Bath & North East Somerset Council

Bath and North East Somerset Council
Home Care Review

A review by the Healthier Communities &Older People Overview and Scrutiny Panel

March 2010

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Contents

Foreword

When we issued our first press release at the beginning of November 2009, we really did not know exactly what response to expect. As ward councillors we had encountered isolated cases of residents receiving less than satisfactory care, in their view, and we were also under an obligation to redeem the Council's pledge to review the situation after the out-sourcing of the Council's provision for home care to five service providers, which make up the Home Care Strategic Partnership.

We were not clear how the home care system worked from the time that a need for care in someone's home was identified and a GP referral made or the discharge arrangements for an elderly person. We needed to understand how the process worked, how different agencies and council teams inter-acted, what each individual client could expect to receive and how effective client feedback and the complaints mechanism was. We are grateful to everyone who facilitated this.

First and foremost, the Steering Group would like to acknowledge the excellent care provided by many care workers. We have received many positive comments about the homecare services provided, particularly about the skills and qualities of individual care workers. Service users highly value care workers who consistently demonstrate kindness, understanding and flexibility. We were also impressed with how the service providers work together to form the Home Care Strategic Partnership.

We would also like to thank all the service users, service providers, and staff, and support from the various B&NES Departments who helped us collate the information that we needed. I would like to extend my personal thanks to:-

- The Commissioning and Contracts Team especially Angela Smith, Caroline Round and Molly Watts.
- The Intake, Assessment and Referral Team led by Dawn Cronin
- Olu Mohammed (Management Accountant)
- The Community Mental Health Team led by Dave Leveridge from AWP
- Adult Care Team – Sue Jackson

None of this would have been possible without the efforts of the Overview and Scrutiny Panel's Project Officer, Donna Vercoe. She has not only kept us to the agenda when further lines of inquiry beckoned, and fascinating anecdotal evidence accumulated, steering us through the process of producing this report, but she has compiled the supporting evidence which is so crucial for embedding this research in the local context. She organised interviews for us and fielded telephone calls from the public. Above all she shifted through my screed and all the other corrections from the rest of the team to produce draft after draft until we had our final report. We all owe her a vote of thanks.

This Steering Group has been very 'hands on', interviewing providers and respondents, visiting Bath Islamic Society and residents' homes, and most importantly, Cllr Will Sandry found the time to 'shadow' a social worker for a day, and a member of the Community Mental Health Team. We very much appreciate the hospitality we have received, and I personally consider it a great privilege to have been able to work on this project in this way.

As this report goes to press, we are aware of possible changes in legislation which may affect our recommendations. In this situation we only commend this report to you, and request that the recommendations are taken very seriously. An Overview and Scrutiny Panel cannot change any Council policy decisions, or alter the service providers' contracts and modes of operation. Nevertheless we hope that all of this report will be studied carefully, and inform the thinking on future policy and practice, upholding the many excellent aspects of the service, and the 'value for money' received.

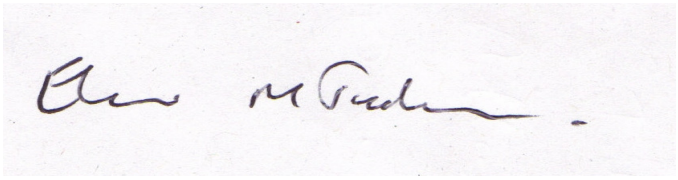
We have very strictly adhered to a policy of confidentiality, but I for one was moved that people took the trouble to revisit painful experiences culminating in the loss of a much loved relative, explaining in detail both excellent care received and occasions when communications broke down. We appreciate their trust, and have carefully weighed all their comments. However, we had to be selective, and could not include everything. We also obviously could not include anything which might identify the informant. We also

received a mass of verbal comment, which at times informed our views and which we have been careful not to misrepresent. We wish to thank everyone who entrusted us with their confidences.

We have not considered the very different Scottish model in any detail because it is a matter of devolved government and because we have not considered the question of how home care should be financed. We have only noted the mechanisms for obtaining financial provision, and whether it is 'value for money'. What we have noted is that some of the improvements requested, for example to improve time-keeping, would mean a considerable increase in costs. What is above money is the level of commitment most carers provide, and the generally excellent relationship between carer and client. The problem with a good service is that it generates high expectations on the one hand, and disappointment on the other that it cannot match what a devoted relative or partner may have provided. However we have to be realistic about resources and human nature. What would be unacceptable from my point of view would be a cost-cutting exercise which resulted in a loss of dignity or efficiency.

This report is not a bench-marking exercise about standards of care and effective mechanisms for delivery, but it is a base line, as the first such exercise, and I very much hope to see it repeated in three years' time before the next round of commissioning so that we can see whether the improvements that we have recommended have been made. The bottom line is that the Council has a responsibility for ensuring good provision, and this report is a part fulfilment of that.

Once again, may I thank all who have participated in the production of this report, especially the council officers, the respondents and the service providers.



Dr Eleanor Jackson
Health Communities & Older People
Overview & Scrutiny Panel

Tables & Charts

Bar Graphs

Pie Charts

Tables

Executive Summary

One of the reasons this review was undertaken was to honour the pledge given by the Healthier Communities and Older People Panel (HCOP) that when the in-house service ended, the new system would be monitored so that the quality of care would not change and it would represent value for money in B&NES.

Since 2008 the (HCOP) Panel has been monitoring Home Care services and receiving regular update reports from service providers and service users. During 2009 the Panel sought the views of members of the public about the possibility of a future review into Home Care, and the responses suggested that Home Care is an issue of concern for many users and providers of Home Care. Following this, the reviews Terms of Reference were agreed at the September 2009 Panel meeting.

This review examines the services provided by each of the five partners who have been commissioned to provide domiciliary care to residents within Bath & North East Somerset. For the purpose of this review, 'Domiciliary Care', also known as 'Home Care', will be focusing on the Home Care that is provided by staff who go to the service user's own home to deliver such services as personal care and domestic tasks, including waking, and sleeping nights.

This review sets out to analyse the present situation of the Home Care service within Bath & North East Somerset and identify best practice approaches and areas for improvement. We did this by examining whether the 5 Home Care providers, which make up the Strategic Domiciliary Care Partnership, are achieving the Council's stated objectives for the service.

Members of the steering group have carried out several research and consultation exercises including widespread marketing of the review, and by encouraging completion of case study forms, making telephone calls, holding an informal session with Service Providers, in order to try to identify and understand the views and issues of service users and providers of these services.

The steering group have focused on elements of the home care services that are very important to service users and service providers when reviewing the quality of home care. These elements include reliability of services, continuity of care, care worker skills, attitudes, competence, training and retention, flexibility of services, knowledge and experience of the needs and wishes of the service users, and communication and complaints.

Some of the key findings from each of the above topics are highlighted below:-

1. The reviews findings have proved that the service is of good quality and is meeting the objectives as set by the Council, but there are some recommendations for improvement included on pages 8-9 of the report. Our main area of concern is the interaction of the Community Mental Health Team with the Strategic Partners in the delivery of domiciliary care for a client.

2. There is an increasing demand for homecare services within B&NES due to an ageing population and Central Government emphasis on providing care in the home rather than in hospitals or residential services. Care work is becoming increasingly complex as providers focus on delivering personal care to clients with 'substantial' needs.

3. There was general agreement amongst the service providers that the concept of governance was not fully understood by their clients. For example, during the informal session each of the Service Providers reported that they encouraged clients to provide them with both positive and developmental feedback about the service, but they were concerned that they did not always get an honest answer from their clients.

   The response from service users and informal carers during consultation suggested that some users were too concerned about losing their care altogether to get involved properly in the process This was said to be frustrating for the Service Provider as without frank responses they could not provide greater improvements to their service.

4. Although the service is generally seen as good, our research showed that some service users and informal carers were concerned with the allocated time of 30 minutes, for example, to wash, dress and make a service user's breakfast. This was not felt to allow sufficient length of time to meet everyone's needs and requirements. The Service Providers agreed that the service does require a degree of flexibility but it also needs a degree of autonomy in order to maintain consistency and continuity of care.

5. After a Care Service Co-ordinator from the Adult Care Team was 'shadowed', it became apparent that clients can often present different and sometimes awkward challenges and it is not always appropriate that re-assessments / reviews are conducted by the same person. Coupled with this, the changing pattern of the Care Managers workloads does not always allow continuity of assessment / re-assessment to be achieved. Yet given the pivotal role of assessment in the whole system, it is essential that it is accomplished to the satisfaction of all concerned

6. The comparative analysis of the Service user feedback forms indicated, that there has been no significant change in satisfaction rates by service users. Overall the service user forms revealed a fairly high satisfaction rate across all of the quality service areas examined, both before and after the commissioning process, with only slight percentage differences between each area and locality provided by the Strategic Home Care Partnership. (See Table 2, Page 20)

7. Over the last 4 years the Council has saved money and maintained the standard of service in practically all cases. The most recent total expenditure figures for 2009/10 show a reduction in the total home care costs, showing a percentage decrease of -17.02% in the total homecare for 2009/10 compared to that of 2008/09.

8. The review investigated whether there was a consistent quality of service being provided by the Strategic Home Care Providers and identified whether there were any rural or urban differences in the care delivered. Our research and consultation revealed that there are no obvious differences between those service users receiving care within the rural areas of Bath & North East Somerset compared to those living in the urban areas such as Bath.

9. The number of service users in receipt of commissioned domiciliary care has reduced by 51 Service Users. This decrease has been in all zones[1], (areas within Bath) apart from zone 4 (Norton-Radstock), which has seen an increase of 15 Service Users. (See table 3, Page 26) This maybe in part due to the support by the Intake, Assessment and Re-enablement team who have successfully rehabilitated service users during the six week support period and do not need ongoing long term domiciliary care.

[1] For an understanding of zones see page 20 of report

Recommendations

1.	**Ongoing review and monitoring of Home Care Services**
	The Review Panel has been made aware of a number of Independent research investigations into the Quality of Our Home Care Service, which include survey work and regulatory inspector work carried out by the Care Quality Commission (CQC) and by the Personal Social Services Research Unit (PSSRU).
1.1	**The Panel recommend that the results from the CQC and the PSSRU are presented annually to the Healthier Communities & Older People Panel for consideration and appropriate action if necessary.**
1.2	**The work already being carried out by the PSSRU and the CQC will mean that it will not be necessary to undertake another full consultation exercise into the current quality and user experience of the Home care services delivered, unless there is some significant and unforeseen changes in circumstances, but instead to gather the results from the work that is already being carried out nationally and regionally and compare them with the findings of this study as this study will provide a baseline.**
1.3	**The Panel should consider undertaking a review in 3 years time, after the Personalisation Agenda has been fully integrated and towards the end of the 5 year Strategic Home Care Partnership contract, which should help to inform future commissioning decision making.**
Resources: All of the above can be met within existing resources	
2.	**Improving the quality of care for service users with significant mental health needs**
	Evidence gathered through shadowing visits undertaken with the B&NES Social Work Team and with the Community Mental Health Team raised the concern that agencies are not accessing sufficient training for their staff to cope with some of the organic and functional mental health problems that older people may exhibit. Therefore we recommend that:-
2.1	**A meeting is convened between Senior Managers and the Community Mental Health Team and the Managers of the Domiciliary Care Providers to analyse training needs and suggest the appropriate training programmes for staff.**
2.2	**That the Community Mental Health Team examines the nature of the information that they provide when referring an individual and convenes a meeting with the care providers to ensure that the information provided is revised to enable the individual's care needs to be assessed with agreed terms of reference / language.**
2.3	**That a representative from the Community Mental Health Team attends and contributes to both the Operational and Strategic (Partnership & Zone meetings) to address particular issues in the delivery of clients care.**
2.4	**We introduce an "actions arising column" within the recordable care plan, so that where care needs or problems arise, actions can be clearly recorded and are auditable**.
2.5	**In the absence of family members in close contact to the client that a member of the Community Mental Health Team attends individual client reviews as this cannot be dealt with under Mental Capacity Legislation.**
Resources: All of the above can be met within existing resources	
3.	**Communication**
	There is an identifiable need for the provision of translation for a number of small ethnic

