ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Cabinet Member for Adult Social Care**
2.	**Date:**	**18 November 2013**
3.	**Title:**	**Paper 3 - Contracting for Care Forum Community and Home Care Services Framework Agreement - Update on 2012-13**
4.	**Programme Area:**	**Neighbourhoods and Adults Services**

5. Summary:

The following report serves to update Cabinet Member on the performance of the commissioned Community and Home Care Services Framework and the activity and delivery in Year One of the contract. This report will be presented to the Adult Social Care Contracting for Care Forum on 10th of December 2013.

This report is appropriately anonymised to protect the commercial interests of independent providers.

6. Recommendations:

- **That this report be received by Members for onward reporting to The Contracting for Care Forum.**

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7. Background and Details

7.1 A tender exercise took place in 2011 (details of the tender award were reported to DLT in December 2011), which resulted in 14 independent sector Domiciliary Care providers being appointed to the Community and Home Care Services (CHCS) Framework Agreement for a period of 3 years to April 2015. There is an option to extend for a further year. The providers appointed to the framework commenced service on the 2nd of April 2012.

7.2 Activity of CHCS

From January 2012 to 31st March 2012 a period of transition took place with the establishment of CHCS branch offices and introduction of service users to new providers. When the CHCS commenced in April 2012, 1,293 Service Users were receiving service.

Around 180 customers requested to be considered for a Direct Payment in order to purchase care from their incumbent provider.

At the close of the first year there has been a 12% reduction in the total number of customers on contracted independent sector home care compared to the previous year.

In 2011-12 there was an average weekly care package duration of 10 hours, which increased to 11 hours/week in 2012-13.

The approximate hours commissioned from the independent sector per week in 2011-12 = 13,700, and in 2012-13 = 12,400/hrs per week representing around a 10% decrease on the previous year.

There has been an overall 5% reduction of customers leaving contracted home care compared to the previous year. It likely that this corresponds with reduced numbers of people with long term needs being admitted to residential care.

Data available shows a correlation between numbers leaving the RMBC Enabling Service and increased use of the CHCS Framework. This indicates that people are being signposted from enabling services to maintenance packages.

To assist Framework providers to manage changes in demand, accurate Enabling Service performance information is necessary.

There was a large variation in the number of people leaving RMBC Enabling Services in 2012-13, and the independent sector experienced difficulty in judging the level of demand. The sector needs to have some level of confidence in the volumes of work transferring, in order to recruit, train, and allocate staff resources appropriately. This links to the Equalities and Human Rights Commission Report (The Cost Of Care) and the work from Unison to agree an Ethical Care Charter, and will be explored when we are looking to go to the market for providers in 2014/15.

In the 4th quarter 2012-13 a combination of a surge of customers leaving the Enabling Service and Intermediate Care, and discharge from acute hospital beds, meant referrals to the Framework were at a peak (27% increase on quarter 2). The increased activity occurred over a few days leading up to Christmas. The sector was also under pressure to support the Enabling Service, which had similar problems with capacity. As a result a number of care packages had to be referred on to the emergency/ stand by service contracted, under separate arrangements, with an independent sector provider.

7.3 Responsiveness of the providers:

Providers were monitored regards their response to care packages being offered. Providers refused a total of 299 times to accept offered packages. This number is inflated as complex care packages, with a combination of higher staffing ratios and less predictable demand, are likely to be refused by a number of providers. Incidents of refusals to accommodate care packages increased in the 4th quarter. This is aligned to the expected and unexpected increase in demand mentioned in paragraph 7.2.

7.4 Direct Payments:

The services appointed to the CHCS Framework are mainly commissioned on behalf of service users by assessment staff via the brokerage team, but they may be purchased via a Direct Payment (DP), if the provider offers this arrangement. Over 2012/13, 22 care packages were purchased from agencies on the Framework using a Direct Payment.

Examination of trends in uptake of DP and the impact on activity of the Framework, shows that the rise in take up of DPs for domiciliary care packages is attributed mainly to the transition period in April 2012. Take up since this point returned to its previous trend of approximately 20 each quarter.

7.8 Quality:

In the first year of activity 5 (35%) of the 14 CHCS were judged to have met the Rotherham MBC Outcome Monitoring Framework rating of ‘Exceeded Outcomes’ and the remaining 9 (75%) where judged to have met the rating of ‘Outcomes Met’.

All of the providers which were inspected by CQC in the first year of activity were found to be compliant with the ESoQS with the exception of 1 provider. Problems leading to the compliance actions concerned the Sheffield service, and did not impact directly on the Rotherham service. Action is being taken to ensure a separate identity for the Rotherham Branch.

Contract Concerns:

Table showing the number of contract concerns over the period April 2012 to March 2013

Period (Quarter)	No. of substantiated Contract Concerns Closed	No. of providers involved (N=14)	Context – No.of care hours delivered in the quarter (approximate)
Q 1	64	11	155,000
Q 2	49	05	149,000
Q 3	05	02	150,000
Q 4	32	11	154,000

A sharp rise in the number of closed substantiated contract concerns during quarter 1 was attributed to:

- A period of relative instability caused by the introduction of new provider organisations
- A large volume transfer of customers to new provider organisations
- Increase in enforcement action taken as a result of newly developed, and robust quality assurance monitoring systems.

