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Report of:	Director of Adult Health & Social Care
Report to:	Adult Health and Social Care Policy Committee
Date of Decision:	15th June 2022
Subject:	Care and Wellbeing Services Transformational Contract

Has an Equality Impact Assessment (EIA) been undertaken?	Yes	✔	No		
If YES, what EIA reference number has it been given? **1058**					
Has appropriate consultation taken place?		Yes	✔	No	
Has a Climate Impact Assessment (CIA) been undertaken?		Yes	✔	No	
Does the report contain confidential or exempt information?	Yes		No	✔	

If YES, give details as to whether the exemption applies to the full report / part of the report and/or appendices and complete below:-

*"The (**report/appendix**) is not for publication because it contains exempt information under Paragraph (**insert relevant paragraph number**) of Schedule 12A of the Local Government Act 1972 (as amended)."*

Purpose of Report:

The purpose of this report is to secure approval for the commissioning strategy for the delivery of Care and Wellbeing Services for adults delivered within their own homes. These services are also known as 'homecare'.

The report will highlight the risks faced by Sheffield City Council (SCC) with regards to its statutory duty under the Care Act to provide an effective, efficient, and sustainable market for the delivery of home care services under the current model. Changes are required to mitigate and eliminate these risks and the proposed commissioning strategy for the new Care and Wellbeing Services Contract is intended to deliver this.

Recommendations:

It is recommended that the Adult Health and Social Care Policy Committee approves the commissioning strategy for the delivery of Care and Wellbeing Services delivered through a 7-year contract term with options up to a further 3 years as set out in this report.

Background Papers:

No papers.

<table>
<tr><th colspan="3">Lead Officer to complete:-</th></tr>
<tr><td rowspan="3">1</td><td rowspan="3">I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.</td><td>Finance: Ann Hardy</td></tr>
<tr><td>Legal: Kevin Carter / Ella Whitehead</td></tr>
<tr><td>Equalities: Ed Sexton</td></tr>
<tr><td colspan="2">Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.</td></tr>
<tr><td>2</td><td>SLB member who approved submission:</td><td>John Macilwraith</td></tr>
<tr><td>3</td><td>Committee Chair consulted:</td><td>Councillor George Lindars-Hammond and Councillor Angela Argenzio</td></tr>
<tr><td rowspan="3">4</td><td colspan="2">I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Committee by the SLB member indicated at 2. In addition, any additional forms have been completed and signed off as required at 1.</td></tr>
<tr><td>Lead Officer Name:
Paul Higginbottom</td><td>Job Title:
Strategic Commissioning Manager</td></tr>
<tr><td colspan="2">Date: 7th June 2022</td></tr>
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1. PROPOSAL

(Explain the proposal, current position and need for change, including any evidence considered, and indicate whether this is something the Council is legally required to do, or whether it is something it is choosing to do)

1.1 The Council must provide home care services, which provide support with 'activities of daily living' for adults living in their own homes. The existing contract is due to expire in April 2023 and the Council intends to begin re-procurement during Summer 2022.

1.2 It is proposed that in this re-procurement the opportunity is taken to re-model the provision of home care services into a new Care & Wellbeing Services model, implemented through a transformational 7-year contract (with an option to extend for 2 years, and a further 1 year).

1.3 The challenges faced in Home Care are replicated across the UK as a result of many years underfunding. In the absence of the required level of investment, the new model will seek to mitigate and remove existing issues affecting quality and efficiency, create stability of provision across Sheffield. This is aimed at creating a foundation for improved experience for people, families, carers, and our care workforce. It will also set out an approach for generating greater collaboration across health and care services in the City as well as developing career pathways for care workers in the City.

2. CURRENT POSITION & NEED FOR CHANGE

2.1 There are 35 providers on the current framework, with the city divided into 21 contract areas and multiple providers operating in each area.

2.2 The Council has a responsibility to maintain oversight of quality and value for money, as well as a secure a stable market with providers that are able to deliver the continuity of support people in Sheffield need.

Increased Demand

2.3 The size of the Council's spend on the home care market has increased significantly in recent years, with around 40,000 hours of care being delivered per week in 2022, escalating from around 32,000 per week at the start of the Covid 19 pandemic. Despite the increase in the overall amount of care commissioned, the number of people in receipt of care has remained static, at around 2,500 per week.

2.4 The increase is therefore linked to a rise from an average of 12 hours per week per support arrangement in 2020, to around 16 by 2022. It is likely that this was due to a decision during the pandemic not to use residential care and therefore reflects the increased complexity of need that care workers in homecare were responding to the pandemic.

2.5 Benchmarking also indicates Sheffield to be an outlier in comparison to the national average, commissioning on average around two hours more per person each week - a total of 5000 hours per week more.

2.6 Consideration of Sheffield demographics, referral rate, complexity of care and benchmarking would indicate that 34,000 planned hours would be required set alongside the provision of a Sheffield City Council Care and Wellbeing Service.

2.7 Care hour types and their definitions, covering Commissioned, Planned and Actual care hours are detailed in **Appendix 1**.

Recruitment & Retention Challenge

2.8 Reflecting challenges across the health and social care sector, local home care providers have been unable to recruit enough new staff, whilst also losing existing workers to other sectors, often with better pay, conditions, career pathways and/or less responsibility and day-to-day challenges - it is estimated that up to 32%[1] of the sector do not see care as long-term career.

2.9 Retention is further impacted by staff leaving the workforce due to retirement or ill health: 26% of care workers in Sheffield are aged over 55[2].

2.10 The most recently available data from Skills for Care[3] confirms annual staff turnover of 50% in the Sheffield independent sector, compared to 35% across Yorkshire & Humber and 2.7% for home care workers employed by the Council.

2.11 High staff turnover and workforce instability impacts negatively on the experiences of people receiving home care; increases changes in support provision; causes delay in support pick up; reduces the quality of care; and increases provider's costs[4].

2.12 Providers have consistently told us that the current position is unsustainable It is therefore imperative that we urgently establish the conditions needed to bring stability to our care workforce sector.

Impact on Quality

2.13 The combined demand and capacity challenges have exacerbated areas of concern predating the pandemic, as described in Healthwatch Sheffield's 2019 report[5] and 2021 report *SpeakUp: A Review of Home Care – The African Caribbean Perspective*[6]*:*

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[1] Home Care Transformation - Committee Report 0.3.pdf (sheffield.gov.uk)
[2] Sheffield_Summary 2021 (skillsforcare.org.uk)
[3] Home - Workforce intelligence (skillsforcare.org.uk)
[4] Skills for Care estimate that the cost of recruiting each care worker is over £3.5k[4]. Replacing half the frontline workforce each year, around 950 care workers, would costs commissioned providers around £3.5m per annum (https://www.skillsforcare.org.uk/Documents/Standards-legislation/CQC/Safe-staffing/Calculating-the-cost-of-recruitment.pdf)
[5] https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/reports-library/20190219_Sheffield_Home%20Care%20Report%20January%202019.pdf
[6]https://www.healthwatchsheffield.co.uk/sites/healthwatchsheffield.co.uk/files/editors/SACMHA%20report_final.pdf

- Late, missed, and inappropriate timing of care visits
- Rushed care visits
- Lack of continuity of care
- Care plans not followed or reviewed regularly
- Lack of opportunities for feedback
- A perception that there is a lack of training, supervision, and monitoring of home care workers
- A lack of culturally appropriate care

2.14 Additionally, the current Home Care payment and charging model - based around time and task and charging on minute by minute of care delivered - is not outcome or quality focused and is not as effective and efficient as it could be for our customers, providers, or the Council.

2.15 The cumulative effect of increase in demand set against significant recruitment and retention challenges has created a situation where the sector struggled to pick up new homecare support referrals. To mitigate this, the Council has had to increase usage of a 'Direct Award' process – whereby the Council secures provision of service directly with a non-contracted provider. While use of Direct Awards is a legitimate response to ensure people have the required support to meet their needs, these arrangements are typically more expensive and do not guarantee quality and continuity of care; annual spend on Home Care Direct Awards has reached £4.7m (around 11% of the overall spend on home care).

3 PROPOSED NEW MODEL

3.1 A sustainable market is one which has a sufficient supply of services (with provider entry and exit), investment, innovation, choice for people who draw on care, and sufficient workforce supply. It also refers to a market which operates in an efficient and effective way, linked to the market shaping duty placed on local authorities under section 5 of the Care Act 2014. Further detail on this can be found in the market sustainability plans section of Department of Health and Social Care Market sustainability and fair cost of care fund 2022 to 2023[7].

3.2 It is proposed to introduce a new approach to homecare in the City by moving towards a community integrated care and wellbeing model. Collective Practice Standards across Adult Social Care and Commissioned services will seek to drive practice that is outcome focused, strength-based, community connected, and person led so that *all* social care support is focused on enabling people to live independently, live the life they want to live and have positive experiences of care.

3.3 It is anticipated that the proposed commissioning strategy for homecare will generate long term transformation and sustainability, and improve the quality and experiences of people who use care by:

- Contracting with a fee rate that is sufficient to sustain a stable market and better workforce retention and recruitment, in turn supporting timelier

[7] Market sustainability and fair cost of care fund 2022 to 2023: guidance - GOV.UK (www.gov.uk)

support pick up, improved continuity of care, and better outcomes for Sheffield people. Section 4 provides further information.

- Improved accessibility, stability, and continuity of care provision by moving to an increased contract duration and guaranteed payment to providers for a proportion of the anticipated volume, supporting business continuity, forecasting, and planning.

- Geographical alignment of support with 2-3 providers in each geographical area, operating as equal partners within multi-disciplinary and collaborative working arrangements across health and social care. It is anticipated that this will strengthen partnership working, improving monitoring arrangements, supporting provider efficiencies and sustainability, and reduce travel for care staff - and in doing so reduce our carbon footprint. To support this approach, the tender process will allow providers to collectively bid via alliances and other consortia arrangements.

