# *Summary Report:*
# *Domiciliary Care B&NES*

**Tuesday 24th March 2015 | 9:30 am**

**Carter Room, Fry's Conference Centre, Keynsham BS31 2AU**

## Attendees

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| • Mike MacCallam | B&NES Council and BaNES CCG |
| • Sue Blackman | B&NES Council and BaNES CCG |
| • Angela Smith | B&NES Council |
| • Avril Baker | Avril Baker Consulting |

## Meeting Summary

Mike MacCallam presented a summary of the purpose and principles of the ***your care, your way*** review. Mike conveyed how all partners and stakeholders will be working together to engage with as many people as possible throughout the duration of the review process. He also explained the definition of community services and the phases and timing of the review.

Mike highlighted some of the key themes which have emerged from engagement events so far including the importance of: early intervention, person-centred care, preventative care, integration, equal and seamless access, building community capacity and significance of social isolation.

## Group Question and Answer Session

Mike invited the group to ask questions to clarify their understanding. The following questions were raised during the session:

**Q1. In relation to volunteers and navigation are you working with the Care Forum?**

Yes we are, particularly linking in with Healthwatch which has recently commenced a project at the RUH following patients/families through from discharge to understand their experiences. We are also looking at the needs of seldom heard groups and those with disabilities, such as the deaf community, as well as engagement events with providers such as DHI where we looked at ways to support those with drug and alcohol problems.

**Q2. Are you designing services around outcomes-based models of care?**

Yes. Designing an outcomes-based model, agreed with our stakeholders, should enable a better understanding of the impact on the individual patient/service user. We are also learning from others about integrating services so that we have one service spanning health and social care. We are also exploring options for funding services through integrated budgets.

**Q3. In relation to the cluster models, will you look at what's in an area already and the local demographics?**

We appreciate the need to consider demographics when designing services. We will be looking at the population base in each area but also what happens at the borders e.g. in Pucklechurch some people have a B&NES GP but also use services in Bristol. The Business Intelligence Unit looks in detail at the population and expected trends that will inform service redesign.

**Q4. A provider shared her experience of working in socially isolated areas such as Blagdon where some patients are registered with GPs in in North Somerset but their District Nurses come from B&NES. There are 72 villages in the surrounding area and many people living there are very isolated. Village Agents work very closely with all parties and can point people towards support e.g. transport scheme being built up which is very good. Volunteer networks are also very strong but there are issues where the GP cannot liaise with neighbours who are supporting patients because they are not family.**

It would be good to expand on this experience in the table workshops. We appreciate the role that volunteers play and are looking at this within the scope of the review. We are also aware that there can be volunteer exhaustion.

**Q5. Village agents organise a monthly roadshow in a different location and get Dial-A-Ride involved to help with transport but there is a limit as to who can participate.**

This supports feedback from others so far about the importance of building connectivity between various care organisations and individual patients. We are also aware of the need to provide ongoing support for patients after their initial discharge.

## Feedback

The room was then split into four groups with facilitators at each table. Participants were asked to think about three key questions:

- what works well currently in your community?
- what are the barriers and how do we overcome them?
- what are the opportunities and how to we seize them?

## What works well?

- Partnership and interagency working
  - sharing knowledge and information
  - Good relationship with GP surgeries, District Nurses and community teams
  - Good relationship with dementia co-ordinators and discharge team, especially handovers
  - Good networks – starting to outreach – incorporating a lot more health services and experts
  - Good support plans but need to improve opportunities for information sharing between relevant parties

- Recognition that we are providing best services under present conditions

- Local carers
  - Praise for person that comes through the door
  - Well-trained staff
  - Continuity of care – same carers can build relationships and spot differences in client's condition
  - Local knowledge of carers about patients and the area e.g. best travel routes
  - Local recruitment e.g. advertising and local job centres
  - Initiatives such as walking rounds and doubling up of walkers and drivers

- Signposting to other services – lists of what's available

- Active community and local volunteer support
  - Strong neighbour support in communities in rural locations
  - Village agents and monthly roadshows – act as navigators, agents know the systems and can help with referrals and transport

