Project 1: Development of the Care & Wellbeing Model

Engagement & Consultation: Response to Queries & Feedback

From February to April 2021 members of the Programme Team have been meeting with local stakeholders to discuss plans for developing a new model of home care in Sheffield, as part of the wider Transformation Programme. The purpose of this document is to collate and respond to queries and feedback raised during these meetings.

At each event people were asked to consider the following questions, in relation to a presentation and discussion about the model and related context about home care in Sheffield:

1. Is there anything you would like to know more about?
2. Based on your own experience, do you feel the new model will support people to live the lives that matter to them?
3. Is there anything else we should consider?

The feedback and queries from the separate events have been collated below under these headings and grouped together where themes emerged. Please note: responses are accurate at the time of writing (early April 2021) but some areas are at an early stage and require further development, and / or there may be changes due to circumstances or further feedback as the project progresses.

If you would like further clarity, or to ask anything else, please contact Chris Boyle (Commissioning Officer) via chris.boyle@sheffield.gov.uk and we'll be happy to respond.

If you would like to remain involved, as the project develops, for example as an expert-by-experience, please also let us know via the same email address.

1. Is there anything you would like to know more about?

Are you going to pilot this new model, how, where, and when? If successful what type of timescale is in place to roll out to the city?

What does procurement of a development partner mean? Who does it mean? What will it cost? Will it be a big cost, and where do experts by experience have an opportunity to contribute?

When are we going to see changes? Why is it taking 4 years to implement the new model? 44 people during the controlled implementation in September seems low when there are so many more people in the city that this need to be considered.

We are going to start a 'controlled implementation' of the new model in Autumn 2021. Analysis in relation to the selection of a specific location is currently taking place.

The Council is intending to procure a development partner to collaborate on the controlled implementation. The term 'controlled implementation' refers to the process of implementing the foundations for the model in a specific geographical area in the city, learning and building an evidence-base over the following two years.

We would like experts-by-experience to have a role in the selection process for the development partner.

An agreed budget is in place for the controlled implementation process. The value of the budget takes into account the requirement for the development partner to contribute to the evaluation process, and specific components of the model, such as improved terms and conditions for care workers.

The delivery partner (responsible for care delivery) will collaborate with the Programme Team and ScHARR[1] (evaluation partner, Sheffield University) to collectively develop and evaluate the new model. There will be a strong focus on listening to people in receipt of care, their carers and families, and their care workers, to develop and refine the model.

Decisions about rolling the model out across the city will be dependent upon the outcomes achieved. However, assuming there are positive results, it is likely this will take place after the two year period is complete. Options for incorporating learning from the project into existing provision will also be examined.

The thinking behind the new model has developed gradually over the past few years, through a combination of research and conversations with stakeholders, however it has only been a formal Programme since 2020, with time lost during that period due to the ongoing pandemic response.

The decision has been taken that the most responsible approach to testing and learning about a new model is to start small, and gradually increase scale, to ensure people are well supported and their stories and feedback effectively listened to.

What reaction has there been from care providers?

There have been conversations and meetings with providers to discuss the ideas as they have developed. In April we are undertaking a 'soft market test'.

The purpose of the soft market test is to inform the market of our intentions, and for providers to ask questions and express interest in applying for a formal tender opportunity, with no obligation for either party. The queries and engagement from providers will contribute to the refinement of our plans, in addition to the feedback of citizens and other stakeholders.

How do we integrate health and social care in the future? There is a shift, but people are still working in silos that are seriously disabling meeting people's needs.

Is there a cross council agreement? Are housing / health on board? Are CCG involved?

One of the key premises behind the new model is that health and social care services need to work closely, with home care a key component of the local health and social care 'system'.

[1] https://www.sheffield.ac.uk/scharr

While there are much wider national and local developments in relation to integration taking place, as a Programme we are seeking to facilitate closer working between home care and other colleagues, teams, and services. This is both in relation to the new model, but also in terms of existing provision.

The Programme is supported by senior leaders in both the Council and CCG, and the Cabinet Member for Health and Social Care. We will be collaborating with closely with colleagues responsible for Continuing Health Care at the CCG.

Respite and care packages, how do they fit into the model?

This is an interesting point and there isn't a specific answer at present. We'll give this more consideration.

It was mentioned that care workers would have more autonomy or be able to respond more quickly, how will that work?

