Dept. of Health & Wellbeing

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Service Review Report

Name of Service: Home Support

1. Introduction

Home support is the delivery of a wide range of personal care and domestic/community support services to people in their own homes. Support may range from a short visit to ensure that a person has taken prescribed medication through to a significant care package meeting assessed needs for personal care such as support to get in and out of bed, bathing/toileting and meal preparation.

People identified with an assessed need for home support provision will be eligible for the service. This includes older and those with a physical disability, sensory impairment, mental health or learning disability.

The majority of this support is delivered by the independent market, the exception being reablement. The contracts for these are due to end on 31 March 2023, therefore the department needs to now undertake a service review. The review will take into consideration the full range of home support currently available in the District, and will co-produced with partners, providers, people who use services, their families and carers.

2. Current Provision and Performance

Current Provision- Overall

Market

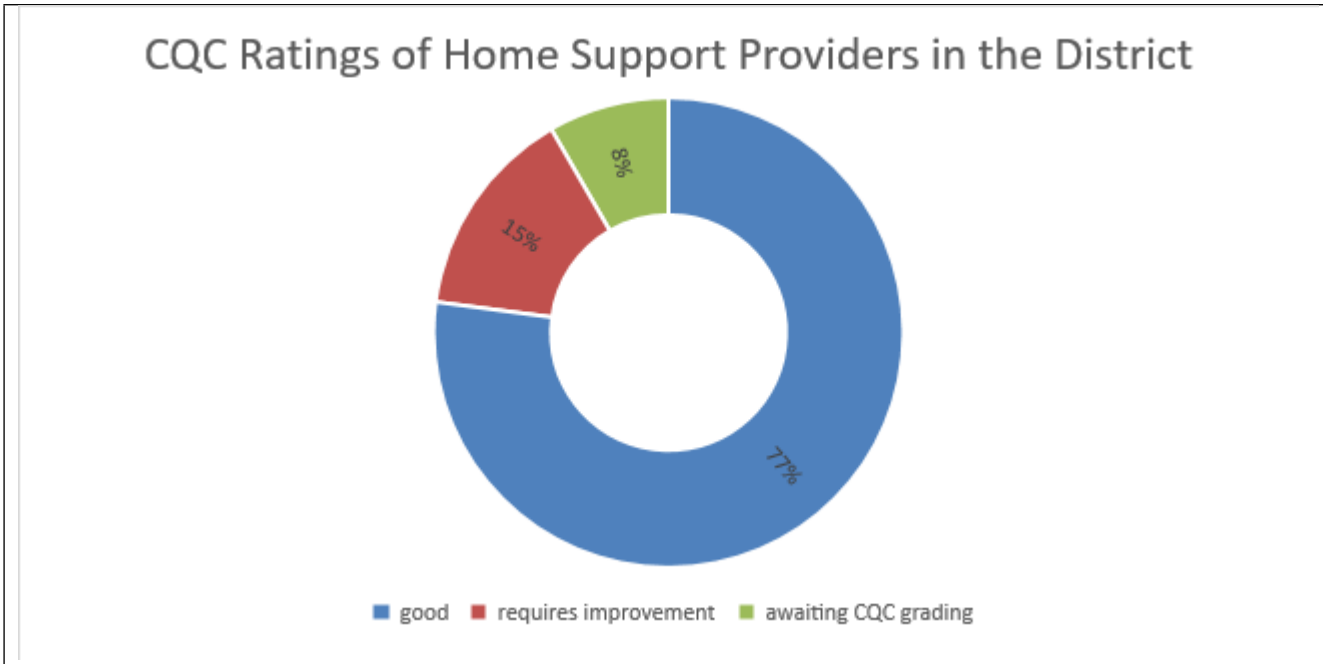
At present the contracts database shows 218 contracts/arrangements including locality are in place with 82 providers delivering against these. More detail of the different arrangements can be found below.

Spend and Hours

The total home support hours commissioned externally are: 28,364.75 (not including CCG, MH or LD). The total weekly spend is £549,000 (not including CCG, MH or LD) and estimated annual spend is projected at £28.6 million for 2022/2023.

Quality

The quality of services in Bradford District shows above the average for England for Good and Outstanding CQC ratings by 2%, with Bradford at 89.7% (England average is 87.7%). However, only a small number of providers in Bradford District have been subject to inspection in recent years, with five services being inspected and rated in 2021, and two services being inspected and rated in 2022 to date. The COVID-19 pandemic impacted on the regulator method of inspection, and which reduced the overall number of inspections taking place nationally- therefore the England average for Good and Outstanding homes may also change.



Data as of August 2022

Locality Contracts

In April 2019, home support locality contracts were introduced, which comprises of 35 geographical areas according to ward, population size and demographic data. These are currently delivered by 16 providers. The locality contract providers do not cover all support packages within their designated areas, for a host of different reasons, such as early contract implementation issues due to lack of TUPE transfers, existing service users not transferring across when provided with option to 'leave or remain', through providers already in place based on individual spot contracts, pre-existing framework call-offs or option to choose an Individual Service Fund 1.

Since the commencement of the locality contracts ten retenders have taken place. The majority of these retenders have been due to poor performance attributed to staffing difficulties, and with a small portion of providers leaving the market due to personal reasons or change in business strategy. All care packages have been transferred successfully without provider market failure but the challenges presented due to staffing i.e. leavers/sickness, has meant prompt timescales for undertaking tender and contract transfer.

STEP Contract

The council introduced Short Tern Enhanced Provision (STEP) contracts in January 2020, on a 2-year short term contract basis, to support the short term needs of people requiring early intervention and immediate home support assistance. Five geographical areas were created with five individual organisations delivering against each of these. At present, four out of the five areas have a provider which is due to one organisation failing to meet CQC regulatory requirements and the Council subsequently ceasing the placement of new packages/ withdrawal of existing packages.

STEP services have been consistently overstretched due to the high number of enablement cases and limited workforce numbers. This is applicable to all four areas with a STEP provider in situ. In addition, the commissioned services have operated on a task and time basis which has meant reliance upon a consistent volume of work however it has always been subject to frequent changes due to its pattern of increase/decrease by needs.

Alongside the introduction of the above STEP services, support with hospital discharge was also commissioned. This came in the form of two separate geographical areas delivered by two individual organisations, with each main hospital (Bradford Royal Infirmary and Airedale General Hospital) assigned a STEP provider. The utilisation of these services has been mixed as the Council's BEST/hospital team have been able to refer directly to the provider delivering support to people from BRI, whilst the provider delivering support to people from AGH only except referrals from health professionals based at the hospital.

IPSAC Spot Contracts* and ISF Framework*

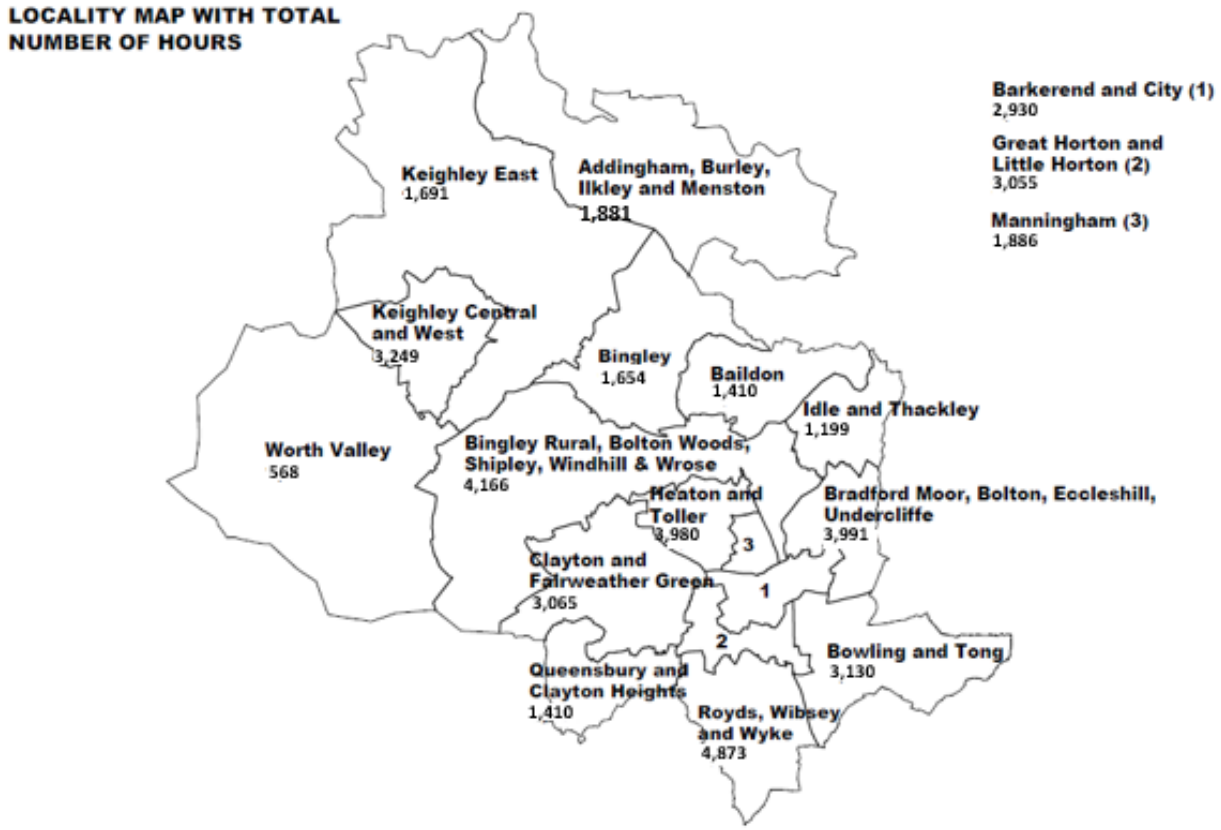
At the same time as introducing the Locality model, the Commissioning Team introduced Individual Service Fund 1. This was to enable individual choice allowing individuals to stay with their current provider) and also to make in-roads to full Individual Service Funds e.g. full choice and control for service users about their support arrangements whilst not facing the challenge of making payment arrangements. This enabled people to remain with their Provider who had been commissioned via the previous IPSAC framework, but is increasingly used by people who wish their long-term care to be provided by the STEP provider or SPOT provider.

Cross- reference with section 3.1 below to see the relative increase in ISFs.

Health

Colleagues from the Personalised Commissioning Team at the ICB (formally CCG) also make placements using BMDC commissioned services when seeking support provision for people with complex healthcare requirements, including split funded packages. In the event BMDC commissioned services are unable to meet the needs of a particular package, then SPOT purchases will be made with Health's own list of Providers. These placements are with organisations that have not been through a Council accreditation, however are on the Council's system for payment purposes. This can present issues when individuals' packages change from fully funded to split funded or ICB funding is no longer required (see Issues, section 4). Currently data shows five organisations funded by ICB only.

Locality map – current hours



Bradford Enablement Support team (BEST)*

The Bradford Enablement and Support Team (BEST) are in-house team that provide short term personal care and support to people at home. Whilst BEST are not commissioned, it is important to understand their role within the system.

BEST provide support to individuals under the following client group categories; Older People, Physical Disabilities, Sensory Impairment, Mental Health and Learning Disability. BEST may deliver a service when the

individual has been discharged from hospital, the individual's health has deteriorated, family are no longer able to provide the required support, or in response to a social care crisis.

BEST works with the individual in creating a person-centred service that maximises their independence. This is usually provided for about 4 weeks, up to a maximum of 6 weeks, without being charged. Once the individual has progressed sufficiently an/d or met their outcomes, the service will become chargeable unless the individual's review has not taken place. After this time, if there are still needs, this is usually provided by a commissioned service.

Currently, there are 158 care package line items for re-ablement services from BEST. On average, 82% of care package line items at BEST are re-enablement services.

3. Current Demand and Future Projections- Older People and Physical Disabilities

3.1 Overall picture of the district

Picture of the District

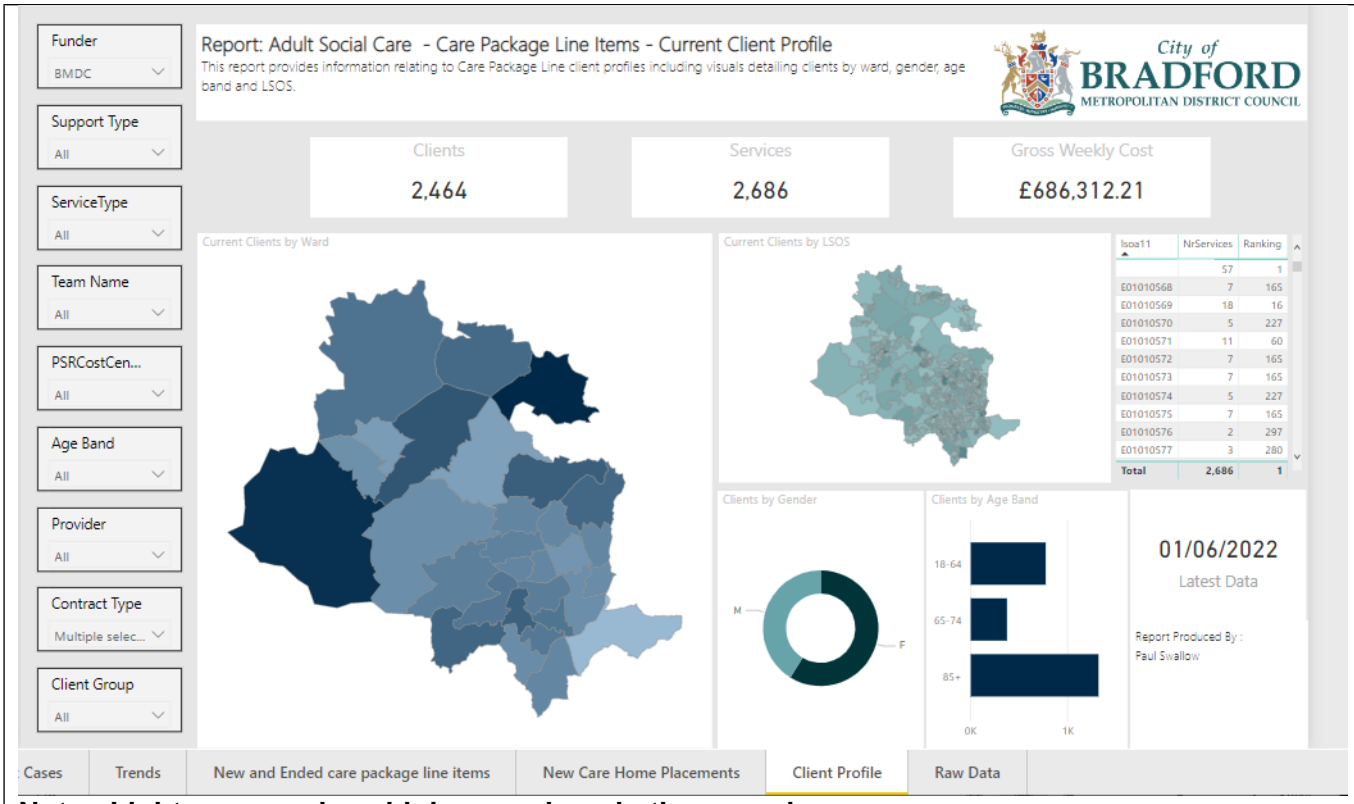
There are 30 wards in Bradford District, which range from the more rural, less densely populated wards like Wharfedale and Worth Valley in the north and west of the District to the more urban densely populated wards like City and Little Horton in the inner city. For the purpose of this tender and accessible service provision some areas differ from the recognised electoral wards.