	communities about the home care provisions available to them. The question has also been raised as to whether service providers and carers are sufficiently sensitive to the cultural and dietary needs of users of African and Afro-Caribbean origin, and this concern needs to be addressed.
3.1	**Recommend that the Councils Equality Team investigate to see that where there is an identified need for Home Care that there is appropriate material available for all ethnic minority groups and that this is reported back to the Healthier Communities and Older People Panel.**
3.2	**Recommend that the Home Care Providers should continue to be asked to evidence their commitment in terms of training and code of conduct to ensuring that sensitivities about appropriate behaviour in ethnic minority homes is respected, especially laws concerning personal hygiene, dietary requirements and purity.**
3.3	The steering group identified the lack of compatibility of various email systems in contributing to the barriers of communication between various Care Teams, and also identified some issues with the security of personal data. **The steering group notes that some work has already commenced on secure email arrangements to support data transfer, but we recommend that the Cabinet Member for Resources initiates a review into how solutions can be achieved and that this is prioritised.**
3.4	During the clients review process the Social Worker is currently required to complete a number of different documents. There are also a number of forms and information sheets about individual budgets which need to be given to the client. Furthermore the new joint assessment form carried out by the Social Worker and covering both the health and social care needs of the client was sampled. The Steering Group identified that the Health data collected on the assessment forms are not being transferred into a data retrieval system. As a result, the value of the form is questioned as data cannot be effectively retrieved and shared between different services, such as Social Services and the PCT. **Recommend that the present documents used by the Council Social Worker should be reviewed to improve efficiency and to ensure that information collected and used is authorised and available to other services.**
Resources: All of the above can be met within existing resources	
4.	**Reliability and timing of Home Care visits**
	The Steering Group identified the need for managing the clients expectations about the delivery of their care.
4.1	**Recommend that Service Providers continue to monitor the time keeping of their care workers and work towards identifying what can reasonably be delivered within the parameters of the Care Assessment.**
4.2	**Recommend that the Social Worker included in a clients referral of care also makes them aware of other services available to them, such as the support of the Voluntary sector.**
4.3	**Recommend that the Service Providers review their communication systems to ensure that there are robust methods for both the clients and service providers to report difficulties or concerns that they have with the delivery of their care.**
Resources: All of the above can be met within existing resources	

Introduction

Background

The decision to move from In-house care to commissioned long term care in Bath & North East Somerset (B&NES)

Since Sept 2006[2] the Council made a decision to embark on a commissioning process for the future provision of long term Home Care services to enable a decision to be made on future providers for long term domiciliary care, which were previously a mixture of in-house and commissioned services and did not demonstrate best value principles as the cost of the in-house Home Care was greater than the cost of services purchased from the independent sector.

Previously, unsuccessful efforts were made to try to transform Bath & North East Somerset provided services into one more able to meet the domiciliary care needs of its population. Therefore a proposal for placing a tender for the provision of these services was developed in order to produce a more flexible and cost effective service.

The Overview & Scrutiny (O&S) Panel oversaw the Commissioned Process and requested a further report on the resources that would be needed by the Councils Home Care Service to develop and submit a bid. This progress report went to the O&S Panel on 10th November 2006. The Assistant Director for Adult Care Housing & Health informed the Panel that the in-house service team had confirmed they did not wish to take forward an in-house bid.

The Council received a number of bids from private providers of Home Care services which resulted in the transfer of In-house Home Care and the re-commissioning of both independently provided Home Care services and the Council's in-house long-term Home Care service. Five providers were appointed as the Home Care Strategic Partners.

Table 1 below sets out the providers and the date each provider become operational,

Provider	Operational from
Agincare B&NES Ltd.	September 2008
Caresouth	June 2008
Way Ahead	May 2008
Carewatch	April 2008
Somerset Care	April 2008

Each of the five Partners have been contracted by the Council to provide domiciliary care, including waking/ sleeping nights and 24hour care as required. They have all set up offices within the Bath and North East Somerset boundary except Somerset Care which successfully operates from Frome and covers a zone in South Bath. Way Ahead, Care South and Agincare have all acquired new office bases in Bath and North East Somerset.

One of the reasons this review was undertaken was the pledge given by the Healthier Communities and Older People Panel (HCOP) that when the in-house service ended, the new system would be constantly monitored and the quality of care would not change, yet would represent value for money in B&NES.

The Healthier Communities and Older People Panel (HCOP) has been monitoring the above Home Care services since 2008 and receiving regular update reports of the service providers and service users. During 2009 the Panel sought the views of members of the public about the possibility of a future review into Home Care, and responses suggested that Home Care is an issue of concern for many users and providers of Home Care. It was agreed at the 19th July [3] 09 Panel meeting that the Panel would receive a draft Terms of Reference for the Home Care Review[4] at the September 09 meeting.

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[2] agenda paper and minutes from September 2006 when decision to put Home Care out to tender was called in:
http://cis/committee_papers/OandSH&SS/HSS060927/01Agenda.htm
http://cis/committee_papers/OandSH&SS/HSS060927Mins/060927.htm
http://cis/committee_papers/OandSHCOP/HCOP090714Mins/090714.htm

[4] http://cis/committee_papers/OandSHCOP/HCOP090908/01Agenda090908.htm

See Appendix 2, for a table of the history of previous spot and block contracts with each of the commissioned Home Care providers, which now make up the Strategic Home Care Partnership, (including a definition of the Spot/ Block Contracts)

Scope

The review included the services provided by each of the five partners who have been commissioned to provide domiciliary care to residents within Bath & North East Somerset. For the purpose of this review, 'Domiciliary Care', also known as 'Home Care', focused on the Home Care that is provided by staff who go to the service user's own home to deliver such services as personal care and domestic tasks, including waking, and sleeping nights.

The review did not investigate residential home care nor the work of national and local charities working with the aged in general. Services may be commissioned from a charity, and a service provider might be registered as a charity but we are not concerned with the working of charities as such

This review analysed the present situation of the Home Care service within Bath & North East Somerset and identified any best practice approaches and investigated any areas for improvement. It has not made any recommendations for a change in the commissioning process. However there are areas of improvement that have been identified which could be made to areas in Social Work practices in the delivery of Home Care.

Recent developments and future challenges in Home Care Provision

Over the last two decades there has been an ongoing shift towards Home Care and away from residential care. This shift towards Home Care has been driven by Government Policy for self-directed and individualised care, older people's preferences to stay at home, and technological advances that make it easier for older people to be supported for longer in their own homes and live independently.

Generally people expect more from the care support services than they did before. Other factors to be considered are:-

1. An increase in the older population over the next 20 years combined with a rise in charges for care services is putting public spending under increasing pressure. This is likely to create major problems for local authorities in the funding of care services in the coming years.

2. Longer survival rates mean that there is an increase in people being ill or disabled for most of their final years. Improved pain relief and the work of hospices means far more people can realise their desire to die with dignity at home than previously.

3. There are now more young disabled and vulnerable people living longer than there were 20 years ago, which is having an impact on long term care.

4. More people see good quality care and a good quality of life as a right, rather than a blessing.

A survey by ***Age Concern England*** 2008 found that 60 per cent of people say the long-term care system does not provide high quality care and over *50* per cent say it has got worse in recent years[5].

There has been considerable media and public interest into the future of long term care. Last year *The Telegraph* published an article about the rise in care charges for the elderly, stating that the "*Fees for elderly people receiving help with tasks like washing, dressing and eating have risen by an average of 45 per cent since 2007*"[6]

These research findings were used to inform the latest Government Green Paper and public consultation.

[5] Quality not Inequality, 2008, Age Concern England
[6] http://www.telegraph.co.uk/health/elderhealth/5663276/Massive-rise-in-care-charges-for-elderly.html June 2009

Relevant Policy developments

Elderly & disabled residents living within the Bath & North East Somerset area are likely to be affected by the current national debate going on which suggests that the situation may change for residents if a National Framework for the care service is introduced in order to eliminate regional inequalities and guarantee adequate funding for those most in need.

Based on the Office of National Statistics figures, there are approximately 35,600[7] males and females aged over 65 and living within the Bath & North East Somerset area who could be affected by Home Care provisions and the current proposals for national legislation before Parliament. [8]

The national debate is focusing on the results from the Green Paper[9] '***Shaping the Future of Care'*** and the consultation work undertaken to try to capture everyone's views about developing a long term care and support system which would be fit for a 21st century. In summary the Green Paper sets out the following proposals and expectations of the National Care Service:-

1. A fair system for everyone
2. Prevention services, to help people stay well and independent for as long as possible.
3. National assessment: wherever you go in England your care needs will be worked out in the same way
4. Easy assessment process: all the services you need will work together smoothly
5. Information: you will be able to understand and find your way through the care system easily
6. Personalised care and support built around the way that you live and around your needs.
7. Fair funding: There is a general move towards focusing on individual budgets and direct payments for Home Care (see below)

The **Personalisation Agenda[10],** which is a long term programme of change announced by Government in putting people first, is intended to alter radically the whole way in which social care services are delivered. The main part of the agenda is about providing increased choice and individualisation for service users. The wider agenda also emphasises prevention and early intervention across health and social care services.

B&NES has been used as a pilot area for testing the use of 'Personal Budgets'. This means that individual needs are translated into a pot of money which the individual then has considerable freedom in spending as they wish, combined with their own resources. People can choose to have a service commissioned for them by the Local Authority. They can also have support with decision making and with employing personal assistants from a dedicated support service. Home care service users are now increasingly opting to use their own personal budgets to purchase home care from the Service Providers.

The Personalisation Agenda (previously known as individual budgets) has now been rolled out in Bath & North East Somerset and more home care service users are now using their own personal budgets to purchase home care from the Service Providers and other agencies. To verify this, one 74 year old respondent was interviewed in depth, and declared the system was excellent, the change the best move he could have taken, and advice from a Bristol agency enabled him to deal with the paperwork involved in effectively employing his own carer was easy. (See **Appendix 3** for more information)

The Personal Care at Home Bill. Subject to the passage through Parliament of the Bill, the intention is that from 1 October 2010 Councils will have to provide free personal care to those who meet the specified criteria. The Government estimates that the Bill would help around 400,000 people with care needs and guarantee free personal care for the 280,000 people with the greatest need. Investigating the practicality of this, or how care is financed is beyond the scope of this enquiry.

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[7] ONS- Mid- Year Population Estimates (2001)
[8] The Personal Care at Home Bill currently before Parliament announced in the Queen's Speech on 18 November 2009 would provide free care for those with the greatest needs, an estimated 280,000 people out of 400,000 with some degree of need.
[9] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_102338
[10] http://www.bathnes.gov.uk/Committee_papers/Executive/WL/2009/090605/01E2010PoorRatedCareHomesPolicy.htm

Purpose

The purpose of this review is not to seek a return to an in-house service but to:-

1. ensure that local residents are receiving the best possible service under the new tendering arrangements,
2. provide a voice to those who use the Home Care Service, and also to those who are concerned about the service being provided
3. support the Council's Corporate Priority "*promoting independence for older people"* by ensuring that the Home Care services being provided are effective.
4. demonstrate that the authority is willing and able to scrutinize its own practices.
5. Explore and analyse achievable improvements which could be made to the delivery of Home Care services, taking into account contractual conditions and financial constraints and publicising best practice.

Objective

The aims of the review process are to examine whether the 5 Home Care providers are achieving the Council's stated objectives from the transition and are:-

1. Achieving best value for money for the Council
2. Providing an appropriate and acceptable service for service users
3. Meeting the contracted conditions of service providers
4. Providing parity of service between rural and urban areas.

Methodology

Every effort was made to try to engage with a diverse range of users and of the commissioned providers of the Home Care service to capture individual views and experiences.

The methodology undertaken can be broken down into three key areas of investigation:-

1. A call for written views and information from local people into the type and level of care being received by users of the Strategic Home Care providers.