At present home care is structured around a fairly rigid 'time and task' model, which people tell us doesn't work well for them. If there is a consistent team of care workers, who know the people they care for and the local area really well, the focus of the care can be upon the outcomes the person in receipt of care wants to achieve, rather than 'time and task'.

The key is ensuring the right foundations are in place. The care team must be well trained and supported, and they need to have access to other professionals when required. There also need to be appropriate terms and conditions for workers, and funding arrangements for providers, which enable greater flexibility and responsiveness, so the focus on what matters to the person, not the minutes delivered.

The most crucial element is that the person is placed at the centre of the support. In some cases the care may be very similar each day, because that is what the person wants and needs. However in other situations there may be more variance, if this works well for the person. Part of the purpose of the controlled implementation is to test how this can work well in practice.

Strength based approach and increasing independence - does this mean less reliance on care or more choice and control over living their lives?

The Social Care Institute for Excellence[2] definition is helpful: *Strengths-based (or asset-based) approaches focus on individuals' strengths (including personal strengths and social and community networks) and not on their deficits. Strengths-based practice is holistic and multidisciplinary and works with the individual to promote their wellbeing. It is outcomes led and not services led*.

In relation to both this approach**,** and increasing independence, this may mean both less reliance on formal care, and more choice and control. For this approach to work effectively, it is crucial the initial assessment and subsequent support plan are based upon on what matters to the person, rather than a set of tasks to be done for them.

There is evidence that working in a more outcomes-focused way can lead to less formal support being required in some cases. There are number of potential reasons for this,

[2] https://www.scie.org.uk/strengths-based-approaches

including home care having closer links with the voluntary sector and community resources, or exploring options for combining some support for individuals living in the same area (also reducing loneliness and isolation).

How do you define outcomes? Will the recipients have a say in what these outcomes are?

What outcomes are required and who determines them? How is this assessed and how is it monitored?

How have you factored in a person-centred approach? What is personalised to one person is not always the same to another.

When we talk about 'outcomes' we are referring to a) what a person wants to achieve and b) the impact, change or effect that an individual experiences as a result of their care and support.

Outcome-focused services aim to achieve the aspirations, goals and priorities identified by the person, working to do 'with' not 'for'. Outcome-focused services should be fundamentally person-centred, recognising that each person is unique and will have different and varying requirements. Working in this way also empowers care workers to be responsive and proactive.

Some of the practical elements of how an outcome-focussed, personalised, approach are embedded requires more work, and the controlled implementation is an opportunity to do this. There is also ongoing work by social work colleagues on developing assessment practice, and social work managers who are part of the Programme Team provide an important link to this work.

High turnover of staff - has any work been done into why there is a high turnover? What's the reason and if you know what are you doing about it?

Wages and retention - increase the minimum wage and retention will grow and there will be less leavers and more experienced staff.

Zero hours contracts - this significantly impacts of turnover.

SCC to look at the providers and see who has the lowest retention.

Loss of 50% of workers - are the right people recruited in the first place? What are you asking for? If they don't meet the criteria don't employ them. Needs to be a shift in recruitment practice.

There are a variety of reasons for staff leaving their role as a home care worker. Often people leave one employer to work for another home care provider. This may be because of a slightly higher rate of pay, or for another reason they wish to move on.

As is well documented, home care can be a challenging and stressful role, and it is often paid at slightly more than the national minimum wage. Recognising the value of care work, and ensuring workers are properly trained and supported, is an intrinsic part of the new model.

From April 2021, the Council is making an investment of £4.2m into the fee rates of contracted care providers, on top of the minimum increase. This a reflection of a shared commitment and strategic direction to improving staff wages over the next few years, so

that all our contracted care providers are ultimately able to become accredited Foundation Living Wage providers, and a demonstrates the alignment of the aims of the Transformation Programme with wider strategic goals.

There are also several ways in which are seeking to both understand more about what impacts upon, and bring about a reduction in, staff turnover. These include:

- Working with the Living Wage Foundation to develop a workforce retention toolkit.
- Gathering data from contracted providers regarding turnover, to support analysis of trends and learning about best practice.
- Undertaking exit interviews with care staff to gather additional intelligence.

Currently huge issue with timings, wrongly timed (visits). Would this model solve that problem?

