Your Home, Your Care, Your Choice

Care and Support for the 21st Century

A Report from Overview & Scrutiny

Contents

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Preface

By Councillor Len Clark

Chairman, Adults and Communities Overview and Scrutiny Committee

The modernisation of Adult Social Care services poses challenges at both a national and local level. Birmingham has risen to the challenge and has made remarkable progress to achieve a two star rating from the Commission for Social Care Inspection.

The transformation in the quality of services has been accomplished through clarity of leadership, effective executive management, robust scrutiny arrangements and a determination by our staff to ensure that elderly and vulnerable citizens receive services of the highest standard. The Directorate's vision and subsequent achievements have been generously supported by Council decisions to inject considerable additional finance, both capital and revenue in to Adult Social Care provision, in recognition that these services must be afforded the highest priority. However, we have identified that it is neither realistic nor affordable for the Directorate to continue providing or commissioning social care services in the way that it currently does.

My Committee has spent considerable time over the past few years scrutinising and influencing the modernisation of residential and day services. It was therefore a natural progression for us to look at home care services. This is an essential element of the care and support spectrum that enables people to maintain or regain their independence. During their lifetime, most people will be involved with Social Care, whether as a recipient of care or as an organiser of a relative or friend's care; social care is everybody's business.

Birmingham is striving for the ideal Adult Social Care system, which would:

- Enable people to assess their own needs and choose the support and care that they want; truly "personalised care".

- Offer people real choice from a market that is receptive and responsive to changing aspirations and demands.

- Be supportive to individuals and their families and carers.

- Reach people sooner and be preventative.

- Be easier to understand, use and be more accessible

- Be affordable, both to the individual and the Local Authority

This in-depth, comprehensive review has not identified any immediate concerns that require urgent action. However, there are significant challenges that will require the Adults and Communities Directorate to change the way that it provides and commissions services for the future. These challenges arise from national policies and priorities, demographic changes and local pressures.

All Councils face difficult decisions about how they use their resources, do they focus on providing services to those with urgent, complex needs or invest in low-level preventive services that improve people's well-being and may prevent the need for more complex, expensive services in the future ?

The Committee have identified key areas that require greater priority by the Directorate, particularly strategic commissioning, market shaping, engaging the Third Sector, developing Social Enterprises and more actively promoting personalisation through individual budgets. Most people are not only willing and capable but are actually the best person to assess their own care and support needs and decide on how best to meet these needs. Their choices may not be the same as the professional's but that is the heart of enabling people to exercise choice and control. Carers should also be seen as having valuable expert knowledge and should be treated as partners in care.

We believe that improving Home Care services through the changes set out in our recommendations, particularly improving commissioning and embracing personalisation will lead to people receiving support that is of high quality, flexible, responsive to changing needs and delivered in a way that suits the individual. None of us should forget that we might require care and support in the future for ourselves or our friends and family and we will want to exercise choice and control. We are committed to promoting the rights of the individual and to ensuring that "Your Home, Your Care, Your Choice" is more than just a title of a report but is a reality for those accessing services in Birmingham.

None of us can shy away from the fact that we cannot continue to deliver and commission care as we currently do; existing funding mechanisms are not adequate for the job. Any Government which is fit for the 21st century must be prepared to make funding care a key priority alongside health care and education. Political leaders must make clear their commitment to this vital agenda.

I wish to conclude by expressing my gratitude to those service users, carers, and organisations whose input into the review has resulted in this challenging and comprehensive report. In addition, my thanks to those Members of the Review Group who engaged in lengthy meetings, contributed objectively and forthrightly to the review process and the resulting conclusions and recommendations in this report. I would also like to thank officers from the Scrutiny Office, the Adults and Communities Directorate and Committee Services for their support.

Summary

The Adults and Communities Overview and Scrutiny Committee has a reputation for challenging under-performance, identifying challenges for the City Council and suggesting where necessary, radical changes to meet the needs of the people of Birmingham. The Committee has been heavily involved in driving change to services that are required to meet the needs of some of the most vulnerable people in the City. The Committee has already been involved in the de-commissioning of residential homes and the radical re-design of day services proposed in the Day Service Scrutiny review, which was presented to Council in 2006. It was therefore a natural progression for the Committee to shift its focus to Home Care services.

Recent Government policies have clearly described a vision for the future of Social Care services, moving away from institutional care towards community services where the individual plays an active role in choosing the services they need and who provides them. There must be a comprehensive range of services to support people to live as independently as possible in the community; many recent studies have shown that most people (older people and those with disabilities and long-term conditions) choose to remain in their own homes for as long as they can manage. Home Care services are fundamental to the delivery of this vision. Service users and carers have stated that without appropriate community-based services they would be unable to cope. People who require care and support, particularly those who fund their own care or make substantial contributions towards the cost of their care, are increasingly pressing for more choice and greater control. Developing the market will be an essential prerequisite; this will be a corporate demand rather than the responsibility falling solely to the Adults and Communities Directorate.

The review has been comprehensive and has looked at all aspects of Home Care from the internal service to the work of external providers and the opportunities available through working with partners including Primary Care Trusts, the Third Sector and Social Enterprises. Fundamental to this review has been a careful consideration of the commissioning process; this needs to be strategically re-directed and sharply focused to drive and develop the market to achieve both quality services and value for money. At the fore of our deliberations has been recognition that the people of Birmingham have differing needs and aspirations and services need to be able to respond to these. The Review Group has acknowledged that there is an ever-increasing commitment to service users and carers having greater choice and being in control of personal budgets and choice of services.

Having undertaken a comprehensive in-depth enquiry, the Committee has not identified any immediate concerns that require urgent action. However, there are significant challenges that will require the Directorate to change the way that it provides and commissions services for the future. The challenges fall into three key areas:

National

The Government has set out its agenda for the future direction of social care in documents such as "Our Health, Our Care, Our Say" and "Putting People First". The direction of travel towards greater independence, choice and well-being will require key changes including:

- Pro-active promotion of direct payments and individual budgets. Greater use of individualised budgets and direct payments will impact on the role of the Directorate in the delivery and commissioning of home care services. It will also require the Directorate to influence and shape the market so that there are high quality services for individuals to purchase.

- Greater emphasis must be placed on preventative services including well-being services.

- The development of strategic commissioning frameworks with key partners including Health and the Third Sector.

- Changes to the assessment process; including streamlining assessments between agencies and the single assessment process.

- Better information and signposting – This is of particular importance to those individuals that self-fund their care or have individual budgets or direct payments.

- Service user and carer expectations have risen and services need to be able to respond to these changing demands.

Demographic

In January 2007, PricewaterhouseCoopers completed a report on behalf of the City Council which identified the challenge presented by the demographic change to the City which includes:

- The population aged over 80 will grow to become a bigger proportion of the older adult community. The number of years of ill-health will increase proportionally and care for the over 80s will also be more intensive, therefore, more expensive.

- Predicted greater proportion of older people with high levels of need.

- Perception and perhaps a reality that affluent older people are currently moving out of the City. Migration out of the City undermines the resources within the City as affluent older people are likely to be replaced by younger people with a low equity base. "Birmingham has more need with less income".

- Ethnicity in Birmingham is changing - there is a growing older BME population and they have specific cultural and religious needs to be addressed.

- Trends such as the decline in co-residence between adults and elderly parents, increase in one-person households, and decrease in willingness of people to support older people in an informal capacity, are evident in Birmingham. Therefore availability of informal care will not keep pace with increases in care needs and demands in the future.

In addition Members identified other demographic issues:

- The cost of caring for people with mental health needs is likely to spiral; particularly for those with dementia. This was supported by the Kings Fund (2008) who reported :

    "Although not the largest group of people with a mental disorder, those with dementia will see the largest increase in numbers, as a result of an increasingly ageing population, in particular people aged 75 and over. The service costs associated with dementia are far higher than all other conditions put together. They currently make up 66 per cent of all mental health service costs; by 2026 it is estimated that they will make up 73 per cent of all mental health service costs (at 2007 prices)... Current service costs, estimated to be £22.50 billion, are projected to increase by 45 per cent to £32.6 billion in 2026 (at 2007 prices). This is primarily due to an estimated increase in service costs for people with dementia of £9.0 billion. Costs will increase by 111 per cent to £47.5 billion if the real pay and price effect (a 2 per cent annual increase in health prices over and above GDP deflator) is taken into account – again, primarily due to the impact of dementia."

- People with Learning Disabilities - There are budget pressures arising from the increasing number of people with learning disabilities and an increase in those who may require care and support.

- The "baby boomer" generation has very different expectations to the current older population, as captured in a recent report by Age Concern. People reaching retirement have an increasingly high set of demands and clear expectations of what they want in retirement.

Local

- The City Council's Community Strategy ("Birmingham 2026 – Our Vision for the Future") and the Local Area Agreement have targets and priorities that relate to people who require support from the City Council. An example of this is the Community Strategy priority to "develop personalised care and support for older people and vulnerable children, young people and adults to live healthier, more independent and more inclusive lives".

- The Directorate's Commissioning Strategies for older people and younger people with disabilities sets out the Adult and Communities Directorate's strategic direction for services. The Directorate is currently shifting the balance from residential services to community services to enable more people to live independently with appropriate support. This is evident in its progress in de-commissioning residential homes and plans to move away from building-based day services, which remain to be clarified and progressed. The Directorate's commissioning

function will need to respond to these challenging priorities and think differently about the strategic role and the way in which the Directorate provides and commissions services.

- Business Transformation should significantly contribute to strategically redirecting service development; however, concentrating upon the introduction of individual budgets, whilst undoubtedly important to accomplishing the objectives as set out above, must be accompanied by considerable structural and organisational change to complement the delivery models. The organisational and structural changes required are currently described as "business as usual". The challenge will be to ensure that these changes are appropriately determined and scheduled to parallel Business Transformation and the market changes implicit in the introduction of individual budgets.

Intermediate Issues

In addition to the strategic issues above, the Review Group also identified intermediate issues that need to be addressed to improve the quality of home care services. These relate to:

- Meeting service user and carers' needs and expectations; including those who currently utilise direct payments, individual budgets and self-purchase care.

- The delivery, management and cost of the Internal Home Care Service.

- The Commissioning of Home Care from external providers.

- Commissioning and shaping the market.

- Committing a significant increase in resources to further develop and support the Third Sector and provide opportunities for Social Enterprise.

- Ensuring that Assessment and Care Management is ready to meet the changes resulting from direct payments, individual budgets and growing demands for services and support.

Conclusions

The overriding conclusions arising from the review are the key policy directions that need to be adopted to meet the challenges of the future: -

- It is neither affordable nor realistic for the Directorate to maintain and plan to continue to deliver and commission care in the way that it currently does given the national, local and demographic challenges.

- Effective commissioning is the key task to drive the necessary change and must be directed to achieve strategic objectives.

- The current commissioning process and policies will not achieve strategic objectives unless applied with integrity and are separate and independent of the provider role.

- It is vitally important that quality and capacity issues be enshrined in the commissioning process.

Home Care services are fundamental to ensuring that vulnerable people in the City maintain their independence and receive the support necessary to play an active role in their communities. The Adults and Communities Directorate recognises the importance of these services but is also realistic about the pressures brought about by changes in demographics, user and carer expectations and changes in the way services are procured and delivered. Current arrangements need to respond to national challenges including the growing use of direct payments and individualised budgets and the increasing number of people who purchase their own care. The City Council's internal home care service must adapt and pay particular attention to clarifying its role within the home care market. The Adults and Communities Directorate must make infrastructure and structural changes to the way it delivers and commissions home care if it is to address the future availability and affordability of home care services.

Summary of Recommendations

	Recommendation	Responsibility	Completion Date
R1	That the Adults and Communities Directorate must urgently review its commissioning arrangements to ensure that they are directed to achieve strategic objectives and are fully integrated with business transformation and value for money procurement. In addition, the Directorate must "commission for quality".	Cabinet Member for Adults and Communities	May 2009
R2	That the Adults and Communities Directorate must provide clarity in respect of the proposed utilisation of personal budgets as a transitional step towards the attainment of Individual Budgets.	Cabinet Member for Adults and Communities	May 2009
R3	That the Adults and Communities Directorate consider developing and implementing a policy that all new applicants for Social Care services receive an individual budget.	Cabinet Member for Adults and Communities	May 2009
R4	That the Adults and Communities Directorate must identify the proportion and influence of self-funders (including those with their own capital /resources and those who receive individual budgets and direct payments). The Directorate to identify how dominant self-funders are in the current market, projections for the future and how this will affect the market.	Cabinet Member for Adults and Communities	November 2009

R5	That the Adults and Communities Directorate must actively engage in market shaping and develop accreditation systems for external and third sector providers. Information about the source and quality of services must be made available to people who choose to self-direct their care and support. Particular attention should be paid to ensuring that the market is able to meet the needs, demands and aspirations of people from BME communities.	Cabinet Member for Adults and Communities	November 2009
R6	That the Adults and Communities Directorate review the role of Operational Managers in the commissioning of services. The commissioning process must be independent of the provider role.	Cabinet Member for Adults and Communities	May 2009
R7	That the role of the internal home care service must be directed by strategic commissioning and procurement. The internal service must respond to the service specification developed by Commissioning and amend its service accordingly. Further that the Adults and Communities Directorate must reach an early decision about its share and role within the market.	Cabinet Member for Adults and Communities	May 2009
R8	That the Adults and Communities Directorate must evaluate the quality of care plans. Care plans need to detail outcomes for service users and carers.	Cabinet Member for Adults and Communities	May 2009
R9	That the Adults and Communities Directorate must develop a thorough knowledge of the Working Neighbourhood Fund and take opportunities to secure funding for developments such as social enterprises. Developing the third sector market and in particular social enterprise initiatives must be afforded greater priority by the Directorate.To achieve this they must provide Officer support to develop and sustain these enterprises.	Cabinet Member for Adults and Communities	May 2009
R10	That the Adults and Communities Directorate must explore more fully the opportunities to work with Health colleagues in the delivery of enablement services. Good practice should be consistently replicated across the City.	Cabinet Member for Adults and Communities	May 2009

R11	That progress towards achievement of these recommendations is reported to the Adults and Communities Overview and Scrutiny Committee in May 2009. The Committee will schedule subsequent progress reports thereafter, until all recommendations are implemented.	Cabinet Member for Adults and Communities	May 2009

1 Introduction

1.1 Reasons for the Review

The review was prompted by concern within the Adults and Communities Overview and Scrutiny Committee that Home Care services had not been subject to a recent review. The Committee had received a report on the performance of the Adults and Communities Directorate and was concerned that the Directorate's past performance for enabling older people to live at home had considerable scope for improvement. This prompted the Committee to make home care, as one of the key services to enable people to live independently, a priority area for review. The Committee had already rigorously scrutinised key services including day services and the development of alternatives to residential care; home care was therefore a natural progression as a key area for the Committee to explore.

1.2 Terms of Reference

1.2.1   The key question posed was :

"How effective are the current home care services in meeting the needs of adults in the City?"

1.2.2   The terms of reference for the review set out specific additional questions that needed to be answered:

- How does in-house provision of home care operate?

- Do the current arrangements provide a quality service that is also cost-effective?

- Are the arrangements for purchasing home care from the external sector robust and cost effective?

- How user orientated is this provision?

- What are user experiences of this service?

- How does current provision fit with the seven outcomes in the "Our Health, Our Care, Our Say "White Paper?

- What are the arrangements for monitoring the performance of home care services?

1.2.3   The review was undertaken by the Adults and Communities Overview and Scrutiny Committee. Membership of the Committee changed over the period of the review, as the review crossed over Municipal years, the Members who worked on the review were:

- Councillor Len Clark (Chairman)
- Councillor Susan Axford
- Councillor Steve Bedser
- Councillor Reg Corns
- Councillor Emily Cox

- Councillor Barbara Dring
- Councillor Bill Evans
- Councillor Talib Hussain
- Councillor Shaukat Ali Khan
- Councillor Gwyn Neilly
- Councillor Barbara Tassa
- Councillor Anne Underwood
- Councillor Jim Whorwood

1.2.4   Natalie Borman led the officer team with research support provided by Gail Sadler and Elizabeth Rattlidge from the Scrutiny Team. A large number of officers from the Adults and Communities Directorate, particularly Jon Tomlinson provided invaluable support. Viv Smith from Committee Services supported the review.

1.2.5   A glossary of useful terms is included as Appendix 2 of this report.

1.3 Methodology

1.3.1   The review group utilised a range of evidence gathering techniques, including:

- Focus groups with service users, carers and third sector organisations.

- Individual and group meetings with external, private home care providers.

- Presentations from Adults and Communities Officers e.g. staff from the User and Carers Involvement Unit, commissioning and contracting, internal Home Care staff, assessment and care management, finance and the business support unit.

- Evidence from other stakeholders including the Chairman of the West Midlands Care Homes Association, Unison and the Associate Director Health and Social Policy, South Birmingham Primary Care Trust.

- Visits and evidence from Leeds City Council who provided expert advice on Social Enterprise. This was provided by Miranda Miller from the Keeping House Social Enterprise (Leeds), Dennis Holmes from Leeds City Council and by Rob Greenland from Social Business Consulting.

- Evidence was also provided by Karen Saville, Bev Maybury and Gavin Croft of Oldham Council on Individual Budgets.

- Members visited the Assist Birmingham Centre to view assistive technology.

2 The Challenges facing the Adults and Communities Directorate

2.1 The National Context

2.1.1   National policy and legislation has clearly indicated that personalised care and systems that put the individual in control of their own care is the cornerstone of Social Care transformation. There is also greater emphasis placed on the role of partnerships between the NHS, third sector organisations and the private sector. The key documents that capture this strategic direction are detailed briefly in this section.

2.1.2   The White Paper "Our Health, Our Care, Our Say" (2006) confirmed the vision set out in the Green Paper "Independence, Well-Being and Choice" (2005). It reaffirmed the outcomes set out for adult social care services in the green paper:

- Improved health and emotional well-being

- Improved quality of life

- Making a positive contribution

- Choice and control

- Freedom from discrimination

- Economic well-being

- Personal dignity

2.1.3   The White Paper identified three key challenges; demographic change, the need to radically realign systems and the need to work with people to support healthier lifestyles. The strategic direction was also set out as:

- More services in local communities closer to people's homes

- Supporting independence and well-being

- Supporting choice and giving people a say

- Supporting people with high levels of need

- A sustained realignment of the health and social care system

2.1.4   Other key strands of the white paper included the importance of effective commissioning, as this is the process whereby public resources are used effectively to meet the needs of local people. In addition, the need to respond to all of the population who require care and support including self-funders was stressed.

2.1.5   "Putting People First: A Shared Vision and Commitment to the transformation of Adult Social Care" (2007) is a ministerial concordat which establishes the collaboration between central and local government, the sector's professional leadership, providers and the regulator. It sets out the shared aims and values, which will guide the transformation of adult social care. Once again the changing role of Social Care is apparent, as is the shift to more personalised services :

"The time has now come to build on best practice and replace paternalistic, reactive care of variable quality with a mainstream system focused on prevention, early intervention, enablement, and high quality personally tailored services. In the future, we want people to have maximum choice, control and power over the support services they receive".

2.1.6   Furthermore, there is recognition that in order to achieve a personalised adult social care system there needs to be "authentic partnership with the local NHS, other statutory agencies, third and private sector providers, users and carers and the whole wider local community".

2.1.7   The Commission for Social Care Inspection (CSCI) Third Annual Report "The State of Social Care in England 2006-07" provided information about the use and cost of Social Care in the UK. The report provided evidence which showed the increasing cost of Social Care for adults; e.g. the Gross Expenditure by Councils in 2005-06 on social care for adults was £14.2 billion, this was a 4.5% rise in real terms from 2004-05. Of this 61% was on older people and 21% on adults aged 18 to 64 with learning disabilities.

2.1.8   There was also evidence about the shift away from institutional residential care towards support and care services being provided in the community e.g. in 2005-06, £2.24 billion net was spent on home care and accounted for 49% of all community services expenditure, up 2% from 2001/02.

2.1.9   The report also shows changes in the market for example from 2001-02 to 2005-06 the percentage of (gross) expenditure on care services with private and voluntary providers grew from 59% to 72%, amounting to £9.3 billion.

2.1.10   The report spoke about the increasing number of people who seek social care support yet are deemed ineligible for council-arranged services and for also those who fund their own social care; this is discussed in section 3.5 of this report.

2.2 The Birmingham Position

Internal and External Home Care Provision in Birmingham

2.2.1 Home Care in Birmingham is provided through an internal home care service and through contractual arrangements with private, external providers. The Committee heard from both types of provider during its evidence gathering sessions. One of the key issues that members explored was the balance between internal and external provision. The following evidence shows the shift over time away from internal provision towards a greater reliance on externally provided home care.

2.2.2 The graph below shows changes in the hours provided by internal and external home care over time in Birmingham. It is apparent that the number of hours provided by the external sector has increased over time.

2.2.3 A similar pattern can be seen in terms of the number of households who receive care from the internal and external sectors.

