THE OUTSOURCING

OF

HOMECARE RE-ABLEMENT SERVICES

A discussion paper to outline the trends, options and recommended approach to outsourcing homecare re-ablement services

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EXECUTIVE SUMMARY

In recent years the interest in and development of outsourced services for homecare re-ablement has increased. Although currently relatively small in number, approximately 20 out of 149 councils, it is clear that this interest will increase as councils seek to secure greater financial efficiencies as they manage growing demand within available funding levels.

Various potential models are outlined in this document. The decision about the 'right' model (local authority trading company, social enterprise, independent provider, etc.) is likely to be influenced by the local view on an acceptable balance between control and risk / liability. However, whichever form is chosen, it will not change the need to ensure that the service fits within an overall range of services and is not merely bolted on. In addition, the need for operational performance management remains – the main difference will be who provides the data rather than which data.

A growth in outsourced services will require a shift in the focus of contracts and the adoption of a proactive operational performance management approach. This will not necessarily be easy for many councils who, in many cases, do not operationally performance manage existing in-house services. However, if we are to release the maximum level of benefit for people undergoing a phase of homecare re-ablement and financial benefit for the council, so that they can manage growing demand, the focus needs to shift towards performance of outputs and outcomes.

The 'body of evidence' already provides guidance on likely targets and these need to be incorporated into contracts for outsourced homecare re-ablement services. Further, these should then be proactively reviewed on a monthly basis, just as they should be for in-house services. This requires not just the ability to manage and report data and information but a shift in the mindset of those charged with managing the outsourced service.

In addition, the training, skills and competency framework needs of the service will not be dependent on whether the service is in-house or outsourced although the mechanisms for delivering it may well be. Therefore, these requirements also need to be incorporated within the contractual arrangements and possibly within the operational arrangements with the provider.

Background

Historically, most if not virtually all homecare re-ablement services have evolved from existing in-house homecare services and few councils appear to have ever considered the need or appropriateness of outsourcing the service. There are some very obvious explanations for this that various councils have shared:

- Value for money reviews encouraged councils to find an appropriate use for existing services that were, comparatively, more costly than external providers of maintenance homecare.

- Large scale inhouse teams of carers were already in place and options to make these staff redundant were not considered to be sensible given the need to fund redundancy payments.

- Some Councils, often influenced by political principles, determined that it was their role to provide care and support and not the independent sector. This was still reflected until quite recently in a few councils where they retained a significant proportion of the 'maintenance' homecare market despite the shift across the rest of the country to use of independent providers.

- The apparent conflict of interests in an external provider being asked to work with people to maximise their independence and reduce their ongoing needs, and thereby reducing the provider's potential future business stream.

- The application of TUPE regulations inhibits external providers from being able to offer cost effective services that also offer cashable efficiencies.

- The belief in a number of councils that their staff provide a far higher quality of service than independent providers are capable of providing.

This situation is changing and an increasing number of councils are now considering the appropriateness and options to outsource homecare re-ablement services, much as they have done with other services and particularly maintenance homecare packages. Further, statements made by the President of the Association of Directors of Adult Social Services (ADASS) at a conference in late 2010 suggest that within five years we can expect to see social services as commissioners and market shapers, having moved out of care provision. The increasing focus on financial performance is also likely to be a, if not the, major driver for councils to consider alternate models for delivery.

Trends in outsourcing

The best and probably only records of the shift in service models has arisen from the work completed by the Care Services Efficiency Delivery (CSED) programme in published directories of homecare re-ablement services. These were primarily based on self-reporting by councils and show the trend.

In the early reports (2007 to 2008) only a couple of councils reported outsourced services. However, in March 2009 eight councils had created or were creating services that were wholly or partially outsourced. By November 2010 this had increased to 17 councils who had or planned to have outsourced services plus a further 3 that had both in-house and outsourced provision. This compares to 129 who operate, or propose to operate, in-house services either on their own or with some input from health partners.

