Agenda Item No. 9

OLDER PEOPLE AND ADULT COMMUNITY SERVICES (OPACS) CONTRACT UPDATE

Older peoples and adult community services workstreams review and Healthwatch learning event

To: Health and Wellbeing Board

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1. PURPOSE

1.1 The purpose of this report is to update the Health and Wellbeing Board for Health Issues on the work to review the Older People's and Adult Community Services (OPACS) model and workstreams. This paper also updates on the Healthwatch learning event, held on 11 May 2016.

2. BACKGROUND

2.1 On 3 December 2015 it was announced that the contract between Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) and UnitingCare had ended because it was financially unsustainable for all involved.

2.2 Although the contract was only in place a short time (eight months) the CCG believes it had started to show the green shoots of improvement. The procurement led to the creation of an innovative Outcomes Framework, improvements in integrating services, and extensive stakeholder engagement.

2.3 Two independent investigations have been carried out (by the CCG and NHS England) into the collapse of the contract. Further reports are expected from NHS England, the National Audit Office and Cambridgeshire and Peterborough NHS Foundation Trust.

3. CCG STAKEHOLDER WORKSHOP, 24 FEBRUARY 2016

3.1 On 24 February 2016 the CCG held a workshop for commissioners and providers involved in delivering older people's and adult community services which showed strong support for the model that had been developed by UnitingCare. The workshop was attended by delegates from a range of organisations including local NHS, local Councils, voluntary organisations and patient groups. The aim of the workshop was to discuss the CCG's emerging thinking. The speakers were from the CCG, Healthwatch Cambridgeshire, Healthwatch Peterborough, Care Network, Cambridgeshire County Council, Peterborough City Council and Cambridgeshire and

Peterborough NHS Foundation Trust. The workshop had an external facilitator who asked groups of attendees to share their priorities. The discussions were split into two rounds; the first focusing on *'Well-Being Prevention and Integrated Working'*; and the second focusing on *'Urgent and Emergency Care'*. Across both discussions a number of common themes emerged which are described in Appendix A.

4. HEALTHWATCH LEARNING EVENT, 11 MAY 2016

4.1 Healthwatch Cambridgeshire and Healthwatch Peterborough, working with Healthwatch Hertfordshire and Healthwatch Northamptonshire organised a Community Stakeholder Learning Event which was held on Wednesday 11 May 2016. The event had two purposes: firstly to share learning from the early termination of the UnitingCare contract, and secondly to consider the future of patient services based on the conclusions of the CCG Service Review. It was a collaborative event organised by Healthwatch and supported by Cambridgeshire and Peterborough Clinical Commissioning Group, Cambridgeshire County Council and Peterborough City Council.

4.2 The purpose of the event was to demonstrate transparency, learning and integration through a day of information sharing and discussion. The objectives were:

- To involve all local stakeholders, and understand together, what the enquiries into the failure of the UnitingCare contract for older peoples services in Peterborough and Cambridgeshire tell us
- To listen to peoples experience of care, and the roles and contribution of all stakeholders in achieving excellence
- To challenge and support the emerging plans for future service organisation and development, and ways that stakeholders can be involved and consulted
- To raise awareness of the local and national implications

4.3 We understand that Healthwatch will publish the outcomes from the learning event in due course.

5. WORK TO THE REVIEW THE WORKSTREAMS

5.1 Since December 2015 the CCG has been working with a wide range of stakeholders, including CPFT, Local Authorities, Healthwatch, providers and other stakeholders to review the current model, taking into account experience to date and the views of stakeholders to determine the best solution on how to deliver the benefits of the model within the resources available.

5.2 This work links to Cambridgeshire's JSNA priority 2 'Support older people to be independent, safe and well' and JSNA priority 4 'Create a safe environment and help to build strong communities, wellbeing and mental health'. The CCG's original drivers for integrating older people's and adult community services are also still applicable.

5.3 The review of the workstreams has taken into account the work of the Better Care Fund, the new Sustainability and Transformation programme and links to the joint vision and delivery plan with Local Authorities for improving outcomes for older people and those with long term conditions through effective integration.

