Joint Adults and Health Scrutiny Review

Integration of Health and Social Care Services in Cumbria

June 2014
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SUMMARY OF THE GROUP’S FINDINGS AND RECOMMENDATIONS

The task group was established in January 2014 to look at how integration of health and social care is progressing in Cumbria. This review was timely, as the Better Care Fund is scheduled to be implemented from April 2015, which will see money transfers from the NHS to local government to support adult social care and to make system changes that will reduce demand on acute hospital services.

The task group met on 11 occasions to undertake either witness sessions, task group meetings or site visits. The group examined the viewpoints of both health and social care professionals, what good practice is apparent elsewhere in the country, the plans and activities in place to integrate services in Cumbria and the level of progress across the county.

It was agreed that the aims of the review should be:

- to seek assurance that the integration of health and social care provision in Cumbria is on course to deliver the expected benefits (service improvement and financial);
- to review how health and social care can engage with communities and service users to demonstrate and encourage the use of improved and different service models;
- understand the extent of joining up of health and social care services in Cumbria, with a view to identifying future service improvements and efficiencies.

In response to these aims, the task group found that:

- removing duplication between health and care services, and working differently, are key elements to making efficiency savings and improving outcomes;
- a starting point should be gaining a comprehensive overview of who currently delivers which services and how;
- there were a number of issues for Cumbria, specifically around leadership, accountability and risk, financial arrangements and how services will be integrated on the ground;
- the link between strategic high level statements and how integration will work in practice is not apparent.

There are examples of good practice in Cumbria with a number of things being put in place to assist in the integration of health and social care services, including:

- an initial assessment of Cumbria’s Better Care Fund Plan indicates it has clear aims and objectives, all relevant partners are engaged in the planning group and the County Council is taking the lead in engaging partners;
Cumbria is helping to lead the way in trialling an ICT system that joins up acute service discharges with referrals to care services and has received recognition at a national level for this work;

innovative approaches to integration in the county are bringing professionals together to work closely to co-ordinate patient flow through health and into social care services;

Cumbria’s well established telecare services provide support in people’s own environment, in common with other areas of the country, with the Clinical Commissioning Group looking at how the telehealth ‘arm’ of this service can be added.

Recommendation 1
The County Council and Health and Care Partners need to identify, as a matter of urgency, a nominated lead - whether an individual or an organisation - to take ownership of the integration agenda, with clearly delineated responsibilities within each organisation.

Recommendation 2
The County Council and Health and Care Partners should:

- develop a jointly agreed clear vision statement for the integration of health and social care services in Cumbria, led by the Health and Wellbeing Board, within the next 3 months;
- develop a clear framework to guide and inform transformational practical models across each area of service, within the next months;
- develop a practical planning tool based on the above framework which allows a systematic cross-service approach to forward planning, continuous development and improvement, risk and barriers to change and successful integration, within the next 9 months.

Recommendation 3
The Health and Wellbeing Board should commission the development of a joint risk register across the whole partnership.

Recommendation 4
The County Council and Health and Care Partners should:

- develop a clear evaluation strategy for the progress of integration, within the next 3 months;
Part of this process should involve identifying key variables affecting outcomes as they emerge during the process of developing integration and encouraging staff participation in evaluating, reviewing and developing integrated services.

Recommendation 5

The County Council and Health and Care Partners should, within the next 6 months, establish a pilot programme, focusing on one area (either geographical or area of service delivery) based on developing a transformational primary care community, allowing new ways of working to be developed and assessed.

Recommendation 6

The integration of the telecare and telehealth services through a single contact centre - as is currently the case in Dumfries and Galloway - is a model of good practice, that should be adopted in Cumbria, over the next 18 months to 2 years.

Recommendation 7

A regular written report should be submitted to the Adults Scrutiny Board on the progress of the integration of health and social care in Cumbria at their quarterly meetings, commencing at their 2 October 2014 meeting.

Recommendation 8

The topic of integration of health and social care should be revisited, in June/July 2015, by a full scrutiny task and finish group.
BACKGROUND AND CONTEXT

In January 2014 the Adults Scrutiny Board and Cumbria Health Scrutiny Committee decided to undertake a joint scrutiny review looking at how integration of health and social care services could work in Cumbria. The review’s aims were to examine and consider:

- what is meant by ‘integration’ in this context and how could it work;
- what the introduction of the Better Care Fund means for the delivery of health and social care services in Cumbria;
- how new arrangements could save money from the NHS acute services and how people needing care can be better supported in the non-acute sector;
- how health and social care can engage with communities and service users to demonstrate and encourage the use of improved and different service models;
- seeking assurance that the integration of health and social care provision in Cumbria can deliver the expected benefits that are forecast, both in terms of service improvement and financially;
- good practice and models of integration from other authorities that could influence Cumbria in shaping local integration;

The task group comprised the following councillors:

- Cllr Mark Wilson (task group chair)
- Cllr Rod Wilson
- Cllr John Mallinson
- Cllr Kevin Hamilton
- Cllr Mike Hawkins
- Cllr Hilary Carrick
- Cllr Carni McCarron-Holmes
- Cllr Vivienne Rees (South Lakeland District Council);
- Cllr Joan Raine (Eden District Council).

National and Local Context

People now live longer and it is in older age that people often need a greater level of both acute health and social care support. The pressures on the acute (ie: hospital) services is becoming greater and there are financial challenges for these services.

For this reason, the government announced in 2013 that the Better Care Fund would be made available to local authorities from April 2015. The fund is worth £3.8bn but crucially this is from money already in the health care system. The idea is that this money is freed up from health services through the delivery of service integration,
and then can be ‘passported’ over to local authority social care services to provide the community-based services that are helping to reduce the demand on the health services.

In 2014-15 £200m will be transferred to councils to prepare for BCF implementation in 2015-16; the conditions for receiving this funding are that councils have jointly agreed and signed off two-year plans for the BCF which meet requirements set out in the planning guidance.

