TO: ADULT SOCIAL CARE OVERVIEW & SCRUTINY PANEL
19th October 2016

DOMICILIARY SUPPORT OPTIONS
Chief Officer: Commissioning and Resources

1 PURPOSE OF REPORT

1.1 To advise the Panel on progress made on developing a new model for the provision of Domiciliary Care.

2 RECOMMENDATION(S)

2.1 The Panel is invited to comment on the proposed Domiciliary Care model which represents a change from current practice and requires a number of different elements of a system to change.

3 REASONS FOR RECOMMENDATION(S)

3.1 An Overview

There is a need to ensure domiciliary care is delivered with greater focus on an individual's outcomes, with a significant emphasis on regaining, preserving or achieving an optimal level of independence and promoting community access and integration.

An asset based approach to delivering support by providers through partnering with the voluntary and community sector will be a key factor in nurturing the resources to identify and activate solutions for people with a need.

The health care and social care systems also need to be considered as a whole rather than as parallel, separate systems including CHC and social care. Jointly commissioning services with health also supports better outcomes for individuals.

The new proposed model will ensure that the support and care delivered in people's own homes can:

- Support people to regain or attain independence to an optimum level
- Maximise and maintain people to live independently for as long as possible
- Support people to achieve their identified individual outcomes
- Decrease isolation and improve health and wellbeing.
- Respond to changing needs and demands
- Provide access to paid support where a need is identified
- Improve quality within domiciliary care services
- Develop links and provide access to the local community and voluntary sector organisations
- Provide access to assistive technology to maximise independence.
- Provide value for money and address the containment of costs

There is a need to shape the market such that it is incentivised to offer affordable, sustainable, consistent person-centred support which offers genuine choice and control to empowered individuals by experienced, appropriately and suitably qualified, and paid care staff.

A financial model will be developed to incentivise the change to enable providers to reduce the need for formal paid care and support. The new contracting arrangements, with a focus on outcomes and partnering with the voluntary and community sector will enable providers to work more creatively and flexibly with people to ensure they meet their needs.

3.2 **Bracknell Forest Council Position**

The current approach to commissioning domiciliary care is unsustainable. Current service provision along with a rise in the older population will result in an increase in the hours of domiciliary care being commissioned. This is both unaffordable and undeliverable given the recruitment difficulties in the sector.

This is evidenced from the Bracknell Forest Joint Strategic Needs Assessment which shows that around 6,000 people aged 65 and over living in the Borough are estimated to be unable to manage at least one or two domestic tasks on their own, with this figure estimated to increase to around 7,000 by 2020.

It is important that a new approach is developed to the way in which care and support is commissioned and delivered so that the growing range and level of need can be met in a more cost effective manner with regard to the availability of resources. That there is a focus on the outcomes achieved as a result of the support delivered, rather than the current arrangement which simply focuses on activity levels (task and time).

The health care and social care systems are currently operating as parallel, separate systems. There is now an opportunity for NHS Continuing Health Care and Social Care, through the introduction of Personal Health Budgets in developing a collaborative integrated approach in providing better outcomes for people with an identified need.

There are risks associated with the move to this new model, but there are greater risks associated with continuing with the existing model. The risks and challenges associated with workforce retention and recruitment, with high levels of staff turnover experienced by many providers and by the regeneration of the town centre requiring 3000 staff from April 2017.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 The alternative option is to maintain the current status quo. However there is no incentive for providers to make links with local communities that could enhance support and enable people to remain living independently within their own home. Furthermore maintaining relationships with 22 providers is time consuming; the volume of work with providers is low in most cases and this has a negative impact on the importance of the relationship the provider has with the commissioner.

A further alternative considered is the introduction of a Lead Provider model, currently in place in Royal Borough Windsor and Maidenhead, where a single provider manages the provision on behalf of the Council, allocating the work and managing other providers to deliver. This option represents significant risks of a lack of flexibility and of having no service at all in the event of the provider failing or red flagged due to concerns.

