Public Document Pack

Cambridge City Council

CAMBRIDGE LOCAL HEALTH PARTNERSHIP

Date: Thursday, 27 March 2014
Time: 1.00 pm
Venue: Committee Room 1 - Guildhall
Contact: Graham Saint **Direct Dial:** 01223 457013

AGENDA

1 APOLOGIES

2 DECLARATIONS OF INTEREST

3 PUBLIC QUESTIONS

This is an opportunity for members of the public to ask a question or make a statement to the Partnership. Please refer to the Public Participation section at the end of this agenda.

4 MINUTES AND MATTERS ARISING *(Pages 7 - 12)*

To approve the minutes of the meeting held on 30th January 2014

5 PRESENTATION ABOUT CAMBS HOME IMPROVEMENT AGENCY *(Pages 13 - 16)*

Pat Strachan, manager of the Cambs Home Improvement Agency, will talk about the work of the agency and how closer working with partners in the future could lead to better health outcomes for service clients. The Home Improvement Agency helps vulnerable people in Cambridge, South Cambridgeshire and Huntingdonshire with home repairs and improvements. A paper outlining the work of the Agency is attached.

6 UPDATE FROM THE HEALTH AND WELLBEING BOARD (HWB)

The Partnership's representative on the Board, Cllr. Sarah Brown, will provide an outline of the issues discussed at the HWB meeting on the 13 February 2014 and a forward look to the next meeting on 3 April 2014.

Details of HWB meetings can be found here: http://www.cambridgeshire.gov.uk/CMSWebsite/Apps/Committees/Committee.aspx?committeeID=70

7 PROGRESS WITH A BETTER CARE PLAN FOR CAMBRIDGESHIRE *(Pages 17 - 34)*

Antoinette Jackson, Chief Executive of Cambridge City Council and district lead for the district BCF group, will give an overview of the "First Cut BCF Plan" for Cambridgeshire and how it is being developed into a more detailed plan, which will need to be submitted by 4 April.
A paper summarising the proposals is attached.

8 PROPOSALS TO IMPROVE OLDER PEOPLE'S HEALTH AND ADULT COMMUNITY SERVICES

A representative from Cambridge and Peterborough Clinical Commissioning Group (CCG) will discuss proposals for improving older people's health care and adult community services within its catchment area. Initial proposals have been put been put forward from a number of organisations and feedback on these is sought in a consultation document launched on 17 March, which will run until 16 June 2014. The full consultation document can be found here:
http://www.cambridgeshireandpeterboroughccg.nhs.uk/have-your-say/older-people-and-adult-community-services.htm

9 SUGGESTED DATES FOR FUTURE MEETINGS

17th July 2014
23rd October 2014
29th January 2015

Information for the Public

Location

The meeting is in the Guildhall on the Market Square (CB2 3QJ).

Between 9 a.m. and 5 p.m. the building is accessible via Peas Hill, Guildhall Street and the Market Square entrances.

After 5 p.m. access is via the Peas Hill entrance.

All the meeting rooms (Committee Room 1, Committee 2 and the Council Chamber) are on the first floor, and are accessible via lifts or stairs.

Public Participation

Some meetings may have parts that will be closed to the public, but the reasons for excluding the press and public will be given.

Most meetings have an opportunity for members of the public to ask questions or make statements.

To ask a question or make a statement please notify the Committee Manager (details listed on the front of the agenda) prior to the deadline.

- For questions and/or statements regarding items on the published agenda, the deadline is the start of the meeting.

- For questions and/or statements regarding items NOT on the published agenda, the deadline is 10 a.m. the day before the meeting.

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meeting can be found at;

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http://democracy.cambridge.gov.uk/ecSDDisplay.aspx?NAME=SD1057&ID=1057&RPID=42096147&sch=doc&cat=13203&path=13020%2c13203

Fire Alarm

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Facilities for disabled people

Level access to the Guildhall is via Peas Hill.

A loop system is available in Committee Room 1, Committee Room 2 and the Council Chamber.

Accessible toilets are available on the ground and first floor.

Meeting papers are available in large print and other formats on request prior to the meeting.

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CAMBRIDGE LOCAL HEALTH PARTNERSHIP 30 January 2014
12.00 - 1.22 pm

Present:
Councillor Sarah Brown: Executive Councillor for Community Wellbeing, Cambridge City Council;
Councillor Catherine Smart: Executive Councillor for Housing, Cambridge City Council;
Mark Freeman: Cambridge Council for Voluntary Services;
Mike Hay: Cambridgeshire County Council, Adult Social Care;
County Councillor Joan Whitehead;
Dr Liz Robin: Director of Public Health, Cambridgeshire County Council;
Elisabeth Locke, HealthWatch Cambridgeshire;
Graham Saint: Strategy Officer, Cambridge City Council;
Jas Lally: Head of Refuse and Environment, Cambridge City Council;
Kate Parker: Cambridgeshire County Council, Public Health;
Rachel Talbot: Cambridge and District Citizens Advice Bureau
Tony Males: CATCH;
Toni Birkin: Committee Manager.

FOR THE INFORMATION OF THE COUNCIL

14/1/CLHP Apologies

Apologies were received from Antoinette Jackson, Rachel Harmer, Geraldine Linehan and Jez Reeve.

14/2/CLHP Public Questions

There were no public questions.

14/3/CLHP Minutes and Matters Arising

The minutes of the meeting of the 24th October 2013 were agreed as a correct record.

