London Borough of Hammersmith & Fulham

# Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

## Supplementary Agenda

**Wednesday 3 December 2014**
**7.00 pm**
**Courtyard Room - Hammersmith Town Hall**

**MEMBERSHIP**

| Administration: | Opposition | Co-optees |
|---|---|---|
| Councillor Rory Vaughan (Chair)<br>Councillor Elaine Chumnery (Vice-chair)<br>Councillor Hannah Barlow | Councillor Andrew Brown<br>Councillor Joe Carlebach | Debbie Domb (HAFCA)<br>Patrick McVeigh (Action on Disability)<br>Bryan Naylor (Age UK) |

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Date Issued: 28 November 2014

London Borough of Hammersmith & Fulham

# Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

## Supplementary Agenda

**3 December 2014**

London Borough of Hammersmith & Fulham

# Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

## Minutes

**Monday 17 November 2014**

**PRESENT**

**Committee members:** Councillors Rory Vaughan (Chair), Elaine Chumnery (Vice-chair), Hannah Barlow, Andrew Brown and, Joe Carlebach

**Co-opted members:** Debbie Domb (HAFCAC), Patrick McVeigh (Action on Disability) and Bryan Naylor (Age UK)

**Other Councillors:** Sue Fennimore (Cabinet Member for Health & Adult Social Care), Vivienne Lukey (Cabinet Member for Social Inclusion) and Sharon Holder (Lead Member for Hospitals & Health Care)

**Witnesses:** Kamran Mallick (Action on Disability), Dawn Stephenson (Age UK) and Paula Murphy (Healthwatch (Central West London)

**Officers:** Liz Bruce (Executive Director for Adult Social Care & Health), Stella Baillie (Director for Provided Services & Mental Health Partnerships), Richard Biscoe (Project Manager, Adult Social Care), Helen Banham (Strategic Lead, Professional Standards and Safeguarding), Marc Cohen (Transformation Project Manager), James Cuthbert (Whole Systems Lead), Nick Marchant (People First), Sue Perrin (Committee Co-ordinator) and Paul Rackham (Head of Community Commissioning)

**21. MINUTES OF THE PREVIOUS MEETING**

The minutes of the meeting held on 7 October 2014 were approved as an accurate record and signed by the Chair, subject to the following amendment:

17. 2015 Medium Term Financial Strategy (MTFS) – Update

Page 6, fifth paragraph, after first sentence add: 'Mrs Wigley stated that the Independent Living Fund would be ring fenced in full for the following financial year.'

The following were noted in respect of:

16. Hammersmith & Fulham Foodbank

Councillor Carlebach had arranged for the Foodbank manager to meet with the catering manager at Westfield, with a view to having a food station at the centre and developing a relationship with the restaurants.

Councillor Fennimore had arranged for the Foodbank manager to meet with the Chief Inspector.

Councillor Fennimore had met with officers to draft a Council policy.

It was noted that Waitrose now had a collection point for the Foodbank.

## 22. APOLOGIES FOR ABSENCE

There were no apologies for absence.

## 23. DECLARATION OF INTEREST

The following declarations of interest were made:

Councillor Hannah Barlow in respect of item 5, in that her employer has a contract with one of the named providers, Care UK.

Councillor Vivienne Lukey as Chair of Hammersmith & Fulham MIND.

Councillor Joe Carlebach was about to be appointed an ambassador for Mencap.

Mr Patrick McVeigh as Chair of the Trustees for Action on Disability.

Ms Debbie Domb is a service user.

Councillor Brown is an elected member of the Safeguarding Adults Executive Board

## 24. CALL FOR EVIDENCE ON ENGAGING HOME CARE SERVICE USERS, CARERS AND FAMILIES

The Chair introduced the 'Call for Evidence' on engaging home care service users, their families and carers', which was a key item in the Administration's manifesto, and welcomed Ms Murphy, Ms Stephenson and Mr Mallick.

Ms Paula Murphy introduced herself as the Director, Healthwatch Central West London (CWL), the independent consumer champion for health and social care. Healthwatch had statutory rights to 'enter and view' any public funded health and social care organisation, including home care across the three boroughs.

Since 2012, local residents, who had been DBS (Disclosure and Barring Service) checked had been trained as Dignity Champions to undertake a person led assessment of services and provide feedback to Healthwatch (CWL) and then report on their findings and make recommendations for improvements to the service. Following submission of the final report, Healthwatch would receive the provider's action plan.

Links to the reports on H&F Healthvision, H&F Sage Care and H&F Care UK had previously been provided.

The Homecare Project Group met on a quarterly basis with the Tri-borough Adult Social Care Commissioners to consider homecare provision and assist with service redesign to inform the current re-commissioning.

Ms Murphy stated that service user feedback was generally positive. However, peer research indicated that there were quite low expectations, focusing on for example, punctuality, nutrition, cleaning and personal needs. There were no expectations in respect of outcomes (at the time of the research). A quality service was being provided, but not for the higher needs of service users, which should continue to be set. Outcomes could be nebulous and subjective and therefore difficult to measure.

In respect of complaints, Ms Murphy commented that service users were reluctant to complain and links with advocacy could be explored further. There was no recognition of providers, with complaints being accumulated across different services. The recording of feedback from Adult Social Care was important. There needed to be a structured approach, not a tick box and qualitative measures.

There was a low level of competitiveness and service users were reluctant to move from one provider to another. There was a need for more choice to allow service users to choose their own care worker and how tasks were performed.

There were concerns in respect of self funders. Currently there was a time limited approach. There needed to be provision of information and engagement with service users. Ms Murphy envisaged a service, where there were real options and a move beyond meeting basic needs.

A report from Age UK Hammersmith & Fulham was tabled. Ms Dawn Stephenson, Chief Executive, stated that Age UK did not have day to day contact with service users, but tended to see people when they were unhappy. Her evidence was therefore partly anecdotal. There was a committed and caring service but there were problems in terms of scheduling and length of visits, travelling time frequently infringing on the length of time, resulting in people feeling rushed and not receiving the care needed. There was concern that carers of people with medical needs such as dementia or stroke related conditions did not have the specialist training and support required.

There was an issue in respect of the poor pay of carers. They should be paid the London living wage, not the minimum wage.

There was a need for a continuity of care. Often older people receiving home care were allocated different carers.

Ms Stephenson outlined the ten key principles, as set out in the report, around which the approach to engaging home care service users, their families and carers should be built:

- the service redesign should involve those service users not normally involved in the process, for example, transport could be provided for those who could not otherwise attend.
- standards should be outcome focused.
- the work of lay assessors should be built into the contract monitoring process. the complaints procedure needed to be made simple to access, to reduce fear of 'reprisal' for service users, who were often reluctant to complain.
- there was a need for integration of care, which should involve service users.
- there was a need for re-ablement to reduce dependency.
- there should be more work in respect of prevention.
- there was a need for joint working and involvement of the third sector.
- services should be designed to meet the diverse and changing needs of older people and their carers.
- support should be provided to unpaid carers.
- transparency should empower people to hold services to account.

The report made a number of recommendations of which Ms Stephenson emphasised the payment of the London living wage, taking steps to eliminate zero hours contracts and scheduling visits to allow adequate time.