- The majority of outsourced services were present in London where 7 of the 12 services operated by providers other than the council were based. In addition, of the 12 services, Hertfordshire had outsourced provision across the county to one provider, Goldsborough.

- Three councils had created wholly owned trading subsidiaries through which all care was now delivered, including homecare re-ablement, These were Essex, Sefton and Stockport.

- A further 2 London boroughs provided an in-house OT service but actual provision of the homecare re-ablement service was outsourced

- Both Kent and Solihull reported a use of both in-house and external providers, whilst Brighton directed new referrals to an in-house service but referrals arising on review to an external provider.

It is known that a number of councils are actively considering outsourced options and it is anticipated that over the coming year to two we shall see a significant increase in these delivery models.

The policy focus on re-ablement, or what should more appropriately be called post discharge support, is likely to increase this trend. It is understood that a few councils have decided to pass-over responsibility for the provision of homecare re-ablement to their health partners in step with the current proposed shift in responsibility, from April 2012, to acute NHS trusts to ensure provision of health and short-term support for certain people in their first 30 days post discharge from hospital. Any such change would seem to ignore some critical factors, namely

- Health partners, and particularly acute health bodies, have no experience or understanding of delivering or commissioning social care support including homecare re-ablement.

- Their focus is <u>only</u> on people discharged from acute hospitals. It is apparent from established services that just over 50% of their referrals are from the community and so these people will be 'missed' be these arrangements.

- Historically intermediate care services have been clinically led and operate on a selective basis. If this approach were to be adopted within a health led re-ablement service then it is likely that a number of people discharged from hospital will not undergo a phase and so fall immediately to social care for ongoing support.

- Health's responsibility is, currently, only for up to the first 30 days post discharge, whilst it is recognised that the majority of homecare re-ablement services operate for up to 6 or possibly 8 weeks. This period has been determined through consideration of the problems arising from re-admission rates rather than the time needed for a short term intervention or support programme to regain or maximise independence. Whilst a significant number of people will have entered and left the service in under 30 days, many people will not

It would seem logical for health to commission homecare re-ablement services from the same provider(s) as councils since this would ensure

- critical mass for providers for financial and operational reasons

- consistency of approach

- a social care model of support rather than reversion to a clinical model of care being adopted

However, it is likely, and not unreasonable, that health partners will not be tied to purchasing homecare re-ablement for 'their' referrals from historical sources merely because of a desire to find an alternate use for a relatively expensive service. Thus, it would seem that some in-house services have a limited opportunity to improve their relative cost effectiveness if they are to retain a long term role in the future market.

Different models

Control v financial liability

The options facing councils would seem to fall into four broad categories with each having associated risks and benefits. However, the main issue that is likely to determine the chosen route is which model provides an acceptable balance for the council between control and risk / financial liability.

Broadly there are four options to consider:

1. Continue with or create an in-house service
    a. Council retains full control over service
    b. However, the Council also retains full liability for staff, etc.
    c. Staff continue to be employed by the council and subject to LA employment arrangements.

2. Create a local authority trading company and transfer the service
    a. Council continues to retain a level of control at a strategic level over the service and 'profits' are retained within the business
    b. Often involves awarding secured contracts for an initial period, albeit that these may taper over the term
    c. The LATC immediately gain and retain the established skill base and knowledge of the previous service
    d. TUPE applies to staff transferred and so the LATC is constrained when compared with other independent providers
    e. Some risks and costs are likely to remain with the council
        .

3. Transfer service provision to a new social enterprise company.
    a. Service costs and related risks are transferred to the provider organisation
    b. Often involves awarding secured contracts for an initial period, albeit that these may taper over the term
    c. The social enterprise immediately gain and retain the established skill base and knowledge of the previous service
    d. TUPE applies to staff transferred and so provider constrained when compared with other independent provider
    e. The council experiences a reduction in its control or influence over the service to the same level as it has with any other independent provider unless incorporated within the secured contract terms
    f. Any profits must be retained within the social enterprise

4. Outsource services to the independent sector.
    a. All service costs and related risks transfer to the independent provider

b. May involve awarding secured contracts for an initial period, albeit these may taper over the term

c. Established skill base and knowledge transferred but likely to dissipate relatively quickly

d. TUPE applies to staff transferred and so the provider is constrained when compared with other independent provider

e. The council experiences a reduction in its control or influence over the service to the same level as it has with any other independent provider unless incorporated within the secured contract terms.

f. The provider will determine what proportion of any profits need to be retained within the business.

