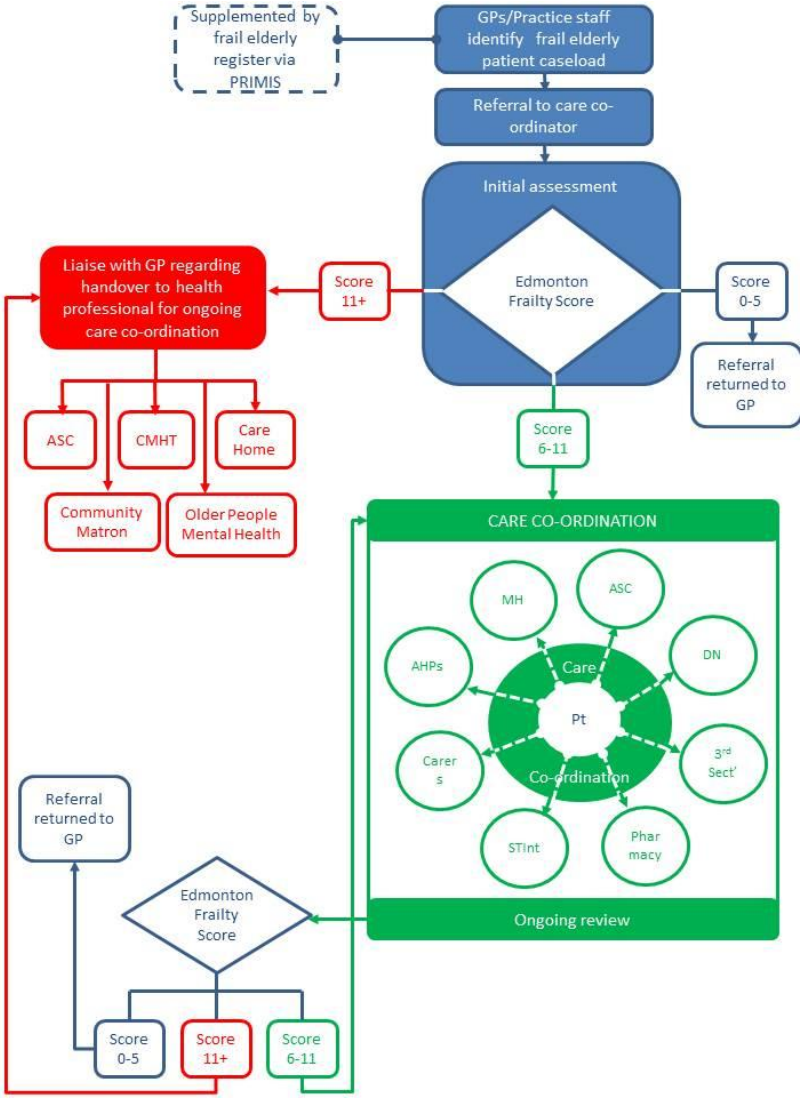
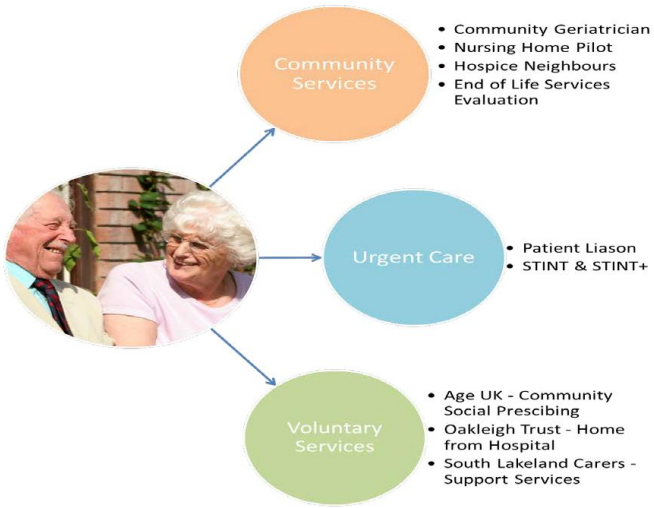