Mr Kamran Mallick, Chief Executive, Action on Disability tabled a report which looked into the provision of care service to users with a formal voice from three perspectives; the client viewpoint; what would really help; and how could this be delivered.

Mr Mallick stated that Action on Disability did not see service users on a regular basis, but had picked up a number of cases through its advocacy work. The number of complaints was low. Service users were often reluctant to complain. They were potentially vulnerable and fearful of reprisals.

The report recommended written and agreed standards to which providers should work (the Care Quality Commission standards were tabled). Service users should be assessed and outcomes set by individuals in partnership with Adult Social Care or other support team.

There should be transparency on care providers' methods of working, for example travel time.

Advocacy could be complemented by a helpline staffed with trained advocates, who could provide reassurance that the conversation would be kept confidential and by working with the Healthwatch Dignity Champions. In addition, existing groups could provide valuable peer support.

Mr Naylor raised points in respect of: contacting those people who were not receiving care but needed to receive care; support for home care issues not being joined up, although outcomes were complementary, not competing; the importance of the personal and sensitive relationship between the service user and the carer not being generally understood; and support for the majority of carers who were unpaid.

Councillor Carlebach noted the inter-related work of health and social care, and suggested that it was be worth approaching Mencap to provide evidence.

Ms Domb noted that the home care service provided only partial support and that it was necessary to apply for other support, and there could be issues around referrals.

Mr McVeigh suggested that there was an opportunity for whole system support, whereby, rather than just meeting clinical needs, holistic care was provided. Health and social care could also link with the voluntary sector.

Ms Domb queried training for Dignity Champions and whether service users were 'asked about or told' outcomes. Ms Murphy responded that Healthwatch (CWL) trained the Dignity Champions to undertake peer reviews to assess home care against ten principles for dignity and care. Healthwatch (CWL) had participated in events for home care workers, to try to inform the market testing. Homecare should be user led, with the service user being involved in both the care needs assessment and home care plan.

Ms Domb commented that home care appeared to be reverting to a prescriptive offer, with a set number of hours for a number of tasks, whereas personalisation had placed the service user at the centre. Ms Murphy responded that service users had a hierarchy of needs and people should be empowered to think about desired outcomes.

Ms Murphy responded to a query that there were approximately 80 Dignity Champions across the three boroughs. Home care visits were particularly resource heavy, as they required two people per visit.

Councillor Brown considered that unpaid carers were not necessarily a bad thing and that there needed to be a discussion as to how the community could be more involved. Ms Stephenson considered that there should be more support for carers, some of whom might have unrecognised support and health needs.

Councillor Brown suggested that zero hours contracts could be appropriate in some circumstances, and queried the impact of the London living wage on the Adult Social Care budget.

Ms Stephenson stated that carers frequently worked for more than one agency, juggling visits, which might be only 15/20 minutes, in order to increase pay.

Councillor Lukey responded in respect of the London living wage that this would help to attract and retain employees, who with proper training and support would derive greater job satisfaction. Adult Social Care had budgeted for the London living wage, which would be included in the tender. There was currently one contract for zero hours, which was coming to an end.

Ms Murphy responded to Councillor Holder's query in respect of examples of good providers, that these tended to be the organisations providing holistic support and links to the community. People felt valued and knew who to contact.

Councillor Chumnery noted the importance of service users and their families having the confidence to complain, and queried how this evidence was captured. Ms Stephenson responded that there an issue in respect of language, whilst service users found it difficult to make a complaint, they should be encouraged to provide feedback. Mr Mallick considered that there should be a continuous feedback process. Ms Murphy suggested that care workers were often aware of issues but were unable to feed it into the organisation.

Councillor Barlow stated that she completely objected to zero hours contracts, and queried what could be done at a local level in respect of quality standards. Ms Murphy suggested support for people to self-manage their own care, the development of resources for integrated access to health and social care and a charter of rights. In addition, the national standards should be developed for application at a local level, working with commissioners, stakeholders and service users.

Ms Murphy responded to Councillor Barlow's subsequent query that providers were held to account through an action plan submitted to commissioners and fed into the Care Quality Commission inspection. Mr McVeigh added that outcomes for an individual receiving care needed to be understood and applied to personal care.

Councillor Vaughan stated that the evidence had given members a lot to consider and highlighted the importance of resolving issues as they arose. The discussion had highlighted a number of issues in respect of service user feedback:

- providers needed to work in such a way that simple feedback is acted upon;
- people were nervous about feedback to carers or organisations; they were nervous about the impact on the relationship;
- there needed to be a process for obtaining feedback; and
- Healthwatch and service users needed to feed into the process, with joined up work on engagement, to include all those voices which needed to be heard.

Councillor Vaughan invited the witnessed to make any final comments.

Ms Murphy emphasised the importance of jointed up feedback, with a framework across the services from entry to exit. Feedback needed to be encouraged and broken down to consider the options. Provider performance should be shown against the service specification.

Ms Stephenson noted the importance of resources to ensure that the information was used. It should be joined up and integrated at the time of the commissioning framework.

Mr Mallick stressed the importance of maintaining funding and support to groups providing advocacy to service users.

**25. INDEPENDENCE, PERSONALISATION AND PREVENTION IN ADULT SOCIAL CARE AND HEALTH**

Mrs Bruce introduced the report, which explained the Adult Social Care plans for a new home care service, which would move away from a time-and-task service towards personalised care that helped people to live as they wished. An 'enabling service' would help and encourage people to look after themselves and provide safe, quality care when they could not.

Personalisation was based on the principles of flexibility, providing choice and outcomes focused.

The new model of home care was based on a local 'patch' approach that helped agencies ensure that customers consistently saw the same care worker. There would be an integrated approach with health services to reduce the number of visits and the number of different people who came into a house. There was an emphasis on workforce development, including recruitment and training.

During the tender, providers would be asked to give a price and to explain how they would meet the service specification. Mrs Bruce would check if the tender included the requirement to pay the London living wage.

**Action: Liz Bruce**

Mr Rackham stated that the procurement was at the invitation to tender stage and therefore the specification could be shared with the committee..

**Action: Paul Rackham**

Mr McVeigh asked for examples of outcomes. Mr Cuthbert responded that the assessment would be outcome focused and that providers would be asked to say how they would achieve the specific outcomes, which would have been agreed with the service user.

Ms Domb queried the split between quality and cost, and the difference between a care plan and support plan. Mrs Bruce responded that the cost was approximately 50-50. Whilst a care plan was a formal document, a support plan was owned and designed by customers, with services being

largely delivered in the ways they wanted. Mr Potter added that the support plan could be changed if the customer no longer wanted something which had been included.

Ms Domb queried whether direct payments would increase if the cost of the new service was higher. Mrs Bruce responded that service users would have to receive adequate resources to purchase the services which they needed.

Councillor Barlow queried the cost of the new service. Mr Rackham responded that there was a financial model but prices were not yet known. Adult Social Care anticipated an increase in cost, but the new enabling service should mean that customers did not need the service for so long.

Councillor Carlebach queried the partnership with health. Mrs Bruce responded that lower level health tasks not requiring qualified nurses were being identified, so that a joined up service could be offered with the home visit. The Community Independence Service would provide out of hospital care for people with complex needs.

