City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Westminster & Royal Borough of Kensington and Chelsea Health & Wellbeing Board

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Classification:	**General Release**
Title:	Complex Care
Report of:	Adult Social Care and Health
Wards Involved:	All
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1. Executive Summary

1.1. This paper and the wider workshop will provide an insight into how the Bi-Borough Place Based Partnership Complex Care programme is developing and how it addresses what is important to our residents and how we are helping to reduce health inequalities across our communities.

1.2. Within the programme four priorities (see next section) have been identified including:

- Care Homes,
- Discharge,
- Palliative and End of Life Care,
- Same Day Access.

1.3. Each of these priorities are being delivered by partnership working with local partners across the bi-borough.

2. What residents are saying?

2.1. Throughout the development of the Health and Well Being strategy and through individual consultations relating to service design, the voice of our residents is key. Below are some of the things people are saying, which relate to the areas covered within Complex Care:

- People living with dementia have found it hard to get **consistent access** to support and services they need.
- Our **end of life** services do not reach wide enough, or appropriately support our diverse communities. Additionally, people want to have access to these services **closer to their home** for patients and those important to them who are supporting their care.
- Palliative care services need to take account of cultural/religious/ethnic considerations in the way services are provided.
- There needs to be **better awareness** and use of advocacy services, especially for people with learning disabilities.
- Care Home residents have struggled to get suitable access to **dental** practitioners.
- People want to have their **care personalised** in the way they need. For example, residents' feedback captured by Healthwatch as part of a care homes review included:

"*The main thing is my freedom. My freedom in moving, my freedom in choosing."*

"The most important thing is freedom or independence. If we don't get the right support, we don't have that. We are stuck indoors."

"My local church is opened now. I get to see familiar people. My life is people."

3. What Complex Care Covers

3.1. The Complex Care Programme is broad but is interconnected as it will impact on all residents, in particular the most vulnerable. The programme scope includes:

Care homes

3.2. This area of work aims to:

i. ensure that people living in care homes receive the same quality of physical health and mental wellbeing support they would receive were they living in their own home.
ii. ensure that care homes in the Bi-Borough are attractive places for residents to live and to receive personalised care that meets their social preferences.
iii. demystify/destigmatise the work of care homes and to improve workforce recruitment and retention.

3.3. The focus of this work to date has been implementing the national **Enhanced Health in Care Homes** standard. These national standards are to make sure there is consistent delivery of specialist nursing support into homes to enhance multi-disciplinary nursing case management. We now have specialist nursing support for all care homes and are undertaking a quality review to ensure care provision, multi-disciplinary discussions, and support with assisting with care home training needs are consistently delivered in line with North West (NW) London Integrated Care Board (ICB) recommended standards.

3.4. The programme is also working to improve the availability of enhanced **dementia in-reach** specialist support into homes to support earlier identification, diagnosis and management of people with dementia. Our mental health providers are undertaking a project in six care homes that provides education, dementia-specific psychology-led training and professional development to support care home staff in caring for people with dementia. Our mental health providers are also exploring how they can further enhance local in-reach provision to support earlier identification and management of individuals with behaviours that challenge.

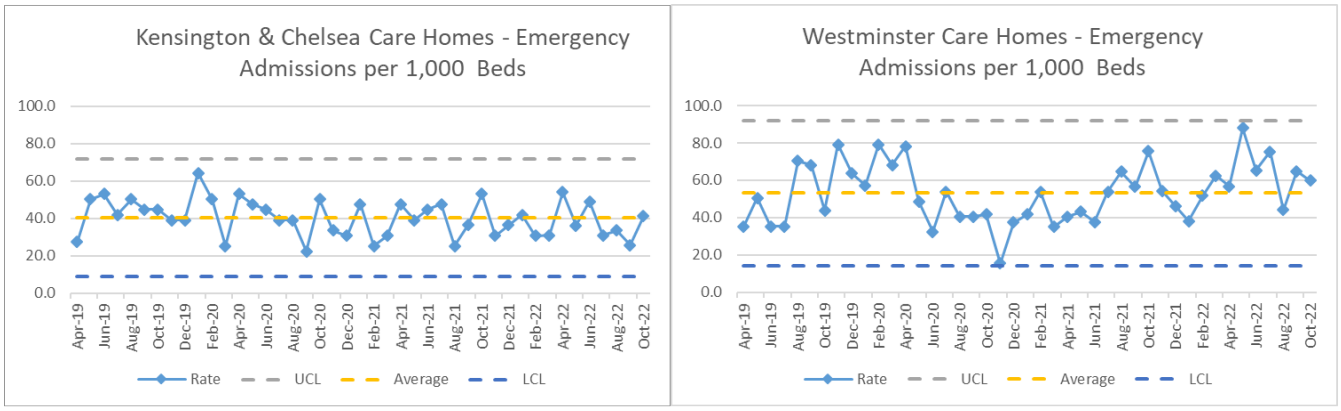
3.5. **Oral healthcare** has been identified as an area of challenge for care homes. To address this, a short-term project has been commissioned from Central London Community Healthcare Trust (CLCH) Specialist Dental Services to improve the oral health of care home residents through training to improve the skills and confidence of staff to supervise, support and assist residents with an effective oral health routine.