**Figure 3 – South Lakeland**



**Better Care Fund delivery systems**

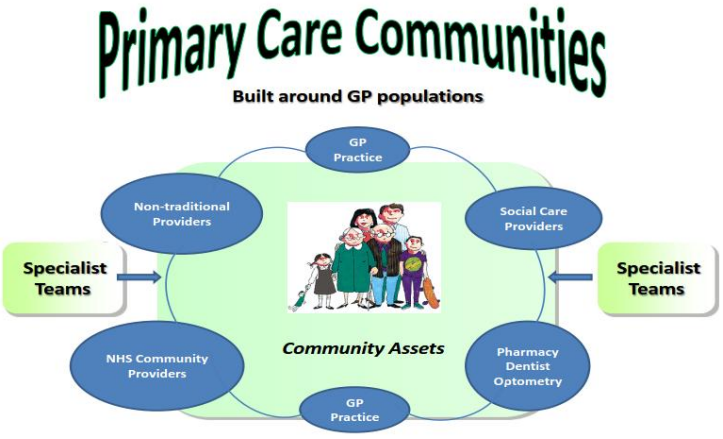
To support this approach, four interconnected systems will be deployed alongside risk stratification:

***Early intervention*** **-** We will support more people to retain their independence and control over their lives.

This will be achieved through robust and innovative partnerships with the third-sector, housing and other groups. Over the next five years, there will be a programme of regular review to ensure these approaches have a clear evidence-base and deliver measurable outcomes. Individuals will have their independence, safety and wellbeing maximised through integrated rehabilitation and reablement services, and access to assistive technologies, equipment and housing adaptations, and carers' support.

***Common Platform*** **-** A 'common platform' will be developed in Cumbria to support GP practices, Primary Care Communities (health, social care and the third sector) and specialist teams (figure 4). It will deliver integration through the development of common pathways and eliminating duplication of care. In doing so, It will positively impact on all aspects of the health and social care system, changing the experience of everyone who comes into contact with our services.

**Figure 4**




***Case management – 'Year of Care'*** – Case management will be systematically applied, using the Year of Care approach, to deliver personalised and effective support and interventions. The Year of Care model already used in Cumbria to support integrated diabetes care, will be applied to frail elderly people through the Better Care Fund plan and expanded over the next five year to other (non-age specific) long-term condition groups.

***The Community and Hospital Interface*** **-** Over the next five years, there will be a greater connection between specialists working in the community, secondary care professionals, and between physical and mental health services. As a result the Cumbria model will shift to enable: senior clinical assessment to admit, not an admission to assess; hospital in-reach by community based professionals; common protocols covering in and out of hospital care; and common information systems.

**Difference to People**

Through the initial implementation of the Cumbria Better Care Fund plan, this preventative model will provide greater quality of life for frail elderly people through the provision of services tailored to meet individual needs and delivered in the most appropriate setting, free up capacity within the wider system to support the general population, and support the long-term sustainability of general health and care services.

**b) Aims and objectives**

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

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

The Cumbria Better Care Fund plan will be used to deliver the following aims and objectives:

1. Embed access to advice, information and support at a community level through partnerships with the third-sector. This will ensure people are supported to maintain their independence and wellbeing at an early stage.

2. Shared policies and protocols will be developed with district councils and housing associations to make best use of available resources across the whole system, and improve access to housing adaptations and specialist housing.

3. Redesign pathways across health and social care to integrate reablement and rehabilitation services. This will enable more people to maximise their independence through therapy-led services. This will also ensure joined-up access to housing, the third sector, assistive technology and carers' support.

4. Integrate health and social care teams around Primary Care Communities. This will ensure a proactive approach to those individuals identified, through risk-stratification tools, as being at at most risk of crisis, residential, nursing or hospital admission.

5. Deliver 7-day access to health and social care services. This will be embedded within a single coordination centre that manages access to inpatient resources and facilitates robust discharges. This will support steps to reduce avoidable hospital admissions, length of stay and delayed discharges.