Graph 1: Internal and external provision (snapshot of hours)

Snapshot of households in receipt of home care in HH1 week
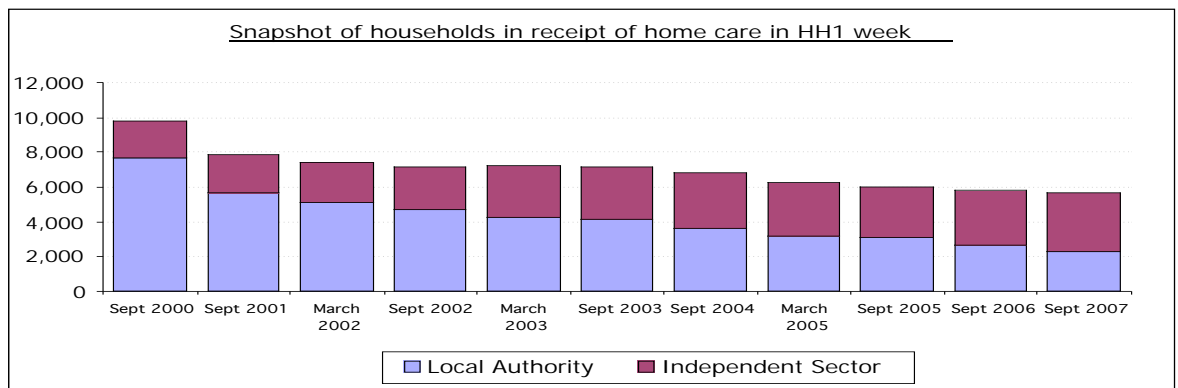
Graph 2: Internal and external provision (snapshot of households)

Snapshot of hours provided in HH1 week
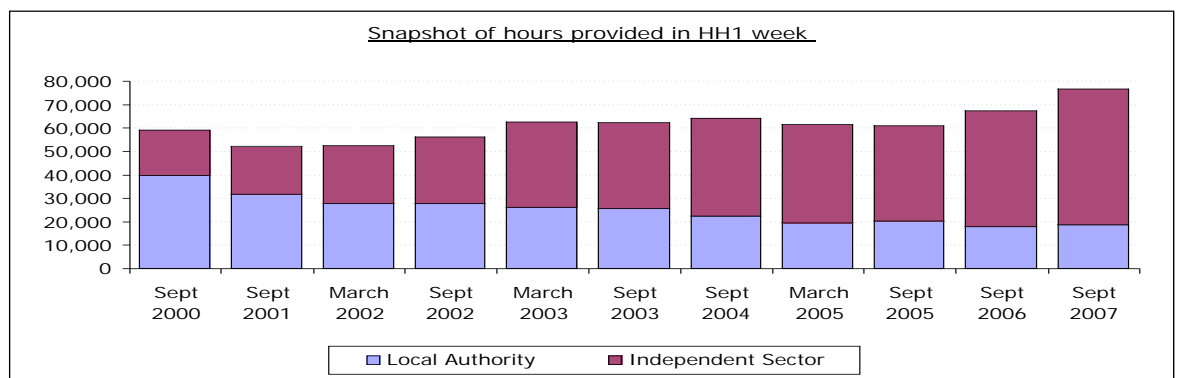
2.2.4 Irrespective of whether services are provided by internal or external providers, it is evident from Graph 2 that the number of households receiving a service has diminished considerably over the last seven years. This is due to excluding people from social care services through the application of tighter Fair Access to Care Service bandings. However, Graphs 3 and 4 clearly show a growth in the complexity and intensity of the care provided. The Committee feels that the Directorate cannot use the tightening of access criteria as a means of managing demand; it must change the way that it provides and commissions care and support.

2.2.5 Members also received data about the level of home care provided to service users. Through the Directorate's returns to the Department of Health, it is evident that the support being provided to service users in Birmingham is becoming increasingly complex and intensive. The Department of Health classes "Intensive Home Care" as more than 10 hours and more than six visits in a week. Graphs 3 and 4 illustrate that the level of intensive care has increased over time. They also show the different levels of intensive home care being provided by the internal and external sectors. The graphs contradict the evidence given to the Committee by the internal home care managers who stated that they believed that they were supplying more complex and intensive home care services than the external providers; this issue is discussed in more detail later in this report.

Graph 3: Shows the change in the provision of intensive home care over time.
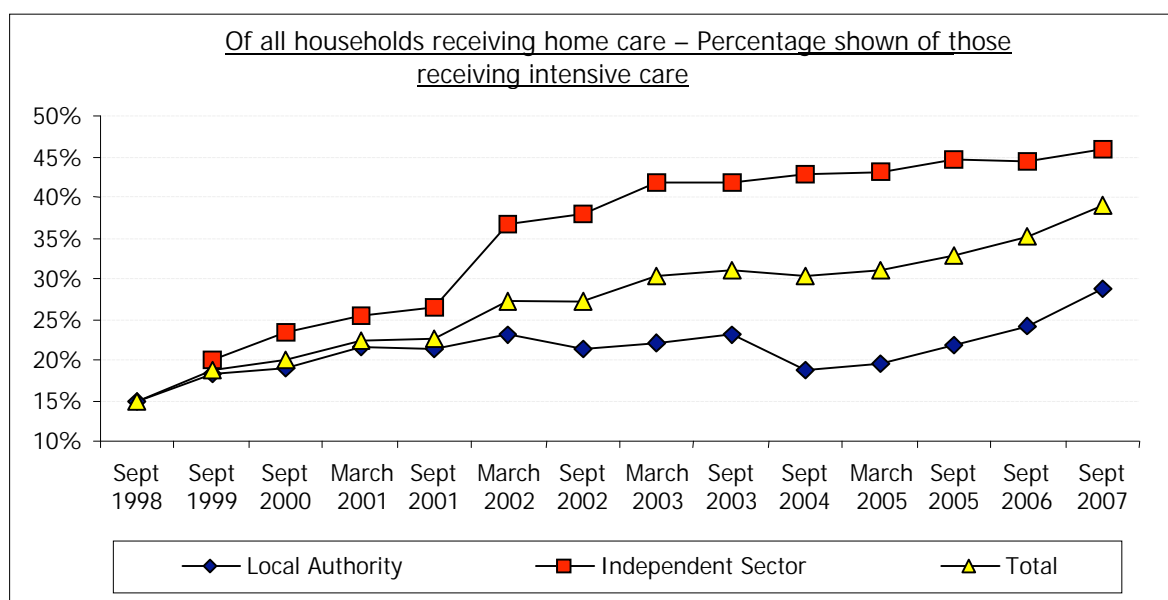
Graph 4: Provision by hour band for all providers

Percentage of households in each of hours bandings - all provision

| | <= 2 hours | > 2 hour and <= 5 hours | > 5 hours and <= 10 hours | > 10 hours |
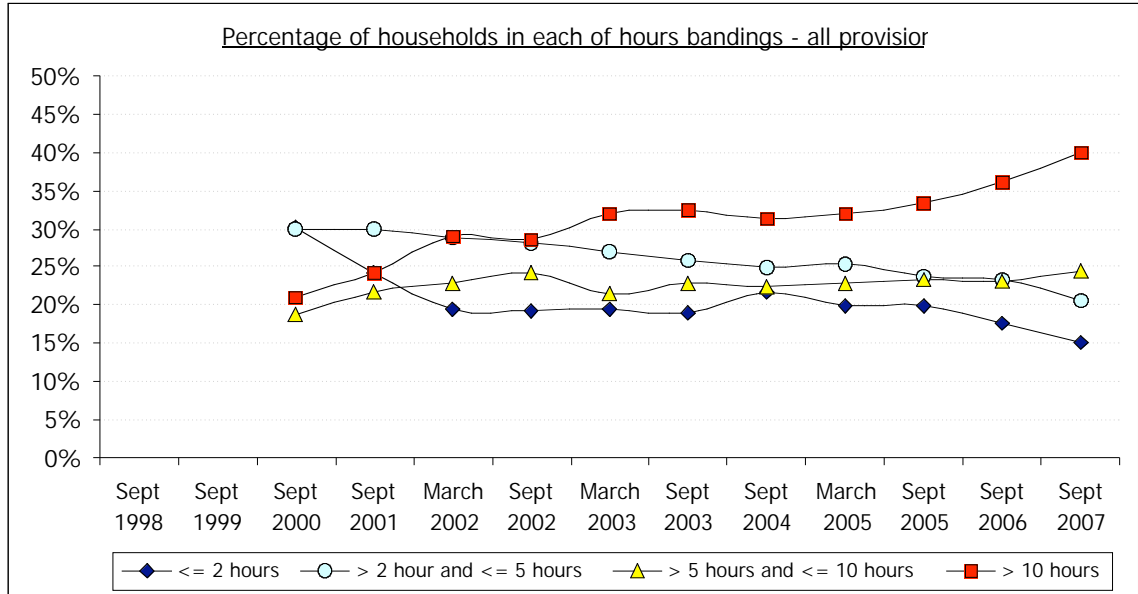
2.2.6   Graphs 5 and 6 breakdown the percentage of households who receive care into hour bandings, again there are clear differences between the internal and external services performance.

Graph 5: Provision by hour band for the local authority provider

Percentage of households in each of hours bandings - local authority provision

| | <= 2 hours | > 2 hour and <= 5 hours | > 5 hours and <= 10 hours | > 10 hours |
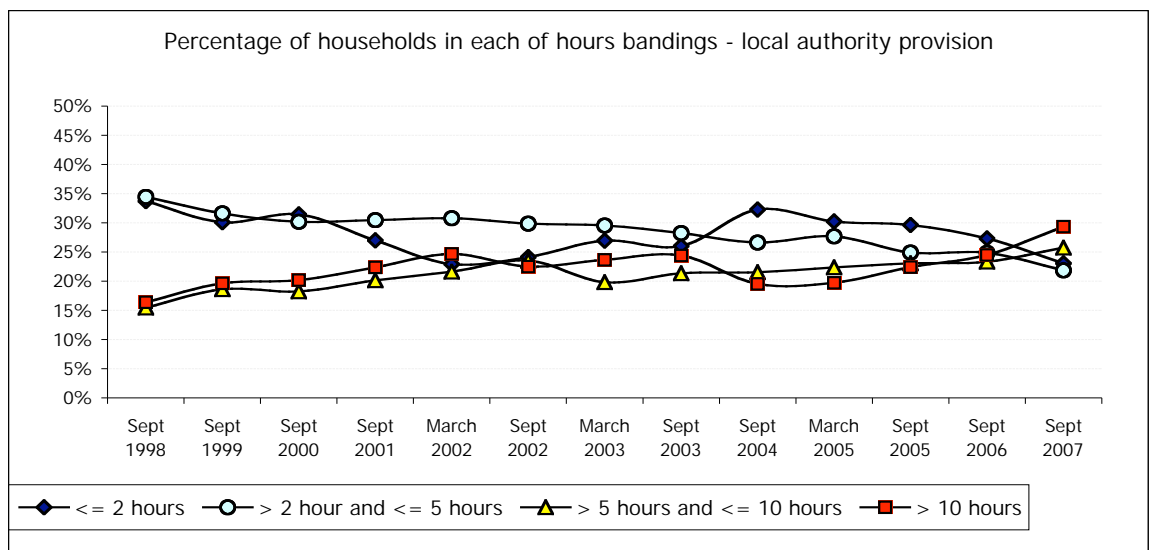
Graph 6: Provision by hour band for the independent sector

Percentage of households in each of hours bandings - external sector provision

Legend: ◆ <= 2 hours ○ > 2 hour and <= 5 hours △ > 5 hours and <= 10 hours ■ > 10 hours
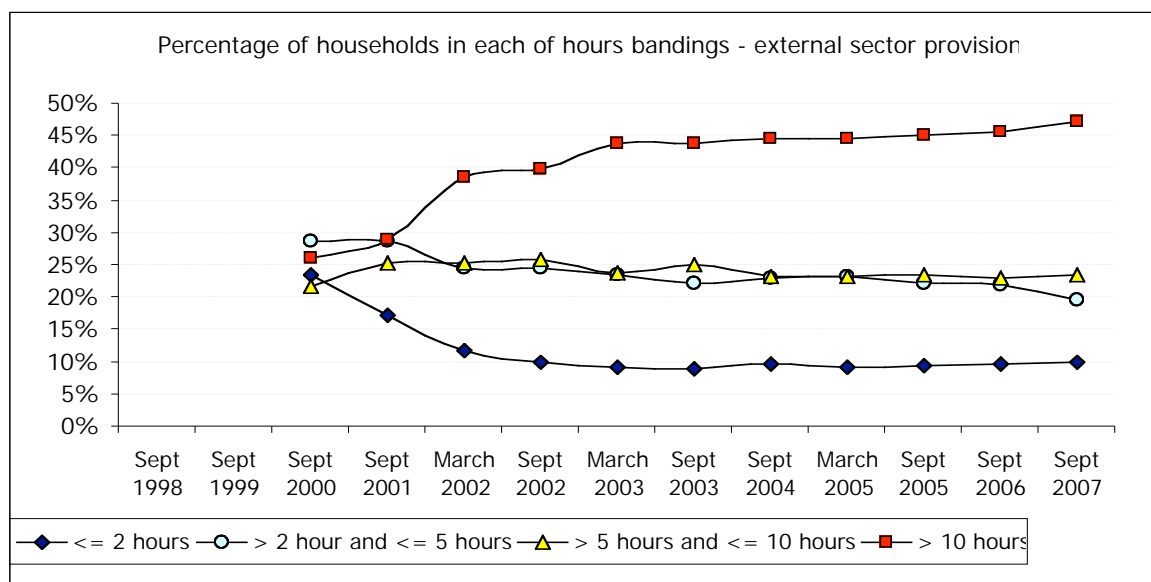
2.2.7   The Department of Health has issued guidance to Local Authorities to help them decide who is eligible for social care services; this is called Fair Access to Care Services (FACS). Local Authorities must decide what levels or bands of need they will meet, taking into account the resources available to them. The FACS guidance describes four bands of need: Critical, Substantial, Moderate and Low. Councils have to ensure that that they can provide or commission services to meet eligible needs, subject to their resources and, that within a council area, individuals in similar circumstances receive services capable of achieving broadly similar outcomes. In Birmingham, services are provided to people in the critical and substantial bands. The table below gives a detailed breakdown for the FACS bandings for people receiving a service at the time of the HH1 return in September 2007. This is shown for both internal and external providers.

Table 1: FACS Bandings for clients receiving services from internal and external providers

	Critical	Substantial	Moderate	Low	Not available	Total
Internal	48.4%	43.7%	2.5%	0.1%	5.3%	100%
External	62.2%	32.6%	1.4%	0.1%	3.7%	100%
Total	56.6%	37.1%	1.8%	0.1%	4.3%	100%

(Note: Data relates to Households. Detail on FACS bands not available for some clients.)

Home Care Finance Information

2.2.8   The tables below set out an expenditure analysis, which has been drawn from the annual return of expenditure to the Department of Health that each Council is required to provide. The expenditure analysis follows a prescribed format.

2.2.9   The activity data has been based on the HH1 return to the Department of Health, which sets out, for one particular week in the year, the level of Home Care activity. In Birmingham, the information is based on the service that is expected to be provided rather than that actually provided. As one particular week for activity is used, the unit costs calculated may be distorted by changes in the pattern of provision over the year and by differences between the service requested and that actually provided.

2.2.10   The internal provision included the costs of direct management and support. The external provision would not include the costs of commissioning or monitoring services.

2.2.11   The unit cost of external provision for 2004/05 would have been distorted because of the change in the de-minimis level for accruals in the year being raised from £50 to £500. As external home care is a high volume/low value business there would have been a significant impact on the level of expenditure accounted for.

2.2.12   The tables below set out the overall costs for home care and then for the internal and external sectors.

2.2.13   It is clear from the tables below that there is a distinct differential between internal and external costs; this is evident in terms of unit costs.

2.2.14   Internal unit costs have increased over the four-year period by approximately 50% despite the number of hours being provided having reduced by approximately 30%.

2.2.15   External unit costs have also significantly increased over the same period but by a more modest amount of approximately 30% despite taking an increased share of the market.

Table 2: Overall costs for home care

Overall Costs	2002/03 £'000	2003/04 £'000	2005/06 £'000	2005/06 £'000	2006/07 £'000
Adults over 65 (incl MH)	30147	30968	31884	33532	38005
Adults with Physical Disabilities	1773	2056	3102	2907	2825
Adults with Learning Disabilities	488	1361	2319	5448	8653
Adults with Mental Health Issues	96	92	152	146	433
Total	32504	34477	37457	42033	49898

Table 3: Overall costs for internal home care provision

Internal Provision	2002/03 £'000	2003/04 £'000	2005/06 £'000	2005/06 £'000	2006/07 £'000
Adults over 65 (incl MH)	19898	17147	19534	17188	18557
Adults with Physical Disabilities	0	0	49	51	7
Adults with Learning Disabilities	0	0	0	4	1
Adults with Mental Health Issues	0	0	4	1	2
Total	19898	17147	19587	17244	18567

Table 4: Overall costs for external home care provision

External Provision	2002/03 £'000	2003/04 £'000	2005/06 £'000	2005/06 £'000	2006/07 £'000
Adults over 65 (incl MH)	10,249	13,822	12,350	16,344	19,448
Adults with Physical Disabilities	1,773	2,056	3,053	2,856	2,818
Adults with Learning Disabilities	488	1,361	2,319	5,444	8,634
Adults with Mental Health Issues	96	92	148	145	431
Total	12,606	17,330	17,870	24,789	31,331

Table 5: Unit costs for home care

Unit Costs	2002/03 £	2003/04 £	2005/06 £	2005/06 £	2006/07 £
Overall Unit Cost	11.13	10.66	11.25	13.29	14.28
Internal Provision	13.82	12.90	16.87	16.39	19.87
External Provision	8.52	9.10	8.24	11.74	12.24

2.2.16 Graph 7 sets out Birmingham's performance around Performance Assessment Framework (PAF) indicator B17- unit cost of home care (which is shown on the vertical axis) for adults and older people average gross hourly cost for home help/care

Graph 7: Compares Birmingham's performance on unit costs with that of comparator group authorities.
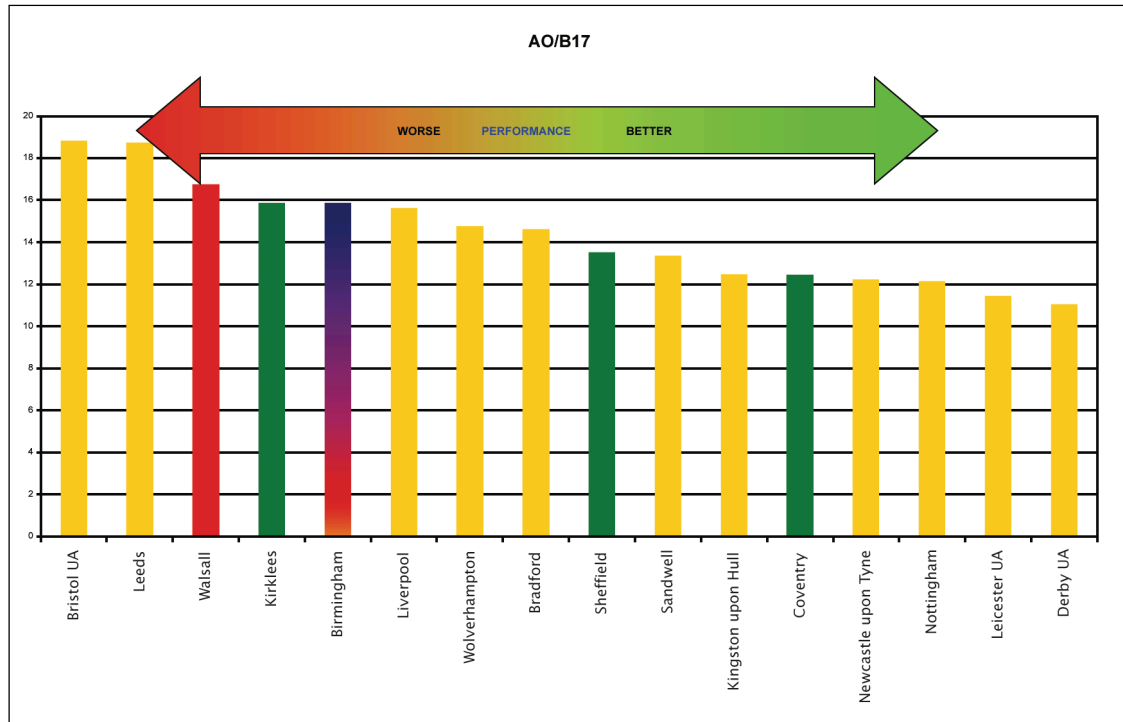
2.3 Demographics

2.3.1 In January 2007, PricewaterhouseCoopers completed a report on behalf of the City Council which identified the challenges presented by the demographic change to the City which include:

- The population aged over 80 years will grow to become a bigger proportion of the older adult community. The number of years of ill-health will increase proportionally and care for the over 80s will also be more intensive, therefore, more expensive.

- Predicted greater proportion of older people with high levels of need.

