Agenda Item No: 4

REVIEW OF ADULT SOCIAL CARE SERVICES PROVIDED BY CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST

To:	**Adults Committee**
Meeting Date:	**9 September 2014**
From:	**Adrian Loades, Executive Director, Children Families and Adults Services**
Electoral division(s):	**All**
Forward Plan ref:	**2014/019** ***Key decision:*** **Yes**

Purpose: To review the options for the future management and delivery of the remaining services provided under the current Section 75 Agreement with Cambridgeshire Community Services NHS Trust. These are the following social care services:

- Reablement services for older people and 18-64 year olds with physical disabilities;
- Occupational Therapy for adults;
- Assistive Technology and Telehealthcare;
- Administrative and management support to the above functions.

These services comprise 257 full time equivalent staff and a budget commitment of £8.18 million per annum.

Recommendation: It is recommended that Committee agree that

1. Negotiations with Cambridgeshire Community Services, and subsequently with the new provider of services for older people and adults with long term conditions as commissioned by the Clinical Commissioning Group, be conducted on the basis that:
   a) The Reablement service is transferred to the direct management by the Council.
   b) The Occupational Therapy services continue to be run and delivered as an integrated service, preferably managed by the successful new provider through a Section 75 Agreement (or contract) with the Council.
   c) The Assistive Technology and Telehealthcare service is transferred to the County Council.
2. A further report on the outcome of negotiations on this basis with Cambridgeshire Community Services, and subsequently with the new provider of services for older people and adults with long term conditions as commissioned by the Clinical Commissioning Group, be brought to the Committee for information and any further decision required.

	Officer contact:
Name:	Richard O'Driscoll
Post:	Head of Service Development, Older People's Services
Email:	Richard.o'driscoll@cambridgeshire.gov.uk
Tel:	01223 729186

1. BACKGROUND

1.1 Since 2002, the Council has entered into a number of partnership agreements with the National Health Service (NHS), now using Section 75 (S.75) of the National Health Service Act 2006.

1.2 The powers described under Section 75 cover:

- **Pooled funds** - the ability for partners each to contribute agreed funds to a single pot to be spent on agreed projects for designated services.

- **Lead Commissioning** - the partners can agree to delegate commissioning of a service to one lead organisation.

- **Integrated provision** - partners can join together their staff, resources and management structure.

1.3 Since 2004, Cambridgeshire County Council and NHS Cambridgeshire have jointly commissioned integrated services for older people. In 2007, due to the separation of commissioning and provider functions in the Primary Care Trust, Cambridgeshire Community Services NHS Trust was formed and became the provider of these services. The Council developed two S.75 Agreements, one for pooled budgets and lead commissioning with NHS Cambridgeshire, and one for Integrated Management with Cambridgeshire Community Services.

1.4 In April 2012 Cabinet decided that the current S.75 Agreement with NHS Cambridgeshire should cease, i.e. that the pooled budget and lead commissioning arrangements for older people's services and occupational therapy services should end, and that the S.75 Agreement between the Council and Cambridgeshire Community Services (CCS) should be refreshed. This was in order to ensure clear accountability on the part of CCS for the delivery of the statutory responsibilities the Council had delegated to them through the S.75 Agreement.

1.5 A subsequent decision was made to return Care Management and Discharge Planning staff from CCS to the direct employment of the Council. This staff transfer took place in October 2013.

1.6 For those services operating with a high degree of integration between health and social care functions it was decided that a further period of review was required. A decision was therefore made to retain a S.75 Agreement with CCS in the short term for the following older people's services:

- Reablement
- Occupational Therapy services
- Assistive Technology and Telehealthcare

This paper now reviews this decision in the light of the factors outlined in section 3.

2.0 CURRENT SERVICE DELIVERY

2.1 **Reablement** predominantly focuses on new service users aged over 65 and younger adults with physical disabilities. It aims to maximise independence by providing intensive short-term interventions at times of crisis, for example after a period of illness or a stay in hospital. The service is provided mainly by support

workers, working closely with occupational therapy and the Assistive Technology team, with input from physiotherapy. Reablement aims to reduce pressure on expensive institutional and long-term domiciliary care support.

