HEALTHIER COMMUNITIES SELECT COMMITTEE		
Title	**'Care at Home': The arrangements for integrating health and care services that support people at home.**	
Contributors	**Executive Director for Community Services**	**Item: 7**
Class	**Part 1**	**3 December 2018**

1. Purpose of Report

1.1 This report outlines the proposal by the London Borough of Lewisham (LBL), Lewisham Clinical Commissioning Group (LCCG), Lewisham and Greenwich NHS Trust (LGT) and South London and Maudsley NHS Trust (SLaM) to bring together a number of services that support adults to live as independently as possible in their own homes.

1.2 This report proposes the development of a formal partnership agreement between the Council and Lewisham and Greenwich NHS Trust ("LGT"), under Section 75 of the National Health Service Act 2006 for the integrated provision of services that support adults in their own homes to improve the quality of service provision.

2. Recommendation

2.1 The Mayor and Cabinet considered a report on 'Care at Home' on 21st November. Members are asked to note the recommendations to:

- Approve the proposal to formally integrate a number of social care and health services that support adults in their own homes.
- Agree that the Council enter into a Section 75 agreement with Lewisham and Greenwich NHS Trust ("LGT") and, in relation to Phase 2, South London and Maudsley NHS Foundation Trust (SLaM) for the integrated provision of services for adults in their own homes.
- Delegate responsibility for reshaping existing arrangements for joint working, which include a Section 75 agreement and necessary associated documents, to the Executive Director for Community Services on the advice for the Executive Director for Resources and Regeneration and the Head of Law.
- Agree to a contribution of £40,000 towards the development of the integrated service.
- Agree that a 'Care at Home Partnership Board' be established within the existing Provider Alliance Development Board as set out in 6.7.
- Note that the recommendations are also subject to approval from Lewisham and Greenwich NHS Trust, South London and Maudsley NHS Foundation Trust and Lewisham CCG as the commissioner of community health services.

3. Executive Summary

3.1 The Government requires every area in England to integrate health and social care by 2020. Lewisham's Health and Care Partners (LHCP)[1] are working together to develop new arrangements for delivering integrated care across the borough.

3.2 Social workers, therapists and district nurses have been working alongside GPs on the same neighbourhood footprint for some time. However, the virtual teams operate with different processes and systems and care remains fragmented.

[1] LHCP includes the London Borough of Lewisham, Lewisham Clinical Commissioning Group, Lewisham and Greenwich NHS Trust, South London and Maudsley NHS Foundation Trust and One Health Lewisham.

3.3 A new way of supporting people at home that builds on the work to date is required. Providers, supported by commissioners, recommend the formal integration of services and functions that provide care at home. The aim is to improve the co-ordination of care, reduce variation and duplication and improve the quality and accessibility of care and support. The working title for the new arrangements is 'Care at Home'. The development of Care at Home will involve reshaping our workforce, building better connections with other services including home care and mental health and creating a shared culture with person centred care at its heart.

4. Background

4.1 Health and care partners across Lewisham recognise that our health and care system needs to change. Lewisham's population is growing, people are living longer - many with a number of long term health conditions - and the demand for care is increasing, both in numbers and complexity (Lewisham's over 60 population is projected to increase by around 33,000 by 2040).

4.2 The cost of delivering our health and care services is increasing yet the support and care delivered across Lewisham is not always provided in the most efficient, effective or co-ordinated way. Information and advice to help people keep healthy and well can be hard to find. Access to services can be difficult and high quality care is also not consistently available. Care is often not well co-ordinated across services, resulting in duplication and confusion, particularly if a person has more than one long term condition.

4.3 Health and care providers are facing recruitment challenges across the system. In south east London 23% of GPs and 33% of nurses are aged over 55 and due to retire in the next decade. Staff shortages are common across health and care including GPs, social workers, occupational therapists, nurses, healthcare assistants and home care workers. This restricts the face to face time professionals can have with patients and service users and increases their workload. The challenges in relation to workforce are set out in detail in Appendix 1: the Outline Business Case (OBC) for Care at Home.

