Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 4 September 2018

Subject: Our Manchester Homecare

Report of: Executive Director Strategic Commissioning and Director of Adult Social Care

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Summary

Our ambition is to put personal care at the heart of care - to be more flexible, to be able to deliver agreed outcomes that are better for the citizen. We'll get out of the way and trust providers to get the job done, while making sure we have checks and balances so we can make sure our residents are safe. We'll have a relentless focus on spotting the 'not quite right' early - those issues that have the potential to require escalation or threaten outcomes for the recipient of care.

This report describes a proposed new model of homecare – 'Our Manchester homecare'. In order to achieve our ambition, it is important this model meets the needs of people who use our services and help support family carers. The new model is therefore:

- focussed on the outcomes that matter to people
- strengths based, starting with the positive what people can do for themselves and supporting people build or maintain skills and confidence
- place-based: matched to the footprint of Integrated Neighbourhood Teams
- centred on continuity of care: the top priority of people using homecare
- predicated on building a trusted partnership with homecare providers

This report sets out the key current issues for our homecare recipients and providers and explains why the existing model needs to change. The new model of homecare will go out to tender later this month.

Recommendations

Committee are asked to endorse the proposed new model of homecare for the people of Manchester.

Wards Affected: All

Alignment to the Our Manchester Strategy Outcomes (if applicable)

Manchester Strategy outcomes	Summary of how this report aligns to the OMS
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	
A highly skilled city: world class and home grown talent sustaining the city's economic success	This service will drive the development of a more highly skilled workforce which can progress through the health and care system
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	The new Our Manchester Homecare service has a strong social value strand, focussed on recruiting local people and building on their skills and knowledge and those of people using the service
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

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Background documents (available for public inspection): None

1.0 Introduction

1.1 Homecare plays an important role in enabling people to live in their home for as long as possible. It offers a preventative approach for people to keep healthy and have a fulfilling quality of life.

1.2 Manchester has always been proud to be ambitious; unwavering in its commitment to help those who need an extra helping hand. This was evident in our commitment to uplift our fee rates and ask our homecare providers to pay their workers the real living wage from April 2018.

1.3 Manchester has always been proud to think big - and on the big challenges facing our society, we're taking big steps to improve outcomes for our residents. One of those challenges is home care.

1.4 Most home care is delivered by private or not-for-profit organisations, not councils; though councils pay for support for some people, depending on their needs and their financial situation. It supports people to remain independent in their own homes and helps people with day-to-day activities like getting up, washing, dressing and eating.

1.5 However, it's more than just the sum of its tasks. It gives people **dignity** and helps them to stay in their own homes, living their own lives. In all the discussions about the reform of adult social care, we should never ever lose sight of the human impact it has for people.

But it could be so much more. We could do so much better. And that's a challenge we should seize with both hands.

1.6 This report sets out a new model of homecare - Our Manchester homecare. The report starts by setting out the key current issues for our homecare users and providers and explains why the model needs to change. The report summarises feedback from homecare users, which has helped shape the design of the new model, alongside extensive engagement with homecare providers, health and social care professionals and frontline care workers, we have also included our commitment to the Ethical Care Charter, expecting providers to offer the real living wage to staff as well as ending zero hours contracts, where appropriate.

1.7 The scope of the new model includes the homecare provided to Manchester residents, we are also taking this opportunity to include residents living in Extra Care schemes and in a second phase we are aiming to include those who qualify for NHS Continuing Healthcare (NHS CHC) funding. The intent is the services will work with and in cohesion with MLCO. This allows us to look at how future services may be delivered as the MLCO develops.

1.8 As part of this procurement we are adding in a requirement for homecare providers to offer a sitting service for carers, paid for through either carers

budgets or personal budgets, via prepaid cards. We are also signalling a forthcoming pilot on Supported Early Discharge from hospital, which aims to guarantee a number of hours of homecare in each neighbourhood, starting in the North, to help people to come home from hospital quickly.

1.9 As we are now in the immediate pre-procurement phase for this service, this report focuses on the high level design of the service, rather than the detail of the commercial, financial and contracting model.

