Report No: 131/2016
PUBLIC REPORT

SCRUTINY PANEL

14 July 2016

HOME (DOMICILIARY) CARE

Report of the Director for People

Strategic Aim:	Meeting the health and wellbeing needs of the community	
Exempt Information	No	
Cabinet Member(s) Responsible:	Mr R Clifton, Portfolio Holder for Health and Adult Social Care	
Contact Officer(s):	John Morley Head of Adult Social Care	01572 758442 jnmorley@rutland.gov.uk
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Ward Councillors	Affects all wards	

DECISION RECOMMENDATIONS
That the Panel: 1. Notes the complexity and diversity of the Home Care provision and the demography of the services Adult Social Care (ASC) commissions. 2. Notes the difficulties both Rutland County Council and providers face in offering services and plans for future delivery 3. Notes the systems ASC has in place to monitor and if necessary intervene if concerns are raised in regards the provider.

1 PURPOSE OF THE REPORT

1.1 The purpose of the report is to provide details of the extent to which we provide home care to eligible vulnerable adults in Rutland. The report will explain the drivers, funding streams and how adults have choice to be provided with commissioned care or to have a direct payment to commission their own care. The report will outline the complexity of matching service user need to available provider's specialities with the diversity of the client group and their respective needs. The report will also cover the difficulties both Rutland County Council and providers face in offering services in the future.

2 BACKGROUND

2.1 The home care industry mainly caters for the elderly but also for younger adults

with physical disabilities, learning disabilities and mental health. These are very different areas to cater for with their own respective specialist knowledge and practices as is often reflected in the make-up and mix of professional teams who commission home care services following assessment.

2.2 The home care industry has experienced strong growth recently due to the demographics of an aging population, advances in health technology that allow for greater survival rates for people with congenital birth defects and better management of long term conditions. Home care is also being seen as a much better route to meeting people's outcomes by providing people with the assistance they need in the longer term. This helps them maintain some independence, improves their wellbeing and allows them to stay in their familiar surroundings.

3 CHANGING PRIORITIES

3.1 There has recently been an active drive to reduce residential admissions from central government to promote longer term wellbeing. With improvements in technology and monitoring equipment, skilled home care providers can both help an elderly client stay at home, which is usually their preference, and at the same time save costs to the wider economy particularly health care and the personal costs of premature institutionalisation.

3.2 The new structure in Rutland County Council's Adult Social Care (ASC) has consistently demonstrated adherence to this principle using home care providers instead of residential care providers.

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	**2013/14**				**2014/15**				**2015/16**			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Admissions	15	11	12	7	6	11	18	11	11	4	3	4
Total Number of Admissions	**45**				**46**				**22**			

3.3 We now have a multidisciplinary prevention and safeguarding team at the front door of the council providing rapid intervention when needed. We established this team as part of our response to the Care Act and its emphasis on prevention. We have empowered social workers and OT's to commission short term home care to enable vulnerable people to be helped over a crisis. The practitioners in the team are supported by our Mental Health social worker and inclusion support as well as carer workers. An example could be a urinary tract infection that has led to fluctuating capacity that can be supported at home rather than admission to a hospital bed.

3.4 To complement our safeguarding and prevention team we have a long term and review team consisting also of social workers and OT's. The role of this team being to support those people in need of care either in their own homes or other

commissioned service who have long term conditions fulfilling another Care Act requirement of promoting wellbeing. This is the team that takes over the care from our prevention and safeguarding team and hospital and reablement team when it is identified long-term involvement by adult social care services need to remain, enabling people to stay at home with our support. The practitioners in this team have a speciality in ongoing complex case management from older people's mental health through to the specialist area of learning disabilities. The practitioners are supported by reviewing officers to monitor care and our direct payments specialist to offer an alternative. The success of the team is a demonstration that with the right intervention and commissioning people can be managed well in their own homes for longer periods.

3.5 Our other short term involvement team is the hospital and reablement team which works very closely with the acute hospitals facilitating discharge with care packages. The team consists of social workers, nurses, physiotherapist and OT's who are able to work across the social care and health service cultures to secure the best outcome for the patient. A major portion of this team is our specialist reablement carers with their supporting therapists. This team has made a great difference enabling people to remain at home longer actively empowering vulnerable people and their families to make decisions other than institutionalisation.

3.6 Our Reablement care team has consistently exceeded the 83.3% national target to prevent readmission to hospital within 91 days of discharge from hospital this quarter achieving an 87% success rate. The success of our teams is evidenced in the non-elective admissions data that is consistently lower than the national target per 100,000 (table below).