4.4 Our communities have told us that they want:

- More face to face time with health and care professionals.
- Better communication and information sharing across service providers and with families.
- Integrated person centred services with a single entry point.
- Staff across the system with the skills and knowledge to help and support residents to look after their own health and wellbeing, to direct their own care and to choose the support and services they need.
- Better care co-ordination and improved support for people to navigate the health and care system.
- Improved access to mental health services and resources, with better signposting to the full range of services available.
- More diverse communication channels about available services.
- Better training and support for care workers to do an effective job.
- Improvements to the way that issues can be escalated and managed together.

4.5 Health and care professionals have told us that:

- Referral processes to other services needs to improve.
- There needs to be better co-ordination and communication between services, particularly with mental health.
- Multi-disciplinary meetings need to focus more on planned prevention rather than emergencies.

4.6 Care at Home is informed by the success of the Buurtzorg model in the Netherlands. Buurtzorg is a unique district nursing system that involves small self-managed teams

providing a holistic approach to care and support. The team undertakes a range of different tasks that would be more commonly delivered by different professionals in the UK, such as a District Nurse and a home care worker.

5. Policy Context

5.1 Mayor and Cabinet's developing strategic policies and plans are committed to providing dignified and compassionate care services. The Council has agreed to the phased implementation of the Ethical Care Charter which marks a key step towards improving the health, safety and dignity of vulnerable people in receipt of home care.

5.2 In 2014, NHS England published its 'Five Year Forward View' setting out its vision for a financially sustainable health and care system. The later document, Next Steps on the NHS Five Year Forward View, highlighted the need for further integration across health and care. The Government requires health and social care to integrate by 2020 and each local area to produce five year Sustainability and Transformation Plans (STP).

5.3 The 'Five Year Forward View' sets out the expectation regarding new ways of delivering health and care that aim to break down the traditional divides between different parts of the health and care system. Commissioners and providers will work differently to pay for, manage and deliver services. A key new way of working will involve providers entering into new collaborative 'alliance' arrangements to deliver services for a given population.

5.4 Care at Home will contribute to the corporate priority of caring for adults and older people and the Council's commitment to working with health services to support older people and adults in need of care. Once in place, Care at Home will contribute to the Council's priority in relation to inspiring efficiency, effectiveness and equity as well as the delivery of the Sustainable Community Strategy, in particular the priority outcomes of improving health outcomes and tackling the specific conditions that affect our citizens; and supporting people with long term conditions so that they can live in their communities and maintain their independence. Care at Home will also contribute to the aims of Lewisham's Health and Wellbeing Strategy which was published in 2013 and refreshed in 2016.

5.5 Lewisham is one of five devolution pilots across London that is exploring the transfer of powers, decision-making and resources to a local level. Lewisham's devolution pilot is focussed on workforce and estates. The London Workforce Board is looking at the workforce needs across health and care, including home care. As a devolution pilot, Lewisham will be involved in the development of new ways of working such as 'hybrid' or 'bridging' roles, new approaches to apprenticeships and joint training.

5.6 Lewisham Health and Care Partners (LHCP) are committed to supporting people to maintain and improve their physical and mental wellbeing, to live independently and to have access to high quality care when needed. Transforming the care that people receive in the community, so that more people can be cared for out of hospital, is critical to achieving this. Care at Home is a key element of LHCP's plans to deliver the vision for Community Based Care[2]. LHCP's ambition is for community based care to be:

- **Proactive and Preventative** – By creating an environment which promotes health and wellbeing, making it easy for people to find the information and advice they need on the support, activities, opportunities available to maintain their own health and wellbeing and to manage their health and care more effectively.
- **Accessible** – By improving delivery and timely access when needed to planned and urgent health and care services in the right setting in the community, which meet the needs of our diverse population and address inequalities. This includes raising

[2] *LHCP Vision for Community Based Care in Lewisham, 2017.*

awareness of the range of health and care services available and increasing children's access to community health services and early intervention support.