1.10 Our current expectation is that the contract management and future commissioning of homecare will transfer to the Manchester Local Care Organisation by December 2019.

2.0 Background

2.1 *What is homecare?*
Homecare is support and personal care which helps people remain living independently in their own homes. In general terms, care workers go into people's homes and provide support with a range of activities such as helping people get up, have a wash, get dressed and go downstairs. Homecare workers help people prepare food and drink and other activities to facilitate their daily lives.

2.2 Homecare in Manchester is delivered by a range of organisations of different sizes, some private sector companies and some not-for-profit organisations. We currently have a framework of 9 providers and spot purchase from a further 11. We have been operating the same model since 2008.

2.3 During the design phase of the model we undertook a wide range of engagement with public and partner organisations, one of the key pieces of work was the development of detailed data base which enabled us to understand the physical health of individuals in the neighbourhoods but in particular what was causing the most breakdown in packages of care.

2.4 NHS CHC homecare is essentially the same service, funded and commissioned by the NHS on the basis that someone has a primary health need.

2.5 Extra Care homecare is also the same core service, however rather than in peoples own homes this is delivered in one of our Extra Care schemes. Extra Care is retirement housing for people aged over 55. People can rent, own or part own their home within the scheme and use the onsite care provision. We currently have seven schemes in the city and have a programme to increase this substantially in the coming years. People in Extra Care have a mix of care needs or none.

2.6 *Who gets homecare?*
Using our data intelligence pack over the course of 12 months, we were able to determine that 2,700 people in Manchester use homecare commissioned by the Council. At any point in time around 1,700 people use this homecare, and:

- 30% have homecare for more than 3 years
- 81% are over 65 years of age
- People under 65 with a Learning Disability or a mental health issue can also be eligible for homecare
- 80% are white British
- 8.6% are Asian/Asian British (17.1% of Manchester population)
- 43% are supported by an unpaid carer
- 63% are women
- We do not hold complete sexual orientation monitoring information for this cohort (this will be a future requirement)

Around 120 people a year use NHS CHC homecare and 140 Extra Care homecare.

2.7 *What does it cost?*
The Council currently spends £16m a year on home care, the new model of outcomes based working, rather than time and task should enable us to be more efficient in our delivery model, as well as at the same time developing Extra Care and reablement. We are working with colleagues in MHCC to establish the detail of CHC costs and packages of care.

3.0 The case for change

3.1 Health and social care reform is critical to achieving the ambitions for the city, as set out in the Our Manchester Strategy. A progressive and equitable city means people living healthier and more fulfilled lives, with much reduced health inequalities across the city. A liveable and low-carbon city requires resilient places and communities where people can live and age well. A thriving and sustainable city needs a healthier population who are able to work and be more productive in work, with fewer people in poor health not benefiting from economic prosperity. Homecare currently exists in a bubble, with little connection to the wider health and care system, or to the wealth of community and voluntary activity in neighbourhoods which could improve people's social connections and quality of life. When something goes wrong for a person using homecare, homecare workers have no route in to 'the system' to get help or support.

3.2 Extra Care homecare and NHS CHC homecare are essentially the same service as core, or generic homecare and yet we procure them separately, pay different rates and ask for different information from providers, an unnecessary administrative burden both for commissioners and providers. Some Manchester residents will use all three types of homecare as their needs fluctuate.

3.3 The demand pressures on Adult Social Care are entrenched and widely known. The Government has recently consulted on changes to the Adult Social Care Relative Needs Funding Formula used for determining funding to Local Authorities which has been in place since 2005/06. The outcome of the consultation was expected to be released in the summer linked to the Green Paper regarding care and support for older people. It is now expected that this

will be delayed until the autumn and it will likely be 2020/21 before any changes are concluded. Manchester residents cannot wait for the outcome of government proposals before progressing with changes to the homecare model and an effective contract framework.

4.0 Recent developments

4.1 In April 2018 the Council agreed to substantially increase the rate paid for homecare from £13.50 an hour to £15.20. The Council placed a number of conditions on homecare companies in return for this uplift, including that providers should pay their staff a minimum of £8.75 an hour. Anecdotally, some providers have told us that this uplift has made "a massive difference" particularly in their ability to recruit under 25s.