These were taken from a number of different sources:

1. Demographic data of service users from the B&NES Commissioning and Contracts Team and also analysis of their service user feedback forms were examined.
2. Written views were submitted to the O&S team and to Steering Group members
3. Marketing of review: Press release, through local newspapers, publicity among local Strategic partnership forum, and general circulation to a wide range of key stakeholders, through local radio (Bath FM), posters & leaflets were submitted to all GP surgeries and Bath & Radstock Library, Norton Radstock Town Council offices, and shops and churches used by elderly people.
4. Local Ward Councillors were asked to speak to local residents about the review
5. Phone Calls were received from users, family members, and carers of users of Home Care.
6. Steering Group members also distributed a number of Home Care user case study forms, which examined some areas of interest in more detail.
7. Consulted with the local Muslim community through BREC, African and Afro-Caribbean families
8. Analysed and referenced the results recently carried on the Service User Experience for people receiving Home Care (2009) In Bath & North East Somerset, by the PSSRU.

2. Engagement work with Service providers *(Management and staff).*The results of the delivery of Home Care were taken from a number of different sources:

1) The steering group held an informal session with the Strategic Partnership in November 2009, in order to gain a collective view of some of the issues and concerns that the Strategic Partnership have and to provide the steering group with a better understanding of the joint delivery of Home Care.
2) Each of the Service Providers which make up the Strategic Home Care Partnership were sent a case study form to complete and return. This form asked detailed questions about the delivery of Home Care within their organisation.
3) Unison data & Agincare Survey results, which investigated the views of Home Care staff who were previously employed in house by B&NES but were TUPE transferred to Agincare Ltd after they won one of the contracts to deliver Home Care in 2008 were also analysed and compared with the group's own results.

3. Additional evidence collected

1) One steering group member undertook two field case studies, with the Social Work Team and the Community Mental Health Team to understand how elderly residents are assessed and referred for Home Care.

2) We also visited a smaller Home Care agency which does not have a contract with B&NES to understand their issues and make comparisons against the findings from the Strategic Home Care Partnership.

3) One group member interviewed members of Bath Islamic Society to understand the perspective of Muslim users of the Interim Care Service and the home care service and talked to a member of BREC who conducted their own survey into experiences of Home Care.

4) One steering group member interviewed an openly gay man to discover if gender orientation and sexuality presented any specific issues and to verify the impression the group had that there was no discrimination.

Findings

1. Research

1. A) what is Home Care? (Domiciliary Care)

Home Care (sometimes known as domiciliary care) is the provision of the personal and domestic services which are necessary to maintain an individual in a reasonable measure of health, hygiene, safety and ease in their own home or sheltered accommodation and to promote their independence and choice of lifestyle.

Home Care covers a wide range of statutory and non statutory services. However, **this review covered the services which are provided by staff who go to the service user's own home to deliver such services as personal care**, (help with washing, dressing, medication etc) **and domestic tasks**, (help with shopping, cleaning, cooking etc), **and more general Domiciliary Care Services**.

A variety of other Home Care services are provided within B&NES, for a full list see **Appendix 4**

1. B) Demographics of B&NES residents receiving Home Care

General Demographics of B&NES residents:
B&NES has a population of 178,300[11] (2007), of which 90% (158,400) of people are classified as 'White British'. The largest Black and Minority Ethnic Groups are 'White Other', representing 3.6% (6,3000) of the total population and 'Chinese or Other Ethnic Group', representing 1.7% (3,000) of the total population. The overall proportion of black and minority ethnic residents is significantly lower than the national average for the population as a whole.

According to the population projections for Bath & North East Somerset, the overall population will increase by 17.6% between 2009 and 2030.The most significant increase will be to our older age groups who are projected to have the highest growth rates: the 75+ age group to increase by 48.8% between 2009 and 2030, while the 65-74 age group to increase by 26.3%. This increase will have a major impact on the way we plan and deliver services across the region over the coming years.

Inequalities
The population of B&NES is relatively prosperous and healthy, with most areas ranking amongst the highest in England for children's health. There are however, still a significant number of deprived communities in the district, and hidden rural poverty. Some of these communities are geographical in nature, whilst others relate to groups of people with particular needs such as some black and minority ethnic groups and people with learning difficulties. However generally we have a lower proportion of the population with a disability or limiting long-term illness.

The life expectancy for residents is longer than regional and national trends although males from the most deprived areas may live 9 years less than males from the more affluent wards and 4 years less than women.

Despite educational achievements which exceed national averages, and those of our neighboring areas, one of our geographical areas is within the most deprived 5% for Education and Skills Deprivation[12].

The demographic distribution is also very uneven, with some wards not only having lower life expectancy, but on average higher birth rates, and more young families. Some communities, such as Norton Radstock, are distinguished by multi-generational extended families, with more than 75% of the population born within a five mile radius of Midsomer Norton and spending their whole lives in the area.[13]

[11] Mid-Year Estimates; sub-authority projections based on continuation of proportions from Census Data (c) Office of National Statistics (2001)
[12] Indices of Multiple Deprivation, 2007, Communities and Local Government
[13] 2004 Background Documents to the Amended and Modified Local Plan, Adopted 2007.

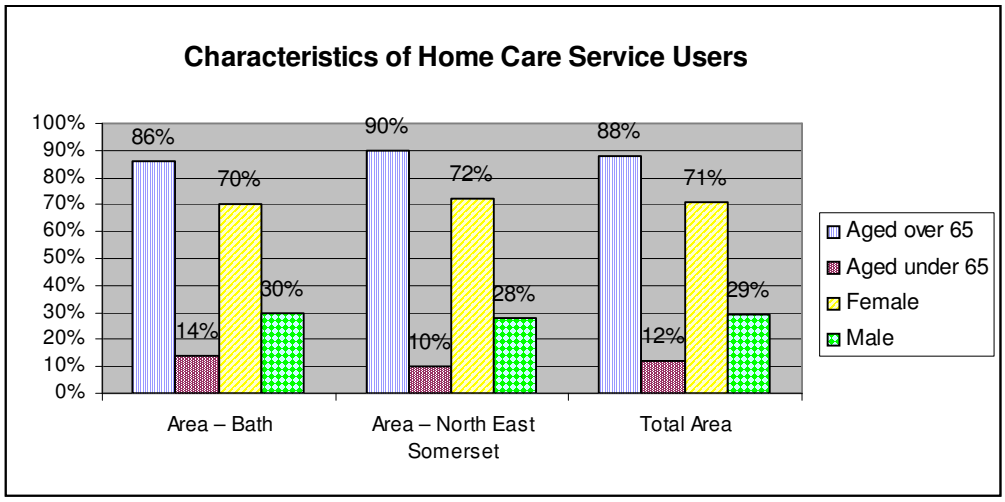
2. Investigation into the type and level of Care being received by users of the Commissioned Home Care Services

The issues, concerns and key findings identified below, are based on the different consultation methods undertaken by the Steering Group and listed on page 13-14 of the report.

2. A) What are the characteristics of our Strategic Home Care users?

Data has been extracted from *Carefirst*[14] regarding the demographics of Service Users who are in receipt of Home Care services from the 5 Strategic Partners. The below bar graph 1 shows the percentage of home care service users aged over 65 and Percentage of Service users under 65 in Bath and North East Somerset. It also highlights the percentage of Service Users who are male and female.

Bar Graph 1



- There is a larger number of elderly females who receive Home Care compared to that of elderly males living in Bath and North East Somerset.

- Based on figures provided to us from *Carefirst* there are currently 750 service users for whom we have commissioned a service in Bath & North East Somerset.

The table below indicates the percentage of service users who receive care from the Strategic Partnership and who have a Mental Health need, a physical disability, learning disability or sensory impairment in Bath and North East Somerset, each of which require a detailed and specialised care plan that matches their needs.

- **A larger proportion of service users that require home care were found to have a physical disability and a smaller number have Mental Health requirements.** *Table 1*

Service User Group	Area – Bath	Area – North East Somerset	Percentage for Total Area
Physical Disability	89.6%	86.3%	88.1%
Mental Health Need	9.4%	12.7%	10.9%
Sensory Impairment	1.0%	0.7%	0.9%
Learning Difficulty	0%	0%	0%
Other	0%	0.3%	0.1%

- We have not found any evidence of discrimination by service users or providers on the grounds of gender or sexual orientation, but there were clients who preferred a same sex carer to themselves for personal care.

[14] Carefirst is the electronic record system which all social work staff use to record information about the service users they work with. See Glossary for full explanation.

- The breakdown of service users based on ethnicity highlighted that the highest percentage (96.3%) of Home Care Service Users are White British. (See **Appendix 5** for full ethnicity table), which is virtually the same as the whole population demographics for the area.

The concerns and issues of ethnic minority groups were also considered for this review. One steering group member spoke to the Bath Islamic Society and gained and insight into some of the care issues developed through their cultural integration into British society.

- Locally most ethnic groups are well integrated into our society. It is no longer the case that people came over, worked hard and retired back to their villages, bought land and businesses and did not need care in Britain. Now the traditional extended family is often under great strain. Previously there was no problem because the sons would look after their parents until death, and without the multiple health complications of the elderly today. Now there may be no sons, and women are working outside the home. There are a few instances of 'chain migration' of older people coming to Britain to be looked after by their children at their own expense.

- After an explanation of the Intermediate Home Care system to members of the Islamic community it became apparent that they were unsure if it was being accessed. This raised concern that if there is no translators, as discovered during the Gynaecological Cancer Services Review[15] they might not understand what is available to them.

- BMESCA (Bath Ethnic Minority Senior Citizens Association) reported to us that they felt that home care for black ethnic minority people locally was not culturally sensitive enough as it did not always take into account cultural and religious dietary needs.

2. B) Assessment and re-assessment of client needs

The initial Intake, Assessment and Re-enablement Team is responsible for where new home care referrals go for up to 6 weeks before they are transferred to the Home Care provided by the Strategic Domiciliary care providers. The Team is an Intermediate Home Care Service aimed at promoting independence and supporting service users to gain or regain daily living skills and confidence, and where possible reducing the level of care required as the service user's independence increases, for example, following a spell in hospital. (See **Appendix 6** for further background information on the role of the Team). note: *This process is only used where there is an identified need for re-enablement.*

Following a GP referral B&NES Social Services undertake the initial Home Care Assessment concerning the client's needs, which is then referred to a 'brokerage[16]' team who approach one of the five Home Care providers.

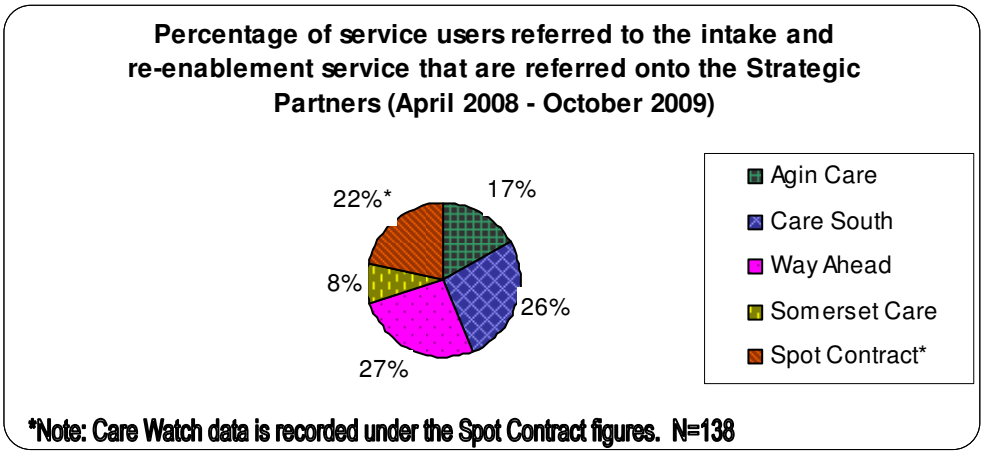
As part of the Home Care Review, the Steering Group investigated the progression from a user's initial intake and assessment to care provided by the Strategic Domiciliary Care providers. The following data was provided to us by the B&NES Intake, Assessment & Re-enablement Team:

Graphical representation of where B&NES Home Care users are transferred to after their progression from the initial intake assessment, and referral team[17]. *Pie Chart 1*

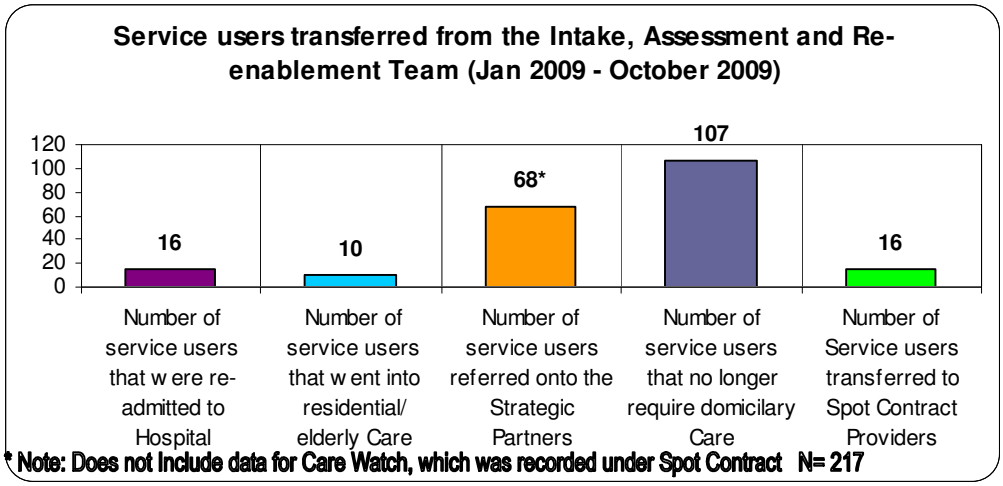
[15] Anne-Marie Jovcic Sas from BREC said that UBHT had translation and interpretation services which the RUH didn't have. Taken from draft minutes http://cis/committee_papers/OandSHCOP/HCOP091217Mins/091217.htm

[16] This is a fairly new initiative, whereby brokerage officers deal with individual budgets for the delivery of Home Care provision*. They take referrals from Social Services and are then allocated a budget from which they can then choose the care and support, which is tailored to a clients needs. They then arrange the budget accordingly.