Seven associated performance measure will be used to monitor these aims and objectives:

1. A slowing in growth of activity levels (against national trend) for inappropriate hospital admissions.
2. Reducing permanent admissions to residential and nursing care.
3. Improving Quality of Life indicators for service users and carers.
4. Reducing delayed transfers of care.
5. Improving the effectiveness of reablement/rehabilitation services (indicators to be developed as part of service planning).
6. Increase the proportion of deaths at place of choice (in the interim as a proxy measure.
7. Increase in the use of personal budgets (social care).

These measures will be used to gauge success in the short, medium and long-term as we move from a disjointed to an integrated health and care system.

- Short-term measures (6-12 months)
- Mid-term measures (12-24 months)
- Long-term measures (24 months onwards)

**c) Description of planned changes**

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

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

The development of this activity is aligned with CCG commissioning priorities and Cumbria County Council's strategic planning priorities - both of which are based upon the Cumbria Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

In addition, Cumbria County Council is engaged with Association of Directors of Adult Social Services (ADASS) with regard to increasing demand for social care assessments as a consequence of the Care Bill and associated funding reforms. This work will inform capacity planning related to both demography and implications from the Care Bill.

| Planned Change | How | Matrix outcome result | Links to | Date by |
|---|---|---|---|---|
| | | | | |
| Adoption of the NHS Number and roll out of STRATA | Data sharing agreements,<br>STRATA referral extension<br>Roll out of additional functions of STRATA | Reduced DToC's | Ongoing data work stream Better Care Together | 2014/15 |
| | | | | |

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| Deliver 7-day access to health and social care services | 7 day services to support pathway redesign for hospital discharge/ admission<br>iSPA/CCC<br>Improved GP access<br>Improved pharmacy delivery<br>Integrated emergency floor<br>Integrated rehab delivery | A slowing in growth of activity levels (against national trend) for inappropriate hospital admissions<br><br>Reduce DToCs | Better Care Together<br>Closer to Home | 2014/15 |
| Shared policies and protocols with district councils and housing association to improve access to housing adaptation and specialist housing | Sustainable model for the delivery of Housing adaptations<br>Access to specialist Housing<br>Introduce Housing Case worker | Reduced admissions to res/nursing homes | | 2014/15 |
| Redesign pathways across health and social care to integrate reablement and rehabilitation services | Implement the reablement review | Improved independence through the use of intermediate Care<br><br>QoL increased | Council Plan<br>Better care Together<br>Closer to home | 2014/15 |
| Develop pathways with NWAS and GP out of hours to share contingency plans | Extend ongoing work with NWAS and CHOC across all the County | A slowing in growth of activity levels (against national trend) for inappropriate hospital admissions | Better care Together<br>Closer to home | 2014/15 |
| Implement a pooled fund for community equipment across Health and Social Care | | A slowing in growth of activity levels (against national trend) for inappropriate hospital admissions<br><br>Reduce DToCs<br><br>QoL increased | | 2015/16 |
| | | | | |

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| Maintain the level and quality of mental health services | REISHES work<br>Introduction of SPA for MH<br>Link work to MH liaison<br>Psychiatric liaison services<br>Management of substance misuse in A&E<br>Ongoing work on Dementia | A slowing in growth of activity levels (against national trend) for inappropriate hospital admissions<br><br>Reduced DToC | | 2014/15 |
| Explore the implications of expanding the existing<br>LD pooled fund arrangement to include<br>mental health under a pooled fund arrangement | Closer working with CCG commissioning<br>Alignment of the specialised Commissioning and CCG commissioning teams | | Council Plan | Explore in 2014/15<br>Beginning 2015/16<br>Full arrangements by 2016/17 |
| For frail elderly and individuals with long term conditions, we will integrate health and social care teams around Primary Care communities | Alignment to Primary Care communities<br>I.<br>Continued use of the established risk stratification tool<br><br>Cross referencing by use of the NHS number with ASC<br><br>Accountable lead professional identified<br><br>Development of Coordinators | A slowing in growth of activity levels (against national trend) for inappropriate hospital admissions<br><br>Reduced permanent admissions to residential/nursing homes<br><br>Reduced delayed transfers of care | Better care Together<br>Closer to Home | 2015/16 |
| Managing the reduction children's admissions by working with all partners | Pathways for asthma, diabetes and epilepsy | A slowing in growth of activity levels (against national trend) for inappropriate hospital admissions | Council plan<br><br>Better care together<br><br>Closer to home | 2015/16 |
| Extending commissioning, procurement and quality assurance activity (across health and social care) to residential and nursing home provision | | A slowing in growth of activity levels (against national trend) for inappropriate hospital admissions | | 2015/16 |
| | | | | |