4.2 This fee uplift appears to have, at least in part, helped stabilise the care market in Manchester, and gives us a platform to build on, to start to transform what homecare looks like, how it is delivered, and how we work with our providers to realise the opportunities offered by the integration of health and social care, place based working and the Our Manchester approach.

5.0 Designing a new model

5.1 *Methodology*
We began work on designing a new model of homecare by undertaking a thorough analysis of the people who use homecare, focussing on understanding which other health and care services these people use, how and why. This analysis has given us a deep insight into how effective homecare services have the potential to improve both the quality of life and, in time, the health outcomes of our homecare population.

5.2 The data only provides part of the picture. In designing our service model we have conducted wide and deep engagement with a range of stakeholders:

- people who use homecare and their carers,
- the voluntary and community sector,
- homecare providers,
- health and social care professionals at all levels, and
- other health and social care commissioners, in Manchester and beyond.

5.3 *What matters to people receiving homecare?*
We spoke to people who use homecare, their families and carers. We did this through 12 face to face interviews, 115 telephone interviews and a number of meetings and workshops.

"It works well when they send the same people and this is really important to me. The carers know me by name, they know where everything is and it makes it really easy to have them in my home"

5.4 We asked people to tell us what is working well, what is not working well and what is important to them for the future of homecare services. Across all of our engagement with homecare users, their carers and families, the same themes

came up many times. The feedback we received is summarised below, in the form of 'I statements':

- *Continuity of and quality of care*: I prefer the same paid carers to come regularly as this means I can build a good relationship with them, helping me to feel comfortable. I think of my paid carers as friends and enjoy having a laugh and a chat with them.

- *Reliable service:* with all of the time allocated to me, delivered. I want to know when the carer is coming and to be told if they are going to be late. I want to feel the carer has time for me and I'm not being rushed.

- *Knowing who to contact*: if I have questions or concerns about my care, if my needs change and to find out about other services, benefits, access to equipment etc.

- *Care planning:* I want to be involved in planning my care and for my unpaid carer and family to be involved too – not just at the start but all of the way through. It's my plan and each care worker who comes to my home should know what is in it.

- *Monitoring*: I want to be involved in monitoring of homecare services and so do my carer and family.

- *Personalised*: I want a service that meets my cultural and other needs: knowing what I like to eat, that I might speak a different language and have a particular lifestyle.

- *Training:* I want continuing training and development for paid care workers so I get quality service now and there is a potential career pathway for them.

5.5 *Data – what did it tell us?*
We have taken advantage of health and care integration to look at the whole picture for our homecare users. We have been able to match the records held in the Council's system Micare, with NHS numbers to understand, for the first time, what happens to people who use homecare in the wider health and care system.

5.6 We have used this data to build 12 neighbourhood profiles showing the demography of our homecare users and also their long term health conditions, the frequency of their hospital admissions, how long they stay in hospital and what the reasons are for their admission. This data has given us insight into the potential for a different kind of homecare to deliver a better experience for homecare users, as well as wider benefits for the health and care system.

5.7 Some of the key findings for our homecare population:

- 92% have one or more, and 76% have two or more long term conditions, such as high blood pressure and diabetes

- People who receive homecare are much more likely than the general population to go to A&E and to be admitted to hospital, going to A&E once every 6 months on average, being admitted to hospital once every 8 months on average and then spending an average of 14.8 days in hospital, compared to 4 days for the rest of the population
- Close to 1 in 2 are rated at high or very high risk of an ***emergency*** hospital admission
- The main reasons people are admitted to hospital are respiratory, genito-urinary and circulation problems
- One in five has a confirmed dementia diagnosis and up to a further one in five has been admitted to hospital with dementia related problems

5.8 *Using the data to engage*
We have taken this data and spoken to homecare users and families, homecare workers, professionals from across the health and care system. We have spent dedicated time with small and larger groups of homecare providers. We have used this engagement to first outline a future service model, and then to develop this model iteratively, as we have continued to engage.

