Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System: Continuing Healthcare Peer Review July 2022

REPORT

Background

- NHS England has commissioned the LGA to deliver a short series of peer reviews of continuing healthcare (CHC) services. CHC is a 'whole system' process, and success is dependent upon effective partnership and multi-disciplinary working. These reviews will bring together system partners to reflect and evaluate local progress and outcomes for local communities.
- The reviews are intended to:
  - Support systems to identify and share improving practice which support personalised, high-quality and safe care – they are not performance management activity
  - Help system leaders understand better their strengths and areas for development to strengthen system leadership and lead to improvements in service delivery – they are not reviews of the operational delivery of the CHC process
  - Provide a safe space for system partners together to consider new and better ways of working together, build shared understanding and agree next steps.
- The review is set against the current context of the Health and Care Act 2022, including the change in leadership structures with the development of integrated care systems (ICSs), and an updated National Framework for NHS continuing healthcare and NHS-funded nursing care and associated guidance to reflect the transfer of responsibility for CHC and funded nursing care (FNC) from clinical commissioning groups (CCGs) to integrated care boards (ICBs).
- A peer review is a sector-led, constructive and supportive process which is founded on a principle of continuous system improvement. It is not an inspection and no rating or score is given. Rather it is an opportunity for systems to reflect on what is working well and what needs developing further locally. This peer review was an opportunity for clinical and care leaders and practitioners from across Buckinghamshire, Oxfordshire and Berkshire West (BOB) to reflect on how CHC is delivered at place level and across the new ICS, and how this delivery might be strengthened in the future.
- The peer review was delivered by an experienced team of peers drawn from senior leaders in health and care, with experience of both CHC and its role within wider service planning and delivery. Insight was collected and triangulated from interviews across each workstream over two days and discussed as a team to reach the position reflected in the feedback session on 20 July 2022 and detailed in this report.
- This report reflects the strengths identified as well as areas for consideration and offers recommendations for how local partnerships and practice might be further developed, to achieve the best outcomes possible for those individuals – and their loved ones – navigating the CHC process across Buckinghamshire, Oxfordshire and Berkshire West.

Peer review process

- To reflect place-based arrangements of continuing healthcare practice and process in BOB, the peer team was split into three sub-teams to cover the footprints of Buckinghamshire, Oxfordshire and Berkshire West (comprising the three unitary authorities of Reading, West Berkshire and Wokingham).
- In advance of the peer review, each of the place-based partnerships received a 'ways of working' self-assessment survey, which was circulated to the workforce involved in the CHC process locally, to get their perception on how they feel the service is working. The results of each place-based partnership's survey are displayed in the cover sheet of their respective sections.
- The peer team fed back for each place-based partnership (included as such in this report) and also on an ICS level – the peer team spoke to the ICS senior lead in CHC as part of this.
- The peer review took place during July 2022, and the timetable included 20 focus groups and sessions over two days, with representation, where possible, from the following organisations and services across the three localities:
    - CHC senior leadership in health and social care
    - Healthwatch, Age UK, and Carers Associations
    - Clinical and social care practitioners from across acute, primary and community settings
    - Finance and commissioning leads
    - Providers
    - Voluntary sector and hospice
- Following initial presentation of the team's findings to system partners on 20 July, this report has been developed for the Buckinghamshire, Oxfordshire and Berkshire West ICS leadership, and their corresponding organisations, to continue their improvement journey.
- Insight was collected and fed back under four key lines of enquiry (KLOEs) – which are detailed in the following slides. This report is structured to include observations against each of these KLOEs and a set of recommendations for each locality, as well as ICS-wide reflections.
- The peer team would like to thank BOB colleagues for their participation in this peer review, recognising the efforts of those who helped us to put the review together, and to all colleagues interviewed for their honesty, openness and willingness to use this opportunity to improve partnership working and practice.

CHC reviews – key lines of enquiry

Strategy & Vision

Making it Real 'I'/'We' Statements

'We have a 'can do' approach which focuses on what matters to people and we think and act creatively to make things happen for them'

'I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and personal goals.'

Conditions for Success

- ✓ Create a desire to make things better for local people
- ✓ Invest time to build relationships and trust
- ✓ Agree a collective vision and shared common purpose
- ✓ Clarify lines of decision making and accountability.
- ✓ Simplify and prioritise plans
- ✓ Develop a shared understanding of performance and capacity based on live, accurate data.

1. Is there a clear vision and common purpose agreed by place and system partners, underpinned by a set of shared priorities? How is this being built on as places and system develop within the new architecture?

2. Is this strategy and vision supported and understood across organisational boundaries and at all levels of the workforce?

3. How is the strategic vision aligned to wider system delivery plans and governance footprints (BCF, ICS)?

4. Are there clear governance structures in place and an agreed set of live metrics to give one version of the truth across the health and care interface? How do system leaders assure themselves that performance issues are being addressed?

CHC reviews – key lines of enquiry

Performance

Making it Real 'I'/'We' Statements

'We tell people about person-centred approaches to planning and managing their support and make sure that they have the information, advice and support to think through what will work best for them.'

'I am supported to make decisions by people who see things from my point of view, with concern for what matters to me, my wellbeing and health'.

Conditions for Success

- ✓ Simplify, standardise and streamline services, pathways and processes
- ✓ Agree shared system responsibility
- ✓ Use a single agreed dataset to drive system improvement, focused on outcomes for individuals
- ✓ Improve patient flow and capacity across the whole system
- ✓ Systematically and sustainably implement the 9 High Impact Changes

1. How do staff across the health and care interface work together to identify people in need of higher levels of care including continuing healthcare?

2. Are pathways simplified and is there a shared understanding of the services available to support people to achieve the best outcomes? Is there a shared understanding of what terms and descriptions of services mean across the system?

3.Are practitioners enabled to make person-centred decisions that are not constrained by system processes and/or service capacity?

4. What model and approach has been adopted to ensure safe, appropriate and quality care for people as they move through the health and care system? Were plans based on evidence and best practice?

- Is there truly a Home First philosophy that promotes independence and to what extent has this been achieved?
- What impact has the Hospital Discharge Policy had on the assessment and provision of CHC?
- Is there a shared, comprehensive understanding of patient flow and a person's destination based on live data?

CHC reviews – key lines of enquiry

Leadership, behaviour & culture

Making it Real 'I'/'We' Statements

'We work in partnership with others to make sure that all our services work seamlessly together from the perspective of the person accessing services'

'I have care and support that is coordinated and everyone works well together and with me'

Conditions for Success

- ✓ Needs to be actively driven by system leaders
- ✓ Agree shared, focused priorities
- ✓ Open communication to build trust
- ✓ Give staff the autonomy to make decisions, supported by clear points of escalation
- ✓ Systematically learn about how the system works and support staff to be involved in continuous improvement
- ✓ Celebrate success and recognise individual contributions

1. How effectively do leaders collaborate to plan and deliver services so that organisations and staff are encouraged to work together to meet the needs of their population?

2. Do partners have autonomy and the freedom to act; are solutions locally designed and delivered? Is there a culture of collaboration rather than blame?

3. Do system leaders create an environment in which frontline staff are empowered to make decisions based on what would have the best outcomes for an individual?

4. How has learning from the pandemic been captured and shared across the system to inform strategic planning and improvement? Is there evidence of meaningful engagement with frontline staff, independent providers, voluntary sector organisations and people who have used services?

