Tool 1: Basic concepts in home care and reablement

This document is part of the Home Care Outcomes-based Commissioning Toolkit developed by the National Commissioning Board for Wales to assist home care commissioners and providers to move the home care service towards a more outcomes-based approach. This is an outline document that will be developed further as the project moves forward.

1 Core Material: Overarching principles of this toolkit

The provision of social services in Wales is governed by the Social Services and Well-Being (Wales) Act 2014. The Act is accompanied by a Code of Practice and guidance on the exercise of social services functions and partnership arrangements. The Code of practice stipulates that:

"In order to seek to promote the well-being of people who need care and support and carers who need support, local authorities need to understand what matters to people and the personal outcomes they wish to achieve".

The provision of health services in Wales is the remit of NHS Wales under the direction of the Welsh Government. Local Health Boards have responsibility for all commissioning and provision of health services in their area. The Welsh Government has produced an Outcomes Framework for the NHS in Wales that it describes on its website as follows:

"The NHS outcomes framework includes only outcomes and outcome indicators that have been determined to measure health related well-being. A delivery framework is in place to support the delivery of health and well-being by health boards and health trusts. "

Generally, the toolkit identifies that there are three models of outcome-based commissioning:

- **Model 1: Outcome Based Care Planning:** (Using outcomes as the basis for planning and reviewing a care package).
- **Model 2: Reward for Achieving Outcomes and customer satisfaction:** Again, Individual focused but concentrating on the financial aspects of meeting outcomes.

- **Model 3: Population based accountability for Outcomes:** Responsibility for the provider(s) for meeting the outcomes of a group of people across a defined geographic area.

2 Purpose of this tool

This tool provides an overview of the basic concepts in home and reablement across Wales and relates them to the three model of outcomes based commissioning which are used throughout the toolkit

3 Overview of home care and reablement concepts

Home care services provide help for people to live at home, generally with a focus on helping them to live more independently. It may include help with daily living activities such as getting out of bed and getting washed and dressed or help with intimate care tasks such as going to the toilet.

Most home care provision in Wales is funded by local authorities, although health funders do fund hospital discharge or home from hospital support services that involve 'personal care' for short intensive periods, in addition, some people do fund their own care, and the NHS does commission some under the NHS Continuing Health Care guidelines.

Local authorities are not allowed to fund or provide health care services but home care workers may help with medicines management (for example prompting people to take medication) or dealing with dressings etc.

Home care providers will generally work with a person to agree a home care plan that will follow on from the requirements of a Care Plan generally drawn up by the local authority (under the Social Services and Well-being (Wales) Act 2014) (SSWBA) or the NHS (if they are commissioning the home care service).

Under the SSWBA the Care plan should focus on what outcomes the person wants to achieve and this should be reflected in the home care plan. In practice, the commissioning of home care and care planning has largely focused on 'contact hours' and specific tasks that need to be undertaken.

Reablement services are a particular form of home care that is usually provided to people who have just been discharged from hospital or are otherwise entering the care system following a crisis or a period of deterioration in their ability to care for themselves. Reablement is often linked in with NHS and other services as part of an overall Intermediate Care service and health funders do fund hospital discharge or home from hospital support services that involve 'personal care' for short intensive periods.

Reablement also precedes a longer-term assessment and the provision of home care or other services on a longer-term basis. Reablement encourages service users to recover the confidence and skills to carry out activities themselves and continue to

live at home. As part of Intermediate Care, reablement is generally provided free of charge for six weeks and is often seen as lasting for no more than that period of time.

However, there is some emerging evidence that 'ongoing' reablement over a period of months can see people become progressively more independent over time.