5.9 *Learning from other areas*
We have spoken to and shared work with other homecare commissioners across Greater Manchester, learning from their approaches. Whilst there are many common features across the different models being employed in Greater Manchester, the Manchester model is highly distinctive, as it builds on how the city has chosen to progress health and social care integration at a place level.

6.0 How is the new model different?

6.1 The overall purpose of the new homecare service is to enable people to stay at home, living as independently as they can and with the best possible quality of life.

6.2 We also want to:

- Support unpaid carers in the valuable work they do
- Make home care a more attractive career option by improving conditions and career pathways, capitalising on the projected increase in the younger working age population in Manchester
- Improve the sustainability of the health and care system by making homecare an integral part of person-centred care, acting as the “eyes and ears” of the health and social care system, to spot when things aren’t quite as they should be, and take steps to make sure things don’t get worse
- Realise additional social value through this contract

6.3 *Key features of Our Manchester homecare*

6.4 The new model, and way of working, will move homecare away from the current rigid ‘time and task’ model, which describes for providers in detail how many calls they will make each day, for how long, and lists the tasks they will

perform. Instead, homecare workers will be given a “budget” of hours. They will plan with people how they will use these hours to help them achieve the **outcomes** which matter to them most.

6.5 In support of achieving these outcomes, the new service will take a **strengths based** approach. This will mean homecare workers working with people, to help them build or maintain their independence, not doing tasks for them, because it’s quicker and easier.

6.6 As set out in 5.4, homecare users have told us how important it is to them that they get to know their carers. **Continuity of care** also makes working towards outcomes and building on strengths much more achievable. The model depends on support being delivered through a small, core team of care workers, who are known to the homecare user and their family, wherever possible.

6.7 The new service will be properly **place based**. This means a true patch or area based model with providers taking responsibility for picking up all packages of care in their area, including where an Extra Care facility exists, the homecare element of this service, and, in time, NHS CHC Homecare. The neighbourhood ‘lots’ will map on to the 12 neighbourhoods agreed as the basis of health and care integration. Homecare providers and Integrated Neighbourhood Teams will be expected to build relationships, at all levels, facilitated by Link Managers. We are asking providers to have a base in the area they are working in and to focus on recruiting (very) local people to work for them.

6.8 Providers will be able to bid as a partnership or consortium and to **subcontract** some of their work to other providers. Together with a variety of lot sizes, this means this work will be open to a range of provider types and sizes - including those in the voluntary and community sectors. We will stipulate that Extra Care homecare must be delivered by the prime provider.

6.9 The new service will develop over time. Our ambition is to move towards a more **highly skilled workforce** delivering specified health and social care interventions, with appropriate governance and oversight. These interventions would be relatively low level, and will focus on those Long Term Conditions most prevalent among our homecare users and the main reasons they are being admitted after a visit to A&E.

6.10 Continuity of care should mean that homecare workers are constantly aware of the homecare user’s needs, and can identify when something has changed, when something is “not quite right” in their physical and mental health and escalate appropriately. Place based working will make the connections between homecare and the rest of the system stronger, facilitating this **escalation** process.

6.11 The new model is predicated on building **trust and partnership** between commissioners and providers. This means a much stronger role for providers in assessment and ongoing review and more freedom for providers to take

decisions with people who use homecare, without always needing to ask for permission. The new delivery model has a requirement for ongoing assessment woven throughout care delivery and the ability to flex, increase and decrease a package of care where necessary. This flexibility enables care to be focused and targeted as required.

7.0 Outcomes

7.1 Individual outcomes for people who use homecare will be agreed between the care provider and the care user (and their family/ carer/ advocate as appropriate). Over the course of the contract period we will work with providers to pilot and establish mechanisms for payment by outcomes.

7.2 The homecare programme will, as a whole, be expected to contribute to a number of outcomes and the providers will be asked to demonstrate how people, in receipt of the service have been supported to remain independent at home for as long as they are able to. This will be undertaken through robust contract management of the primary providers and MLCO.