5. How have information governance arrangements and the rapid development of digital solutions enabled and improved information sharing across health and social care?

CHC reviews – key lines of enquiry

Community Capacity

Making it Real 'I'/'We' Statements

'We talk with people to find out what matters most to them, their strengths and what they want to achieve and build these into their personalised care and support plans.'

'I have a co-produced personal plan that sets out how I can be as active and involved in my community as possible.'

Conditions for Success

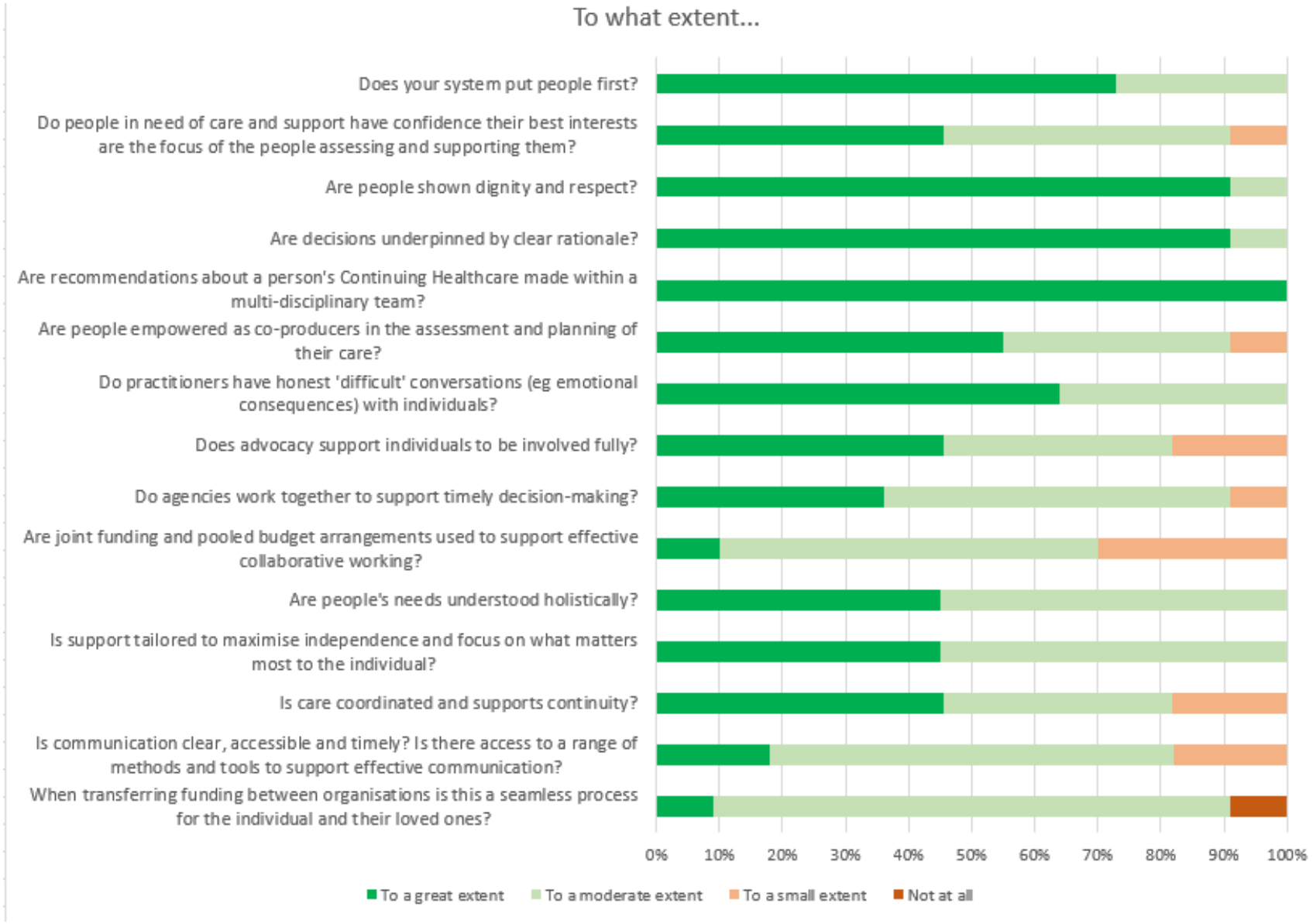
- ✓ Align system capacity to population need
- ✓ Recognise the role the third sector plays in building community resilience
- ✓ Less reliance on bed based solutions is needed for home first models to succeed
- ✓ Co-produce the future market strategy and create flexible employment opportunities
- ✓ Agree pooled budgets and risk share arrangements underpinned by evidence

1. Is there a joined-up, strengths-based approach to commissioning and delivery across health and care? What risk sharing and pooled budget arrangements are in place?
2. Is there a joint commitment to adapting the market based on a shared understanding of current demand and capacity? Is capacity based on actual demand or the demand that would achieve the best possible outcomes?
   - Are independent and voluntary sector providers engaged with as system partners as well as providers?
   - Are opportunities to expand the use of digital solutions and assistive technology being explored?
3. Is there a strategy for ensuring there are sufficient staff who have the right skills across the health and care system? How are system partners (including independent providers) using this experience to work together to develop the workforce to meet both the current and future needs of the local population?
4. How do system partners assure themselves that resources supporting the interface of health and social care are achieving sustainable high quality care and promoting people's independence?
5. How personalised is your approach to supporting people's long term care and how are personal health budgets used to enable this?

Overview

- The peer team would like to thank all those involved in what was at times a challenging review. We met staff of the highest calibre, demonstrating strong reflective practice and creative care planning. We met managers and other staff wholly committed to wanting to achieve the right outcomes for the people they serve and others struggling with trying to move forward in very difficult circumstances. We also met strong and vibrant patient representatives keen to maintain the good practice, and an independent sector which want to be engaged and involved.
- The peer team found areas of excellent practice in Buckinghamshire and Oxfordshire, which, if made universal across the ICS and supported by consistent processes and assurance, can provide the ICS with a foundation for excellence in delivery of CHC.
- The peer team heard about examples of strong and effective partnerships, which have been hard won in Oxfordshire over several years, and which are now developing in Buckinghamshire as a result of colleagues taking a similar approach to Oxfordshire and investing in the transformation. These partnerships, and the work that has led to them, can provide a model which could support Berkshire West to address some of the challenges which this locality presently faces.
- As is the case in all areas of the health and care system, resources are a constant issue. This relates to workforce (both for clinical and care leadership, and in middle management roles); and to finance, where demographics and changing population needs are placing an increasing strain on health and social care budgets. There is understandable concern about the rising cost of CHC. This should not be addressed by focusing on the numbers of people in receipt of CHC, but by looking across the ICB and its services, at the effective use of reablement; the deployment of specialist teams, for example learning disability; and the opportunity for creative joint commissioning.
- The peer team heard from colleagues their commitment to and enthusiasm for the journey ahead, with a genuine ambition and willingness to improve outcomes for people and their carers across the whole system. Any improvement plans that are developed would benefit from input from those with lived experience, family carers, advocacy groups and representatives from providers in both the independent and voluntary sectors. Colleagues that the peer teams were able to speak to from these groups were engaged and open to being involved in this work.
- We heard an articulation of your ambition that “all people who are eligible across Buckinghamshire, Oxfordshire and Berkshire West will get CHC at the right time and in the right place”. This is welcome, however more work is needed to develop a clear and consistent understanding of what this means in practice across the ICS, perhaps including a Joint Funding Policy and Disputes Policy and shared approach to appeals panels and resolution of disputes (which could in turn help to resolve the backlog of disputed cases where these are found).
- The formation of the ICS might offer the perfect opportunity in this regard, to build on the observations and recommendations of this peer review, but also to take best practice learning from across your system and develop a shared and more equitable approach to CHC, for the benefit of your community.

