Democratic Services

ADDITIONAL AGENDA PAPERS

CABINET

12 OCTOBER 2015

ITEM 11
DOMICILIARY CARE SERVICES HOME CARE PROVISION
ANNEXES A + B
(Pages 2 to 47)

ITEM 21
(REVISED REPORT)
INVESTMENT IN PROPERTY FUND FOR TEMPORARY ACCOMMODATION
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ANNEX A

Domiciliary Care Review

June 2015

Milton Keynes Council

Milton Keynes Council: Domiciliary Care Review 2015

CONTENTS

Introduction

Domiciliary care is increasingly a challenge for local authorities, the NHS and service providers across the country. Concerns about the viability and sustainability of the sector make it the focus of a number of national reviews and papers in recent months.

Milton Keynes Council (MKC) currently commissions domiciliary care services to provide care and support to people to live independently in their own homes. Approximately 9,500 hours of care are provided per week, through some 14,000 visits. The value of these services is circa £9m per annum.

In 2012 the Council moved to structure and formalise the mixed economy of providers delivering domiciliary care services, introducing a 'Preferred Providers List' (PPL), which initially resulted in 15 successful independent care providers. The PPL operates under a formally procured Framework Agreement, and is a contractual arrangement that is in place until September 2016.

The Council started to 'spot purchase' additional provision in 2014, due to some of the original PPL providers withdrawing from the contract, leading to supply and demand issues. The four spot providers are contracted on the same terms and rates as the PPL providers. As of April 2015 there were 17 external providers working with the Council and one other going through the contracting process, accounting for 71% of domiciliary care package spend at December 2014.

The PPL providers operate alongside services provided by the Council's internal homecare teams, comprising of a mix of specialist dementia services, more traditional domiciliary care services, sheltered housing schemes and Intermediate Care and Reablement Teams. These services account for circa 29% of activity at December 2014.

There are a number of drivers of demand affecting capacity locally, which will require further investigation as a result of the review. What is clear though is that, although there has been growth in providers and market capacity, the current PPL has not been able to meet the rate of growth in demand. The review aims to understand what the issues are relating to this, and to have a better understanding of the costs associated with both the external and internal provision.

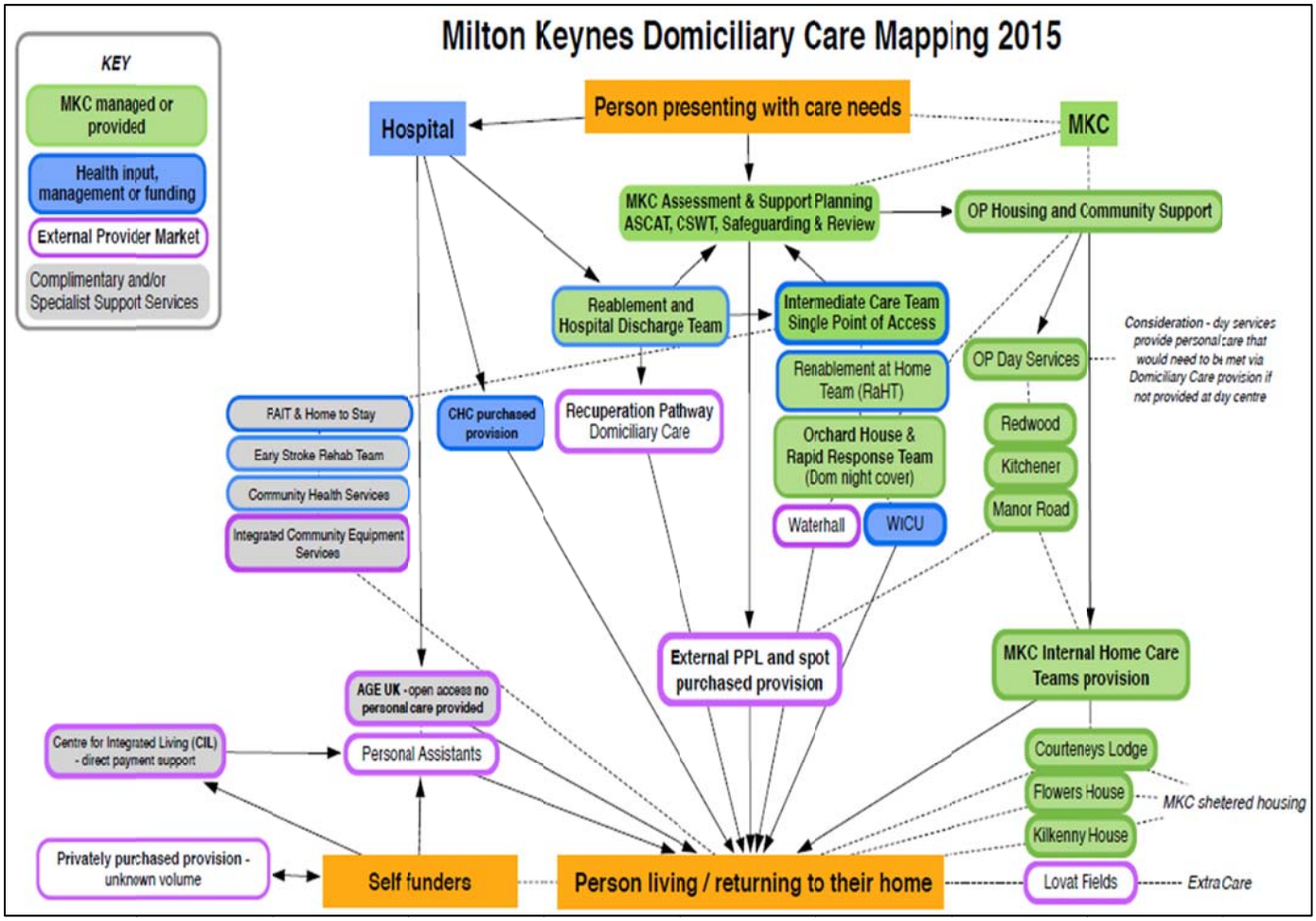
Figure 1 demonstrates the scope of the local market to gain understanding across the organisation and stakeholders of the focus on the review. This map is not exhaustive but aims to map an overview of the sector and its associated activities.

The main drivers of demand locally are:

- Adult Social Care purchasing through the PPL – the majority of which is Older People and Physical Disabilities via Community Social Work Team (CSWT).
- Adult Social Care service users purchasing via direct payments.
- Children with Disabilities Team purchasing.
- Continuing Health Care (CHC) – health funded on-going medical care purchased via PPL and other local providers.

- Self-funders organising and paying for their own care; potential increased role for the Council following the Care Act.
- Reablement and Hospital Discharge Team
- Personal Care provided in sheltered housing schemes

Figure 1



The following issues have emerged:

- **Capacity in the local provision** – activity has increased over the duration of the PPL by 41% (3017 hours per week), but demand has consistently out grown supply.
- **Demographic pressures** – Milton Keynes is estimated to see growth of the 65+ population of 38% between 2015 and 2021, potentially increasing future demand.
- **Increased complexity of need** – a system moving towards community provision and away from acute care: evidence of increasing level of need locally with rising demand for double handed care i.e. care needs requiring two carers.
- **Staff recruitment and retention** – issues recruiting volumes/quality of staff needed. Staff remuneration in competition with the wider employment market, such as retail.
- **Reliance on too few providers** – external provider market grown from 8 to 17 providers but currently 50% of external spend is with four providers, accounting for 35% of all spend.

- **Care Act duties** – new duties towards self-funders and the sustainability of the local care economy (self-funders acknowledged to subsidise local authority activity nationally), market failure and active market facilitation.
- **Rates paid to providers** – broadly in line with average, but growing national concern about rates paid. Need to consider rates in relation to other sectors locally, not necessarily domiciliary care in other areas.

Locally and nationally there are pressures on the Health and Social Care system, increasing need, changing age demographics and large reductions in local government core funding. This review aims to hold a stock take, reflect on the lessons learnt since 2012 and contribute proposals about the future of Domiciliary Care in Milton Keynes.

Background

Prior to the PPL the Council purchased services on a spot basis from nine providers. Although all the providers were paid the same rates, these were varied and complex with 18 different rates paid. Quality in the market also varied. With increasing personalisation of social care budgets simpler unit costs were sought so people could opt to withdraw their social care funding to spend as they wished. This also enabled the use of a Resource Allocation System to ensure the funding allocated was more equitable.

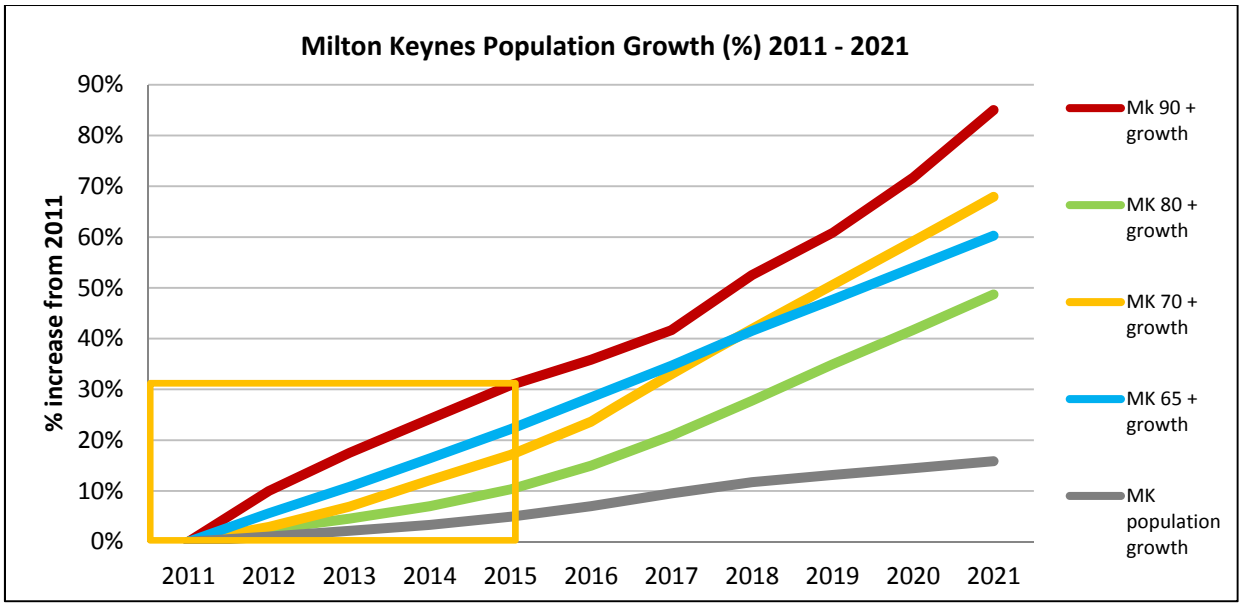
The PPL put in place a fixed cost structure, removing price as a competitive lever in the market. This was to address concerns that providers would be too aggressive on price if both price and quality were factors in gaining access to the PPL, and then providers not delivering a safe and financially viable service.

Providers therefore were qualified by meeting minimum quality thresholds of 100%; however the cost threshold was established in advance, calculated by MKC Finance, using benchmarking data. The failure of some previous providers to pass the quality threshold for entering the PPL caused a long process of either; transferring people to new providers, or people opting to take a direct payment to source their own care and continuing to use these providers.

An aim of the process was also to increase the number of providers operating in the local market, and the amount of capacity available. The process opened the market to national providers to expand choice and build capacity. Six national providers set up branches in Milton Keynes as a result.

Prior to the PPL there were nine external providers working with the Council, this has grown to 13 PPL providers and five additional spot purchased providers. Although external market share has only grown a few percentage points in comparison to internal provision, the hours delivered by external providers have grown by 42%.

Demographic Profile



Source; Milton Keynes Council, 2011

The orange box shows the population growth of age groups during the time since the beginning of the PPL and clearly demonstrates future demographic pressures, the majority of which will be faced in the next round of domiciliary care provision commissioned.

As with National trends, Milton Keynes is experiencing an ageing population. The population is projected to increase by 15.85% from 249,900 in 2011 to 289,500 in 2021. Growth of the 65+ age group is projected to be higher with 60% growth forecast by 2021 from 2011. At the time of writing the 65+ age group has grown by some 15.5%, versus 4.9% growth of whole population since the start of the PPL.

The 65+ age group (blue line) have experienced growth of 22% since 2011 with the group now accounting for around £6.8m, or 77.2% of all spend. Projected growth of a further 38% means potential spend increase of £2.6m to an approximate £9.4m spend per annum by 2021, before any other factors driving demand are considered.

Data shows a 34.4% increase in hours delivered the 65+ group per week between 2012 (snapshot taken pre PPL) to the same week in 2014. Appendix 1 Figure 6 gives an in depth breakdown of comparative data, with more detailed data in Appendix 2.

The Domiciliary Care Sector in Milton Keynes

Activity

Due to the rise in demand, and resulting capacity issues, there has been a perception that the PPL failed to increase capacity and develop the market. It is the case however that capacity has been built in both internal and external provision, but that demand has outstripped supply.