Passporting Better Care Fund monies is dependent on the following conditions being met: joint agreement of action; protection of services; 7-day access to health and social care; data-sharing; joint approach to assessment; agreement on impact changes in acute services.

There are some fundamental difficulties with creating greater links between health services, which are free at the point of contact and social care services which always need to be paid for.

Reducing the Demand for Acute Services

How can you take away the demand for acute services? Older people often end up being admitted to hospital when they have reached crisis point, such as injuries sustained at home, or long term health conditions (eg: respiratory disease, heart conditions or diabetes). Pivotal to reducing the demands on acute services are the following key points:

- preventing the need for hospital admission;
- reducing the length of hospital stay in those cases where admission cannot be avoided;
- preventing delayed transfers of care.

This can be achieved by:

- being more proactive around the preventative agenda that is, preventing people becoming unwell or incapacitated in the first place;
- when someone does present as needing treatment or support, taking a different approach to assessment (currently someone is taken to hospital and then assessed, from where they may be admitted or discharged to the care of primary services);
- ensuring that patients are supported to return home as soon as possible, where it is in their interest;
- ensuring that, where someone requires additional care or support to return home, arrangements are in place so that they are not in hospital longer than they need to be.
A recent King’s Fund report outlines the scale of the challenge for integrating health and social care and raises the following points:

- around half of people in care homes meet the entire cost themselves for those with assets worth £23,250 or more; under Dilnot reforms, being introduced in 2017, that figure rises to £118,000;
- advances in medical technologies is the main reason for rising health care costs;
- the average health spend on someone aged 85 plus is around 10 times the amount spent per head on people aged 5 to 30 years of age;
- studies from around the world show that between 25% and 40% of the lifetime cost of health care occurs in the last 18 months of someone’s life;
- although the Better Care Fund is set at £3.8bn, the total health and social care budget is closer to £120bn;
- in conclusion, the report states that there are three areas of failure of alignment between England’s current health and social care system, which are in regard to entitlements, funding streams and organisations;
- the King’s Fund proposes a solution of a single, ring-fenced budget for health and social care that is commissioned as one single service.

The task group’s brief

In order to ensure that they were able to fully explore the preparations for integration and understand the extent to which health and social care services are working in a joined up manner, Members wanted to identify key areas and questions that would help to guide and inform the review. They were assisted by Health and Care officers Louise Freeman (District Lead for Furness) and Adrienne Halliwell (District Lead for Eden).

Members considered 3 case studies to consider how integration was being trialled elsewhere in the country, and these were:

- Rapid Response Assessment Service (Thurrock);
- Assistive Technologies (Norfolk);
- Integrated Dementia Crisis Services (West Sussex).

These scenarios illustrated how a host of services can be needed for one person and how ‘wrap-around’ services are key to producing good outcomes for service users. Key concepts here include coordination between services; timeliness and speed of response to individual need; and delivery of quality services.

The task group identified key concerns as being around:
- risk, both financially and for the delivery of integrated services
- how community-based and care services can actively keep people from using acute services;
- providing 'single-point' access to services;
- how communication and co-ordination across the various health and care services can be achieved.

Crucially, members wanted to find out how these factors were being addressed and planned for in Cumbria.
LINK TO COUNCIL AND COMMUNITY PRIORITIES

The Council Plan for 2014-17 has a key priority of supporting older and vulnerable people to live independent and healthy lives. Under this priority there are specific key ambitions to:

- work with our partners in the health sector to bring services, particularly for adults with combined health and social care needs, together;
- explore the creation of a single commissioning body – in order to improve services and reduce costs;
- focus on prevention and proactive support for excluded and vulnerable adults, through the coordination of a range of key services.

This scrutiny review on integration of health and social care services takes these ambitions as its starting point, to examine what plans are in place and what preparations are being made to create a seamless set of services specifically geared to the needs of older people in our communities.
EVIDENCE SESSIONS

In order to gain a full understanding of what the issues are for Cumbria and how integration could be achieved, 18 witnesses took part in the review process. Of these, 13 met the task group in witness sessions, whilst the remaining 5 met councillors and/or the scrutiny officer on site visits. The full list of those witnesses who kindly support this review are attached at Appendix 1.

An outline of the key points arising from each meeting is shown below.

24 February 2014 - Richard Parry, Corporate Director of Health and Care Services

The Corporate Director was invited to talk to the task group about the Better Care Fund and how it is planned to passport this money from health to care services, and to provide the task group with an overall understanding of the work taking place around the integration of health and social care in Cumbria.

The Director outlined how the national vision for health and social care is centred around the individual and how Cumbria’s Health and Care Alliance is part of a wider approach to overseeing the integration agenda in Cumbria (comprised of Chief Executives, Medical Directors from acute services in Cumbria, NHS England, County Council and Clinical Commissioning Group).

The following performance indicators are being used in Cumbria, against which some payment will dependent:

- supporting discharged individuals/preventing unnecessary admissions;
- agreement of the impact on the acute sector;
- ensuring there is an accountable professional lead;
- delayed transfers of care;
- avoidable emergency admissions.

The Better Care Fund Plan (submitted to NHS England on 4th April 2014) was developed by the Better Care Board, comprised of representatives from the third sector, clinical commissioning group, HealthWatch and the County Council. This jointly agreed plan was built upon existing health and social care activity.

Work underway includes bringing in 7-day services, on line referral systems for use across services, practical approaches to avoiding hospital admissions and unifying ICT systems so that electronic information can be shared between services.

