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Community Health and Well-being Service pilot

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Report of: Project Director – Social Care Transformation

Report to: Interim Director of Adults and Health

Will the decision be open for call in? ☒ Yes ☐ No

Does the report contain confidential or exempt information? ☐ Yes ☒ No

Brief summary

This report seeks permission to pilot a new approach to home care that we are calling the Community Health and Well-being Service as it seeks to provide a holistic approach to care where providers will also deliver services on behalf of the Leeds Community Healthcare NHS Trust. It is the next stage in the Council's commitment to deliver against the aspirations set out in the Unison Ethical Care Charter and the GMB Home Care Commissioning Charter.

We know that satisfaction with home care services has fallen with only 62% of respondents to a Leeds Healthwatch survey in 2019 saying they were satisfied with their care (a fall from 90% in 2016). Customer satisfaction is intrinsically linked to the workforce challenges in home care with a turnover rate of 35.8%, a vacancy rate of 11.6% and 42% of staff on zero-hour contracts in Leeds. The pilot aims to test a new approach to home care that will address, amongst others, these issues.

Recommendations

The Interim Director of Adults and Health is recommended to:-

a) To approve the request to commence the procurement of a pilot Community Health and Wellbeing service on an 18 month contract commencing 1st April 2024 with an estimated total value of £5,730,000 and award as a result of the procurement

b) To approve the procurement for an independent academic evaluation of the pilot on a two year contract commencing 1st November 2025 with up to a total value of £60,000.

What is this report about?

1 In 2015, Leeds City Council signed up to the Unison Ethical Care Charter and in 2022 it also signed up to the GMB Home Care Commissioning Charter. Since 2015 the Council has steadily invested more in homecare to improve the wages of staff and in 2023-24 achieved the objective of paying the Living Wage Foundation's recommended wage (also known as the Real Living Wage). However, there is more to achieve in terms of meeting the requirements of the Charters including ceasing to commission on a "time and task" basis, reducing/ eliminating zero-hour contracts, paying for whole shift, developing career pathways and ensuring care also tackles social isolation, promotes well-being and focuses on prevention.

2 Home care remains one of the most challenging areas of social care. The National Centre for Social Research British Attitudes survey has been conducted annually since 1983. The most recent survey was carried out between 7 September and 30 October 2022 and asked a nationally representative sample (across England Scotland and Wales) of 3,362 people about their satisfaction with the NHS and social care overall. Just 14% of respondents said they were satisfied with social care.

3 Dissatisfaction with social care rose significantly in 2022, with 57% of people saying they were dissatisfied (up from 50% in 2021). Dissatisfaction with social care was high across all ages, income groups, sexes and supporters of different political parties. The top reason for dissatisfaction with social care was that people don't get all the social care they need (64%) followed by the pay, working conditions and training for social care workers not being adequate (57%) and there not being enough support for unpaid carers (49%).

4 Looking at Leeds Adult Social Care Outcomes Framework results we can see:

1. Overall satisfaction of people who use services with their care and support was 64.4% in 2021-22 (down from 66.7% in 2020-21)
2. Overall satisfaction of carers with social services was 32.5% in 2021-22 (down from 38 in 2018-19 when the last survey was conducted)
3. The proportion of people who use services who say those services make them feel safe and secure was 83% in 2021-22 (down from 87.6% in 2020-21)

5 The bi-annual Healthwatch survey of Leeds Home care users Report-Homecare-2019.pdf (healthwatchleeds.co.uk), which was last conducted in 2019, reported that only 62% of those who responded to the survey said they were satisfied with their home care service which is a drop from 90% in 2016. Concerns raised referred to staffing and timeliness, communication, and systems and monitoring.

6 The most recent Skills for Care data (2021-22) indicates that there are 9500 home care workers in Leeds. 50% are on zero contract hours (compared to an England average of 46%), the turnover rate is 40% and the vacancy rate is 13%. Average years of experience in the sector is 6.5 years and average years of experience in the role is 3.1 years. 86% of the workforce is female, 78% white and 22% from Black, Asian or Minority Ethnic communities.

7 In summary, the home care sector is characterised by some significant challenges in both satisfaction from people who draw on care and support and workforce recruitment and retention.

8 Our vision for the Community Health and Well-being Service is *to support people to live in the place they call home with the people and things they love, in communities where people look out for one another, doing things that matter to them.*

9 The objectives of the Community Health and Well-being can be divided into two categories: (a) those that impact on individuals and (b) those that are about systems working and processes.