The following shows the increase in activity across different aspects of the market between 2012 and 2014, Appendix 1 of this report contains further data. For data comparison,

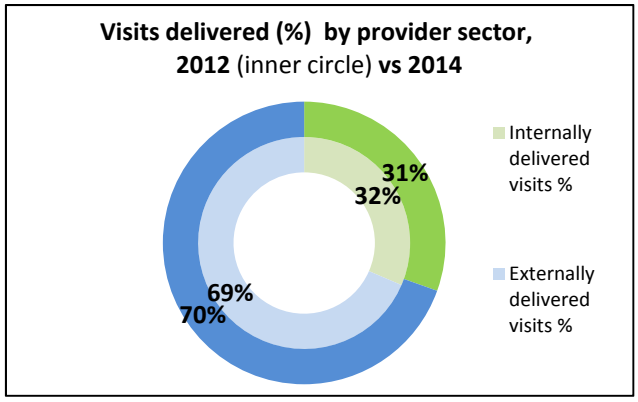
CONTROCC data has been used with snapshots taken from the 1st July 2012, 8 weeks before the start of the PPL and the 1st July 2014.
Both demand and capacity has risen during the PPL with a 17.7% increase in people being supported and 41% increase in hours delivered per week across both sectors, with no uplift in rates paid to providers. The increase is driven solely by demand for services.

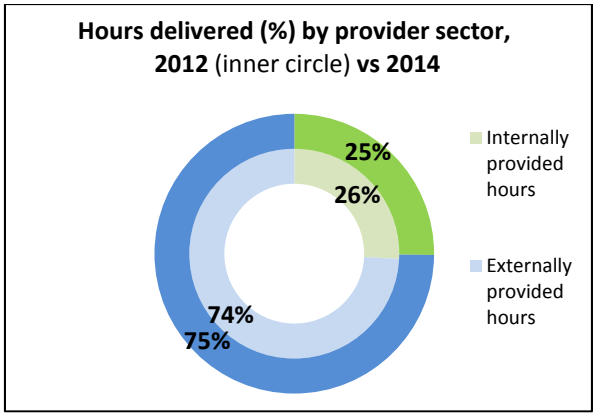
	Snapshot 1/7/12	Snapshot 1/7/14
Weekly Hrs delivered	7371	10388
Percentage increase of hours		**40.93%**
Clients	764	899
Percentage increase of clients		**17.67%**
Weekly spend	**£136,378**	**£192,435**

External provision has seen the greater increase in hours delivered at 42% compared to 37.5% internal. This evidences that the external market has grown both in activity and market share, a strategic objective of the PPL.

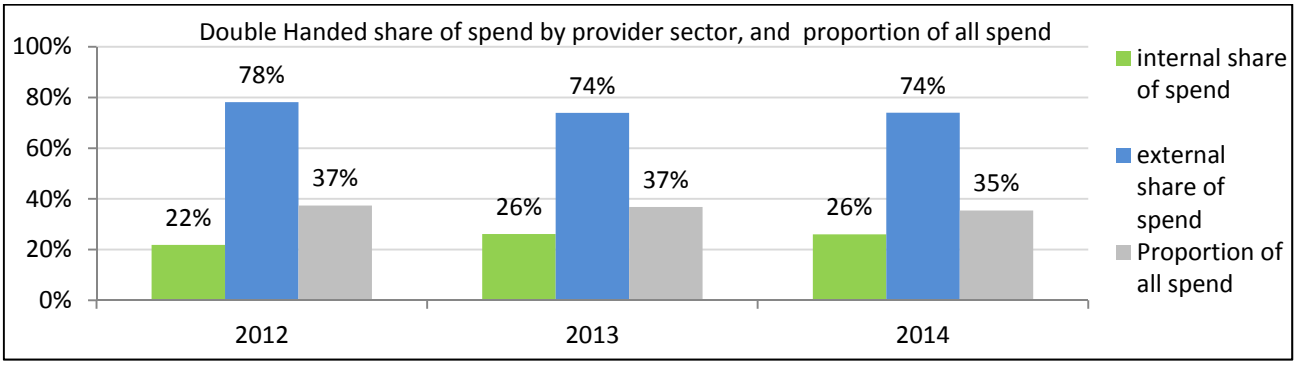
	Snapshot 1/7/12	Snapshot 1/7/14
Externally provided hours	5471	7776
External hours increase %		**42.13%**
Internally provider hours	1900	**2613**
Internal hours increase %		**37.53%**

The volume of visits has broadly grown in line with the growth in hours between sectors. The distribution of this growth as visits varies between sectors; with internal services delivering 25% of hours, but 31% of visit activity. This is however broadly consistent with pre PPL activity.

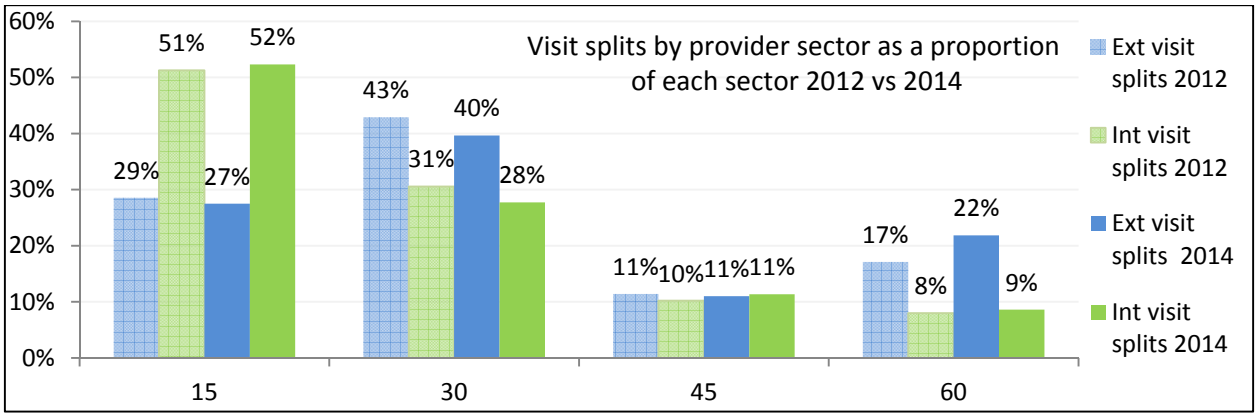




Although the proportion of all spend on double handed care has dropped from 37% to 35%, spend on double handed care has increased overall by £17,000 per week (34%) since 2012. The share of double handed care delivered by external providers has reduced as a proportion of all the double handed care delivered. In contrast internal services share has risen, suggesting internal services are meeting increasingly higher needs.



The split of different visit times and changes in these since 2012, between the providers, show that external services have reduced the proportion of 15 and 30 minute visits, whilst increasing the proportion of 60 minute visits delivered. In contrast internal services have increased the proportion of activity they deliver in 15 minute visits.



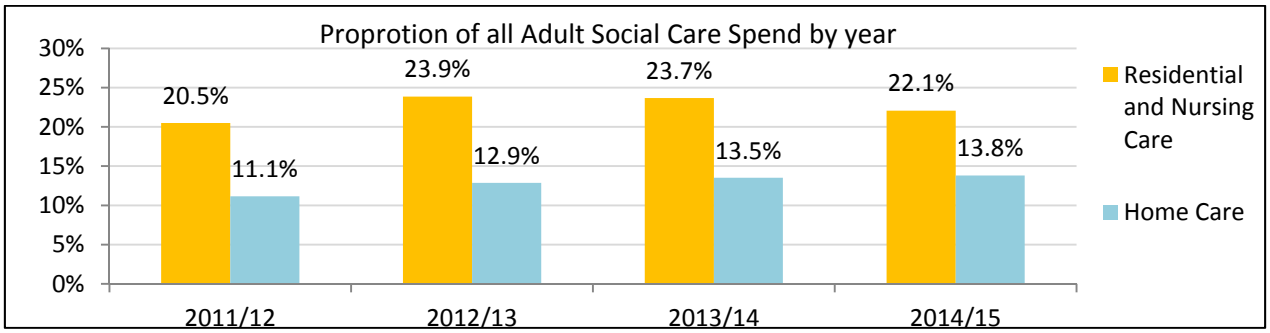
This comparative data, presented in more depth in Appendix 1, points to evidence of:

- Increased capacity in the market since the start of the PPL.
- Considerable growth across both sectors.

- Greater growth in the external market compared to internal.
- Increased levels of need with a consistent rise in double handed care.
- Internal services now delivering a greater proportion of double handed care compared to 2012.
- Internal services delivering a disproportionately higher share of visits (30%) compared to share of hours (25%).
- Internal services delivering a greater proportion of their activity as 15 minute calls whilst external services have reduced this proportion.

This would seem to broadly point to the PPL having been successful in meeting its aims of increasing capacity and developing the provider market. However understanding the role, cost and value that internal services play in the market needs further investigation.

Domiciliary Care has grown as a proportion of all Adult Social Care spend, as Residential and Nursing Care has fallen. The graph below details spends for Older People and Physical Disabilities. Mental Health and Learning Disabilities use specialist providers through dedicated budgets.



Circa 9500 hours and 14,000 visits are provided every week with 35% of this spend providing double handed care, which as discussed previously is likely to increase.

As at December 1st 2014, the four largest external providers provided 50% of all external spend and 35% of total spend. The Council's Internal Home Care service remains the largest single provider providing around 15%. This is potentially due to providing a disproportionate share of more costly and less profitable activity.

The share of spend for internal services is likely to be higher when the true unit cost of providing the service is understood. It appears that as demand has grown, the external market has grown but not as much as demand. Therefore internal services have grown to fill the shortfall.

The split between provider sectors for different support tasks varies:

- **63% receive less than 10 hours per week -** 70% of people accessing internal services, compared to 62% of external. It may be the case that some people are receiving as service from both internal and external so adds to more than 10 hours.
- **92% of people receive personal care -** 97% of people accessing internal services, compared to 88% of external.

- **29% receive some kind of support for domestic tasks -** 24% of people accessing internal and 30% external.
- **12% receive support for shopping -** 8% of people accessing internal services, compared to 13% of external.

There is a lack of night care being provided, which again will become an increasing issue as needs increase. Currently only one external provider provides this service, which is costly. Internal services mostly provide this service, which will also increase their prominence in market share but is a sign of the added value internal services are providing.

Further analysis is needed on investigating different groups and levels of needs being supported. This will be best achieved following the development of a Domiciliary Care reporting framework. More analysis is needed on:

- Those purchasing domiciliary care via direct payments.
- Use of the market to meet the needs of those with Mental Health and Learning Disabilities.
- Services to support carers.
- The demand for night time services; specifically internal team's contribution to meeting this need.
- The contribution of Older Peoples day centres providing personal care and other support tasks that would need to be met by domiciliary care services otherwise.
- The levels of need met by each provider sector.
- How the geography of MK affects service provision and how can capacity could be built by analysis of this kind.

Costs

The rates paid on the PPL were set by a formula to factor in the increased costs incurred of providing short visit times, in an attempt to fund services on a fair and sustainable basis, shown below:

Length of visit (minutes)	PPL Rate £
5	£5.26
10	£6.07
15	**£6.87**
20	£7.68
25	£8.48
30	**£9.29**
35	£10.09
40	£10.90
45	**£11.70**
50	£12.51
55	£13.31
60	**£14.12**

The structure of the rates was designed to:

- Enable purchasing in five minute intervals but these have not been used. Care planners have purchased in multiples of 15 minutes.
- Enable the introduction of 'real time' purchasing of services.

The Council did not implement the systems to pay on 'real time' delivery, but does use this technology for contract monitoring and safeguarding purposes. There has been no inflationary uplift in rates paid to providers since the start of the PPL.

Although both sectors have seen growth in the amount of hours delivered under the PPL (37% internal / 41% external), internal services deliver 25% of hours but 31% of all visits. Further analysis is needed but this may be caused by a number of factors:

- Internal services may be supporting people with higher needs and therefore more visits per day, some of which may be shorter calls as part of larger packages.
- Internal services provide night time support of multiple short visits; this is costly and currently limited availability via the PPL.
- External providers don't want to deliver short visit times as they are resource intensive. Preferring work that both retains staff and offers a financial return.

Recently when engaging with new providers to increase capacity, the issue of Council rates prevented discussions progressing. In addition providers were reluctant to provide visits of less than 45 minutes. The reason given was that staff did not want to spend time travelling between visits as travel time is unpaid. In order to attract the best staff and pay competitive wages the providers were unwilling to move on either of these points.

Benchmarking

Other areas pay a range of rates; this review has considered two benchmarking exercises.

Firstly the UK Home Care Association (UKHCA) published a benchmarking report in February 2015. This national benchmarking was conducted using Freedom of Information requests; data has been taken from this report and averaged by different areas in the table below. The Council provided a late response so was not included in the report.