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|---|---|---|---|---|
| Development of services to delay the need for residential or nursing home placements and support to prevent unnecessary hospital admissions for residential and nursing homes | Enhancement of continence advice and support to residential and nursing home placement and community settings | A slowing in growth of activity levels (against national trend) for inappropriate hospital admissions<br><br>Reduced permanent admissions to residential/nursing homes | Better Care Together<br>Closer to Home<br>Council Plan | Explore 2014/15<br>Implement 2015/16 |
| Embed access to advice, information and support at a community level through partnerships with the third-sector | Early help and intervention.<br>Carer services.<br><br>Information and advice. | | Council Plan | 2014/15 |
| Development of an aligned workforce | Aligned policies<br>Joint training<br>Clear accountabilities and roles<br>Combined workforce planning | | Council Plan | 2015/16 |

**d) Implications for the acute sector**

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

Although the CCG itself will achieve financial balance in 2013/14, some of Cumbria's NHS providers have had to access external financial support, and will continue to need to do so in 2014/15.

Plans will be developed across the whole system which capitalise on the new models of care described elsewhere in the document to enable acute service reorientation and more efficient use of resources to achieve improved outcomes.

Each NHS Trust, and the CCG, is required by each of the relevant national organisations to produce a two year operational plan, and a five year strategic plan. The timescales are:

- 4 April 2014: Submission of final 2 year plans and draft 5 year
- 20 June 2014: Submission of final 5 year plans

The Cumbria Better Care Fund plan fully reflects these integrated plans.

The CCG draft two and five year plans shows a slowing in growth in activity levels (approximately 1 per cent each year) for inappropriate hospital admissions (against national trend) to 2016/17, and a gradual decline from 2017/18.

The effective implementation of the Better Care Fund plan will support this trajectory and enable the freeing up of additional capacity within acute services to better realign secondary care's ability to deliver acute care more appropriately, including the repatriation of out-of-county elective activity closer to home.

CQUIN will be used in line with the CCG commissioning and contracting arrangements to support the delivery of the Better Care Fund Plan outcomes for patients and service users.

**e) Governance**

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

In south Cumbria, the clinical strategy review programme board (Better Care Together) is working with partners covered by the University Hospitals of Morecambe Bay (UHMBFT) area.

This programme board has partners from all statutory organisations, including those from north Lancashire. The formal governance arrangements are through a well-defined project management structure overseen by the programme board. Senior representatives from partner organisations make up the programme board's membership. Reporting to the programme board is a number of sub-groups and working-groups that include partners from Cumbria Healthwatch, user groups and third sector representatives. The Cumbria Better Care Fund plan is fully reflected in this work.

In north Cumbria, a similar structure is in place to support the clinical strategy review for the North Cumbria University Hospitals NHS Trust (NCUHT) area. As in the south, the Cumbria Better Care Fund plan is fully reflected in the north Cumbria programme board's work.

