| HEALTHIER COMMUNITIES SELECT COMMITTEE | | |
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| **Title** | **'Care at Home': Progress Update** | |
| **Contributors** | **Executive Director for Community Services** | **Date: 7** |
| **Class** | **Part 1** | **11 February 2019** |

## 1. Purpose of Report

1.1 In December 2018, members noted 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 provides a progress update on activity to develop 'Care at Home'. It also provides further detail on the benefits for patients and service users.

## 2. Recommendation

2.1 Members are asked to note the progress in relation to developing 'Care at Home'.

## 3. Policy Context

3.1 The 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.

3.2 In January 2019, NHS England published its 'Long Term Plan' setting out its vision for a financially sustainable health and care system. Building on the work to integrate health and care to date, the plan commits to increasing the focus on NHS organisations to work with their local partners.

3.3 Care at Home will contribute to Lewisham's Health and Wellbeing Strategy, the corporate priority to care 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. 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 relating to improving health outcomes and supporting people with long term conditions so that they can maintain their independence.

3.4 Lewisham Health and Care Partners[1] (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. Care at Home will support LHCP to deliver its ambition for community based care i.e. care that is preventative and pro-active, accessible and co-ordinated.

## 4. Background

4.1 The Government wants every area in England to integrate health and social care by 2020. Lewisham's Health and Care Partners are working together to develop new arrangements for delivering integrated care across the borough. Social workers, therapists and district

[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.

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.

4.2 Building on the work to date, services and functions that provide care and support to people in their own homes are now being formally integrated. The aim is to improve the co-ordination of care, reduce variation and duplication and improve the quality and accessibility of care and support.

## 5. Progress Update

5.1 *Partnership Agreement* – The Mayor and Cabinet delegated responsibility for reshaping existing arrangements for joint working to the Executive Director for Community Services on the advice for the Executive Director for Resources and Regeneration and the Head of Law. LBL and LGT have now agreed the principles of the partnership agreement and a Section 75 will be developed by April. The schedules that set out the detail of the agreement will continue to be developed over the next 6-9 months.

5.2 *Engagement and Co-production* – building on the LHCP engagement event in October, two Experience Based Co-design (EBCD) workshops will take place in March 2019. EBCD is an approach that enables staff and patients/service users to co-design services. The approach is different to other service improvement techniques in that it involves gathering experiences from patients/service users and staff through in-depth interviewing, observations and group discussions. A short edited film is created from the interviews and staff and patients/service users are brought together to identify and implement activities that will improve the service. The workshops will involve staff from LBL, LGT and domiciliary care providers as well as patient / service users.

5.3 *Governance* – the Care at Home Partnership Board will now involve representatives from the voluntary sector. A Steering Group with representation from primary care, mental health, community health and adult social care has been set up and terms of reference agreed. An Operational Group is meeting every two weeks to oversee the delivery of the project plan. The group has prioritised activity to support collaborative approaches to assessment, care planning and training. The initial focus for this will be pressure care and patients / service users that require double handed packages of care, both areas where collaborative working could quickly realise positive benefits.

5.4 *Project management* – a full time project manager has been appointed and starts on 4th February. The project manager will be working closely with operational managers and front line staff. Key areas of focus in the next six months include:

- Co-ordinating two Experience Based Co-design workshops and supporting staff to progress identified areas.
- Developing and delivering initial communications to all teams in scope.
- Supporting operational leads to establish consistent joint neighbourhood meetings for the services in scope.
- Working with the Mental Health Provider Alliance Group to develop and deliver a joint workshop to explore interfaces.
- Working with estates leads to complete the move of Neighbourhood 1 Adult Social Care team to the Waldron.
- Initiating key projects including: apprenticeships; workforce development and collaborative working with domiciliary care.

## 6. Benefits for Patients / Service Users

6.1 The Care at Home Business Case set out key deliverables which will contribute to the outcomes agreed by Lewisham's health and care partnership. These 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.
- 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.

6.2 The following case studies illustrate the range of benefits to different patients / service users with complex health and care needs.

6.3 **Case Study 1: John**

John is 82. He lives on his own and has a heart condition and diabetes. He has become increasingly frail, has lost weight and is struggling to manage his personal care. John has become very socially isolated since his wife died two years ago and is feeling depressed. He has three children but they do not live in London. The GP has made a referral to SCAIT for a social care assessment and has asked the DN service to visit to monitor blood sugar levels and administer insulin.

