Leicester, Leicestershire and Rutland (LLR) Framework for Integrated Personalised Care

Part A -Management Guidance

1.0 Introduction:

1.1 The Leicester, Leicestershire and Rutland (LLR) Framework for Integrated Personalised Care supersedes the LLR Health and Social Care Protocol (2014) and is underpinned by the LLR Person-Centred Leadership Framework.

1.2 The fundamental principle of this Framework is that care commissioned and delivered to the patients and citizens of LLR is person-centred and tailored to meet their individual needs.

1.3 It's purpose is to support the undertaking of tasks on behalf of a partner agency in a way that is safe, appropriate and equitable. This is a reciprocal arrangement between Health and Social Care meaning that staff from Health may undertake some Social Care tasks and staff from Social Care may undertake some Health tasks. All staff will receive appropriate training and be assessed for competency for any task that they are required to undertake. Proper clinical oversight will be maintained over the person's health needs in relation to any delegated healthcare task. Additionally, any financial cost and recovery associated with a commissioned support package will be appropriately apportioned to the organisation accountable for the delivery or delegation of the said task.

1.4 Therefore, the following sections are designed to facilitate constructive and effective dialogue, supported by national legislation and guidance, between partners across the LLR Integrated Care System to achieve this end.

2.0 Background:

2.1 This framework has been jointly developed by the following partner organisations operating across Leicester, Leicestershire and Rutland:

- East Leicestershire and Rutland Clinical Commissioning Group
- Leicester City Clinical Commissioning Group
- Leicester City Council

- Leicestershire County Council
- Rutland County Council
- West Leicestershire Clinical Commissioning Group
- Leicestershire Partnership Trust
- Midland & Lancashire Commissioning Support Unit
- Primary care

2.3 The development of this framework has emerged from a review of the LLR Health and Social Care Protocol (2014) in a context of growing demand, with increasing complexity of need, and reducing resources across all health and social care partners and against a backdrop of ongoing budgetary pressures and significant challenge in relation to capacity across all parts of the system.

2.4 In addition to this there has been an ongoing drive towards integration across Health and Social Care, including the development of Integrated Neighbourhood teams operating in relation to Primary Care Networks, recognising that local arrangements for this between localities. A variety of solutions, including **Home First** support and the effective utilisation of the voluntary sector and wider community assets, and/or new ways of working are also emerging in different geographies across LLR.

2.5 This Framework builds upon the best practices established by the LLR Health and Social Care Protocol (2014), as outlined in the principles below, but deliberately avoids a defined task approach in favour of a MDT approach to support planning which is both person centred and an effective support of the individual and represents value for money

3.0 Principles:

3.1 **Care and Support is person-centred.** Discussions and decisions around care requirements will involve the person where possible and their families and carers. The principle of supporting people in their home where-ever possible will apply. To achieve this, services will be delivered in an integrated way to meet the person's health and social care needs. This will ensure that care is well co-ordinated and provides a better patient experience. This approach will provide continuity because the person will continue to have the involvement of support they are already familiar with where possible and appropriate, with a view to building system resilience and optimising health, wellbeing and independence. (Home First Principles)

3.2 **Efficient use of resources.** Care will be delivered ensuring the best value for money; this relates particularly to call frequency and workforce skills. We will aim to utilise wider services, including reviewing any health or social care

services the person is already receiving and utilising wider community services and resources, including the use of Assistive Technology.

3.3 **Trusted assessment.** Trust is established through constructive and transparent dialogue between partners. Trusted assessment reduces the need for multiple or duplicate assessments, streamlines the experiences for people and ensures the efficient use of system resources.

3.4 **"If you're there and competent to perform a task, then do it!"** This long-standing LLR principle supports the previous two. This is a reciprocal arrangement between Health and Social Care meaning that staff from Health may undertake some Social Care tasks and staff from Social Care may undertake some Health tasks, following appropriate training and assessment of competency. Where additional ad hoc tasks become regular occurrences, it may be necessary to re-evaluate the effectiveness of a care plan and modify a care package accordingly.