Avoiding admission to hospital in the first place is key, where clinically acceptable. One challenge is how much you can move assessment out into the community and how services themselves can be delivered in a different way. Members were advised that in Cumbria, a reduction in acute admissions of 20% would save around £30m. The task group also sought clarity on how monies saved from acute services will be used to support community based services.
For Cumbria, the available funding through the Better Care Fund will be £38m and plans are being worked up for how that might be spent. Built into the County Council’s Medium Term Financial Plan are sums of £5m, £10m and £15m savings related to the Better Care Fund. This would come directly from the Clinical Commissioning Group out of their budget.

To achieve health and social care integration, Members were advised that there needs to be a fully laid out vision and we need to understand what is meant by integration: is it cooperative or collaborative? How will it work in practice?

17 March 2014 – Peter Knock, Service Development Manager, Health and Care Services

The task group had asked for a witness who could illustrate how technology was being used to help people live independently in their own homes, supporting them to have the confidence to do so.

Assistive technology is a term that refers to any equipment that assists someone in their everyday life. It covers both ‘telecare’ and ‘telehealth’ and encompasses equipment that is installed in the home, or carried with the person when they leave the home.

The principal benefits of assistive technology are that it:

- helps to reduce risks to an individual both in and outside their home;
- ensures that emergency assistance for an individual can be ‘triggered’ if needed;
- assists people across a range of ages and is not exclusively for the older population;
- supports people who would otherwise have to go into residential care, allowing them to stay in their own homes;
- can be used to assess an individual’s needs in their own home, by monitoring personal routines using motion and door sensors.

**Telecare:**

Telecare is a system whereby equipment in the home is linked to a local monitoring centre, with staff then able to contact the service user to see whether they need assistance. Sensors that can be worn on the person, including wrist devices or pendants; these can be fitted with either alarm buttons, falls detectors or tracking devices, identifying where someone is and/or whether they have had a fall and may be incapacitated. The system can also be set up to alert a relative, neighbour or other nominated person to go and check on the service user.

Examples of this technology and some of its uses are outlined below.
Temperature sensors can determine whether a room becomes too hot or too cold, alerting the monitoring centre if a cooker is left on or the heating is not being turned on.

Door sensors can be used to tell if someone is opening the door. Used in tandem with a motion sensor this helps identify whether someone has left their house, perhaps in the middle of the night. Where motion sensors are used to assess someone’s needs, this is done through the involvement of a social worker.

Door sensors can be used in conjunction with recorded voice messages, using a familiar voice such as a relative to remind someone to take their keys and coat when leaving the house.

Service users arranging Telecare through Health and Care Services pay up to £1.81 per week, comprising a £1 monitoring service fee and 0.81p for the maintenance of equipment. Service users arranging Telecare privately will negotiate charges with their chosen provider. A sample price is around £2.99 per week.

**Telehealth:**

The use of tablets and iPads is more appropriate for the telehealth side of things, which is where a patient can have an appointment with a doctor, consultant or other health professional via Skype. A key benefit of providing health consultations remotely is that this immediately removes the need for a patient to travel to see a health professional. These can also be used for motivation coaching and as part of reablement services, where someone has physical exercises they need to perform daily to aid their recovery.

Equipment can also be provided to service users to allow monitoring of long-term health conditions, including Chronic Obstructive Pulmonary Disorder, heart disease, diabetes and so on. Equipment can be used to monitor lung function, blood glucose, blood oxygen, blood pressure and heart rate and so on. Information can be sent to a monitoring centre where an alert is triggered if the readings provided are outside normal parameters for that person and a clinician can be alerted who can then contact the service user. There are currently two projects in Cumbria involving remote monitoring (in Allerdale and Furness).

In Cumbria the Clinical Commissioning Group (CCG) is developing an overarching strategy on telehealth which, if commissioned jointly. It could use the same monitoring centres for telecare, using the same providers and installers currently used.

The ‘Just Checking’ assessment tool helps social workers understand what is going on in someone’s life and identifies whether they need residential care, or the type of support they need in their own home.
At the close of the session, members asked about the perceptions of people living with assistive technologies and whether some people find having equipment installed to be intrusive rather than helpful. The officer responded that, anecdotally, people feel more confident having assistive technologies in their homes and that assistive technology is less intrusive than alternatives such as using a person to check on them periodically. However, particularly for Just Checking assessment equipment and telehealth appointments, the task group felt there were potential issues for the culture and attitudes of service users.

17 March 2014 – Dr John Howarth, Director of Service Improvement, Cumbria Partnership NHS Foundation Trust

The aim of this session was to find out what practical steps were being taken by the NHS to reduce hospital admissions and reduce the length of hospital stays for older people in Cumbria and find out examples of collaborative working.

Healthcare in Cumbria – Current Challenges, Future Models

The health service faces massive financial challenges in Cumbria with both acute trusts in significant financial deficit. In addition recruitment and retention of staff is an increasing problem. A further issue that was highlighted was capacity, for example a comparison between Cumbria’s community nursing teams and Scottish nursing teams ‘dependency’ scores, shows double the number of people on Cumbria’s caseloads with most severe dependency and half the number of the least severe needs.

Cumbria has the oldest population in the north west with the associated impact on health services. Over the next 20 years the population aged over 85 years will double and this brings with it a series of associated issues including an expected 60% increase in the number of registered blind, a greater number of people with mobility problems and more people at risk of having falls. The number of dementia cases is predicted to rise by 80% in the next 20 years in the county. General hospital admissions are expected to rise 60% over that time unless we design a different model delivering more care outside hospital.

About 50% of health spend is on acute care – we need to shift the balance to more care delivered in the community. The life time health spend on an individual tends to be clustered around the last couple of years of their life and is focused on crisis-based admissions to acute services. We need more ‘up stream’ prevention care, avoiding crises. This will reduce pressures on acute services.

A new paradigm in health care is needed, with a whole system approach and a shift to early care and self-care, with gaps in health inequalities tackled in Cumbria.