14/4/CLHP Presentation from Citizens Advice Bureau

The Partnership received a presentation from Rachel Talbot of the Cambridge and District Citizens Advice Bureau (CAB). Rachel was keen to promote closer

working between CAB and local GPs and referred to evidence that referrals from GPs to qualified advice givers both saved GP time and improved outcomes for individuals.

The presentation covered the following points:

i. There was a significant distinction between sign-posting, information giving and offering qualified advice. The advice could help resolve the problem.
ii. Debt and employment issues often caused stress and lead to poor health.
iii. GPs were often treating the symptoms of stress and closer working with CAB could help reduce the causes of a patient's anxiety.
iv. Derby GPs were able to 'prescribe' advice and this could provide a role model for a local pilot.
v. Debt related issues remained the top issues that the CAB was asked to assist with.
vi. The CAB was looking to map of advice services in Cambridge to help clarify how different providers could work together.

The Partnership made the following comments in response to the presentation:

i. A large number of people could improve the quality of their lives by claiming the benefits they were entitled to.
ii. GPs would find it helpful to receive direction about good practice in completing medical information to support benefit claims.
iii. The Care and Support Bill was expected to offer new guidance on mapping what advice services are provided in any given area.
iv. Changes to benefit claim forms, in particular those relating to children with disabilities, were noted as a problem.
v. It would be useful to develop a local map of advice services in partnership to avoid duplicating work.

Jas Lally suggested a workshop to consider the following two issues:

Advice service mapping.

How to add clarity to the definitions of Information Services, Signposting, Advice and Advocacy.

Exploring how the Cambridge CAB could work more closely with local GPs.

This would be followed by a cascading of the lessons learnt, and if requires a follow up session between GP's and the CAB.

Action: Jas Lally to arrange workshop/s

14/5/CLHP Update from the Health and Wellbeing Board

The Executive Councillor for Community Wellbeing updated the partnership on the recent Health and Wellbeing Board. The partnership noted the key issues from the meeting as follows:

i. The continued failure to recognise the population growth of Cambridge and Cambridgeshire and the pressure this placed on health and social care services. This lead to an inequality with other parts of the country who were receiving more resources per person.
ii. Primary care issues, in particular, increased pressure for GP service to be available for longer.
iii. Better Care Funding and its associated focus on prevention and keeping people away from acute and adult care services.

The Partnership agreed that a coordinated approach to lobbying central government, involving NHS England, City Councillors and County Councillors, was needed to address the financial inequalities noted above. Cambridge AHead, a new partnership involving the Universities and leading companies in Cambridge had offered its support.

14/6/CLHP Better Care Fund

In the absence of Simon Willson, Jas Lally gave the Partnership an oral update on the progress of outlining the use of the Better Care Fund (Integration Transformation Fund) taking into account the government's guidance. A considerable about of work had been done on this matter and 108 submissions had been received. Events were taking place which would capture ideas and help define proposals.

Timeframes were agreed to be tight as a follow up meeting of the Board to consider and evaluate initial proposals was planned for the 13th February 2014.

Liz Robins confirmed that funding conditions would include better information sharing and the need for improved access to GPs. She stated that a lot of work

was being done to pull out the key themes and to establishing a strategic overview.

Themes had been identified as:

Home;
Needing Help; and,
In Hospital.

The Partnership made the following comments:

i. Crisis management appeared to be assuming priority over preventative work, the fund should not be used to plug any short-term gaps caused by cuts in services but look to the longer-term.
ii. Barriers between agencies were being broken down in the process of preparing proposals.
iii. Work would continue after this initial outline stage, with the aim of being open and inclusive about the more detailed stage to follow.
iv. Concerns were raised that small independent service providers would not be aware that they needed to respond to the consultation and might find themselves without funding in the future because their work had not been recognised.

14/7/CLHP Progress on Outstanding Action from the Last Meeting

Action One: Liz Robin
Clarifications from Drug and Alcohol Service regarding selection of lead agency for individual client.

Liz Robin confirmed this matter had been followed up with the Drug and Alcohol Service. Their approach was to call a multi-agency meeting, often limited to one or two agencies, at which a lead agency was agreed according to the client's most pressing need. She confirmed that from April, the drug and alcohol services would be combined into a single agency.

The Partnership suggested the MEANS approach could be considered or something similar to ECINS.

The Partnership agreed that while appointing a lead agency for troubled families work was a good idea, it would be hard to establish a methodology to appoint that agency.

Graham Saint / Alan Carter
Investigate feasibility of workshop to discuss Health and Housing links.

Graham Saint reported that this suggestion had come out of a sub-regional event that some members had attended. It seemed, from discussions in the Partnership at this meeting that a smaller meeting between local housing leads and local GPs might help improve local links between housing and health.

Jas Lally agreed to arrange a meeting between local housing leads and local GPs to talk about improving local links between housing and health services.

Action: Jas Lally to arrange a meeting.

14/8/CLHP Date of Next Meeting

The partnership noted the later start time and the date of the next meeting as 1.00pm on 27th March 2014.

The meeting ended at 1.22 pm

CHAIR

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Cambridge Local Health Partnership **ITEM 5.**

27 March 2014

About Cambs Home Improvement Agency

When did we start?

Officially set up from April 2013, Cambs HIA brings together 3 Home Improvement Agencies- a partnership between South Cambridgeshire, City and Huntingdonshire councils.
Our main base is at South Cambridgeshire District Council offices in Cambourne. We have satellite bases at Hobson House in the City and Pathfinder House in Huntingdon.

What do we do?

We repair, improve and adapt homes to enable people to continue to live independently, working very closely with councils, their private sector housing grants programmes, county occupational therapists and a wide range of other organisations. We work with people of all ages-including disabled children, older people, those who are terminally ill and people who are living in poor housing conditions.

