BEST VALUE REVIEW OF HOME CARE FOR OLDER PEOPLE

JUNE 2005

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1 DERBY'S APPROACH TO BEST VALUE

Best Value reviews help Derby City Council find out how good our services really are. They are an opportunity for us to tackle the real issues facing our services. We use them to identify the things that we need to do to deliver real service improvements in the future.

The scope of the review was determined by a group of stakeholders (older people, carers, service providers, assessors, statutory and voluntary sector colleagues) meeting at a scoping event where everybody was given the opportunity to raise the issues they felt were affecting the delivery of the service. Stakeholders were also invited back for a second session where they were given the opportunity to fundamentally challenge the way the service is provided now.

This report follows the revised format for the reporting of reviews. In the past, final reports have been very long. This report aims to capture the key elements of the review, concentrates on the issues identified at the scoping event and considers options to address these issues in the future.

2 EXECUTIVE SUMMARY

This Best Value Review of Home Care for Older People has been undertaken using the Authority's approved methodology and tool kit. Through the completion of a baseline assessment and through the "4Cs[1]" analysis a substantial amount of data and information about the service has been gathered. This is available separate to this report for inspection and consideration. The main body of the report summarises this information and draws together those key issues that are then reflected in the improvement plan.

2.1 Summary of the existing service

"Home Care for Older People" should be taken to refer to a number of domiciliary services currently provided or commissioned by the Council, rather than any single unified service:

- Social Services' own "in-house" home care service
- Home care services provided in partnership arrangements, for instance the Dementia Service of the Mental Health Partnership
- The independent sector home care agencies commissioned by Social Services
- The voluntary sector agencies grant funded by Social Services to provide practical support for older people in their own homes

These services provide a range of support for older people, from intensive help with personal care needs to periodic support with domestic tasks. Voluntary sector provision (which is currently very small) widens the focus to include other practical tasks and social support.

2.2 Terms of Reference identified at the Scoping Event

The following headings were prioritised at an initial scoping event by the majority of stakeholders. It was agreed that they would comprise the five Terms of Reference of the review.

1. **Commissioning** that is more strategic and transparent
2. **Workforce Planning** that ensures future stability
3. **Standards** that are clearly articulated and adhered to
4. **Prevention** that enables older people to stay independent for longer
5. **Communication** that means older people are well informed and can exercise choices about their future

[1] Best Value methodology to **C**hallenge the service, **C**onsult stakeholders about performance, **C**ompare with other services across the country and **C**ompete with the best in terms of value for money.

2.3 Main Issues

Analysing these Terms of Reference, the review has found the following to be the main issues for the home care service in Derby:

Commissioning	1	Overall numbers of older people being supported at home are gradually decreasing as more "intensive" home care packages are commissioned from within the same resource base.
	2	The home care service is not effectively geared to ensuring older people remain as independent as possible for as long as possible
	3	The balance between internal provision and external commissioning is not delivering value-for-money to the Council
	4	Procurement and contracting arrangements are often not fit-for-purpose
Workforce Planning	1	Recruitment and retention of home care staff should be more joined-up and strategic
	2	Home care staff need more focused training and infrastructure in order to support commissioning objectives
Standards	1	Information about standards is not always shared consistently or effectively
	2	The capacity to strategically monitor and improve home care standards is lacking
	3	Current procurement arrangements are too fragmented to enable consistent and effective monitoring of standards
Prevention	1	There is no common way of defining and measuring preventative services
	2	Overall numbers of older people being supported at home are gradually decreasing so "lower level" prevention is benefiting fewer people
	3	"Higher level" prevention is not resulting in significantly fewer older people being admitted to residential or nursing care
Communication	1	Many stakeholders in this review have felt that clear communication is often lacking

2.4 Core objectives

The Review has considered the above issues and agreed two core objectives which will be expanded in the attached Report and Improvement Plan:

- More older people will be supported to remain living at home for longer
- Home care resources, including staffing, will be re-designed to deliver value for money and stability for the future.

These objectives will be achieved by:

- Expanding the role of the voluntary and community sector in providing local, socially inclusive preventative services
- Reconfiguring the in-house service to provide a short-term intensive, reablement service, crisis response and specialist services
- Enhancing the ability of the independent sector to provide a higher proportion of longer-term, stable packages of care.

3 INTRODUCTION TO THE REVIEW

3.1 Establishing Terms of Reference

The Derby City Council Corporate Plan 2004-2007 stated the need to "implement a change programme for home care to make best use of the skills and resources of the service, in line with national and local priorities managed through a 5-year plan".

This Best Value Review of Home Care for Older People in Derby began in April 2004 and was undertaken in the context of the Council's approach to providing services, which are fit for purpose, have longevity and are sustainable for the people of Derby. The Review was completed by a team of Council employees and wider stakeholders and was led by Mick Connell, Assistant Director (Community Care).

The scope of the review was established at a "Scoping Event" held in May 2004 where a range of stakeholders met. These included councillors, employees, representatives from partner organisations in the statutory or voluntary sectors and, most importantly, older people and their carers. This Event provided the opportunity to identify the key issues affecting the service and to prioritise these including a risk assessment exercise.

