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Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru
Care and Social Services Inspectorate Wales

National review of *domiciliary care* in Wales

Wrexham County Borough Council

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Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
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Background to the local authority review of domiciliary care

1.1. This inspection took place over five days in January 2016 as part of the larger national review of domiciliary care.

1.2. The purpose of the review was to assess the success of the local authority's social services in achieving outcomes that matter to people, by evaluating the efficiency and quality of domiciliary care commissioned by the local authority. Methods used during the review of the local authority included considering information provided by the local authority before and during the visits; discussion with commissioners; a focus group with care providers; and examining six cases of people using domiciliary care, including discussion with individual people where appropriate. An individual report for each of the six authorities will be published at the same time as an overview report for Wales.

1.3. The larger national review of domiciliary care in Wales will draw upon a wide range of information including discussion with commissioners, providers, staff and people using services and their carers, gathered during detailed fieldwork in six local authorities, and enhanced inspections of selected domiciliary care agencies. A national survey of all local authorities was undertaken along with questionnaires for provider agencies who organise domiciliary care, questionnaires for care workers who directly provide care and questionnaires for people who receive care and their carers. Discussion took place with care providers and commissioners during three regional workshops and during meetings with representative groups including the Welsh Senate of Older People, Age Connects and Cymru Older People Alliance (COPA).

2. Introduction: The approach to commissioning, procurement and brokerage taken by the local authority

2.1. The local authority recently developed a new model of commissioning domiciliary care that is intended to deliver a more efficient, targeted and sustainable service with improved economies of scale. This resulted in awarding contracts to five providers, each of which is aligned to a single geographical zone.

2.2. This approach builds on a review process that began in 2010 which identified the need to embrace a domiciliary care commissioning strategy that moved beyond traditional procurement methods through seeking interventions which either prevented or reduced the need for longer-term care.

2.3. The 2013 departmental commissioning strategy developed this theme further and provided a high-level framework for general outcomes that were largely population-based. This was underpinned by a number of supporting plans, such as the commissioning strategy for older people which was produced the same year.

2.4. A Freedom of Information request the following year revealed that approximately 27% of all domiciliary care visits lasted 15 minutes and this galvanised the local authority to further reflect upon its approach to commissioning domiciliary care.

2.5. As a consequence, the local authority determined to abandon its framework agreement with 17 independent sector providers in anticipation of its September 2015 end date and decided to focus its attention on a smaller number that could work in a localised and more consistent way. At the time, the local authority arranged the delivery of over 10,000 hours of domiciliary care a week to almost 900 people at a cost of approximately £8.5million.

2.6. Commissioners sought to adopt an outcome-based approach and referenced the model employed by Wiltshire County Council that utilises a payments-by-results framework. This remains work in progress and, although there is a commitment to outcome-based commissioning, current practice does not yet reflect this aspiration. As a consequence, there is currently little evidence of any activity that explicitly seeks to incentivise providers to be rewarded for supporting people to achieve greater independence.

2.7. The local authority developed a market position statement in 2015 with the intention of providing clear messages about projected need and business opportunities. Such documents should convey important information about direction of travel, future demand, current supply, models of practice, future resourcing and details of support for choice, innovation and development. Whilst it partly succeeds in addressing a number of these components, more work is needed in order to better describe the local authority's vision for the future delivery of domiciliary care.

2.8. The new procurement arrangements became operational in June 2015 with the five selected providers contracted to deliver approximately 7,500 hours per week to over 600 people.

2.9. The independent sector has a progressively strong place at the partnership table and the local authority increasingly recognises its key role in supporting people to live independently at home. However, short-term reablement activity remains primarily an in-house service with consequent reduced scope for independent providers to deliver a measurable outcome-based service.

3. What commissioners told us

3.1. The local authority was mindful of the need to develop a more sustainable commissioning approach for domiciliary care and sought to use the impending end of the previous framework agreement as an opportunity to consider potential alternative models.