Awareness about Home Improvement Agencies is generally not well developed. We are hoping to do more to raise awareness about our work in the coming year. There is more information on our website www.cambshia.org and in our publications. Hard copies of these will be available at the CLHP meeting.

Do we work in all types of housing?

We currently work mainly with people who own or privately rent their homes. However, adaptations in most of the social housing in Huntingdonshire are done via Cambs HIA and we also do some work for other Registered Social landlords throughout our area. Adaptations in council owned homes in Cambridge City and South Cambs are undertaken by council's directly.

What have we delivered?

In 2012-13, we did 266 Disabled adaptations and 59 Repairs Assistance jobs.
75% of the disabled adaptation jobs we did were for access to suitable bathing facilities or to the upstairs of a person's home. The majority of our work is with older people. Typically, there are a smaller number of major works (e.g. extensions) and these are usually for disabled adults or children.
We undertook capital works totalling nearly £2.5M in 2013/14

In the current year, by 5 January we had completed 320 grant funded Disabled Adaptations and 60 Repairs Assistance jobs. Our total available capital budget for the year is £3.65M.

National & local picture

The demand for adaptations continues to rise due to longer life expectancy, medical advance. Plus more pre-term babies, children and people with long term conditions now living independently.
There is some research evidence and plenty of personal stories to evidence the benefits of improving housing conditions and doing disabled adaptations.
In Cambridgeshire, the number of older people is forecast to rise until steadily until 2021. Most are in good health but the number of frail older people is increasing.
Currently, people in Cambridgeshire typically wait around 14 weeks for an OT assessment. The process is bureaucratic, complex and does not evidence a person centred approach. Although some of this probably cannot be

avoided there is much more we can do to improve it (especially if there is Member support at County and district level and support from CCGs (Clinical Commissioning Groups).

A national review of DFGs (Disabled Facilities Grants) was shelved. However, there is widespread recognition that the current system needs fundamental review. The Local Government Network commissioned independent research by Astral Consulting that reported in June 2013. In summary the recommendations included:
(1) integrated delivery of DFG services (2) development of a local Adaptations Strategy (3) system shift towards helping people make their own choices (4) increase of funding from equity release and by registered social landlords (5) Investment by CCGs in revenue support for housing related preventative services including Handyperson schemes (NOTE: this has historically happens in Cambridgeshire & is due to be re-considered by the Health & Well-Being Board in April).

About Our Better Care Fund bid

The Cambs HIA bid is for "A suitable Home for Life" project. Proposing transformational change based on existing services.

- to proactively assist people to plan for and meet their need for safe, adapted, well maintained, warm and suitable housing (including access to a wide range of information support and services)
- to develop a much more strategic joined up, open and comprehensive approach to delivering suitable housing conditions in a shared way, including cost sharing.

Summary of key outcomes:

- Development of an approach that is focussed on the individual, personal choice and decision-making.
- Radical review of the adaptations process-quicker, more streamlined, more person centred, easier to understand
- Co-location of specialist housing OTs with the HIA (Home Improvement Agency)
- Pro-actively plan to deliver a county wide HIA operation (Cambridge City, South Cambs, Huntingdonshire, Fenland and East Cambridgeshire)
- Ensure close co-ordination between the HIA and county wide Handyperson/Healthy Homes schemes in future.
- Develop a comprehensive adaptations strategy
- Closer alignment of discretionary and top-up funding policies across statutory agencies
- Closer co-ordination of aids, equipment, telecare & medicare facilities and other additional complementary services identified
- Development of support and services for frailer older people
- The impact of a successful bid will depend on the commitment and level of active involvement of key partners

Other features:

- There is experience elsewhere in the country to draw own
- There is evidence of the benefits of our proposals, although more research is needed
- The project meets most of the BCF outcomes
- The project can be implemented quickly using an existing partnership accountability model (but expanded)

Three case studies

Disabled Facilities Grant for a child in Huntingdonshire.

Child W, aged 2, has a condition called Dandy Walker Malformation. He has significant global development delay and complex seizure activity. He lives with his parents in a privately owned 3 bedroomed terraced property.
An Occupational Therapy assessment determined that major adaptations were required to the property to provide a Through Floor Lift, changing bench, 4 hoists and building works to accommodate the lift and provide an en-suite bathroom.

The total costs were £38,000. An application for a maximum DFG was successful and the rest of the funding was sourced independently by the parents as loans from other family members.

Difficulties due to the construction of the property were identified (due to the load bearing required by the hoists). Cambs HIA employed a structural engineer to carry out a survey and make recommendations. Substantial pre-installation requirements were identified including coordination of 4 different contractors. The agency also sought to minimise disruption for the family and to keep costs down a second hand changing bench was sourced reducing the overall costs by almost £3,000.

Disabled Facilities Grant (with complications) for an older adult in Cambridge

Mr M, aged 71, lived in a 3 bedroomed house with his wife, 4 daughters and a son. Mr M suffered with severe cognitive impairment in addition to other health problems.

A feasibility study (Cambs HIA Surveyor and Occupational Therapist) was carried out identifying the need for a ground floor extension to provide a ground floor bedroom, and bathroom extension (for washing and sleeping facilities with carer assistance.