2.2 **The Occupational Therapy service** is jointly delivered by Health-funded occupational therapists (OTs) and physiotherapists, and Council-funded OTs. Provision includes assessment of functional ability, education on preventative techniques, rehabilitative approaches, information and advice, requisitioning of equipment to promote functional independence, and advice with regard to minor and major housing adaptations. The integrated Occupational Therapy service covers all adults, not just older people and many of their most complex cases are people with physical disability under 65.

2.3 **The Assistive Technology and Telehealthcare (ATT) Team** assesses for and provides both telecare and telehealth equipment. The team also incorporates the Environmental Control Service (a small specialist activity for individuals with severe disability). Telecare is the use of sensor and communication technologies to monitor the safety and wellbeing of vulnerable people in their normal place of residence and alert appropriate people when help or action is required. Examples include falls sensors, bed/chair occupancy sensors & medication reminder systems. The provision of telecare products primarily meets social care needs. Telehealth monitoring is the remote exchange of physiological data between a patient at home and healthcare professionals in a different location to assist in diagnosis and monitoring (this could include support for people with lung function problems, diabetes and other long term conditions). Examples include blood glucose monitoring, blood pressure monitoring and activity /sleep monitoring.

3.0 RATIONALE FOR REVIEWING REMAINING SERVICE ARRANGEMENTS

3.1 ***Cessation of CCS older people's services:*** The Clinical Commissioning Group is undertaking a competitive tendering process for the future commissioning and delivery of older people's services and services for adults with long term conditions. The contract is due to be awarded in September 2014 and to be operational by 1st April 2015. This will involve the transfer of all older people's community health services from Cambridgeshire Community Services (CCS) to a new provider, including the funding for the NHS element of the above integrated services which are also partly funded and commissioned by Cambridgeshire County Council. As the above services are vital to the Council's demand management and transformation requirements, it is essential to take a view on the future arrangements that best meet the Council's objectives. As a consequence of the new provider being appointed, CCS have indicated that they will be unable to continue to provide the services outlined in section 2.

3.2 ***Organisational capacity:*** The adult social care system is currently under considerable pressure and this is unlikely to reduce in the foreseeable future. This strain is caused primarily by financial and demographic pressures, and meeting these pressures will require large-scale change across organisational boundaries. There are also new legislative and policy requirements coming in to force in 2015, including the Care Act and the Better Care Fund. In order to deliver these requirements, social care services will need to marshal all available resources to respond more rapidly to meeting new demands whilst at the same time maintaining quality and improving outcomes in partnership. There is a need to consider how services are best managed and configured to meet these challenges.

3.3 ***Financial pressures:*** As budgets continue to tighten, the Council needs to be in the strongest position to work strategically with its key partners – the Clinical Commissioning Group and Local Commissioning Groups, District and City Councils, and the community and voluntary sector. We need to review how we will be best placed to do this. It is also the case that the services currently managed by CCS are critical to achieving the Council's objectives in relation to preventing the escalation of need and therefore higher cost support, and avoiding hospital admission. We need to make sure that future delivery arrangements place the Council in the best position to exercise tight and responsive budgetary control.

3.4 ***Learning from experience:*** In order for the Council to deliver its adult social care priorities we need to maintain a sharp focus on all operational activity. The success of the service transfer to date gives a proven model on which to build our approach. The view of the local authority is that the services that returned to the Council in October have continued to operate successfully, with a clear focus on Council priorities and requirements. It should be noted however that some NHS colleagues have expressed concerns that services are less integrated. The Council is happy to address these concerns going forward and retains a strong commitment to change and improve effectiveness and positive staff morale. Experience has also shown that regardless of changes in organisation or management, staff who are co-located and work closely together on a daily basis are well placed to continue to function in an integrated way with other organisations.

3.5 The primary trigger for the review of future arrangements for these services is the CCG's procurement exercise. It should be noted that the current services are generally managed well by CCS and there are no major enduring performance issues. However, the CCG procurement exercise and the consideration of future arrangements in the light of future challenges faced by the Council, prompt the recommendations set out in this report.

4.0 REVIEW PROCESS

4.1 Officers have considered the following points in undertaking a review of the current arrangements:

- Financial benefits and risks
- Service benefits and risks
- Specific options related to individual services
- The views of staff currently employed in these services, and the views of people who use these services (via the Older People's Partnership Board).

