Collaborative Commissioning Action Plan Launch

Friday 8 January 2021

Agenda

2.00 Welcome and introductions

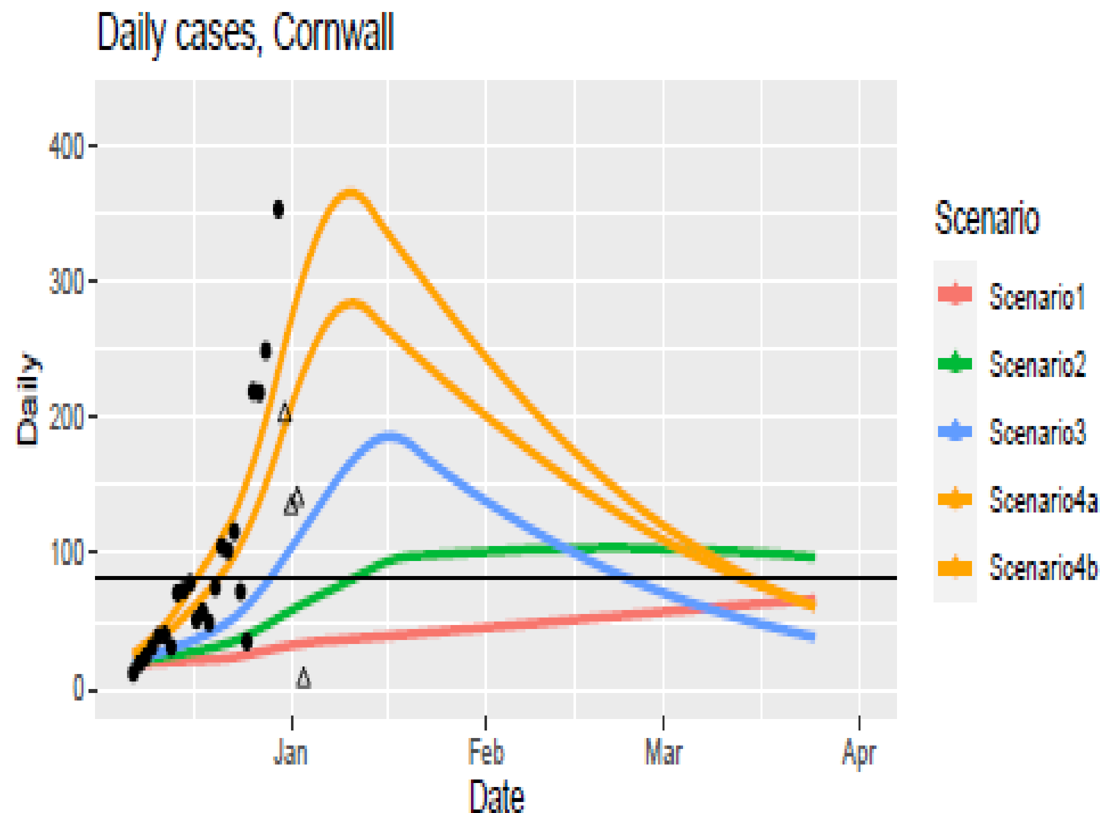
2.10 Current position and approach

2.25 Collaborative Commissioning Plan

Current Position and Approach

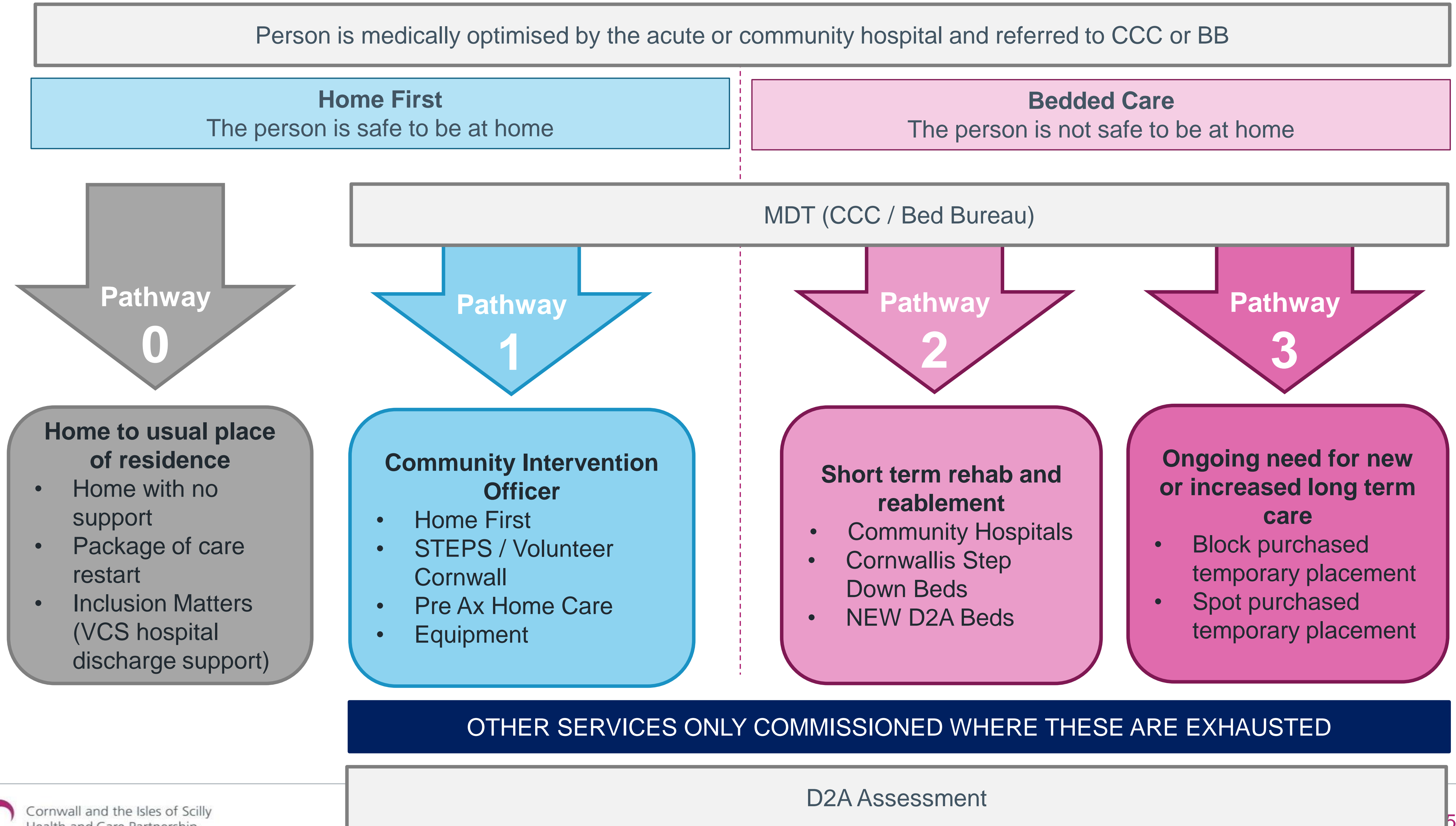
Friday 8 January 2021

Current Covid Position (7/1): Positive cases vs modelling



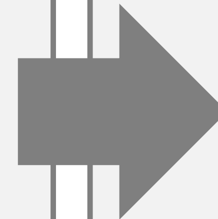
- Material change over last 2-3 weeks (assumed to be driven by new variant) meaning much higher case growth than during Sep-Nov in similar conditions
- Modelling currently tracking scenario 4a (R=1.6), assumes case peak on 16th January
- **All modelling assumes measures sufficient to reduce R to below 1 are in place by 9th January (with effect following 7 days later) – lockdown announced to take effect from 6th January – remains to be seen if sufficient to reduce R to below 1**
- Triangles relate to last few days (where additional cases will still be added into totals), likely that v highest point is outlier following Christmas

Cornwall D2A Pathways and Services – Winter 2020/1



PATHWAY 0 - No additional support (50%)

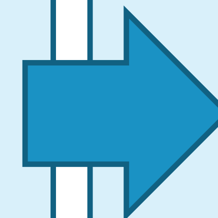
- Safe to be at home AND
- Fully independent – no additional support required OR
- Requires support from voluntary and community sector AND/OR
- Requires restart of existing care package with no change



Person returns to normal placement of residents including care home

PATHWAY 1 – Additional Support at Home (45%)