- Improving quality, being responsive to individuals changing needs and preferences, and fostering independence by moving away from a time and task model (where the focus is delivery on requested hours) to an outcome-based model aligned to our Care Act duties. An outcome-based model is a model where care is focussed upon the priorities and goals a person wants to achieve to improve their wellbeing and independence through the support they receive from the provider. Providers will be asked to demonstrate – including through Trusted Reviews - how they have enabled an individual to improve their wellbeing and live more independently and in doing so reduce the need for care and support, enable more positive experiences of care and managed new referrals in a timely and safe way. (The Trusted Reviewer model is described in **Appendix 3**.)

- Changes to the payment and charging model. Switching from payment based on minutes of care delivered to payment based on planned care will shift the emphasis away from time and task; it will give providers more certainty and people more timely and more reliable invoices; and it will reduce complexity and improve efficiency.

- Asking providers to ensure a robust workforce development plan which ensures the recruitment and retention of a diverse care workforce so that individuals are supported by a workforce that reflects the population of Sheffield, reflects their cultural preferences, and delivers culturally appropriate care. This will also be managed through our contract oversight.

- Valuing and developing our care workers by supporting successful providers to promote learning and skills and develop care apprenticeships and career pathways for care staff in the City in partnership with the Council. Qualification, practice and quality standards for managers and care workforce will be specified, and ongoing development opportunities will be provided to strengthen leadership and key skills in the sector - such as dementia, falls prevention, manual handling passports, enablement and mental health and wellbeing. A valued workforce will also likely improve staff

retention and reducing turnover to 15% would save providers over £2.7 million in recruitment costs over the course of the contract.

- Promoting, innovation and independence through enablement, and greater use of technology, equipment, and adaptations and empowering providers to work in partnership with individuals, their families, and carers to promote and develop innovative new ways of enabling individuals to live as independently as possible.

- Identifying unpaid Carers through empowering providers to be able to refer to, and work in partnership with Carers support services so that we build innovation and greater awareness of support to unpaid carers.

- Focus our care and wellbeing provision on enabling individuals to be as independent through developing new approaches and contractual arrangements for cleaning and shopping to afford individuals further choices in relation to these types of care arrangements.

- A 'test of change' project is being delivered to develop and improve implementation of this transformational contract. Further information on the test of change is provided in Appendix 2. This will include the potential future introduction of payment by shift for care workers if the cost benefits can be evidenced.

4 SUSTAINABLE FEE RATE

4.1 The Care Act 2014 places a duty on local authorities to assure themselves and have evidence that fee levels are appropriate to provide the agreed quality of care and enable providers to effectively support people who draw on care and invest in staff development, innovation, and improvement.

4.2 As part of the service remodelling and procurement strategy development for homecare, we have engaged with providers to better understand this. 17 providers responded to support our analysis. This work has indicated that the current rate of approximately £19.05 per hour is not sufficient to sustain a stable and quality homecare market.

4.3 The available budget for 23/24 is circa **£36m.** As we navigate person centred care, we would hope to make efficiencies elsewhere in the system to be able to maintain this level of budget, unless there is significant investment into social care from Central Government, through the fair cost of care exercise or social care levy. We also have the option of redirecting resource from another part of the budget that we purchase care from. The table below demonstrates the cost of the service based on three different hourly rates, and four potential scenarios for demand based on delivery hours:

Total Contract Hours per week	Fee Rate £19p/hr	Fee Rate £20p/hr	Fee Rate £21p/hr	Fee Rate £22p/hr
	£'000s			
32,000	£31,616	£33,280]	£34,944	£36,608
34,000	£33,592	£35,360	£37,128	£38,896
36,000	£35,568	£37,440	£39,312	£41,184
38,000	£37,544	£39,520	£41,496	£43,472

4.4 A rate of £21 per hour for a total 34,000 contracted hours per week would be a significant step for Sheffield and our ambition towards implementing foundation living wage. We anticipate that this rate – together with the move to planned care over a 7 years + 2 +1 contract and consolidation of the market will support our commissioning objectives and better outcomes for Sheffield people. We also anticipate that staff will see the benefit of an increased fee rate in their terms and conditions.

4.5 A number of actions are in train, with the aim of reducing our current delivery of care hours down to 34,000 hours per week. These are set out further in **Appendix 3.**

4.6 To afford the remaining £1.1m pressure on the budget from this proposed increased rate, it is anticipated that the £200,000 will be offset by financial contributions and efficiency gained through the introduction of planned care, which leaves a pressure of £0.9m from 2023/2024. This £0.9m is planned to be offset by joint work with NHS Sheffield Clinical Commissioning Group to review and redesign care provision in the City as part of our strategic move towards more independent living and preventative approaches in the City.

5. HOW DOES THIS DECISION CONTRIBUTE?

(Explain how this proposal will contribute to the ambitions within the Corporate Plan and what it will mean for people who live, work, learn in or visit the City. For example, does it increase or reduce inequalities and is the decision inclusive?; does it have an impact on climate change?; does it improve the customer experience?; is there an economic impact?)

5.1 As stated in the One Year Plan for 2021/22, the Council committed to '*review our homecare services* (to ensure) *that we are delivering support that enables people to live independently at home in Sheffield*'. The changes described through the implementation of the Care & Wellbeing Service seeks to delivers that commitment.

5.2 As set out earlier in this report, the current position is unsustainable, both financially, and qualitatively. Many issues have the potential to impact more greatly on some communities, reinforcing existing inequalities.

5.3 The contract will contribute to the Adult Social Care Strategy, 'Living the Life You Want to Live'[8], and is a key component of the Adult Health and Social Care Transformational Programme.

The contract also supports a broad range of strategic objectives for the Council and city, and is aligned with existing policies and commitments, including:

- *Our Sheffield: One Year Plan*[9]
- *Conversations Count*[10]: our approach to adult social care, which focuses on listening to people, their strengths, and independence.
- *Team around the Person*[11]: where professionals work together to find the best solutions when someone's needs have changed, or a situation escalated.
- *ACP Workforce Development Strategy*[12]: a vision of 'developing our people in a joined-up way to deliver holistic, person-centred and integrated care'.
- *Unison Ethical Care Charter*[13]*:* signed up to by the Council in 2017[14], the Charter 'establishes a minimum baseline for the safety, quality and dignity of care' & *GMB Ethical Home Care Commissioning Charter 2022*[15]
- *Ethical Procurement Policy*[16]*:* driving ethical standards and increasing social value for the city through procurement.
- The contribution made to Sheffield's Climate Emergency can be found in the Climate Impact Assessment, **Appendix 4**

5.4 The aim of the changes is that all people in receipt of care, and their carers and families, will see a benefit from improvements in quality and a stable home care market. We will also expect providers to demonstrate, in the tender and subsequent service delivery, a values-based approach to recruitment and have an excellent understanding of the demographics and cultural diversity of their locality.

6. HAS THERE BEEN ANY CONSULTATION?

6.1 **Market & Citizen Engagement**
Extensive market and citizen engagement has been conducted and is detailed in **Appendix 5.** Dedicated sessions are ongoing to ensure care workers understand and have contributed to our vision for the future.

6.2 **Postal & Online Engagement**

[8] https://www.sheffield.gov.uk/home/social-care/our-vision
[9] https://democracy.sheffield.gov.uk/mgConvert2PDF.aspx?ID=45712
[10] https://www.sheffield.gov.uk/home/social-care/adult-social-care-local-account
[11] https://www.sheffield.gov.uk/home/social-care/tap
[12] Paper Cii Workforce Strategy v3.2 - October 2019 - FINAL.pdf (sheffieldccg.nhs.uk)
[13] On-line-Catalogue220142.pdf (unison.org.uk)
[14] https://www.unison.org.uk/news/article/2017/10/scheffield-charter/
[15] https://www.gmb.org.uk/sites/default/files/2022%20Care%20Commissioning%20Charter.pdf
[16] Ethical Procurement Policy.pdf (sheffield.gov.uk)

In addition, a targeted consultation was held between 7 March and 17 April 2022 to seek the views of people receiving home care, unpaid carers, and others with an interest.

The consultation focused on current recipients of home care and whether there should be a change to paying and charging for home care based on *planned* care from *actual* care.

559 responses were received. 46% of all respondents agreed, and 16% disagreed with the proposed change. 16% did not mind either way, 22% were unsure. The full results of the survey can be found in **Appendix 6**.

7. RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

7.1 Equality of Opportunity Implications

7.1.1 Decisions need to take into account the requirements of the Public Sector Equality Duty contained in Section 149 of the Equality Act 2010. This is the duty to have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it

7.1.2 The Equality Act 2010 identifies the following groups as a protected characteristic: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

7.1.3 An Equality Impact Assessment has been completed and is summarised below. There is expected to be an overall positive impact through new model of care:

- The service specification (and model of care) will support a strength-based approach, supporting people with independence and wellbeing, and locality-based collaborations with primary care networks. There is a risk that this approach will broaden the care offer and increased costs.
- The changes proposed have been collaboratively developed with a range of stakeholders, in response to information gathered from extensive engagement and consultation with people from a variety of backgrounds.

7.1.4 However, there are potential impacts in terms of changes in provider:

- Some in receipt of home care will need to change providers. To mitigate, the option and support to move to a Direct Payment if people wish to remain with their current provider will be available.

7.1.5 Impacts on people who share different protected characteristics:

- Primary impacts are in relation to protected characteristics of Age and Disability.
- Disproportionate impact on women (because of the demographic profile of home care customers).
- Opportunities to address low usage and confidence in home care by some BAME communities through utilising the locality-based model to enhance recruitment, cultural understanding, and expertise/knowledge.
- No anticipated direct impacts in relation to other protected characteristics.
- Providers would be expected to be able demonstrate diversity awareness and responsiveness to the needs, identity, and choices of everyone within the support provided.

7.1.6 Other impacts:

- Indirect financial implications for people receiving home care through proposed change to payments/charging (but would not automatically lead to any increase in individuals charged-for contributions).
- Impacts on informal carers in terms of expected reductions in waiting time for home care but also potential need to support with any need to change provider or change to a Direct Payment.
- Better integration and closer ties with the Voluntary, Charity, & Faith (VCF) sectors, helping with non-regulated support needs and addressing loneliness and isolation.
- Implications for unsuccessful provider organisations, who will need to adhere to their HR/legal processes and responsibilities.

