Division(s): N/A

CABINET – 26 JANUARY 2015

Adult Social Care: Short Term Community Services

Report by John Jackson, Director of Adult Social Services

Introduction

1. Short term support (also called intermediate care) refers to a range of services that are usually used to support people following a period of illness or an event which has made them less able to get by in their day to day lives, for example, after a stay in hospital or an injury. They aim to:
   - promote faster recovery from illness;
   - avoid unnecessary acute hospital admission;
   - prevent premature admission to long term residential care;
   - support timely discharge from hospital;
   - and enable people to regain their independence.

2. In Oxfordshire, these non-bed-based, community services include:
   - Hospital discharge support (including “discharge to assess” services)
   - Reablement Services
   - Support at home in a social care crisis

3. The current system of short term support in Oxfordshire has evolved piecemeal with services created in response to perceived problems and without a proper strategic consideration of the pathway as a whole. There are currently at least seven different services in place, with overlapping referral criteria, service models, and delivery mechanisms. It is difficult for professionals or members of the public to understand the most appropriate route that people should follow through them to meet their specific needs.

4. Our overall system faces a substantial delayed transfer of care issue with many patients being cared for in an inpatient bed when they are medically fit for discharge. There is a significant home care workforce challenge, and a gap between demand and capacity. The current short term services fail to play their part in helping to address these issues and support people to avoid bed based care, or to be discharged effectively.

5. Alongside this, other issues include: demographic projections which predict significant increases both in demand and in people's level of need; and the severe financial pressure facing the council. These short term services are key to preventing escalation of need, a corporate priority, and reducing the overall costs to the whole health and social care system. There is a known gap in capacity for services to support discharge to the community. Oxfordshire Clinical Commissioning Group, our key partner in commissioning intermediate care, acknowledge the difficult decisions that need to be made by the council to

address the financial pressures. They are keen to work with us to find a system wide solution but cannot support any reductions to spend in these areas.

The new strategic pathway

6. The new pathway for non-bed-based services brings together the existing service functions to avoid hospital and care home admissions, and to support people to be discharged from hospital. It aims to form a coherent support, enabling people to move rapidly into independence, where this is possible. It will support people with a wide range of levels of need: from settling-in support for people leaving hospital or picking up an uninjured person after a fall; to short-term help relearning daily living skills; to overnight or live-in care for people with high-level, complex needs.

7. We are expecting increased demand through this pathway due to an ageing population. We are also expecting the service user case mix to changes as the health and social system changes to move away from bed-based services to more services provided at home.

8. This pathway consists of two services: the Urgent Response and Telecare Service; and the Hospital Discharge and Reablement Service. These services will replace, not duplicate, existing short-term community services.

Urgent Response & Telecare Service

9. This service will support people in social care crisis in the community. People can access the response when needed through their telecare alarm or by phone through a health or social care professional. The service aims to support the ambulatory pathway to avoid hospital admissions, and prevent inappropriate use of respite beds.

10. All services which provide a rapid response require spare staff capacity (a buffer) to be able to respond quickly and effectively when needed. By combining all the services with a rapid response, this buffer can be provided more consistently (meaning fewer declined referrals), more effectively (leading to a quicker pick up time) and more cost effectively.

11. The existing services, which will be combined into the Urgent Response and Telecare Service, are:

Name	**Provider**	**Volumes**	**2015/16 budget (OCC funding)**
Alert Service 24/7 response & call monitoring & telecare assessment	Community Voice	4100 registered service users, of whom 3300 use the 24/7 response; 500 visits per month	£1,335,000
Crisis Response Service	Abicare	656 service users in 2014/15 of whom 480 required more than one visit	£617,000
Emergency Carers	Community	3700 registered service users;	£180,000

Name	Provider	Volumes	2015/16 budget (OCC funding)
Support Service	Voice	approx. 100 visits per year	
Total			**£2,147,000**

12. One of the Council budget options proposes to save £200k by reducing duplication and overheads, to create a more cost effective and responsive service. Therefore, subject to council approval of that budget option, the provisional budget for 2016/17 is £1,947,000.

13. There is a well-developed market for telecare and response services. Our modelling suggests that a council-led tender process could attract a good quality provider for approximately £1.8m, a saving of an additional £100k. The total saving of £300k, compared to the current budget, will be achieved with minimal impact on service delivery (as the savings come from removing the costs of duplication in the current delivery).

