Norfolk County Council
at your service

Adult Social Care Committee

Date: **Thursday 23rd October 2014**

Time: **10am**

Venue: **Edwards Room, County Hall, Norwich**

SUPPLEMENTARY
A g e n d a

6. Recommissioning Homecare **(Page A2)**
Report by Director of Community Services

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Adult Social Care Committee

Item No. 6

Report title:	**Recommissioning Homecare**
Date of meeting:	**23 October 2014**
Responsible Chief Officer:	**Harold Bodmer**

Strategic impact

The proposals will enable the Council to secure home care services, providing core care in a prevention framework and with a clear strategy to secure and improve quality.

This allows the Council to address its statutory duties in the Care Act 2014 in respect of promoting individual wellbeing through preventing, reducing or delaying the need for care and support in the provision of home care services.

Executive summary

Following consideration of a report entitled 'Remodelling Home Care for Norfolk' at the meeting on 22 September 2014 of the Adult Social Services Committee, members asked officers to prepare a scoping report for the October meeting of the Committee. The report was asked to include costed options for sourcing home care services in the future including the option of sourcing home care in-house through directly employing staff.

The Council currently invests about £48m a year on home care and support at home services. Over £17m of this investment is through 24 block contracts with eight providers. 12 of these contracts come to an end and must be replaced by November 2015 in the East and West of the county with the remainder requiring replacement in November 2016. This provides an opportunity to implement a revised commissioning model and sourcing strategy for home care:

1) To build on the benefits of existing home care services:
    a. Ensure good quality personal care
    b. Use preventative approaches which reduce demand on care services
    c. Deliver better outcomes for individuals
    d. Provide services which are flexible to individuals' needs
2) To address concerns in some of the current arrangements about:
    a. Variable service quality
    b. Variable market resilience
    c. Use of zero hours contracts and related workforce issues
    d. Opportunities to strengthen the care economy.

It is proposed that this is achieved through revising our approach to home care in Norfolk by:

a) revising the model of home care which the Council commissions, and
b) developing our strategy for sourcing home care using contracts which secure a focus on outcomes for individuals. The sourcing strategy also proposes the development by the Council of an arm's length home care provider.

In order to secure an approach based on promoting independence it is proposed that the Council's existing reablement service – Norfolk First Support – has a strengthened role as the 'gateway' to home care.

Recommendations:

It is recommended that the Committee:

a) **Approves the implementation of the new service model for home care services in Norfolk as set out in appendix 1.**

b) **Approves the implementation of the proposed sourcing strategy to procure block contracted services from the market alongside the development of an arm's length Council home care provider to promote resilience, quality and workforce issues in the market.**

c) **Confirms its commitment to the care workforce through the Unison Ethical Care Charter stages 1 and 2 and that these are reinforced in future contracts and that stage 3, including payment of the Living Wage, is scoped for future implementation.**

d) **Approves the proposed increased investment in the quality assurance and monitoring of home care on an invest to save basis.**

e) **Requests officers further scope the potential to invest more in reablement in order to reduce demand on future services as an invest to save opportunity, and bring this back to the Committee.**

1 Proposal

1.1 The proposal before members is to implement a revised commissioning approach for home care in Norfolk comprising:

a) A revised service model for commissioning home care, and
b) A revised strategy for sourcing home care.

1.2 The new commissioning strategy for home care has been developed in response to new duties under the Care Act 2014 in relation to prevention, the promotion of individual wellbeing and to the use of community assets and resources to support people to continue to live as independently as possible in their communities.

1.3 The first opportunity to implement the new strategy will be in November 2015 when 12 block contracts for home care services become due for replacement.

2 Evidence

2.1 **A revised service model for home care in Norfolk**

2.1.1 At the Committee meeting on 22nd September 2014, a paper was received setting out the proposals for the Council to commission a revised service model for home care, underpinned by a move from 'time and task' approaches to home care to a model focused on delivering wider outcomes for the individual.

2.1.2 The model is set out in appendix 1 and proposes to secure the existing requirement to deliver good quality personal care, but introduces a stronger focus on restoring independence and achieving outcomes which matter to the individual.

2.1.3 There has been a programme of engagement with people who use home care services to understand what they seek from the service. In addition, engagement with providers of home care services has allowed us to test the opportunities for

change in home care provision.

2.2 **A revised sourcing strategy for home care**

2.2.1 The existing contractual arrangements for 12 block contracts in the East and West of the County come to an end in November 2015 and the remaining 12 block contracts in the central areas of Norfolk end in November 2016. There is very limited scope to adjust the timescales within which a major recommissioning, procurement and transition process needs to be managed which means that decisions are needed to allow the process to commence.

2.2.2 This report provides members with a strategic outline case which evidences the need for a procurement process to secure a new service model for home care that tackles market risk and service quality as well as affordability and new legal requirements contained in the Care Act 2014.

2.3 **Part One: The Strategic Case**

2.3.1 The purpose of the strategic case is to identify the key drivers of change, the key concerns about the way the market operates now and what needs to happen to address both.