- City ward has the highest population total with 24,260 people and Wharfedale has the lowest population total with 11,850 people
- Bradford District has 1.9% of empty homes and 6.2% of homes which are overcrowded. City ward has the highest percentage of empty homes (4.2%) and Baildon ward has the lowest percentage (0.7%). Manningham ward has the highest percentage of overcrowded homes (17.8%) and Wharfedale ward has the lowest percentage (1.2%)
- Life expectancy in Bradford District is 81.5 years for females and 77.5 years for males. Keighley Central ward has the lowest life expectancy for females (76.8 years) and Wharfedale ward has the highest life expectancy for females 85.3 years). Manningham has the lowest life expectancy for males (72.3 years) and Wharfedale has the highest life expectancy for males (84.7 years)
- Bradford District has 12 wards which were identified as being within the 10% deprived in England, according to the Index of Multiple Deprivation 2015 - Manningham, Bowling & Barkerend, Little Horton, Bradford Moor, Tong, Keighley Central, Toller, City, Great Horton, Eccleshill, Bolton & Undercliffe and Royds. Ilkley ward and Wharfedale ward are within the 10% least deprived wards in England.

Homecare Packages of Support

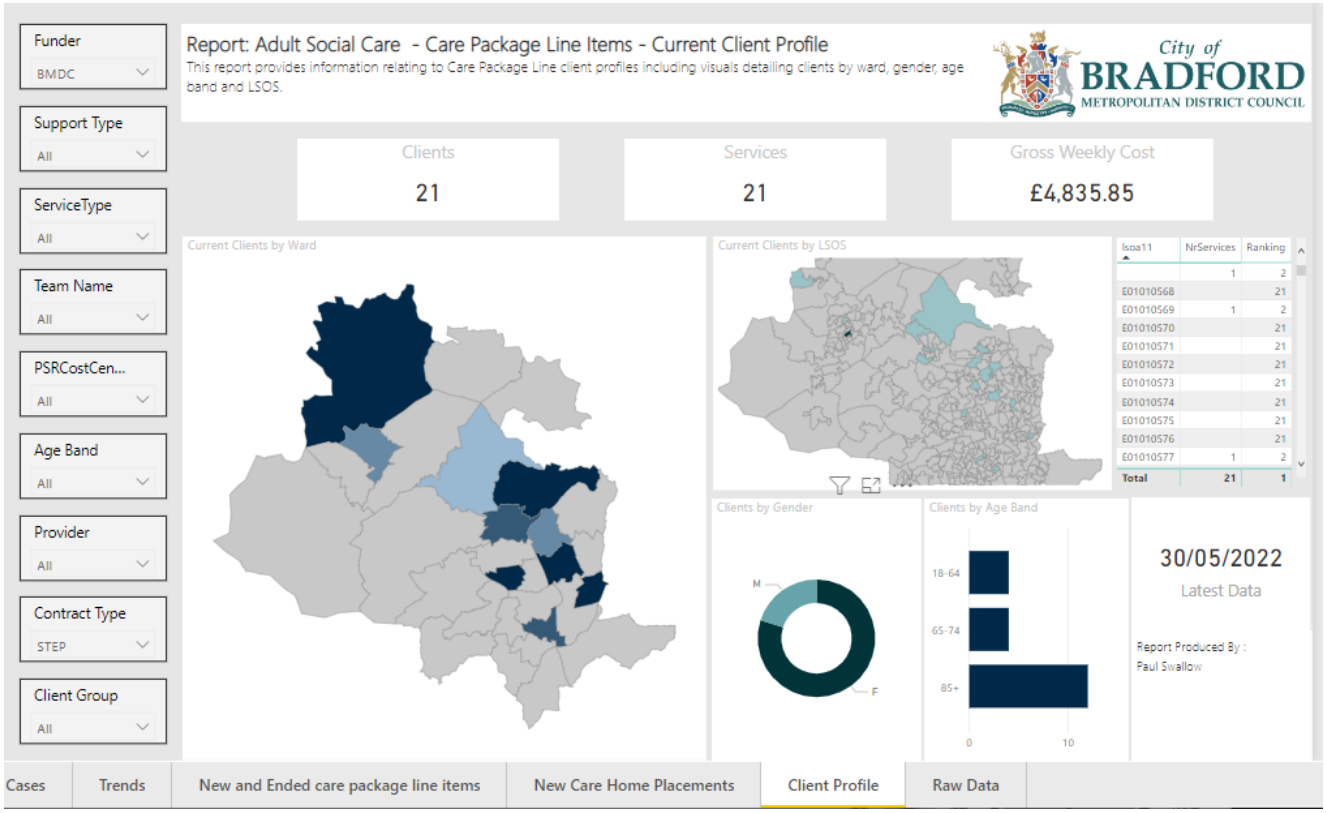
Demand for services are high across the Bradford district. The graph below shows that as of June 2022 currently 2,464 people are receiving 2,686 services through homecare or ISF homecare within the Bradford District.

1,315 of the individuals receiving a package of support are those who are in the 85+ age bracket.



Note - Lighter areas show higher numbers in the map above

The STEP contracts are delivered in limited areas and not district wide due to capacity issues within the providers. This results in the locality providers addressing the gaps, in particular the gaps in the areas of highest demand



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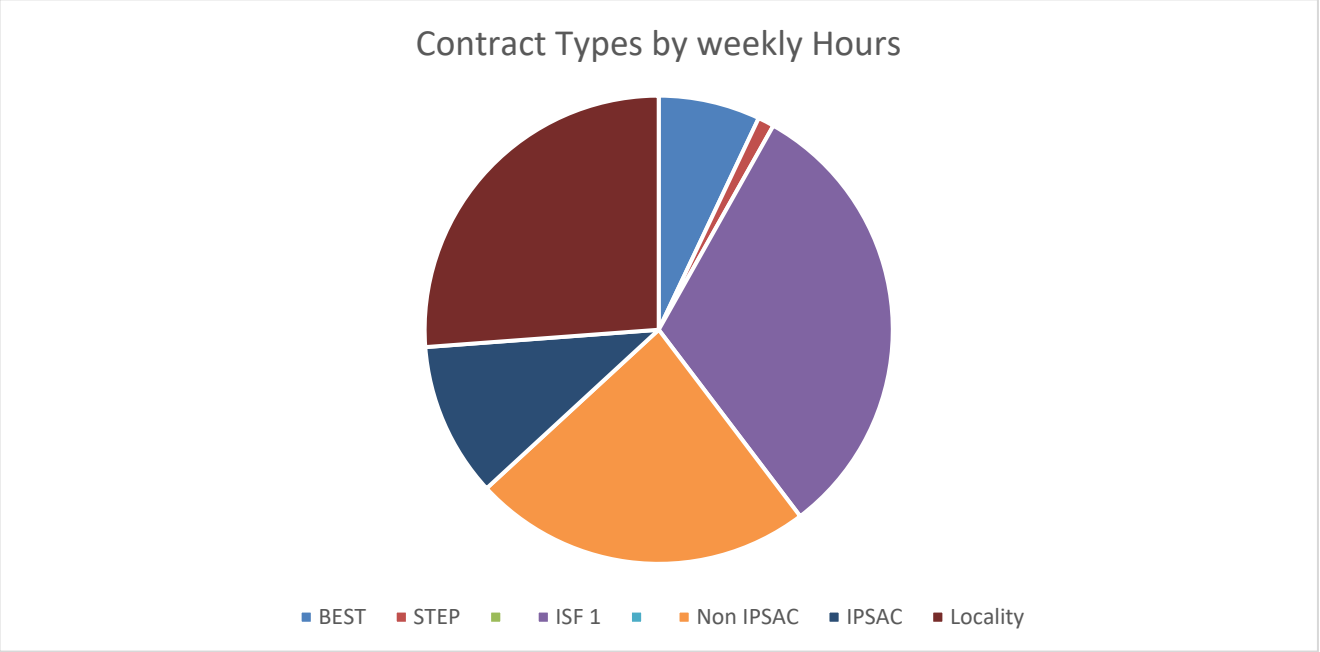


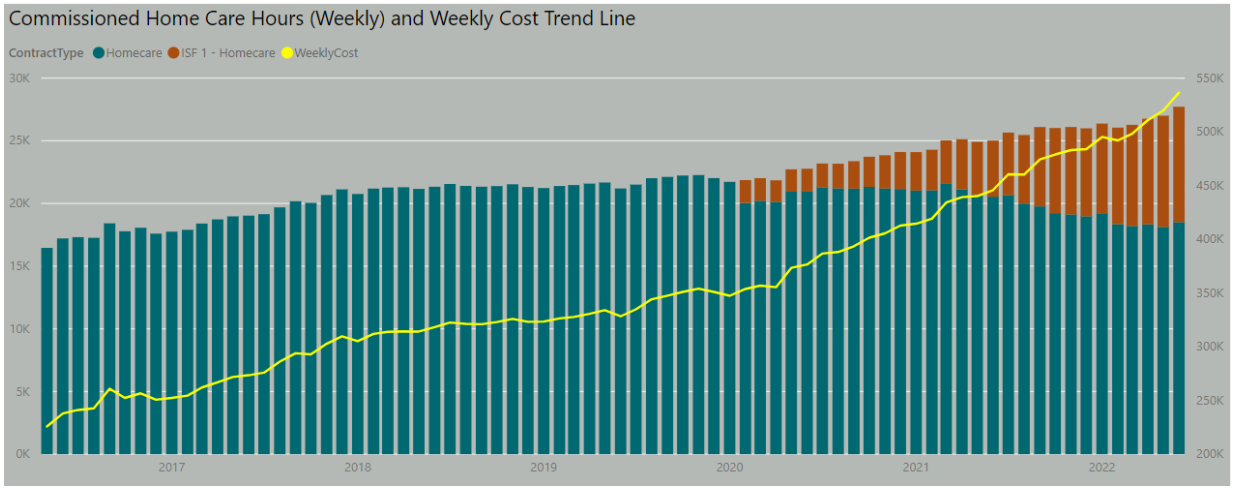
Snapshot taken July 2022

3.2 Demand and trends*

There has been a year on year increase in the total number of home support hours commissioned. This is reflected in the weekly cost of home support to the Council.

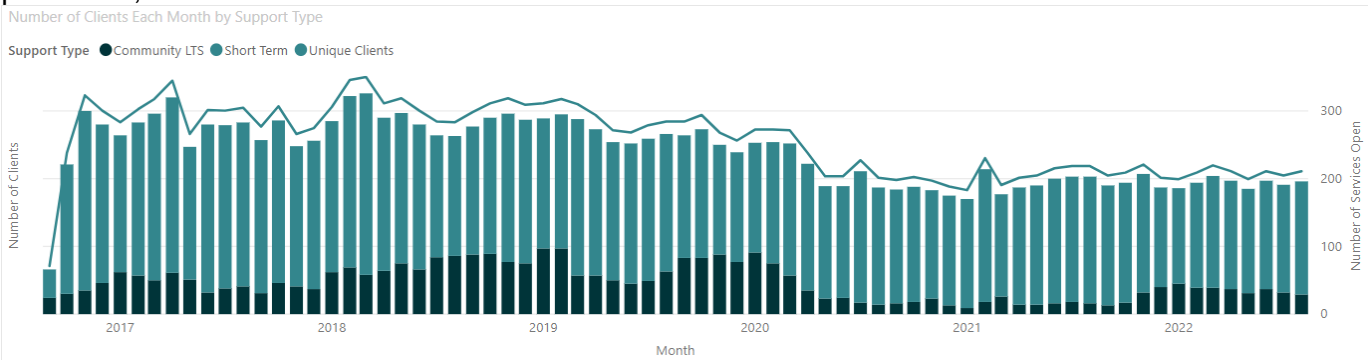
Approximately 2,100 hours (July 2022) of home support is commissioned from externally commissioned providers a week. 29% of the hours are supported through the Locality Contracts. The percentage of hours being picked up by locality contracts is decreasing over time which is balanced through the increase in ISF contracts which has now increased to 34%. During the same time Direct Payments have been increasing over time to now 11% of the market share

Individual choice and demand is increasing as evidence by the number of requests from people to choose a specific provider increasing, this is largely where people have been placed with a Short Term Enhanced Provision provider (or 'STEP' provision) rather than move onto a Locality Provider for their area of residence.