- Perception and perhaps a reality that affluent older people are currently moving out of the City. Migration out of the City undermines the resources within the City as affluent older people are likely to be replaced by younger people with a low equity base. "Birmingham has more need with less income."

- Ethnicity in Birmingham is changing - there is a growing older Black and Minority Ethnic (BME) population and there are likely to be specific cultural and religious needs which will need to be addressed.

- Trends such as the decline in co-residence between adults and elderly parents; increase in one-person households, and decrease in willingness of people to support older people in an informal capacity, are evident in Birmingham. Therefore availability of informal care will not keep pace with increases in care needs and demands in the future.

2.3.2   In addition Members identified other demographic issues:

- The cost of caring for people with mental health needs is likely to spiral, particularly for those with dementia (Kings Fund 2008).

- There are budget pressures arising from the increasing number of people with learning disabilities and an increase in those who may require care and support.

- The "baby boomer" generation has very different expectations to the current older population, as captured in a recent report by Age Concern. People reaching retirement have an increasingly high set of demands and clear expectations of what they want in retirement.

3   Evidence & Findings

3.1 Service Users and Carers

Focus Groups

3.1.1   The Review Group held three consultation events for service users, carers and third sector organisations in the latter part of 2007. The events took place in three locations across the City i.e. Sutton Coldfield, Kings Heath and the City Centre. Invitations to the events were sent to individuals who had previously had contact with the User Involvement & Carers Unit within the Adults & Communities Directorate. Each of the events was attended by, at least, three Members of the Review Group.

3.1.2   At each of the events, participants were separated into small discussion groups, which were facilitated by Scrutiny Officers and asked for their views on the following questions:

- Have you, or the person you care for, ever used Home Care Service in Birmingham? If so, were they Council Home Care services or from a private agency?

- Would you like to tell us about your experience of Home Care Services? Are there any issues you would like to raise?

- What could we do to improve Home Care Services in Birmingham?

3.1.3   A slightly different set of questions was used for the third sector organisations. Namely:-

- Do you provide Home Care Services in Birmingham?

- If you do, is it under contract with Birmingham City Council?

- Do you have any issues that you want to raise with us about Home Care?

- What improvements do you think we could make to Home Care in Birmingham?

- If you do not provide Home Care would you be interested in providing this service?

- Are you aware of Community Enterprises and Community Interest Companies – would you be interested in setting up one of these?

3.1.4   The responses we received to these questions were very similar on each occasion. The same issues and suggestions for improvement arose repeatedly. These included:-

Issues

- Social Care Assessment: Not enough social workers to carry out assessments; the timescale for receiving an assessment and feedback is too long; there ought to be more time allocated for assessments and assessments should include more than one meeting with the service user.

- Care Plan: There is a lack of flexibility in care plans i.e. care workers will only carry out tasks that are included in the care plan. Service users said that instead of home carers doing the

same tasks every week, it would be helpful if they could do ad hoc tasks such as change curtains, replace light bulbs, shopping, a little gardening etc.

- **Care Workers:** One of the main issues was concerning the time that care workers were allocated for each visit. On the one hand, we were told of care workers who were completing tasks as fast as possible in order to get away quickly and, therefore, not using all of the allotted time. Whilst on the other, we were told that carers were not allocated enough time to complete all the tasks on the care plan. The timing of visits was not always convenient, "the home care service should fit in with the service user, not the other way round". We were told that there needs to be a change in attitude in order to respond to the market, "care is needed 24 hours a day, not just 9.00am-5.00pm".

  It was felt that training for home care workers was an issue that still needed addressing. We were given an example of a carer having to show a care worker how to lift her mother out of a chair because the care worker had not received the appropriate training. We were also told of a lack of hygiene from some care workers e.g. they do not use gloves or aprons. There was a general perception that City Council home care workers received better training than external providers, therefore the care received was better. In reality, it appears that a lack of training was not always the problem but sometimes there was an inability to apply that training. For example, one diabetic service user told of her experience of home care workers not wanting to undertake the task of washing her feet and others who said they did not know how to carry out the task correctly.

- **Standards:** The quality of home care received was variable, ranging from "not good enough" to "excellent". It was reported that there needs to be greater consistency in home care standards. It appeared that where a service user had a visit from a regular care worker, they could build a relationship of trust and were a lot happier than those who never knew which home carer would be attending. Overall, service users either did not know how to complain or did not feel comfortable about complaining about the service they received because they thought that if they did the service would be withdrawn. It was also felt that if a complaint had to be made it would be taken more seriously by the City Council than external providers.

- **Communication:** The ability to contact a service provider should be made easier. Service users do not want long lists of telephone numbers as this causes confusion and frustration. They would like one telephone number, which they can call and get through to someone who can help.

  There is a lack of communication between service providers and users when a regular care worker is unable to attend and a new or temporary home care worker has to provide cover or when a care worker, for some reason or another, is running late.

  Unfortunately, it was also mentioned that there were occasions when there were some communication problems between the service user and the care worker due to a language barrier.

- **Finance:** The main concern around the issue of finance was that of direct payments. Most participants said that they did not understand the system of direct payments. They also felt that it had not been publicised very well and, therefore, there was a lack of awareness about this being an alternative to in-house provision. One service user, who was using direct payments to pay for care, was unsure of holiday entitlement, tax and national insurance deductions for her employee and uncertain about where to find information and assistance.

  Service users also highlighted difficulties when completing the documentation associated with monitoring direct payments i.e. insufficient space for those service users with larger writing to complete them properly.

  There was also resentment that payments for the cost of care are index linked, which service users say was not the case when the need for care services was first requested.

  It was felt that the financial assessment process was nosey and intrusive and staff who carry out the assessments should be more sympathetic. Service users also reported unacceptable delays in telling them about their financial contribution.

Improvements

- **Social Care Assessment/Care Plan:** It was suggested that all home care workers should be made aware and have a good understanding of other cultures. Indeed, cultural needs should be taken into consideration and included as part of the assessment.

  Further, the assessment should be carried out by a skilled and experienced independent professional rather than a social worker. Apart from presenting the service user with impartial advice on all available care options, this would also help to shorten the timescale for receiving and reviewing an assessment.

- **Home Care Workers:** One of the main issues that service users were concerned about was the amount of time that care workers spent on each visit. In order that service users only pay for the exact amount of time that care workers spend in a service user's home, there is a need for some form of electronic clocking-in monitoring system.

  All care workers, whether they are employed by the City Council or external agencies, should be trained to exactly the same standard. It was suggested that service users should be allowed to see copies of care workers' training certificates, which should be updated and revised annually.

  Some service users stated it would be helpful if carers were 'matched' with service users i.e. taking into consideration age, gender, cultural needs.

  An improved package of pay and conditions of employment should be implemented and used as an incentive to encourage recruitment of additional care workers to the market and to ensure the quality of home carers employed.

- **Standards:** Service users requested more information about the standard of service they should be receiving and in the event of those standards not being met, who they could contact to complain. It was also suggested that perhaps an independent body should be set up to deal with complaints.

   Service users and carers would like spot checks carried out on external agency care workers to ensure standards are the same across the board and the management of external agencies should be held accountable for quality provision.

- **Communication:** There needs to be a system in place to alert people to any problems that may affect their visit. For example, if their regular care worker is unable to attend then they should be given the name of the person who will be attending or if the visit will take place later than expected this should also be relayed.

   There needs to be a forum for more on-going consultation and dialogue between providers and users of the service to ensure quality of care.

   It was also suggested that the Adults & Communities Directorate should provide a Citywide approved list of service providers such as handymen, gardeners, cleaners etc. which service users can be assured are both trustworthy and provide value for money. A list would greatly assist those choosing to receive a direct payment.

- **Finance:** Service users requested that more information is made available about direct payments and the documentation that needs to be completed to record expenditure is redesigned to take into consideration disabled service users. Another issue that was raised about direct payments was that of safeguarding elderly people who might otherwise be open to exploitation.

Survey

3.1.5   This section sets out the summary results from a home care survey which was carried out by the Adults and Communities Directorate. This survey of the views of home care users aged 65 and over was carried out in February 2006.

3.1.6   The survey was carried out at the request of the Department of Health and the Commission for Social Care Inspection (CSCI). The Department of Health survey was used to derive two Performance Assessment Framework Indicators. These indicators are used by the Department of Health and CSCI to assess the performance of Councils with Social Services Responsibilities. Further information about the Assessment Framework can be found on the CSCI website www.csci.gov.uk.

3.1.7   To carry out the survey a list of all Home Care clients was derived from the care broker's database and from Local Authority home care teams. All those aged under 65 or where no data was available on Date of Birth, were excluded. A random sample was taken of those aged 65+ and sent to internal home care teams and the care brokers for checking. The aim

of the checking exercise was to ensure that contact details were correct, that the service user was still in receipt of a service, and to remove deceased clients. In addition, all those in active dispute with the council were removed from the list (in accordance with DH / CSCI guidelines).

3.1.8   For the survey, 1070 clients were selected, at random, to take part in the survey. This means that approximately one in five service users aged 65 or over were surveyed. In total, 624 people returned their survey forms. This represents a 58.3% response rate, which is within the guidelines set by the Department of Health.

Summary of results

3.1.9   Overall levels of satisfaction with home care have improved in the City since 2003. Table 6 below illustrates, as a percentage, the increase in the proportion of respondents who state that they are 'extremely' or 'very' satisfied with the help they receive in their own home. Whilst table 7 shows the same information but in terms of the number of people.

Table 6: Satisfaction Levels

Response	2003	Feb 2006
Extremely satisfied	16.5%	20.8%
Very satisfied	30.0%	32.1%
Quite satisfied	33.5%	34.3%
Neither satisfied nor dissatisfied	9.6%	7.4%
Fairly dissatisfied	4.4%	1.9%
Very dissatisfied	1.4%	1.0%
Extremely dissatisfied	1.2%	0.8%
No response	3.5%	1.8%

Table 7: Satisfaction Levels

Response	2003	2006
Extremely satisfied	129	130
Very satisfied	234	200
Quite satisfied	261	214
Neither satisfied nor dissatisfied	75	46
Fairly dissatisfied	34	12
Very dissatisfied	11	6
Extremely dissatisfied	9	5
No response	27	11

Note: Number of people in receipt of home care from the Council decreased 2003 – 2006.

3.1.10 The Department of Health has derived a Performance Assessment Framework indicator (PAF D52 – Users satisfied with social services) from the results of the question on satisfaction.

3.1.11 Calculating Birmingham's result using this indicator definition gives 53.8% (130+200/613). This is an improvement on the result for 2003 – 48.2% (129+234/753).

3.1.12 Graph 8 illustrates Birmingham's result for users satisfied with social services compared with other core cities.

Graph 8: Satisfaction Levels – Comparison with Other Local Authorities
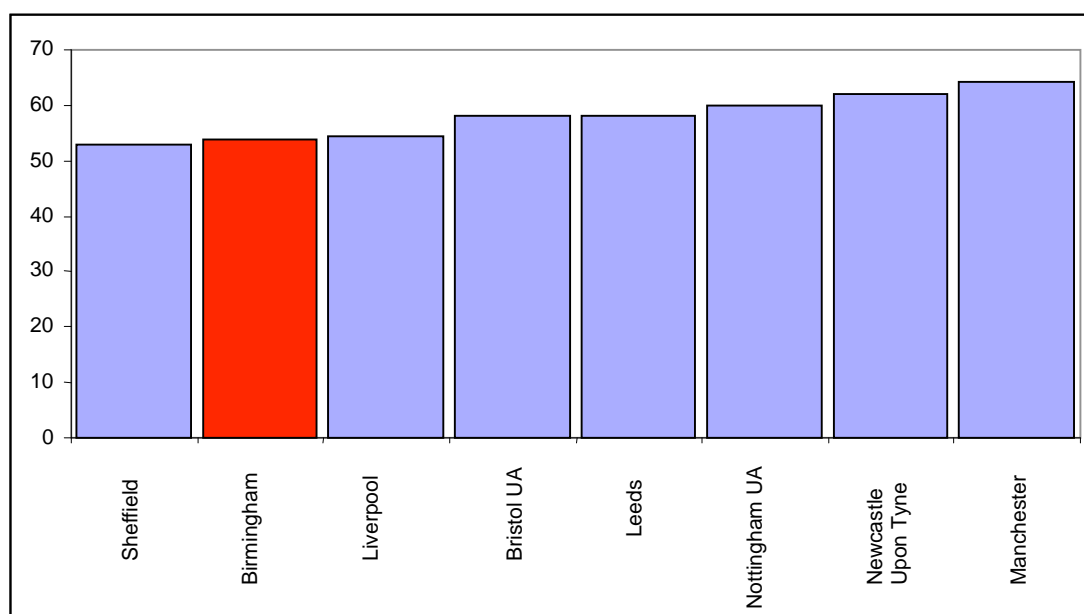
Source: Core Cities (provisional data)

Key - Birmingham 53.8%

3.1.13   Users of Local Authority services are on average more satisfied than users of independent sector services. However, this gap has narrowed since 2003. This is illustrated in percentage terms in graph 9 below.

Graph 9: Satisfaction Levels – Comparison of 2003 and 2006 for Birmingham
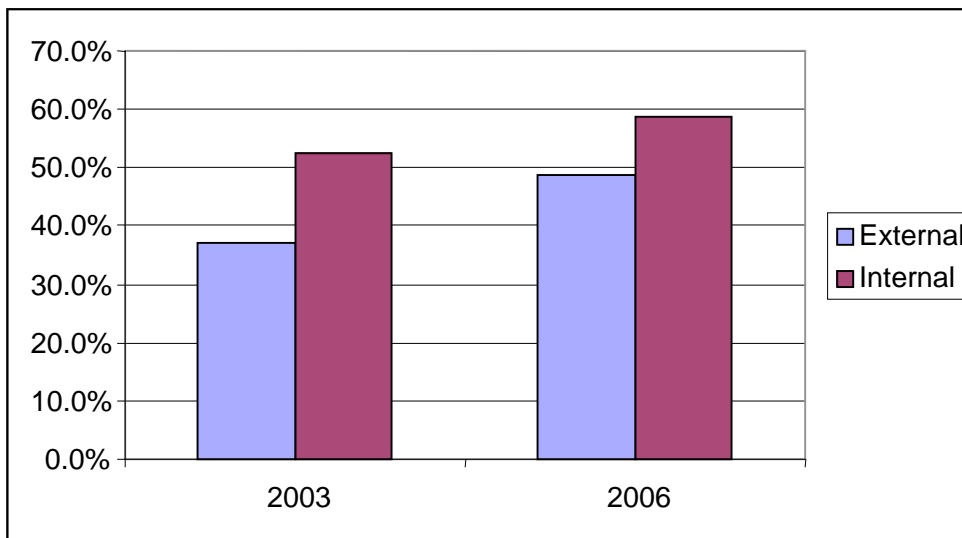
3.1.14   There is less variation in the quality of Local Authority services than in the independent sector.

3.1.15   Graph 10 illustrates the percentage of respondents stating that they were very or extremely satisfied by provider. (The identity of the providers is not shown for confidentiality reasons).

Graph 10: Satisfaction levels with Internal and External Care Providers
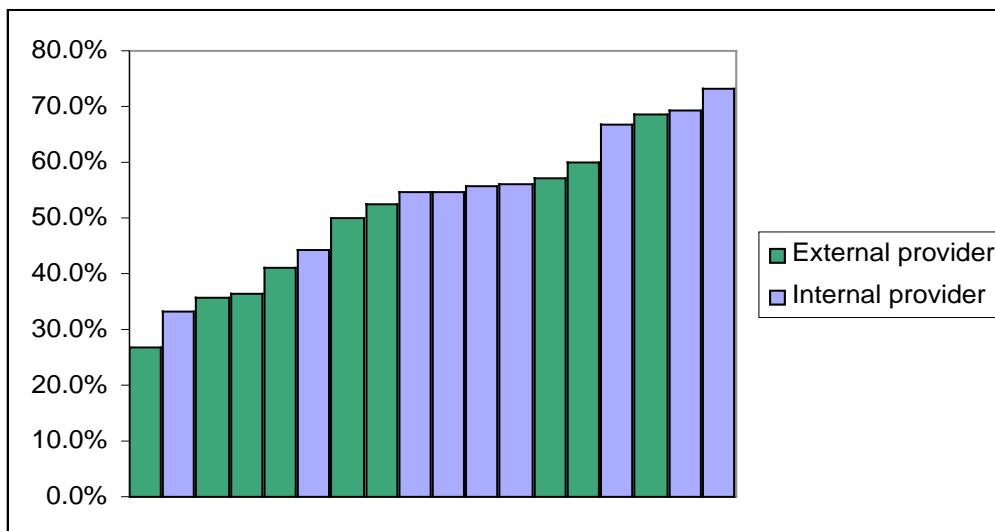
3.1.16   This graph shows the results for providers with more than 10 responses (18 providers). It is evident that satisfaction levels for internal providers are higher in this group. However, it is important to note that survey forms were received which relate to services provided by 62 providers (internal and external).

Black and Minority Ethnic Issues

3.1.17   For most of the questions asked, the highest and lowest performing agencies tend to belong to the independent sector however; the quality of the information is variable in that some of these agencies have low numbers of respondents. Black and minority ethnic groups are less satisfied with the services they receive than 'white' service users.

3.1.18   Table 8 illustrates the satisfaction with help received from Social Care & Health, by ethnic group (2006).

Table 8: Satisfaction Levels by Ethnic Group

Response	2006 'White' Groups	2006 Other Ethnic Groups	2003 'White' Groups	2003 Other Ethnic Groups
Extremely satisfied	22.4%	10.9%	18%	8%
Very satisfied	33.9%	21.9%	32%	22%
Quite satisfied	34.2%	40.6%	34%	39%
Neither satisfied nor dissatisfied	6.9%	12.5%	10%	8%
Fairly dissatisfied	1.5%	6.3%	4%	15%
Very dissatisfied	0.5%	4.7%	1%	3%
Extremely dissatisfied	0.5%	3.1%	1%	3%

3.1.19   It is evident from the table above that there were considerably lower levels of satisfaction with Home Care services amongst those people from BME communities.

3.1.20   A recent publication from CSCI "Putting People First: Equality and Diversity Matters" (2008) focused on providing appropriate services for black and minority ethnic people. One of the main issues highlighted in the report was providing personalised support:

"The key to achieving appropriate social care services for black and minority ethnic people is personalised support that addresses the needs of the individual, rather than adapting services based on generalisations about cultural requirements ... Personalised services cannot be achieved for black and minority ethnic people by just responding to individual needs as they arise. Services need to take a systematic approach to removing barriers that may prevent black and minority ethnic people from receiving appropriate support. These barriers include organisational processes or assumptions and the behaviour of individual staff, which may amount to either intentional or unwitting discrimination."

3.1.21   The report outlines what black and minority ethnic people said about what they want:

- accessible information about services leading to options about which services they use
- control over decisions about their future
- services that recognise difference's in people's cultures, without making assumptions
- support from staff with positive and respectful attitudes towards them
- services that enable them to have contact with people that are important to them
- and be connected to communities
- to feel safe and be free from discrimination
- opportunities to give feedback and to improve services.

3.1.22   Members were hopeful that the strategic re-direction towards individual budgets would significantly increase choice and control.

3.2 Internal Home Care

3.2.1   The Committee received evidence several times during the course of the review from senior managers with responsibility for the internal home care service. Members of the Scrutiny Team also held a focus group with frontline internal home carers.

3.2.2   From March 2007, internal home care services moved from area based management structures to citywide management under the leadership of the Older Adults Service Director. Members heard that there were issues of inconsistent practice and operation of the home care service with some very good examples of service development, which needed to be implemented in all areas.

3.2.3   The Internal service provided information about work in progress which included:

- Development of a short-term service in all areas to respond to hospital discharge or community support needs.

- Development of enablement services established in some areas with plans to extend city-wide (SEARCH model).

- Review of workforce development and NVQ strategy towards focus on maximising independence.

- New medication procedures in place to give clarity and ensure safety where Home Care is asked to provide this support.

- All teams having recruitment 'Open Days' bringing greater success and increasing capacity.

- All staff working to flexible contracts making the service more able to respond 24/7 to the needs of service users and carers.

- Increasing levels of intensive support to people with intensive and complex needs.

- Robust performance monitoring arrangements in place to monitor activity and set targets.

- User surveys and appraisals completed to obtain feedback on how service users and carers perceive service quality.

- Improving efficiency by making more use of I.T. by developing infrastructure to support business processes with clear links to performance monitoring.

o   Care Time

Care time is an electronic/system based scheduling tool. Home Care Organisers currently have to deal with many changes to the work schedules and programmes of home carers. For example; if a service user goes into hospital or to respite, they may have a number of visits, each day which need to be cancelled and notification given to staff. Additionally the "free time" created needs to be utilised by redirecting care to someone else to make best use of time. Alternatively, a member of staff is going to be absent and service users need to be provided with a different carer. Home care organisers have to achieve these changes by dealing with very complex, range of calls and visits needed and ranges of staff and their availability. Care Time is a system, which will provide information about the availability of staff within requested criteria and can provide additional management information.

o   Highlander

This project involved getting all care packages on to the Care First record management system. The outcome of the project was to enable greater efficiencies and management information on activity, quantity, type and financial forecasting of all home care services. It would also produce information that could be used for market shaping.

o   Auto text – mobile working.