Five key issues were identified by the Scoping Event and were approved by the Council's Cabinet. These became the review's Terms of Reference:

1. **Commissioning:** the need for clarity on the types of home care services that should be commissioned through understanding local needs and current service performance.
2. **Workforce Planning**: the need to ensure current and future stability and capacity of the home care workforce, particularly in the areas of training, recruitment and retention.
3. **Standards**: the need to continuously develop and provide services that meet national and local Health and Social Care standards and targets.
4. **Prevention:** the need to deliver services that enable healthy living and promote independence.
5. **Communication**: the need to communicate in an efficient and effective way with the wider community, in order to promote better access to services.

These Terms of Reference have formed the basis of the work completed under each stage of the Review.

3.2 Research methods

The Review has been completed according to the Council's toolkit. The first stage was to complete a **Baseline Assessment** that summarised the state of the service at the point the Review began. This is used as the starting point for **Challenge, Consult, Compare, Compete** analysis which examines each of the Terms of Reference in turn. The main sources of information for this work are as follows:

A Challenge

- Local and national guidance and statute
- The findings of the SSI/Audit Commission Joint Review of Derby Social Services (2003)
- The Challenge Event[2] held by the Best Value Review on 27 July 2004 and attended by a range of stakeholders comparable to the Scoping Event. This produced a long list of local "challenges" to current ways of delivering home care.

B Consult

- Questionnaires from older people who receive a home care service directly from the Council (75) and via an independent sector agency (33).
- Questionnaires from Home Care Assistants and managers currently working for the Council's home care service (80).
- Questionnaires from 12 independent sector agencies that the Council currently contracts with, as well as 30 voluntary sector organisations who deliver services for older people in Derby.
- 27 face-to-face home visits to service users in Derby, 2 service user focus groups, and 3 focus groups for carers who look after older people in the city.

C Compare

- Department of Health data from the Performance Assessment Framework (PAF) comparing Derby's performance in key areas with comparator authorities as well as national leaders.
- Recently published national survey work.
- Work from Beacon Authorities, acclaimed as such for the innovative and high quality work they do around older people and home care.
- Other examples of best practice from benchmarking organisations like the IDeA.

[2] The Challenge Event looked at the issues identified by the terms of reference and asked:
- What do we do well?
- What do we not do so well?
- How can we change it?

D Compete

- Analysis of the preceding three sections to determine, on the basis of what local older people and other stakeholders want as well as challenges to best practice from inside and outside Derby, what it is that would make the home care service truly competitive.

3.3 Background to the service

The Council has a statutory duty to provide community care services for people who have been assessed as requiring those services and meeting current eligibility criteria[3]. Services do not necessarily have to be directly provided by the Local Authority but can also be provided by an agency commissioned by the Authority.

As noted in the Executive Summary, current home care for older people within Derby reflects a mix of services commissioned "internally" (through Social Services' own home care team) and "externally" (via the independent sector including grant funding to voluntary organisations).

The statutory basis of the service is:

- The 1989 NHS and Community Care Act: promoted the development of domiciliary services to ensure that whenever possible people can receive care in their own home. Home care services are viewed as integral to the concept of community care.

- The White Paper, "*Modernising Social Services* "(1999): set out the national priorities for the improvement of social care services, and is based around three key themes – promoting independence, improving protection and raising standards.

- National Care Standards Act 2000: set clear parameters around quality of care for older people (and other service user groups). These standards are inspected and enforced by the Commission for Social Care Inspection and apply to independent providers as well as Council home care services.

- The National Service Framework for Older People: published in March 2001 and applies across health and social care. The framework is based on eight key standards and includes a 10-year programme for action linking services to support independence and promote good health, specialised services for key conditions, and culture change so that all older people and their carers are always treated with respect dignity and fairness

[3] Local Authority Social Services Departments are obliged to publish eligibility criteria for adults under the Department of Health's framework of "Fair Access to Care Services". The framework consists of four levels of need (from "Low" to "Critical"), and Local Authorities are obliged to examine their resources and decide which of the levels they can directly address.

- The Green Paper "*Independence, Well Being and Choice – Our vision for the future of social care for adults in England*" was published in April 2005. It puts forward plans to extend Direct Payments for older people (covering social care and also other types of provision) and focuses on strategic commissioning to keep very dependent people safe but also to encourage development of low-level preventative services.

Service developments must support the following Council objectives:

- Modernise social care - specifically including adult home care (Corporate Plan 2005/8 top priority)
- "Implement 24 hour management cover, increasing intensive-level packages and reconfiguring low-level support towards prevention to help more adults and older people live at home" (Corporate Plan 2005/8 key outcome 4.6)

3.4 Distribution of resources

Table 1: Type and expenditure on services commissioned

2004-05	Council's service	Independent sector service	Voluntary sector grant funded[4]
Cost (£millions)	6.2	1.7	0.075
Service users	2743	251	838

This simple table gives an indication of the overall home care spend on older people, as well as the total number of people helped. Just under 3,000 older people get a home care service from either the Council or an independent sector agency after an assessment of their needs. The older people in receipt of a grant-funded voluntary sector service may also be receiving a Council or an independent sector service.

The expenditure per person by the independent sector is higher because they are providing a much greater volume of service to each individual on average (ie most of the referrals they receive from the Council are for older people with high level needs). The reasons for this will be explored later.

