Outline Business Case: Delivering Care at Home in Lewisham

Version 11

Date: **6 November 2018**

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Version	Change Summary	Change author	Date
2	Added 4.2, a diagram showing the relationship with other health and care services, section on governance, further detail on financial and legal implications.	Carmel Langstaff	30/8/18
3	Added staffing details for rehab teams (Page 5). Minor amendments to wording e.g. re: financial implications.	Carmel Langstaff	11/09/18
4	Added section on synergies with other transformation programmes (see 4.4), section on leadership (see 6.1) and reference to the need for a full equalities analysis assessment (see 11).	Rachael Crampton / Carmel Langstaff	12/9/18
5	Clarified position re: business support (see 4.1).	Carmel Langstaff	14/9/18
6	Added sections on population health (3.1), overview of statutory responsibilities / regulatory compliance requirements (4.1 and Appendix 1), reference to Patient Reference Groups (6.2), developed the governance model in Figure 6.	Carmel Langstaff	18/9/18
7	More detail on the resource plan and potential return on investment, draft scope for the Section 75 agreement (appendix 3) and Draft Principles of Collaboration and Co-operation for the Provider Alliance (Appendix 2).	Carmel Langstaff	25/10/18
8	Removed section on Legal Implications following advice from LBL Legal Services.	Carmel Langstaff	29/10/18
9	Amended Sections 4.1, 9.1 and 10 following feedback from providers.	Carmel Langstaff	31/10/18
10	Amended Sections 6.1, 9 and 10 following feedback from providers and commissioners.	Carmel Langstaff	1/11/18
11	Amended Sections 4.2, 4.3.1, 8 and 9.1.	Carmel Langstaff	6/11/18

Reviewers

Version	Reviewer	Role	Date
1	Joan Hutton, Beth Williams	Nominated by PADB to develop the OBC.	12/9/18
2	Aileen Buckton, Martin Wilkinson, Joan Hutton, Beth Williams, Charles Gostling.	Key partners and stakeholders	10/9/18
4	Aileen Buckton, Martin Wilkinson, Ben Travis, Joanne McCaffrey.	Senior leaders	14/9/18
4	Joan Hutton, Beth Williams, Kate Pottinger, Corinne Moocarme, Evelyn Idise, Cha Power, Dan Harwood, Aaron Hamilton.	Care at Home Delivery Group	18/9/18
8	Provider Alliance Development Board and Joan Hutton, Joanne McCaffrey, Beth Williams, Evelyn Idise, Diana Braithwaite.	PADB, senior leaders.	26/10/19

Approvals

Version	Approver	Role	Date
6	Provider Alliance Development Board	Board overseeing 'Care at Home'	28/9/18
9	Provider Alliance Development Board	Board overseeing 'Care at Home'	31/10/18
11	Martin Wilkinson	SRO	6/11/18

1. Purpose of OBC

This Outline Business Case provides the background and strategic context to a more integrated approach to delivering care at home in Lewisham. It outlines the scope, key deliverables and expected outcomes and sets out the case for investment for Phase 1 based on an analysis of the costs, risks and benefits.

2. Background:

In March 2018, Lewisham Health and Care Partners[1] (LHCP) agreed to develop a more integrated approach to supporting people in their own homes. Providers, supported by commissioners, agreed to formally integrate services and functions that provide care at home. The aim is to improve the co-ordination of care, a key element of the shared vision for Community Based Care[2], 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'.

London Borough of Lewisham'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.

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 and potentially offers opportunities for health and care providers to work differently in future.

The following activity to develop 'Care at Home' has been undertaken since March:

- LHCP agreed that Martin Wilkinson would provide the strategic lead to oversee the development of 'Care at Home' within his existing MD role.
- A *Provider Alliance Development Board* (PADB) providing high level strategic direction and a *Care at Home Delivery Group* (CaHDG) responsible for the development, planning and implementation of the agreed proposals have been established.
- The PADB agreed that Phase 1 would focus on bringing together a number of Adult Social Care services with District Nursing. The governance arrangements would be developed alongside the operational arrangements.
- Planning for 'Care at Home' has been aligned to the planning of new integrated mental health services for adults.
- Planning for 'Care at Home' has been aligned to the development of new home care contracts, overseen by a separate group.

3. The Case for Change

3.1 Overview

Health and Care Partners across Lewisham have recognised for many years the need for change within our local health and care system. Lewisham's population is growing and people are living

[1] *Members include representatives from Lewisham Clinical Commissioning Group, Lewisham and Greenwich NHS Trust, South London and Maudsley NHS Foundation Trust, One Health Lewisham and the London Borough of Lewisham.*
[2] *LHCP Vision for Community Based Care in Lewisham, 2017.*

longer, many with a number of long term health conditions and 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. 14.4% of people in Lewisham identify themselves as having limitations in carrying out day-to-day activities (equivalent to around 39,000 people). There are significant health inequalities in Lewisham and high quality care is not consistently available all the time. Working together, LHCP want to achieve a sustainable and accessible health and care system to better support people to maintain and improve their physical and mental wellbeing, to live independently and to have access to high quality care when needed.

There are recruitment challenges across the system with shortages in a range of staff areas including qualified and experienced social workers, occupational therapists and district nurses. Staff shortages are causing delays to care and increased costs to providers through bank and agency fees. While work to ensure staff are deployed more effectively is on-going, further integration would provide a greater opportunity for flexibility across organisations. Staff satisfaction varies across providers but is generally considered a challenge. The NHS Draft Workforce Strategy emphasises the importance of better system wide workforce planning with a focus on career progression across organisations to improving recruitment and retention. Developing a shared culture and better relationships within integrated teams would improve communication, reducing duplication and delays to care and support.

Key services that support people at home (social care, therapists and district nurses), have been organised, alongside GPs, on the same neighbourhood footprint. While these virtual 'Neighbourhood Community Teams' (NCTs) have enabled professionals to work better together, care remains fragmented. Organisations have different processes and systems which prevents more integrated working. High quality care is not consistently available all the time as multi-disciplinary working within the NCTs and between the NCTs and mental health and domiciliary care, key providers of support to people at home, varies significantly.

3.2 Challenges and opportunities

There are opportunities for efficiencies in relation to neighbourhood assessment and care planning. Multiple assessments are undertaken across different adult social care and provider services (e.g. the overview assessment, the Enablement assessment and the assessment undertaken by the home care agency). A more integrated approach could potentially streamline these processes. Initial work on the assessment processes of adult social care and district nursing has identified a significant overlap in the information collected. While work to better understand the overlap across adult social care and district nursing is ongoing, a trusted assessor approach has the potential to considerably reduce the time spent on assessments as well as improving the patient / service user experience i.e. by only telling their story once.

There are also opportunities for efficiencies in relation to the delivery of care by ensuring that the right professional is providing the required care. Both adult social care and district nursing have developed roles e.g. support planners and health care assistants who can undertake tasks previously completed by qualified social workers, OTs and nurses. In addition, a team of Neighbourhood Co-ordinators was established in 2015 to support multi-disciplinary working, liaising between professionals within the NCT and with services outside it. The team has effectively reduced time spent by professionals chasing information and freed up capacity for tasks that require professional expertise. 'Hybrid' or 'bridging' roles that span social care and district nursing to create a more

flexible workforce could be developed. Clinical governance issues and concerns could be addressed within a formally integrated service.

The investment in population health also presents opportunities to enable better co-ordination of care. The population health and care programme aims to support health and care professionals, providers and commissioners, to develop new evidence-based, ways of working, which best support the needs of the people of Lewisham and pave the way for similar work at a SE London and London level. The work will collate a range of local health and care data into a single management information system, seek to better understand how it is, and can be, used and then create a common and consistent care record, and population-based tools, to help to inform better care delivery and future service design. Outputs of this work include:

- A single unified care record, showing all relevant health and care data in one place for every person or patient and professionals, which will improve the speed of decision making and safety, help professionals to work more cohesively together and to create single care plans (which in future would be able to be shared via the system itself).
- Specific population-based registries, such as a register of people with diabetes or related needs, which will improve identification of needs, risk stratification and prioritisation, call out and deal with care gaps and improve our understanding of the whole population using a complete data set.
- An analytics platform, with the ability to run queries to support evidence-based decision making, provision or commissioning, using a complete data set to give a single version of the truth.
- An information governance and communications approach to underpin the whole programme and ensure it is legally sound and supports our ambitions and use cases.