Some of the Home Care teams now have tablet PCs that they are able to take out to service user's homes. At these visits, they complete assessments such as their health and safety risk assessment. The detail is entered onto the pre-set template, when they return to the office details are then uploaded to records. This system cuts down on repetitive writing, saves time and improves accuracy.

Work has started to look at developing a Rapid Response service.

3.2.4   Members were informed that the service has benefited from the new management structure and having a manager to lead on developments citywide. It was reported that there is greater consistency and more robust performance management of the service.

3.2.5   Domiciliary care services (home care) are registered and inspected by the Commission for Social Care Inspection (CSCI). Services are given a quality rating of between 0 and 3 stars which indicate whether a service is overall poor, adequate, good or excellent. The rating is based on how well a service is performing against the Department of Health's National Standards for Domiciliary Care. Members were pleased to hear that the internal home care service has met and indeed exceeded the national care standards –see table 9 below.

Table 9: Rating of internal home care service against the Department of Health National Standards

	Northfield 24/10/2006	Selly Oak 19/02/2007	Hall Green 19/07/2006	Night Care 17/10/2007	HoB 20/10/2006	Perry Barr 16/02/2007	Yardley 03/10/2006	Erdington 24/01/2007	Sutton 31/08/2006	Average of Standards
Percentage 4's	21.05%	0.00%	30.77%	0.00%	5.26%	41.18%	35.29%	0.00%	0.00%	14.84%
Percentage 3's	68.42%	74.07%	61.54%	100.00%	68.42%	58.82%	64.71%	100.00%	64.29%	73.36%
Percentage 2's	10.53%	25.93%	7.69%	0.00%	26.32%	0.00%	0.00%	0.00%	35.71%	11.80%
Percentage 1's	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
No. 4's	4	0	8	0	1	7	6	0	0	3
No. 3's	13	20	16	15	13	10	11	16	9	14
No. 2's	2	7	2	0	5	0	0	0	5	2
No. 1's	0	0	0	0	0	0	0	0	0	0
Standard 27	3	3	4	3	3	0	4	0	3	4
Standard 26	4	2	3	3	3	4	3	3	3	4
Standard 25	0	3	3	0	0	0	0	0	0	6
Standard 24	3	2	3	3	0	3	0	0	0	4
Standard 23	0	3	0	0	0	0	0	0	0	0
Standard 22	3	2	4	3	3	4	4	3	3	4
Standard 21	4	3	4	3	2	4	3	3	3	4
Standard 20	3	3	4	0	0	3	0	0	0	4
Standard 19	4	2	3	3	2	4	4	3	2	3
Standard 18	3	3	3	0	0	0	0	0	0	5
Standard 17	3	2	2	3	3	4	3	3	3	3
Standard 16	0	3	4	0	2	3	0	0	0	4
Standard 15	0	3	3	0	0	0	0	0	0	6
Standard 14	3	3	3	3	3	4	4	3	2	4
Standard 13	0	2	4	0	3	3	3	0	0	4
Standard 12	2	3	3	3	3	3	3	3	2	3
Standard 11	3	3	3	3	3	3	3	3	3	3
Standard 10	3	3	4	3	2	3	3	3	2	3
Standard 9	0	3	3	0	3	0	0	3	0	4
Standard 8	4	3	3	3	4	4	4	3	3	4
Standard 7	3	2	4	3	2	0	3	3	2	3
Standard 6	2	3	2	0	3	3	3	3	0	3
Standard 5	0	3	3	3	0	3	0	3	0	4
Standard 4	0	3	3	3	0	0	0	0	0	6
Standard 3	3	3	3	3	0	0	0	4	3	0
Standard 2	3	3	3	3	3	3	3	3	3	3
Standard 1	3	3	3	0	3	3	3	3	3	3

KEY

4	Standard Exceeded	Commendable
3	Standard Met	No Shortfalls
2	Standard Almost Met	Minor Shortfalls
1	Standard Not Met	Major Shortfalls
0	Standards not assessed on this occasion	

3.2.6   further report was received in February 2008, which gave progress against the actions set out above. The report listed the services plans and current developments as:

- New service delivery model for Adults and Communities to have a constituency focus, to develop stronger 'local' focus and to seek opportunities for closer working with other services.

- Home Care Teams to be realigned / restructured to fit the new service delivery model. Each constituency will have dedicated home care service linked to the Assessment and Care Management Service and local services.

- Further development of short term services to be consistent in all teams and to:

    o Support people discharged from hospital.

    o Support people in the community to prevent inappropriate admission to hospital or residential care.

    o Provide service with an enablement focus.

- Extra Care Sheltered Housing Development – All teams recruiting and inducting staff to enhance home care provision by providing dedicated 24 hour service in schemes.

3.2.7   Development of Quality Management System for implementation April 2008 to reach the Service's objective "to provide a service which improves quality of life exercised through choice and control and promotes personal dignity and respect".

Home Care Review – Home Care Workers Focus Group

3.2.8   Home care workers attending this Focus Group came from three different Council teams: 6-week hospital discharge team; 12-week short-term care team and a long-term home care team – across three constituencies of the city. Some of the issues that were raised were:-

Training

3.2.9   There was disparity between home carers about the amount of training that was received. Whilst some teams were offered training and refresher courses every year in, for example, manual handling, life support and first aid, others said that training was not readily available and that they had raised the matter with their manager in their supervision sessions. It was suggested that there should be a list of training courses available over a 12 month period and care workers should be given the opportunity of choosing which courses they wanted to attend, in addition to mandatory training. They also said it would be helpful to receive training on medicines i.e. a description of what they are used for etc. It was suggested that a course in sign language might help overcome some communication problems that care workers have with service users.

Information

3.2.10   The information that was available to home care workers about a service user varied from one team to another. The Hospital Discharge Team has access to a service user's care plan before they make their first visit, whereas by the time the person was handed over to the '12 Week' Team the care plan was not always to hand. All the home care workers said they would like more information about the service user's needs and medical history in order to give quality care. One example was if a client was diabetic, it would be essential that medication be administered in a timely manner. Another suggestion was that it would be helpful to know the service user's likes and dislikes before making a visit. Home care workers could use a family life book, which contains photographs etc, to gain an insight into the service user's past in order to 'break the ice'. This would also be useful when dealing with people with dementia who have difficulty communicating. Finally, all home care workers agreed that the service user should be told when their 'usual' care worker is taking leave in order that they are prepared for when a new care worker visits.

Other Services

3.2.11   Home care workers said there were various other services that service users requested but either were not or could not be provided by the City Council. They often asked for help/information on the following services:

- Gardening

- Hairdressing

- Shopping

- Housekeeping e.g. washing net curtains

- Befriending e.g. Home from Home service was mentioned.

- Socialising – someone to take them out.

- Service users ask home care workers to take them out in their car – care workers explained that even though they are insured, they are not allowed to take them out and also added that because of risk assessments/health & safety/care plans etc they are not allowed to do a lot of things.

3.2.12   Home carers agreed that it would be helpful if a list of Criminal Record Bureau (CRB) checked personnel who provide such services could be produced and made available to service users.

Work Issues

3.2.13   Some care workers felt that there was not always enough time allocated to carry out the duties included in the care plan, but in the event that extra time was needed for one reason or another, care workers could always telephone the office and make a request.

3.2.14   Another issue raised was that the families of service users sometimes did not treat home care workers too well i.e. there is a lot of 'nit picking'. For example, timeliness is one of the main complaints. They expect care workers to always be 'on time' but this is not always possible.

3.2.15   Occasionally, care workers were confronted with aggressive clients. When faced with this situation, a care worker would not attend to the client alone but would be accompanied by a colleague.   If the service user refused to calm down, the care workers would leave the situation and return later. This situation can be very stressful for care workers.

3.2.16   Another issue highlighted was that of night working. It appears not all teams work in the same way. Some teams work in two's i.e. a driver and a walker, whilst others work alone. Those that work alone said that they had been told that it would prove too expensive to work in two's. There was also the problem of trying to locate a new address, by oneself, in the dark, which can be very stressful. Further, the area that the team covers can mean that some care workers are spending a lot of time travelling. For example, the Ladywood/Small Heath Team covers a large area i.e. Handsworth to Sparkbrook, whilst Hall Green is simply split into east and west. The care workers agreed it would make more sense to be given a specific area, as in the case of Hall Green. This would enable them to get to know the area, cut down on time spent travelling and save the City Council money be cutting the cost of mileage.

Complaints

3.2.17   Care workers said that overall, they got the impression that service users were happy with Council provision more than private agencies. The feedback they got was that the Council provide professional staff.

3.2.18   When asked about the complaints procedure, care workers said that they explained the procedure when on their first visit to the service user. They explained to the client that complaints are not always a bad thing and that, in fact, help to improve the service provided.

3.2.19   The representative from the '6 week' short-term intervention team said that service appraisal sheets were left with service users just before the end of the 6 week duration. The appraisal sheets are confidential and are returned in prepaid envelopes. The care workers receive feedback at periodic intervals.

3.2.20   Finally, all home care workers were agreed that service users complain about being charged for services and worry about the cost. In some cases, workers have known people

to cut down on the amount of help they receive by reducing time slots reduce the cost, even though they probably need more help.

3.3 External Providers

3.3.1   A group of managers from external home care gave evidence to the full Committee. In addition, a member of the Scrutiny Team went out to see each of the agencies to have further discussions about their views on working in partnership with the City Council.

3.3.2   The external providers raised a number of issues relating to providing services in Birmingham. The main areas that the organisations were keen to discuss were financial arrangements, commissioning and contracting, assessments of service users and contact with Duty and Assessment Teams. Many of the issues and experiences were shared by a number of the organisations:

Finance

3.3.3   Organisations raised concerns about the delay in them receiving payments for the services that they have provided on behalf of the City Council. To give an indication of the level of money owed, one organisation reported being owed £100,000. Organisations were also unhappy that they also experienced delays in receiving the agreed inflationary increases.

3.3.4   One of the reasons why organisations payments are delayed is that if there is any slight variation between the service ordered and the service delivered the organisations invoice is not paid. This could be a minor variation such as a service user cancelling a visit they have a hospital appointment. Organisations are investing considerable staff time in notifying the Directorate of variations in service and wondered whether this was the most efficient way to record changes in service. It was hoped that improvements to the finance system "Highlander" would bring about considerable improvements.

Commissioning and Contracting

3.3.5   Many of the issues raised by the agencies were concerned with procurement, commissioning and contracting. There was particular disquiet about the contractual and financial arrangements.

3.3.6   Agencies felt that the current arrangements made it difficult to undertake long-term planning which affected their ability to develop their services and train and recruit staff.

3.3.7   Agencies reported that the contract price paid by the Adults and Communities Directorate was inadequate, as it did not always cover the costs of the agency e.g. paying Occupational Therapists to do assessments and training of staff on manual handling.

3.3.8   Agencies also made comment about the move away from block contracts; this had caused considerable difficulty for some agencies that had relied on a guaranteed level of work.

Duty and Assessment

3.3.9   Agencies reported that the quality of the care plans they received was variable; as was the level of detail about the service user. Some care plans lacked basic information such as how to access the service user's property or essential information about service user's medical conditions. Some agencies said that they had been told that they could not be given additional information, as it would contravene data protection legislation. Agencies reported that having insufficient information about a service user had the potential to put both the service users and the agency workers at risk.

3.3.10 Agencies expressed frustration at being unable to contact a social worker if they had a particular concern about an individual service user's care package. Examples given included the need to urgently increase the level of Home Care support provided to a service user. They believed that waiting for the Duty Social Worker to call them back (which could take several days) was not appropriate. One of the specialist agencies had managed to obtain a link social worker and this had resulted in major improvements to communication.

3.3.11 There are issues about the links between Adults and Communities Duty and Assessment teams and the agencies; however most agencies reported that the introduction of care brokers had led to an improvement i.e. agencies had less calls from individual social workers asking them if they could take on care packages as the care brokers sent an email to agencies each day outlining all the service users who needed a service. It was reported that there was some difference in the way that the care brokers worked in the city; those agencies that covered the whole of the City expressed a wish that that the role of care brokers was more consistent.

3.3.12 Agencies felt that the Directorate's charging policy caused difficulties for both them and service users. They reported that service users were often not informed of their charge until after the service had started. As a result of this delay, service users often cancelled the service once they were notified of the charge.

3.3.13 Agencies believed that they should be more actively involved in service user reviews; in many cases they were not invited to attend or contribute in writing to review meetings. This resulted in case reviews taking place without the full picture being available as agencies often have more knowledge about the service user than the person undertaking the review.

Other Issues

3.3.14   In relation to Direct Payments and Individualised budgets, some agencies reported that they were concerned that social workers were putting undue pressure on service users to accept a direct payment. The agencies also expressed concern that they may lose staff as more service users choose to receive a direct payment or individualised budget. There did not appear to be a realisation by some agencies that direct payments and individualised budgets could provide them with an opportunity to expand their operation. Concerns were also expressed about the quality of some staff employed to provide care via a direct payment or individualised budgets.

3.3.15   Some agencies spoke of how the need to tailor their services to specific communities could cause difficulties. Staff needed to be educated about the needs of particular groups and to deliver services appropriately. Where an agency provided a service to a very specific community such as the Chinese community there were particular issues relating to recruiting and retaining staff with particular skills such as fluency in a particular language. In some cases, there was a need to involve an interpreter in recruitment, training or translating care plans and this was not reflected in the contract price paid to the agency.

3.3.16   The availability of public transport for Home Care staff was also raised. Some agencies reported having difficulty in their staff travelling between service user's homes outside of core hours, for example on a Sunday morning when bus services are limited.

3.3.17   At the end of the evidence-gathering session, each of the agencies were asked to comment on what one thing they would improve or change to make providing home care in Birmingham. All of the agencies made similar comments about the payment that they received and the need to make improvements to the payments systems.

3.4 Commissioning

3.4.1   Members received presentations from key staff within the Directorate's Commissioning and Contracting function. Members also viewed a commissioning toolkit that was developed in partnership with an organisation called Care and Health. Members were not impressed with the toolkit as it appeared very theoretical and lacked practical applications.

3.4.2   Very early on in the review, Members decided that effective commissioning was the key to any discussion about improving home care services. This is echoed in the recently published "Common Core Principles to Support Self Care" (Skills for Health and Skills for Care – May 2008) where the key message for commissioners was:-

"Commissioning is at the heart of developing services that are fair, personalised, effective and safe, and focussed on improving the quality of care".

3.4.3   During the course of the review commissioning arrangements were continually being raised by Members, external providers and senior managers from within the Directorate as an area where there needed to be greater clarity. During presentations to the Committee, it
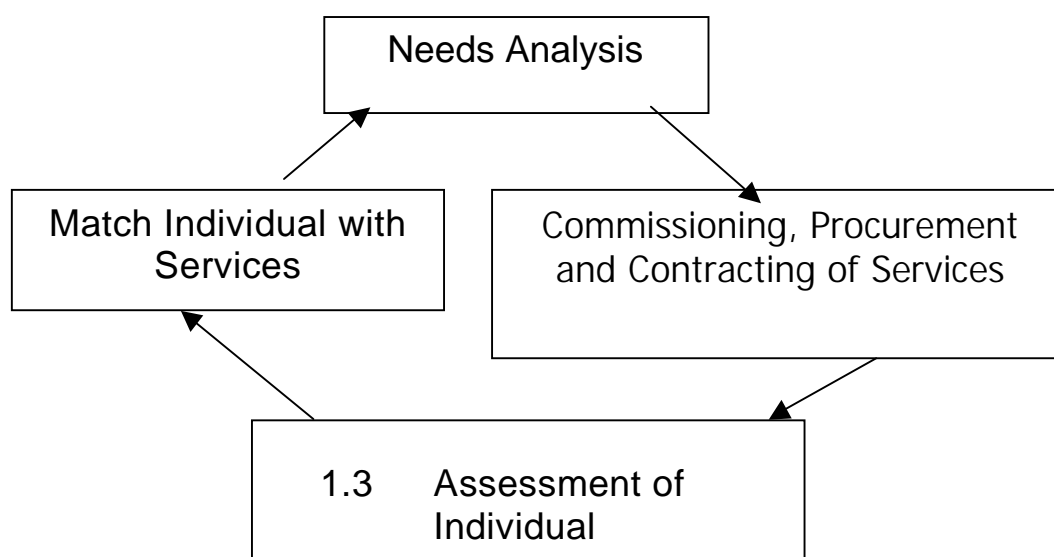
was evident that the Directorate's current commissioning arrangements were not fit for purpose. Members were disappointed with the evidence presented as it was piecemeal and did not have a clear strategic direction. Members heard evidence about the Directorate's many Commissioning Strategies but felt that these had not resulted in significant improvements to services.

3.4.4   Having heard considerable evidence form commissioning and contracting officers on a number of occasions, Members requested that the Directorate provide a more comprehensive paper that clearly detailed the Directorate's strategic plan for the future of commissioning; this additional information is reproduced in sections 3.4.5 to 3.4.21 of this report.

3.4.5   The Adults & Communities Directorate reported that it is currently undergoing a major change in the way that services are commissioned moving from being a 'grant funder' to being an 'investor'. The outcome-focused commissioning approach is based on service providers knowing the needs of the people to be served, which services should be offered and the results that are anticipated to make a difference.

3.4.6   The Directorate gave evidence about the drivers for change. The concordat 'Putting People First' set the direction of travel for Adults and Communities transformation for the next three years. It raised a number of key areas for the total transformation of adult social care services including, amongst others: individualisation, quality services, commissioning for all citizens including self-funders, and closer integration with health; CSCI will be required to align its inspection and regulation of LA's with this and the Health and Social Care Bill with its focus on 'safe and quality services'.

3.4.7   The 'Local Government and Public Involvement in Health Act' alongside the recent publications 'Creating Strong Safe and Prosperous Communities' and 'Delivering Health and Well-being in Partnership' place duties in regards to engagement, partnership and increasingly person led or personalised approaches

3.4.8   Central government sees commissioning in all its forms as the key vehicle for the delivery of a complex and interlocking transformational agenda. In regards to transparency, contestability and equity in providing safe and quality services, regardless of who pays, then all commissioned services, internal and external, must be required to meet the same standards.

3.4.9   The changing demographic and economic drivers will place volume pressures to match the pressures of improving quality and value for money. All of these will affect the management of resources.

3.4.10   The Directorate set out its current commissioning model; this is detailed in this paragraph. Commissioning can be defined as the process resulting from strategic and individual decisions, which ensures the availability of a range of best value services for the citizen.

The main functions of the Commissioning Unit are: Strategic Commissioning and macro commissioning for well-being and services that are safe and of high quality for all citizens; procurement as a specific purchasing tool in delivering the commissioning outcome for individuals from external markets, contracting and contract management of legal relationships with external providers; Place Shaping in terms of influencing the geography of the infra structure such as transport; Market Shaping in terms of developing robust and agile markets ; Monitoring for safe and quality services; Customer insight. All of these inter related functions must include (rather than involve) customer insight or engagement / communication with all citizens of Birmingham whether spending the public or personal pound. None of these functions should be seen as related to specific conditions or ages but for the citizen, holistic and cross cutting, however much of it is currently with age related contracts and rates, and with condition specific teams and functions.