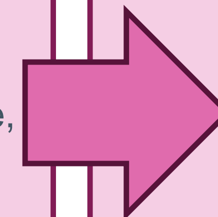
- Safe to be at home AND
- Requires assessment and some additional care and support e.g. therapy, nursing, reablement, home care, equipment



Person returns to normal placement of residence with interim support

PATHWAY 2 –Temporary bedded care – short term (4%)

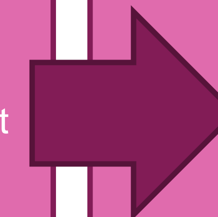
- Not safe to be at home AND
- Requires assessment and some additional care and support e.g. medical care, therapy, nursing, reablement, equipment



Person is transferred to a non acute bed and received rehab / Reablement until able to safely return to place of residence

PATHWAY 3 – Temporary bedded care – long term (1%)

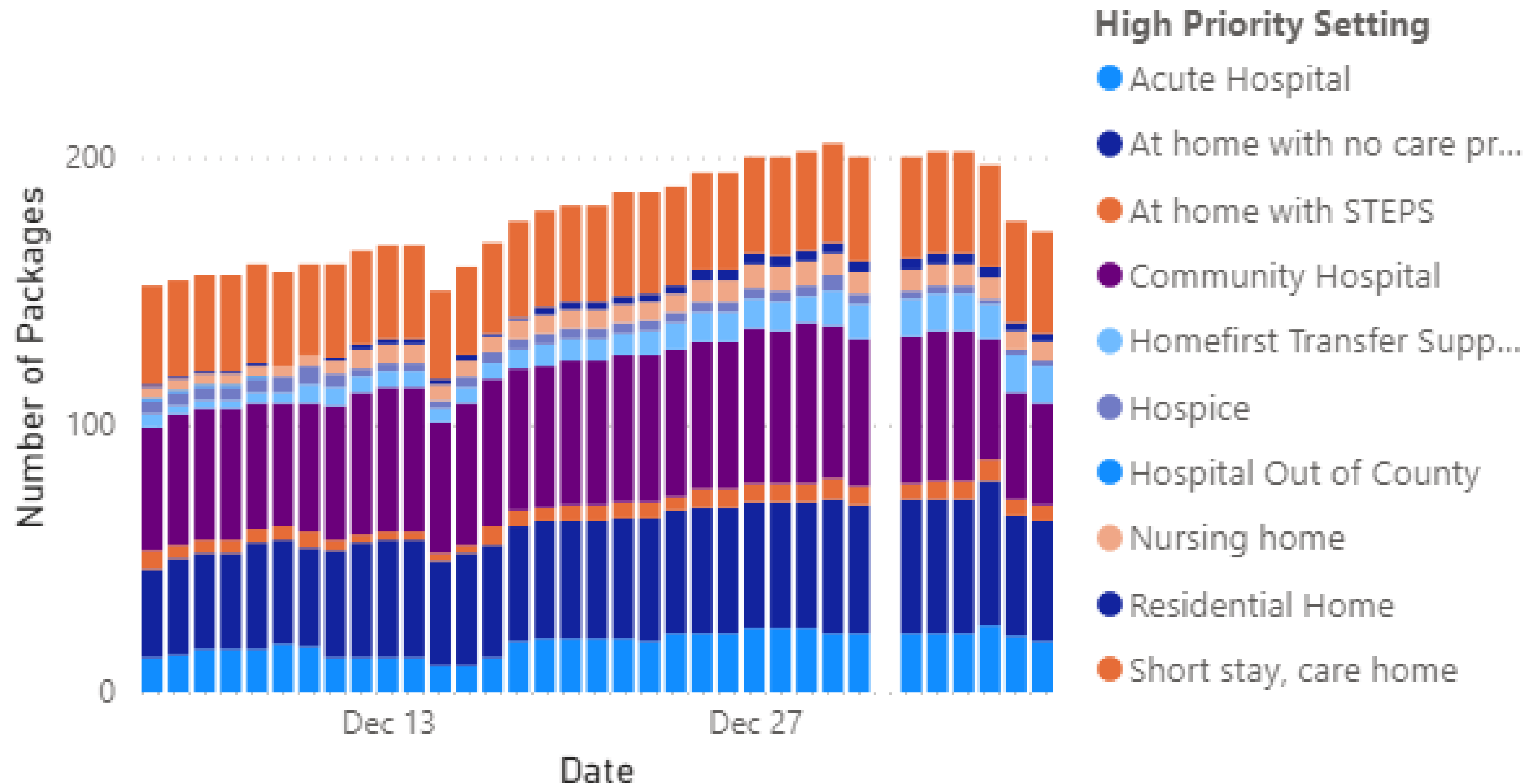
- Not safe to be at home AND
- Complex with significant long term health and social care need likely to be met in bedded care setting
- Significant change in needs requiring new type of placement