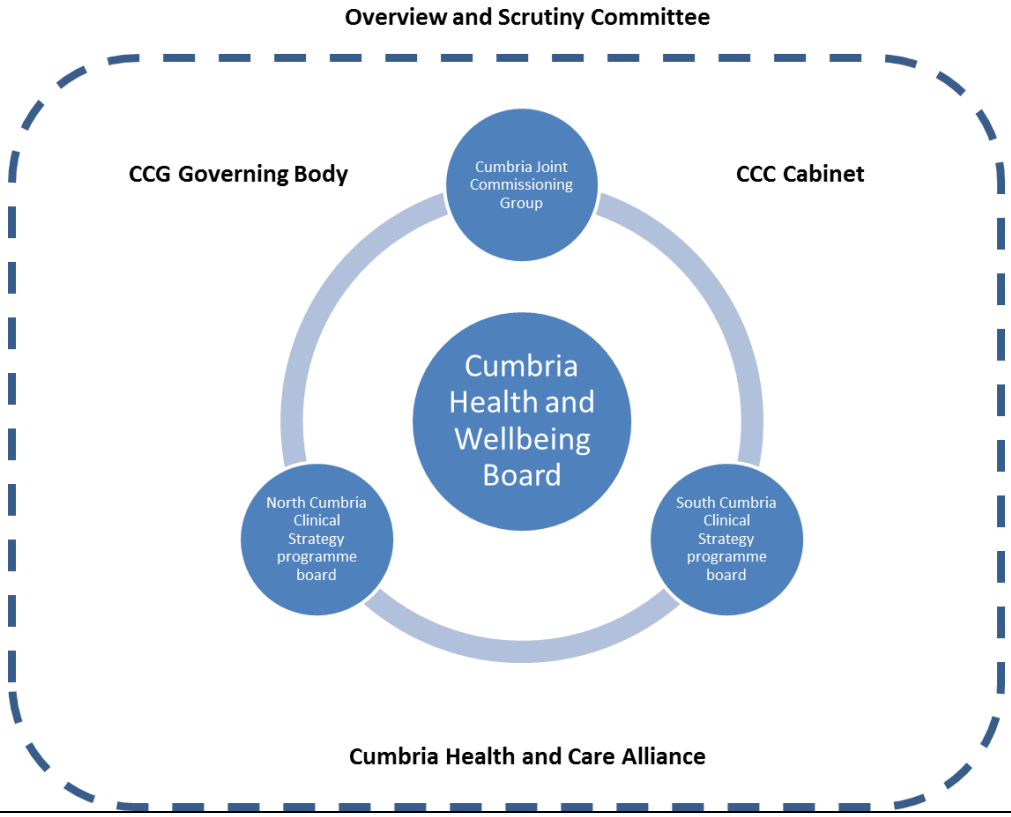
Both programme boards are working as part of the Cumbria Health and Care Alliance. Specifically for the Cumbria Better Care Fund, an operational group consisting of all partners is in place and meets on a monthly basis. This is jointly chaired by representatives who are also members of the north and south clinical strategy review programme boards.

The work of this operational group is supported by the Cumbria Health and Wellbeing Board, and accountable to the CCG Governing Body and Cumbria County Council's Cabinet.

The Cumbria Joint Commissioning Group will take forward performance management of the plan within the governance structures summarised in the diagram below (figure 5).

These will be aligned to, and implemented through, the NCUHT area and UHMBFT area clinical strategy working-groups and sub-groups as both processes progress.

**Figure 5**




# 3) NATIONAL CONDITIONS

### a) Protecting social care services

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

Social Care has a number of statutory duties including undertaking statutory assessment if needed and meeting eligible needs in a person centred way. This will be achieved through ensuring that workforce skills and capacity are maintained to meet demand for statutory assessments of need. For people who do not meet eligible needs criteria, we will ensure investment in a range of community asset-based models of support to reduce escalating need. This includes the existing Neighbourhood Care Independence programme – a jointly commissioned health and care service which utilities the assets of the third sector and community volunteers to support adults to remain independent.

The existing eligibility criteria for social care will be maintained. For people with eligible needs, we will promote independence, safety and wellbeing through the delivery of rehabilitation and reablement services to minimise demand for formally arranged services.

For people with on-going, eligible needs, we will ensure that a range of support services are available that support choice and control, and deliver quality outcomes: this will include access to equipment, adaptations, practical support in the home, extra-care housing, residential and nursing care placements.

Support for self-funding social care users will continue to be provided through the county council's Paying for Care service, (www.payingforcare.org), the Cumbria Support Directory (www.cumbriasupportdirectory.org.uk) and requirements set out in the Care Bill.