Mr Naylor queried communications with service users. Officers responded that there had been a big education campaign for providers and people who delivered care, and also conversations with organisations which delivered care. Consultation with service users had not yet started. Implementation of the new service was likely to begin in April 2015. It was hoped that the process would be clearer and made simpler to understand what service users could expect, in simple clear language,

Councillor Chumnery queried the continuity of staff. Mr Rackham responded that staff moving over to the new service provider would depend on who won the tender and which services users said that they really wanted. It was thought that because of the different way in which service were being contracted, TUPE would apply only for some carers. To mitigate the impact of possible loss of staff, officers would work closely with the new team to phase in the service. Contracts would be separate by borough and patch, and if they did not meet the standards they could be terminated.

Councillor Brown queried whether the London living wage had been built into the financial model. Mrs Bruce responded that payment of the London living wage had been based on the fact that re-ablement and the Community Independence Service would provide out of hospital care and there would be a reduced need for services. The move from a time and task service to an enabling service would result in less input over a period of time. The model had built in risk and change.

Councillor Holder queried the monitoring process. Officers responded that the contracts would be monitored with information collected from a variety of sources, including real time information from the provider. Investment would be made in a home care electronic monitoring system, which would indicate which carer had made the visit and for how long, resulting in paying only for the care actually delivered. Healthwatch would be more involved in the new

contract monitoring regime and would be the main representative of customers and carers. There would also be the traditional complaints system.

Mrs Bruce emphasised the innovative nature of the service. The new contracts were designed to encourage a local workforce and officers were working with colleges to prepare skills training. Home care workers who lived near their customers were more likely to provide a much better care service and outcomes.

Councillor Vaughan noted that the discussion had clearly indicated the need for a change of mind set for both service users and providers, for example to understand how the care plan would look in practice, as opposed to a list of things which people would do, when service users would be informed and how articulated.

Councillor Vaughan thanked the witnesses and officers.

**RESOLVED THAT:**

The committee recommended that:

1. Officers seek legal advice in respect of TUPE rights of carers.

2. Service users be involved in the tender process.

## 26. SAFEGUARDING ADULTS EXECUTIVE BOARD: ANNUAL REPORT 2013/2014

Ms Banham introduced the inaugural report of the Safeguarding Adults Executive Board, which had an independent Chair. The report showed progress in consolidating the governance of adult safeguarding in the three boroughs to meet the requirements of the Care Act, 2014. It required local authorities to;

- make (or cause to be made) enquiries if a person is at risk of abuse and neglect, and unable to protect themselves;
- establish a Safeguarding Adults Board; and
- arrange for there to be a review of a case where the Safeguarding Adults Board knows or suspects death, or serious harm, resulted from abuse or neglect.

The single client information system for Adult Social Care across the three boroughs was being redesigned to accommodate the requirements of the Act. This was also in line with 'Making Safeguarding Personal'.

The report set out the headline findings in Safeguarding Adults Return 2013-2014 against the Board's safeguarding outcomes, giving comparisons with Inner London, Outer London and London.

Ms Banham highlighted:

- The total number of people for whom a safeguarding referral was made across the three boroughs was 1,250 in 2013-2014, equivalent to 271 referrals per 100,000 population aged 18 and over, slightly higher than the average for London.
- More investigations had led to safeguarding.
- More people had access to an advocate.

Councillor Brown suggested that, in addition to statistics, some elements of safeguarding and prevention should be looked at in greater detail. Ms Banham responded by referring to the work with the Quality Care Commission on the maintenance of standards and with Healthwatch and providers themselves. Ms Banham noted the importance of early warning when things were going wrong.

Councillor Holder noted that the police, who were a key stakeholder, were not included in the membership of the Safeguarding Adults Board. Ms Banham responded that the police were very involved, but because of a change in personnel, had not make a submission. There was good engagement with the police in respect of case work, but development work was challenged.

Mr McVeigh queried whether any of the applications for authorising deprivations of liberty were inappropriate. Ms Banham responded that there was an assessment of mental health to determine capacity and of best interests, and gave an example of a Court of Protection decision in respect of a person in supported care, who did not want to be in a restricted situation. The person returned home for three months before returning to supported care.

Councillor Vaughan queried how the process would be managed in view of the projected ten-fold increase in the number of applications for authorisation under the Deprivation of Liberty Safeguards in 2014-2015, and the impact on resources. Mrs Bruce responded that, in view of the impact on people's lives and financially of making the wrong decision, it might be necessary to allocate more resources.

Mr Naylor queried the role of Adult Safeguarding in respect of sex trafficking and in respect of historical child abuse to ensure that it could not be repeated. Ms Banham responded that Adult Safeguarding was very involved with the police in respect of domestic violence. There were also a number of other agencies involved. Historical child abuse was not an issue which would be picked up locally, unless a person approached Adult Social Care and was eligible for services. It was intended to work more closely with the Children's Safeguarding Board, and look at a shared agenda.

Councillor Chumnery queried whether any training was offered to voluntary organisations and whether there would be significant differences if there was a Hammersmith & Fulham Safeguarding Board. Ms Baillie responded that the tri-borough was a comparatively small area, with a lot of shared hospitals and services.

It was agreed that a local report on safeguarding adults would be added to the work programme.

**Action: Committee Co-ordinator**

Ms Banham responded in respect of voluntary organisations, that Healthwatch was a member of the Adults Safeguarding Board and that work was ongoing with providers through community engagement groups. The work of the Executive Board was carried out through four work streams: Community Engagement; Developing Best Practice; Measuring Effectiveness; and a safeguarding adults review. The Community Engagement work stream hosted a 'Training for Trainers Safeguarding Adults programme, which had been taken up by twenty third sector-organisations. This had substantially increased the capability and capacity of organisations in the three boroughs to train their staff on recognising, reporting and preventing abuse.

***The Chair proposed, and it was agreed by the committee, that the guillotine be extended to the earlier of either the conclusion of item 27 or 10.30pm.***

Councillor Vaughan queried how outcomes were measured. Ms Banham responded that the Measuring Effectiveness work stream measured the extent to which outcomes were delivered. Measures included surveys, an annual audit and peer audit.

**RESOLVED:**

That the Annual Report be noted.

## 27. ADULT SOCIAL CARE INFORMATION AND SIGNPOSTING WEBSITE - PEOPLE FIRST

Mr Potter introduced People First, a signposting and information site for the residents (or friends, family, carers etc) of the three boroughs, which would meet the requirements of the Care Act 2014. The site also had links to more detailed sources of information.

The site was up and running at Westminster and Kensington and Chelsea. The Committee was invited to view the site (www.peoplefirstinfo.org.uk) and e-mail any questions or comments.

Mr Naylor commented that some older people needed help to become competent with technology. Mr Potter responded that information in respect of cheap/free courses was available, in addition to in-house sessions.

In response to Mr Naylor's comment regarding the marketing of the product, Mr Biscoe stated that the product had been demonstrated to various groups and the feedback taken on board. The product sat on a corporate website, with users being automatically redirected.

Council Fennimore referred to the digital inclusion work across the borough, which she would bring back to the committee.