Person is transferred to a new long term bed for complex support or assessment

Discharge o Assess Assessment and Ongoing Plan

High priority unmet need (domiciliary care)



Snapshot: Thursday 7 January 2021

Patients in hospital currently awaiting discharge

Friday 18 December 2020

Category	UHP	RCHT	CFT	TOTAL
Care Home	6	7	21	34
Dom Care/Pathway 1	0	17	43	60
Community Hospitals	2	5	3	10
Other	1	8	2	11
TOTAL	9	37	69	115

Thursday 24 December 2020

Category	UHP	RCHT	CFT	TOTAL
Care Home	5	14	21	40
Dom Care	2	19	50	71
Community Hospitals	2	10	0	12
Other	0	7	3	10
TOTAL	9	50	74	133

Thursday 31 December 2020

Category	UHP	RCHT	CFT	TOTAL
Care Home	8	20	26	54
Dom Care	4	24	49	75
Community Hospitals	0	20	6	28
Other	0	3	4	7
TOTAL	12	67	85	164

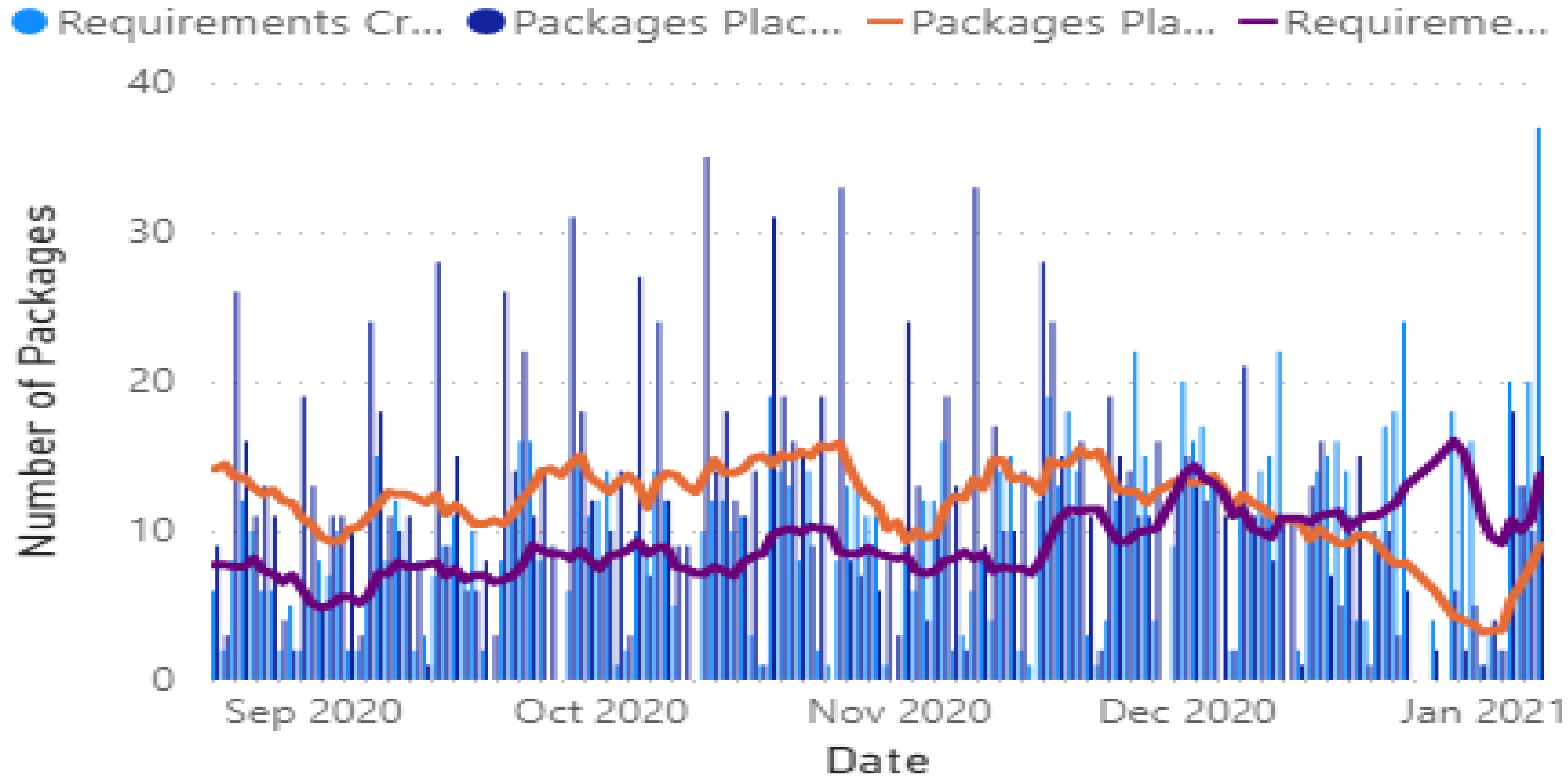
Thursday 7 January 2020

Category	UHP	RCHT	CFT	TOTAL
Care Home	7	25	21	53
Dom Care	1	16	36	53
Community Hospitals	1	18	5	24
Other	1	4	6	11
TOTAL	10	63	68	141

Additional factors

- UHP and RCHT working to reduce bed occupancy level to 55-65% within next 10 days
- Surgery to be prioritised
- Required to move people rapidly out of hospital and home
- Temporary requirement to move people off pathway and into care home beds (100+)

Domiciliary Care packages placed



W/E	Placed
20/11	119
27/11	95
4/12	89
11/12	88
18/12	74
25/12	-
1/1	47
8/1	146

Demand Forecast

Pathway	(Average 1 July – 30 October)					January 2021 Reasonable Worst Case Scenario			
	RCH (% of discharges)	CFT (% of discharges)	UHP	Total Daily (7 days)	Total Weekly	Total Daily (7 days)	Total Weekly	**Additional Surge Capacity**	**Weekday Target**
1	6.2 (4.7%)	5.5 (46.7%)	1.4	13.1	92	13.4	133	**100**	**18**
2	3.5 (2.7%)	0.1 (0.6%)	2.1	5.7	40	6.7	48	**100**	**10**
3	1.3 (1%)	1.1 (9.4%)	0.4	2.8	20	4	28		**6**

New home care placements: 120+ per week
New care home placements: 30 per week

Collaborative Commissioning Plan

Friday 8 January 2021

Home Care Commissioning