Table 2: Age distribution

Age	Percentage of total receiving home care	Percentage of age group population in Derby
Under 65	14%	
65-74	14%	9%
75-84	39%	6%
85-104	32%	2%

The table above illustrates that the vast majority (86%) of people receiving home-based support from social services are aged 65 or over. The relationship between the two percentage columns also makes it clear (as we might expect) that the likelihood of home care receipt increases with age.

[4] Voluntary sector service covers Live at Home Scheme providing low-level practical support for older people and Crossroads scheme providing home-based respite support for older people who are carers.

3.5 Demographic issues

Table 3: Population growth for older people (thousands)

Derby	2003	2008	2013	2018	2023	2028
AGES 60-64	10.5	12.9	12.1	12.4	14.4	16.0
AGES 65-69	10.0	9.9	12.2	11.5	11.9	13.8
AGES 70-74	9.2	9.1	9.1	11.4	10.8	11.2
AGES 75-79	7.8	7.8	7.9	8.1	10.2	9.8
AGES 80-84	6.0	5.9	6.1	6.4	6.7	8.5
AGES 85+	4.2	5.1	5.7	6.3	7.1	8.0
Total aged 60+	47.7	50.7	53.1	56.1	61.1	67.3

ONS - 2003 population projections

The population aged over 60 years in Derby is projected to grow by approximately the same rate as the England average, but at a slower rate than is expected for the East Midlands population as a whole.

- These increasing numbers of older people will clearly place extra demand on the health and social care economy, including home care.
- It will be more important than ever to develop effective services that offer value for money in keeping older people safe and independent at home for longer.

The table above also hints at specific planning issues for different age groups in Derby:

- Between now and 2013 the population of 70-84 year olds will remain relatively stable. After 2013 the population of this age group is expected to rise more markedly. This indicates that, while no rapid changes are required immediately, the Local Authority will be sensible to use this time to plan the developments that will support a larger population in 10 years.

- By contrast, the projections indicate a more immediate risk from the growth of people aged 85 and over living in Derby. This population of the very oldest people in the city will have the highest social care needs that require the most intensive support.

Table 4: Ethnicity: % of resident population in each group (2001 Census)

Ethnic Group - Percentages	**Derby**	**East Midlands**
White	**87.45**	**93.49**
White; British	84.39	91.26
White; Irish	1.38	0.85
White; Other White	1.68	1.37
Mixed	**1.79**	**1.03**
Mixed; White and Black Caribbean	1.03	0.50
Mixed; White and Black African	0.09	0.08
Mixed; White and Asian	0.44	0.27
Mixed; Other Mixed	0.22	0.19
Asian or Asian British	**8.36**	**4.05**
Asian or Asian British; Indian	3.84	2.93
Asian or Asian British; Pakistani	3.96	0.67
Asian or Asian British; Bangladeshi	0.09	0.17
Asian or Asian British; Other Asian	0.46	0.28
Black or Black British	**1.76**	**0.95**
Black or Black British; Caribbean	1.40	0.64
Black or Black British; African	0.20	0.22
Black or Black British; Other Black	0.16	0.09
Chinese or Other Ethnic Group	**0.65**	**0.49**
Chinese or Other Ethnic Group; Chinese	0.39	0.31
Chinese or Other Ethnic Group; Other Ethnic Group	0.26	0.18

Derby’s total population at the 2001 Census was 221,708. Therefore, 1% above can be seen to correspond to approximately 2200 people.

The table, looking at total population, tells us that Derby has a markedly higher proportion of residents who are not from a “White British” background than the East Midlands average. This applies to all population groups except those describing themselves as Bangladeshi or African.

The four largest population groups apart from White British can be seen to be the Pakistani (8712), Indian (8448), Black Caribbean (3080) and Irish (3036) groups.

Table 5: Ethnicity and age for White and Asian population groups (2001 Census)

	Overall	**Aged 60-70**	**Aged 70+**
Total (number)	221708	20388	26679
White (percentage)	87.45%	89.98%	94.58%
Asian (percentage)	8.36%	7.85%	3.43%

The table above is intended to illustrate that people from black and minority ethnic backgrounds are less represented in older Derby population groups than they are in younger cohorts. There are two main hypotheses for this:

- The black and minority Ethnic population in Derby is generally younger, having been more recently established in the city.
- The black and minority ethnic population has a lower life expectancy, correlated with socio-economic position.

Further details about specific ethnic groups is obtainable. However, the overall consequence in terms of planning home care is that we should expect a steadily increasing proportion of older people from black and minority ethnic backgrounds as time goes on, as the general BME population grows older and also as any inequalities are addressed.

Table 6: Religion: % of resident population in each group (2001 Census)

People stating religion as:	**Derby**	**East Midlands**
Christian	67.42	71.99
Buddhist	0.20	0.18
Hindu	0.61	1.60
Jewish	0.06	0.10
Muslim	4.49	1.68
Sikh	3.23	0.80
Other religions	0.25	0.24
No religion	15.88	15.94
Religion not stated	7.86	7.48

When considering present and future configuration of services for older people from minority backgrounds it is important to incorporate religion. The table above (once again 1% corresponds with approximately 2,200 people) indicates that there are substantial Muslim and Sikh presences in Derby, with perhaps a lower percentage of people stating their religion was Hindu than might be expected in view of the ethnicity data.