Mr McVeigh queried how the content would be updated Mr Biscoe responded that this would be done partly by avoiding the duplication of information and signposting to other sites and the secondment of Adult Social Care practitioners three days a week.

Members suggested that the product could be promoted through newspapers, community centres and voluntary organisations.

Councillor Vaughan queried how the Hammersmith & Fulham cost of £170,000 compared with Westminster and Kensington & Chelsea. Mr Biscoe responded that the Hammersmith & Fulham cost was lower because of economies of scale. The software costs were cheaper and a lot of the work has already been completed.

**RESOLVED THAT:**

The report be noted.

## 28. WORK PROGRAMME

The work programme was received.

## 29. DATES OF FUTURE MEETINGS

3 December 2014
January 2015: date to be confirmed
4 February 2015
13 April 2015

Meeting started: 7.00 pm
Meeting ended: 10.30 pm

Chairman .....

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**APPENDIX 1**

# Recommendation and Action Tracking

The schedule below sets out progress in respect of those substantive recommendations and actions arising from the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

| Minute No. | Item | Action/recommendation | Lead Responsibility Progress/Outcome | Status |
|---|---|---|---|---|
| 6. | Imperial College Healthcare NHS Trust: Cancer Services Update | Information to be provided in respect of:<br>Vaccinations:<br>(i) whether flu vaccines would also be offered to patients at Queen Charlotte's hospital:<br>(ii) the number of vaccinations given to patients and staff, to include the provision of the shingles vaccine.<br><br>(iii) Cancer Care: action to improve the time between a patient presenting at their GP and a clinical referral. | Imperial College Healthcare NHS Trust | |
| 7. | Shaping a Healthier Future: Update | Information to be provided in respect of:<br>(i) current patient numbers and the capacity of the new Parkview Centre for Health & Wellbeing<br>(ii) further detail in respect of where the patients who used the Central Middlesex and Hammersmith Hospitals lived<br>Hammersmith Hospital<br>(iii) the community groups identified | H&F CCG/Shaping a Healthier Future<br>Information provided<br><br>A full list of community groups which have received leaflets and posters about the changes as well as the list of organisations we are engaging in face-to-face | Complete |

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| | | (iv) communication plan: evaluation criteria<br><br>(v) skills-gap analysis and methodology<br><br>(vi) expected patient numbers following the closure of the A&E. | meetings provided. | |
| 17. | 2015 Medium Term Financial Strategy | A written response in respect of servicing the Council's debt to be provided. | Response provided by Hitesh Jolapara. | Complete |
| 18. | H&F Clinical Commissioning Group/Imperial College Healthcare Trust | Information to be provided in respect of:<br><br>(i) flu vaccination rates for staff.<br><br>(ii) the board level meetings at which the Shaping a Healthier proposals had been discussed.<br><br>(iii) foundation trust application (if in public domain) | Imperial College Healthcare NHS Trust | |
| 27. | Independence, Personalisation and Prevention in ASC | (i) Members to be informed whether the tender included the requirement to pay the London living wage.<br><br>(ii) The tender specification to be circulated to members. | Liz Bruce<br><br>Paul Rackham | |

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| | **London Borough of Hammersmith & Fulham**<br><br>**HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY & ADVISORY COMMITTEE**<br><br>**27 November 2014** |
| **CUSTOMER JOURNEY: IMPROVING FRONT-LINE HEALTH AND SOCIAL CARE SERVICES** | |
| **Report of the Executive Director, Adult Social Care** | |
| **Open Report** | |
| **Classification** For Policy & Advisory Review & Comment<br><br>**Key Decision: No** | |
| **Wards Affected:** All | |
| **Accountable Executive Director:** Liz Bruce | |
| **Report Author:** James Cuthbert | **Contact Details:**<br>Tel: 07792 963 830<br>E-mail: james.cuthbert@lbhf.gov.uk |

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| AUTHORISED BY: .....<br><br>……<br><br>.DATE: …….. | AUTHORISED BY: .....<br><br>……<br><br>.DATE: …….. |

## 1. EXECUTIVE SUMMARY

1.1. This is a proposal to reform Adult Social Care Operations.

1.2. Operations delivers many of the Council's duties to people who need care and support because they are unwell, disabled or have problems managing everyday life. Operations also provides a social service. Its staff help people to live at home, supporting them and their families and providing short-term services, like reablement, that help people recover from illness, injury and personal crises that put their independence at risk.

1.3. Work with people who use services has given us a lot of evidence about the need for improvement and things we can change. Work to improve people's experience of the service will not happen in isolation. The Care Act clarifies those duties and extends them to more residents, especially

those who care for others and those who now arrange and pay for their own care. The Borough's population has grown a lot in recent years and the number of older people who live here will grow quickly for the rest of this decade. The service helps more people to live at home and avoid stays in hospitals and care homes. We expect this growth of care at home to continue. It asks more of Operations.

1.4. The Council's medium-term financial plans include savings in Operations, most of whose budget pays for staff. This report suggests that the Better Care Fund Plan allows us to invest in some parts of Operations that help people retain their independence and reduce the need for long-term care services. The benefits and risks of this approach are explained in the Options Appraisal.

## 2. INTRODUCTION AND BACKGROUND

2.1. Customer Journey is the name for the programme that will change Adult Social Care's front-line service, Operations.

2.2. Operations is the service that meets Adult Social Care's statutory duties to residents. Those duties define the rules that decide whether people are eligible for the Council to pay for care and support services and cannot afford to pay for any or all of that service. Operations arranges and pays for services for those are who are eligible and it reviews people from time to time to make sure that their care and support meets their needs. Operations is also an important part of safeguarding. It investigates and sometimes intervenes when a vulnerable person has suffered abuse or neglect. This includes people who do not use council services and some people who do not use formal care services at all.

2.3. Operations also provides social services. The Community Independence Service provides reablement and other kinds of short-term support that help people retain their independence, normally after a crisis in their life. The teams that support people who use long-term care services also provide professional social work and occupational therapy. They help people with challenges that personal services like home care do not tackle: coping with bereavement, family breakdown or problems coping with day-to-day activities such as paying bills and rent that risk homelessness without support. These professional services reduce demand for long-term care services. They helping a family that cares for a relative can help people avoid institutional care. Good social work and occupational therapy helps people avoid crises that need help from other public services, such as housing, the NHS and the police.

2.4. Operations needs reform. Since 2012, Operations' senior management team has worked across three boroughs. In 2013 a plan to create a single front-line service, integrated with community health services, was not accepted. The three boroughs now use the same frameworki computer system to record their work and run their processes. This was a significant

achievement. Beyond this, each council's front-line still works in the same way that it did before they became part of the Adult Social Care shared service. The savings from restructuring this service are part of the Council's medium-term financial plan. The rest of this introduction explains five reasons for such a change. Those reasons relate to:

(i) the size of Hammersmith and Fulham's population and the number of people who will need for care;
(ii) the Council's legal duties to support people who need care;
(iii) a national and local policy of care at home;
(iv) funding for the NHS and Adult Social Care for the rest of the decade;
(v) residents' views and experiences of our service

2.5. The Borough's population is changing. The 2011 Census found that 182,500 people live in the Borough about 17,000 more than the most recent estimates. Residents are living longer. Between 2002 and 2013, the life expectancy of women aged 65 increased by one year, to 86.6 years; and men by nearly two years, to 83.5. In just the next four years—the term of the Council's medium-term financial plan—the number of people living in the Borough who are aged 65 and more is expected to grow by more than 900 (5%). Nearly 300 of those people will be aged 85 and older, 13% more than live in the Borough today.