There is an opportunity to align the development of Care at Home with other transformation activity taking place at Lewisham and Greenwich Trust and within Adult Social Care. This is set out in more detail in 4.4.

3.2 Learning from pilots in 2017-18

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.

A 16 week 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 ED contacts.

4. Care at Home - Initial Scope

4.1 Overview of Care at Home Teams in Phase 1

Lewisham's health and care providers (LBL, LGT, SLaM, OHL and the core GP workforce) have agreed the scope of the first phase of Care at Home. It is proposed that the new arrangements build on the existing Neighbourhood Community Teams (NCTs) to improve the delivery of co-ordinated, person centred care at a neighbourhood level and improve the use of resources to support admission avoidance and hospital discharge.

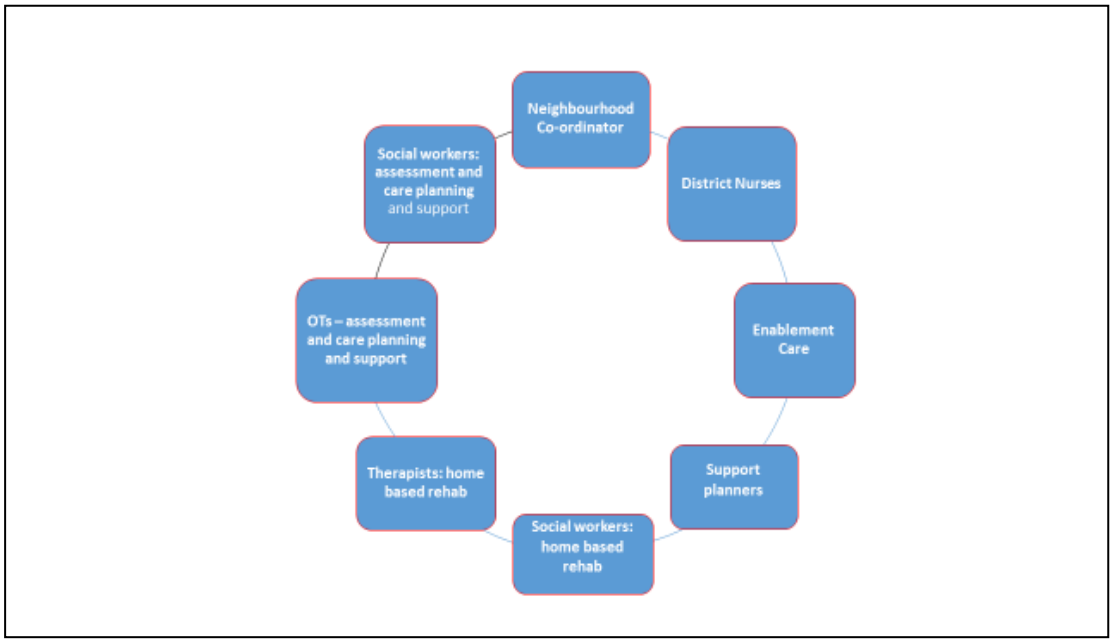
Adult Social Care services are required to fulfil the statutory functions set out in The Care Act 2014. District Nursing and Enablement Care services are subject to CQC regulations.

The first phase of Care at Home will focus on adults and include the following teams:

- Adult social care: Integrated Neighbourhoods (assessment and care planning) – four teams of social workers, OTs, case management officers. Approximately 57 FTE staff in total.
- Home based rehabilitation (joint adult social care and therapies) - a multi-disciplinary supported discharge team that works with the Enablement Care Team to provide up to 6 weeks of home based rehabilitation to people identified as needing support to prevent admission to hospital or to facilitate discharge from an acute bed. An estimated 28 FTE staff in total currently provide homes based rehab.
- Lewisham Adults Therapies Team (LATT) provides long term therapies support for adults living at home. An estimated 30 FTE staff in total.
- Adult social care: Enablement Care Team - the team supports the rehabilitation hub to deliver enablement care and support for up to 6 weeks. It comprises senior enablement officers, enablement work planners, enablement officers and specialist enablement officers. From September 2018, the team will be based on a neighbourhood footprint. Approximately 55 posts.
- District Nursing: four teams of district nurses (a combination of Band 5, 6 and 7 nurses) PCAP (Band 4), health care assistants (Band 3) and a team administrator. Two Band 8a nurses manage two neighbourhoods. Approximately 81 FTE staff in total.
- Neighbourhood Co-ordinators: work across the Neighbourhood Community Teams, supporting multi-disciplinary working, communication and information sharing. Team of 4 FTE posts.

The estimated total number of staff involved is 255. This will need to verified as part of the detailed planning to support implementation. The Care at Home teams will also require administrative support and arrangements for that will need to be considered further. The range of roles that will be within each neighbourhood 'Care at Home' team is shown below (Figure 1).

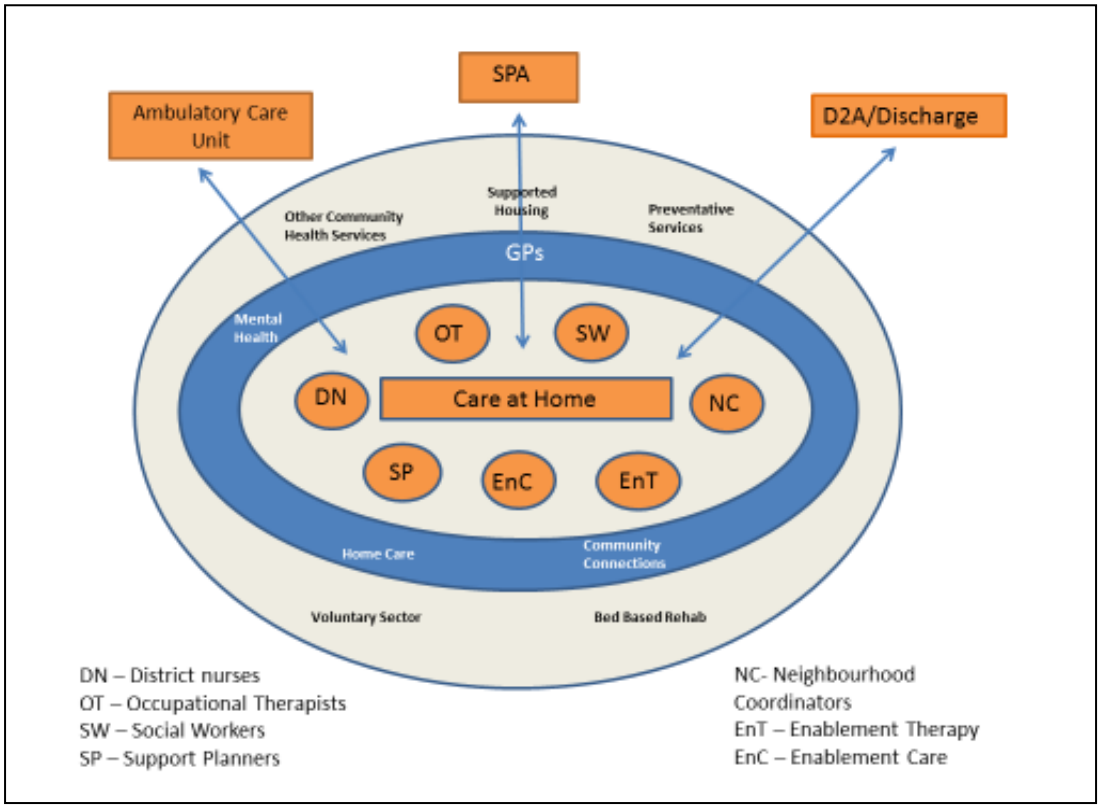
Figure 1: Roles within each Neighbourhood 'Care at Home' team



4.2 Relationship Between Care at Home Teams and Wider Health and Care Services:

The Care at Home teams will work closely with a range of health and care professionals as illustrated below.