	Lowest Price	Average Price	Highest Price
MKC Rate	£14.12	£17.81**	£14.12
Bordering Authorities average*; Beds/Bucks/Northants	£12.54	£15.16	£21.29
East of England average*	£11.99	£14.54	£19.25
East of England & South East*	£12.55	£15.15	£20.99
6 'statistical comparator' authorities from the above groups*	£12.92	£14.09	£17.07

*These comparative figures are averages of averages which hide variances. The averaging method used in the submissions of other areas is not known.

**The 'average price' is calculated as total spend, divided by the total number of hours delivered. Shorter visits incur increased costs and are paid at different rates (see the cost structure on page 8). The average fluctuates

depending on the snapshot of data. The MKC average is averaging against a fixed price structure, not a range of prices paid to different providers and is therefore more comparable to the 'highest price' benchmarks.

This average rate raises similar questions as to why external providers are providing 75% of hours, but only 70% visits.

Benchmarking was undertaken in October 2014 with neighbouring authorities and 'statistical neighbours'. Authorities operate a number of different pricing structures and cover a range of varying geographical and economic areas, making comparisons difficult. Out of the 17 returns the Council's rates compared as; higher than six, similar to four and lower than seven other authorities.

The Council rates are currently lower than the UKHCA calculated 'minimum wage rate' of £15.73, and 'living wage rate of £18.59 per hour. The MKC rates appear 'average' compared to other areas. However this is a market that is increasingly the cause of concern, with concerns about the sustainability of rates paid and implications of the Care Act.

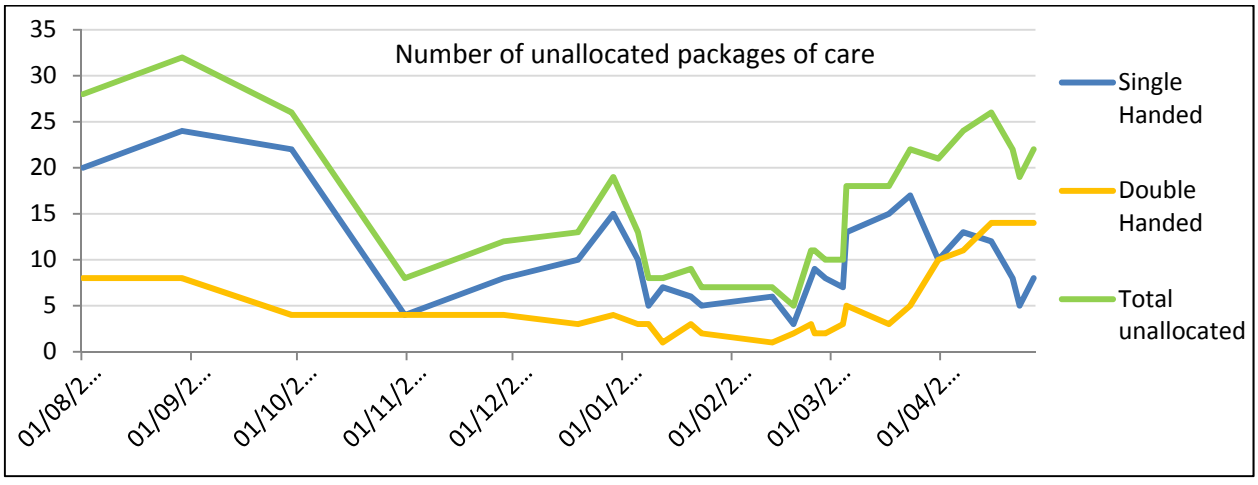
Rates need to be considered in the context of Milton Keynes's economy and employment market, to increase capacity in the workforce.

Current Issues Affecting the Sector

Market Forces

There has been an emerging issue in the last year since two providers withdrew from working with the Council, and closed branches in Milton Keynes. The providers felt delivering the service was unsustainable without guaranteed hours. This meant 30 packages of care needed to be re-allocated quickly. Although re-allocation was achieved, the market was unable to absorb this demand on top of the baseline of new packages that need allocating each week.

The impact of this can be seen in the graph below up until October 2014, and coincided with the start of increased winter pressures across the system. The effect of the system resilience project can be seen through December to February but since then pressure has continued to build in the system.



What is of particular concern is the rise of cases requiring double handed care, which are more problematic to source (shown in the chart above as 'cases unallocated'). These accounted for 50% of unallocated cases, this trend continued to rise throughout April 2015, and is a potential indicator of rising needs. Added to this is the requirement to ensure timely hospital discharge, and the added pressure from this can lead to people being 'over-assessed' whilst in an acute setting, as well as over reliance on risk averse clinical judgements being made. This has and continues to put additional pressure on a market sector that is already stretched. This can be seen above; the overall number of cases drops as the market takes single handed packages of care, and not the packages of these higher needs.

Care Act

The Care Act both places new, and redefines existing, duties on local authorities with the act being implemented in two phases in April 2015 and 2016. In addition to the broad principles of the Act, more specific duties will affect the domiciliary care market and the direction of this review, particularly duties in relation to the role of the Council to all citizens in the market and the care economy as a whole;

- Market facilitation responsibilities to develop a sustainable local care economy.
- Ensuring rates paid to providers enable sustainable services and are sufficient to meet the costs of providing the service.
- Ensuring staff who work in services are appropriately remunerated.
- Have oversight and protect against provider failure.
- Transparency in communications and work with provider organisations, making intentions clear through Market Position Statements.
- Duties towards self-funders to navigate and broker their care in the market. This includes self-funders accessing services at local authority rates, potentially impacting on providers and the Council

In relation to Domiciliary Care, as an increasing area of activity and spend, the Act has implications for the Council's role within the market. There are an estimated 500 self-funders who could access domiciliary care provision through the Council's PPL processes and rates, with the possible effects of:

- Increasing demand for PPL services and therefore reducing the capacity available to the Council.
- Increasing the proportion of income for providers coming from the Council's rates.

- The need to establish the 'real unit cost' of internal provision to make the service available to self-funders from April 2016. This does though offer opportunities for income generation for the Council.

Health and Integrated Working

Following a successful pilot between December 2014 and March 2015, additional domiciliary care was commissioned as a block, to support the pathway, funded from

System Resilience funds. The Better Care Fund will be used to commission this service for one year until the retendering of the PPL.

The pilot supported higher levels of need and activity for individuals:

- 65% (28 of 43) needing three or more visits per day.
- 23% (10 of 43) needing five or more visits per day.
- 14% of people needing double handed care.
- 33% (5 of 15) referred in December were later readmitted to hospital, although reducing to 20% over the whole three month period.
- The pilot provided night time cover, which is currently only provided by a few providers and is very costly under current terms.

The pilot supported 43 people to return home, delivering 2832 hours and 5021 visits in the first three months. Excluding the start-up and step-down phases the pilot averaged delivery of 469 visits and 264 hours of support per week. It was successful in providing increased capacity. The block contract meant there was a higher level of control and stability over the pathway and provided a dedicated service for referrers.

The Recuperation Pathway contributes to more joined up care for service users but also supports Milton Keynes Clinical Commissioning Groups' (MKCCG) objectives of increasing flow through the hospital, as well as meeting the Council's legal obligations regarding 'Transfers of Care' to community settings. The effect of the pilot on community capacity can also be seen in the 'unallocated cases' data section of this report.

Milton Keynes Clinical Commissioning Group (MKCCG) procures domiciliary care services locally for Continuing Healthcare (CHC) purposes, both from PPL providers and providers the Council does not currently contract with. Although CHC is relatively low numbers of people, they can be high volumes of care per head and sometimes require more specialist skills. CHC commissioners are less restricted and more able to navigate the wider market and pay higher rates than the Council, which has a potential impact on supply for the Council.

MKCCG currently commissions domiciliary care provision via contracting arrangements with Northamptonshire Commissioning Support Unit (CSU), at the time of writing it is planned that this service will be returning to Milton Keynes. This offers an opportunity for joint contracting and purchasing of services.

MKCCG/CHC colleagues are currently completing a process of harmonisation to bring package costs more in line with the Councils rates. Although CHC colleagues purchase care in a fundamentally different way, pricing whole packages as opposed to purchasing per hour. More investigation is required in this part of the market, but as with the Children with Disabilities Team, and the Recuperation Pathway it is likely to continue to be thought of, and best managed, as distinct to the wider domiciliary care market.

Services to Support Children and Families

Children with Disabilities Team (CWDT) have used the PPL to source provision. CWDT do not use Frameworki for care planning and purchasing, so spend and activity is not represented in the analysis of this paper and are in addition to the figures quoted. Numbers

requiring support are low but spend per head is high, in line with the needs and complexity of the young people and their families. A snapshot of activity taken in January 2015 suggests the service purchases about £240,000 per annum and provides services to around 70 young people and their families at any given time.

The CWDT team manager and children's commissioners report that the PPL has not served the needs of the children or the team well. Providers on the PPL have lacked the skill and understanding of the needs and there is a feeling that major parts of this work need to be seen as a distinct specialist provision, although there are some care needs that are more generic domiciliary care this is a small proportion.

The team supports children and families with physical, learning, autistic and behavioural needs. Support is for a range of activities either to directly support the daily living, health or behavioural needs of the child or provide respite provision to support the sustainability of families. The oversubscribed provision at Furze House, the Council's respite service, where children spend time away from their families, has increased capacity issues further.

Capacity has been an on-going and increasing issue for CWDT and has led to spot purchasing from alternative providers. Some new providers initially accepted the PPL rates, but have failed to provide the required capacity. Some specialist nursing agencies have been used, usually when the Council has become responsible for care packages initiated by CHC, and it is in the best interests of the child to continue the service.

In March 2015 the team took the operational decision to increase the rate to £15 per hour in a bid to attract more capacity in the required provision. It appears that his has not, to date, provided the required increase of capacity. Discussions are continuing and the Children's commissioning officer is investigating expansion of provision in other ways.

Market Facilitation

This review identified the need to engage with providers in an open and transparent way. Aside from duties under the Care Act, an understanding of the challenges faced by both providers and the Council needs to be established, if sustainable solutions are to be found for meeting the needs of citizens, the Council and providers.

Providers are aware of the review and have already received some feedback via the quarterly Domiciliary Care Forum (DCF).

Minutes of previous DCF forums have been reviewed to help inform the direction of the review. In August 2014 the forum met and providers were asked to contribute thoughts about the challenges they faced operating in MK.

Provider views of issues affecting them in Milton Keynes:

- Rates paid by the local authority to providers.
- Rising business costs; business insurances, lease cars, cost of premises
- CQC compliance
- Costs associated with the geography of Milton Keynes and the reliance on cars for transport: busses are often used in other towns to travel.

- Lack of ability to recruit carers who drive or have their own cars, reports of providers leasing cars and minibuses to transport carers.
- Investing in staff, who then move to work in residential care homes.
- Difficulties in guaranteeing hours to staff meaning the use of zero hour's contracts.
- Demand is at peak times of the day (breakfast/lunch etc.) meaning a need for many employees, therefore unable to allocate many hours to each employee.
- Increase in the needs of clients including double-handed care and nursing tasks: medication, PEG feeding, stoma care, blood sugars, and communication difficulties: viewed as over and above 'basic care' tasks.

The Care Workforce

Intrinsically linked to the quality and capacity of services is the ability to recruit, retain and develop a competent and caring workforce. In this review there is the recurrent theme that at the heart of capacity and quality issues is the local care workforce.

Increasingly there is a consensus from providers about the issues affecting staff recruitment and retention; and therefore capacity locally:

- Competition with other industries and sectors in Milton Keynes.
- Comparatively low rates of pay – potentially making care work less attractive.
- Competition with care homes, staff work at one location without split shifts and don't have to travel or use own vehicles
- Competition between providers for staff, staff moving around to whoever is paying the most per hour at any given time and therefore not increasing capacity in the market
- Feedback from one provider, working across Milton Keynes and Bedfordshire is that for every one applicant in Milton Keynes there are five in the Bedfordshire business. This points to a need to further investigate not only the care economy in Milton Keynes but the wider employment economy.
- Staff usually only get paid for 'contact time'; one provider reports that staff may only get paid for 5.5 hours in every 8 hours at work.

Skills for Care National Minimum Data Set (NMDS) report that 597 people work in domiciliary care in Milton Keynes, or rather there are 597 records returned by employers. The same data however predicts that 3050 (53.4%) of the estimated 5712 care jobs locally are in are 'Adult Domiciliary' positions.

It is likely the case that records are only returned from employers with the infrastructure and resource to do so, or are higher quality employers. Contact is being made with Skills for Care to gain a list of employers who have submitted data. What is increasingly clear though is that staffing will form a critical role in the sustainability of the market in meeting future need.