*What will be different for John and the professionals who co-ordinate his care in future?*

- John would receive a single assessment by one person from the Care at Home team who would co-ordinate the care he needs (physical and mental health) as his key worker. He would tell his story once. One assessment, trusted by other health and care professionals, would save unnecessary duplication.
- The approach to the assessment would identify what is important for John. It would be holistic and person centred.
- The key worker would draw on strong knowledge of and relationships with other professionals (developed through sharing office space, regular collaborative working and joint training) to organise the care and support that John needs and wants quickly. This may include support from voluntary and community sector organisations.
- Care workers and district nurses will work closely together to support John. His blood sugar levels and insulin administration may be delivered by specially trained carers under the supervision and guidance of the district nurses. The carers would raise any concerns about John's condition with the district Nurses who would respond quickly to prevent any deterioration in his health.
- Health and care professionals would work more collaboratively to make the best use of resources and provide the right care at the right time.
- A single referral process for an integrated team would mean that the GP only refers once, saving clinical time.

6.4 **Case Study 2: Jim**

Jim is 68 and lives with his wife Yvonne. He was diagnosed with dementia a year ago and requires help with washing and dressing. In recent months his dementia has become more severe and he is becoming increasingly agitated. His wife is struggling to cope and frequently calls both his GP and Linkline. The GP has asked the District Nurse to visit to

take blood tests to rule out any physical causes for his deterioration. The GP has also referred Jim to the Community Mental Health Team. Two new care workers recently joined the team. They have limited experience of caring for people with dementia and want to know more about how best to care for Jim.

*What will be different for Jim and the professionals who co-ordinate his care in future?*

- Care workers would work more closely with other health and care professionals to support Jim. The carers would have noticed Jim's deterioration, spoken with his wife and liaised with the GP to access additional support for Jim more quickly. The care workers may have had training to take bloods under the guidance of the district nurses.
- Carers with skills and experience in caring for people with dementia would be allocated to work with his existing carers to support Jim.
- The team would identify a key worker with the most relevant skills, such as a CPN (Community Psychiatric Nurse) to support Jim.
- The support needs of Jim and his wife Yvonne would be considered by the key worker.
- One care plan would be developed for Jim, rather than a care plan by each individual professional. The care plan would be accessible to Jim, his family and all those involved with his care.

6.5 **Case Study 3: Dianne**

Dianne is 55 and has a long term neurological condition which presents as a personality disorder. Dianne is morbidly obese and has developed severe pressure sores. Dianne has difficulty managing her medicine and frequently calls the GP when she feels unwell, requesting a home visit. The DNs visit every day to care for Dianne's pressure sores. Carers also visit each day to support Dianne with her personal hygiene but she is frequently reluctant to let them into the house.

*What will be different for Dianne and the professionals who co-ordinate her care in future?*

- The team would identify a key worker, possibly a district nurse with a good relationship with Dianne. The key worker would liaise with other professionals, such as LIMOS (Lewisham Medicines Optimisation Service) to help Dianne manage her medication.
- Care workers and district nurses would work closely together to support Dianne. They would organise joint visits to support Dianne to build a better relationship with the carers. The carers would have better knowledge of pressure care and quickly raise any concerns with the district Nurses. This could prevent Dianne being admitted to hospital.
- The district nurses would work with OTs in the team to carry out a joint assessment to get Dianne the support she needs to help manage her pressure sores.
- Better medicines management and pressure care would result in Dianne feeling less unwell and potentially reduce the number of requests for a GP to visit.

## 10. Financial Implications

10.1 The financial implications were set out in the previous report submitted in December. There is no further update.

## 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 the Care at Home arrangements. 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 Council has agreed to 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. Responsibility for reshaping existing arrangements for joint working, which include a Section 75 agreement and necessary associated documents, has been delegated to the Executive Director for Community Services on the advice for the Executive Director for Resources and Regeneration and the Head of Law.

## 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 Progress continues to be made to develop and deliver the integrated arrangements set out in the Outline Business Case for Care at Home which will enable improved outcomes for service users and patients, achieve efficiencies as well as 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.