3.5 **Timely, effective reviews of care and care planning.** A person's needs will fluctuate and it is important to ensure that commissioned care is effective, responsive and constitutes value for money.

3.6 **MDT decision making.** For care to be holistic and personalised the perspectives of all relevant professional disciplines should be represented in discussions with service users and families/carers. The MDT is empowered and supported to make decisions.

3.7 **Asset-based approach to care planning**. Commissioned care should promote independence and support people to maintain health and well-being. People should be supported to self-care wherever possible.

3.8 **Make Every Contact Count.** All conversations present opportunities for care-givers to assess the health and wellbeing of patients, citizens and their

carers; signposting and referring to appropriate services or support groups as appropriate.

3.9 **Effective clinical governance.** There will be appropriate clinical oversight of care from the most appropriate clinical service, including specific clinical governance for the actual activity or task being delegated; either primary care or community nursing for patients in receipt of these services.

4.0 Statutory Duties and National Guidance:

4.1 A range of Statutory Frameworks and Guidance documents underpin and inform decision making around the delegation of support tasks between Health and Social Care. This section provides a brief overview of some key definitions and their sources for reference.

4.2 The National Framework for Continuing Healthcare and Funded Nursing Care (2018) provides helpful guidance around determining health and social care needs

(Paragraph 50)

4.3 **What is a health need?**

Whilst there is not a legal definition of a health need (in the context of NHS Continuing Healthcare), in general terms it can be said that such a need is one related to the treatment, control, management or prevention of a disease, illness, injury or disability, and the care or aftercare of a person with these needs (whether or not the tasks involved have to be carried out by a health professional).

(Paragraph 51)

4.4 **What is a social care need?**

An individual has eligible needs under the Care Act 2014 where these needs arise from (or relate to) a physical or mental impairment or illness which results in them being unable to achieve two or more of the ***following*** *outcomes which is, or is likely to have, a significant impact on their wellbeing:*

• *managing and maintaining nutrition;*

- *maintaining personal hygiene;*
- *managing toilet needs;*
- *being appropriately clothed;*
- *being able to make use of the home safely;*
- *maintaining a habitable home environment;*
- *developing and maintaining family or other personal relationships;*
- *accessing and engaging in work, training, education or volunteering;*
- *making use of necessary facilities or services in the local community, including public transport and recreational facilities or services; and*
- *carrying out any caring responsibilities the adult has for a child.*

4.5 **In addition**,

(Paragraph 43)

Section 22 of the Care Act 2014 places a limit on the care and support that can lawfully be provided to individuals by local authorities. That limit is set out in section 22(1) and is as follows:

A local authority may not meet needs under sections 18 to 20 by providing or arranging for the provision of a service or facility that is required to be provided under the National Health Service Act 2006 unless-

(a) doing so would be merely incidental or ancillary to doing something else to meet needs under those sections, and

(b) the service or facility in question would be of a nature that the local authority could be expected to provide'.

Joint Packages

4.6 If a person is not eligible for NHS Continuing Healthcare, they may potentially receive a joint package of health and social care. This is where an individual's care or support package is funded by both the NHS and the local authority. This may apply where specific needs have been identified through the Decision Support Tools that are beyond the powers of the local authority to meet on its own and are not provided by NHS core services. This could be because the specific needs are not of a nature that a local authority could be expected to meet, or because they are not incidental or ancillary to something

which the Local Authority would be doing to meet needs under sections 18-20 of the Care Act 2014. It should be noted that joint packages can be provided in any setting.

4.7 In all circumstances, delegation does not cancel the duty of care of the NHS for delivery of health care tasks whether fully funded by the NHS or jointly or to ensure safe delivery of the care package

4.8 Similarly any MDT decision in relation to the delegation of an activity from Health to Social Care will have regard to legal limits on what a local authority responsible for provision of social care services is lawfully permitted to do.

