BCF Quarterly return – section 8, narrative

Progress with the BCF in Cambridgeshire has been broadly in line with planned activity. However, we acknowledge that we did not meet our target for non-elective admissions in the first quarter of 2015/16. We believe that the reasons for underachieving in the non-elective admissions target are largely due to the fact that Q1 has been a period of setting up and mobilisation. For example, the UnitingCare (UC) contract commenced on 1 April 2015. The initiatives launched in Q1 will require time to make an impact – for example OneCall and JET were launched on 6 May, but were only expanded to full geographical coverage and 24/7 operation from 1 July. The impact of local CCG initiatives for under 65s also have had a similar lead in time. Further, the BCF transformation projects have been establishing themselves during this period, and given that they are more focused on medium term transformation were not expected to have a significant impact on non-elective admissions during the first quarter. The performance payment has been made to acute providers reimbursing them for the additional non elective activity as per the CCG's contractual obligations.

The most significant area of spend and activity has been on the Older People and Adult Community Services Contract let by the CCG to the new 'Lead Provider' in Cambridgeshire - UnitingCare.

UnitingCare has begun service delivery in this quarter and made progress towards establishing new services. The following key features of the UnitingCare care model are now being phased in across Cambridgeshire and Peterborough:

• Integrated teams: 17 neighbourhood teams across Cambridgeshire and Peterborough. Each team will support up to six GP practices, and will provide community-based healthcare centred around the patient. These teams will each include a combination of community nurses, psychiatric nurses, allied health professionals, and support workers, all working together providing planned and rapid response services to meet the needs of the patient. Neighbourhood teams will be supported by specialist health care professionals in four integrated care teams, based in Huntingdon, Peterborough, Cambridge and Fenland/Ely. These teams will include a housing co-ordinator to ensure any accommodation issues are addressed, alongside consultants, geriatricians, psychiatrists, cardiologists, respiratory physicians and palliative care consultants for advice and consultation. The configuration of the Neighbourhood Teams has been developed, engagement with staff is underway leading to consultation with staff and implementation of new arrangements from September 2015.

• OneCall- UnitingCare single point of co-ordination: the new OneCall Service was launched on 6th May 2015, taking referrals from GPs in its first phase. The aim is that services will be accessible via a single telephone number available to GPs, out of hours services, community and mental health teams, hospitals, social care teams, voluntary organisations, residential care homes as well as patients and carers. Staffed by professionals with access to expert

clinical advice, it will provide people with guidance and advice as well as signposting them to relevant services or support.

UnitingCare will work with GPs and their teams to identify the patients at greatest risk of deterioration or future hospital admission and then co-ordinate their care through regular reviews by a multidisciplinary team comprising health, social care and housing support professionals.

• Joint Emergency Team (JET): the new JET service was launched on 6th May 2015, taking referrals from GPs and operating during daytime hours only in its first phase. It is being rolled out as a 24/7 emergency service that will work alongside ambulances and out of hours GPs to undertake assessments and provide immediate treatment or care in the patients home, preventing unnecessary referrals to hospital and allowing more people to receive care in the comfort of their own home.

• Wellbeing and prevention: UnitingCare will work closely with voluntary organisations and social care to deliver services and support for adults and older people to help keep people well.

• Technology: Currently different organisations use different electronic patient record systems, which means for example GPs cannot see what hospital staff have added and vice-versa. The new technology will bring together summaries of all the different records for that one patient, creating a single view of the whole patient record. This will speed up some of the processes making it easier to make decisions. It will also enable patients to view their own records. The first phase will be the launch of a 'single view of the patient record' in July 2015.

Other transformation projects

The scope of the OPACS contract does not include social care, however to be successful it is essential that services are closely integrated between health, social care and other related services.

Our BCF Transformation Projects are also continuing to progress and are being jointly developed across Cambridgeshire and Peterborough. The first quarter has been a period of development for the projects, which aim to deliver transformation to the local system in the medium term.

• Data Sharing: To deliver an effective and secure joint approach to data sharing across the whole system, enabling improved co-ordination and integration of services for adults and older people.

The Data Sharing project is underway. A Board has been established and has agreed a comprehensive project plan and dashboard, which will steer the project going forward. Additional outcomes and statements were added to ensure there is a clear service user focus:

- Patients and service users will have a better experience of care and improved outcomes;
- Patients and service users will have access to their own data;
- "My privacy and wishes will be respected";
- "Professionals will be able to access my information when it is to my benefit, if and when they need to"; and
- "I won't have to keep telling my story to different professionals from different places".

The immediate focus is on expanding the UnitingCare 'OneView' to include social care teams, with a particular focus in the first instance on discharge planning and reablement teams. Each Council has consulted with practitioners to understand what health information would be valuable from a social care perspective and also what social care information may be available that would be useful to share with health. Technical discussions have started on how to enable the uploading of social care data into OneView.

In addition, a piece of work will be developed to ensure that patients and service users are consulted and their feedback collected on the development of data sharing models.

• 7-Day Working: To expand 7 day and out of hours working to ensure a safe, effective and caring response is available 24 hours a day, seven days a week, to prevent avoidable admissions and promote discharge from hospital.

There is an inclusive project plan and a dashboard established. This project is being led by each SRG in Cambridgeshire and Peterborough. SRGs are considering the priorities for each area to develop plans for seven day working. Priorities have been established and a plan developed by the Peterborough SRG, and the process is ongoing in other areas.

• Information, Communication and Advice: To develop and deliver high quality sources of information and advice based on individuals' needs as opposed to organisational boundaries. This will include an agreed principle of 'no wrong front door', building on good work already underway in Peterborough and Cambridgeshire.

Monthly core group meetings are now in place for this project workstream. Next steps have been agreed and a series of work has commenced to establish the priorities for a shared project across Cambridgeshire and Peterborough.

• Person Centred System - To enhance and improve person centred care across the entire system, ensuring that care and support is planned and co-ordinated by Integrated Care

Teams; establishing a process for joint assessments with an accountable lead professional; and that an integrated approach to identifying risk is established across different sectors.

This project is being led by UnitingCare as it is strongly linked to the development of the UnitingCare Service model – the scope includes Multi-Disciplinary Team working, approaches to risk assessment, and shared care plans. A monthly project steering group will provide governance and monitoring for this project.

• Ageing Healthily and Prevention - To develop community based preventative services to support and enable older people in particular to enjoy long and healthy lives and feel safe within their communities. This work is to be led by Public Health in Cambridgeshire and Peterborough. During the last quarter, priorities have been developed and a project team formed, which will meet for the first time towards the end of Q2. The project will include a series of targeted evidence-based health programmes and interventions for the following key priority areas:

- Falls
- Mental Health & Dementia
- Physical Activity & Nutrition
- Incontinence and urinary tract infections (UTI's)
- Multimorbidity
- Social isolation and loneliness

The project will also incorporate the development of the Voluntary Sector-led Wellbeing Service, which forms part of the new UnitingCare service model.