Figure 2: Relationship Between Care at Home Teams and Wider Health and Care Services



The teams will have especially close working relationships with primary care, home care, Community Connections (the consortium of voluntary sector organisations that support vulnerable and socially isolated adults) and mental health (both older adults and working age adults). The Care at Home Teams will also work closely with the single point of access which will provide the key mechanism for referrals.

The Care at Home teams will:

- Work in a different, more collaborative way with home care agencies. The lead providers will be involved with operational planning and the day to day co-ordination of care on the ground. Building on the approach to procurement in the last cycle, the specification will be outcomes focussed and a mechanism for charging will be developed to support that. An integrated approach to training 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. The specification will also explore the potential for home care providers to develop enhanced roles with a specific focus e.g. dementia and diabetes.
- Build on the multi-disciplinary working with primary care, improving multi-disciplinary meetings (MDMs) and developing new opportunities to work more effectively with GPs. Regular MDMs are now established in every practice (co-ordinating monthly MDMs is a requirement of the Primary Care PMS contract). MDMs involve GPs, social care, district nursing and more recently mental health, although there is considerable variation in terms of quality and effectiveness. Integrated Care at Home teams will support greater consistency across MDMs. Building on the learning from the pilots undertaken in 2017 (see 3.2), Care at Home will look to develop a key worker approach and involve home care providers in practice based MDMs. The teams will also explore opportunities to streamline referral processes from primary care.
- Work more effectively with adult mental health services, especially Older Adults Mental Health. Joint training will improve knowledge of services and criteria for support. Key working will be developed to improve communication and reduce hand offs. Further involvement of OAMH in the SPA will be explored and referral processes will be reviewed. Work is currently underway to test a specific MDM with an older adults mental health focus at South Lewisham Group Practice. This could be developed in other practices with large numbers of older adults. It is envisaged that additional mental health clinical capacity will be required to support Care at Home. This could be a resource that is realigned or may be potentially an additional resource that is required.
- Work more effectively with Community Connections, the consortium of voluntary sector providers that delivers key initiatives to support vulnerable and isolated adults. These include co-ordinating the Neighbourhood Community Development Partnerships as well as connecting individuals to support available in the community. The consortium will be strengthened to include other voluntary sector providers and links with practice based MDMs will be further developed.

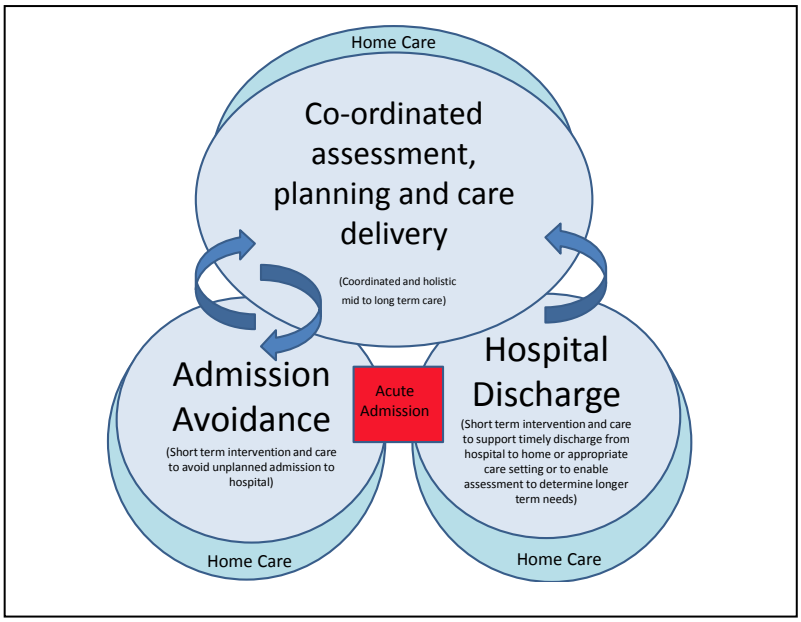
The Care at Home teams will also work with a wider range of health and care services including community health services (e.g. podiatry, SALT, HEN), preventative services delivered by health and by the voluntary sector (e.g. Falls Service, SAIL), supported housing. Both the Single Point of Access

(the first point of contact adult social care and district nursing), the D2A team and hospital discharge service and the Ambulatory Care Unit are key interfaces, reflecting the core functions of Care at Home.

4.3 Core Functions:

Care at Home will initially have 3 core functions: co-ordinated assessment, planning and care delivery, supporting hospital discharge and supporting admission avoidance as represented in Figure 3 below. Each neighbourhood Care at Home team will provide all 3 functions on a neighbourhood basis, with staff working a flexible way that spans organisational boundaries wherever possible. Home care will work closely with the Care at Home teams to support all core functions.

Figure 3: Care at Home teams – core functions



4.3.1 *Co-ordinated Assessment, Planning and Care Delivery:*

The four co-located neighbourhood Care at Home teams will deliver more efficient assessment and care planning through streamlined and shared assessment and care planning processes. Key working and trusted assessor roles will be developed to provide more co-ordinated care and support. The Care at Home teams will include Enablement Care under the same management structure, facilitating more effective multi-disciplinary working across enablement, social care, occupational therapy and district nursing. Demand will be managed more effectively through the development of the Single Point of Access (SPA) as outlined in 4.4.2.

There are opportunities to strengthen the relationships with primary care in relation to assessment and care planning. Improved communication, a joint approach to assessment and care planning, key worker roles and a more flexible workforce will enable greater co-ordination across primary care and Care at Home.

Home Care will continue to be organised on a neighbourhood basis. A new Service Specification will be co-produced by Neighbourhood Care at Home Teams. It will strengthen the requirement for home care agencies to work much more proactively with the Neighbourhood Teams and engage in multi-disciplinary assessments, care planning and reviews. The new specification will be in place by 1st April 2020.

Summary of patient / service users across the services:

- Approximately 300 social care assessments are undertaken each month.
- An average of 162 people receive enablement care support each month.
- An average of 3068 people receive support from the district nursing team each month.
- 1880 people accessed support with their personal care from home care agencies in 2017-18 (an average of 156 a month). 73% of these people were still receiving care at the end of the year.

4.3.2 *Supporting hospital discharge / D2A:*

The Care at Home neighbourhood teams will proactively support people ready for discharge to co-ordinate timely transfer into the community.

The intention is to expand Discharge to Assess (D2A) increasing the numbers and complexity of the patients that can be discharged from an acute bed. Going forward D2A will become the default discharge pathway for all patients to ensure, wherever possible, assessment for longer term care needs will be completed at their ordinary place of residence. Care at Home could proactively work with the discharge teams to 'in reach', identifying people that require care and support and reducing delayed transfers of care. The Neighbourhood Co-ordinators' role could be developed to support better co-ordination of discharged patients / service users into the community.

Building on the learning from the flexible roles pilot, the aim is to develop new 'hybrid' health and care roles, initially in Enablement Care. As Enablement Care provides up to 6 weeks free support through adult social care, developing a hybrid role in this function would prevent potentially complex administration in relation to charging.

Summary of patient / service users across the services:

- Approximately 108 people that require home based and bed based rehabilitation and social care support are discharged each month. On average, 42% of these are discharged through D2A.

4.3.3 *Supporting admission avoidance:*

There is an opportunity to engage social care professionals earlier through a better interface between the ACU and Care at Home. Care at Home could provide short term interventions that may prevent and / or delay the need for a long term package of care.

Approximately 500 people attend the ACU each month. It is estimated that Care at Home could support up to a third of these individuals. Although a more detailed analysis of the data is required, at a first look approximately 170 ACU patients a month could be supported by the Care at Home teams through integrated short term interventions. This support could be delivered by an expanded

Enablement Care function. If the evidence demonstrates a return on investment, a realignment of the resources that are currently used to support these individuals would be necessary to facilitate the shift away from the acute to community services. It is envisaged that additional geriatrician capacity will be required, either through the remodelled ACU or within the Care at Home teams.