While there may always be occasions where a care worker is delayed due to unexpected events, it is hoped that the new model mitigates a number of the factors that may currently contribute to this issue, by embedding the following:

- Sufficient staff capacity
- Assessor and provider working jointly with person at the outset to establish expectations, feasibility and agreed parameters
- More joined up working between home care and other services, for example guidance from community pharmacies in terms of rationalising medication regimes and understand requirements for timing and frequency of care visits
- More efficient neighbourhood working
- Increased ownership for care workers of their neighbourhood 'patch'
- Improved communication in the event of issues.

How many people with a Learning Disability receive care from home care providers?

There are current 60 people with a learning disability in receipt of home care from a contracted home care provider (of around 2,800 people in total in receipt of home care).

With regards to the controlled implementation, how do you plan on including people with learning disabilities in this and how will the new model work for people with learning disabilities?

People will receive support from the provider in the controlled implementation if they live in the relevant geographical area and support from a home care provider is the most appropriate option to meet their outcomes and needs. This could include people with a learning disability but will depend on this being the best option for that person, for example in comparison to supported living, and will be considered on a person-by-person basis.

In terms of how the new model will work for people with a learning disability, more development and consideration is required. However establishing the correct foundations will enhance the opportunity for everyone to receive excellent support.

Would we need to apply for additional funding from the council? Health and Social Care are already underfunded.

The scope of the project is Council-arranged home care, as opposed to Direct Payments. Arrangements for charging where people make a contribution or pay for all of their care will follow the relevant local / national policy.

If 14% of people are re-admitted within 14 days (from hospital) is this because of poor care? Or inappropriate discharge?

Research published in September 2020 by Yorkshire Quality & Safety Research Group[3] describes the risks of the first few weeks back at home with ongoing care needs:

- *One in five patients experiences an adverse event during this transition, 62% of which could be prevented or minimised.*
- *13.8% of patients are readmitted to hospital within 30 days of discharge.*
- *Although not all readmissions represent poor quality care, around 30% are considered avoidable and if we factor in the risks associated with being in hospital (e.g. post-hospital syndrome) this figure is likely to be much higher. Transitions are particularly risky for older adults who are more likely to have multiple comorbidities and complex health and/or social care needs.*

Where do PA's come into the figures?

All about care providers and not about PA's. Nothing is mentioned about the PA's. And about people providing care who are not paid?

When PA's get ill where's the back up? They do a lot and are underpaid for it.

The person that takes charge of the money becomes an employer and they might not want to be. They want to be a facilitator. They are left vulnerable with h&s and maternity.

Noting that care workers are paid at or just above minimum wage, if this is seen as a problem, could Direct Payments increase to allow better remuneration of Personal Assistants and training offers be improved to encourage retention?

PA's aren't within the scope of the home care transformation programme.

However, Mary Gardner, Strategic Commissioning Manager for Direct Payments, is leading the Direct Payments Improvement Programme and has provided the following information:

The aim of the Direct Payment Improvement programme is to review the approach to Direct Payments in Sheffield and create an improved offer for people of all ages who use care and support, by delivering a flexible approach and simplified way of working. It will ensure people have full choice and control over their support by enabling flexibility of use, simplifying our processes, improving information and support and building a thriving creative marketplace; including developing the PA workforce offer and money management offer. The programme fully involves people who use Direct Payments in its design and decision making.

As part of the Direct Payment programme we are looking at how we support the PA workforce. We have a dedicated project looking at the role of PA and considering the wage offer. As a result of this on-going work we have been able to arrange an automatic increase for Direct Payments. From April 2021 people who employ PAs have been given a 5.66% increase in their Direct Payment. This is to pass on as a pay increase to their PAs

[3] https://yqsr.org/wp-content/uploads/2020/10/How-to-promote-safety-during-transitions-in-care-Guide-for-CCGs-and-NHS-Trusts-1.pdf

meaning PAs who were receiving a wage of 8.72 (the minimum wage) can now have an increase of up to 9.21, 30p above the new minimum wage.

If you have any questions about the Improvement Programme or Direct Payments more generally, Mary can be contacted at mary.gardner@sheffield.gov.uk.