3.4.11   The traditional model of adults social care commissioning is one that responds to the transactional and traditional model of:

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                    ┌─────────────────────┐
                    │   Needs Analysis    │
                    └─────────────────────┘
        ┌──────────────────────┐   ┌──────────────────────────┐
        │ Match Individual with│   │ Commissioning, Procurement│
        │      Services        │   │  and Contracting of Services│
        └──────────────────────┘   └──────────────────────────┘
                    ┌─────────────────────┐
                    │  1.3    Assessment of│
                    │      Individual     │
                    └─────────────────────┘
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Within this model the roles of various officers can be seen as:
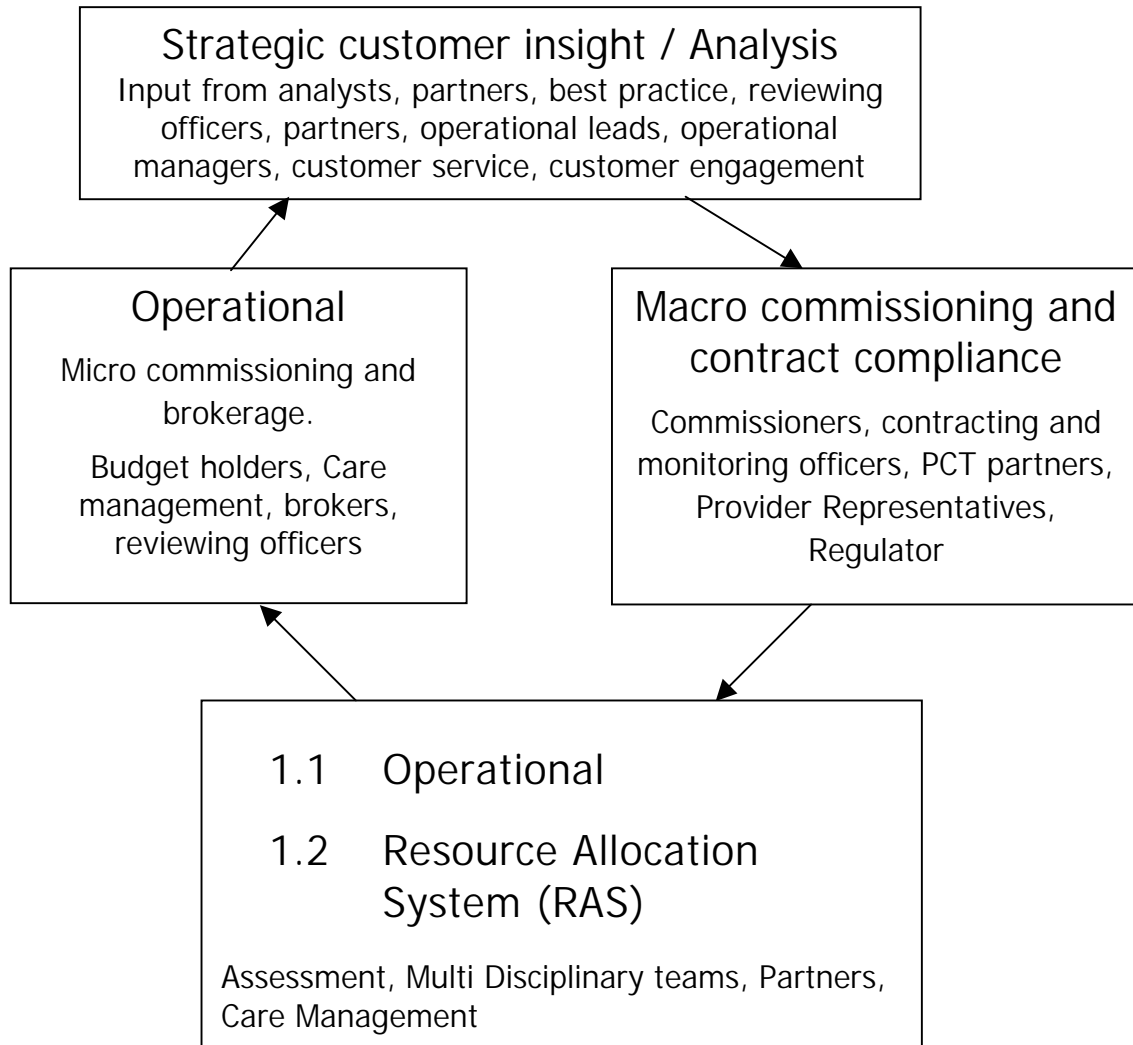
3.4.12 Within this current model, the functions of commissioning are dispersed across the Directorate. Commissioners and market shapers tend to do the macro commissioning and procurement, operational staff, from heads of service to social workers, tend to do the micro commissioning and micro procurement. As the majority of budgetary control sits within the operational side, this can lead to 'off contract' procurement and the design of services that are 'operationally' driven as opposed to 'commissioning' driven with commissioning as a function being in a supportive as opposed to a leadership role.

3.4.13 Commissioning for outcomes requires assessing for outcomes and reviewing the delivery of outcome based services. However as the current model is service driven the links between outcome based reviews, by the operational staff, and the service led contract monitoring, have not been explicit, this is being addressed with improved links between the monitoring staff and operational teams, and a changing role for monitoring staff as quality assurers.

3.4.14   In terms of the individualisation agenda, with the potential for citizens with personalised budgets purchasing services themselves or via brokers, this involving micro commissioning, procurement and contracting. The current commissioning, procurement, contract management, monitoring, assessment and review functions, in the Adults and Communities Directorate, continue to reflect the traditional roles they evolved to meet and are no longer fit for purpose.

Commissioning for 'Putting People First'

3.4.15   The drivers require 'Adults and Communities' to be commissioning for all the citizens of Birmingham. Well-being will need to address the preventative agenda in terms of reducing the volume of citizens using high-end 'Adult Care' services, increasing the proportion utilising generic citizen support services universally.

3.4.16   To provide a commissioning lead the Unit needs to be able to commission, contract, where required, and monitor all adult care services both internally and externally provided.

3.4.17   The commissioning functions will need to address the individual citizen as holding a personalised budget made up of the personal and public pound in whatever proportion from 100% personal (self funding) to 100% public (including NHS funding such as RNCC and Direct Payments). The citizen at the heart of what we do, with full engagement.

3.4.18   The operational side will be commissioned to provide the assessment within the Resource Allocation System (RAS) where the information provided within 'Self Assessment' and any Multi Disciplinary input is matched to service criteria. This will lead to the identification of the personal budget including the personal contribution as well as health, housing and social care inputs. There will also be a requirement to signpost towards low-level services promoting social inclusion, well-being and prevention; these will involve third sector, community and universal services. The RAS will of necessity include a review process to ensure that the resource allocation and 'brokered' personalised services are providing the appropriate outcomes and if the assessed needs have changed in nature or degree. The outcomes of the RAS and the reviews will need to input into the customer insight to inform strategic commissioning and market shaping decisions.

3.4.19   The micro commissioning / procurement will require a commissioned brokerage system independent of the assessment process. This will provide an independent check of the RAS, and enable transparent procurement decisions as to where (internal, independent or third sector) services are purchased to deliver outcomes for the citizen. The reviewing process within the RAS will provide 'governance' from the local authority in relation to how the 'public' element of the personalised budget is being spent. The procurement decisions at the brokerage level can then be aggregated to influence strategic commissioning and market shaping decisions. These are further informed by what the citizen of Birmingham

wishes to purchase to meet their assessed needs, rather than the current service led analysis.

3.4.20 This commissioning model would look like:
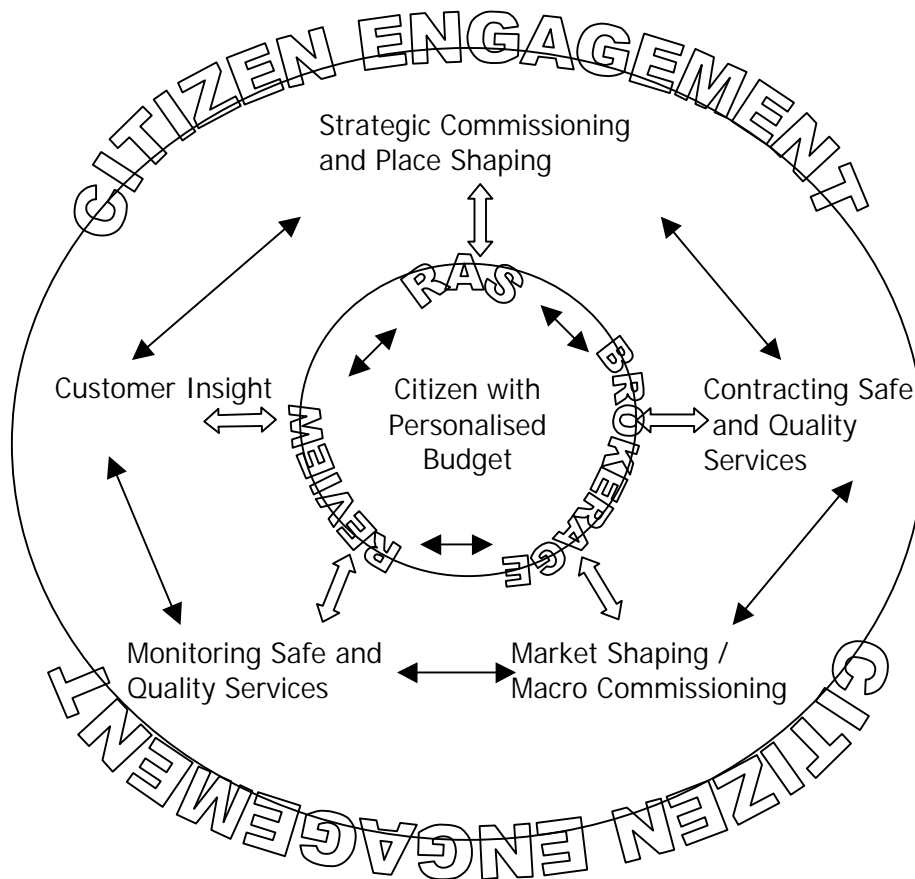
Market Shaping

3.4.21 A Scrutiny team member met with an officer from the Directorate's Commissioning function to discuss the position in respect of market shaping.

3.4.22 The Adults and Communities Directorate has recently attempted to improve its commissioning function by developing new market shaper posts. Market shaping is essential if the Directorate is to develop its ability to contract with a range of providers. It is essential that the home care market in Birmingham is stimulated so that those using Direct Payments and Individualised budgets have a range of services to choose from.

3.4.23 As the White Paper, Our Health, Our Care, Our Say, states:-
"If individuals using services are to have real empowerment and choice, the market will need to be developed and supported to offer a wider range of services, tailored to meet the rising expectations and needs of an increasingly elderly, divers and culturally rich population.

To do this, services must be secured for the whole community, including for those people who fund their own care. It means developing commissioning that stimulates and supports the local market."

3.4.24 Under the new system of personalised individual budgets, service users who are eligible for publicly funded social care under Fair Access to Care Services criteria, will be given personal budgets to purchase services, which best meet their health and personal needs. Therefore, once social workers have assessed the level of help a person needs to live in their own homes, they will have the right to choose and shop around for their own care packages and will be looking to purchase a variety of services to meet their individual needs.

3.4.25 Marketing shaping is an integral part of the commissioning process, which identifies and develops services, which are available for service users and carers to purchase. It comprises of several elements which include:-

- Ensuring that there is quality service provision available at a reasonable and competitive price that can be monitored for quality assurance, by working with current market providers to improve service provision e.g. targeting of consistent poor or quality providers (in Birmingham, we charge providers £30 per incident for proven incidents of service failures).

- Renegotiating the content and volume of contracts with external providers as well as renegotiating prices with poor quality providers.

- Working with poor providers to improve quality including action plans, suspensions and, where a provider cannot demonstrate sustained improvement, decommissioning.

- Developing the internal/external workforce - Large external organisations are, usually, in a position to arrange training sessions for their staff but smaller agencies cannot afford to do so. (The Adults and Communities Directorate are organising training sessions, for not only internal staff, but also allocating places for independent and third sector organisations and sharing the cost).

3.4.26 In order to check the quality of standards in domiciliary care, the Directorate are to pilot an electronic home monitoring system with the independent and third sector providers. This system will not only monitor the time spent by home care workers in user's homes, but also automatically generate timesheets rather than those that are manually completed by care workers; automating payments to providers; and monitoring volumes and cost of services provided.

3.4.27 Providers and their representatives are involved in negotiations on contracts and tendering exercises, currently with changing the older persons residential and nursing home contracts to deliver quality as the norm; and the re-tendering of home care provision.

3.4.28 The Directorate are currently designing a 'Council Contract' for service users who wish to organise their own services. The 'Contract' will be accessible on the website and will enable personal budget holders and people with their own funds (so-called self-funders) to enter into a contract with the Council to provide services and the Council will monitor the quality of the service.

3.4.29 Under the market shapers a quality assessment tool is being developed, initially for providers of residential and nursing home care. This tool will in turn be part of the intelligence to publish our own quality rating for services, this will be available publicly to enable informed decision making by self-funders, those with personal budgets, and those brokering services on behalf of the individual citizen.

3.4.30 A Consultant is currently examining the number of service providers across the City. Various models of service provider are being considered including:-

1. 10 large home care providers i.e. one for each constituency;

2. An infinite number of providers, primarily from the third sector; or

3. A mix of both large and third sector providers.

3.4.31 The models are currently undergoing a costs/benefits/gains analysis.

3.4.32 In order for market shaping to be totally effective it needs to be undertaken 'across the board' covering both external and internal provision. At present, it only applies to external organisations, as the internal home care section holds its own budget and can, therefore, procure their own services, which may include off-contract purchase. This can lead to huge differences in the price paid for the same service.

3.4.33 Other issues which have an impact on how the Directorate manages 'market shaping' include:-

• Contracts negotiated with external providers which stipulate certain criteria regarding working conditions etc cannot be applied to internal staff because they are already bound by internal strategic human resources policies;

• There are six market shaper posts in the Commissioning Section but, to date, only two positions have been filled. The posts that have been filled were recruited before Pay and Grading and the posts have now been downgraded.   The new grade will prove a real problem in recruiting to the remaining four posts because the remuneration for these posts does not compare favourably with other similar vacant posts both locally and nationally.

3.5 Self Directed Care

3.5.1   Members of the review group were keen to hear what the impact of self- directed care would have on current home care provision and commissioning arrangements. For the purposes of this report, self-directed care relates to direct payments, individual budgets and self-funders.

3.5.2   Our Health, Our Care, Our Say (2006) reinforced that "services must be secured for the whole community, including for those people who will fund their own care. It means developing commissioning that stimulates and supports the local market. It means strengthening local community capacity through using the voluntary, community and independent sectors".

3.5.3   Local Authorities have a responsibility to support those people who require care but are ineligible for services from or funded by the Local Authority due to their financial position i.e. "self funders" and those who are ineligible for services because of the tightening of eligibility criteria. The CSCI Report "The State of Social Care in England 2006-07" stated that since 1997, the numbers of households receiving supported home care has fallen from 479,000 to 358,000 in 2006, though the total number of hours had increased because the average number of hours that each eligible person received had increased.

3.5.4   The report estimated that were all Councils to set their eligibility thresholds at "substantial" and "critical", the average provision of council-supported Home Care would fall by just under 20%.

Direct Payments

3.5.5   The review team heard evidence from a number of officers with responsibility for Direct Payments and Individualised Budgets. The Adults and Communities Overview and Scrutiny Committee has received numerous reports about Direct Payments in the last few years and has remained concerned about the lack of progress in getting more people to choose direct payments as an alternative to council provided services. Members are committed to introducing self-directed care as it offers service users and carers real choice and control

3.5.6   Direct Payments were introduced by the Government just over 10 years ago through the direct payment legislation. The underlying intention was to give people increased flexibility and choice over the way their assessed needs were met. This set the direction of travel for the future of Social Care. Subsequent legislation and guidance extended this scheme to all client groups and made it a duty to offer a direct payment as an alternative to a direct service for almost all users and carers.

3.5.7   The direct payments scheme was implemented in Birmingham in 1998 and has been developed and grown in line with new government guidance. Increased take up of Direct Payments as a way of giving greater choice and control is a key theme in the 5 year Commissioning Strategies, which are linked to the 'white paper'. Staff procedures, financial structures and monitoring arrangements have been agreed and information has been made available in various languages and formats.

3.5.8   Table 10 below shows that there has been considerable progress made in the last few years in the number of people using direct payments. However, Members are concerned that a City as large as Birmingham does not appear to have made as much progress as other Local Authorities such as Essex.

3.5.9   It is widely thought that Direct Payments and indeed, Individual Budgets could be particularly attractive to people from BME communities who require support and care services. The care market in Birmingham does not appear to have a range of services that are able to meet the needs of specific community groups. Table 11 shows that there has been some interest in receiving a direct payment from particular BME communities.

Table 10: Number of people receiving a Direct Payment as at 31st March

Client Group	2003			2004			2005			2006			2007			2008		
	18-64	65+	Total	18-64	65+	Total	18-64	65+	Total	18-64	65+	Total	18-64	65+	Total	18-64	65+	Total
Physical and sensory disability and frailty	101	19	120	127	26	153	173	73	246	196	100	296	237	139	376	323	252	575
Learning disability	19	0	19	35	0	35	41	0	41	52	0	52	77	0	77	140	3	143
Mental health	1	1	2	1	2	3	2	4	6	7	13	20	8	20	28	17	46	63
Substance misuse	0	0	0	0	0	0	0	1	1	1	0	1	0	0	0	0	1	1
Vulnerable people	4	5	9	2	10	12	5	12	17	3	14	17	2	18	20	2	20	22
Total	125	25	150	165	38	203	221	90	311	259	127	386	324	177	501	482	322	804

Table 11:   Ethnicity (excluding carers) of those receiving a Direct Payment as at July 2007

	July 07
Asian Other	12
Bangladeshi	4
Black Other	9
Black African	15
Black African Car.	85
Chinese	3
Gujerati	3
Indian	38
Irish	17
Kashmiri	7
Mixed Parentage	21
Other	13
Pakistani	116
Refused	2
Sikh	9
White Other	15
White UK	437 (=53%)
Yemeni	3
Not Known	2
TOTAL	811

3.5.10   The Committee enquired as to the impact of direct payments on the future of home care services in Birmingham; the response from the Lead Officer is outlined below:

"As the uptake of direct payments increases this will inevitably have an impact on the commissioning of services, as people must be positively offered a direct payment and given the choice to meet their needs in this way. This has already led to a move away from block contracting for younger adult's services. Alongside the decommissioning by block contracting and in- house provision, there will be a need for market development to facilitate further choice of alternative resources to meet an individual's care needs"

3.5.11   The Care Services Improvement Partnership (CSIP) which was set up to development of social care and health services commented on the move towards personalisation:

"The development and adoption of appropriate commissioning strategies is essential to embed these changes in a appreciation of the wider needs of the local population and to ensure that funds are unlocked from 'block' contract

arrangements and in-house provision and made available for the increased uptake of direct payments' (CSIP 2006)

Individual Budgets

3.5.12 The policy shift towards personalisation started by Direct Payments will be continued through the introduction of individual budgets. The idea behind individualised budgets is similar to Direct Payments; enabling people needing social care and associated services to design that support and to give them the power to decide the services they need. The Department of Health (2008) describes the key features of individual budgets as:

- A transparent allocation of resources, giving individuals a clear cash or notional sum for them to use on their care or support package

- A streamlined assessment process across agencies, meaning les time giving information

- Bringing together a variety of streams of support and/or funding, from more than one agency

- Giving individuals the ability to use the budget in a way that best suits their own particular requirements

- Support from a broker or advocate, family or friends, as the individual desires.

3.5.13 In its Individual Budgets Newsletter, the Department of Health (2008) confirmed that the future of Social Care is self-directed support:

"These are not separated initiatives or fleeting experiments, but the future for social care in the next decade and beyond"

The Position in Birmingham

3.5.14 The committee received a presentation on Individual Budgets in Birmingham at an early point in the review. At that time, the Adults & Communities Directorate had been preparing to take part in a pilot of individualised budget approaches. The object of the Pilots was to make a fundamental shift in the way Authorities operate, so that "Self-Directed Support" becomes the normal way that we support vulnerable people.

3.5.15 Members received evidence about the risks that individualised budgets pose to the Adults and Communities Directorate. "Two obvious ones stand out, although there are many others. The first risk is that the changes are seen as just small changes to existing practices. Some may be just that but taken together they are very significant. They will impact on many staff activities and the way many services are managed. The second is financial. The changes will not lead to extra cost but we shall have to adapt the way we manage budgets and plan spending. This is why a big part of the preparation for the Pilot has focused on the financial processes involved."

3.5.16　The Individual Budgets projects within the Directorate are based on the recognition that introducing more personalised services (or Self Directed Care) impacts on every aspect of the Directorate's functioning, not just front line practice.

3.5.17　The principle of Self Directed Care is the strong underlying philosophy behind the Future Operating Model developed by the Directorate and agreed corporately through the Transformation Programme. Self Directed Care through Individual Budgets is central to the Adults and Communities Directorate Transformation Programme. The plan is to have 70% of service users on Individual Budgets over the next 10 years. This will be a radical change from where we are now and affects all parts of the Directorate, our partners and providers of service.

3.5.18　When the Directorate embarked on its pilot projects around Self Directed Care it was clear that, although the principles of personalisation are similar across user groups, there are specific considerations which would influence how each area needed to develop. It was, therefore, decided to go ahead with a number of pilots in a separate but co-ordinated manner.

Definition

3.5.19　The terminology in use around Individual Budgets was clarified as a result of the DoH's Putting People First Concordant. The terms in use can be defined as follows:

- Direct Payments – are means tested, cash payments given to service users in lieu of community care services they have been assessed as needing. They are intended to give users greater choice in their care. Direct Payments give responsibility to recipients to employ people or commission services, including taking on all the responsibilities of an employer. There is an established Direct Payments Scheme in Birmingham and increasing numbers are opting for this.

- Personal Budgets (PB) – are an allocation of A&C funding given to users after assessment. Users can either take their Personal Budget as a Direct Payment or while still choosing how their care needs are met and by whom, leave the council with the responsibility to commission services. People may also choose to have some combination of the two.

- Individual Budgets (IB) - differ from Personal Budgets in that they cover a multitude of funding streams in addition to the A&C PB such as Independent Living Fund, Access to Work etc.

- Self Directed Support (SDS) – is support that is determined and controlled by the service user, based on an assessment of need by the state. (Includes receiving cash as indicated above, spending on services that meet the individual's needs, choosing the hospital the person wishes to attend).