3.6. In addition to the healthcare priorities, **social priorities** are equally important for residents in care homes. There is considerable variation in ability of residents to connect with their local communities. To address this point, a user experience research project has been designed to hear from residents about their experiences and preferences.

3.7. A key area of support being led by this workstream is addressing the challenges with consistent staff training, workforce development and high turnover for care home staff. We are delivering a programme to support care home (and home care) providers to attract, train and develop a skilled social care workforce. This includes identifying existing learning and development provision, and challenges around access and uptake to inform a future course design, that will support development of career pathways.

3.7 In terms of performance one key metric tracked is emergency admissions per 1,000 (figure 1). Average performance is in line with plan and there have been no significant changes. Furthermore, ambulance and urgent hospital admissions for Care Home residents has not significantly changed since the outbreak of the Covid.

Figure 1: Emergency Admissions per 1,000



Palliative and End of Life Care.

3.8 This is a relatively new programme that is focused on improving the local delivery of Palliative and End of Life Care services for people who are approaching the end of their life, through improved joint working by all key local health and care partners.

3.9 It is being taken forward through the Bi-Borough Palliative and End of Life Care (PEOLC) forum that has patient and carers representation in addition to key health and care partners. The aim of the programme is to use local knowledge, feedback and joint ownership of our assessment against the national PEOLC Ambitions self-assessment framework.

3.10 This framework sets out recommended standards to evidence the delivery of high quality care against 6 ambitions of:

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is coordinated
- All staff are prepared to care
- Each community is prepared to help

3.11 Some emerging themes to address include:

- Improving public and clinical access to PEOLC information to support care delivery and awareness by residents and carers
- Improving access to and utilisation of the new Universal Care Plan (UCP) to support access to up to date clinical and care information that provides better informed care delivery across the system.

3.12 The PEOLC forum also provides a platform to engage with the NW London ICS Community Based Specialist Palliative Care review programme and development of a new model of care. The new model of care is still in development and we are currently awaiting the proposed next steps to support this work.

3.13 The inpatient unit at Central London Community Healthcare NHS Trust's (CLCH) Pembridge Palliative Care Centre continues to remain suspended

until further notice following its closure due to a lack of specialist palliative care consultant cover and being unable to recruit due to that national shortage of trained personnel. All other services (24/7 advice line including palliative care consultant support, community specialist palliative care nursing service, rehabilitation team support service, social work and bereavement support service, and day hospice services at the Pembridge Palliative Care Centre are unaffected and continue to operate.

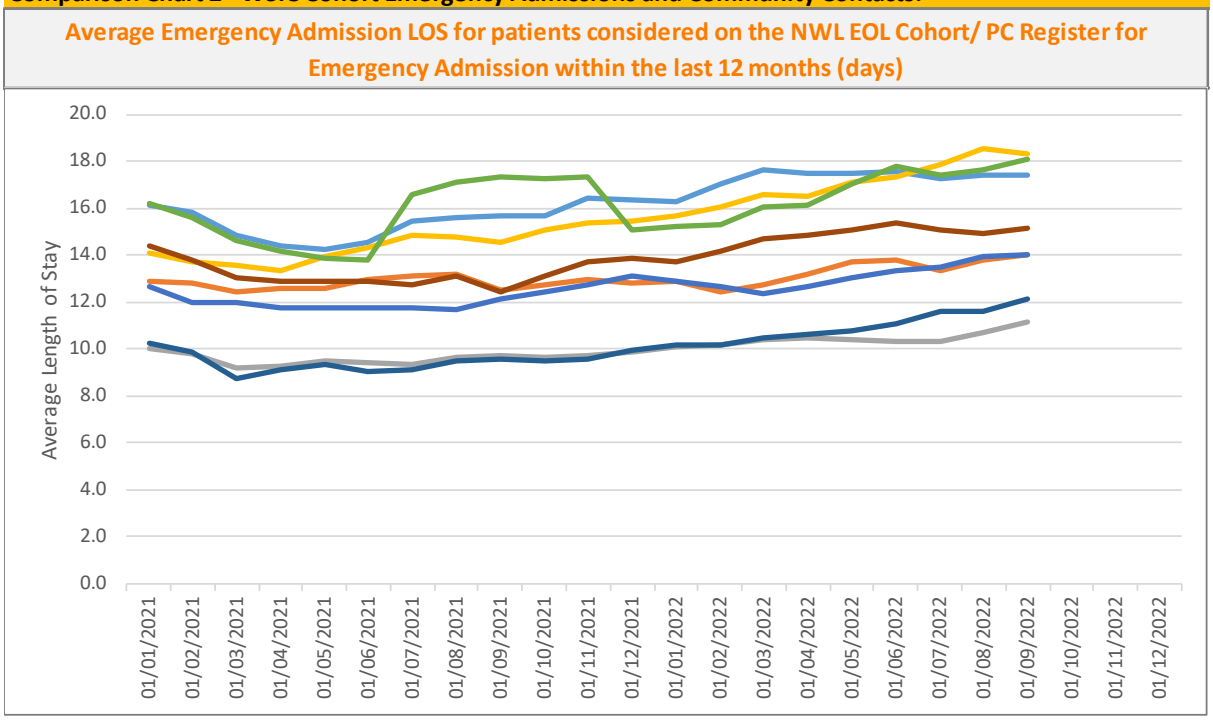
3.14 When Pembridge inpatient unit was suspended in 2019, health committed to completion of the community-based specialist palliative care review prior to any decisions being made on the future of this unit. Whilst acknowledging the local frustrations on the lack of clarity for the future, health remain committed to do a clear process and transparency on next steps and have recently published the engagement outcome report (see www.nwlondonics.nhs.uk/cspc detailing all the feedback received and outlined next steps.