Plans were submitted and permission was received. However the plans had to be changed following an objection under the Party Wall Act by the immediate neighbour. Negotiation and amendment to the planning permission resolved this. Then the Surveyor had to liaise with Anglian Water to establish that the drainage to this property were not a Public Sewer

A start date for the work had to be cancelled when the client was admitted to intensive care and remained there for more than 6 weeks. Due to his illness Mr M's needs had changed and the Occupational Therapist was required to revisit her original assessment and make changes to accommodate these. The local authority was able to contribute discretionary funding as the total costs of work exceeded the maximum mandatory grant of £30,000

Repairs Assistance. Adult in South Cambs.

Miss R was referred to Cambs HIA by an advocate from Women's Aid. She lived in a pre-fabricated building. Miss R was on benefits and was struggling to meet the costs of her energy bills. The property was inadequately insulated and the heating was via a calor gas fired boiler that was more than 15 years old and kept cutting out. A surveyor visited the property to establish the work that should be prioritised, as the local authority could only provide a maximum grant of £5,000.

An agreement was reached with the client that a new oil fired combination boiler should be installed. The costs exceeded the maximum grant available so the CHIA Caseworker discussed this problem with the client and her mother. It was suggested that the costs could be reduced if the existing tank on the mother's property could be shared. An agreement was reached and signed to enable the works to be completed within the budget available.

How to contact us

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By: Pat Strachan
Date: 11 March 2014

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Cambridge Local Health Partnership ITEM 7

27 March 2014

Update on Better Care Fund Proposals

1 Introduction

1.1 This paper summarises the 100+ proposals received by the Better Care Fund during January 2014.

2 Categorisation of Proposals

2.1 We asked for proposals in January 2014. We received more than 100 proposals from the County Council, the CCG, district councils, service providers and the voluntary sector.

2.2 A team from the CCG and the County Council sorted the proposals into 14 themes. These themes have then been grouped into four areas:

Area	Themes
Support that is provided for people at home (i.e. primary prevention / tertiary prevention)	• Carers • Homes / healthy lifestyles / primary prevention • Isolation • Community medicine • End of life
Support that is provided when people need help (i.e. secondary prevention / crisis prevention)	• Secondary prevention • Chronic illness management • Dementia • Mental health / chaotic lives • Response to Care Bill • Crisis prevention / recovery • Multi-agency working
Support that is provided to help people when they are ready to leave hospital (i.e. discharge pathways)	• Discharge planning
Investment in infrastructure to support integration	• Capacity to work between organisations

2.3 Many of these proposals could fit into more than one category – the intention here is to group ideas that are most similar so their implications for commissioning under BCF can be considered together; not to provide a comprehensive or perfectly accurate categorisation.

2.4 The proposals are detailed in Appendix 1. Particularly large-scale proposals, in terms of client group numbers or amount of transformative change, have been marked with **.

3 Comments on Proposals

3.1 These proposals represent a broad scale of interventions in terms of the target group, some relate to a group of villages, some to districts, and some to the whole county. They also have a broad scope in terms of amount of change implied by the proposal – some are extensions of business-as-usual, e.g. establishing a brokerage unit for residential / nursing care placements, others are fundamental changes, e.g. commissioning a comprehensive and exhaustive carer support service. Most fall somewhere in the middle, and will imply different amounts of change depending how they are implemented.

3.2 Broadly speaking, the proposals have been grouped according to the focus of their impact. The proposals that provide support to people at home tend to be focused on primary prevention. As such, their impact on health and wellbeing and subsequent impact on demand for acute and social care services is likely to be felt in the longer-term. However, the impact of the support provided to people when they need help is likely to be felt more rapidly by the acute and social care services, as admission avoidance and intensive return-to-independence services could start diverting people away from acute or social care services as soon as they are operational (similarly with the hospital discharge proposals).

3.3 Some proposals can be 'traditionally' commissioned, in the sense that there is a clear target group and service area, a clear mandate for change, and (relatively) clear funding arrangements (e.g. carers' services, discharge support). However, many proposals in the second group, around multi-disciplinary working especially, do not have a well-defined and agreed target group, and services must be very flexible to have a positive aggregate impact (because the people the services will be supporting will have different and specific personal circumstances and issues).

3.4 A common risk stratification tool which triangulates between the main health and social care issues identified in the JSNA and the demographics and patterns in demand for acute and social care services would allow the development and commissioning of more generic services and an assessment of their impact. This would also avoid doing an explicit trade-off exercise between the different groups identified in the proposals (e.g. should funding support women who have experienced sexual violence or older people with cardiac health problems?).

4. The Proposals in Relation to the National Conditions

4.1 BCF work is also required to address national conditions. These are:

a) Plans to be jointly agreed – Plans are being discussed and developed by CCC and CCG, and will be subject to agreement by CCC, CCG governing bodies and the Health and Wellbeing Board.
b) Protection for social care services – No proposals currently suggest reducing social care services *per se*, although a number imply transformation so that services are focused on re-ablement / return to independence / avoidance of long-term admission. The definition of 'protecting social care services' should be locally agreed, which may require further discussion.
c) 7 day working – The proposals received so far suggest the development of 7 day services in rapid response intermediate care and discharge from hospital. This seems to meet the national requirement to 'support patients being discharged and prevent unnecessary admissions at weekends'.
d) Data sharing – work is progressing on using NHS number as part of business-as-usual, and understanding plans for open APIs and appropriate Information Governance.
e) Joint approach to care planning – the multi-disciplinary teams proposal is specific about the development of joint assessment and care plans for the groups targeted by MDTs. The risk stratification tool described above needs to be developed in order to specify the proportion of the population who would receive joint assessments and care plans via MDT / intermediate care / discharge from hospital arrangements.
f) Agreement of impact upon acute services - This is a matter for discussion by the Executive Group.

