Strategic Commissioning Intentions and Delivery Plan

Home Care Services

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1. Executive Summary

Across Cornwall those involved in social care, health and housing are starting to radically reshape the way services are delivered, ensuring community based preventative, enabling and care services are supporting people to stay in their own homes for as long as possible. This document sets out the strategic direction for Home Care service provision in Cornwall for all adults with assessed eligible care needs; including those in transition from children's to adult's services.

The aim is to ensure Home Care services set high expectations to support adults to remain living in their own home safely and to take part in purposeful activities in their local communities. To achieve this aim there will need to be an increased focus on promoting independent living skills and community resilience. This includes enabling providers to have delegated responsibility to design and manage care and support levels through a person centred approach promoting services that enable people to maximise their independence and use community resources to reduce social isolation and improve health and wellbeing.

The Childrens Families and Adults Directorate (CFA) has a strong commitment to developing partnerships; the ongoing appetite to deliver change collectively is crucial to the success of delivering our Intentions. The strategic approach to Home Care has been and continues to be developed through engagement, consultation and partnership working with a variety of statutory and voluntary agencies as well as the community, this includes:

- People with eligible social care needs and their carers
    - people with learning disabilities, physical disabilities, autism, mental health needs and/or sensory needs
    - people with age related illnesses, including dementia
    - people in transition
    - other client groups with eligible social care needs
- Care and Support Providers
- Acute Hospital Trusts
- NHS Kernow Clinical Commissioning Group

The purpose of the Home Care Commissioning Intentions are to:

- Support an understanding of the strategic direction for Home Care services and community based support services across Cornwall.
- Help plan and shape the market across Cornwall to ensure that there are a range of appropriate good quality care and support options that promote reablement, independence, social inclusion and use of community assets.
- Enable Cornwall Council to adequately plan for future expenditure for care and support services and alternative solutions.

- Improve health and social care outcomes, to move away from complex systems to simplistic pathways to care and support provision.
- Respond to the increasing demand upon all care and support services not only as a result of an ageing population but also the multiple or complex needs of clients.

These strategic commissioning intentions for Home Care services were developed with Home Care service providers, people that use the services and health and social care partners across Cornwall. In summary, these intentions include, ensuring that;

- People are supported proactively to navigate the health and social care system through effective and accessible information, advice and guidance.
- Services are delivered that work in partnership to deliver solutions that maximise independence and enable individuals, where appropriate to reduce reliance on formal Home Care services.
- A person and their carers feel supported and have a positive experience from utilising good quality Home Care services in Cornwall to achieve the person's agreed outcomes.
- Diverse services are developed that prevent admission to hospital and support safe and timely discharges to ensure quality care is available in the right setting at the right time.
- Effective Business Systems and tools are robust and support the aims and objectives of the Commissioning Intentions and Service Delivery Model.
- People are supported to maximise their funding options and identify care solutions that offer choice and best value for money

In summary, the delivery of these commissioning intentions is a key tool to support the transformation of services and supports the movement towards personalisation giving people choice and control over where and how they live their lives. The overarching aim, key outcomes and benefits are set out and have been established through co-production methods applied to the development of our Intentions.

AIM: Improve outcomes for vulnerable people through enabling control, personalisation and independence