There have been some high-profile problems with home care services in Wales, and home care services are often seen as being on the edge of crisis. The UK Home Care Association (UKHCA) represents many provider organisations and regularly issues reports highlighting what they see as the low level of payments to providers. The 2016 UKHCA report[1] estimated the average rate paid in Wales as £14.99 per hour – above the UK average (which was £14.58 per hour), but below the UKHCA calculated 'fair' rate of £16.70 per hour. This is often linked to problems with recruitment and retention of home care staff, with rates of pay often at or just above minimum wage levels. Because of these problems some providers rely heavily on the use of agency staff to maintain their services. This can lead to variability in the quality and reliability of services.

Rurality is also a factor that impacts upon home care services in some parts of Wales, with large geographic areas sometimes greatly increasing the travelling distances for home care staff.

The commissioning and procurement of home care varies across Wales with a range of approaches used. Spot purchasing, block contracts, Framework Agreements and Dynamic Purchasing systems are all in use in different parts of Wales. In part these different arrangements reflect the prevailing market conditions in different parts of the country, but also reflect locally-established practice.

One further point is worth making at this juncture. Not everybody views outcomes in the same way. Some organisations see it as a label to apply to whichever approach they are using at the present time. Some, more reasonably, identify a generic set of outcomes for either a population or for individuals and use them as the basis for their approach. Others, however, very much see outcomes as being related to a specific individual and an expression of that individual's needs and priorities.

The Care and Social Services Inspectorate (Wales) (CSSIW) carried out a national review of home care services in 2016 and produced a report.

The review found that that the way domiciliary care services are commissioned and procured has a direct impact on the experiences of people who receive care.

It also found that where care and support is arranged for a set length of time with fixed tasks (a 'time and task' basis) is more likely to result in inflexible, rushed care, especially when call times (visits) are short. They also found that care purchased at low prices tends to lead to more problems with recruiting and keeping care workers.

[1] 'The home Care Deficit' UKHCA October 2016

The review found that most people, most of the time, are happy with and appreciate the care they receive, but considered this remarkable given how systems around traditional domiciliary care are designed.
The review also found that arrangements for purchasing care in councils and health boards are extremely varied. This comes at a very high cost in terms of potential care and support capacity, duplication and inefficient administration.

CSSIW found that many commissioners are considering outcome-based commissioning and were looking for a way to use it. However, commissioners were anxious to get it right but are concerned about avoiding costs rising or services failing. CSSIW identified a small number of councils were developing an approach to outcomes-based commissioning for home care.

Finally, the review found that there is a serious lack of care and support capacity and the market is very fragile. Amongst their recommendations, they included one that regional partnership boards, local government and local health boards should:

'(Promote)… the use of flexible, outcome-based services and move away from 'time and task' systems.'

Set out below are the three models of outcomes-based commissioning being considered with this toolkit and an overview of how they might affect home care services?

Model 1: Outcome Based Care Planning: (Using outcomes as the basis for planning and reviewing a care package)
Adoption of this model should lead to a change in thinking and practice within home care services, with the service being more aware of the need to achieve outcomes rather than just carrying out designated tasks. There should be an opportunity for more flexibility in terms of how and when the services are provided, and more negotiation between the provider and the service user about how to support the service user in achieving their outcomes. It may increase the complexity of the role of the home care worker, and require a greater degree of skill and on their part and a greater range of competencies.

Model 2: Reward for Achieving Outcomes and customer satisfaction: (Again, Individual focused but concentrating on the financial aspects of meeting outcomes)
Adoption of this model would require all the changes outlined in Model 1, above, and also add a considerable amount of complexity to the financial and payment arrangements between the commissioner and the provider. Firstly, there would be a need to identify precisely if, and when reward related-outcomes have been achieved.

There would need to be agreement on what proportion of the payment is related to the achievement of the outcomes, and when it should be paid.

There may well need to be procedures to 'review' the feasibility of the outcomes identified when they are not met, and the contribution of the home care towards those outcomes that have been achieved. Also, it remains the case that where

providers do support a person to achieve greater independence they may be diminishing the volume of work on offer to themselves, and this may mean there is a need for 'profit-sharing' between commissioners and providers when this is achieved.