14. A procurement for the Urgent Response and Telecare Service will take six months; work has already begun preparing tender documents with the intention of going to the market in a standard County Council procurement process in March, subject to Council approval. If this process is approved and continues, contracts will be awarded by June for the service to start 1 October 2016.

15. **Cabinet is recommended to approve this service model and procurement approach.**

Hospital Discharge & Reablement Service

16. Contracts for the existing services below will be allowed to end on 30 September 2016, and the services brought together to create the new Hospital Discharge & Reablement Service.

Name	Provider	Volumes	2015/16 budgets	
			OCCG funding	OCC funding
D2A	Day And Nightcare Assistance	348 new service users plus 277 with extended stays	-	£1,200,000
Reablement	Oxford Health NHS Foundation Trust	2760 service users plus 654 with post-reablement home care	-	£4,400,000*
Home From Hospital	British Red Cross	578 service users with 2248 visits	-	£38,000
Supported Hospital Discharge Service	Oxford University Hospitals NHS Foundation Trust	Approx 1,900 people in 2014/15	£1,500,000	
Total			**£7,138,000**	

* includes £1.5m NHS contribution via Better Care Fund

17. There are two Council budget options which relate to reablement: a proposal to save £440k by reviewing and redesigning hospital discharge services; and an

option to save £300k by delivering more effective, lower cost community-based reablement. This means that, subject to council approval of that budget option, the total budget for 2016/17 for a combined service would be £6,398,000, including £1.5m from Oxfordshire Clinical Commissioning Group and £1.5m NHS contribution via Better Care Fund.

Outcomes Based Commissioning

18. The changes to short term support and reablement are being considered as part of Outcomes Based Commissioning for Older People, a broader programme of work being progressed across Oxfordshire for the provision of urgent care, which was previously approved by Cabinet (16 September 2014).

19. In February 2015, two NHS Trusts, Oxford University Hospitals NHS Foundation Trust and Oxford Health NHS Foundation Trust were successfully designated Most Capable Provider by Oxfordshire Clinical Commissioning Group to redesign and rationalise the service delivery infrastructure, pathways and clinical capability for the provision of urgent care services, with a particular focus on older people and adults with complex health and social care needs. A contractual 'outcomes-based' approach is being progressed, using an Alliance contracting approach with a pooled budget and incentivisation for delivery over a five year (fixed price) resource.

20. Oxford University Hospitals NHS Foundation Trust and Oxford Health NHS Foundation Trust have proposed bringing together the work of their current discharge support and reablement services (Supported Hospital Discharge Service and Oxfordshire Reablement Service) to deliver an improved and more efficient service for patients prior to the start of any Alliance Outcomes Based Contract.

Required activity and outcomes

21. The Hospital Discharge and Reablement Service will work with people leaving hospital and those in the community to increase their abilities and independence. Our aim is that everyone should have the opportunity to receive reablement before they begin long term care. This is both better for the individual as it gives them a better chance of regaining their previous levels of health and activity and is cheaper for the council as it does not need to provide as many long term care packages.

22. We therefore want to ensure that there is sufficient reablement to provide this opportunity. The proposed plan will move Oxfordshire from a position where it is providing reablement to fewer people than the national average to a position where it is providing top quartile performance, both in numbers of people receiving reablement and the number of those who leave the service requiring no ongoing support.

23. Modelling agreed by health providers and health and social care commissioners, suggests that in 2016, 110,000 direct contact hours of

reablement and discharge provision are required in Oxfordshire, to support 6,000 people. This rises to 120,000 hours for 6,750 people in 2020.

24. In 2014/15, the Department of Health introduced a new national measure within the Adult Social Care Outcome Framework - 2D: 'the proportion of those new clients who received short-term services during the year, where no further request was made for ongoing (i.e. on-going financial commitment) support'. As last year was the first time these figures have been produced it could be seen as experimental. Oxfordshire's figure was 64.1%, the national average was 72.2%, and a figure of 80% would place Oxfordshire just outside the top quartile.

Service delivery options

25. There are various options for delivering this service, including splitting it into two services, one focussed on hospital discharge and one on community reablement. This has the benefits that the community service could focus solely on referrals from the community without being deflected by the pressure to accept hospital discharges, and it lowers the risk of having one underperforming service which is unable to meet our needs. However it increases duplication, potentially reduces the overall capacity, and introduces the risk that a community service would be unable to build the complex relationships required to increase community referrals from the various NHS services in the hospital avoidance ambulatory pathway.