COMMISSIONING INTENTIONS	•BENEFITS
INFO, ADVICE AND GUIDANCE: Easy to understand and accessible information, advice and guidance is available	• Will support people to navigate the health and social care systems • Will enable people to make informed decisions about their care • Will empower people to develop community assets and alternative solutions to care in their locality
PARTNERSHIP SOLUTIONS: Commission services that work in partnership to develop the market to deliver solutions that maximise independence and enable individuals.	• Will recognise what people can do rather than what they can't and enable people to use their own assets, eg. family , friends, community support • Will encourage diversity of services, use of technology and innovation in the marketplace • Will ensure multi-agency joint working delivers good quality support services that meet the evolving outcomes and goals of individuals receiving services • Will ensure quality services, that recognise good practice and positive outcomes for people
WHOLE SYSTEM SOLUTIONS: Commission services that prevent admission to hospital and support safe and timely discharges that ensure care is available in the right setting at the right time.	• Will improve communication across the health and social care system • Will improve timely access to quality health and social care services in the community • Will enable easier application of flexible support levels to meet fluctuating needs of individuals • Will improve transfer of knowledge and skills to care staff in the community
BUSINESS SYSTEMS: Business systems will be robust, enable collaborative working and support delivery of the Commissioning Intentions and System Delivery Models	• Will use technology and resource effectively, to support business functions • Will improve market development and sustainability • Will improve local knowledge and community resilience • Will improve cross-sector consistency, alignment and performance
FUNDING SOLUTIONS: Funding is maximised across the whole system enabling Home Care provision to offer best value for money	• Will support people to take control their own personal budgets and care solutions • Will support people to have more choice about care solutions • Will ensure expectations of service provision are realistic, well managed and achievable. • Will support financially sustainable diverse quality service provision • Will support skilled workforce recruitment and retention • Will ensure support in the community offers the best quality and value solution.

2. Introduction

Everybody in our community has the right to feel as healthy, safe, well and independent as possible. Most people will have access to a range of people, services and organisations that help them to achieve these outcomes and to be protected from abuse and neglect. This might be through their social network, family or employment circumstances, and through access to universal services or more targeted services.

The Commissioning Intentions for Home Care services have been developed with a range of health and social care commissioners and other professionals in Cornwall. It draws conclusions from evidence including the Joint Strategic Needs Assessment, data about the current utilisation of services, engagement with service providers and service users.

2.1 Aims for Home Care Services

NHS
Kernow Clinical Commissioning Group

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CORNWALL COUNCIL

Our Aims

We will help adults with care needs to find support that improves their health and wellbeing so they can live as independently as possible.

We will ensure services are safe and effective and delivered in ways that improve people's experiences and outcomes.

We will protect the most vulnerable and ensure people are supported to live the lives they want in their communities, with the best possible opportunity to improve their physical and mental wellbeing and stay safe.

In scope: The focus for future Home Care services is the development and use of a wide range of flexible care and support services and approaches

that provide high quality care for adults with assessed eligible health and social care needs delivered in their home. This includes:

- ✓ people with learning disabilities and/ or physical disabilities and/ or autism and/ or mental health needs and/ or sensory needs
- ✓ people with age related illnesses, including dementia
- ✓ people in transition from children's to adult services
- ✓ other client groups with assessed eligible social care needs

Out of scope: It is essential that all preventative, care and support and housing services are seen as a component of a whole system approach to the provision of care and support, from low level early intervention services to residential care homes. However, this document does not cover strategic commissioning intentions related to:

- × Residential care homes
- × Housing based care solutions
- × Community solutions, such as Day Services
- × Prevention and early intervention services (including homelessness)
- × Children's and family services

2.2 Objectives for Home Care Services in Cornwall

Home Care services are designed to help people to remain independent within their own home, for as long as they choose. This aim will be achieved through the following objectives:

- ➢ Support people to live in their own homes in the community
- ➢ Create a diverse, stable, sustainable market that will offer people that use services choice and control over their lives
- ➢ Embed key principles and drivers to meet the requirements set out in national and local legislation, guidance and directives.
- ➢ Ensure consistent, good quality Home Care services, which are fit for purpose, equitable, flexible and responsive to crisis
- ➢ Ensure a diverse Provider market for Home Care across all sectors
- ➢ Introduce standardised service specifications for Home Care services for Health and Social Care
- ➢ Ensure effective, robust contract and performance monitoring methods for Home Care services are aligned across both sectors

