APPENDIX A

CAMBRIDGESHIRE INTEGRATION TRANSFORMATION FUND

VISION AND PRINCIPLES – FOR CONSULTATION

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Cambridgeshire County Council
Cambridgeshire and Peterborough Clinical Commissioning Group

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VERSION CONTROL

Version	Author	Date	Comments
0.1	Tom Barden, CCC	13/11/13	First draft
0.2	Matthew Smith, CCG	15/11/13	Amendments and addition of CCG OP Programme information
0.3	Geoff Hinkins, CCC	15/11/13	Editing, additional strategy information
0.4	Geoff Hinkins, CCC	20/11/13	Adding draft consultation questions, more clearly highlighting the vision
0.5	Simon Willson	25/11/13	Adding changes following CFA MT, CCC

1 Introduction

1.1 Nationally, the health and social care system in the UK is under enormous pressure. Demand for services is increasing at a time when funding is decreasing. This is most obvious in the case of emergency admissions to hospital, which rose by 27 per cent in England in the period 2000-01 to 2011-12.[1] This increase has come about because more people are attending A&E than before, and more of those people are being admitted to hospital than before.

1.2 The National Audit Office believes that this increase in people attending A&E is a symptom of health and social care services not working effectively. Patients who could be using primary care, community care or social services turn up in A&E because it is the most visible and easily accessible place to turn to for help. The additional pressures this places on A&E departments has a knock-on effect to other services, leading to cancellation of planned operations, longer waiting times, and increased costs. Simply increasing funding to expand capacity in the system is not an option because the Department of Health expects the NHS to make very large savings over the coming years.

1.3 The social care system is also under pressure nationally. It faces a 'complex mix of changing demography, rising need and increased public expectations,'[2] and has been described by former Minister for Care, Paul Burstow, as 'unsustainable… leaving increasing numbers of people struggling to cope.' These issues are sharpened by the fact that councils are having to make unprecedented savings from their budgets due to reductions in funding from central Government.

1.4 In order to start to address these problems, the Government announced in the June 2013 Spending Round the creation of the Integration Transformation Fund (ITF), a change to the way that some NHS budget is allocated with the explicit intention of integrating health and social care systems at a local level. Local councils and health services are expected to submit plans to Government explaining how they will use this fund to improve local services.

1.5 The County Council and the Clinical Commissioning Group have set out in this paper a shared vision and principles for the use of ITF. It is intended to start a conversation between local people, service providers and local authorities about our ambitions for the health and social care system in Cambridgeshire to meet the challenges of an ageing population, disparate local services and severely restricted funding, and to explore how we might use the resources in ITF to realise those ambitions.

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[1] See *Emergency admissions to hospital: managing the demand* National Audit Office October 2013.

[2] Glasby, J *et. al* 'Turning the welfare state upside down? Developing a new adult social care offer' Health Services Management Centre, University of Birmingham 2013

2 About ITF

2.1 The Integration Transformation Fund (ITF) was announced in June 2013 as part of the Treasury Spending Round. The Spending Round statement was as follows:

> [The Government will] put £3.8 billion into a pooled budget for health and social care services to work more closely together in local areas, in order to deliver better services to older and disabled people, keeping them out of hospital and avoiding long hospital stays; and £200 million for local authorities from the NHS in 2014-15 to ensure change can start immediately through investment in new systems and ways of working[3]

2.2 It is important to note that this is not 'new' investment from Government but a re-allocation of money that is currently in health services' budgets. It is estimated by NHS England that for the average CCG, shifting money into the fund will effectively reduce spending that is directly controlled by the CCG by 3%.

2.3 Policy on ITF is being set out jointly by NHS England and the LGA. Policy information is available from http://goo.gl/2MJsSq. At the time of writing, the most recent update was 17 October 2013.

2.4 Government, NHS England and the LGA expect that this funding will be used to significantly affect the pattern of local services, shifting resource and demand away from acute services focused on treatment and towards community based services, focused on prevention.

2.4 Some information has been released by Government about the NHS budgets that will be affected by ITF. It will be funded from £1.9bn that is already allocated to joint arrangements and £1.9bn from other NHS allocations. The existing joint funding part is made up of:

- £130m Carers' Breaks funding
- £300m CCG reablement funding
- c£350m capital grant funding (including £220m Disabled Facilities Grant)
- £1.1bn existing transfer from health to social care (the existing sustainability fund transfer)[4]

No information is available at the time of writing about which budgets the Government envisages CCGs will divert to create the other half of ITF.