- Personalisation – the process by which state provided support is adapted to meet the needs of people receiving these services

Examples of Self Directed Care Activities in Birmingham A&C

Fair Access to Short Breaks for Carers is the new policy and process for agreeing short breaks, developed in conjunction with service users and carers. The Directorate is exploring the use of a pre-payment cards for short breaks which could be applied to Individual Budgets.

Learning Disabilities Individual Budgets Pilot - working with 15 young people in transition from children to adult services. Budget includes both A&C Personal Budget and Independent Living Fund allocation. Mencap to act as brokers in lieu of A&C Social Workers. Pilot commenced March 2008.

Older Adults Personal Budget Pilot ran from Dec 07 – April 08 and trialled the use of a Resource Allocation System and Support Planning tools with all new eligible OA service users approaching A&C for support.

Commitment to Joint IB with Health. Within the Birmingham Health & Wellbeing Partnership and the Local Area Agreements, Individual Budgets is a main work stream for both the PCTs and the Directorate. A partnership group is being formed to develop an Individual Patient Budget Pilot

Physical Disabilities Individual Budgets Pilot with 6 service users with multiple sclerosis to address their potential for the management of notional budgets. This will be planned through a stakeholder event in October 2008 with an overarching implementation team.

FASBC Pre-payment cards

Learning Disabilities Individual Budgets

Self Directed Care

Older Adults Personal Budgets

Joint IB with Health

Physical Disabilities Long Term Conditions

Early Indications from Older Adults Pilot

3.5.20   The Older Adults (OA) Pilot introduced a major change in the Directorate's approach to support planning for older people. It challenged traditional ways of working by providing older people with information up front on the amount of money available to support them and encouraging them to decide how this was spent. This required a significant cultural shift for staff who (unless a person opted for DP) previously determined service users' needs according to a menu of traditional services. The new approach sought to offer the same level of choice and control that DP's gave a service user to all, even if they chose not to manage the money themselves.

3.5.21   When the Older Adults pilot commenced the terminology in use was 'Individual Budgets'. This term has been clarified with the introduction of 'Putting People First'. The pilot has aligned itself to the new terminology, which identified its work to determine a cash allocation up front as 'Personal Budgets'. Developing a system for calculating a PB is seen as a useful starting point for developments around IB's and was the basis on which the Older Adults work started. The Older Adults pilot is at the evaluation stage though some of the initial findings are outlined below:

3.5.22   Feedback from Service Users indicated that:

- A high percentage of services users felt they had choice and control over their care arrangements and reported were satisfied with their care arrangements.

- Social Workers were most likely to assist service users with planning their care (57%) with approx a quarter receiving support from someone else and a fifth planning their own care. There was wide variation in who it was felt would be best placed to support with planning.

3.5.23   Feedback from Staff indicated that:

- Staff felt there were issues over the equity of allocation through the RAS and a strong desire for further training and support around how to implement the processes better,

- The new process was felt to allow greater flexibility, creativity and innovation and gave service users more control of plans for their care arrangements

3.5.24   Financial and Process Issues:

- There is a need to stream line and improve the overall planning paperwork

- Further financial assessment is being undertaken to analyse the affordability and sustainability of this approach.

Early indications from the Learning Disabilities Pilot

3.5.25   This pilot has only just started but so far all participants have chosen to spend their allocation on non-traditional services. Although before embarking on the pilot the young people and their families had been thinking of day care, this has not proved to be what they chose to spend their allocation on.

Future Plans

3.5.26   As part of the Transformation work iMPOWER, an organisation who supported the development of pilot authorities Individual Budgets under In Control, has been commissioned to work with us to introduce the changes required to meet the Transformation objective of 70 % IB's within 10 years.

3.5.27   iMPOWER will support the Directorate in looking at the results of the Older Adults evaluation, the work on the Learning Disabilities pilot, the benefits to be delivered through Transformation and the steps we need to take to deliver the A&C Business Case.

3.5.28   Individual Budgets is a work stream of the BHWP theme of Personalisation. In addition it is a priority within the LAA. This will support the partnership work necessary to introduce Individual Budgets as part of the Transformation Programme. The move to offer IB's to all service users remains a central part of the Transformation Programme.

3.5.29   It is noted that none of the pilots currently address the specific requirement of an individual budget in a holistic sense. The Review Group therefore presume the pilot projects referred to are transitional improvements towards achieving the objectives approved by the transformation programme.

Individual Budgets – Evidence from Oldham Council

3.5.30   A small group from the Review team visited Oldham to hear about their individual budgets scheme. Oldham has been acknowledged as a national leader in the area of individual budgets. The review group wanted to understand how Oldham had managed to be so successful in encouraging people to take-up individual budgets and to hear about any lessons to be learnt.

3.5.31   The team from Oldham were very clear that at the time that they started their individual budgets "journey" that social care in Oldham was a failing service, they told us that they had to "think big as the system was broken". They therefore decided that making individual budgets a success and much more than a "pilot" was a priority for the Council. The Council changed the whole system for Social Care, anyone requesting Social Care support received an individual budget as there was no other option available to them. As a result Oldham

developed a sophisticated system of self-assessment, support planning and risk assessment to underpin the new system.

3.5.32   Oldham introduced their individual budgets scheme in March 2006; they currently have 800 people in receipt of an individual budget. There are 2000 people involved in the process; this could be at the stage of self-assessment, support planning or positive risk assessment. For the purpose of comparison, Oldham has a population of 220,000. Consequently, they have seen higher levels of service user satisfaction and more effective budget control.

3.5.33   It was interesting to learn that people who received an Individual Budget chose to spend their allocation on services that maintained or restored elements of their lifestyle; they did not necessarily purchase traditional care and support services.

3.5.34   Oldham was very open about some of the challenges that they had faced. One challenge was that they had a large internal service that needed to decide on its place in the market place and adapt its service. There was also considerable resistance from social workers who were unsure about their role in the process, many saw it as eradicating their assessment function; the position of many social workers has shifted to seeing the benefit to service users and carers of individualised budgets. The market also provided a challenge; Oldham officers said that if they were to do one thing differently it would be to shape and develop the market at a much earlier stage. This also had implications for commissioning and procurement; with a sharp move to commissioning for quality rather than quantity. They provided a diagram of a commissioning sandwich (reproduced below) which clearly demonstrated the challenge for commissioning. The role of commissioning is to ensure that there are a range of services "different fillings" available for people to purchase, to encourage the growth of preventative services and to ensure that the council's internal service developed itself to be able to support the "high cost / risk" and "prevention" areas of the market.

3.5.35   Similar challenges will need to be met by Birmingham City Council's assessment and care management staff, commissioners and internal home care service.

The Oldham Council Commissioning Sandwich

High cost / risk

Different fillings

Prevention
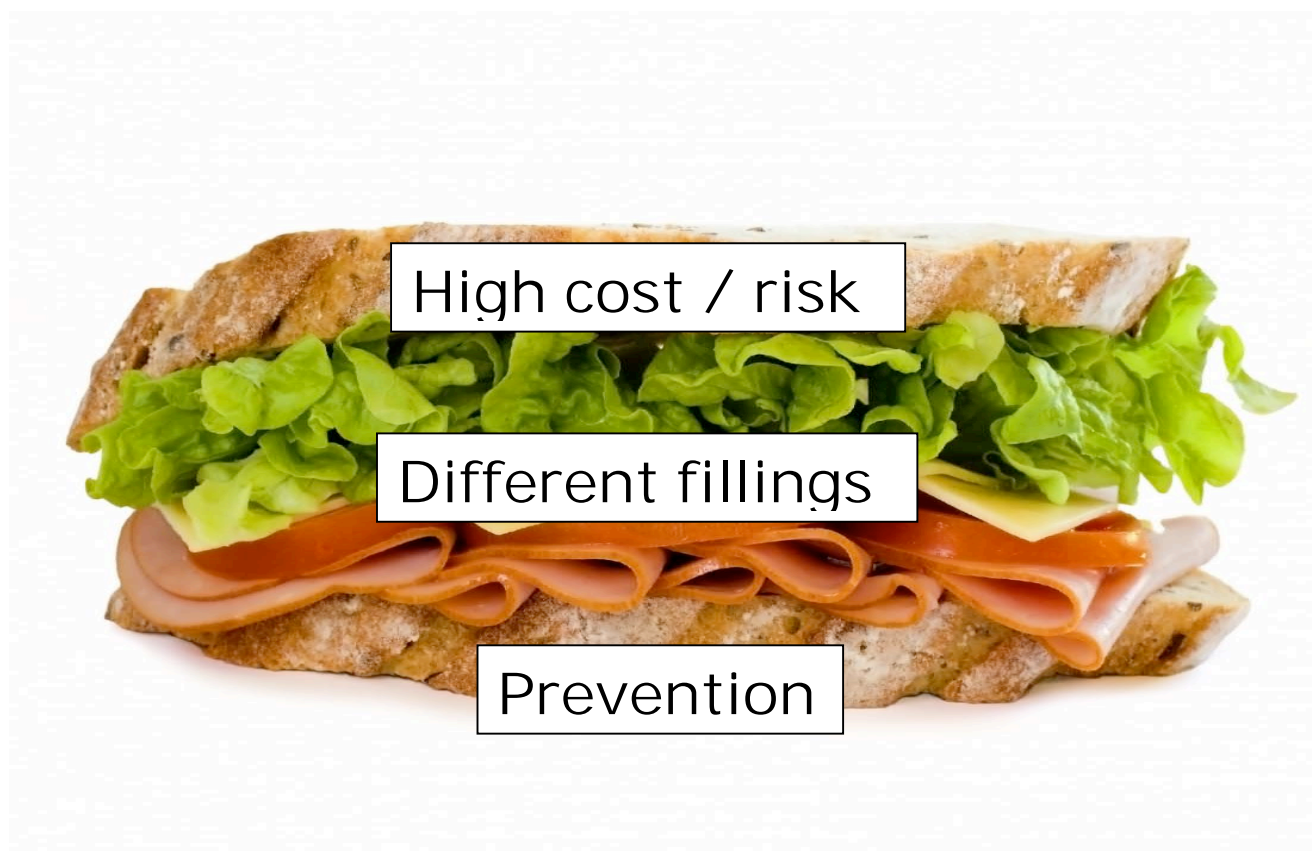
3.5.36 Oldham provided some very powerful "customer" stories about the changes that Individual Budgets has made in people's lives. Oldham were very publicly "outed" in the media for funding a football season ticket for someone instead of providing council services. We met the partner of the man who purchased the ticket and it became very clear that for this man with a condition that resulted in him losing much of his independence and control; the individualised budget had enabled him to purchase the season ticket for someone who would accompany him to the game, describe the action (as he had sight loss) and gave his partner a few hours respite and all it actually cost was less than £5 per hour.

3.5.37 Members were very impressed with enthusiasm and professionalism of the staff that we met in Oldham and intend to ensure that Birmingham replicates the success of Oldham.

Self Funders

3.5.38 The Adults and Communities Directorate has a responsibility to assist those people who need support and care services but have assets that make them ineligible for services. We believe that there are a growing number of people who choose to purchase their own care but may require support, guidance and advice from the Directorate.

3.5.39   The CSCI Third Annual Report "The State of Social Care in England 2006-07" stated that in March 2006 it was estimated that of the people who were ineligible for council-supported care in the community, just fewer than 150,000 older people purchased care privately.

3.5.40   The City Council is currently undertaking a major modernisation project called "Business Transformation". As part of its full business case, the Adults and Communities Directorate have used national demographic data to project current and future demands on service. However, the Directorate does not appear to have concrete data about the current level of self-purchasing or predictions of the future demand from self-funders in Birmingham.

3.6 Social Enterprise

Introduction

3.6.1   According to the Cabinet Office (Office of the Third Sector) publication Social enterprise action plan – Scaling new heights, the definition of a "social enterprise" is:-
"A business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners."

3.6.2   There are several models of social enterprise including Company Limited by Shares; Company Limited by Guarantee; Industrial and Provident Society (Cooperative); Industrial and Provident Society (Community Benefit Society); Community Interest Company and Charitable Incorporated Organisation. The model that organisations choose depends upon the nature of the activities being undertaken, key stakeholder requirements, the governance structure and access to finance. The aims of a social enterprise are:-

- Job creation, training and provision of local services.

- A commitment to building skills in local areas.

- Ownership and governance structures based on participation not for personal gain.

- Reinvesting profits back into the business.

3.6.3   Recent statistics state that there are currently 55,000 social enterprises in the United Kingdom generating more than £27 billion turnover and contributing more than £8 billion GDP (gross domestic product) per year.

3.6.4   A 'Baseline Study of Social Enterprise in Birmingham and Solihull' was published in September 2007. Some of the key facts to emerge from the study are:-

- There are about 320 social enterprises.

- The social enterprise sector employs about 12,480 people, of which about two thirds are full time staff.

- 46% of social enterprises classify themselves as voluntary sector organisations; 28% as not for profit organisations and 12% as social enterprises.

- At least 62% of organisations are charities and about 51% are companies limited by guarantee (40% of social enterprises were registered as both a charity and company limited by guarantee).

- 31% of social enterprises are branches of larger organisations and 29% are affiliated to a larger organisation.

- About 60% of employment is concentrated in larger companies that employ more than 100 people. These organisations are mainly either housing associations or social care organisations.

- Staff numbers of increased in social enterprises over the past year by a net balance of +11%

- Organisations expect numbers of paid staff to increase over the next year by a net balance of +34%

- Organisations indicated that turnover had increased over the past 12 months by a net balance of +17%.

- The main service activities of social enterprises are: - training (55% of social enterprises); counselling/advise work (51%); education and research (43%); services for people with a disability (41%); health and social care – children and families (37%); and youth services (33%).

3.6.5   Central Government are keen for local authorities to actively engage with community enterprises by encouraging them to provide public services, but also become local employers, market makers and stakeholders in local communities. Indeed, the new Working Neighbourhoods Fund (WNF) which becomes a single fund replacing the Neighbourhood Renewal Fund and incorporates the Deprived Areas Fund, includes an element of reward grant of £50 million to be allocated to local authorities who have agreed relevant LAA targets. The money is to be used to "motivate areas with the highest worklessness and to do so in a way that empowers the local communities affected. This includes the possible role of social enterprise activities and community budgeting in empowering those communities that have started to make progress."

Community Interest Companies/South Birmingham PCT

3.6.6   The review group received a verbal presentation from the Associate Director Health and Social Policy, South Birmingham PCT about a Community Interest Company, which had developed out of South Birmingham PCT in 2006.

3.6.7   South Birmingham PCT has a history of developing new kinds of training, qualifications and workforce, particular in the fields of Family Support, Access to Services and Long Term Conditions. This work had grown to a point where further growth and development was constrained by being part of the structure of a statutory organisation. In July 2006, this set of activities was taken over by Gateway Family Services CIC.

3.6.8   Gateway Family Services works with organisations in health, social care and early year's services that want to improve their local service delivery and increase local community representation in the workforce. GFS not only delivers health benefits but also creates social and economic opportunities by recruiting, training and accrediting people from disadvantaged communities to take up local employment opportunities.

3.6.9   GFS has 3 areas of 'core' business:-

• Training Programmes – Participants are recruited locally and follow an accredited course as part of a designed career pathway into jobs within the Health, Care and Children's Services sector. At present, GFS is the only known West Midlands provider of the, Department of Health approved, City and Guilds qualification for Health Trainers.

• Employment Support – Provision of pre- and post-employment support to ensure that people can overcome their barriers to training and employment.

• Community Health – Outreach Workers from the Increasing Male Life Expectancy: The Healthy Heart Service and Reducing Infant Mortality: The Pregnancy Outreach Workers Service work with communities to identify their needs, ensuring services are culturally appropriate and accessible.

3.6.10   GFS has traded successfully since its establishment and has moved from a position of employing 8 full-time members of staff to 81 and has an annual turnover of £1.4 million.

Leeds City Council - 'Keeping House'

3.6.11   A research study was carried out by the Scrutiny Office to investigate homecare provision in other local authorities, essentially the core cities. Following the presentation of this information to the review group, Leeds City Council was identified as a local authority whose internal/external homecare provision was not only comparable to Birmingham, but who was ahead of the game in seeking to address the challenge of providing domestic

services to an aging population. It was agreed that a small group of Members and officers would visit Leeds to see 'first hand' what work had been carried out. The visiting group met with Leeds City Council officers and visited two social enterprises, namely UpBEAt and Care & Repair.

3.6.12   In 2005, Leeds City Council, like local authorities across the country, had to face the challenges of:-

a)   meeting the needs of an aging population who are living longer, and

b)   easing the increasing pressure on care services from older and disabled people, mostly on low incomes, who require a range of domestic support services in order to maintain their independence in their own homes for as long as possible.

3.6.13   Leeds City Council recognised that there was a danger that preventative services like shopping, cleaning and gardening were going to disappear completely, so they invested in a programme called 'Keeping House'.

3.6.14   Keeping House is a partnership programme sponsored by Leeds City Council Adult Social Services, which committed £900,000 over the course of 3 years to investigate whether they could develop a 'test bed' to see if they could make the programme work.

3.6.15   Due to a change in eligibility criteria for care services, instead of receiving a social care assessment and a means-tested homecare service from the local authority, older and disabled people who do not meet the criteria are signposted to a wide range of local housekeeping services. People are charged directly for the services by the providers themselves. In other words, these basic domestic services are no longer paid for by the local authority.

3.6.16   The aim of the programme was to create and stimulate the growth of socially enterprising organisations, bringing together public, private and third sector organisations for the benefit of the whole community to create social capital for the future.

How Keeping House Works

3.6.17   The programme is overseen by a partnership board chaired by Leeds City Council's Adult Social Care and includes members representing older people and the social enterprise and voluntary sectors. The management team includes social enterprise advisers, voluntary sector and social care staff. The programme has commissioned social enterprise consultants on a 3-year contract.

3.6.18   A Keeping House investments panel, chaired by a Keeping House partnership board from West Yorkshire Social Enterprise, meets quarterly to consider applications for grants and investments. Small grants are given to groups to enable them to purchase training for members of staff, equipment, gain business advice and develop business plans. They have access to social enterprise advisers to assist them. The grant has to be spent within 6 months and the applicants have to explain how they have used the money to develop their

enterprise proposals. Thereafter, investments of up to £10,000 per year, for up to 3 years, can be applied for. These allow organisations to begin to deliver services, build up their client base and subsidise costs while beginning to generate income and reducing investment with an aim for achieving full cost recovery. The amount of the investment is based on the Business Plan and financial projections which must demonstrate clear steps towards sustainability within 3 years.

3.6.19   The following are examples of services that are being delivered locally to meet the needs of service users and making their lives easier.

Angels Housekeeping

3.6.20   Angels was one of the first organisations to take up the 'Keeping House' challenge. Angels Housekeeping Community Interest Company was established with the aid of grant support from the Keeping House programme. The company also had access to a support service, which meant that advice was always on-hand. Keeping House put Angels in touch with Social Business Consulting who helped them access support from West Yorkshire Community Accounting Service (WYCAS) and Social Enterprise Link, who worked with them on their business plan and gave general advice on establishing the social enterprise model of business.

3.6.21   When the business was set up, 2 years ago, it employed four people, it now has 30 employees. The aim of the business was to get 250 customers to ensure that Angels Housekeeping can survive without any grant funding and plough the profits back into the area. The target of 250 customers has now been exceeded with Angels providing approximately 400 hours of care to those customers each week. In order to deliver an affordable service to elderly people, Angels has a charging structure that gives discounted rates to people over 60. Full paying customers, who are mostly young professionals and families, make up the rest. The success of Angels depends on getting the right balance between the two different types of customer.

UpBEAt Community Enterprise

3.6.22   Bramley Elderly Action is a longstanding neighbourhood charitable organisation serving the over 60s. After consulting with their members, it became apparent that there was a need for a reasonably priced and more importantly, trustworthy service in the area that could provide gardening, painting and decorating, odd jobs, shopping, transport to lunch clubs etc. Therefore, UpBEAt was set up.

3.6.23   UpBEAt is a collaborative partnership with one of the largest private employers in the area, Elite Group Logistics. Elite manages the warehousing and distribution of goods for a number of large companies. Elite rely on local support, for example, when applying for planning permission to develop large warehouses. Elite state that the partnership is a way of giving something back to the community and a way of thanking them. They provide

support to UpBEAt by processing the monthly accounts, wages, providing storage, as well as office space for the gardeners.

3.6.24 A further advantage of the social enterprise between the two partners is that when UpBEAt's gardeners are unable to work outside due to bad weather, Elite employ them in the distribution warehouse.

3.6.25 UpBEAt also provide an escorted shopping service for a nominal fee.

3.6.26 Service users are picked-up from home and taken to a large supermarket where they are given time not only to shop, but socialise with their friends at the in-store coffee shop.

UpBEAt Disability Aids Service

3.6.27 The disability aids service has, until now, provided gadgets and products to aid independent living on a local level. Elite Group Logistics is to use its expertise in mass mailing to launch a disability aids catalogue and make the service available nationally.