7.2 Financial and Commercial Implications

7.2.1 The detailed impacts of the proposed plans are outlined in the body of the report. The current delivery would cost £43.7m should care hours remain at 40,000 hours each week, against a budget provision of £36m, 2023/24 budget. The net position would be £7.7m over the 2023/24 budget provision. In order to bring the contract in on budget the number of care hours would need to be reduced to 33,000 hours.

7.2.2 The proposal is to reduce the hours of care delivered to 34,000 hours, which would cost £37.1m, as set out in section 2.4. There will be a small increase in client contributions and improved collection rates, approx. £200k, with the aim of offsetting some of these costs reducing the budget gap to £1m.

7.2.3 Section 4.6 of the report identifies the proposal to address the £1m gap by joint work with NHS Sheffield Clinical Commissioning Group to review residential care provision in the City as part of the strategic move towards more independent living and preventative approaches in the City.

7.2.4 There is a risk to this recommendation in that it requires a minimum reduction of 4,000 hours from the current delivered hours, and this may not be achieved.

7.2.5 Separate contracts shall be let with selected providers on a 7-year initial term contract with two options to extend: the first for 2 years and the second for 1 year. The procurement will be conducted via the light touch regime under

regulation 76 of the Public Contract Regulations 2015. The contract will contain break clauses to help mitigate the risk should the costs become unaffordable.

7.2.6 The contract price shall reflect the principles established from the Cost of Care Exercise and be inclusive of a predefined annual uplift formula. The procurement timescales to establish agreed contracts by May 2023 are challenging but achievable, considerable expert resource may be required to adequately complete the procurement evaluation and service implementation stages. It is expected that TUPE considerations will be considerable and potentially complex factors during the implementation stage.

7.3 Legal Implications

7.3.1 Under the Care Act 2014, the Council has a duty to meet the eligible needs of those in its area and it may do this through Council- arranged services. The nature of this duty means that the service is essentially demand-led. However, the Council has mechanisms to help manage the resulting cost pressures, including through the assessment/review, procurement and contracting processes, and through the management of the resulting contracts.

7.3.2 The various changes proposed in the new commissioning strategy will require significant development work during the preparation of the contract documents to support the realisation of the benefits outlined in this report.

7.3.3 (1) There is a tension between the desire to stabilise the market by giving price certainty, and the Council's desire to retain flexibility so that it can manage volatile demand and budget pressures. For example, current inflation pressure on providers is noted, but it is not proposed to give certainty when it comes to compensating for inflation during the long term of the contract – it is not proposed to hardwire a guaranteed uplift. Similarly, a long contract term is proposed, so that providers have a certain return on investment, but appropriate break/review clauses, for the benefit of the Council, are also proposed.

7.3.4 (2) Changes such as the move to provider payment of the basis of planned hours and the move to outcome-focused care increase provider influence over the actual care delivered. Given the acknowledged financial position of providers, there may be pressure on the specification of the services and the management of the contracts, if any negative impact on the services is to be avoided. The scope of the discretions – and of any statutory delegation of functions to the providers – will need to be clear, and the mechanisms for monitoring these aspects of provider performance effective. Otherwise, there may be reductions in care and/or increase in costs.

7.3.5 (3) The charging arrangements discussed above will need to ensure that the charges to clients because of the move to payment on the basis of planned hours do not, in individual cases, lead to charges which are greater than the costs of provision, in line with the Care Act 2014.

7.3.6 (4) The move to outcome-focused care may take account of the desires of the individual, but it must always be clearly set within the context of the complex

statutory regime relating to needs assessment, eligibility criteria and care and support plans.

7.3.7 (5) The potential future introduction of payment by shift for care workers, may need to be specifically considered – and decided on – in the context of social value, under the Public Services (Social Value) Act 2012. This is because the Council may otherwise be constrained by Part III Local Government Act 1988 restrictions on the Council having regard to (what might otherwise be regarded as) 'non-commercial matters' under the legislation.

7.3.8 The key contract and procurement issue with the proposed transformational contract is that the law requires there to be clarity and transparency when it comes to the impact of change on the contracted providers.

7.3.9 The reasons for this are both commercial and regulatory. The commercial side is that providers may either be deterred from the competition or not implement (and not be bound, contractually to implement) change during the contract if the commercial impact on them is not clear or cannot be ascertained from the terms of the contract itself.

7.3.10 On the regulatory side, the Public Contracts Regulations 2015 ('the Regulations') set out limits to the changes which can be made during the term of a contract, and provide that change outside those limits amounts to the award of a new contract, and cannot lawfully be implemented during the contract. Detailed advice on this will inform the procurement strategy, but the main relevant route to lawful change would be for the contract to include clear descriptions of each change and of the impact of it on the provider – in the words of the Regulations, for the contract to include 'precise and unequivocal review clauses'.

7.3.11 The Regulations specifically permit the award of contracts on a fixed price basis, where the providers compete on quality only.

7.4 Climate Implications

7.4.1 The contribution made to Sheffield's Climate Emergency can be found in the Climate Impact Assessment, **Appendix 4**

7.5 Other Implications

7.5.1 The proposed changes will result in a reduced number of providers from 35 to 15. Mobilisation to the new contract will therefore mean that some people will see their provider change.

This has implications for people receiving care, as well as implications for Adult Social Care capacity to manage this transfer of care, and for providers and the home care workforce.

A worst case scenario would see 2,400 care packages to be transferred between providers along with the TUPE of the workforces.

Mobilisation planning is underway to mitigate the impacts of this and will be informed by our Test of Change (**Appendix 2**). This will help us to ensure that this transfer is managed as positively as possible.

7.6 ALTERNATIVE OPTIONS CONSIDERED

7.6.1 The provision of Home Care services is a statutory obligation under the Care Act 2014, and discontinuing services is not an option.

7.6.2 *Do not go out to procurement / Tender under similar model*

It is not possible to extend the contract further and being out of contract opens the Council to unacceptable financial, legal and reputational risk.

The existing contract arrangements are not providing value for money. The market is fragile and current framework provision is not sufficient to deliver the levels of care needed. As a result, many support packages being procured via Direct Awards. Direct Award provision is a more expensive and higher risk form of care, and a higher risk to administer and charge for. The procurement strategy set out in this report specifically seeks to mitigate this.

Doing nothing is also likely to exacerbate issues with retention and recruitment in the sector, further reducing the Council's control of the market and ability to set its own rates of care. There is also a risk that delays supporting pick up will worsen, with risks of harm to people

7.6.3 *Agree to procurement strategy at lower rate.*

Agreement to award contracts at a rate of £19ph would be within budget at the point where delivery hours reduce to 36,500pw or fewer. However, this is not recommended for the following reasons:

- We anticipate that the Fair Cost of Care Exercise will increase the rate of care substantially, and agreeing the contract at this rate will require the Council to make sizable increases later.

- This current rate is contributing to the instability and insufficiency in the market. It is also likely that providers will not want to enter contracts with the Council at this rate. This means that continuing to contract at this rate will not make the shift required in market sustainability and leaves us vulnerable to the same risk around delays and package failure and the need to procure via Direct Awards – leading to further pressures to the ASC budget.

8. REASONS FOR RECOMMENDATIONS

8.1 The current contract for Home Care services will expire in April 2023 and further arrangements must be put in place to ensure that the service continues after that date to fulfil our statutory duties.

8.2 Like many other Local Authorities our Home Care market is in a fragile and fragmented state. This requires transformational change to deliver a sustainable and affordable market which operates effectively, improving the service experience and delivering the best possible outcomes for people in receipt of care.

8.3 The proposed 7 (+2 +1) year transformational contract will enable us to:

- introduce early changes that aim to have the maximum impact in underpinning the market - providing resilience, sustainability, and affordability.
- design, develop, and test change initiatives such as the strategic shift from 'time and task' to outcome-based service delivery

9. APPENDICIES

Number	Description
1	Care Hour Types and their Definitions
2	The Care and Wellbeing Model -Test of Change
3	Approach to managing and stabilising planned care hours at 34,000 per week
4	Climate Impact Assessment
5	Care and Wellbeing Services Consultation and Engagement
6	Home Care Payments and Charging Consultation Report

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Care Hours Delivered – Types and definitions

Care Hour Type	Definition
Commissioned Hours	The original number of care hours requested by a social worker via a support plan
Planned Hours	The time scheduled for visits on care providers rotas, which will include temporary changes to care visits where advanced notice has been given (hospital stays, relatives staying, additional hours for a short-term health episode etc.)
Actual Hours	The real time a care worker spends on a visit to a person's home to deliver care (clocked in/clocked out).

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Care and Wellbeing Model: Test of Change

A 'test of change' project is starting in June 2022 which will enable the transformational elements of the new Care and Wellbeing contract to be tested, and an evidence-base developed prior to implementation at a larger scale across the city, with the aim of future proofing services.

Funded through the Integrated Better Care Fund (iBCF)[1], commissioners will work with a single provider, Fosse Healthcare, procured through a competitive tender process in early 2022, and with Sheffield University (ScHARR)[2] as the evaluation partner. The project will run for two years in Netherthorpe, Upperthorpe and Walkley, until May 2024, gradually increasing scale to delivery of around 700 weekly care hours over its duration.

Key elements to be tested include improvements to care worker terms and conditions, multi-disciplinary working, closer links with the voluntary sector, the provider operating as a trusted reviewer and the impact of digital technology. The project will utilise an action learning ethos, enabling areas of positive learning to be cascaded to the wider delivery of home care services across the city while the project is live.

The overarching evidence-base and independent expert evaluation will be instrumental in informing the transformational elements of the new contract. The transformational changes will be introduced using a staged approach, reflecting the need to ensure the contract is first effectively mobilised in year 1, particularly given the existing challenging environment and level of change inherent in the rationalisation of the market and areas.

[1] Improved Better Care Fund

[2] School of Health & Related Research, Sheffield Univesity

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Appendix 3: Managing demand: Long Term Sustainability of Social Care Market

It is planned that the new model will generate long term sustainability of care by empowering providers to implement strength based, enablement and wellbeing focused practice aligned to greater use of technology in line with commitment 3 of the Adult Social Care Strategy.