Table to show Rutland non elective admissions represented to per 100000 people for comparison					
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
Rutland	691	637	685	702	678
per 100,000 general population	1868	1722	1852	1898	1828
BCF Target per 100000	2125	1837	1917	1919	2066
Difference	-257	-115	-65	-21	-238
Cumulative Diff.	-257	-372	-437	-458	-696

4 TYPES OF CARE

4.1 The type of care needed determines the level of licensing and skill required of the caregiver. Although family members can be caregivers, there is a need for independent agencies to sometimes provide skilled and trained caregivers to fill the gap when family members need to work during the day or are unable to support. There are two main types of commissioned home care that are based upon the level of skilled care needed.

4.2 The first, social care or non-medical care can provide a wide range of services to ensure a person's continued quality of life. The personal care duties performed by a carer may include their bathing, washing and dressing, and assisting with their personal and oral hygiene, toileting, and maintenance of their appearance.

4.3 If the needs of the person cared for are further complicated with moving & handling issues, behavioural concerns or perhaps making accusations then two carers are required on each visit of which typically occur up to four times per day

for a minimum of 30 minutes per visit. Occasionally these care packages can be provided by a live in carer over 24 hours per day across the year.

4.4 The second is medical based care needs to be commissioned for people living with long-term medical conditions such as advanced dementia, cancer, Parkinson's disease or Multiple Sclerosis for example. Home carers with such specialist training work with the support of district nurses for example and can undertake more clinical tasks such as managing Percutaneous Endoscopic Gastrostomy feeds (PEG feeds), dressing wounds and managing catheters or stomas. These tasks can be clinically delegated by a healthcare professional to a suitably trained professional carer.

4.5 RCC is also signed up to the Health and Social Care protocol that seeks to enable delegated tasks between social care and health professionals to help remove duplication within the system. A carer for example can help with eye drops rather than a nurse making a special additional trip to administer the drops. It may be the visiting nurse could prepare food rather than a carer specifically doing the task. It is ultimately the service user who benefits by not having multiple people coming to their home with some thought, delegation and coordination.

5 CLIENT GROUPS

5.1 The elderly is by far the biggest client group requiring care. Both types of care are often needed to enable the elderly to stay in their own home perhaps with advancing dementia who are prone to wandering or hitting out at carers. Inherent to all these cases is the need for basic personal care from prompting medication that can be lifesaving through to food preparation and support with feeding to ensure choking does not occur.

5.2 The adults between the ages of 18 and 65 tend to be the more complex acquired disabilities needing home care. In Rutland our commissioned carers support conditions such as Spinal Injury, Brain Injury, Stroke, Schizophrenia and Multiple Sclerosis to give a far from exhaustive example of the variety of conditions and therefor varying skills required. The rest of the group consists of learning disabilities.

5.3 Complex learning disabilities require a further set of specialised skills in home care which can be highlighted from the recent transforming care initiative following the Winterbourne View concordat. To enable people with complex learning disabilities to move out of longer term assessment centres back into the community requires very skilled home care workers. These workers have to manage often severe challenging behaviour while maintaining the dignity of the person and protecting others including the public if enabling the person to access the community. People with less complex learning disabilities need specialist support rather than care as do people being supported through mental health episodes not severe enough to require medical intervention. Support is about enabling and showing how, rather than doing to. All of these are specialist areas requiring a diverse workforce with specific skills in addition to the accepted home care model existing in the minds of most lay people.

5.4 The Care Act now puts a duty on local authorities to provide care for vulnerable prisoners in need in the confines of the prison. This is an area for carers who

are not intimidated by their environment and are not affected by closed in places. The same applies to other need groups such as hoarders or people who self-neglect that agree to accept our support.

5.5 Informal carers save the national economy billions of pounds per year and home care is a major factor in supporting them to continue in their role. A well-known consequence of caring for a loved one is the change in the relationship between the carer and the cared for. The relationship will change greatly as time passes, for example the case of a wife caring for her husband with dementia. She will experience feelings of grief and bereavement as the illness progresses, not just in the period after the person's death.

5.6 There are so many changes that occur along the way when caring for someone with dementia of other life changing disability that it can be difficult for carers to deal with their feelings. Other family members, especially children, may also be affected. Home care prevents the cross over from the personal relationship to the more formal caring role so enabling and preserving that all important and encompassing personal relationship. Furthermore it enables "me time".

6 FUNDING

6.1 People over the national savings threshold of £23,250; differentiate between those who set up their own care and those who we set up care for. In the case of the self-funding person or those over the threshold the council has no influence except for a duty to intervene in the event of provider failure.