5 SUPPORTING INFORMATION

5.1 The Care Act 2014

The Care Act 2014 sets out the principle that the core purpose of adult care and support is to help people to achieve their outcomes (what matters to them) and the impact on their wellbeing. There are responsibilities on Councils for "market-shaping", to stimulate the whole local market, not just the part which the Council purchases from directly. This duty is defined as the "shaping the future direction of the market" through a mix of providers (including small and large, generalist and specialist) and incentivising change to offer affordable person-centred support which offers genuine choice and control. The Care Act also sets out the duties to promote and support local providers within the care and support market.

Bracknell Forest has to improve and invest in the future of the home care force with a link to the wider policy initiatives to ensure a joined up approach and set out a pathway to address current and future needs. This will allow the facilitating of opportunities in how domiciliary need is assessed, planned and delivered to produce the steps necessary to improve the status of caring as a career. Bracknell Forest Council will be taking a proactive collaborative approach with Providers and the NHS in exploring opportunities to reshape the market and increase the level of quality within the local domiciliary market whilst ensuring the requirements of the Care Act 2014 are met.

5.2 The Domiciliary Care Position in Bracknell

There are twenty two approved domiciliary care providers commissioned by Bracknell Forest Council to meet the needs of older people and people with long term conditions who have been assessed as eligible for support funded by adult social care. In 2014/15, they delivered home based care to an average of 400 people each week in the borough; approximately 5,000 hours of domiciliary support is commissioned by Bracknell Forest Council per week.

The current contracts are spot contracts; there are no block or framework agreements to which the council is tied in. All providers work for the one agreed rate £16.71 per hour. The Council stipulates that carers must be paid the equivalent of the Bracknell Forest supplement and for travel time which exceeds the requirement of the Care Act 2014 to pay carers the National Minimum Wage of £15.74/hour (United Kingdom Homecare Association 2015).

There has been a marked upward trend with a doubling of hours of domiciliary support commissioned for the same number of people, leading to a doubling of costs within a 5 year period from £2m to £4m. There is no satisfactory explanation for this increase over and above the reduction in residential placements which does not account for the whole increase.

Traditionally "care to place" is between 200-400 hours per week; in Autumn 2015, this peaked at 700 hours. The in-ability for providers to recruit locally was cited as the issue. Both Bracknell Forest Council and Berkshire Care Association ran web-based and radio campaigns. The situation has improved significantly with the "care to place" in March, April and May 2016 being between 30 and 130 hours per week. Providers are currently reporting that there are no issues with recruitment.

In order to ensure that care packages are right-sized, to prevent increased need and to minimise dependency for support, the Better Care Fund has increased investment

in the Intermediate Care Domiciliary Reablement team for “Social Care Reablement”. The department has also resourced a small team (temporarily) to review existing packages of care to ensure they are not over and above what people need to remain independent.

5.3 The Domiciliary Care Model (current and future)

The current service model is a traditional model and based on task and time, with little or no flexibility and therefore tends ‘to do things for people’, rather than support people ‘to do things for themselves’, thus creating dependency. People tend to be regarded as passive recipients of care and support.

Providers are currently disconnected from the care planning process leading to support being allocated on the basis of task, time and availability of provider. This approach does not promote maximising independence.

A move away from “fixing problems” to an asset based approach which focuses on prevention and early intervention and where people are enabled to recognise their strengths and abilities to co-produce solutions to their needs working in partnership with support and service providers. Greater integration between health and social care focussing on outcomes based care; determined by individual service users will be a key part in redefining the offer to be people with an identified need.

Beginning with an assessment of a person’s needs with the person, the practitioner and provider focusing on achieving greater independence where ever possible, will give clear direction in the delivery of the support to be provided. With the provider supporting the person to regain their skills to maximise independence will enable those outcomes to be achieved. With the right support, alternative provision, such as a structured offer from the voluntary and community sector provision could be developed to provide specialist or community care offer. However the aim to identify solutions and resources that are available in their communities will require providers to work with individuals differently to access wider support networks in the community.

A maximising independence approach as part of care provision with people being supported to do as much as possible for themselves as the default position will require a significant cultural change both within the council, the individual with a need and the provider market.