[17] Intake & Re-enablement Team, Ongoing Service Report figures, (April 2008 to-date)



Bar Graph 2



- The above bar graph (2) illustrates that the majority of service users no longer require further Domiciliary Care after receiving support by the Initial, Intake, Assessment and Re-enablement Team.

- There have been many pieces of research carried out about the benefits of this service and its reduction in referrals, which can be evidenced in the results that we received. Since its introduction within B&NES, the service has significantly reduced the need for large ongoing referral packages of long term care and has become a valuable addition to the Home Care system.

- There are two Assessments completed, one which identifies the care needs and entitlement by B&NES (Council and Client) and a statutory requirement for an assessment by the Care provider and Client, which considers the detail of providing the care package. This enables the client to speak freely to both, particularly when the quality of care questionnaire form is completed as the care provider will not be present.

- The figure below indicates the current number of mental health referrals into the Intake, assessment and Re-Enablement team. These do not include all mental health referrals for homecare April 2008 – March 2009 = 43 / April 2009 – December 2009 = 23.

- People with existing mental health problems stay with the Adult Community Mental Health Team (CMHT) when reaching the age of 65 unless there are compelling reasons to move them to the older people CMHT. Clients entering the service have a broadly 50/50 split between Functional Mental Health problems and Organic Mental Health problems (Dementia).

- There are approximately 800 CMHT service users. It is believed that there are about 50 service users who are set up and funded by the CMHT for home care which is contacted out to external providers. There are also other service users who use the home care providers and their service will be privately funded and arranged.

- The Council's Community Mental Health Teams are managed by AWP and operationally it is an AWP service. There are three strands to the service: 1) Community Mental Health Team (For Referrals, Assessments and care co-ordination) 2) Intensive Support Team (Short duration intensive support) 3) Therapy Team (OT/Psychology / Physiotherapy

Through evidence gathered by shadowing a Social Worker from the Adult Care Team and the Mental Health Team and through information collated from service users and providers the review Panel were able to identify several issues after the transfer of an individual's care to the one of the Strategic Home Care Providers:-

1. There was a positive response to the quality of the brief provided by the Social Workers. However, there was a less favourable response to the brief provided when the client had Mental Health needs. Evidence gathered from shadowing a social worker (Adult Care Team) identified several reasons that can be attributed to the above response. The first is that the Community Mental Health Team use different referral paperwork than that used by the Adult Care Team. However this paperwork was sampled during the visits with the Mental Health Team and although it was different it was found to be detailed and of good quality. The referral paperwork used is standard paperwork which meets both national and AWP requirements but may change in the future as a new computer system is introduced.

2. Evidence gathered through shadowing visits undertaken with the B&NES Social Work Team and with the Community Mental Health Team raised the concern that agencies are not accessing sufficient training for their staff to cope with some of the organic and functional mental health problems that older people may exhibit.

3. The client and relatives may be in denial about their level of needs and not state clearly the degree of incapacity. Consequently there are sometimes surprises for the Service Provider because the assessment has not picked up other illnesses such as Dementia though given the daily fluctuations in mental

4. It was also pointed out to us that prior to the new system being introduced, a joint assessment with the appointed council social worker was the norm, and had worked well, but this no longer happens. One of the reasons for this change was based on the practicalities of undertaking two assessments i.e. getting two people together at the same time at a remote location can be difficult. The two organisations were also found to approach things from different perspectives.

5. Any care worker should be able to go into a home and pick up the care plan for that client and deliver their requirements. However some service users have very complex and detailed care plans and after the councillor's shadowing visit with the social worker there was a concern that where there is a new or 'one off' substitute carer they may not always have sufficient time to follow such specific and complex care plans, which could be difficult for even the most experienced home carer in the limited time available to deliver the care package**.**

6. The issue that we have identified through the informal interviews exposed the problem of creating effective partnerships between the Home Care Support Team, the Mental Health Team and the service providers. The care providing agencies did however admit that they were 'on a steep learning curve' and were now holding monthly inter-agency management meetings.

However there does appear to be a lack of clarity about attendance by the CMHT at the block provider's area meetings with the B&NES adult homecare team.

7. (AWP/Council) and (NHS B&NES/Council) use different computer systems and have different care monitoring / recording software.

2. C) is there a consistent quality of service being provided by the Strategic Domiciliary Care providers?

A combination of service users forms completed by the social worker and evidence gathered from local residents who responded to the review have been compared and analysed.

Analysis of Service User feedback forms

Methodology: The service user feedback form is completed by a social worker as part of the yearly review of a service users care/support plan and sent to the Commissioning and Contracts Team to be used as part of the contract review with each Strategic Partner.

The analysis has been divided into the 4 zones, as well as directly comparing Bath with North East Somerset. All quality monitoring forms analysed are from the start date of the Strategic Partnership contract with the 5 Strategic Partners. e.g. only quality monitoring forms received after April 2008 were included for Carewatch and Somerset Care and only quality monitoring forms received after September 2008 were included for Agincare. 20% of service users residing in Areas 3 and 4 have been surveyed. These were chosen randomly from every fifth service user on our database which is in alphabetical order. If that service user had not completed a service user feedback form (this could be because their yearly review had not yet been completed) then the next service user on the list with a service user feedback form was chosen.

It was also important to ensure there was not a disproportionate number of feedback forms from one provider within each locality and therefore in Area 3 and Area 4 the percentage of the total number of service users for each provider was worked out and then this proportion of service users were taken from each provider. For example in Area 3 – Keynsham NES. There are 92 Service users in receipt of commissioned care from the Strategic Partners. 20% of 92 is 18 Service Users.

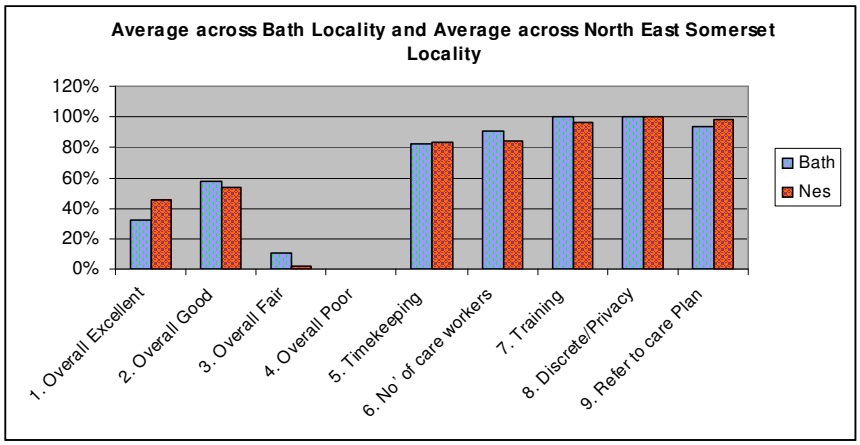
For Areas 1 and 2 – Bath North and Bath South, the Commissioning and Contracts team has not received 20% of feedback forms from service users in each locality. Therefore the decision was made to use all the feedback forms that have been received from service users in each of these localities in order to maximise the pool of feedback forms used. Otherwise too small a number of respondents would have resulted in low figures which could not be statistically significant, or could be distorted by one exceptional case appearing as the norm for that area.

Table 2 Analysis of Service Users forms

Question	Zone Area 1 Bath North	Zone Area 2 Bath South	Zone Area 3 NES Keynsham	Zone Area 4 NES Norton Radstock
Q1. Overall how would you rate your domiciliary care service?: Excellent	35%	29%	44%	46%
Q2. Good	59%	57%	56%	51%
Q3. Fair	6%	14%	0%	3% *
Q4. Poor	0%	0%	0%	0%
Q.5 Are you happy with the timekeeping of the Care Workers and are you contacted about any change to your care?	81%	83%	72%	95%
Q6. Do you feel that the number of care workers involved in your care plan is acceptable?	88%	93%	77%	92%
Q7. Do you think the Care Workers are properly trained and experienced in the tasks they assist you with?	100%	100%	100%	92%
Q8. Do you feel that Care Workers are discreet and respect your privacy?	100%	100%	100%	100%
Q9.Do you feel Care Workers understand your needs and refer to your care plan?	94%	93%	100%	97%

- One Service User rated the service as fair as he did not want to have young care workers providing him with support to meet his care needs.

- The table indicates a higher dissatisfaction in the Bath South area. However, consideration should also be given to the way in which the data has been collected which may indicate a sample problem. On the other hand, it may relate to a local problem, or a particular care worker. This will need to be monitored to ensure that it is not sustained in the future.
- It is also worth noting that when a service user changes service provider it may create anxiety and unrest for the service user as they adjust to form relationships with the new service provider.
- The service user forms revealed a fairly high satisfaction rate across all of the quality service areas examined, with only slight percentage differences between each area and locality provided by the Strategic Home Care Partnership. *(Bar graph 3, below)*



- **During 2009 the Personal Social Services Research Unit (PSSRU)[18] carried out research into the user experience for people receiving Home Care in Bath & North East Somerset and found that overall the satisfaction rates for home care users in B&NES was higher than in other local authorities.** For example, the overall treatment by carers, understanding the situation, responding to queries, finding information and advice was considered better compared to other authorities.

We received a mixture of responses from the service users and carers who wrote in or telephoned about the quality of the care that they had received:-

Service user C: "They *offer a very user friendly service - i.e. companion service, shopping in a wheel chair. Every patient's treatment is tailor made to his specific needs (i.e. if you need to have your cat fed, this is specifically arranged on the form and there is an extensive report on your physical problems)".*

There were no CMHT clients who responded to our consultation about the quality of their care.

Reliability & Timing of visits

In comparison to the above service user forms administered by the social worker evidence was also submitted confidentially from local residents responding specifically to our review which allowed us to identify in depth any issues and concerns that may not have been picked up on the service user forms.

From gathering the issues and concerns of local residents we identified specific concerns regarding the reliability and timing of Home Care visits. These include:-

- The lack of travelling time allocated for carers travelling from one service user to another. We received several reports from service users providing examples of how this has caused them great stress, particularly when they think a carer is not coming.

- Several service users have stressed their concern with the 30 minutes allocation to shower, dress and get a service user's breakfast and allow quality time to chat.

[18] PSSRU (www.pssru.ac.uk) PSSRU User Experience Survey for People Receiving Home Care, 2009 Summary of Results for Bath and North East Somerset by Juliette Malley and Jane Dennett, Discussion Paper 2686/908 Oct 09

- It can also be deemed offensive when a client is from a culture where politeness and greeting is more important to them although no dis-respect is intended.