- We want to achieve a model of home care commissioning that provides good quality of support to people and enables them to remain as independent as possible in their own homes and supports system flow to make best use of health and social care resources. To enable this we need our approach to support a market that:

  - Is efficient and profitable to achieve sustainability
  - Encourages flexibility and collaborative working to meet the demands of the system at anyone time
  - Provides confidence to allow expansion and contraction dependent on demand
  - Allows low overheads so cost is in delivery
  - Is resilient and responsive to system demands
  - Is innovative and creative in how demand is met e.g. video/telephone checks, technology enabled care

Problems with Existing Arrangements

- Concerns that contractual compliance measures are not proportionate
- Contracts based on time and task which can create perverse incentives about which clients are accepted
- Fragmented market with mainly lower volume providers. This can have positives but means disproportionate overheads reducing money to pay for direct care
- Inability for some of the market to offer assured contracts leading to recruitment and retention problems
- Higher cost of delivery in some geographic areas

What Could We Do?

- There are a range of models used elsewhere. The Kings Fund advocate a geographically zoned model
- Progress towards cost and volume contracts linked to outcome measures.
- Review existing contractual terms including unit costs
- A model could be based on a lead provider system or use incentives to help collaborative working
- Incentives could be used to encourage different approaches to delivering wellbeing outcomes for clients
- Consider upskilling staff to enable them to operate as wellbeing practitioners and manage health tasks eg PEG, Colostomy, Diabetes
- Closer working with health e.g. district nursing etc for prioritisation purposes