3.15 Health anticipate completing the work to develop a new model of care in the next month. A number of metrics are monitored by NW London to assess the impact of the system in supporting our residents,

- Average LOS for patients on NWL EOL Cohort
- Percentage of deaths that occur in hospital.

Key:			
Brent	Ealing	Harrow	Hounslow
Central London	Hammersmith and Fulham	Hillingdon	West London

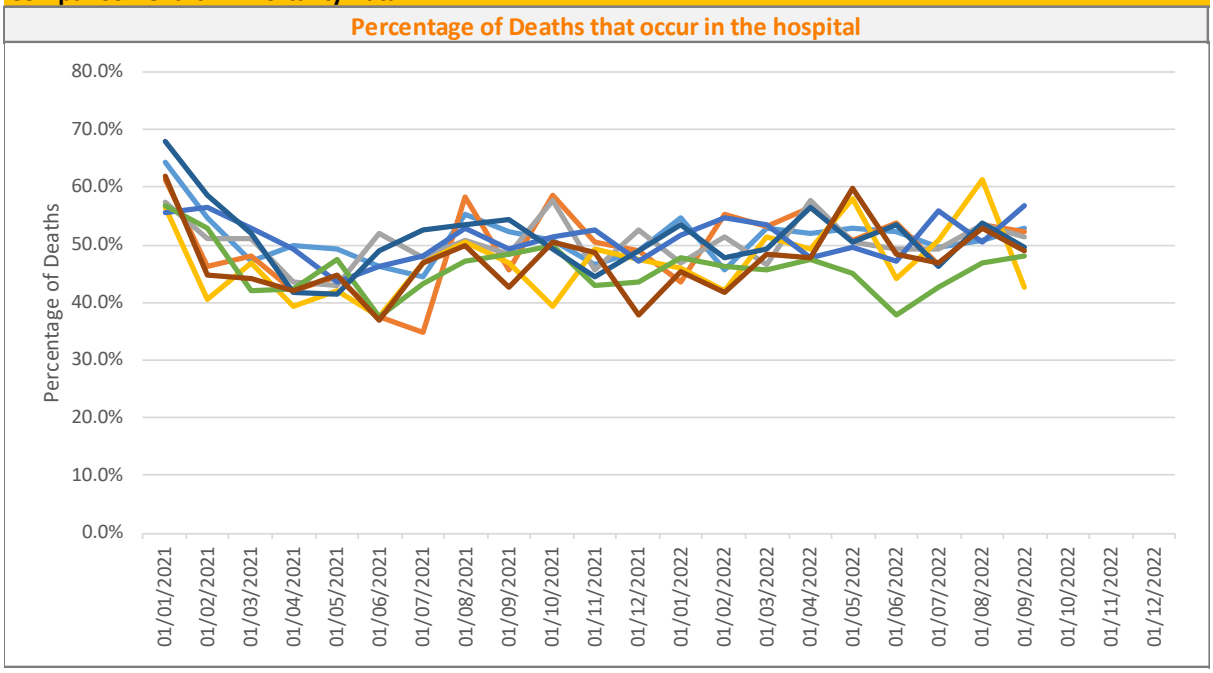
Comparison Chart 2 - WSIC Cohort Emergency Admissions and Community Contacts:



Our Bi-Borough length of stay is in line with the trend seen for other NW London boroughs and continues to be around the mid-range period spent in hospital.