BEST has continued to place packages externally over the last two years. A consistent trend has been the continuous week on week placements to the external provider market. Discharge to Assess pathways have increased the requirement upon Bradford Enablement Support Team to utilise external providers. It is anticipated that service demand will significantly increase based on historic trends of more demand for support at home.

The graph below provides a trend line relating to the number of clients who have received support from BEST per month, from 2017 - 2022.



Approximately 45% of all home support provision requires 2 carers per visit (known as 'double handed' visits)

The data will be analysed to establish the trajectory and trends of double handed visits in terms of how many are temporary due to enablement and how many go on to become single handed and if there are any trends to this.

PowerBI data reports that on average each person receives 14 hours of support per week. The average size of packages has been increasing since the start on 2020, but are still below 2018 levels. The graph and table below maps the average weekly home care hours per client, from 2017 – 2022.

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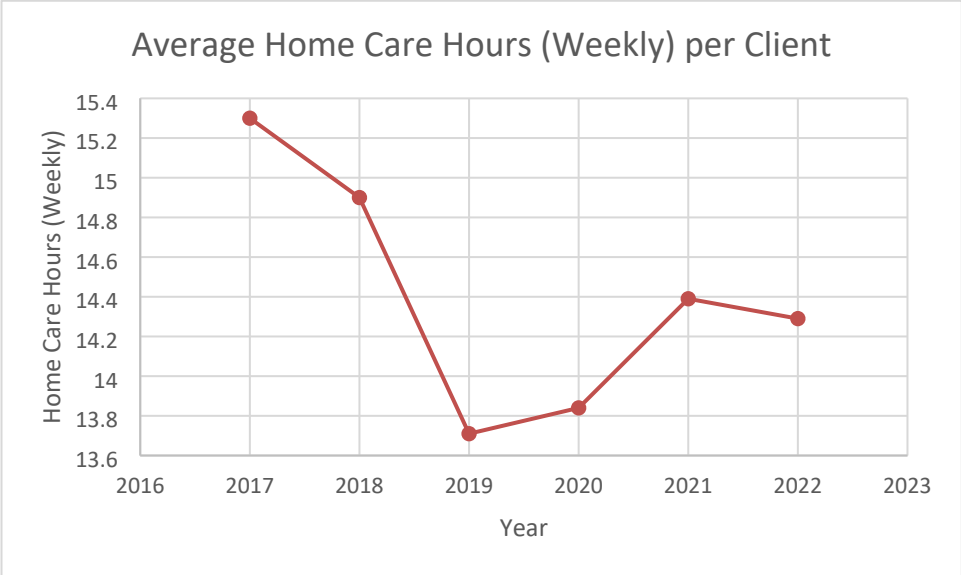


Table of Commissioned Home Care Hours (Weekly) per Client, per Calendar Year

Year	Average Home Care hours (weekly) per client
2017	15.3
2018	14.9

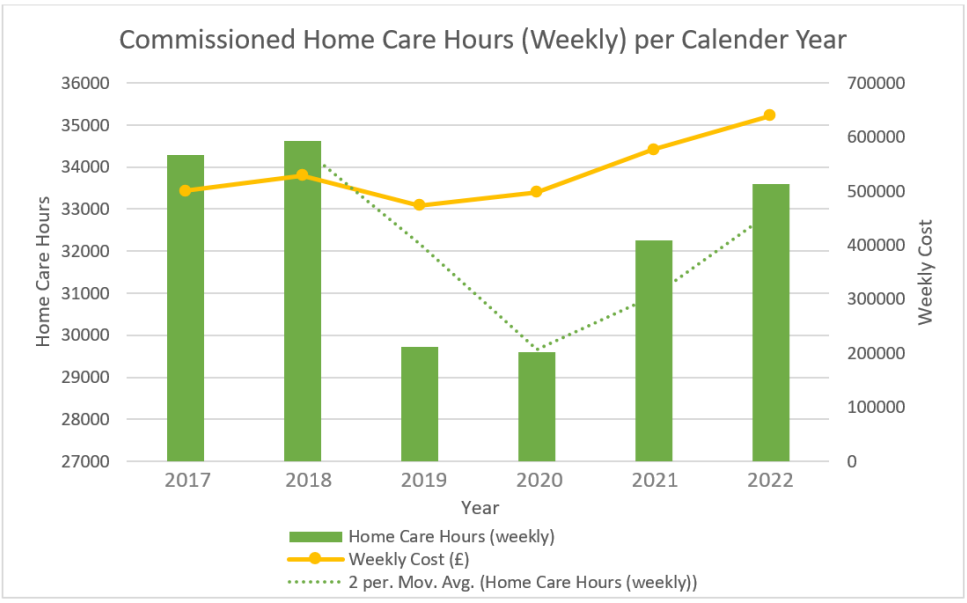
2019	13.71
2020	13.84
2021	14.39
2022	14.29

The table below shows the number of hours commissioned annually, which is increasing year on year.

Table of Commissioned Home Care Hours (Weekly) per Calendar Year

Year	Home Care Hours (weekly)
2017	34277.08
2018	34625.76
2019	29730.09
2020	29600.08
2021	32251.76
2022	33588.52

However, whilst the hours may not be back to 2018 level, the cost has surpassed this and continues its upwards trajectory.



[1]

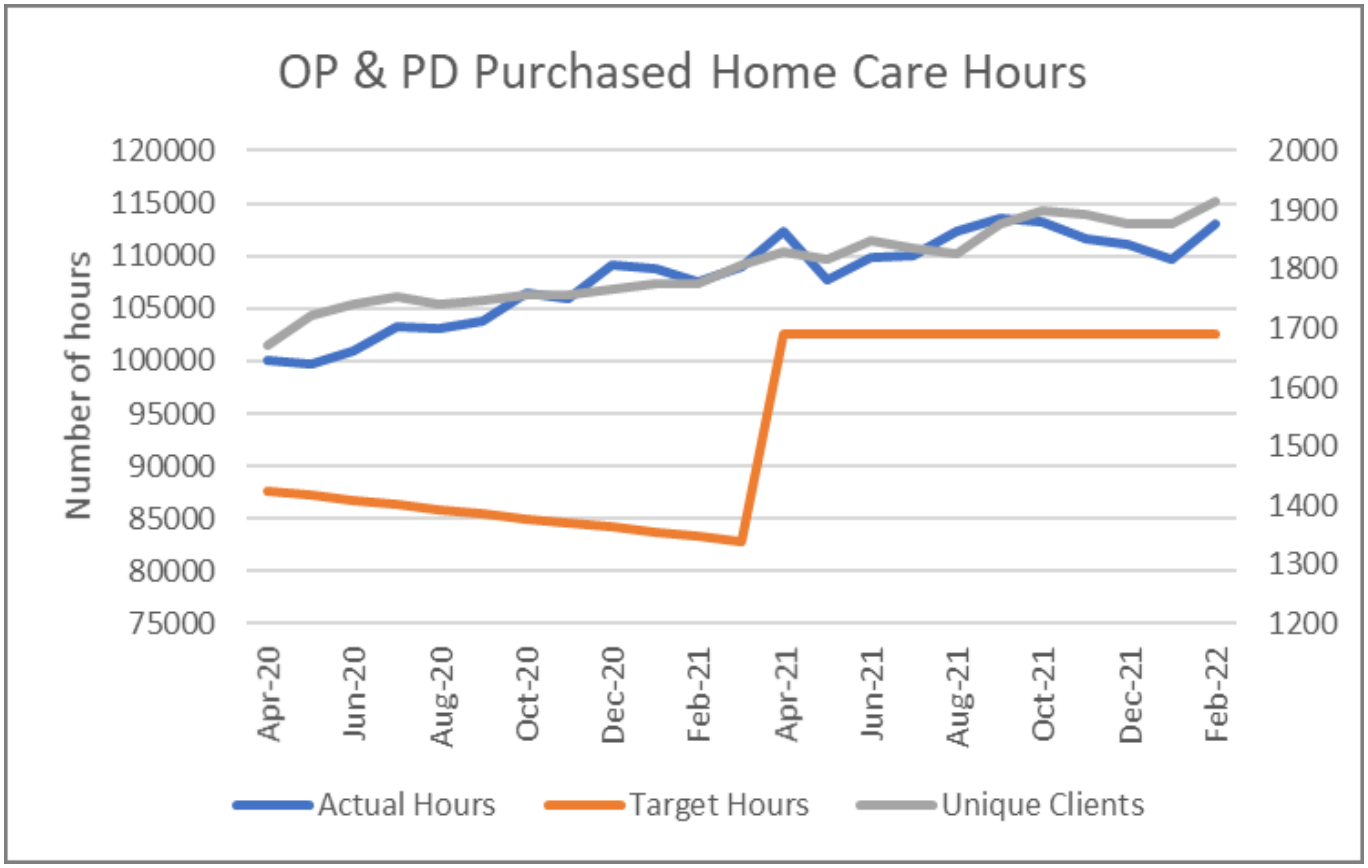
[2]

[1] The average commissioned home care hours and weekly cost for 2022 is based on data collected from 1 January 2022 to 1 August 2022.
[2] The average commissioned home care hours per client and weekly cost per client for 2022 is based on data collected from 1 January 2022 to 1 August 2022.

[3]At June 2022, the trajectory for the annual cost of Long Term Care Homecare predicts an overspend of £3.3m. The number of commissioned hours for Home Care dropped significantly during 2019/20 and is gradually rising again against a backdrop of significantly increasing costs to provide the service.

	Annual Net Budget £m	Annual Forecast £m	Forecast Variance £m
Homecare (including ISF1)	9.2	12.5	3.3

Data from PowerBI reports that commissioned home care hours have increased by 3,461 hours between May and June 2022. Current levels are 113,075 versus a target of 102,603 for the end of the year 2021/22.



Workforce and Provision

The ONS estimate that in 2034 there will be 344 people of pensionable age for every 1,000 of working age, rising from 310 in 2014.[4] This may make it harder to recruit the paid carers needed to meet the growing demand for care. These projections are sensitive to long term assumptions about net migration. As inward migrants are generally young, lower net migration means an older population.

Deloitte Insights[5] have published a paper on transforming social care outlining that being more efficient or cost effective measures will no longer be sufficient to produce meaningful change in social care. The focus must move to early intervention and create paths to greater self-sufficiency and resilience.

[4] This assumes disability rates remain constant and current patterns of care are maintained. However, recent trends suggest that the prevalence of disability in older groups may be increasing

[5] Future of social care | Deloitte Insights

The fragility of the home support market has been raised as a concern by the CQC, which has highlighted large churn among providers registering and deregistering (many of which have not been inspected). Home support providers employ around 147,000 people in Yorkshire and the Humber and there are around 6,800 vacancies across social care at any one time. More than half of care workers are employed on a zero-hours contract and turnover for domiciliary care staff is at 33.8 per cent. [6]

In Bradford there are 11,500 jobs in the independent sector and an additional 950 jobs working for direct payment recipients. It is reasonable to extrapolate that the Bradford district carries approximately 5% vacancies (575) in line with the Yorkshire and Humber statistics.

Forecasts show that if the adult social care workforce grows proportionally to the projected number of people aged 65 and over in the population between 2020 and 2035, an increase of 28% (3,220 extra jobs) would be required by 2035.

Employers with favourable workforce metrics (such as high levels of learning and development), on average, had better outcomes (lower staff turnover and/or high CQC ratings).

4. Consultation

Consultation has been undertaken and is continuing with Service Users, Independent Providers and Departmental Staff. A summary of the consultations undertaken to date or planned is listed below.

Due to the large amount of data, 'themes' from this have been pulled together and can be found in section Appendices 1 and 2, and have been used to partly inform the 'Issues' section at 5.2 and 'Good practice' at 6.5.

4.1 Service Users

Provider Feedback

The provider 121 discussion included a question about any themes or trends that providers are aware of around service delivery and Home Support.

Service User Feedback

We are developing and trialling an electronic workshop format to ascertain the views of service users. This will be completed via an electronic and paper based survey to a sample a cohort of 300 - 400 users with an anticipated 10 - 15% response rate.

*Review of the Commissioning Team Customer Care Log (CCL)**

Year (April-April)	Number of Concerns	Number of Safeguarding Referrals	Numbers of Complaints
2022-present	103	174	17
2021-2022	326	309	48
2020-2021	351	157	31
2019-2020	284	169	36
2018-2019	226	143	80

[6] https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/regional-information/Yorkshire-Humber/Yorkshire-Humber.aspx

Upon review of the Customer Care Log, the key issues identified in relation to concerns or complaints raised against providers are about the length of visits, specifically, calls are not delivered within call times, such as 30 minutes, due to carers rushing; calls are not delivered at set times, i.e. 8am morning call and medication errors. Themes show that providers that are the most responsive to the requests of the Council Brokerage Teams package uptake often incur higher frequencies of referrals. The trend reflects that the more packages being picked up by a provider the higher the chance of a referral being made.

4.2 Independent Providers

121 discussions
Six providers have been approached to take part in 121 meetings to discuss in more depth the challenges and positives in their area in context of Home Support. Key areas we are looking to understand more fully are

- What contract types they currently deliver and what are the advantages and challenges with each of them?
- What are the areas that cause a disproportionate amount of work to complete?
- The impact that the lack of capacity (or anything else) has on their work area
- What are the messages/themes they are hearing from service users about the challenges and positives?

Shadowing
Shadowing both on rounds and in office, covering in particular rota planning is in the early planning stage and will be looked in to further in line with current COVID restrictions and limitations in place.