Carer A : "*I seem to spend most of my time saying' sorry I am late, the traffic these days is so busy at times, and when you know you should be at someone's house to get them, showered and make them breakfast, this makes you stressed out too. The carer maybe the only person that the service users see, and sometimes they provide the only opportunity for them to have a cuppa and a chat with them, of course this is not practical or you would never get around but, it's so sad sometimes rushing off to your next service user"*

Continuity of Care received

- Service users felt that there is not always enough staff to deliver continuous care which they felt causes care workers to become over stretched, over worked, leading to an increase in sickness and work pressure.

- Service users also cited the lack of sufficient time spent by care workers as having an effect on the continuity of care delivered. For example, some service users were concerned about the number of clients that care staff had to see in one day and the amount of time allocated for each visit. Service users also coupled this with the consistency of the same carer, which can create both confusion and dissatisfaction for the service users and their families.

Service User B: *"There is not sufficient time to provide care properly for each client and I feel that there is not enough staff to give sufficient time to each person, they all have different needs and therefore require different requirements of the length of time needed to care for them. Instead time appears to be taken up by the administration of note taking or the carer having to see too many clients within a short space of time. For example 'the carer informed a member of my family that she had 12 people to put to bed between 5:30 – 10:30pm"*

2. D) Is there a clear transparency of information provided for service users about; *Service standards, what services are provided for them, clear lines of accountability i.e. who to complain to, the cost of their care and so on?*

Communication

- Many comments by service users focus on how well carers communicate with them about their care, which helps the user feel comfortable about the care that they are receiving for example; One service user commented on how every month she receives a newsletter telling her what is going on and she can ring one of the team if she has any queries. However, this was not always the case as there were a small number of service users and family members who felt that they were not always kept informed of changes to the delivery of a service user's care. (see below)

- Two service users reported of a reduction in the interaction between different agencies, such as the meals on wheels service, which they felt affected the sharing of information about their care. However one reason for this is the fact that the sharing of client information is now protected by the Data Protection Act, which restricts certain information being openly shared amongst other care and support agencies.

- Part of the problem seems to be a high level or expectation by clients, who want quality human contact rather than the mechanical performance of albeit necessary tasks, and carers who would like to stop and chat, but have to rush on to the next visit.

All of the providers saw the issue of communication with clients and their families as of considerable importance when delivering Home Care. The Strategic Partnership provided us with a list of methods and processes which they felt demonstrated how they ensure that a client receives information about the care that they are receiving. (See **Appendix 7** for full list of methods and processes)

Based on the analysis and investigation into the communication methods and processes used by the Strategic Partnership, and also the other referral teams, the steering group raised the following key points:-

- During the review process the Social Worker is currently required to complete a number of different documents. There are also a number of forms and information sheets about personal budgets which need to be given to the client.[19]

- The new joint assessment completed by the Social Worker, covering both the health and social care needs of the client was sampled. The Steering Group identified that health data collected on the assessment forms are not being transferred into a data retrieval system. As a result, the value of the form is questionable as data cannot be effectively retrieved and shared between different services, such as Social Services/ teams within Social Services and the PCT.

- There appears to be less similarity between the more recent communication methods used. For example, at least one service provider produces a client newsletter, but not all do, several have user group meetings, whilst one does not have any.

- There is a secure email communication system between the care brokers and the care providers, but not between the Adult Care Team (including *CMHT, Sensory Services, Learning difficulties, RUH etc*) and the care providers.

- Each client has a home care folder which records details of each visit by the service provider. This is a useful record if properly completed, and is a legally required document. During the shadowing visit with the CMHT we saw evidence of poor record keeping, although there was an obvious significant improvement following complaints from the CMHT to the provider.

- In another service user's home visited with the CMHT we were able to follow the record trail in the home care folder relating to an ulcer on the client's leg. On further investigation, it was found that the home care agency had not alerted the district nurse or the homecare team to the ongoing problem. There is also some evidence of instances where a carer reported a problem to the agency but the information had not been passed on.

How does a user complain about the service that they receive?

- Each of the care providers have a feedback and complaints procedure, which is part of their contract, and is detailed in the information pack left at the service users home address. The small number of service users whom we spoke to on the telephone were aware of who they needed to contact or knew how to get the details that they required if they wished to make a complaint.

- **There was general agreement amongst the service providers that the concept of governance was not understood by their clients. For example, during the informal session each of the Service Providers reported that they encouraged clients to provide them with both positive and developmental feedback about the service, but they were concerned that they did not always get an honest answer from their clients.**

- **The response from service users and informal carers during consultation suggested that some users, were concerned about losing their care altogether to get involved properly in the process This was felt to be frustrating for the Service Provider as they do not always get open responses which could help to provide greater improvements to their service**

- Some elderly residents did not see the need to complain about their care workers, which a community leader felt was down to the fact that their generation had such a tough time during the war that they are just glad that they have Home Care at all.

[19] Evidence based on Cllr Sandry's visit to the Home Care Team and his observation of the six documents currently used by one social worker during a clients review.

- The providers reported that where there is a complaint, blame is very often allocated to 'the office' and not the actual carer, and that complaints generally seemed to either relate to continuity of care or erratic time-keeping. This suggests that there maybe a genuine problem with 'the office', or a sub-conscious transference of responsibility because the client does not want the carer to be blamed.

Are service users aware of the cost of their care?

- This was a difficult area to determine as it was a sensitive area to approach with service users. However, what we did ascertain is that the majority of users felt that they knew how to find information on the cost of their care if they needed it, and would often refer to a family member or carer worker who would be able to explain this information to them if they needed it.

- One area of cost that was highlighted to us surrounded Personal Direct Payment Budgets: 28% of elderly B&NES residents who are eligible for Home Care budgets have opted for an individual budget. This low figure could be due to the large number of elderly residents who have some element of Dementia and have difficulty in dealing with their own finances, coupled with little family support which can mean the scheme is confusing or be considered a financial burden. However, one respondent interviewed at length about the new system could not speak too highly of it, and also of an agency in Bristol who will help with the paperwork, such as payslips and tax deductions for a small fee.

Other concerns raised by service users included:-

- Staff Safety: Some clients are worried about the vulnerability of lone female carers moving from house to house in neighbourhoods they considered unsafe or when it is particularly dark during the winter months. A Muslim respondent was also concerned about an instance where a woman working on her own with mentally ill clients was the subject of improper suggestions.
- Meals on wheels: several residents complained about the standard of the meals on wheels with one resident buying ready meals instead, as she felt that they were healthier and cheaper than what she was receiving from the service. Others reported to BREC that they could not get the dietary requirements of their culture and religion met.
- A small private home care agency that we visited reported to us that since the amalgamation, smaller Home Care agencies feel that they are not being offered work, and their service is being withdrawn in favour of the larger service providers. They felt that this is having a detrimental effect on the client, particularly when they have become familiar and are happy with their current service provider, a point which they felt has been ignored. However, the use of personal budgets will avoid this problem, since clients may commission assistance from whoever they please.

  We found the evidence from this agency a useful comparator with the Partnership agencies especially with regard to time-keeping for visits.

3. Analysis of the delivery of previous and current Home Care Services provided by the Home Care Strategic Partnership

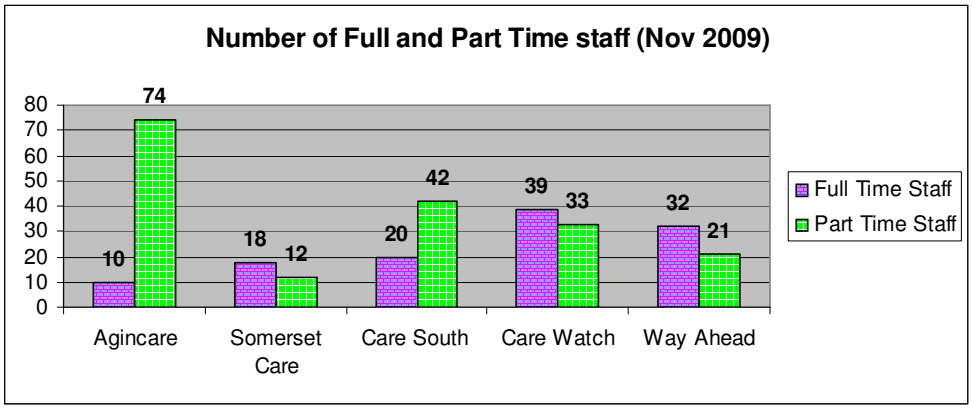
The present system has been running for 18 months. Some agencies have inherited employees under TUPE (principally Agincare), others started from scratch in the region. All the providers asserted that they were doing their best within the constraints placed upon them to provide the best service they could.

3. A) Characteristics of Strategic Home Care providers

All of the providers which make up the Strategic Partnership deliver both personal and domestic care. *(See below figures)*

Private for profit organisation	3	Carers Organisation	0
Charity Organisation	1	Voluntary organisation	0
Private non profit organisation	1		

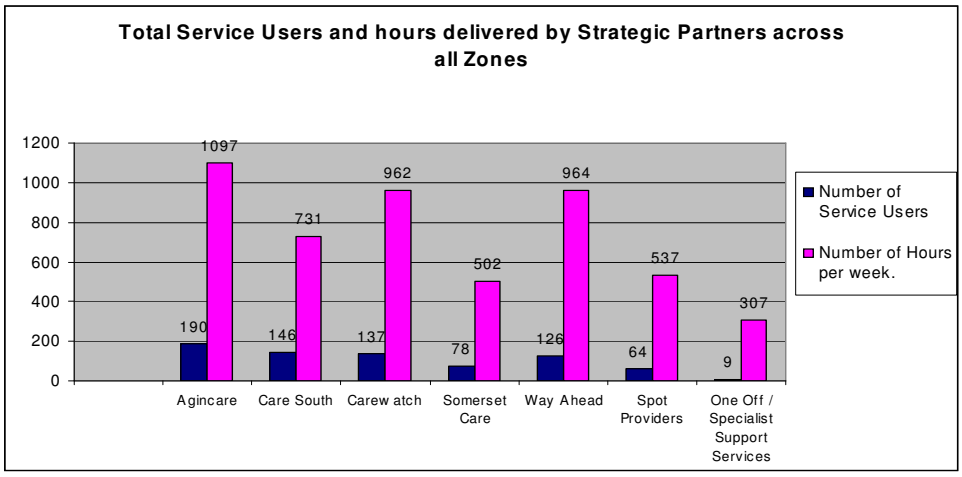
- Agincare B&NES has the lowest number of full time staff but the highest number of part time staff. (*See below bar graph 4)*



Total number of service users and hours delivered by the Strategic Partners across all Zones

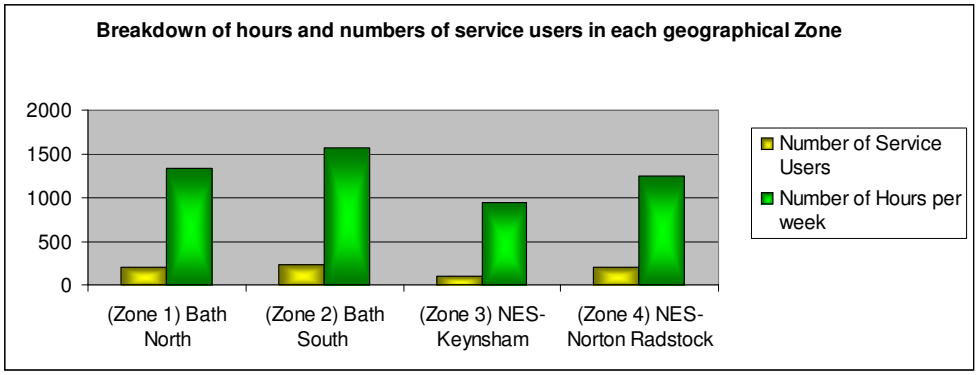
- The amount of care hours by service providers varies every week, simply because of the nature of the service that they provide e.g. hours may decrease due to service user's hospitalisation or increase if their condition deteriorates

Bar Graph 5



- The total number of service users across all Zones is 750 and the total number of hours delivered per week is 5100. *(Extracted from Care First Data)*
- A client's preferred choice of Home Care service provider is governed by where they live in B&NES.
- There is also more than one provider covering each area, with up to a maximum of three. (See below breakdown graph)

