REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 25 MARCH 2021**

SUBJECT: **OUTCOME BASED CARE AT HOME**

BY: **CHIEF SOCIAL WORK OFFICER**

1. REASON FOR REPORT

1.1. To inform the Board of the commissioning plans for an outcome-based Care at Home service

2. RECOMMENDATION

2.1. It is recommended that the Moray Integration Joint Board (MIJB):

i) agree the plan for commissioning an outcome-based care at home service; and

ii) note the indicative timeline for the delivery of an alternate model for commissioning care at home;

3. BACKGROUND

3.1 The delivery of Social Care (Self-directed Support) (Scotland) Act 2013 places the individual at the centre of the assessment process recognising they are best placed to define their needs, make choices and take more control of their lives. The traditional way of providing care at home through time and task does not underpin the values and principles of Self-Directed Support, which is focussed around person centred planning, identifying personal outcomes, and establishing the most appropriate way to meet those outcomes in an individualised and flexible way.

3.2 Care at home nationally and locally is facing significant challenges in workforce and provider sustainability as well as increasing demands and costs. Change is needed as the system is unable to operate with traditional models of delivery. Currently care at home is commissioned via a competitive tendering exercise where we contract with our providers to deliver the task which needs to be completed and the time that will be required. This is commonly referred to as “time and task” commissioning.

3.3 The independent review of adult social care in Scotland (published 3 February 2021) recommended a range of changes needed in commissioning. A shift from

competitive to collaborative commissioning must take place and alternatives to competitive tendering developed and implemented at pace is required. Decisions must focus on the person's needs, not solely driven by budget limitation. Moray's existing traditional care at home contract has been extended to allow sufficient time to focus on the proposed new outcome-based commissioning, supporting recommendations in the independent care review.

3.4 The new model of care at home service underpins the Home First approach whilst committing to working with people not as passive recipients but as partners in their own care, treatment and support. It is therefore vital to have a sustainable care at home market providing flexible and good quality outcome-based care.

3.5 The plan for the new model of care at home involves Health and Social Care Moray (HSCM) working with a care at home external partner to jointly deliver an outcomes-based care at home service across Moray, whilst meeting the specific needs of each locality. The external partner will work in close partnership with our internal service through virtual team meetings. The contract will be awarded on the 1st July 2021 with implementation on the 1st November 2021. The following three-month period is the transition period when the existing care packages will transfer, and any staff transfers under TUPE legislation will take place. The transition is a complex process and at this current time, there may be factors/elements which are not yet known and will have to be dealt with as and when they arise.

3.6 The operational process involves Social Workers assessing and agreeing high level outcomes with the individual. The care provider and the individual agree how best to meet their needs. Over the first 6-8 weeks of care and support, the provider and individual will review their needs collaboratively and agree the future plan. A philosophy of re-ablement and/or recovery is at the core of service delivery. This includes reducing service provision as appropriate if the person has been re-abled which is defined as being able to carry out an activity of daily living independently. This will be underpinned by the use of supportive technology.

3.7 In line with the Commissioning timeline and to complement the retendering of the care at home service, a project group was formed to support the delivery of the overarching aims which are to:

- Support the delivery of a personal outcomes approach between the care provider and service user based on a good conversation;

- Develop the underpinning processes and procedures to support this change in the way that care at home support is provided; *and*

- Through a three month development phase ensure that underpinning processes are fit for purpose.

3.8 The underpinning project plan will aim to ensure that the necessary training and the revised operational and performance management frameworks are in place by the time that the new care at home contract begins on 1 November 2021. The three month development period will also be used to refine the project plan to meet the aims of the project.

The project plan includes the following workstreams:

Phase 1 (pre contract) Oct – July

- **Process and Documentation** – Develop and refine processes and associated documentation which are outcome based and co-produced with homecare staff;
- **Communication and Engagement** – Communicate and inform all internal and external stakeholders;
- **Commissioning** – Create a commissioning document setting out requirements for outcome-based care at home with evaluation including Service User involvement;
- **Training and Development -** Develop a package of training materials and information sessions to support the delivery of change management and behavioural changes;
- **Service User Transition** – Support service users and families to be prepared for a possible change in provider through SDS conversations;
- **Workforce Structure** - Review and audit existing workforce structure to be redesigned if required;
- **Reporting** – Gain organisational approval and understanding; and
- **Performance Management** – Develop a personal outcomes performance management framework capturing qualitative data which is able to be shared at management and front-line level.

