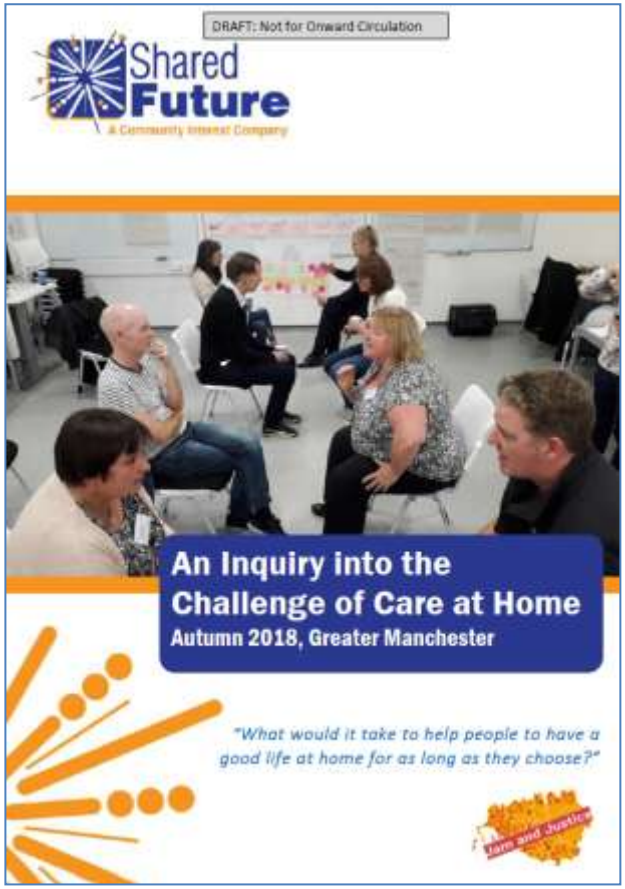
The Inquiry into the Challenge of Care at Home

Launch of the Recommendations

12th December 2018



The Inquiry into the Challenge of Care at Home

The Challenge:

"What would it take to help people to have a good life at home for as long as they choose?"

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The Plan for Today

Welcome – Katie and Amanda, facilitators of the Inquiry

Setting the Scene: Mark Fitton, Director of Adult Social Care, Stockport MBC, on the work of the GMHSCP Living Well at Home Delivery Group

About the Inquiry: Jez Hall, Director, Shared Future CIC

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The Plan for Today (continued)

Recommendations of the Inquiry in the Challenge of Care at Home – Delivered by the Inquiry Participants

Questions & Answers from the Room

Workshops Round 1: How could these recommendations be implemented?
REFRESHMENT BREAK

Workshops Round 2:
Workshop Feedback

Next Steps :

THANKS AND CLOSE

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Adult Social Care Transformation Programme:

Living Well at Home

GMHSCP - Our vision

"To deliver the greatest and fastest possible improvement to the health and wellbeing of the 2.8m people of Greater Manchester"