Buckinghamshire 'Ways of working' self-assessment survey



Buckinghamshire – Strategy and Vision

- There has been an impressive improvement journey over the past four years, for which Buckinghamshire colleagues can be very proud. The peer team felt strongly that there was a collaborative approach from leadership through to practitioners and a particular success in the many disputes of 18-24 months ago to being now reduced to nil. The peer team was impressed by how positive and productive relationships were at all levels of the CHC process. Work is now being done to forecast future demand, examine current commissioning intentions and review current financial predictions.

- The strength of the leadership by the CCG CHC lead and the local authority CHC lead was very impressive and deserves a specific mention in this review. This has not been without some very hard work – *"mindfulness to work together"*, *"married to the local authority – we cannot divorce"* – and an understanding and grasp that it was within their gift to work it out and sort the challenges themselves. This is very clear to the staff that they lead, who understand the strategic vision and know they are supported to do the right thing for the person involved in the CHC process.

- The joint approach works well for the population being served and it is clear that the positive relationships are underpinned by mutual trust and respect. The peer team felt that staff were empowered and entrusted to work effectively together to make as many decisions within the multidisciplinary team (MDT) as possible, minimising the need to escalate to the decision-making panel, thereby achieving a quicker decision turnaround. An example of where this has worked well and had a significant impact on individuals is the success of fast track care being delivered by a local hospice service.

- There was an acknowledgement that there is still work to do, with recognition of some tension between the cost of providing the assessment service and the cost of commissioning this by the ICB, and that additional resources may be needed (e.g. an additional post). There is not a full section 75 in place currently, and while the local authority commissions all CHC, it was reported that it may not have the commissioning ability for the most complex packages of care.

- Similarly, there is a recognition of a lack of local provision for individuals with complex learning disability and autism (LDA) needs, and acknowledgement of a need to have commissioners for more specialist packages of care, which may need shaping. (The peer team noted that individuals historically sectioned and discharged on s117 will become CHC eligible, and the ICB may need to assure itself that it is ready for this. Similarly, individuals with an LDA diagnosis will no longer be sectioned unless they have mental health issues that require this form of liberty deprivation (i.e. on the basis of behaviour alone), and there needs to be options available in a crisis other than hospital.)

Buckinghamshire – Performance

- The peer team was impressed by practitioners who peers felt kept the focus on the individual and their outcomes, with good practice examples being cited around onward referral, mental health and wider wellbeing. As well as being a good end in itself, this is an opportunity to manage or even reduce the size of care packages, and one way to balance demand with financial pressures without threatening the present approach to eligibility, which, to Buckinghamshire colleagues felt "right".

- The peer team heard some concern about triage becoming too stringent, and that verbal evidence needs to carry as much weight as the written word, especially for individuals and their representatives. Person-centred care provision that focuses on an individual's strengths can, in the long term, lead to cost reduction in other health and social care services through less acute hospital admissions and referrals to GPs, mental health and LD services, and avoidance of LD hospital admission.

- The training that has been developed and provided by Oxford Health Foundation Trust (OHFT) in the past few years has now been rolled out into the Buckinghamshire system and has been positively received by colleagues, contributing to a better rounded and more consistent understanding of CHC. Understanding of the needs of the complex family dynamics, the clinical needs and the safeguarding concerns involved in CHC needs time and investment in staff – *"time taken to do CHC well is not inconsiderable*".

- The peer team was impressed by the processes of sign-off and financial oversight – and suggests this practice is shared with the wider system. Strong linkage and regular information flow between practice, commissioning and finance allow the local system to track capacity, and supports it to forecast spend accordingly. It also enables staff to maintain oversight of commissioned packages of care and develop appropriate challenge of these within frontline practice. Checklists are completed by NHS, Buckinghamshire County Council and provider staff trained in their use, and the involvement of the local authority is checked if another trained person has completed the checklist.

- The peer team heard some excellent practice, in line with the National Framework, with neither health nor social care staff seen as gatekeepers of access to services. The emphasis is on needs and evidence, and with proportionate evidence to back up decision support tool (DST) content – this has the power to promote access and equity for all those who are potentially eligible. People eligible for CHC continue to have access to the universal services, and individuals and their representatives are involved in assessment, with advocacy available where needed.

- Providers are keen to be engaged with and listened to. There is an ongoing reliance on agency staff to provide the commissioned CHC assessment and case management model, and we hope that the additional substantive clinical post will be easily recruited to.

Buckinghamshire – Leadership, Behaviour and Culture

- There was evidence of a strong commitment to partnership working, both from managers and clinicians, and the peer team heard of many successes resulting from this. The introduction of the NHS CHC Operational Group was endorsed by health and social care operational leads, and is a strong demonstration of joint leadership, including terms of reference, joint working protocol, regular joint workshops, and an ambition to embed CHC champions in district nursing and homecare teams.

- The strong leadership was also reflected in the approach to management of money within the system and there is clear and appropriate separation between the decisions of the DST and the funding of the case – with eligibility driving decision-making. The s75 is being revamped and creative approaches are being considered to make the best use of scarce resources. The approach taken when the system was struggling – to look at what Oxfordshire was doing and mirror – was commendable as was the introduction of consultants to help with the transformation required.

- The strength of the senior leadership relationship filters down, encouraging open and frank conversations at all levels. Leaders create safe spaces in which to have those conversations, using evidence to make decisions and supporting staff to learn from the discussion. Colleagues accept that they do not always get it right, but taking the approaches of learning together and trusting each other to avoid duplicating assessments, and embedding the clinical review in the process before the DST, are important enablers to getting it right. Extra training is provided as a result of learning, for example seizure management and Mental Health Act training. People and their loved ones attend all DSTs, in an area where the population is not afraid to challenge.

- Staff feel empowered to have a professional dispute, holding each other to account but maintaining the mutual respect and trust that underpins the right culture. There is a determination to sort out issues, *"between ourselves – nothing will go to arbitration*", and all in the best interests of the individual. CHC leaders are accessible to staff to discuss cases and practice, and there is a network of champions in nursing homes and other health and social care teams in the hospital and in the community. The CCG encourages a positive approach to CHC.

- The peer team heard that there are few home care options for adult NHS CHS, and wondered whether there is real choice available to individuals about where their care will be provided. Overemphasis on safety and sustainability promotes risk-adverse practice, potentially leading to poorer outcomes for individuals where they are driven by cost and not individual choice – it is worth reflecting on whether there is really choice over where care is provided. Choice policies have had legal threats previously on the grounds of impeding basic human rights to have a family life. A regular review of cases against the National Framework (possibly on a peer basis with for example Oxfordshire colleagues) could provide assurance that you are NHS Continuing Healthcare compliant in this regard, and that local practice is defendable if challenged.