Phase 2 (Contract awarded) Aug-Nov

- **Process and Documentation** – Develop and refine processes and associated documentation which are outcome based and co-produced with homecare staff;
- **Communication and Engagement** – Communicate and inform all internal and external stakeholders;
- **Continuous Professional Development -** Support change management and behavioural change through coaching, mentoring and supervision**;** and
- **Workforce Changes –** Implement workforces changes identified within the three-month development period.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 There have been several research reports looking at what people want from care delivered in their home and exploring what good-quality care looks like, with strong common themes including:

- **Person-centred care** – caring for all the person's needs together in a holistic, integrated way;
- **Valuing and involving people,** as well as their carers and family members – ensuring that people are able to express their preferences, views and feelings. This may include ensuring that people have choices and that their views about how to make improvements are sought, listened to and acted on;
- **Continuity of care** – ensuring that care is consistent and reliable. This may include ensuring that people have a properly reviewed care plan, that care workers are known to the person and limited to a small number of people visiting, providing reliable and flexible visit times, planning for missed or late

visits, and ensuring that people are able to contact services between appointments;

- **Personal manner of staff** – a caring and compassionate approach to care. This may include effective communication, getting to know the person and building relationships to ensure that care happens the way the person likes it;
- **Development and skills of staff** – ensuring that staff are equipped with the training, supervision and experience to do their jobs effectively. This may include regular meetings for staff, personal development and training on particular conditions such as dementia; and
- **Good information about services and choices** – ensuring that people know where to get advice and understand their choices about local care options, including quality and financial advice. Focus on wellbeing, prevention, promoting independence and connection to communities – to be able to stay in their own homes and be supported to do things themselves. This may include linking people to be able to contribute to their local communities and social groups. (*Healthwatch 2017; Maybin et al 2016; CQC 2013; ADASS et al 2017.2017); SCIE 2014; NICE 2016).*

4.2 The new model of outcome-based care at home aligns with what people are saying they want and value from a care at home service. It supports the values and principles of SDS, supports Moray's strategic plan whilst underpinning recommendations from the Independent Care Review for Adult Social Care Scotland.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"

Moving towards outcomes-based care has a good strategic fit with two of the three strategic drivers in the IJB Strategic Plan, namely HOME FIRST (being supported at home or in a homely setting as far as possible) and PARTNERS IN CARE (making choices and taking control over decisions affecting our care and support).

(b) Policy and Legal

There are 2 main legal reference points for this project which the MIJB are legally responsible for:

- Section 12A of the Social Work (Scotland) Act 1968 – the duty to assess adults need for care and support; and
- The Social Care (Self-Directed Support) (Scotland) Act 2013 the legal basis for choice over care and support.

(c) Financial implications

Assuming an implementation date of 1 November 2021, it is estimated that the additional costs associated with this project will be £260,000 for the 2021/22 financial year. The full year effect of which would be in the region of £600,000. This estimate is based on the national benchmark rate. The Chief Financial Officer has acknowledged this budget pressure in financial planning for 2021/22.

(d) Risk Implications and Mitigation

The scale of this work should not be underestimated. The risks around being unable to successfully embed an outcome-based care at home service in our culture and system will be identified through the project plan and mitigations identified accordingly. The change management required will be resource intensive and is likely to require re-prioritisation of existing resources and priorities.

There is a perceived risk that market choice will be reduced. HSCM are facilitators in the health and social care market development whilst service users are their own commissioners through SDS.

(e) Staffing Implications

The staffing implications associated with this project are still to be defined. There is a specific project workstream focusing on potential staff implications and any proposals for change will be progressed in line with respective employers agreed policies and procedures in respect of change management and organisations changes as appropriate.

(f) Property

No property issues identified at this point.

(g) Equalities/Socio Economic Impact

EIA will be further developed as the project continues, in liaison with the Equal Opportunities Officer.

(h) Consultations

Chief Social Work Officer; Chief Financial Officer MIJB, Self-Directed Support Officer; Senior HR advisor; Service Manager Internal Services, Internal Home Care Managers, Equal Opportunities Officer and Tracey Sutherland, Committee Services Officer have been consulted.

6. CONCLUSION

6.1. The Board are asked to agree the plan for commissioning an outcomes-based care at home service, noting the shift in paradigm for delivering homecare from time and task to personal outcomes, whilst recognising the linkages to national and local policy.

Author of Report: Carmen Gillies Senior Project Officer HSCM
Background Papers: With Author
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