Snap Survey
A Snap Survey has been circulated to all providers who have contracts for Locality Areas, IPSAC, Non IPSAC, ISF and STEP to understand the priorities, challenges and positives they experience within contract delivery across the various contracts. The Bradford Care Association also circulated the email to provider encouraging them to respond to the survey. Of the 82 providers who currently deliver services for Home Support and we had 25 responses, giving a 30% response rate. The analysis is in Appendix 2.

The feedback supported the information already collated internally, however with additional detail around cost of living, recruitment and relationship with the department.

Provider Contract Meetings
A review of the home support provider monitoring reports carried out over the last 12 months was undertaken in order to capture provider's future plans and developments.

The vast majority of service providers are feeding back difficulties with identifying new staff and retaining existing staff due to market pressures. Specifically, it's becoming increasingly challenging to compete alongside the supermarkets, health and beauty and courier sectors which are offering better pay and terms and conditions. Also, for people who want to work in health and social care, providers have given feedback to say it is becoming unaffordable for their staff. The greatest challenge is workforce for providers to be able to provide a level of service that meets existing demand levels, which reflects the fragility of the local market place.

BCA staffing discussions
Discussion take place frequently with the BCA which is informing our workforce strategy. See section 6.5 'Good practice'

Service Improvement Board/ Provider meetings
Providers have identified a need for work to be done to improve communication streams between provider, social worker and service user to avoid cancellation of packages. The Support Options Team are currently in talks with care home managers to discuss capacity, communication breakdown and call times to try see how things could improve.

Lessons Learnt meeting
On 16 May 2022, Commissioning Managers and Contract and Quality managers held a meeting to discuss the current home support contracts and identify lessons learnt. Items that were identified for review include

workforce pressures, contract layering, collecting information on providers' performance and market engagement. These are reflected in the issues section below.

Winter Pressures*

In order to increase resilience over Winter, additional funding was made available to

- increase the hourly rate that Locality or ISF providers were paid so that they were on par with STEP, in order to encourage them to pick up short-term packages
- Increase the hourly around the Wharfedale area where were having difficulties moving packages on
- Pilot a new approach around Ilkley, using to cars and employing drivers to transport non-driving staff to and around the area.

This was funded from DTA money and stopped on 31st March. The initiatives are still being evaluated: on the surface they successful in terms of increase in packages in that area, however more work is needed to be done to unpick any ripple effect on other areas (e.g. a corresponding decrease in another part of the district) and the full cost of the pilot; this was expensive and may not be viable for full-time delivery.

4.3 Departmental Staff

Qualitative research with Health and Social Care Staff

Throughout May and June, a series of discussions were held with 15 staff across areas that intersected with the delivery of Home Support. These focussed on building a picture of the role that Home Support plays within the different elements of the system and capturing both the positives and challenges their team were experiencing, as well as any suggestions for improvement. All the meetings were transcribed and themes were pulled in to a document Themes from Home Support Feedback are in Appendix 1

Capacity meetings

A weekly meeting is held with departmental staff, identifying difficulties in placing packages with providers due to issues with capacity. From these, trends are identified and system pressures discussed.

Workshop with DMT/ Key System Partners/ Providers

A workshop with DMT is scheduled for 29th June

Further workshops with Key System Partners and Providers will follow - dates TBC

A workshop with HOSC members is pencilled in for August, with a follow up report in September.

5. Current issues

5.1 National Issues

5.1.1 Home Support nationally

It is recognised nationally that Home Support it is critical to the longstanding strategic intention to enable people to 'age in place' and to deliver care as close as possible to people's homes, however for many years the home support market across England has been fragile with both large national providers and smaller local providers struggling to maintain business. The 'churn' seen in the Bradford market is reflected nationally, with pre-pandemic 39% of local authorities having had experience of home support providers ceasing to trade.

Key issues seen nationally are[7]:

- Difficulties recruiting and retaining staff
- Difficulties delivering in rural, diverse or deprived areas
- Insufficient funding
- Extensive growth in the need for home support (the DHSC have predicted a 57% increase in people needing support between 2018 and 2038)

[7] https://www.kingsfund.org.uk/sites/default/files/2018-12/Home-care-in-England-report.pdf; https://www.homecare.co.uk/news/article.cfm/id/1653300/More-home-care-staff-quitting; https://www.homecare.co.uk/advice/home-care-facts-and-stats-number-of-providers-service-users-workforce

- The lack of a long-term vision for social care

5.1.2 Workforce recruitment and retention

Recruitment and retention has become increasingly challenging than before the pandemic[8]. Locally home support providers are reporting more competition with other sectors, with recruitment/retention generally against supermarkets, health/beauty, and the hospitality sectors.

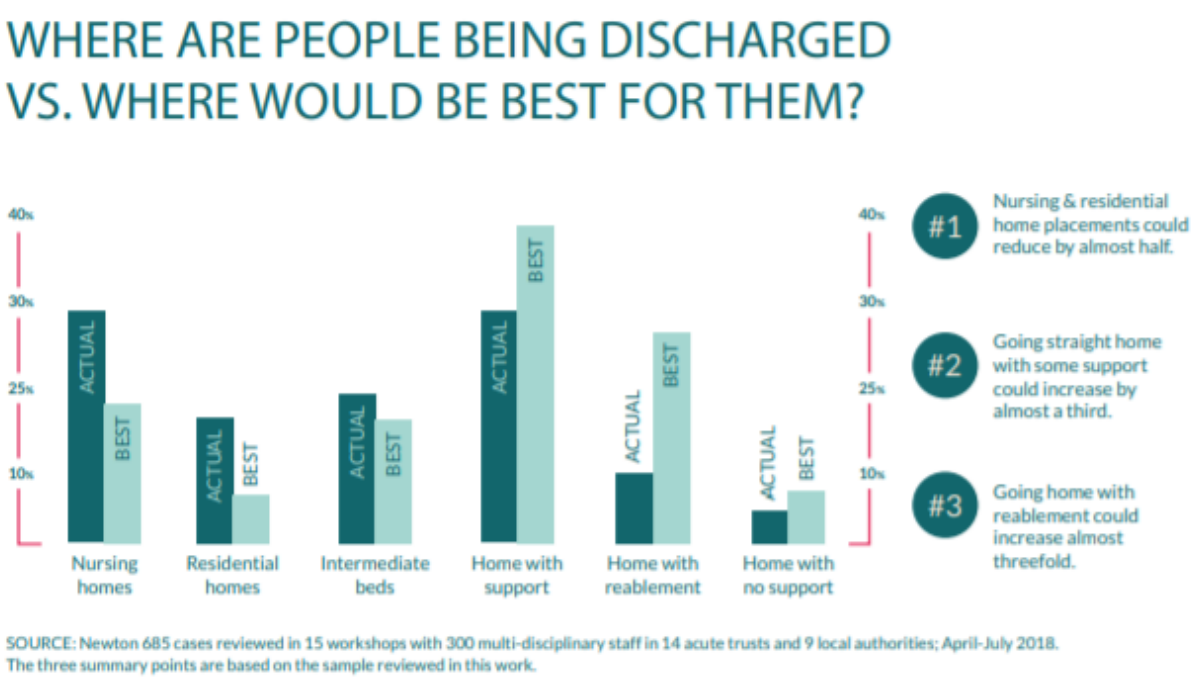
High staff turnover and workforce instability impacts negatively on the experiences of people receiving home support; increases changes in support provision; causes delay in support pick up; reduces the quality of care and increases provider's costs Skills for Care estimate that the cost of recruiting each care worker is over £3.5k. Replacing half the frontline workforce each year, around 950 care workers, would costs commissioned providers around £3.5m per annum [9]

5.1.3 Discharge to Assess

Once people no longer need acute hospital care, being at home or in a community setting (such as a care home) is generally considered the best place for them to continue recovery. However, unnecessary delays in being discharged from hospital are a problem that too many people experience. NHS figures suggested that on 13 March 2022, 12.9% of all available acute hospital beds were occupied by patients who no longer needed to be there

NHS North East and Yorkshire Region have identified discharge and flow issues, and the greatest pressure is home with reablement where demand is outstripping capacity in a significant way

Below shows where people are being discharged to and where would be best for them[10]



5.1.4 Changes to the way we arrange and pay for support

The recent white paper People at the Heart of Care sets out funded initiatives to implement proposals put forward in the Care Act. These include a 'cap' on care costs i.e. the maximum amount a person can be expected to pay for social care costs in their lifetime. It also presents that the Local Authority will play much

[8] Home care worker recruitment and retention 'harder than ever before', UKHCA finds (homecareinsight.co.uk)
[9] Calculating the cost of recruitment (skillsforcare.org.uk)
[10] Produced by NHS England and NHS Improvement for NHSEI North East Yorks Regional Webinar August 2021

more of a role in arranging people's care when they are self-funded, and addressing the gap in costs between them and those who are eligible for LA funding and access care at LA negotiated rates.

In preparation for this, we need to conduct and consider the findings from Market sustainability and fair cost of care exercise, ensuring the end result is a stable, diverse market with sufficient supply.

5.2 Local issues

From consultation detailed in section 4 above, the following issues with the market and current model have been pulled together into themes.

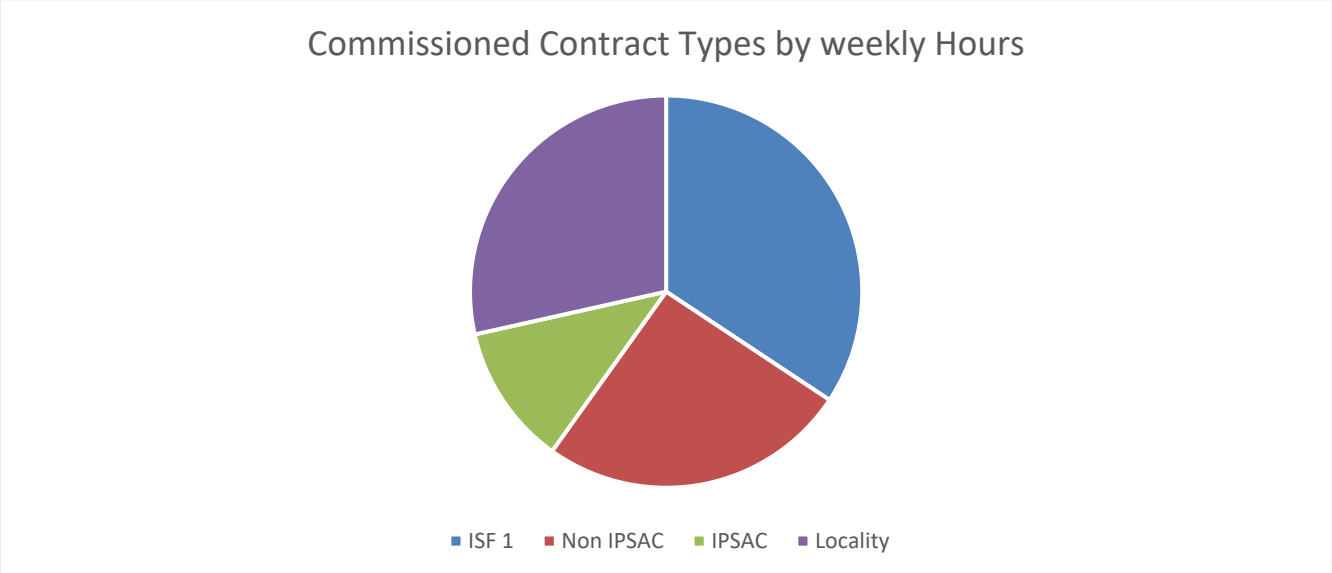
Provider/ Market Issues

5.2.1 Fragmented Market

The current Home Support market is fragmented, with 82 organisations with 218 number of contracts between them who have been accredited at various points over the last decade or longer. This large number of different types of providers has often been the result of offering choice to Service Users however has meant that contracts are layered over each other as an increasing number of frameworks/ contract types are introduced. Section 2 above provides the detail of these.

To date, the Council operates four different types of contracts for long term support, which were all introduced at different periods over the last nine years and continue to be utilised. With the Council's brokerage teams taking a tapered approach to selecting organisations from current to old contract type based on their capacity to accept the support package/s.

This has resulted in the ISF 1 contract having the largest share of the market at 34% of available hours and the locality contract taking just 29% of the available package hours



Data taken as a snapshot on 27 July 2022

Further work will be undertaken to map commissioned contract types by hours across the localities

5.2.2 Disparate locations

- Providers may not be able to create economies of scale
- There is less 'concentration' of service users so that the effectiveness of the localities is diminished
- The previous evaluation process meant that some local providers had to move from the area where they were established, to a new location they were less familiar with.

5.2.3 Market failure

- When setting up the Locality contracts previously, a far larger number of Service users stayed with their current provider than anticipated, so that the 'indicative numbers' in the tender were much lower than expected. Many providers were slow to start up and ten defaulted on their contract, meaning that the area had to be re-tendered immediately.
- In the last 24 months, five service providers have withdrawn from the delivery of home support provision for OP/PD/SI. This has been largely attributed to staffing difficulties, with one provider leaving the market due to their own personal circumstances.
- In the last 12 months, three providers have defaulted on their contracts. This was due to poor levels of performance, with recovery plans being introduced.
- Conversely, there are some Providers who now have such a large number of packages/ hours that we could become too reliant on them which poses risk- it becomes difficult to manage under-performance - Providers can go in to default with few or no consequences- and we cannot afford for them to fail if there is likely no alternative when we retender.

5.2.4 Throughput between providers

- The introduction of STEP has impacted on the flow of packages to Locality with the individual staying with the STEP provider for long-term support via an ISF. The levels of long term support picked up by Locality providers has been much reduced since 2019.
- There is currently no incentive for Providers to enable people quickly or pass packages on to other providers.
- When Locality Providers do not pick up the package in the area, this is then advertised on Connect To Support. Other providers can then pick this work up but there is only a general onus of them to do this, and difficult/ complex/ night packages which are less attractive may take weeks to be picked up.
- Providers are sometimes competing against each other in one area as they have had to step in to different locations.