Bar Graph 6



2. B) A comparison of service levels provided prior to the contract start date with service levels currently provided by the 5 contracted partner organisations

Table 3 below, provides the number of service users and number of hours of care provided in each zone before (25th March 2008) and after commisioning the Strategic Home Care Partnership. (20th October 2009)

- **The number of service users in receipt of commissioned domiciliary care has reduced by 51 Service Users. This decrease has been in all zones, apart from zone 4 (Norton-Radstock), which has seen an increase of 15 Service Users.**

Table 3

Area	Date	Number of Service Users	Number of hours per week
Zone 1 *Bath North*	25th March 2008	220	1476
	20th October 2009	201	1339
	Difference	Decrease of 19 Service Users	Decrease of 137 Hours
Zone 2 *Bath South*	25th March 2008	258	1682
	20th October 2009	238	1566
	Difference	Decrease of 20 Service Users	Decrease of 119 hours
Zone 3 *NES-Keynsham*	25th March 2008	135	848
	20th October 2009	108	943
	Difference	Decrease of 27 Service Users	Increase of 95 hours
Zone 4 *NES-Norton Radstock*	25th March 2008	188	1096
	20th October 2009	203	1252
	Difference	Increase of 15 Service Users	Increase of 156 hours
Zone 1 & 2 - *Bath*	25th March 2008	478	3158
	20th October 2009	439	2905
	Difference	Decrease of 39 Service Users	Decrease of 253 hours per week
Zone 3 and 4 *– North East Somerset.*	25th March 2008	323	1944
	20th October 2009	311	2195
	Difference	Decrease of 12 Service Users	Increase of 251 hours per week
Totals	25th March 2008	801	5102
	20th October 2009	750	5100
	Difference	Decrease of 51 Service Users	Decrease of 2 hours

The reason for the overall decrease in numbers could be explained in a number of ways:

1. Some service users may have opted to have a **direct payment package** in order to meet their identified needs and have directly employed a personal assistant.
2. Some service users may have been supported by the Intake, Assessment and Re-enablement team and have successfully been rehabilitated during this six week support and do not need ongoing long term domiciliary care.
3. Some service users may have moved into the other **'Extra Care Housing Schemes'** which have opened between March 2008 and October 2009, (e.g. *Greenacres Court in Midsomer Norton which opened in February 2008 and The Hawthorns, which opened in December 2008*). Both schemes have 30 extra care flats each. The domiciliary care for these schemes is provided by care workers directly employed by Bath and North East Somerset Council.

- **There has also been a very small (2 hour) overall decrease in the number of care hours commissioned across Bath and North East Somerset.** This is not a significant change

- **In North East Somerset there has been an increase of 251 hours per week**. An explanation for this could be that there has been an increase in the number of service users with complex health needs supported by a care package to remain living in their own homes. Therefore the hours of support needed in order for a persons needs to be met has increased for some care packages. This explanation has not been analysed in any detail and therefore it is important to note that alternative explanations may explain this trend.

Service user feedback forms for B&NES in house service, Agincare B&NES Ltd (Jan – June 2008) were compared against forms received for Agincare since they have become operational (Jan – June 2009) *(47 Feedback forms were received for In House Service/ 45 Feedback forms received for Agincare BANES Ltd)*

- **Although the response rate was fairly low one may deduce from the comparative analysis of the Agincare forms, that there has not been an improvement, nor a reduction in satisfaction rates by service users. Overall the service was rated as good, both before and after the commissioning process.** For a full table of the results see **Appendix 5**.

- Unison and Agincare also provided us with their staff survey results which captured the views of home care staff during 2009. The staff that completed the survey were previously employed in-house by B&NES but were TUPE transferred to Agincare Ltd after they won one of the contracts to deliver Home Care in 2008. However, the responses received from both were fairly low in number and therefore cannot be used to provide any substantive representation of the views of the staff that were transferred.

3. C) Analysis and Assessment of Front Line Service provision *(i.e. appropriately trained staff, flexible and well managed working patterns/ hours, staff retention and turnover)*

Reliability
Reliability was seen as a significant quality mark by the providers and each were found to have policies in place to ensure that they deliver a flexible and reliable service. (This is detailed in the service user's folder left at their home)

The key issues which make it difficult for the Strategic Providers to deliver a flexible & reliable service

Table 4

The Client	Staff issues	Other
Hospital appointments which disrupt the service or mean a wasted trip if the client has forgotten to inform them	Delays in staff CRB checks	Traffic problems (particularly in and around Bath)
Transport to and from hospital can also compound the problem	When staff sickness levels are high and it becomes difficult to care for clients at the times required and preferred	Seasonal and severe weather conditions
Managing and trying to meet all clients expectations	Problems with the carer's childcare or illness of children, as well as holidays, may mean difficulties in letting the client know there is a change or a delay.	The requirements and immediate needs of emergency care provision
The changing needs of clients and carers.		

- The Strategic Providers highlighted the point that not only is it essential that they contact the client about any changes to the delivery of their care but that the clients also inform them with any changes so that the care providers can make the necessary amendments.

- One of the care providers did acknowledge that there are some difficulties in meeting the preference for early visits each morning and said that "*this can cause a 'bottle neck' of clients expecting early calls, with not enough staff to meet the need*".

- **The service providers agreed that the service does require a degree of flexibility but it also needs a degree of autonomy in order to maintain consistency and continuity of care.**

Continuity

Recruitment, retention and turnover of staff since the transition to the Strategic Home Care partnership

Each of the Home Care providers had different turnover rates depending on the time that they had been established. They were all "relaxed" about the turnover rates for their business and did not feel that they had specific problems in comparison to the National Average of approximately 21%.

1. Agincare had taken on most of the transferred staff from the Council under the TUPE arrangements. Agincare said the losses were what they would expect after the commissioning period. They have experienced a stable workforce since Sept 2009. However several people have retired before Christmas and they are now currently recruiting staff to replace them.
2. Care watch said that they continued as usual (the other provider with TUPE employees). Some of their staff went into residential care posts, or left care work all together and15% were unsuitable. In the past 12 months they have had 26 leavers but are hoping to recruit approximately 2 people per month.
3. Somerset Care have not had any issues with recruitment and retention. 51% of their staff have over 2 year's Home Care experience.
4. Care South had a small number of TUPE staff, most of whom stayed. They recruited an additional 76 of whom 52 stayed. 6 were dismissed. 18 resigned.
5. Way Ahead had a relatively rapid turnover for about 6 months. Of 42 leavers, 27 left in less than 3 months because the job was not what they thought. This was due to a high percentage of staff who were relatively new to Home Care and *"did not fully appreciate the reality of the role and the challenges that it presents"*, 7 also had been dismissed as unsuitable. Somerset Care had also started from scratch with recruitment so had no long term workers, unlike Agincare which had a high retention rate of those who retained the first two years.

Home Care staff provided us with several issues surrounding the turnover of staff, these include:
1. Employing a large number of women with small children, who are unable to provide greater flexibility for clients because of their childcare arrangements.
2. Staff moving into Residential Care where there is not the responsibility for getting to successive clients on time
3. Other better paid opportunities
4. Some individuals find that the job is too challenging, both physically and mentally, for them and some become stressed with having to travel or deal with clients' deteriorating health and bereavement**.**
5. One provider reported that the "*main qualification is personality and life skills, and lack of these often becomes the reason why an applicant is not successful*". They also prefer to train their own people rather than inherit bad habits picked up from other organisations.

Home Care providers also provided us with several issues that can make it difficult to maintain continuity of care and maintain a properly skilled workforce:-

1. For the TUPE employees the transfer was a change of culture. For example; sickness had become a problem as some staff members were *a*llegedly regularly ringing in sick because they felt that they were entitled a certain amount of sick leave per year.
2. Two of the care providers have experienced an increase in male applicants in the last 12 months which has presented a number of issues regarding equal opportunities and promoting service user choice. For example, Muslim service users have to have a carer of the same sex due to religious and cultural beliefs. Non-Muslims may prefer that anyway.
3. Seasonal pressures, particularly during the winter months
4. Changes to service users visit times, due to hospital appointments or general care package changes.
5. Staff training / absences
6. Emergencies
7. The ratio of full-time and part-time staff i.e. many staff are doing a second job and are part time, which is felt by the providers to affect the continuity of care delivered.

All of the Home Care Providers have a business continuity plan and disaster recovery plan to ensure that they have detailed actions to take to minimise any disruption to the care service for clients.

A good example of this is from how the providers have coped with the recent snow conditions that have hit the South West during Christmas and early January 2010. Each of the providers had made their own continuity plans before the snow fell. This included telephoning all of their clients, each client being given priority criteria indicating which clients would need someone to get to them in the snow. Other clients

were assessed as potentially being able to cope without a visit for a day i.e. the more complex the case the more resources there needed to be put into it.

How important is staff continuity to the Home Care Strategic Partnership?

- The Strategic Home Care providers believe that the views of the service user about their continuity of care and support are extremely important. One service provider reported that *"continuity had to be measured against the needs of the service user and people's ideas and expectations of what constitutes continuity, which proves that it is not an exact science but needs to be discussed with each service user individually"*

- The Providers felt that it is usually impossible to supply a single carer worker to provide all the care an individual requires, but most have opted for a team approach, so that the number of different carer workers is kept to a minimum. They also aim to provide the same carer or carers on a rotating basis, particularly if several visits a day are required. This then ensures that a trusting relationship is built up between service user and carer worker.

- Home Care time sheets updated in the carer's home information pack allow the service user to know in advance who is coming and what time they arrive and depart and endeavour to inform users and relatives in advance if there is to be a change in their care worker.

- After a social worker from the Adult Care Team was 'shadowed', it became apparent that clients can often present different and sometimes awkward challenges and it is not always appropriate that re-assessments / reviews are conducted by the same person. Coupled with this, the changing pattern of the social workers' workloads does not always allow continuity of assessment / re-assessment to be achieved. Yet given the pivotal role of assessment in the whole system, it is essential it be accomplished to the satisfaction of all concerned

- Adult Care teams have recently been re-organised into three geographical areas which are linked to GP surgeries throughout the authority. Although these areas do not coincide with the care zones in the authority, for reasons of geography and patient choice this arrangement seems logical and may result in better continuity of review for the client when appropriate.

How do Service Providers ensure that they have sufficiently trained staff?

- The Strategic Home Care Providers appear to have little difficulty recruiting staff, one incentive being the fact there are enhancements to their pay when they gain further qualifications such as an NVQ or equivalent. The majority of service providers report that due to the robust training systems combined with the ability to access further training through B&NES, they feel that they have not experienced any real major barriers in maintaining a properly skilled work force

- All of the service providers place a great emphasis on the training of staff and provide regular updates with new legislation requirements or any specialist requirements that staff may need. They have also invested in the initial induction training programme so that each staff member starts with a range of knowledge and skills to assist them in providing care.

- Staff have in service training alongside an experienced care worker until they feel confident in their work. This is confirmed by on-going supervision and appraisal and by on 'spot observations' by supervisors in client's homes.

- Each of the service providers encourage staff to take all training opportunities available to them in order to assist their future development and role.

The regular practices that service providers use to maintain quality customer service standards.

1. Regular face to face reviews with clients using a quality monitoring questionnaire
2. Observation of carers as part of the National Care Standards
3. Quick response rate to concerns and complaints which can be audited

4. All of the Strategic Home Care providers undertake an Annual Quality Assurance Questionnaire completed by clients and carers, which helps to identify things that are going well and areas of opportunity for improvement.
5. Quarterly service user meetings allow issues & concerns to be raised and addressed.
6. Work performance monitoring of carers allows supervisors to measure the quality and standard of care being delivered.

All of the above are recorded for review by commissioners and fed back into internal strategies for improving on staff training, internal process and service delivery.

What attitudes are essential in the delivery of a good quality Home Care service?

All of the service providers agree that there are numerous attitudes that are key to delivering a good quality service, some of these are listed below:

1. A very caring attitude
2. A very conscientious attitude
3. A very calm attitude
4. The needs and wishes preferences of the client should always be the top priority of staff whenever practical
5. Staff who are willing to talk through things and actively seek feedback

Overall the service user response to their carer's attitude towards them was very good, an example of the types of comments received include**:** "*The carers who come to see me do provide an excellent service"*

Research also suggests that it is often very difficult for elderly people to adapt to care, particularly when they have led a very independent life, and they will often find it difficult to hand over virtually all their independence to someone else. Conversely some service users reported to us how well some carers have dealt with this and provided us with examples of how they have demonstrated a sensitive attitude when delivering individual care.