6.2 However, the council does cap the hourly rate charged for home care to £13.00 per hour, whereas the actual cost to the Council is £15.75 per hour. The council is therefore paying £2.75p per hour in subsidies for people who are eligible to pay for their care. The Council also limits the total amount that any person contributes to £422.00 per week even for those people who are above the national financial threshold of £23,250. The total cost of home care to the council 2015 – 2016 was £1,047,123.

6.3 For people who fall under the threshold of £23,250 they are entitled to a financial assessment under section 17of the Care Ac 2014 to see if they should make any contribution to their care. Section 14 of the Care Act 2014 gives councils a power to charge adult recipients of non-residential services. Where service users are asked to contribute to their care costs, a charge towards the cost of non-residential social services, this can raise additional income, which should be used to develop services.

6.4 The different types of non-residential care councils can charge for are:

i. Meals at home, or in day care

ii. Day care

iii. Domestic help

iv. Personal home care

v. Other support from social services, e.g. transport, equipment and housing adaptations not provided through Disabled Facilities Grants.

As a minimum, users' incomes should not be reduced by charges below "basic" levels of Income Support, as defined in the fairer charging guidance, or the Guarantee Credit element of Pension Credit, plus a buffer of not less than 25%.

6.5 An alternative to home care is direct payments though the take up of these has been very low. In this case the service user has a payment in lieu of carers to arrange their own care with a company of their choice or indeed a person of their choice. The council has no say in their choices but does review the provision of the direct payment to ensure it is being correctly utilise and adequately meeting the person's needs. Direct payments also are subject to a financial assessment under section 17 of the Care Act 2014.

6.6 The funding between the two main types of care, social care and health care can be complex as often funding is joint between the council and health known as Continuing Health Care Funding (CHC). Such cases need our social workers to attend the CHC panel and discuss with health professionals the primary need of the service user/patient. A further complication is that social care provision is means tested (as described above) whereas health provision is free at the point of contact. These cases tend to be the large care packages we provide as a council and are open to changes in the funding responsibility as the needs of the person change.

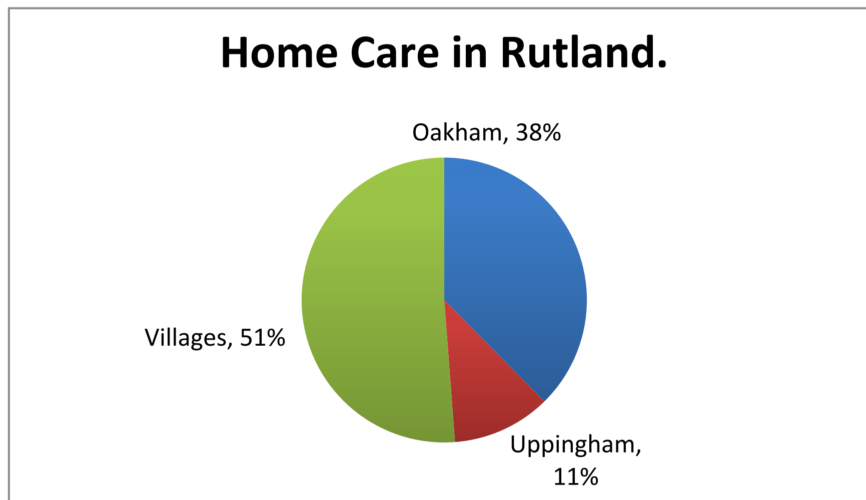
6.7 The National Health Service Act 2006 (which replaced the partnership provisions in the National Health Service Act 1999) did not alter the local authority powers to charge in the event of a partnership arrangement. In agreeing partnership arrangements, agencies have to consider how best to manage charging (where local councils charge for services) and how to clarify the difference between charged-for and non-charged for services. In entering into an arrangement, the partners need to agree on the approach to be taken on charging and in Rutland the council recharges the CCG through Continuing Health Care for the health care provision of a package.

7 THE RUTLAND PICTURE

7.1 Unlike in a densely populated area, where there is little need for excessive travel between service users, Rutland is very rural in nature often having just one, two or three service users in a village. This is an added expense to the provider in both time and money.

7.2 Commissioners and providers also have to consider the primary need of the assessed person. It may be one of the service users in the aforementioned village is an older person with dementia while another is a younger adult with acquired brain injury needing very complex care then another needing inclusion support for accessing the community due to mental health problems. This may mean different sets of carers attending the same village further lessening the available carer pool.

7.3 The chart below represents the percentages of the service spread throughout the county. In Oakham there are 47 commissioned services being provided, in Uppingham there are 14 leaving 64 in the surrounding villages. The total home care provision to Rutland residents in need of social care support at the time of writing is 125.