Care & Repair Leeds

3.6.28 Care & Repair was an existing care agency that was known for its home improvement service. The 'Keeping House' programme gave it room to expand. In addition to many home improvement services including maintenance, electrical, plumbing, heating, gardening etc. it now provides a city-wide home delivery service for people who need continence products, paediatric supplies or mobility aids at a fee of £6 per delivery. The service currently has 200 clients on its list but the number is still growing.

3.6.29 Care & Repair hold a list of self-employed workers to carry out home improvements. Care & Repair are considering introducing a membership fee to providers for the privilege of being included on the list.

3.6.30 During our discussions with both social enterprises one of the many questions posed was 'how do their clients feel about having to pay for service provision?' We were told that they did not mind paying as long as they received a quality service at a reasonable price. Indeed, we were given an example of where users of the UpBEAt shopping service had offered to pay more for the up-keep of the minibus used to transport them.

3.6.31 It was evident from the interviews that took place during the visit to Leeds that the Keeping House programme, even though it is still early days, has made a significant impact on encouraging the growth of social enterprise in Leeds.

3.7 Assistive Technology

3.7.1 Assistive Technology (A/T) is an inclusive term to describe any device which enables independence and covers everything from simple equipment to complex intelligent technology. At its simplest, equipment can assist people to manage basic functions (e.g. grab rails) or it can be complex systems which can reduce the need for packages of care (e.g. wander alerts).

3.7.2 Members attended the Assist Birmingham Centre (ABC) to view and discuss the impact of assistive technology on promoting independence. Members also received a report outlining progress with Assistive Technologies and the creation of an Assistive Technology Strategy.

3.7.3 Members were advised that "Putting People First" calls for a retail model for community equipment and also for technology. The Department of Health is putting considerable pressure on Local Authorities to take this model on board as they believe there are significant benefits to be made. In fact Self-Directed Support will not work without a strong retail market as people will not have sufficient choices when redeeming Individual Budgets.

3.7.4 The Directorate's report outlined its aims in shaping the market for low level needs/self-funders/ individual budgets:

- That when we signpost it is to reputable resources.

- That when we issue vouchers/prescriptions it is to approved dealers in order that we can account for the use of public money and measure outcomes.

- That self-funders are able to realise the benefits of a reputable market place if they wish.

- Aspirationally we would hope that the above policies would allow a growth in availability, choice and improved design for goods and services for older and disabled people and their carers.

- As a result of transformed services we would expect to see - a financial shift away from high cost care and an overall a reduction in the cost of care.

3.7.5 The report also showed how the Directorate intends to shape the market for complex services:

- The use of assistive and advanced technology is the routine way of doing business across health and social care and housing, using both the commercial and 3rd sector as appropriate.

3.7.6 This will result in:

- Complex services having an integrated approach to the use of advanced assistive technologies and traditional equipment

- The redesigning of the way equipment is managed to take account of personalisation and the use of Individual Budgets in Health as well as Social Care.

- An expected reduction in the cost of care through more holistic approaches.

- People having more choice and control in how care is delivered.

- Carers being able to manage their responsibilities better.

3.7.7   Much detailed work has begun to implement the Assistive Technology strategy and a draft action plan has been prepared.

3.7.8   It is also worth noting that the Department of Health (Care Services Efficiency Delivery Programme), in conjunction with key stakeholders, is currently undertaking an options appraisal exercise for introducing a national loan equipment home delivery service. The options include:-

- Key existing stores could be utilised as regional distribution centres.

- New contracts, either local or regional, could be let.

- Existing private sector national distribution networks could be utilised.

3.7.9   The model is not mandatory and the decision to adopt it or not will be made by individual local authorities and their health partners.

3.8 Home Care Provision in Other Local Authorities

Background

3.8.1   There appears to be a national trend to move away from providing Home Care within the Local Authority, instead the majority of Home Care is now being provided by the Independent (Voluntary, Not for Profit and Private) Sector.

3.8.2   The amount of hours provided by the Independent Sector has grown considerably in the last fifteen years, going on average from providing only a 2% share of the nation's Home Care in 1992, to having just over three quarters of the market share in 2006. There still appears to be a steady growth in this sector, in the last few years the gap between in-house and independent provision has increased with the split shifting from 30.7% Internal, 69.3% Independent in 2004, to 24.6% Internal, 75.4% Independent in 2006[1].

3.8.3   Only 10 of the 150 Councils with Social Services Responsibilities (CSSR) provide more than 50% of Home Care contact hours internally (Leeds City Council and our neighbour Dudley Metropolitan Borough being two such authorities). The only five authorities to completely outsource their Home Care are London Boroughs, Barnet, Brent, Harrow, Lambeth and

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[1] Source: Community Care Statistics, NHS Health & Social Care Information Centre

Southwark; with a further two London Boroughs, Westminster and Bexley, keeping a nominal 0.4% and 0.5% of Home Care provision in-house respectively.

3.8.4   Between 1992 and 2002 there was a dramatic increase in the number of contact hours provided, some 77% increase; since 2003, the number of hours has increased more steadily by approximately 5% or 6% a year.

Comment

Comparisons with Other Authorities

3.8.5   The table below shows how Home Care provision is shared across the Local Authority and the Independent Sector in each of the core cities, as taken from the most recent Community Care Statistics complied by the NHS Health and Social Care Information Centre. Also included is the total number of contact hours in each city to give a sense of the scale of the service. It is interesting that that the total number of contact hours provided in Manchester equals that of Birmingham.

Table 12: Care Provision across the Local Authority and Independent Sect in the Core Cities

Council with Social Services Responsibilities	Contact Hours		Percentage (rounded numbers)	
	Local Authority	Independent	Local Authority	Independent
Birmingham	17965	49220	26.7	73.3
Bristol	8375	10690	43.9	56.1
Leeds	23480	19550	54.6	45.4
Liverpool	10995	42310	20.6	79.4
Manchester	12680	54475	18.9	81.1
Newcastle	5845	36430	13.8	86.2
Nottingham	5135	15730	24.6	75.4
Sheffield	16375	34000	32.5	67.5
National Total	*920060*	*2818440*	*24.6*	*75.4*

Source: Community Care Statistics, NHS Health and Social Care Information Centre
England survey week September 2006

3.8.6   To give some idea of the local picture the table below shows how the provision of home care is split in some of our neighbouring authorities:

**Table 13: Care Provision across the Local Authority and Independent Sector in our neighbouring authorities**

Council with Social Services Responsibilities	Contact Hours		Percentage (rounded numbers)	
	Local Authority	Independent	Local Authority	Independent
Birmingham	17965	49220	26.7	73.3
Coventry	5165	28575	15.3	84.7
Dudley	11060	9315	54.3	45.7
Sandwell	3265	19435	14.4	85.6
Solihull	1980	9435	17.3	82.7
Walsall	2150	23925	8.2	91.8
Wolverhampton	2865	17250	14.3	85.7
National Total	*920060*	*2818440*	*24.6*	*75.4*

Source: NHS Health and Social Care Information Centre
England survey week September 2006

3.8.7   Further to the differences between in-house and independent provision highlighted above, it is worth noting the differences between authorities regarding the type of service that is provided by each sector. The Pie charts overleaf highlight the differences between the core cities.

3.8.8   These pie charts show that Nottingham is the only core city that has eliminated a service, offering no out-of hours service; and Manchester has completely outsourced its out of hours service which makes up only 1% of its Home Care.

3.8.9   With the exception of Bristol, Manchester and Nottingham, each of the core cities retains an element of in-house provision for each of the Home Care services rather than completely contracting a service out to the independent sector; however, the amount of in-house provision for overnight, live-in and 24 hour services appears to be nominal (or none existent) in all core cities except Manchester.

3.8.10   If you look at the ratio between the different services, rather than the sector they are provided by, Birmingham is comparable with Bristol, Leeds, Liverpool and Newcastle.

Sheffield

Nottingham

Newcastle

Manchester

Liverpool

Leeds

Bristol

Birmingham

Legend:

- Normal Hours: In-house
- Normal Hours: Independent Sector
- Out of Hours: In-house
- Out of Hours: Independent Sector
- Overnight, live-in and 24 hour services: In-house
- Overnight, live-in and 24 hour services: Independent
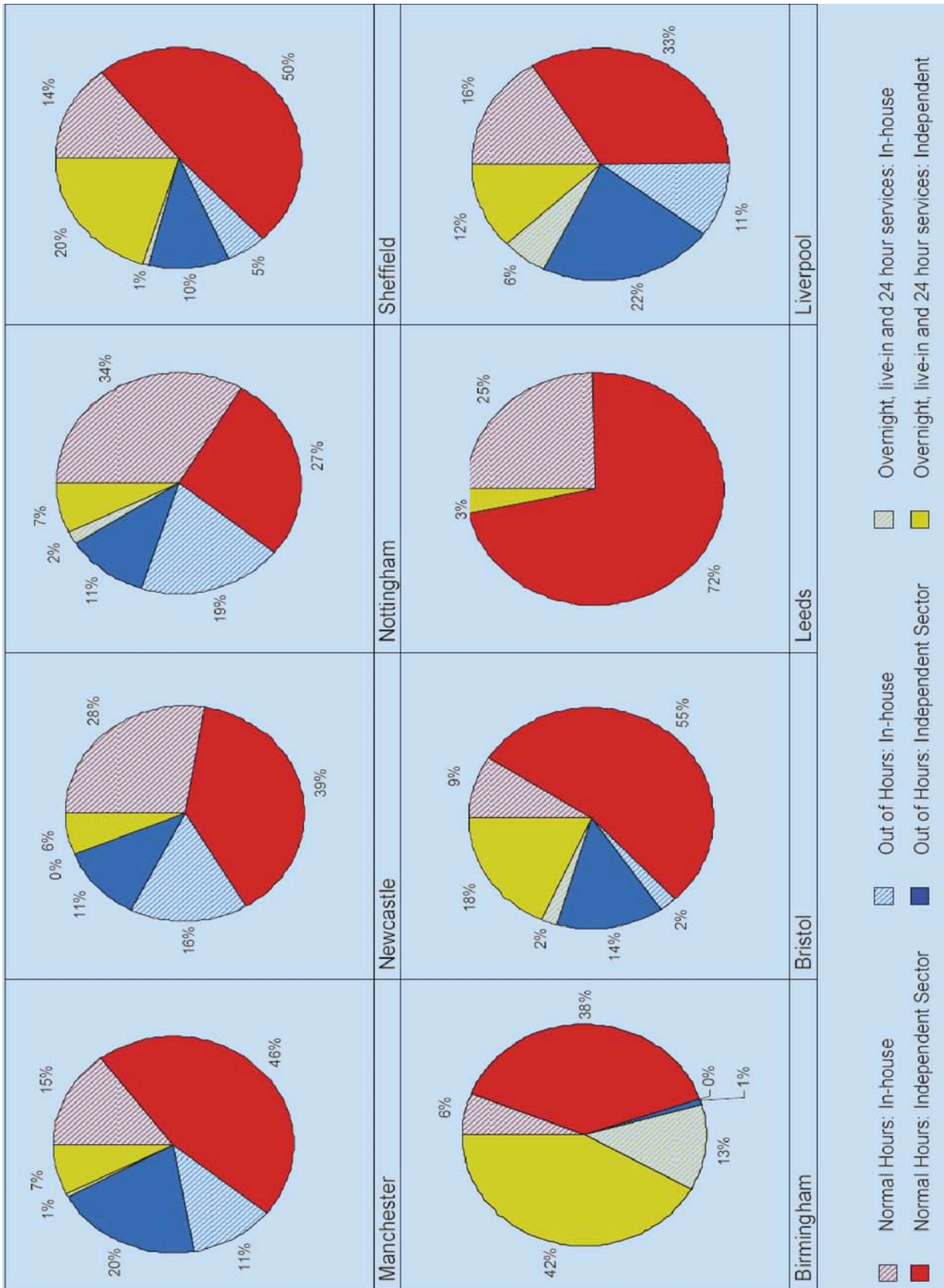
Case Studies

Bristol City Council

3.8.11   Bristol has recently attempted to make changes to its Home Care provision. The City Council has produced a document detailing the advantages and disadvantages of different Home Care models i.e. retaining status quo; reducing the in-house service by 50%; reducing the in-house service to make it a specialist provider; and completely out-sourcing its Home Care.

3.8.12   Early in 2007, the City Council approved that the split between internal and independent provision move from approximately 48% internal: 52% external to nearer 20% internal:80% external. In addition, they agreed that the focus of provision be changed so that its in-house team would only provide assessment and intensive short-term support, whereas longer-term care would be provided by the Independent Sector.

3.8.13   Although aiming for no job losses or reduction in pay or conditions for its existing staff with these changes, the decision to alter its Home Care provision met with opposition. The Council was handed a petition signed by over 9,000 people in protest against the plans to "privatise" the Home Care service.

3.8.14   Subsequently, the plans to change Home Care provision in Bristol have been put on hold. However, it appears that Home Care may be shortly back on the agenda as a report on the future of Home Care was presented to the Adults Community Care Select Scrutiny Committee at its meeting on the 9th July 2007.

Leeds City Council

3.8.15   Leeds City Council undertook a scrutiny of its Home Care in 2003, the recommendation being to commission a stand alone domiciliary support scheme and examine opportunities for the voluntary sector.

3.8.16   Leeds still provides the majority of its Home Care services in-house with the remainder being provided by the Independent Sector.

3.8.17   In the past, Leeds had spot contracts with approximately 30 different providers across the City. However, recently it has reduced this number to just six providers; Members may be interested to hear that since the inception of the new contracts in April 2006, Leeds has not needed to step outside of the arrangements and contract with any other provider. Leeds now aims to establish a longer-term relationship with these six providers who are committed to working to a specific model of care and outcome framework and an agreed and understandable fee structure.

3.8.18   One of Leeds' contracts is with Anchor Trust, a national not-for profit provider of housing support and care; the remainder are with commercial companies. Within its procurement process Leeds sought to attract providers established as social firms but in hind-sight feels that the procurement process may have been a little too early on for such providers to have developed the necessary acumen to go to tender.

3.8.19   The contract arrangements adopted by Leeds City Council appear to be relatively straight forward. Leeds is divided into 5 localities; each locality has at least two independent sector providers alongside the direct care provider. The independent providers have a contract for a specific number of 'core' hours per locality at an hourly price which has reflected their need to cover fixed costs. Each contractor then provides a further number of hours (with no upper limit) at a different (lower) price to be called off as required - essentially a cost and volume contract. The contractors work to a specification which emphasises the focus on longer term personal care, maintenance and support outcomes (this contract reflects the current best practice guidance recently publicised by CSCI).

3.8.20   Leeds has managed to reduce its reliance and pressure on Home Care by developing "Keeping House". More details of the "Keeping House" Programme can be found in section 3.6.11.

3.9 Unison

3.9.1   The Birmingham Branch of Unison was invited to submit their views on the Home Care Service at the beginning of the review and was asked if they wanted to make any changes or additions to their submission towards the end of the review. The following is the entirety of the initial submission made by the Chair of the Home Care Section:
"When the Home Care Service was originally set up, the aim was to offer to the Service Users of Birmingham City Council an "in-house" Service that enabled those Service Users to remain in there own homes, giving maximum control over their care.

Service Users were enabled to receive a Service that met their individual needs enabling them to pursue their preferred lifestyles. Service Users were enabled to choose from a wide range of Services, and were assessed by Home Care Organisers, who regularly visited these Service Users at Home.

The Service at that time offered personal care, general household tasks, and freshly prepared foods given at times of choice, alongside information, support and advice. Adequate time was allocated to safely carry out these tasks, and staffing levels were adequate to cope with the demands of the User Led Service.

Currently the "in house" Home Care Service has chosen to provide more specialist provision, and the current care packages are all timed calls which do not provide the full range of services that were previously provided. Service Users are no longer able to have a cooked meal prepared and cooked at home with food of their choice, these Service Users being enabled to access pre-prepared meals for the microwave or other alternatives, and there has been a phasing out of general household tasks.

The Service is being directed to a Service who provides direct care, which is personal care, medication, with access to pre-prepared meals. The assessments for the Service user is no longer carried out by the Home Care Organiser, and it is to the Service Users detriment.

Home Care Assistants are informing me that if a Service User goes into Hospital, after two weeks, there is no requirement to provide an "in-house" Service on discharge from Hospital, and that some of the Area Offices will only take on a new Service User if two calls a day are required, and tasks can only be done if they are on the Care Plan. If the Care Plan is in-correct, a re-assessment can take six weeks, which is a long time to wait if you are in a difficult situation.

Unison believes that the quality and care element within the Service has gone, being replaced with the emphasis being on care for Service Users with dementia and rehabilitation, but we have a huge amount of Service Users in need of long term care and support that are being sign-posted to the Private Sector.

Unison believes that all Service Users in Birmingham should be enabled to access the "in-house" Service and that the Service should meet the total needs of this Service User Group. The "in-house" Service should provide assistance with all day to day living tasks to enable the Service Users of Birmingham City Council to access individual support to meet there individual needs, meeting preferences and cultural needs. "

4 Conclusions and Recommendations

4.1 The Challenge for Birmingham

- It is neither affordable nor realistic for the Directorate to maintain and plan to continue to deliver and commission care in the way that it currently does given the national, local and demographic challenges.

- There are significant challenges that will require the Adults and Communities Directorate to change the way that it provides and commissions services. The Challenges fall into 3 key areas:

National

The Government has set out its agenda for the future direction of social care in documents such as "Our Health, Our Care, Our Say" and "Putting People First". The direction of travel towards greater independence, choice and well-being will require key changes in the way that Local Authorities provide support and care.

Demographic

The Council will face significant challenges arising from the demographic change to the City. These challenges include a growing older population with increasingly complex needs, more people with dementia, the migration of more affluent older people out of the City, changes in the ethnicity of the popluation and a growing number of people who choose to self-direct their own care.

Local

At a local level, there are also many challenges, these include meeting the targets and priorities set out in the City Council's Community Strategy and Local Area Agreement. The Adults and Communities Directorate must also rise to the challenges set out in its commissioning strategies, develop its strategic commissioning arrangements and succeed in implementing its Business Transformation programme.

Further details about the national, demographic and local challenges are in Section 2 of this report.

	Recommendation	Responsibility	Completion Date
R4	That the Adults and Communities Directorate must identify the proportion and influence of self-funders (including those with their own capital /resources and those who receive individual budgets and direct payments). The Directorate to identify how dominant self-funders are in the current market, projections for the future and how this will affect the market.	Cabinet Member for Adults and Communities	November 2009

4.2 Service Users and Carers

- Those service users and carers who attended the focus groups expressed a preference for receiving an in-house home care service. Service users were concerned about the movement between internal and external providers and vice versa. Even where service users had not experienced movement from internal home care to an external provider, they perceived that the external provision would be of a poorer quality. In essence, service users were reluctant to consider change regardless of whether they were receiving internal or external provision.

- Some concerns were raised by users and carers about the quality and consistency of care and the attitude of carers regardless of which sector was providing the care. A lack of awareness about how to complain was evident. In addition, some users and carers stated that they were afraid of repercussions if they made a complaint.

- Hostility was shown by service users and carers towards the Fairer Charging policy. Some users didn't feel that they ought to use their specific care benefits to pay for services. Also, the delay in service users being assessed and informed about their charge added to their frustration. Members felt that such delays could result in the cancellation of services once people were advised of their financial contribution. Members are aware that the Directorate are reviewing the fairer charging arrangements and the Scrutiny Committee will be closely monitoring progress in the area.

- Service users and carers would like the Adults and Communities Directorate to be able to recommend agencies and/or individuals who will assist with Home Care, domestic and handyperson tasks. It was suggested that the Directorate could introduce a "charter mark" for quality services and produce a list for the public.

- There needs to be additional support available for those individuals who are self-funders; in terms of information, advice and signposting. The needs of this group are not currently being addressed by the Council.

- There was a general lack of awareness amongst service users and carers about Direct Payments and Individualised Budgets. There was also a lack of enthusiasm for Direct Payments

and Individualised budgets as service users and carers were unsure that there was enough capacity within the market to enable them to purchase high quality care and support.

4.3 Commissioning and Procurement

- Any improvements to Home Care Services, whether provided internally or purchased externally are reliant on an effective specification being provided by commissioning. Members concluded that commissioning is the key task to drive the necessary change for service improvement.

- Members found that there was a lack of clarity about the strategic role of commissioning within the Adults and Communities Directorate and a lack a clarity around its relationship with the objectives of business transformation and procurement.

- The Commissioning function appeared to lack direction. Despite the existence of numerous commissioning strategies, the importance of Commissioning within the Directorate did not appear to have been recognised. There appeared to be a lack of understanding about what commissioning involves; it is far more than contracting and procuring services. This was a view that was shared by the Inspectorate:

  "The Departmental Service Commissioning strategy 2005 – 2010 failed to act as an effective improvement tool. The intentions were vague and the implementation and monitoring arrangements for the plan were lamentable. No key indicators were set out – simply an aspiration that '…all agencies need to agree a core set of indicators that are rigorously monitored at an operational level." (CSCI Inspection of Birmingham "Independence, Well-Being and Choice" 2007)

- The current commissioning process will not achieve strategic objectives unless it has integrity and is separate and independent of the provider role and is fully integrated with business transformation and value for money procurement. In addition, the Directorate must "commission for quality." The Directorate must further develop its mechanisms for monitoring the performance of services and tackling poor performance.