5.0 Governance:

5.1 The Leicester, Leicestershire and Rutland (LLR) Framework for Integrated Personalised Care has been jointly developed by the partner organisations detailed above. Governance arrangements are through the Integrated Personalised Care Board (IPCB), which is a Sub-group of the Primary Community and Systems Design Group. The Integrated Personalised Care Board will:

i) Receive reported issues from staff having practical problems with the use of the Framework

ii) Discuss and agree on how reported issues should be dealt with

iii) Oversee dissemination, promotion of rulings made and issue of new guidance

iv) Oversee updates to the Framework and; issue and promote new versions of the Framework

v) Monitor use of the Framework, with particular regard to its impact on the nine equality strands. The protected characteristics covered by the Equality Act (2010) are:

• age

• disability

• gender reassignment

• marriage and civil partnership (but only in respect of eliminating unlawful discrimination)

• pregnancy and maternity

• race – this includes ethnic or national origins, colour or nationality

• religion or belief – this includes lack of belief

• gender

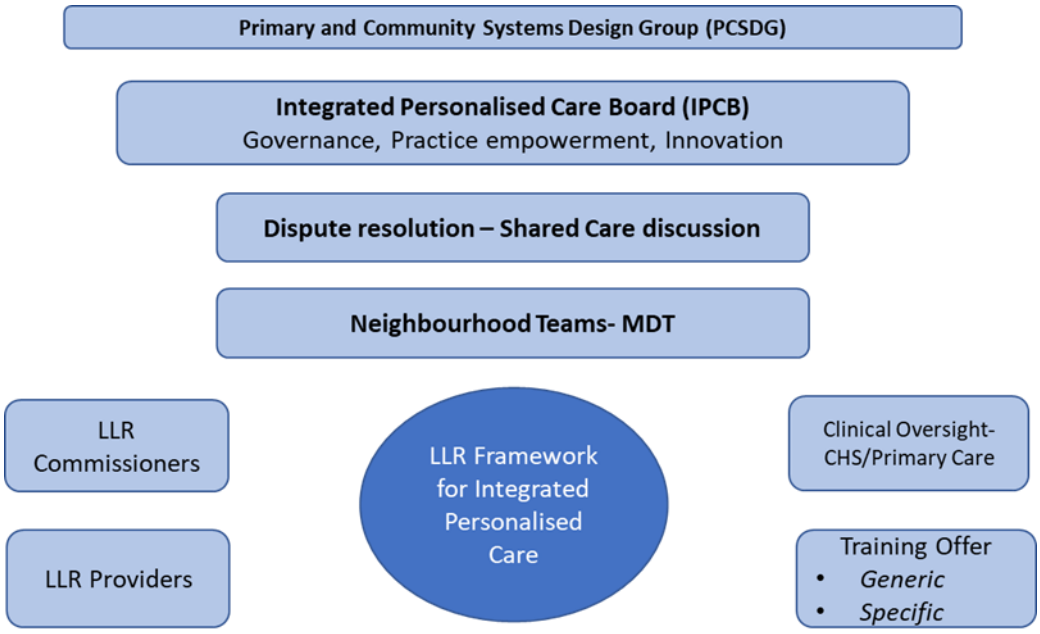
• sexual orientation

vi) Oversee training and delegation/competence sign off processes and programmes

vii) Identify new areas for joint and delegated working

viii) Receive themes from shared care panel for shared learning

The Integrated Personalised Care Board will include one member from each of the partner organisations listed in the introduction.



Escalation:

5.2 Where consensus around assessment or care planning has not been achieved through a meeting of the MDT (i.e. Integrated Neighbourhood Team), a Shared Care discussion will be convened for resolution. Decisions from the Shared care discussion will be documented and shared with the Integrated Personalised Care Board, which provides overall governance responsibility for this Framework. Documented decisions will form the basis of

'best practice' to support and inform future Integrated Neighbourhood team decision making in similar circumstances.