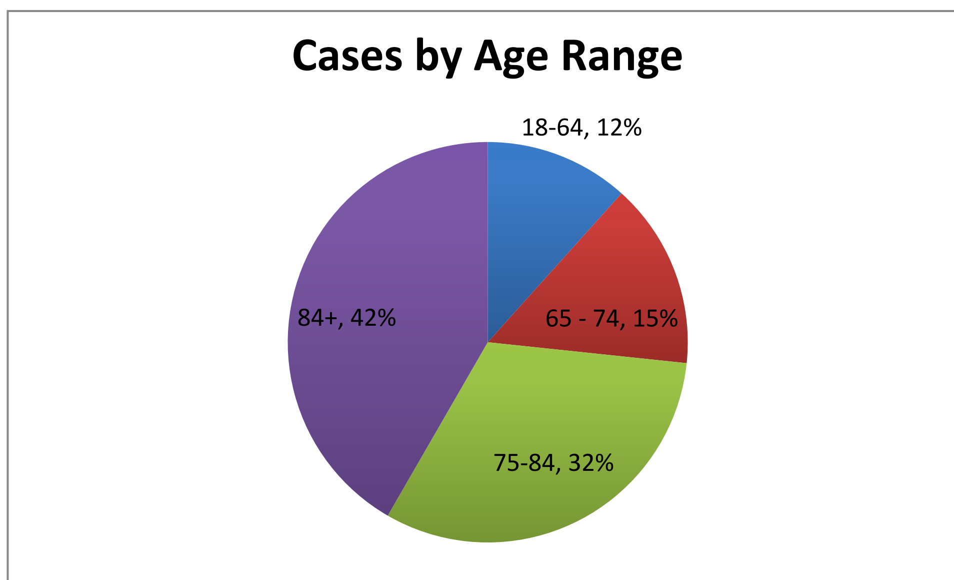


Of the 125 people we commission home care for the hours are very broadly made up as follows: older people, people with learning disabilities, younger adults, mental health and carers.

7.4 The table below gives a breakdown of how the hours are made up for social care funded packages for both service users and their carers.

Social inclusion	Care Hours	Carers Hours	Sitting Service
84	852.3	174.5	104

Of the 125 people we commission homecare for the vast majority are those above the age of 65.



Of these15 packages include day care and 23 packages are provided through direct payments.

7.5 The number of hours received is outlined below, the majority of cases with the larger packages of homecare are aged 18-64.

Hours of home care per week	Numbers
Up to 14 hours	74
14 hours to 20 hours	29
21 hours to 34 hours	15
35 hours or more	7

7.6 Broadly the packages contain one or more of the following services: personal care, night support, assistive technology (falls detector, GPS tracker), day care, laundry allowance, respite, direct payment, equipment, food preparation and medication prompting. Some care requires more than one carer, although the numbers of these are low, accounting for just 9 of the packages of home care.

7.7 In terms of health funding 1 package is 100% CHC (over 65), 1 package 75% CHC (under 65 age group) and 4 packages 50% with CHC (3 under 65, 1 over).

7.8 There are currently five people with a learning disability who have a home care element to their package of care enabling them to live meaningful lives in the Rutland community including to access work.

8 QUALITY MONITORING

8.1 The home care providers we commission are all registered with the Care Quality Commission (CQC). The council monitors the quality of care through contract visits to ensure a number of quality elements such as staff vetting that agreed training is taking place, that care plans are effective or monitoring the number of complaints. If concerns are found officers will draw up an action plan with the provider to assist them and work with them to bring the establishment or practice up to the expected practice standards.

8.2 The Council also monitors the registered providers through the reviews of individuals that the council funds. Health does the same for people they fund. These reviews provide feedback on the providers' practice, especially as many providers offer services to multiple council funded individuals.

8.3 Every two weeks our Council Officers come together to discuss care providers to collate intelligence into a risk matrix. This collated intelligence enables Council Officers to identify patterns that are indicators for more serious problems, as well as forming the basis to their visits.