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[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209036/spending-round-2013-complete.pdf

[4] For Cambridgeshire arrangements see item 3, Health and Wellbeing Board meeting 17 Oct 2013, http://www.cambridgeshire.gov.uk/CMSWebsite/Apps/Committees/Meeting.aspx?meetingID=636

2.5 Some of the money will be awarded based on performance in 2014/15 and 2015/16. Performance targets may be set in the following areas:

- Delayed transfers of care
- Emergency admissions
- Effectiveness of reablement
- Admissions to residential and nursing care
- Patient and service user experience

2.6 No specific information is available at the time of writing about the amount of funding the Government envisages Cambridgeshire and Peterborough CCG will need to divert to ITF. The advice that the CCG has received so far suggests that the TFI is set at 3% of the CCGs base allocation. This means that Cambridgeshire could expect £25m to transfer in 15/16.

3 The situation locally

3.1 Cambridgeshire is a county of around 620,000 people. It was the fastest growing shire county in England in the period 2001-2011, growing by 12%.[5] It is set to continue to grow at about the same rate over the next 10 years. Overall health and life expectancy are well above national averages for Cambridgeshire as a whole, although there are significant differences between our communities, which are closely linked to socio-economic differences.

3.2 More information about the health of people in the county can be found in the Health and Wellbeing Strategy, available at http://www.cambridgeshire.gov.uk/council/partnerships/health-wellbeing-board.htm and the Cambridgeshire JSNA, available at http://www.cambridgeshirejsna.org.uk/.

3.3 People over 65 make up a significant proportion of the county's population. Furthermore, in common with similar areas around the country, the number of people over 65 in the county has been increasing more quickly than the overall rate of growth. Older people are more at risk of needing to use health and social care services. Work done as part of the JSNA showed that nearly half of resources (45%) used in hospital care (which itself is the largest single area of spend in Cambridgeshire on health services) are used helping people over 65. Over two-fifths of the adult social care budget (43%) was used supporting people over 65. Much of these resources are used to support people who fall into the most elderly and frail age groups, over 80 or over 85. People who are over 80 make up the majority of users of home care packages and residential or nursing care, and resources used for unplanned hospital admissions were highest amongst the very

[5] *Census 2011: Cambridgeshire Snapshot* Research and Performance, Cambridgeshire County Council, 2012 http://www.cambridgeshire.gov.uk/NR/rdonlyres/80EA41E7-C981-452E-8861-1D2F2A61783C/0/Cambridgeshire_snapshotV2.pdf

oldest age group (over 85). The high rate of growth in the number of older people in Cambridgeshire is putting very heavy pressure on these budgets.

3.4 At the same time, locally the County Council and the Clinical Commissioning Group, in common with other publicly funded bodies providing services in the county, are trying to make savings to their budgets and cope with an anticipated increase in demand. The County Council must make the following savings to its adult social care budget:

Cambridgeshire County Council Adult Social Care Budget 2013-18[6]

Year	2013-14	2014-15	2015-16	2016-17	2017-18
Budget (£m)	195	188	187	187	190
Savings required (£m)	12	18	15	14	10
% of budget	6	9	8	7	5

3.5 There is therefore a twin pressure on the health and social care system. Much of the resources that go into it are used to support older people. The number of older people is rising much faster than the number of people generally, generating rising levels of demand for health and social care services. Regardless of the financial situation, this would create difficulties for local services. However, the bodies which commission and fund those services are receiving less money from the Government and must reduce their spending.

3.6 There are numerous shortcomings in current service provision. There is evidence of a lack of 'joined up working' between acute – community – primary care and social care organisations. The way in which services are organised is reactive to illness rather than proactive to prevent crises and maintain independence. This results in known current service issues – pressure on Emergency Departments, high occupancy in hospital beds, delayed transfers of care, extended lengths of stay in hospital, and pressure on limited resources in community and primary care services. In addition, there are issues with information sharing, financial incentives not being aligned to support effective care, and short term contracts.