This is supported by the introduction of planned care hours, better workforce conditions, and better efficiency of working allowing us to bring and maintain care hours to required demands levels; i.e. from current 40,000 hours per week to 34,000 hours per week.

During the pandemic, adult social care saw an increase in the number of care hours needed to support people to remain at home and avoid residential care. Although the number of people did not increase, the complexity did which resulted in the increased usage of care. An ongoing programme of reviews is underway to bring care levels closer to pre pandemic levels and with that enable the new contract to start with the required demand level of 34,000 per week.

- It is anticipated that a reduction of 1,000 hours can be achieved through redirecting the provision of cleaning and shopping services, where these are the only or primary care being delivered.
- In reviewing support hours increased specifically due to the pandemic as well as those that have not been reviewed in the last 24 months, a further reduction of 3,000 hours is expected
- Through the implementation of our practice standards and enablement approach, and appropriate provision of home care, a reduction in the size of new packages will reduction the average weekly delivery of care by 2,000 hours

This is set alongside a transformational approach to move towards strength based and personalised practice as a partnership with health colleagues across Sheffield: providers contracted to deliver the new Care and Wellbeing Services will work to enable people to live more independently and to demonstrate this with a review outcome completed by a Trusted Reviewer.

As part of the new contract, a dedicated Reviewer (1FTE) will be employed by each of the 15 providers to do this work, with 50% of the cost shared by Sheffield City Council, for the duration of the contract.

The implementation of the trusted reviewer process will support reviews closer to the person in receipt of care, delivering better care and outcomes and providing more flexible and responsive services that promote enablement and independence. Care workers have the greatest contact with the person in receipt of care and their family and are often best placed to recognise changes in needs and circumstances. Changes are made in full consultation with the person in receipt of care and colleagues in adult social care, which complements the statutory review process.

In turn, this will help build capacity in adult social care for statutory responsibilities, including formal reviews. We anticipate that this will improve our demand management.

We will begin this work in our mobilisation period and year 1 of the contract and anticipate the benefits of Trusted Reviewers being almost £2 million per annum by the end of year four. This is based on 15 workers completing 3 reviews a week, across 45 weeks of the year, and an average of 1 hour reduction per review = 2025 hours reduction in total, spread equally over 3 years.

Trusted Reviewer - Annual Impact

	23/24	24/25	25/26	26/27	Total
Trusted Reviewer costs	£225,000	£225,000	£225,000	£225,000	**£900,000**
IT costs	£45,000	£15,000	£15,000	£15,000	**£90,000**

Trusted Reviewer Savings	-£365,000	-£1,095,000	-£1,835,000	-£2,210,000	**-£5,505,000**
Total	-£95,000	-£855,000	-£1,595,000	-£1,970,000	**-£4,515,000**

Through the introduction of payment on planned hours, an enablement approach, reviews and trusted reviewers, our focus will shift from performance managing if providers have completed assessed care hours and charging by the minute to that of working in partnership and empowering providers so that they can innovate to evidence improved outcomes, experiences, and independence for the people and in doing so reduce new demand and respond on a timely basis to request and need for support.

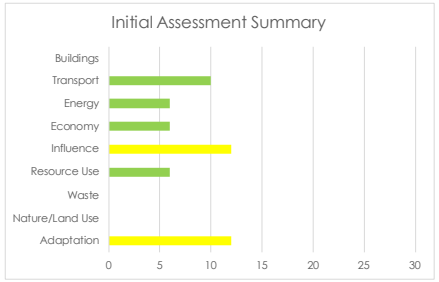
Climate Change Impact Assessment Summary

Project/Proposal Name	Care and Wellbeing Service – Transformational Contract Development	**Portfolio**	People
Decision Type	Key Leader Decision	**Lead Co-op Exec Member**	George Lindars-Hammond
One Year Plan Area	Education, Health and Care	**Lead Officer**	Paul Higginbottom / Alexis Chappell
Date CIA Completed	19/04/22	**CIA Author**	Chris Roebuck
		Sign Off/Date	

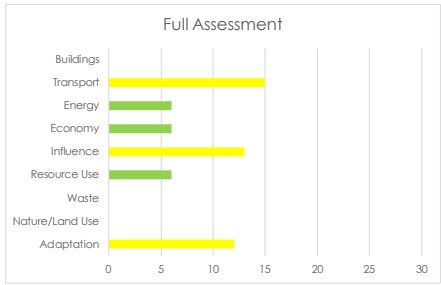
Project Description and CIA Assessment Summary	The current Home Care contract is coming to an end in April 2023 and will be replaced by a new Care and Wellbeing Service which will focus on more localised services from a smaller number of providers, which will support a more personalised service for people and help to stabilise the market. The reduction in the number of providers from 35 operating across the city to around 16 aligned to locality areas, will improve efficiency for both SCC and the providers and also allow those providers more flexibility and time to deliver care. More localised delivery will reduce the amount of travel, in particular the use of private vehicles as carers drive between areas, with a view to grouping rounds to allow them to walk between homes. Furthermore, it is envisaged that people without a car, who want to work in the sector, will be able to pick up the walking rounds near to where they live. This will reduce the number of trips being made by staff between their home address and area of work. There are additional co-benefits to this as well, such as, opening up job opportunities for those who don't have access to their own vehicle but want to enter employment in this sector and also a financial saving ie fuel cost. Health and wellbeing benefit - workers health and wellbeing will benefit from walking their rounds rather than driving between homes.

Rapid Assessment	Does the project or proposal have an impact in the following areas? Select all those that apply. Only complete the sections you have selected here in the assessment.		
Buildings	No	**Influence**	Yes
Transport	Yes	**Resource Use**	Yes
Energy	Yes	**Waste**	No
Economy	Yes	**Nature/Land Use**	No
		Adaptation	Yes

Initial Assessment Summary



Full Assessment Summary

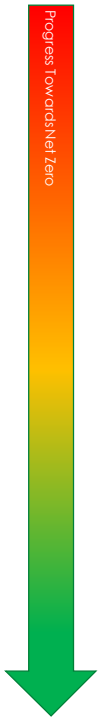


>=27	The project will increase the amount of CO2e released compared to before.
21-26	The project will maintain similar levels of CO2e emissions compared to before.
12-20	The project will achieve a moderate decrease in CO2e emissions compared to before.
3-11	The project will acheve a significant decrease in CO2e emissions compared to before.
0-2	The project can be considered to achieve net zero CO2e emissions.

Initial Assessment

Category	Impact	Description of Project Impact	Score
Buildings and Infrastructure	Construction		NA
	Use		NA
	Land use in development		NA
Transport	Demand Reduction	The project aims to move from a time and task model to a more outcomes based approach which will focus on working with people to improve their quality of life and enablement and over time reduce the number of visits required, therefore reducing the demand. Secondly, the new model will allow carers to be more flexible and stay longer at certain times and potentially then have fewer visits over the week. Currently the time and task model requires a visit to be made even if it is not always needed. Moving to more localised services will also reduce overall mileage by grouping visits closer together and enabling carers to work nearer to where they live.	5
	Decarbonisation of Transport		NA
	Increasing Active Travel	More localised services will have two impacts. Firstly the homes being visited being grouped closely together (more so in urban areas) will allow carers to walk between visits rather than driving and also we know that not having access to a vehicle prevents people becoming carers. It is envisaged that the localised model will allow people to work near where they live and reduce the number of trips between areas to start work. For example a carer who lives in Walkley travelling to Handsworth to start work.	5
Energy	Decarbonisation of Fuel		NA
	Demand Reduction/Efficiency Improvements	Moving to electronic call monitoring and subsequent invoicing and payments will reduce the number of paper based systems and improve efficiency.	6
	Increasing infrastructure for renewables generation		NA
Economy	Development of low carbon businesses		NA
	Increase in low carbon skills/training		NA
	Improved business sustainability	Moving to a localised system will enable providers to reduce the overall carbon footprint associated with their service.	6
Influence	Awareness Raising	The new approach will increase awareness of climate change with both our providers and the people receiving care, as the market reshaping to create a smaller localised market and the environmental benefits form a key part of the contract. The new contract shows a commitment to reducing car usage in this sector and the mapping of usage will again be part of the reshaping work.	6
	Climate Leadership		NA
	Working with Stakeholders	We will work with providers to find the best way to map areas to minimise their CO2e emissiong and capture data.	6
Resource Use	Water Use		NA

10	The project will significantly increase the amount of CO2e released compared to before.
9	The project will increase the amount of CO2e released compared to before.
8	The project will maintain similar levels of CO2e emissions compared to before.
7	
6	The project will achieve a moderate decrease in CO2e emissions compared to before.
5	
4	
3	The project will achieve a significant decrease in CO2e emissions compared to before.
2	
1	
0	The project can be considered to achieve net zero CO2e emissions.
Carbon Negative	The project is actively removing CO2e from the atmosphere.