- Encourage innovation through coproduction and investment into sustainable solutions that enable independence and reduce demand on formal service delivery models
- Encourage increased use of Assistive Technology and other innovative alternatives to traditional care services
- Join up Health and Social Care commissioning to ensure "whole system" solutions are sought
- Reduce avoidable hospital admissions and demands on Emergency Services
- Reduce number of individuals experiencing delayed hospital discharge due to lack of care services in the community
- Reduce barriers to cross-sector information pathways and improve access to shared care and support plans.
- Embed personalisation through coproduction of person centred, outcomes focussed services that build social capital and include strategic stakeholders i.e. voluntary and community sector
- Ensure active encouragement for people to take responsibility to improve their own health and wellbeing, including nutrition and hydration
- Implement robust procedures to protect people from abuse or neglect

These aims and objectives link closely with other strategic partners such as Cornwall Housing, Cornwall Council and Isles of Scilly Safeguarding Adults Board, Devon and Cornwall police, Primary Care Trusts, Acute Hospital Trusts, other Cornwall Council service areas, other NHS service areas and the Voluntary Sector.

3. The Position in Cornwall

3.1 Health and Social Care Commissioning

There are four principal routes to accessing health and social care support:

- Children who currently receive services through Children, School & Families become an adult, this is called transition.
- When people are discharged from hospital following a period of ill health, medical crisis or trauma
- GP or Medical Professional referral.
- When people, either through age or disability, realise they need additional support.

Assessment: For the majority of people needing social care services in their homes, Cornwall Council's Access Team will be the first stage of their

journey. Anyone can make a referral on behalf of someone who needs care and support. An individual's health and social care needs are assessed in line with legislative requirements and they will be advised how they can access support to meet their needs. People who are assessed for social care support but fall below the threshold of needs eligibility, as set out in the Care Act 2014, will be sign posted to information and advice to enable them to access support to meet their needs privately.

Charging: If an individual is assessed as meeting the threshold for social care support a detailed conversation will follow to help the individual work out what support would help, which will include a financial assessment to identify any financial contribution the individual may be legally obliged to make towards the cost of their care. People eligible for healthcare support from NHS Kernow are not required to contribute to the costs of their care.

Joint Commissioning: By sharing endeavours to deliver the aims of both NHS Kernow and Cornwall Council for the delivery of Home Care services, there is recognition of the potential to further improve benefits to the people that use the services, whether through improved quality, cost effectiveness or person centred outcomes, including;

- Joint investment in innovation
- Rationalisation of commercial arrangements
- Alignment of pricing structures and contractual requirements
- Reduced public sector competition for homecare service supply
- Improved choice, control and continuity of care
- Continuous improvement of personalised care provision.
- Coproduction of a modern workable 'whole system' solution
- Growth and sustainability of high quality service provision

NHS Kernow and Cornwall Council are committed to working jointly to commission Home Care services that have aligned contract requirements, charge rates and monitoring procedures as part of the continued development of strategic commissioning for the whole system