Model 3: Population based accountability for Outcomes: (Responsibility for the provider(s) for meeting the outcomes of a group of people across a defined geographic area).
The adoption of this model would require some significant changes both to the commissioning and payment arrangements for home care and to the role and responsibility of the provider. As with option 2, there would be a need to identify the relevant outcomes to be set and to agree what proportion of the payments to the provider (if any) would be linked to the achievement of those outcomes. Providers would have to be able to think much more strategically and there may be implications for the local market as it would not be possible for more than one provider to operate in a locality (potentially denying choice to service users). However, the adoption of a more strategic approach to home care could have significant benefits for the population as a whole.

4 Care pathway example: Hospital discharge into reablement and/or home care

West Norfolk Clinical Commissioning Group (CCG) became aware that patients in hospital on the Continuing Health Care (CHC) pathway were experiencing delays to their discharge and the assessment process was protracted and sometimes confusing.
A high number of complaints from families about the process led the CCG to investigate the issue and to 'co-design' a new pathway with local health and social care partners. Changes were introduced in January 2016 to improve the CHC pathway for patients, families and staff. These changes are based on good evidence that undertaking CHC assessments in hospital is not best practice.

When the CHC assessment (to determine whether long-term care needs are primarily 'health' related) is carried out too early, i.e. before the patient has achieved their optimal recovery, their CHC eligibility can be of a temporary nature as they continue to recover.
This raises expectations for the people receiving care and sometimes should be reversed following a review, thereby creating high numbers of appeals and complaints. The two-stage CHC assessment process (eligibility 'checklist' followed by a full assessment if positive) takes time to conduct in hospital at a time when patients often have the potential for significant recovery, making it an unreliable measure of on-going support needs.

It also puts a delay in the discharge process, for a group of patients that are vulnerable to hospital complications such as falls and infections when they should be moved to a more appropriate setting to complete their rehabilitation.

CHC assessments are therefore no longer carried out in hospital but are now conducted instead in the community once the patient has reached their optimal

recovery. This means that CHC assessments are no longer part of complex hospital discharge planning.

The care that patients need on discharge is agreed by the Multi-Disciplinary Team (MDT) in charge of their care and the discharge planning team.
The assessment tool used to determine the patient's care needs on discharge is a short 5-domain 'quick-list' which has been accepted by social care partners and is being tested for consistency in the community against the CHC 'checklist' to see whether it is an accurate predictor of needs prior to full CHC assessment.

4.1 Hospital discharges: categories and process

- The patient is identified by the MDT as able to go home to their normal place of residence with social care support on discharge: The hospital raises an assessment notice and discharge notice to social care; which can/could include the provision of domiciliary care. Any nursing needs can be met by the community nursing service in the patient's home.

- The patient has discharge care needs which can be met in a residential care home: The hospital raises an assessment notice to social care. The patient's care needs can be met by care home staff and/or community nursing service in the care home.

- If the patient has nursing care needs which cannot be met by Social Services: The patient is discharged (depending on their level of nursing need) either to: a) Virtual Ward' hospital at home care team; b) Community NHS hospital; c) Community rehabilitation unit; d) Nursing/care home bed, with community nursing and therapy support.