Buckinghamshire – Community Capacity

- Providers identified that the commissioning of CHC by the local authority was done well but providers are concerned that the introduction of the ICS will affect current levels of expenditure – it is not a discretionary spend and needs to be properly funded according to eligible need.

- In Buckinghamshire, providers see work being done to model the cost of CHC and strong relationships between health and social care leaders, but there is concern that the burden of CHC may shift to the care provider if needs are not understood and if funding is inadequate.

- The providers see pragmatism in the policy and funding, and are keen that Buckinghamshire looks at the joint funding model in Oxfordshire, particularly in relation to home-based care – *"CHC is not a treatment option"*; it is a funding source.

- There is concern that the improvements made at place level could get lost in the move to the ICS and providers want to see the right balance between local delivery and accountability, and a BOB-wide approach.

- The provision of the CHC assessments by the OHFT clinical staff impressed the peer team, who wanted it recognised in this feedback. Collaborative working with the MDT; honest and open conversations between staff; the operation of the decision-making panel; and the handling and reduction in numbers of disputes all deserve highlighting. Dedicated training for care providers as well as the open lines of communication between health staff and the local authority are further examples of good practice.

- The peer team was particularly impressed with the case example of an individual with a learning disability who was said to need extra one-to-one care. The clinical lead explored what the intensive support team could offer to address the underlying causes of the challenging behaviour. This then became an integral part of the package of care, resulting in expert support for the individual without increasing the CHC costs. This is an excellent example of how to provide an efficient approach to CHC without denying people their right to CHC support. Developing an understanding of the causes of challenging behaviour and addressing it in such a way is not only effective in delivering the best outcome but also avoids unnecessary admissions to specialist hospitals and long-term care.

Buckinghamshire – Recommendations

- What has been achieved is impressive and has taken time to build, implement and embed – we would urge Buckinghamshire to seek to maintain these relationships and established partnership working to survive the churn of personnel, reorganisation and changes in governance. The improved outcomes for your community are demonstrative of the strength in collaboration – we hope this helps you to evaluate your progress and be proud of what you have achieved so far.

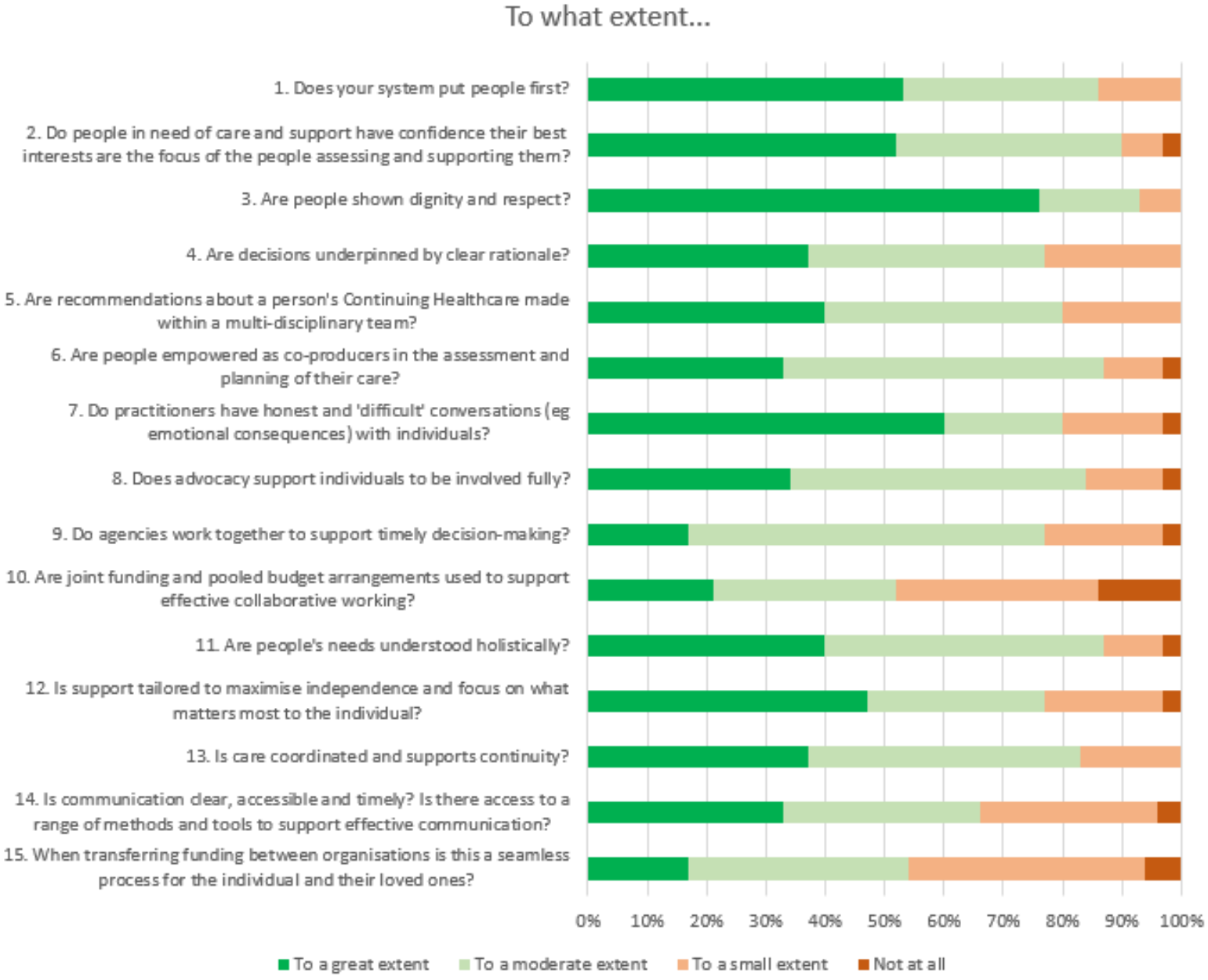
- It is worth reflecting on whether the excellent service that is being provided to the population is too reliant on agency staff to provide the commissioned CHC assessment and case management model. We urge you to ensure any changes are co-designed with the clinical leads to ensure that case management does not become more complex and time-consuming, impacting on assessment and review, and consider where it can be streamlined.

- Consideration might helpfully be given to further joint commissioning arrangements and capacity assessment, in particular for more complex cases, specialist services, and for example CHC for younger people, and consider how to align across all commissioning in the wider market (e.g. around discharge to assess) as this will impact on market shaping and cost.

- It would be helpful to evaluate your processes regularly with those using CHC and their loved ones, to ensure that process is built around the person.

- Sharing local processes for financial sign-off and budgetary oversight with others in the ICS could support learning in other parts of the system, while also offering peer challenge back to Buckinghamshire practice around eligibility, access, choice and packages of care.

Berkshire West 'Ways of working' self-assessment survey



Berkshire West – Strategy and Vision

- Berkshire West is a more complex part of the ICS, given the absence of place co-terminosity, but it was clear to the peer team that the significant tensions between representatives of different organisations went beyond this. The peer team was deeply concerned for staff across the system. It was clear that they were working within an environment which did not support them to productively discuss and address issues and concerns. There were examples of very poor communication, a lack of trust and collaboration between organisations and a defensiveness on the part of both health and social care colleagues.

- The difficulties arising from poor relationships between health and social care providers frustrate the potential for a joint vision for CHC in Berkshire West. Colleagues presented a story of frustration at the past and present ways of working, but no ambition for the future, and no plans about how to improve the CHC journey for those coming through in future.

