Report No: 75/2017
PUBLIC REPORT

SCRUTINY PANEL

6 April 2017

HOMECARE RECOMMISSIONING

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	
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DECISION RECOMMENDATIONS
That the Panel: 1) Notes the content of the report and presentation, and for Members to provide input into potential options for homecare prior to soft market testing.

1 PURPOSE OF THE REPORT

1.1 To inform members of the potential homecare models that could be effective and sustainable in Rutland and for further comments from members prior to soft market testing.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 Currently the Council commissions over 63,000 hours of homecare support per year to approximately 85 people. This figure is set to rise in the future due to an ageing population, people living longer with more complex conditions, and people having the choice to remain living at home with appropriate support in place. The Council need to ensure that homecare services are able to meet future demands and are fit for purpose; therefore we are looking at other models for commissioning these services.

2.2 The Council tendered homecare provision in 2013 and currently has a framework agreement in place with 4 domiciliary care agencies to provide care packages to older people. The framework contract is in place until May 2018 and allows the Council to directly award care packages to providers when the need arises.

2.3 Although there were 8 providers initially on the Framework, over the life of the

Framework 3 have withdrawn due to the low volume of work or to difficulties of staffing calls in Rutland.

2.4 In order to ensure sufficient carers are available to meet packages, a number of additional providers have been awarded contracts. These are known as 'second tier' providers and are used where those on the Framework have no capacity. There are 7 such providers currently.

2.5 The two tier approach to providers makes the process of commissioning packages more complex, but as the current contracts are structured is necessary.

2.6 Over the lifetime of the current contract, the market has struggled to respond to the challenge of providing home care support within Rutland due to capacity issues, and due to staffing recruitment and retention difficulties.

2.7 As part of the re-commissioning process it is important to understand the views of service users, carers and providers in relation to support given, the challenges, and how improvements might be made.

2.8 Scrutiny received a report in February 2017 (Report No: 28/2017) setting out the way in which feedback was obtained from service users, carers and providers regarding the current homecare provision in Rutland and the themed responses, including:

- **Standard of care**: The quality of care and support provided by staff who are well trained, and have a knowledge and understanding of service user needs.
- **Consistency of call times**: The times required to support and whether these are at a regular time each day, to which the service user has agreed.
- **Consistency of carers**: The regularity with which carers visit the same service user, and having an understanding of their support needs.
- **Rate of pay**: The rate paid to the provider for the cost of services and the pay received by a carer.
- **Communication**: the way in which service users, providers, carers, and social care share relevant information with each other to ensure effective and safe services.
- **Recruitment and retention of staff**: Recruitment of suitable staff to meet service needs and retaining current staff in the workforce.

2.9 The views of both those who are receiving, and those who are providing home care support have contributed to the development of these models.

2.10 The models developed need to ensure they address the issues identified, as well as take into account the aging population in Rutland and the priority for health and social care to support people to maintain their independence for longer and in their own homes.

2.11 The models developed have also taken account of good practise examples both in the UK and abroad.

2.12 As a result various models of homecare have been identified that could be suitable to meet the needs of Rutland residents both now and in the future. Three models that have been developed are:

i) An improved Framework of preferred providers

ii) Relationship-based homecare

iii) ‘Whole care’ approach with relationship based support

Appendix A gives further details on each model, the illustrative figures within each, and other models not considered suitable for Rutland - this is for reference as a presentation on the options will be given in the meeting.

2.13 Specialist service provisions for support at home have not been included in these models. These services are provided by staff with specialised training in relation to a particular condition.

3 NEXT STEPS

3.1 Officers propose to carry out soft market testing with the models considered throughout April and May 2017, followed by procurement (dependent on the model) in August 2017.

4 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

4.1 The way in which home care is provided in Rutland needs to change to reflect the growing population and demand for services as well as supporting people to manage long term conditions more effectively, reducing the need for acute services. In order to support this, a new innovative provision of home care will need to be considered that addresses some of the fundamental issues that affect supporting someone in their own home not only now but in the future.