26. To achieve the most cost-effective service and the most efficient, streamlined pathway, we are recommending the option to keep one combined service for hospital discharge and community reablement. However the option to split the service could be revisited at a later date if the risk of underperformance became a more significant factor.

27. A combined reablement service could be achieved in three ways:
    - The *continuity of provider* approach:
        - This would use the NHS most capable provider process to roll the service into an existing Oxfordshire Clinical Commissioning Group contract for health services, where the value of the reablement services would represent less than 10% of the broader contract.
        - Funding would sit in the pooled budget and the reablement elements of the broader service would continue to be monitored and managed as part of a county council contract management process.
        - Improvement and delivery trajectories towards the desired number of hours (110,000 pa) and outcomes (80% people requiring no ongoing support) would be agreed as clear gateways within the contract, which would have a total cost of £6.4M pa.
    - The *in house* approach:
        - This would result in the current services moving into the Council, sitting alongside operational social work teams.
        - More work needs to be done to develop the costs and structures associated with this model but experience from other local authorities indicates an in house model could deliver 110,000 hours

for a total cost of approx. £6.5M pa, depending on the levels of therapy and social work input.

- The *procurement* approach:
  - It would take six months to procure the service with a formal tender process, with the Council acting as lead commissioner.
  - Procurement advice based on the current local and national state of the market, together with soft market testing, indicate that a reablement service could be procured from the market for approx. £4.95M pa.

28. The pros and cons of each approach are laid out in the table below:

Approach	Pros	Cons
Continuity of provider	• Achieves a stable service managed by a single health provider • Current NHS providers are fully embedded in the complex referral pathways (and operate some of the referring services) so are better able to control flow to the service • Simpler for clients being discharged to move from one NHS service to another • If current providers can increase efficiency, delivers better savings home care spend (potentially over £4m) than with the procurement approach (see below) • Provider commitment to meeting increased demand on flat cash basis so better long term value • Achieves stable workforce (last time the service was tendered 60% of staff left the service)	• Risk that current providers are unable to deliver the increased number of hours and improved outcomes for people which are required - the Oxfordshire Reablement Service is currently operating below targets • Costs of the service are potentially higher than they would be if we go out to the market
In house	• By transferring staff with skills in supporting and working with older people within the council, this could increase workforce capacity in a workforce limited environment. This would also reduce council redundancy costs, whilst retaining skilled and trained staff. • Spend similar to Continuity of Provider approach which is lower than current services	• Would take more set up time which is not available
Procurement	• Would create a clear, flexible social-care-focussed service • Market testing suggests that this would deliver the cheapest service, if a new provider was found. Savings could be up to £1.4M (on top of the budget options already proposed to council)	• Experience of tendering for this service, and from the current home care market, suggests that there is a high risk that a tender process may not find a provider capable of delivering the service • A new provider would have to build many complex relationships with NHS services which may impact on its effectiveness both in the short and longer term • Significant risk of workforce instability and negative impact on service delivery while procurement takes place • Could increase costs of

Approach	Pros	Cons
		health services for Oxfordshire Clinical Commissioning Group • A non-integrated reablement service potentially creates more hand-offs for clients being discharged from hospital.

29. The biggest single issue facing social care is the capacity of the workforce. Last time the service went out to market, 60% of the staff left the service, having a major impact on delivery through the tender period and in year one of the contract. This would have knock on effects to system flow and whole system issues such as delayed transfers of care.

30. There is a significant risk that a new provider would take time to recruit enough staff to deliver the new hours required and the possibility of going straight to tender may destabilise the existing workforce. The Continuity of Provider approach ensures a stable workforce which in turn gives the service the best chance of increasing its outcomes. Oxford Health NHS Foundation Trust has held the existing contract since 2012 and performance on outcomes has increased each year. A new provider without the history and skill mix may struggle to reach the target for no ongoing care.

31. In 2015, 1125 people started a new home care package and an additional 379 started home care via direct payment. Of these only 513, fewer than 50%, had been through reablement. If 80% of the 1125 people had received reablement - 900 people, and 80% of these people - 720 people had been successfully reabled, then the council would save over £4 million per year.

32. Therefore consideration of the different approaches suggests that, although the spend directly on the service may be up to £1.4m less by taking the Procurement approach, if successful the Continuity of Provider approach would save over £2m more overall by reducing home care costs. The Continuity of Provider approach could deliver the most progressive, preventive service for the best overall public value.