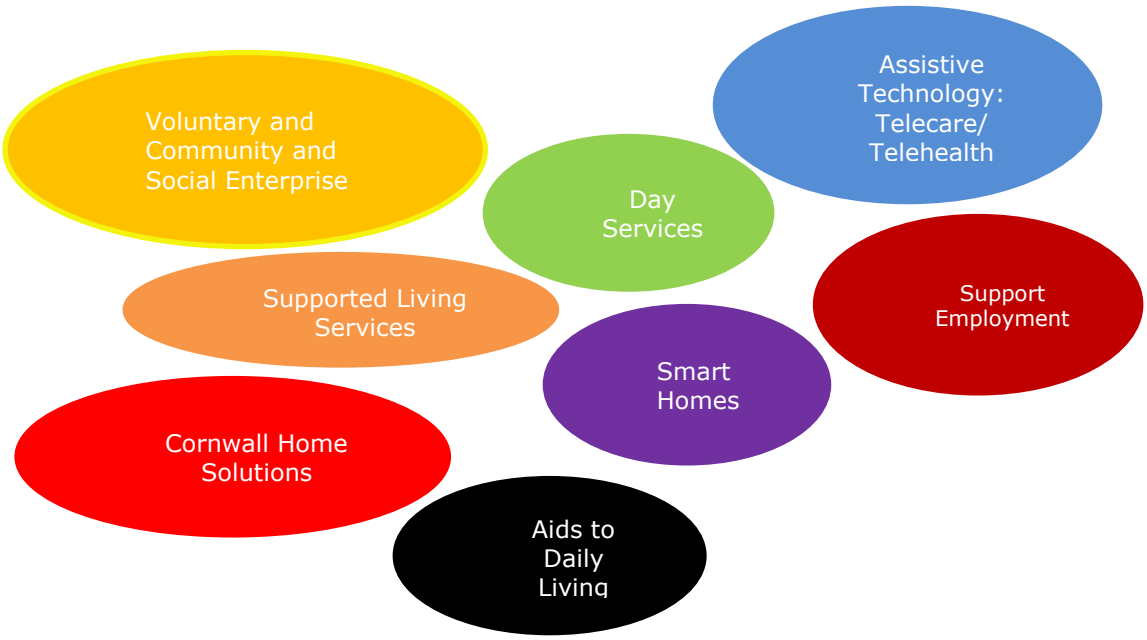
3.2 Universal Wellbeing Services

This area of provision includes all people living in our communities. The focus is on maintaining independence, improving physical and mental health and promoting wellbeing. Factors include appropriate housing, universal access to good quality information and advice, supporting safer neighbourhoods, promoting good health and active lifestyles and combating discrimination.

Services and policies that promote wellbeing focus on the importance of living healthy lifestyles and recognise the important link between work and health. Good employment and healthy working places help to prevent

deterioration of mental and physical wellbeing and enable people to remain independent. Health Promotion services encourage healthy life styles through assistance to stop smoking, reduce alcohol intake, increase healthy diet and exercise, and awareness raising regarding conditions such as diabetes.

3.3 Community Based Care and Housing Solutions



Services that offer community based care solutions in addition to more traditionally known Domiciliary Care are available to residents of Cornwall.

Commissioning intentions related to universal wellbeing services and community based care and housing solutions, are detailed separately. However, it is vital that these services and all support available in the community are considered when developing a pathway of provision.

4. Home Care in Cornwall

Home Care is the service widely recognised as playing a crucial role in effectively supporting people's care in their own homes. This can also be known as Domiciliary Care or Home Care. This support helps people to manage their personal care and other practical household tasks and can be purchased by people needing this support privately, using a Direct Payment, Personal Health Budget or being supported by the NHS or Local Authority who will commission the service on an individual's behalf. It can take the form of short regular drop-in visits from care workers employed by a Care

Agency or shifts that may provide support for up to twenty four hours a day.

Home Care Services in Cornwall provide support to people to meet their care and support needs. These might include: personal care, domestic support, outreach in the community, living skills, sleeping nights and waking night's services.

To date, Home Care services have been commissioned separately by Cornwall Council's Children's Families and Adults Directorate and NHS Kernow. Both organisations commission their services from an external service provider market that consists of commercial, charitable and community interest companies and both have separate contract requirements, price structure, brokerage processes and monitoring procedures. However, both organisations are committed to jointly commissioning services in the future

Health Buyers and Brokerage: Support planning for social care is undertaken by Childrens Families and Adults (CFA) as part of the care management role. Brokerage is also undertaken by CFA through the in-house brokerage team who contact service providers to place packages of care using a process agreed with contracted Providers.

NHS Kernow approach the Home Care market through the Health Buyer Team. Health Buyers negotiate the terms and pricing of an award of a packages of care dependent on a person's needs and the complexity of the service and skills needed to support the individual.

NHS Kernow and Cornwall Council have expressed commitment for these two service teams to align their processes and work collaboratively to support their future agreed commissioning intentions.

Direct Payments: In Social Care people can choose to take their assessed Personal Budget as a Direct Cash Payment and can undertake their support planning and purchase services directly themselves. Support to manage the financial requirements of purchasing services through a Direct Payment

can also be obtained from independent organisations set up to deliver this role.