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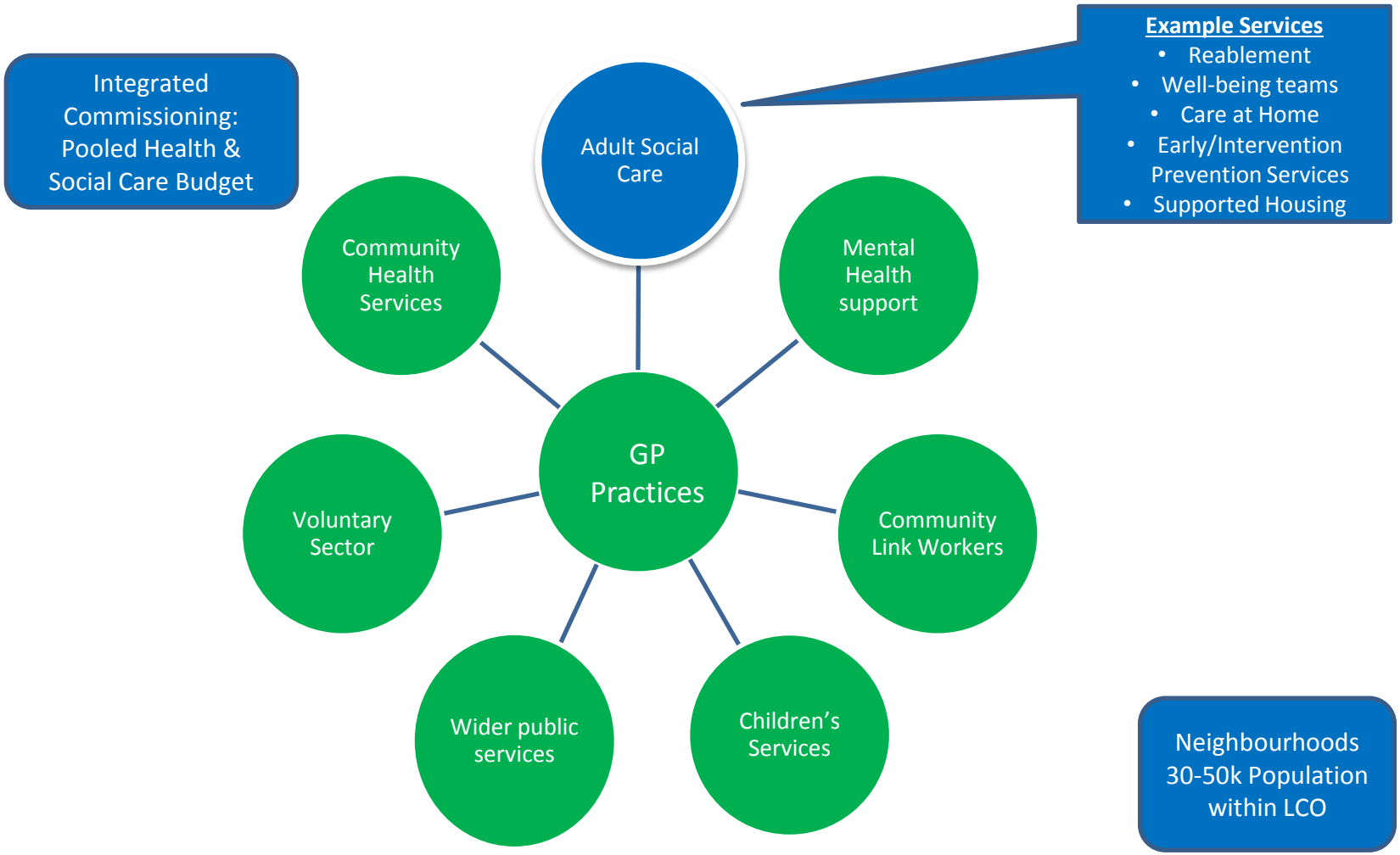
Social care as part of the neighbourhood model in GM



The Adult Social Care Transformation Programme

PRIORITY WORKSTREAMS

Living Well at Home

- Personalised care and support
- Quality
- Workforce
- high impact models
- Tech and innovation
- Reforming the wider system

Learning Disabilities

GM LD Strategy

Family based care (shared lives)

Complex Needs

Supported employment

Residential and Nursing

Quality improvement and best practice

Teaching care homes

Primary Care and urgent care Contribution

Medication optimisation

GM provider engagement

Support for Carers

Early Identification

Improving Health and wellbeing

Carers as real and expert partners

right help at the right time

Young and young adult carers

Carers in/into employment

CROSS CUTTING

LED BY GM ASC HEADS OF COMMISSIONING

NW Market Oversight Response

Expansion of extra care
Aging well housing strategy
Wellbeing support at home
LD supported accommodation
LD enablement services
Understanding mental health

ENABLING WORKSTREAMS

LINKING INTO EACH OF THE ABOVE PLUS THE FOLLOWING ADDITIONAL PRIORITIES

Supported Housing

Age friendly housing
Evidence base
LD and MH accommodation
Enabling planning and delivery
Intermediate tier
Technology enabled care

Workforce

Registered Managers

Apprenticeships

The overall vision/ambition:

A new model of independent living and support delivered through transformed adult social care and health

This will keep people well and independent in their own homes and communities of choice as well as develop careers in care which offer progression routes through education and apprenticeship opportunities.

The model will not just be about formal care but will embrace innovative and alternative opportunities such as Wellbeing Teams and independent living models, all underpinned by an asset based approach. It will ensure interventions and prevention models are in place so that people can avoid going into long term support services and it should also change the way the money drives the outcomes with payment reform incentivising the retention of independence.

Further, it will build on the unique infrastructure in GM, with Local Care Organisations and new Single Commissioning Functions (integration of commissioning between Local Authorities and CCGs) with pooled health and care budgets and a single Accountable Officer for place-based leadership.