4.4 Synergies with other transformation programmes

4.4.1 *Ambulatory Care Unit and Adult Community Services Transformation (ACU/ACS)*

Running alongside the design of 'Care at Home' is the proposal for the development of the Ambulatory Care Unit (ACU) and adult community health services. The aim is to support a reduction in the number of Emergency Department attendances and admissions as well as supporting faster discharge.

This programme of work is looking to develop:

- Ongoing streamlining and redesign of adult community services to ensure good quality and efficient care
- A community hub that provides a single co-ordinated response for adult primary and community care referrals. The principle is for no patient to be sent to hospital (non-elective) without a prior discussion. The hub would build on the existing Primary Care consultant phone-line, based in the Ambulatory Care Unit, to offer a more responsive telephone referral route. It is expected that a service level agreement would provide a consistent call response for advice, triage and clear handover of care.
- The scope beyond general medicine and move the Surgical Assessment Unit in to the ACU followed by cardiology, diabetes and frailty.
- Extended access to the ACU by opening beyond 8pm on a Monday to Friday and at the weekend to support any further admission avoidance.
- The hospital frailty model by extending it to the community through additional community geriatrician capacity.
- Multi-disciplinary working within the ACU / community health services to more effectively support discharge.

Further analysis is required to understand the service demand and activity shifts, resourcing requirements and costs. It is expected that:

- GP visits will be reduced where it is more appropriate for a nurse home visit. South Lewisham, the Jenner and Bellingham Green practices estimate that would have prevented 409 GP visits over the last financial year
- A reduction and shift in ACU follow up activity (currently there are around 225 follow up appointments a month). There is potential to reduce this through different staffing arrangements, telephone follow up or through more effective multi-disciplinary working.
- Mid to moderate frail elderly patients (currently about 70 a week in the Critical Dependency Unit or the ED) could be identified earlier and managed better preventing deterioration of their condition
- Referrals directly from community teams to GPs to co-ordinate care for more complex patients.

The Care at Home and ACU/ACS transformation will need to be aligned to prevent any potential duplication of resources and cohorts. For example, both proposals highlight the need for additional geriatrician capacity and multi-disciplinary support at home.

4.4.2 *The District Nurse and Social Care Single Point of Access (SPA)*

This will be developed concurrently with the Care at Home service to manage demand more effectively. Building on the work to date, planning is underway for a super hub with one phone number, open 7 days a week (8am to 8pm), taking calls from public and professionals. The hub will respond to queries relating to physical health, social care, mental health and safeguarding and ensure that the right support is provided as quickly as possible. The SPA will reduce hand offs and provide a rapid response using joined up technology and access to clinical and professional support at all levels.

Discussions have already taken place with commissioners and social care about synergies between the DN and social care SPA and the vision for the ACU/ACS hub.

4.4.3 *D2A mapping*

The D2A process is currently being reviewed. Mapping took place in August to understand how the current D2A process could be improved and where there is scope to discharge more patients under this model.

4.4.4 *Mental health*

Activity to develop a Mental Health Provider Alliance is on-going. A review of mental health pathways (including crisis pathways, common and serious mental health illness pathways) is being undertaken to identify opportunities to streamline and improve care. There may be opportunities to align activity to the development of Care at Home.

4.5 Key Deliverables:

Workforce:

- More co-ordinated care and support through, for example, key working and expanded trusted assessor roles within a multi-disciplinary team.
- New 'bridging' or 'hybrid' roles to reduce duplication, improve quality and staff retention.
- Joint training and development 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.

Care delivery:

- An integrated approach to risk stratification
- An integrated approach to service redesign to develop pathways that operate effectively and collaboratively across the system.
- A shared approach to assessment and care planning for patients / service users with complex health and care needs.
- The development of key working across the integrated Care at Home teams to provide more co-ordinated care and support.
- An integrated and co-ordinated approach to transfers of care from hospital to the community.
- An integrated and co-ordinated approach to working with the Ambulatory Care Unit to prevent admission.

Strengthened Neighbourhood Care Networks:

- Better multi-disciplinary working between the Care at Home teams and community based health and care services.
- Stronger connections between the statutory health and care sector and the voluntary and community sector.

4.5 Summary of Key Challenges:

Phase 1 of the Care at Home partnership is large scale and complex. It presents a number of challenges including the following:

- Lack of capacity to lead the change.
- Flow of resources across the providers, for example, if the teams provided short term interventions for patients leaving the ACU, these would need to be resourced.
- Engagement is needed with patients, service users and key providers (primary care, home care, mental health and the voluntary sector) to better understand different needs and pressures across the system.
- Clinical governance issues need to be resolved to enable greater flexibility in roles working across organisational boundaries.
- Activity to develop Care at Home is provider led but will require agreement from commissioners.
- The STP is looking to develop closer working across boroughs with a particular focus on bringing together arrangements for hospital discharge and community based care. This may impact on the development of local plans.

The financial implications are considered more fully in section 9 and the challenges are addressed in more detail in the risk register.

5 Future Scope:

Care at Home will be expanded in subsequent phases to include the following services and functions:

- Specialist dementia care.
- Some community mental health services including Older Adults Mental Health.

Residential and nursing care and specialist services supporting people with Learning Disabilities are *not* currently being considered as in scope. However, 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
- Supported Discharge
- Specialist mental health social work teams
- Emergency Department social care team
- End of life care.

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.

6 Approach to Delivery

The Provider Alliance Development Board has agreed that activity to develop Care at Home will be provider led but supported by commissioners.

6.1 Management and Staffing Arrangements

It is proposed that:

- The Head of Adult Social Care and the General Manager and Head of Adult Community Services provide joint leadership of the Care at Home teams.
- An integrated management structure is developed whereby operational leadership of the teams is undertaken by either a social care professional or a community nurse lead. Professional and clinical support would continue to be provided by respective professional leads through a matrix management arrangement.

The terms and conditions for staff will not be affected.

6.2 Key activity:

The draft Outline Delivery Plan 2018-19 (Appendix 4) sets out high level approach to the delivery of phase 1. It is proposed that activity is managed within the following three key workstreams:

1. Workforce
2. Performance and Finance
3. Pathways and Relationships (including Trusted Assessor roles and multi-disciplinary working

The key activity is summarised below:

- *Agree resources:* detailed activity and financial modelling to identify and secure the resources required to implement the delivery and operational plans.
- *Establish the operational delivery model:* engage staff, patients and service users in the development of the neighbourhood Care at Home teams. Work with partners including existing Patient Reference Groups to co-produce service redesign activity. Providers to lead on service review activity to deliver strategic objectives for target populations including frailty, diabetes and dementia.
- *Align commissioning processes and establish contract values*: the contractual implications of the proposed model to be resolved (specifically separating the community services element of the overall LGT contract); commissioning processes for key contracts including district nursing and home care to be aligned; the scale of efficiencies and the timetable for delivering them to be agreed.
- *Agree risk and gain share*: proposals relating to risk and gain share to be developed; sovereign boards to agree delegation.

- *Develop an integrated approach to workforce:* develop a joint approach to key workforce development activity. This will involve the development of new, hybrid roles and functions as well as an integrated approach to OD.
- *Develop an integrated approach to ICT:* work with the Strategic ICT group and the Population Health Group to ensure ICT development is fit for purpose and delivers key tools including a single care plan. Information sharing agreements to be agreed.
- *Establish the legal framework*: revise existing and establish partnership agreements including Section 75 agreements; agree approach to aligning resource, delegating functions, accountability for operational delivery and responsibility for aligned budgets.
- *Agree the approach to developing future phases:* map options for an arms-length service and agree approach to implementation.

Activity will be aligned with work being undertaken to develop integrated provider arrangements for adult mental health services.