Although religion and ethnicity should not be conflated automatically, the assumption around population growth of older people in Derby from "minority" religious backgrounds is likely to be valid.

4 THE KEY CHALLENGES FOR DERBY

4.1 COMMISSIONING

4.1.1 The increasing population of older people

The previous section describes this in more detail. There is nothing to indicate that Derby is in any way unusual in its population profile but the key issues are as follows:

- Steadily increasing year-on-year population of older people aged over 85 meaning a larger cohort of people likely to need more high-volume and complex care.
- Relatively stable population of older people aged 70-85 until 2013, at which point steady increase is expected here also. This group will continue to need a range of home care inputs, including quite low-level preventative support designed to prevent deterioration.
- Increasing representation of older people from black and minority ethnic backgrounds.

4.1.2 The balance between intensive[5] and non-intensive home care provision

Comparative data from the Department of Health's Performance Assessment Framework (PAF) provides a clear overall picture of home care success and areas for development.

- It shows Derby to be historically one of the worst performers in its comparator group at keeping older people out of residential or nursing homes (16th out of 16 in 2004).
- The high residential care figures correlate with similarly poor performance in providing intensive home care for Derby's older people (15th out of 16 in 2004).
- However, Derby provides home care for more older people than anybody else in its comparator group (1st out of 16 in 2004). This is because Derby provides a large number of lower-level home care packages (52% of the total number of packages in 2004 were for two hours or less per week).

In recent years, intensive home care (and avoidance of residential care) performance has improved but the total number of older people helped to live at home has decreased[6]. This is because, without strategic change, the pressure to provide more home care packages of 10 hours or more has meant there is less resource for lower-level interventions.

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[5] "Intensive" home care is defined by the Department of Health as more than 10 contact hours and six or more visits per week.

[6] 3760 home care packages were provided in 2002, compared to 3320 in 2003 and 3113 in 2004 (figures taken from Department of Health HH1 returns)

4.1.3 The challenge of Direct Payments

Local Authorities now have a statutory duty to promote Direct Payments[7], maximising the choice available to the older person and further moving away from traditional notions of provided care.

- Derby is a leader in provision of Direct Payments for older people, in the top three authorities in its comparator group.
- However, numbers of older people in receipt of Direct Payments are still relatively small, far away from Government expectations that they will become the norm. Thirty nine older people currently receive Direct Payments in Derby.

4.1.4 Differentiation of services

There is very little home care for older people in Derby that is aimed at "specialist" service user groups[8]. No specialist home care is commissioned through independent sector agencies[9].

There is also very little differentiation in terms of geographical area:

- the in-house service runs home care teams that work in five geographical areas but the boundaries do not conform with Area Panels and indeed fluctuate due to supply and demand issues
- independent sector agencies are not commissioned on a geographical basis at all and instead receive referrals across the city.

4.1.5 The balance between internal and external commissioning

The current differentiation between in-house and independent sector home care is not strategic nor efficient in use of resources.

- The vast majority of households in receipt of home care are served by Social Services' in-house provision.
- Almost all independent sector services are commissioned for service users who need intensive home care support.
- The in-house service, in spite of the fact that it has a higher unit cost, manages almost all the "non-intensive" support received by Derby households (98% of the packages that were for less than 10 hours per week in 2004).

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[7] Direct Payments are cash payments made by Councils in lieu of services. The older person can choose who they pay to meet their assessed needs, rather than having a care arrangement provided for them by Social Services.

[8] The prevalence of dementia in an overall population of older people aged 65+ years is generally around 10% (Hoffman et al, 1991). However, the prevalence of dementia in the population requiring home care in Derby is estimated locally at around 12.6% (currently 258 older people receiving home care are categorised as having mental health needs).

[9] A specialist dementia team is being developed by the Derby Mental Health Partnership. The Council also has a home care service that focuses on supporting hospital discharge.

- The need to commission more intensive home care services has led to the Council's in-house home care service taking more of these on and lessening its focus on lower-level packages[10], which are not being commissioned elsewhere.

Table 7: Cost and focus of in-house and independent sector home care

	In-house	Independent
Unit cost per hour	£14.91	£11.68
% of households supported overall	92%	8%
% of households receiving non-intensive home care	98%	2%
% of households receiving intensive home care	55%	45%
% of households receiving overnight care	0%	100%

4.1.6 The cost of the independent sector

It is important not to see the independent sector as a convenient cheaper option without looking at some of the factors underlying this:

- Derby's fee rates are at the lower end of the spectrum when compared with other East Midlands Local Authorities (United Kingdom Home Care Association, UKHCA national survey, 2004).
- The Joint Review found that the differential between in-house and independent sector was significant in terms of recruitment and retention for the latter: "*Once staff have been trained by providers they are sometimes recruited to the in-house service on much better terms and conditions*".

All independent sector agencies surveyed were keen to expand their provision but felt that the level of Local Authority rates inhibited this in Derby. Benchmarking information backed this up.

4.1.7 The implications for Procurement

Derby currently commissions almost all of its independent sector provision through individual "spot" contracts. This means that there are hundreds of agreements with agencies in operation at any one time. UKHCA benchmarking has indicated that Derby is in the minority through not having a significant amount of home care contracting on a "block" or "cost and volume" basis. The advantages of this approach are that:

- Larger more strategic contracts tend to offer more value for money and are easier to monitor consistently.