2. Based on your own experience, do you feel the new model will support people to live the lives that matter to them?

Proof is in the testing of the model
Employing your own PAs good flexibility but sometimes difficult to recruit and manage, this new approach could lead to similar support
New way of thinking about care so it fits with what people want out of their lives
There are some providers that are already doing fantastic jobs, and we wouldn't want to lose this.
System needs to be more flexible, so it works for the needs of the person not the needs of the system.
Need for change in culture and providers being responsive to feedback
Improved communication between different organisations and person receiving care leading to less breakdown.
Not enough detail about the model, too broad to visualise. Seems to address the important issues, but not enough to know yet
Unless people who receive the care are part of the decision making the implementation won't work. It it's co-design, the people who are being asked now should continue to be part of the development.
Needs to be more input from experts with experience.
Better involvement of carers who should / could feel more valued and a part of supporting someone
The elephant in this room is the whole social care funding model which distorts provision according to need. Not an attack - we can only do what we can do.
First time I've been excited for the future. It's absolutely about the carers. My heart goes out to them – eating dinner in their cars on the way to the next call.
Really good to test – like the approach you've described.
Brilliant idea re the Transformation Network – seems so disjointed at present.
The model would definitely be an improvement in people's lives – more of a say and if care workers more supported, then the client is better supported at the end of the day.

3. Is there anything else we should consider?

Move away from time and task - sometimes tasks can take much longer than on care plan. Needs to be huge shift in mindset of people who assess and make decisions, not just front line that needs tweaking.

Agreed. Moving away from 'time and task' is a significant change in both culture and practice. We recognise that we can't just make changes to one element and expect everything to magically become outcome-focussed, it needs a 'whole-systems' approach.

We have colleagues from our social work teams in the Programme Team and have recently started a 'transformation network' bringing together colleagues from adult social care and independent sector providers, to work on finding collective solutions and support the transformation work. There is clearly lots of work to do, but we hope we have established a constructive starting point.

How is quality going to be checked? People who are receiving the service need to have a direct input

To achieve the outcomes as required by the person receiving care a greater degree of checking on the quality of actual care delivery, whereas at present, the main focus is on record keeping. While record keeping is important, it may not match the actual care being delivered. The opportunities to deliver bad quality really need to be at least minimised and where possible removed.

The detail of quality assurance and monitoring isn't in place at this fairly early stage, but we absolutely agree with the principle of people in receipt of care having direct input. This is important both in terms of developing the new model through the 'controlled implementation', and in terms of quality assurance.

The number of complaints will be much larger than known about – not everyone makes a complaint, even when they're not happy with the care they receive.

Perhaps the difficulties people face when they are complaining leads to the frustration that prompts violence and abuse shown to carers. I wonder if investigations into abuse events might show this.

It's a fair point about the volume of complaints, we'd agree. Even taking this into account, we think that there are consistent themes in relation to the concerns regarding home care at present, which help to shape the areas for change as we move forward.

With regards to harassment and abuse of care workers, it is important to strongly emphasise that, as with any other worker, home care staff have the absolute right to work without being subjected to such incidents.

However, it is also a reasonable conclusion that any such issues that may arise out of frustration should be reduced if the correct foundations are in place to improve care and decrease quality issues.

Idea of increasing reviews; worry about care package being reduced. People try to reduce contact with social care due to anxiety about reviews.

One of the issues is unmet need - where the needs had either not been adequately assessed at the beginning of care or had changed during the delivery of care. Difficulty for care staff / providers in flagging unmet need and getting follow up in terms of increased support.

My experience of the annual review was that it was focused on justifying reducing the budget - not need.

We contacted the Service Manager's from the Localities social work teams regarding the above points and they have provided the following information:

The Care Act 2014 requires local authority Adult Social Care to adopt a preventative approach. This approach does not necessarily infer a reduction to the services that are being provided to meet an individual's needs but could mean that we may look, with the individual, at how their needs can be met by using a range of resources. For instance in addition to or in support of hands on care 'tools' that can assist in promoting independence, for example technology that may not have been available in the past that can now help to meet a persons need. Similarly, guidance from Physio and Occupational therapists can play a significant role in assisting an individual to live a fulfilling life without significant packages of care.

These specialist services can assist Adult Social Care professionals to look at how we can promote a person's independence, using less restrictive and intrusive methods and enabling that person to maintain dignity and self-worth. This could mean that if a person either no longer requires support or their needs can be met without formal support or in a less restrictive way this should be recognised as a good thing.