Financial incentives to providers for reducing needs of individuals over time and meeting defined outcomes will be critical not only in obtaining buy-in from providers but in developing and supporting the market.

5.4 Market Engagement

In order to obtain the optimum model for future delivery, the Council is looking to co-produce the final model in conjunction with both the Domiciliary Care market, and with the voluntary sector. This approach allows providers and the voluntary sector to help shape the future delivery of service, within the parameters laid out above. There is no perfect outcome based domiciliary care model that can be simply adopted in Bracknell Forest. To this end, a series of workshops with the private and voluntary sectors are taking place through September and October.

Some of the issues to be covered in the series of workshops are:

- Financial model

  The extent to which delivering hours, as opposed to delivering outcomes, is rewarded in the price.

- Creating “zones” (if applicable)

  Should Bracknell Forest be divided into geographical zones for providers to bid for work within a zone – is this helpful, or unhelpful.

- Employing an asset based approach

  How can we commission services that recognise that people, either on their own or as part of a wider network, are capable of contributing to their own care and improving the care of others.

- New relationships with the voluntary sector

  How can the domiciliary care providers work with the voluntary sector to deliver outcomes to people, especially in those areas of work for an individual that do not required a CQC registered provider

- Timescales/phases for moving to a new model

  Should the Council switch over to its new model from Day 1 of the new contracts, or should it be phased over time,

5.5 **Procurement Process**

In order to deliver an outcome-based, flexible and sustainable Domiciliary Care model, ongoing engagement and support of providers will be vital. Extensive consultation and dialogue with the market (domiciliary care providers, community and voluntary sector) during the tender preparation through stakeholder and market shaping events will need to be considered.

It is further proposed that the Council will work actively with providers to improve training and development opportunities for care staff including facilitating specialised training in particular areas in order to better meet the specific i.e. behaviours which are challenging and support the sharing of best practice.

There will be a clear expectation for providers to partner with the community and voluntary sector and detail within their tender submission how they will engage, co-ordinate and provide access to the community in a meaningful and active way to people with an identified need.

The proposed tender will reduce the number of providers we work with, thereby providing an opportunity to proactively work with a targeted number of agencies to share best practice and work with them to provide solutions to market issues, such as capacity and workforce. The significant reduction in the number of providers contracted with will need to be appropriately managed

An implication of the proposals is that not all providers currently delivering services for the Council or NHS (Continuing Health Care) will continue to do so in the future. It is anticipated that some staff will be protected by TUPE where the majority of their job is focused on providing a service to people with a need through the Council or NHS. The risk is that some staff may leave the sector to work within the new service industry within Bracknell Town Centre or will not be eligible for TUPE.

To respond to the issues and challenges the proposal is to establish an integrated framework with a reduced number of providers to:

- assure supply across the Bracknell
- address the viability of the proposed service model
- support sustainability in the market and in the workforce
- enhance quality and focus on outcomes
- develop arrangements which are manageable to run and consistent
- ensure value for money
- work within budget constraints
- categorise risks
- establish interim operational arrangements

There will be inclusion within the scope of the framework agreement for

- 'maintaining" independence' care and support at home
- maximising independence' care and support at home
- associated services funded through NHS Continuing Health Care

The key metrics for this are:

- Reducing the length of inpatient stays
- Reduced re-admissions within 30 days following discharge
- Improving hospital discharges
- People returning to their own homes and being diverted from residential settings

5.6 **Procurement Timetable**

Proposed Procurement Plan (see attached)

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 An EIA screening will be undertaken as part of the procurement planning process.

Borough Treasurer

6.2 At this stage there are no financial implications to consider. These will be developed as part of the development of the model.

Equalities Impact Assessment

6.3 Not completed at this stage

Strategic Risk Management Issues

6.4 The Council needs to ensure that there are adequate and suitable resources to meet its obligations under the legislation

Other Officers

6.5 Alison Cronin

7 CONSULTATION

Principle Groups Consulted

7.1 Not completed at this stage

Method of Consultation

7.2 Not completed at this stage

Representations Received

7.3 Not completed at this stage

Background Papers

Appendix 1: Procurement Plan

Contact for further information

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