3.2. In particular, it was determined to address the issues presented by a geographically fragmented model of procurement that led to providers delivering services throughout the county borough with limited potential to maximise efficiencies or secure economies of scale. Its strategy was focused upon developing the external market to manage service demand and performance, and through better mapping of market capacity to meet future demand. It produced a business case in October 2014 that outlined the benefits of adopting a more managed and targeted approach to procurement.

3.3. The local authority also anticipated that it could secure a 5% saving through a more rigorous re-tendering process that would deliver £420,000 savings in 2015/16 against the previous year's domiciliary care budget. This was to be achieved by offering more work to fewer providers within large dedicated geographical areas. The goal was to secure improved economies of scale to bring increased capacity, greater continuity of care and reduced hourly rates. Furthermore, the local authority saw that the delivery of a more localised service would improve the ability of providers to develop robust contingency plans to better address surges in demand.

3.4. This resulted in the decision to outline five geographical zones within the county borough area that would be subject to a new tendering process. Contracts would be awarded for a five-year period, with potential for a two-year extension.

3.5. As part of its evaluation, the local authority looked at models of commissioning adopted elsewhere and specifically those aligned to outcome-based results. It was keen to implement a commissioning framework that focused the efforts of providers on clear objectives that were directly linked to explicit rewards. By signalling its intention to move away from a time and task procurement model, the local authority provided a firm statement that it wished to shift the focus to a more person-centred approach with greater emphasis upon reablement and improving the quality of care services.

3.6. The local authority specified that successful tenders would be subject to stages one and two of the UNISON ethical care charter in order to ensure that the dignity and quality of life for people using services is maintained by care workers who are assured of sustainable pay, conditions and training levels. This embraced the concept that working conditions are intrinsically bound up with the quality of care. As a consequence, commissioners provided a clear expectation that care was given on the basis of need, that 15 minute visits would generally not be procured and that workers could access terms and conditions of employment that were more attractive.

3.7. As part of its cost-modelling process, the local authority developed a virtual domiciliary care agency budget and hourly rate calculator based on an approach adopted by the UK Home Care Association. However, the calculations assumed a national minimum wage of £6.50 per hour applicable in early 2015. When considered on the basis of the delivery of 2,000 hours a week, the local authority model determined a break-even cost per hour of £12.10, from which it calculated a threshold rate of £12.50 for urban, and £13.50 for rural areas. These levels were used in costing the provision of direct payments for people who did not wish to transfer to a new provider, and also as part of the tendering process for determining whether bids were potentially too low and unsustainable.

3.8. For the five successful bidders, the lowest was at £12.99 and the highest at £14.48. The tendering process considered bids from 15 providers and was subject to evaluation criteria based 60% on quality and 40% on cost – the latter specifying that the lowest bidder would be awarded the full 40%, with competitors receiving a score equivalent to the percentage difference above the lowest bid. The award criteria document did not specify any bid thresholds as part of the commercial evaluation.

3.9. The local authority contract required successful applicants to operate from an office in the county borough area that is registered with us. Further safeguards included the need for providers to 'not operate the service from its office until the CSSIW have [sic] informed the purchaser that the office is registered and are able to provide domiciliary care services which will enable service users to remain in their own homes maintaining maximum independence, minimising risks and promoting quality of life'.

3.10. The five successful bids were awarded contracts in March 2015 that provided exclusivity within the allocated zone. Four were existing providers to the local authority, while one was a new entrant to the local market without a local office registered with us. At the time of our review in January 2016, the provider was operational within the county borough area, despite not fulfilling the registration specification of the local authority.

3.11. Commissioners were conscious that there would be a period of transition meaning a change of provider for a significant number of people receiving domiciliary care. As a consequence, it wrote to all service users to explain the changes and also provided a dedicated information line to address any questions or concerns. The local authority reported that the transition affected a significant proportion of people, 92% of whom

experienced a change of provider. At the time of our review, 91 people had taken up the option of direct payments with a provider of their choice, where possible to do so at the allocated fee level, therefore maintaining the continuity of their care arrangements.

