SPOTLIGHT ON HEALTH AND SOCIAL CARE

Visioning the future of health and community well-being in a post COVID world

COMMUNITY BUSINESS MUTUAL AID: SESSION SUMMARY DOCUMENT - Tuesday 30th June

This is a summary document of the discussions that were had in each of the sessions run on the CB Mutual Aid, Spotlight on Health and Social Care call, hosted by the Power to Change, Health and Social Care Community of Practice.

CONTENTS

VISUALISING THE FUTURE FOR HEALTH AND SOCIAL/COMMUNITY CARE

RESPONSE TO COVID

MENTAL WELLBEING AND PHYSICAL HEALTH

Most of the mental wellbeing and physical health services are now provided through digital platforms – zoom, skype, telephone and websites.

CHALLENGES

- Not everyone has access to the internet or IT equipment
- Language barriers
- Privacy issues
- People feeling uncomfortable sharing their challenges while other family members are around
- Lack of IT skills
- People with mental wellbeing issues mention that there is a lack of visual clues/ body language and therapists sounding different
- More formal setting
- People having to take responsibility to convey information to health staff e.g. measuring weight accurately, oral hygiene, blood pressure etc.
- Costs associated with staff working from home and IT costs.

DOMICILIARY CARE

The service continues to provide care in peoples home – personal care and social inclusion.

CHALLENGES

- Availability of PPE equipment
- Protecting staff and service users – hygiene
- Extra staff availability to cover for people on sick, self-isolation and in some cases where they don't want to work, to reduce risk to themselves and family
- Recruitment and retention of care staff

THE FUTURE FOR HEALTH CARE

CONSIDERATIONS

- A single, digital-first “front door” for health services is being established. The patient journey starts with an app or online and is then redirected to the optimal care setting regardless of physical or virtual modality. Multiple providers of digital solutions have been working with the National Health Service (NHS), for example.
- Massive expansion of home-based care likely will be supplemented with artificial intelligence (AI). Virtual care via AI, phone-based diagnostics, and other virtual patient engagement platforms are expected to be part of this expansion.
- Emergency room (ER) visits may decline or shift to online platforms given concerns about community transmission of the virus. Short- to medium-term declines in admissions for elective care/procedures are likely, which will require providers to manage operations more efficiently
- Integrated care systems (ICSs) are a key part of the NHS long-term plan, and are intended to bring about major changes in how health and care services are planned, paid for and delivered. ICSs are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners, to collectively plan and integrate care to meet the needs of their population.
- The development of Primary Care Networks, coalitions of surgeries covering populations of approx 50,000 to design services that serve their communities and to become local commissioners, offers the opportunity for 3rd sector organisations to develop relationships and to deliver services that join up their knowledge and reach into communities with clinical services: to form population health based responses.
- The need to work with a wide range of partners was noted - including academic partners, innovation centres, Social Care Institute for Excellence etc.
- Digital or non-digital - very conscious of access issues and the need to tackle digital exclusion. However there had been some "wins"" with the Network of Wellbeing noting that they had massively increased their network and reach.

CHALLENGES

- In 2017 NHS England stated, “ our aim is to use the next several years to make the biggest national move to integrated care of any major western country” - Integration of health and social care has been at the top of the agenda for nearly ten years – it is still a long way off as can be seen in the experience of the care sector compared to the NHS acute services over the Covid emergency. However, system change does offer opportunities, so it is useful to have a look at it.
- At a local level there was concern that the strong working relationship that has been made during the Covid period is not allowed to fall back: "the Local Authority trusted us before - don't revert to type". Felt there had been huge positives for reputation build up through the Covid response from community anchor organisations.

OPPORTUNITIES

Providers may look to new opportunities such as telehealth consultations, home healthcare services, non-ER-based primary community care, and more proactive regular health screening. Providers may be faced with several strategic choices:

- Licensing third-party telehealth services/solutions versus building their own offerings
- Expanding into community-provided primary care services focused on selected clinical disciplines (for example, paediatrics, obstetrics, gynaecology)
- Expanding into the provision of remote behavioural health services and screenings, with the assumption that payers will be willing to reimburse for these services

Governments are already exploring innovative partnerships with the private sector to manage the crisis. These partnerships may continue in the future and could take many forms, including funded mandates for capacity e.g. The NHS has secured short-term capacity (beds and critical care personnel in the private sector effectively underwriting short-term sustainability).