The 'living well at home' framework

1. Personalised care & support

Outcomes based individual support offer developed with people and families Valuing strengths, assets and diversity

A thriving and resilient community model

Community and voluntary sector support

Incorporating a re-ablement offer

Wellbeing teams /innovation models

Ways to tackle loneliness and isolation and foster a more vibrant community offer

Place based commissioning

Co-designing and adopting new models of care and support at home across GM

2. Quality

A joint GM Quality standard, supporting excellence in care and support at home

Joint QA and improvement process based on a collaborative and supportive approach

Enhanced wellbeing and lived experience for individuals, families and carers (informal)

Use of national research and best practice to inform quality standards

Engaging paid and unpaid carers as expert partners

3. Workforce

Values based recruitment and training – including dignity, respect, trust, honesty

Skills for Life – Training Support and progression, Apprenticeships

Technology enabled care and support– development of staff

Management and Leadership Development Asset based approach

Ethical employment framework /Pay and Conditions

Pre-Employment support

Engagement and Business Support

Volunteers

4. High impact models

Care closer to home, including integrated primary, acute, community, mental health, VCS and social care.

Targeted case management delivered by upskilled multi-disciplinary teams, with streamlined discharge planning

Specialist acute-based consultants and nurses via technology or face to face visit

Community response teams supporting people in care homes and at home

GPs working alongside a wider team of social care, nursing and specialist colleagues.

Support in a crisis or emergency

Assessment and support planning (care mgmt)

5. Technology and Innovation

Mobile working solutions

Better Technology enabled care

Single electronic care record

Electronic systems to enhance quality assurance

New innovations in the sector

Linking into local and regional opportunities for evaluation and learning

Finding new ways to support paid and unpaid carers

6. Reforming the wider system

Working with others across the system to improve the financial and contract system/commissioning infrastructure

Approaches around charging

Capitation and a single budget aligned with incentives

Working with Urgent Care to improve links to hospital discharge and primary care at home

Seeking to connect systems across traditional boundaries of health, social care and housing, recognising the broader determinants of health and wellbeing

How will we know if the programmes are having any impact

- We want to work together across localities to help ensure a continued focus on quality, to **promote excellence in care and support, and genuine quality of life and experience, based on what matters to people individually.**
- As part of this, more people will be genuinely involved in planning their own **personalised support**, and feel that this is building on their strengths and individual preferences
- More **community based support** will be available in local neighbourhoods, offering support at the right time and helping to prevent loneliness and isolation, whether you are in a care home or in your own home.
- We need to improve our recruitment and retention of care and support staff, driving improvements in safe staffing levels and reduced reliance on agency staff. Skills shortages and turnover will be addressed through a new **workforce deal including new roles and career prospects for people**
- If we get this right, this should have an impact on the level of avoidable non elective attendance and admissions to acute hospitals and a **reduction in falls or avoidable harm**
- This will also need to happen alongside enhanced **support for informal carers and family members**

Greater Manchester Health and Social Care Partnership

Conclusion

- Huge opportunity to think differently about how **funding is configured across Health and Social Care Services, and use pooled budgets or payment reform to make much better use of the funding available**
- There is a clear opportunity through system reform, to change the way in which services are commissioned, **away from `time and task' towards services geared far more flexibly to individual needs and preferences**
- Working in **smaller neighbourhood teams** has many advantages in terms of reducing travel time for staff (therefore increasing time for support), improving the knowledge of workers in local areas, mutual support, trust and communication between all concerned.
- **So going forward, our programme will bring together a number of elements and be known as `Living Well at Home' – wherever you live**

... in your own home	... in Supported Housing	... In an Extra Care scheme	... in Residential or Nursing Care Homes	... in Intermediate Care, or Complex and Specialist