5.4 The CCG and Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) remain committed to the outcomes and service model which was developed through the OPACS work. The CCG has commissioned services for 2016/17 from CPFT and other providers which reflects the conclusions of this review, and are aligned to both the Better Care Fund and the

new Sustainability and Transformation Programme (STP). The new contract will allow the delivery of all existing services provided by CPFT. We are making significant investment in progressing the service model. In summary, we intend to build on the Neighbourhood Team approach, continue funding the Joint Emergency Team (JET), the Dementia Intensive Support Service (DIST) and to make additional investment in community intermediate care capacity.

5.5 Although we remain fully committed to the model, the financial constraints we face mean that it is not possible to match the level of additional funding in services originally intended by UnitingCare for 2016/17. It is important that the CCG works with CPFT and other partners to manage expectations by being transparent about what we are not in a position to develop in 2016/17.

5.6 A summary of the recommendations, approved by the CCG Governing Body on 10 May 2016, are set out below:

Early Intervention and Well-Being Service	• Better coordinated and understood 'Well-Being Service', supported by an electronic directory of services • Cover all adults who may be vulnerable or at risk of developing more acute health or social care needs • CCG works with partner Local Authorities to commission these services, including social prescribing • Work with partners towards the vision for joined up advice and support, via STP and BCF processes
Neighbourhood Teams	• The CCG builds on and supports development of the 16 Neighbourhood Teams • Focus on developing joined up team working with primary care, social care and third sector services • Seek opportunities for closer working between Neighbourhood Teams and emerging 'primary care at scale' groups, including selection of NTs as 'demonstrator sites'
Case Finding, Case Management and Multi-Disciplinary Working	• Shift to more proactive care and develop 'case finding' by building on existing work and tools • Test use of the 'Rockwood' Frailty Score across the system • Adopt the draft Operational Policy for case management • A consistent approach to effective MDT coordination.

Integrating Information	• Wider consultation on the proposed solution (maximising the benefits from existing systems) and detailed development of an agreed model • Progress work via the Better Care Fund Data Sharing Group to support engagement and change as well as providing governance for the project(s) • Aligning with the wider digital roadmap, as well as the wider programmes of work within the – Better Care Fund, Sustainability and Transformation
Primary Care, Prevention and Long Term Conditions	• Development of improved care pathways for Long Term Conditions is taken forward by the STP Proactive Care & Prevention programme • Development of primary care at scale is linked with the development of OPAC services, and also taken forward as part of the STP Proactive Care and Prevention programme • Identify demonstrator sites where partners are able and willing to accelerate local integrated working
Single Point of Access (OneCall)	• The 'new OneCall' service operated by CPFT is evaluated for 6 months • The option to integrate 'OneCall' functions with the new Integrated Urgent Care service from October 2016 is reviewed in the light of the 6 month evaluation
Joint Emergency Teams	• The CCG continues to invest in the JET in 2016/17 • That the CCG, CPFT and other partners work to deliver on a joint improvement plan to continue to improve the JET service in terms of effective operation, onward pathways, and also appropriate referral into the service
Discharge & Intermediate Care	• Develop the discharge planning protocol • Carry out the intermediate care beds review • Develop community intermediate care in line with the UEC Vanguard proposals, including Integrated Care Workers.

Working with Care Homes	• That the CCG rolls out the Care Educator approach in line with the UEC Vanguard proposals • That the CCG reviews the Care Home Local Enhanced Service with a view to offering a more comprehensive approach during 2016/17
Other Services	• Investment in the Dementia Intensive Support Service should continue • Further development of End of Life Care Services will be taken forward within the Urgent & Emergency Care workstream of the STP services
The Outcomes Framework	• Outcomes Framework metrics are built into Better Care Fund plan outcomes • The Outcomes Framework should be reviewed to take into account the new context in which it is operating, updated national outcomes guidance and experience to date • This review should if possible identify a small number of key outcome metrics which the whole health and social care system can sign up to and measure performance against
Integrator Function	• Further development of the OPAC Service model is taken forward through the relevant STP workstreams and Better Care Fund structures • The CCG should work with CPFT to produce localised performance reporting which supports both front-line staff and the commissioning process • Engagement work should be taken forward in future via the STP and BCF processes • Regular communications for staff and other stakeholders should be produced to update on progress and services.

