Midlothian Integration Joint Board

Thursday 5th October 2017, at 2.00pm

Care at Home Review

Item number:	**5.3**

Executive summary

This report explains the need for a comprehensive review of care at home services across the whole of Midlothian which follows a light touch review published in April 2017[1]. The primary purpose of this care at home review is to improve the quality, efficiency and effectiveness of in-house and external care at home services.

To support the primary purpose, the commissioning of community services will be strengthened by improvement focused service development that support IJB local priorities and, promote a partnership approach across the third sector to reduce duplication, improve care pathways and build on community assets.

Board members are asked to agree to:

- *the steps being taken in the short term to improve delivery of the Care at Home service.*
- *the development of a collaborative approach to inform longer term service redesign within the context of an integrated locality approach.*

[1] Care at Home is where the heart is: A service review of domiciliary care for older people in Midlothian (April, 2017)

Report

Care at Home Review

1 Purpose

To update the Integration Joint Board on progress and approach to reviewing care at home services across Midlothian.

2 Recommendations

The IJB is asked to agree to:

- the steps being taken in the short term to improve delivery of the Care at Home service.
- the development of a collaborative approach to inform longer term service redesign within the context of an integrated locality approach.

3 Background and main report

3.1 The Care at Home Review set out an action plan for change (Appendix One). This report outlines progress made in the implementation of the plan.

3.2 To secure and attempt to build capacity an “Invitation To Tender” resulted in securing three care at home providers into a three year framework agreement commencing 1st October 2017.

3.3 The new framework agreement secures additional capacity to provide care across Midlothian for new business not being picked up by the current providers.

3.4 The care workers previously employed by Mears (West) and Carr Gomm have been transferred into Midlothian Council terms and are operating as a team providing care in the Midlothian West area.

3.5 Monthly performance monitoring and quality assurance procedures have been introduced for all care at home providers and in-house care teams. The focus is on monitoring capacity usage, staff turnover and key quality indicators.

3.6 Geo-mapping of care at home service provision has been developed to allow identification of opportunities for care workers to be coordinated more effectively across in-house and external provision. Regular meetings with care coordinators using geo-mapping will be implemented from mid October 2017.

3.7 Greater usage of the in-house electronic system to provide more effective audit and management information is being implemented. The use of electronic and mobile phone monitoring systems is planned for implementation November 2017.

3.8 Community and workforce communication has tapped into existing forums to raise awareness to the scale, challenges and actions being taken to improve care at home. Identifying areas for practice improvement and reducing well intentioned thinking behind referrals that increase care at home pressures have been identified and acted upon.

3.9 Services will co-located with third sector partners into social care and primary care settings. This will enable identification of overlap in service provision and look to create partnerships for commissioned services beyond 31st March 2018.

3.10 Positive talks with UNISON have commenced about developing the Unison Ethical Care Charter to allow greater development and coordination of a care workforce across sectors.

3.11 We are sharing our approach and experience within the care at home market with other local authorities in Scotland facing similar challenges. They include:

- Care providers are pulling out of loss making, unsustainable contracts and co-ordinating a workforce efficiently is proving a significant challenge.
- Care employers are experiencing staff moving from one provider to another or from provider into the public sector. This is incurring duplication of training, administration and ultimately disruption for care delivery and capacity across the care at home system.
- There is a lack of skilled, experienced care co-ordinators who are key to utilising capacity effectively.

3.12 Key outcomes of the local Care at Home Project are (See Appendix 2):

- To shape the care 'market' within Midlothian.
- People have access to the right care at the right time and right setting.
- People have a say in their Care and Support plans that are in line with their eligibility criteria.
- People have realistic outcomes focused conversations with health and social care staff and community services.
- People and communities have a say in the design and delivery of services.
- People in hospital don't face delay in returning home or to a homely setting.
- Unpaid carers fulfil their caring role and have a life outside of that role.
- Public funds are used more efficiently.
- Preventative and reablement services will be delivered effectively.