Action

- We would like to form a reference group of providers to work closely with in the next few months to set out a range of options that best achieve the outcomes we are aiming for.
- The reference group will include a mixed representative group of providers to represent geography, size of provider and specialist interests
- The aim would be to work to a timescale of having options analysed by October 2021, to give a lead in time for implementing any changes by April 2022
- Alongside this, we would work with the market to take forward the operational and process focused actions that were built from Embrace. These follow on the next few slides

Demand management

- There are currently nearly 550 clients on the unmet demand list
- 80%+ of high priority home care requests have not had a package of reablement support.
- It is not clear whether, the other clients on the unmet demand list have had reablement
- It is not clear if a strength and assets based conversation has taken place and other community options exhausted
- Client specific requirements continue to be recorded on DPS
- 181 requirements have not been reviewed and have been open on the DPS for 50+ days
- Home care should be the penultimate choice to meet eligible needs with other options exhausted beforehand.
- We do not know the true demand for home care and this may mean we are deploying resources poorly.

Action

- Actions are part of the D2A pathway. Aim is to ensure that nobody goes direct to home care without reablement/other options being exhausted first
- We also need to ensure that all demand over 14 days on DPS has been reviewed to ensure it remains appropriate
- We also need to reinforce the Cornwall Offer to reduce rejections of packages and give providers the most flexibility in responding to requirements
- A forecasting model is required. This was initiated in 2020 and needs to be completed to help with strategic planning

Provider-led Reviews

Provider Led Reviews were introduced in March 2020 and initially 20 providers submitted reviews. The process was formalised to ensure reviews were Care Act compliant and providers were selected who had a CQC rating of good or better. Providers nominated named staff who were trained in using the review process. The number of providers has dropped – we need to work with providers to restart the process and improve it. 94% of PLRs were agreed, indicating a high level of accuracy

Action

- Locality Commissioning Managers to relaunch current process working closely with brokers/buyers and care management
- Re-establish the development group to provide oversight and coproduction as the process evolves
- Review criteria (both health and social care) for providers taking part to increase flexibility and enable more to be involved
- Ensure verification by ASC is light touch and turnaround times are fast
- Support providers to use the RAG based approach to determining safe levels of care
- Work with providers to take process to next step where initially responsibilities under the care act can be delegated and subsequently the process automated using the professional portal into Mosaic