(a) Objectives impacting on individuals
- improve people's experience of care
- improve outcomes for people who use the service
- improve the experience and outcomes for informal carers
- improve the pay of care support workers
- improve recruitment and retention in care support worker roles
- develop a better career pathway for care workers
- increase job satisfaction in the care support worker role

(b) Systems working and processes
- ensure the voice of the person is central to the design and development of the new service
- maximise the use of technology to promote independence
- maximise the benefits of delivering an integrated service with Leeds Community Healthcare Trust
- create stronger links between home care services and other agencies in the neighbourhood for promote community connection and to promote the well-being of people who use the service
- improve co-ordination of the "team around the person" e.g. with the Third Sector, Primary Care Networks, the Integrated Neighbourhood Teams
- improve business processes in the administration of home care services
- evaluate the sustainability of the service model in the longer term

We will use the learning from the pilot to inform our approach to the re-tender of the wider home care service in the city.

10 The Community Health and Well-being Service intends to move away from commissioning on a time and task basis and will have the following characteristics:

- Jointly commissioned by Council and Leeds Community Healthcare Trust (LCH)
- Commissioned on a neighbourhood footprint based on population
- Payment model which enables care staff to be paid for whole shift
- Staff trained in a "promoting independence" philosophy with Occupational Therapy support to right-size care packages
- Providers given the flexibility to change packages within agreed parameters so they are responsive to changing needs and are "right-sized"
- Providers to deliver delegated health care tasks on behalf of LCH as well as social care tasks

- Partnership with providers based on collaboration not competition
- Fewer providers per geographical area to minimise time spent travelling and reduce the carbon footprint of care
- Values-based recruitment of local people into support worker roles to support local people
- Citizens supported to reconnect to family, friends and communities to build their resilience, so an emergency doesn't turn into a crisis
- Maximum use of technology
- New integrated care roles and career pathways to be developed
- Stronger links with the local Third Sector to support more social contact
- Social worker role will establish eligibility, agree a personal budget and desired outcomes with the citizen
- Citizen, provider and social worker will draw up support plan together based on desired outcomes

11 In order to test the viability of this model we would like to pilot it in one area of the city. This will in turn inform the specification for a new home care service which we intend to tender for in 2025. The area selected covers Bramley, Stanningley, Armley, Farnley and Wortley.

What impact will this proposal have?

12 The intention of the pilot is to test in the field whether the proposed model (a) achieves improved outcomes for citizens, (b) improves the recruitment and retention of care workers and (c) is affordable and delivers good value for money. It will inform the service specification and commissioning approach for the wider tender of homecare for the rest of the city in 2025.

13 At the moment there are 30 home care providers in the pilot area delivering care to between 1-40 people as part of their business.

We intend to contract with 2-3 providers in the pilot area who will be required to pick up at least 90% of all new packages:

Service Type	Commissioned Hours	Invoiced Hours	Service Users
Home Care	3,265.90	3,051.25	201

This will require some individuals transferring their support arrangements to one of the new providers. It may have a detrimental impact on some providers and the viability of their business.

14 The Transfer of Undertakings (Protection of Employment) TUPE regulations may apply should a service need to transfer to a new provider.

15 Some individuals may prefer to take a Direct Payment to purchase their care from one of the spot providers but previous experience tells us that most people are happy to transfer to a new provider.

How does this proposal impact the three pillars of the Best City Ambition?

☒ Health and Wellbeing ☒ Inclusive Growth ☒ Zero Carbon

16 The pilot project contributes to all of the three pillars of the Best City Ambition. With respect to the Health and Well-being Strategy, the pilot helps deliver against the following priorities: to be an Age Friendly City where people age well; strong, engaged and well-connected communities; maximise the benefits from information and technology; a stronger focus on prevention; support self-care with more people managing their own conditions; a valued, well-trained and supportive workforce and the best care, in the right place at the right time.

17 The Inclusive Growth strategy sets out an ambition for Leeds to be a place that innovates and is a test bed for new ideas. What the Council is trying to achieve in creating a Community Health and Well-being Service is completely new in England and has not been attempted at scale. A key part of the model is recruiting local people from within neighbourhoods to support other people in that neighbourhood who have care and support needs. Care staff will be trained to work in a different way that promotes independence and uses their community knowledge to help people reconnect.

18 By designing the service to be hyperlocal we aim to reduce the number of car miles and therefore reduce the carbon footprint of care services and contributing the Zero Carbon ambition.

What consultation and engagement has taken place?

Wards affected:		
Have ward members been consulted?	☒ Yes	☐ No

19 The design of the new service has been co-produced with a range of stakeholders including people use care and support services, carers, trade unions, NHS colleagues, care workers and care providers. We commissioned Healthwatch to facilitate a Citizens Panel which is diverse in its membership. We also have a Provider Forum and a Care Workers Forum. We have a bi-monthly Stakeholder Board chaired by the Executive Member for Adult Social Care, Public Health and Active Lifestyles.

