Minutes

Care at Home and Home Care Partnership Meeting

Date:	10 August, 2017
Time:	14.00 – 16.00
Location:	Trelawny Room, New County Hall, Treyew Road, Truro TR1 3AY

Attendees:

Jonathan Price	Service Director, Adult Transformation and Commissioning
Claire Leandro	Service Director, Adult Care and Support
Kieran Topping	Service Director (Commercial Services)
Kim Dowsing	Head of Commissioning Working Age Adults
Liz Nichols	Head of Commissioning Later Life
Ann Smith	Head of Service (East), Adult Care & Support, Adult Safeguarding Lead
Vicki Allan	Commissioning Manager
Martin Body	Programme Manager
Niall Waters-Fuller	Head of Commercial (Interim)
Angela Stevens	Senior Finance Business Analyst
David Sullivan	Project Manager
Gill Thornton	Programme Manager
Rebecca Yorke	Senior Supply Chain Specialist
Diane Dyckhoff	Trewcare
Lynn Toman	Brandon Trust
Amanda Stratford	CEO, Healthwatchcornwall
Angela Stevens	Senior Finance Business Analyst
Iris Chalmers	Minute Taker, PA to Jonathan Price

Apologies:

Bernadette Edwards	KCCG
Stuart Whittacker	Mencap
Kevin McHale	Taylors of Grampound
Sara Rowe	KCCG
Kate Alcock	CC
Sandy Williams	CC
Karen Hooper	CC
Gina Pearson	CC
Neil Hamilton	CC
Richard Best	RCHT
Steve Gray	CC

Cornwall Partners in Care (CPIC)

- David Smith
- Carol Richards
- Denis Winder
- Jennifer Nancarrow-Allen
- Peni Rapo

Apologies:

- Mary Anson
- Trish Berriman

1 **Welcome and apologies**

Jonathan Price welcomed colleagues to the meeting. He took the opportunity to introduce himself and acknowledged that this was the first meeting he has attended in his new role as Service Director Adult Transformation and Commissioning. He had however had had the opportunity to meet colleagues at the successful Market Engagement Event held on 13.07.2017. He reiterated the importance of this forum, the Council's commitment and confirmed that dates for this meeting have now been issued.

He introduced Kieran Topping, who had previously chaired the meetings. Kieran Topping advised colleagues on the current work within his service. He touched upon the Modern Slavery, a working group who will be reviewing the situation in Cornwall and seeking volunteers to join the group. More information will be cascaded when available.

Review and update of the Action Grid from the meeting held on 16.06.2017

- Home Care - share findings from provider & service user engagement
  Update: This item was presented at Market Engagement Event on 13.07.2017 – Closed

- Home care - develop survey and issue via survey monkey.
  Update: Karen Hooper to update at the meeting on 10.08.2017 – Outstanding

- Care Homes - attend future Care Home Forum meetings
  Update: An invitation has been extended to Jonathan Price to attend a meeting in October, which has been accepted – Closed

- Share rockwood frailty scoring
  Update: This is Circulated via the minutes of today, please see Appendix 1 – Closed

- Circulate links to discharge to assess models
  Update: An update has been requested from Bernie Edwards – Outstanding

- Update on red bag vanguard scheme
  Update: David Smith advised that meetings have taken place with Frazer Underwood for both Residential and Nursing Homes. There is a delay in obtaining the bags until September, it is proposed to have a dedicated email address and special form to provide Treliske with information about the client. Action: The form is currently being devised will be brought to this meeting when the final version is available, placed on the forward plan – Outstanding

- Update on iBCF / £12m
  Update: This is an agenda item – Closed

- Feedback on meeting with Richard Best

Update: Discharge arrangements meeting with CPIC all in hand – Closed

- Providers to share views on gross/ net payments at next meeting
  Update: This question was asked at the Market Engagement Event.
  Action: Update was requested for the September meeting, Karen Hooper to provide an update.

3 CPIC Update

Trusted Assessor

It is acknowledge how valuable this role is to prevent bed block. Funding is in place, role profiles agreed with a view to going out to recruit. As part of partnership working, colleagues would welcome input into how this is going to work preferably before the person is appointed and to also be part of the recruitment process. A copy of the job description would be welcome, acknowledging that this may have been sent to Mary Anson direct.
Action 01: Martin Body to link with Kate Alcock. He further advised of the High Impact Change Model, of which the Trusted Assessor is one of the eight criteria. Cornwall wish to be an exemplar in that area and Kate Alcock is working with CPIC to reviewing the criteria and how we achieve this

Provider Representation on H&WBB on STP and BCF

It was asked that consideration be given to this request. Jonathan Price advised that BCF is currently at its initial development for submission in September. An invitation has been extended to Jeanette Halfpenny to the forthcoming September Co-production Workshop on 20.09.2017 to be held at Liskeard. **Action 02: Jonathan Price representation on the H&WBB was taken as an action**.
Update: We have provider representation for NHS providers, it is Phil Confue from CPFT. There is nothing in the constitution in relation to any further membership from the private/care sector.