[10] It is important to note from the table below that the in-house service, as well as providing almost all the low-level home care service, also has a solid base in intensive provision (55% of total). It should not be dismissed as "only" a domestic service.

- Block contracts in terms of geographical area or specialist service are conducive to the "differentiated" provision previously identified as a shortfall in Derby.

However, too many large block contracts squeeze smaller providers out of the market and curtail choice. Derby has a number of smaller providers who are committed to the City and want to continue to work in partnership with Social Services. Block contracts also pose a financial risk in terms of the development of Direct Payments as resources tied up in these areas will not be able to "follow" older people into Direct Payments.

4.2 WORKFORCE PLANNING

4.2.1 The need for a strategic overview

In summary, the Review found that there was not enough of a relationship between Commissioning strategies (how many services of what type are needed?) and Workforce Planning strategies (who is going to staff the services, and how will they be trained and supported?) The sections below will explore this in terms of:

- the need for co-operation between in-house and independent sector home care employers to safeguard and develop their labour market.
- the need for co-ordination between health and social care to develop more integrated job descriptions that will increase flexibility, lessen duplication and better enable both job satisfaction and career progression.

4.2.2 Recruiting and retaining staff

The in-house service and independent sector providers have both demonstrated considerable skills and expertise in supporting older people with complex needs. However, several factors inhibit their capacity to staff an effective service.

- staffing age profile shows a natural depletion of the in-house workforce over the next five years due to retirement. Dependent on Government changes to the retirement age, we may see up to a 25% reduction to the in-house home care team[11].
- nationally recruitment to traditional home care jobs has diminished as the range of alternatives in the local market for the same rate of pay increase. (65% of independent sector providers reported concerns around the recruitment and retention of staff)

[11] There are as many workers aged over 60 as there are under 30 in the in-house home care service.

- Terms and Conditions in the Council's in-house service are generally better than in independent sector agencies. This would not necessarily be unhealthy in itself if the division of labour between the in-house service and the external sector was differentiated logically. However, as shown in the previous section, this is not the case.

Although Social Services Workforce Learning and Development Section provide resources that are accessible to the independent sector as well as the in-house home care workforce (it is now a requirement to spend a proportionate amount of Training and Human Resources Grants in the independent sector), the Review found overall that there was still not enough sense of the strategic overview and mutual co-operation [12] that was needed to safeguard the sector as a whole.

4.2.3 Flexibility of work roles

Some areas were found where existing workforce organisation lagged behind commissioning imperatives:

- Although almost all In-House staff now operate under contract conditions which allow the service to be potentially accessible at all times of day or night, the prevailing practice is still to refer night-time and other anti-social hours home care to the independent sector. As a result, some of In-House's intensive cases are shared with the independent sector, which can lead to consistency and accountability problems.

More fundamentally though, many stakeholders commented on the need for home care roles to be more joined-up with Health provision: most often District Nursing and Intermediate Care.

- Catheter care (which home carers currently cannot offer) was observed by informal carers as an illogical division between health and social care which meant older people got a fragmented rather than joined-up service.
- Benchmarking work noted workforce development strategies in several Local Authorities that developed integrated posts with Primary Care Trusts such as Bolton's Trainee Assistant Practitioner (TAP) that incorporated Physiotherapy and Occupational Therapy training to keep older people independent for longer.
- This is consistent with latest Health Service thinking which emphasises jobs with broader responsibilities, crossing traditional boundaries, so care for older people can be provided in a holistic manner.

[12] Blackpool and South Gloucestershire were best practice authorities whose workforce development strategies sought to develop the whole home care market.

4.3 STANDARDS

4.3.1 Maintaining standards

It is important to note that, of service users surveyed, a very high proportion expressed satisfaction with their home care service: 99% of in-house service users and 78% of independent sector service users felt their service performed "very well" or "quite well". However, at all the consultation events undertaken older people and carers brought up home care issues around timekeeping and agreement of tasks. The Review has found that Social Services are in a weak position to be able to manage this consistently:

- Spot contracting leads to multiple agreements and complex bureaucracy which is difficult to monitor strategically.
- Maintenance of independent sector standards tends to depend on good working relationships between care managers and agencies.
- The Contracts Team has one Contract Monitoring Officer to cover the whole city.
- The Council's in-house home care service effectively monitor themselves: there is nothing to suggest they do not do this rigorously and professionally but it would be more strategically effective if all home care could be monitored consistently whether internally or externally provided.

The UKHCA national benchmarking survey (2004) found that complex spot contract arrangements and poorly resourced central monitoring teams both tended to adversely influence monitoring quality. The best outcomes were from strategic approaches to monitoring that incorporated a number of inputs: care management feedback, central questionnaires, etc.

4.4 PREVENTION

4.4.1 A strategic approach to prevention

The integrated health and social care agenda is often chiefly focused around crisis avoidance and resolution (typically preventing older people going into hospital unnecessarily or helping them leave hospital safely earlier). However, there is also an increasingly prevalent impulse around lower level prevention and healthy living, consistent with the National Service Framework for Older People and the recent Public Health White Paper. Both of these themes place more emphasis on shorter-term rehabilitation than ongoing maintenance.