2.4 **Key drivers of change**

2.4.1 **Legal duties under the Care Act 2014**

2.4.1.1 The Care Act requires councils to promote individual wellbeing, to prevent the need for care and support and where care and support is required to reduce or delay the need for it.

2.4.1.2 This new market development duty in the Act also requires the Council to promote an efficient and effective market in care services in which the consumer can choose from a variety of providers who together provide a variety of high quality services.

2.4.1.3 In discharging the market development duty the Council must have regard in particular to

a) The importance of ensuring the sustainability of the market (in circumstances where it is operating effectively as well as in circumstances where it is not)
b) The importance of fostering continuous improvement in the quality of such services and the efficiency and effectiveness with which such services are provided and of encouraging innovation in their provision
c) The importance of fostering a workforce whose members are able to ensure the delivery of high quality services.

2.4.2 **Local Government Act 1999**

Best Value

2.4.2.1 The Best Value regime continues to apply to the Council requiring it to seek continuous improvement in the provision of services. The statutory guidance emphasises the importance of effectiveness, efficiency and economy in the provision of services. Any new ways of working will need to be capable of being delivered within budgetary constraints.

2.4.3 **Member Concerns**

2.2.3.1 Members highlighted in particular:

a) Concerns about the workforce including low pay, zero hours contracts and low employment status leading to high staff turnover and poor continuity and quality of care. Members noted the very high staff turnover rate in independently

provided home care in Norfolk at 56% and the prevalence of zero hours contracts in independently provided home care in Norfolk at 74%

b) The previous Cabinet decision to develop Norfolk's commitment to the home care workforce
c) The need to secure affordability for any change including the possibility of reusing investment released from less reliance on residential care to fund greater investment in home care as part of a preventative strategy
d) The need to secure reliable high quality home care services in the light of market failure and the ongoing process to reprovide Care UK home care packages.

2.5 **Market issues**

2.5.1 **Reliability and market failure**

2.5.1.1 Home care is a crucial service upon which vulnerable individuals must be able to rely and in which the Council can have confidence as a commissioner of services. Continuity and reliability are vital.

2.5.1.2 There will always be some change in the market requiring the transfer of services to alternative providers. Over the past four years, four small spot providers have ceased providing and all the care packages were successfully reprovided by the market.

2.5.1.3 However, the failure in 2014 of the service provided in the Broadland area by Care UK, a large block provider, affected over 200 people and had a major impact. The majority of these care packages are being taken up by other block contract providers with the remainder going to spot contract providers.

2.5.1.4 In the circumstances of this substantial difficulty, the market on its own was not able to respond quickly enough to avoid the need to deploy the Council's own in house rehabilitation service, Norfolk First Response and the Council's Community Interest Company, Independence Matters, without whom there was a real risk that some service users would have received no service at all.

2.5.1.5 The preferred option for sourcing home care will, therefore, need to be capable of addressing the new sustainability requirement in section 5 of the Care Act which explicitly requires that the Council is able to act in circumstances of market failure. This means having the capacity to respond to such unplanned demand for home care services and to respond to provider quality and provider failures in a way that is sustainable and reliable.

2.6 **Quality**

2.6.1 The quality of the care provided is key and the Council has responsibilities to contract for quality services and to assure quality.

2.6.2 Home care is a Care Quality Commission regulated service and all providers are legally obliged to comply with the regulatory standards. This is the foundation of our quality assurance, but the Council has a wider structure of contract and quality requirements to secure good quality services.

2.6.3 The preferred sourcing option will need to explicitly address care quality. Although home care quality is good for most people most of the time, there continue to be complaints and concerns reflecting unacceptable quality. The Council will continue to set high standards and it is proposed that the Council invests further in monitoring these crucial services even more closely, given the importance of these services to vulnerable people and the scale of investment the Council makes in home care. An additional resource focused in each locality would allow for close monitoring and support of the services in the area, ensuring services are delivered to the standard

expected, but also would allow for ensuring impact within the local health and care systems is maximised.

2.6.4 It is therefore proposed that an additional quality assurance post is established for each of the five localities, and that this is undertaken on an invest to save basis, where the initial funding is recouped through better use of purchase of care funding.

2.7 **Workforce**

2.7.1 The quality of care is directly impacted by the skills, knowledge and behaviours of the care workers themselves. The workforce is characterised by low pay and low esteem in spite of the very valuable and demanding work that is carried out increasingly with clients who have more complex needs. There are also limited opportunities for career progression.

2.7.2 Continuity of care is very important to service users; however staff turnover rates in independently provided home care in Norfolk have risen on average to over 50%. This means that, as an average, the entire workforce has to be replaced every two years causing discontinuity of care and additional cost which is reflected in current contract prices. There would, therefore, appear to be scope for improved terms and conditions, at least in part funded through lower staff turnover.