5.2.5 Discharge to Assess

The pandemic accelerated the direction of travel for people to be assessed outside of an acute setting. This approach was implemented quickly as a necessity, but now needs to be built into the business as usual.

- Due to the earlier discharge we are seeing people requiring Home Support (Pathway 1) but who are likely to have higher, complex needs resulting in an increase in package size and often double-ups. DTA processes have put significant pressure on Providers due to issues around the quality of discharge information, the quick response time needed, their ability to access service such as Occupational Therapy and larger packages of support decreasing in size suddenly after DTA funding is ended.
- Short-term packages often involve the same amount of back-office time to set up as a long-term package, which makes them financially less attractive and can act as a disincentive.
- Where BEST are unable to meet demand, STEP and Locality (or others) may potentially pick up. Both contracts require Providers to meet all new 'demand' for service within 4 hours and 2 hours respectively (the latter being where this includes people being discharged from hospital with on-going support needs) but rarely meet these short timescales.
- Providers do not have the capacity to be agile and responsive to rapid response packages or taking packages out of hours. This is generally due to rotas developed one week in advance, and workforce issues which means they are unable to pivot quickly.
- Discharges from hospital for end of life care are sent to providers who are not able to navigate the fast track pathway resulting in additional assessments and poorer care for the individual

The impact of this is a back- up in hospital discharges, ideally there would be a steady, manageable stream rather than ebb and flow.

5.2.6 Reablement

The STEP service that was introduced to supplement BEST has worked well to support the flow out of hospital, however has caused an impact on the wider system

- STEP were commissioned as an intermediate service, with time and task clauses within their contract
- The specification does not require them to work to the same standards as BEST, nor do they have access to the same level of resources.
- This can result in a second rate service to the individual (compared to BEST). Statistical analysis across BEST, STEP and the wider homecare market show that there is a small difference in the amount of positive outcomes across each areas, but when the positive outcomes are analysed it is notable that BEST have

the largest percentage (67%) who are able to self-manage without a package of care.
- STEP services have had issues with recruitment resulting in the wider Home Support market being asked to fill the gap in service
- Data analysis is not robust enough to draw definitive conclusion due to the small cohort of people within the BEST service as opposed to BEST and the wider homecare
- Reablement support on DTA can cover a range of tasks from visits to ensure medication is taken through to enabling an individual to undertake tasks independently

5.2.7 ***Service lines***

Often people leaving hospital require a temporary increase in hours over their normal package. If this is classified as reablement, it is funded by the Council for up to 6 weeks. On discharge BEST will take on the whole package as enablement even if they had an existing package before

- This means the entire package is free to the individual as the council is unable to claim a client contribution.
- BEST are delivering previously assessed support needs (rather than just reablement) to the individual. This situation is being considered internally to understand the most appropriate way to ensure the individual is supported by their original provider, so that BEST can deliver just the reablement aspect of a package.
- Home support service lines are not being ended in a timely manner by the social worker, this is causing issues for BEST when a package is referred to them. This is also causing a discrepancy between the hours we commission and the hours we deliver as commissioned hours are inflated due to the line not being ended.

5.2.8 Parity of Costs

There is a discrepancy in the market between different providers for intermediate care. STEP providers are currently paid £20.60 p/h as a reflection of the increased monitoring of the changes during the initial period of support to people identified as requiring assessment and package adjustments, as well as more frequent communication with the Council's Reviewing Teams. However, STEP cannot meet the demand, so not all packages were being picked up within timescales, increasing pressure on the hospitals/ BEST. As part of Winter Resilience, all providers were given an interim uplift for this work, paid from DTA funding. This has now stopped and the different rates have recommenced.

5.2.9 Hospital Retainers

There is a hospital retainer scheme where by Providers are paid at the hourly rate for up to four (4) weeks to keep the package open whilst a person is in hospital. This has been previously praised by the CQC peer review that took place in 2018/19, however Providers are often not taking back the original package, due to the increased size of package. (see also DTA at 5.2.6)

5.2.10 Non-social care activity

There are packages of care that include non- regulated activity such as domestic support, shopping and social inclusion. These are funded at the same price as personal care. They can also be included as part of a reablement package without any charge to the individual for 6 weeks. During consultation it raised that locally these are partly responsible for the increasing home support hours however is difficult to monitor due to lack of discrete service line.

5.2.11 Brokerage Systems

We currently have 2 Brokerage Teams: For general reablement and DTA support, the BEST Duty Team can place with STEP Providers but also use the rest of the market to pick up the work as needed. Support Options Team broker for long-term work on Connect to Support. If Locality providers do not pick up for their area, Support Options will follow up and/ or use the rest of the market to support.

- BEST team work 7 days a week and contact the providers directly to place enablement packages and push the packages towards them. This is resource intensive but due to the urgency is often faster.
- Support Options place packages on Connect to Support for providers to pick up packages., however Providers do not always check CTS frequently. Support Options then use a lot of resource following this up having to then constantly phone and email Providers, and check/ update CTS.
- This has created somewhat of a competing situation where the general market may be approached by BEST and feel they have no need to check CTS.

- Connect to Support – placement system is used for the placement of OP and PD/SI support packages. It also includes LD/MH when the existing placement methods have been exhausted or providers cannot be identified to meet the requirements of the support package. The local CCG have adopted the same platform recently but the level of implementation/utilisation and impact on Providers needs to be understood further with the CCG.

5.2.12 Working Hours

There is a disconnect between staffing hours for the Provider market (including back- office) the BEST Team, hospital teams and the needs of Service Users. Provider back office and Support Options generally work office hours Mon-Fri, where BEST work longer shifts with some availability through evening (and overnight). Hospitals are 24/7 as are Service User needs.

- When hospitals discharge late in the day (especially Fri pm to Monday) it is often difficult to put support in place.
- New packages often do not start until Monday
- It is difficult to put in quickly a short-term intervention to react to a temporary situation eg urine infection
- This is likely more of an issue regarding short-term work: when Support Options have trialled working weekends and bank holidays – the results were 95-99% down time for Support Options as no or very few referrals were coming through – so staff were paid, but with no work to do

5.2.13 Locality Boundaries and 'Challenging' Areas*

In the last tender, smaller service delivery areas were created to align the provision with internal operational localities. This aimed to expand the potential work pool by allowing for the recruitment of staff that may not drive. Generally, the move to smaller areas has had a lot of positives (see section 4.1) however the effectiveness of this has been diluted by the market fragmentation and they do not fully utilise a CLS approach and link to Area teams/ hubs.

Future commissioning will review the boundaries, in particular around Health areas to ascertain if any adjustments need to be made to existing locality areas.

5.2.13.1 Ilkley/ Burley/ Menston

These areas continue to be challenging. They cover a significant geographical area that is not walkable across the whole locality, and as much of the area is rural or very rural there are poor public transport links. Whilst some other locality providers have been successful in recruiting carers who live locally, this has not been so successful in the Ilkley locality, probably due to the demographics in that area, which in most parts is far more affluent than most other areas of the district, and possibly with an older demographic

Data suggests the vast majority of providers operate around Bradford City Centre, whilst fewer numbers appear in the centre and towards the boundaries of the district. This indicates that providers are seeking to operate in the urban areas of Bradford District where we see a higher population of people but not necessarily older age adults. Over the winter periods, it has become increasingly apparent that we experience a shortage of supply in more rural parts of the district, e.g. In Addingham, Ilkley, Menston and Burley and Wharfdale, provider options were so low that a grant had to be introduced towards the end of 2021, with only one organisation coming forward for this. The MoonBoots pilot (paying for people and fuel so that walkers could be driven to around rural areas) was successful but came at a high cost.

5.2.13.2 South

South Constituency providers on the whole have been new to the District and have taken a long time to establish, or have not fully established – this has started to impact on BEST in 2020 with long term placements taking longer than normal to place, meaning that people were staying with BEST longer in this area compared to other areas (Ilkley aside)

Non- personal care Home Support Hours

5.2.14 Sitting Service

During Covid-19 the Timeout sitting service has only been able to offer a limited service. In most cases this has meant that people who have a current home support service have not been receiving their usual Timeout

service (priority has been given to people who are receiving no other home support services) or new services have not been offered if home support is in place.

BEST colleagues have identified that this has led to an increased demand for home support providers to deliver 'sitting services' to support carer breaks. This has an impact on the budget but also has an impact on service capacity and hospital discharge.

5.2.15 Domestic/ Social Hours

Home support contract Providers are delivering for social inclusion, shopping, cleaning etc. and we are unable to establish how much of the contract is delivering this type of work – packages that include these types of tasks mask the true picture of positive outcomes for enablement

5.2.16 Nights

Night Roaming/task and time visits are included in the existing agreements for the locality providers. The volume of work is inconsistent and deemed as unviable because demand is very low for night support across the whole district and providers cannot attract staff to work on a night call basis paid for on task and time. When packages are placed on CTS they are generally not picked up.

5.2.17 New Provider Requests*

When new packages of care are sent to the provider market to be picked up the providers are sometimes unable to accommodate the times that an individual wish to receive their care which can cause difficulties with the relationship between individual and provider company. There is often a mismatch in expectations between providers and individuals about what constitutes a late call which can result in the individual in expressing a wish to change providers.

Consideration needs to be given to how we communicate with social workers, individuals and providers to ensure that expectations are managed to be realistic with a focus towards conflict resolution and not an immediate move towards a change of providers.

The change to package form is used to both amend packages and end packages and requires the same level of detail for both. The amount of detail required is contributing to the forms not being completed in a timely manner which then causes financial and time challenges to backdate changes. This process has been reviewed and a pilots for a new approach are in place.

5.2.18 Staffing

In addition to the general pressures that are being faced nationally as described in section 5.1 above, some of the specific issues noted in Bradford are:

- As a result of the workforce challenges, Providers are more likely to pick up packages that are more straight-forward to deliver, so more complex packages are not always picked up in a timely manner
- Some staff are moving from one sector to another as the opportunities for career progression are limited by the current time and task model
- Staff are moving out the sector into Health as there is no clear pathway/ opportunities within Bradford sector. When people are recruited to more senior roles e.g. care coordinator, care manager and RM but not sufficient people entering the system
- Having staff who can drive is often essential to delivering services and maintaining capacity within provision. Due to the pandemic there is increase demand driving tests meaning availability is limited with dates being offered three to six months from booking. Bradford Providers regularly raise this as an issue, particularly in more rural areas with poorer transport links.
- Providers report a lack of integration on the frontline between health and social care. Staff continue to feel under-valued and second class to NHS. Costs of internal recruitment and no accommodation available.

Further detail and the Workforce Strategy is in 6.5.6 below

5.2.19 Sector recruitment

Social Care is not the only sector struggling to recruit and retain staff (including Nursing Home staff). Initial discussion with BDCT colleagues highlighted a shortage of district nurses- there is the potential here for opportunities to work together to address overall capacity issues.

5.2.20 Ethical Care Charter

The Ethical Care Charter highlights how poor terms and conditions for workers can help contribute towards lower standards of care for people in receipt of homecare services. The charter includes a number of practical recommendations to ensure that carers travel time is funded, that they do not have to rush from one client to the next, and that residents should keep the same carer as far as possible.

The new contracts set out to address the issue of very short call provision (15 minute visits) by phasing these out, in line with the Unison Ethical Care Charter. In 2021/22 a 7.2% uplift was applied to contract home support rates in recognition of the need to improve the terms and conditions of staff in the sector. In a recent survey 97% of providers reported increasing staff wages as a result of this uplift.

In August 2021, a survey was carried out which included key questions about the Ethical Care Charter. 35 providers responded to the survey. 63% of the providers that responded to the survey stated that they were meeting stage one of the Ethical Care Charter. The barrier considered for not meeting stage one was put forward as being unable to meet mileage cost (23p per mile). 43% of providers that responded to the survey stated that they were meeting stage two of the Ethical Care Charter, with barriers put forward for those not meeting stage two as being the uncertainty of work and the Council's uplift not sufficiently allowing for this. 29% of the providers that responded believed they were meeting stage three of the criteria. The barriers put forward for not being able to meet stage three were a lack of funds within the organisation to be able to pay the real living wage, an unsustainable hourly rate payed by the local authority when compared to the UKHSA and insufficient care fees paid to them for staff to be able to work full shifts and offer improved terms and conditions.

5.2.21 Cost of living

The sharp increase in cost of living has exacerbated difficulties in the workforce. Feedback from the Provider Snap Survey and BCA express concerns regarding the rising cost of fuel, general cost of living and competing with other markets eg retail and hospitality, and supports the national issues detailed in section 5.1.2). In addition to this, providers reported,

- Neighbouring Authority Leeds has committed to have specified a minimum payment to staff of £10.50. Some staff have left to work over the border and a Provider who works in both reports that this has created a divide in the team as Bradford staff are paid less.
- Some staff are worried about using their cars for work due to the rise in petrol costs. This will have a high impact in the more rural areas where we already struggle.
- Lack of car drivers is further exacerbated by the cost of learning to drive, car, insurance and petrol (see also 5.2.17)
- No payment for Covid19 absences
- The cap on universal credit and hours that people can work.