5.0 FINANCIAL BENEFITS AND RISKS

5.1 The annual budget and full time equivalent staffing for the services under consideration are as follows:

Social Care functions	**TOTAL CCC funding**	of which staffing	of which non-staffing	staffing FTE as at Oct 13
Reablement	**£5,967,580**	5,524,280	443,300	206.54
Occupational Therapy	**£1,523,100**	1,448,700	74,400	41.72
Assistive Technology and Telehealthcare	**£250,200**	110,600	139,600	4.18
Management contribution	**£189,020**	184,500	4,520	4.5
Serco costs	**£250,500**			
Subtotal	**£8,180,400**			256.94

5.2 This budget includes contributions from Cambridgeshire County Council to management and back office (Serco) functions as above.

5.3 Currently these functions operate within CCS as integrated social care and health services funded through a combination of local authority funding (shown above) and NHS contributions. This complicates attempts to disaggregate activity and respective financing. However, the following table provides indicative Health funding to each strand of the currently integrated operations:

Overarching service	**Health Investment**	**Health focus**
Intermediate Care & Reablement	**£2,732,700**	Intermediate care - supported recovery, admissions avoidance & end of life care
Physiotherapy and Occupational Therapy	**£3,276,600**	Predominantly physiotherapy
Assistive Technology	**£236,000**	Telehealth vital signs monitoring, medication management
Subtotal	**£6,243,000**	

5.4 As it stands, the agreement for the services in paragraph 5.1 is at the pre-set fixed value above. Risk and reward of over or under-spend currently sit with CCS. Whilst delivering these services in-house may create greater financial risks for the Council, there are also potential benefits and efficiencies to be gained in developing greater synergies with other services already delivered by the Council. For example, closer working between social care teams and assistive technology services would ensure that equipment and assistive technology solutions are considered at the earliest opportunity so as to avoid costly care packages. This would apply to Children's Services as well as Adults, since the Assistive Technology service is a "cradle to grave" service. Direct management by the Council would also enable more transparent governance arrangements for both finance and performance, for example through clearer management information. There may also over time be opportunities for further efficiencies through rationalisation.

5.5 TUPE (Transfer of Undertakings – Protection of Employment) regulations will apply for staff transferring out of CCS. Due to the integrated nature of the services CCS currently provides, the process of identification of the staff to transfer under TUPE will be complex. The Council would seek to ensure that the workforce it employs at the point of any transfer is commensurate with the funding available and present activity levels. Experience from the transfer-in of staff on NHS terms and conditions in 2013 is that, where new appointments are made onto County Council pay-scales, potential disharmonies in staff costs between pay scales have been mitigated by national pay decisions, application of County Council employment policies and staff gradually electing to transfer terms and conditions.

5.6 Identifying which back office and management posts should transfer (e.g. operational managers, Finance and Human Resources) would be complex, and there may be a need to invest in back office support capacity if insufficient capacity is transferred from CCS. Equally, there may be savings to be made in driving out any duplication. In addition, the Council may find itself in a position where it could be required to meet additional revenue costs associated with occupying CCS buildings, should CCS or the new provider choose to charge the Council.

6.0 CROSS-SERVICE BENEFITS AND RISKS – SHORT-TERM

6.1 **Recruitment and morale:** In light of the current procurement exercise, a transfer of staff from CCS to a new employer is inevitable. For many staff, transferring to the Council may be seen as a more positive option, although some have expressed concerns about potential changes to terms and conditions. In general staff who have a clinical background and have always been employed by the NHS (such as NHS-funded occupational therapists) are most likely to have concerns about transferring from the NHS to a non-NHS organisation. Staff holding social care posts (the majority of those CCS staff currently funded by the County Council) may view the opportunity to work more closely with Social Care colleagues within the Council in a positive light.

6.2 **Capacity to manage the transfer:** Should the Council decide to transfer the remaining services, there may be limited capacity in our existing support services, including those provided by LGSS, to conduct a transfer quickly. Increasing the size and functions of the Older People and Mental Health Directorate will also make additional demands on the LGSS services that support the Directorate. Early communication and contingency planning have begun in order to mitigate these risks.