	Food and Drink		NA
	Products	Moving to electronic call monitoring and subsequent invoicing and payments will reduce the number of paper based systems and improve efficiency.	6
	Services		NA
Waste	**Waste Reduction**		NA
	Waste Hierarchy		NA
	Circular Economy		NA
Nature/Land Use	**Biodiversity**		NA
	Carbon Storage		NA
	Flood Management		NA
Adaptation	**Exposure to climate change impacts**	A shift to more people working near to where they live will mean less disruption to services in the event of adverse weather which impedes travel.	6
	Vulnerable Groups		NA
	Just Transition	We know that not having access to a vehicle prevents people becoming carers; a co-benefit of the localised approach is widening the potential for people without a vehicle to become carers.	6

Full Assessment

Category	Impact	Description of Project Impact	Mitigation Measures	Mitigated Score	Procurement Action Required?	Proposed KPI/Measure
Buildings and Infrastructure	**Construction**			NA		
	Use			NA		
	Land use in development			NA		
Transport	**Demand Reduction**	The project aims to move from a time and task model to a more outcomes based approach which will focus on working with people to improve their quality of life and enablement and over time reduce the number of visits required, therefore reducing the demand. Secondly, the new model will allow carers to be more flexible and stay longer at certain times and potentially then have fewer visits over the week. Currently the time and task model requires a visit to be made even if it is not always needed. Moving to more localised services will also reduce overall mileage by grouping visits closer together and enabling carers to work nearer to where they live.	Measures to be monitored in contract: 1)Record the number of care hours delivered in an area under the current contract and then under the new contract, per person. This will take into account any increase or decrease in the number of people receiving a care service over time. A reduction in demand will naturally lead to fewer visits. 2)Record the number of individual visits in an area under the current contract and under the new contract. 3)Record the number of car pooling journeys and the number of people involved to identify the number of miles saved / not driven. A car pool system whereby workers travel together to an area and then walk their rounds would be acceptable if there is no alternative to using a vehicle. Calculating the number of miles saved will be difficult as we do not have that data currently to create a baseline, plus there are several prroviders operating in a locality and the new model will have only 2 providers per localiity so it is not comparable.	5	Yes	Care hours/ person; No. visits per locality; Carer mileage, car pool journeys
	Decarbonisation of Transport		Car pooling could be promoted and adopted by providers alongside the use of pool electric vehicles. It is unlikely that carers would purchase their own electric vehicles.	5		Car pool journeys mileage, miles driven in EVs
	Increasing Active Travel	More localised services will have two impacts. Firstly the homes being visited being grouped closely together (more so in urban areas) will allow carers to walk between visits rather than driving and also we know that not having access to a vehicle prevents people becoming carers. It is envisaged that the localised model will allow people to work near where they live and reduce the number of trips between areas to start work. For example a carer who lives in Walkley travelling to Handsworth to start work.	Identify the number of new walking routes in place and the number of journeys by car that have been avoided. This would require some assumptions about the route that would have been taken if not for the intervention as the new contract is a completely different approach to the current and therefore not comparable. Record the number of staff recruited locally to work on those walking routes. Again some assumptions as noted above would need to be made. There will be an expecation that providers are clear with staff that short distances should be carried out on foot and not in a vehicle.	5		Mileage avoided
Energy	**Decarbonisation of Fuel**			NA		
	Demand Reduction/Efficiency Improvements	Moving to electronic call monitoring and subsequent invoicing and payments will reduce the number of paper based systems and improve efficiency.		6		
	Increasing infrastructure for renewables generation			NA		

10	The project will significantly increase the amount of CO2e released compared to before.
9	The project will increase the amount of CO2e released compared to before.
8	The project will maintain similar levels of CO2e emissions compared to before.
7	
6	The project will achieve a moderate decrease in CO2e emissions compared to before.
5	
4	
3	The project will achieve a significant decrease in CO2e emissions compared to before.
2	
1	
0	The project can be considered to achieve net zero CO2e emissions.
Carbon Negative	The project is actively removing CO2e from the atmosphere.

Progress Towards Net Zero

Economy	**Development of low carbon businesses**			NA		
	Increase in low carbon skills/training			NA		
	Improved business sustainability	Moving to a localised system will enable providers to reduce the overall carbon footprint associated with their service.	Providers will be required to provide information on their approach to minimising their environmental impact and reducing emmissions through the tender process.	6		Tender scoring
Influence	**Awareness Raising**	The new approach will increase awareness of climate change with both our providers and the people receiving care, as the market reshaping to create a smaller localised market and the environmental benefits form a key part of the contract. The new contract shows a commitment to reducing car usage in this sector and the mapping of usage will again be part of the reshaping work.	This will be communicated through ongoing communications work with different stakeholders and through press releases. The benefits of the localised service delivery will be communicated.	7		
	Climate Leadership			NA		
	Working with Stakeholders	We will work with providers to find the best way to map areas to minimise their CO2e emissions and capture data.		6		
Resource Use	**Water Use**			NA		
	Food and Drink			NA		
	Products	Moving to electronic call monitoring and subsequent invoicing and payments will reduce the number of paper based systems and improve efficiency.	No further measures required.	6		
	Services			NA		
Waste	**Waste Reduction**			NA		
	Waste Hierarchy			NA		
	Circular Economy			NA		
Nature/Land Use	**Biodiversity**			NA		
	Carbon Storage			NA		
	Flood Management			NA		
Adaptation	**Exposure to climate change impacts**	A shift to more people working near to where they live will mean less disruption to services in the event of adverse weather which impedes travel.	SCC and Providers have contingency plans in place for adverse weather conditions that will be updated to reflect the walking and localised provision.	6		
	Vulnerable Groups					
	Just Transition	We know that not having access to a vehicle prevents people becoming carers; a co-benefit of the localised approach is widening the potential for people without a vehicle to become carers.	Providers to advertise jobs that do not require a car and recruit specifically to those positions with no expectation that people will need ot travel unless car pooling pick up and drop off is set up	6		Number of workers recruited to walking rounds

Form 2 - Attach as appendix, include the summary and refer to the appendix, what elements can be included in the contract and under contract monitoring

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Care and Wellbeing Service: Consultation and Engagement Events

Event / Group / Service	Attendees	Date
Sheffield Equality Partnership	Elected members, Carers Centre, Disability Sheffield, Age UK, Together Women, Faithstar,	2/2/21
Carers Centre	Chief Officer	3/2/21
LGBT Sheffield	Chair LGBT Sheffield	8/2/21
Carers Voice	People with lived experience of being a carer, Carers Centre, SYC, elected members	1/3/21
Carers Consultation	JA, carer for her mother, 95, who has dementia and is also supported by home care workers.	1/3/21
Home Care Forum: programme launch	Framework providers	10/3/21
Home Care Forum: programme launch	Framework providers	12/3/21
Consultation event with Healthwatch & Disability Sheffield	Open invitation; people with lived experience of home care, professional stakeholders.	17/3/21
Provider Q&A	Framework providers	19/3/21
Learning Disability Partnership Board	People with lived experiences of learning disabilities, their families, carers and professionals	22/3/21
Transformation Development Network	ASC and provider colleagues	23/3/21
Registered Managers Network	Home care registered managers	8/3/21
Adults Service Improvement Forum	People with lived experiences of social care	24/3/21
Improving Accountable Care Forum	People with lived experiences of social care and other local stakeholders	13/4/21
Market Engagement event	Home care providers (open invitation)	21/4/21
Market Engagement event	Home care providers (open invitation)	23/4/21
Webinar (with Faithstar)	BAME organisations (providers / representative groups)	30/4/21
Faithstar drop-in session	As above	14/5/21
Market Engagement event	Home care providers (contracted)	17/2/22
Market Engagement event	Home care providers (non-contracted)	22/2/22
1:1 provider meetings	Individual meetings further to the initial engagement events (11 meetings in total)	7/2 – 14/3/22
Meet the Buyer event	Home care providers (open event)	25/3/22
Care Worker Forum	Frontline care workers	11/5/22

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Home Care charging and payments consultation 2022

Report of consultation responses

1.0 Summary

1.1 The consultation focused on current recipients of home care and a central question – whether there should be a change to paying and charging for home care based on *planned* care from *actual* care. Further supporting and supplementary questions were also included in the consultation.

1.2 559 postal/phone and on-line responses were received – 87% of which were from people receiving home care and at least 8% from unpaid carers and family members.

1.3 Overall, around 46% of all respondents agreed with the proposed change and 16% disagreed with the proposed change. 16% did not mind either way, 22% were unsure.

1.4 The main points from the written feedback to this question were that:

- **There is some qualified support for the change** and less than one in six respondents were opposed to it.
- Quality of care experience and related factors may only have limited influence on whether people agreed with the change.
- There is concern that the change could lead to shorter care visits – the contract should consider how this could be monitored and addressed without all the onus being on the home care recipient.
- There is a need to consider any unintended consequences around flexibility in the new contract – e.g. when people may want/need to cancel a planned visit (which may also generate a saving).
- There should be an easier process for seeking changes to a care plan.
- A small but evident minority of respondents who were unsure or said they didn't mind underlines a need to ensure that future communication about any change and what it means for people is as clear as possible.
- There was some concern that the change may not lead to care worker investment in the way intended.

1.5 In response to other consultation questions, feedback also showed that:

- Around 84% of home care recipients have a care plan in their home.
- Around 67% of visits by home care workers to people's homes last as long as planned; but 22% end early, (with a lot of feedback about 'rushed' visits).
- On average, respondents score the quality of home care received 7 out of 10.
- Around 68% of respondents feel home care has helped to maintain or increase independence.
- Around 47% of respondents have the same care worker most of the time.

- Around 29% of respondents feel their care workers know them and understands their needs really well, while 45% of respondents feel their care workers know enough about them and their needs.
- Around 76% of respondents have an unpaid carer (e.g. family member), and 48% of respondents feel there is the right amount of contact between the care worker and unpaid carer.

1.6 The feedback to these questions strongly suggests that **the new home care contract should seek to address:**

- Better adherence to care plans
- Monitoring care workers/visits and the accessibility of feedback channels for home care recipients
- Lack of consistency of care workers, multiple care workers and turnover of staff, which has an impact on home care recipients
- Communication between care workers and unpaid carers.

2.0 Method of the consultation

2.1 The consultation ran from 7 March to 17 April 2022.

2.2 It primarily targeted current recipients of home care (and/or named points of contact) via letters, which included a paper survey and stamped addressed envelope, and an option to respond by phone.

2.3 The consultation was also available as an on-line survey on Citizen Space and promoted via a weblink, enabling home care recipients as well as others with an interest to respond.

3.0 Reason for the consultation

3.1 The consultation was driven by the Home Care Transformation Programme and re-procurement of the home care contract to commence in 2023. The new model of care intends to move away from ‘time and task’ to more outcome-focused support.

3.2 Changing the way home care is paid for and home care recipients’ financial contributions are charged for from being based on actual care received to planned care would support the ambitions of the new contract. The consultation aimed to test this.

4.0 Purpose and design of consultation

4.1 In-line with the primary audience of the consultation, questions were framed around respondents' current experience of home care as a recipient or as an unpaid carer (e.g. family member). However, respondents could also reply based on a previous experience or more indirect experience.