Discussions are ongoing with acute trusts with regard to forming joint medical links between them to support local community teams to deliver care outside hospital –
bringing the specialist skills out into the community. In addition we have plans to roll out what we are calling ‘primary care communities’. These are integrated teams working around clusters of GP practices looking after a defined population built up from GP practice lists. This is a ‘one team approach and will take a local devolved health budget spending more of this budget on prevention and admission avoidance.

17 March 2014 - Justine Anderson, Locality General Manager, Cumbria Partnership NHS Foundation Trust

The Hub – Cumberland Infirmary

This is a pilot scheme based at the Cumberland Infirmary atrium to help avoid unnecessary hospital admissions, reduce the length of time of hospital stay and prevent delayed transfer of care out of hospital into other care settings, called ‘The Hub’ is based on a Royal College of Physicians model.

Hosted by the Cumbria Partnership Trust and overseen by a multi-disciplinary team of social workers, nurses, administration staff, physiotherapists and operational managers, the pilot looks at pathways for patients from GP surgeries, into acute services and back out again.

At the time of this meeting the Hub had been running for 6 weeks and was funded partly from monies from the winter pressure funding for North Cumbria. This followed the operational challenges raised by the previous winter, specifically around better information sharing, ensuring information is up to date and better co-ordination between professionals to aid patient flow through the system.

The Hub has 4 key functions:

- professional point of contact ‘triage’ function by phone
  senior nurse and GP discuss the need for patient hospital admission, as an admission avoidance function, looking at alternative services and care; a patient’s medical information is on screen at The Hub where details may then be passed on to acute colleagues in the admissions unit.

- older person’s assessment team
  full comprehensive geriatric assessment for frail elderly people aged 85 years plus; introduced in February 2014 this has had an impact with more than a third of people straight home with a management plan and package of care in place, many of whom would previously have been admitted.

- integrated discharge team
  this team is multi-disciplinary and works with ward teams on more complex cases to ensure safe and efficient discharge; since inception in January 2014, the average length of hospital stay for older people has reduced by 20%.

- patient tracking and care co-ordination
patients are tracked from admission to ward and since inception in November 2013 this has helped improve waiting times for the accident and emergency ward significantly.

Historically, the system of transferring patients from one service to the next has been fragmented and expecting clinical colleagues to navigate through the social care system has been problematic; so a more co-ordinated approach removes that need.

21 March 2014 – Dr Rebecca Wagstaff, Acting Director of Public Health

The task group wanted to find out more about how Public Health could help in the prevention of people needing to access health services. The task group were advised that getting a healthy start in life and staying healthy throughout, helps to reduce pressures on health care systems. Factors that determine health throughout life (shown as percentage of impact) are: lifestyle – 40%; social and economic circumstances – 40%; health services – 10%; genetics – 10%.

In Cumbria, South Lakes and Eden enjoy the best overall health, whilst Barrow, Carlisle and Copeland is comparatively poor. Social and economic drivers include community and culture, housing, education, where you live, quality of schools and parental attitude to education, which in turn influences job prospects and lifestyle choices. The task group explored the issue of how local government can support the population to be healthier and have a lesser need for health services?

Building healthy lifestyle habits is key to maintaining good health throughout life. Other positive factors include access to green and open spaces, which promotes good mental health and wellbeing. For the County Council, all Corporate Directors should see health as their business too, building such issues into all areas of service. It is also important in 2-tier areas to bring district councils in too and this is starting to happen in Cumbria.

Members were advised that including health matters as part of a child’s education is a good approach but not enough of this is being done. Educating children about the impacts of smoking and obesity would be an important part of this, because it informs future generations of the long-term health benefits of choosing a healthy lifestyle and avoiding physically damaging habits. Members felt that building healthy lifestyle education into school curricula would be a good way to inform future generations, but, were not entirely convinced that people in higher socio-economic groups were immune to poor lifestyle choices. However, members recognised preventative services as having a key role in avoiding some long-term health conditions and issues.
21 March 2014 – David Blacklock, Chief Executive of People First (provider of HealthWatch for County Council)

The task group wanted to talk to the Chief Executive responsible for the delivery of HealthWatch because of the role they play in working closely with members of the public on issues of health and social care services.

The task group were advised that HealthWatch is the independent consumer champion for health and social care customers. HealthWatch gathers information from people’s experiences of health and care services and makes that data available on its website in reports and at decision making forums. HealthWatch offers an information and signposting service helping people to make informed choices about where they go for their care.

HealthWatch Cumbria engages with public and patients in a number of ways, via their website and through events, including drop-in ‘surgeries’, roadshows and regular district HealthWatch meetings. HealthWatch can ask patients for their perceptions on services and provide independent information and feedback to bodies including the Cumbria Health Scrutiny Committee, Care Quality Commission, health and care providers, Clinical Commissioning Group, and Cumbria Health and Care Alliance. HealthWatch Cumbria also has a statutory seat at the Health and wellbeing Board.

In terms of integration, HealthWatch sees its role as overseeing the planning and implementation, as critical friends and guardians of the public interest. HealthWatch can bring the voice of the public to the table of decision-makers and voice their concerns. Public consultation will be a key way of engaging and informing the public about integration and what this will mean for service delivery going forward.

The Chief Executive provided a summation of the key areas of concern on integration, from a HealthWatch viewpoint:

- there needs to be a clear direction and credible plan for transformation;
- there is a lack of basic information to the public with regard to what is happening;
- services need to change and the public need to understand why and what will happen next;
- there is confusion about transformation and where the money is coming from to support services outside acute hospitals (a Better Care Fund will take money from acute services and put that money into community care, this is not ‘new money’);
- in terms of providing community based services, a concern is whether the infrastructure exists for these to be delivered; more staff, more training and more operational infrastructure
how do we go from the current system to an integrated one; at some point the acute services must disinvest so that the investment can be made in the community model of care.

where more services are going to be delivered in communities and people’s homes this brings in issues around staff supervision;

the role of the third sector with more agile, flexible, dynamic and creative ethos; it is important that the third sector are involved in the integration agenda because they may well be providing some of the associated services.