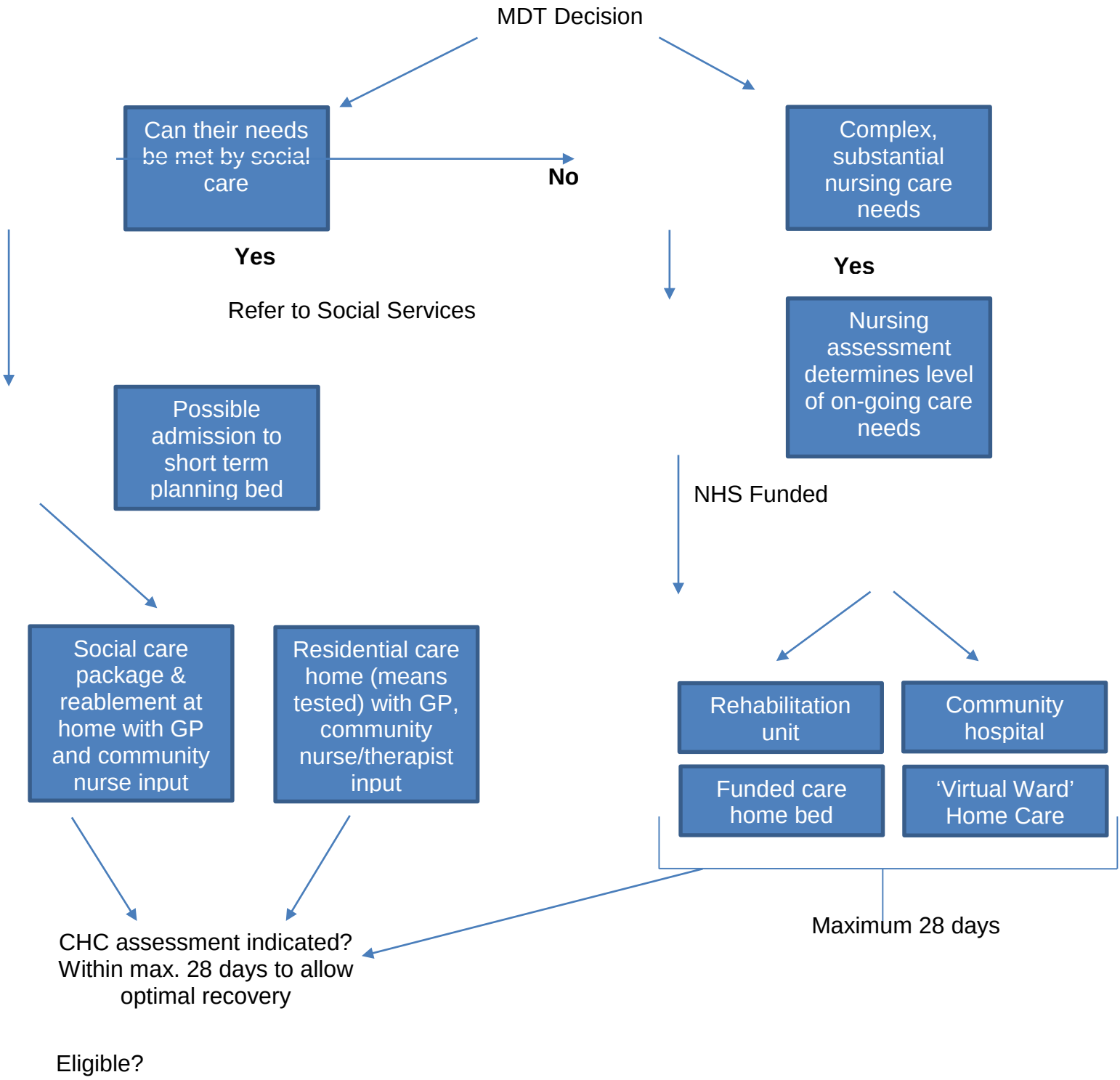
4.2 Benefits

A person on the new pathway is assessed and discharged faster and are as a result less at risk of developing complications arising from being in hospital. For frail elderly people, these include loss of mobility, dexterity and cognitive function, all of which decline rapidly on admission to hospital, along with increased risk of falls and infection.

The new discharge pathway encourages hospital nurses to focus on the needs of the patient and to develop discharge care plans that meet those needs, rather than depending on a complex framework to make that judgement. This greatly reduces the level of bureaucracy and 'form-filling' in hospital and re-focuses the nurses on patients' needs and experiences.