National Living Wage for Sleep In Duties

Providers are required to pay the National Living Wage and ask that the Council recognise this when commissioning services. Jonathan Price advised that our Finance colleagues are reviewing this. **Action 03: Update at future meeting, placed on the forward plan for October.**

Flu Vaccinations of Staff

The request for financial assistance was made. Gill Thornton confirmed that this has been put forward as an iBCF scheme and a pilot is being undertaken which Mary Anson is involved with.

Certification of Deaths

This originated from Devon Doctors Verification of Death Policy and was introduced to Nursing Homes in August. A request was made that such information involving a major change, extra responsibility, associate training and cost be cascaded out in a succinct and effective way, it had not been raised in this forum. **Action 04: Gill Thornton to discuss with Tryphaena Doyle and ask**

her to contact David Smith.

Amendment to Minute, as agreed at the meeting on 07.09.2017
Certification of Deaths, page 3

- Gill Thornton confirmed that she had contacted Tryphaena Doyle to make contact with David Smith. David Smith advised that this had not happened.
- It was further confirmed that this had not been introduced to Nursing Homes in August. Tryphaena Doyle of the KCCG indicated that she believed the letters had been issued.

The following amendment was agreed:

Providers attending this meeting reiterated that they had not received notification and Mary Anson advised that she too had surveyed 10 additional homes who confirmed the same.
Action 07**:** Jonathan Price will liaise with the KCCG for confirmation.
Update 07.09.2017: Tryphaena Doyle at the KCCG confirmed she will ask Cornwall Health to make direct contact with David Smith as the policy is theirs, and not the KCCG.

Demonstration of new quality package, Quick Solutions,
Ann Smith advised of her conversation with both Bernie Edwards and Vicki Thomas at the KCCG of the variable success of this package, this will be a joint piece of work with Health, Cornwall Council and providers to provide a baseline. **Action 05: Update to be requested from Bernie Edwards and circulated to the group.**

General

- 2% extra funding ring-fenced for Adult Social Care, the precept clarification sought. **Action 06: Update item for September agenda, placed on forward plan for October.**

- The CPIC in representing a wider membership asked that consideration be given to issuing briefing notes on particular initiatives. **Action 06: We will look to review the internet web pages for Commissioning, which will incorporate all information including the minutes from this meeting. Karen Hooper to take this forward.**

4 3 Conversations Model: Ann Smith

The Council are developing a three stage conversation model 3 Conversations Cornwall. Our ambition is that it could shape the way all council staff work with people in the future. We want to replace the traditional way we assess the needs of individuals with a new approach which focuses on listening to people and supports them to live as independently as possible in their own homes for longer without the need for formal services.

Conversation 1: Listen and Connect, listen hard. Understand what really matters. Connect to resources and supports that help someone get on with their chosen life, independently.

Conversation 2: Work intensively with people in crisis, what needs to change urgently to help someone regain control of their life? Put these into an emergency plan and, with colleagues, help to make the most important things change.

Conversation 3: Build a good life, *for some people support in building a good life will be required.* What does 'a good life' look like? What resources, connections and support will enable the person to live that chosen life? How do these need to be organised?

We have three innovation sites up and running across the County (East: Bodmin/Liskeard – Mid: St Austell/Truro – West: Camborne and Penzance) staffed by Social Workers, Occupational Therapists, Occupational Therapist Assistants and Admin. The teams are collating information on a daily basis with an evaluation taking place towards the end of September.

It is recognised the importance of partnership working with providers in both terms of engagement and to be part of the evaluation as this model develops and the new services evolve. It is envisaged that we will ascertain the offer of resources, by geographical patches, and map the providers in that area.

5 Potential Conference Safeguarding/Quality and Providers: Claire Leandro/Ann Smith

A priority from the **Safeguarding Adults Board** for the coming year is how do we work better with providers, ensuring the quality is right and work together as a collective to support people.

As of 04.09.2017 Safeguarding and Quality will sit under Ann Smith, who is keen to look at ideas to work collaboratively around safeguarding rather than being reactive, how to measure quality in terms of outcomes, what is 'good' and to enable shared learning. She touched upon the themes from the care sector and the opportunity to come together to look at the details of what they are eg Falls, how does that impact with non-elective admissions? A Conference would be a starting point to shape this work going forward. She wanted to enquire of colleagues today if there was an appetite for this approach and the following colleagues volunteered Lynn Toman and Peni Rapo to work with Ann Smith to shape the Conference. **Action 07 : Iris Chalmers to share their contacts details with Ann Smith.** √**Completed**

6 Commissioning of Home Care and Support Lifestyles Update
Home Care: Liz Nichols and Kim Dowsing

We have undertaken a service user engagement survey, via focus groups in Day Centres and on line, we are also speaking to Stakeholders in Social Care and Discharge Teams to get service users' views. The response rate to the on line survey has been well received 15%. A report will be compiled to summarise all of the findings from this work which will inform the service specification. A service specification is being developed and there is an assigned consultant assisting with this work.