Shared development work across all the above areas……

Quality	Personalisation	Workforce	High Impact Models/Neighbourhoods	Technology and Innovation	System Reform	Future Market Development and Supported Housing
• Quality of care and support • Quality of experience and outcomes • Improving partnerships and integrated approaches • Teaching care homes • Primary and urgent care interface	• Wellbeing teams • Vibrant community offer • Different conversa-tions • Age friendly communities	• Leadership • Skills and values • Recruitment and retention • Workforce strategy • Finding new ways to support paid and unpaid carers	• Care closer to home, including integrated primary, acute, community, mental health, VCS and social care • Targeted Case management delivered by multi-disciplinary teams, • Community response teams supporting people in care homes and at home • Working with Urgent Care to improve links to hospital discharge and primary care at home	• Mobile working solutions • Better Technology enabled care • Single electronic care record • Electronic systems to enhance quality assurance • Linking into local and regional opportunities for evaluation and learning • Support new model of care • Stock take existing technology • Link with Health Innovation Manchester	• Working with others across the system to improve the financial and contract system/commissioning infrastructure • Review current charging systems • Capitation and a single budget aligned with incentives • Seeking to connect systems across traditional boundaries of health, social care and housing, recognising the broader determinants of health and wellbeing – • Creating toolkits to enable local delivery	• Ensuring a strategic & pro-active approach to market changes & challenges • Predictive modelling of need including Intermediate Care; • Evidence base – across all areas • Intermediate Care; analysis of current provision and future need, and GM Plan • Up-scaled extra care provision • Learning Disabilities and Mental Health accommodation • Transforming Care and Complex needs • Transitions • Care Home Accommodation quality review

The Inquiry into the Challenge of Care at Home

Table 1: Commissioning and Service Reform

Commissioning practices are currently too rigid to accurately reflect a personalised approach.

Stop commissioning 'time and task' services, that fuel a one size approach; Time to build relationships needs funding as it leads to greater independence in the long run; Co-design/co-production in all tenders; Investigate other financial models to bring back cash into the [care] sector; Incentivise providers to facilitate independence outcomes; [The current model] Stops small or local providers [and we] need a diverse market; [Move towards an] Approved provider list, meeting the criteria [describe elsewhere in these recommendations] instead of a preferred provider closed shop.

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Table 1: Commissioning and Service Reform

[Prioritise] Earlier intervention.

An earlier investment in prevention services will reduce long term costs.

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Table 1: Commissioning and Service Reform

Recognising and valuing the contribution of unpaid carers.

Improve their support [while at] work and improve support for their own health and wellbeing; Prevent burnout and crisis intervention; Reduce carers own use of health and social care services in the future; Carers save the system £11bn a year. It [the system] will not cope without their support, so they need to be supported.

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Table 2: Informed Choices and Patient Involvement

Care navigation models to be developed and available from 18+.

Information is necessary to enable choices; Information can be held anywhere (in pubs, community centres and supermarkets); Believe strongly in [promoting of] a social prescribing model that supports mental, physical and emotional health; [Social] Prescriptions need [information on] costs attached to it, so that provider services aren't at risk.

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Table 2: Informed Choices and Patient Involvement

Greater integration of Health, Social care, Housing, Voluntary Services and the service uses, to share information and resources, and [improve] care planning.

Information should be managed by the individual rather than the service; Permission held in a single technological record; Break down boundaries between services and [reduce] institutional hierarchies; Move towards one file per person that's owned by them; make co-production mandatory in the commissioning cycle.

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Table 2: Informed Choices and Patient Involvement

Individualised approach for everyone that incorporates their personal wishes.

Everyone has different needs and wishes.

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Table 3: Valuing Care Staff

Consider creating a professional body for social care workers, similar to the General Medical Council or Nursing Medical Council.

Improve morale, improve recruitment and retention; Maintain regulations and continual professional development; Workers more valued and respected.

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Table 3: Valuing Care Staff

Improve terms and conditions for the contracts of Social Care Workers, and ensure these meeting legal requirements.

Improve recruitment and retention; Workers feel valued and respected; providers save money; Abides by the law!; Raises status and professionalism of workers.

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Table 3: Valuing Care Staff

Introduce banding structure for care workers based on experience and qualification.

Improve recruitment and retention; Provides career pathway and opportunities for progression; Feel more valued and respected.

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Table 4: Infrastructure and Technology that can support Care at Home

Suitable, safe, reasonable accommodation for all.

To remain independent; reduces need to move; More likely to want to remain in home for longer; [Improves] Safety.

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Table 4: Infrastructure and Technology that can support Care at Home

Good public transport remains essential to a good life at home.

Integrated transport system to support [the care] infrastructure; Improve access; Reduce cost; Public transport free at 60 as in London, Scotland and Wales.

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Table 4: Infrastructure and Technology that can support Care at Home

Appropriate use of technology to enable people to remain independent, connected and safe

[More use of new technology, such as] Facetime, skype and whattsapp; Voice controlled assistance(echo/alarm); Assistive technologies/healthcare technology; Buddy GPs; Welfare checks.