2.7.3 In addition, the terms and conditions of employment in home care are characterised by minimum wage and zero hours contracts which are contributing to discontinuity of care and therefore poor care quality.

2.7.4 Over 70% of employment contracts in independently provided home care in Norfolk are zero hours contracts according to the National Minimum Dataset. Whilst these contracts can provide flexible working opportunities for some people, when used to this extent they are likely also to contribute to a risk of service failure as there is no obligation on the part of the employee to accept the work offered.

2.7.5 Some of the larger national companies are recognising the problems with zero hours contracts and are beginning to offer guaranteed hours contracts instead. In Norfolk many smaller providers currently offer a mix of guaranteed hours and zero hours contracts.

2.7.6 In order to address these issues, Members asked for consideration of the Unison Ethical Care Charter and the opportunity to commission home care services which adhere to the Ethical Care Charter. The proposed service model at appendix 1 is consistent with the Ethical Care Charter, ensuring a focus on individual needs and outcomes rather than simply time and task.

2.7.7 The requirements of stage 1 and 2 of the Unison Ethical Care Charter can be secured in new contractual arrangements and reflect the workforce development issues as required by section 5 of the Care Act. In particular the Council could incorporate conditions within future contracts that reflect the HMRC position in relation to minimum wage legislation. This means that ordinary costs of business such as travel costs, personal protective equipment and communications equipment are not passed on to the employee as this risks the net take home pay being less than the minimum wage after these expenses are deducted.

2.7.8 On this basis future contracts could include clauses that

a) ban the enforced use of zero hours contracts and promote guaranteed hours contracts as the norm
b) require travel costs and travel time to be paid in accordance with HMRC recommendations
c) require training to be delivered in work time at the employers expense
d) require personal protective equipment and communications equipment to be

paid for by the employer.

2.7.9 Some of these requirements may have financial consequences for providers. The impact would vary across the provider base because individual providers' terms and conditions including rates of pay vary. Some provide protective equipment and communications equipment at their own expense and some do not. Travel costs are compensated at differing rates. These requirements would be put to the market as part of a competitive procurement process.

2.7.10 Stage 3 of the Ethical Care Charter however would mean that in commissioning home care the Council would need to:

a) require appropriate sickness schemes to be available to all workers
b) require the Living Wage to be the minimum payment for hourly paid workers.

The impact of these requirements is more difficult to anticipate and carries risk of significant impact on costs to the Council.

2.7.11 Some providers already pay more than the Living Wage but many do not. The National Minimum Dataset indicates that the median hourly pay for a carer working for an independent home care provider in Norfolk is £7 an hour. The Living Wage is currently £7.65 an hour. Approximately 1.2 million hours of contracted home care are currently provided annually. Looking purely at the hourly pay rate and assuming that there is no scope for efficiencies within the businesses concerned it would appear that an additional investment of about £0.65 per hour of home care delivered *on average* would enable providers to pay at Living Wage levels. The additional cost to the Council on this basis would be £0.78m.

2.7.12 The United Kingdom Association of Home Care Providers recommends an hourly rate of £18 to enable providers to pay at Living Wage levels. This is £2.73 an hour more than the average contract rate in Norfolk. If we took this figure as the basis for determining the level of additional investment required the Council would need to invest an additional £3.27m. The rationale behind the £18 figure has been publicly challenged by the Association of Directors of Adult Social Services.

2.7.13 On the other hand the proposal to shift more of the current level of investment from spot contracts which carry more business risk and therefore command a price premium, to block contracts, together with further changes in working practices already taking place in the market, may mean that no additional investment as a whole is required to enable providers to pay the Living Wage.

2.7.14 Clearly further more detailed work would be required to estimate the extent of the further investment required, if any, to enable all providers to pay care workers the Living Wage. Officers are continuing to work with providers to better understand costs of business.

2.7.15 However, a staged approach to adopting the principles of the Ethical Care Charter would introduce improved conditions of employment initially as reflected at stage 1 and 2, while the potential to work to stage 3 is further considered. Our collaborative work with Norfolk's home care providers to understand their costs and opportunities already reflects much of the good practice set out in the Charter.

2.7.16 In addition to our local commissioning, in determining future level and type of investment in the home care market as a means of enabling workforce issues to be tackled, the Council may recognise the national direction of travel and the fact that the market is already moving in the desired direction without any increase in investment from councils at this time. This is mainly due to national pressure, including HMRC scrutiny.

2.7.17 Whilst pay is important it is the retention of care workers, supported by long term employment relationships through guaranteed hours contracts, a commitment to training and opportunities to move up the career ladder is also vital and enables continuity of care. Any workforce strategy needs to focus on this key retention issue as well as the rate of pay.

2.8 **Economy**

2.8.1 The care economy is a key part of the Norfolk economy as a whole and needs to grow sustainably to be able to meet the needs of an ageing population. This will require a new focus on workforce development and investing in care as a career irrespective of the preferred option. Getting the commissioning approach right is key to success.