4.2 As recruitment and retention have been an issue in Rutland for some time it is important to consider how these models support the growth, development and progression of staff working in this industry as a result of their training and experience.

4.3 Officers have developed three models which have incorporated the feedback from service users, carers, and providers and consider the future demand for services in Rutland.

4.4 Illustrative figures have been included but will be developed further as more information is gathered which may affect the cost of each model. However, as the market is changing and the demand for these services increases we need to look at a balance of sustainable cost against outcomes achieved for those receiving support.

4.5 That Members consider the options of models for the provision of domiciliary services in Rutland and provide input prior to soft market testing.

5 BACKGROUND PAPERS

5.1 Report 131/2016 Home (Domiciliary) Care tabled at People (Adults & Health) Scrutiny Panel July 2016 sets out background detail on the provision of home care in Rutland.

5.2 Minutes of the meeting of the People (Adults & Health) Scrutiny Panel held on Thursday, 22nd September, 2016.

6 APPENDICES

6.1 Appendix A: Options for home care models in Rutland

6.2 Appendix B: Timetable for the re-commissioning of domiciliary care provision in Rutland.

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

Appendix A:

Options for home care models in Rutland

1. **Option 1: An improved framework of preferred providers**

What this model is and how it will work

1.1. A framework enables a single procurement process for multiple providers of a service, who are then 'called off' (purchased) from the framework to provide services for individuals. These providers have a contract with the Council. As care packages are required these are brokered to providers based on the individual's support needs and call time requirements.

1.2. This model commissions packages of care based on the time taken to support an individual with a particular task(s) in order for their support needs to be met.

1.3. Although this model is similar to the current homecare provision improvements would be made within the contract in relation to the quality of service delivery; standards of support; minimum training requirements for staff; and expectation of providers.

1.4. Providers applying for a position on the framework will need to evidence that they have the following in place:

- A sustainable wage that is competitive with other service industries, promotes employment, attracts staff who can deliver quality and addresses issues such as payment for travel and training time
- An hourly rate that includes good quality mandatory training across a range of care areas, and inclusive of travel time
- Career progression and training that is aligned to the national Skills for Care programme for this sector
- Values based recruitment practice for all care workers and agency staff to ensure that they recruit caring people.

1.5. Providers will need to evidence that the support given is outcome focussed ensuring that they are continually working with individuals to promote independence, and evidence will be required to show how this is assisting with improving a person's quality of life and reducing the level of support required.

1.6. Framework review intervals will take place annually in which if further providers are required they will be able to join the framework. Where providers are under-performing they will be removed from the framework.

1.7. With a smaller pool of framework providers there will need to be a positive move in ensuring care packages in similar locations are distributed more effectively so that there are fewer providers working in the same area, or on the same street.

Risks and issues

1.8. The issues with the model of a preferred provider framework is that providers on the current framework have limited capacity to support new packages of care, there are recruitment and retention difficulties, training opportunities within Rutland are limited, and there are more rural areas in Rutland affecting the time required to travel between calls. These could be potential risks should a similar model be considered – these may be reduced in future by actions outlined below. However capacity

amongst providers has been a long standing issue and is unlikely to be resolved quickly or without significant changes.

1.9. Another potential risk would be that of the cost of services and if the fee rate is viable for providers going forward. To reduce this, the Council could increase the cost per hour to be in line with that advised by the United Kingdom Homecare Association (UKHCA) or providers could bid for a contract, advise what level of cost would be appropriate and provide a breakdown of cost to support this. This could prove to be an expensive alternative if requested increases in rates were high, or it may reduce the number of potential providers where providers felt the rate would not be substantial enough. The risk with this is that the Council may be left with a limited amount of providers working in Rutland.

1.10. An alternative to this would be two fees rates for Rutland: an urban and a rural hourly rate. For this to be implemented there would need to be discussions as to which areas would be classed as urban and rural. This would assist where there have previously been difficulties covering care packages in the villages that are further from the main towns, requiring more travel time, and where fewer care packages are located.