4 April 2014 – Task and Finish Desktop Research Meeting

Transformation Challenge Award – Bournemouth’s ‘Better Together’

One of the winning bids in the government’s Transformation Challenge Award, Bournemouth’s Better Together was particularly interesting for the task group because it expanded on the key theoretical and infrastructural elements for integrating health and social care services.

The basis for the bid is integrating services so that they are “person-centred, outcome-focussed, preventative, [and provide] co-ordinated care”. The bid identified 4 distinct areas of intervention: managing demand; improving effectiveness; integrating commissioning; and integrating service delivery.

With a total health and social care spend across the area of £1.2bn per year, the plans in place aim to bring about a ‘whole system integration’ which will involve rethinking the approach to managing and reducing the demand for services.

Pooled Health and Care Budgets

There are a number of councils across the country planning to pool their entire adult care budgets with the NHS as part of the Better Care Fund programme, allowing them to increase their budget considerably.

The Local Government Chronicle highlighted these plans in an article in February this year which named Birmingham City Council, Sunderland City Council and Oxfordshire County Council as having put forward a radical approach to funding for health and care services going forward. If plans come to fruition, this would mean these councils’ funds would increase (respectively) from £80m to £200m, from £25m to £150-200m and from £38m to £300m.

Although these plans have been hailed as ambitious and innovative, it is unclear how these will pan out and the task group will watch with interest to see how these arrangements progress.
23 April 2014 – Teleconference with Heather Mitchell (Chief Executive) and Haydn Jones (Director of Finance) at SEQOL

The task group wanted to hear from another authority where a successful model of health and social care integration was already working.

Launched in 2011, SEQOL is a Swindon-based Mutual Pathfinder with 845 employees delivering integrated health and social care services. It has a joint 4½ year contract from Swindon Borough Council and NHS Swindon to provide the following services:

- intermediate care;
- community nursing;
- social work;
- supported employment.

It is a Community Interest Company, with each employee having the right to a buy a share for £1. Examples of early success include an increase in patient visits for the community nursing team and efficiency savings of £3.9m from the original baseline.

Swindon has a long history of integrated services, with joint community teams, joint funding and jointly appointed directors. It has a population of 210k people with just one hospital.

For leadership and governance arrangements, SEQOL started with a blank sheet, and put in place 3 organisational ‘layers’: an overarching Board, Operational Coordinators and front line staff with management arrangements in place. It is held to account through contractual arrangements and normal council reporting procedures.

At the Swindon hospital this new arrangement oversees people from pre-admission to post-discharge, with a ‘front door’ service involving crisis team, ambulatory care, social workers, community equipment and occupational therapists. This means that people can be managed through the process of admission to hospital, to community support and back into their homes more quickly and effectively.

Services continue to evolve and change in response to need and recently the hospital discharge team moved to 7-day working, which allows discharges to continue over a weekend, removing the backlog at the start of each week.

The task group reflected on this witness session taking away the following key points:

- the way staff culture had changed due to staff involvement in setting up the social enterprise, being shareholders and the long-running experience of integrated working between health and social care services in Swindon;
the way that the public were engaged from an early enough point to understand why services were going to be delivered in a different way, and why this was happening, ensured public support for the integration agenda;

with having only one hospital, the link with acute services in Swindon is far less complicated than in Cumbria, where there are a number of different acute services being provided at a number of different sites.

28 April 2014 – Representatives from Grant Thornton UK LLP

Grant Thornton is a UK-based chartered accountancy firm that has recently undertaken work as part of its 2013/14 audit of the County Council to provide an assessment on the value for money arrangements of Cumbria’s Better Care Fund. This work has been approached from a key partner perspective, including County Council, Clinical Commissioning Groups and Provider Trusts.

The task group received a presentation on the Better Care Fund in Cumbria from Grant Thornton Representatives: Gareth Kelly – External Audit Manager, Assurance; Jackie Bellard – Engagement and District Lead.

The presentation covered the following points:

- national issues around governance;
- local work done on the Better Care Fund;
- achieving transformation through redistribution of existing funding;
- working closely to deliver innovative approaches;
- assessment of Cumbria’s plans.

Governance and Risk

Grant Thornton has a governance institute and each year they look at specific themes arising, publishing national governance reviews across local government, NHS, Not for Profit, Corporate and Housing sectors. This year they have undertaken an NHS Governance review under the following key themes: leadership and culture; collaboration and changes in landscape; integrated health and social care agenda, including workforce and recruitment.

A key task in preparation for integration of services is to develop adequate governance and risk management arrangements. There needs to be an effective partnership and risk management arrangements in place to deliver that.

There are 3 or 4 key risks identified for the Better Care Fund in Cumbria:

- not delivering integration of services;
- leadership and capacity;
- recruitment;
- organisations not being able to achieve a culture change.
A recommended starting point to address some of these risks is to carry out joint
arrangements is the assessment and identification of risks and opportunities against
the objectives of the partnership. From this is the development of joint risk registers.
The joint risk register provides a tremendous opportunity to pull capacity and
resources together and identify who is taking responsibility for each identified risk.
Risk communication is the most important part of building a partnership framework,
creating a set of objectives for a partnership and ensuring each area of risk has
ownership. Early engagement and dialogue between partners is key.

**Value for Money of Better Care Fund**

Grant Thornton has completed an assessment across some of the key partners,
taking in CCG, NHS providers and the County Council. For providers, the key issues
have been: governance arrangements; Better Care Fund joint plan; input from
various partners and their capacity to deliver on the plan.