6.3 Principles / Ways of Working:

Developing new integrated arrangements for care at home will be informed by Lewisham's Partnership Commissioning Intentions for Adults 2017-19, which set out the expectation of providers to deliver advice, support and care that is:

- Population based – which is a way of looking at patients/service users not just as individuals but as a part of a wider population.
- Expanding and strengthening primary and community care - shifting the majority of outpatient care out of hospital. This will result in most of care being provided at home or near to people's homes.
- Promoting health and wellbeing - helping people to get the right advice, support and care in the right place, first time with a shift towards proactive and preventative services and supporting community development.
- Providing an integrated response to the needs of the individual– a holistic response -physical, mental and social needs - giving people control of their own care and empowering them to be independent, make informed choices and take control to meet their individual needs.
- Evidence based and outcome focused - meeting the needs of whole population, addressing inequality and equalities issues.
- Co-produced with patients, service users, carers and wider communities - in partnership with the people and communities.
- A whole system approach - a health and care system that is safe, sustainable and provides high quality care consistently.

7 Expected Outcomes and Measuring Success

Bringing services that support people at home closer together is expected to achieve a step change in the delivery of care at home. London Borough of Lewisham's developing strategic policies and plans are committed to providing dignified and compassionate care services. Lewisham's Partnership Commissioning Intentions for Adults 2017-19[3] 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:

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

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:

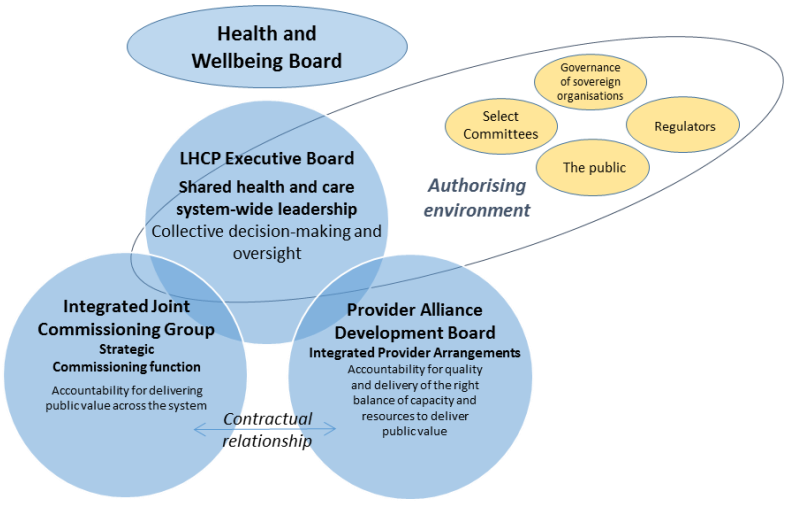
- An increase in the proportion of people feeling supported to manage their long term conditions
- A reduction in avoidable emergency admissions
- An increase in the proportion of older people (65 & over) who are still at home 91 days after discharge
- A reduction in delayed transfers from hospital
- 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.

All services that will come together within Care at Home have individual performance indicators. Services are subject to statutory requirements, CQC regulations (e.g. Enablement Care and District Nursing) and clinical regulations (e.g. District Nursing) – see Appendix 1. 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 Governance

The overarching governance arrangements are summarised below in Figure 5:

Figure 5: Overarching Governance Arrangements



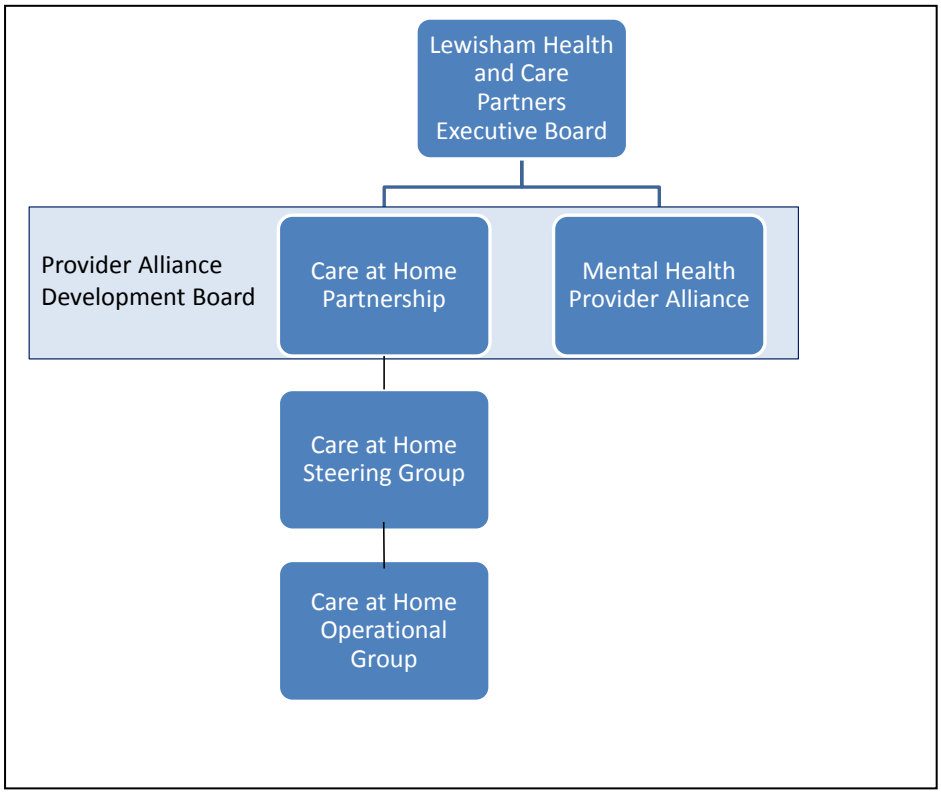
The Provider Alliance Development Board (PADB) was established in June 2018 to oversee the two distinct but related areas of provider development – Care at Home and Adults Mental Health. Given the need to involve different providers at a strategic level, it is proposed that the PADB will be developed to comprise of a Care at Home Partnership and an Adults Mental Health Alliance and envisaged that meetings will form part 1 and part 2 of the PADB as illustrated in Figure 6.

The Care at Home Partnership will provide strategic direction and ensure that the workforce, financial, clinical, legal and governance requirements of the integrated provider arrangements are appropriately managed. The Care at Home Partnership will monitor progress made by both the Care at Home Steering Group (formerly the Delivery Group) and the Care at Home Operational Group.

A Care at Home Delivery Group was set up in July 2018. Given the scope of Phase 1, it is proposed that this Delivery Group becomes a Steering Group focussed on ensuring that Care at Home is aligned to other improvement activity within mental health, primary care, adult community health services and adult social care. The Steering Group will undertake initial planning for future phases of Care at Home and provide oversight of an operational group, comprising the service managers involved in delivering Care at Home that will manage the operational delivery of Care at Home.

Work to improve neighbourhood care (e.g. the development of Local Care Networks, training to support multi-disciplinary meetings) will continue alongside the activity to deliver Care at Home.

Figure 6. Proposed Governance and Partnership Arrangements for Care at Home



9 Financial implications

9.1 Overview of budgets involved

Services:		***Budget:***
Directly managed LBL services	Adult social care: Integrated Neighbourhoods	£3,036,656
	Adult social care: Enablement Care	£1,756,255
	Adult social care: Home Based Rehab	£794,930
LBL Commissioned Services:	Home Care	£14,000,000
LCCG Commissioned Services:	District Nursing	£7,570,394
	Lewisham Adult Therapies Team	£1,335,270
	Supported Discharge (therapies element)	£940,000 (estimated)
	Total:	£29,433,505

The budgets will be finalised as part of the development of the Section 75 agreement.

9.2 Phase 1 Resource Implications

This Outline Business Case describes the work being undertaken to bring together a number of neighbourhood services that currently support residents to live as independently as possible in their own homes within the community. If approved, detailed proposals will be developed regarding reshaping existing arrangements for joint working which include a Section 75 agreement and any necessary associated documents. The first phase of development will seek to ring-fence and align rather than pool budgets.