Any model that involves the transfer of an undertaking currently invokes TUPE regulations but anecdotally LATCs have reported that they are able to operate flatter management structures, are removed from much of the bureaucracy of the LA and are able to engage and operate on a more commercial basis than was previously the case. They are also able to enter the self-pay market and so establish a stronger financial position.

However, the speed and degree to which any of these outsourced models are able to adopt independent sector employment terms for new / additional staff and practices for all staff will have a direct impact on their ability to compete on a level basis with other independent providers. It is only at this point that they will be able to release the full order of benefit to the council. Any secured contract period provides a degree of protection but the duration of this period needs to balance both the council's need to release benefits and the organisations ability to change practices and develop additional markets.

Cost effectiveness of outsourced homecare re-ablement services

Despite there being a small but growing number of outsourced services, there is little if any evidence to illustrate or quantify the order of benefit that is released through these arrangements. That situation reflects the following factors:

1. The maturity and scale of most outsourced services means that other than two of three of the services, most are of insufficient scale as yet.

2. Not surprisingly, these organisations are unwilling to share detailed financial and performance information because they now operate, to varying extents, in the commercial world.

As stated previously, outsourced services have reported that the new structure affords greater freedom and allows for flatter management structures, changes to work practices that enable them to become more responsive, and the ability to make decisions more quickly.

Intuitively these services should be more cost effective than when they operated internally but based on the limited sharing of information, it would seem that few councils have changed their contracting arrangements from measuring inputs to contracting for and being able to monitor anything close to outputs or outcomes.

Sharing of financial benefits

We are not aware of many examples of UK councils that have sought to create a benefit sharing structure within their contractual relationship with the outsourced or even external providers. This reflects the maturity of the market.

One council decided to create further homecare re-ablement capacity by entering into agreements with a limited number of external providers to provide a service. The approach required referrals to be assessed into one of four bands of need based on the number of hours required each week. A standard funding level was established for the first four weeks for each band, after which the funding level stepped down unless a case was made for a higher level to be made. Thus, this approach makes a step-down in funding the norm during the homecare re-ablement phase. However, on its own it does nothing about the level of commissioned hours required post the homecare re-ablement phase.

To consider shared benefit models one must look to similar services abroad where the external provider market is and has been the norm for a number of years. Although not identical, there are a number of similarities with markets in both Australia and New Zealand in terms of demographics, range of social care and health services, etc. However, a major difference is the fact that providers are, in the main, independent. For instance, in Victoria, Australia, local councils provide less than 5% of the social care support contracted directly by the Department of Health in the state.

In New Zealand trials have been held whereby contracts between District Health Boards and providers contained a 'profit share' arrangement. Savings as a result of the restorative service (similar in approach to homecare re-ablement although not identical) were cut into bands with a progressive proportion of the saving being retained by the provider.

Protocols with regard to data, assessment tools, process, etc. are far more consistent than is the case in England but despite this, they encountered significant problems with operating and monitoring such an approach and so, it is understood, the trials have been abandoned.

What to Outsource

At an early stage of the process to consider outsourcing the homecare re-ablement service, one needs to determine which parts of the 'process' or 'service' are to be outsourced.

For instance, is it 'merely' the staff that deliver the service, or does it include those who will undertake the re-ablement assessment, plan and review ? Does it include those who undertake assessments for and provide telecare and assistive technology equipment ?

The Outsourcing section of the CSEDHomecare Re-ablement Implementation Toolkit [1] provides a useful description of five distinct profiles and allows services to consider options adopted by other councils.