5.3 Where cases are joint funded, disputes will be taken via Midland & Lancashire Commissioning Support Unit using the existing LLR inter-agency resolution policy.

5.4 Where a Healthcare task has been identified, care must not be disrupted and, where there is an identified gap in services, additional care will be commissioned and delivered by Health services without prejudice until a funding decision is made.

Delegation and Funding:

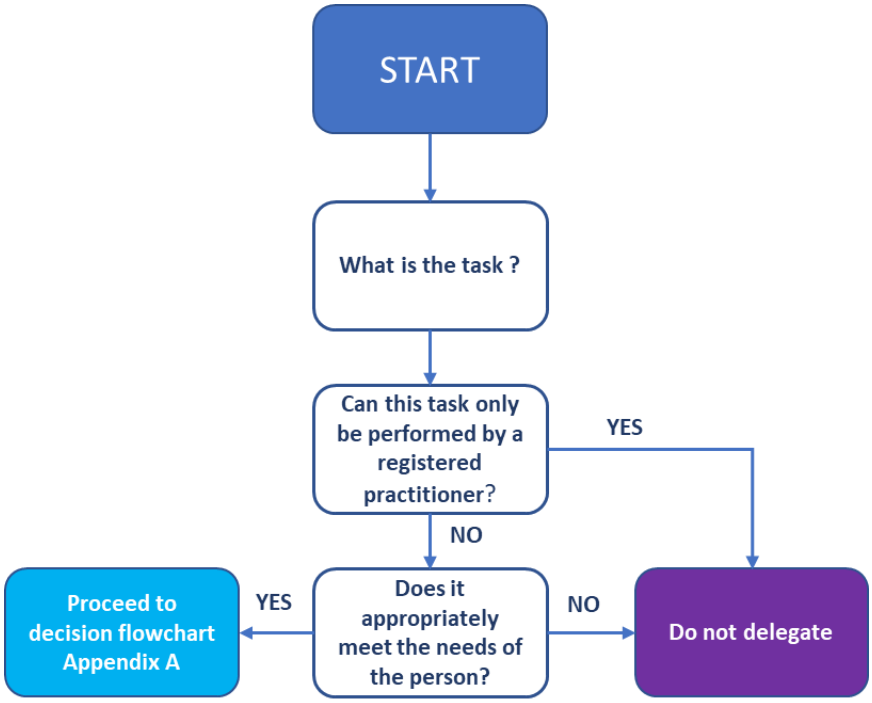
5.5 It is important that CCGs, as the responsible bodies for planning and commissioning healthcare services in their local area, put in place a clinical governance framework for delegation of health tasks to an appropriate partner organisation. This means that there should be a clearly identified local process for making decisions about what can and cannot be delegated. The process should include how training and assessment of competence will be provided, how any ongoing support and review of competence will be provided, and how ongoing clinical review of the person's needs is maintained and by whom.

5.6 The healthcare tasks that are delegated to adult social care may be delegated to social care workers providing services to all people in all settings (i.e. people's own homes, day care centres, registered care homes, supported living units)

5.7 Whilst many care providers will be contracted to undertake delegated tasks in line with this Framework, that task must be formally identified and accepted by the provider. Additionally, competency to carry out the task safely and appropriately must be established, and consent must always be obtained from the person in receipt of support.

5.8 This Framework draws upon best practice from the NHS England guidance document- **Delegation of healthcare tasks to personal assistants within personal health budgets and Integrated Personal Commissioning (2017).**

5.9 The following flowchart illustrates the decision-making process for delegation of healthcare tasks to Care Workers:



5.8 Delegated tasks will be identified and agreed through the locality MDT (usually the Integrated Neighbourhood Team)-It is anticipated that the majority of these will be straightforward and appropriate, with the relevant training and assessed competency, and will be incorporated into the support plan without alteration.

5.9 Where a task is assessed as being straightforward and appropriate, with the relevant training and assessed competency, but cannot be incorporated into the support plan without alteration, the MDT will agree a new support plan, apportioning the cost of any additional commissioned time. See **Appendix A**: flow diagram for delegating and agreeing funding.