Providers continue to explore how they can make best use of existing resources to support the new partnership arrangements:

- LGT is considering the potential for additional geriatrician capacity within the Ambulatory Care Unit (ACU) as part of their programme to transform community health services. This will in turn support the provider alliance through stronger links between the ACU and Care at Home.
- The commissioning team are exploring how existing posts could be refocused to provide the additional support (e.g. monitoring) required to improve the quality of home care contracts.
- Adult Social Care and District Nursing are exploring opportunities to provide backfill to release capacity from operational leads through vacant posts.

- Partners are exploring what clinical support they could provide from existing resources. The CCG Clinical Directors have offered to provide on-going clinical advice / input. While they have limited capacity, this input may be sufficient to implement phase 1. In addition, the LMC representative on the Provider Alliance Development Board has identified a GP to provide clinical input from a primary care perspective.
- Some project management support can be provided from the Whole System Model of Care Team (funded through the Better Care Fund). The team will also be able to draw on expertise from the Population Health System programme which will provide mechanisms for data sharing and a joint assessment.

The following table provides an indication of the additional resources that may be required to implement Phase 1.

Area:	***Estimated Cost:***
Financial modelling	10
Project management / support	80
Additional clinical support	10
Communications and engagement	5
Legal expertise	15
ESTIMATED Total:	120k

It is anticipated that the additional resources will be sourced from a combination of provider contributions and the Better Care Fund.

Additional resources may also be required to support the further development of flexible roles within home care. There are opportunities to develop enhanced roles within home care which may release efficiencies elsewhere in the system, but there may be cost implications to that.

As well as additional resources, achieving the core functions set out in section 4.3, will require a change in the flow of resources from the acute to Care at Home. As outlined in 4.3.3, if additional short term interventions were delivered by the Care at Home teams, it would be necessary to realign resources that are currently used to support individuals in acute settings. The potential additional pressures on primary care also need to be recognised. The pilots undertaken in 2017 and 18 (see 3.2) all reduced ED attendances and admissions but involved additional GP input. Further modelling is required to provide details of the resource implications.

10 Return on Investment

Providers are not expected to reduce expenditure in the short-term, however once implemented, Care at Home is expected to generate significant efficiencies for the providers as well as providing better outcomes for service users.

It's possible from preliminary modelling to indicate key areas where efficiencies could be achieved and estimate the level of those efficiencies. However, it should be noted that while this preliminary modelling is informed by the evaluation of the 'Flexible Roles' pilot (see 3.2), this was a relatively small scale pilot. Furthermore, some additional costs may be incurred to achieve the return on investment outlined, for example costs associated with additional care worker hours. It is therefore proposed to undertake detailed modelling to provide a comprehensive and robust analysis of the potential return on investment as well as any potential additional costs.

10.1 Assessment

Approximately 300 social care assessments are undertaken each month. In Lewisham it is standard practice for social care assessments to be undertaken by a qualified social worker, however this is not a legal requirement. Separate assessments are undertaken by Occupational Therapists, Enablement Care and Home Care. District Nurses also receive on average 950 new referrals each month. There are core questions in all these different assessments that are common to each one.

A 'trusted assessor' approach has been established in relation to the ordering of equipment, where district nurses are 'trusted' to undertake the assessment and order the equipment. Building on this, there are opportunities to create a single assessment for core questions that could be completed by any health and care professional. This would create a range of efficiencies, including:

- One professional would gather the core information in one visit rather than 2 + professionals in 2+ visits. Follow up 'specialist' assessments would be quicker to complete, some non-complex social care assessments could be for example completed over the phone.
- Time spent travelling to visit patients / service users would be reduced.
- Sharing this assessment with home care providers would prevent the need for a new assessment being undertaken by them.
- Some care planning could also be undertaken by a 'trusted assessor'.

Detailed modelling is required to better understand how many shared assessments could be undertaken and the potential savings this could achieve.

10.2 Diabetes

Blood Glucose Monitoring is the highest reason that district nurses support patients in Lewisham (30% of the total). The second highest reason that district nurses support patients in Lewisham is to provide support with insulin administration (29% of the total).

Community health service provision often cannot meet demand and in some areas in the UK the supervision or administration of insulin is undertaken by non-registered practitioners. The Care Quality Commission requires effective systems to be in place to protect people from the risks associated with unsafe use and management of medicines. In addition, the Royal College of Nursing (RCN, 2011) offers clear guidance on accountability and delegation to non-registered practitioners. There are, however, several examples of effective collaborative programmes that support the

quality and safety agenda relating to insulin administration by non-registered practitioners. Diabetes UK has also published a guide to managing insulin administration in the community.[4]

One particular programme in a community nursing team in Shropshire is cited in the Journal of Diabetes Nursing (issue 17/6/15). This demonstrated that through a robust training programme and collaboration with older individuals with diabetes, their families, and registered and non-registered practitioners alike, insulin administration can be undertaken safely within regulatory parameters. Given the logistics of matching certain insulin regimens with food consumption, involving the home care workforce in supporting diabetes management is a holistic and logical approach.

LGT already has a policy in place allowing unregistered Health Care Assistants and Primary Care Assistant Practitioners employed by the Trust to administer insulin. As accountability and supervision remains with the Registered Nurse, delegating this responsibility to carers employed by another organisation would require a strong clinical governance framework.

Although more detailed modelling is required to provide an accurate estimate of the potential saving, if the number of district nursing calls for blood glucose monitoring and insulin administration were both reduced by 50%, this would result in 30% fewer calls.

10.3 Wound Care

Wound care is the third highest reason that district nurses support patients in Lewisham (7% of the total). Leg ulcer care represents 3.5% of the total and pressure ulcer care and monitoring represents 3.7% of the total. The combined figure for wound care, leg ulcer care and pressure care represents 14.2% of the total district nursing visits.

In the 'Flexible Roles' pilot, the district nurses felt that a third of wound / leg ulcer / pressure care cases improved more quickly as a result of the better continuity and co-ordination of care. The improved knowledge of the care workers also had the potential to prevent more pressure sores from developing and or/ accelerating. The potential impact is significant. If for example, 800 patients with pressure sores / wound care needs required 10 fewer visits from a district nurse, the saving is estimated to be **£344,000**. If a further 200 pressure sores are prevented from needing a district nurse input a year, assuming the district nurse input would of 15 visits, this could save an estimated **£64,500**. A more pro-active and co-ordinated approach would also reduce and hopefully prevent staff having to investigate incidents regarding the quality of care in relation to pressure sores.

Detailed modelling would consider the potential financial impact and potential additional costs (e.g. in relation to care workers) in more detail.

10.4 Providing 'Double Handed' Care

[4] https://www.diabetes.org.uk/about_us/news/insulin-delegation-guide

On average, 185 people that require 'double handed' support from home care in Lewisham per year. Without data to ascertain the district nursing input for these patients / service users, it's difficult to estimate the potential efficiencies. However, using the data from the Neighbourhood 2 'Flexible Roles' pilot as a proxy, the district nurses visited these patients an average of 2.2 times per week. If care workers and district nurses were able to co-ordinate joint visits, it would be possible to 'stand down' one care worker, saving an estimated **£58,645** per year (based on figures cited in Curtis L., Burns A., *Unit Costs of Health and Social Care 2017*).

In theory, there is also potential for a co-ordinated visit between a care worker and a district nurse to save on district nursing time too. It has not been possible to obtain the data on the number of visits where two district nurses attend. However, there are on average approximately 430 DN contacts per day. If 10% of these visits require two (Band 5 or Band 4) district nurses and one care worker could be utilised to support one district nurse, a total of 15,695 district nurse visits a year could potentially be saved. The average actual cost per hour of a Band 5 and a Band 4 district nurse is £32.5[5]. Assuming visits lasting 30 minutes, the potential savings would be **£255,043** per year. Even with a more conservative estimate of 5% of total visits, the saving would be **£127,521** per year.

10.5 Reduced hand offs

The team in the 'Flexible Roles' pilot reflected that easier communication between the district nurses and the care workers prevented delays with care. Care workers could contact the nurses directly on their phones as opposed to contacting their office where someone would contact the District Nurse Call Centre who would contact the relevant team who would contact / allocate a nurse (i.e. one call rather than four).