Below is some comparative data from the NMDS on the local care sector and bordering authorities and England. Of note in this data is:

- 'Average hourly rate' in comparison to other areas will be the focus of further work. Anecdotally providers report this to be closer to £8 per hour. The rate quoted may be the averaged rate including non-paid travel time.
- 'Employment' types including - the proportion of zero hours contracts
- Workforce vacancy rates at the higher end of comparators

Measure	MK	Comparator
Average hourly rate (of 261 staff entries)	**£6.90**	England £7.21 Bucks £8.00 Northants £8.08 Central Beds £8.00
Employed – **Full time**	**37.4%**	England 49.1%
Employed – **Part time**	**38.4%**	England 36.6%
Neither of these (**Zero Hours**)	**24.1%**	England 14.3%
Workforce Vacancy rates	**11%**	England 9.2% Bucks 7.6% Northants 9% Central Beds 12.4%

MKC offers providers access to free statutory training to support the development of the workforce. This meets the requirements of the DASS statutory functions.

The Council are working with schools and colleges to facilitate work experience opportunities and apprenticeships in care settings. A new venture for 2015 is the establishment of a City and Guilds registered assessment centre providing Qualifications and Credit Framework (QCF) Diplomas in Health and Social Care to the sector.

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Milton Keynes Council

Home Care Review & Options Appraisal

Report

September 2015

OXFORD BROOKES UNIVERSITY

http://ipc.brookes.ac.uk

Milton Keynes Council

Home Care Review & Options Appraisal Report

Contents

1 Introduction

This home care review and options appraisal has been produced for Milton Keynes Council (MKC) by the Institute of Public Care (IPC). It looks at the current position and options for change for the commissioning of community home care provision in Milton Keynes.

The scope includes both the externally-commissioned and internal community home care service. It does not include internal home care provided by dedicated on-site teams as part of MKC's extra care and sheltered housing schemes. Also excluded is the care provided by the Intermediate Care Team, for which a separate review is planned in the near future.

The review seeks to provide accurate information about costs and activity. It also sets services in Milton Keynes in the context of the current and future needs of the population, and against best practice in home care and in market facilitation.

Options for change are described and evaluated. They must meet the following broad criteria:

- Deliver person-centred care and keep service users safe.
- Improve the efficiency and effectiveness of service delivery.
- Provide value for money in a time of budgetary restraint.
- Be sustainable.

MKC wish to review arrangements for commissioning home care, and explore as widely as possible what the options might be. This paper sets out the context, considers what good quality home care looks like and reviews the local picture against this, and then sets out potential options for change.

2 Methodology

To inform this paper, IPC have undertaken the following activities during June – August 2015:

- Desk research, including looking at best practice and drawing on previous reviews conducted by IPC for MKC, and IPC's work with other councils and providers.
- Data analysis, including:
    - A review of data from the recent home care staff survey conducted by MKC. 51 responses were received representing approximately 6% of the current workforce (from six providers including the internal service).
    - A review of data from the recent external provider survey conducted by MKC. 11 managers responded from 9 different organisations.
    - Safeguarding, complaints and compliments data.
    - Financial and activity data.
- A case file audit. 13 case files of adults (11/13 for people aged over 65) of people receiving less than 10 hours care per week were reviewed via the Frameworki

system. 9/13 were receiving a service from an external provider, and 4/13 were receiving care from the internal service. Note that approximately 880 people receive a home care service[1], the case file audit is therefore not a statistically representative sample.

- Interviews with external providers. A mixture of face to face and telephone interviews were conducted with eight external home care providers (four of which are currently on MKC's preferred provider list (PPL) and four are contracted via spot purchasing). Notes from the interviews are provided as Appendix A.
- An interview with the Head of Service Older People's Housing and Community Support, as head of the internal community home care service.

In addition to the above, this report also builds on findings within the recent internal Domiciliary Care Review[2].

3 Context

A major employer across the country, home care is generally a low wage sector with low status and profile, and has been susceptible to cost-cutting in recent years as a result of reduced local authority budgets. IPC reported that nationally home care services were 'struggling'[3] in 2012 and there is evidence that the situation has not improved since. Allied Healthcare – the largest provider of home care to local authorities – was put up for sale in January following 9.8% losses in revenues, and Saga as the parent company have valued it at £0, quoting the market as being 'highly fragmented'[4].

Prospects for the sector, with the rises in the minimum wage and further reductions planned for local authority budgets, against the backdrop of an ageing population, do not look optimistic. The UK Home Care Association (UKHCA) has warned that 'the additional costs of the new National Living Wage could lead to a catastrophic failure of home-based care services'[5].

In April 2015, the government introduced the Care Certificate, which will be administered jointly by Skills for Care and Health Education England, and will replace the existing National Minimum Training Standards and the Common Induction Standards in England.

Also in April 2015, in response to the Francis Enquiry, new standards (the Fundamental Standards of Quality and Safety) have been introduced, which cover the conduct and level of training of care providers, the protection of service users and the character and candour of directors[6].

[1] Milton Keynes Council (May 2015). Domiciliary Care Review, Interim Report.
[2] Milton Keynes Council (May 2015). Domiciliary Care Review, Interim Report.
[3] IPC (October 2012). Where the heart is…a review of the older people's home care market in England.
[4] Saga plc (2015). Annual report and accounts for the year ending 31 January 2015.
[5] UKHCA (27 July 2015). Open Letter to Chancellor of the Exchequer on National Living Wage.
[6] For information on the Fundamental Standards see: http://www.cqc.org.uk/content/publishing-new-fundamental-standards

Locally in Milton Keynes the Council is facing an overall budget cut of £16m in the next financial year, with £4.9m of savings expected to come from adult social care, representing over 6% of the department's budget.

Against this, MKC is reporting 'overwhelming' increases in the demand for home care and is experiencing a lack of capacity in the market. There is a constant waiting list for home care (for example, as at 5 August 2015 there were 16 people waiting for a home care service). Recruitment and retention of home care staff has been highlighted as a major issue[7]. Milton Keynes with its proximity to London is an area of high employment. The unemployment rate is 4.4% overall for the South East region, and currently averages 3.1% for ages 25-64[8]. In addition, unemployment in Milton Keynes has been decreasing recently – from 8.6% in Spring 2013, down to 5.4% in March 2015[9].

The overall population of Milton Keynes is rising and this will result in a corresponding increase in care needs. The table below gives some indicators to illustrate the rising need for care locally within the next five years. It should be noted that Milton Keynes is slightly 'behind the curve' in that as a 'new town' it will be seeing increased numbers of older people a few years later than other local authorities.

Milton Keynes projected populations 2015-2020[10]

	2015	2020	% change
Population	263,100	280,700	7%
Population aged 65+	33,900	41,000	21%
Population aged 80+	10,115	11,920	18%
People with dementia aged 18+	2,205	2755	25%
People aged 65+ with a limiting long term illness whose day-to-day activities are limited a lot	7,876	9,617	22%
People aged 18-64 with a serious physical disability	3,622	3,878	7%

As shown above, the larger increases in population will be seen in the older people age groups – i.e. those more likely to have care needs. This trend is set to continue, rising sharply to 57,100 people over 65 by 2030. The impact on the requirement for care services generally will therefore be significant.

The Care Act introduces a new framework for a means assessment, the upper capital limit is currently £23,250, below this an eligible adult can seek means tested support

[7] Ibid
[8] Office for National Statistics (August 2015). Table X02 Regional unemployment by age (experimental statistics), South East Region.
[9] Office for National Statistics (July 2015). Table M01 Model based estimates of unemployment
[10] Institute of Public Care (2015). POPPI Projecting Older People Population Information www.poppi.org.uk and PANSI Projecting Adult Needs & Service Information www.pansi.org.uk Accessed 9 July 2015.

from their local authority. Milton Keynes as a whole is relatively affluent. There are 17 areas within the least deprived 10% in England; these are in rural areas, Newport Pagnell and some areas in the city. However there are seven lower super output areas (LSOAs) which are within the most deprived 10%, and overall there are 24 LSOAs within the most deprived 30%[11]. This picture implies that whilst many people would be able to afford to pay for their own home care, there will be large numbers who will require support from the Council.

4 What does good home care look like?

4.1 The home care sector

Home care (also known as domiciliary care) is a term that is used to describe a range of care and support programmes that aim to help people live in their own homes and maintain their independence.

Home care can take many forms including support with domestic tasks, shopping, home maintenance, personal care, social activities, rehabilitation and recovery and support for people who are dying, and can link with other services in the community, such as supported housing, community health services and voluntary sector services. Appendix B provides details of three key models of care at home.

4.1.1 Care delivered

Between 1 April 2013 and 31 March 2014, 469,725 adults used domiciliary care services funded by a local authority; of those 79% were aged 65 or over[12].
Just over one fifth of people who use these services are those under the age of 65 years who have either a physical disability, learning disability or mental health problems.

Those who receive home care may be in receipt of state funded care or may pay for the service themselves (self-funder). Laing and Buisson estimate that in 2015 207,509 people in England will receive privately funded domiciliary care[13].
Self-funders (including those who receive direct payments) account for between a third and half of home care purchased. However, an estimated 80% of all home care business is still being contracted for by or via local authorities and therefore their market influence remains considerable[14].

The provision of home care services grew significantly in the 2000's[15]. However, over recent years the overall number of hours of care delivered in England has been reducing[16].

In 2014 estimates for the numbers of care hours per person were as follows[17]:

[11] Milton Keynes Observatory (2013). Social Atlas 2013.
[12] HSCIC (December 2014). Annex E, Table P2f
[13] Mickelborough, P. (2013) Laing and Buisson, Domiciliary Care Market Report
[14] IPC (2012). Where the heart is ... a review of the older people's home care market in England.
[15] CQC (2013). Not just a number. Home care inspection programme: national overview.
[16] UKHCA (2015). Domiciliary Care Market Overview. Estimate using HSCIC data.
[17] HSCIC (December 2014). Table H1

Hours of care planned	% of care packages
2 or less	10
Between 2 and 5	18
Between 5 and 10	27
10 or more including overnight / live-in	46

4.1.2 Commissioning

Currently, 92.1% of all state-funded domiciliary care in England is delivered by the independent sector. The remaining 7.9% is delivered by the statutory sector.[18] This follows an ongoing trend where the independent sector is responsible for a growing percentage of domiciliary care delivery (up from 81% in 2008/9).

UKHCA have found that the average price paid by local authorities for domiciliary care for older people in England was £13.77 per hour[19]. The Health and Social Care Information Centre records that the average price paid for an hour of domiciliary care in England was £15.50 (this includes all client groups, including specialist packages for younger adults with complex needs).

By contrast UKHCA [20] have calculated a minimum price for homecare services which is currently set at £15.74 per hour, rising to £16.16 in October 2015, and £16.70 from April 2016. The price achieves compliance with increases in the national minimum wage and national living wage.

4.1.3 Workforce

Care workers represent 63% of workers in the sector. The age profile for care workers shows that 87.6% are aged 25 and over, with 12.4% aged under 25. 86% of care workers are female. Overall staff turnover in the sector is running at 24.3%; for care workers this is 32.4%[21].

4.2 What people say is important

CQC summarise the following as characteristics of good home care[22]:

- There is good written information about the services and choices available, and this is explained face-to-face.
- Relatives and carers are routinely involved in decisions about care.
- People are encouraged and supported to express their views. Detailed records document their preferences and choices, care plans in the home are kept up to date and care workers complete the daily logs accurately. There are regular reviews and risk assessments to adjust care plans and respond to changing needs and preferences.

[18] HSCIC (December 2014), Community Care Statistics: Social Services Activity, England, 2013-14 Final Release, Table 4.2 p. 50. Available at: http://www.hscic.gov.uk/catalogue/PUB16133
[19] UKHCA (4 March 2015). The Homecare Deficit: Funding of Older People's Homecare
[20] UKHCA (July 2015). A minimum price for home care.
[21] Skills for Care (2015) National Minimum Data Set
[22] CQC (2013). Not just a number. Home care inspection programme: national overview.

- Care workers are properly introduced to people receiving services before the service starts. There is continuity of care workers, with any changes notified in advance.
- Care workers routinely knock and announce their arrival. Staff wear ID badges to confirm their identity and are aware of security requirements.
- Care workers show kindness, friendliness and gentleness, with respect for property and belongings.
- People's views are gathered in a variety of ways; survey results are acted on and they inform improvements, which are communicated back to people. Customer satisfaction surveys are supplemented by personal contact from the management team.
- Staff understand people's illnesses, so are better able to provide the right amount of support when needed. They have a good understanding of dementia.
- People using services are given written information about the types and signs of abuse and they are aware of who to contact at the agency if they have concerns.
- Inductions for care workers are monitored with supervision and include a period of 'shadowing' an experienced care worker. Training is included in induction and ongoing training is routinely updated, with attendance documented.
- Care workers have a clear understanding of what constitutes abuse, including failure to provide care in the right way.
- All staff undergo a DBS check before the provider offers a position and asks for references.
- Staff are not asked to undertake tasks unless they have the necessary knowledge and skills.
- There is good communication between workers, regular staff and team meetings, and regular information and updates for staff.
- Managers carry out systematic quality checking. They capture feedback from staff and use it to improve services. People are given information about how to complain, any learning from the complaint is fed back to the complainant, and action plans are developed to address any issues.