2.6. The Care Act and the Children and Families Act have clarified and extended the Council's legal duties. A national standard of eligibility for services will replace the local standards that were introduced under Fair Access to Care Services in the last decade. More people, including some carers and people who pay for their own care, will have new rights to assessments and financial support. Increasing demand in recent years under the existing legal duties has stretched the front line. These new rights and duties are good for people but they create more demand for council-funded care. Nationally, and in Hammersmith and Fulham, we are still estimating the work and the expenditure that the Care Act will create, but it is clear that Operations will work with more people because of it. We will need to create more time and resources to meet the Council's new legal duties.

2.7. For some years the national policy of care in the community has meant that more and more complex care that would once have happened in hospitals and care homes now happens in or near people's own homes. New initiatives, like the Better Care Fund, mean this trend will continue. Evidence from surveys says that providing these services offer a safe and good quality alternative to hospital and residential care, people normally prefer them. It means that community health and care services, including Operations, will help people with more complex and more acute care-needs at home. This asks more of front-line social care professionals. Social workers and occupational therapists in particular play an important part in supporting people at home.

2.8. The Local Government Association recently estimated that local government has made savings of £3.53BN (26%) in Adult Social Care since 2010. Experts in health and social care funding estimate a gap in the NHS budget of £30BN between now and the end of this decade and in Adult Social Care of £4.3BN (29%) over the same period. These forecasts cannot be applied directly to Hammersmith and Fulham. The Council's medium-term financial plan shows the budget for Adult Social Care, £64.403M this year, will be £56.316M in 2016/17. Operations employs 138 full-time equivalent staff and has a staff budget of just under £6M. In 2015/16 the budget will reduce to £5.357M and to £4.024M in 2016/17. These savings, combined with new demands from a growing population that needs more care at home and has new legal rights, cannot be achieved by organising and funding Operations as it is now. The proposals in the next section show how investment from the Better Care Fund will make a major contribution towards these plans for next year.

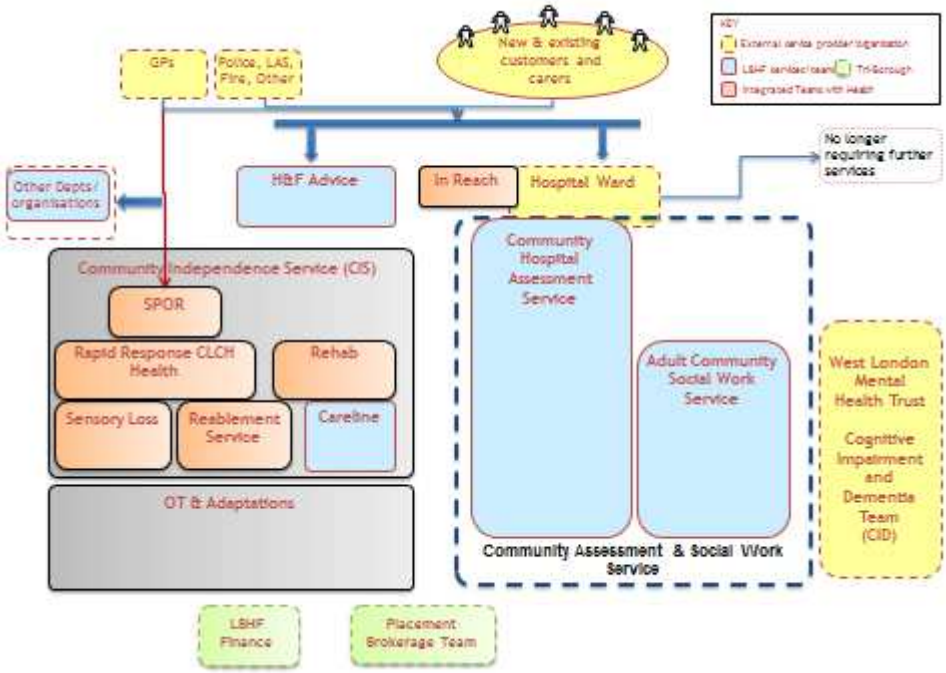
2.9. In spring 2014, the three councils commissioned an independent review of Operations beginning with focus groups from each borough. The 120 people involved in this research represented all the main groups that use services, including carers and young people approaching adulthood and preparing for the transition from Children's Services to Adult Social Care. They explained their experiences and the reviewers picked four things that matter most to these groups: control, quality, coordination, and clarity. They said their service could improve in all four:

(i) People are listened-to and involved in the design and development of their care and support. This is "control."
(ii) Everyone involved in a person's care and support does what they say they will, when they say they will. Capable, well-trained staff have time to help people achieve the outcomes they want. This is "quality."
(iii) It is easy to find the right help. People don't get lost between different teams and between Adult Social Care and other important services, like the NHS. Services feel integrated. This is "coordination."
(iv) People know what they can and cannot expect, how and when help is provided and by whom. People are kept informed about things that might affect them. This is "clarity."

## 3. PROPOSAL AND ISSUES

3.1. The introduction of this report gives five reasons for change. In this section we explain a plan to reform Operations that addresses all five of them. The plan has been developed with people who use services but in a less formal way than the review described in section 4.9. The designs that we explain in this section, which will be illustrated with a presentation during the Committee, were prepared by a small team that frequently visited people using services and small groups of front-line staff. The Customer Journey review provided a lot of information about things people do not like about our service. These designs were prepared by asking people what would work better.

3.2. This section begins by describing Operations now to illustrate what the Customer Journey will change and to illustrate how the changes should affect people's experience of the service. The detailed design is not complete; nor is the statistical work that estimates how much it will cost to run a new service that can meet the demands of the coming years.




A larger version of this diagram appears at the end of this document.