3.7 We are already seeing some of the effects of this situation. Generally, Cambridgeshire is in a similar situation to its statistical neighbours. It is difficult getting people out of hospital, too many of them are unable to get the care they need at home. Emergency admissions have been going up, with consequent impacts on planned operations. Admissions to nursing care, the most expensive form of social care support, are increasing. The effects on the system go beyond impacts on services

[6] Source: Cambridgeshire County Council Business Plans

for older people only – cancellation of elective surgery could affect anyone.

3.7 Without change in the system there is a significant risk that the current trends in the performance of the system will continue and be exacerbated by the pressure on spending. Waiting times for planned operations and health services could rise; it may become more difficult to find social care for people who need it (potentially increasing the pressures on A&E and emergency health services); service quality might fall as staff have to see more and more people in the day.

3.8 This description of the situation has not discussed many other services that people rely upon that have an impact on their health and wellbeing, such as housing, community safety, transport, leisure or education. The economic situation, household income and employment are also recognised to have a major impact on health and wellbeing, as noted by the Health and Wellbeing Strategy. Taken together, all of these factors have an effect on demand for health and social care services, and of the effectiveness of those services in terms of the outcomes people experience following support. For example, it is much harder to recover from a hip operation if your house cannot be adapted so you can live there without needing to go up and down stairs. We recognise that it is crucial to get all of these elements working together in order to prevent people needing the most intensive types of health and social care service as much as possible.

4 Proposed vision and principles for ITF in Cambridgeshire

4.1 Reforming the system – our vision

Our long-term shared vision is to bring together all of the public agencies that provide health and social care support, especially for older people, to co-ordinate services such as health, social care and housing, to maximise individuals' access to information, advice and support in their communities, helping them to live as independently as possible in the most appropriate setting.[7] We believe this transformation will also require the input of a range of health and social care providers as well the greater involvement of the community and voluntary sectors.

4.2 The County Council and the CCG believe that ITF offers an important opportunity to transform the system in Cambridgeshire to meet the needs of a rapidly ageing population better, and by doing so, ease the pressure on the system more generally, enabling it to provide better services to the whole population of the county. In the current financial

[7] Adapted from 'Older People Community Budgeting: Principles and project ideas' available from notes of item 3 of Health and Wellbeing Board 17 October 2013, at http://www.cambridgeshire.gov.uk/CMSWebsite/Apps/Committees/Meeting.aspx?meetingID=636

climate, this is also likely to be a unique opportunity to re-think how significant chunks of money are spent.

4.3 Fundamentally, we believe that ITF should be used for genuine transformation of the health and social care system in Cambridgeshire, not to plug a gap in the social care or health budgets brought about by increasing demand and reducing budgets. This transformation is not just about reducing admissions to hospital, but rather about changing the whole system so that it is focused on supporting people wherever possible with person-centered and professionally-led primary / community / social care, with the goal of living as independently as possible. This aligns with the principles set out by Government, NHS England and LGA, is consistent with the priorities set out in Cambridgeshire's Health and Wellbeing Strategy 2012-17, and builds upon the recent work of the Cambridgeshire Public Service Board on Community Budgeting for Older People. It is also well-supported by evidence that clinical and service integration delivers better outcomes for people, particularly if groups of patients or service users are clearly identified and services for them are joined up around their needs.[8]

4.4 **Effects on services**

We think it is important to be clear about what this will mean, especially because this is not new investment in the system, but a re-organisation of existing funding and services. There is likely to be an increase in the support available for older and disabled people in primary / community health and social care services, and by managing demand in this way, a decrease in the need for support at acute level, with corresponding changes in acute services. We will be working towards single health and social care assessments that will require a much closer level of integration between primary health (GPs), community health (e.g. district nursing, physiotherapy) and social care (support to live independently), so that these services can identify, support and intervene much earlier to prevent a crisis occurring or someone feeling they are unable to access the support they need. This will require a different way of working from our service providers and will require us to develop an infrastructure that will allow both the voluntary and community sectors to play a greater role of supporting people more effectively in their communities

If we are successful, funding for unplanned admissions to hospital, particularly for people who are 80 and over, will be reduced because people will not need to go to hospital in the same numbers as they do at the moment, and lengths of stay will be shorter.