An initial assessment of Cumbria’s Better Care Fund Plan raised the following
positive points: clear aims and objectives linked to bringing health economy into
financial stability, Closer to Home and Better Care Together projects; the CCG, third
sector and HealthWatch are part of the planning group for the Better Care Fund; the
strategic alliance appears to be working well and the County Council is taking the
lead to engage all partners to provide the detail needed in the submission of the final
plan.

Initial findings were subsequently updated at 28 April, with development areas
highlighted by Grant Thornton then including:

- develop detailed financial and operational plans;
- tax implications of new pooling arrangements to be fully considered;
- fully assess impact on providers, continued consultation to secure buy-in;
- develop robust but simple partnership governance and risk arrangements.

It was noted that findings from wider reviews of other BCF areas had found similar
issues.

**29 April 2014 – John Roebuck, STRATA Lead, Clinical Commissioning Group**

The task group had been told by the Corporate Director for Health and Care
Services that an IT system for e-referral and resource management called STRATA
was being trialled in parts of Cumbria, to support a co-ordinated approach to
transfers of care and discharge from hospital. The task group invited the lead for
STRATA in Cumbria to tell them about the system’s capabilities and how it was
being used.

STRATA is an electronic referral and resource management system, with a proven
track record in Canada where it has been used for 12 years across 9 provinces.
In Cumbria STRATA is funded by the Clinical Commissioning Group who are responsible for its maintenance and roll-out, costing £300k per year; this is the first time in the UK this is being used across health and care providers in one area and also links with non-acute services outside the county. Acute, community and adult social care staff have been involved in identifying what information is needed on the STRATA system to refer patients out of acute and community settings and into adult social care services.

NHS England have identified Cumbria as an exemplar site (along with Bristol and Bradford) that they want to promote and support in rolling out the initiative more quickly, giving it Rapid Accelerator Status for this work.

The task group were advised that Cumbria has high levels of readmissions to hospital, people being stuck in hospital beds and sometimes the wrong beds. It is in the interests of acute trusts to move patients around appropriately, because inappropriate referrals means patients can end up back in acute care unnecessarily. The introduction of an electronic system can help to reduce delayed transfers of care. Making referrals to the service with the rights skills, staff and equipment helps avoid this. There are a host of possible referrals for people leaving hospital, including: physiotherapy; occupational therapy; equipment services; mental health; patient transport.

All hospitals in the University Hospitals of Morecambe Bay Foundation trust are using the system, together with community teams from Cumbria Partnership Foundation Trust with the following breakdown:

- 250 referrals are going out from Morecambe Bay hospitals to adult social care services in Cumbria and Lancashire;
- a similar number of referral from Cumbria Partnership’s community services and mental health referrals are sent electronically to adult social care;
- around 500 referrals per month are going to adult social care across Cumbria and Lancashire.

It is anticipated that North Cumbria University Hospitals trust will begin to implement the system in June/July 2014 across both hospital sites.

Morecambe Bay’s electronic patient records system is integrated into STRATA; demographic information on that system automatically populates the STRATA system when a new referral is initiated. Further Integration with existing data systems is in progress including ‘Realtime’ in the North Cumbria Acute Trust, ‘EMIS’ for Cumbria Partnership Foundation Trust and ‘Liquid Logic’ for both Adult Social Care and Children’s Services at the County Council.

The long term plan for STRATA in Cumbria includes rolling this out to all parts of Cumbria and NHS England have identified Cumbria as having Rapid Accelerator Status for this work. Other services have expressed an interest in joining up
including Cumbria’s out of hours GP service ‘CHOC’; North West Ambulance Service; hospices and palliative care services; jointly commissioned intermediate care beds in care homes; and Greater Manchester Drug and Alcohol Service.

**STRATA Reporting**

The discussion moved on to focus on the reporting available through this system. The STRATA IQ reports can also provide transparent data, available to both the sender and receiver of referrals, including volumes of referrals and workloads. Trends are emerging through the use of the STRATA system and are now available to support performance management and proactively manage blockages in patient pathways.

Analysis by age group is also available, showing around 94% of people accessing adult social care are aged 60 and over, and 20% of patients over 90 years of age.

The data also shows inappropriate referrals – called ‘denials’ – and whilst in the past these have been anecdotal, they are now collated, due to the STRATA system. These are referrals coming back from adult social care, from community or acute services and has a current trend of around 8% of overall referrals.

The long term aim for STRATA in Cumbria is to have 100% join up between health and social care system and will be around a 2-3 year project as a minimum.

The use of IT systems in supporting the integration agenda was an issue the task group had identified at its scoping meeting, so members saw STRATA as an important building block for integrating services, avoiding delayed transfers of care and reducing the length of hospital stays unnecessarily.

**1 May 2014 – Site Visit to Dumfries and Galloway Telecare Contact Centre**

The site visit was supported by the following officers from Dumfries and Galloway:

- Keith Percival – Senior Manager, Contact Centre and Customer Service Development;
- Ian Callander – Contact Centre Principal Officer;
- Rose Black – Senior Social Worker, seconded to Contact Centre;
- Lorrain Hyland – Tele-healthcare Lead Officer, Putting You First.

**Telecare at Dumfries and Galloway Council**

The Contact Centre is split into 2 units, the main Council Contact Centre that delivers a range of services to customers from council tax to adult social work referrals, badged as ‘DG Direct’. The second part is Care Call, which deal with the 24-7 monitoring of telecare clients, assessment and installation of telecare equipment and recently the telehealth project ‘Annan Remote Monitoring’. There are 20 full time equivalent posts in DG Direct, Care Call have a core of 11 staff, working various shift
patterns, as well as a number of relief staff. Between the hours of 8am to 10pm there are 2 staff on duty and from 10pm to 8am there is 1 member of staff on duty.

It was explained that the assistive technologies in service users’ homes enhances their safety and independence including older people, people with mental health issues, and also people experiencing domestic violence. Equipment provided includes wrist straps, fall and smoke detectors, door sensors and pressure sensors. The telecare service started in 1987 and since then, the equipment has become smaller and less obtrusive.