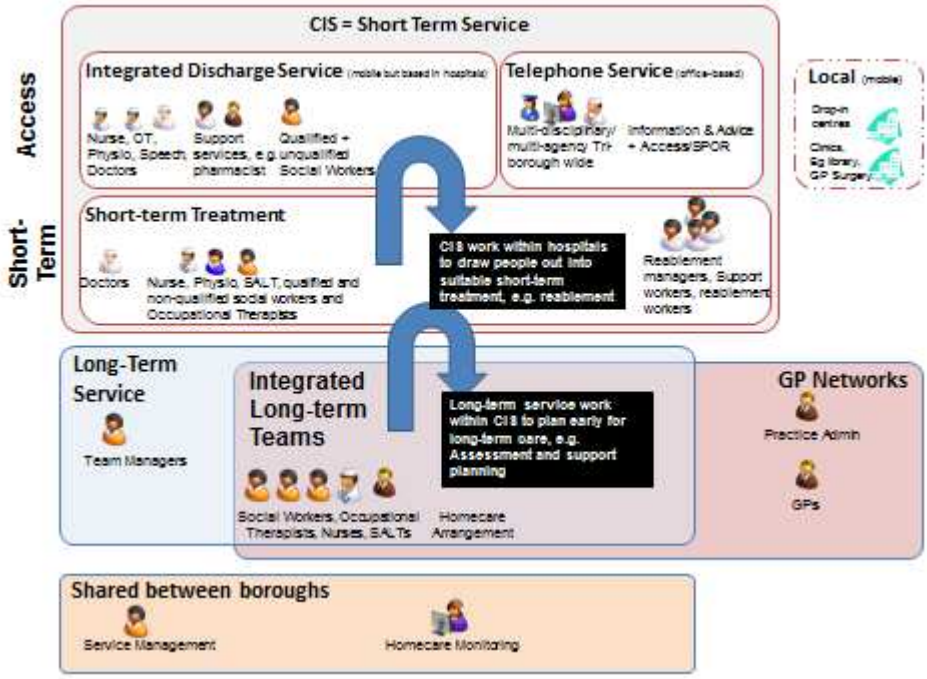
3.3. The Customer Journey review frequently heard that people and staff alike are unsure whom to ask for help. This seems to be because there are too many different teams, too many places to contact for help or for a referral and not enough coordination between Adult Social Care and the other services that people who use our services need, especially the NHS. For example, a small Information and Advice Service; a Single Point of Referral (SPoR) in the CIS; a Community and Hospital Advice and Assessment Service; and a Community Social Work Service all provide as points of access to Adult Social Care. It is not clear to residents and professionals in other services which to ask for help. People say that they are passed around between teams, some of whom are themselves unclear whom is responsible for what. People who use the service and staff who work in it have identified the same problem.

3.4. A simpler service structure with a clearer role for each team will help. The next diagram shows a service that has just two parts:

(i) A short-term, integrated Community Independence Service to help people when a problem with their health or a crisis in their life puts them at risk of losing their independence. This service also acts as a place to come for advice and information for residents and for professionals from other services; and it is the way in for people new to the service and need

an assessment. It operates in hospitals and in the community. This is a health and social care service that is not subject to means-tests nor to charges.

(ii) A local service for people whose long-term needs are mostly stable that helps them manage their support and lead an independent life. It works closely with GPs and other community health services. It manages Adult Social Care's long-term care budgets and observes the Council's policies on means-testing and charging for care services.




A larger version of this diagram appears at the end of this document

3.5. Hammersmith & Fulham's Community Independence service will receive £0.870M new investment through the Better Care Fund (BCF) in 2015/16. The design of the CIS does not need substantial change. It is the model for a new service in all three boroughs, each with its own investment from the BCF. Hammersmith & Fulham's investment allows the service to grow and to act as the main point of access to Adult Social Care. It will offer help and advice about care for people who do not want or do not need formal services from the Council. It will take referrals for people who need medical care, social care or both. It will assess and help people plan the care and support they need when they leave the service.

3.6. Using the CIS as the main point of access ensures that everyone who comes to Operations is offered a short period of reablement before any assessment for long-term care. Policies will ensure that people who will not benefit from reablement are not compelled to have it.

3.7. Investment in CIS from the BCF helps us retain and train front-line staff so that the service can support more people. (This investment plan was

explained in a recent report to Cabinet.) We hope some staff will move from their roles other areas of Operations to the CIS; some must be recruited. Planning is under way and numbers will be available at the beginning of next year.

3.8. More reablement helps to reduce demand in the parts of Operations that support people who need long-term care. It also reduces the cost of long-term care services including home care, Direct Payments and especially residential care.

3.9. CIS is a short-term service. It is designed to offer no more than twelve weeks of support, often less, and to conclude by helping people to work out what further support they need. 54% of people who use reablement in the current CIS leave without needing long-term care. As more people with higher needs use the service, this proportion may fall because the service only reduces the needs of people with more acute and complex conditions. They still need long-term care and support. Operations still needs teams to support them. We know that access to those teams will mostly come through CIS. The next sections address how the teams should be staffed and organised.

3.10. They should be organised to help people leaving the CIS feel safe and supported as they transfer to long-term care. This will mean a lot communication and planning between the professional responsible for a person's care in CIS and the person who will plan their care in long-term team.

3.11. They should be organised to work with GPs and community health teams. A repeated theme of the Customer Journey review was that these services were not well joined up. Operations cannot solve this problem alone. It is too soon to make long-term social care teams part of a single integrated service, as we plan with CIS. Long-term teams manage most of the Adult Social Care budget and it is not yet clear how those budgets would be managed in a fully integrated service. But the foundations of a more integrated service are becoming clear. Many staff in Operations now share a building, Parkview, with their NHS colleagues. Hammersmith & Fulham's GP have formed networks that work together to serve patients often do, or will, use care services. Working with groups of GPs, serving many thousands of patients, resolves many of the difficulties of working with lots of GP practices. These networks are the foundation of teams of different professions that between them coordinate care and support. The plan for those teams is part of North-West London's Whole System Integrated Care programme. It recognises the value of front-line social care staff, especially social workers and occupational therapists, in these multi-disciplinary health teams.

3.12. Long-term teams should work locally. Social and economic conditions can vary widely over quite small distances. The professionals who work in these teams need to understand where the people they work with live,

their communities and the organisations that can help people with more than formal care.

3.13. Long-term teams need to balance their statutory work and their professional service. Currently assessment team is separate from the team that does casework. In recent years the social work team has had to complete more assessments, which is not its purpose. Separating assessment from social teams does not ensure that we can provide both. A plan for a small number of combined long-term teams doing both kinds of work requires a capacity plan to make sure that statutory duties like assessments leave time for valuable professional services.

3.14. People who use the long-term term service should not experience more transfers. Once someone has settled into a long-term team, they should expect no more hand-overs unless their needs change to the point where they need intensive help from the Community Independence Service, perhaps because they have been in hospital. In even these cases, we know that the CIS can support someone without assuming full responsibility for a person's care. Our estimates suggest that we probably cannot have a dedicated day-to-day caseworker for everyone in a long-term team. It should be possible to ensure that everyone knows who is responsible for them if they need help and who will normally be expected to do planned reviews of their care. The team should include all the professions and specialisms people need to plan, arrange and manage their care. It should also include people who can help people work out how to use their Personal Budgets.

## 4. OPTIONS AND ANALYSIS OF OPTIONS

4.1. This proposal balances the need to improve Operations' front-line service, growing demand and the need for savings. It argues for a clearer and simpler structure, investing in short-term services to help people retain and regain their independence. Provisional estimates of the amount we might save from a more efficient organisation and process are significant but might not suffice to meet Operations' the medium-term financial plan targets.

4.2. Better Care Fund investment in the Community Independence Service and to help with the Care Act gives us an opportunity to sustain and improve front-line services. The Better Care Fund Plan says that investment from the NHS in Adult Social Care will reduce the need for and cost of hospital and long-term care services, especially residential and nursing care services. Such an approach will mean that funding for Operations depends increasingly on the BCF, on revenues from the CCG and therefore on the NHS's financial position. Hammersmith & Fulham's BCF plan extends from 2015 to 2019. The financial agreement on which investment in Operations depends is so far for 2015/16 only. This proposal therefore creates a new service that addresses all five reasons for reform in Operations. But the funding for that service is uncertain from the second year. Continued

funding will depend in part on the success of the BCF and the new Community Independence Service in particular.