A survey (of service users and relatives, providers, care workers, and council staff) considered the top 3 priorities most important in delivering good homecare were[23]:

- Sufficient time for care.
- Friendly, respectful, capable care workers.
- Choice about services eg when visits happen, who visits and what care workers do.

Respondents to the survey also identified the key challenges currently facing care workers to be time limitations, pay and conditions and insufficient training. The challenges for providers were identified as shortage of skilled care workers and not enough fully trained, as well as council commissioning.

[23] Guardian Professional and DH (2013). Attitudes to home care in England.

4.3 The living wage and ethical care charter

The Living Wage, is an hourly rate set independently and updated annually, calculated according to the basic cost of living in the UK. The current UK Living Wage is £7.85 an hour[24], and the current London Living Wage is £9.15 an hour[25]. Employers choose to pay the Living Wage on a voluntary basis[26].

In contrast, the government's new National Living Wage (NLW), based on median earnings, will be £7.20 per hour from April 2016, and will apply to those aged 25 and over. The government will ask the Low Pay Commission, which currently recommends the level of the minimum wage, to suggest a figure for the National Living Wage in April 2017. The aim is for the National Living Wage to increase to more than £9 by 2020, subject to sustained economic growth.

The existing national minimum wage (NMW) will rise by 20p to £6.70 per hour from October 2015 for those aged 21 and over.

UKHCA cite a number of issues[27] connected with the payment of the minimum wage in home care:

- The NMW Regulations require that "working time" is paid at the NMW or above over a pay reference period (according to the frequency that the worker is paid and not more than a month). In the case of homecare workers, "working time" effectively means the time they spend in the service user's home ("contact time") and the time spent travelling between their different visits during the day (travel to the first visit and from the last visit are not included).
- As a general principle, it is not unlawful for care workers to be paid by reference solely to their "contact time", so long as the total pay divided by total "working time" ("contact time" and applicable travel time") over the reference period is at NMW or above. Where careworkers' pay is calculated by reference to "contact time" only, the rate paid for "contact time" must be sufficiently high to comply with NMW, once the applicable travel time is included.
- With very few exceptions, councils (who purchase the majority of homecare services), pay providers by reference to "contact time" only, leaving the provider to ensure that they meet the costs of the service, including NMW compliance from this payment. Over recent years, councils have councils have exploited their dominant purchasing power to save money by:

    - (1) reducing hourly rates they pay to providers either by requiring cost-reductions, or not increasing prices paid in line with inflation etc. and
    - (2) reducing the length of homecare visits. This increases the length of travel time compared to "contact time" and places an incredible strain on providers' ability to reward their vital workforce for the incredibly important work they do.

[24] Calculated by Centre for Research in Social Policy at Loughborough University
[25] Calculated by the Greater London Authority
[26] Living Wage Foundation, at http://www.livingwage.org.uk/what-living-wage [accessed August 2015]
[27] UKHCA (7 October 2013)

- The Low Pay Commission has repeatedly warned councils to ensure that they are paying the full cost of care, and that central government should investigate council's commissioning practice.
- There is a general lack of easily available guidance from Government or HMRC that deals with the complexity of this issue for employers.

Some councils (e.g. Reading, Lancashire CC, Optalis [Wokingham], Southwark) are introducing, or have already introduced, an '**Ethical Care Charter'**[28] which incorporates payment of the living wage and sets out conditions for home care workers.

4.4 How is care at home delivered?

ADASS identified 8 top tips for commissioning and arranging home care services to ensure that services are of sufficient quality, reflecting dignity, safety and compassion. The tips are designed to help assurance processes in consideration of care at home provided through a domiciliary care service[29]:

- Assure yourself people who use services are at the heart of all activities surrounding domiciliary care.
- Consider political engagement and domiciliary care.
- Assure yourself care management processes around domiciliary care are robust.
- Assure yourself there is a professional and effective commissioning process in place.
- Assure yourself of the contracting process, employment terms and conditions and the status of the domiciliary business in your area.
- Be assured there are good partnership approaches with providers.
- Be assured there are good partnerships with other commissioners.
- Be assured there are good partnership approaches with CQC, police and others with a stake in quality assurance and standard setting.

4.5 Procurement and the market

The approach taken to procuring the preferred model is critical to its likelihood of success, but clearly should not be the driving factor in the design of the model: " *Councils have enormous commissioning power: if they have a clear view of what they would like to see in their providers, they can support this through their commissioning practice*."[30]

Approaches taken to procuring care services have moved away from the traditional block contracts as a response to the personalisation agenda, and there has been a tendency to interpret the delivery of choice as being reflected by the number of providers in the market, usually within a framework agreement.

The options that are increasingly being explored in the commissioning of home care are:

[28] Developed by UNISON. Available at https://www.unison.org.uk/content/uploads/2013/11/On-line-Catalogue220142.pdf
[29] ADASS (2013). Top tips for directors: commissioning and arranging home care services.
[30] LGIU (2012). Outcomes Matter: Effective Commissioning in Domiciliary Care

- Is the contract going to be outcomes based? Are we able to move away from time based payment systems towards one based on the delivery of outcomes?
- Is there going to be an element of incentivisation within the contract to reward the delivery of outcomes?
- Is there going to be a move away from framework agreements with a large number of providers toward a smaller number, potentially with geographically based contracts?
- Is the contract going to provide for generic services, or for a number of different types of specialist service?

UKHCA undertook a comprehensive survey of the way homecare services are commissioned identifying a number of concerns[31]:

- Short homecare visits being commissioned by councils to undertake intimate personal care, with risks to the dignity and safety of people who use services.
- Continued downward-pressure on the prices paid for care, where lowest price has overtaken quality of service in commissioning decisions.
- Contracting arrangements which have resulted in visit times and the hourly rates paid for care as the decisive factors in the viability of the sector.

Long term underfunding of the social care system, exacerbated by significant cuts to local authority budgets in recent years has left local authority commissioners struggling to keep pace with demand and many people using services are seeing their eligibility for care re-assessed by their council, most of whom now only offer support to those classified as having substantial or critical needs[32]. These clients will often require a more intensive service (intensive homecare is defined as more than 10 contact hours and 6 or more visits during the week), which is in direct conflict with local authorities commissioning of short home care visits[33].

The LGIU survey suggested that a key issue is the relationship between the commissioner and the provider: "*Giving them the space to innovate is likely to expand the range of products available in the market more broadly, offering care users in both the funded and self-funded categories a better choice of quality services.*[34]

Wiltshire and Bristol have a zoned approach to contracting. In Bristol the expectation is that each zoned provider "*can play a key role in their local community, making the best use of the local infrastructure and resources to improve the lives of service users (e.g. make use of local libraries and activities at leisure centres) and contribute to the local community (e.g. by recruiting staff that live locally*). For Wiltshire the aspiration was that "*fewer providers would reduce the council's costs (through economies of scale and reduced travel times) but also enable a reliable set of partners who were fully engaged in the vision*." Although it is not yet clear that either authority will achieve these aspirations, these are good examples of the rationale behind taking this approach.

[31] UKHCA (2012). Commissioning survey 2012: Care is not a commodity.
[32] UKHCA (2013). An overview of the UK domiciliary care sector.
[33] UKHCA (2013). An overview of the UK domiciliary care sector.
[34] LGIU (2012). Outcomes Matter: Effective Commissioning in Domiciliary Care

There is also a case for moving away from a time based approach to payment towards one which actively encourages innovation from the provider. As the LGIU noted: "*Reliance on a time-task approach has left many authorities nowhere to go in making savings but to cut down the hourly rate they pay to providers and use tools such as electronic monitoring to minimise payment outside contact time with service users. While such tools have a value, there are limits to the extent to which savings can be made in this way without affecting the quality of the service and the conditions of workers in the care sector, and damaging the relationship with providers*"[35].

4.6 Delivery factors

No research has yet identified the variety of models for how home care services can be organised[36]. However, research has identified areas for consideration when developing a domiciliary care service including[37]:

- The respective balance of power between care manager and provider manager to modify services for individual clients as necessary. Providers are often constrained by time and task orientated contracts detailing when and what is to be done for clients and the need to go back to the care manager to make any changes to the arrangements.
- Size of teams and in number of hours worked by staff members. Some teams comprise many workers each working only a few hours per week compared to other teams of few workers each working full time.
- Services approach to evening, weekend and public holiday provision must be deemed part of its model for service even if the service avoids covering these times itself.
- Systems for providing cover for staff who are unavailable through illness, holidays or job changes and how to manage sudden needs for extra help.
- System for managing times of peak demand (eg around getting clients up in the morning, meal times and bed times). This could reflect more part time staff to cover those hours or fewer staff but less flexibility over times offered and therefore staggering of time slots for clients.

More recently research[38] has identified features contributing to the effectiveness of re-ablement services including: service user characteristics and expectations; staff commitment, attitudes and skills; flexibility and prompt intervention; thorough and consistent recording systems; and rapid access to equipment and specialist skills in the team. Factors external to the re-ablement services themselves also had implications for their effectiveness including: a clear, widely understood vision of the service; access to a wide range of specialist skills; and capacity within long-term homecare services. Support working in social care is ill-defined and, with increasing integration across health and social care roles alongside other factors influencing the direction of

[35] LGIU (2012). Outcomes Matter: Effective Commissioning in Domiciliary Care
[36] Patmore C (2002). Towards flexible, person-centred home care services: A guide to some useful literature for planning, managing or evaluating services for older people. SPRU: York.
[37] Patmore C (2002). Towards flexible, person-centred home care services: A guide to some useful literature for planning, managing or evaluating services for older people. SPRU: York.
[38] Rabiee P and Glendinning C (2011). Organisation and delivery of home care re-ablement: what makes a difference? *Health and Social Care in the Community*; **19** (5): 495-503.

homecare, expectations of care staff and other professionals are changing. These include[39]:

- The impact integration can have on professional identity[40]. There is some professional anxiety amongst health workers in particular where there is seen to be overlap in tasks or a change in their role seen as demoting what they do[41]. There is evidence to suggest the need to focus on service users/patients and outcomes to overcome professional boundaries[42].
- Outcomes versus task and time based provision of care. The move towards outcome focused care involves a huge shift in thinking for some and will need careful implementation and training.
- LA eligibility looking at those with greatest need resulting in more clients needing intensive care (often medical care) implying more specialist workers. Furthermore, as the number of people living with dementia increase, there is a need to ensure staff are appropriately trained for the care they deliver.

There is also the widely recognised challenge of resourcing home care services, with staff typically on zero hours based contracts. Wiltshire have required a change to salaried staff as part of their new model, and it will be interesting to see the impact this has on the quality of the service provided, and hence its cost effectiveness.

4.7 How do you facilitate a high quality, sustainable home care market?

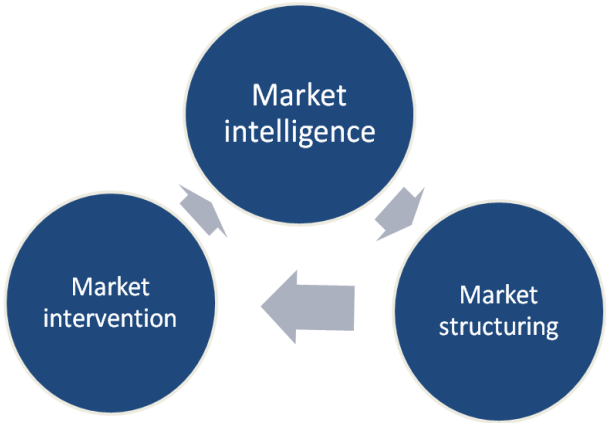
Market facilitation can be defined as follows:

"Based on a good understanding of need and demand, market facilitation is the process by which strategic commissioners ensure there is diverse, appropriate and affordable provision available to meet needs and deliver effective outcomes both now and in the future."[43]

IPC describes a three stage model of market facilitation:[44]

Market intelligence – The development of a common and shared perspective of supply and demand (including any gaps in provision), leading to an evidenced, published, market position statement for a given market.

[39] Social Care Workforce Research Unit (2008). Support workers: their role and tasks: a scoping review. Kings College London.
[40] IPC (2013). Evidence review – integrated health and social care: a skills for care discussion paper. Skills for Care.
[41] Social Care Workforce Research Unit (2008). Support workers: their role and tasks: a scoping review. Kings College London.
[42] IPC (2013). Evidence review – integrated health and social care: a skills for care discussion paper. Skills for Care.
[43] IPC Market Analysis Centre (2012) *What is Market Facilitation?* Produced for the Department of Health as part of the DCMQC programme.
[44] IPC (2009) *Transforming the Market for Social Care. A Model for Market Facilitation.* Oxford: Oxford Brookes University



Market structuring – This covers the activities of commissioners designed to give any market shape and structure, where commissioner and provider behaviour is visible and the outcomes they are trying to achieve agreed, or at least accepted.

Market intervention – The interventions commissioners make in order to deliver the kind of market believed to be necessary for any given community.