- The peer team was very concerned to hear about the people at the centre of unresolved disputed cases – some of which have been ongoing for up to four years. The uncertainty surrounding these will have a detrimental impact on the quality of care being offered to those people and raises serious concerns. This is at odds with the ICS's stated vision for the population in BOB. The peer team was told there was poor communication, poor relationships and potential variation in terms of eligibility to CHC, contributing to a backlog of cases in dispute.

- There was, however, an acknowledgement from all organisations around the need for change and a commitment to address the challenges, to create a better culture for everyone working in the service. It is important for the leadership to appreciate that there is unity around this; no one person is responsible for changing the culture in a system but each person is responsible for their behaviour, and the commitment to create a better environment for each other brings hope for positive change.

- We understand that the need for change is recognised within the ICS and we are keen to encourage a co-designed, collaborative approach between the NHS and local authorities, along with other local patient representatives and the care sector, to develop and sustain a different approach, learning from the successful approaches developed in Oxfordshire and Buckinghamshire.

Berkshire West – Performance

- Across the reviews sessions with the Berkshire West system, the peer team saw a focus on process over practice, from both health and social care perspectives. The team heard staff found it difficult to reflect on practice in a constructive and developmental way, assuming a defensive position when professional challenge is offered. Rather than holding each other accountable for providing the best care for their people, the reflex is to defend their own colleagues and organisation because of the history of poor relationships.

- There was considerable mention from staff of the variation in CHC process and delivery compared to other places within BOB, and the peer team considered whether the local population are achieving their best outcomes – would we feel confident as an individual or their family member that they were getting the best service and the right outcome? Can this part of BOB feel confident that all those eligible for CHC are receiving it in a way that reflects best practice and is equitable to the rest of BOB? This should include considering how services, such as reablement or complex care, and commissioning are utilised to support best outcomes.

- There is tension between the different ways of working with each local authority and the different resource challenges faced by each. The peer team heard of variation between them to support the CHC process which can cause challenges in communication and delays for individuals. The parameters of the National Framework are a challenge in this respect and there is not alignment in its understanding or application. The peer team heard examples of a local authority not having adequate resource to prepare for and attend a DST at short notice. Again, there would appear to be an obvious opportunity to look at the approach taken in the rest of BOB to reflect that good practice and build a new approach across the Berkshire West patch. The geography of three local authorities need not be a barrier – there are many complex systems nationally which make this work with collaborative leadership, clear vision and strategy and a person-centred approach to care.

- Significant work has been undertaken to develop processes and procedure in Berkshire West. This is a useful base from which to build, maintaining what has worked well and revisiting those ways of working that have not been a success, with an additional emphasis on learning from what works well in the other parts of BOB.

- We heard of significant communication issues between health and social care and an inability for colleagues to identify their counterparts in the other organisations. We would urge any transformation work to ensure adequate time and attention is given to developing and restoring the very difficult relationships in a supportive way, recognising how hard it has been for all staff to work in CHC in this place over recent years.

Berkshire West – Leadership, Behaviour and Culture

- The opening presentations on Day One made it clear that there were serious challenges to partnership working between the leadership from health and social care – and this was present throughout the two days of the peer review, with this culture pervading to the more junior workforce. The peer team spoke to partner organisations which were impacted by this lack of collaborative working and heard their concern for those individuals and their loved ones trying to navigate the CHC process in Berkshire West at the most vulnerable time in their lives.

- Demographic and inflationary pressures have put huge pressure on health and social care budgets, and there was much discussion about this by staff during the review. It was evident to the peer team that there is a lack of trust and collaboration between leaders, which we believe is preventing them from coming together to resolve the financial challenges for CHC in the system.

- It should be noted that health colleagues considered relationships and process to be improving, citing work to improve CHC processes within the National Framework requirements. They were surprised that local authority colleagues did not share their view. The resulting tensions, alongside the admission from both health and social care colleagues that they felt unable to have open conversations in the absence of facilitators, led all to agree to arrange meetings separately for health colleagues and social care colleagues. The peer team notes there is no regular forum which constructively deals with the challenges staff are facing, though we are aware that the ICS has put in place consultancy support to address this. The peer team felt that this was urgently needed.

- The challenges between health and social care organisations in Berkshire West are very visible to partner organisations, which have serious concerns for the individuals at the centre of these. "*Instead of taking a 'how can I help you' approach, there is a 'how can I not be landed with you' approach.*"

- There is a focus on old cases – a significant amount of time in sessions was spent discussing previous CHC reviews and the issue of disputed cases. The peer team felt strongly that colleagues needed support to move to a more forward-thinking approach, to be more ambitious than historic, and to give them a vision that they can work toward.

- The peer team heard of significant constraints in workforce capacity in both health and social care, making it difficult to meet local CHC demands, and both training and recruitment were noted as issues. New staff could not find organisational charts, contact details for colleagues and other partners. New staff coming in expressed dismay at how the situation had been allowed to go on for so long.

Berkshire West – Community Capacity

- The local care market is keen to see greater clarity in the forecasting and joint commissioning of CHC in terms of placements and funded packages of care at home. It is looking more toward supporting neighbouring localities where the demand for CHC is clear and the commissioning relationship more established.

- There was agreement from providers that the Market Position Statement *"outlines a commitment that we are not experiencing"*. Providers detailed *"difficult"* working relationships with both health and social care organisations, with no health representation at provider forums and a challenging negotiation process for uplifts.

- The peer team heard frustration from local care providers, which felt that the local CHC processes made it difficult for the most vulnerable. We heard that the 'end of life' emergency process is not quick enough, and when applying for urgent CHC where situations are critical, processes can be hugely time-consuming for care staff at a time when the individual needs support in place rapidly.