Currently, the option of a Direct Payment is restricted to people that have the capacity to manage their own support planning and budget, however, with the development of Individual Managed Funds (IMF) or Individual Support Funds (ISF) being progressed elsewhere in the UK, Cornwall Council will review the option to appoint independent organisations to direct care and manage finances of individuals that lack capacity to manage their own Direct Payment in the future, this could provide more choice and control to the individual requiring support.

It is anticipated that increased use of Direct Payments that enable more choice and control for individuals purchasing their own support is likely to continue to increase year on year in Cornwall. Cornwall Council will continue to review and consider systems available to streamline and implement smooth application of Direct Payments, such as but not limited to, pre-paid cards.

In March 2017 there were c.1600 people in Cornwall in receipt of a Personal Budget in the form of a Direct Payment.

Personal Health Budgets: In Health Care, patients can choose to receive funding for their care through a Personal Health Budget (PHB) and can undertake their own support planning and purchase services directly themselves. NHS Kernow are supporting more people to access PHBs and this is a clear direction for the future.

Quality Assurance: Cornwall Council and NHS Kernow function to implement preventative, reactive and development measures in respect of improving Home Care services commissioned. Information about performance, concerns and issues are shared across both commissioning bodies and with the Care Quality Commission (CQC).

Preventing poor performance may include carrying out quality assurance assessments and informing and consulting the market on best practice and legislative requirements. Reactive measures may include working with service providers in respect of responding to any incident reported to each body or working with providers in respect of any safeguarding incidents reported. Developing improved services may be achieved by setting actions to improve standards, develop learning and sector-wide standards, work collaboratively and support service providers.

4.1 Early Intervention Service (EIS) and Short Term Enablement Planning (STEPS)

In Cornwall, NHS Kernow and Cornwall Council support some individuals to access services that provide early intervention and reablement and supports people for a limited period of time after a health or social care crisis at home.

The aim for these services is to build up people's strength and confidence so they can return to their usual routine at home. The service will also look at any adjustments or equipment that might help, including things like fitting a lifeline alarm, using a medication aid or arranging equipment.

This type of service is provided free of charge for a limited period.

If ongoing support is required a social care needs assessment is undertaken by Cornwall Council and support plans developed, this may then involve the Council commissioning care services on behalf of the individual.

It is anticipated during 2017-2020 that these services will be reviewed with consideration to improvements that can be made to support people to be discharged from hospital and a programme of reablement implemented and monitored for effectiveness.

4.2 Home Care: Personal Care and Domestic Support

Home Care services are designed to help people to remain independent within their own home, for as long as they choose, most often support provided by Home Care service providers focusses on personal care that include, but are not limited to; supporting people to get up or go to bed, washing, showering, bathing and dressing, moving and transferring, continence support, medication management and application and support with sensory loss equipment, and/or domestic tasks that include, but are not limited to; assistance with food, nutrition and hydration, cleaning for essential hygiene requirements including house trained pets, bed changing, support with household management as part of a planned programme that promotes independence.

4.3 Outreach and Support Activities in the Community

Outreach and Activities in the Community are activities which a person may participate in so as to meet their agreed Outcomes. These activities may require the support of a care provider in order for the person to participate. For example, a care provider may need to accompany a person to an activity run by a community group in order for them to remain safe and supported. Activities are not funded by a Personal Budget but the support provided in accompanying the person to the activity is included in the scope of Home Care services.

4.4 Continuing Healthcare (CHC)

When an individual has an identified ongoing Primary Health Care Need their support can be funded through NHS Continuing Health Care (CHC). This is care provided outside of hospital that is arranged and funded by the NHS and is exempt from charge to the individual using the service irrespective of their financial position. It is only available for people who need ongoing healthcare, meet the eligibility checklist criteria for consideration and are approved for funding by the CHC panel through the

application of a Decision Support Tool. Further information about CHC eligibility, applications and funding can be found at http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/nhs-continuing-care.aspx

If NHS Continuing Health Care status is awarded in someone's own home, it will cover social and health care costs. Currently, care provided at home and funded through CHC can be provided through a care provider commissioned by NHS Kernow or purchased directly using a Personal Health Budget.