Key:			
Brent	Ealing	Harrow	Hounslow
Central London	Hammersmith and Fulham	Hillingdon	West London

Comparison Chart 4 - Mortality Data:



Our Bi-Borough performance is in line with the trend seen for other NW London boroughs and continues to be lower than at the start of 2021.

Discharge.

3.16 For people being discharged from hospital having the right care, at the right time, and in the right place is critical to improving the outcomes of people. This is important because having people staying in a hospital longer not only reduces the ability of the hospital to treat some else, but it does not help improve the health outcomes of the person with a longer stay. For example, national evidence has shown that 10 days in an acute setting results in in about 10 years of ageing in the muscles of people over 80yrs and a wait of more than two days (in hospital) negates the additional benefit of intermediate care.

3.17 By focusing on reducing discharge delays this will improve outcomes for older people and also reduce the cost of care across the system. However, reducing the number of discharge delays is complex and through this area we are seeking to achieve a sustainable reduction in discharge delays.

3.18 In September 2022 the Bi-Borough changed its approach to discharge to assess and re-enforced social care and multidisciplinary discharge planning with the intention of improving flow in the hospital, reducing oversubscription of care to ensure care capacity is targeted and available where it is needed.

3.19 Over the winter period, often seen as a period of peak demand for admissions and discharges, a number of activities have been undertaken to improve our performance. Appendix A provides a summary of the different work

programmes, whilst appendix B provides a summary of the additional funding and impact received at short notice over winter to support discharge planning.

3.20 The Place Based Partnership have worked together to introduce additional access to local authority reablement care and home care, increased capacity in NHS Home First / Rapid Response services and ringfenced placement capacity in care homes.

3.21 The acute Trusts have reviewed their discharge hubs and recommendations from the review are to be implemented. Specific initiatives such as 'Better Together' at Imperial bring disciplines closer together to plan discharges. Specific events such as Multi Agency Discharge Events (MADE) have brought through themes that require specific action planning, including housing and homeless pathways, mental health discharges, early identification and notification of people with complex discharge care needs and introduction of a new digital monitoring system called Optica.

Same Day Access

3.22 The Fuller Stocktake (see https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/) underpins the NHS ambition to improve the health outcomes of the nation and sets out a number of areas where, by working differently across a range of partners, these can be achieved.

3.23 Same Day Urgent Care is a new area but has a number of underlying principles including:

- People need to be able to access same-day urgent care
- GPs need to be able to provide continuity of care to those patients who need it most

3.24 Over the past 3 months the Bi-Borough Place Based Partnership has been working with a range of partners to look at how these principles can be delivered through integrated neighbourhood teams.

3.25 For urgent care to be effective it is important that people can have access in their community, for example from their home through 111 or going to community pharmacy, prior to needing a GP referral. Having sought this advice people may require an immediate referral into emergency care or go online or talk to somebody before walking into a hospital emergency department.

3.26 However, we know people have different needs and for a number of people having access to an in-person GP appointment is a priority for them. If we can design support services around a GP, then it will be possible to prioritise these people and to provide other support to people that do not require or don't need a face to face.

4.0 Complex Care Workshop

4.1 There are two elements to the wider complex care workshop:

Person with Lived Experiences

4.2 A local resident will be talking about her experiences and insights into living within the borough and how she has interacted with the wider health and care system. This is a powerful opportunity for the HWB membership to hear and listen to individual experiences and to understand how these experiences have been supported or impacted on by our services.

Market Stalls

4.3 The market stalls will cover four areas to highlight the need for multi-disciplinary working across partners to address the wider social determinants of health to support residents. The stalls include:

- **Discharge Planning** - this stall will be led by community health and care providers and will provide opportunities to understand the work that is underway to improve discharge planning, especially for people pathway 1 redesign.
- **Care Homes**
- **Good Health –** Opportunity to present new models of care and how these are support the Same Day Access work programme area of complex care. Violet Melchett and Golborne GP practices will be available to talk about their work and ambitions to improve the health of our communities.
- **Community Safety**– keeping people safe at home has been identified as a key priority for our residents. This will be an opportunity to hear about what support is available and how this contributes to improving the health and wellbeing our residents and communities.

4.4 Following the market stalls key issues will be captured and presented back to the HWB in the March meeting and fed into the HWB strategy.

Recommendations

1. To note the report

APPENDICES

Appendix A – Winter Interventions
Appendix B – Summary of additional winter funding
Appendix C - NWL Discharge Leaflet
Appendix D - British Red Cross Winter Poster