Agenda Item

Report

Report to:	**Social Work Resources Committee**
Date of Meeting:	**2 October 2019**
Report by:	**Director, Health and Social Care**

Subject:	**Locality Redesign - Care at Home**

1. Purpose of Report

1.1. The purpose of the report is to:-

- reflect on the issues arising from the Hamilton Care at Home inspection and how this relates to the wider service
- consider the future function and structure for the Care at Home Service within the construct of the Health and Social Care Partnerships' four locality teams
- propose that there is a need to review the structures that support Care at Home delivery to reflect demographic pressures, changes in statutory duties and regulation, making use of new technology and to reflect the changing role for Care at Home within the overall Health and Social Care system. The report proposes a need to redesign:
  - re-ablement and crisis intervention models
  - assessment and care management functions so that these functions that currently sit within the Service are more closely aligned with Fieldwork Services
  - carer support structures to ensure home care workers are effectively supported in line with the new National care standards and the Scottish Social Services Council requirements
  - the scheduling of care using new electronic functionality to ensure the scheduling service and duty desk model are optimised to secure the benefits of the planned implementation of a new scheduling tool

2. Recommendation(s)

2.1. The Committee is asked to approve the following recommendation(s):-

(1) that the Chief Officer's intentions to focus the partnership's Care at Home Service on being a provider of services be noted;

(2) to note that a review of service functions will take place with a report being submitted to a future meeting of the Social Work Resources Committee for consideration; and

(3) that the Health and Social Care Partnership's intention to focus a substantial core of the internal Care at Home Service on re-ablement and rapid response interventions, including aligning initial assessment resources with the Integrated Community Support Teams, be noted.

3. Background

3.1. The Care at Home Service plays a pivotal role in achieving the strategic goal of supporting people to live independently and safely at home and in doing so also underpins another of the Integrated Joint Board's (IJB's) strategic planning intentions of managing the pressures on unscheduled care. It is an integral part of the whole Health and Social Care system, which includes Community Care, Residential and Nursing Care and Hospital Care, and needs to operate smoothly to avoid adverse impacts elsewhere in the system.

3.2. The paper reflects on the impact of demographic demand and the need to ensure that the Care at Home Service evolves to both manage increased volumes of demand and complexity of need. It must also deliver on the IJB's strategic goals of focusing more strongly on early intervention and supporting people to draw on their personal and social assets to better manage the impact of health conditions and achieve better outcomes. The paper discusses both issues related to service capacity and service models and highlights the need to concentrate more on rehabilitation and re-ablement models of care.

3.3. The paper is also concerned with the infrastructure that supports the service's 800 fte Carers. This comprises of team members who undertake assessments and reviews, directly supervise Carers and those who schedule their work. The current model was established a number of years ago and, in the meantime, the Service has grown in size and the legislative and regulatory environment has changed significantly, indicating a need to reconsider and modernise these structures.

3.4. The paper references issues arising from the most recent Care Inspectorate reports related to the effectiveness of the embedded care management resources. The issues have primarily come to the fore within the Hamilton Service but there are important issues highlighted through their inspection for the entire service to consider. These are primarily:

- the quality of the care management
- meeting the requirement to complete six monthly service reviews
- ensuring Carers are well supported and feel confident in their role
- ensuring consistency of care delivery in the context of challenging levels of demand
- having sufficient capacity in the system to meet demand

3.5. Hamilton inspection and action plan

3.5.1. There have been issues about the functioning of the Hamilton Care at Home Service being highlighted by the Care Inspectorate since 2012 when the current model became operational, which have prevailed through to 2019 despite the considerable efforts of a number of managers to resolve them. As this Service has been unable to make the improvements required by the Care Inspectorate, their grading model mandated a further reduction in grades for the service. The Health and Social Care Partnership's (HSCP's) management team initiated action following the 2018 inspection to begin to address the issues by securing Social Work Resources Committee (SWC) approval for three additional Team Leader posts. However, the most recent inspection coincided with these employees commencing employment and before any impact could be achieved. Following consultation with the Care Inspectorate, the HSCP's senior team have established a comprehensive action plan

to support the Hamilton Service to make the necessary improvements. The key components of this plan are:

- an improvement steering group jointly chaired by the Chief Social Work Officer (CSWO) and Head of Health and Social Care
- commissioning an external expert review of the root causes of the challenges and to identify the exemplars of best practice elsewhere in the South Lanarkshire Council (SLC) Service
- reorganising the boundaries of the service to reduce the scale of the Service
- refreshing the management of the Service
- raising the seniority level of the registered Manager to improve governance
- deploying additional temporary resources to support both the management of the improvement programme and also the operational challenges such as overdue reviews
- improving quality assurance systems

3.6. There has been significant progress with this improvement plan albeit that operationally it will require an extended period of intervention to embed the necessary changes to culture and practice. Some key actions are:

- improvement steering group meets weekly
- critical analysis report completed
- the Services operating from the East Kilbride and Clydesdale localities have been achieving more positive Care Inspectorate grades. It is on that basis that the Operational Manager for Clydesdale has assumed responsibility for the Larkhall/Stonehouse teams and the East Kilbride Operations Manager for the Blantyre team
- a new Operations Manager has taken over the management of a smaller scaled Hamilton Service
- a new Service Manager has been appointed and will commence in early October 2019 following approval by the Social Work Resources Committee in June 2019 for the post
- a Fieldwork Manager has been overseeing improvements in care management
- targeted training for Co-ordinators has been delivered by the Fieldwork Manager (strategic support)
- regular liaison with the Care Inspectorate

3.7. Key challenges and improvement actions for the Service

3.7.1. The pressure upon the Care at Home Service to have capacity to match demographic demand is considerable particularly in relation to supporting hospital discharge. It is anticipated that this demand pressure will continue to increase year on year for the foreseeable future. To manage demand, the Service is committed to implementing the Council's revised prioritisation framework and ensuring that the primary offer of support is focused on helping service users to regain and maintain their independence. The Service intends to strengthen the existing "Support your Independence" model and link more firmly to the HSCP's Integrated Community Support Team model so as to maximise the impact of the integrated resources. Such a model will better ensure that resources are targeted effectively towards ensuring personal outcomes related to living independently are promoted and thereby mitigate some of the impacts of the demographic pressures.

3.8. The statutory framework requires each service user to be assessed, be offered one of the four options under the Self Directed Support (SDS) Act, have a clear and

effective care plan and be subject to regular review. The Care Inspectorate reports have raised questions about the robustness of the current Care at Home model in the context of this legislation, the new National Care Standards and increasing complexity of need. This paper proposes that a review and redesign of the assessment and care management model is required.

3.9. In a similar vein, this report proposes a redesign in relation to the management and supervision arrangements within the Care at Home Service. Considerable work has been undertaken to match the scale of the front line Carer Service to the needs of the population and to deliver the Service efficiently. However, both the Service and the regulator are indicating a need to look more closely at the support mechanisms for the Care at Home workforce. Carers, Supervisors and Managers are now all required to register with Scottish Social Services Council as well as the Service being regulated by the Care Inspectorate. Carers are supporting people with complex health conditions including Dementia and delivering palliative care. They therefore need significant training inputs and access to regular supervision and support.

3.10. This report further proposes a need to revise the staffing model to support the use of the new scheduling and monitoring tool which is being purchased to improve the efficiency of both the management of the Service and the deployment of Carers.

4. Assessment and Care Management

4.1. Assessment, care planning and review is a statutory and fundamental role for Social Work. It determines the individual's eligibility for services in accordance with the established prioritisation framework, identifies the outcomes to be met and the risks to be managed. The Care Inspectorate requires Carers to be able to access for each service user a personal profile and a support plan which identifies the outcomes to be met and how this is to happen and includes risk management information on matters such as specific health conditions, for example, Diabetes/Parkinson's; physical environment; moving and assisting; special diets; medication; skin integrity etc. The care plan should address the issues identified and provide clear direction to the Carers.