33. To mitigate the risks of this approach and give commissioners confidence that providers are on track to deliver increased performance (and resultant increased value for money), we would require the health provider to pass agreed gateways over the next twelve months. These gateways include the number of hours delivered, and the outcomes of the service. In the event the provider fails a gateway, commissioners would default to the procurement approach.

34. Contractually, Oxfordshire Clinical Commissioning Group would have a rolling 6 month contract in place with the provider, renewed quarterly, with provider commitment to continue delivering for 6 months at contracted rate in the event of gateway failure. Once the final gateway is passed the service contract would move to sit in line with other health contracts – ideally within a broader five year

contract. The work of the existing services with non-NHS providers, which end on 30 September 2016, will be absorbed into this contract from 1 October.

35. The total hours of reablement in each gateway target excludes therapy (which is provided by the community therapy service outside this contract), but includes assessment (as this is a core function of reablement), and post reablement domiciliary care (care for those who have reached their reablement potential but need some ongoing support and have not yet transferred to another provider) provided directly by the service.

36. The outcomes targets in the gateways are stretch targets with an aspiration to get to a top quartile performing service. Health commissioners, who are significant funders of this service, have asked that we allow flexibility in the gateway targets while the Outcomes Based Commissioning Agreement is agreed.

37. The payment arrangements for the current Oxfordshire Reablement Service are based on delivery of activity which has enabled commissioners to invest underspends in alternative services to help mitigate the impact of underperformance on the system. Providers have asked that the new contract is block-funded as this allows them to invest in service provision but a fully block contract exposes commissioners to financial risk arising from any underperformance. It is recommended that we move to a composite payment mechanism which is part block and part activity based to minimise the risks to commissioners while allowing some service investment funding.

Post short term support and seasonal flexibility

38. We anticipate that there will still be some demand for post reablement domiciliary care after people have received reablement. Although our new help to live at home (domiciliary care) contracts require a two day response for planned referrals (which all post short term support would be) the current average sourcing period is 11 days.

39. On top of the contracted hours of reablement, the service will be required to provide appropriate support to keep people at home and safe in the event that help to live at home cannot pick up care. The spend on post short term support is in addition to the budgets identified in this paper and will come from home care pooled funding. It is chargeable at average home care rates and mechanisms will be put in place to ensure that people are appropriately charged.

40. There are periods in the year where demand is higher than at other times, particularly the December/January/February (winter) period. We will expect providers to staff their services accordingly as there will be no additional funding to cover this.

Financial and Staff Implications

41. The financial implications are laid out in detail in the paper. Subject to council approval of the budget options and a successful tender for the Urgent Response & Telecare Service, savings from service efficiencies could come to £1.04m from budgets totalling £9.3m.

42. There are financial risks to the providers of providing increased levels of service with the same year-on-year budget over the term of the contract, with issues of staff cost inflation and savings on Oxfordshire Clinical Commissioning Group investment. The perspective of the current provider is that wage inflation will require the £6.4m year one budget to be increased on an annual basis, and it is anticipated by them that this will reach a cumulative impact of £1.5m by year five.

43. These issues need to be resolved before the Outcomes Based Commissioning Agreement is agreed.

44. There is very little impact on council staff as all the people working in these services are employed by external providers. The Urgent Response & Telecare Service may change providers when tendered; staff working primarily on the current service would have the right to transfer to the new employer. There may be some job losses in the combined service as the reduction in duplication could mean fewer people are needed to deliver the same level of service. In the Hospital Discharge & Reablement Service, staff would have to transfer to the new Alliance organisation which may be disruptive but the new service requires more capacity than the existing ones so we are not expecting there to be job losses within the NHS providers.

Equalities Implications

45. No group will be particularly disadvantaged by these proposals.

46. The telecare element of the Urgent Response and Telecare Service is likely to be available to self-funders at a lower cost than the current council service, making it more affordable for those who wish to purchase the service for themselves.

RECOMMENDATIONS

47. **The Cabinet is RECOMMENDED to approve:**

    (a) **the service model and procurement approach for the Urgent Response and Telecare Service;**

    (b) **the Continuity of Provider approach to deliver a combined Hospital Discharge & Reablement Service (including community reablement);**

    (c) **the proposed gateways, including the option to change the approach to the procurement option if the provider fails to meet**

the gateway targets, delegating final approval of the gateways to the Director of Adult Social Services.

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Background papers: Demand; Current Service Performance, Proposed gateways for Hospital Discharge & Reablement Service, Budget, Spend, and Activity for November 2014 to October 2015 (confidential, circulated to Cabinet Members only)

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