SCRUTINY COMMISSION FOR RURAL COMMUNITIES	Agenda Item No. 4
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Report of the Executive Director of UnitingCare Partnership

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UNITINGCARE PARTNERSHIP

1. PURPOSE

1.1 To provide the Commission with the requested update on the UnitingCare Partnership.

2. RECOMMENDATIONS

2.1 The Commission is being asked to note the contents of the report.

3. BACKGROUND

3.1 On 1 April 2015, UnitingCare Partnership became responsible for the provision of all healthcare services for people aged 65 and over and community care for people aged 18 and over as part of a five-year contract. UnitingCare is a partnership between Cambridge University Hospitals NHS Foundation Trust (CUH) and Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). This was following a two-year procurement lead by the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) to ensure local care was better integrated and joined up around the needs of the patient. The services included emergency hospital care, community and mental health services for older people and adult community services.

3.2 There were a number of other reasons for the procurement including:

- The Cambridgeshire and Peterborough health system is not financially sustainable and if nothing is done, it will face a financial gap of at least £250 m by 2018/19;
- The population of Cambridgeshire and Peterborough is increasing and there will be a greater proportion of older people in five years' time;
- Demand for mental health services continues to increase;
- There are significant levels of deprivation and inequality that need to be addressed; and
- People are living longer and health outcomes are generally good but there are significant differences in people's health across our system.

3.3 In order to make the necessary improvements, UnitingCare will transform existing services to ensure; services are more joined-up around the needs of the patient; organisational boundaries don't get in the way of delivering quality care; and by introducing new ways of working to reduce unnecessary hospital admissions.

3.4 For this client group, by March 2017 UnitingCare intends to:

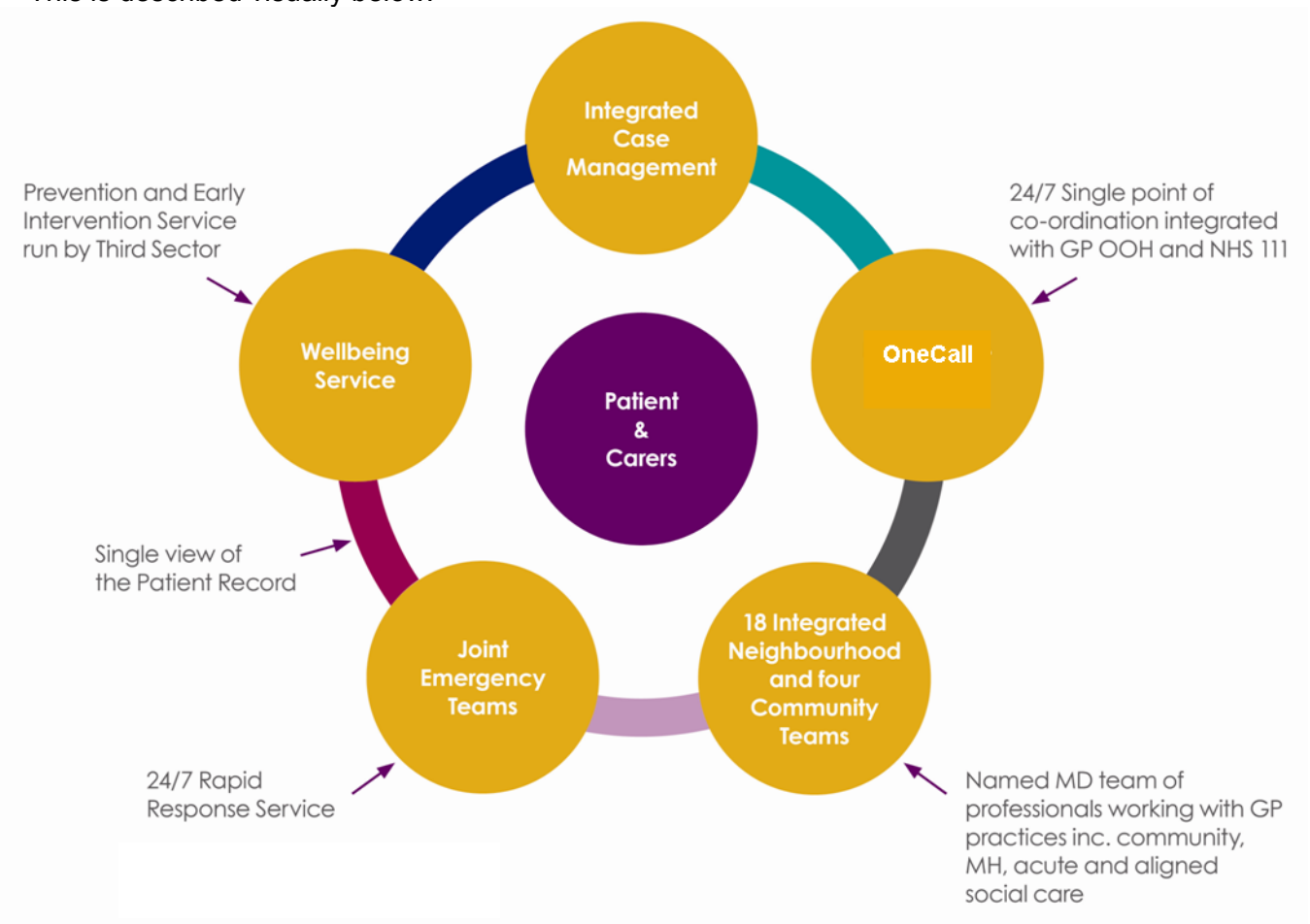
- Reduce avoidable admissions to hospital by 19% over the outturn in March 2015;
- Reduce the length of time people stay in hospital when they are fit to go home by 19% over the outturn in March 2015;
- Reduce avoidable A&E attendances by 24% over the outturn achieved in March 2015.