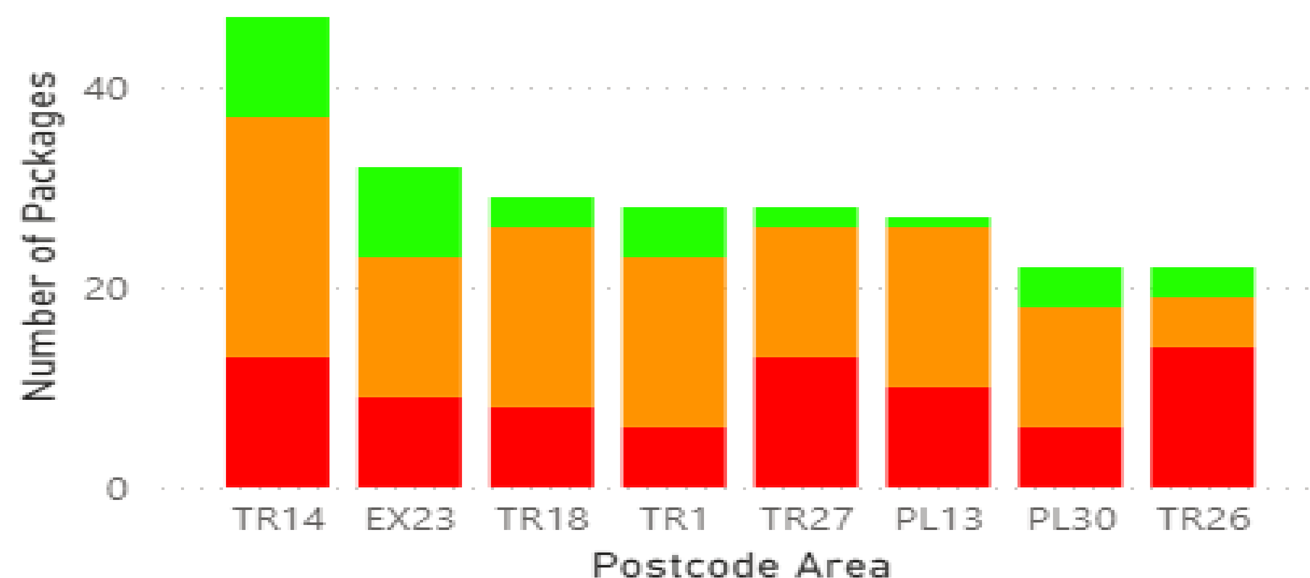
Capacity optimisation

We need to ensure we make best use of existing capacity. An approach was trialled in TR16 in February 2020 and identified a potential productivity improvement of 8% by adjusting visit times, swapping “bad fit” packages with other providers and having better data visibility to match suitable packages from the unmet demand and wider DPS list. The approach was rolled out wider using geographic mapping and engagement via Teams. The momentum has slowed significantly and needs to be refocused as Business as usual

Action

- Roll out plan to be led by locality commissioning managers with support from brokers/buyers
- First 3 optimisation sessions (1 for each locality) to take place immediately. Target areas: For West, TR26/27 and TR14 Mid, TR1 and East, EX23. Providers will be contacted now
- Process to be – Initial analysis by Health and Social Care to produce map and ideas on opportunities followed by advance information for preparation by providers. A virtual workshop would then take place to agree changes.
- Extend to other locations based on analysis of hard to place areas. Aim to optimise efficient rounds for health and social care packages
- Roll out mapping capability to enable providers to use this directly

Open domiciliary care requirements



Between 10 and 20 open requests

- TR3
- TR4
- PL14
- TR19
- TR12
- PL25
- TR11
- TR13
- TR16
- TR20
- PL24
- PL26
- PL27

Block Contracts/Meeting Demand in Hard to Place Areas

Block contracts have been used for a few years in Cornwall. Utilisation has been varied. They can be a useful tool to give market confidence and assurance of cashflow to be able to invest and grow in areas where capacity is an issue. A flexible approach is required to ensure use of blocks is effective

Action

- Reset contract terms to minimise the risk of void payments
- Consider other approaches including unit cost variation, incentivisation, up front payments (to cover recruitment costs)
- Ensure existing blocks are managed effectively
- New blocks to be considered in areas where data tells us unmet demand is high and optimisations workshops have taken place
- Locality Commissioners and health colleagues to work with support from performance analysts to progress alongside optimisation and PLR workstreams

Broker/Buyer process

The DPS process is complicated and on average it takes 10 days to place a package of home care. This is due to time lags waiting for process steps to be completed by either the provider or the brokers/buyers. We need to explore the process further to reduce the time taken to place packages. This would be an interim step in advance of any wider change to the approach to commissioning home care. The processes for health buyers and ASC brokers have differences and there is an opportunity to improve both

Action

- Refresh mapping work undertaken in 2020, confirming opportunities to remove process steps or automate
- Embed optimisation process and PLR
- Complete alignment in processes to enable more flexible use of staff resources - there are some quick wins that can be implemented very quickly. This alignment needs to incude common process for escalation and non DPS purchasing
- Work with the wider system to ensure that requests for care packages are sent to buying teams at the earliest opportunity in an attempt to secure capacity.
- Finalise revised “to be process”

Reference Group and Wider Governance

- The reference group will be part of wider engagement. The membership is proposed as:

- 3 providers who have less than 2000 hours per week
- 3 providers who have between 2000 and 5000 hours per week
- 3 providers who have more than 5000 hours per week

- A check will be made to ensure that providers to be invited ensures representation that includes:
  - Those who operate in urban and those in rural areas,
  - Those who deliver health and those who deliver social care packages
  - At least 1 from each locality

- Wider governance will include engagement with all providers to share output of development work
- Small working groups will be set up for specific issues

Information Classification: CONTROLLED

	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY
Demand management	Cornwall offer adherence audit; DPS cleanse Ongoing; DTA Work Programme						
Provider-led Reviews	Phase 2 relaunch; Further webinars, driving engagement; Impact evaluation	Phase 3 Development		Phase 3 Launch			
Capacity optimisation	Met/unmet demand mapping; DPS engagement survey; Utilisation workshops relaunched						
Market development	Block terms revised; Block contract adherence management	Options assessment on unit costs etc	Targeted new block contracts				
Broker/buyer process	Review mapping	Validation of proposed changes		Implement changes