Department of Health & Social Care

Ministry of Housing, Communities & Local Government

Local Government Association

NHS

Top tips for implementing a collaborative commissioning approach to Home First

Integration and Better Care Fund

Introduction

These top tips seek to enable health and care systems to identify what they need to commission to enable people to remain living independently at home, avoiding unnecessary admissions to hospital and enabling a safe and timely discharge home after a hospital stay

Following a Home First discharge philosophy, they aim to:

- Encourage joint working between health and social care
- Facilitate creative solutions in partnership with the voluntary and community sector, and the wider community
- Cut out delay in assessing and commissioning care
- Improve the organising of care at the end of a period of recovery and reablement
- Focus on a strength-based approach
- Support informal carers and wider family network
- Enable people who fund their own support to make effective choices

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Developing system priorities

- Establish a **place-based joint vision and ambition** to support a Home First approach, based on an assessment of the needs of the communities you serve
- Establish **joint commissioning priorities** to underpin the vision based on the needs of your local community drawn from an analysis of your current demand and capacity plans
- **Involve wider partners** – especially the voluntary and community sector – as strategic partners not just delivery agents
- **Be realistic about what can be achieved** within agreed timescales – this relies on ambition, evidence-based decisions, clear and deliverable plans, and agreement that when things get difficult, partners will avoid blame, change course or look for quick fixes
- **Improve what you have first** before commissioning new services
- Drive **long-term strategic change informed by learning**, such as from insights from staff in the system or technological developments, and not a series of quick fixes
- Embed the principle that **co-design and co-production** underpin intelligent commissioning
- Create a positive, enabling ‘**culture of collaboration**’ at all levels of leadership; this should assume a shared approach to risk, responsibility and resources to deliver improved outcomes

Governance and joint funding arrangements

Maintaining the Home First approach

- **Senior leadership ambition and oversight, and shared system vision** and narrative are essential to maintain focus, clinical buy-in and risk share
- Do not overlook the **importance of relationships** – the most successful systems are those with positive senior relationships, which set the tone for how their organisations behave
- Home First has been in place for many years in some systems, so there is a **wealth of evidence demonstrating the benefits for people and the public purse** from reablement. Evaluate your current joint spend on discharge to assess/Home First and Better Care Fund schemes and redirect where necessary to support Home First objectives
- Commissioning collaboratively as a system enables **benefits to be realised for the whole system** but this needs to deliver for all in terms of improved outcomes and experiences for people, cost avoidance, cashable savings, and better access to services
- **Positive joint engagement and governance** via local political scrutiny, NHS boards, local Healthwatch and community representatives is key to maintaining sustainable change, especially during times of extreme pressure

Partnerships and integration opportunities

There are many partnership and integration approaches which can support Home First:

- Collaborative, joint, aligned or integrated commissioning
- Single points of access and integrated discharge teams
- Joint rehabilitation and reablement teams
- Continuing health care – jointly commissioned and provided
- Adult mental health – jointly commissioned and provided
- Integrated learning disability service – jointly commissioned and provided
- Senior responsible officer for hospital discharge and flow – system appointment
- Jointly funded posts, working across one or more partner
- Shared or integrated record systems with primary care, and community and acute trust(s)

Enablers for partnership working

- **Shared vision and system priorities** (as described above), with agreed shared commitment to improving health and wellbeing through delivering preventative, person-centred and strengths-based care and support which is co-produced with individuals, their families and the community
- A **place-based approach**, developing co-located and/or coterminous arrangements for commissioning and delivery arrangements, where appropriate; and where not to agree effective working arrangement
- **System-wide models of care and support** that promote health and wellbeing, independence, community support and self-care
- Building on **joint or pooled funding agreements**, including section 75s or 113
- Established **accountability arrangements** including the role of overview and scrutiny committees
- **Shared posts**, across commissioners in council and CCG as well as providers, such as council and NHS trust
- **Joint back office functions** including human resources, communications, strategy, and learning and development

Collaborative commissioning to deliver Home First

Improving health and wellbeing

- Identify and adopt a population health management approach and align commissioning intentions and market position statements to support those most at risk, enabling them to remain living independently at home for longer
- Increase the provision of and access to preventative services to align them to priority groups and work with other councils to ensure access to leisure and other local services to support social prescribing and a strength-based approach to community support
- Strengthen the relationship with housing services to ensure the commissioning of the range of accommodation your community needs; consider how to incorporate relevant indicators when developing measurable outcomes
- Develop an understanding of the needs of those people who may suffering from post/long COVID conditions and commission appropriate services

Collaborative commissioning to deliver Home First

Strengthening primary and community health and care services

- Use models of ‘right-sizing’ community services to match staffing to community demand against current capacity*; ensure this modelling accounts for the post-COVID population
- Consider what reshaping of the market is necessary in terms of shifting the balance of both services and settings to support a Home First approach
- Allow single point of access and integrated discharge teams to access directly joint therapy led reablement and rehabilitation services to ensure pathways from hospital deliver the best outcomes for people – make sure you remove access criteria as these inhibit Home First
- Create acute and primary care support to the community to enable extended health care at home, such as giving intravenous antibiotics in people’s homes, potentially through joint working by community rapid response teams and acute same day emergency care teams
- Create co-located or integrated community health and social care teams within primary care network boundaries aligned to local voluntary and community organisations and care providers to create the Home First network of support and care

* For further information, see Institute of Public Care publications on discharge: https://ipc.brookes.ac.uk/publications