4.7.1 Market Intelligence

Effective facilitation of the market in relation to home care starts from developing good market intelligence. Such intelligence can then be used to stimulate the market in particular directions, and to inform discussions with providers, service users, family members and carers and other stakeholders about the type of support and services that might be needed now and in the future.

4.7.2 Market Structuring

The Care Act states that a diverse market is one in which people using social care and support services and their carers have *'a variety of high quality providers to choose from who (taken together) provide a variety of services'.* The statutory guidance to the Act goes on to say that this means the market should include a variety of different providers and different types of services, and that this should represent a genuine choice of service type, not simply a selection of providers offering similar services.

Promoting market diversity is characterised by an openness to new ways of doing things, encouragement for innovation and the 'shared endeavour' of commissioners, providers and people with care and support needs, carers and family members working collaboratively to find the best solutions.

4.7.3 Market Intervention

Procurement methods can limit capacity of the market to diversify by making entry to new and different types of organisations prohibitively difficult. While important changes to EU procurement regulations (set out in the EU Procurement Directive 2014) were introduced in the UK through the Public Contracts Regulations 2015, these should not make taking a flexible approach more difficult not least because social care services are exempted from the full directive through the establishment of a Light Touch Regime (LTR).

4.8 Principles for good home care

Drawing on the evidence provided in the sections above, the following principles for achieving and delivering quality home care are suggested:

- **Robust assessment & support planning processes**. The assessment and care planning/brokerage processes are effective, reviews are timely, and changes to a person's needs are accommodated appropriately and efficiently. Good information and advice is given to people about services, providers and choices.
- **Outcome focused person centred care** focuses on the impact of the service on an individual's quality of life, and embodies a targeted and early intervention/prevention approach to promote prevent or reduce or delay admission to hospital, nursing care or residential care, connects people into their communities and makes best use of community assets.
- **Skilled and valued frontline staff** are at the core of a quality service. The key components are: effective management, support and training, and pay and conditions which at least meet the NMW and are ethical.
- **Sufficient capacity and sustainability of the market.** Capacity across the whole market is able to meet current and future need. Providers are paid the right price for care and the level of risk in the market is minimised.
- **Delivery arrangements.** Flexible delivery arrangements suit the needs of service users whilst being cost-effective for providers to deliver.
- **Effective market facilitation.** Good market intelligence is available, and effective partnerships exist, in particular between commissioners and key stakeholders such as elected members, providers, service users, families and carers, other commissioners and care management.
- **Service monitoring** Systematic, proportionate and effective monitoring processes help to ensure that the service is functioning safely and to a high quality. Safeguarding issues and complaints are dealt with appropriately. Service user, family and carer views are used to improve services.
- **Make best use of the resources available.** The total budget for home care is spent wisely and as effectively as possible.

Within these principles are implicit the desire for services to be locally based and enable consistent, flexible, safe support that is high quality and can evidence its contribution to a customer's wellbeing.

5 Home care in Milton Keynes

5.1 Current arrangements

Home care in Milton Keynes is provided via a mixture of an internal service and external companies. Since 2012 the Council has operated a Preferred Provider List (PPL) for the delivery of externally-commissioned home care provision, accessed via a competitive tendering process. The PPL contracts are due to finish in September 2016. In April 2015, there were 13 external providers on the PPL and a further 4 commissioned via spot purchases.

A significant proportion of home care (estimated at 25%[45]) is provided via the internal community home care service, which employs 141 staff, including 123 care workers and 5 admin support. The internal service is well established, well thought of, and along with the externally-commissioned provision has grown to meet demand over the last two years.

An estimated total of 9,500 hours of home care, through some 14,000 visits, are provided per week, via managed budgets, with a value of circa £9.5m per annum[46]. Spend on home care for older people and adults with a physical disability in 2013/14 accounted for 14% of the overall adult social care budget, compared to 23% for residential and nursing care for the same group[47].
The home care service covers all client groups and all ages, although in practice the bulk of care (74%) is delivered to older people.
The sub sections below map current arrangements against the principles for good home care, as set out in section 4.8 above.

5.2 Assessment & care planning processes

The assessment and care planning/brokerage processes are effective, reviews are timely, and changes to a person's needs are accommodated appropriately and efficiently. Good information and advice is given to people about services, providers and choices.

Assessment and care planning processes represent the 'gateway' to home care. Against national trends, locally the demand for home care has been rising. Steps being taken to manage demand are as follows:

- A one-off review by OT of all 'double handed' home care packages is underway to ensure that needs warrant two carers.
- A proposed one-off review of all other care packages against need.
- A plan to moving shopping/cleaning provision out to the voluntary sector.
- Increased use of equipment including telecare and telehealth.
- Maximising the use of information and advice.
- The planned introduction of activities (external to home care) to reduce social isolation as recommended in a recent report[48].
- Further training for social workers to support culture change, including encouraging innovative solutions to people's care needs.

Care plans do not always reflect current needs. Some providers commented that in the time period between assessment and delivery of care, the person's situation sometimes changes, or for other reasons the assessment is sometimes inaccurate, and an element of 'reassessment' is undertaken by the provider prior to the delivery of care. This causes more effort for all concerned.

[45] Milton Keynes Council (May 2015). Domiciliary Care Review, Interim Report. Figures in this paper also cover home care delivered to sheltered housing and extra care schemes – these are outside the scope of this review.
[46] Ibid
[47] Financial data
[48] Open University (26 May 2015). Social isolation and loneliness in people aged 55 and over in Milton Keynes

More effective and timely reviews are needed on an ongoing basis. A change in care needs can take up to six months to be processed following notification from the provider – although changes classed as urgent are processed much more quickly. Providers may make minor changes to care packages themselves but larger changes must be referred to the case manager.

One provider cited a gap in terms of information and advice in that a directory of approved providers is not made available to service users.

5.3 Outcome focused person centred care

Outcome focussed person centred care focuses on the impact of the service on an individual's quality of life, and embodies a targeted and early intervention/prevention approach to promote prevent or reduce or delay admission to hospital, nursing care or residential care, connects people into their communities and makes best use of community assets.

The principle function of the home care service in Milton Keynes is to maintain people in their own homes and prevent the need for acute or residential care. A review of hours delivered[49] found that approximately 63% of service users receive less than 10 hours of care per week which is higher than the national average of 55%[50], which indicates that care might be being given to some people inappropriately. However, a brief case file audit of service users receiving less than 10 hours care[51] indicated that of the 13 case files reviewed, each person had a serious long term or terminal condition, and the 10 hours of home care or less that they were receiving was essential to maintain them in their own homes. This is also borne out by looking at the reasons people leave the service. For example looking at data for 588 'service leavers' since 1/4/13, 203 (34%) had died, and a further 201 (34%) had moved onto permanent hospital admission, residential or nursing care. A further 76 (13%) changed provider; the remaining 19% did not have reasons categorised.

Reablement is provided by the Intermediate Care Service. This service is currently being re-specified; it is understood that it has a high success rate albeit a low rate of access. It is not clear currently whether the low access rate is due to lack of capacity, low rate of need, or a lack of awareness, i.e. whether other parts of the system are unaware that they can refer people to the service. After people have received this service (i.e. that they have been reabled as far as possible, but still have eligible needs) they are referred to the home care service.

The Care-Act compliant Assessment form on the Frameworki system represents an improvement on the previous form, in that it facilitates a holistic view of the person including their 'story'. However, critically, it is not possible to record the outcomes for a person. The care manager selects an 'outcome area' but is not required to turn the need into an outcome for the individual. Subsequently the Care and Support Plan document also does not contain outcomes.

[49] Milton Keynes Council (May 2015). Domiciliary Care Review, Interim Report.
[50] HSCIC (December 2014). Table H1.
[51] IPC case file audit of 13 home care files, August 2015. Approximately 880 people receive a home care service, the case file audit is therefore not a statistically representative sample.

The focus of care and support for most cases viewed in the brief file audit[52] concentrated on meeting physical care needs only. For 11/13 files, there was little focus on the person's social / emotional needs (whether they had needs or not was not always clear). Care being commissioned was mostly traditional in nature – a home care service delivering personal care and for some, attendance at a day centre. There was little evidence of innovation and little focus on use of voluntary sector/community resources. However, there was some evidence from providers that care workers were using innovative approaches – for example organising a performance of a local production of the Wizard of Oz for a service user in their own home.

Some providers had experience of working under outcomes based contracts. One reported that they had worked with several authorities who allocated hours of care to a client, asking the provider to work out with the client what care was needed. This approach worked well, with service users being able to 'bank' hours to save up for a day trip for example.

It was not clear whether service users were offered choices – for example time of day when the care was being delivered, as provider's case files were not reviewed. However some providers (most notably the internal provider) offered people a choice of care worker, and made sure that those providing cover would be introduced by the main worker beforehand.

In terms of practice, 15 minute visits form 52% of all visits by the internal service, and 27% of all visits provided by the external service. Whilst 15 minute calls in theory can be appropriate (for example to give medication), 42% of staff in the survey responded that 15 minutes is not enough time, i.e. that too much is being asked of care workers during this length of visit. For example, one member of staff (in the internal service) responded that a visit would need to include:

Usually lunch or toileting visits but these often run over as micro meals take roughly 10 minutes plus the time to plate up and take to toilet (it cannot be done!).

Worryingly, over a third of staff (34.9%) indicated that they were able to spend the amount of time with service users as identified in their care plan, but that this was not long enough. Staff did mostly report however that people receive a consistent service either all or most of the time (89%).

Looking at the numbers of complaints and compliments, there was a significant difference between the internal and external provision (even taking into account that external provision is estimated at three times more in volume than internal[53]), as the table below illustrates:

[52] IPC case file audit of 13 home care files, August 2015. Approximately 880 people receive a home care service, the case file audit is therefore not a statistically representative sample.
[53] Estimated proportions based on snapshot data. Milton Keynes Council (May 2015). Domiciliary Care Review, Interim Report.

Milton Keynes community home care, compliments and complaints 2013-15

Indicator	Service	% of total hours delivered[54]	2013-14	2014-15
Compliments	Internal	25%	6	3
	External	75%	30	84
Complaints	Internal	25%	4	1
	External	75%	52	61

Whilst the internal service received a fraction of the overall number of complaints, it also received a fraction of the compliments. However the internal service runs an annual client survey and this provides people with a regular opportunity to comment – for example in the Annual Survey 2015, one comment reads:

Thank you very much for all the kindness the carers give me and what a wonderful and caring team they are.

In the internal survey, service users were asked to give an overall rating for the service and the percentage rating the service either "good" or "excellent" totalled 82%. It is not clear whether an annual survey is run for externally-commissioned care.

5.4 Skilled and valued frontline staff

Skilled and valued frontline staff are at the core of a quality service. The key components are: effective management, support and training, and pay and conditions which at least meet the NMW and are ethical.

Recruitment of staff was of critical concern to all the external providers interviewed. Many were confident that they could grow their local business if only suitable staff could be found. Reasons included the high rate of employment locally and the opportunities to earn better pay in shops, warehouses and in hospitals, and the inability to pay more to care workers as a result of the rates paid by the Council. The internal provider had fared better in recent years due the rate of pay and terms and conditions available.

Hourly rates where reported in the external market vary between £6.86 and £9 (although £9 is a weekend rate only), with an average of £7.54 for weekdays. Although providers who were interviewed pay a mileage rate (admittedly not enough to cover car maintenance), not all pay for travel time. In the internal service, hourly pay is £9.30.

Whilst all rates of pay quoted exceed the current NMW of £6.50 per hour, where some providers do not pay for travelling time there is a danger that they are therefore not paying enough to meet the minimum. Many providers do not pay the current living wage of £7.85 per hour.

All external providers interviewed employed workers under zero hour contracts as these offered the flexibility needed for those unable to work in the school holidays. However many were also introducing 'guaranteed hours' in an effort to recruit, with one about to

[54] Estimated proportions based on snapshot data. Milton Keynes (May 2015). Domiciliary Care Review.

offer full-time positions salaried between £16-18k (giving 'tight' margins of £3-4 per hour).

External providers had made significant efforts to recruit, including via:

- Recruitment agencies
- Online advertising and Facebook
- Adverts in the press ('not worth the money')
- Targeted leaflet drops to selected 'working-class' households (prompted just 30 enquiries)
- 'Open days' and stalls at local events
- Offering 'Recommend a friend' rewards to existing staff
- Making links with colleges including with people on health and social care courses locally to recruit into placements. (Not successful - typically people under 25 do not have their own car, and placements do not fit well with delivery of care in people's homes).

The overall level of enquiries appears relatively healthy but providers alluded to problems converting these into employees, with some reporting that 'only 1 person in 10' reaches the point of delivering care. Reasons for leaving early on include:

- DBS checks can take between 3 hours and over 6 months to process.
- Whilst the training provided by the Council is 'excellent' some attendees find out the higher rates that others are earning whilst on the course.
- Sometimes there is a wait for some types of Council-provided training.
- Expectations of what care is do not match the reality. For example some find the level of responsibility too high e.g. administering Warfarin.