- Technological advancements, which would include AI-based diagnostics, cloud-based storage of medical records, and integration of information across the care continuum in and outside the hospitals. Digital tools to facilitate remote communication between providers and patients will continue to be developed and improved, in conjunction with point-of-care devices and home-based monitoring devices. Additionally, real-time data can create effective use of supplies and allow staff to work efficiently.
- Greater flexibility in reimbursement models from payers, and, in particular, for telehealth and home healthcare services. This model may require payers to have evidence that telehealth is providing similar/better outcomes (for example, data indicating that more convenient refills enable better compliance among patients with chronic diseases).
- Consumer adoption, which will be driven by more informed consumers demanding a seamless technology experience irrespective of the care setting. Consumers may want the ability to have end-to-end delivery of care, including home/office delivery of medications. The ability to build trust in the new care setting is also critical to sustain the continued use of online/home-based services. New incentives and capability building to sustain the new operating model will also be needed.
- It is often stated that the care system is broken and there is a real determination to move away from “time and task” to a more holistic service. This again may lead to opportunities for brokerage services and micro-enterprises serving local needs to develop. There is also the need to change the perception of the value of care work and models of self-managed teams emerging that offer skill development and greater autonomy in determining holistic care.

- The role of physical activities in the health preventative agenda was mentioned and Sport England as a potential funder for those furthest from physical activity due to health issues was shared.
- There was interest in different organisations structures which could result in care being done differently and being paid better with more career/skill development options. One attendee involved in developing a care co-op in Kirklees.

EXAMPLES

- In my locality (13 surgeries and 130,000 residents) we have become a member of the Locality Partnership Boards, chaired by Clinical Commissioning Group, and have been commissioned to deliver the social prescribing service in that locality. We are co-designing pathways such as frailty and mental health services, bringing in the specialist knowledge of other 3rd sector partners.
- In Bristol a number of us are involved in a Keep it Local project supported by Locality and Power to Change to work with the City Council to co-produce community asset based models of care, specifically looking at those in receipt of Direct Payments and looking at opportunities to move towards Independent Service Funds which offer more personalised arrangement where the service provider works with the person to provide flexible support.

HOW TO BE MORE HUMAN WITH STAFF AND TEAMS WHILE SUPPORTING RESILIENCE AND LEARNING IN OUR COMMUNITIES

THEMES

- Opportunity for taking on new roles in this situation (e.g. with furloughed staff), redeployment of staff
- Need for more local collaboration to ease pressure
- Situation highlighting where participation can be increased with people. These decisions must go out to the community all the time.
- Staff wellbeing in isolation and their anxieties (especially in challenging lines of work), more human touch with colleagues, checking in personally, honesty and transparency, framing expectations
- Being real: we did have to think about survival.
- Silver linings: where the situation has facilitated new ways of working and collaborations. What can we keep going after this? Personal touch staff meetings, radio show, online offers

CONSIDERATIONS

- Combatting staff heightened anxiety with transparency - non-patronising sharing of info.
- Situation has highlighted how we can increase participation so people feel ownership of what we're doing. That's our key through this.

CHALLENGES

- Necessary to be very human in our work but a massive barrier right now
- Maintaining connection with community challenge: how is the wider community feeling/coping?
- As a small org anyway, one staff member furloughed, taking on every role (keeping touch with people, finding funding).
- Finding new collaborations to take the pressure off: e.g. partnering with local college for patchwork projects
- Some staff do feel isolated - and it's important they feel well mentally in this line of work - encouraging honesty about their experience working from home, checking in more

OPPORTUNITIES

- It's the time to facilitate people to do things themselves from their homes or where they are
- A more human touch with staff
- Framing expectations with staff
- Taking that transparency with staff wider to the community?
- Being intentional about checking in with staff personally - how they are. Not just professional.