While the choice of model (e.g. LATC, social enterprise, etc.) has consequences for contractual and transition arrangements, the operating model and decision parameters around homecare re-ablement remain similar.

Implementation

Although not common, we are aware from discussions with a few councils that they appear to be adopting an approach whereby they are leaving the outsourced provider to resolve issues of process and service performance despite the fact that the council will be the organisation that is forced to 'pick-up' the bill for poor performance through excessive ongoing homecare packages which may last for years.

Process

Many, but not all, Councils would seem to accept that the implementation of a homecare re-ablement service requires an overall consideration and fundamental change to their processes, both around the service and within it, when compared to the existing maintenance homecare service. Homecare Re-ablement does not work in isolation and it cannot be merely bolted on to a process that is, at worst, flawed or at best, not compatible.

Thus, many councils have considered and revised the whole referral, assessment and care management pathway so that homecare re-ablement becomes the default route. This principle applies whether the service is to be operated by an in-house provider or outsourced.

Performance monitoring

Few councils would seem to have developed their contracting approach beyond one that focuses merely on inputs when the service they are seeking should have clear outputs even if clear outcomes take longer to quantify and build into contracts.

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[1] CSED Homecare Re-ablement Implementation Toolkit, CSED Dept of Health, Mar 2011

Evidence from a range of effective services provide clear targets for both inputs and outputs. These should be included within contractual arrangements and systems established so that these can be monitored and acted upon monthly. In this regard, we believe that there are few differences between an in-house and outsourced service in terms of most operational performance data and reporting. The differences lie more in who does it.

Thus, not only should these be included within the contract documentation, they should have a direct impact on the funding levels and continuation of the contract. Performance outside of the target levels should be considered on an exceptions basis but it will need a proactive contract management approach by the council and include operational performance information if they are to ensure that the outputs and outcomes are achieved.

The targets and monitoring for the outsourced service should include the following items:

- **Response times**:
  The time lapse between referral to the provider and service starting will be important.

- **Service outcomes**:
  Performance targets for service should indicate the proportions of people expected to achieve different bands of independence. For instance, based on some of the better performing services, but not the best, these could reasonably be set at

  - 50% not requiring ongoing homecare
  - 16% requiring a reduced homecare package
  - 16% requiring the same size of homecare package
  - 8% requiring an increased package
  - 10% not completing their homecare re-ablement phase

  In the early life of a new service these will need to be 'toned down' but then progessively raised in subsequent years. It is critical to set these targets and benchmark them against other councils to ensure that the service is providing maximum benefit and maximum value for the council.

  As experience is gained one could refine these. For instance, one could set a benchmark for the size of the average reduced, maintained and increased package. This data is already available from the body of evidence but councils may wish to gain local experience first before adopting these.

- **Average duration of the homecare re-ablement phase**:
  Most councils provide the service for up to 6 weeks. In most services the majority of service users are ready to move on to independence or to a

...... specialists in health and social care

homecare package after between 4-6 weeks. It is advisable to measure the average number of weeks in the reablement service and, if this figure starts edging up, investigate the reasons. More often than not, the delays are largely procedural (delays in reviews) or provider capacity constraints (inability to place clients with ongoing care needs with providers)

- **Staff contact hours**:
A council may feel that this is a step too far and that this should be left to the provider to manage as long as the outcome and duration targets are met. However, it should be remembered that if an execessively high number of contact hours are being used then this will be reflected in the cost of the service. Conversely, if the number of contact hours are significantly low then this could well indicate that a poor quality of service is being provided.

Other targets and areas for monitoring internal to the council should include

- **Intake volumes**:
The council need to know how actual referral volumes are comparing to the target for their community. It is advisable to base the target volume of service users entering the re-ablement service on the total number of the council's new service users. For example, many councils set a target re-ablement intake volume as 80-90% of the total intake of new users. In the absence of local data, a good proxy is that the average volume of people going through re-ablement should be equivalent to at least 2.1% of the local over-65 population.