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

The focus of the Cumbria Better Care Fund plan (with individuals and communities) is to better utilise resources to deliver earlier identification, prevention and support services for frail elderly people, thus maximising the use and impact of resources to reduce costly and unnecessary acute interventions.

The plan looks to provide integrated solutions to address cost pressures in order that resources can be directed to where they will provide maximum benefit and impact.

Social care provision will be protected by understanding the value of these services along with integrated delivery and commissioning focusing on outcomes through pooled resources and a reduction in the duplication of effort

In addition, the county council's budget savings process for 2014/17 will see the protection and modernisation of front-line services supported through efficiency savings in management, commissioning and procurement, and business support services.

We will develop awareness across organisations of statutory duties through the pooling of resources and the investment and promotion of services to reduce the level of need; including rehabilitation and reablement, assistive technology and home adaptations to promote safety and independence.

Regardless of organisational boundaries the workforce will be supported to gain the necessary skills to: work in a more integrated way, avoid duplication and have sufficient capacity, the right knowledge skills and competencies to deliver choice and good outcomes.

The health and social care workforce will be developed and managed across the whole system. This change in emphasis will be supported through the newly formed Cumbria Learning and Improvement Collaborative (an initiative that brings together the education, training, development and improvement work across health and care in Cumbria).

A cross-organisational workforce plan will be developed, commencing with aligned policies and procedures, an analysis of required skills and competencies and a whole systems delivery plan.

At present a range of frontline health and care professionals are involved in various work-streams in order to ensure frontline involvement in developing these new models.

### b) 7 day services to support discharge

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

Delivery of 7-day access to health and social care services will work to avoid inappropriate admissions to A&E services and facilitate timely discharges, through developing an increase in flexibility across GPs, community providers and assessment functions 7 days per week. These newly configured services will ensure appropriate community services are available to reduce the demand on the acute sector.

The objectives of these changes are:

- A slowing in growth of activity levels (against national trend) for inappropriate hospital admissions.
- Reduction in delayed transfers of care.
- Reduction in admissions to long term care.
- Care at the right time and the right place.
- Reduction in the number of people attending A&E services inappropriately.
- Reduced length of stay

People will be able to be discharged from hospital at the weekend through the availability of staff able to medically approve, plan discharge and link-up with a suitable provider in a timely way if they have on-going care needs. Patient transport systems will be play an important role in the delivery of this programme.

Strategic commitment to this approach is evidenced through the Cumbria Health and Wellbeing Board's authorisation of the Cumbria Better Care Fund plan, the commissioning intentions of the CCG and Cumbria County Council, and NHS providers service planning.

Currently there is a range of operational options that are being trialled to ensure optimum 7-day working arrangements which will be subject to evaluation. These options include:

- An integrated single point of access for unscheduled care and hospital discharges
- Social worker presence in A&E units 7 days a week
- Improvement in pharmacy delivery in acute hospitals through 7-day pharmacy cover
- Access to Generic Domiciliary Care (GDC), reablement and rehabilitation 7 days a week
- Access to step up/step down beds in the system 7-days a week
- Introduction of integrated emergency floors at acute hospitals in Cumbria

**c) Data sharing**

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

| |
|---|
| The NHS Number is not currently used as the primary identifier for correspondence across all health and care services. |

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

| |
|---|
| Full implementation of the NHS Number is not currently used as the primary identifier for correspondence. This will be introduced across all health and care services and will be implemented during 2014/15.<br><br>Data sharing is considerably enhanced through the shared use of the STRATA system, which enables real time electronic referrals to be made across the NHS system, and into Adult Social Care. |

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

| |
|---|
| Yes |

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

| |
|---|
| Yes |

**d) Joint assessment and accountable lead professional**

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

As described in section '2 a' of this document, joint work is being undertaken to ensure a sustained and proactive approach underpinned by clear accountability arrangements

RAIDR (a dashboard analysis and reporting tool) is in place for all GP practices to assist in identifying the Better Care Fund population that needs a joint care plan and an accountable lead professional.