- More equality and consistency in care provision and care allocation.
- Stakeholders work in partnership to achieve agreed priorities.
- Centralising and localising of services where it makes sense to do so.
- A workforce that has career opportunities, flexibility of working and support to combine a working life with the life they have outside of their role.
- Individual, community and service needs will be identified and responded to sooner, in a planned way and with a focus on local and strategic priorities.
- Communities assets are strengthened

4 Policy Implications

4.1 The outcomes of this project are in line with the Midlothian IJB Strategic Plan 2016-2019, The Joint Strategy for Older People in Midlothian 2016-2019, Midlothian IJB Local Improvement Goals and National Health and Wellbeing outcomes.

5 Equalities Implications

5.1 An Equalities Impact Assessment will be incorporated into the redesign process.

6 Resource Implications

6.1 The total annual spend on care at home services is.£6m.There are considerable financial pressures arising from service failure of the external sector and inefficiencies in the in-house service.

6.2 The Reablement service secures significant savings through the use of the Reablement approach to reduce the cost of care packages. However the overall costs of in-house services when bench marked against other authorities is considerably higher. This is partly attributable to inefficiencies in the Complex Care Service and the high cost of on call arrangements within the Merrit Service together with high sickness absence.

6.3 The recent invitation to tender has attracted three providers to establish a framework to meet new packages of care across Midlothian that cannot ordinarily be taken on by the service provider for that region. The rates submitted by providers within the framework agreement are higher than existing contract arrangements.

6.4 The current pressures within the service means that that not all service needs are being met including patients delayed in hospital. This means that the financial pressures in the sector are under stated.

7 Risk

7.1 There is a high risk of existing care at home service provision continuing to require unplanned intervention due to quality assurance or exit by service providers. Risk is minimised by implementing the business improvement approach (see Appendix Two).

7.2 There is a risk of the project fuelling uncertainty across community and workforce that is disproportionate to what is going well. This will be mitigated through Realistic Care, Realistic Expectations communications plan.

7.3 There is risk of developing a common view of the remodelling care at home as producing a 'quick fix' or 'forever' solution. A structure supporting a continual improvement approach is developing.

7.4 There is risk of disruption across in-house teams, external care provision and community providers if structures and workforce are remodelled. This disruption can be reduced by engaging people in the change discussion and future planning.

8 Involving people

8.1 The project will actively involve all key stakeholders including service users, family, carers, workforce and communities.

8.2 The project will formally and informally engage with key people in Midlothian and beyond through learning from passed and present experiences in reshaping care.

9 Background Papers

9.1 [1] Care at Home is here the heart is: A service review of domiciliary care for older people in Midlothian (April, 2017)