3. D) Identifying value for money from the Home Care Strategic Partnership

Identify the difference in cost before (In-house home care) and after the commissioning process (2007-2009) identifying any savings/ loss

- There has been a reduction in the cost of the purchase of Home care by -13.15% compared to the end figures of 2008/09 (+ 31.41%) and the average cost per hour for care is cheaper to that of care that is provided In house. The figures for 2008/09 purchased Home care included part year transfer of the In-House service to Agincare, set-up costs for the new partnership and some double running costs.

- **Over the last 4 years the Council has made savings, with the most recent total expenditure figures for 2009/10, for all Home Care, showing a percentage decrease of -17.02% in the total homecare for 2009/10 compared to that of 2008/09.**

The unit costs for In-House provision exclude overheads i.e. management and accommodation costs within Adult Social Care and Corporate overheads e.g. payroll, legal finance etc. An estimate of the percentage allowance for overheads would be 16% which would mean the Total Average Cost in 2007/08 is £32.22 per hour.

Comparison of the cost of Home Care with a similar service in a similar Unitary Authority

The figures below (Table 8) must be approached with caution, as what various authorities include in this calculation is not always consistent and might skew the results. For example; the results for Bath includes our in-house Mental Health Outreach Service which is an expensive service and also some voluntary organisations that we fund.

The indicators do not refer to only “Home Care” as covered in this review but can include any service that is defined as Home Care within the Department of Health Guidelines for completing these returns. It is also worth noting that in 2008/09, B&NES incurred some double running costs as a result of re-tendering.

Table 8: Note: Calculations have been based on the expenditure, per population indicators

Authority/ Council	2006/ 07	2008/ 09	Increase/ Decrease	Income as a % of Service Expenditure for 2008/09	
Bath	14.10	19.15	5.05	Bath	6.98%
Bournemouth	14.74	16.37	1.63	Bournemouth	17.28%
Bristol	18.83	22.41	3.58	Bristol	8.15%
Cornwall	15.50	16.28	0.78	Cornwall	8.69%
Devon	16.49	21.14	4.65	Devon	7.63%
Dorset	18.54	22.99	4.45	Dorset	14.08%
Gloucestershire	13.31	16.63	3.32	Gloucestershire	18.83%
Plymouth	16.17	15.44	-0.73	Plymouth	9.88%
Poole	20.57	21.38	0.81	Poole	14.40%
Somerset	13.38	14.26	0.88	Somerset	14.99%
South Glos	17.09	18.06	0.97	South Glos	11.70%
Swindon	15.38	16.03	0.65	Swindon	11.27%
Torbay	12.81	16.90	4.09	Torbay	11.43%
Wilts	11.46	10.81	-0.65	Wilts	9.44%
Average	15.60	17.70	2.11	Average	11.77%

FAMILY DATA Average gross hourly cost for home help/care		Department of Health Figures 2006/ 2007	
Bath and North East Somerset UA	14.13	Solihull	15.12
Bury	12.12	South Gloucestershire UA	17.09
Calderdale	18.05	Southend-on-Sea UA	14.11
Darlington UA	11.50	Stockport	11.22
East Riding of Yorkshire UA	13.74	Swindon UA	15.38
Isle of Wight UA	16.29	Trafford	19.27
North Somerset UA	19.04	Warrington UA	14.71
Poole UA	20.57	York UA	15.41

Conclusion

During the preparation and writing of this report we have watched a National debate begin as a result of the proposed legislation for the provision of Personal Care in the home in England and the broadsheet newspapers have produced in-depth articles on the issues. We cannot comment on this, but it does serve to emphasize the importance of our report. Generally speaking, while finding that the service as now delivered is of a generally high standard, we did find individual instances of less than good practice. As in any new complex programme, improvements can and should be made. It is for this reason that we have recommended an in-depth review in three years time.

In a time of transition, and also of changes in the national scene, it is hard to predict how the standard of care would improve if the measures we recommend were adopted. However, we do think that the relatively simple changes we recommend would reduce the stress on carers and clients alike, and would streamline procedures and make them more intelligible to professionals and non-professionals alike. We also hope that the use of translation will make the service accessible to a small minority of elderly people who have not mastered English. We are aware that many people may not have commented because they found no need for change, and were perfectly satisfied with their care – good news is not news to many- but also that we only had a limited sample and limited scope for investigation. We can only conclude by thanking again everyone who co-operated with us in what we feel was a very worthwhile exercise.

We are confident that our recommendations, while being realisable within existing budgets, could make a significant improvement to the functioning of the system

Next Steps

The final Report and Recommendations will be presented to the full Healthier Communities & Older People O&S Panel meeting on the **9th March 2010**. The relevant Cabinet Members, Cllr Vic Pritchard, (Adult Social Services & Housing) and Malcolm Hanney (Resources) will then receive the recommendations and supporting briefing papers and will have up to 6 weeks to respond to them (estimated return by **9th April 2010)**

The Cabinet has the following options:

- **Accept** the Panel's recommendation
- **Reject** the Panel's recommendation
- **Defer** a decision on the recommendation because a response cannot be given at this time. This could be because the recommendation needs to be considered in light of a future Cabinet decision, imminent legislation, relevant strategy development or budget considerations, etc.

Implementation Date

- For 'Accept' decision responses, give the date that the recommendation will be implemented.
- For 'Defer' decision responses, give the date that the recommendation will be reconsidered.
- For 'Reject' decisions this is not applicable so write n/a.

Appendix 1 What is Overview & Scrutiny?

What are the aims of Overview and Scrutiny?

• To hold the Cabinet and officers to account
• To ensure that Council services provide good value
• To examine issues that impact on the lives of Bath and North East Somerset residents
• To promote issues which are of relevance to local people and actively engage them in the scrutiny process
• To scrutinise the provision of local health services.

What type of work do Overview and Scrutiny Panels undertake?

When choosing issues to investigate, panels will question whether recommendations could tangibly improve a service for the local community. A work programme is agreed for the year ahead, with each panel focusing on an area of service delivery (although in some instances, joint panels can be convened to undertake work). Panels can also act as a catalyst – calling other public bodies to account for their actions.

What doesn't Overview and Scrutiny do?

• Make decisions about Council policies and services. Panels can only make recommendations to the Cabinet or Council.
• Deal with individual queries or complaints. These should be pursued either through Council Connect or the Council's Suggestion and Complaint service (Tel: **01225 39 40 41** E-mail: **councilconnect@bathnes.gov.uk**)
• The panels can not investigate regulatory or 'quasi-judicial' decisions, such as planning or licensing decisions.

How can members of the public be involved?
By:
• Attending public meetings of Overview and Scrutiny panels
• Suggesting a topic for a scrutiny review
• Giving evidence to a panel
• Sending in comments about any of the reviews being undertaken to **scruntiny@bathnes.gov.uk**
• Staying updated by looking at **www.bathnes.gov.uk/scrutiny**.

What are Overview and Scrutiny meetings like?

O&S panels meet regularly, during both daytime and evenings. Meetings usually last for about 2-3 hours. The agenda and reports for a panel meeting are published about a week beforehand and are available at **www.bathnes.gov.uk** (under 'Minutes, Agendas and Reports') and also at the Council's public information points. Meetings have a formal structure, but are run in an informal, accessible way with free and open discussion.

Appendix 2: History of previous Spot/ Block Contracts for each of the Commissioned Home Care Providers, which make up the Strategic Home Care Partnership

Agincare	Care South	Care Watch	Somerset Care	Way Ahead
Established in 1993. Agincare was one of the first independent domiciliary care providers in the UK.	non profit company and registered charity	Was set up in **July 1999** Is the only Service provider who has a franchise with B&NES to work exclusively with and only operate within B&NES.	Was set up in **1991.** Is one of the largest non-profit care companies within the UK and in particular Southern England, providing Domiciliary & Residential care.	A family run business providing care in local communities since 1994. Offering a range of care and support services (Domiciliary & housing related support services across Somerset & B&NES.
Prior to Commissioning of Home Care Strategic Partners				
1. applied to be an authorised provider of Domiciliary Care Services in Bath & North East Somerset in **2003**	1. Care South did not operate in Bath and North East Somerset prior to being awarded the Strategic Partnership Contract.	1. Carewatch had a block contract in the Bath area (Bath North). They also had a spot contract to cover other areas within the Bath and North East Somerset locality, which did not fall within the block contract area.	1. Somerset Care had a block contract in the Bath area. They also had a spot contract to cover other areas within the Bath and North East Somerset locality, which did not fall within the block contract area.	1. Way Ahead did not operate in Bath and North East Somerset prior to being awarded the Strategic Partnership contract.
2. Application successful and in **2004** Spot Contract awarded set out terms/ condition of business		2. First won Block contract in **2002**, within the area that they currently work Bath North	2. First won Block contract within the Geographical area of Bath in 2003 (Bath South)	
3. **Jan 2007** Were not providing any packages of care as part of the spot contract due to unavailability of carers in the area.				
Tendering/ Commissioning				
4. Tendered for Strategic Partnership Contract in **2007** and won - TUPE Transfer of B&NES Home Care staff, and commenced providing a service from September 2008. -Cover all 4 Zones (all B&NES locality) - No need for Spot Contract to continue as all work to be commissioned under the Strategic Partnership block contract. All service users receiving a service from the in-house service continued to receive a service from Agincare.	2. Won Strategic Partnership Block contract to deliver Domiciliary Care Services in **2008 within two zones of B&NES.** -TUPE transferred 12 staff from outgoing Block Provider. - All service users from outgoing Block Provider transferred to Care South, including service users who were privately funding their care.	3. Care Watch, continue to provide Domiciliary services to B&NES under the Strategic Partnership block contract arrangements.	3. The Strategic Partnership Block contract won in 2008 covers the same geographical area of Bath in which Somerset Care had their previous block contract from 2003. Note: They do not operate outside of their geographical area.	1.Won Strategic Partnership Block Contract for two zones and began operating in May 2008. A new provider to the area so at the start of the contract they had no staff and needed to recruit a brand new staff team.
5. **March 2008 -** A Spot provider gave notice of their wish/intention to terminate their contract with Bath and North East Somerset Council. It was envisaged through a mapping exercise that these service users would be offered the opportunity of transferring to Agincare's Strategic Partnership contract, However as the spot provider gave notice six months before the Strategic Partnership contract had been formally signed and was operational, Service users who wished to transfer to Agincare were transferred to Agincare's spot contract arrangement as an interim measure and this care was managed from their Chippenham Office.	3. Care staff transferring from the outgoing Block Provider to Care South resulted in consistent care for the transferred service users Although Care South won a contract for 2 zones they do provide care on an out of zone basis if the Strategic Partners within that zone cannot deliver the service.	4. Carewatch no longer has a spot contract with Bath and North East Somerset Council. They do still provide support to service users out of their Strategic Partnership block contract area. The rates charged for these "out of zone" packages are the same as their agreed Strategic Partnership contract rates.		Although Way Ahead won a contract for 2 zones they do provide care on an out of zone basis if the Strategic Partners within that zone cannot deliver the service.
6. The Spot contract with Agincare ended on the **22nd March 2009** All service users in receipt of care from				

Agincare under the Spot Contract had either transferred to Agincare's Strategic Partnership Contract or to other providers within the Strategic Partnership.				
7.				

To be included on the Bath & North East Somerset's authorised list of providers (e.g. providers with whom we would commission work) organisations had to be:

1. Registered as a domiciliary care agency with the Care Quality Commission (previously National Care Standards Commission (NCSC), and Commission for Social Care Inspectorate (CSCI))
2. Signed up to a Bath & North East Somerset Domiciliary Care Contract or Supported Living Contract
3. Be the direct employer of care staff delivering the service.
4. Be able to provide both personal and domestic care.
5. Committed to providing B&NES with copies of NCSC/CSCI/CQC inspection reports and or policy and procedure documents on request.