Some providers said that the Council could do more to assist – for example to promote home care as a valuable and worthwhile occupation (see Appendix A). The training that the Council provides is much appreciated by providers.

In terms of working conditions, internal staff spend less hours travelling, have more frequent supervision, better pay, and staff are longer serving. External staff work longer hours and subsequently travel more to achieve similar income.

There is no ethical charter in place for home care workers.

5.5 Capacity and sustainability

Capacity across the whole market is able to meet current and future need. Providers are paid the right price for care and the level of risk in the market is minimised.

Most of the home care providers consulted are currently reliant on the council for the vast majority of their business, with very few self-funders or direct payments. The exceptions were Mears Care (20-40% self-funders), Olney Care Services (60-80% self-funders), Home Instead Milton Keynes (80-100% self-funders) and ExcelCare24 (80-100% direct payments/CHC). For most providers self-funders were not an attractive option due to increased transaction costs and risk.

Capacity is a critical issue, and one of the main causes of this is the lack of frontline staff. In order to recruit staff, providers need to offer competitive wages. The rates paid by the internal service appear to be sufficient to attract the right staff (although terms and conditions will also make a difference), but external providers currently pay less than this, and working conditions are not as good. Office space in Milton Keynes is at a premium and therefore an additional expense for external providers.

The hourly rate that Milton Keynes pays providers is £14.12[55] which is below the rates that UKHCA have calculated as a minimum price for homecare services (which is currently set at £15.74 per hour, rising to £16.16 in October 2015, and £16.70 from April 2016[56].). This does not currently give local providers sufficient room to attract staff locally, and the situation will become even less sustainable as minimum wages rise. The number of complaints regarding external providers (as detailed above) appears relatively high, indicating issues with the quality of care delivered, and this also impacts on sustainability.

The other key reason for a lack of capacity is increasing demand. As described above, MKC are undertaking a number of activities to reduce demand. If demand is not stemmed then the overall market will soon become unsustainable.

The number of externally-commissioned providers, from the evidence available, appears to be about right. The pool of suitable staff is probably relatively fixed in number (given the local economy and current pay and conditions), and having more providers in the market is not likely to change this, given recruitment efforts to date. One provider said that 'we would all be fighting for the same carers'. A larger number of providers would also result in more back office costs, and less commissioner resource available to each provider to build and maintain relationships.

The internal service is currently the **'**Provider of last resort', providing the valuable service of taking on complex (often double-handed) cases which other providers reject, for example there are some cases with serious challenging behaviour and difficult family members. There are also cases in remote areas, such as outlying villages.

Of the current internal client base, 15 percent of the total intake is due to the service user being passed on from independent care agencies. Recent cases by way of example include;

- Client one: Was transferred to the service due to their disabling disease, conduct and behaviour to carers, being rude, insulting and very demanding.
- Client two: Came to the service after being with numerous agencies and safeguarding issues having been raised.
- Client three: Agencies were unable to support the demands of this client, with both demanding family and specific cultural requirements.

As previously mentioned use of the voluntary sector is underdeveloped in Milton Keynes and it is not clear how much is being made of available social/community capital to support sustainability of the market. Relationships with established local agencies may

[55] Milton Keynes Council (May 2015). Domiciliary Care Review, Interim Report.
[56] UKHCA (July 2015). A minimum price for home care.

have become more strained in recent years due to reductions in investment. Day opportunities are very limited and a visiting service for older people (once a week) done for those living in social housing was cut in April 2015.

5.6 Delivery arrangements

Flexible delivery arrangements suit the needs of service users whilst being cost-effective for providers to deliver.

Many providers (with two exceptions) were happy with covering the whole of the Milton Keynes area, and felt that any move towards geographical 'zones' would have a negative effect on their business. They also felt that assigning minimum quotas of provision to providers (with perhaps some sub-contracting to others) would be detrimental and create risk in the market, quoting councils elsewhere where this approach had failed. Conversely Allied were keen that zones and quotas should be put in place.

The internal service has very local programmes of work – there are 6 'patches' and each of these teams offer one of six people to the client. Scheduling of visits was described as 'labour intensive', conducted by very long-serving team leaders. The internal service provider felt that two teams would be more efficient than 6. An upgrade to the CareFree software will assist with organising visits using postcodes and GPS.

New cases are sent to all providers by email – the first provider to respond is allocated the case; this means that cases can be allocated within a few minutes. Some providers find this approach unhelpful as they need time to think about whether they are best placed to meet that person's needs and/or cover that geographical location. Occasionally providers respond, but later on withdraw, which causes more effort and delay.

The demand for care at particular times of day causes major issues for providers, as there can be too many visits to cover at peak times.

Where a care worker may deliver additional time (e.g. waiting with the service user for an ambulance), delays are experienced whilst the process of 'proving' the additional time gets approved by the Council. This can mean that the worker has to wait to be paid for this extra time for several weeks.

All external providers complained about the way in which they are paid by the council. A spreadsheet of planned home care is sent to the provider, for the latter to 'correct' to prove actual care delivered and secure payment. Current arrangements were described as 'antiquated', create a perverse incentive, and a huge unnecessary administrative burden. The external providers monitoring spreadsheet asks for the same information and therefore creates duplication and more work. For many the admin takes one day a week, whereas electronic systems (as used by neighbouring authorities) would reduce this to half a day per month.

The internal provider has a concern that inaccurate assessment (detailed above) and inaccurate/delayed recording result in higher costs for the Council, as people and providers are over and undercharged.

External providers also complained about having to use the NHS medicine administration records (MAR-charts) for each client, as opposed to providing their own charts, which they need for regulatory purposes.

5.7 Market facilitation

Good market intelligence is available, and effective partnerships exist, in particular between commissioners and key stakeholders such as elected members, providers, service users, families and carers, other commissioners and care management.

Much work has been done to develop market intelligence. There is an MPS for adult social care in place and the recent Domiciliary Care Review provides a detailed analysis of the data available. The MPS will be seen comparatively by providers, and it is important that this document contains messages which might attract providers to Milton Keynes over and above other localities – the 'local offer' is not yet set out in the latest draft. There are some known gaps in intelligence data, and work to collect it is planned.

External providers described mature relationships with the Council, finding MKC staff 'more responsible and more proactive' than at other councils, 'communication is good' and providers 'feel respected'. There was particular praise for the Purchasing & Procurement Officer, and also for the Safeguarding team.

Commissioners hold a providers forum every three months. However, many providers felt that relationships with commissioners could be improved and that more of a 'presence' would be beneficial, for example by paying regular visits to company offices. The requirement to have an office in or within 10 miles of Milton Keynes suited all except Allied whose office 13 miles away did not meet the criteria, and for whom having an extra office in Milton Keynes increased costs. The internal provider said that relationships with commissioners were 'improving'.

It was not clear about how much market facilitation activity had extended to the voluntary sector, which is a sector currently underdeveloped in Milton Keynes, nor to other key stakeholders, including service users, families and carers. The importance of engaging with elected members in particular will be critical to supporting home care as a pivotal part of the overall care and support 'system'.

5.8 Service monitoring

Systematic, proportionate and effective monitoring processes help to ensure that the service is functioning safely and to a high quality. Safeguarding issues and complaints are dealt with appropriately. Service user, family and carer views are used to improve services.

Service monitoring of the external provision appears effective. High-performing providers interviewed described a 'light touch' approach from MKC; providers with problems interviewed reported much more of a 'hand-ons' approach from the Council.

Both the internal and external service are monitored. However commissioners only monitor the external service, and non-commissioning staff monitor the internal service. This arrangement has been in place for some time and gives rise to the following issues:

- Separate and different monitoring processes and activities are in place, and therefore
- It is not possible for commissioners to have a view of the 'whole market' and
- There is not a 'level playing field' for providers, as the internal service is treated differently as a result.

There is also a lack of financial 'grip' on the whole market. There are inherent problems with obtaining some data and the matching up of planned and actual activity and financial data is difficult due to system set up and lack of resources to provide source data. There is a requirement to establish accurate and regular figures for the real cost of home care including unit costs across the whole market in order to manage the business effectively.

5.9 Use of resources

The total budget for home care is spent wisely and as effectively as possible.

Whilst the financial and activity data provided in this section are as accurate as it has been possible to achieve to date, figures are estimates and therefore should be treated with caution.

Using available data, and based on hours of care delivered (as opposed to number of visits delivered) it is possible to estimate an overall hourly rate for home care, to facilitate comparison.

Activity data is recorded by the internal service. Estimated annual costs for the internal service are given in the following table:

Milton Keynes internal home care service, estimated gross costs and activity, 2013-2015

Year	Cost of internal service[57]	Total hours of care delivered[58]	Estimated hourly rate
	A	B	A/B
13/14	£3,003,334	102,690	£29.25
14/15	£2,569,805	107,836	£23.83[59]

As a comparison, estimated annual costs for the external provision are given in the following table:

[57] Supplied by the Head of Service Older People's Housing and Community Support, 9 September 2015. Costs include overheads (including duty team and admin, all office expenditure, HR, payroll and pension). Costs do not include income, sheltered housing with care or laundry. **Costs of central recharges are excluded, therefore this estimate is likely to be low.**

[58] CareFree system data as supplied by the Head of Service Older People's Housing and Community Support, 9 September 2015.

[59] A Job Evaluation Scheme reduced levels of enhancements paid to care workers – this was introduced during 2014/15, resulting in reduced costs from the previous year. 2015/16 will be the first year in which the reduced enhancements will have been applied throughout the whole year and as a result, the hourly rate is expected to drop further.

Milton Keynes external home care provision, estimated gross costs and activity, 2014/15[60]

Year	Cost of external service	Total hours of care delivered by external provision	Estimated hourly rate
	A	B	A/B
14/15	£6,557,848.78	371,473	£17.65[61]

From the data provided above, the cost of the internal provision at £23.83 per hour is £6.18 per hour (35%) higher than that of external provision.

The value that the internal service brings can be demonstrated as evidenced above through factors such as: acting as provider of last resort, receiving few complaints, able to recruit and retain staff effectively, and offer acceptable pay and conditions; however it is a lot more expensive to run. By contrast, the external provision suffers from a number of disadvantages: the low rate paid by the Council for home care contributes to a lack of sustainability through lower wages, recruitment difficulties, and quality issues.

This comparison suggests that there is scope to improve how the overall budget is spent, addressing the differences between internal and external costs.

Obtaining the right financial and activity data on a regular basis is a key challenge for commissioners, as without it is not possible to be sure whether resources are being used wisely or effectively.

6 Options for change

From local, national and benchmarking data, a number of possible options have been identified. These will be assessed in more detail in the remainder of this report:

- Do nothing.
- Create a 'spin out' organisation for the internal community home care service. *Descriptions of some of the types of 'spin out' organisations, together with examples, are provided as Appendix C.*
- Externalise all community home care.
- Increase the proportion of care provided by the internal service.

Option	Efficiency	Effectiveness	Economy
Do nothing	Challenges The home care market is not sustainable and	Advantages The internal service acts as 'provider of last	Challenges Costs will continue to rise in line with demand.

[60] Financial and activity data supplied by the Head of Contracts, 10 September 2015. Data does not include sleep in, live in or 'waking nights' care.
[61] The rate paid to providers for a 60 minute visit is £14.12, however higher rates are paid for visits of 45 (£11.70), 30 (£9.29) or 15 (£6.87) minutes.

Option	Efficiency	Effectiveness	Economy
	there is a lack of capacity. Services are commissioned on a time and task basis. Recruitment issues prevent quality providers from expanding their business. There are inefficiencies in both the external and internal service. Some aspects of delivery arrangements and service monitoring impact on provider efficiency.	resort' <u>Challenges</u> There is a consistent waiting list for home care. The home care 'system' is predominantly focussed on physical needs. There are complaints about the external service. Service users are not presented with a choice of provider.	The internal service is more expensive compared to external provision.
Create a 'spin out'	<u>Advantages</u> Opportunity to make the internal service more efficient. Opportunity to grow the internal service. Opportunities for the internal service to make money for the council by providing services to other organisations. <u>Challenges</u> As detailed at the end of appendix C, the change process is long and demanding. There is significant risk involved in taking this approach and an effective business case is paramount.	<u>Advantages</u> The internal service is retained as provider of last resort. Reduced requirement for poorer performing external provision. <u>Challenges</u> The current capacity of the internal service needs to be maintained during the transition. There is a high risk of staff turnover in the early years.	<u>Advantages</u> Opportunity to make savings including through reduction of overheads. <u>Challenges</u> The ability of the Council to make savings when the set up of the new organisation needs investment during its initial 'protection period' (see appendix C). Robust modelling of cost savings and an strong evidence base will be required.
Externalise all community home care	<u>Advantages</u> Opportunity to raise rates paid to external providers (e.g. to the UKHCA minimum price for home care) to improve sustainability. Recruitment and retention of staff may improve if providers offer better terms to workers as a result.	<u>Challenges</u> The vital role of provider of last resort would need to be replaced by external provider/s. There is likely to be an impact on the quality of care delivered if the current rates are not increased; the number of complaints could increase.	<u>Advantages</u> Overall costs for community home care would decrease. <u>Challenges</u> Financial gains would be tempered by the need to pay external providers the UKHCA minimum price for home care, and pay for new

Option	Efficiency	Effectiveness	Economy
			arrangements to provide 'provider of last resort' from external provision.
Increase volume of care provided internally	Advantages Overall capacity improves as the internal service is better able to recruit and retain staff. Challenges The internal service is not as efficient as it could be.	Advantages There may be fewer complaints.	Challenges Costs would rise by an estimated average of £6.18 per additional hour of care delivered by the internal service.