4.5 This is easy to say and hard to do. Recognising that the way that change is done is as important as the change that is aimed at, the next

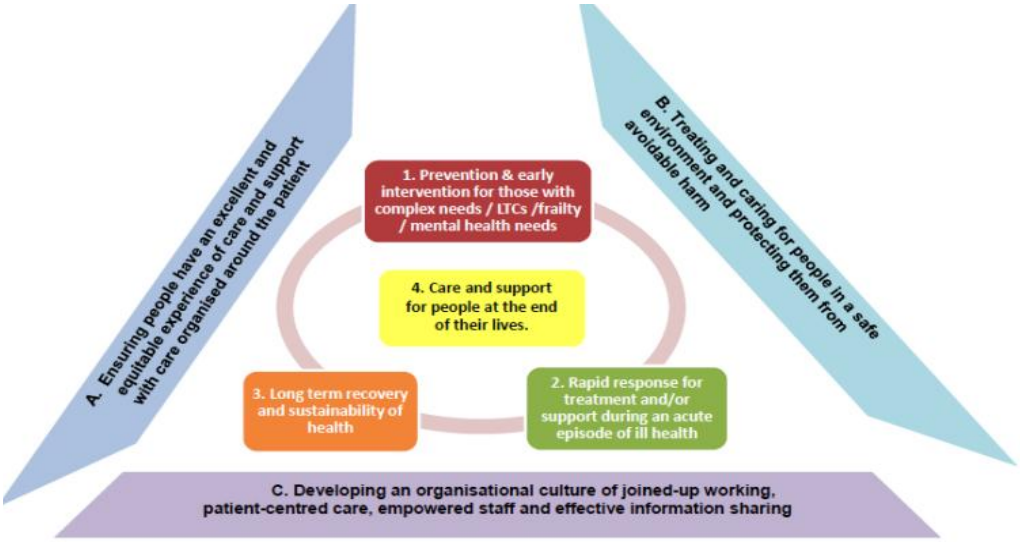
[8] See 'Clinical and service integration' Curry, N and Ham, C; King's Fund 2010; available from http://www.kingsfund.org.uk/sites/files/kf/Clinical-and-service-integration-Natasha-Curry-Chris-Ham-22-November-2010.pdf

four principles set out 'rules' we are proposing to govern what we do to achieve this vision.

4.6 **Measuring success**

We will measure our success primarily by analysis of demand for acute health services (such as emergency bed days) and formal social care services (such as a paid agency carer supporting someone at home, or someone moving into residential or nursing care home), using current levels of demand as a baseline (and allowing for the impact of demographic change so the 'baseline' keeps pace with population change and growth). We will build on the Outcomes Framework which has been developed to support the CCG Older People Programme and procurement process. This has a major focus on patient and carer experience, and triangulating data from several sources to measure outcomes. The Outcomes Framework structure is shown in the diagram below:

CCG Outcomes Framework: Domains



We will also use other measures that show us whether the system is effective, such as delayed transfers of care, the effectiveness of short-term recovery-focused services like reablement, and patient and user experience of services. We will therefore seek to deliver services that have a positive impact as measured by these measures.

4.7 **Open, honest and evidence-based**

It is recognised that the basis of the funding for ITF is money that is already committed to health and social care services of many different types. Some services will need to change to support the aim set out above, others will need stability. Discussions should be open, honest

and evidence-based in order to make sure we use the money in the best way.

4.8 **Early intervention and supporting independence**
The plans set out in the ITF should align with existing or developing strategies, such as the CCG Older People's Programme, the Older People's Strategy in development by the County Council, the Cambridgeshire Health and Wellbeing Strategy 2012-17, and the work on Community Budgeting for Older People. A key principle of all of these strategies is that people experience the best outcomes when they are able to live independently at home, and supporting them to do so will be a theme throughout all proposals in the Integration Plan. There will be other important themes also, including coherence and integration of services, the importance of identifying vulnerability and acting to prevent deterioration, ensuring professional judgement is valued and free to be flexible, and that services are person-centred.

4.9 **Support for everyone**
It is recognised that health and social care services for older people make up a major part of activity in health and social care generally; but working age people with disabilities and people of all ages with mental health issues also experience unnecessary hospital admissions and institutional social care support. Proposals under ITF should not be solely focused on supporting older people at the expense of others such as those physical, sensory or learning disabilities or those with mental health conditions.