4.2 BCF includes approximately £500k capital and £1.3m revenue for meeting the statutory duties set out in the Care and Support Bill. Until the final Care Bill and associated regulations are passed it is difficult to be exact on whether the outlined proposals will meet the new statutory duties. Broadly speaking, the main changes will be:

- More people eligible for carers' support through new eligibility criteria for carers. There are proposals in the area of carers' services which would be likely to support delivery of the new responsibilities
- More people eligible for social care through potentially more generous eligibility criteria. Discussion is continuing on this at a national level and the final criteria are not yet available
- More duties on the provision of information and advice to self-funders - the proposals include community-based information and advice which is likely to support delivery of this work.
- A large increase in assessments as any individual wishing to qualify for the £72,500 cap on individual contributions will require a local authority social

care assessment. The proposal to expand the social worker team for assessment will be likely to support delivery of this responsibility.

- Maintenance of 'care accounts' for self-funders and administration of the £72,500 cap on individual contributions to social care. This is likely to require both revenue funding and capital funding in ensuring our systems can cope with the care account
- A significant expansion in 'deferred payments' - allowing people to put off selling their house to pay for their care until after their death. Whilst we do offer some deferred payments at present, each one carries a significant administrative and legal cost. It is not yet known how many more deferred payments we are likely to see under the new arrangements.

5 Suggested Key Areas for Change

5.1 The BCF form requires an explanation of key changes that will be made. It is suggested that the following is included on the form. This shows the areas of changes and highlights the most commonly proposed work or services in each area. Further development is needed to commission any of the proposals mentioned here. Furthermore, this list is not exclusive and does not imply that any proposals not mentioned here will not continue to be developed as part of the next round of discussions.

(A) Support for people at home – *to help people to live independently at home, either preventing them needing acute or long-term health and social care or minimising their needs*

- Integrating carers' services and meeting the requirements of the Care & Support Bill, so carer breakdown is avoided
- Integrating Disabled Facilities Grant, occupational therapy, home improvement, advice and guidance to provide comprehensive housing service for vulnerable groups, possibly countywide, so housing is safe
- Community-based services providing relatively informal support for people with low-level conditions or who are coping with changes in circumstances, for example peer coaching for people with disabilities, so low-level conditions do not deteriorate
- Extending community medicine, for example supporting community pharmacies to do more medication management, developing occupational therapy and physiotherapy to be more accessible and support people to be more independent, so long-term support services are minimised
- Develop a small grants pot to provide broader primary prevention activities or other patient-group specific interventions, so people are more resilient and can cope independently

(B) Support for people in need of help – *to help people who have had a crisis (or who are at the most risk of crisis) to get back to living independently so they don't need long-term or acute health and social care services*

- Development of support or recovery programmes for people with long-term conditions, at a variety of levels of need – for example a support service for people with mental health issues who are very vulnerable and a further crisis that would result in breakdown, or telehealth remote monitoring for people at risk of hospital admission, so long-term support services are minimised
- Develop a common risk stratification tool, scale up multi-disciplinary teams across the county to respond to the results, develop a shared health and social care database, so we can identify people most at risk of crisis and respond with a joined-up proactive package of support to prevent crisis
- Develop and extend integrated intermediate care and rapid response services across the county for hospital and social care admission avoidance, including developing community step-up beds for use by GPs / MDTs and for hospital discharge, so we can avoid someone in crisis being admitted to hospital wherever possible

(C) Support for people to leave hospital – *to help people be discharged from hospital as quickly as is safe so they can recover at home (or another appropriate place)*

- Expand teams to do 7 day discharge planning and discharge, so people don't have to wait for staff to be available at weekends to be discharged
- Develop 'return home' package (could be voluntary or private sector provider(s)), to help people be discharged from hospital safely and speedily, with support to help them back to independence

(D) Investment in infrastructure to support integration – *to work between organisations to develop common approaches to assessment, treatment and support*

- Establish joint team to oversee integration activity, so there is capacity to do the development work necessary to common assessments, joint services, and joined-up packages of care and support

5.2 The organisation of proposals into areas (A), (B), (C) allows them to be aligned with the implied strategic changes that emerge from the Health and Wellbeing Strategy, the CCG OP Programme, and the development of a joint CCC-CCG OP Strategy. (C) is particularly aligned with the aims of the BCF to ensure slick discharge from hospital.

5.3 The detail under (A),(B),(C),(D) above is not a final statement of services that will be funded by the BCF. The process of calling for ideas has yielded a wide variety of proposals, from across the whole system, and the themes outlined above were some of the most commonly proposed areas. The number of responses and the relative similarity of the themes suggests that there is a significant amount of agreement about strategy and commitment to contribute to change amongst commissioners and providers in Cambridgeshire, which is very positive given the scale of the strategic ambition to transform the system. There will be further discussion with respondents to the first call for ideas and other contributors following submission of the outline plan to Government on 14 February ahead of the second submission in April, and further development throughout 2014-15 ahead of the transfer of funding to the BCF in April 2015.

5.4 In Cambridgeshire, it was already recognised that changes are necessary to meet the financial and demand challenges the health and social care system is facing when the BCF was announced, and the fund was welcomed in the *Vision and Principles* document as an opportunity to speed up the pace of change to meet these challenges. The decision of local agencies to face these challenges meant that some work was already underway to pilot integrated and flexible working to support independence, such as the multi-disciplinary team pilots in GP practices and the introduction of reablement into the hospital discharge pathway. Many of the proposals received as part of the call for ideas respond to the experience of these pilots and suggest going further faster – for example, extending multi-disciplinary teams across the county. It is the expectation of the local system that the degree of change implied by these proposals is not limited by the specification of the pilot but is as ambitious as the scale of the challenge facing the system as a whole. This may mean expanding the scale of a proposal (for example the number of GP surgeries with a multi-disciplinary team), the pace of service delivery (for example designing a service that responds within an hour, 24 hours a day, rather than within 3 hours in the working week), or the expectation of service efficacy (for example designing a service where the intervention is specifically time-limited to ensure that it maintains throughput and can support as many people as it was designed to support).