Is there any potential for place-based home teams which combine health and social care needs?

Neighbourhood based approach, good to be local but not forgetting about citywide specialist organisations.

Is there a way that Home Care can be managed by a micro locality model, this could save time traveling and build on community?

Council needs to factor in whether a care company has the staff and flexibility to react to the situation, coverage and location.

Choice - people should have a choice of provider.

The controlled implementation will involve working with a single provider in a geographical area. This provides a good opportunity to develop efficiencies and build links with the community and other services.

However we recognise that there are complexities. While having a number of providers operating in each area (as happens now) is less efficient, this does support stronger contingency arrangements and helps 'flow' i.e. people being able to be discharged from hospital and other services to a home care service in a timely way.

How can we make sure communication is simple, easy to understand plain English? I suggest you also use experts by experience within your engagement to develop the model and understand that one size does not fit all.

Adult Social Care uses terminology that excludes younger people, this need to be addressed.

This is a really important issue (and we recognise the irony of stating that in such a lengthy document but felt it important to be comprehensive in responding to feedback).

We want to work closely with experts-by-experience and other colleagues who can support us to get communication right for people, for example with ensuring terminology is inclusive. If there are any instances where this you feel this is the case in this document, please do let us know via chris.boyle@sheffield.gov.uk.

Can you work with the representatives from the Learning Disabilities Partnership Board to communicate and engage?

Some people with a learning disability that have their own unique ways of communication. What will you do to help these people?

Yes, we will definitely continue to work with the Board and to engage with the experts, for instance in terms of communication. We'll be following up the ways of doing this that were suggested when we met.

Cost of the service really important, finance a major concern for people.

We recognise this is really important to people on an individual basis, and at a wider level, effective use of resources is a key foundation of the programme and model. We are working with the Income & Payments Programme, which is developing plans for making improvement to both our mechanisms for paying providers and customers.

Suppliers of services offering apprenticeship (this used to happen).

Look at providing presentations on what a care workers job would be like for Y10/Y11 to engage with schools early on to help young people decide on a career choice.

There are some exciting developments focussed upon workforce development, which are broader and led outside of the Programme, but that we'll be closely linked to, and are supportive of our aims. These include designing a training programme for people who are interested in a job/career in social care but haven't got experience and are linked in to the 'Care Sector Routeway' national initiative. The aims of the workforce development programme include:

- *a programme recognised across Sheffield building towards a 'Sheffield Standard'*
- *building capacity / skills across the city*
- *work with people / providers to identify and offer work shadowing opportunities after they have completed the initial training*
- *help providers to identify people coming through the programme that they would want to employ themselves*

You need to be aware of the different scales and scope of carers, it's not just one group. For example, parent carers, young carers, adult carers that all have home care packages. You need to have a broader idea of what the issues are before you can review. Young carers identification is also important, is there a need for training around carers and parent's needs? *Another issue is inadequate financial support for family Carers. This impacts on the overall quality of provision for home support, as, with the best will in the world, it damages partnership working.*
With regards to the variety of circumstances of those with caring responsibilities, this is an absolutely valid point, requiring further work, listening and discussion. In the same way that the care and support that is provided needs to be personalised to the individual, similarly the interaction, support to, and communication with, carers needs to be sensitive and responsive to their particular circumstances. We agree with the point about financial support to family carers. A direct impact upon home care provision is perhaps hard to establish, but it undoubtedly makes the circumstances many carers face more challenging, and a number of people working in care in a professional capacity will also have caring responsibilities in their personal lives. The following context provided by Pauline Kimantas from the Carers Centre is useful: *It is the case that carers are more likely to experience financial hardship / poverty, especially if they've been caring for many years and/or have given up paid employment to provide care. This is due to the very low level of 'replacement income' welfare benefits (i.e. Carers Allowance for working age carers) and the additional costs of disability. It's an issue that's been campaigned on for many years at national level, and Sheffield Carers Centre supported the recent campaign to try and get the government to increase Carers Allowance by £20 per week in line with the increase in Universal Credit due to the pandemic.* *Citizens Advice Sheffield are one of our contract delivery partners and provide excellent welfare rights and debt advice and support for carers, so we ensure as far as possible that carers' incomes are maximised. Nevertheless, the financial situation for too many family carers remains very difficult and changes to welfare benefits are really needed.*