4.2 The consultation was anonymous, although respondents were able to leave comments and contact details if they wished to.

4.3 The consultation's principal aim was to ask if respondents agreed with a central question – whether there should be a change to paying and charging for home care based on *planned* care (as set out in people's care plans) from *actual* care (as calculated through care worker timesheets and provider invoices).

4.4 The consultation included questions which supported the central question, asking if the respondent:

- Receives home care, is an unpaid carer and/or has another role
- Has a care plan
- Has care worker(s) visits that tend to last for their planned duration or for a longer or shorter time

4.5 The consultation also included supplementary questions about:

- Quality of home care received
- Independence maintained or increased through home care
- Continuity of care worker(s)
- Knowledge and skills of care worker(s)
- The presence of unpaid carers
- Contact between unpaid carers and care workers

5.0 Response rate

5.1 559 responses to the consultation were received, of which
512 were by post or phone, and
47 were on-line

5.2 By comparison, in April 2022 there were approximately 2,645 people recorded as being known to the Council with active home care services.

6.0 Responses to questions

Question 1 - Please choose one or more of the options to describe yourself

6.1 Over 87% of respondents were receiving or had received home care, rising to 90% of postal/phone respondents and falling to 60% of on-line respondents.

6.2 The majority of other responses came from unpaid carers (family members) – nearly 8% overall, over 6% postal/phone and 21% on-line.

6.3 A further 15% of on-line respondents declared 'another role or interest'; however their written comments showed that these were almost exclusively family members of a home care recipient. There were two online responses (representing 4%) from people working in health and social care.

	Overall	Post/ phone	On-line
I am an unpaid carer or have been an unpaid carer	7.7%	6.5%	21.3%
I am someone who receives home care or has received home care	**87.5%**	**90.0%**	**59.6%**
I have another role or interest	1.4%	1.6%	14.9%
I work in home care	0.2%	0.2%	0.0%
I work in another part of the health and social care sector	0.4%	0.0%	4.3%
Not Given	1.6%	1.8%	0.0%

Question 2 - Do you have a care plan in your home?

6.4 Overall, around 84% of respondents said there was a care plan in the individual's home; 8% said there was no care plan there.

6.5 Feedback covered several themes. Representative comments included:

Flexibility of care plan:

- *My husband's needs vary from visit to visit so it may take more or less time but the carers log in and out and this plan works very well for him. It is totally flexible and doesn't need changing.*
- *Not as flexible as I'd like, no late visits to home available.*

Record-keeping can be poor:

- *The time shown on the daily records does not always agree with the amount charged.*
- *There have been instances when the care worker has lied about the time of her visits when completing her records. This has been evidenced by more than one member of the family - i.e. putting that she has been there much longer than she actually has.*

Digitisation:

- *When [provider] went digital all documentation was taken away*
- *The care plan is not updated regularly to cover changes and any changes are not visible in the care providers online portal.*
- *My care plan is online, I can have access*

Care plan not always followed:

- *The care company workers never read it so don't follow it right.*
- *Nobody follows it*
- *Different carers do refer to it*
- *Detailed care plan in place for mum with severe Alzheimer's. Time on each visit has been agreed based on her needs. The carer logs in and out of the premises. BIG issue. Very few carers read it particularly if they have not been in before. The care plan is reviewed on a regular basis.*
- *Carers do not do most things in the care plan*
- *About 10 mins into a 20 mins visit on the care plan I was to have a shower once a week but that doesn't happen, my niece has to come and shower me.*
- *They just play on their phones instead of doing tasks they are supposed to*
- *I go each night to complete tasks that make mum comfortable. Some of which are in a care plan that have either not been completed or the carer has not felt safe to do, e.g. bathing mum.*

Out of date or uniformed care plans:

- *it is out of date so no good*
- *none of the information is recorded in the care plan*
- *Our care plan has not been updated since we first started with care for my wife in 2017. We were sent a review to which we made our own suggestions for changes but haven't heard anything since we sent it back.*
- *My Mum's care plan at the moment isn't working but we're having to wait until the go ahead from social services meaning that Mum is becoming agitated and asking the carers to leave.*
- *Care plan was set up following an assessment when my point of contact wasn't there so it doesn't cover all my needs because they took the word of a confused 90 year old man.*
- *Care plan was updated July last year without inviting me to be there to support my mum during its completion…. my mum is in her 80s and doesn't always ask for the support she needs.*

6.6 **Main points from feedback about care plans:**

- Care workers need to know/read/follow the care plan
- Keeping the care plan up to date and involving the right people (including family) in this
- Record-keeping/monitoring and care workers
- Making sure the care plan is available/accessible to people
- The new contract should consider how these issues could be reinforced

Question 3 - Please choose the statement that best describes your care visits for most of the time

6.7 Overall, around 67% of respondents said care visits tended to last for the planned time.

6.8 Postal/phone respondents were more likely to say this, (69% of home care recipients and 60% of unpaid carers), compared to on-line responses (43% and 25% respectively).

6.9 Overall, 22% of respondents said the care worker tended to leave earlier than planned. Postal/phone respondents were less likely to say this (21% of home care recipients and 17% of unpaid carers) compared to on-line respondents (39% and 50%).

6.10 Care workers were much less likely to stay beyond the planned time (2% overall), reflecting written comments received (see below). Perhaps not surprisingly, unpaid carers were less sure how long visits lasted.

	Overall	Home care client		Unpaid carer	
		Post/ Phone	On-line	Post/ Phone	On-line
I tend to ask my care worker to leave earlier than planned most visits	1.3%	1.1%	0.0%	0.0%	12.5%
My care worker tends to leave earlier than planned most visits	**21.6%**	**20.8%**	**39.3%**	**16.7%**	**50.0%**
My care worker tends to stay for the planned time most visits	**66.5%**	**69.4%**	**42.9%**	**60.0%**	**25.0%**
My care worker tends to stay longer than planned most visits	2.4%	2.0%	7.1%	6.7%	0.0%
I'm not sure	7.7%	6.7%	7.1%	16.7%	12.5%

6.11 Feedback covered several themes. Representative comments included:

Care workers cancelling or not coming:

- *Due to staff shortages care packaging is not effective nor fit for purpose on many occasions staff have not arrived. My sister has been asked to help me but this has not been possible due to her family commitments.*
- *Care workers not always on time or don't turn up*
- *Sometimes they cancel or don't come*

Care workers coming at inappropriate times:

- *Care visits should be 6 hours apart. We often get visits apart under 6 hours. This should be 6 hours for tablet medication. I have spoken to Green Square on numerous times, they say it's noted, nothing changes.*
- *sometimes they might arrive at 3.30 for tea time call :(*
- *The times they come in are very erratic especially in the mornings. They can be early as 7am or later than 10am*
- *Carers change time to suit them. Too early for meals.*
- *The carers that come at the weekend aren't interested in my care and needs.*
- *Number of home care visits is as originally agreed at start of care plan, but agreed timing of home care visits is not adhered to.*

- *We have constantly asked for the carer to visit after a certain time but some carers ignore our request. They arrive much too early so we have to turn them away. Carers who know my wife usually come after the requested time but some carers just want to get home as soon as possible so they're not interested in my wife's needs. There are certain days that we know that we're likely to be told that there's no carer to come in the evening.*

Regular (familiar) care workers make a difference:

- *Regular carer stays. Some other carers do not complete all tasks/ stay. They say I have refused without prompting me to do it to make me comfortable.*
- *The regular carers stay the right amount of time.*
- *My care is not reliable when my main carer is off, sometimes I don't get care.*
- *Yes unless they are stand in carers*
- *When the more regular carer is there, I have some sort of peace that mum is being cared for.*
- *Stand-in carers leave early as a rule*

There is some good experience with care workers:

- *Excellent carers and very good support from them.*
- *The girls and men who came were all lovely but always in a rush! The care company was another matter.*
- *Some older carers tend to just feed me and go or be on their phones. The younger carers seem to do more and talk to me*
- *They stay longer if necessary*
- *Often ask if I need anything else*
- *My carers are very obliging when longer stays are required*
- *I enjoy seeing my carers, we always have a good laugh.*
- *I love them to have a chat*

Care workers are pushed for time:

- *Care workers always in a rush. A 30 minute call is usually 5 minutes.*
- *The morning visit should be 45 mins, other calls 20 mins. My mum feels the call in the morning is rushed, we understand they have other calls, but my mum is not very good first thing.*
- *Lunch time call is often shorter than planned time.*
- *10 minutes at most unless they stay for a coffee*
- *They seem to fly in and out and are always in a rush.*
- *Get done what needs doing then leave*
- *They are usually given a time which is usually not long enough to give the care they want to*
- *Care workers always seem to be in a hurry to leave, tasks/care elements included in the care plan, e.g. emptying commode, application of medication, are sometimes forgotten/missed.*
- *They always leave early, with very limited interaction*
- *The care workers visit me twice a day and do the minimum in the short time they are with me, usually washing and dressing/undressing. This is frequently*

only 10-15 minutes per call, less than the agreed visit duration. My elderly husband is my unpaid full time carer, he has his own health issues but the care workers still leave some agreed care plan tasks to him.

Paying for time not used:

- *We are paying for time that our care workers do not use.*
- *All last year I mainly did [care] myself – the carers never turn up or would come too late … if it wasn't for me he wouldn't have been dressed but he still had to pay*
- *So we would end up paying more than necessary each month? Care worker rarely stays for the allocated 30 mins. This would be unfair.*

The onus is on the home care recipient to highlight issues:

- *I am not capable of communicating to my son about how long my care worker stays. I don't really know.*
- *They would sometimes only be here for 10 mins and others they would come sign the book and leave as my wife was caring for me.*
- *Don't know as I don't know how long they should stay*
- *It seems the onus is on the clients to negotiate with the care providers for all issues and as I have already found this takes time and causes more stress.*

6.12 **Main points from feedback about care visits:**

- Based on feedback about current practice, around **two out of three care visits last for the planned time**, suggesting that changing to payments and charging based on planned care from actual care *may* not have a widespread impact for most people.
- However, the feedback also suggests that around **one out of five care visits end before the planned time** – a significant minority.
- The responsibility is on the home care recipient to report short visits – an issue that the new home contract may need to address.
- There was a lot of feedback about rushed visits and insufficient reference to care plans – particularly by 'non-regular' (occasional) care workers.
- Feedback also recorded visits being cancelled or visits at inappropriate times.