1.11. A further risk would be how providers continue to support the more complex care packages, even with the additional payment. From the current framework providers have struggled to manage and continue supporting complex cases and as a result have handed care packages back to the Council. Should this model be implemented there would be the risk that similar situations occur. This not only affects the market and the provision of services but affects service users and their wellbeing due to the inconsistency of support and transition across services and/or providers.

Benefits

1.12. By implementing framework reviews and allowing new providers to join this annually ensures the Council can monitor the level of need for services and ensure appropriate support is in place, building capacity within the service. This model would also support the sustainability of local businesses and ensuring providers are performing to the standard the Council and service users expect.

1.13. By considering how care packages are effectively distributed will reduce the travel time between visits, increase capacity for providers, and will provide service users with more consistent call times and regular carers. The Council can also work more effectively with a smaller pool of providers ensuring standards of care are maintained to a high level.

1.14. The benefits of this model, with the improvements to be made, is that there will be a mixed pool of providers continuing to offer service users the choice as to those suitable to meet their support needs at appropriate times for them. Staff will also be supported through better working conditions as a result of a competitive wage and available training opportunities.

1.15. By increasing the fee rate to providers with that advised by the UKHCA would include a percentage of the travel time per care visit, and be in line with the National Living Wage. This would allow providers to ensure carers receive a competitive wage to that of other industries and ensure they are paid for an aspect of the travel time rather than the current ‘contact time only’ model. Using the UKHCA per hour costing

model incorporating the National Living Wage, and allowing 15 minutes of travel time per hour of care, the fee rate required would be £18.66 per hour.

Financial implications

1.16. Officers have modelled a Framework approach with the current care packages in adult social care to see how it could be managed in Rutland with the pool of providers available. The cost of this model based on current and predicted increase in service needs throughout 2017/2018, and uplifting the current hourly rate from £16.46 to £18.66, would be between approximately £1.191m- £1.234m.

2. Option 2: Relationship-based Homecare

What the model is and how it will work

2.1. This model moves away from the traditional 'time and task' orientated model to one which is more responsive and outcome focussed by using salaried staff, enabling each carer to have a detailed knowledge of the individual prior to support and respond effectively to how a service user is feeling on that particular day. The support provided will be tailored to not only meet the physical needs, but also the social and emotional needs of the individual and (any) informal carer(s).

2.2. The model will consist of small self-managing teams providing co-ordinated care and support for a specific catchment area, typically consisting of between 13 to 16 service users. This would equate to 64 full time equivalent staff based on the current level of care packages.

2.3. The service user and carer are introduced and get to know each other before any support is carried out. They would be able to find out each other's like/dislikes, what's important to that person and how best they feel they can be supported. The carer and service user then identify how the relationship and care should be managed, including discussions on how they wanted their care delivered and what outcomes they wanted to achieve.

2.4. The support given would be flexible and appropriate to that service user on that day. For example should a service user need more support than usual then the carer would not need to request permission to carry out further support but would be able to assist, and where required refer onto other services ensuring any further risks or deterioration in health and wellbeing is supported and taking a more proactive approach to assisting someone living independently in their own home. The support would consist of daily activities, such as personal care, meal preparation and medication support, weekly activities, such as shopping and attending appointments, and flexi time to carry out particular hobbies and activities to promote community inclusion and reduce isolation.

2.5. The salaries of the staff would be competitive in comparison to other industries and are reflective of the increase in responsibilities. These would also increase dependent on the development and training achieved.

2.6. The service would link to and/or directly provide reablement support to actively promote self-care and independence, working with service users to prevent situations escalating.

Risks and issues

2.7. The risks involved with this model are that providers may not want to be involved/ bid due to the financial impact this may have with the intention of reinvesting any profit back into the business to ensure continued growth and development can be achieved. Providers may also feel it is not suitable to be part of a consortium as the service will need to be renamed and re-established therefore providers may feel this will affect their service, or recognition of service, that is already in situ.

2.8. Due to this model being delivered through potentially a single provider or consortium of providers, there could be issues affecting service delivery if the provider is not of an appropriate standard.