7.9 Contract Enforcement:

In quarter 1 two CHCS providers were placed in contract default and 1 provider was working to an action plan, with a voluntary suspension of new packages:

The first contract default was issued to a provider who worked to a Special Measures Improvement Plan. The Provider implemented a number of new operational systems and quality checks and the contract default was lifted after 4 weeks and resulted in a dramatic reduction in concerns raised about this provider.

The second default was issued in June 2012 and was in place for an extended period. The majority of the objectives on the Special Measures Improvement Plan were achieved in a reasonable time but contract default remained in place to enable the provider to evidence a period of stability and to resolve some ongoing staffing issues. This provider operates in an area where recruitment is difficult.

A voluntary suspension of new packages was undertaken by one provider as a result of problems experienced with managers at their branch which resulted in an action plan being invoked. The issue was quickly rectified and the suspension lifted.

In quarter 4, 1 provider underwent an enforced suspension of new care packages as a result of issues with training and recruitment and selection. The provider complied with an action plan and the suspension of placements was shortly lifted.

In quarters 2 and 3 no contract defaults, embargos or contract terminations were served.

8. Financial Implications

8.1 Analysis of efficiency outcomes at the tender award stage indicated that the average hourly rate of £12.96 (2011-12) was reduced to £12.06 (2012-13) as a result of the tender exercise.

8.2 Gross Expenditure on contracted independent sector home care 2012-13 was £7.4m.

Table showing CHCS gross expenditure breakdown by client group:

Client Group	**Gross Expenditure 2012-13**
Older People	£6,219,885
Physical Disability	£1,122,885
Learning Disability	£89,634
Total	**£7,432,404**

9. Risks and Uncertainties

9.1 There are changes to the Brokerage Team planned in November 2013, approved through Cabinet Member. The service will be provided by dedicated Team Administration staff in future. There will be consultation and guidance to providers but it is expected that there may be some transitional issues as the new delivery method is introduced. It is important that the allocation guidelines continue to be followed to avoid problems with stability of the CHCS Framework. A risk assessment has been undertaken and actions recommended to mitigate risks associated with the change.

9.2 Regular meetings take place with providers on care standards, referral levels and capacity, financial sustainability, management/ leadership, training and development needs, and recruitment and staffing issues.

9.3 In September 2013 RMBC completed and returned a national survey by the Equalities and Human Rights Commission. The survey related to action /due regard by Councils to the recommendations contained in the EHRC report: ‘Close to Home’. The report considers the impact of home care practices on the human rights of vulnerable people using commissioned services. The return found RMBC compliant with the majority of EHRC recommendations and working towards compliance

in all other areas. We expect to receive formal feedback and further guidance from EHRC in November 2013.

10.4 The Unison ‘Time to Care’ national survey was undertaken in June/July 2012 and the consequent report published in October 2012.

Unison are seeking a dialogue with commissioners to establish a baseline of safety, quality and dignity of care through assurance around employment conditions within the care sector. They are calling for Councils to commit to becoming Ethical Care Councils by only commissioning home care services which adhere to the Unison Ethical Care Charter.

Rotherham MBC can demonstrate that contracted care providers agree with the majority of the principles outlined in the Ethical Care Charter, and our principles mirror current legislation/policy.

Our contracted services are continuously monitored in line with standards set out in our service specification and Framework Agreement terms and conditions. Deviation from this standard will result in intervention that is supportive of the organisation to improve. Where it is found that improvement is not achieved the default notices will be served to protect service users.

We will take the opportunity presented by the expiration of the contract in April 2015 to make sure that current guidance and principles apply to any new commissioned services.

11. Policy and Performance Agenda Implications

Performance expectations for the first year of the CHCS Framework have been achieved:

- Adequate capacity has been secured in both rural and urban areas.
- The introduction of the Framework has reduced waiting times for new packages, and streamlined allocation.
- Quality has been maintained of a relatively high standard with the Commissioning and Contracting function robustly enforcing the contract terms and conditions to eliminate small pockets of poor practice.
- There are indications that people are remaining at home as opposed to going into residential care and that service users are purchasing care from the Framework using Direct Payments.
- There are high levels of satisfaction with services as measured by the Social Care Users Survey, and the ASCOF toolkit:

  ‘Outcomes for 8 service users who engaged in a face to face survey:

  - All felt that the care workers helped them to maintain control of their life
  - The majority felt the carers helped them to feel better about themselves and to feel safe.
  - Half said that they felt receiving care gave them some additional social contact’

- ‘Coordinators were observed in their working environment and there were clear examples of liaison with other professionals and information sharing for the benefit of the service user’
- ‘The involvement of an Independent Mental Capacity Advocate was evidenced and this was utilised to formulate a very detailed and person centred care plan. Staff had also received training on dementia and the mental capacity act alongside their mandatory training’
- ‘Information recorded on care plans indicated that emphasis was placed on service users remaining in control, precautions being taken to maintain dignity and the requirement to meet personal/cultural preferences’

11. Background Papers and Consultation

1. Community and Home Care Services Service Specification and Framework Agreement.
2. DH Care Networks: Market Facilitation – Transforming the Market for Social Care :August 2009 http://www.dhcarenetworks.org.uk/BetterCommissioning/Whatsnewonsite/?parent=2612&child=5957
3. DH Putting People First Commissioning for Personalisation : A Framework for Local Authority Commissioners.
4. Close to Home: An inquiry into older people and human rights in home care carried out in 2010 by the Equalities and Human Rights Commission

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