The authorised list application process entailed the Commissioning and Contracts Team undertaking certain checks on organisations before they could be included on the authorised provider list. Providers had to provide a copy of their certificate of registration with NCSC/CSCI, a copy of their insurance certificates, a copy of their statement of purpose, a management structure, and a schedule of charges. They also had to provide contact details of two local authorities who were purchasing domiciliary care services from them, and who would be willing to be approached for a written reference.

Appendix 3: Information about Personal Budgets (formally individual budgets)

What are the benefits of Personal Budgets?
A Personal Budget allows you to have more control over the way your support and care is organised. You have greater choice about the organisations and individuals who you can ask to support you. You can also have more say over exactly what they do and when they do it.

How do Personal Budgets work?
Firstly, you will need to have an assessment by a social worker/case manager, who will help you identify your eligible needs. Once this assessment is complete, they will tell you how much money you are eligible for in a year.

You will then be asked to write a 'Support Plan' to say how you will use the money. The Support Plan must be agreed by the local authority before it can begin.

You can receive help in planning how to spend your Budget?
You can complete your Support Plan on your own, but it may be useful to ask someone else for help. This could be a friend, a member of your family or another person or group of people you trust. Alternatively, you can ask your Case Manager to help you.

You will be asked to make an assessed financial contribution towards your Personal Budget please refer to the Financial Contribution Information Sheet.

What you can spend your money on?
At your assessment, your Case Manager will agree with you what the outcomes of your Support Plan should be. You can use the money on anything that helps you to achieve these outcomes.

Once your Support Plan is agreed, you must only use the money to pay for things that are in it. If you want to make significant changes, you should contact your Case Manager.

These are a few examples of some of the ways you could spend your Personal Budget:

- employing support workers or personal assistants: these can be friends or members of your family but you are not allowed to employ a close family member if that person also lives with you
- buying services from an agency or organisation
- paying expenses for unpaid helpers
- buying specialist equipment

Who will arrange and pay for the help or support that I need?
There are three ways of organising and paying for your assistance and support:

a) Direct Payment
If you want to manage your support yourself, you can receive the money as a Direct Payment. You will then be responsible for paying the people who are assisting you and will have control over your arrangements. You will need to open a separate bank account for the PB money to be paid into.

b) Using an Agent
If you do not want the responsibility of managing your own support, you can arrange for your Budget to be paid to someone else who can manage it on your behalf. This person is called your Agent and can be a family member, friend or group of friends. There are also a number of independent organisations who can act for you in this way.

c) Support organised by Social Services
You can ask Social Services to organise your support for you. However, Social Services can only organise support from their own services or from organisations and agencies they have contracts with. The choice of organisation you can use is therefore more limited. Social Services cannot employ individuals on your behalf

Appendix 4: Other Domiciliary Care Services provided by Bath & North East Somerset Council

- Sitting or Home respite services, where a worker stays with a person in their own home for a few hours to give a carer a break from caring

- Family Link Service, similar to a sitting service, available as a specialist service for people with a learning difficulty, provided for the dual purpose of giving the carer a break and providing social or life skills training for the cared for person.

- Home Support Service, where a worker undertakes activities with the service user, usually this is task centered short term work with a rehabilitative purpose.

- Community Meals, Hot and frozen

- Occupational Therapy Services, which are provide aids and adaptations to the home.

- Extra Care Housing, which provides sheltered housing which includes a domicilary care service on site.

Appendix 5: Tables / Charts

4.1 The below table indicates the percentage of Service Users in each Ethnic Group in Bath and North East Somerset. The majority of which are White British.

Ethnicity	Area – Bath	Area – North East Somerset	Percentage for Total Area
White British	94.0%	99.0%	96.3%
White Irish	0.3%	0.3%	0.3%
White Other	2.3%	0	1.3%
Mixed Other	0.3%	0	0.1%
Asian Indian	0.8%	0	0.4%
Asian Other	0.3%	0	0.1%
Black Caribbean	0.5%	0	0.3%
Other Ethnic Group	0.5%	0	0.3%
Not Stated	1.0%	0.7%	0.9%

4.2 Comparison of service users feedback forms for B&NES in house service, Agincare B&NES Ltd (Jan – June 2008) compared to forms received for Agincare since they have become operational (Jan – June 2009)

Question	BANES Homecare	Agincare BANES Ltd.
Q1. Overall how would you rate your domiciliary care service?: Excellent	58%	51%
Q2. Good	36%	49%
Q3. Fair	2%	0%
Q4. Overall Poor	0%	0%
Did not answer	4%	0%
Q5 Are you happy with the timekeeping of the Care Workers and are you contacted about any change to your care?	98%	95%
Q6.Do you feel that the number of care workers involved in your care plan is acceptable?	100%	100%
Q7. Do you think the Care Workers are properly trained and experienced in the tasks they assist you with?	100%	100%
Q8.Do you feel that Care Workers are discreet and respect your privacy?	100%	100%
Q9.Do you feel Care Workers understand your needs and refer to you care plan?	100%	100%

There has not been an improvement or reduction in satisfaction rates.

Appendix 6: Background information on the initial Intake, Assessment and Re-enablement Team, where new referrals go for up to 6 weeks before being transferred to the Home Care provided by the Strategic Domiciliary care providers

This is an intermediate Home Care Service aimed at promoting independence and supporting Service users to gain or regain daily living skills and confidence, and where possible reduce the level of care required as the service user's independence increases. The Team also act as an initial response service to Adult Care in cases where the Duty Team have identified that the provision of the service is an alternative to Residential care or hospital admission.

They will also, monitor, review and adjust service/care plans to ensure that assessed eligible needs are subsequently met, and make recommendations on the on-going commissioning for individual service users with Adult Care & Commissioning Teams.

The service is short term (up to a maximum of 6 weeks), and will not be provided for longer than necessary. The service is only provided for up to 12 weeks for people who are receiving a rehabilitation programme following a cerebral stroke.

The key service objectives for the Team are :-

- Timely intervention
- Enable hospital discharge
- Stabilise care plans
- Support individuals in regaining as much independence as possible
- Prevent inappropriate admissions to hospital/care homes

Elegibility:
The service is for adults over eighteen years old who are resident in Bath and North East Somerset, who have been referred and assessed as needing a Home Care service. This may include service users who require further assessment and/or re-enablement to clarify the nature of their long term care needs.

Care provision: (The estimated size of the service required to meet local needs is 400 hrs per week[20])

The Commissioning Team provide, along with other documentation, an outcome focused care plan that has been agreed by the Service User and/or Carer and are responsible for the ongoing assessment, enablement and monitoring of the service user in achieving the outcomes agreed on their support plan.

The Intake Team will provide the Commissioning teams with the information they need to arrange the most appropriate levels of care to meet the desired outcomes of the service user's service plan, including the advice of a qualified therapist or other professionals involved in the service user's care, and agree a commencement date with the Commissioning Team.

Reviews & Future Commissioning:
Towards the end of an indivdiual's period of re-enablement, usually after 4 weeks, (or earlier if appropriate), the CommisioningTeam, will arrange a formal review of their care needs. The intake and re-enablment Team will forward reports about amended services and recommendations to the Commissioning Team who will then draw up the final care plan, and commission any longer term services if required.

The Commissioning Team will be responsible for the official closure of cases and entering the required information into the Care Management review system for any ongoing reviews. Future commissioning of service packages will be the responsibility of the Adult Care & Commissioning teams who will commission new services within 2 weeks of the 4 weekly review.

[20] B&NES, Social & Housing Services, Home Care Intake Service, Specification, Jan 2009

Appendix 7:

The Strategic Partnership provided us with a list of methods and processes which they felt demonstrated how they ensure that a client receives information about the care that they are receiving:-

- Team supervisors ensure that effective channels of communication are developed within the Local Authority and that as much service user information is gained during the referral process and before the initial visits.

- Each client is initially visited by a care supervisor/advisor who will give them an information pack, which contains all the relevant details of the care being provided to them and this will be explained to them, including their point of contact with the company. This is kept in the home of the client and is updated as and when necessary. It also provides the opportunity for the service user to ask any questions they have or request for special requirements.

  The service providers also ensure that the service user understands the care that they are given through the information packs, which are available in different formats and languages for service users.

- Each of the Home Care Strategic Service providers have a system of record keeping which is a condition of their registration, which is kept in the client's house.

- Some of the providers hold quarterly service user meetings with invites to all service users and their representatives to attend. This allows direct feedback about changes to the delivery of their care.

- The Strategic Partners meet monthly via either the Strategic Partnership, Zone meetings and through informal meetings which allows for the sharing of information.

- Each of the service providers currently use different rota systems and methods to determine the optimum number of staff to deliver a service, which is chosen to match their individual business needs. However, all of these systems perform similar functions and the end results are very similar across all of the providers. For example, one of the providers is currently using a sophisticated computer software programme called 'Dom Care' to timetable visits, map areas, texts carers and alert the operator when a phone call is needed. Clients are also supplied with the telephone numbers of the offices and encouraged to contact the support staff if their carer did not appear within the agreed time slot.

- All clients receive regular care need reviews which help to identify any communication issues. The reviews are a standardized method of communication, used by all providers that are undertaken every three – six months.

Glossary of Terms

Adult Care Team: Adult Care Teams in Bath & North East Somerset currently commission domiciliary care packages for older people who are physically frail and those with mild to moderate dementia and for younger disabled adults. Care commissioned could include personal care and domestic support. The Adult Care Team is also responsible for undertaking carers' assessments, which may result in services being commissioned for the carer.

Block Contract: A block contract normally involves payment of a fee for a defined range and standard of service. A block contract approach is used to guarantee service availability from a provider. It also gives the provider some security with regards to guaranteed income. For example; our current block contract arrangement, agrees target hours with the service provider. They will receive an upfront payment, which helps their cash flow and provides reassurance that they are our preferred providers for work that we commission on behalf of service users.

Carer: The Service User's relative or friend who provides a substantial amount of care to the service user.

Care first: Carefirst is the electronic record system which all social work staff use to record information about the service users they work with. For example they record all actions taken, assessment dates, input packages of care and record who is providing care to a service user, the service users date of birth, address, ethnicity, religion, to name a few of the functions. The feedback for this review has not been gathered in one go, but has been collated as a continuous process, from the start of the Strategic Partnership contracts (each one starting on different dates), therefore a representative sample has been analysed for each provider.

Care Plan: The documents setting out the care required and the way the Service User's assessed needs are to be met, also called a Service Plan or a Support Plan.

Care service Co-ordinator: A member of Bath and North East Somerset staff who is responsible for assessing, monitoring and reviewing Service Users care**.**

Care Worker /Domiciliary Care Worker: Any person employed or engaged by the Service Provider to carry out the service.

Care Quality Commission (CQC): The Care Quality Commission is the independent regulator of health and social care in England. The CQC regulate care provided by the NHS, local authorities, private companies and voluntary organisations and aim to ensure better care is provided for everyone - in hospitals, care homes and people's own homes.

Geographical Zone: One of the four areas in Bath and North East Somerset within which domiciliary care services are to be delivered

Home Care Assessment & Reviewing Officer: A member of Bath and North East Somerset staff who is responsible for reviewing a Service User's domiciliary care provision against the Service Plan

Personal Social Services Research Unit (PSSRU): conducts high quality research on social and health care to inform and influence policy, practice and theory.

Service User: The recipient of domiciliary care.

Social Worker: A member of Bath and North East Somerset staff, who is responsible for assessing, monitoring and reviewing Service User's care

Strategic Home Care Partnership: Each of the five home care Partners, Agincare, Care South, Way Ahead, Somerset Care, Care Watch have been contracted by the Council to provide domiciliary care, including waking/ sleeping nights and 24hour care as required. 2 or 3 of these providers work in each geographical zone. The aim of the strategic partnership is that the providers will work in partnership with each other and with the Council to develop the Home care service in B&NES over the next 5 years.

Spot Contract: A framework contract from which services can be purchased on a case by case basis (and as and when required) in line with predefined and agreed terms and conditions on which the Council will do business

with them There is no guaranteed level of service, and consequently unit costs for purchasing of a service can be higher than block contract arrangements. There is currently no intention of expanding the number of Spot Providers on the current authorised list.

The Transfer of Undertakings (Protection of Employment) Regulations (TUPE) preserve employees' terms and conditions when a business or undertaking, or part of one, is transferred to a new employer