Source Documents	**Location**
Cambridgeshire and Peterborough CCG Governing Body paper, 10 May 2016 (Agenda item 2).	http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/GB%20Meetings/2016-17/20160510/Agenda%20Item%2002.1a%20-%20OPAC%20Service%20Review%20v4.2.pdf

APPENDIX A: 24TH FEBRUARY 2016 STAKEHOLDER FEEDBACK SUMMARY

Summary outputs from the two open discussions at the OPACS workshop on the 24th of February 2016

1. Introduction and Executive Summary

Outlined below is a summary of the key outputs from a stakeholder workshop to agree our future priorities in Older People and Adult Care Services.

The discussions were split into two rounds; the first focusing on *'Well-Being Prevention and Integrated Working'*; and the second focusing on *'Urgent and Emergency Care'*. Across both discussions a number of common themes emerged including:

What's working:

- Clear, shared vision – there is a lot of buy in to the vision and model, and a strong feeling this must continue beyond UnitedCare
- The outcome based approach
- Integration – long way to still go, but have already seen a good results of agencies working together and the co-location of staff e.g. in neighbourhood teams etc.
- Connecting with the voluntary sector – this is seen as a vital area for further work, but there has been good progress in pilots of involving them in discharge teams etc.
- JET – although still need further work on skills mix and integration with other services

What we need to improve and rethink our approach to:

- Greater focus on implementation – need to move out of planning into action, with a view to learning as we move forward
- Data and information sharing, and a better Directory of Services
- Better engagement of / partnership with the voluntary sector

What we should STOP doing:

- People accessing expensive services they don't need – e.g. sending them to hospital when it is not the best place for them
- Duplication across the system – e.g. assessments
- Culturally, playing it safe – need to be more innovative, and open to learning from different approaches

Goals/priorities for the next 12 months:

- Continued focus on integration; improving handovers, putting a greater focus on prevention and improving sharing of learning across the system
- Better engagement and partnership with the voluntary sector
- Data sharing and universal access to it
- Single point of access needs further work
- Getting an accurate DOS
- Engagement and education of the public behind our vision

2. First Round – Focusing on Well-Being, Prevention and Integrated Working

Working Well

- Cohesive vision across the system
  - Everyone working towards the same objectives
  - Vision is bringing the right services together
  - Vision that GPs are bought into
- Outcomes focus
- Integration of Health and Social Care
  - Willingness of different organisations/agencies to work together (attitude shift)
  - Staff still enthusiastic about integration – need to capitalise on this
  - Joint working in neighbourhood teams – early stages of making it work, but some good 'green shoots' emerging which we need to maintain
  - CPFT and Social Care now working together well
  - Multi disciplinary teams around localities
- Broad engagement of multiple services that have a role to play in prevention
  - Engagement of Lead Professionals other than just GPs and Social Care
- Connecting with the 3rd/voluntary sector
  - Using voluntary organisations as our eyes and ears
  - Work with Voluntary Sector on Wellbeing Services
  - Discharge from hospital/handover from NHS to voluntary sector
- Efforts to share information
  - Moves towards data in one place – still long way to go
  - Directory of Services developing well in Peterborough
  - Single Point of Contact in Hunts for Community Teams
- Care Home Education
- District Nursing
- JET working well in HUNTS
- Health Watch
- Peterborough Partnership Board
- MDT meetings

Needs to improve; need to rethink our approach to:

- Communicating/selling the vision to all key stakeholders; including patients
  - i.e. Shared vision at top level not filtered all the way down to the coal face
  - Need a common language – still confusion amongst professionals on terminology (e.g. case management)

    - Better patient education regarding services – patients need to understand the model and feel engaged/empowered. More dialogue (time) in Primary Care with patients about choices
    - Link to Carers and empowering them
- Need clear communication around changes as a result of the end of the contract with Uniting Care
- Greater focus on implementation of the vision
    - Delivering what we said we would do in relation to JET, NT, MDT, Care home Education etc.
    - Focus on action and learning, rather than trying to figure out the perfect approach first
    - Need clear communication around what is replace Oneview
- Better feedback and evidence informed approaches
    - Single pathway for feedback (Health and Social Care)
    - Coordinated analysis of feedback
- Enabling better data sharing is absolutely critical
    - Data linking, not just sharing
    - Need to channel all work on Directory of Services though one process (connect to 111)
- Better partnership with the 3rd sector / Voluntary sector
    - They need more stability
    - 3rd sector have some issues around the contract
- Right response the first time
- JET
    - Need clearly defined aims within the organisation
    - Better understanding and trust driving referrals
- Intermediate Care
    - Need seamless transition between reablement and I.C.
    - And immediate access
- Scope for joint commissioning to improve
- How to make better use of our resources
    - Reducing duplication
    - Driving efficiencies
    - Capturing and making full use of community resources
- How we move to a greater focus of resources on prevention
- Continued focus on improving integration
    - Increasing trust between organisations