- **Source of intake**:
Whilst there may not be a target, it is useful to measure the
intake from various sources, e.g. area offices, contact centres, hospital teams etc, to show trends and also the effectiveness of the interfaces with other groups.

- **Returns to service**:
Clearly a critical element of the cost effectiveness for a homecare re-ablement service is the average duration a person is able to maintain or retain a given level of independence. Therefore, it will be important to understand how long people are able to remain support free or maintained at the level of care achieved when they complete their phase before a package or change of package is required. Again, the body of evidence indicates the likely trend against time.

- **Service user feedback**:
Many services measure customer feedback either through an exit questionnaire sent by post or by a face-to-face interview. Here again it is useful to set some expectations on return rates, performance in key areas and measure performance trends. Questions often focus on key areas such as

professionalism, timeliness, quality of care, and whether desired outcomes were met, and compare responses against corporate standards.

Postal questionnaires have proved cheaper, but are less likely to elicit a response; whereas face-to-face interviews are more likely to get a response, they require greater investment, and it might be worth employing a third party (e.g. voluntary organisation) to conduct these, since care must be taken to ensure the responses are not prejudiced

Learning and Development

An important element of the L&D work with any service, whether it be in-house or outsourced, is the need to support staff through the process to adopt the re-ablement approach. This is particularly important for those who are making a shift from a previous caring and support role within a maintenance homecare service but will also apply to new recruits.

Consideration will need to be given as whether, and if so to what extent, a council wishes to provide this for outsourced services. Few external providers have any experience of providing homecare re-ablement despite some insisting that they already work in this way. Quite simply they do not, as in fact nor did many of the existing in-house homecare teams because that was not their remit, function, skill set or training. Further, the whole basis of their funding did not encourage or require them to maximise a person's independence and assist the majority to cease requiring service.

Clearly a council could consider making their in-house training available where they intend to operate both in-house and outsourced services but this is likely to be more difficult if the whole service is to be outsourced. Therefore, consideration will need to be given to the skill and competency framework required of the workforce if they are to deliver an effective homecare re-ablement approach.

As with other sections above, this is no different whether the service is delivered by an in-house or outsourced provider. Clearly a council could choose to leave this 'detail' to the provider, but as with other areas outlined above, the consequences of inadequate or inappropriate training and competencies will result in poorer levels of independence for the individuals concerned and a greater financial demand than is necessary on the council.

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GPA was founded by Gerald Pilkington who has over 26 years of experience working in health and social care across the independent sector (acute, long-term care and rehabilitation) and NHS.

Gerald was previously Chief Executive of a not-for-profit group that owned care homes and acute hospitals across England and Wales, and managed others under contract. He has also served as a Trustee and non-executive Director of a not-for-profit hospital. He has direct experience of acquisitions, the planning and commissioning of new-build care homes, and major refurbishments.

More recently Gerald was the national lead for homecare re-ablement within the Care Services Efficiency Delivery programme at the Department of Health, supporting 152 English local authorities to achieve their efficiency targets within adult social care. Working with services and academic research teams he has built the most comprehensive body of evidence of the effectiveness of homecare re-ablement within the UK. He has shared this with local authorities and provided support as they implement a new service or improve an existing service.

As a result of his knowledge and experience he has also been a key note speaker at four state / territory conferences and the 2008 national HACC conference in Australia, and a speaker at the 2010 International Federation on Ageing Conference in Melbourne. More recently he was a key note speaker at the New Zealand Home Health Association's 2011 annual conference in Wellington. He has also had a paper published: *Homecare re-ablement: Why and how providers and commissioners can implement a service:* Journal of Care Services Management, September 2008

GPA's approach is flexible as we are able to work in a project management, interim management or consultancy role to suit the nature of the work and our client's needs.

We work closely with a range of other associates, each of whom has specialist knowledge and skills across the health and social care arena. We also work with other professionals who have relevant knowledge of the sector's needs, including architects, valuers and human resource specialists.