5 Links to other local work

5.1 The CCG Older People programme

5.1.1 The CCG has been working closely with Cambridgeshire County Council and other stakeholders on its Older People Programme, which is very well aligned to the aims of the ITF. The vision and aims for the CCG Older People Programme are:

1. For older people to be proactively supported to maintain their health, well-being and independence for as long as possible, receiving care in their home and local community wherever possible;
2. For care to be provided in an integrated way with services organised around the patient;
3. To ensure that services are designed and implemented locally, building on best practice;
4. To provide the right contractual and financial incentives for good care and outcomes
5. To work with patients and representative groups to design how we commission services

5.1.2 The first part of the programme has focused on work to specify local aims and outcomes for the future of services for older people. The

programme provides a clinical drive to organise care around the patient by commissioning a joined up hospital and community service specifically for older people, and using NHS funds in ways which support staff to work better together. The CCG has embarked on a major procurement for Integrated Older People Pathway and Adult Community Services. The procurement is based on an outcome specification, and is designed through a two stage competitive dialogue process to select one or more Lead Providers which will take over responsibility for community, acute and mental health services for older people in summer 2014.

5.2 County Council Draft Older People's Strategy

5.2.1 The County Council has developed a draft Older People's Strategy, which will be consulted on during Autumn and Winter 2013. The County Council hopes to support older people to live independently, in their own homes and communities for as long as possible. As with the CCG's older people programme, the strategy will emphasise how our the Council can organise its services around the needs and wishes of older people and make sure it works alongside carers, family, friends and communities rather than operating in isolation; as well as emphasising joint work across the health and social care system. The draft strategy proposes the following outcomes:

1. Older people remain living at home and in their own communities for as long as possible into later life
2. Older people are supported to retain or regain the skills and confidence to look after themselves into older age
3. Carers of older people are supported to cope with and sustain their caring role
4. The number of people requiring complex or intensive support packages is minimised through successful early intervention
5. Older people who need ongoing care and support feel in control of their support plan and are able to choose the support which is right for them
6. Older people are supported to live with dignity throughout their later lives
7. Older people are protected from harm and isolation

5.2.2 Similar outcomes have been set for under 65 year olds with physical and sensory disabilities as well as those with mental health conditions that require the support of adult social care services. These clients groups, along those with learning disabilities, are also included in the scope of the ITF.

6 Government conditions

6.1 As well as the local strategic direction provided above, the Government has imposed a number of conditions on the use of ITF, which will have implications for what we include in our ITF action plan.

- *Plans must be jointly agreed by the County Council and the CCG and signed off by the Health and Wellbeing Board*. The development of plans for ITF will take place in two phases – an initial phase, involving stakeholders and the Health and Wellbeing Board, to develop this vision and principles into an action plan that can be submitted to Government, then a secondary phase, to be undertaken during 2014-15 to develop the detail of implementation. Further consultation will be undertaken surrounding each proposal.

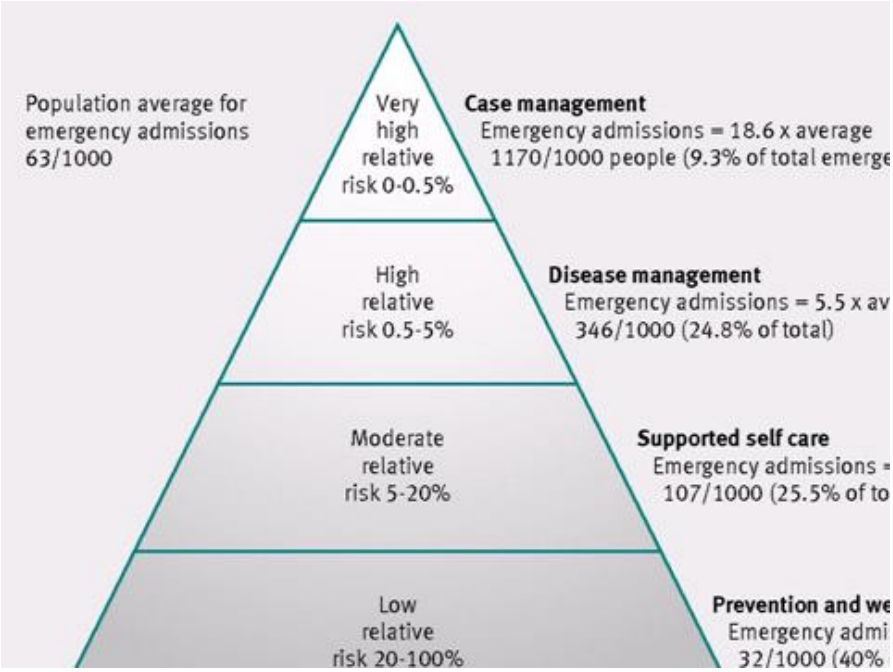
- *Plans must protect social care services*. Anybody's support needs currently met by social care will continue to be met under any new arrangements for social care proposed under ITF. This does not mean that services will remain the same – for example, a short-term intensive recovery programme like reablement may mean that someone learns how to live more independently. As a result their need for formal support would be reduced, and their formal social care package might be reduced appropriately. We may also wish to protect other services – for example, equipment and adaptations available from the Disabled Facilities Grant.