- **Co-ordinated** – So that people receive personalised health and care services which are coordinated around them, delivered closer to home, and which integrate physical and mental health and care services, helping them to live independently for as long as possible.

6. Care at Home: Summary of the Outline Business Case (OBC)

6.1 **Scope:** Phase 1 will focus on bringing together a number of Adult Social Care services with District Nursing. Four integrated teams, one in each neighbourhood, will improve the delivery of co-ordinated, person centred care for adults at a neighbourhood level. The teams will be co-located in the neighbourhoods. A key element of Phase 1 is the development of greater collaborative working with home care providers to the extent that they operate as part of the Care at Home teams.

The first phase of Care at Home will include the following teams and comprise approximately 250 staff:

- Adult social care - Integrated Neighbourhood Team (assessment and care planning), Enablement Care.
- Home based rehabilitation (joint adult social care and therapies service).
- District Nursing (delivered by Lewisham and Greenwich Trust).
- Neighbourhood Co-ordinators (work across Adult Social Care, District Nursing and Primary Care).

In Phase 2, Care at Home will be expanded to include specialist community mental health services including Older Adults Mental Health. Care at Home could potentially include a range of other services in the future such as some preventative services, some supported housing provision, some specialist nursing services and specialist mental health social work teams.

6.2 **Functions:** Care at Home will initially have 3 core functions: co-ordinated assessment, planning and care delivery, supporting hospital discharge and supporting admission avoidance. Each Care at Home team will provide all 3 functions on a neighbourhood basis, with staff working in a flexible way that spans organisational boundaries wherever possible.

6.3 **Collaborative working with Home Care:** The lead home care providers will be involved in both the development and delivery of Care at Home. The providers will play a key role on the Operational Group and will operate as key members of the Care at Home teams, working alongside social care and district nursing staff to co-ordinate care on a day to day basis. A request for Mayor and Cabinet to extend the current contracts to enable the development of the new specification for home care will be made in December 2018.

The new service specification for home care will be co-produced by the Care at Home Teams. Home Care will continue to be organised on a neighbourhood footprint. The specification will be outcomes focused and strengthen the requirement for home care staff to proactively engage in multi-disciplinary assessments, care planning and reviews. An integrated approach to training and apprenticeships across Care at Home and home care will be developed. Opportunities to delegate authority to home care staff enabling them to undertake tasks currently managed by health and care professionals will be fully explored. This could involve the development of enhanced roles with a specific focus e.g. dementia and diabetes.

6.4 **Working with other Health and Care Professionals:** The teams will have especially close working relationships with primary care, mental health (both older adults and working age adults), Community Connections (the consortium of voluntary sector

organisations that support vulnerable and socially isolated adults) and the Single Point of Access (SPA), the first point of contact adult social care and district nursing. Work will be undertaken with these professionals / services to develop more effective multi-disciplinary working, joint training, key working and streamlined referral processes.

The Care at Home teams will also work with a wider range of health and care services including community health services (e.g. podiatry, Speech and Language Therapy, Home Enteral Nutrition), preventative services delivered by health and by the voluntary sector (e.g. Community Connections) and supported housing.

6.5 **Key Deliverables and Outcomes:** The OBC sets out key deliverables in relation to workforce, care delivery and strengthened neighbourhood networks. The expected outcomes and proposed principles and ways of working are aligned to Lewisham's Partnership Commissioning Intentions for Adults 2017-19.

Key deliverables include:

- A shared approach to assessment and care planning for patients / service users with complex health and care needs.
- More co-ordinated care and support through, for example, key working and expanded trusted assessor roles within multi-disciplinary teams.
- New 'bridging' or 'hybrid' roles to reduce duplication, improve quality and staff retention.
- Joint training and on-going support to raise quality, deliver holistic care and improve patient and service user experience.
- Utilising technology to improve communication between health and care professionals and between professionals and patients / service users.
- Co-located teams with staff having access to all relevant information.
- Stronger connections between the statutory health and care sector and the voluntary and community sector.