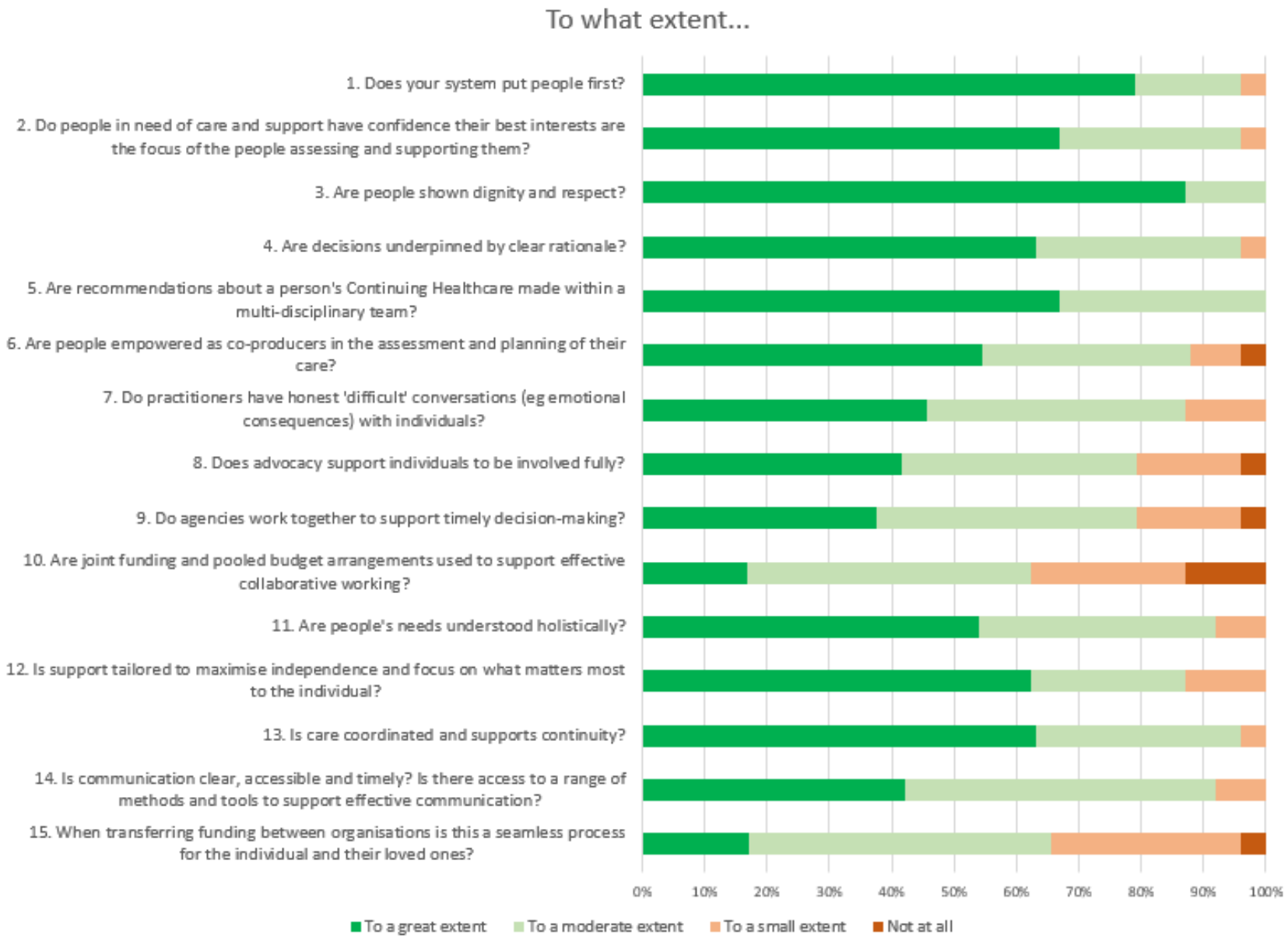
- The peer team is concerned that the collective clinical staffing resource is insufficient and needs adjusting, alongside the commissioning forecasting of the likely eligible need for CHC going forward. There is also uncertainty arising from any adjustments made to the processes and practice identified in the transformation programme. An obvious place to start is the comparison within the ICS but then with places in other ICSs with similar demographics and size.

- The voluntary sector and patient representatives both within Berkshire West and more widely within BOB are keen to help with the transformation needed to address the concerns identified, through a process of co-design and co-production and creating a new way forward.

Berkshire West – Recommendations

- The very visible issues in Berkshire West need resolving for staff, the local population, and the ICS, and this will need senior executive health and social care oversight and commitment, to ensure the transformational change required is driven forward, underpinned by a clear shared vision and person-centred approach.
- The peer team saw health and social care staff show concern and support for colleagues in their organisation operating in the very stressful environment of CHC. Adherence to the National Framework is not mutually exclusive with positive relationships – there is a need to work together to understand the wider pressures and create ways of working which support all organisations.
- We understand from colleagues in the review that the dispute process pre-dates the senior CHC leadership – it needs urgently reviewing and aligning to the other good practice in the ICS. Significant work needs to be done to bring a close to those cases still in historic dispute via a task and finish group or using external support.
- The experience of individuals and their carers will be fundamental to the transformation process, and they need to be part of the co-design of Berkshire West CHC. It would also be helpful to consider commissioning a generalised advocacy contract for the locality, to ensure there is a clear offer to all individuals receiving services including those moving through their CHC journey.
- The approach to partnership within the CHC structures should be wider than just between NHS and local authority representation, including also ICS senior leadership, provider and voluntary sector representatives, and individuals and their families and carers. This should be designed into a refreshed and inclusive meeting structure, which could support system leaders, clinicians and partners (including voluntary sector and advocacy groups) to come together to build trust in a shared process.
- Experience from elsewhere in the ICS around both CHC delivery (process and practice) and developing improvement in partnership working in this area could inform a co-designed OD programme with individuals and carers; this could support staff through a significant cultural and practice transformation with a focus on people's experience and outcomes.
- There is a need for a user guide for individuals, and their families and carers to navigate CHC in the system, including helpful contacts and mapping of organisational processes and timelines. There may be examples of similar products within the ICS which could be used as a starting point.
- There were pieces of good practice identified by health colleagues that could offer some 'quick wins' to improve working and offer more streamlined practice – for example each local authority having a CHC email inbox, to ensure queries are being picked up. Key information for individuals and a single point of access would be useful additions to the ICB website.
- There is a need to regularly evaluate processes to enable partner organisations to constructively feedback where things are not working – for example family carer form or care home checklist. Co-design needs to be central to any redesign of processes/ways of working to ensure that they are fit for purpose and sustainable.
- Where appropriate, Berkshire West colleagues should call upon the ICB's responsibility to audit fast track activity and provide feedback to referees when a fast track has been used inappropriately; fast tracks should not be turned down.

Oxfordshire 'Ways of working' self-assessment survey



Oxfordshire – Strategy and Vision

- The peer team found that there was a lot of good practice to applaud in Oxfordshire, which was set out in the joint presentation at the beginning of the session. It set out a strong position of CHC in Oxfordshire and the peer team was impressed with conversations across the two days that substantiated this view.

- There is clarity in the strategic intent and vision for CHC in Oxfordshire and this is recognised by health and social care staff and external stakeholders. The progress made is impressive as it came from a place of siloed working, insufficient resources and defensive organisational behaviour. This has been turned around to achieve the current approach and the peer team was keen to recognise the work and commitment that went in to achieve this.

- There has been a recognition of the need to invest in CHC resources and staffing in order to achieve this good practice sustainably as well as ensuring the clinical staff are available to carry out the assessments. There has been a strategic intent to resolve the historical disputes and cases which will free staff and commissioners to concentrate on the way forward.

- Overwhelmingly staff expressed concern that future changes either as a result of our review or as a result of the introduction of the ICS could see some of the very good relationships and outcomes for people being eroded in return for uniformity. Oxfordshire colleagues wanted strategic leaders to be very aware of those concerns going forward.

- The peer team was made aware that there was a certain amount of uncertainty regarding future roles for the finance team following the formation of BOB. They did report they expected to be told to find savings within CHC but thought this could be done via improvements in commissioning rather than a reduction in people supported. A new recording system may help with data in this area.

Oxfordshire – Performance

- The peer team observed that, likely as a result of the strong joint working and collaborative approach, performance around CHC in Oxfordshire is strong: we saw a real focus on person-centred practice with no assessments waiting more than 12 weeks. The system scored 83% in a recent self assessed NHS assurance exercise and feedback from partners and advocacy organisations was very positive. It would be good to further test that out with individuals and carers.

- The team heard that there is excellent training which is being delivered by OHFT and which has been an essential part of driving this change. Involving partners and individuals receiving CHC in the development of this will have supported the person-centred approach which felt like a real strength in local CHC delivery.