4.2. Effective care management determines the nature of the care to be delivered by the Care at Home provider. South Lanarkshire Care at Home Service is one of a number of providers commissioned to support SLC residents. As a provider, the SLC Service has to undertake a service review for each service user at least six monthly.

4.3. A legacy issue which this report is addressing was the decision to merge the care management resource for older adults in receipt of a Care at Home Service with the staff who were effectively the provider of the Service. Whilst this model may have made good business sense historically, it is no longer fit for purpose. Changes in policy and legislation, along with a change in the balance between in-house and framework providers, cannot be properly supported with this model. This has contributed significantly to the issues within the Hamilton Service and there are elements of similar risk emerging in the other areas, particularly the Cambuslang locality.

4.4. It is therefore proposed that the community would be better served by the Care at Home Service focusing on being a provider of services. Assessment and care management functions should be separated out from the provider element of the service and embedded in a fieldwork model of delivery and governance. These two distinct functions require different skill sets.

5. Focus on Re-ablement and Rapid Response

5.1. Most people are referred to Care at Home due to a deterioration in their capacity to care for themselves and often at a point when their care needs begin to exceed what informal Carers can provide for them. A large number of referrals are from hospital following a health crisis or a fall for example. Similarly, community based referrals are often triggered by some form of crisis event.

5.2. The HSCP intends to reinvigorate the existing Supporting Your Independence (SYI) approach by establishing dedicated re-ablement teams within each locality that are scaled to meet the level of new demand. These teams will also provide the Rapid Response Service required to avert a crisis or support an immediate care need such as end of life care.

5.3. This segment of the Service forms one element of the spectrum of intermediate care interventions. It will interface with the new care facilities and hubs that are already planned for Blantyre and Lanark and contribute significantly to the spokes. Ultimately, this service will support a range of rapid access and neighbourhood oriented integrated systems of delivering short term care which promote positive outcomes for the population of South Lanarkshire.

5.4. There is a significant opportunity to align Council and NHS practitioners to support this delivery model. There are currently parallel strands of service: Council employed Occupational Therapists, Support Workers and Co-ordinators in Care at Home; NHS employed Nurses and Allied Health Professionals in the Integrated Community Support Teams (ICST). It is proposed that these teams work together within streamlined care pathways, which maximise their impact through a person centred approach to assessment and intervention. The SYI Service will be aligned to this element of the Service to deliver person centred, goal focused re-ablement outcomes and provide an SDS compliant assessment where the service user has ongoing care needs.

6. The role of Co-ordinators

6.1. Carer Support - the carer role has evolved to meet the needs of a generally frailer cohort of service users and with a concentration on personal care tasks. Carers are typically asked to support people with a range of health conditions (for example. diabetes, COPD, Parkinson's) which each have different and accumulating impacts on the adult and requiring differing approaches to support, including how Carers assist people with medication and safely make use of equipment. The work force is now registered with the Scottish Social Services Council and the service is regulated by the Care Inspectorate against new National Care Standards. The aggregated result of these elements is that the service and the Council as the employer must ensure that there is sufficient supervision and management resource to ensure Carers are properly supported and trained to be confident and competent in their work. There are indicators from self-evaluation and care inspectorate feedback that the service needs to consider the level and a nature of the support it offers so that it is matched to the changing regulatory and operational environment. It is proposed that a review of the supervision model takes place.