6.6 **Approach to Delivery:** It is proposed to deliver Phase 1 through three key workstreams: Workforce, Performance and Finance, Pathways and Relationships (including trusted assessor and multi-disciplinary working). A draft outline delivery plan has been included in the OBC. An integrated staffing structure will be developed with professional and clinical support continuing to be provided by respective professional leads through a matrix management arrangement. No changes will be made to terms and conditions. A draft Risk Register has been included in the OBC.

6.7 **Governance:** A Care at Home Partnership Board will be developed within the existing Provider Alliance Development Board[3] to enable a clearer focus on delivering Phase 1 of Care at Home. The OBC proposes that a Section 75 agreement will provide the mechanism to bring the services formally together in Phase 1. The Section 75 agreement will set out the approach to aligning budgets and delegating authority (for example to enable the team to act as 'trusted assessors').

The partnership arrangements required for an expanded Care at Home service beyond Phase 1 will be considered to ensure robust governance and accountability. An options analysis will be developed concurrently with the initial phase.

7. Expected Outcomes and Measuring Success

[3] The Provider Alliance Development Board (PADB) is accountable to the Lewisham Health and Care Partnership Executive Board (LHCP). Members include the London Borough of Lewisham, Lewisham and Greenwich NHS Trust, South London and Maudsley NHS Foundation Trust, One Health Lewisham and Lewisham Clinical Commissioning Group.

7.1 Bringing services that support people at home closer together is expected to achieve a step change in the delivery of care at home. Mayor and Cabinet's developing strategic policies and plans are committed to delivering dignified and compassionate care. Lewisham's Partnership Commissioning Intentions for Adults 2017-19[4] set out the high-level health and care outcomes required to transform health and care in the borough. Care at Home will contribute to Lewisham's overall key outcome measures for Community Based Care, specifically the following:

Better health and care outcomes through:

- An increase in health-related quality of life for those with long term conditions (physical and mental health).

Better service user and patient experience of health and care through:

- Consistent, high quality care, localised where possible and in the most appropriate setting – 'Right care, right time, right quality'
- Holistic care where their mental health needs are treated with equal importance to their physical needs and which integrates physical and mental health and care services
- Personalised care developed in partnership with professionals, empowering people to have choice and control over their care.

Best sustainability across health and care in Lewisham through:

- An increase in the proportion of people feeling supported to manage their long-term conditions
- A reduction in avoidable emergency admissions
- An increase in the proportion of older people (65 & over) who are still at home 91 days after discharge
- A reduction in delayed transfers from hospital
- A reduction in the number of people admitted to residential care or nursing homes
- A reduction in the number of people requiring on-going care and support.

7.2 An integrated performance framework will be established to bring together the existing KPIs and ensure that performance against the key outcomes is being measured.

8. Progress to date

8.1 Lewisham Health and Care Partners have taken a number of steps to improve services at a neighbourhood level, raising quality and building better connections across different organisations and with the voluntary and community sector. A range of health and care services are now organised on a neighbourhood footprint based around GP registered lists in the following geographical areas:

(1) North Lewisham
(2) Central Lewisham
(3) South East Lewisham
(4) South West Lewisham.

8.2 Neighbourhood Co-ordinators (one in each neighbourhood) have been in post since November 2015. The Co-ordinators support multi-disciplinary working, liaising between professionals within the NCT and with services outside it. Funded by the Better Care Fund, the Neighbourhood Co-ordinators work across health and social care to improve multi-disciplinary working for those people with complex health and social care needs. The team facilitates effective liaison between formal and informal health and care providers across Lewisham. 1551 'referrals' (requests for support) were made to the Neighbourhood Co-ordinators in 2017-18 (a 24% increase on the previous year). These 'referrals' range from straightforward signposting or information chasing to supporting the co-ordination of case conferences for more complex cases.