2.9 **Affordability**

2.9.1 The current financial climate means that all councils need to secure service improvements wherever possible within challenging expenditure envelopes often accompanied by the need for real reductions in expenditure. Norfolk is no exception which means that any options for change must not only address the issues at hand but also meet the affordability criteria of the Council. The starting assumption, therefore, is that any sourcing option must be capable of being delivered within the current budgetary constraints.

2.10 **Part Two The Economic Case**

2.10.1 The economic case incorporates the evaluation of the risks and benefits of any options under consideration together with an assessment of value for money, achievability and affordability.

2.10.2 The options are judged against the probability of being able to successfully address issues that are critical for success. These critical success criteria are derived from the key drivers of change, the state of the market and the outcomes that the Council requires within achievability and affordability constraints.

2.10.3 The Care Act requires a preventative approach to care, which is reflected in the Council's strategic approach to adult social services. Reducing the need for home care by ensuring that wherever possible people are either fully restored to wellbeing or only require a reduced package of care following a period of reablement will be key to managing demand and reducing cost pressures in the future. There is a link between reablement, home care and residential care and the opportunity to divert investment upstream to prevent, reduce or delay the need for residential care and potentially even home care.

2.10.4 Scoping the increased application of reablement prior to establishing home care packages, as proposed in the model, seeks to further reduce demand on services and to promote individual wellbeing, along with assistive technology and home modifications where appropriate.

2.10.5 This approach will ensure that the demand for ongoing home care is minimised.

3 Options

3.1 **Critical success criteria against which to test the sourcing options:**

1) The arrangements promote individual wellbeing by significantly increasing the prevention, reduction or delay in the need for home care or residential care services
2) The arrangements provide the resilience needed to provide high quality home

care in hard to reach areas, where there is poor provider quality or provider failure and in times of service transition

3) The arrangements promote diversity and choice for people who need support to live independently at home
4) The arrangements will help foster and develop the care workforce
5) The arrangements promote guaranteed hours contracts and ban the enforced use of zero hours contracts
6) The arrangements can be put in place by November 2015
7) The arrangements are affordable.

And a final test, which reflects a composite of the key criteria set out above:

8) The arrangements allow the Council to meets its duties under the Care Act.

Three options are tested in this paper. The options appraisal includes the status quo both to assess its merits and to provide a benchmark. All options are assumed to deliver the new service model set out in appendix 1.

3.2 **Option 1: The status quo**

3.2.1 This option reflects existing arrangements, with 24 block contracts alongside spot contracting with accredited providers.

3.2.2 All Councils will need to test their current commissioning arrangements against the new duties under the Care Act. If we were to secure the new outcomes-based service model under our existing block and spot sourcing arrangements, the arrangement would be likely to deliver the required service changes in terms of wellbeing. Our contract would oblige providers to work within specified employment conditions so we could be confident of achieving workforce improvements.

3.2.3 However, the evidence of recent service delivery under this model shows that the current sourcing arrangements have struggled to provide the resilience we need to ensure that everyone continues to receive the quality of services they require, particularly if providers fail, are changed or if they experience drops in quality. Recent experience in managing the difficulties in the Broadland contracts highlighted the risk in seeking to rely on the external market for resilience and demonstrated the value of the Council's in-house provision to deliver this flexibility.

3.2.4 It is in the area of resilience that this option is weakest and would risk not robustly addressing an existing risk and a requirement of the Care Act.

3.3 **Option 2: In-house service**

3.3.1 Bringing all home care services in house could deliver a new focus on promoting individual wellbeing through prevention, although this would require investment in both cultural and organisational change. An in-house option could also address the workforce and zero hours issues.

3.3.2 This option could address the resilience issues as the Council will be able to direct the resource as required. However, it would place reliance wholly on an in-house service rather than benefiting from independent sector capacity and expertise.

3.3.3 The key challenge of the in-house option, however, is that it brings substantial additional costs. This is principally because of the legal requirement for the Council to enrol all the staff transferring from existing providers (who would have TUPE rights) and any new recruits into the Local Government Pension Scheme. This would give rise to avoidable payroll costs of about 15% or £4.5m a year.

3.3.4 In addition, the creation of a monopoly home care provider for Council commissioned home care would reduce choice, market competition and have a

major impact on the current market upon which people who fund their own care are reliant. This option would also obviate the Council's ability to test the market for value for money through competitive procurements in the future. It may be difficult to evidence that Best Value was being achieved in such an arrangement.

3.3.5 From 1st April next year Section 5 of the Care Act 2014 will impose a duty to promote the efficient and effective operation of a market in services for meeting care and support needs.

3.3.6 Further, draft guidance on the Care Act notes that the Act will require local authority commissioning procedures to "*encourage a variety of different providers and different types of services*" (para 4.34) including "*voluntary and community based organisations, including user-led organisations, mutual and small businesses*" (para 4.35). While the draft guidance envisages that local authorities may have "*approved lists and frameworks that are used to limit the number of providers they work with*" it requires that they "*must have regard to ensuring that there is still a reasonable choice for people who need care and support*" (para 4.36).