3.12. Despite its ambitions, commissioning has not yet adopted an outcome-based methodology, and current priorities are driven by the need to secure the right volume of service delivered safely at the right price. In particular, the local authority had not fully anticipated capacity issues in the central urban zone within six months of the new contract awards. As a consequence, the in-house reablement service is currently covering gaps in provision, although the local authority anticipates that this will be time limited. Nevertheless, this was identified as a potential risk early within the commissioning process and its impact needs to be reviewed at the earliest opportunity.

3.13. At the time of the review there were emerging capacity issues in four of the five allocated zones, with 33 of the 37 requests for care remaining outstanding that week, comprising over 300 hours of care. This was already impacting upon the in-house reablement service that had to provide additional support where possible. In January 2016, the five selected providers were delivering 6,700 hours per week to 555 people.

4. What people who provide a domiciliary care service told us

4.1. The local authority has developed a positive working relationship with providers based on a transparent and constructive approach to commissioning. There is strong commitment to consultation that is fundamental to determining the chosen procurement model. This has remained a core component throughout the process and has been subsequently valued by those providers who were successfully awarded contracts.

4.2. The intention to adopt new procurement arrangements were expressed in a domiciliary care 'meet the buyer' event in early January 2015. Together with a programme of ongoing engagement activity, this provided potential bidders with key information to enable consideration of viable business opportunities.

4.3. Providers told us the local authority is an effective communicator and said they were appropriately consulted and influential in shaping a number of key aspects of the agreed framework model. They described how their input rebalanced some of the geographical zoning so that there were some pockets of higher population in predominantly rural areas. They also considered that the local authority was careful to stress that tendering fees would need to be realistic if care services were to be sustainable.

4.4. Providers said they were well supported by the local authority during the transition period of transferring contracts to the successful bidders. In particular, they valued the allocation of a dedicated contracts officer for each successful bidder and stated that this has underpinned an increasingly strong partnership. Although a significant number of

people have been affected by the transfer of care, the local authority worked hard with providers to ensure that people using services were subject to minimal disruption in delivery of their care.

4.5. However, a number described care plans not being up to date at the time of the transfer and difficulties experienced when commissioners agree specific times for visits without determining if the provider can achieve this.

4.6. For most, recruitment remains an issue and although some considered fee levels a contributory factor, others argued that there was a general need to do more to raise the profile of care work as an attractive occupation.

4.7. Emerging issues in meeting demand have prompted some providers to explore the feasibility of subcontracting care work when not able to allocate, but this has largely proven problematic with potential alternative providers not able to match the fee level applicable to a number recently awarded contracts. This would mean some providers subcontracting work at a financial loss and has so far proven insurmountable.

5. What people who use domiciliary care told us

5.1. People told us that, generally, the local authority had managed the transition process reasonably well, albeit with some early difficulties that many had anticipated as realistic considering the scale involved. We saw letters in people's homes that provided information about the changes and also evidence that any concerns had been appropriately addressed.

5.2. However, the challenges faced by providers in subcontracting were also likely to be mirrored by people considering direct payments as a potential means of maintaining their existing care arrangements – for some people, this was unlikely to be a realistic or viable option as it would invariably mean 'top up' payments at the £12.50 rate.

5.3. Nevertheless, most people expressed a view that care arrangements were generally appropriate and we saw some notable examples of good outcomes being achieved through collaborative working by the local authority and its partners. Care plans, in the main, were sufficiently detailed and captured the perspective of service users, although not all were up-to-date. Many, but not all, were outcome-focused and this remains a work in progress.

5.4. In some instances, reviews had not taken place when scheduled and, in light of the transition, the local authority should ensure that where a new provider has been procured, an early face-to-face evaluation takes place that is focused upon how well needs are being met. Whilst a telephone survey of a sizeable number of people has

been conducted, and may serve as a valuable means of measuring initial qualitative views, it has structural and control limitations and is not a substitute for professional review.

5.5. The survey revealed that most people are satisfied with the care arrangements being provided, albeit with a significant number having experienced ongoing issues beyond the 'teething' period immediately following the transfer.

5.6. Some of the things people told us were:

> "Care workers are very good and always do their best."
>
> "Some staff need a lot of guidance and do not seem to have had much experience."
>
> "It's getting better, but there were lots of problems at first."