5.5 The key risk of the current strategy is that there is not a reduction in demand for acute services, and since they are paid for according to demand, other services that are key to the delivery of the strategy are unexpectedly financially restrained and the system lurches to a focus on emergency and acute services. Payment-by-results for the BCF funded activity may mitigate some of these risks but Health and Wellbeing Board, CCC and CCG decision-makers should be satisfied that they understand the impact of failure; specifically, the loss of the performance related element of the BCF (which is

already committed and spent on services in Cambridgeshire, so this would be a net loss) and the failure to address the short and longer term pressures of demand and financial restraint.

Paper prepared by:

Tom Barden, CCC 4 February 2014 (Final Version for HWB Board)

Appendix 1

Summary of proposals

Support that is provided for people at home

- Carers

Proposals for carers came from two potential bidders. The Care & Support Bill gives increased rights to family/informal carers, including the right to an assessment and a more personalised service through personal budgets. The Government requires that local plans set out how much money is used for carer-specific services, taking into into the NHS funding previously used for carers' breaks.

One bidder proposed developing a family assessment methodology for social care assessment**, which would encompass the new statutory responsibilities for assessment of carers contained in the Care & Support Bill. A bidder also proposed developing a new system of supporting carers at different levels, reaching out to the 60,000 with advice and information and providing more intensive personalised services for the smaller numbers of people within the 60,000 who provide more significant levels of care.

The second bidder proposed developing an integrated carer support service** outside any individual statutory agency that would meet these responsibilities.

There were also two specific proposals: reviewing the system of respite beds for carers of people with dementia, as it appears that the stock of these beds has reduced drastically recently, and expanding the emergency respite support provided for carers.

- Homes / healthy lifestyles / primary prevention

This theme linked housing / homes and activity and exercise. Disabled Facilities Grant (DFG) proposals were also included here.

DFG is ring-fenced so should be considered as a proposal under this theme.

Two providers proposed the development of a comprehensive range of accommodation solutions that support people to stay independent for as long as possible and reduce or delay the need for higher cost health and/or social care services**. This would involve a capital development strategy and a re-development of sheltered housing strategies.

Home improvement

Three proposals were received for an integrated home improvement service, primarily focused at older and disabled people who might receive support from DFG.

The first proposal was for a new countywide 'Home For Life' service**, that would co-ordinate occupational therapy, home adaptations under DFG, small DIY jobs and advice and guidance. Supportive proposals were received in relation to this proposal from three local district councils, and the bid also claimed support from a fourth local district: the fifth district in Cambridgeshire has not yet committed to this bid. Impact on key metrics was not specified. Roughly £500k revenue and £2m capital per year was requested (not including the potential cost should the fifth district become involved, or the handyperson scheme).

One district council proposed a separate integrated and extended DFG service offering occupational therapy, grant processing and home improvement services, which they have been discussing with other local authorities in the East of England.

One bidder proposed scaling up Home Improvement Agency activity as part of a falls prevention strategy.

Activity / exercise for falls prevention

Activity / exercise classes were proposed by district councils and health partners. Three district councils proposed expanding and refreshing activity classes to primarily reduce falls and build better overall health amongst older people. Another district council proposed expanding community activities more generally, including social isolation issues, but using evidence from physical activity programmes. One bidder also proposed with evidence from Public Health exercise classes as a falls prevention measure in older people.

Sheltered / extra care housing

Two proposals were received in the area of sheltered / extra care housing.

One bidder proposed introducing health screening in sheltered / care home housing it manages.

One district council (on behalf of a local Strategy Group) proposed using BCF to commit to funding the revenue costs of extra care schemes which will be developed over the next few years, based on the hypothesis that Extra Care is more cost effective than residential / nursing or home-care.

Other

A bidder proposed a comprehensive primary prevention service involving active case management and regular telephone support for people with long-term conditions or who are isolated**, with the aim of signposting to activities for supporting wellbeing, provision of low level support and referrals on to GP or community rapid response teams.

Another bidder proposed expanding information and advice services to include health, social care, housing, debt, financial advice, in order to prevent breakdown in

people living independently to reduce likelihood of hospital or social care admissions. The same bidder proposed a programme to find out older people's priorities based on the Age Concern work in Warwickshire. It also proposed the development of partnership boards in adult social care and health more widely, to integrate user experience and feedback mechanisms as other elements of the system are integrated, and implement a quality assurance system.

A provider proposed a peer coaching project to support people over 50 with disabilities to adapt their lives to their condition, so that they are more resilient and less likely to experience a crisis.

One organisation proposed extending its service to support people at high risk of having a stroke.

Another organisation proposed establishing a set of self-referred programmes to support people who may have a low-level mental health problem or who are having trouble regulating their behaviour to prevent deterioration.

A bidder raised a proposal to address fuel poverty as a means to preventing ill health.

A proposal for the development of a small grants pot to respond to the demand from VCS for a range of projects that could support specific or small client groups.

- Isolation

All projects were aimed at older people.

One provider proposed a project to develop 'virtual communities' of care home residents, possibly by using tools like video conferencing or Skype.