The estimated cost of four hand offs based on 4 x 5 minute calls (using data from Curtis L., Burns A., *Unit Costs of Health and Social Care 2017)* = £7.95. If the District Nurse Call Centre received 100 calls a week from home care agencies, based on the estimated cost of the current approach, it's possible to estimate the potential savings to the system as **£41,340**.

10.6 Reduced Emergency Department Attendances and Hospital Admissions

The 'Flexible Roles' pilot indicated the potential for more co-ordinated care to reduce ED attendance and admissions. Although the evaluation indicated a 21% reduction, excluding one patient who was an outlier, the reduction was 60%. Without data on the potential number of people that could be cared for by an integrated nursing and care team, it is difficult to estimate the saving in terms of ED attendances.

The average cost of an ED attendance in Lewisham is £177.02. In Lewisham, on average 25.51% of ED attendances result in an admission with an average stay of 5 days. The income received from an average stay is £2,281.

It is possible to estimate the costs saved (using the pilot data as a proxy) as follows*:

[5] Curtis L., Burns A., *Unit Costs of Health and Social Care 2017*

	20% reduction in ED attendances	40% reduction in ED attendances	60% reduction in ED attendances
Savings on the cost of ED attendance	£21,242	£42,484	£63,727
Savings on the income received from average admission	£69,821	£139,642	£209,477
TOTAL	£91,063	£182,126	£273,204

*This is based on the 400 people attending ED 1.5 times per year. While this may be a conservative estimate of the number of people that will be supported by Care at Home and the average ED attendance, the pilot data is relatively small scale. Detailed modelling is required to provide a more robust projection in relation the impact on secondary care.

10.8 Summary

This summary uses the pilot data as a proxy for areas where savings are expected. Detailed modelling will provide estimates in relation to assessment and diabetes care and will further test the initial modelling. In addition to the areas highlighted, there are expected to be a number of other areas where efficiencies could be achieved.

Area	Potential saving per year
Assessment and care planning	Requires more detailed modelling
Diabetes care	Requires more detailed modelling
Reducing duplication re: double handed care • Care worker hours • District nursing hours (based on 10% of the total visits)	 **£58,645** **£255,043**
Wound Care: If 800 patients with pressure sores / wound care needs required 5 fewer visits from a district nurse.	**£172,000**
Reducing hand offs: based on the estimated cost of 4 x 5 minute calls and on 100 calls a week from home care agencies to the DN call centre each week.	**£41,340**
Reduction in ED attendances: based on a 40% reduction on 300 people attending ED 1.5 times per year.	**£42,484**
Reduction in admissions: based on a 40% reduction in ED attendances (from 400 people attending ED 1.5 times per year).	**£139,642**
TOTAL	**£709,154**

11 Equalities Implications

Initial consideration of the likely impact of the proposal on the borough's diverse communities has concluded that it will not discriminate against any service users or adversely impact on any characteristics protected under the Equality Act 2010. The aim of the proposal is to positively impact

on patients and service users by improving access to higher quality care and support through better co-ordination and closer working with GPs. More 'joined-up' care will help reduce inequalities for individuals, families, carers and local communities.

An Equality Analysis Assessment (EAA) on the operational delivery model will provide a detailed analysis of the proposed changes to service delivery on each of the 9 protected characteristics: age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. This will include positive and adverse impacts and outline what measures will be put in place (or are planned) to minimise any adverse impact on a particular protected characteristic.

The proposals will disproportionately affect older people, people with disabilities and women as they are more likely to be in receipt of a social care and community health services than the rest of the population.

An updated Information Sharing Agreement is required to enable the partners to share data on use of their services. This data will inform the Equality Analysis Assessment.

Appendix 1: Overview of Statutory Responsibilities and Regulatory Frameworks

1. Statutory responsibilities:

(a) *Adult Social Care*:

The Care Act 2014 aims to put people at the centre of their care and support and maximise their involvement. It requires local authorities to adopt a person-centred approach, shifting away from providing services to meeting needs. The Act sets out the responsibility of local authorities in the promotion of individual wellbeing and on preventing or delaying the need for support. This involves signposting people to any existing community resources, facilities and assets to help prevent their needs from escalating further. Local authorities are required to:

- Establish and maintain an information and advice service, available to everyone, not just people who are entitled to care and support from the council. The service must include help with signposting including to financial advice. Information will be provided in accessible ways not just on a website, or leaflets in a GPs office, but tailored to the needs of local people.
- Facilitate a diverse, vibrant and sustainable market for care and support services that benefits the whole population.
- Promote integration with the NHS and work with other key partners to improve services locally.
- Arrange for an independent advocate to help people communicate their views, wishes and feelings when required.
- Carry out needs or carers assessments where it appears to an authority that a person has some care and support needs. The Act establishes a national minimum threshold at which people will be eligible for support.
- Produce care and support plans and offer a personal budget once an assessment has been made.
- Review Care and Support plans to ensure they continue to meet the needs of the person.
- Operate a deferred payments scheme whereby people can pay for their care costs without selling their home in their lifetime.
- Establish a safeguarding adults board and act if they believe an adult is, or is at risk of, being abused or neglected. They must also set up a safeguarding adults board including key stakeholders. This board will carry out safeguarding adults reviews when people die as a result of neglect or abuse and there's a concern that the local authority, or its partners, could have done more.

(b) Functions of NHS Bodies

The NHS is responsible for the function of providing, or making arrangements for the provision of, services under sections 2 and 3(1) of the 1977 National Health Service Act, including rehabilitation services and services intended to avoid admission to hospital and under section 5(1), (1A), and (1B) of, and Schedule 1 to, the 1977 National Health Service Act.

2. Regulatory Compliance

District Nursing services, local authority Enablement services and home care services are monitored by the CQC.

Appendix 2: Draft Principles of Collaboration and Co-operation

PRINCIPLES OF COLLABORATION AND CO-OPERATION FOR THE PROVIDER ALLIANCE

The Partners shall at all times during the Term act reasonably and in good faith in their dealings with one another and shall operate in accordance the following agreed principles:

1. The need to deliver improved health and care outcomes for the population served by the Partners should not be prejudiced by the individual interests of any Partner.
2. Equality and equity of the Partners.
3. Complementary capabilities applied to common interests.
4. Mutual transparency of data in relation to the Provider Alliance/s and the delivery of the Services.
5. Fair and proportionate distribution of risk and reward.
6. The Provider Alliance/s will be granted autonomy and authority to make decisions and deliver the Services in accordance with an overarching Partnership Agreement/s.
7. The Provider Alliance will, through the proper discharge of all obligations under an overarching Partnership Agreement/s be empowered to pursue its agreed priorities, to reshape how services work, individually and collectively, without restrictive decision making or process.

In consideration of the mutual benefits and obligations under an overarching Partnership Agreement/s, the Partners will work together to achieve the following objectives:

- Improve the health and wellbeing of people in Lewisham.
- Proactively support people's health by starting well, living well, ageing well and at the end of life.
- Improve both mental and physical health.
- Provide services fairly, to reduce local variation in healthy lives.
- Strengthen the social determinants of health and promote healthy lifestyles.
- Enable healthy lifestyle choices and prevent ill health.
- Support improvements in wider determinants of health including housing and employment.
- Ensure services are safe, equitable and of a high standard with less variation.
- Co-ordinate health and care, ensuring safety, quality, value for money and high standards for all.
- Enable people and communities to be active partners in their health and wellbeing.
- Build on the strengths of communities, voluntary groups and social networks.

- Invest in individuals and carers, supporting them to manage their own health.
- Achieve a sustainable system.
- Transform the health and care system, moving our focus from hospital to the community.
- Balance our finances now and in future years.
- Develop our workforce so we have committed, healthy, skilled, people where and when they are needed.
- Develop our collective estate to improve access to and efficiency of health and care services.

Appendix 3: Scope of the Section 75 Agreement

The Section 75 agreement will be between (1) The London Borough of Lewisham (the "Council") and (2) Lewisham and Greenwich NHS Trust ("LGT"). Lewisham CCG commissions key services within the agreement but will be a partner of an overarching partnership agreement, rather than a party to the Section 75.