4.3 A person with complex care needs on discharge from hospital

(Assessed by ward nurses/ discharge team, agreed by MDT and recorded)



Yes: CHC funding awarded, home care or residential placement

No: social care is means – tested, domiciliary care or residential placement

5 Good Practice Examples

Several authorities across England and Wales have looked to move towards a more outcomes-based approach to commissioning home care and reablement services. Whilst none has been without difficulty each has arrived at an approach to commissioning outcomes-based home care and has carefully articulated what is their approach.

Wiltshire is perhaps the best-known and their work has been the subject of evaluation by John Bolton, reported on through IPC papers (available at https://ipc.brookes.ac.uk/publications.html). At the core of the Wiltshire approach was the statement that:

"In Wiltshire, the provider will be allocated a sum of money based on the defined outcomes that the older person and their assessment and care management worker have agreed. The provider is responsible with the customer for the delivery of those outcomes. The service can be described as "personalised", in that it offers an individually tailored package according to the outcomes agreed and specified by the customer. Older people within Wiltshire still have the option to receive the money agreed themselves and to manage it as a Direct Payment (where they will pay the Provider themselves)" (John Bolton, IPC ibid)

In Wales, **Carmarthenshire** have recently introduced a new Framework agreement and specification for home care that retains a payments systems based upon hours of service, but requires providers to work to a Service Delivery Plan completed in line with the initial assessment of the service user carried out by the local authority. As the service specification puts it:

"The Service Delivery Plan must be completed in line with the Service Purchaser's assessment of the individual's need as detailed in the Care / Support Plan. The Service Provider must produce a methodology to achieving the desired outcomes; this will be translated into the service delivery plan. The Service Provider must complete the service delivery plan in accordance with the Service Purchaser's guidance in Appendix 3.

The Service Delivery Plan will include:

- All tasks and activities to be undertaken by the Service Provider.
- Evidence of person centred care.
- Issues of risk or special need.

The Service Purchaser recommends that the Service Provider refers to the 'Outcomes Star' approach which measures and supports progress for service users towards self- reliance or other goals. It also relates to the broad themes set out in 'Putting People First'.

With regard to the outcomes themselves the specification states that:

'In order to identify and deliver outcomes to Service Users with a range of needs, the Service Provider will be required to ensure that they have appropriate numbers of staff who are trained and skilled to provide the services defined. There will also be an expectation that the Service Provider ensures that their organisational frameworks support the improvement of service provision and are delivered in line with national guidance and legislation in relation to these areas. The Service Purchaser is committed to delivering the following key outcomes:

- *Improved Health and Wellbeing*
- *Improved Quality of Life*
- *Freedom from Discrimination and Harassment*
- *Maintaining Personal Dignity and Respect*
- *Making a Positive Contribution*

Service Providers will be expected to deliver services that contribute to achieving the key outcomes by ensuring that:

Service User's Independence and daily living skills are maintained and enhanced Service Users are able to choose the way in which the service is planned and Delivered:

- *Service Users are afforded privacy*
- *Service Users confidentiality is maintained*
- *Service User's dignity is respected*
- *Service Users individuality is acknowledged and respected*
- *Service Users receive a flexible services*
- *Carers are supported'*

(Carmarthenshire County Council, Service Specification, Domiciliary Care and Support Service, Framework Agreement, 6th July 2015 – 30 June 2019).
The CSSIW inspection report into Carmarthenshire's home care services emphasised the importance of properly aligning assessment and care management practice with the Service Development Plan process.

On a very different track, Hampshire County Council engaged SPECTRUM CIL to co-ordinate a three-year initiative to encourage the strategic involvement of user led and community groups, and develop new and existing ULO's to be more sustainable. Whilst not directly focused upon commissioning outcomes-based services this approach gave them a different opportunity to find out what outcomes people were looking for from the service.

Hampshire sought to make participating in the competition as simple and easy as possible. There was a simple entry form with a small number of questions covering people's ideas about different aspects of Home Care.