3.3.7 The in-house option would seem contrary to both the express duty contained within Section 5 of the Care Act and the draft guidance.

3.4 Option 3: The mixed sourcing strategy

3.4.1 A mixed sourcing strategy is proposed, which benefits from the advantages of the range of providers in the market, including the Council's own provision.

3.4.2 Firstly, it is proposed to test the market through a competitive procurement process which will offer geographically based outcomes-based contracts to the market. The contracts will cover smaller geographies than the current block contracts in order to create more providers operating locally as the quality and cost of the service is closely linked to travel times. This will also reduce reliance on premium priced spot contract arrangements and give smaller providers reduced business risk.

3.4.3 Alongside the market, it is proposed to develop capacity within the Council's arm's length community interest company, Independence Matters (IM). It is proposed that over the next 12 months IM can build up its home care capacity. It is already registered as a home care provider with the Care Quality Commission and is fully compliant at the highest level with the Unison Ethical Care Charter and so is a workforce exemplar. The relationship that Independence Matters has with the Council means that the Council could rely on Independence Matters to provide high quality services where and when required to address the resilience issues that the Council is facing.

3.4.4 The evaluation below recognises the fit between the mixed sourcing arrangement and the critical success criteria.

3.5 Summary assessment against the critical success factors

3.5.1 The table below sets out the assessment of the likelihood of each option being able to achieve the relevant critical success factor. Marks were allocated using a five point scale as shown below:

1. Very unlikely
2. Unlikely
3. Neither likely nor unlikely
4. Likely
5. Very likely.

3.5.2 The table below illustrates the results.

Critical Success Criteria		Status Quo	In-house	Mixed model
1	Wellbeing	5	5	5
2	Resilience	2	5	5
3	Diversity	4	2	5
4	Workforce	4	5	4
5	Zero hours culture	4	5	4
6	Achievable	5	5	5
7	Affordable	4	2	4
	Total	**28**	**29**	**32**
	Overall Care Act compliance	2	2	4

3.5.3 Whilst each of the options is able to deliver many of the critical success criteria, the distinguishing factors are:

a) the status quo arrangement has demonstrated it is unlikely to secure sufficient resilience and therefore is unlikely to meet a key requirement of the Care Act
b) the in-house model does not provide for diversity of provision and therefore is unlikely to meet a key requirement of the Care Act
c) the mixed model allows for both resilience and diversity of provision, benefiting from the combination of in-house and independent sector provision.

It is for this reason that the mixed model is the preferred sourcing approach.

4 Financial Implications

4.1 In summary, the financial implications of the proposals for commissioning home care in Norfolk are:

4.2 Under the Care Act regulations setting out new eligibility criteria will be published in due course but these are not expected to have a material effect on the numbers of people assessed as eligible under the current criteria used in Norfolk and therefore the costs.

4.3 The nature of the work that providers undertake under the proposed outcomes based contracts will not in itself have a material effect on the cost of providing services.

4.4 Testing the market through a new procurement process will establish a current market price which is expected to be competitive and the reduced reliance on more expensive spot contracts could provide some modest savings which are already anticipated in budget planning.

4.5 It is thought that the proposed investment in demand management through an enhanced rehabilitation service will be self-financing within the health and care system as a whole but further analysis of the business model is required to be fully confident about this. This can be brought to Committee.

4.6 There will be an additional cost of £226k to support quality assurance and contract monitoring capability to ensure that the Council gets the full benefits of its substantial investment in the home care market. It is proposed that this is seen as an invest to save opportunity where the investment in quality assurance in year one is recouped from the benefits over the following year.

5 Issues, risks and innovation

5.1 The proposed commissioning approach sets out an innovative approach to moving forward with home care with an emphasis on outcomes which is recognised as good practice. However, it is recognised that such a change needs to be delivered in a way which manages transition with care. A project approach will be used to support delivery of change.

5.2 A phased approach has been proposed in order to support management of risk. Cultural and organisational change will be required from providers and the Council in order to successfully move to an outcomes based approach. It is proposed that risks are managed through phasing implementation in the east and west of the county as previously described.

5.3 The new commissioning model will require providers to develop a focus on outcomes and to support their staff to do so. Our existing engagement with providers has indicated their interest in and early support to this approach. The Council has an existing programme of support to the home care workforce development which will contribute to this change.

6 Background papers

Report to Norfolk County Council Cabinet April 2014: Home Care in Norfolk: Supporting Quality and Excellence Homecare in Norfolk - Cabinet April 2014

Report to Norfolk County Council Adult Social Care Committee September 2014: Remodelling Home Care for Norfolk Remodelling of Homecare - ASC Committee September 2014

Officer Contact

If you have any questions about matters contained in this paper or want to see copies of any assessments, e.g. equality impact assessment, please get in touch with:

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Appendix 1 – A revised home support model for Norfolk

1. Context

The approach to the re-design and re-commissioning of home care seeks to address a number of key strategic priorities:

- Ensuring a range of good quality services across all areas of the county
- Promoting a properly remunerated and well supported care workforce
- Reducing demand and admissions to residential care
- Avoiding unnecessary admissions to hospital
- Maximising the impact of the Council's investment in services on people's wellbeing and independence.