5.7. A number of people told us they had been pleased with their previous care arrangements, but that since the transition they had experienced many different care workers, sometimes with limited knowledge of their needs, and that the timing of visits had occasionally varied notably from what they had experienced beforehand.

5.8. One person informed us that ten different care workers had visited that week. Another described an unhelpful response when alerting a provider about missed visits. Others described periods of reduced visits without any notification, whilst some expressed the view that it was not worth raising any issues with the provider and felt that there was a 'take it or leave it' attitude with some of the people spoken to.

5.9. We found that capacity issues, particularly at times with most demand, have also sometimes driven the review process and the local authority needs to ensure these remain person-centred and that sufficient time is allocated to realistically meet need. For example, an email to the local authority from a provider stated it was under pressure to provide a number of calls at the same time. The provider suggested reducing the amount of time spent with a service user in order to accommodate the needs of others – this was subsequently agreed by the local authority in November 2015, in the face of objections by the service user and family carers. This decision also disregarded the outcome of a review only conducted in June 2015, just prior to the transfer, that did not identify any changed needs, nor the amount of time required to support these.

6. Analysis

6.1. The local authority recognised the fragility of its previous commissioning arrangements and took important steps intended to secure a more sustainable model of procurement.

6.2. It adopted a market-facing approach underpinned by good communication systems and a positive working relationship with providers. It developed a market position statement that provides a good general overview, although more work is needed to better describe its vision for the future delivery of domiciliary care.

6.3. The local authority's commitment to the development of an outcome-based framework of commissioning remains work in progress, as it is not yet clear how providers will be incentivised to achieve better long-term outcomes for people, particularly as reablement services are solely delivered by the local authority's in-house service.

6.4. The local authority signalled its intention to move away from a 'time and task' approach, reduce the volume of 15 minute visits and focus upon procuring domiciliary care on the basis of need that lessens the need for longer-term support.

6.5. Commissioners are increasingly aware of the importance of reshaping services to better meet complex care needs and maximise the opportunities to achieve independence. A number of key factors specified in the original business case have been realised and the local authority has, in particular, achieved its goal of working with fewer providers operating in zoned areas that are securing better value for money. Contracts have been designed to ensure improved terms of employment and working conditions for care workers, specifically aligned to stages one and two of the UNISION ethical care charter.

6.6. However, capacity issues with four of the five providers are having a significant impact in the ability to get the right care to people at the right time. As a consequence, the local authority needs to review, within the context of a challenging financial position, whether any link exists between fees levels and current inability to meet demand within contractual agreements. The local authority's own calculations suggested a £12.10 break-even point based upon the minimum wage – for some providers, their contract fee provides limited scope for flexibility in recruitment.

6.7. The impact is that 300 hours of care were not able to be procured at the time of the review, affecting 33 people. This either led to delays in a service being provided or in the reablement service having to work with people for longer periods than anticipated.

6.8. Subcontracting was not proving to be a viable option for those providers, in particular who had submitted highly competitive bids, as it would invariably result in a service being provided at financial loss – clearly a position that is unsustainable.

6.9. For some people, the provision of direct payments as a means of retaining their original provider was not realistic, as it was based upon calculated fee levels lower than those that have so far proven problematic for provider subcontracting.

6.10. Although most people using services are generally content with the quality of care, a significant proportion reported mixed views. Many had anticipated potential issues at the

time of provider transition, particularly in the continuity of care, but for too many this continues to remain a key cause of anxiety when confronted with inexperienced and unfamiliar care workers.

7. Areas for consideration

7.1. The local authority should consider an early review of the effectiveness and sustainability of its new commissioning model.

7.2. An evaluation should be conducted in order to determine how current capacity issues affect the delivery of person centred care arrangements.

7.3. Commissioners should review the impact of fee levels and whether there is any correlation with recruitment and the ability of providers to subcontract work.

7.4. In line with its original business case, the local authority should determine ways to incorporate an outcome-based incentive for providers.

7.5. The local authority should review its quality assurance systems and explore how best to respond to people's concerns about the continuity of care and other matters affecting the quality of care.