Collaborative commissioning to deliver Home First

Personalised care and support

- Develop the market and the workforce to increase support for personal assistants, live-in care using direct payments, and personal health budgets; these support people to live good lives at home, avoid hospital admission and enable discharge home instead of into bed-based care; they also support continuing healthcare packages
- Think flexibly and realistically about how to supplement statutory care and support resources with artificial intelligence and smart technology as a standard feature of support at home; consider how contracts can be updated to bring in the use of new technologies
- Support family and informal carers through tailored support and respite designed to meet their needs and maintain their strength, resilience and mental health
- Create a web of collaborative voluntary sector support jointly commissioned to provide flexible, responsive services treated as equal partners; this may involve building up the voluntary sector's infrastructure and capacity

Collaborative commissioning to deliver Home First

Supporting the care market

- Engaging the care providers in the design of the future Home First market is key as fewer people choose to go into long-term care
- This will require a joint workforce approach retaining the current workforce – built up during COVID-19 – to move into community support from bed-based care, developing skills and new patterns of working
- Identify the over-supply and gaps in the market and create a strategy to address working with care providers to respond to this shift, such as developing community-based dementia care, reducing residential care beds and increasing nursing care provision
- Build on the links between primary and community care, and the care market to ensure these can access clinical advice to manage complex cases 24/7, enable seven-day discharges and avoid unnecessary admissions and readmissions
- Build community health and social care support for those with learning and physical disabilities and challenging behaviour – Home First is an approach for all

Collaborative commissioning to deliver Home First

Improving access to mental health services

- Separate commissioning of mental health services creates a separate response to people's mental and physical health needs – commissioners need to collaborate within and across organisations to create holistic care
- Ensuring there is skilled and responsive challenging behaviour support for mental health and learning disability is key to avoiding unnecessary admission to acute and specialist facilities – this demand needs reviewing after the COVID pandemic
- Review dementia and other older people mental health pathways jointly with specialist community and voluntary sector agencies and care providers to deliver creative, joined-up home-based care and support – there are still too many people in bed-based care by default or because of a lack of capacity
- Personal health and care budgets with trained and supported personal assistants and/or live-in support provide a home-based alternative to bed-based care for people with dementia
- Preventative, 'low-level' community based mental health services are an essential part of a Home First community offer

Transformation programmes – Portsmouth example

PSEH has identified 3 priority programme to support co-ordination of priority actions and optimise benefits realisation, contributing to wider system and national objectives

Managing Flow	Place Based Care	Healthy Communities
✓ Build system resilience (demand and capacity in balance with agility to flex in response to surge, transparency of end to end flow) ✓ Shift to out of hospital care (reduce acute footfall) ✓ Right place, first time (patient outcomes and experience)	✓ Build locality resilience (general practice, care homes , PCN development) ✓ Joined up delivery (integrated service offers and seamless transition) ✓ Keep people at home (outcomes and experience)	✓ Build individual and community resilience (demand management) ✓ Support vulnerable groups (targeted response) ✓ Prevention and self-care (outcomes and experience)
• Embed innovations in elective and cancer care • Implement waiting list recovery schemes • Deliver diagnostic access programme • Implement 111 First model across PSEH • Increase access to Same Day Emergency Care (SDEC) service model • Fully embed admission avoidance schemes and ensure consistent implementation. • Fully embed Discharge to Assess model across PSEH • Develop robust plans for operational resilience (including Winter Plan) • Implement sustainable solution to appropriately redirect mental health patients with no physical health needs from ED • Embed Acute Paediatric Mental Health Service in ED and Wards • Fully implement Advice and Guidance as the initial referral route into acute and community paediatrics from Primary Care	• Implement Enhanced Care Home Teams and enhance specialist community nursing to improve long-term condition management • Mobilise Intermediate Care models including Seacole provision • To mature integrated locality care teams and the proactive management of frail/ high risk vulnerable and end of life patients • Restore primary care activity and support PCNs to deliver DES requirements • Ensure resilience in all General Practices • Agree future commissioning arrangements for Home Visiting Service (FGSEH) • Extend the provision of the integrated Children's Community Nursing teams across acute and community services, including 111 and incorporating pathway interfaces with the mobilisation of the paediatric 111 desk • Fully recover IAPT services and expand in line with LTP expectations • Reduction of CYP & Adults (with a learning disability, autism or both) within specialist inpatient setting • Receive regular feedback from the Provider Collaborative (Hants and Dorset) regarding the mobilisation of the Closer 2 Home team to reduce number of CYP and adults within a specialist mental health inpatient setting • Eliminate mental health dormitory wards (Hants)	• Strengthen PSEH leadership and focus on tackling inequalities with collaborative local planning and delivery • Protect the most vulnerable from Covid-19 through deeper engagement and collaboration with communities • Restore NHS Services inclusively through improved data recording and insights • Develop digital enabled and inclusive care pathways focusing on core programme areas such as 111 First, GP triage • Accelerate preventative programmes focusing on flu vaccination, those with Long-Term Conditions, Learning Disability Health Checks and maternity continuity of care and elective long waiters • Support those suffering from mental ill health • Expand the use of community based approaches building on ways in which people and communities have responded to Covid-19 • Embed social value (wellbeing of people, place and prosperity) into our approach across place • Accelerate the Population Health role of PCNs • Build our PHM capacity • Progress the development of a Health Equity Board to understand the magnitude of health inequalities and the impact of work to address it