5.2.22 Procurement and Accreditation

- The financial limits places on providers as part of the previous due diligence meant that some new-start-ups to the area were awarded, where already established providers where not awarded business. Observations by the Contract team have noted that local providers will 'see out' rough patches, possible due to a commitment to the area. They are also more engaged in Service Improvement and forums.
- The evaluation process meant that some current providers/ local providers had to move from the area where they were already established, and a new entrant to the market took over. It generally acknowledged that Providers and their staff perform better in areas they are familiar with, as well as facilitating better outcomes for service users due to their knowledge of community links.
- There is currently no mechanism for new Providers to be added strategically (although this could increase market fragmentation)
- Some providers are on more than once framework e.g. Locality Contracts and ISF Framework and some providers who we still place with have not had been through any recent accreditation e.g. the previous IPSAC framework. This means that we have carried out different due diligence on some Providers, some of whom will not have undergone any recent assurance.
- There is also a 'backdoor' approval process whereby Providers who have been accredited by Health are added to the Council's payment system and may deliver jointly funded packages.

- Some of the recent tenders for Localities where there has been market failure, have been awarded to Providers who are already struggling. They have been slow to start up and in some cases still under-performing.
- Each time there is a new tender/ a provider fails, there is a risk ok staff being lost to the Social Care sector. In addition, staff do not always TUPE to the new provider which makes it difficult for providers to pick up the full packages needed as there is no guarantee of workforce.

6. Evidence and best practice – what others are doing, alternative service models etc.

6.1 Policies and Direction of travel

National

- Hospital Discharge and Community Support[11]
- The Health and Social Care Approach to Winter Pressures[12]
- Health and Care Act 2022[13]
- People at the Heart of Care: Adult Social Care Reform White Paper[14]
- Market Sustainability and Fair cost of Care Fund 2022 to 2023[15]
- Levelling Up the United Kingdom[16]
- Home First/Discharge to Assess[17]
- Unison's Ethical Care Charter[18]
- Social Care Reform and Independent Review by Baroness Cavendish[19]
- The Health Foundation How ageing affects health and care need in England[20]
- Future of an Ageing population[21]
- REAL Centre Making Health and Care Services More Sustainable[22]
- Think Local Act Personal – The Asset Based Area[23]

Internal

- Home First
- Commissioning strategy
- The Joint Health and Wellbeing Strategy[24] outlines the key priorities for implementing the 'Better Health, Better Lives' priority of the Bradford District Plan.

6.2 Alternative Models

Policy-makers have outlined their ambitions to provide joined-up care closer to home and enable people to remain independent and in their own homes. Home Support/ Care is a central component of meeting these ambitions. Against a backdrop of varying quality of care and rising demand, some innovative models and approaches to commissioning[25] and delivering home support are emerging.

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[11] https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance
[12] https://www.gov.uk/government/publications/the-health-and-social-care-approach-to-winter
[13] https://bills.parliament.uk/bills/3022
[14] https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper
[15] https://www.gov.uk/government/publications/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023-guidance
[16] https://www.gov.uk/government/publications/levelling-up-the-united-kingdom
[17] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/overall-approach/discharge-to-assess
[18] https://www.unison.org.uk/content/uploads/2013/11/On-line-Catalogue220142.pdf
[19] https://www.gov.uk/government/publications/social-care-reform-an-independent-review-by-baroness-cavendish
[20] https://www.health.org.uk/publications/our-ageing-population
[21] https://assets.publishing.service.gov.uk/future-of-an-ageing-population.pdf
[22] https://www.health.org.uk/what-we-do/real-centre
[23] https://www.thinklocalactpersonal.org.uk/Latest/The-Asset-Based-Area-/
[24] Joint Health and Wellbeing Strategy 2018-23.pdf (bradford.gov.uk)
[25] New-models-of-home-care.pdf

The extent to which these approaches have been adopted and are widely used varies in lots of ways and for a number of reasons. Despite some being long established in policy rhetoric, such as outcomes-based commissioning, the extent to which finding examples of them in practice is limited. Traditional approaches to commissioning are commonly cited as a barrier to spreading innovative models of care.

Some alternative models of providing care at home – for example, Shared Lives and the US Capable programme – have robust evidence to demonstrate improved quality and/or impact. Others show great promise and the following direct extracts from the Kings Fund New Models for home are provided for reference below.

6.2.1 Wellbeing Teams
Self-managed teams that focus on person-centred care and supporting people in their communities, inspired by the Buurtzorg approach. Care is based on a support sequence co-designed with the person to deliver their priorities. This sequence is repeated every six months to ensure that people are able to live well at home and are connected to their community. It involves moving through the following steps:

- self-care – a health coaching approach focused on what can be done to make the individual feel more confident in how they are managing their care at home
- digital or assistive technology – this may include remote sensors or facilitating video calls with family members who do not live nearby
- community – this may include lunch clubs or falls clinics
- wellbeing teams are the final step in the sequence.

Wellbeing teams are small, self-managed and neighbourhood-based. Individuals choose their own team using video introductions and one-page profiles, with a guarantee of no more than four people. They design an ideal week for the person, where visits have an indicative time related to what they are trying to achieve in that visit. Reduced travel time and lack of hierarchy provides low back-office costs. Wellbeing teams work closely with Community Circles to provide support beyond formal services. Wellbeing teams are being developed in a range of formats, including with local authorities incorporating reablement teams, or teams that are based in GP surgeries

Locally this model could be aligned with a community led support with Area teams or a wider integrated approach, but which will be a significant culture shift and require a collaborative agreement to move towards that new way of working

6.2.2 Outcome Based Commissioning
Moving to outcomes-based commissioning requires investment and time to realise benefits as well as new ways of working. The onus is on providers to take financial risk and this may be less attractive for some providers. One of the barriers to implementing outcomes-based commissioning is that outcomes are difficult to measure, which means that providing assurance for commissioners is more complex. Technology and digital approaches to care management may enable a more outcomes-focused approach to care – for example, with programmes that enable capturing of data about individuals (see ‘Co-ordinated care planning’). Conversely, existing technical approaches such as electronic call monitoring, which may be used to provide assurance based on time, can often act as a barrier to adopting new cultures of trust and relationships that enable outcomes-based approaches. Outcomes should be measured against progress towards personal goals.

One potential challenge with outcomes-based approaches is that they could lead providers to cherry-pick individuals who will provide good outcomes. This is linked to complexities of measuring outcomes and linking payment to results. Outcomes-based contracts themselves will not hold providers to account for achieving improved outcomes for service users, and ongoing constructive relationships between providers and commissioners will be required.

Locally we need to consider how to build in incentives or requirements to address potential issues about packages not being picked up but also an incentive to reduce the package, e.g. through informal or community support or re-able the person where possible. Care will need to be taken to ensure that this does not create perverse incentives or destabilise the market through unintended consequences.

6.2.3 Integrated health and social care community-based teams
Working with services beyond social care such as district nursing, occupational therapy, housing and other public services offers an opportunity to maximise assets and ensure that people's experiences of care are co-ordinated and person-centred

Integrated community teams bring together community health, social care and other professionals. They exist in many forms: some use stratification and case management approaches aimed at specific populations, others are based on principles of placed-based teams such as the Buurtzorg example of Autonomous team working, while others still are aligned with GP practices. Key elements include shared assessments and care planning, which have the potential to reduce duplication and improve co-ordination of care. There is potential for alternative approaches to workforce and traditional roles – for example, having more generalist or flexible roles. Some approaches are commissioned jointly by the local authority and the CCG. The important elements are that working together enables care that is focused on meeting all of a person's needs

Locally, an integrated approach could open up the possibilities for a career pathway for workers within the organisation that they work for and putting in place suitable packages of remuneration to acknowledge differing skills and workloads within the career pathway, providing better parity with Health.

'The effectiveness of new care models is very dependent on whether those implementing them really understand that they are about new models and not about organisational re-structuring.'

6.2.4 Assistive Technology
While some new models, such as technological adaptation, may be considered to have potential to reduce demand or usage of formal care services, there is little evidence to date that this is happening. Cost saving may be an unrealistic aim of some or all new models of home support, particularly if home support budgets are considered in isolation and in the short term.

While there are multiple examples of technologies and tools that may be very effective at promoting independence, preventing falls and helping to manage risks, the impact these have on changing the approach to statutory home support services is limited and there is a question about the extent of demand for them. These technologies do not remove the need for care services. They should be viewed as an enabling tool for care workers and service users where new ways of working have been developed, as a preventive tool and in supporting informal carers.

Issues with assistive technology include a lack of ongoing support for the use of the technology, inappropriate choice of equipment for personal capabilities and circumstances at the assessment stage, and a failure to keep its use under constant review.

Home automation and advanced telecare: A home automation package, including a light path that comes on when someone steps out of bed, gas and smoke sensors, fall alert devices, alarms, and 24/7 remote telecare call centre assistance. An evaluation found that it contributed to a reduction in falls, reduction in hospitalisation, reduction in depression, and carer productivity (Carretero 2014).'

Locally this will need a two pronged approach and would be dependent upon the robustness of the existing digital infrastructure. A locality based approach could facilitate implementation to address differing infrastructure requirements.

Carer marketplaces
Examples such as SuperCarers and Care.com aim to reduce cost and promote consumer choice by linking self-funders directly to individual care workers. Care.com is in part funded by Google Capital and also operates across childcare, petcare and cleaning, among other sectors. They may offer greater choice and cheaper service provision. However, these are introductory platforms that do not provide services directly and are not CQC registered.

To facilitate development within the district time and support would need to be put in to developing the PA market and existing micro providers and supporting self-funders to access that market with confidence. This is out of scope of the re-tender but could work alongside it.

6.3 National Good Practice/ Examples

Wellbeing teams in Calderdale and London. Equal Care Co-op[26] is an example of a company who is working to set up wellbeing teams working in circles of support. Equal Care first established in London and have been placed on the Home Support Approved Provider List in Calderdale where they now have established an office base and presence

Outcomes-based commissioning in Wiltshire: Wiltshire is an example of a large-scale change in commissioning approach, which involved reducing 90 individual contracts worth £14 million to eight outcomes-based contracts with four providers worth £11 million. Wiltshire's **Help to Live at Home service**[27] is an outcomes-based model for commissioning domiciliary care with payment-by-results on rehabilitation. Since its launch, it has enabled the council to place fewer people every year in long-term care and to make significant financial savings

Systems thinking in Gwynedd Council
Systems thinking considers systems as whole entities, rather than looking at their individual components. This enables complex relationships and their effects to be examined. Applying systems thinking approaches requires a fundamental shift from thinking in a step-by step, linear way to a circular, more holistic way that views complex problems as interrelated. Gwynedd Council[28] introduced systems thinking to develop a new way of working in 2022 with a 5 + 4 year contract. It has taken up to 6 years to develop and change prior to implementation and were supported by Vanguard Systems Thinking

Carer Marketplace in Devon
Devon have developed Humans of the Peninsula[29] which aims to connect people to join their dedicated network for both paid and unpaid opportunities to support people throughout the Peninsula to make life a bit better for everyone. Tasks advertised are such as clearing the fridge, shopping, looking after the home such as cleaning and laundry, paying bills, cooking, giving people prompts to take meds, making appointments and providing companionship, all to ensure a person's wellbeing needs are met, so they can remain well in the community. This project has been built up during the pandemic capitalising on the interest in volunteering opportunities during that time.

Helen Sanderson in Leeds
Leeds are implementing the Helen Sanderson teams model and also moving away from a finance model to try and have a flexible service – they will be piloting something soon. Leeds are looking at annualised hours, so people can have flexibility through a month. Also integrating with district nursing so may take on some preventative visits. May also pay provider as a team rather than hours. Leeds has taken 2 years of planning and pilots to reach this stage in implementation whilst having support from the Helen Sanderson organisation.

Isle of Wight Personal Assistant Initiative
Personal assistants (PAs) can enable people to be more independent and in control of their lives. The Isle of Wight Council has worked with partners to establish a personal assistant market that is well placed to support residents in their own homes and reduce avoidable admissions to care homes.

The council has used PAs[30] to avoid and reduce care home admissions by increasing the number of PAs across the island, focusing on rural localities whereby historically home support capacity was limited and resulted in care home admission. Providing training to PAs to support complex needs, for example, manual handling training, meds training etc Implementing a specific PA scheme related to support hospital discharge

[26] https://www.equalcare.coop/
[27] https://www.local.gov.uk/adult-social-care-Wiltshire's Help to Live at Home service.
[28] https://www.gwynedd.llyw.cymru/Adults-and-older-people/Home-Care-Project.aspx
[29] https://www.humansofthepeninsula.co.uk/
[30] https://local.gov.uk/isle-wight-personal-assistant-hospital-discharge-initiative-and-pa-hub.

to home and in addition utilised PAs to support crisis situations in the community whereby care home admission was often the default position.

6.4 Regional overview

Yorkshire & Humber Region
The Yorkshire and Humber [31] meeting in March 2022 captured the regional position for local authorities and where each of them are in the commissioning process with regards to their immediate area. At the time, 8 out of 15 Local Authorities in the Yorkshire and Humber are recommissioning their Home Support in the next year. Some discussion was held about the differences across each area and the number of providers that work across different local authorities.

Barnsley are looking to do a joint cost modelling for a flat rate or bandwith

North Lincolnshire have a base rate with rural and complex additions but welcome consideration of a regional contract. They are also looking to increase technology usage

Leeds are moving away from a finance model to try to have a more flexible services with consideration of annualised hours and integrating with district nursing to take on some preventative visits. Also considering paying providers as teams not hours.

Rotherham are looking to undertake a joint contract with Health. Looking at a flexible model, particularly around a trusted assessor model to increase capacity and the ability to decommission care packages

East Riding looking at a large open framework with an ambition to move from task and finish to outcomes based that supports the market

North Yorkshire are moving from an approved provider list linking in PAMMS work and outcome based approaches

Sheffield looking towards a locality based model and piloting neighbourhood and outcome based work

York have an outcome based specification and rapid service in place that is not able to expand with providers who are stretched and some leaving the market

Kirklees have moved to a principal provider per neighbourhood with that one having 70% of the market

Wakefield
The local authority Commissioners proposed a transformational contract over several years which would allow flexibility to adapt to a culture shift within the Council and Providers. Their Procurement team were positive; however, the legal team would not endorse the proposal which resulted in the team running out of time to deliver a step change. Two contracts were then put in place over short timescales to facilitate change every couple of years to get to the culture change envisaged.