- The Directorate through the commissioning process must be able to influence, shape and develop the market to encourage all providers to meet the demands resulting from the increased take up of direct payments, individualised budgets and self-funders:

  "Improvements in commissioning and market management were also developing a growing range of services within the wider social care market but these developments could have been better informed by intelligence about needs and gaps in services held by frontline operational staff." (CSCI Inspection of Birmingham - Independence, Well-Being and Choice 2007).

- The Directorate must also be in a position to advise the holders of individual budgets, Direct Payments and self-funders on the availability and quality of services that they may purchase. People who purchase their own care must be supported by the Directorate to ensure that they receive the same level of support and guidance as those people who receive their service through the Directorate.

- The current contracting arrangements do not appear to be satisfactory, either for the Directorate or external providers. Some external agencies expressed dissatisfaction with the current content of contracts e.g. a lack of qualitative measures.

- It is vitally important that qualitative and capacity issues are enshrined in the commissioning process.

- It is essential that improvements are made to the monitoring arrangements of contracts with external home care providers but also equal attention must be paid to monitoring the internal service.

- There seems to be a lack of innovative thinking in the commissioning process and in particular the engagement of the Third Sector. The Directorate has not seized the opportunity to develop and stimulate the market, for example by exploring the potential of Social Enterprises. Other Local Authorities have made efforts to stimulate the market through social enterprise and are now reaping the rewards, Birmingham must take urgent action to engage with the Social Enterprise agenda.

	Recommendation	Responsibility	Completion Date
R1	That the Adults and Communities Directorate must urgently review its commissioning arrangements to ensure that they are directed to achieve strategic objectives and are fully integrated with business transformation and value for money procurement. In addition, the Directorate must "commission for quality".	Cabinet Member for Adults and Communities	May 2009
R5	That the Adults and Communities Directorate must actively engage in market shaping and develop accreditation systems for external and third sector providers. Information about the source and quality of services must be made available to people who choose to self-direct their care and support. Particular attention should be paid to ensuring that the market is able to meet the needs, demands and aspirations of people from BME communities.	Cabinet Member for Adults and Communities	November 2009

4.4 Internal Home Care

- Generally, there is a high level of user and carer satisfaction with the internal home care service; this is evidenced through the survey detailed overleaf. This might lead people to a view that there is no need for change. However, demographic pressures and the shift towards greater user and care choice and personalisation mean that this is not the case.

- The internal Home Care service believed that it focussed its delivery on complex, short term and enablement services. However, the evidence presented showed that there was inconsistency across the City, both in terms of those areas that provided an enablement service and the data showed that some external agencies were also managing highly complex packages of care.

- Members felt that the Adults and Communities Directorate must reach a decision about its share and role within the market. The internal home care service must have a clear remit and should consider focusing on more specialist, complex packages of care with a focus on enablement. The challenge for the Directorate is to cost-effectively fit into the market.

- Members were concerned that Operational Managers had responsibility for both the management of internal home care services and purchasing from external home care providers. In reality, the Committee found that they utilised the budget to cover internal services costs first and commissioned from the external sector with the remainder of the budget. This did not appear to be an effective way of managing the market as Operational Managers had a clear conflict of interests, which compromised the objectives of commissioning.

- Members were concerned that the organisation and management of the internal service resulted in the cost of the service being higher than the external sector.

- The internal home care service is endeavouring to develop services in partnership with health colleagues in the Primary Care Trusts but progress appears to have been limited.

- Many of the findings of this review were echoed by the 2007 CSCI Inspection into "Independence, Well-Being and Choice" which reported:

    "However, the in-house home care service remained 50 per cent more expensive than commissioned care. Manager's claims about the assumed inevitably higher quality of the care provided by the in-house service could not be evidenced but the issues of both cost and quality of this service were under active review by the Scrutiny Committee. Managers were unable to identify any savings that had been made from jointly providing services with health partners."

- Members did recognise that efforts were being made to bring about greater consistency in internal provision and in training staff in enablement.

R6	That the Adults and Communities Directorate review the role of Operational Managers in the commissioning of services. The commissioning process must be independent of the provider role.	Cabinet Member for Adults and Communities	May 2009
R7	That the role of the internal home care service must be directed by strategic commissioning and procurement. The internal service must respond to the service specification developed by Commissioning and amend its service accordingly. Further that the Adults and Communities Directorate must reach an early decision about its share and role within the market.	Cabinet Member for Adults and Communities	May 2009

4.5 External Providers of Home Care

- Members felt that within the group of external providers that they met there were considerable differences in the quality of the service provided.

- Not surprisingly external providers main interests in relation to their contact with the City Council were concentrated on volume of work, share of the market, price and payment systems. Future expectations and qualitative issues did not appear to be paramount concerns. Their wider role in the market place and the future expectations of service users were not paramount concerns. In summary, Members were disappointed that external providers currently see themselves as merely suppliers of service.

- Members were made aware of difficulties associated with processing payments to external home care providers. Many providers raised this as their principal concern about providing services in Birmingham. Members were advised of improvements that have been made to the internal financial system, which links service provision with payment. However, External providers continue to have concerns about the impracticality of fulfilling the Directorate's requirement to be informed about slight variations in service. Members believed that the system needed to be simplified whilst still maintaining the integrity of the financial procedures. Members were also made aware of the challenges that have arisen because of the introduction of the new Voyager financial system.

- The majority of external providers were finding recruiting and retaining staff problematic. The external providers recognised that there was a shortage of people in the City that wanted to work as care staff and, therefore, they were in direct competition with the City Council Home Care service and other providers who were offering enhanced conditions of employment.

- Members were concerned that most external providers were employing staff on zero contracts. Zero contracts means employing staff with no guarnteed terms and conditions of employment. Zero contracts inevitably make offering training and development opportunities problematic as frontline home care staff may leave if they are offered the opportunity of working for an alternative agency that provides better terms and conditions of employment. Members raised concerns about the ability of these agencies to deliver consistently high quality services to vulnerable service users when some of them did not have a stable workforce.

- Although some agencies were providng training to their staff in most cases there appeared to be room for improvement. Members felt that support needed to be given to external providers to train staff to ensure consistent standards of care. Members supported the external providers desire to access training made available to internal home care staff or to have joint training with internal home carers.

- External providers raised concerns about the quality and level of details in the care plans that they received about individual service users who they were expected to care for. Members were concerned about the level of detail and quality of the information given to Home Carers which could potentially put service users and carers at risk. The Directorate need to review their care planning arrangements.

- External providers identified difficulties in contacting the Adults and Communities Directorate. They asked for clarity about who their point of contact should be in the Directorate – this related to assessment and care management staff, finance staff and commissioning and contracting staff. The Directorate need to clarify roles and responsibilities of staff and communicate this clearly to external providers.

- External providers were unhappy about the current arrangements for consultation and engagement used by the Directorate. There were different experiences across the City. Members supported their request for an ongoing City-wide forum which would facilitate ongoing dialogue with the Directorate and to share good practice

- The CSCI Inspection of Birmingham of Independence, Well-Being and Choice 2007 made comments about External Home Care provision. The Inspectors reinforced Members concern about the stability of external providers:

"Service users and carers told service inspectors of complaints about independent home care providers missing appointments and failures to complete tasks properly, which had gone without resolution. One carer said," The department pay for 30 minute calls, but they only stay 10 minutes. I am fed up with telling them about it. Nothing happens; it is a waste of their money and a poor service for my Mum".

"Some independent sector providers had experienced instability and uncertainty about the future level of services that would be required by the council when their current contract expired."

4.6 Assessment and Care Management

- Members concluded that there appears to be differences in the quality of care planning across the City. There is a lack of clarity about the role of care brokers and social workers; this results in confusion and frustration for external agencies. Agencies need clear guidance about the role of the broker and clarity about who within Adults and Communities to contact when they are experiencing difficulties.

- The quality of care planning within the City needs to be evaluated. Care plans appear to be task-orientated rather than focussing on outcomes for service users and carers. Members recognised that this would require a cultural shift and additional training for some Adults and Communities staff. This concern was also raised by the recent CSCI inspection:

    "Overall, care planning was satisfactory insofar as it listed and procured services to meet social care needs. However, care planning was often unambitious and lacked a focus on outcomes and improvement. Some care plans were task focused and missed opportunities to be creative and to prioritise the delivery of personalised care through care plans that specifically reflected the wants, ambitions and capacity of service users and carers."

	Recommendation	Responsibility	Completion Date
R8	That the Adults and Communities Directorate must evaluate the quality of care plans. Care plans need to detail outcomes for service users and carers.	Cabinet Member for Adults and Communities	May 2009

4.7 Self Directed Care

- The Directorate needs to expand the support and guidance it provides to those people who choose to purchase their own care (self-funders) or use Direct Payments and Individualised Budgets.

- Members were disappointed with the number of people receiving a Direct Payment. Other Local Authorities particularly Essex have had much more success in encouraging service users and carers to see Direct Payments as an alternative to council provided services. The Directorate need to find new ways to promote individualised budgets and direct payments as a viable alternative to its own services. The Inspectorate recognised that the Directorate has reprioritised and modernised its scheme, however:

   "The Department had a target to ensure that every service user had some kind of self-directed care by 2009. However, the aspiration was ambitious, as carers were not convinced that the necessary cultural changes were taking place within the approach of assessment staff to ensure that opportunities for self-directed care were grasped. One carer stated, "They are still thinking about provision of services to meet the limitations of the service user's disability. They need to think about using direct payments to provide support for people to do things that they want to do". (CSCI Inspection of Birmingham - Independence, Well-Being and Choice 2007)

- Any improvement in the uptake of Direct Payments and Individualised Budgets will require the full support of key staff within assessment and care management.

   "Some staff were not fully aware of the availability of emerging services for promoting independence and this had a negative impact on their ability to design ambitious and outcome focused care plans." (CSCI Inspection of Birmingham - Independence, Well-Being and Choice 2007)

- The Directorate have been hailing individual budgets as a key component of its Business Transformation Programme. The Programme should bring about service improvement and result in financial savings. Individual budgets are the key driver to ensure that cost savings are driven to meet future needs and to meet the challenge of demographics. The increased take up of Individual budgets should also result in increased service user control and choice. However, it has been noted in other forums that Individual Budgets are not the answer to a Council's financial challenge:

   "What we have found, on the whole, is that it does not save money. Where people have been traditionally on very expensive and complex packages of care it's saved about 10% of the money in order to produce very much better

   results for people, but   especially for older people where

traditionally packages of care have not been large or generous it is not an opportunity to save money. It's not going to solve the financial problems facing adult's social care because of the demographics."

(John Dixon – Director of Adults & Children's Services in West Sussex and President of Association of Directors of Adult Social Services)

- The Review team received some important evidence towards the end of the review from the Adults and Communities Directorate about the self-directed care pilots. Members were told that the pilots were of personal budgets rather than individual budgets. The lead officer from the Directorate tried to reassure Members that this was merely an issue of definition. Members did not accept this point and were left questioning the value of these pilots on a number of fronts. Firstly and most importantly, the pilots did not appear to place the user at the heart of the pilot. The absolute premise of self-directed care is just that, that the user of the service directs their care. In the pilots, the priority appears less on the user directing their own care and more on the Directorate retaining control and direction. Members were disappointed that the pilots placed so little importance on the engagement of service users in a self-assessment process.

- Members felt that the pilots also placed too much emphasis on the financial contribution of the Adults and Communities Directorate and did not take the opportunity to include other sources of funding e.g. from Primary Care Trusts.

- Members strongly believe that the Directorate must clarify their position in relation to Individual Budgets. If the Directorate are using personal budgets as a transitional step towards the introduction of individual budgets then a strategic plan must be in place setting out how the Directorate will achieve the move from personal to individual budgets.

	Recommendation	Responsibility	Completion Date
R2	That the Adults and Communities Directorate must provide clarity in respect of the proposed utilisation of personal budgets as a transitional step towards the attainment of Individual Budgets.	Cabinet Member for Adults and Communities	May 2009
R3	That the Adults and Communities Directorate consider developing and implementing a policy that all new applicants for Social Care services receive an individual budget.	Cabinet Member for Adults and Communities	May 2009

4.8   Third Sector and Social Enterprises

- The Directorate needs to engage more fully with partners including Third Sector organisations and Primary Care Trusts to develop services that complement and add to the current range of home care services. Members were disappointed with the level of engagement with key partners, such as Health and community organisations despite there being a shared commitment to improving the health, well-being and independence of people within the City.

- Members found that there is generally modest engagement with the third sector but there is considerable scope for developing potential e.g. exploring the possibilities around social enterprise.

- There appears to be low level engagement with third sector agencies with regard to home care although a multiplicity of agencies do provide services that fit the well-being agenda category e.g. luncheon clubs, befriending.

- Members were concerned that other Local Authorities appear to have been much more successful in attracting third sector agencies to provide home care in their location. Members questioned why key agencies such as Age Concern were not providing home care services in the City. Once again Members saw this as being the result of the Directorate not using its resources to shape and influence the market. Developing the third sector market and in particular social enterprise initiatives must be afforded greater priority by the Directorate.

	Recommendation	Responsibility	Completion Date
R9	That the Adults and Communities Directorate must develop a thorough knowledge of the Working Neighbourhood Fund and take opportunities to secure funding for developments such as social enterprises. Developing the third sector market and in particular social enterprise initiatives must be afforded greater priority by the Directorate.To achieve this they must provide Officer support to develop and sustain these enterprises.	Cabinet Member for Adults and Communities	May 2009

4.9 Links to Other Services

- Assistive Technology has the potential to revolutionise the care and support provided to people who currently receive home care services. Assistive technology if fully utilised could enable people to either live without the need for home care services or a reduced level of home care intervention.

- Any changes or improvements to Home Care provision must not be made in isolation. It is essential that there is cross Directorate collaboration where appropriate i.e. the Adults and Communities Directorate should be involved in discussions about care or support provided in any sheltered and extra care housing schemes.

- The Adults and Communities Directorate did not appear to be making the most of the opportunity to work in partnership with Health colleagues. There were examples of good practice where health professionals were involved in assessments and enablement programmes; if found to be effective these need to be replicated across the City.

	Recommendation	Responsibility	Completion Date
R10	That the Adults and Communities Directorate must explore more fully the opportunities to work with Health colleagues in the delivery of enablement services. Good practice should be consistently replicated across the City.	Cabinet Member for Adults and Communities	May 2009

5   Conclusion

We cannot respond to demand for service by continuing to restrict access to services when the demographics are dictating that more and more people are requiring care and support.

It is neither affordable nor realistic for the Directorate to maintain and plan to continue to deliver and commission care in the way that it currently does given the national, demographic and local challenges.

It is very clear that Home Care services cannot remain as they are and commissioning arrangements must be strategically re-directed to respond to the challenge of increasing customer choice and their aspirations to influence and control the quality of their lives.

6 Appendices

6.1 Appendix 1 – Review Pro-forma

Home Care Review Outline

Subject of review	Home Care
Overview and Scrutiny Committee	Social Care

Reasons for Conducting the Review

Reasons for conducting this review	The Home Care arrangements have not been subject to recent review. The Scrutiny Committee has chosen to look at Home Support as this is an important service to enable people to live at home. The recent Delivery and Improvement Statement (DIS) noted deterioration in the Directorates performance for enabling older people to live at home and this has prompted the Committee to make home care a priority area for review.
Key question that the review is seeking to answer	How effective are the current home care services in meeting the needs of adults in the City?
Objectives of review / Areas for investigation	There are a number of questions to be addressed: • How does in-house provision of home care operate? • Do the current arrangements provide a quality service that is also cost-effective? • Are the arrangements for purchasing home care from the external sector robust and cost effective? • How user orientated is this provision? • What are user experiences of this service? • How does current provision fit with the seven outcomes in the White Paper? • What are the arrangements for monitoring the performance of home care services?
Outcomes expected from conducting this work	The review will inform and influence the Adults and Communities Directorate provision and operational model for home care services.

Your Home, Your Care, Your Choice

Project Plan and Resourcing

Member Involvement

Lead Member	Councillor Len Clark
Other Members involved	Councillors Reg Corns, Emily Cox, Talib Hussain, Steve Bedser, Barbara Tassa
Are all parties on the Overview and Scrutiny Committee involved?	Yes
Key Cabinet Member	Cabinet Member for Adults and Communities
Other Cabinet portfolios covered	Local Services and Community Safety

Officer and External Involvement

Link Officer	Steve Wise
Lead Review Officer	Jon Tomlinson /Natalie Borman

Council Departments Expected to Contribute

Contact / Department	Objective	Contribution Expected
Adults and Communities Directorate (Bill Robertson and Peter Hay) Cabinet Member for Adults and Communities (Councillor Sue Anderson) Home Care co-ordinating teams/staff/managers	• How does in-house provision of home care operate? • Does the current service provide a quality service that is also cost-effective? • Are the arrangements for purchasing home care from the external sector robust and cost effective? • How user orientated is this provision? • What are user expectations? • How does current provision fit with the seven outcomes in the White Paper? • What are the arrangements for monitoring the performance of home care services?	Presentation on the current position of regarding Home Care services from the Adults and Communities Directorate Attendance at a Scrutiny Committee Meeting

External Organisations Expected to Contribute

Contact / Organisation	Objective	Contribution Expected
Voluntary organisations Faith and other minority community group representatives	• Are the voluntary sector and/or other community groups involved in delivery of home care? If so what is the nature of their involvement? Is their potential for a more enhanced role?	Attendance at a Scrutiny Committee meeting
Users	• What are user experiences of home support?	Feedback through questionnaire(s)/ Previous survey results

Publicity and Awareness of the Review

Publicity activities to be undertaken	• Press release issued at the start of the Review • Review included on City Council website

Time Frame for Core Phases of Review

Phase	Time Required	Completion Date
Meetings and evidence gathering sessions	Review to commence in September 2006. Meetings to be held September – December 2006	September – December 2006
Drafting the report		December 2006
Consideration of draft report by Committee		January 2007
8-Day Rule: Executive Comment		January 2007
Reporting to Committee		January /February 2007
Reporting to Council Business Management Committee		
Reporting to the City Council		April 2007

Specific Costs Identified

Anticipated call on Scrutiny Budget	No costs anticipated other than possible costs of travelling

6.2   Appendix 2 - Glossary

Assistive Technology

Related to helping people maintain their independence, for example, using equipment and adaptations in their homes. Assistive technology includes innovations to assist with communication, equipment for people with a hearing disability, access for people with a visual disability, computer access for people with a learning disability, supporting people with dementia, linking housing and assistive technology, mobility, and wherever possible assessing physical ability to inform design. Telecare and telemedicine enable individuals to be treated outside hospital settings and, by assisting the work of GPs and community care teams, enable individuals with chronic illnesses or disabilities to live independently.

Direct Payments

A way for people who need social care services to have more control over the service they receive. People who are eligible for services (day care, personal care, respite care etc) can opt to receive the money for the service from the local authority and purchase it themselves. In this way they can choose the exact service they want, when they want it and who provides it. Councils have a duty to make a direct payment to people who can consent to have them. This means that direct payments should be discussed as a first option with everyone, at each assessment and each review.

Enablement

Methods used by health and social care workers to support the people they work with and encourage them to be as independent as possible

Fair Access to Care Services (FACS)

Provides a national framework within which councils must set their eligibility criteria for adult social care based upon individual needs and the associated risks to their independence. There are four eligibility bands: critical, substantial, moderate and low.

Individual Budgets

Individual Budgets are designed to bring about independence and choice for people receiving care or support. It gives them a full understanding of the finance that is available, in order to empower them to take control and make decisions about the care that they receive

Individual budgets puts people in the centre of the planning process, and recognises they are the person best placed to understand their own needs and how to meet them.

Individual budgets are flexible enough to allow people who are satisfied with existing services to keep these, and also give people a range of options for building up more individually tailored support, using Direct Payments and other routes.

Performance Indicators

Ways of measuring particular aspects of what an organisation does and comparing its performance against targets.

Reablement

The active process of regaining skills, confidence and independence.

Social Enterprises

Businesses involved in social enterprise have primarily social objectives. Their surpluses are reinvested principally in the business or community.

Telecare

A combination of equipment, monitoring and response that can help individuals to remain independent at home. It can include basic community alarm services able to respond in an emergency and provide regular contact by telephone as well as detectors, which detect factors such as falls, fire or gas and trigger a warning to a response centre. Telecare can work in a preventative or monitoring mode, for example, through monitoring signs, which can provide early warning of deterioration, prompting a response from family or professionals. Telecare can also provide safety and security by protecting against bogus callers and burglary.

Third Sector

Term used to describe the range of institutions, which occupy the space between the State and the private sector. These include small local community and voluntary groups, registered charities both large and small, foundations, trusts and the growing number of social enterprises and co-operatives. Third sector organisations share common characteristics in the social, environmental or cultural objectives they pursue; their independence from government; and in the reinvestment of surpluses for those same objectives.

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