4. THE UNITINGCARE MODEL

4.1 UnitingCare is implementing an evidence based model of integrated care with the following key components:

Clinical frailty assessment	A simple frailty assessment that will identify people who will be put into UCP's case management system who need both health and social care.
Case management	Intensive case management for the 5% (increasing to 15% over 3 years) of patients who are at greatest risk of future admission, to avoid crisis and reduce risk of hospital episode. Also to provide identifiable care co-ordinators for other patients.
Single View of the Patient record	Acts as an integration engine to provide all health and social care professionals with a single unified view of patient records including acute, community, GP and social care information.
Single point of coordination	Access 24/7 to a single telephone number for all healthcare professionals, social care, nursing homes, third sector and identified patients and carers. It will provide information, navigation, coordination and deployment of community services.
Neighbourhood teams	18 multi-disciplinary teams aligned to GP practices across the county comprising: community nurses, therapists and psychiatric nurses with an average of approx. 60 whole time equivalent staff per team with integrated social work support. The teams will also support out of hours cover for planned and rapid response teams working across a locality (ICT) with enhanced staffing levels.
Integrated care teams (ICT)	Four teams in Huntingdon, Peterborough, Cambridge, Fenland/ Ely comprising specialist nursing and therapy staff e.g. respiratory, neurology, cardiology, and tissue viability (approx. 100 whole time equivalent staff per ICT),which will liaise with acute trust specialists from the long term condition (LTC) pathways to avoid crises and hospital admission.
Joint emergency team (JET)	Urgent service to assess, initiate and plan care for people in the community without referral to secondary care. Maximum response time two hours and available 24/7.

4.2 This is described visually below:



4.3 For more information on the UnitingCare service model please visit www.unitingcare.co.uk.

5. WHERE ARE WE NOW

5.1 UnitingCare took over responsibility for healthcare for this client group on the 1 April 2015. For the first phase of implementation from April to the end of June 2015, our priority was to ensure the safe transfer of services from previous providers (1,400 staff transferred employer). This was achieved successfully and without major disruption to services. On the 6th May, we then began the transformation of care through the launch of two new services initially on limited hours and restricted geography: OneCall and the Joint Emergency Team (JET). Both OneCall and JET subsequently became 24/7 services across the entire geography on the 1 July 2015. The service is now taking referrals from health care professionals and care homes, There are now approximately 30 calls per week to the Borderline and Peterborough area, nearly 100% of patients are seen without needing to be admitted to hospital and 80% of referrals are seen within two hours

5.2 An important phase of transformation was launched on the 22 July 2015 accompanied by a significant communications and engagement campaign called ‘Home’s Best’. This is aimed at raising awareness of UnitingCare’s aims and its service plans; creating a sense of urgency and pace regarding the changes that need to be made and garnering further ideas from across the health and social care system for how it could operate in an integrated way. (Please see link to video at https://www.youtube.com/watch?v=9mZGqZ0--4E))

5.3 This phase of transformation started on 22 July and includes the following :-

- Full rollout of the 24/7 Joint Emergency Team and OneCall to Care homes and patients
- Launch of the Single View of the Patient Record

- Launch of 17 Neighbourhood Teams and 4 Integrated Care Teams including 7 day working
- Roll out of the Wellbeing Service – prevention and early intervention
- The development of a new case management and care co-ordination process
- The development of a single assessment process between health and social care
- Better Discharge arrangements and increasing community intermediate care capacity to reduce delayed transfers of care
- Reviewing the approach to the front door of A&E departments
- A new Dementia Intensive Support Team

6. CONCLUSION

6.1 UnitingCare is committed to improving patient care by ensuring it is provided closer to people's home by avoiding unnecessary admissions to hospital and improving discharge back into the community. We are also committed to supporting people's wellbeing to prevent crisis from happening. Implementation of the UnitingCare model will also enable delivery of the main components of the Better Care Fund for both Cambridgeshire County Council and Peterborough City Council. UnitingCare has established strong links and joint working arrangements with both councils.

6.2 With the growth in population and acuity, it is estimated that admissions to hospital from this client group will grow by 31% by 2020 if we continue to deliver services in the same way This would represent neither good patient care nor is it affordable.

6.3 In order to prevent this from happening, we need to avoid 17 more hospital admissions across the county per day from 1 September 2015 over and above what we achieved at the end of March 2015. Not only is it important to avoid admissions but also to reduce the number of days a patient has to wait in hospital once they are fit to go home. This is a huge undertaking. Every part of the Cambridgeshire and Peterborough health and social care system will need to play its part in helping to achieve this objective.

7. BACKGROUND DOCUMENTS

None.

8. APPENDICES

None.