4.3. This proposal is mostly about change to the organisation and funding of Operations. Our evidence suggests that the Customer Journey programme must begin with these questions but should not end with them. Better experience and better outcomes need coherent service-structure and a clear purpose: to help people live at home and stay safe and well. We won't achieve that just by reorganising the service and investing in CIS. That needs a longer-term programme of training and development. Sustainable improvement depends on better customer service and professional practice. These are topics for future reports to the Committee when plans are more definite.

## 5. CONSULTATION

5.1. Section 3 of the report describes a research project that consulted 120 people who use the service and established their views about it and how it should improve. The designed team has since worked informally with people using services to test ideas for change.

5.2. This report asks the Policy and Accountability Committee for its views and advice about the proposals in Section 3. Subsequently we will produce a formal proposal and a business case explaining the requirements and plans for formal consultations with residents and with staff. The nature of those consultations depends to some extent on acceptance of the option that is proposed in Section 4.

## 6. EQUALITY IMPLICATIONS

6.1. This proposal aims to sustain and improve services. In their current state none of the plans imply disadvantage or disproportionate effects on any group.

6.2. A full business case will include an Equality Impact Assessments the medium-term financial plan.

## 7. LEGAL IMPLICATIONS

7.1. This proposal is designed to help the Council comply with its new legal duties in the Care Act. Detailed analysis of its legal implications will feature in the full business case.

## 8. FINANCIAL AND RESOURCES IMPLICATIONS

8.1. This proposal defines the combination of savings and investment in a new operation.

8.2. The budget and savings estimates are taken from the Council's draft medium-term financial plans. The proposed new service enables savings of £0.5M in 2015/16 and plans for additional savings £1.3M for 2016/17.

8.3. The investment is taken from Hammersmith & Fulham's Better Care Fund Plan that was agreed in Cabinet on 3 November 2014. Subject to the Committee's view on these proposals, and especially the options-analysis, a full business case will explain the finance and resourcing of a new service.