6.3 **Leadership and management:** Managers within CCS have joint responsibility across health and social care services. Whilst we would anticipate some difficulty in disaggregating management functions, there are clear rules around this - TUPE rules will apply. Any transfer process would need to be carefully co-ordinated to avoid destabilising service provision. There would need to be a clear sense of purpose and direction throughout this period.

7.0 CROSS-SERVICE BENEFITS AND RISKS – LONGER TERM

7.1 **Performance:** Service transfer to an external provider may present the Council with a challenge in terms of driving performance and ensuring best value. A particular benefit of returning services to the Council would be derived from bringing decision-making and service delivery closer together, making the delivery of policy more effective and increasing the accountability for performance at both a strategic and operational level. It would also allow for more responsive monitoring of service quality, and would assist in responding to user feedback and community issues more quickly.

7.2 **Responsiveness:** Direct management by the Council would enable greater flexibility in the service activities we offer and help us to be more responsive to changing demands and needs. One example would be by linking more directly with key partners such as the Independent Service Providers (ISPs), voluntary sector and GP-led commissioning. It would also mean that the Council would be able to more directly link to key policy initiatives such as Transforming Lives.

7.3 **Integrated services:** These services are generally integrated with health provision, and disaggregation would potentially be complex. In all cases, the Council will want to avoid undermining the way in which services work in an integrated manner and ensure that service users do not experience a less joined-up service. Hence, regardless of who employs the staff, any transfer proposals would need to consider co-location of services as they stand and continued collaboration with the new provider once appointed. The Council will recognise the need to remain committed to functional integration regardless of management structure.

8.0 THE VIEWS OF CCS STAFF AND SERVICE USERS

8.1 Council staff facilitated a meeting with a representative groups of CCS staff to seek views on future organisational arrangements. Representatives from Reablement, Occupational Therapy, ATT, Physiotherapy and CCS management were present.

8.2 CCS staff expressed serious concerns about the potential impact of disaggregation. Views expressed were:

- Integrated teams should be retained regardless of employing organisation. This includes physiotherapy. Professional support is secure and could continue to work under any management structure.
- Teams should be co-located to further strengthen relationships.
- Teams should have clearly defined targets and performance indicators, shared across organisations.
- Teams should retain a single IT system.

8.3 Views of staff were based on the desire to provide the most effective service rather than preference for any particular organisation.

8.4 The Older People's Partnership Board expressed the view that the key issue is the delivery of a service that is integrated for the service user, regardless of who is the employing organisation.

8.5 We therefore need to ensure that any future delivery mechanism can provide continued integration, co-location and shared performance indicators, as well as providing further opportunities to build wider integrated teams where appropriate.

9.0 OPTIONS FOR REABLEMENT

9.1 Council-funded reablement staff work within the intermediate tier of provision, with a focus on intensive short-term interventions. Where an intermediate care solution is required to support early discharge from hospital or to prevent an admission, reablement support workers can be involved in providing the personal care component of the package, with Health staff providing the nursing and therapy component. The Council is significantly the biggest funder in this service area, with around 70% of this intermediate tier being funded by the Council.

9.2 Reablement is an essential element of the delivery of the proactive, preventative and personalised model of social care and social work described in Transforming Lives. Any future delivery mechanism would need to ensure a clear focus on these County Council Social Care priorities.

9.3 Options for future delivery include:

- The County Council could commission the new provider to deliver reablement services, with all intermediate tier staff transferring from CCS to the new provider.
- Reablement could be subject to a full procurement process, with the winning bidder taking on the Council-funded reablement staff.
- The Council could provide reablement services directly, and existing CCS staff employed in Reablement would transfer to the Council's Older People's and Mental Health Directorate.

9.4 The Council could commission the new provider to deliver reablement services on our behalf, which would mean that the Council-funded staff would transfer to the new provider alongside the Health-funded staff. This would maintain an integrated

service. However, we know that strategies for the intermediate tier will take time to develop and become embedded in the new provision, and there is a concern that the Council's requirement to implement the new model of social care and social work to meet its own service and financial challenges is not compatible with this timescale.

9.5 Undertaking a full new procurement process may stimulate the voluntary or independent sector to provide a more cost-effective solution, hence helping the Older People's Directorate meet its financial challenge. However, at this stage there is probably not sufficient capacity within the independent sector to deliver such large-scale provision within tight timescales, and opportunities for integration with Health colleagues would not be possible. Equally, this would be a major procurement exercise and the timeline for completion would not be realistic. So whilst this is an option, it would be considered a high risk strategy at this point in time.