For example: Their ideas for maximising choice and control and buying power for Home Care users (including self-funders);

- Their Ideas for producing the outcomes users want from Home Care.
- The best way of monitoring the quality of Home Care services;
- How users were involved in developing ideas – which is obviously central to the whole idea of the competition.

With regard to reablement and outcomes, a knowledge exchange project set out with the aim of embedding personal outcomes within the reablement service in North Lanarkshire Council. They looked at the potential benefits of an outcomes approach in for re-ablement, as well as factors identified as supporting and hindering the implementation of an outcomes-based approach. A summary of their findings is that:

- For people using services and carers, there was support for maximizing independence, which was associated with dignity and having a sense of achievement. However, a flexible approach is required by the service home support, to allow for variations in individuals' day to day ability to manage.
- The importance **of individual motivation as a requirement to successful reablement** was highlighted in with emphasis on the importance of clear explanations and opportunities to be involved in goal-setting.
- The importance of **getting the engagement with individual's right**, emerges as a critical factor to the success of reablement. However, the potential for resistance to reablement from individuals and families emerged as a significant concern for staff and managers/commissioners. The expectations of the service had a very significant bearing on whether individuals were motivated to participate, and that people who had previously had a mainstream service were therefore less likely to engage.
- People using home support services and their families reported that they wanted to **be more involved in decision-making** about their home support service. While this group valued independence, and linked it to dignity, they also wanted recognition that their health might vary from day to day, requiring flexibility from the service.
- In North Lanarkshire, the importance of investment in staff training and support was a key theme.
- The risk of reablement achievements being undone is emphasized, through handover to a traditional home care service at the end suggests that a change in focus from the provision of reablement services to the development of a reablement culture aimed at all service users is necessary, as the route to achieving the highest possible levels of independence.
- In North Lanarkshire whilst they sought to build ethos across the service, the mainstream service largely runs on a task and time model. The contradictions of running two models of home support side by side were evident.
- In North Lanarkshire, it was recognised that a focus on personal outcomes could provide the richer picture and understanding of the wider impact of reablement

Embedding outcomes in the reablement model in North Lanarkshire, Emma Miller, University of Strathclyde, October 2013.

6 Other materials

Unsurprisingly, there is a wide range of material available about Re-ablement and Home Care and how to commission them, and also a wide range of literature around outcome-based approaches.

An early paper on outcomes in home care is Sawyer, L, An Outcome-Based Approach to Domiciliary Care, First published in the Journal of Integrated Care, Volume13, Issue 3, June 2005

In terms of outcomes, the NEF publication Commissioning for Outcomes and Co-production is a helpful introduction to Outcomes-based approaches that usefully links it to co-production.

The NAO Successful Commissioning Toolkit also helpfully focuses upon Outcomes as does John Bolton's paper Emerging practice in outcome-based commissioning for social care

More specifically with regard to home care and re-ablement, there are a range of useful resources to use:

UKHCA website Resources page.

The Code of Practice for UKHCA Members is a helpful insight into what good practice in home care looks like from the provider perspective.

The LGIU has produced a useful discussion document: Outcomes Matter: Effective Commissioning in Domiciliary Care, Mears Group for LGIU October 2012
NICE has produced Guidance on Home Care, (Home care: delivering personal care and practical support to older people living in their own homes),
which has a particular emphasis on having an outcomes-based approach and has draft guidance out on Reablement Services

ADASS have produced Top Tips for Directors Commissioning and Arranging Home Care

SCIE have a useful resource that covers outcomes as part of the approach to Re-aliment - Maximising the Potential of Re-ablement

The CSSIW themed review of domiciliary care National Review of domiciliary Care in Wales offers a good overview of the recent position and current issues in commissioning home care and links to local inspection reports.

TLAP received a presentation in March 2017 from Atlantic Customer Solutions that looked at outcomes based home care and reported on a survey of the views of home care provider managers and identified a number of English authorities pursuing

outcomes-based approaches, as well as reporting on a research approach by the Newcastle Institute for Ageing.