7.3 We are also setting a number of service level outcomes, grouped below:

Home care population

- Improved overall satisfaction with home care services
- Reduction in avoidable use of acute services (as above)
- Reduction in number, and rise in average age, of admission to residential and nursing care
- Increased connection to community activities and reduced social isolation
- Improved quality of life

Carers

- Increase in the proportion of carers who report that they have been included or consulted in discussions about the person they care for (always, usually or sometimes felt involved)
- Reduction in carer breakdown

Homecare workers

- Improvements in satisfaction of workers
- Gaining qualifications
- Better career development pathways

Homecare providers

Improve the sustainability and quality of the homecare workforce, for example by:

- Increasing the number of apprentices
- Improving the qualification levels of staff (e.g. no. of staff with NVQ 2 & 3)

- Reducing staff turnover rates, particularly within the first six months of employment (either permanent or temporary)

Health and care system

- Reduction in avoidable use of acute services (as above)
- Reduction in number, and rise in average age, of admission to residential and nursing care
- Reduction in homecare hours

8.0 Personalisation and personal budgets

8.1 We are committed to commissioning services that deliver high quality personalised care services, where outcomes are achieved through the use of Personal Budgets (Individual Budgets & Personal Health Budgets). With the introduction of the Care Act in 2015 this approach was further reinforced, commissioners will work with the successful providers on how individual citizens can access care and support services in both Homecare and Extra Care settings using their cash individual budget, including through the use of prepaid cards.

8.2 A Personal Health Budget (PHB) is an amount of money to support an individual's identified healthcare and wellbeing needs, planned and agreed between the individual and/or brokerage service and the NHS. CHC recipients will have a 'right to have' a PHB, including direct payment. The use of personal health budgets is just one way in which the NHS can tailor services for people to enable them to have choice, control and flexibility over their care.

9.0 Finance and Cost Benefit Analysis

9.1 Across the MHCC Pooled Budget £16.5m is currently spent on homecare core (1,085,498 hours) with a further £1.9m on Extra Care (149,328 hours).

9.2 The latest financial modelling indicates that investment of £1.607m will be required in 2019/20 to deliver the new Homecare model, with a further investment of £343k in in 2020/21 and a further £253k in 2021/22.

9.3 Budget allocated for the national living wage increases will be used to meet £1.062m of the investment in 2019/20, rising to £1.395m in 2020/21. Further investment of £545k is required in 2019/20, it is being determined if this could be met from carry forward of projected underspend on the Adult Social Care grant in 2018/19. From 2020/21 an estimated £555k will need to be retained from savings to fund continuing investment into the model.

9.4 It is expected that over a three year period there will be savings made through bringing services into neighbourhoods, and no longer using the time and task model. The intent is to use part of the savings to re-invest into the model over time.

9.5 The new model of homecare is a strengths based model and we would expect the provider to work with us to improve the wellbeing of people and to reduce the hours of care for specific individuals. This is expected to deliver savings of £0.75m in year one which has been included in the approved budget for 2019/20 and a further £0.75m in 2020/21 of which £0.555m will need to be retained. The £0.75m saving each year is equivalent to 47,200 hours in 2019/20 or 4.3% of the budgeted hours.

9.6 There will also be a lower unit cost due to working in a neighbourhood and from improved retention of staff. Any further savings across Health and Social Care will be reviewed and captured as the scheme progresses, these will be reported in line with the evaluation process. However, as the MLCO matures along with MHCC joint commissioning intentions there is an acknowledgement that homecare is likely to increase as care moves from Acute setting to home based care.

10.0 Social value

10.1 Manchester's strong commitment to delivering social value through its procurement activity is reflected in the model for Our Manchester homecare. Many of the key features described above (investing in the workforce, local base and recruitment) are part of the overall ask of providers, rather than a separate social value 'ask'.