2.9. This model would also create difficulties in the quality assurance of the market as the Council would not be able to monitor providers outside of this model, unless in the event of a safeguarding incident, due to not commissioning packages of care with them.

2.10. As a result of this model being provided through a single organisation there would be difficulties in building in the multi-disciplinary support and clinical roles required, such as nursing support, without increasing the cost of this model. This could also mean there would still be duplication across organisations as they would not be directly linking with each other for the relevant support.

2.11. A further risk is that of service users transitioning between providers and the effect this may have on an individual's wellbeing. If the service user agrees to transfer to the new provider then there would need to be an implementation plan to mitigate any negative impact of transfer on the individual. Further options would need to be considered for those wishing to remain with the current provider, such as the use of direct payments where appropriate.

2.12. Due to the services remaining demand led it is important to ensure this model is open to growth and is subject to the demand of homecare support required within Rutland.

Benefits

2.13. With carers working in smaller areas this will reduce the travel time required between visits and will increase capacity for new packages of care. It will allow carers to spend more time appropriately supporting service users without longer journeys in between calls and without being constrained by time allocated visits. Reducing the number of carers working in each catchment will enable consistency for service users and will allow the carers and service users to build positive working relationships. Carers would be salaried which would encompass their whole working time rather than the traditional model of 'contact time'- the time spent supporting a service user.

2.14. By offering competitive salaries for staff will attract people into the care profession and provide improved terms and conditions. By recruiting and retaining well trained and knowledgeable staff ensures that service users receive a high standard of support.

2.15. Service users' advised that being able to have a positive working relationship with the carers has an impact on an individual's wellbeing and quality of life, achieving the outcomes they have set, and improving their independence. Carers also advised that

they felt better job satisfaction working with people more regularly as they are able to see a person become more confident, independent and they can see the general improvements to a person's overall wellbeing over time and how the support they have given has done this.

2.16. With staff having a good knowledge of the local community, some activities may be able to be supported by informal carers and community networks and individuals may just need the information on these in order to access them.

2.17. The success of this model would be measured by the number of service users with reduced support needs, overall satisfaction received from the service and improvements on a person's quality of life. This would be achieved by feedback from interviews, care management reviews and the journals that each staff member completes providing evidence that the service user is being supported to achieve the outcomes they have discussed and that are meaningful to them. A carer competency framework will ensure that the service is consistent, successful, effective and safe due to the working practises of individuals.

2.18. Through linking to and/or directly providing reablement support this would reduce the need for higher levels of support and/or the need for individuals to transition into acute services or residential care.

2.19. This service could be developed and managed through a not-for-profit model ensuring any surplus revenue was reinvested back into the business to support growth and development: this would assist with developing staff further through training and support, and recruiting staff to meet the demand for support in Rutland.

Financial implications

2.20. Officers have modelled this approach with the current care packages to establish the level of staff required and to identify how the catchment areas could be devised. Based on the current service needs, and the number of staff required to support this model, the cost would be approximately £1.334m.

3. Option 3: 'Whole care' approach with relationship based support

What the model is and how it will work

3.1. This model expands the concept of homecare to encompass end to end care within an integrated health and social care framework. This would provide a range of support and interventions, from lower end, basic support through homecare, reablement, and some healthcare interventions.

3.2. Using similar principles to model 2 staff would work in specific catchment areas, but with various professionals working throughout the team to support staff and service users across Rutland. This model is based on similar models throughout the UK and Europe including the Netherland's Buurtzorg model, Wiltshire's Help to Live at Home, and the Raglan Project in Wales.

3.3. This model has been based on taking a more holistic approach that looks at all aspects of support the individual may require within one service and how frontline staff can be trained to provide basic interventions and assistance which will reduce the need for several services visiting a particular individual. For example, staff will be trained to carry out specific healthcare tasks under clinical supervision therefore

reducing the need for health services although expertise in this area will be based within the team.

3.4. Several spot contracts would be held with providers locally in order to continue commissioning low level, packages of domiciliary support with an outcome based approach to encourage individuals to achieve the outcomes they have set and support with self-help and independent living.