The shift is to commissioning services that "enable" and therefore aim to lessen dependency in the longer term. There is a sense of "invest to save" here: do more early should mean less is necessary later.

Examination of best practice indicated other Authorities[13] that had more of a strategic grip on prevention than Derby. They clearly articulated their plans and earmarked resources and approaches to deliver better outcomes for older people that were based on available evidence about prevention.

For instance, Portsmouth described Prevention at three levels:

- **Primary** prevention "targeted at relatively healthy older people whose primary needs are social engagement. The object is to improve quality of life via social inclusion and thus prevent unnecessary engagement with Social Services".
- **Secondary** prevention "targeted at those people who have a greater level of dependency and who may already be clients of Social Services or another statutory agency".
- **Tertiary** prevention "targeted at people with high dependency needs, who are receiving very high level care packages, day care or even residential care and aims to prevent further deterioration and the need for even higher levels of care".

Derby City Council does not currently have a Prevention Strategy, either for home care or for older people's services in general, and would definitely benefit from this articulation of a Corporate and partnership preventative approach at all levels of service delivery.

4.4.2 Lack of focus of existing services

There are indications that current provision does not address prevention as well as it could:

- The Joint Review[14] (2003) reported that Derby's large amount of low-level home care was not necessarily enabling older people to maintain independence for longer and recommended replacing the cleaning service "*with better targeted preventative services*".

- The Commissioning section has already shown that, although Derby helps a relatively high number of older people via home care, it does not do well in terms of helping them stay at home rather than moving into institutional care. This provision of low-level support has not increased independence outcomes for older people. In fact the opposite hypothesis is possible: that services have induced premature dependency in older people, even though this is difficult to evidence.

4.4.3 What older people want

Older people were clear that work around prevention was important, but did not want this to be at a cost of providing less intensive support:

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[13] Lewisham, Portsmouth, Birmingham

[14] A review of the Social Services Department by the Social Services Inspectorate & Audit Commission that was carried out between October and December 2002.

- Consistent with the drive for intensive home care mentioned previously, most older people surveyed (60%) did feel that services should be prioritised on people with high needs who might otherwise have to go into hospital or care.
- However, older people consulted were also clear that they wanted a wider range of low-level services – for instance help with practical tasks like changing light bulbs, hanging curtains and gardening.

4.4.4 Intermediate care

A theme amongst Authorities that had taken this work furthest[15] was to extend intermediate care principles to home care delivery.

The idea is that an older person, referred at a point of crisis, could then be supported with a high-resource time-limited (typically six weeks) care package that could rebuild their skills and confidence.

The approach aims to provide value for money through lessening longer-term dependency on services. In terms of a high-expertise, intensive intervention, Authorities developing this model have seen it as an opportunity to utilise their in-house services to their full potential.

4.5 COMMUNICATION

4.5.1 Being clear about intention

Effective communication is probably the area of the Review most highlighted by older people and their carers. It involves clear definition of those things service users most need to know.

- What the home care workforce can and cannot do
- What services will be commissioned and at what priority
- Which standards will be adhered to and what will happen if they are not
- What home care is trying to achieve and where the place of the older person and carer is within it

This Review will only enable successful progress in Commissioning Workforce Planning, Standards and Prevention if it ensures clear and accurate Communication that means older people and their carers are at the centre of the service.

[15] Bolton, Oldham

5 OPTIONS APPRAISAL

The Project Team, having examined the **Baseline Assessment** and the **Challenge, Consult, Compare, Compete** analysis, then discussed the main issues for home care delivery and the best options to ensure that older people were helped in the most effective way.

A matrix format was used to visualise some of the options around these issues. This ensured the team had a clear visual recognition of the options selected and a consensus on the choice had been reached.

The main issues and options that arose from Derby's existing performance are as follows:

5.1 Commissioning Issue 1:

Overall numbers of older people being supported at home are gradually decreasing as more "intensive" home care packages are commissioned from within the same resource base.

- The "do nothing" option was rejected:
  - Although (see below) yet more intensive home care packages will be required in the future, it is not acceptable to simply erode lower level (ie non-intensive) home care packages to enable more intensive provision.
  - There is a developing evidence base for the value of low-level support to older people in their homes that builds social inclusion and offers practical confidence-building support.[16]
- The Project Team agreed that more older people should be supported at home rather than less.
  - The key here, in an environment where new funding was unlikely, was to make better use of existing resources. Almost all low-level home care packages were being provided through the in-house service at a relatively high unit cost in relation to the complexity of service delivered.
  - The key proposal in aiming to deliver more home care to more people was felt to be the refocusing of in-house home care away from low-level home care (see below).

[16] *Excluded Older People* Social Exclusion Unit Interim Report, Office of the Deputy PM, 2005

5.2 Commissioning Issue 2:

The home care service was not effectively geared to ensuring older people remained as independent as possible for as long as possible.