If an individual has a disability, or is diagnosed with a long term illness or condition, this does not necessarily mean that they will be eligible for CHC. The individual must have a primary health need, where, taken as a whole, the nursing or other health services required by the individual cannot lawfully be provided by social services or are beyond those that a local authority can be expected to provide. (Department Of Health, 2010)

There is an assessment process that must be applied to all people accessing CHC funding. Four key areas relating to the individual's health needs are assessed. These include nature, complexity, intensity and unpredictability. Healthcare staff use a Decision Support Tool in order to consider these areas, and assess the individual's eligibility for CHC funded care.

5. Our Commissioning Intentions

Legislation, national policy drivers and local strategies and plans have also been analysed in order to inform the development of our Intentions.

Our Aim: Improve outcomes for vulnerable people through enabling control, personalisation and independence

Information, Advice and Guidance: Easy to understand and accessible information, advice and guidance is available

- People told us and other stakeholders that they wanted more support to navigate their way through health and social care systems. A single point of contact would enable a simplified access to care and support solutions for people in need.
- Clear concise easily understandable information about available services, costs and pathways are required to enable people to make informed decisions about how they may choose to meet their care and support needs.
- Information about local clubs and activities that support vulnerable community members should be provided. Support for enabling local areas to develop their own community assets building resilience and promoting neighbourliness will promote good health and wellbeing provide alternative choice and care solutions.

Partnership Solutions: Commission services that work in partnership to develop the market to deliver solutions that maximise independence and enable individuals.

Care assessment and support would enable people more if they had a focus for what a person can do rather than what they can't. Often encouraging and enabling people to use their own assets, eg. family, friends and community support delivers a longer term solution that empowers people to achieve positive outcomes through maximising their own levels of independence.

Supply markets should be encouraged to be diverse in their approaches to providing support and to make use of alternative types of support that enable positive outcomes for people in receipt of their services.

Minimising traditional Home Care approaches and embracing and encouraging new technology and innovations developed as health and social care solutions will ensure that people that need support with personal and healthcare tasks have an available skilled workforce to respond effectively to demands on these services.

Multi-agency joint working will be required as working in partnership will deliver support services that meet the evolving outcomes and goals of individuals receiving services

Whole System Solutions: Commission services that prevent admission to hospital and support safe and timely discharges that ensure quality care is available in the right setting at the right time.

Stakeholders in the health and social care system in Cornwall have consistently reported that poor communication across the health and social care system disadvantage people in need of support receiving fit for purpose services. By enabling a sharing of information between those people caring for individuals whether in a professional or informal capacity will ensure that planned support interventions are timely and effective delivering rapid responsive services that can achieve a person's reablement potential quickly.

Improved sharing of information, flexible services and joint working to develop effective support plans will enable faster returns to home following episodes that may have required hospitalisation or temporary residence in care settings.

Working in partnership will encourage a positive transfer of knowledge and skills of best practice approaches between workers in the community and in residential or hospital settings.

Support levels need to be flexible to adapt to the fluctuating needs of individuals, working in partnership will ensure responsive services that ensure people receive the right level of quality care in the right setting that they require and is person centred.

Multi partner care and treatment planning will ensure people reaching end of life and in need of intensive support are provided quality health and

social care that works together and respects the need for minimal intrusive interventions through joint working.

Business Services: Health and social care contracts and business systems and Service Providers business approaches will be robust, enable collaborative working and support delivery of the Commissioning Intentions and System Delivery Models

Improved use of technology and resource will support business functions and services to be optimised to be effective and support delivery of services to individuals.

Market development and sustainability will be a focus for all stakeholders ensuring that supply and demand are managed effectively and that provision and resource is optimised.

Knowledge of local community assets and whole system care solutions will support joined up thinking and improve choice and control for individuals, as well as building individuals' resilience.