10.2 We will ask providers to demonstrate how they are already delivering social value and any additional measures they would implement as part of this contract. Some potential areas for realising additional social value through this contract are listed below:

- Environmental:
  -The neighbourhood model should decrease the amount of car travel necessary. Can visits be grouped to increase the number that can be carried out on foot, or by bicycle?
  - Can food choices and shopping support the local economy, reduce food miles and encourage new experiences through food?
  - Is recycling part of providers' business model and are there ways to increase recycling, reuse products or reduce single use products

- Economic:
  - Paying the Manchester Living Wage and ensuring this is promoted throughout the supply chain (including any subcontractors).
  - Recruitment practices which encourage people living in the communities where care is delivered to work as care workers, which gives a better cultural match, means people should have a good understanding of community and voluntary activity in the area, and reduces travelling.
  - Providing employment opportunities to people who have been unemployed for some time, particularly those in the city's priority groups.

- Social:
  - Connecting people using homecare to other services and people

- Using the knowledge and skills of local people, including homecare workers and homecare users to build connections and links in the local community
- Working with local voluntary sector organisations on joint projects

10.3 We have included some social value key performance indicators in the list of data we are expecting from providers.

11.0 Equality Analysis

11.1 We have completed an equality analysis on the proposed new model of homecare. Overall, the analysis found the new model would be likely to improve the service for groups with protected characteristics as it will be more personal, focussing on people's outcomes and goals rather than a set of generic tasks. Continuity of care will facilitate this personal, tailored approach. In addition, the requirement for providers to be based in local areas, recruiting local people means an increased likelihood that the service will respond to the diverse needs of Manchester residents.

11.2 The analysis did find a current issue in that most people using homecare are White or White British (80.0%) which is higher than the overall population (66.6%). The proportion of Asian / Asian British people using the service (9.4%) is lower than the overall population (17.1%) while the proportion of Black / Black British (8.1%) is similar to the overall population (8.6%).

11.3 As part of mobilisation work and ongoing service delivery, providers and Integrated Neighbourhood Teams will work together to identify individuals from under-represented groups eligible for homecare who would benefit from the service, focussing first on the lower than expected take up of homecare in the Asian/Asian British population.

11.4 The specification for the new service is clear that the city is ethnically diverse and is home to many communities of interest and identity and that in particular the city has a thriving LGBT community. This means that service providers must take account of our various communities when planning the provision of services, for example by recruiting staff from those communities and providing information to all staff on dietary, personal care and religious requirements.

11.5 The specification also signals that we are considering introducing an LGBT kitemark for care, which whilst particularly relevant in our forthcoming LGBT Extra Care scheme, is also relevant to the rest of homecare. Older LGBT people in the city have told us that they fear discrimination from care services.

12.0 Risks and dependencies

12.1 As highlighted above, the homecare market is fragile nationally and tender exercises inevitably bring some change and instability for a period. Much work has been done with providers over the past year to try to mitigate this risk, primarily the fee uplift described and also co-design and engagement work as part of the development of this service model. A provider event in July attracted around 70 attendees from 35 current, past and new providers.

12.2 The model described is predicated on interdependencies with a large number of other services and new care models which are also being developed. In particular, the success of Integrated Neighbourhood Teams is a critical factor in the success of the new homecare model. The successful implementation of the move to Liquidlogic will also have a significant impact, as will, over a longer period, the Manchester Care Record and an agreed model of Trusted Assessment.

12.3 Business cases for Assistive Technology, enhanced reablement and High Impact Primary Care assume that their successful implementation will lead to a reduction in homecare hours. Any issues for these projects will therefore have an impact on the new model of homecare.

12.4 Successful implementation of the new model will require ongoing work with providers and health and care services over a long period. We will need to work with MLCO colleagues to ensure this resource can be secured and maintained.

13.0 Next steps

13.1 The new model of homecare – Our Manchester homecare – will go out to tender later this month. Evaluation of the tender will be against a series of method statements and will involve users of homecare as full scoring members of the panel.

13.2 A detailed communications and engagement plan for the mobilisation of the contract is currently in draft. We are planning carefully how and when to communicate forthcoming changes to homecare users and others.

13.3 We are aiming to award the contract before the end of the calendar year before moving into an intensive period of contract mobilisation, with contract implementation starting from April 2019.