6.2. Scheduling - the Service will implement a new electronic scheduling and monitoring system for Care at Home in 2020. This would replace a largely manual process within the locality offices and improve the information that is pushed through to Carers' mobile devices regarding the visits they require to undertake. This system will match service demands and Carer availability within a set of agreed parameters. This results in Carers being scheduled optimally and transactional processes being

streamlined. The introduction of the scheduling system also provides a further opportunity to focus resources on the core functions of:

- scheduling
- carer support and supervision
- assessment and care management

6.3. At the moment, the operational model and systems have a degree of unhelpful overlap in these distinct roles. It is proposed that a discrete scheduling team will need to be established to deliver a predominately administrative set of tasks. Team members would be appropriately graded administrator roles. It would be an overarching service to provide flexibility and resilience but team members would retain a locality focus to their scheduling activity. Scheduling activity occurs throughout the day, seven days per week. However, the current model does not fully support this. It is proposed that the HSCP bring forward proposals to remodel the scheduling arrangements which include options for extending the scheduling service to operate an extended day over seven days.

6.4. Duty Desk - the locality Care at Home Services also provide a duty desk. This addresses a range of activities and events. These include:

- throughout the day, Carers seeking advice on responding to service users falling or being unwell, no access to property. These need to be followed up straight way with contact with Carers families, GP's etc
- rescheduling missed visits, vehicle issues
- families calling in about changing circumstances
- general enquiries and complaints
- Carers becoming unwell and not starting/leaving shift

6.5. This is a very busy role given the many thousands of individual care episodes undertaken each week and requires capacity sufficient to match demand. Many of the events dealt with impact on scheduling, for example, a Carer attending to a faller/sick person will be delayed in their run requiring rescheduling activity to take place. It is therefore proposed that the proposals noted in paragraph 6.3 also address how the duty service should be aligned with the schedulers so that each locality has focused duty/scheduling capacity.

6.6. Managing Cover - Care at Home is a registered 24/7/365 Service and Co-ordinators spend considerable tranches of time organising staff cover. All staff leave, training, sickness absence etc has to be covered by another Carer. This is similar to a Care Home/Hospital ward which also need continuous staff cover. The staffing model included some peripatetic cover but it is insufficient and results in costly and inconsistent cover arrangements. The intention is to increase the number of peripatetic staff to a level of circa 20% of the core staff to take account of the planned absences of the core team. The overall impact of this model will be to reduce the use of premium rate overtime and most importantly have sufficient staff available to deliver a consistent service with the minimum necessary number of Carers to the recipient.

7. Employee Implications

7.1. The majority of the employee implications in this report relate to re-aligning existing staffing and financial resources to support the HSCP's strategic aims. The report does however identify a need to:

- Consider requirements in assessment and care management (section 4)

- remodel the support infrastructure to take advantage of the new electronic scheduling tool and to improve the interface with Carers (section 6)
- redesign the model for supporting Carers (section 6)

8. Financial Implications

8.1. It is considered that several elements of this report refers to redesign activity which is achievable within the available resource to target services optimally, improve flow and efficiency. However, this report also highlights the need to address the challenges of ensuring the service meets its regulatory requirements into the future. Work is required to consider:

- capacity to deliver both core care management and service review functions
- infrastructure to support Carers throughout the operational day

8.2. The service will consider the areas raised in this report, and will work with colleagues in Finance and Corporate Resources and the Chief Financial Officer of the Health and Social Care Partnership to consider the financial implications. These will be reported back to committee.

9. Other Implications

9.1. There is potential risk in relation to service quality and outcomes for service users if improvement activity is not commenced. The improvement actions that will be taken forward are intended to better manage and reduce the level of risk.

9.2. There are no sustainable development issues associated with this report.

9.3. There are no other issues associated with this report.

10. Equality Impact Assessment and Consultation Arrangements

10.1. There is no requirement to carry out an impact assessment in terms of the proposals contained within this report.

10.2. Full consultation will take place with Trade Unions and other stakeholders in terms of the information contained in this report.

Val de Souza
Director, Health and Social Care

12 September 2019

Link(s) to Council Values/Ambitions/Objectives

- Improve later life
- Deliver better health and social care outcomes for all

Previous References

- Social Work Resources Committee – 7 August 2019

List of Background Papers

- none

Contact for Further Information

If you would like to inspect the background papers or want further information, please contact:-

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