Question 4 - Do you agree with the proposed change?

6.13 Respondents were asked the central question if they agreed with the proposed change to paying and charging for home care based on planned care from actual care.

6.14 Overall, where a response was given, around 46% of all respondents agreed with the proposed change and 16% disagreed with the proposed change. 16% did not mind either way, 22% were unsure.

6.15 Postal/phone respondents were more likely to agree with the change and around four times as many postal/phone respondents agreed with the change as disagreed.

6.16 On-line respondents were less likely to agree – home care recipients were evenly split, with one in three both agreeing and disagreeing and one in four being unsure. Unpaid carers were three and a half more likely to disagree than agree on-line.

	Overall	Home care client		Unpaid carer	
		Post/ Phone	On-line	Post/ Phone	On-line
Yes I agree with the change	**45.5%**	**44.9%**	**32.1%**	**42.4%**	**20.0%**
No I don't agree with the change	16.1%	12.6%	32.1%	18.2%	70.0%
I don't mind either way	16.3%	16.9%	10.7%	9.1%	0.0%
I'm not sure	22.0%	19.7%	25.0%	30.3%	10.0%

6.17 Responses were analysed to consider if quality of home care received could be an influential factor in whether respondents agreed with the proposed change or not.

6.18 There appeared to be some but limited correlation between respondents' assessment of the quality of care received (see Question 5 below) and whether they agreed with the proposed change. The higher the quality of care score, the more likely respondents were to agree; conversely, the lower the quality of care score, the less likely.

6.19 Of respondents who assessed quality of care lowest (0-3 out of 10), 43% did not agree with the change but 27% did agree.

6.20 Respondents who scored quality of care the highest (9-10) were nearly five times more likely to agree than disagree with the change; however, the percentage who agreed was still under half of respondents (48%). Respondents who scored quality of care the highest were also most ambivalent about the change – 21% did not mind either way.

Quality score out of 10:	**0-3**	**4-6**	**7-8**	**9-10**
No I don't agree with the change	43.2%	16.6%	14.1%	10.2%
Yes I agree with the change	27.0%	39.6%	46.0%	47.6%
I don't mind either way	8.1%	16.0%	12.3%	21.1%
I'm not sure	16.2%	23.7%	23.3%	16.9%

6.21 There was further analysis to consider correlation between respondents agreeing with the proposed change and the extent to which they had provided positive answers to the questions about a care plan (question 2), home care visits (question 3), having the same care worker (question 7), the

knowledge/skills of care workers (question 8) and whether home care had supported their independence (question 6).

6.22 There was limited correlation:

- 47% of respondents who said they had a care plan in their home agreed with the change.
- 51% of respondents who said their care workers stayed for the full call duration or longer agreed with the change.
- 48% of respondents who said their homecare improved or maintained their independence agreed with the change.
- 48% of respondents who said they had the same care worker most of the time agreed with the change.
- 49% of respondents who said their care workers knew them well enough to provide care agreed with the change.

6.23 Feedback suggested there was **qualified support for the change**. Representative comments included:

- *Prefer to know exactly how much I need to pay based on care plan as carers do not stay allocated time*
- *Yes the change is ok provided that carers stay and provide for the planned time*
- *I agree with the change as long as I can get all of the calls needed and that no call is cancelled, and as long as at each visit/call everything that needs to be done is done and that they are not rushing to just get finished early, meaning they are not giving the full care that would be needed.*
- *Simplifying a complex system*
- *I hope this would be a fairer system*
- *I don't think the planned care/time ratio is relevant. It is more about doing the actual care that is stated in the plan.*

There were concerns that the change might increase the likelihood of **shortened care visits and paying for care not provided**. Representative comments included:

- *If the care company are to be paid the same regardless of the amount of time spend they will have an incentive to spend less time but I will be charged the same regardless.*
- *I think the carers would be clock watching if he went over the plan time and he would worry about asking them to do extra.*
- *Why should my Dad be paying for something he is not receiving.*
- *If you change the way that we pay then we will be paying for care that we're not getting.*
- *At least there is a level of challenge with allocated time.*
- *I want to pay for what I use, that is fair, I don't want to pay for what I don't use, that isn't fair and I can't afford it. There will be no incentive (and actually a disincentive) for care workers to spend more time with me on a day if I need it on very rare occasions. I don't need or want the same amount each month, especially if it is at the cost of me paying for time that I don't need. Changing my care plan is a very difficult process.*

There is a need to **monitor care workers and service quality**:

- *The cost is extortionate when the care company does so little to monitor their staff and quality of service*
- *My concern is around who will monitor whether the task is completed. At least if they are allocated a specific time there is a some sort of challenge available that is hoped the care provider will investigate.*

There was some concern that **the change might inhibit flexibility**. Representative comments included:

- *My husband's needs vary from visit to visit so the care plan times can be longer or shorter, it's unpredictable so I cannot see how a set payment would benefit us or those like us, in fact it would be worse because if carers stayed longer they would lose out money wise and if they spent less time we would have to pay for time not used.*
- *You say the plan is more flexible but it seems to be less flexible and would not encourage more attention to varying needs.*
- *Mum may have different needs on different days, it would be good to know the carer is coming for a certain amount of time so that we can tell the carer what needs to be done.*
- *Dad's needs differ, it is difficult to know requirements. Sometimes he is asleep for example. Prescribing times in advance may not work, it needs to average out across the day. Otherwise the service may diminish.*
- *From past experience when additional time/ or double handling has been required due to unforeseen circumstances the care company have really stepped up and delivered*
- *This would depend on whether this charge would be flexible. Someone may need a lot of care initially and then need less later as they adapt to their change in circumstances (or vice versa). This could mean they are paying for more care than they need.*
- *I arrange and pay for my dad's carers on his behalf. I sometimes cancel care visits if I can be there and it isn't always the same days every week. If we always pay the same I'm afraid we would be paying for care visits that we don't have.*
- *I frequently cancel visits for hospital visits and/ or social days out with family / friends that I don't think I should pay for. I sometimes stay with family overnight on special occasions also.*

There was some **support for the principle of enabling staff investment** but there were concerns that the change might not achieve this. Representative comments included:

- *The idea of releasing the admin burden so that more can be channelled onto actually improving service delivery makes total sense*
- *There is an incentive for care companies to cut short visits (and the care workers salary) and assumes that service users don't go on holiday etc.*
- *I can see no advantage for the care workers. They are already working VERY LONG hours, with no travelling time between clients and precious little breaks.*

- *As the time allocated is not long enough and therefore care workers will not receive the pay entitled and this will result in being cut and insufficient care.*
- *I think your wishes are honourable, but with the difficulty of recruiting new carers and the current shortage they may be impractical.*
- *Unless staffing shortages are addressed I feel the quality of care won't improve. Weekends seem to be the times when less staff are available.*

Several respondents said they already pay a fixed amount each time. Other comments queried if the change would have any **impact on contributions**, for example:

- *It all sounds good in principle but at what cost.*
- *Yes providing there will not be a big increase in the care costs.*
- *The main problem voiced by most people is not being able to pay the contributions because they feel they are too high and the method used to calculate them is unfair and unrealistic…. It's not a matter of being able to budget better, it's that they feel they don't have enough money to pay the contributions without reducing other essential expenses like food and power. That is why so many people refuse to accept all or part of the care they are assessed as needing.*

There is a need to **monitor the change**:

- *Any system implemented should be subject to a periodic review.*

6.24 **Main points from feedback about the proposal to change:**

- There is some qualified support for the change and only one in seven respondents were opposed to it.
- Quality of care experience and related factors may only have limited influence on whether people agreed with the change.
- There is concern that the change could lead to shorter care visits – the contract should consider how this could be monitored and addressed without all the onus being on the home care recipient.
- There is a need to consider any unintended consequences around flexibility in the new contract – e.g. when people may want/need to cancel a planned visit (which may also generate a saving).
- There should be an easier process for seeking changes to a care plan.
- A small but evident minority of respondents who were unsure or said they didn't mind underlines a need to ensure that future communication about any change and what it means for people is as clear as possible.
- There was some concern that the change may not lead to care worker investment in the way intended.

Question 5 - On a scale of 0 to 10, how do you feel about the quality of the home care service you have experience of?

6.25 Average overall score was 7.0
Average postal/phone score 7.0

Average on-line score was 6.2

Question 6 - Do you feel home care has helped you to maintain or increase your independence?

6.26 Overall, around 68% of respondents said home care had helped to maintain or increase independence.

6.27 Postal/phone respondents were most likely to agree with this statement (72% of home care recipients and 49% of unpaid carers) compared to on-line respondents (46% and 30% respectively).

	Overall	Home care client		Unpaid carer	
		Post/ Phone	On-line	Post/ Phone	On-line
Yes	**67.8%**	**72.2%**	**46.4%**	**48.5%**	**30.0%**
No	11.3%	10.0%	25.0%	12.1%	30.0%
I'm not sure	10.7%	10.6%	17.9%	6.1%	10.0%
It's not relevant to me	6.6%	3.5%	10.7%	24.2%	30.0%

6.28 There was some correlation between responses to this other questions:

- 90% of respondents who scored quality at 7 or higher said they had a care plan in their home.
- 81% of respondents who scored quality at 7 or higher said their care workers stayed for the full call duration or longer.
- 87% of respondents who scored care quality at 7 or higher said their homecare has improved or maintained their independence.
- 59% of respondents who scored quality at 7 or higher said they regularly have the same care workers.
- 92% of respondents who scored quality at 7 or higher said their care workers knew them well enough to provide care.