Y&H ADASS Homecare Group
Suggestions have been made by the participants of the Y&H ADASS Home Care group about moving towards universal terms and conditions with basic standard clauses that are region wide to support providers whilst still enabling a tailored package that would work for individual authorities. This is being considered by the Y&H ADASS Homecare Group as a positive suggestion.

6.5 Internal Good Practice

[31] Yorkshire and Humber ADASS Homecare Group 22-23.docx"

6.5.1 Delayed Transfers of Care (DTOC)
Bradford stats are top in the country. Historically, Bradford Districts and Craven have low levels of delayed transfers of care (DTOCs). Bradford is ranked 7 nationally and 3 compared with statistical neighbours, with current performance at 3.6 per 100,000 population. The NHS England target is for Bradford to perform better than 3.8 per 100,000 for all delays. This has only been achievable by all parts of the system pulling together, but notably

- Pre-pandemic Bradford already had in place a discharge model that included Enablement Coordinators and Trusted Assessors which help facilitate a faster discharge.
- Bradford has the Bradford Enablement Support Team (BEST) an Outstanding in-house reablement team (BEST), and the Home Support Reviewing Team (HRST) which can both work with people effectively and then reducing packages quickly.

6.5.2 Localities
In the last tender, smaller service delivery areas were created to align the provision with internal operational localities. This aimed to expand the potential work pool by allowing for the recruitment of staff that may not drive from the local area and reduce journey time. Generally, the move to smaller areas has been welcomed.

6.5.3 Partnership working
There are generally good relationships across the system. The introduction of the Capacity meeting has helped bridge understanding across the system and Service Improvement Board and provider forums offer opportunity for dialogue with Providers. There have been a couple of 'Quick Wins' meetings where Providers have shared ideas which Commissioning has been able to develop, or their own good practice and innovations, in order to build resilience across the sector and BEST and Support Options have worked to 'group' packages together for Providers.

Some of the comments from the Qualitative Interviews include
- Change is already happening and there is appetite for improving further
- Co-production, partnership working and increased communication are the key areas teams are working on
- We have good foundations to build upon and expand on
- There is recognition that change will not happen in isolation and teams are ready to take further steps into co production
- Co-location has been very positive for understanding other team pressures

6.5.4 Community Led Support in Bradford
Community Led Support seeks to change the culture and practice of community health and social work delivery so that it becomes more clearly values-driven, community focused in achieving outcomes, empowering of staff and a true partnership with local people. It has a person-centred flexible support service which supports people to take control of their lives, and do the things they want to do. Ideally working closely with the people they support, their families and carers to deliver a wide range of supported leisure, learning, and employment opportunities.

6.5.5 Providers' response to Covid and DTA
Providers have been tested significantly since the start of the pandemic, taking on short term support packages and supporting discharge to assess model.

6.5.6 Recruitment and retention
The Bradford Workforce Strategy
Skills for Care is a workforce development body that the Council has commissioned to undertake the Bradford Workforce Social Care Strategy. The aims, key priorities, and objectives of the Bradford Workforce Strategy are detailed in the pdf document below.

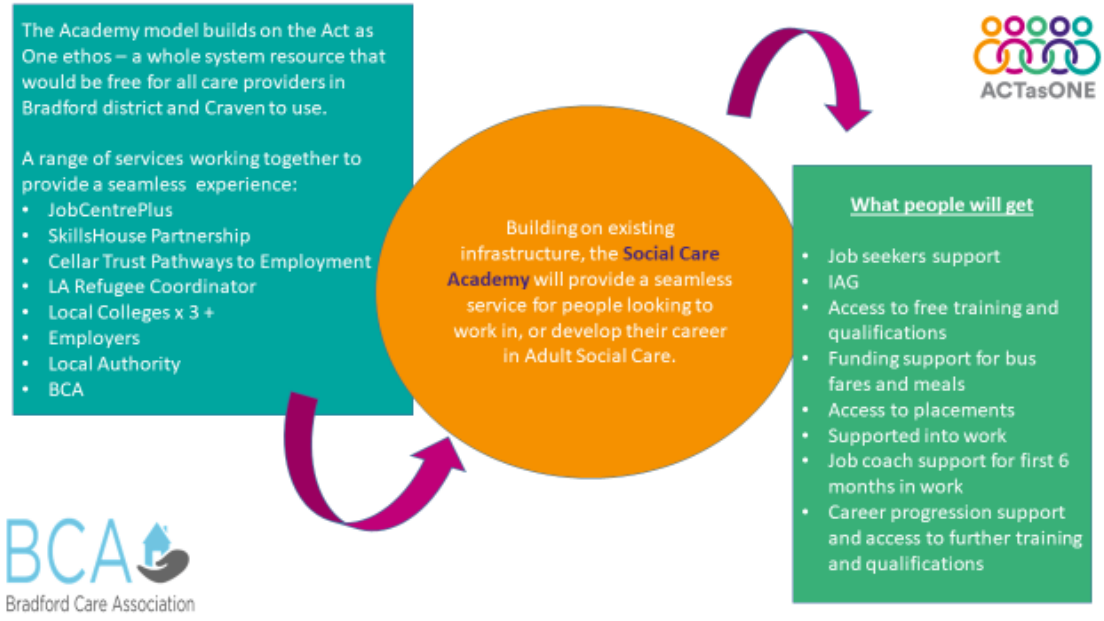
Bradford Workforce Strategy .pdf

Advertising Strategy
The Council have employed various methods of advertising to support recruitment in the adult social care sector.

- The Council have distributed leaflets and posters encouraging people to join the adult social care sector to local units across the Bradford District to support recruitment in local areas.
- The Marketing and Communications Team, for the Health and Wellbeing department, are making magnetic car signs that will signpost individuals to job vacancies, i.e., the Bradford Cares Website. The magnetic car signs will be attached to Council vehicles used for social care.
- The Council are using master adverts to advertise vacancies in adult social care. Previously, managers were responsible for advertising vacancies for their own service area. Master adverts filter vacancies by job role, rather than service area. For example, the Council may advertise a vacancy for an Enablement Assistant. The advert will list the service areas that are recruiting for an Enablement Assistant, as opposed to each service area advertising for an Enablement Assistant. Master adverts are being used to streamline the job hunting and recruitment process.
- The Council are arranging for ambassadors to visit schools and speak to students about career pathways in social care. Students will have the opportunity to learn about the benefits of working in social care.

Social Care Academy Model
Initiatives to support recruitment and retention are being planned ahead of autumn and winter when service pressures are expected to increase. The BCA are working with the Council to develop a more strategic approach to recruitment.

The Social Care Academy model was built on existing projects and infrastructure. The flowchart below lists the range of services working together to support recruitment and the ways people are being supported with job hunting and career progression opportunities. The model intends to encourage students and young people to join the adult social care sector by making access to training, qualifications and work placements more convenient. There is opportunity for more funding into the Social Care Academy as a result of the Prince's Trust £40,000 grant.



The Bradford Cares Recruitment Portal
The Bradford Cares Recruitment Portal was developed by the BCA and the Council to allow the Council and independent care providers to advertise their job vacancies and inform individuals interested in working in the adult social care sector of the variety of jobs available.

Independent care providers, who are BCA members, can contact the BCA admin and request a job vacancy form. The provider will complete the vacancy form and return to the BCA admin. The BCA will add the vacancy to the job portal and update the provider if they have success with recruiting using the Bradford Cares Portal.

Bradford Cares offers a streamlined approach to recruitment and job seeking as it helps match job seekers with care providers who have job vacancies.

The Bradford Cares Recruitment Portal can be accessed using this link: https://bradfordcares.co.uk/

SkillsHouse Jobseeker Pathway
Jobseekers are encouraged to contact SkillsHouse. SkillsHouse will provide the job seeker with an application form and support them with completion. SkillsHouse use value based recruitment to assess job seekers and ensure only appropriate applicants are chosen. Jobseekers are directed to the relevant job seeker categories based on their experience and their interests in care work. Job seekers are expected to complete the recruitment pathway, by following whichever route into social care that is best for them. SkillsHouse will support job seekers with completing of the Care Certificate. SkillsHouse will ensure that applicants are fully understand what is expected of them as part of the recruitment pathway.

The different job seeker categories can be found in the flow chart below.

6.5.7 Quick Wins

We invited members of the Service Improvement Board for the Home Support Services alongside internal colleagues, to discuss ways the council can support providers over the winter period with packages coming out of hospitals, whilst recruitment and staffing is challenging.

There were a number of suggestions brought forward, and providers were asked to prioritise those which they felt would be the most beneficial and achievable. Successes included, parking passes for Home Support staff (on par with District Nurses), access to volunteer –driven 4X4 vehicles for emergencies and sharing of staff benefits

7. Proposals for New Ways of Working

Below are 4 new ways of working which draw on the research detailed in section 6. These are not mutually exclusive, for example self-governing teams will need to be community-based, utilising a strength-based approach to support.

We need to be brave, we need to think long-term, we need to trust

7.1 Self-Governing Teams

These are self-managed teams that focus on person-centred care and supporting people in their communities, inspired by the Buurtzorg and Helen Sanderson approaches as detailed in section 6.2.1.

It is a move away from time and task to more outcome – based results therefore also incorporate Outcome Based Commissioning detailed in 6.2.2. as well as a Community Led Support approach. It will involve a substantial culture change for Providers but also Social Workers with a view to working to outcome focussed care and support plans.

Potential Features	Potential benefits
Small, self-governing teams which are neighbourhood based	Increased staff retention- more valued/ trusted, guaranteed income, set hours
More emphasis on developing self-care, community links, unpaid support, AST before delivering personal care.	Reduction in budget Security of Hours
Consistent, recognisable staff.	Better outcomes for people.
Builds on CLS approach	More personal and person-centred
Move from time and task to outcome based	More flexible and able to respond to quickly

Move to permanent contracts/	Could everyone have some level of reablement?
Shift patterns (no split shifts)	Staff more valued/ trusted – staff retention
Utilise non-drivers.	Opens up recruitment pool.
	Job Security

Note – the benefits are not necessarily aligned to the features

7.2 Integrated Teams

- These would be based in the community and be more integrated with Heath and Social Care Teams as detailed in section 6.2.3
- This could range from working more closely with Social Workers and/ or co-location to fuller integration with Health colleagues
- These Locality boundaries are (for the most part) running close to Area Team boundaries and could be potentially mapped against Primary Care Networks.

Potential Features	Potential Benefits
Build on 5 Area team Localities and/ or 12 Bradford and District community partnerships	Better experience for Service Users/ continuity of care
Co-locations	Fewer complaints and requests for new provider.
Joined-up, holistic approach.	Reduced staff turnover
Better links in to VCS and informal networks	Reduction in commissioned support
Reduced travel time.	Bigger pool of potential workers
Utilise non-drivers.	
Established providers with a good knowledge and links to the local area	

Note– the benefits are not necessarily aligned to the features

7.3 Skilled workforce/ career of choice

This is reimagining the workforce so that the Home Support staff can be skilled – up/ specialise in different areas.

Potential Features	Potential benefits
Career progression/ opportunities within smaller teams	More attractive to potential staff
Specialities: range from domestic, personal care and healthcare*	Care priming market for Health

Apprenticeships	Better retention
Different rates of pay/ better remunerated	More esteemed career More Skilled Up workforce

Note– the benefits are not necessarily aligned to the features

7.4 Technology

This is the incorporating elements (or more) of that detailed in Assistive Technology at 7.4

Potential Features	Potential benefits
ECM	Greater independence for Service users
Info sharing	Reduced spend – fewer calls Don't have to keep telling the same story
Telecare	Prevention, early intervention when trends show intervention required and greater independence for the service user. Increased peace of mind for the family
Assistive Technology/ Technology Enabled Care (TEC)	May be less intrusive Free up staff time

Note – the benefits are not necessarily aligned to the features

8. What is our appetite for change? Feedback from DMT

A workshop was held with DMT. As part of this, an exercise discussing what was in scope/ out of scope took place, with some clear and some still to be explored.

There was also a lot of appetite for the above new ways of working, and a high-level prioritisation exercise was completed which indicates when different aspects of the models should be rolled out. This will be considered in the next stage.