Two proposals were received to expand day centre / mobile warden provision from two separate providers.

One provider proposed extending its community transport scheme in East Cambs and Fenland.

Another organisation proposed expanding befriending and timebanking schemes to reduce isolation amongst older people.

A local district council proposed extending its older people's services brand across the county, using fair events to promote activities that older people could take part in.

- Community medicine

All proposals related to frail or vulnerable older people.

Two proposals were received relating to parish nursing for small groups of villages. These proposals could be examined further to see if the concept could be applied across the county for all rural areas with vulnerable older people living there.

The administering of medication was also an issue for two proposals. The first bidder proposed training care staff to deliver a wider variety of medications, which could support the rationalisation of visits by different agencies. The second proposed developing the role of community pharmacies in medication management, particularly in care homes.

The second provider also proposed developing and extending the occupational therapy and physiotherapy service to reduce demand for home care (e.g. by rationalising the need for 'double-up' carers) but also to provide more support in the community to maximise rehabilitation. Accord Health proposed reviewing people with non-complex social care packages to make sure packages were using all community resources and making the best use of the statutory support of different agencies. Similarly, one bidder proposed developing the Assistive Technology service to make equipment more widely available.

- End of life

End of life care was identified as a source of avoidable hospital admissions by a bidder, which proposed extending home based end of life care to reduce admissions.

A bereavement counselling service proposed extending its remit, arguing that this would reduce visits to the GP by bereaved people.

Support that is provided for people when they need help

- Secondary prevention

Secondary prevention for specific conditions

Some submissions proposed support for people suffering from specific conditions. One provider suggested cardiac and respiratory rehabilitation services in the community to reduce re-admission rates for people with these conditions, based upon evidence suggested by Public Health. Another proposed an integrated low vision service to reduce falls, depression, hospital admissions amongst older people with low vision.

Telehealth

Three bidders all proposed an expansion of telehealth remote monitoring. Evidence suggests that this is effective in reducing hospital admissions for people with chronic heart failure – two of the bidders proposed extending this service to older / vulnerable people and people living in sheltered housing more frequently than currently.

Other

A local hospital submitted a proposal containing a range of ideas for specialist services for older people that came from their older people's strategy**.

A provider proposed a change the threshold at which home care is no longer deemed cost effective from the provision of 22 hours per week to 33 hours per week, which would enable more people to continue to live at home and fewer people moving into residential / nursing care because their need for support had gone above 22 hours per week.

Another bidder proposed establishing an integrated health and social care transitions team for children and young people with a disability and support from health or social care who are finishing their formal education, with the aim of smoothing the change from children's services to adult services.

- Chronic illness management

Proposals under this theme are targeted at particular groups, and are aimed at reducing avoidable hospital / residential / nursing care admissions by effective management of illness in the community at home.

One bidder proposed piloting a Wellness Centre in Cambridge to support people with long-term conditions by co-locating different services. The centre would be in Brookfields Hospital.

A provider proposed expanding services for people with dual sensory loss. Another bidder also proposed expanding services for people over 65 who have a hearing or visual impairment.

One bidder proposed establishing a support service for people with Acquired Brain Injury in Fenland. Another bidder also proposed generally developing new housing and support services for people with Acquired Brain Injury.

Two organisations proposed developing a comprehensive recovery programme for people with long term health conditions (mental health and physical health) or those who meet the social care threshold (critical/substantial)**. The bid would build on the successful existing recovery college model operated by one of the bidders.

- Dementia

The number of people with dementia is predicted to rise and these patients use a lot of health and social care services.

One provider proposed expanding case management of dementia patients via the Dementia Support Team, which is associated with delayed institutional care.

A local hospital trust proposed developing a transition unit to support people with Learning Disabilities to move to specialist dementia care placements, providing appropriate care away outside acute hospitals.

- Mental health / chaotic lives

Proposals in this theme are aimed at supporting adults who have mental health issues or who are chronically excluded from society. Chronically excluded people may have a range of mental health, substance abuse, alcohol abuse, housing issues; and are frequent users of health and community services as a result.

Two bidders jointly proposed developing a service available for people who have a low level mental health problem associated with another crisis in their lives and who could deteriorate without a short-term intervention, ending up using more services than they had to.

A district council proposed piloting a multi-disciplinary team to work with people with persistent anti-social behaviour to co-ordinate different agencies' support for them with the aim of reducing disproportionate statutory service use. Another provider also proposed continuing the successful project to work with chronically excluded adults leading chaotic lives in Cambridge City.

One organisation proposed expanding a particular method of treatment for alcoholics, currently established in Huntingdonshire.

A bidder proposed developing new services for people with autism and Aspergers Syndrome, as required by the Autism Act.

Another organisation proposed that a service supporting older homeless people to live independently should continue to be funded.

A provider proposed extending the counselling services available to women who have experienced sexual violence, with the intention of reducing use of health and social care services in the longer-term.

- Response to Care Bill

Any changes to services as a result of the Care and Support Bill must be funded by BCF. Changes around carers' services are covered in 'carers' above, but the Bill also implies a need to do more assessments as a result of the changes in the social care funding system.

One organisation proposed establishing a peripatetic team of social workers to help with existing peaks in demand for assessments, e.g. winter pressures, implementation of new assessment procedures. This will help with reducing hospital and residential / nursing care admissions because people who are not assessed but are in need must manage independently or by relying on other services that do not have an assessment, e.g. A&E / emergency hospital.

However, the proposal of expanding the social worker team for assessments is also relevant in the response to the Care & Support Bill.