9.6 Delivery of Transforming Lives would be better supported through more direct influence on how the reablement service develops, and this is best achieved through direct management of the Council-funded part of the service. It would be easier for the Council to ensure that staff are focused and involved in Transforming Lives and assured that resources are focused on its own Social Care strategic priorities. We would need to recognise that co-location continues to be important, and work with the new provider to make sure that the integration within the intermediate tier does not become fragmented. Direct management of reablement services would enable the Council to achieve greater collaboration with the third sector and extend the range of intermediate solutions. It is also possible that the Council would be able to exert significant influence on the priorities for the new provider because of the Council's considerable investment in the intermediate tier.

9.7 **Recommended option for Reablement:** It is recommended that Reablement is transferred to direct management by the Council. This option would enable the Council to ensure that these essential services provide value for money and are focussed on our Social Care strategic priorities to support the successful delivery of Transforming Lives.

10.0 OPTIONS FOR OCCUPATIONAL THERAPY

10.1 Council-funded OTs operate within a fully integrated team of OTs and physiotherapists. Around 30% of the funding for this team comes from the Council, and 70% from Health. The integration of health and social care OT services has resulted in significant improvements to waiting times. The service works well as a fully integrated team, and hence any option for future delivery will need to ensure this integration can continue.

10.2 Options for future delivery of this service include:

- The integrated Occupational Therapy team as a whole could transfer to the new provider, so that the team can continue to operate in a fully integrated capacity, building on current good practice.
- The Council-funded OTs could transfer to the Council, which would enable us to create a wider reablement function within the Older People's Directorate. The physiotherapy service and NHS-funded OTs would transfer to the new provider as commissioned by the CCG.

10.3 Should the Council decide to commission the new provider to provide the Council-funded OT service alongside the NHS-funded service, the fully integrated service

could continue, as well as the strong working relationships with physiotherapy. Waiting times for assessments would continue at current positive levels if the new provider maintains or builds upon current good practice. The Council would need to ensure robust commissioning and contract monitoring arrangements so that we can tightly manage performance.

10.4 Transfer of the Council-funded OT service back into the Council would necessitate disaggregation of the integrated OT team. Disaggregation would undo the positive work on integration within the NHS which has taken place over the past ten years, with a likely negative impact on service performance. Longer waiting lists impact upon the duration of reablement services, creating more costly homecare packages. Equally, waiting times can lead to the need for more acute crisis intervention, for example, as a result of falls which then necessitate hospital admission. Service users would experience duplication and confusion of roles and responsibilities – which the integrated service was put in place to avoid.

10.5 **Recommended option for Occupational Therapy Services:** It is recommended that these services continue to be delivered as an integrated service. This is on the basis that it would be almost impossible to disentangle the Council-funded OTs and there would be limited benefit to service users. On balance, the preferred option would be for the integrated Occupational Therapy service to be managed by the new provider through a direct contract, since this would enable the close working with physiotherapists to continue. However, we would need to be reassured that the new provider has good management information systems in place so that we can manage the contract effectively.

11.0 OPTIONS FOR THE ASSISTIVE TECHNOLOGY AND TELEHEALTHCARE (ATT) TEAM

11.1 There are eight staff in this service area, with 50% funding from Health and 50% from the Council. This is a small but critical service area which is key to the Council's demand management strategies – maximising the use of innovative technology to support independence and to reduce costly care packages. This team is fully integrated, with the same staff fulfilling both telecare (social care focus) and telehealth (health focus) functions. As it stands, disaggregation would be very difficult within this fully integrated team. Any future delivery model will need to recognise this.

11.2 Options for this service include:

- The team as a whole transfers to the new provider, with the Council contracting with the new provider to deliver the telecare aspect alongside the telehealth component.
- The Council-funded part of the team could transfer to the Council, with the telehealth component being delivered by a separate team under the new provider.
- The team as a whole transfers to the Council.

11.3 We know that disaggregation of this team would be very difficult, and we also know that this is a vital service for the Council going forward. Whilst commissioning the new provider to also deliver the Council-funded part of the service would enable integration with Health colleagues to be maintained, the team may become isolated from any services transferring to the Council. There is a risk that the telecare aspect of the service would become less important than the telehealth aspect, resulting in less emphasis on prevention. Equally, integrated delivery would be compromised should half the service transfer to the new provider and half to the Council.