## What are the barriers and how do we overcome them?

- Patient communications and information
  - Communications and information between all parties especially on borders where some care services split between B&NES and neighbouring CCGs/Councils and where several services are involved
  - Confidentiality especially in rural areas where people all know one another and the carers (can also be a positive)

- Discharge arrangements
  - planning provision of domiciliary care when patients have to be re-admitted
  - Hospital communications – need more involvement of homecare staff in discharge
  - Lack of discharge equipment - can lead to injuries for homecare staff

- Dealing with regulatory red tape  e.g. CQC requirements for assessment doubling up

- How services are commissioned
  - Need to get away from time and task based approach and manage in more sustainable way i.e. commission and provide on an 'outcomes based' approach
  - Self-preservation – providers trying to protect their service's 'own interests'

- Contracts and terms and conditions
  - Difficulty recruiting carers  - can overcome by paying in block e.g. pay travel time
  - Need to have a choice and variety of contracts  - from fixed to zero hours
  - Retention of staff – costs £5K to train homecare worker and then they go and work at RUH or for Sirona on better T&Cs
  - Managing expectations – as workforce is not big enough or flexible enough as not everyone can work set hours

- Relationship can be difficult between elderly patients and carers if carers are very young (can also be a positive if they know the local area well)

- Funding by Councils to provide resilience if circumstances change – e.g. if care visits need to be increased plus issue of backdating funding

- Better use of technology – introduce earlier in support for individuals so they are more confident in using (example from Spain)

- Lack of recognition of skills of workforce reinforced by negative media portrayal of home care

- GPs lack of understanding as to what domiciliary care can provide

- Changing attitudes

## What are the opportunities and how do we seize them?

- Better use of technology
  - System co-produced by people/focus group who use it i.e. offer phone not internet if person not IT literate
  - Use technology to spread the word but ensure jargon free, clear and user friendly
  - Example of the Brokerage team in North Somerset where they use a website to match gaps in service and postcodes of patients with available staff/hours – saves staff time ringing around
  - Better use and trust in assistive technology

- Early intervention services – staff aligned to GP cluster e.g. in a hub to supply information and arrange access plus technology to back up such as apps and website

- Staff support
  - Need resources to help support local carers e.g. scooter rental scheme in North Somerset and Mums' Run in Chew Valley – to allow mums to work limited hours around school drop off/pick up
  - Local knowledge and resources – in bad weather can call on farmers to collect staff

- Create better image and raise profile of social care in the media not just health care

- Improve terms and conditions for staff – make comparable with NHS staff

- Consider commissioning needs on geographical basis

- Ensure individual budgets provide what the person wants to achieve

- Better partnership working
  - Linking services
  - Integration - make the most of relationships between health and social care and the voluntary sector
  - First response – can signpost to other services as long as maintain good community knowledge and working relationships
  - e.g. Tesco and Diabetes UK - involving dietician, dietary plans, leading to lunch clubs

- Better training
  - Sharing of training facilities – more use of hospital facilities and before someone is discharged include homecare staff who will be providing the care in the training and discharge plan
  - Floating support – trained in all aspects so they can be used in an emergency and provide seamless care

- All staff to work in a reabling way – mind-set

- Language needs to change from cover to support

- Educational approach for support network of person too – manage their expectations

## Summary

Sue Blackman highlighted the following key points she had taken away from the session which would be more fully documented in a feedback report.

- Strong partnership working between providers of domiciliary care
- Relationships are key with individuals to provide continuity of care
- Technology can help with access to services and delivery
- Demand outweighs supply
- How to commission for outcomes and finance flexible working
- Raising the profile to help attract staff
- Knowledge of local carers and how to harness
- Integration between acute services and secondary care to inform packages of care

Sue thanked everyone for their input and concluded by encouraging attendees to share the information about the review and encourage people to feedback through different channels. The next step as the project moves to Phase 2 will be the running of focus groups in June/July to start working up options for models of care. Invitations will be going out in April and the project is looking for representatives across the board to join these groups.