- The "do nothing" option was rejected:
  - Although "intensive" home care packages are increasing in number and less older people are having to move out of their homes and into residential or nursing care, improvement is too gradual to catch up with high-performing Local Authorities.
  - Criticism from the Joint Review and feedback from older people in Derby also backed up the need for change.
  - Finally, the increasing number of people aged over 85 in Derby projected year-on-year into the foreseeable future was a further reason why such incremental change was not an effective strategy.
- The Project Team agreed on the development of an Intermediate Care approach for home care:
  - Older people needed a more focused service following crisis or deterioration to give them the best possible chance to regain independence.
  - This period of "rehabilitation", when service provision would be more intensive and flexible, would be followed by longer-term more regular support if this was necessary once the situation had been assessed and the older person had been assisted to recover.
- The Project Team agreed that some home care would need to be provided on a "specialist" basis but that most would be generic:
  - The Project Team felt that most home care provision for older people needed to be generic and requiring a broad range of skills (and that it would be counter-productive to try to specialise too far as this would erode those generic skills).
  - However some areas (for instance dementia support, support for older people from specific religious or ethnic communities) needed specialist provision in order to effectively meet the needs of these groups.

5.3 Commissioning Issue 3:

The balance between internal provision and external commissioning was not delivering value-for-money to the Council.

- The "do nothing" option was rejected:
  - The expertise and infrastructure of the in-house home care service is not being best utilised through the substantial proportion of low-level service provided. At present a large amount of the service is not delivering value for money to the Council.
  - This current balance of home care delivery makes it very difficult within the same resource base to develop value-for-money preventative services that can benefit more older people than is currently the case.
  - The independent sector agencies are key players at present but need a more stable and clear commissioning arrangement to help ensure their stability.
- The Project Team agreed that the Council's in-house service should be focused upon crisis intervention and very complex care:
  - The use of in-house services in this way would avoid the risks and transaction costs to the Council involved in trying to procure independent sector services at short notice.
  - It would also justify the higher unit cost of the in-house service by utilising the resource for the most complex and skilled care.
  - The service would need to move towards 24/7 availability, including night-time cover.
- The Project Team agreed that independent sector home care should be focused upon stable, longer-term packages:
  - Independent sector agencies have already shown themselves to manage intensive care packages successfully, but have less ability to manage very fluctuating and complex care needs.
  - Stable care arrangements will benefit the agencies themselves, and should result in less transaction costs for the Council.
- The Project Team agreed that the Voluntary and Community Sector (VCS) should be developed to provide more low-level preventative support:
  - VCS support is often provided more locally to older people's needs, in a way they can better relate to.
  - It also offers the practical, low-level tasks that older people say they want at much less cost and with much greater flexibility than statutory services.

5.4 Commissioning Issue 4:

Procurement and contracting arrangements were often not fit-for-purpose

- The "do nothing" option was rejected:
  - The plethora of spot contracting arrangements for home care were making it difficult to ensure procurement was strategic and offered value-for-money.
- The Project Team agreed that greater use of block and cost/volume contracting should enable a more strategic grip on the home care market:
  - Block contracts could be established geographically, co-terminous with in-house home care arrangements, Area Panels and PCT configurations where possible. Geographical block contracts would lessen travel expenses and improve value for money.
  - Some city-wide specialist block contracts, for instance for older people with specific conditions or from particular cultural backgrounds, might also serve these populations better.
  - However, there was agreement that very large block contracts were counterproductive: they could squeeze out smaller home care providers and also tie up resources which might then be "spent twice" through the expansion of Direct Payments.
- The Project Team agreed that contract arrangements would need to understand the relationship between quality and cost:
  - Independent sector home care provision was seen as of key strategic importance to the Council being able to help more older people at home.
  - Derby currently pays an hourly rate below the average for the East Midlands, and analysis of the market indicated that a higher baseline was required to ensure supply remained stable.
  - Rather than competitive tendering resulting in contracts being given to the very cheapest providers who might not ensure quality or sustainability, the Project Team agreed that the Council needed an understanding of the basic "cost of care" to ensure that quality as well as economy resulted from improved contracting.

5.5 Workforce Planning Issue 1:

Recruitment and retention of home care staff could be more joined-up and strategic

- The "do nothing" option was rejected:
  - Current workforce conditions were felt to be unstable, with a loyal but ageing in-house workforce and a more transient independent sector workforce. Competition between the in-house and independent sectors was felt to often be counterproductive. Threats from other employment sectors, e.g. retail, needed a co-ordinated response.
- The Project Team agreed that a partnership approach was necessary:
  - The need for a visible strategic framework to approach workforce planning across the sector was identified. Complete collaboration was felt to be unrealistic: some differentiation and competition was viewed as healthy and necessary. The key was to be pragmatic: obvious gains were identifiable from collaboration (notably around CSCI registration and training).
- The Project Team agreed that more transparency was important:
  - As above, it was not proposed that independent sector and in-house home care employees should be completely interchangeable: the commissioning model proposed different roles for in-house and independent sector service delivery and this should be reflected in employee support.
  - However, the need to make sure funding for the independent sector is adequate to support recruitment and retention of staff is acknowledged in Commissioning Issue 4.
  - Terms and conditions that related to clearly understood aims of service delivery would be likely to improve job satisfaction across the in-house and independent sectors.

5.6 Workforce Planning Issue 2:

Home care staff needed the right training and infrastructure in order to support commissioning objectives

- The "do nothing" option was rejected:
  - The proposed Commissioning changes were felt not to be viable without a skilled and contextualised workforce.
  - More integrated arrangements with Health were perceived to be an inevitability that would create the need for a home care workforce with broader skills and a clearer interface with other professionals.
  - More integrated workforce planning would also create more development and career progression opportunities that would support recruitment and retention.