- While practice and partnership in Oxfordshire are strong, there appeared to be a disconnect between delivery and practice on the one hand, and financial management and budgetary control on the other; costs are seen as too high and rising. *"We just keep spending money…"* CHC is a needs-led process, so if demand goes up, spend will go up too, but it appeared that predicted and actual spend were aligned with practice (reporting). It would seem appropriate for the CHC team to be kept informed of the spend and projected spend under their remit. Application of the eligibility criteria feels appropriate from the discussions with practitioners, and there is good person-centred practice, but there might be ways in which the system could be more efficient in delivering outcomes and services, without this being a "levelling down" in line with areas of lower spend.

- The joint commissioning approach means that a practitioner is responsible for a person, with a pragmatic approach to allocation of funding, and Care Act and CHC eligibility assessments are done jointly. Local authority staff are not always involved in assessments, and it is common practice for the assessor to also draw up the care and support plan, and source the provision in most cases (this is true for the dedicated CHC team and others for example fast track individuals from hospice). This could be seen as a further endorsement of the trust between professionals, but Oxfordshire should always ensure multi-disciplinary input into assessment.

- There is much to be applauded in assessors also sourcing support, not least of which it is a person-centred approach as the individual has less people to deal with and the staff that know them see through the process. It is, however, a time-consuming process and could lead to inconsistencies in commissioning and loss of potential savings as a result. Consideration of when this could be safely handled by a dedicated commissioning team could be worthwhile – but do maintain focus on a person-centred approach and continue to build process around this.

- The peer team heard that in the past there had been regular meetings between CHC assessing staff and the systems finance team. This enabled assessors to have an understanding of the budget and its projected spend, but this has not happened for over three years and now the team is not aware of its spend. There is a more stringent approach to financial sign-off in Buckinghamshire which Oxfordshire colleagues could look towards or challenge themselves against, but remaining aware of the risk that financial pressures are brought to bear through this, resulting in criteria or processes that are rigid.

Oxfordshire – Leadership, Behaviour and Culture

- The peer team was impressed by the strength and consistently positive feedback about partnerships around CHC in the Oxfordshire system. There is a good relationship between NHS and local authority partners more widely, and a fully integrated health and social care team with joint funding and some pooled budgets. Section 75 arrangements are in place over and above mandated Better Care Fund (BCF), and there is a strong consensus and partnership around BCF planning. It was acknowledged that this had been hard won over the past four-to-five years, and some of the peers (who had previously supported the system around system flow) were surprised and pleased to see the degree of positive change.

- It was suggested (but not triangulated fully) that greater access to advice and advocacy, and greater clarity about the process, would be helpful for individuals, families and partners, especially at an early stage. This is something which could be considered alongside roll-out of the very positive training which is already being delivered.

- The system has worked hard to develop the right leadership, behaviours and culture to embed a successful CHC approach and they are keen, as are external stakeholders, to see this approach sustained as Oxfordshire becomes part of the BOB ICS. This message was given to and heard by the peer review team very loudly.

Oxfordshire – Community Capacity

- The peer team did consider whether there is sufficient prevention and reablement (available, or being used by CHC teams) to mitigate against increased costs associated with growing demand. Some interviewees reported a shortage of home-based care support, and peers wondered whether there was a possible over-reliance on the high number of pathway 2 beds in the system, or a relative lack of rehab/reablement dedicated services.
- The current system appears to work well but that does not mean better outcomes or value could not be achieved through consideration of the wider pathway.
- The home support specification does include a reablement approach but current guidance advises against care workers trying to carry out maintenance support and reablement work at the same time, and that better results will be achieved with dedicated workers.
- Similarly, there does not seem to be any value in having two equipment pathways and processes, and these could be aligned to create the same pathways for everyone, to maximise their outcomes regardless of whether they are to be funded through CHC.
- In terms of the available community resources, OHFT has added in what it can, but wider challenges remain around workforce and care capacity and this might be an area for wider exploration in developing future commissioning intentions. This could be an opportunity for the ICS to develop joint approaches to workforce and relationships with the care market, as it begins to change with the increasing dependency in the population and need to commission for better outcomes to achieve greater efficiency.
- The voluntary sector and patient representatives spoke very highly of the leadership in the Oxfordshire system – the peer team did not hear high numbers of concerns or complaints about CHC in their collective inbox and praised the introduction of the CHC helpline and toolkit which had led to a significant reduction in the queries they received. They did, however, say that there was still a need to increase essential information and publicity about CHC.
- There is a need also to increase the availability of advocacy as more people are in need and this is difficult to source.

Oxfordshire – Recommendations

- The peer team was impressed with the work in Oxfordshire and recognises that the comments we make as part of this review are additional reflections to improve what is already a very good approach. Most importantly, there is a person-centred approach for people and their carers, and the staff feel empowered to seek the best outcomes for the people they serve.
- As in other areas of this review, there is learning and challenge that could be developed through engagement with other parts of the system. For Oxfordshire this would have particular benefit in a closer connection between practice and budgetary management/forecasting, to allow more local reflection on commissioning decisions and options. Buckinghamshire has a closer link between practice and financial management (while maintaining good practice and outcomes) and some peer-to-peer case reviews – and consideration of how neighbouring processes operate and benefit – could assure Oxfordshire of both quality and value, while retaining the excellent person-centred approach.
- Conversely, Oxfordshire could share both its excellent training provision more widely with partners in the ICS (this is already happening in Buckinghamshire) as well as its experience of the work involved in developing its partnerships over the past few years. While this can provide a hopeful model for colleagues in Berkshire West system, it will also offer a chance for Oxfordshire colleagues to reflect on and celebrate their very positive journey, and how to maintain this as the ICS moves forward.
- It will be important to protect the excellent working practice and relationships against an ICS move toward uniformity – localised working appears to be producing best outcomes for the Oxfordshire community and this needs to be maintained while recognising the current inequalities across the ICS. A levelling up agenda is the right way to achieve equitable success in CHC across the system, not levelling down in terms of practice, process and outcome.
- There could be further consideration of how wider pathway capacity (around reablement for example) could be developed to mitigate the impact of increasing demand – while this is a system-wide challenge, it may apply most to Oxfordshire where the financial envelope may be more stretched. For instance, while there are no easy solutions to a lack of home-based support (for both CHC and discharge to assess), it may be possible for improved procurement of such services if some resources can be moved from bed-based options. This could be something that forms part of discussions around wider commissioning intentions.