EXAMPLES

- Working remotely has given leadership quality time to work together as a team
- Made a framework for decision making at start of crisis and being open with staff team: hope and positive, doing everything possible to keep jobs, commitment to adaptability as staff.
- Staying in touch with people by phone, door knocking, surveys, listening to how people are doing (appreciative enquiry approach), leaflets and linking people to volunteers
- Maintaining connection with people through activities created online e.g. online choir
- New newsletter - place for members and volunteers to express themselves, share their stories

- Different community hubs engaging with each other now, wasn't possible before geographically
- Radio show established - interviews, sharing stories, speakers

HOW DO WE MAINTAIN AND CONTINUE TO BUILD PARTNERSHIPS?

CONTEXT

- Explosion of volunteers through the Mutual Aid Groups (MAGs), the councils' own CAN and also volunteers coming forward to support different local charities
    - Organised by wards with central admin team - c. 1,000 MAG volunteers on main groups plus host of street based groups
    - Efficient process for understanding who volunteers are, and for cascading requests for support to them
- Would have been really easy for council to ignore or marginalise the MAGs but instead they have sought to support us - weekly phone calls initially and agreement to pass on requests for support to MAGs where it makes most sense to be done by local volunteer
- Council has actively involved the MAGs in wider partnership discussions with other 3rd sector organisations - again created opportunities for those groups to see the value of tapping into local people - e.g. Food Bank and Link Workers and others
- Local Pharmacies - good example of where job should be done by a local volunteer rather than a "service" or NHS responder App - not always easy to get agreement from pharmacies

WHAT HAS WORKED WELL?

- Close cooperation between council and local resident groups, e.g. MAGs. Council not trying to command and control the whole response.
- Spirit of collaboration over competition which was often common between third sector groups prior to crisis

WHAT HAS WORKED NOT SO WELL?

- Tension between council, and big VCS orgs who both might see threat from local resident groups, e.g. mutual aid
- Also council & large VCS very risk-wary, safeguarding-focused, which whilst important often gets in the way of giving support quickly and effectively
- Most volunteers coming forward during crisis have been (white), middle class - obviously deep structural issues here (+ more likely to have free-time during this period etc). But

important to think about how we try to shift that, reach hard-to-reach groups that may be able to be involved in helping, and be more inclusive

CONSIDERATIONS

- Need to work together to generate a shift in the way that statutory and commissioned services consider support requests they get - they need to ask "wouldn't this be better done by a friendly neighbour?" and they need a way to access those friendly neighbours.
- Need to find a way to support the administration of the MAGs as this crisis abates.
    - lots of people will no longer have the ability or inclination to support or manage but many will want to sustain and develop the connections they have made locally
    - how do we make this happen? The administration of the MAGs needs resource
    - do we create a new organisation or could this be done by an existing local organisation - must be kept local!

CHALLENGES

- Hard for some organisations / people to not fixate on risk - are these people DBS checked, who are they? Is it safe etc
- A lot of what MAG volunteers can do are things that others are funded to do e.g. "Befriending", so local MAG volunteers can be seen as threatening - if a local neighbour can do this my service may no longer be required?
- Too many volunteers - hard to find things for people to do

Challenge is that lots of people are thinking about this and risk is that the local magic of what has happened during COVID 19 gets diluted. For example we know that lots of people are wrestling with the question - how do we support the explosion of volunteering that has emerged during this crisis?

- We are thinking about it locally
- The council is thinking about it
- The NW London STP is thinking about it
- National Government has appointed people to look at as well - Danny Kruger etc

OPPORTUNITIES

- Investment needed into community infrastructure, especially at a hyper-local level.
- Need for formalisation to make this sustainable
- Look at successful rural community business models

HOW DO WE MAINTAIN AND BUILD THE INCREASED LEVELS OF COMMUNITY ACTION FOR WELLBEING?