- *Plans must show how 7 day services will be introduced in health and social care to support discharge from hospital and unnecessary admissions to hospital*. Success will mean that people will be able to be discharged from hospital at the weekend, because the staff are there to medically approve discharge, plan their discharge and link up with a suitable provider if they need ongoing care. This will mean service providers needing to change their staffing patterns to allow this, which might mean changes in terms and conditions or working hours for staff in hospitals, social services, housing or care providers.

- *Plans must show how better information sharing between the NHS and the County Council will be introduced, including using people's NHS number as their primary identifier*. 97% of social care records already contain NHS numbers. People will be routinely asked for their consent to share data between health and social care. More information will be recorded about social care services in health systems, especially SystmOne, the IT system used by the majority of GP practices locally, and more information about health services will be available to social workers. This will enable joint planning and support patients, service users, clinicians and social care staff to make better decisions about care and treatment based on a holistic consideration of individual needs.

- *Plans must set out an approach to joint care assessment and planning and show the proportion of the population who will receive such support*. Across Cambridgeshire, Local Commissioning Groups (made up of groups of GP practices) are currently introducing multi-disciplinary teams (MDTs) to provide better and more holistic support to frail elderly or other vulnerable people. MDT assessments will become

the norm for people who fall into these categories. They bring together social, medical and community care plans involving GPs, hospital doctors, nurses, physiotherapy, social workers and voluntary or community groups. If MDTs supported all social care service users, they would be supporting around 9,000 people, around 1.5% of the population. However, if they were also able to support everyone who is 80 or over for example, they would be supporting 30,000 people, around 5% of the population, and the most important age group for the intensive instutional services we are trying to reduce the need for. Risk stratification will form a key component of the solutions being worked on by bidders as part of the CCG procurement for Integrated Older People Pathway and Adult Community Services. The illustration below emphasises the need to ensure that proactive care approaches extend beyond the most intensive service users at the top of the pyramid, to cover those who are at moderate to high relative risk of admission to hospital.



- *Plans must set out the impact of changes on the acute sector and show they have been agreed*. The intention is to reduce emergency bed days which encompasses reducing unnecessary hospital admissions, reducing length of stay, delay transfers of care and readmissions. The CCG has undertaken detailed analysis and benchmarking to develop trajectories for reduction in EBDs. These have been built into the Outcomes Framework which forms the basis of the CCG procurement. In the meantime, there are a range of projects in progress with acute and community providers designed to reduce reliance on emergency hospital care.

7 A proposed model

7.1 In addressing the required areas below and local strategic priorities, it is proposed that the model adopted in Cambridgeshire will have the following characteristics:

7.1 A united approach to advice and information on community and public sector services. This will include developing robust and reliable sources of advice and support for older people before they become frail or need to access the statutory system; and providing universal information and advice about services from all partner agencies, which should be quick to access, clear, friendly and personalised;

7.2 Investment in community capacity to enable people to meet their needs with support in their local community. This could include extension of the community navigator system; and work to consider people's social capital alongside their other assets and support people to be engaged in their families and communities. Further development and investment in community capacity will prevent some people from entering a crisis, potentially reducing long term care costs.

7.3 Coordinated and intelligence-led early identification and early intervention. This might include professionals being proactive in identifying need rather than waiting for it to be presented as a formal referral; Ensuring that the workforce are able to feed back as much intelligence as possible as to the needs of the service users they are supporting and how service delivery and deployment of available resources can be improved; further improving information sharing between the range of organisations in contact with older people about individuals at risk of requiring more support in future; Social Workers having greater identification with a community and working with other agencies to identify those at risk and commissioning interventions, preferably through the voluntary and community sector for needs that might be below the thresholds for statutory assessment; and giving professional freedom to deliver a flexible response to need to avoid escalation of cost.

