REPORT TO: Health Policy & Performance Board

DATE: 20th September 2016

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health and Wellbeing

SUBJECT: Transforming Domiciliary Care

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To present the Board with the proposed developments in relation to Domiciliary Care delivered through Halton Borough Council.

2.0 RECOMMENDED

2.1 RECOMMENDED: That the Board:

1) Note contents of the report.

3.0 SUPPORTING INFORMATION

3.1 Current Picture

In Halton there are currently 9 providers who work in four different zones as agreed through the last tender process carried out in 2014. Some of the providers receive a block of hours and some are part of a spot purchase framework agreement. The providers support a total of 736 people and deliver in excess of 350,000 hours of care per year with an annual expenditure of more than £4.3million.

3.2 The amount of care and the overall expenditure is set to rise over the coming years at an estimated rate of between 2-3% per year and although there are some excellent examples of high level care within the sector, it is clear that we will need to make improvements to meet the needs of an ageing population in the coming years.

3.3 The current contract runs until June 2017 and we are in the process of conducting a review of the domiciliary service in Halton. This review will support the development of a new service specification and will form the basis of the tender process that will be undertaken towards the end of 2016.

3.3 We have already commenced with reviewing the current domiciliary care sector in the borough. This has led to understanding the key principles that are at the heart of an outcome based domiciliary care service, these include:

- Moving away from a one size fits all approach

- Adopting a preventative model
- Keep people independent
- Improve quality of life
- Increase community participation
- Improve Health and Wellbeing

3.4 Consultation

As part of the review we have carried out a significant amount of engagement with people who use the service and carers. The views expressed were as follows:

- Services can be too time and tasked focused opposed to providing quality and interaction
- Restrictive role of some carers “that is not my job”
- Carers are not recognised for the role they do
- Professional barriers are put in place by services and agencies who should be working together
- Carers play a crucial part in safety – they need to be better equipped in identifying risks as well as understanding social isolation.
- Unsatisfactory assessment process – not always face-to-face, social worker may have limited contact with an individual and not always have an ongoing process in place
- Lack of continuity with care teams
- Need more access to preventative support and services
- Assessments and care plans need to identify possible solutions to help people improve their outcomes
- Increased knowledge of domiciliary care providers on the support and services available and how to access them
- More flexibility
- Emergency response

We have also had the initial meeting with providers, the voluntary sector, social work teams, GPs and CCG colleagues.

3.5 The New Model of Care

It is clear from the feedback that we have already collected that there is a need for change, too many pressures on times, limited capacity, poor recruitment, financial pressures, waiting lists. It is also clear that when we start to consider “the ideal” that people would like to see; then we have challenges on just how practical it will be to deliver. To help we have set out five broad groups that can define need:

1. Prevention and promotion – large number of the population who remain healthy and can access information to continue to support their health and wellbeing
2. Limited need / community participation – people who need some form of low-level support, but this can often be delivered through volunteer or community organisations
3. Service users with personal care needs – people who still have some independence, but have traditional personal care needs that need to be addressed

4. Service users with higher / long term care needs – people currently supported by domiciliary care providers but who have complex or specialist needs
5. Reablement – people who require an intensive short-term intervention that will help them to achieve a specific outcome.

By using these broad groups we can start to map the numbers and also the financial burden in these areas. Therefore if we consider groups 3 and 4 we know that these two groups support 376 people as a total, we have also concluded that 42% of these people fall into group 4 and have complex needs, whilst 58% of people are in group 3.

3.6 Opportunities for New Ways of Working

In 2015 The National Lottery opened up a new funding initiative aimed at Local Authorities developing changes within existing service provision to realise significant improvements in outcomes, both for an individual and financial for health and social care. The fund that was established was not a traditional grant funding pot, but was being offered through a Social Impact Bond (SIB).

The application was in three stages:
Stage 1 – Expression of Interest
Stage 2 – Application for development grant funding (up to £50,000)
Stage 3 – Full application for Social Impact Bond (up to £1,000,000)

So far we have been successful at stage 1 and stage 2 and we now have until September 22nd 2016 to submit our full application.

3.7 What is a Social Impact Bond?

Social Impact Bonds are a new concept in public service delivery. National research suggests that they have many benefits, including bringing additional investment into public services, encouraging more innovative service delivery and creating a better contract management. However, they can also be complex and challenging to establish and implement.

A Social Impact Bond is essentially a type of payment by results (PbR) contract. Like other Payment by Results, a commissioner (usually one or more public sector bodies) agrees to pay for outcomes delivered by service providers, and unless those outcomes are achieved, the commissioner doesn't pay. Where a SIB differs from PbR is that the providers do not use their own money to fund their services until they get paid – instead, money is raised from so-called 'social investors' who get a return if the outcomes are achieved. Usually the providers get paid up front by a third party body who holds the contract, rather than holding the contract directly.

4.0 POLICY IMPLICATIONS

There are significant changes that will need to happen in relation to full implementation, however the design, action plans and overall implementation plan will be completed as part of the National Lottery funding application and will be available from September 2016.

5.0 FINANCIAL/ RESOURCE IMPLICATIONS

5.1 None identified through this report

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

There are no implications for this priority.

6.2 Employment, Learning & Skills in Halton

There are no implications for this priority.

6.3 A Healthy Halton

The 736 people who are supported through Domiciliary Care are an important part of the overall Health and Social Care landscape. They account for a significant amount of the budget and capacity continues to be stretched. Any changes in this area will impact internally, but will also have an impact on the care that individuals receive. This must be managed sensitively and safely for each person.

6.4 A Safer Halton

There are no implications for this priority.

6.5 Halton's Urban Renewal

There are no implications for this priority.

7.0 RISK ANALYSIS

7.1 None identified.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 There are no implications for this priority.

9.0 LIST OF BACKGROIUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

9.1 None under the meaning of the Act.