We will use this risk tool to enable cross reference through the NHS number into social care, allowing us to identify the population for joint assessment and care planning

All people who are identified as high risk of admission will have an agreed accountable lead professional.

The lead professional is defined as a qualified practitioner irrespective of their professional role, who has responsibility for co-ordinating care, keeping in touch with the service user, and ensuring their care plan is delivered and reviewed as required.

Again as described in section '2 a' of this document, an Integrated Care Planning Model (ICPM) is a delivery system for Cumbria's older people which takes account of optimising and maintaining an individual's overall wellbeing and, where necessary, health and social care input through six essential elements. The elements are as follows:

1. A systematic assessment of health and social care needs when required.

2. The appointment of a named lead professional.

3. Joint working with all organisations/agencies involved, where multidisciplinary groups with a single entry/contact point for agencies/ services will be the two focus points for delivery of joint working.

4. An agreed shared Care Plan, based on the joint working and based on a stepped level of care need 1-4.

5. The sharing of essential information between provider agencies.

Regular reviews to reconsider need and change plans as necessary.

# 4) RISKS

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

| Risk | Risk rating | Mitigating Actions |
|---|---|---|
| Efficiencies not delivered:<br><br>Performance related funding reliant on outcomes that may not be evidenced in the short to medium term | HIGH impact<br>MEDIUM likelihood | Close monitoring and evaluation of the programme through governance arrangements via the BCF Board and regular updates to the Health and Wellbeing Board, CCG board and Cabinet.<br><br>Monitoring will ensure that services/projects within the programme are fit for purpose and meeting expected outcomes within timescales.<br><br>Services to be procured on an outcomes basis with funding linked to outcomes therefore a shared risk between commissioners and providers |
| The health and care system is unable to deliver managed transformation | HIGH impact<br>MEDIUM likelihood | Early and continued engagement with Acute Trusts through system-wide re-design. Work programmes agreed in partnership at a senior level |
| Individual and organisational behaviours slow to change leading to an inability to ensure appropriate skills within the system-wide workforce. Specific Recruitment and retention issues in some areas. | HIGH impact<br>HIGH likelihood | Establishment of Cumbria Learning and Improving Network; continued involvement with Care Sector Improvement Alliance; and a system-wide recruitment and retention approach.<br><br>Development of a new workforce model as an immediate priority.<br><br>Use of agency staff to bridge gaps.<br><br>Phase delivery to accommodate extended recruitment timescales<br><br>All staff to receive regular newsletters/updates on progress and next steps. Clear and simple messages without jargon. |

| Risk | Risk rating | Mitigating Actions |
|---|---|---|
| | | All staff will be trained on detail and change of practice resulting from BCF programme and Care Bill.<br><br>Policy and procedural updates to support new practice |
| Insufficient leadership and/or operational capacity to deliver this major transformation change programme | HIGH impact<br>MEDIUM likelihood | Strong governance arrangement and the ability of partners to challenge one another constructively, honestly and openly<br><br>Provide programme/project management capacity, including backfilling for operational staff as required. |
| Insufficient engagement with patients, service users and the public, so future services do not meet the needs of the local community | HIGH impact<br>MEDIUM likelihood | Ensure sufficient capacity and expertise is made available to deliver a comprehensive communication and engagement plan |
| Scheduling of change is complex with risk of potential gaps if traditional services are reoriented before new capacity is in place | HIGH impact<br>MEDIUM likelihood | Transition planning and co-design critical. Close project management and pre-planned schedules to underpin plan |
| Provider market in health and social care is insufficiently developed to support the future services required in the community | MEDIUM impact<br>MEDIUM likelihood | Develop market management strategy to support the local joint work programmes across Cumbria |
| Organisations (all) are unable to change relationships, culture and behaviours | HIGH impact<br>MEDIUM likelihood | Strong leadership from the Cumbria BCF Board. Programme of change management interventions to support service transformation |
| As yet unknown impacts of care Bill | HIGH impact<br>MEDIUM likelihood | Robust preparation - Modelling of processes and finances to support implementation of Care Bill.<br><br>Use emerging national guidance, check list and tools to support preparation. |