Support Lifestyles: Kim Dowsing

Following events we are working with operational staff, service users and SL providers to develop a specification. We are also reviewing the accommodation programme at the same time.

7 Care Home Update

This work is being led by Kate Alcock. The key focus of the Fair Cost of Care initiative is to understand the actual cost of care in the local market and to utilise

this intelligence to inform the future fee methodology. The new contract and specification will be aligned between the Council and Kernow CCG. This project is on target for completion and will be taken to the Council's November Cabinet. We are planning to implement the new approach from 1 April.

The Council and NHS Kernow are also in the process of developing a market positon statement. Part of this work will include a review of the current Care Home provision in Cornwall, to assess whether they will remain fit for purpose or require investment.

It was also advised that the Council intends to issue an Expression of Interest (EOI) to identify providers to work with the Council and NHS Kernow to develop a model for an exemplar care home for people with dementia. Three Care Homes are being sought to work with Council and NHS Kernow to share best practice. Funding will be available for this work.

8 BCF

The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible. The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them integrated health and social care services, resulting in an improved experience and better quality of life

Cornwall has been allocated approximately £24m over the next three years, currently proposed 17/18 £12m, 18/19 £8m and 19/20 £4m. Cornwall has 17 schemes grouped around 4 themes. The additional funding known as iBCF will be spent in year across the following themes in line with the grant conditions to reduce Delayed Discharges

1. Assessment & Review - These schemes are focused on eliminating assessment backlogs and in so doing impact NEL admissions and DTOC.
    - Occupational therapy waiting lists
    - Care home reviews
    - Assessments waiting lists

2. Market stabilisation – Incorporates schemes that focus on Care Homes and Care at Home impacting DTOC.
    - Addressing lack of care provision
    - Improving dementia care
    - Market stabilisation – home care
    - Market stabilisation – care homes
    - Care Solutions (Brokerage) hub
3. Patient Flow (DTOC) – Includes schemes that build community based reablement capacity and are focused on impacting DTOC.
    - Discharge to Assess Pathway 1 (Home) – Generic Support Workers
    - Pathway flats
    - STEPS (Intermediate Care) capacity
    - Discharge to Assess Pathway 3 (GP support)

4. Prevention – These schemes are focused on enabling people to remain in

their normal place of residence be it at home or in a care home thereby reducing NEL admissions which indirectly impact DTOC

- Mental health (voluntary sector)
- Informal family/carer grants
- Enhanced care home support

In early July **the BCF Planning guidance, spanning 2 years,** was finally published. The submission to ADASS (Association of Director Adult Social Services is 06.09.2017. The NHS submission is to be delivered by 11.09.207. The narrative is currently being undertaken for the submission.

9 Any other Business

Reciprocal Arrangements with Treliske and Providers in relation to the admittance of a patient.

Discharge Email System: David Smith advised of the work which had been undertaken with Treliske in relation to this system and this will go live next week.
Red Bag: as discussed earlier in the meeting he advised of the pilot for this initiative where information accompanies the patient being admitted and is returned on their discharge.

The date of our next meeting is:
7 September, 2017 10.00 – 12.00
Trevithick Room, Sedgemoor Centre, St Austell, PL25 5AS

Attachments:

Attachment 1

D2A Criteria
Pathway 1

1. Frail patient with a score > 4 on Rockwood frailty scale and resident in Cornwall.
2. Patient does not require Acute hospital bed and medical/Therapy needs can be supported in the community.
3. Patient has the potential – gauged by therapists experience to be 'Reabled' within 14 days.
4. STEPs or GSW support (depending area) available on day of discharge (am/pm) if required
5. Technical Officer Available on day of discharge if required to install minor adaptations.
6. Night sitter availability if required on night of discharge.
7. Community Services (STEPs/Community team as required) able to provide a review within 2 hours of discharge if high risk & 24 hours of discharge if low risk
8. Discharge from the acute setting can be achieved by Midday- if not plan for discharge following morning.
9. Patient has been in Hospital less than 72 hours or meets criteria 3.
10. The ICT/STEPs team will be responsible for completing the Reablement plan once patient home NOT in-patient Services at RCHT/ West Cornwall.
11. ED/MAU MDT have undertaken an integrated assessment of the patient and agreed them as suitable for discharge to assess Pathway 1.

Pathway 2

1. Frail patient with a score > 4 on Rockwood frailty and resident in Cornwall.
2. Patient requires a focused period of rehabilitation within the Community within a setting that can provide 24 hours support for up to 7-14 days.
3. ED/MAU MDT have undertaken an integrated assessment of the patient and agreed them as suitable for discharge to assess Pathway 2.
4. Link with Onward Care to initiate transfer.

Pathway 3

1. Frail patient with a score > 5 on Rockwood frailty and resident in Cornwall
2. Patient has complex care needs and may be CHC or is already CHC funded and requires a period of assessment/ re-assessment .
3. ED/MAU MDT have undertaken an integrated assessment of the patient and agreed them as suitable for discharge to assess Pathway 3
4. Link with Onward Care to initiate Transfer.

Rockwood Scale

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

1. Canadian Study on Health & Aging. Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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