Demand for services in people's own homes has increased over the last 10 years and demographic information indicates that the numbers of those in need will increase significantly over the next decade. Norfolk currently has levels of admissions to residential care that are significantly higher than comparable authorities. The provision of effective care and support in people's own homes is a key strand in reducing this demand.

The type of service commissioned influences the pattern of need. If we are to deal with the current pressures on adult social care, and continue to meet the needs of our communities, home care services will need to enable people to reach their full reablement potential and should be based on the premise of reducing or stabilising dependence on service provision wherever possible.

Increasingly national policy objectives are expressed in terms of the outcomes they are intended to deliver for service users and evidence from commissioned models of care indicate that a fundamental shift to the use of outcome-based models is successful in supporting frail older people in their own homes with enhanced quality of life. In addition evidence indicates that where outcomes-based services have been implemented staff retention is improved (Sawyer 2005).

Achieving the transformation of home care from a 'time and task' base to an outcomes base is a complex task and it is clear from authorities that have successfully implemented the cultural and organisation shift to outcomes based commissioning of home care that the approach needs to be owned and championed at a very high level. Achieving these outcomes requires a remodelling of the current system of home care, building on what works, and will require changes for providers and for the Council's internal systems and processes.

2. Aims of the home care service model

The overarching rational of the model being proposed is that it must:

a) Provide a personalised and good quality personal care service that maximises people's ability to stay in their own homes and maintain their independence; avoiding and delaying the need for admissions to residential care
b) Provide a service based on recovery and prevention recognising that maintenance or effective support as dependence increases will be an outcome for some people
c) Support the management of demand for the service by moving away from an approach that fosters dependence (time and task) and toward an approach that maximises independence (outcome-based)
d) Be built around the expressed wishes of service users and expressed in relation to the outcomes they want and that support them to move towards greater independence
e) Provide a resilient service that is equitable across Norfolk.

The proposed model also supports the critical success factors identified within the main body of the report. This new model for home care can be delivered whichever sourcing strategy is adopted and it can be implemented in a staged approach:

1. Implement an outcomes-based model of home care, which focuses on regaining and maintaining independence and which maximised the skills and aptitudes of the workforce
2. Establish reablement and rehabilitation for those coming in to care services by extending the existing reablement services incrementally using an 'invest to save' rationale.

3. The revised commissioning approach to home care
The revised model for home care is proposed to meet the aims outlined above and will deliver:

3.1 An outcomes-based approach
Developing home care from a service model focused on time and task, to a service which focuses on outcomes reflects what people tell us they want from their home care services. It reflects emerging best practice in commissioning and aligns with Department of Health policy (DH 2005) on providing care and support as part of a community. The rationale in the proposed model is based on the goal of supporting people to achieve and maintain independence.

The existing focus on task-orientated visits militates against care provider ability to respond flexibly to changing needs of service users and as a consequence misses opportunities to promote independence and quality of life. The new model recognises that while home care services need to deliver core personal care, they can also assist people to meet their desired outcomes, for example by providing more flexible care or by helping them find solutions to social needs within their communities.

Development of clear outcome statements will be used to translate individual customer outcomes – this enables the recording and monitoring of performance of providers.

An example of outcomes and the way in which they can be used is:

I can participate in my local community	I can use public transport or have access to transport
	I can access local amenities (shops, faith groups, pub etc.)
	I can visit/receive visits from family and friends when I want

An outcomes-based approach will ensure that core care needs are met, but will set these in the context of personal outcomes and the overarching aim of achieving as much independence as is possible at every stage.

The fundamental change from traditional services will be that the Council and providers will focus on helping customers achieve outcomes that are defined in Support Plans and rather than limiting the service to delivering a prescribed number of units of service.

3.2 A reablement approach
It is proposed that the potential is scoped for Norfolk's reablement service, Norfolk First Support, to become the front door for home care in the future in order to ensure that all those capable of reablement have their needs appropriately assessed and support to achieve these.

Independent research demonstrates that reablement improves independence, prolongs people's ability to live at home and removes or reduces the need for commissioned care hours in comparison with standard home care. Findings from separate studies show:

- Following reablement people's need for social care services is reduced by 60% compared to if they had used conventional home care (2010 Glendenning et al.)
- 62% of reablement users no longer need a service after 6-12 weeks (5% in the control group) and that 26% had a reduced requirement for home care (SCIE 2011)

Local evidence supports the assertion that provision of reablement reduces the subsequent need for home care and contributes to a better quality of life for recipients; this is a key tool in managing future demand for home care services.

A focus on reablement will be embedded into an outcomes-based approach. However it is also proposed that the potential for all referrals for home care to go through Norfolk First Support is scoped as an invest to save proposal.