7 Recommendations

1. Doing nothing is not recommended as a viable option given the current challenges.
2. Increasing the volume of care provided internally is also not a viable option due to cost.
3. Creating a 'spin out' organisation for the internal community home care service is a potential option, given its critical contribution to market stability. It is recommended that a feasibility study is undertaken to explore potential benefits and establish the 'appetite for change' within MKC.
4. If creation of a 'spin out' organisation is found to be not feasible, then all provision would need to be externally commissioned, and the internal service decommissioned.

8 Next steps

In addition to the overarching options, from the review of home care a number of next steps are recommended below.

Regardless of which option is selected above:

- **Pay the UKHCA minimum price for home care**, which will be £16.16 per hour from October 2015, rising to £16.70 in April 2017. This will improve stability and sustainability in the market, ensuring payment of the national minimum wage/national living wage (although it would not be enough to cover payment of the living wage of £7.85 per hour[62]). The current rate of £14.12 per hour is expected to increase but the new rate has not yet been fixed. Using the current rate, this represents an increase of £2.04 per hour from October to end March 2016. If 371,473[63] hours of care are delivered annually by external providers, the additional cost would therefore be £2.04 x 371,473 = £757,805.
- **Introduce an ethical care charter**, which embodies payment of the living wage. This will ensure a minimum set of terms and conditions for care workers across the board, to help improve recruitment and retention of staff with the aim of improving

[62] Calculated by the Centre for Research in Social Policy at Loughborough University
[63] Activity data supplied by the Head of Contracts, 10 September 2015..

quality, capacity and sustainability in the external market. Providers and care workers would need to be engaged in the drawing up of the charter.

- **Support the recruitment and retention of care workers** for example by presenting home care as a profession in a positive light through local media, and offering care workers 'local passes' giving free access to Council amenities such as parking, swimming etc. Further suggestions made by providers are included in Appendix A**.**
- **Introduce outcome-based commissioning.** Care is commissioned and delivered more effectively (and therefore more efficiently) using an outcomes-based approach, rather than by time and task. An early step would be to adjust forms on Frameworki to record service user outcomes on the Assessment, and on the Care and Support Plan.
- **Continue to reduce demand.** A broad range of activities is being undertaken already; this effort needs to be sustained, and clear and realistic plans for investment drawn up (in particular for increasing the use of assistive technology, and reducing social isolation). There may be mileage in exploring whether there are any additional routes which could be taken.
- **Improve reporting systems**, to ensure that regular and accurate reports are in place to keep track of all planned and actual activity and costs for home care.
- **Introduce monthly visits to provider offices**, to improve communications, monitoring and engagement, particularly for those providers who do not attend the provider forum.
- **Maintain the current number of providers**; a larger number of providers would increase costs and reduce sustainability by spreading the limited number of care workers too thinly.
- **Reduce both council and provider back office costs significantly and reduce the margin for error** by automating the way in which providers are paid. This will require up-front investment in systems and processes, but efficiency gains would be quickly realised once new systems are in place.
- **Review provider monitoring forms** with a view to reducing duplication – similar information is collected for invoicing purposes.
- **Improve use of the internal Frameworki system by operational staff** to ensure records are accurate and specifically up to date. This would ensure a better 'match' between data for care planned and data for care delivered, reducing the need for additional enquiries and/or admin with the 'system'.

Dependent on the option selected above:

- **Improve efficiency in the internal service** as a step towards creating a commercially-viable 'spin out' organisation, for example by reducing the six geographically based teams down to two.
- **Monitor and review the whole market**, i.e. commissioners to monitor and review the internal service in the same way as the external, introducing a 'level playing field' across the whole market. The internal annual service user survey could usefully be extended to cover the external provision.

Institute of Public Care
14 September 2015

Wards Affected: All Wards

ITEM 21

CABINET

12 OCTOBER 2015

REVISED REPORT

INVESTMENT IN PROPERTY FUND FOR TEMPORARY ACCOMMODATION

Responsible Cabinet Member:	Councillor O'Neill (Cabinet Member for Housing and Regeneration)
Report Sponsor:	Jane Reed (Service Director Housing and Community)
Author and contact:	John Russell (Housing Development Officer) Tel: 01908 253212

Executive Summary:

Discharging its duty to provide temporary accommodation to households that it accepts as statutory homeless and that have no immediate settled housing costs the Council £979k last year, and due to an increase in demand is forecast to cost an estimated £1.6m in 2015/16.

B&B is unsuitable housing for family households. The Council is working on a variety of options to obtain more self-contained temporary accommodation for rent to reduce or eliminate the use of B&B.

The option recommended here is for the Council to invest £5m in the Real Lettings Property Fund (match-funded by £5m from Big Society Capital) to purchase a portfolio of up to 70 flats in the open market in Milton Keynes.

The scheme will result in net savings of up to £3.3m in B&B costs and the investment will provide a financial return to the council which will largely off-set the cost of borrowing.

This will require approval by the Council, with the scheme funded by Prudential Borrowing.

1 Recommendation(s)

1.1 That the Council be recommended to:

1.1.1 approve prudential borrowing of £5m to fund a £5m investment in the Real Lettings Property Fund,

1.1.2 approve an addition to the 2015/16 Capital Programme Resource Allocation and Spend Approval of £5m

1.1.3 amend the Treasury Management Strategy by inclusion of joint property investments within the class of permitted investments.

1.2 That, subject to the council approving the additional expenditure, the Corporate Director of Place be authorised, in consultation with the Corporate Director of

Resources, to agree the detailed terms of investment and complete the agreement with Resonance UK (the Real Lettings Property Fund Manager).

2 Issues

2.1 Milton Keynes Council has a duty to secure housing for households that it accepts as statutory homeless (within the meaning of Part VII of the 1996 Housing Act) or to provide interim temporary accommodation. This is increasingly out of area B&B as there is a shortage in Milton Keynes of alternative accommodation. While demand continues to increase, the supply of properties available for temporary or permanent rent is reducing.

2.2 B&B accommodation cost the Council's General Fund £979k in 2014/15 - in 2015/16 the cost is forecast to be £1.6m and there were 137 households in B&B at 9 August 2015. B&B also provides an unsuitable environment for families to live in - short-stay rooms generally located out of the Borough away from work, schools, and friends and family, and without the facilities such as cooking and washing that self-contained accommodation offers. The Council is working on a variety of short, medium and long-term options to reduce or eliminate its use.

2.3 Real Lettings Fund

2.3.1 The Council's investment (and the match-funding) in the Real Lettings fund will provide up to 70 self-contained flats to address the urgent need for suitable temporary accommodation. The Council will invest £5m in the Real Lettings Property Fund managed by Resonance UK - a Social Investment Company - to purchase up to 70 properties in the open market in Milton Keynes over 18 months.

2.3.2 St Mungo's Broadway - a Registered Charity and, as St Mungo Community Housing Association, a Registered Provider with the HCA - will manage the properties which will be let to homeless households nominated by Milton Keynes Council at LHA rates. The placement fee of £3000 paid by the Council for each new nomination will go toward a comprehensive support package provided by St Mungo's to help each family to set up and manage its tenancy, and to move on to permanent housing.

2.3.3 As rent will be charged at LHA level, those households eligible for full Housing Benefit should have the full rent paid through benefit and the Council should have no additional 'top-up' costs for any shortfall in rent. St Mungo's Broadway will be responsible for the maintenance of the properties and collection of the rent.

2.3.4 The fund offers a far better temporary housing solution for families in need as well as reducing the need for B&B. The ability to provide additional temporary accommodation for homeless families within Milton Keynes will also reduce the costs of Home to School Transport, estimated at £240k for the current year..

2.3.5 The Council's investment will initially fund the acquisition of up to 70 properties over 18 months. It is then tied in for 5 years. The Council then has an option to extend its investment for 2 years, withdraw or buy out the match funder. The Real Lettings Fund is open to other local authorities outside of London and the

rate of return will be linked to the overall performance of the fund. The Council's equity will also be a proportion of the overall fund, not the assets which are in Milton Keynes (as explained in the Annex).

2.4 **Medium Term Position**

2.4.1 The Real Lettings proposal is for an investment by the Council of £5m (which will be match-funded) for the purchase of up to 70 flats for temporary accommodation. Purchase will be over a period of 18 months - time to evaluate the scheme's success as the number of units increase. If it works as intended, there may be an option to extend the investment to meet further demand.

2.4.2 However there are risks due to the time limited nature, the refinancing risk at the end of five years, and of changes to investors at the end of five years and the value of properties at this point.

2.4.3 Homelessness is likely to be an issue for the longer term for the Council. The council will need to adopt a range of approaches to manage and mitigate the pressure, of which this proposal is one.

2.4.4 A further option is to use the experience gained from this fund to create a local pool of temporary accommodation, purchased directly by the Council, but managed by an external provider to ensure successful outcomes are achieved, with a limited risk to the Council. This will be fully considered based on the experience gained from this investment fund model.

2.5 No external consultation is required or has been carried out.

3 **Options**

3.1 **Do Nothing -** as there is insufficient alternative temporary accommodation available locally, the Council would continue to place homeless households in expensive and largely out of area B&B with an increasing cost to the General Fund. Homeless families would be placed in an unsatisfactory and disruptive environment. It would also miss a low-risk investment opportunity to reduce B&B costs.

3.2 **Purchase Properties for Temporary Accommodation on the Open Market** - the Council would need to invest at least £10m for the purchase of up to 70 properties. This would need political support, would take time to implement any purchase programme through procurement and approval requirements, and the Council would take the risk for its investment.

3.3 **Invest in Real Lettings Property -** the investment will provide speedy delivery of up to 70 properties over 18 months to address the urgent need for temporary accommodation for homeless households, and reduce reliance on expensive B&B. It will also provide a low-risk investment for the Council. This is the recommended Option.

4 **Implications**

4.1 Policy

It will contribute towards the Housing Strategy 2012 objective - Reduction of the number of Households in Bed and Breakfast. Housing performance measures it will help to achieve are: B&B cost reduction

4.2 Resources and Risk

Failure to act would result in continuing spending on B&B accommodation, which is not currently budgeted for in the Council's Budget 2015-16 or the Medium Term Plan, and on Home to School Transport.

Investment through the fund and with management through St Mungo's Broadway secures match-funding, minimises and shares risks, and provides opportunities to learn from the Council's and partners' experiences of this approach to investment in additional temporary accommodation.

Financing this proposal through Prudential Borrowing is a proper purpose within the CIPFA Treasury Management Code. This has been confirmed by the council's treasury management advisers.

The Treasury Management Strategy does not currently provide for investment in vehicles such as Real Lettings, and Council should be asked to amend the strategy to do so.

Annex 1 to the report, which is not for publication by virtue of Paragraph 3 (Information Relating to the Financial or Business Affairs of the Authority) of Part 1 of Schedule 12A of the Local Government Act 1972, sets out additional financial and governance issues involved in the proposed investment. These matters are considered to be restricted as they contain commercially confidential information and references to the Council's negotiating position.

Annex 2 sets out additional information about the issues involved in the proposed investment

The Resource Allocation and Spend Approval amendment of £5m will be added to the capital programme for 2015/16. This project will be funded by prudential borrowing

Y	Capital	Y	Revenue	N	Accommodation
N	IT	Y	Medium Term Plan	N	Asset Management

4.3 Carbon and Energy Management

All properties will be at Decent Homes Standard or above.

4.4 Legal

4.4.1 The Council has a legal duty to secure housing for homeless families (Housing Act 1996).

4.4.2 The Right to Buy would not be triggered, as the Council would not own the properties.

4.4.3 The Local Government Act 2003 empowers the Council to borrow money for any purpose relevant to its functions, or for the purposes of the prudent management of its financial affairs.

4.5 Other Implications

Y	Equalities/Diversity	N	Sustainability	N	Human Rights
N	E-Government	N	Stakeholders	N	Crime and Disorder

Annex A- Real Lettings Property Fund – Investment in Temporary Accommodation (Not for publication by virtue of Paragraph 3 (Information Relating to the Financial or Business Affairs of the Authority) of Part 1 of Schedule 12A of the Local Government Act 1972)

Annex B - Real Lettings Property Fund – Investment in Temporary Accommodation