11.4 Negotiating a transfer of the whole service to the Council would enable closer integration with social care teams - as well as possible integration with Reablement should this service also transfer to the Council – and this would mean that ATT could be used most effectively. There are clear and positive links to be made with the Council's Sensory services which would add value to both services. The "cradle to grave" nature of this service means there are closer links to be made across the whole of our Children, Families and Adults Services. This option would need to be accompanied by a clear commitment to maintain strong links with Health commissioners to ensure that the telehealth component is delivered appropriately. This option would need full and robust agreement with the new provider. Early conversations with possible providers have indicated that they are very interested in the ATT service and see it as a key asset for development, as does the Council. One possible scenario is that the Council proposes to take the whole service and cover the NHS component of the funding and the new provider uses the current CCG investment to create a new service that is focussed more on telehealth – though we would need to guard against the risk of service duplication.

11.5 **Recommended option for ATT Services:** It is recommended that the Council negotiates to transfer this integrated services fully to the Council. Anticipating that the new provider would also wish to retain management of this service, negotiations will need to take place as to whether the Council will need to take full funding responsibility and cover the funding gap of £236,000.

12.0 ALIGNMENT WITH CORPORATE PRIORITIES

12.1 **Developing the local economy for the benefit of all**

The prime focus of these services is to keep an older person or those with physical disabilities active and independent. This means that they are more able to fulfil their role as active citizens, get involved in a range of community functions such as volunteering, and continue to be active consumers which will be of benefit to the local economy.

7.212.2 **Helping people live healthy and independent lives**

This report evaluates options to ensure that the Council can maintain a clear focus on supporting older people or those with physical disabilities to live as independently as possible.

12.3 **Supporting and protecting vulnerable people**

This report evaluates options to ensure that the Council can continue to provide care to vulnerable older people. In the longer term the Council will seek to develop these services, working with partners, to best meet the needs of vulnerable older people in Cambridgeshire.

13.0 SIGNIFICANT IMPLICATIONS

8.113.1 **Resource Implications**

Financial benefits and risks are outlined in detail in section 5 of this report. Effective governance is required to ensure that the services are delivered within the allocated budgets. This report evaluates options to achieve closer monitoring and control of spend, as well as how to ensure that preventative services are most effective in preventing higher cost interventions.

It should be noted that any significant staff transfer will require some change of management structure within our Older People's and Mental Health Directorate. It is not yet clear what management capacity would transfer from CCS, so there may be some resource implications in this regard.

13.2 **Statutory, Risk and Legal Implications**

The services currently provided by CCS support the Council's statutory responsibilities. The report above sets out details of significant risk implications in sections 5, 6 and 7.

The S.75 agreement with CCS would normally require six months' notice of termination. Anything outside of this timescale would require full agreement from CCS. Some of the activities that will need to be conducted in order for a transfer of staff and responsibilities to take place include:

- Agreeing which staff will transfer to the authority;
- Making arrangements for payroll and pensions;
- Regular communication with affected staff and other stakeholders;
- Reviewing arrangements for property currently occupied by CCS staff;
- Legal considerations surrounding the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) transfer;
- Agreement with the CCG concerning Health functions that might transfer to the Council and management of transition;
- Agreement with partners on any residual costs resulting from transfer.

13.3 **Equality and Diversity Implications**

The report evaluates options to ensure that social care provision best supports all people requiring these services, underpinned by principles of access and inclusion.

13.4 **Engagement and Consultation Implications**

The views of CCS managers are included in the report, as are the views of service user groups. Any future changes in services arrangements will be subject to full consultation with service users, staff and partner organisations.

13.5 **Localism and Local Member Involvement**

There are no significant implications within this category.

13.6 **Public Health Implications**

These services are critical to health improvement. At their best they can make the difference between some retaining their mobility and independence or being admitted to hospital or a residential or nursing home. They are key to rehabilitation after someone has had a fall or similar incident.

Source Documents	**Location**
Section 75 Partnership Agreement – Older People and Occupational Health	Legal Services, SH1201 Shire Hall, Cambridge CB3 0AP