5.10 In each case, it is an important principle that support planning uses a partnership approach between the Health and Social care practitioners and the person, along with their family and carers as appropriate. Consent must be given and recorded on the support plan for any task to be delegated.

5.11 In some instances, the MDT may determine that a task is not appropriate for delegation, either for a specific patient or on a broader basis. Some tasks must be done by a registered nurse and cannot be delegated. Typically, these tasks might include:

- Administration of intravenous (IV) drugs
- Some complex dressings for wounds
- Insertion or removal of a urinary catheter

- Syringe drivers

This is not an exhaustive list and there will be a corresponding range of tasks that are the exclusive remit and domain of Adult Social Care. Additional detail will be outlined in the associated Practice Guidance (Part B). The Integrated Personalised Care Board will provide governance and oversight for MDT decision making, building a repository of case examples that will inform development of Practice Guidance and future decision making.

Clinical oversight:

5.12 Clinical governance needs to include arrangements for ongoing oversight and contact arrangements for advice and reassessment. This is particularly important where a patient's needs are known to be changing or fluctuating, but it must be in place in all circumstances.

5.13 MDT decisions to delegate tasks to social care must take account of clinical risk and the clinical record reflect the outcome decision in respect of managing the complexity of that risk-

Primary Care – for patients not in receipt of community nursing or therapy service. For tasks that do not require specific training, such as medication prompts or eyedrops, the Primary Care practice associated with the Integrated Neighbourhood Team that oversees the individuals assessment/support plan will retain clinical governance and ongoing oversight, as appropriate, for the delegated task.

Community Health Services: For patients who are open to this service, Community Health Services will retain clinical oversight as appropriate, for the delegated task. In such circumstances where the activity is an ongoing support need, but the patient is no longer open to CHS, arrangements will be made to transfer this responsibility to the patients Primary Care practice.

Review:

5.14 Formal MDT reviews of care packages and delegated tasks must take place three months after initiation and at 12-month intervals thereafter as a minimum; and whenever a change in need has been identified.