Like Cumbria, the equipment is loaned out to service users, recovered when no longer needed and recycled for other users. This service caters for around 3500 clients in the Dumfries and Galloway area.

**Telehealth at Dumfries and Galloway Council**

The telehealth service is a collaboration with NHS partners, seeking to take a role in the preventative agenda, ensuring that people at risk are supported in their homes, to help avoid the need for acute services later on. This can include assisting people at risk of falls, people over a certain age, people with long-term health conditions and people who have recently lost their partner.

In the Contact Centre, the telehealth project has a data system with a number of users who require daily/regular health monitoring. Information comes from service users on telehealth equipment to the contact centre database. There are a range of things being monitored including respiratory, heart conditions and diabetes. The system raises an alert if a reading is not within normal range or is not submitted by a certain time. This ‘technical triage’ part of the service is run by the contact centre and would originally have been overseen by clinical teams.

Monitoring equipment is installed after a referral from a GP. Although initially clinical teams were unsure of non-clinical staff dealing with their clients, they are now confident in the model and therefore freed up to do other areas of their work. The monitoring fee is £3.75 per week, with the equipment being loaned not purchased by the user.

There are 73 projects being managed through the Putting You First initiative which is a 5 year change fund programme involving partners from NHS, Council, third and independent sector. The programme aims to realise efficiencies across these services.

Results from the first quarter of data has shown a reduction in the number of hospital admissions for the group of people being monitored; at this stage it is not clear whether this is an anomaly or whether this will be a continuing trend.
Social Work Adult Referrals

Based on the model of activity in East Lothian and other authorities, this approach has been working for almost a year in Dumfries and Galloway. In setting up the system, a large amount of social work queries were collated, to identify the sorts of questions call handlers would receive. Staff are housed in one half of the call-centre in what is called the social work ‘Pod’, dealing specifically with adult referrals.

There are 4 call handlers currently, but evaluation is underway to evidence the need for more, with around 6 being the ideal number for the volume of calls. One outcome has been reduced call frequency for other services, including Occupational Therapy, who are finding themselves freed up to get on with their assessment and support work.

A Care Call pilot is about to start, with referrals kept within the Pod, dealing with assessment, finance, installation and so on, with individuals being fast tracked into Care Call without the need for a social worker to visit and provide a referral. Future planning to introduce children and families social work.

1 May 2014 – Site Visit to Cockermouth Hospital and Health Centre

The task group had heard about a development in Cockermouth where a number of services, at different levels of service provision, were being brought together on one site. Members wanted to see how this was working in practice and what, if any, issues had arisen from this new way of working.

Cllr Mark Wilson, Cllr Hilary Carrick and Cllr Mike Hawkins visited the Cockermouth hospital site, and were met by Integrated Matron Tracey Porter (for Cockermouth Hospital and Maryport Community Hospital).

This facility was built after the 2009 floods in Cockermouth and has a number of services within it:

- doctors surgeries and nurse consulting facilities;
- 11 hospital beds with 2 theatres for minor operations and treatment;
- out-patients physio suite;
- number of out-patients services;
- 2 education/meeting rooms;
- community hospital on ground floor.

This community hospital has step-up facilities for patients in their own communities and step-down for those coming from acute trusts.

The task group met a small group of staff, including Dr Simon Dessert, to talk about the STRATA system used on site to send e-referrals to adult social care services. There were some issues reported with the STRATA system, in terms of patients being transferred over from health to social care services and it was suggested
improvements could be made to facilitate the transition from one area of service to another. Where delays occur from health to social care services, due to funding issues, this means a potential barrier in referral system.

Staff at the Cockermouth Community Hospital reported that operating and using the STRATA system had aided the smooth running at the hospital and on occasion opportunities for better joint working practices were highlighted. Staff members reflected that there should be a working practice which is based on a shared expectation that actions be planned for the right time at each point of someone’s progress through the system, so that their patient journey is seamless as they move between service/support arrangements.
FINDINGS AND CONCLUSIONS

The task group have found that, whilst work towards integrating health and social care services is being done across the county, this has emerged in a piecemeal fashion, without evidence of this being part of a grand overarching plan.

The use of an electronic referral system between health and social care services is an important aspect of facilitating more efficient transfers from acute to care services, but this needs to translate into action. Where a patient is transferred out of acute care to other care services, or discharged from acute to their home environment with the necessary support in place to do that, the information on the system needs to match the actions taken to provide that support. Where actions are delayed, for reasons of funding or logistics, this means outcomes for patients are not as expected.

Although the Better Care Plan has many positive aspects, in terms of identifying key activities and having engaged key partners in its development, there are 3 key elements that need to be addressed as quickly as possible and these are: leadership, accountability and risk. There needs to be agreed leadership from the Council’s partners, identifying who is responsible for what and ensuring that a joint risk register is compiled.

Key factors in achieving efficiency savings between services and improving outcomes for service users, include avoiding duplication between health and care services and initiating different ways of working. This is all well and good, but the task group are concerned that it is not currently clear what services are delivered where, by whom and how. There appears to be no accurate comprehensive picture.

A mapping exercise would be a good starting point to identify critical points at which service duplication could be eliminated and different ways of working could be employed. Swindon Council identified service duplication as a starting point when planning the delivery of health and care services and bringing two previously separate cultures of working together.

Within each area of service, the effectiveness, efficiency and potential of the workforce should be maximised by identifying the skills available and best matching them to the roles that will need to be carried out in the future. This will require a review of the workforce and their existing roles.

The task group conclude that there are broader questions around how the Better Care Fund will work in practice, not just in Cumbria but across the country. The aim of integration is to reduce the financial spend in the NHS, taking some aspects of service delivery (that can be provided elsewhere than in a hospital) and passporting that saved money over to social care services who, in theory, are providing those community-based services. However, if this model worked as it is supposed to, this
still leaves an issue for Cumbria, which has recently been identified as having a ‘distressed’ health economy.