What are the resource implications?

20 A key element of the service design is to ensure workers are paid for the whole time they are at work. At the moment, a worker is given a set of visits to undertake which has a travel allowance built into their roster. If the care provider is not able to plan a run with consecutive calls, a care worker may have some down time that they do not get paid for yet the down time is not sufficient to return home or do something else. This means that care workers can, for example, be at work for nine hours but only get paid for eight hours.

21 In order to pay for the whole time a care worker is at work (except for planned breaks), the hourly rate will be adjusted to include a shift allowance which means it goes up from £22.35 to £24.50 ph, and this will be subject to the annual uplift for 2024/25. Without any change to how the service is commissioned and delivered this would create a **£353,016k** per year pressure on the home care budget in the pilot area (based on 2023/24 rates) however we have looked at both the payment mechanism and what aspects of the model we believe will reduce the overall number of hours needed to support the same number of people that will bring the model back into a cost neutral impact.

22 How we pay providers has a big impact across the service. It is not just about managing the Council's budget, but ensuring providers are paid a fair rate for their services, are able to maintain capacity and can demonstrate value for money. From the Council's side, it is about the administrative burden of paying invoices and dealing with a great number of time-related billing queries.

23 We have consulted with people who use services, providers and internal colleagues on service delivery, billing and invoicing and analysed data relating to call times and billing enquires / refunds. Our analysis shows that there is an opportunity to change how we track delivery through the collection of call monitoring data and reconcile this across a four-week period to increase visibility for the provider, person who uses services and contract / finance teams.

24 Under the new pilot, we will work with providers to flex and adjust service delivery to better meet the needs of citizens and plan effective rotas. We are changing how we pay providers for this contract in order to achieve this flexibility and maintain capacity to pay staff for a full shift and deliver a balanced budget,

25 The proposal is to have a split fee approach based on how we cover operational (back office) costs versus actual care delivery. We know that providers have fairly fixed costs for their back office functions. With a fluctuating fee based on visit times, providers tell us they can run into difficulties running the business if their fixed costs are not covered due to low demand. This payment will be made on the basis of a guaranteed minimum number of hours to cover the back office costs and maintain good levels of staffing. The remainder will be paid for the care hours delivered plus a five minute tolerance per visit for entering / leaving / PPE. Care hours includes time spent in the home and time spent outside the home on tasks to the benefit of the service user, e.g. ringing the Community Nurse or arranging for a trusted trader to fix a leaking tap. The advantage of this model is that Providers can maintain capacity with a guaranteed minimum income and it encourages care workers to stay for the duration of the visit. The challenge of this approach is that it may cost the Council more if demand is not closely managed. It may also be potentially harder to administer on both sides.

26 With the support of consultants Newton, a number of opportunities have been identified to reduce the overall expenditure on home care services through the new pilot model. These are:

- Collaborative decision making at start of services
- Scheduling shorter visits only where appropriate
- Measuring outcomes and promoting independence
- Collaborative annual reviews
- Monitoring and reconciling visit data

27 In summary the financial implication of the pilot are as follows:

Current approach	£
Current annual cost in pilot area based on current delivery / payment model	3,716,700
Annual cost based on new rate based on current delivery / payment model	4,074,300
Difference	357,600

New approach

Annual cost of service based on split fee approach and new model	3,819,712	
Current annual cost of service based on current delivery / payment model	3,716,700	
Difference	103,012	(+ 2.7%)

Based on the Newton data analysis and consultation with the market on the benefits of the new model, alongside more rigorous data tracking, we are confident that the 2.7% required saving can be achieved to deliver a balanced budget for the pilot contract.

28 The figures above relate to the LCC social care delivery. LCH will reimburse LCC for the hours delivered for their referrals at the same rate. LCH have also committed to paying LCC an additional administrative fee at a rate to be determined to manage the contract, payments and referrals.

29 The funding for the evaluation is from the ringfenced social transformation budget.

What are the key risks and how are they being managed?

30 The key risks are (a) the mobilisation period, the challenge of reducing from 30 providers to 2 – 3 providers, (b) whether sufficient reduction in home care hours can be achieved to offset the increased unit cost (c) whether the new contracting mechanism delivers savings compared to the current contract and (d) whether providers are sufficiently motivated to adjust packages of care.