Stakeholders report a lack of consistency in approach from public sector commissioners and system controls and processes make it difficult with business sustainability planning and resilience building. Public service commissioners are committed to ensuring cross-sector consistency for Home Care services with alignment of processes and requirements and by working together to drive good performance standards across the care sector.

Funding: Funding is maximised across the whole system enabling Home Care provision to offer best value for money

People supported to take control of their own personal budgets have more choice about care solutions. Information about support and care services in local communities will be easily accessible and will ensure that support chosen offers the best value solution.

Supply market development, optimisation of business costs and commitment to growth of good quality, diverse services will enable financial sustainability of the provider market.

Co-production of an operating model and funding methodology for Home Care services in Cornwall will achieve best quality and value solutions.

A commitment to the development of career pathways and attractive employment terms and conditions for care workers will aid recruitment and retention of the Home Care workforce in Cornwall.

6. Strategic Delivery Plan

		Commissioning Intentions for Home Care Services	Delivery Method
COMMISSIONING INTENTIONS	Information, Advice and Guidance	• Will support people to navigate the health and social care systems • Will enable people to make informed decisions about their care • Will empower people to develop community assets and alternative solutions to care in their locality	• Care navigation embedded in health and social care systems • Care and Assessment workers enabled with care solutions information • Service Providers commissioned to empower people to access community assets and care solutions available to them • VCSE provider commissioned to develop Third Sector • Community Assets mapped • A Pathway of Provision will be developed.
	Partnership Solutions	• Will recognise what people can do rather than what they can't and enable people to use their own assets, eg. family , friends, community support • Will encourage diversity of services, use of technology and innovation in the marketplace • Will ensure multi-agency joint working delivers support services that meet the evolving outcomes and goals of individuals receiving services • Will recognise good practice and positive outcomes for people	• Care and Assessment planning training • Three conversation model for care and assessment will be implemented. • Co-development of advanced technology approaches to care • Effective co-production methods will be adopted for development of service models for Home Care in Cornwall. • Supplier and Market partnership working will increase, regular facilitated Provider Forum and Partnership Boards will encourage opportunities for viable initiatives that support development and sustainability of the markets that meet people's needs.

	Whole System Solutions	• Will improve communication across the health and social care system • Will improve timely access to health and social care services in the community • Will enable easier application of flexible support levels to meet fluctuating needs of individuals • Will improve transfer of knowledge and skills to care staff in the community	• Development of shared information tools such as Care Passports, etc. • Development of a Shared Data Platform for Health and Social Care • Aligned contract terms and service models will be commissioned by health and social care partners • Development of responsive systems that enable shared accountability for delivering person centred services • Opportunities for training and knowledge sharing solutions will be improved
	Business Services	• Will use technology and resource effectively, to support business functions • Will improve market development and sustainability • Will enable businesses to optimise available provision through use of effective business support solutions • Will improve local knowledge and community resilience • Will improve cross-sector consistency, alignment and performance	• Use of technology in care service delivery will be increased through raised profiles of available solutions and increased co-working with new developers of technology in care • Health and Social Care contracts, performance monitoring and processes will be aligned. • Closer relationships between Commissioners, Community Networks and Locality based care and assessment teams will be created.

	Funding	• Will support people to take control their own personal budgets and care solutions • Will support people to have more choice about care solutions • Will ensure expectations of service provision are realistic, well managed and achievable. • Will support financially sustainable diverse service provision • Will support workforce recruitment and retention • Will ensure support in the community offers the best quality and value solution.	• Payment mechanisms and support for people that receive Personal Budgets as Direct Payments will be simplified and ensure easy access. • Three conversation model of support planning will be implemented • Workforce planning will be undertaken with the markets and relevant employment and skills organisations • Reward and Recognition schemes for care workers will be further developed. • Good news stories will be shared and positive messaging will be improved. • Service gap analysis will be robust and identify effective solutions • Robust financial monitoring and accountability will be assured

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Childrens Families and Adults

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