6.29 Feedback covered broad themes. Representative comments included:

Variation between care workers and quality of care:

- *Carers above 5 rating, let down by irregular attending times, not informed by head office when late or change.*
- *Care quality is not consistent. Shortage of carers, sometimes with no training,*
- *sometimes they do things for my relative rather than help him do it himself , this deskilling him. Others are excellent.*
- *Quality of care all depends on who you get for your visits. Quality of carers is very different depending on the carer, some are excellent and go beyond expectations, others are almost useless.*
- *When I get the regular carers who have been coming in for over 2 years they know my husband and are very caring to him.*

- *The only time problems occur is when my regular carer is unavailable.*

Some support for maintaining/increasing independence:

- *Definitely allowed me to stay in my own home.*
- *Having dementia I have lost my independence. The carer assists me with my day to day living.*
- *Some carers are better than others, some warrant a 10, others a 3 or 4. I have kept my independence and not had to go into a care home.*
- *It's the support from family that has maintained mum's independence.*

6.30 **Main points from feedback about quality of care and support for independence:**

- As reflected throughout the consultation feedback, consistent ('regular') care workers are said to have a generally more positive impact on the support and experience for home care recipients, in contrast to home care with multiple, inexperienced or changing care workers.
- Through the data response and written comments, there is some evidence that home care in its current contract/model is helping to maintain or increase people's independence to some degree.

Question 7 - Do you have the same care worker most of the time?

6.31 Overall, there was an even split between respondents who had the same care worker most of the time and those who did not. On-line respondents were less likely to say this.

	Overall	Home care client		Unpaid carer	
		Post/ Phone	On-line	Post/ Phone	On-line
Yes	46.5%	47.5%	39.3%	60.6%	30.0%
No	46.9%	46.9%	60.7%	27.3%	70.0%
I'm not sure	2.2%	2.2%	0.0%	0.0%	0.0%

Question 8 - How well do you feel your care worker(s) knows you and understands your care and support needs?

6.32 Overall, 29% of all respondents said the care worker knows the home care recipient really well, (this was despite over 46% of respondents saying in Question 6 that there was consistency of same care worker).

6.33 Over 45% of all respondents said their care workers know them well enough to provide care. Post/phone respondents were most likely to say this.

	Overall	Home care client		Unpaid carer	
		Post/ Phone	On-line	Post/ Phone	On-line
My care worker(s) knows me and understands my needs really well	29.0%	31.2%	28.6%	15.2%	10.0%
My care worker(s) knows enough about me and my needs to provide care	45.4%	47.7%	32.1%	48.5%	20.0%
My care worker(s) doesn't know me and doesn't understand my needs well enough	14.1%	12.2%	32.1%	18.2%	40.0%
I'm not sure	4.7%	4.1%	7.1%	0.0%	0.0%

6.34 Feedback showed a very mixed experience of care workers and their knowledge. Representative comments include:

Some good experience with care workers:

- *My staff team know me well*
- *I have a great relationship with my care workers*
- *She is the most amazing carer I could wish for.*
- *My main few carers are fantastic but if we have one of the others to cover they might not be as good.*

Variability/inconsistency:

- *Depends on who attends*
- *2 of the girls really took time to get to know us but the others didn't attend often though.*
- *It differs with each care worker. Some just focus on tasks required whilst others make a connection*
- *If the worker has a day off it is completely different and disorganised*

Missing health and wellbeing support needs:

- *Sometimes eating and drinking is ignored. Dehydration is a major issue.*
- *Some care workers are not aware I am profoundly deaf.*
- *Support plan done by someone who does not know me and how I live*
- *don't understand my mental illness and basic needs*
- *Care worker should know each patient i.e. what's needed. Mum's care is medication, they should know it's 6 hours apart.*
- *competence of some carers leaves a lot to be desired - many are young and do not know how to make some basic meals.*

Multiple and changing care workers:

- *Too many different care workers*

- *Got a new care company and still getting to know each other*
- *Certain carers my mum cannot understand, this results in limited communication.*
- *Multiple carers, don't keep note well, poor understanding of English*
- *Turnover of staff is a big problem.*
- *The workers change all the time so every time I get used to someone they don't come again. I don't like this.*
- *My care co. has a large turnover of staff and can have as many as ten different carers in any period of seven days*

6.35 **Main points from feedback about quality of care and support for independence:**

- Positive feedback about the qualities of care workers should be harnessed if possible within the new contract. However, the contract should also consider the lack of consistency of care workers, multiple care workers and turnover of staff, which were reported issues and have an impact on the care and experience that home care recipients have.
- For some respondents, this manifests itself in basic gaps in care around food or medication.

Question 9 - Do you have support from a family member or friend as an unpaid carer?

6.36 Overall, around 76% of respondents said there was an unpaid carer.

6.37 Home care recipients were more likely to say they had an unpaid carer if they responded on-line (82%) than if they responded by post or phone (nearly 75%). But unpaid carers were much more likely to identify themselves in that role if they replied by post/phone (85%) compared to on-line (60%).

	Overall	Home care client		Unpaid carer	
		Post/ Phone	On-line	Post/ Phone	On-line
Yes	75.7%	74.8%	82.1%	84.9%	60.0%
No	17.7%	20.0%	10.7%	6.1%	10.0%
I'm not sure	1.4%	1.5%	3.6%	0.0%	0.0%
It's not relevant to me	2.7%	0.5%	3.6%	9.1%	30.0%

Question 10 - How much contact does your care worker(s) have with your unpaid carer(s)?

6.38 Overall, nearly half (48%) of all respondents said there was the right amount of contact between carer workers and unpaid carers.

6.39 Relative to other questions, there was also some consistency between the responses from home care recipients both by post/phone and on-line. However, unpaid carers were much more likely to say they had the right amount of contact if they responded by post/phone (58%) compared to on-line (40%).

	Overall	Home care client		Unpaid carer	
		Post/ Phone	On-line	Post/ Phone	On-line
There's the right amount of contact between my care worker(s) and unpaid carer(s)	47.9%	49.0%	46.4%	57.6%	40.0%
There's not enough contact between my care worker(s) and unpaid carer(s)	16.3%	13.7%	35.7%	18.2%	20.0%
There's too much contact between my care worker(s) and unpaid carer(s)	2.2%	2.4%	0.0%	3.0%	0.0%
I'm not sure	7.2%	6.7%	3.6%	9.1%	10.0%
It's not relevant to me	15.7%	15.8%	14.3%	9.1%	20.0%

6.40 Feedback showed a very mixed experience of care workers and their knowledge. Representative comments include:

Written communication could be improved:

- *We think that a written daily log would be a benefit to us, rather than an app that we do not have access to.*
- *No MAR sheets or care plan. My daughters have no idea what the carers do.*
- *My daughter will write notes as contact with my care workers.*
- *Carers record info in the case record, anything important would have to pass through office, sometimes I don't hear of important info / events*

Contact is limited by the timing of the care visits:

- *Dad's carers are only there when I can't be so I rarely see them.*
- *Because the care worker comes first thing in the morning there is very little contact with the carers. Contact is made if we need to cancel carers visits i.e. hospital appointments.*
- *when me and my sister go to my mums, we very rarely see the carers*

Lack of contact is a problem form some respondents:

- *There's no contact at all!! I have to rely on my mum telling me if she has any obvious health problems as the care company relay nothing to me.*

- *3 or 4 short phone calls in 2 years.*
- *They never seem to have enough staff so you never know who is coming.*
- *My mum has to be there to make sure the carers meet my needs otherwise they don't.*

Limited contact works better for some people than others:

- *Mum's care workers are very good and understand her very well and only contact me if they cannot resolve things themselves.*
- *1 member of staff is very good at contacting my family if there are any issues, others don't.*
- *There's no contact really, there's no need for any*
- *Works well with communication*
- *We have an excellent relationship with the workers and none are strangers to us*

Families may initiate contact with care workers / providers more than the other way round:

- *Usually only contact is made if my family contact the carers.*
- *I feel I don't see the carers often enough, I only speak to them when I make a complaint*

There are some difficulties with relationships/roles:

- *Unpaid carers don't know what they can do to make carers do their job right*
- *The carers treat my family as interfering busy bodies*
- *My husband is my unpaid carer and feels alienated, they don't consult him.*
- *My niece does my shopping, cleaning washing and everything. They don't have enough contact with each other.*
- *Would be good if informed of things*

6.41 **Main points from feedback about unpaid carers and care workers:**

- While there is feedback showing that written and verbal communication between care workers and unpaid carers is taking place, responses highlight this should be improved, and the new contact may want to consider this.
- Feedback suggests more could be done by care workers (and home care providers) to initiate and maintain this communication with unpaid carers.
- There is some evidence of a lack of knowledge of each other's roles, which can only be to the detriment of the home care recipient.

7.0 Conclusions based on the consultation feedback

7.1 Based on the consultation feedback:

There is some **qualified support for the change** to paying and charging on planned care. However:

- There are concerns that the change could lead to shorter care visits and *less* flexibility (e.g. to change arrangements or ask for care over what is planned).

- The new contract should consider how this could be monitored and addressed without all the onus being on the home care recipient.
- There was some concern that the change may not lead to care worker investment in the way intended.
- The reasons and implications of the change may not be fully understood by a minority of people, which should be addressed through future communications and processes.

Improvements to care plans are needed through the new contract to help ensure:

- Care workers know/read/follow the care plan.
- The care plan up is to date and involves the right people (including family).
- The care plan is available/accessible to people.
- There is an easier process for seeking changes to a care plan.

Monitoring and accessible feedback channels are needed to help ensure:

- There is not a shortening in care visit time (as many respondents fear).
- Care visits become less rushed than is currently reported, not more rushed.
- There is a reduction in care workers not visiting or cancelling, or visiting at times that are inappropriate to the purpose of the care.

Current home care arrangements score 7 out of 10 on quality of care and support for independence:

- The new contract should consider those elements that home care recipients consider successful within the current arrangements.

Lack of consistency of care workers, multiple care workers and turnover of staff have an impact on the care and experience of home care recipients:

- The new contract should consider care worker investment.

Communication between care workers and unpaid carers should be improved:

- The new contact should consider this, in particular expecting more of care workers (and home care providers) to initiate and maintain this.

Ed Sexton and Jason Smart

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