CONTEXT

Barriers that have been broken down since crisis began:

- Rigidity in ways of working within and between organisations
- Lack of access to decision-makers
- The ways statutory services were tendered (consult and then compete)
- Organisations with similar missions not partnering as they can be competitors

CONSIDERATIONS

Enablers/principles:

- Humanising the work and partnerships
- Power of relationship
- Building them through getting to know each other as individuals (zoom has enabled)
- This helps us reframe our expectations of others (e.g. competitors, or the 'enemy')
- These relationships allowing new innovations and projects
- New tendering process where ex-competitors coming together and co-creating solutions based on need, and statutory partners funding

CHALLENGES

- Managing risk and e.g. safeguarding
- Certain bodies can still be quite rigid

OPPORTUNITIES

- New approach - old competitors working together to design service based on need, and LA paying
- It's been much easier to have sustained conversations with decision-makers
- The flexibility of community organisations (whereas were previously rigid)
- Old barrier - the way services were tendered (consult followed by compete)
- The importance of trust
- Certain partners still too rigid to partner effectively (e.g. GP practices)
- Key principle - willingness to be flexible in approach, and to learn ongoing
- Key principle - importance of relationship (helps reframe expectations)
- Safeguarding & risk assessment can get in the way if they rigidify things

- Using new community channels to gain new access (e.g. SLACK, WhatsApp, Twilio)
- Bringing people together based on similar interest
- Opportunity to move activities online to face to face as crisis ebbs
- Importance of collecting evidence of impact/value to help sustain
- Key principle - relating to partners as individuals (e.g. helped by working at home with cats!)
- How relationships naturally form partnerships

EXAMPLES

- Helping local SOS groups through fundraising. Want to see if this can be sustained.
- Opened up Wi-Fi
- Recycling of devices
- Care network to ensure no one falls through gaps
- Local traders self-organising to get support
- Local people making face masks for others
- Network on local change-makers, accessing funding
- Addressing the gap between local aid groups and those who can't access social media - via phoneline
- Community response unit in local hall
- Connecting mosques with local food banks, and halal providers
- Helping local people connect with local groups
- Local art classes for social engagement
- Food parcels being delivered. Help with accessing medicines

WHAT IS THE ROLE OF PHYSICAL ASSETS IN DELIVERING HEALTH AND SOCIAL CARE?

CONTEXT

How can the money from the public sector, in this case mainly health, flow through to community settings to acknowledge and invest in activities that have clear Health and Social Care (H&SC) outcomes? This appears as frustrating for many of the commissioners as community providers and the picture is pretty much the same all over the country, with a few notable exceptions.

CONSIDERATIONS

- Primary Care Networks (PCN's) have the bulk of funds flowing through them now for community based interventions and CB's should seek them out to discuss what they do and the benefit they can add. However, some in the group have direct experience of this new

arrangement and have tried in vain to get connected and found that beyond the funding of new Social Prescriber posts, there seems to be little appetite for funding activities delivered at community settings.

- Nervousness on the part of some non-traditional H&SC settings to put themselves under the spotlight on having to deliver tangible health outcomes at speed, particularly where their key role is connectivity and offering activities and opportunities to tackle isolation, loneliness and its impact on mental health.
- We need to re-assess the reliance on bricks and mortar, especially where a building is completely reliant on community hire. What used to be the holy grail of acquiring assets has been turned on its head right now, as these could quickly become liabilities without innovation.

CHALLENGES

Will vulnerable people want to come back to your buildings? What impact might this have on the viability of physical assets? And how might your offer need to change to continue or indeed grow health and social care services?

There is genuine concern that many of the most vulnerable customers/service users, will have now formed new habits whilst being isolated at home and are likely to feel very nervous about coming back to groups and building based services. Many have gotten used to having telephone calls/welfare calls and doorstep deliveries of essentials, which has been made possible with emergency based changes to services that CB's and VCSE have made happen and through the army of volunteers. However, most of us do not feel these services are sustainable longer term, whilst we have buildings to run and make viable through group activities and service delivery on site. In addition, it is feared that some of the most vulnerable that are at home, would ironically be those that would actually benefit the most from getting out and connecting in the community again

OPPORTUNITIES

- Suggestion that there needs to be a lot of scoping of the CB's that have assets and especially those with social investment/debt finance and how diversification of building use could make assets more viable. An example given of a Village Hall in Dorset, where they have invested in a small housing scheme at the side, which makes the Village Hall more viable. It would be good to get a toolkit from examples like this.