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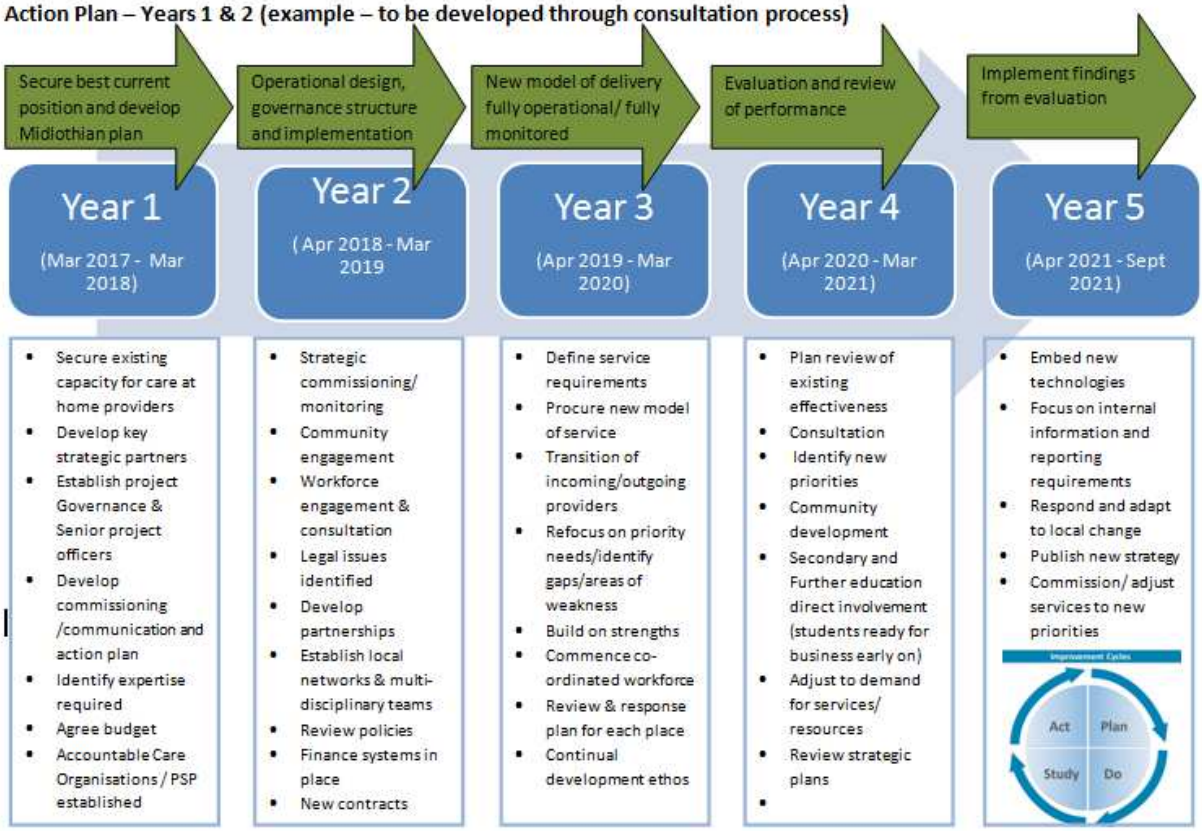
Appendix One

Action Plan – Years 1 & 2 (example – to be developed through consultation process)



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Appendix Two

Short Term steps to improve delivery of the Care at Home Service

- *Use geographical mapping to reduce travel time and better coordinate care worker visits.*
- *Participate in strongly linked projects: Penicuik multi-disciplinary team approach; Workforce development; Realistic Care, Realistic Expectations.*
- *Increase and improve quality assurance monitoring for in-house and external care at home service providers.*
- *Put in place exception reporting tools for service managers and care team coordinators to raise awareness of opportunities to release care worker capacity and plan ahead for times when capacity is lower than needed.*
- *Reduce the number of instances when multiple carers from multiple providers are attending the same location at the same or similar time where it makes sense to do so.*
- *To use CM2000 (in-house electronic workforce management software) to support move towards technology, reduce paper recording and paper management, improve service management and quality of care provided.*
- *To use findings from recent Care Inspection Report of in-house care at home service to implement all recommendations within report within 6 months.*
- *To improve care pathways and assessment process for service users and teams making referrals into reablement and complex care teams.*
- *To undertake desktop and location based research to inform analysis and evidence.*
- *Realign staffing structure within 'in-house' care at home service to ensure maximum efficiency and improve quality of care experience*
- *Ensure Care and Support plans are reablement and outcomes focused, completed in partnership with service users and unpaid carers, and acted upon.*

The Development of a Collaborative Approach to inform longer term Service Redesign within the context of an Integrated Locality Approach

- *Meet 1:1 with managers of third sector community services, including the third sector interface, with regards to future commissioning and IJB local priorities.*
- *Facilitate round table discussions with health & social care, community services management and key staff to identify needs, demand, gaps and actions to use co-production to develop services*
- *To use existing Health & Social Care Partnership wide consultations, initiatives and communications to build review. These include: Hot Topics; MOPA; Workforce development, review of UNISON's Ethical care charter, Care at home provider forums; Care at home- schedule of practitioner discussions at Midlothian*

Community Hospital, Bonnyrigg Health Centre, Adult Community Care – all staff meeting; VOCAL – Carers Action Group

- *To use information from care inspectorate report of in-house and external providers to access provider customer satisfaction surveys/ evidence*

- *To conduct a public, service user and un-paid carer survey focused on care at home provision*