RECOMMENDATIONS AND RATIONALE

Recommendation 1

The County Council and Health and Care Partners need to identify, as a matter of urgency, a nominated lead - whether an individual or an organisation - to take ownership of the integration agenda, with clearly delineated responsibilities within each organisation.

Rationale: the task group found leadership and accountability were two emerging themes from the review. An individual or organisation needs to take the lead in integrating services; each of the partner organisations then need to have specific responsibilities for which they can be held accountable.

Recommendation 2

The County Council and Health and Care Partners should:

- develop a jointly agreed clear vision statement for the integration of health and social care services in Cumbria, led by the Health and Wellbeing Board, within the next 3 months;
- develop a clear framework to guide and inform transformational practical models across each area of service, within the next 6 to 12 months;
- develop a practical planning tool based on the above framework which allows a systematic cross-service approach to forward planning, continuous development and improvement, risk and barriers to change and successful integration, within the next 9 months.

Rationale: the task group considers these to be 3 key requirements to assist in both the planning and practicalities of integration.

Recommendation 3

The Health and Wellbeing Board should commission the development of a joint risk register across the whole partnership.

Rationale: witnesses from Grant Thornton identified the starting point for joint arrangements as being assessment and identification of risks and from this a joint risk register can be developed; this is something that needs to be in place to identify risks across the wider partnership as the integration of services progresses.

Recommendation 4

The County Council and Health and Care Partners should:
- develop a clear evaluation strategy for the progress of integration, within the next 3 months;

Part of this process should involve identifying key variables affecting outcomes as they emerge during the process of developing integration and encouraging staff participation in evaluating, reviewing and developing integrated services.

**Rationale:** as integration progresses, it is vital to ensure that the process is subject to an ongoing evaluation, this will allow partners to know what has been achieved, where immediate priorities are and how to progress going forward; the involvement of staff in the process is something that the task group observed had had good outcomes for the integrated service delivery in Swindon.

**Recommendation 5**

The County Council and Health and Care Partners should, within the next 6 months, establish a pilot programme, focusing on one area (either geographical or area of service delivery) based on developing a transformational primary care community, allowing new ways of working to be developed and assessed.

**Rationale:** the task group felt that particularly for somewhere with the geography of Cumbria, a good approach would be to run a pilot for integration of services, to see how that works, before an integrated model is rolled out across other areas of the county.

**Recommendation 6**

The integration of the telecare and telehealth services through a single contact centre - as is currently the case in Dumfries and Galloway - is a model of good practice, that should be adopted in Cumbria, over the next 18 months to 2 years.

**Rationale:** developing the existing telecare services in Cumbria by bringing in the telehealth element, and basing this on a joined up service that is working elsewhere in the country, is necessary for Cumbria to progress this important element of integration.

**Recommendation 7**

A regular written report should be submitted to the Adults Scrutiny Board on the progress of the integration of health and social care in Cumbria at their quarterly meetings, commencing at their 2 October 2014 meeting.

**Rationale:** the task group are keen that scrutiny members are updated on a regular basis to monitor the progress of integration.
Recommendation 8

The topic of integration of health and social care should be revisited, in June/July 2015, by a full scrutiny task and finish group.

*Rationale: the task group feel that the time will be right in mid-2015 for a follow-up review to assess how far integration has progressed and what issues have emerged since the end of the 2014 review.*
LIST OF WITNESSES

The task group held the following witness sessions/meetings/site visits (listed in chronological order):

7 February 2014 – scoping session
Louise Freeman – District Lead for Furness;
Adrienne Halliwell – District Lead for Eden

24 February 2014
Richard Parry – Corporate Director for Health and Care Services

17 March 2014
Peter Knock – Service Development Manager (Health and Care Services)
Dr John Howarth – Director of Service Improvement (Cumbria Partnership NHS Foundation Trust)
Justine Anderson – Locality General Manager (Cumbria Partnership NHS Foundation Trust)

21 March 2014
Dr Rebecca Wagstaff – Acting Director, Public Health (County Council)
David Blacklock – HealthWatch at People First (Chief Executive)

4 April 2014
Task Group members held a ‘desktop’ meeting to look at the King’s Fund Report ‘A New Settlement for Health and Social Care’, the outcomes of the Integrated Care Pilots and the Bournemouth’s Better Together initiative and to consider findings to date and emerging key questions for forthcoming witnesses.

23 April 2014 – teleconference with SEQOL in Swindon
Heather Mitchell – Chief Executive of SEQOL
Haydn Jones – Director of Finance of SEQOL
28 April 2014

Gareth Kelly – External Audit Manager, Assurance, Grant Thornton UK LLP
Jackie Bellard – Engagement and District Lead, Grant Thornton UK LLP

29 April 2014

John Roebuck – STRATA Lead for Clinical Commissioning Group

1 May 2014 – Site Visits

Keith Percival – Service Manager, Contact Centre and Customer Service Development (Community and Customer Services) Dumfries and Galloway Council
Iain Callander – Contact Centre Principal Officer (Community and Customer Services) Dumfries and Galloway Council
Rosie Black – Senior Social Worker, Seconded to Contact Centre, Dumfries and Galloway Council
Lorrain Hyland – Tele-Health Care Lead Officer, Putting You First, NHS
Tracey Porter – Integrated Matron at Cockermouth Community Hospital and Health Centre
Dr Simon Desert – Clinical Lead for Cockermouth

6 May 2014

Task Group members held a catch-up meeting to look at the outcomes and findings of the two site visits and to identify any further witnesses they wished to meet.

2 June 2014

Task Group members held a wrap-up meeting to finalise the scrutiny review report.