[4] *See: Lewisham's Partnership Commissioning Intentions for Adults 2017-19*

8.3 Three pilots were undertaken to test ways to improve multi-disciplinary working in GP practices between May and October 2017. The pilots involved more frequent multi-disciplinary meetings (MDMs) that included a wider range of professionals, including mental health and home care providers. The evaluation demonstrates a wide range of positive impacts that enabled more co-ordinated, person centred care and support:

- Stronger relationships were developed enabling a culture focussed on delivering co-ordinated, compassionate care.
- The flow of information across different professional teams and the speed of referrals both improved.
- Members of the team developed new skills and knowledge enabling them to case manage more effectively, reducing delays to care.
- The greater involvement of mental health professionals enabled more effective and timely referrals to mental health services.

Participants have commented that they felt the team established a shared culture with compassion at its heart e.g.: *'I felt that everyone involved was committed to providing compassionate care'.* In the feedback, participants commented on the level of professional respect within the MDM (*'there was an overarching respect for each professional attending'*) and the improvements to working relationships (*'we have developed a stronger relationship with the GP practice as a result of our joint working'*).

The learning from the pilots has been used to shape the new Standard Operating Procedure for practice based multi-disciplinary meetings (MDMs). Mental health professionals are now engaging with MDMs more consistently. Funding for training and development activity to improve MDMs has been secured and a programme is being rolled out in November 2018.

8.4 A 16 week 'Flexible Roles' pilot to test how district nurses and home care workers could work better together took place between January and May 2018. A small team of 3 district nurses and 6-8 care workers came together to work as one team in Neighbourhood 2. The team worked more flexibly to co-ordinate care and support and reduce duplication for those patients / service users that had both care and on-going nursing needs. The evaluation has highlighted a number of positive impacts:

- A better understanding of different roles broke down barriers and increased respect and trust.
- Strong relationships were developed that improved communication, preventing delays with care and support.
- A shared culture focussed on delivering high quality, co-ordinated care was developed.
- Through closer working with the district nurses, the care workers developed and enhanced their knowledge and experience, enabling them to manage care more effectively and involve nurses at an early stage to prevent crises.
- A 21% reduction in Emergency Department attendances.

8.5 To further strengthen networking across the neighbourhoods, four Neighbourhood Community Development Partnerships have been established. These neighbourhood partnerships bring together voluntary and community sector organisations and groups in that area to support community development, to work with statutory partners in the area and to build stronger, healthier communities.

8.6 LHCP have committed to co-locating district nurses and neighbourhood adult social care teams to improve multi-disciplinary working. The Neighbourhood 1 team is scheduled to co-locate in by January 2019. Locations for the NCTs in N2, 3 and 4 have been identified and these projects will be managed through the One Public Estate initiative.

8.7 Senior and front line staff from across the health and care system have been actively involved with developing activity to improve multi-disciplinary working. The 'Flexible Roles' pilot was informed by feedback from a workshop with a range of health and care staff in September 2017 to explore the potential to develop greater collaboration within the services that support people at home.

8.8 Engagement with stakeholders has taken place throughout September and October. This has included:

- The Care at Home Steering Group – includes representatives from district nursing, adult social care, primary care, mental health and community health and home care commissioners.
- CCG Clinical Directors.

8.9 LHCP held an engagement event for public and professionals in October 2018. A key focus was improving care and support for people in the own homes. There was positive support for the principle of Care at Home particularly for:

- Better communication and information sharing across service providers and with families.
- Better training and support for care workers to do an effective job.

9. Next Steps

9.1 Further engagement with staff and stakeholders on the proposal for Care at Home will be undertaken. Consideration will be given to the on-going involvement of trade unions in relation to the future development of the service. A formal consultation with staff affected will take place in line with the Council's and LGT's policies and procedures. Full engagement will be sought from the unions representing the staff across the organisations involved.