- The Project Team agreed that health and social care pathways should be more co-ordinated:
  - This co-ordination would lessen duplication for the older person and support better outcomes via therapy and nursing inputs.
  - The principle of questioning the existing boundaries and making pragmatic changes to responsibilities in the name of person-centred care should be extended to all home care roles.
  - Some specialist approaches, for instance the proposed in-house home care intermediate care model, should give rise to integrated job descriptions on the lines of Bolton's Trainee Assistant Practitioner.
  - The key was to make sure that workforce arrangements were co-ordinated with commissioning plans: this might lead to integration in some areas and differentiation in others.

5.7	**Standards Issue 1:** Information about standards was not always shared consistently or effectively

- The "do nothing" option was rejected:
  - Overall resource issues played a part (see below), but more efficient sharing of information would be largely cost-neutral, avoid duplication and enable more robust responses to non-compliance.
- The Project Team supported a clear Departmental strategy about home care standards:
  - This would include being clear about the role of Care Management to pass information on (for instance at the point of review), being clear about the range of monitoring approaches to be used and the ends to be achieved.
- The Project Team supported consistency in monitoring of in-house and independent sector standards:
  - The same methodology and approach should be applied to monitoring all home care services, whether they are commissioned or provided.

5.8	**Standards Issue 2:** The capacity to strategically monitor and improve home care standards was lacking

- The "do nothing" option was rejected:
  - Current strategic monitoring capacity was recognised as low, particularly in relation to the sheer amount of home care business. National survey work (UKHCA 2003) had correlated lack of monitoring capacity with worse outcomes in terms of service quality.

- The Project Team agreed that an increase in specialist contracts monitoring capacity was necessary:
  - This could be a combination of "brokerage" type support which would specialise in the arrangement of individual care packages (possibly from within Care Management teams) and "contracts" type support which would focus on the collation of procurement, outcome and compliance information.

5.9 **Standards Issue 3:**

Current procurement arrangements were too fragmented to enable consistent and effective monitoring of standards

- The "do nothing" option was rejected:
  - As with Commissioning Issue 4, individual spot contract arrangements were difficult to monitor strategically.
- The Project Team agreed that strategic use of Block Contracting would improve monitoring and compliance:
  - As with Commissioning Issue 4, Block Contracting should not be universal, but use for selected key business with a common set of expectations and review requirements would substantially streamline the monitoring of standards.
- The Project Team also felt that there was a relationship between funding and standards:
  - This reiterates the conclusions drawn in Commissioning Issue 4 and Workforce Planning Issue 1.

5.10 **Prevention Issue 1:**

There was no common way of defining and measuring preventative services

- The "do nothing" option was rejected:
  - This links with Commissioning Issue 2. The cost of not defining and achieving preventative services would be more older people unnecessarily losing independence to the point of residential or nursing care placement.
- The Project Team supported a Prevention Strategy for Older People:
  - This would be clear about the way resources were to be commissioned preventatively, and define preventative service approaches from the very lowest to the very highest levels of need. It would also provide a mechanism for gathering evidence about "what worked" to validate and refine preventative approaches.

- The Project Team agreed that Social Services should be engaged with prevention at all levels:
  - This might take the form of signposting to other community services at the most basic levels of need, to commissioning voluntary and community sector organisations to provide low-level support, to very intensive and intermediate care type support proposed for the in-house service.
- The Project Team supported a Corporate approach to prevention:
  - It was clear that older people had multiple needs relating to prevention of deterioration (e.g. Transport, Leisure, Housing, Health) that Social Services homecare alone could not address. Any Prevention Strategy for Older People needed to involve a wide array of local partners. The Local Area Agreement might act as a useful catalyst for this: agreeing shared outcomes and targets for older peoples' prevention and making the best use of funding streams to achieve them.

5.11	**Prevention Issue 2:** Overall numbers of older people being supported at home are gradually decreasing so "lower level" prevention is benefiting fewer people

- See Commissioning Issues 1 and 3:
  - Developing preventative approaches with the voluntary and community sector that are more locally responsive and economical than the current low-level in-house provision will enable more older people to be helped in more preventative ways.

5.12	**Prevention Issue 3:** "Higher level" prevention is not resulting in significantly fewer older people being admitted to residential or nursing care

- See Commissioning Issue 2:
  - An intermediate care approach to home care delivery would provide value for money from the in-house service and work with older people to regain confidence after periods of difficulty, rather than locking them into dependency.

5.13 **Communication Issue 1:**

Many stakeholders in this review felt that clear communication was often lacking

- The “do nothing” option was rejected:
  - Failure to improve communication would endanger almost all aspects of the Best Value Review.
  - Clear communication with older people and their carers was necessary to place them at the centre of service provision.
  - Clear communication with those seeking to deliver home care, whether internally or externally to the Council, was necessary in order to ensure strategic service development and well-motivated and focused workforces.
- The Project Team recommended a more strategic and consistent approach to communicating with stakeholders:
  - Linking better with existing forums of older people and their carers, underpinned by implementation of the Information Strategy for Older People.
  - Making all stakeholders aware of home care commissioning strategies and their opportunities to contribute.
  - Making prospective service providers aware of tender processes.
  - Making current providers aware of service standards and ways these will be monitored.