- Crisis prevention / recovery

Short term response services

There were four proposals in the area of short-term response services, designed to try to avoid admission to hospital for older people living in the community.

The first proposed strengthening intermediate care**, e.g. night care, nursing, end of life care, sitting services, emergency personal care, reablement, with the intention of supporting people to live independently for longer. A rapid response team was also proposed, available within one hour of referral. Another provider also proposed a rapid response team, called a 'Joint Emergency Team' (JET)**, able to link together ambulance, health and social care staff (and offer similar services to the intermediate care expansion above).

The same organisation proposed developing a joint falls prevention pathway that encompasses health and social care services.

The third bid came from a district council, and proposed extending its falls assistance service to be able to sign more people up.

Several providers jointly proposed a crisis support service led by VCS to provide support to GPs and hospitals in the winter to support early discharge of older

patients and do case-finding of GP patient lists to try to prevent crises and deterioration leading to hospital admission.

Alternatives to hospital / residential / nursing admission

Two organisations both proposed an alternative to hospital admission using places in the community. A third organisation proposed an increase in 'step-up' beds available as a short-term alternative to hospital admission.

One bidder proposed using VCS to support patients in community rather than admit to hospital.

Another bidder proposed establishing an overnight personal care team, as difficulty finding that particular service is often a key consideration in admitting someone to residential / nursing care.

A provider proposed establishing 'hospital at home', additional home care support to prevent admission to hospital.

- Multi-agency working

Proposals in this theme focus on the ways in which services can work together to support vulnerable groups, e.g. older people, to live independently. They mainly focus on groups of people who would be identified by a risk stratification tool developed using health and social care criteria, who would usually be older or disabled

Multi-disciplinary teams and databases

One provider** proposed multi-disciplinary 'team around the person' working, which would include single assessment, rapid response and crisis prevention and joint working. This should be seen in the context of their bid as part of the OP Procurement Programme.

Two organisations both proposed expanding the multi-disciplinary teams in GP practices to include health and social workers**. This would enable the development of a multi-agency system of early identification of risk, joint assessment (using a common assessment framework) and action planning. Increasing spending on social care / community services like this is expected to reduce the costs associated with hospital, particularly for end of life care. It is also expected to reduce the rate of delayed discharge from hospital. (See Public Health evidence, and evidence provided by Kirsteen Watson re OP procurement).

A provider proposed developing a multi-disciplinary approach using Care Co-ordinators**, and developing a culture of integration amongst the MDTs using specific cultural change methodology.

An organisation proposed the development of a predictive modelling tool that would support multi-disciplinary working, which should be seen in the context of their overall bid under the OP Procurement Programme**.

Three bidders also suggested including the VCS in the multi-disciplinary teams and ensuring good co-ordination of such services. Two similar bids from separate providers were also received.

Another group of three bidders also proposed a database for patients with health and social care information that would also be accessible to VCS agencies. Relatedly, a provider proposed a single patient portal to promote information sharing between health and social care.

Activities to ensure that NHS number is used as primary identifier by all agencies, a 'national condition' of BCF, would also be included under this theme.

Other proposals

A provider proposed a care home review team, composed of a geriatrician, social worker, paramedic and pharmacist, to review people living in care homes to prevent crises developing. Another bidder made a similar proposal, to establish teams to train care homes in falls, pressure ulcers, end of life care and UTIs to reduce hospital admissions.

Another provider explained a number of ways they would integrate care and work together with other agencies should they be successful in the OP Programme Procurement**.

One organisation proposed developing a joint commissioning 'Brokerage Unit' that commissions residential / nursing placements for older people. This would mean quicker and slicker discharge from hospital.

The same organisation also proposed piloting integrated health and social care personal budgets.

The third bid from this organisation proposed putting key health and social care information on a special type of bus pass so that these can be read by emergency response team if necessary.

Support that is provided to help people when they are ready to leave hospital

Improved discharge planning capacity

One provider proposed an expansion of discharge planning pathways, including an early supported discharge pathway for stokes. Two other organisations proposed the development of a 7-day discharge planning service, which would include specialist mental health workers to ensure that all adults and older people – including those with dementia and other mental health issues – do not experience a discharge delays. This would all be underpinned by a provider's proposal to expand the complex discharge team. Another organisation proposed establishing 'community discharge teams' to support each acute trust with discharge.

Pathway development

An organisation proposed expanding the re-ablement service to reduce discharge delays and to increase admission avoidance. Another provider proposed allowing homecare agencies provide "return home" packages. A separate bidder proposed the establishment of an A&E discharge support service. A fourth bidder proposed using BCF funding to support a complex care pathway which would allow the paying of higher unit costs to reduce discharge delays. A fifth bidder proposed allowing care agencies to set their own care grids. This would reduce the volume of tasks undertaken by staff involved in the discharge planning process.

Increased capacity

A district council proposed the development of a sheltered housing scheme specifically aimed at supporting the hospital discharge process. Another district council made a similar proposal, advocating the establishment of specific temporary accommodation units within the area to facilitate the hospital discharge process. A provider proposed reviewing the utilisation and effectiveness of interim beds, and using BCF funding to stimulate the domiciliary care market to increase capacity; another provider also made this proposal. Another bidder proposed the creation of a fast transport service which would be supported by dedicated carers in order to reduce discharge delays.

Other proposals

A proposal for support to develop the health economics and impact analysis of BCF-funded interventions.

A proposal to establish an Integration Team to oversee the development and implementation of projects to integrate health, social care and other services, which would project manage and act as a 'doing' resource for pathway development and business process change activity.

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