9.2 By January 2019, the Care at Home Partnership Board will be in place to oversee the following activity:

- The development of the Section 75 agreement to commence in April 2019
- Engagement and communications as part of the wider LHCP engagement and communications plan.
- Workforce development as part of the wider LHCP workforce development plan.
- The inter-operability of IT systems to enable the development of a single assessment and care plan aligning with wider LHCP IT developments.

9.3 An Operational Group has been established and will oversee the following between January and March

- Initial testing of the integrated management structure for the Care at Home teams.
- The development of operational processes for the new Care at Home teams.

10. Financial Implications

10.1 This report seeks approval for a proposal to formally integrate a number of social care and health services that support adults in their own homes. The reasons for this approach are set out in the attached Outline Business Case (OBC).

10.2 The OBC provides an overview of the budgets involved in Phase 1 (section 9.1). The proposal is to ring-fence and align rather than pool budgets. The overall Council budget for the services being considered for integration is £19.588m - £5.588m for social work staff and £14m (approx.) for home services purchased from the 4 lead providers..

10.3 The OBC sets out the resource implications for the implementation of Phase 1 (section 9.2). Implementing Care at Home will require additional investment initially. External

funding, including the Better Care Fund, will provide a significant proportion of this. All providers will also contribute to the additional resources required. The Council will be expected to contribute £40,000. Provision for this will be made through additional resources allocated to the local authority through the Improved Better Care Fund (IBCF).

10.4 Delivering efficiencies and savings for the Council and other partners alongside improvements to care is a key driver for Care at Home. The OBC provides a preliminary indication of the potential return on investment (section 10.8). This draws on data gathered in the recent 'Flexible Roles' pilot. Detailed modelling will provide a more robust indication of the return on investment and the timescales in which that could be achieved. Partners will consider risk and gain share agreements as a key next step.

10.5 Mayor and Cabinet have been asked to delegate responsibility for reshaping existing arrangements for joint working, which include a Section 75 agreement and necessary associated documents, to the Executive Director for Community Services on the advice for the Executive Director for Resources and Regeneration and the Head of Law.

11. Legal Implications

11.1 The Council has various statutory obligations to provide services to individuals, including those services which will be affected by the changes proposed by this report. However, the proposed changes will not alter those obligations and to that extent there are no specific legal implications arising from this report.

11.2 The report proposes that the Council enter into an arrangement (called in this report a 'Section 75 Agreement) with Lewisham and Greenwich NHS Trust (LGT, an NHS body) under which certain functions of LGT and certain health-related functions of the Council will be delivered. The Council has powers to enter into such an arrangement under Section 75 of the National Health Service Act 2006, and will need to comply with relevant regulations (in particular the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000) and relevant guidance.

11.3 Before making the decision, Mayor and Cabinet must be satisfied that the proposal is likely to lead to an improvement in the way in which the Council's functions are exercised. The report including the Appendix sets out the proposed improvements.

11.4 The report seeks a delegation of authority to the Executive Director for Community Services (on the advice from the Executive Director for Resources and Regeneration and the Head of Law) to sign the necessary documentation.

12. Crime and Disorder Implications

12.1 There are no crime and disorder implications arising from this report.

13. Equalities Implications

13.1 The OBC sets out the preliminary activity undertaken in relation to equalities impact analysis. An Equalities Analysis Assessment will be undertaken on the final operating and delivery model to ensure that its implementation would not affect adversely any resident with a protected characteristic.

14. Environmental Implications

14.1 There are no environmental implications arising from this report.

15. Conclusion

15.1 Care at Home will enable commissioners and providers of health and care services to work better together to improve outcomes for service users and patients. It will achieve efficiencies and more effective and flexible use of resources.

Background Documents

None

If you would like further information on this report please contact Carmel Langstaff on carmel.langstaff@lewisham.gov.uk / 020 8314 9579.