3.3 Care planning

Assessments for outcomes would be carried out by Norfolk County Council staff as now, however care planning, the process of translating the service user's outcomes into a plan that determines how care will be delivered, would be carried out between the care provider and the service user. The model would allow for more individualised approach and would expect the provider to work more flexibly and innovatively to meet the service users' preferences and aspirations. This builds on the close knowledge that exists between the service user and the provider. There is some evidence that this way of working is potentially more satisfying for staff which can contribute to staff recruitment and retention.

This does not represent a significant change from current practice but will formalise the existing good practice in relationship between customer and provider and the emphasis of responsibility for the provider.

3.4 Greater community involvement

The new model will also develop the role of the provider in identifying and connecting service users to wider community connections and support. This reflects the ambition to meet wider personal outcomes than simply meeting care needs, for example engaging with housing-related support or local social connections to avoid loneliness.

3.5 Provision for those with specialist or complex needs

Provision for those with complex needs, such as dementia, is needed if people are to be supported to stay at home and out of residential care. It is proposed that an enhanced service would be provided as part of the home support offer to ensure that needs can be effectively met, as conditions progress.

This offer needs to be co-ordinated with mainstream health provision and is consistent with aims to integrate provision of health services such as continuing health care.

3.6 Consideration of a payment by results (PBR) system

In terms of contracting, payment by results can be a powerful mechanism to incentivise provider behaviour and can potentially drive service improvements and achieve increased value for money by aligning incentives to desired outcomes. It is currently being successfully utilised in the Wiltshire Home Support model.

The PBR model offers a mechanism of incentivising providers to support customers to maintain and improve their independence rather than creating dependence. While a more complex payment system, it does offer the opportunity to transform service delivery and the service that customers receive.

There several ways in which PBR can be implemented:

- A pure form would involve individual outcomes recorded, preferably through a shared IT interface, and then payments made accordingly. This mechanism would link well with proposed electronic home care monitoring systems and provides a very personalised service.
- An alternative, but possibly less administratively onerous, system would be to aggregate outcomes on each block contract and pay a proportion of the block sum based on change

outcomes. This mechanism is simpler and still ensures providers remain accountable for outcomes achieved.

It is proposed that PBR be investigated to determine whether it offers advantages to Norfolk in incentivising provider behaviors. There is some complexity in implementing a PBR system and its potential use would be further investigated and considered for implementation in November 2016.

3.7 Exploring potential to include continuing health care (CHC)

Under continuing health care, the NHS commissions broadly similar home care providers, undertaking similar tasks to social care funded services. Commissioning these services jointly should provide economies in administration, improvements in service provision and increase the range of training/skills for home care staff.

Integration of this provision is consistent with Better Care Fund outcomes and is currently being explored with Clinical Commissioning Groups.

3.8 Use of electronic monitoring

Electronic monitoring (EM) is crucial to maximise effectiveness, and can be used to monitor achievement of outcomes. The use of EM will fit with the maintenance level of provision and will support quality assurance staff in validating outcomes. This is an existing project within the Putting People First programme, with efficiencies specifically on the maintenance aspect and the Council's administration of home care.

EM requires care workers to log in and out of a visit to a customer's home. This would also record missed or late visits. Reports run from these systems will allow us to gauge the way agencies plan and co-ordinate work and assist with block contract monitoring with earlier and better knowledge of block usage in order to maximise the use of blocks and avoid costly spot prices. In addition, electronic invoicing will enable more efficient and accurate invoice matching and entry of variations and should benefit both the Council and provider.

The electronic monitoring project aims to have the first providers switching to the new electronic systems from April 2015 with roll out over time. The new model is consistent with this development.

3.9 Norfolk County Council staffing and resources

Transforming services will require a process of change for Council staff including shifting from processes whereby someone's needs are assessed and time allocated to meet needs, to an assessment which is focused on reablement and outcomes.

In order to implement the proposed model, the Council's quality assurance will need to be strengthened to allow for closer monitoring of quality and validating of outcomes. This is consistent with findings of other authorities and the anticipated cost of additional provision will support maintenance of quality outcomes. Contract monitoring of block contracts will ensure resource use is maximised.

In addition, a good quality service is dependent on the quality of staff and organisations delivering the service. These factors are considered in the main body of this paper detailing the market approach but are also addressed through the model proposed.

4. Financial Implications

The key areas of financial impact of the proposed model are around areas of fundamental change. Eligibility for services or the fundamental nature of tasks undertaken does not change therefore the costs and cost pressures of implementing the model are limited to:

4.1 Increasing demand

Over the next 10 years the numbers of people aged 65 and over are forecast to grow by 21%. Increases in those aged 85 years and older are forecast to grow by 40%. Currently over 80% of home care provision is delivered to those over 65 and current estimates suggest that around a quarter of all people over 65 years old in Norfolk have some level of social care need. Currently approximately 2.8% of the population over 65 receive domiciliary care – if this level remained constant this will equate to over 1000 additional people requiring the service in 2021.