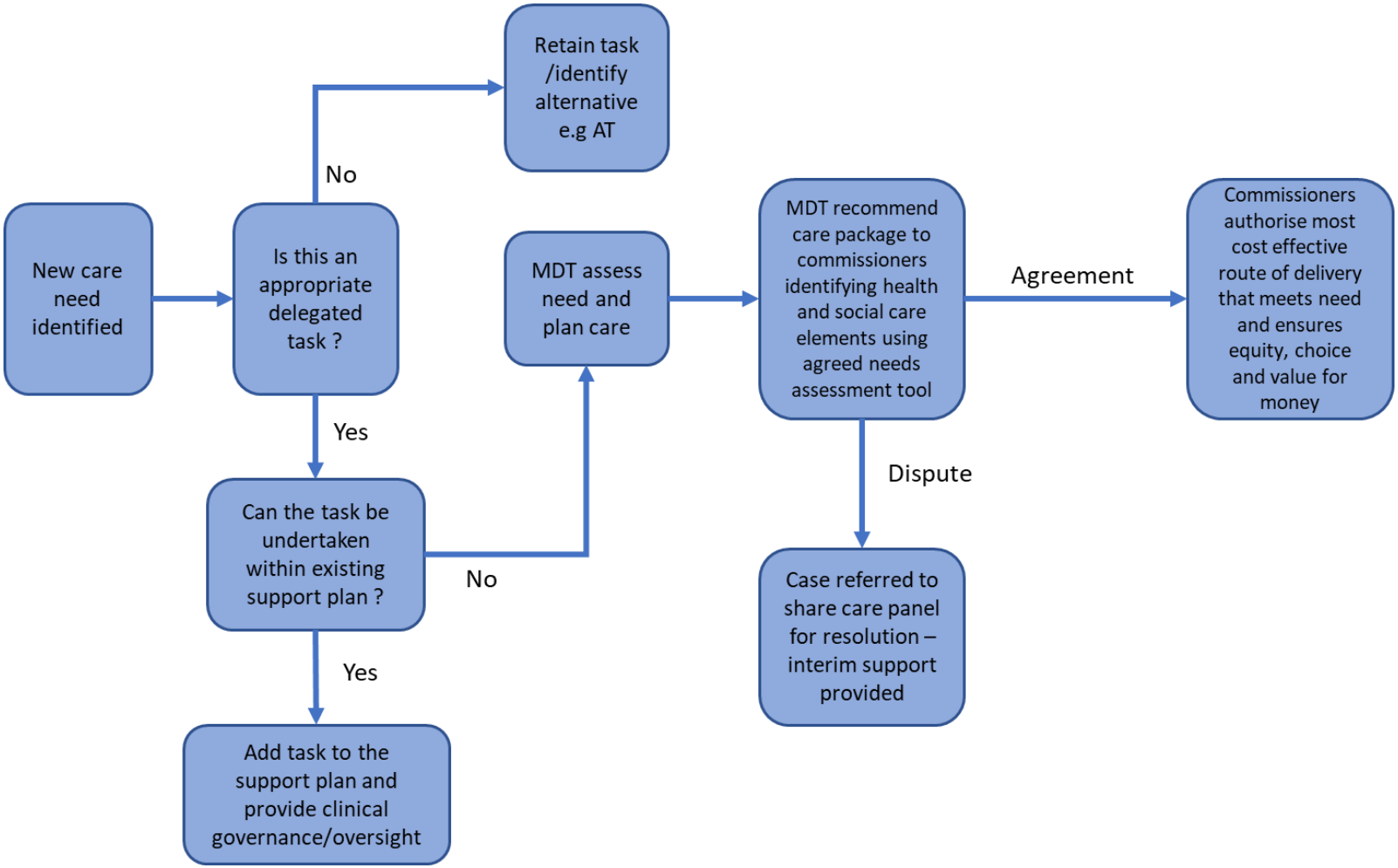
Where there has been a significant change in need, a MDT meeting should be convened to reassess and plan care.

6.0 Training:

6.1 For tasks that can be delegated, the support plan needs to identify how the associated training will be provided and who will be responsible for assessment of competence, ongoing support to the Care worker, and clinical review of the person's needs. The approach to provision of appropriate training and assessment of competence of Care workers in healthcare tasks is likely to vary from one locality to another and will need to be proportionate to the specific task. The following are the key components to be considered in order to establish an appropriate local system for training and assessment of competence:

- Identification of the healthcare task/s most likely to be delegated.
- Identifying and agreeing the knowledge and skills required to achieve competence in each task.
- Development of training materials for each task.
- Identification of how and by whom the knowledge training will be delivered and assessed and the standard it will be assessed against.
- Identifying how and by whom the skills training will be delivered, competence assessed and the standard it will be assessed against.
- Identifying how achievement of competence will be recorded.
    - Identifying how and when any refresher training and reassessment of competence will be provided.
- Identifying ongoing support requirements.
- Identifying a process to follow when a Care Worker does not achieve the required competence.
- Establishing how the Care Worker will be able to be released for training and any backfill costs met.
    - Identifying any associated risks related to delivery of the task and providing relevant training for the Care Worker to know how to deliver the task safely, avoiding injury to the person and to themselves.

Appendix A


New care need identified
Is this an appropriate delegated task ?
No
Retain task /identify alternative e.g AT
Yes
Can the task be undertaken within existing support plan ?
No
Yes
Add task to the support plan and provide clinical governance/oversight
MDT assess need and plan care
MDT recommend care package to commissioners identifying health and social care elements using agreed needs assessment tool
Agreement
Commissioners authorise most cost effective route of delivery that meets need and ensures equity, choice and value for money
Dispute
Case referred to share care panel for resolution – interim support provided