7.4 An improved approach to crisis management and recovery. This might include a process for rapid escalation and action when a crisis occurs in the life of an older person; this is likely to involve a coordinated response from all agencies working in multi-disciplinary teams to provide intensive support in the short term and encompassing services such as respite care. Support should focus on ensuring that when the crisis is over older people and their carers remain as independent as possible and avoid short term crises triggering a deterioration which leads to long term health or social care need.

8 What would this mean for people?

8.1 Patients and social care service users should expect their care plans and support to be more joined up and sensible. Their GP would know what support they get from social services, and they should expect their social worker to know when they last went to the GP and what they discussed. They should expect to be encouraged to go to voluntary and community groups like lunch clubs, exercise classes, and other positive social events, so that if there is a crisis they know people they can rely on to help them through it. They should expect support to be short-term, high quality, and appropriate to their situation; and help them get back on their feet. When support ends, they should know that it will be available for them again if they need it. They should know who to contact if they think they might need help, and consequently spend less time at A&E or in hospital.

8.2 GPs, community health workers, social workers, housing workers and other professionals in the health and social care system should expect to work more closely together with the express intention of supporting the patient or service user to require as little support as possible to live independently. This is likely to involve a single assessment process, a joint care plan, and system-wide common ways of identifying risk and measuring outcomes. They should trust each other to help the patient or service user make good decisions about what support they need next, and they should trust each others' agencies to work co-operatively and understand that getting things right for the patient or service user is in everyone's interests. They should have wide room for professional judgement, and wherever possible make preventative interventions to stop deterioration, even if that intervention is more expensive in the short term. They should be able to access more information about the patient or service user's support from other agencies, and they should make time for working together.

8.3 Hospital staff should expect to see fewer frail and elderly patients. They should work closely with professionals who are based in community services, whether that is medical, social, housing or voluntary. They should have access to more information about patients, including non-medical involvements by other services, and they should use this information to help them make good decisions with patients about the most appropriate care for them. Sometimes, this might mean not treating people in hospital, but they should also expect community based services to be easier to access and take on complex cases.

9 Next steps

9.1 We have outlined a vision and a set of principles that we think are important to how we will use ITF in Cambridgeshire. The King's Fund emphasises that it is important to find common cause with partners, develop a shared narrative to explain why integrated care matters, and

put together a persuasive vision to describe what integrated care will achieve.[9] We would like this paper to start this conversation.

9.2 We have not set out any specific projects in detail. The Public Health Team in the County Council is currently doing a review of the evidence of what works in integrated care, which is due to report at the end of November. There are many other projects already up and running, such as the introduction of multi-disciplinary teams in Local Commissioning Groups, and existing integrated teams, upon which we can build to achieve a more integrated system at a clinical and service level.

9.3 This paper sets out a vision for use of the ITF, to bring together all of the public agencies that provide health and social care support, especially for older people, to co-ordinate services such as health, social care and housing, to maximise individuals' access to information, advice and support in their communities, helping them to live as independently as possible in the most appropriate setting.[1] We would welcome your views on the following questions.

Q1 Do you agree with this vision as the overarching goal for our ITF programme?

9.4 Section 4 sets out a number of principles for use of the ITF in Cambridgeshire.

Q2 Do you agree that these principles will support us in achieving the vision and making the most of the opportunity presented by the ITF funding?

9.5 Section 7 sets out some features of a proposed model for use of the ITF.

Q3 Do you agree that using the ITF funding to support these proposals is the right approach and will help achieve our vision?

9.6 Finally,

Q4. What other opportunities are there to join up the work of agencies that provide health and social care and make our arrangements more effective and efficient?

[9] See *Making integrated care happen at scale and pace* King's Fund, 2013, available from http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-integrated-care-happen-kingsfund-mar13.pdf

[1] Adapted from 'Older People Community Budgeting: Principles and project ideas' available from notes of item 3 of Health and Wellbeing Board 17 October 2013, at http://www.cambridgeshire.gov.uk/CMSWebsite/Apps/Committees/Meeting.aspx?meetingID=636