31 In order to mitigate the risk during mobilisation there will be a comprehensive communication strategy with people who use services and care staff to explain the benefits of the new service offer to ensure the maximum number of service users and staff transfer to the new providers. We will take a risk-based approach to undertake reviews of everyone in the pilot area during the transition period. This is to ensure their new provider has the most up-to-date understanding of their support needs when taking over their care.

32 If a more efficient use of home care hours cannot be achieved in the pilot area, the maximum exposure to increased costs is £103,012 per year so a contingency sum of £155,000 has been set aside to cover this during the 18-month pilot period. This is being funded via ringfenced development funding to support the piloting of the Community Health and Well-being Service. Once the service goes live there will be monthly meetings with providers to monitor performance against the objectives of the pilot and we have asked for complete transparency over costs.

33 Considerable thought has been put into how to incentivise the right behaviour from providers. The proposal is to pay a minimum guarantee of hours in the pilot area so providers are assured their fixed overheads are covered irrespective of the volume of hours they provide.

What are the legal implications?

34 Part 1 of the Care Act 2014 sets out the general responsibilities of local authorities to promote the well-being of people with care and support needs and section 8 refers to “care and support at home or in the community” as one of the ways people’s needs may be met.

35 The İnterim Director of Adults and Health is authorised to commence the procurement of the pilot. This is a key decision as the estimated total value of the contract is £5,730,000 (and a further £60,000 for an academic partner, and is therefore subject to Call In.

36 This report does not contain any exempt or confidential information under the Access to Information Rules.

37 Subsequent decisions arising from this report, for example, to award the contract, will be treated as a consequence of this Key Decision and will therefore be treated as a significant operational decision at most, which will not be subject to call in.

38 The pilot will be commissioned through an open tender process advertised through Yortender. A parallel process is being undertaken to review contracting arrangements for the rest of the city that will enable the pilot area to be extracted and services maintained in the interim period. The pilot tender will be evaluated on a 100% quality basis, including the social value return, due to the fixed hourly rate offered under the contract.

39 The pilot will be co-commissioned with LCH in two Lots. Lot 1 will be social care referrals and Lot 2 will be LCH referrals. The overarching contract and Lot 1 will be based on LCC terms and conditions, with LCH short form terms and conditions applied to services drawn down thorough Lot 2. A memorandum of understanding will be entered into to set out robust financial and governance arrangements between LCC and LCH, including the hierarchy of terms and conditions. The memorandum of understanding will include reference to roles and responsibilities for each partner and the providers in relation to recording, reporting, clinical oversight, contract management, safeguarding and dispute resolution.

40 The academic evaluation will be procured through an open advertisement on Yortender. The tenders will be scored on a quality / price separated basis with the final provider selected on the basis of the lowest price submission from all that reach our minimum quality threshold. Method statement question/s will completed on the proposed time, staffing, resources and social value for the evaluation to ensure that value for money is considered.

41 The Transfer of Undertakings (Protection of Employment) TUPE Regulations may apply should a service need to transfer to a new provider. Plans are already in place to ensure all care workers are informed of their rights under TUPE. Employment legal advice from LCC's Legal Services will be sought ahead of any transfers taking place.

42 Procurement and Commercial Services will advise and support the procurement activities to ensure compliance with Procurement regulations and governance

43 This is a key decision and this report does not contain any exempt or confidential information under the Access to Information Rules.

Options, timescales and measuring success

What other options were considered?

44 We could continue to commission home care in the same way and accept that it will continue to have issues with customer satisfaction and staff recruitment and retention.

45 The option to recommission the whole city under the new model was considered and rejected due to the potential budget pressure and efficiency targets required. The pilot manages the risk and enables us to test and adapt the new model alongside LCH and plan for a citywide rollout.

46 The option to commission the evaluation through the ICB's Health and Care Evaluation Framework was considered and rejected as there is only one academic institution on the framework for the appropriate lot. Opening up the tender to a wider selection of organisations, especially those with knowledge of the city, will ensure we have the best possible evaluation partner to test this ambitious programme.

How will success be measured?

47 The objectives of the pilot are set out in paragraph 9 of the report and the success of the pilot will be measured against those objectives. We will also commission an independent academic evaluation of the pilot which will to measure the success of the pilot against these same objectives.

What is the timetable and who will be responsible for implementation?

48 The procurement timetables are set out below and implementation will be the responsibility of the Project Director: Social Care Transformation.

CHWS Pilot

Tender Open	18.09.23
Tender Close	31.10.23
Award	04.01.24
Phased mobilisation	18.01.24
New contract starts	15.04.24

CHWS Evaluation

Tender Open	06.11.23
Tender Close	27.11.23
Award	04.11.23

Appendices

- Equality Impact Assessment

Background papers

- None