9. Next Steps

Model Development

- Discussions to be held with other Commissioned Areas to develop a firmer picture of services in-scope (or in principle)
- Commissioning to bring back a firmer proposal to DMT to include:
    - Outline plan and model
    - Recommendations for contract type
    - Options Appraisal re procurement
    - Risk and Issue log
    - Decision logs
- Dependent on commitment and resource from all partners

10. Authors and Approvers

10.1 Author Alex Lorrison, Jacqui Turner, Rominder Dhothar
Date: 18/08/2022

Appendix 1
Consultation themes from 1 to 1 meetings with managers across the system

Key Positives

- Change is already happening and there is appetite for improving further
- Co-production, partnership working and increased communication are the key areas teams are working on
- We have good foundations to build upon and expand on
- There is recognition that change will not happen in isolation and teams are ready to take further steps into co production

Issues/theme	**Detail**	**How we can mitigate/solve/address**	**Issue Area – Hospital/ Procurement/ Commissioning**
Flow of patient journey	Challenges throughout the whole system Patients are being discharged from hospital to make way for those who are waiting to be admitted and can sometimes risk being readmitted Patients being discharged to BEST and they are struggling to then make space by discharging in to the provider market	Solution is system wide and will be impacted by all the measures put in place to address issues noted below	System wide
Locality Contracts	Providers are unable to take 100% of the individuals due to staff capacity Restricts choice for individuals about providers Challenges if there is a provider breakdown Been propping up with layers of additional contracts Providers given locality contracts where they do not usually have a presence Larger companies are finding it difficult to enter the market	Move from locality with only 1 provider and consider a shared option of 70/30 or other so providers can flex between each other in the locality areas or a provider in one area and neighbouring localities can provide for the 30% Ensure providers can demonstrate the positives of their local presence or an ability to be locally present and able to meet demand within a set timeframe – this becomes easier with a shared locality Move from legacy contracts to new provider contract – can only be done quickly and efficiently if we get the capacity and flow right Work closely with provider market to keep stability and	Commissioning – tender, tender questions and specification clauses Some input from Procurement and Legal Consultation input from providers Input from SW and BEST re assessments to transfer to the new providers

Issues/theme	Detail	How we can mitigate/solve/address	Issue Area – Hospital/ Procurement/ Commissioning
	Smaller companies are struggling to meet capacity demand Too much change causes instability in the provider market due to staff uncertainty Providers can go in to default with few to no consequences as the tender process is considered lengthy	capacity in place during any transitions - need to work within the legal and procurement framework when doing this Will all individuals need to be assessed to transfer? If staying with same provider no assessments and prioritise those who will be changing, BEST assessment will sufficient for transfer. Will need to consider procedure and SW message needs to be rigorous We need to take action when providers go in to contract default in a timely ways	
End of Life Pathway on Discharge from Hospital	Discharges from hospital for end of life care are sent to providers who are not able to navigate the fast track pathway resulting in additional assessments and poorer care for the individual BEST not always being able to pick up in the 4 hour guideline	Providers to liaise closely with BEST to work together to move the individual to the fast track service using the OT specialist within the BEST team Reviewing the discharge process and potential for co-producing internal standards to work too https://chshealthcare.co.uk/	Commissioning with specification clauses for working with BEST and developing knowledge and links to the Fast Track service
BEST – flow and capacity issues	struggling to be able take cases from the hospital and at the other end to move people on in to home care providers Receiving inappropriate referrals eg UCR for Mental Health support or for where enablement element not required which takes time to redirect	BEST to be fully staffed A flexible STEP contract or clause in specification to step up and step down for BEST peaks and troughs. Better flow would resolve this too Communication and training across the teams to raise awareness and understanding of appropriate referrals and pathways to ensure better patient care and support	Commissioning with Specification communication ??
Hospital Discharge and BEST	BEST not picking up packages quickly enough for the hospital BEST finding the hospital delays to be challenging for pick up	Co-location has been very positive for understanding other team pressures Trusted assessor model works well in Bradford and would be a solid base for co-producing internal standards for discharge	Hospital and BEST collaboration Can we do capacity modelling?

Issues/theme	Detail	How we can mitigate/solve/address	Issue Area – Hospital/ Procurement/ Commissioning
	Hospital teams not joined up which can cause pressures with clunky discharges Discharge on pathway one is the biggest challenge for hospital (now moved to home first model but old pathway one cohort still a challenge) Hospitals putting people where there are spaces and this results in poor care	pathways which could include discharge slots East Lancs have a set number of slots each day for discharge and patients get booked in and suggested as potential model to adapt	
BEST and Existing Packages	On discharge BEST will take on the whole package as enablement even if they had an existing package before Providers are not taking back the original package, particularly if they are unable to accommodate an increase	Consider split packages between BEST and provider during enablement process with option for BEST to step down and provider to step up where appropriate to maintain continued support for the individual	Commissioning through specification clauses Closer collaboration with BEST and Providers
STEP Contract	T&Cs do not have any enablement aspects and positive outcomes are not as high as BEST Links with flow – BEST had capacity issues so STEP introduced who had capacity issues and home care introduced	Assisted Lives do good partnership working with BEST – pull this in to future contracts Specific clauses around working in co-production with BEST, consider areas of co-location for specific points during the transfer of the individual to a STEP service Consider if STEP service should be additional step up step down service or built in to the main contract. How much is required if BEST is not carrying vacancies BEST OT assessor will facilitate a more timely ability to move person on to a chargeable service after enablement has finished	Commissioning and procurement – T&Cs and Specification, tender questions BEST, in particular OT assessors

Issues/theme	Detail	How we can mitigate/solve/address	Issue Area – Hospital/ Procurement/ Commissioning
S243 – changes to packages and cessation of packages	Currently no incentive to work out issues prior to provider breakdown Providers submitting S243 increases months after they have commenced and requesting backdated payments S243 increases in provision being paid for months without an assessment occurring Support Options spending a substantive amount of time to unpick issues each week and to check backdated payments which could be utilised more effectively to reduce other pressures within their team	Put in place processes that incentivise open communication and trust to resolve issues when first raised SW to work proactively to support individual and provider communication and manage expectations of call times BEST dedicated OTs to carry out rapid assessments to approve increases to packages Cease backdated payments for increases due to late submission of S243 by provider Having staff who are reflective of communities and who are culturally capable and supportive	Commissioning through specification clauses Procurement Communication with providers and SW to support resolving of issues at first instance Collaboration between BEST and providers
Communication and understanding of roles across teams	Teams along the whole system – know their area but not clear on what it available from other teams in the process Area highlighted - Inconsistent messages from SW and lack of understanding on their part about how their decisions impact on other teams	Co-location Co-production Work shadowing Central hub for information and sign posting available across the whole system	Hospital BEST Providers Commissioning Contracts Procurement
Providers	Hospital retainers being paid but not taking person back, especially if there is an increase Being able to step up and step down support to react to a temporary situation eg urine infection Recruitment and retention issues for provider staff	Suggestion of considering Time Out model of annualised hours to support step up and step down situations Look at fair cost of care and providers signing up to Ethical Care Charter Potential for exploring mix of contract types for provider staff to improve staff retention including shift work	Commissioning specification and T&Cs clauses Procurement Providers

Issues/theme	Detail	How we can mitigate/solve/address	Issue Area – Hospital/ Procurement/ Commissioning
	Providers do not have the capacity to be agile and responsive to rapid response packages or taking packages out of hours		
Providers and Home Care Tasks	Home care contract delivering for social inclusion, shopping, cleaning etc. and we are unable to establish how much of the contract is delivering this type of work – packages that include these types of tasks mask the true picture of positive outcomes for enablement Providers are cherry picking contracts that they have staff skills to deliver so more complex packages are not always picked up in a timely manner as providers do not always have the skill set available to deliver that support	Consider additional payment lines on ContrOCC to enable analysis of support types – will require SW to ensure they select the correct payment lines when inputting a package Split costs for differing levels of skills within the contract Enabling requires longer to carry out than doing for and will need to be addressed within call times Need to skill up providers to undertake more complex work or support health for enablement packages	Support Options Commissioning Providers
Staff recruitment across Providers BEST and Health	Some staff are moving from one sector to another as the opportunities for career progression are limited by the current time and task model	A more holistic view of career progression and training to undertake different types of tasks within sectors could increase the opportunities for individual staff within areas to flex up and down to roles that are a good fit with their ambitions and skill sets. Eg training workers to take bloods and increase pay in line with skills	Providers Commissioning Hospitals Health BEST
Support Options and BEST brokerage systems	Have 2 brokerage systems BEST contact the providers to place enablement packages and push the packages towards them Support Options place packages on Connect to	Review the two systems to work out how they can be streamlined to work in partnership and reduce potential for provider issues	BEST and Support Options

Issues/theme	Detail	How we can mitigate/solve/address	Issue Area – Hospital/ Procurement/ Commissioning
	Support for providers to pull packages		
Support Options	constantly first point of call for queries	Set up a central information portal for FAQs to reduce the amount of queries and recurring queries	Support Options Commissioning for sign posting

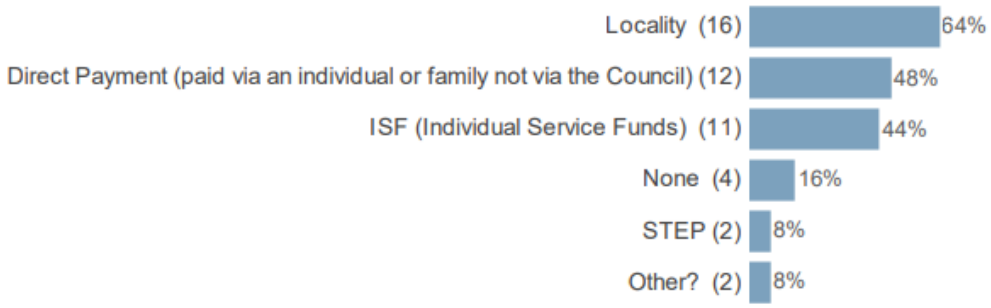
Appendix 2

Home Support Survey Summary - Providers

The survey was sent to all providers currently delivering Home Support for Bradford via the Commissioning Inbox on 10 June 2022. A reminder was sent on 17 and 20 June. The Bradford Care Association also circulated the email to provider encouraging them to respond to the survey. **The closing date for responses was 6pm Monday 20th June**

There are currently 82 providers who deliver services for Home Care and we had 25 responses giving a 30% response rate. The survey was designed so that it could be anonymous but allowed for details should anyone wish to put themselves forward to be contacted further and 16 providers left contact details.

What type of Home Care contract(s) do you hold or deliver in the Bradford District? (please tick all that apply)

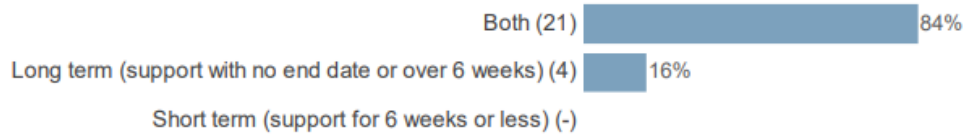


Please specify

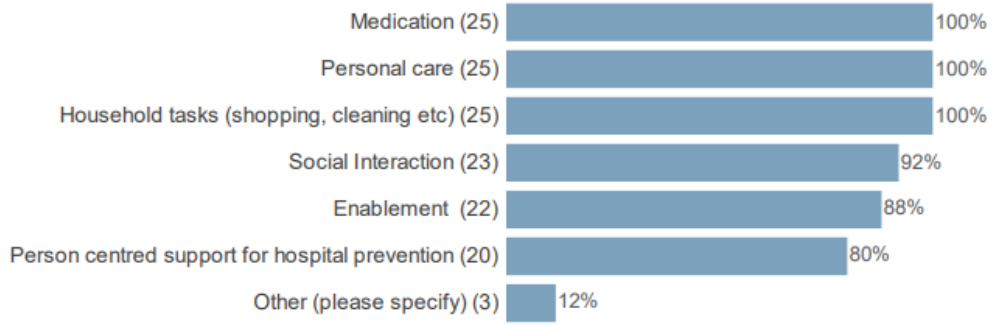
CCG

isc's for individuals

What length of support do you deliver?



What types of support do you deliver? (please tick all that apply)



Companionship

Respite care, companionship

complex care

Outside of workforce, what are your biggest challenges?

Challenges	Biggest challenges	Top two
Organisational costs/overheads	**4**	3
Family intervention in care eg giving medication	**1**	
Staff pay	**1**	3
Compliance with red tape/recruitment	**4**	2
Recruitment	**5**	6
Digital Innovation	**1**	1
Location of calls	1	1
Fuel costs/ cost of living	7	6
Accurate information from Bradford colleagues	4	2
Consistency of SW	1	1

Specific areas that have been highlighted as issues around working practice are

- Family intervention, sometimes meds are given before care staff arrive so the Dossette box has an empty slot which we have to then chase to find out why which is time consuming
- Setting new employee quickly so they can join the team
- getting correct and accurate information regarding potential residents
- Chasing payments with Support Options
- poor hospital discharges
- dates for transfer not being passed on to the various agencies people who need to know
- Assessment with inaccurate or out of date information.
- not recognised by Bradford Council in comparison to the bigger companies
- having a regular social worker for people being supported if their needs change.

Specific areas that have been highlighted as issues around the contract are

- Travel and location of calls
- Voids in properties in areas that are not desirable to people looking at vacancies
- Not having a contract with Bradford Council
- lack of support from the council
- Processes of tendering for small businesses
- lack of information and direction provided to care providers who are not on the Bradford Council framework

What is working well?

Working Well	Biggest impact	Top two
Carer/service user relationships	4	3
Internal team working	6	4
Staff and staff retention	5	4
Investing in staff - training and career pathway	5	6
Digital solutions	4	4
The geographic placement of packages	3	1
Recruitment	2	2
Support from Bfd	3	1
Staff pay	1	

Specific areas that have been highlighted around supporting staff are

- Training programme - New in house programme specifically designed for our company
- We have invested in a career pathway that provides front line staff the opportunity to develop within the business
- Staff on line training

Specific areas that have been highlighted around digital solutions are

- Electronic systems e.g. real time care records and training platform.
- Care management app, electronic system is going well, as contributes towards making the service more effective
- Technology has made life easier using mobile Apps

Specific areas that have been highlighted around the Local Authority are

- The geographic placement of packages
- Communication with the local authority regarding adjustments and reassessments
- Working closely with Best and the professionals - sometimes they do understand our predicament

It is recognised that workforce is one of the most pressing issues generally for Home Support, what do you feel are the specific challenges you have encountered recently in this area?

Specific Challenges	
Recruitment	12
Pay	8
Cost of living	8
Non drivers	4

The biggest issue identified is the recruitment of staff and the barriers of unsocial hours, low pay and the rising costs of living that are affecting the ability of staff to use their own vehicles due to the rising fuel costs. One provider has mentioned they have been subsidising the cost of petrol for their employees

Specific areas that have been highlighted are

- People not wanting to join care and not being able to drive
- Petrol costs - staff threatening not to use their cars for work
- There is no integration on the frontline between health and social care
- Staff continue to feel undervalued and second class to NHS
- Recruitment in Bradford is the biggest challenge and there is little support from the Commissioning team, apart from pressure
- inability to recruit staff who can drive
- Non drivers applying for driver roles