EXAMPLES

- Bradford CCG are piloting a new way of working in districts that starts with developing a local forum with GP's, CCG rep and a local VCS Anchor Org. The Forum collates info on demographics and needs and agrees to split funds on this basis for community based

providers. Unfortunately the first pilot only had 3 months delivery before COVID-19, so has not had a chance to be evaluated but there seems to be a commitment to it.

- The Bevy, community pub, is a great example of where they take an order of a pint around to someone's house locally and sit in the garden (at a safe 3 meters distance) to enjoy a pint and a chat.
- An innovative and radical approach was suggested based on an approach being tried in Scotland (see https://bellacaledonia.org.uk/2020/01/18/the-community-is-the-currency/) based on a 1000 year old concept, called "Land use credits". A radical but simple approach using a shared agreement between Landlords, Land owners, land users/tenants based around use for community good.

HOW SMALL COMMUNITY-LED ORGANISATIONS CAN ENGAGE WITH PUBLIC SECTOR MARKETS

THEMES

- The importance and value of partnership working
- Plenty of opportunities
- Open door and mind policy
- Information - Interested in changes in procurement practice
- Sharing
- Learning and enjoying
- Connections

CONSIDERATIONS

Ten Tops Tips for Organisations keen to engage with the Post-Covid Social Care and Health Market (Community Catalysts)

1. Understand how your local market place has changed – some certainties will have crumbled (building based day services for large numbers of people; traditional home care provision; residential care; services that can only be delivered by health professionals)
2. Talk – to people involved in social prescribing, health and social care commissioners, carers groups, people-led organisations – about where the gaps are and what people want
3. Understand money flow and its restrictions – personal health budgets, money linked to social prescribing, personal budgets and direct payments, ISFs, spot-contracts, grants (coming back in), small block contracts, self-funders
4. 4Understand the rules and regulations – CQC, HMRC, food standards agency, local authority or health procurement – that affect the service you want to deliver. Keep your ear to the ground as rules may change rapidly.

5. Design and deliver your service to meet identified gaps and earn you whatever you need to earn – and talk again to possible customers (is it what they actually want and can they pay for it?)
6. Understand other organisations interested in the same market – new and established diversifying to deliver new services (competitor analysis). Are there too many of you going for the same market? What are they charging? What is your USP that might give you a competitive edge or should you look for a different market?
7. Research the best ways to get information out to your customers. Websites (council and otherwise); Facebook groups and other social media; council networks.
8. Develop strong relationships with your main customers so that you hear quickly about changes in council or health strategies, new gaps in the market etc . The post-Covid era is likely to be very fluid with sudden changes in direction from commissioners and customers.
9. Join provider and other groups so that you are part of and can influence formal conversations about policy changes
10. Use social and other media to talk about what you are doing and get the people you support to tell their story

Patricia Reilly's, Top Tips

1. Look at the service you can provide and develop a menu of services
2. Calculate unit cost for each service, one that provides you with full cost recovery - NCVO
3. Set up an invoicing service if you do not have one now. A lot of Local Authorities (LAs) do not allow withdrawing cash so people need an invoice to pay. Make payment as simple and as accessible as possible. Increasingly pre-payment cards are being encouraged by some LAs so set up a card payment system if you don't have one. There are lots of low-cost options out there. Make sure you include this cost in your full cost recovery calculation above
4. Establish links with Local Authority/CCG, cultivate and maintain relationships
5. Connect with the Direct Payments/Self Directed Support Service, cultivate and maintain relationships
6. Connect with your local User LED Organisation (who may or may not be the same as the support service) cultivate and maintain relationships
7. Know what checks and balances LA and Clinical Commissioning Group (CCG) expect of Voluntary and Community Sector (VCS) organisations
8. Join local VCS groups normally run via local Council for Voluntary Services (CVS) to help increase your visibility and can provide links to above
9. Make sure you, your staff and volunteers know what your offer is and promote it far and wide in an accessible way

10. Communicate with your customers/clients/members being open, honest and transparent. Always respond to their requests, give feedback, ask for feedback and manage their expectations