3.5. Low level packages of care would be those that are non-complex ensuring the market could sustain the support for the duration required. Previously providers have found it difficult, or have been unable, to continue supporting some packages of care due to the complexity and level of support needed. This in turn affects the continuity and consistency of support for service users. Based on the current level of support 15% of care packages would be commissioned with providers. This will assist with maintaining the market and providing greater efficiencies across the provision of services.

Risks and issues

3.6. The risk with this model would be understanding the level of engagement and support required from the CCG and the wider engagement from health providers.

3.7. Further risks include the effect this model may have on the wider homecare market in Rutland and the sustainability of spot providers, and how packages would be commissioned with providers based on the level of need and complexity. With the current care packages and those with low level support needs approximately 15% would be commissioned with providers.

Benefits

3.8. This model would support the career progression of staff and reduce the duplication of services. The staff within this model would also be able to directly refer onto other services required and request assistance or advice from other professionals within the team based on their expertise is specific areas.

3.9. This model includes multi-disciplinary support and clinical supervision which would meet the whole care needs of an individual, and in a more responsive and dynamic way.

3.10. By continuing with several spot purchase contracts ensures the Council continues to support the market and is able to monitor the standard of support received by individuals through regular contract monitoring visits carried out.

3.11. This model builds on the existing integration of health and social care services in Rutland. It could potentially develop to become aligned to the wider multi-specialist community provider approach.

Financial implications

3.12. The ‘Whole care’ approach would be of a reduction in cost to option 2 as current staff and resources would be utilised more effectively and 15% of care packages would be commissioned to providers with the UKHCA recommended hourly rate of £18.66. The total cost would be approximately £1.101m.

4. Other options considered:

A number of other options were considered and rejected on the basis that they would not be effective in Rutland. These were:

Block contract:

4.1. This model allows the council to have a contract with providers for a set amount of hours per week or per month. This would ensure that a certain amount of hours are carried out by providers so they can support with care packages. Rutland currently commissions c1227 hours per week which in order to give sufficient block contracts, for this model to be sustainable for providers, would significantly reduce the overall number of providers contracted by the Council.

4.2. The pool of available providers would thereby be reduced and there would be a reliance on these providers to meet future demands. This could also cause the Council risk if a provider failed and would affect the remaining capacity across Rutland.

4.3. Although the block contract would specify the amount of hours a provider is required to carry out, generally block contracts do not specify when the hours must be provided. This can in turn affect capacity and ensuring call times are suitable to meet individual service users' needs.

Prime provider model:

4.4. Officers have looked at authorities who have implemented the prime provider model: the county is split into geographical areas or via GP zones and there is 1 provider in each area that will support with packages of care. The main provider can subcontract packages of care to other providers in the area but the prime provider will be responsible for this care package on-going. Having 1 provider per area enables providers to have more capacity as they are not picking up packages across a wide geography with more travel time required.

4.5. This model of domiciliary care would not be suitable for Rutland due to the size and geography: with only 2 central towns, and more rural locations than urban, the county would ultimately be split into 2 locations with the towns being central to these therefore only supporting 2 providers. Within both neighbouring authorities there has been significant difficulty in recruiting staff to support the geographical areas causing providers capacity issues. This would be reflected if Rutland supported this model as providers would require staff to continue supporting with private packages of care. This could also cause a high risk to the Council should there be issues with providers in terms of safeguarding and compliance where there are only 2 contractors involved.

Appendix B: Indicative Timetable for Re-commissioning of Domiciliary Care Provision (dependent on the model)

Stage	**Date of completion**
Consultation with service users, carers, and providers	Oct 2016- March 2017
Develop model- soft market testing	April - May 2017
Write specification, ITT preparation	June - July 2017
Cabinet for approval to procure	July 2017
Tender issued/ OJEU Notice published with mandatory pre-qualification questionnaire and ITT.	August 2017
Final Tenders submitted	October 2017
Final Tenders evaluated/ Clarification meetings	November 2017
Clarification meetings	November 2017
Award contract	December 2017
Implementation period/ sort of TUPE	December 2017- 30th May 2018
Start of contract	31st May 2018