8.4 Overall, however, the statutory responsibilities for ensuring standards are maintained by registered providers are with the CQC. Officers share both soft intelligence and report actual concerns about a provider with CQC. It is CQC's duty to ensure "compliance" and looks specifically at the list below:

a) *Safe*: people are protected from abuse and avoidable harm.

b) *Effective*: people's care, treatment and support achieve good outcomes, help to maintain quality of life and are based on the best available evidence.

c) *Caring*: staff involve and treat people with compassion, kindness, dignity and respect.

d) *Responsive*: services are organised so that they meet people's needs.

e) *Well-led*: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around the individual's needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

8.5 Against these CQC publish ratings for each provider, as well as an overall rating. The ratings are Outstanding, Good, Requires Improvement and Inadequate. The ratings for all home care companies the council commissions either from the framework or by spot purchase are available on the CQC web site.

http://www.cqc.org.uk/content/services-your-home

8.6 If a provider does not meet a good rating but the impact on quality is not significant or there are no widespread concerns, then this will be rated as requires improvement. If the impact on quality is significant or there are widespread concerns, then this will be rated as inadequate. It should be noted that CQC may recommend areas for improvement, even though a regulation has not been breached, to help a provider move to a higher rating.

8.7 Where a provider is not meeting a legal requirement or struggles to do so consistently, but people using the service are not at immediate risk of harm, CQC may use their power to require a report from the provider. The report must explain the action the provider is taking or proposes to take to meet the relevant legal requirement(s). The Local Authority's Contracts Monitoring Officers will work with CQC at this point. CQC will return to the registered provider to ensure the action plan is being worked to and that standards are coming back to compliance.

8.8 Beyond this CQC may work with the various bodies to 'enforce' the standards. Depending on the service and the circumstances, they can work with local authorities, regulatory bodies and even the police to ensure that actions are taken.

9 SAFEGUARDING

9.1 If CQC have a safeguarding concern, where 'abuse' is suspected (beyond compliance) to have happened, they inform the Local Authority. It is the Council who have the statutory duty for safeguarding vulnerable adults. Reports of suspected abuse come to a SPOC (single point of access) to which all of the above professionals and members of the public have a duty to report into if they suspect 'abuse' is occurring. If CQC believe a registered body has gone beyond compliance infringement and has entered the thresholds for safeguarding, then CQC will directly inform officers at the local authority through the SPOC who will at this point take over if officers agree it is a safeguarding matter. This is the decision of the local authority not CQC.

10 SUSTAINABLE HOME CARE - FUTURE COMMISSIONING

10.1 The current contracts are in place to May 2018 and have been running for 5 years. They were set up as a Framework arrangement, allowing a number of providers to be contracted to provide care. New packages of care are offered to all providers on the Framework, providers who are able to pick up the package then respond and the service user is allocated to them. There are currently 6 providers on the Framework.

10.2 Since the Framework was established, there have been a number of additional providers who have approached the Council to provide home care in Rutland. As those providers on the Framework do not always have capacity to pick up packages of care, additional providers have been taken on following a due diligence and interview process, these are known as second tier providers and are able to have packages commissioned from them if no Framework provider is able to undertake the care. This in itself makes the processes of commissioning packages more complex, but as the current contracts are structured is necessary.

10.3 In addition, and as noted in Section 7, there are a number of issues which impact on providers and their ability to deliver quality services in Rutland, including:

10.3.1 **Workforce** - there is a very limited workforce locally and the majority of home care staff come from outside the county. Providers note that recruitment is often difficult and this impacts on their capacity.

10.3.2 **Travel** - due to the rural nature of the county, travel time and costs are higher for providers working in Rutland. This in turn impacts on the number of packages they are able to undertake due to the time it takes to get from one service user to another - for example, a carer can only do a few morning calls to bathe and dress a service user as more time is spent travelling than in their caring capacity .

10.3.3 **Volume of work** – The level of care packages available to commission from providers in Rutland is relatively small, consequently providers usually have a limited number of carers employed to cover Rutland and this in turn leads to them being unable to undertake packages of care because they do not have sufficient staff, which leads to lower volumes of work per provider.

10.4 Cabinet have approved plans to undertake the re-commissioning of home care over the next two years, with new contracts to start from May 2018. There is clearly a need to undertake much more detailed and wider consultation with providers, other stakeholders and with service users to understand in detail the issues and to develop possible models to address.

10.5 The models developed will need to address the issues identified above, as well a take into account the aging population in Rutland and the priority across health and social care to help people maintain the independence of service users for longer. A number of local providers have already engaged in discussions with officers and are willing to share ideas and models they work to in other areas to look at whether they might work for Rutland.

10.6 The re-commissioning will start from September this year in three phases:

1) Consultation with providers, service users and stakeholders on the current services in Rutland and detailed data analysis including trends of homecare use and projections for future need.

2) Development of possible models and soft market testing, to see whether the models developed are feasible for providers and would receive tenders during procurement.

3) Procurement of the agreed model of service to be undertaken during 2017, allowing sufficient time to work with service users to allay any concerns about changes to providers and to allow implementation of new service models from May 2018.

11 THERE ARE NO APPENDICES

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577. (18pt)