The objectives and scope of the integrated service are set out in the Business Case for 'Care at Home'. The partners share a vision for the provision of proactive and preventative, accessible and co-ordinated community based care and are committed to seeking the best use of resources to meet the needs of people that receive care at home. The partners agree that fulfilment of the aims and outcomes referred to in the Business Case will lead to improvements in quality and cost and time efficiencies in relation to the way their relevant functions are provided.

The key elements of the Section 75 agreement are as follows:

1. *Delegation of functions:*

- The partners agree to delegate responsibility for completing the 'core' assessment and care planning to each other through the development of 'trusted assessor' and 'key worker' roles.
- Operational management of the integrated teams will be delegated to enable a district nurse or a social care professional to manage the integrated teams.

2. *Leadership:* The partners will provide joint leadership at a strategic level. Relevant resources will be managed and monitored jointly.

3. *Governance:* The Care at Home Partnership Board will oversee the development of the integrated service. The Care at Home Partnership Board reports to the Lewisham Health and Care Partners Executive Board which is accountable to the Health and Wellbeing Board with decisions requiring executive action reported to each organisation's sovereign board.

4. *Access to support services:* The partners will continue to provide all appropriate support services e.g. HR, payroll, legal, IT for their employees.

5. *Performance management:* The partners will develop a shared set of performance indicators.

6. *Information sharing:* The partners agree to open book accounting and transparent sharing of data. Partners will develop a shared IT system that facilitates information sharing.

7. *Operational policies and processes:* The partners agree to develop shared operational policies and processes, utilising the full potential of available technology.

8. *Financial contributions, risk and gain share and shared assets:* Each partner will make the following contribution to Phase 1: £40,000. Partners will agree the risk and gain share and develop a shared asset register.

9. *Duration:* The agreed duration of the arrangements will be 3 years. The agreement will be reviewed annually. Partners will agree arrangements for variation or termination of the arrangements.

Appendix 4: Draft Outline Delivery Plan 2018/19

Area	Key activity	Q2			Q3			Q4		
		July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Resources	Agree outline resource plan									
	Identify financial modelling support									
	Identify clinical support									
	Identify legal expertise									
Scope	Agree initial scope									
	Agree future scope of arrangements to be in place in 2019/20									
Workforce	Joint Provider Workforce Plan developed and agreed									
	Produce joint workforce implementation plan									
	Define and agree approaches to improving competencies and capabilities, recruitment and accelerating talent									
	Identify estate requirements for workforce development.									
	Engage and involve all staff in the development of new operational models									
Operational Delivery Model	Analyse data to assess workforce needs of operational models									
	Identify priority functions for operational delivery model									
	Agree plan for priority operational redesign									
	Identify staff requirements to implement 2018/19 operational model including leadership and management roles									

	Identify staff requirements to implement 2019/20 operational model including leadership and management roles										
	Staff consultation										
	Agree shared approach to risk stratification and population segmentation										
	Agree plan for priority pathway redesign										
	Implement priority pathway redesign										
	Test shared assessment / trusted assessor roles										
ICT	Define provider requirements for data, information and registries from population health system										
	Develop and test shared assessment and care plan										
	Agree joint requirements for local infrastruture and hardware developments										
	Identify ICT strategic and operational requirements to inform estate developments										
Comms and engagement	Develop a Public Engagement Plan to involve the public and service users in the development of new models, pathways and functions										
	Identify key stakeholders and agree stakeholder engagement plan										
	Agree key messages and undertake comms activity with Lewisham patients and residents.										
Commissioning processes / contract values	Detailed financial and activity modelling										
	Scale of efficiencies agreed										
	Contractual implications of arrangements identified										

	Approach to contractual arrangements agreed										
	Approach to procurement of key contracts agreed										
	New home care specification in place.										
Legal Framework	Revise existing / establish new Section 75 and necessary associated documents.										
	Agree process for aligning resources between providers										
	Agree accountability for operational delivery, integrated budgets etc.										
	Sovereign boards to agree proposals for Section 75 for 2019/20										
	Map options for more formal partnership arrangements										
Governance	Agree supporting operational development groups										
	Sharing agreements to ensure appropriate information governance to be established										
	Identify interdependencies with SEL STP groups and workstreams										
	Governance proposals agreed by respective provider organisations										

Appendix 5: Care at Home - Risk Register

Theme	Risk Description	Risk Score			Planned activity to mitigate impact
		Impact	Likeli-hood	Score	
Resources / Procurement	*Limited financial and activity modelling:*	4	3	12	• Key financial / service level data to be collated and analysed. • Develop a sharing agreement to enable data to be shared.
	Home care: • New specification won't raise quality and deliver a more outcomes focussed approach • Lack of sufficient financial incentive • The workforce development between home care and 'Care at Home' may require additional resources	4	3	12	Extension to current contracts will be requested in December 2018.
	Procurement for district nursing: • Complexity of disaggregating the Community Services contract.	1	2	2	On-going work with the CCG commissioners
	Securing provider contributions to the outline resource plan.	4	1	4	Discussion with providers at the Provider Alliance Development Board
	Securing clinical support.	3	2	6	Work out what clinical support required initially and develop a cross programme approach to resourcing.
	Lack of clarity regarding future scope and approach to phased implementation beyond phase 1 and phase 2..	2	2	4	Provider consider options analysis informed by research on other alliance approaches.
Benefits	*Lack of clarity regarding benefits for specific patient cohorts.*	2	1	2	• Build on initial activity with additional work to identify benefits for patients / service users. • Develop communications using the pen portraits. • Plan wider engagement activity for operational staff, patients and service users.
Workforce	*Lack of in depth and shared understanding of skills required and within system currently.*	3	3	9	Secure agreement from providers on draft skills matrix and circulate.
	Workforce engagement doesn't meet objectives.	4	2	8	Detailed planning involving workforce and OD leads.

	No group focussed on workforce / lack of capacity to deliver.	3	2	6	Develop a workforce task and finish group to include primary care providers.
	No integrated workforce plan.	3	4	12	Task and Finish Group to develop a workforce plan that prioritises: • Developing an asset based approach • Developing new / different roles / functions • Developing trusted assessor roles • Developing shared culture and behaviours • Skills development and on-going support for new roles. • Exploring opportunities re: the PA market. • Exploring opportunities re: support planning • Developing key worker principle • Exploring how different roles could work together
Information Technology / Information Sharing	*IT unable to support a shared assessment and care plan.*	4	2	8	Agree timetable with the Pop Health team.
Communications / Engagement	*No communications capacity to deliver activity required:* Need to communicate with staff across the partnership, the public, home care providers	4	2	8	• Produce position statement for home care providers. • Produce initial comms for staff.
	Need to engage service users / patients and families in developing an asset based approach:	3	3	9	Plan approach with engagement leads.
Governance	*Lack of clarity on the organisational model to be developed.*	2	2	4	Agree timetable for options analysis; implementation etc.
	Timeframe for legal advice on organisational model	2	2	4	Identify how providers will approach legal advice at an early stage.
Implementation	*The implementation of Phase 1 may present unforeseen challenges.*	3	4	12	Care at Home Operational Group will support leads to overcome challenges
	Delays with implementation.	3	3	9	Care at Home Steering Group and Operational Group highly engaged.
	Potential disruption to service users during implementation.	5	2	10	Detailed planning will be undertaken once any potential disruption has been identified.
Managing Interfaces	*Lack of clarity re: interface with Mental Health Provider Alliance activity.*	3	3	9	• Interface workshop agreed by Provider Alliance Board • Continue to consider interface with Kenny Gregory and SLaM leads. • Invite OAMH Commissioner to join the Care at Home Steering Group.
	Demand not managed effectively by the SPA.	3	2	8	Get agreement on the timetable / scope for the redesigned SPA.

	Difficult to align the timetable for Care at Home with the redevelopment of the ACU.	2	4	8	Include the ACU leads on the Care at Home Steering Group.
	STP / SEL				TBC