- Integration between Social Care and Acutes
- Co-location of OOH Services?
- NTs joined up with Primary Care
- Closer links with Housing in Las

- MDT working/access to MDT

Stop doing:

- Duplication in the system – e.g. in assessments
- People accessing expensive services they don't need – put more experienced people on Triage
- Repeat prescriptions
- Single Disease based schemes
- Funding patient/users with poor life style choices – need to be more brutal in promoting health

Goals/priorities for the next 12 months:

- Set out a clear set of unambiguous goals and milestones; improving our effectiveness in prioritising across the system
  - and reprioritise investment to align with these new priorities
  - Then get on with it! I.e. focus on action, and learning from doing it.
- Single point of access needs to work much better
- Data sharing; and universal access to it – absolutely critical
- Continuing drive towards prevention
  - GP engagement
  - E.g. Falls prevention; Dementia Awareness; clear pathway around Frailty
- Better engagement with voluntary sector
- Greater connection to JET – i.e. maximizing use of it
- Social Prescribing (don't reinvent the wheel)
- Workforce plan as a key enabler
  - Embed vision
  - Workforce recruitment
  - Empower staff – create a culture where mistakes are okay with a focus on learning from them
- Improving sharing of learning across the system

3. Second Round – Focusing on Urgent and Emergency Care

Working Well

- Our vision and model is the right approach – need to stick with it and hold our nerve

    - We have a clear view of what we want to do for older people, based on good insight into their needs and who is best placed to do what
- Outcome based approach
- Integration and co-location of staff (as an increasing part of this)
- Working across the whole system operationally
- Funding through the Vanguard
- Concept of Jet – when it works well it is brilliant, but still variable
- Voluntary organisations being embedded in the discharge teams
    - Doing ward rounds in Hunts
    - Community Warden
- GPs working at front door of A&E
    - And greater involvement in 111 and 999
- Ambulance response and Ambulatory Care – brilliant
- Amber Care Bundle – EOL
- Health watch works well
- Comms by UnitingCare worked well – need to retain this
- System 1 template – is it used though?

Needs to improve; need to rethink our approach to:

- Information sharing / Directory of Services
    - Improve the DOS
    - Knowledge of Health and Social Care Services
- Engage Volunteer sector more
    - Have capacity there which is not been taken up
    - Single point of access for voluntary sector
    - How are they engaging with key initiatives/schemes like neighborhood teams
- JET skill mix and integration with other services
- Escalation to the Community rather than Acute
    - Step change /shift in seeing ‘acute’ as the place of safety
    - Ambulance role in Community; rather than ‘scoop and run’
- Hospital discharge
    - Making sure patients opportunity to go home is not missed
- Alignment of Social Care and NTs
- EOL pathway
- Intermediate Care tier – Beds/home care

- Need to know how all the work streams fit together – i.e. Vanguard, BCF, CPFT programme, STP etc. – and what are the priorities

Stop doing:

- Sending people to hospital when it is not the best place for them
  - Stop promoting hospital care as always the best
  - Stop open door at A&E; put other services in front
  - Stop over medcalising people; frailty etc.
- Stop thinking we can make the transition without investment in alternatives to hospital
- Duplication across the system
  - E.g. Assessments
- Procurement and competition between providers – it gets in the way of collaboration
- Short term funding - need longer to make it work
- Culturally – stop risk aversion/playing it safe/playing by the rules

Goals/priorities for the next 12 months:

- Continuing our work on integration
  - Health and Social Care
  - Seamless handover between 111 / OOH's; JET etc.
  - NTs working with Councils – truly integrated, multi disciplinary NT's
  - Improve join up between voluntary sector and JET
- Discharge
  - Including roll out of voluntary sector involvement in discharge team
- Get an accurate DOS sorted – including for the voluntary sector
- Data sharing – to enable good data based decisions right across the system; including by the voluntary sector
- Change public behavior around what services they go to, by raising awareness of options and which is best for different needs; and increasing confidence in the system
- Sort EOLC
- Develop ICBs to ensure coordination and communication
- Make decisions on community beds
- Reduce variation through understanding what works