# Objectives

- Create a single management structure for quality monitoring of care at home
- Develop a comprehensive pandemic contingency plan
- Engage with providers regularly at a policy and commissioning level to ensure adherence to service specification through development of a matching unit and flexible care visits
- Creation of a peripatetic internal care at home team
- Complete test of change to expand selfmanagement by HART+
- Creation of robust links between Integrated Hospital Discharge Team, HART and Care at Home
- Ensure physical activity is integral to support service users and their families
- Continue to ensure TEC and Digital solutions are integral to support service users and their families
- Create a greater choice of services within 5DS options 1 and 2
- Creation of group/s which support co-production and can identify the needs of the community
- > Develop community brokerage models
- Create a shared co-desgn space
- Use 555C open badges to collect, manage and share evidence of learning
- Map training requirements for all providers of care at home services
- Creation and delivery of Key Aspects of Care workshop
- > Create a shared resource of training information
- > Promote careers in care
- Streamline and improve advertising for all care providers
- > Review how urban/rural rates are applied
- Use technology tools to support staff wellbeing Support PAs and self-employed carers in the community
- Create bank arrangements for Personal Assistants
- Create referral pathway to the CiC to support people arranging option 1 packages
- > Improve emotional support for carers
- Establish social care provider networks of mutual support

# Process / Key Actions

### 1st Phase

# Internal Review

Prop to deliver an our short-term response to impact of Covid-19 & our longer-term redesign of the Call model

- Increased management structure
- Robust contract manitoring
- Clear roles and responsibilities for Health and Social Work within contingency plan
- Manning integration of Discharge Hub, HDT & HART

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## 2nd Phase

# Responding to the Effects of

To implement an immediate solution to manage unmet need in community & hospital

- Data analysis
- Identification of issues
   Increased Resources
- Implementation phase of integration of Discharge Hub, HDT & HART

# 3rd Phase ledesign of Care at Hom

To design a flexible, responsive, outcome based approach to supporting people at home

- Co-design a care at home model with providers, unpaid carers and service users
- Local ownership and solutions
- Community development
- Outcomes-based commissioning

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# Integration Planning and Delivery Principles

- Are integrated from the point of view of service-users
- Take account of the particular needs of different service-users
- Takes account of the particular needs of service-users in different parts of the area in which the service is being provided

NEAR FUTURE

- Take account of the particular characteristics and circumstances of different service-users
- Respects the rights of service-users
- Take account of the dignity of service-users
- Take account of the participation by service-users in the community in which service-users live
- Protects and improves the safety of service-users
- Improves the quality of the service
- Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
- Best anticipates needs and prevents them arising

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# Outcomes/Outputs

- ✓ Increased ability to react to changes required as a result of robust monitoring.
- ✓ Closer and more collaborative working with the independent sector
- √ Increased ability to monitor and respond to locality-based issues
  with delivering care at home
- Increased ability to respond to changes in need due to pandemic surges or demographic changes
- Increased resource and capacity to have a more permanent impact on reducing unmet need in the hospital and community
- ✓ Creation of an environment where discharge to assess can operate
  effectively
- ✓ Person centred approach to care delivery.
- ✓ Smaller teams with increased consistency of staff
- ✓ Increased ability to support capacity and flow from hospital to
  community.
- Provision of an integrated, coordinated approach and response to referrals for discharges
- √ Improved clarity and quality of leadership around discharge.