People over 85 are evidenced to require higher levels of social care in the home hence the 40% increase in this cohort of the population could result in significantly higher costs.

It is likely that the number of assessments and potential customers will increase as a result of the Care Act which emphasises the importance of a new conversation with citizens and communities, based on the premise that more creative solutions to address needs and minimise dependence, must be found.

The new model of home care will contribute to managing the increasing demand which is already anticipated in budget planning.

4.2 Norfolk First Support reablement service

NFS provides a well evidenced service providing reablement to a proportion of existing users of Council funded home care. The model proposes that this service may be extended to all those who receive Council home care which would involve an expansion of the current service. This has the evidenced potential to reduce needs for home support after reablement and would maximise the impact of the proposed model of home care.

This is proposed as an ‘invest to save’ approach with a projection that the ongoing costs of new entrants to the domiciliary care system would have reduced care needs after reablement. Reductions in admissions to hospital and residential care would also be expected from improvements in reablement and a more responsive home care service focused on outcomes.

The option to expand reablement services could maximise the impact of the proposed model of home care however, the model can be implemented without this expansion.

Currently approximately 49% of the referrals received by NFS are reabled prior to being referred on to a care service. The department is analysing the reasons why some people go directly to home care without reablement and will then carry out a cost benefit analysis to ascertain whether in order for NFS to meet the reablement needs, where appropriate, of all those referred for a home care service it appears that an increase in service provision would be required. This would be an invest to save proposal: the ongoing costs of new entrants to the domiciliary care system would have reduced on going care needs. The details around this are currently being worked on.

The increase in investment in reablement services would also contribute to the long term aim of managing levels of need and reducing pressure on the whole system including primary care, hospitals and residential care.

5 Care planning and community involvement

Providers currently undertake much day to day care planning with service users as this is the point at which engagement and activities are planned. The proposal is to formalise and enable this approach which is not considered to require additional resources.

The engagement of wider community resources and assets would use existing and developing prevention resources and would enable home care service users to benefit from them. This may create more use of prevention services over time, but initially is a focus on targeting this priority group with linkage into community assets.

6 Norfolk County Council/System changes:

Changes to Council resources will be required in order to manage a system based more closely on the outcomes people wish to achieve. An initial scoping of resources indicates that additional quality assurance staff will be required to support revised assessments focusing on potential as well as needs and effectively supporting delivery of an outcome based system in addition to ensuring robust contract monitoring.

Table 1 shows projected benefits and pressures of the proposed model

Area	Benefits/pressures	Comment
Norfolk First Support	Benefit of minimising the care needs of all people as they enter the service, thus reducing their package of formal care. Potential increased investment to be determined by invest to save analysis.	Additional cost represents the increase required to re-able all new entrants to home care each year – this could be flexed according to the intensity of service proposed and remodelling of the service to ensure most vulnerable people are targeted
Council and system costs	Benefit of creating much more robust quality assurance of the home care service which maximises quality and impact. Cost: £0.226m p.a.	Additional QA/contract monitoring resource based on 1 post per CCG area (i.e. 5 full time equivalent posts)
Care planning and community involvement	Neutral cost – but inclusion of wider prevention services potentially brings additional resource.	In future, developing community assets may expand the range of opportunities available.
Management of demand	Potential cost avoidance to be determined by invest to save analysis.	Current modelling is based on national evidence on the reduction of home care required following a reablement intervention. There are additional potential benefits from reductions of admissions to hospitals or residential care.

7. Incremental Approach to Manage Risk

A phased approach has been proposed in order to support management of risk. Cultural and organisational change will be required from providers and the Council in order to successfully move to an outcomes based approach. It is proposed that risks are managed through phasing implementation in the east and west and supporting transitions on any transfer of services to new providers.

8. Conclusions

The model proposed is founded on the principles of prevention and demand management with additional focus on the support needed to reduce admissions to hospitals and care homes. It is based on the premise that the reduction and stabilisation of dependence on home care services will support management of demand for the service. Flexible provision based on people's

expressed outcomes should facilitate people to stay in their homes longer and achieve improved quality of life.

Currently service provision does not maximise people's potential for reablement and does not adequately support demand management for services, including residential care. The benefits of the proposed model include potential reduction of need for services, reductions in those who require residential or hospital services, an improved career structure for care workers and an improved experience of care and support for individuals. Investment in stronger quality assurance is proposed to secure sufficient oversight of this important area of service and it is proposed that this is focused on local areas.

It is proposed that there is further analysis undertaken in order to consider an invest to save proposal with regard to further investment in reablement as the gateway to home care.

The proposed model represents a significant shift in the way in which the Council commissions and contracts for home care. It is consistent with emerging best practice and with the focus in the Care Act on prevention and wellbeing. It does however require initial additional investment and management of the risks and benefits inherent with any change in a large and complex system of care.

9. References

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