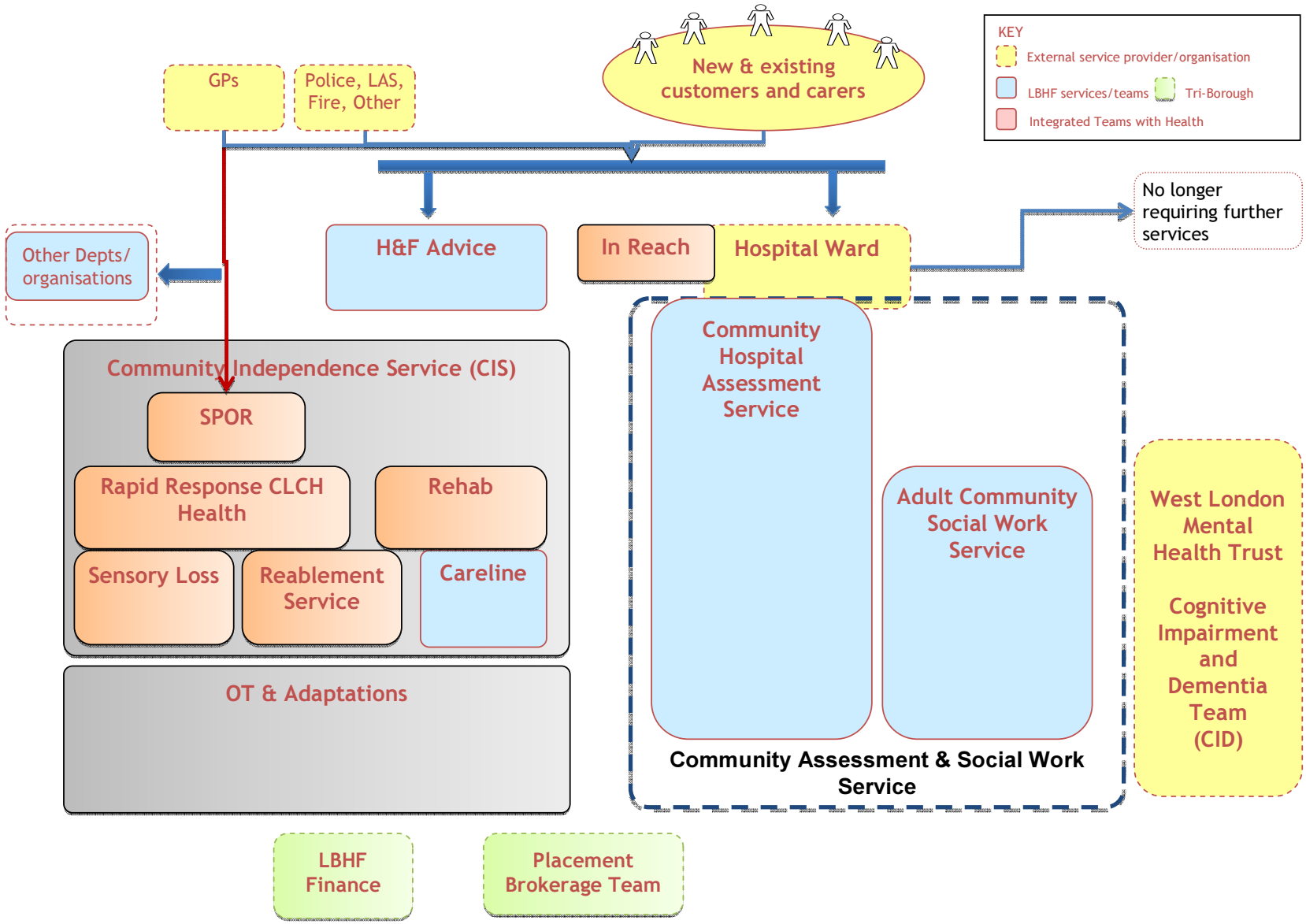
## 9. RISK MANAGEMENT

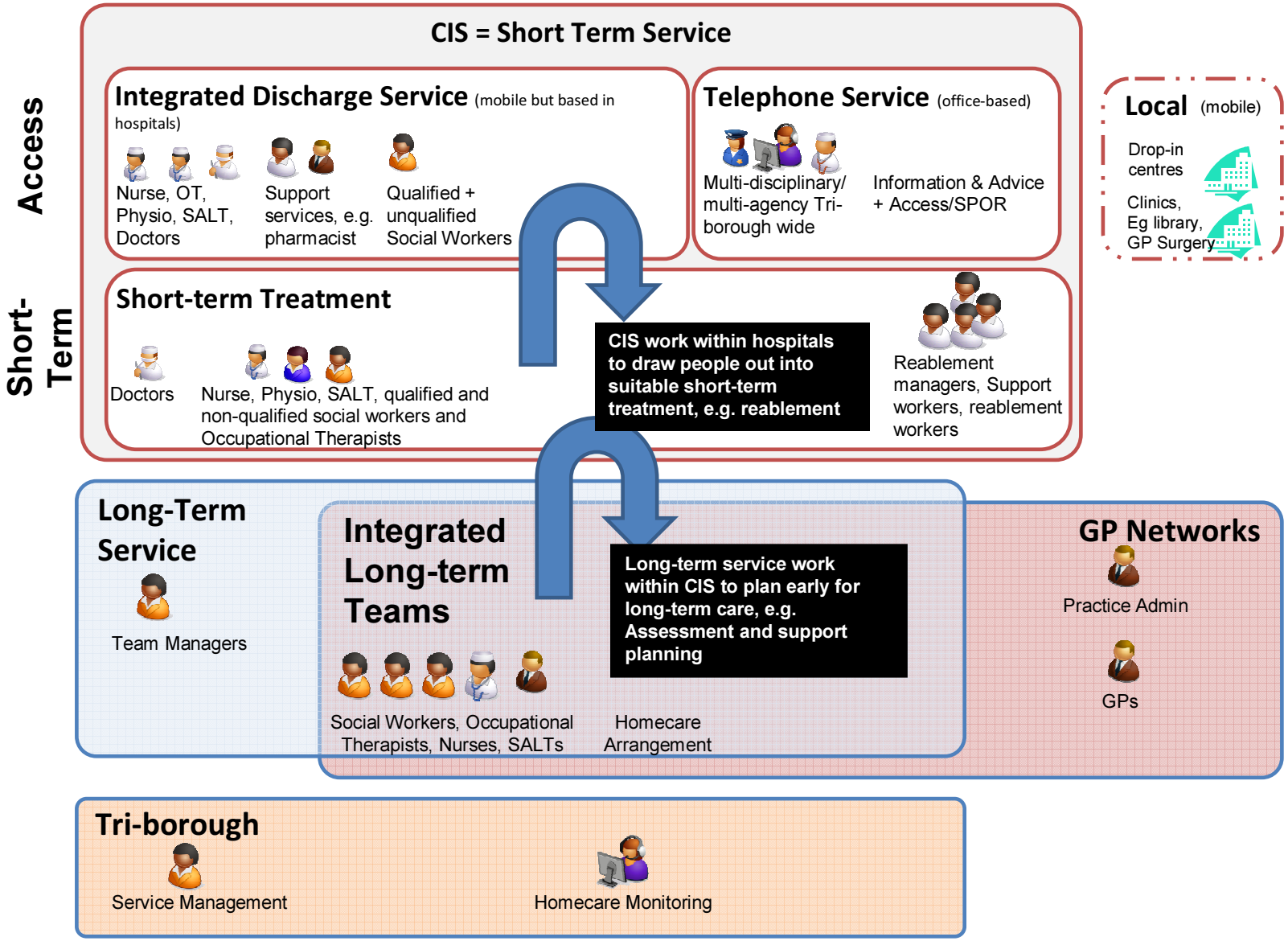
9.1. Risks are explained in the options-analysis.

## 10. PROCUREMENT AND IT STRATEGY IMPLICATIONS

10.1. This proposal affects an in-house service whose staff are employed by the Council. It contains no proposal to procure the service that Operations provides.

10.2. The proposal will imply changes to and enhancements of computer systems. An integrated health and social care CIS need better access to the GP and community health records to provide coordinated care. A proposal to make these systems available to CIS is in development now. All parts of the service will need access to a new Home Care monitoring system. These plans were mentioned at the Committee's previous meeting and will be explained in more detail in any business case for Customer Journey.


KEY
External service provider/organisation
LBHF services/teams
Tri-Borough
Integrated Teams with Health
GPs
Police, LAS, Fire, Other
New & existing customers and carers
Other Depts/ organisations
H&F Advice
In Reach
Hospital Ward
No longer requiring further services
Community Independence Service (CIS)
SPOR
Rapid Response CLCH Health
Rehab
Sensory Loss
Reablement Service
Careline
OT & Adaptations
Community Hospital Assessment Service
Adult Community Social Work Service
Community Assessment & Social Work Service
West London Mental Health Trust
Cognitive Impairment and Dementia Team (CID)
LBHF Finance
Placement Brokerage Team


CIS = Short Term Service
Access
Integrated Discharge Service (mobile but based in hospitals)
Nurse, OT, Physio, SALT, Doctors
Support services, e.g. pharmacist
Qualified + unqualified Social Workers
Telephone Service (office-based)
Multi-disciplinary/ multi-agency Tri-borough wide
Information & Advice + Access/SPOR
Local (mobile)
Drop-in centres
Clinics, Eg library, GP Surgery
Short-Term
Short-term Treatment
Doctors
Nurse, Physio, SALT, qualified and non-qualified social workers and Occupational Therapists
CIS work within hospitals to draw people out into suitable short-term treatment, e.g. reablement
Reablement managers, Support workers, reablement workers
Long-Term Service
Team Managers
Integrated Long-term Teams
Social Workers, Occupational Therapists, Nurses, SALTs
Homecare Arrangement
Long-term service work within CIS to plan early for long-term care, e.g. Assessment and support planning
GP Networks
Practice Admin
GPs
Tri-borough
Service Management
Homecare Monitoring

## Health, Social Care and Social Inclusion Policy and Accountability Committee

| **Work Programme 2014/2015** |
|---|
| **22 July 2014** |
| Imperial: Cancer Services Update<br>Shaping a Healthier Future: Update on programme and decisions to date.<br>Healthwatch: Presentation on its Role and Work<br>Care Act: Update |
| **7 October 2014** |
| Hammersmith & Fulham Foodbank<br>Imperial College Healthcare NHS Trust:<br>(i) update following closure of Hammersmith Hospital Accident & Emergency Department<br>(ii) update on outline business case for clinical services across the three main hospital sites, following Trust Board meeting<br>Medium Term Financial Strategy (Update) |
| **17 November 2014** |
| Adult Social Care Information and Signposting Website – People First<br>Call for Evidence: Engaging Home Care Service Users, their Families and Carers<br>Independence, Personalisation and Prevention in Adult Social Care and Health<br>Safeguarding Adults: Annual Report |
| **3 December 2014** |
| Healthwatch<br>Adult Social Care Customer Feedback: Annual Report 2013/2014<br>Customer Journey: Improving Front-line Health & Social Care Services<br>Meals on Wheels |
| **6 January 2015** |
| Imperial College Healthcare NHS Trust:<br><br>Francis Report: Actions in response to the report recommendations<br><br>Revenue Budget and Council Tax |
| **4 February 2015** |
| Care Act : Go Live implications<br><br>GP Networks and Enhanced Opening Hours<br><br>H&F CCG: Annual Health Performance Report<br><br>Individual Budget Changes/Self Directed Support/Personalisation |

| |
|---|
| Transition from children's to adult social care: Update<br><br>Review of Learning Disabilities Day Services |
| **13 April 2015** |
| Equality and Diversity Programmes and Support for Vulnerable Groups<br><br>Public Health:  Prevention Strategy |
| **2015/2016 Meetings** |
| Digital Inclusion Strategy<br><br>H&F Foodbank<br><br>Safeguarding Adults: H&F Report |