ICS Observations

- Peers recognised that there are areas of "legitimate" difference across the system. Consideration as to what is best done at ICS level and what is best implemented at place level will be important for CHC delivery (as indeed it will for many other areas of work going forward) in BOB, not least to avoid destabilising existing good practice where things are working well.
- In all ICSs where multiple health and care systems have been brought into a single new organisation, different processes, approaches and cultures in different parts of the whole risk inequitable outcomes or experience of CHC processes for individuals, as well as confusion between staff doing similar roles in different parts of the wider system around what is expected of them. A shared approach to core governance, oversight, and assurance of practice and processes associated with CHC would satisfy concerns in this regard, while not necessarily implying that all localities need to use identical approaches in frontline teams.
- There are areas of strong performance for CHC across the ICS, but the data suggests that there is also inconsistency of take-up, outcomes and process across the whole. We heard concern expressed about differences in the approach to CHC leading to a difference in the offer across the ICS, and whether this is acceptable. For example, how choice was balanced against costs was differentially managed between different systems (for example, what if a home care provider costs more than nursing care).
- It is worth looking across the system to see what works, develop peer-led assurance processes, baselining against the number of referrals, conversions, waiting times, and financial data.
- The positive example of work in Buckinghamshire recently – in 2018 the system was an outlier for CHC so made the decision to outsource to OHFT which was already providing the CHC assessment service for Oxfordshire – led to the number of CHC cases dropping to 410, and clinical and commissioning practice now appears to be robust and working well for individuals receiving care.
- The peer team heard about examples of strong and effective partnerships, which have been hard won in Oxfordshire over the past several years, and which are now developing also in Buckinghamshire. The latter are perhaps at a slightly less advanced stage of practical implementation (such as around pooled budgets, or shared processes), but this is a work in progress, and with a clear direction of travel. The peer team urges the ICS to draw from the success in Oxfordshire and Buckinghamshire to provide a model for Berkshire West to address some of the challenges which they presently face. *"Up to a year ago, OHFT CHC team and Buckinghamshire County Council commissioners were speaking different languages…CHC experts were brought into CCG(ICS), and this has been sorted."*
- Resources are a constant challenge in terms of workforce (both for clinical and care leadership, and in middle management roles); and to finance where demographics and changing population needs are placing an increasing strain on budgets. For workforce, consideration could be given to opportunities to take a strategic approach across the ICS. OHFT is looking at innovative ways of improving recruitment including recruitment and retention incentives, wider advertising, flexibility for core hours, compressed hours, hybrid working, and different roles (and bandings). Building on some of these initiatives, and potentially looking to develop more joint or aligned posts could help.

ICS Observations

- Costs of care packages are rising due to inflationary issues and creates pressure on budgets. Developing greater collaboration between commissioning and planning care – and the costs associated with this – would help to forecast demand and potentially to identify variability in practice across the ICS. While CHC is needs-led funding and budgetary management should not impact on eligibility, greater scrutiny of commissioned care could offer the potential for greater market management and shaping, or indeed to encourage the use of services such as reablement, which might mitigate some of the pressures arising from demography.

- Baselining spend and sharing learning between different parts of the system could be helpful – but not with an assumption that all parts of the system would reduce cost in line with the lowest, rather that best clinical practice be used as a baseline for best value. For example, a dedicated post within the previous Buckinghamshire CCG has been used to forecast CHC activity and ensure any overspends are recouped efficiently; stratifying people meeting CHC eligibility is being looked at to see if funding could be spent differently (starting with end of life services, where hospices involved in Fast Track followed up on people who do not meet CHC eligibility to understand what support could be provided).

- Peers explored a similar question around the availability and use of specific services; is there sufficient capacity across wider pathways, not just in CHC delivery? And if so, is it being sufficiently prioritised and utilised? For example, a greater emphasis on reablement or early intervention to ensure that all people have the opportunity to optimise their functioning and abilities ahead of a CHC checklist and potential DST would have the potential not only to improve outcomes, but maybe also to reduce costs of CHC packages and demand on other health services including acute hospitals. Person-centred practice can develop efficiencies in service by early intervention and reablement, and investment in models of care that keep people at home early on can avoid higher-cost CHC packages. Demography and complexity of needs are increasing pressure on CHC and mitigating this through prevention / reablement and by best use of care planning is key.

- The peer team was uncertain whether sufficient consideration is at present given to different client groups (e.g. LD, autism, dementia, in particular those with challenging behaviours) and how provision may need to be adapted to their needs? For instance, can those with dementia / delirium be assessed at home rather than in a care setting, to get best assessment of their future needs?

- There is a lot of concern about the impact of ICS changes, in teams or roles and likely restructures in such functions as finance and commissioning. Similarly, some staff were concerned that future changes, either as a result of this review, or through coming together as a wider ICS, could see some of the very good relationships and outcomes being eroded as a price for uniformity. Mitigating the impact of the resulting uncertainty and anxiety for staff will be important over the coming months, as will protecting and finding ways to celebrate good practice where it is happening under the current system.

- We heard that joint training provided an important means of developing relationships and shared vision, as well as shared understanding of processes and practice. There appears to be some good examples of joint approaches to training which have had positive impact – in Oxfordshire, for example – and rolling this out more widely could be a quick win, bringing people together to work on the issues they are grappling with.

ICS Recommendations

- The ICS needs to examine what is working well in the component parts of BOB, to consider how best practice and process can be achieved across the patch, and how the ICS can get the best outcomes for the population served.
- There needs to be a new governance framework to establish what should happen at place level and what can be consistent across the ICS – this should be co-designed with all partners and stakeholders.
- The person-centred practice seen by the peer team needs to be embedded across the ICS, with leadership ensuring that this is delivered in the most efficient way which makes best use of resources and maximises the outcomes for people and their carers. The NHS components of an integrated CHC service could have a dotted line to the nursing directorate for quality oversight especially focusing on patient experience.
- The clinical practice we heard about in Oxfordshire and Buckinghamshire needs to be supported and built on, and considered in the transformation of the Berkshire West approach. There is an urgent need for transformational change in CHC in Berkshire West, which we understand the ICS has already commissioned. This needs to be co-designed and co-produced by all partners and stakeholders to ensure engagement and commitment.
- The implementation of policy, practice and procedures needs review across the ICS to ensure that all staff are aware of the latest guidance. The excellent training and support given to staff in Oxfordshire and Buckinghamshire needs to be available to all.
- There are many more opportunities to collaborate across the ICS in terms of market shaping and joint commissioning. A joint workforce strategy, for example, would reduce the overhead costs for all partners.
- Collaboration is also needed to increase the communication with and engagement of the care market with joint provider forums and training to build parity of partnership with the sector.
- There is a need to move away from the difference in access to CHC across the ICS. Understanding why this is and what needs to be done will need careful exploration of the data and qualitative analysis of case reviews to understand where the inconsistencies are and how they affect outcomes for people and their carers. The ICS should be confident that everyone who is eligible for CHC funding is in receipt of it.
- Underpinning this, as part of the wider work bringing partners together in the new ICS, there is a need to develop a single, clearly stated and widely communicated, statement about the strategic ambition and vision for CHC across Buckinghamshire, Oxfordshire and Berkshire West. While local clinical and commissioning processes may vary across the place footprints, ICS leaders should work towards equality of outcomes for individuals on their continuing healthcare journey, regardless of where they live in BOB.

Next Steps

- We would like to thank Buckinghamshire, Oxfordshire and Berkshire West ICS for welcoming the peer team into your system, and for your openness and frankness with peers. It has been a privilege to meet you and your colleagues, and to hear about your journey, and the work you have been doing.
- Buckinghamshire, Oxfordshire and Berkshire West ICS should be commended for their engagement in this CHC peer review at this early stage in the development of the ICS: this is one of the first we have done. We hope that it may provide a model for future support and we would welcome feedback on the approach and support to cascade the learning from this review to other systems.
- This report is the last stage of the formal peer review, but the first step of the journey onwards from it. We would encourage Buckinghamshire, Oxfordshire and Berkshire West ICS to share key messages from this report among its partners, and to develop a plan for how to respond to it.
- As part of that process Buckinghamshire, Oxfordshire and Berkshire West ICS might consider what further support from the Local Government Association or NHS England might be helpful, and we will be pleased to discuss this further.