HEALTH AND SOCIAL CARE SCRUTINY COMMITTEE

SELECT COMMITTEE REVIEW OF CARE AT HOME

December 2015

Report, together with formal minutes, oral and written evidence
HEALTH AND SOCIAL CARE SCRUTINY COMMITTEE

The Health and Social Care Scrutiny Committee is appointed by Cornwall Council. Its Terms of Reference are set out in the Scrutiny Procedure Rules within the Council's Constitution:


Health and Social Care Scrutiny Committee Membership

Chairman - Cllr Mike Eathorne - Gibbons (Independent)
Vice Chairman - Cllr David Parsons (Liberal Democrat)

Cllr Neil Burden (Independent)
Cllr Lisa Gorman (Conservative)
Cllr Pat Harvey (Independent)
Cllr Sue James (Liberal Democrat)
Cllr Phil Martin (Independent)
Cllr Sue Nicholas (Conservative)
Cllr Rob Rotchell (Liberal Democrat)
Cllr Hanna Toms (Labour)

Care At Home Select Committee Membership

Cllr Mike Eathorne - Gibbons (Independent)
Cllr Phil Martin (Independent)
Cllr Sue Nicholas (Conservative)
Cllr David Parsons (Liberal Democrat)
Cllr Rob Rotchell (Liberal Democrat)
Cllr Hanna Toms (Labour)

Powers

The Committee is one of two Scrutiny Committees established by Cornwall Council, the powers of which are set out in the Scrutiny Procedure Rules within the Council's Constitution.

Scrutiny Staff

The scrutiny staff supporting the select committee review were Leanne Martin (Democratic and Governance Officer) and Vickie Hacking (Democratic and Governance Officer).

Contacts

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<table>
<thead>
<tr>
<th>CONTENTS</th>
<th>PAGE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>4</td>
</tr>
<tr>
<td>The Process</td>
<td>6</td>
</tr>
<tr>
<td>Recommendations and Observations</td>
<td>7</td>
</tr>
<tr>
<td>Terms of Reference of the Review</td>
<td>15</td>
</tr>
<tr>
<td>Formal Minutes</td>
<td>17</td>
</tr>
<tr>
<td>Witnesses</td>
<td>59</td>
</tr>
<tr>
<td>List of printed written evidence</td>
<td>60</td>
</tr>
</tbody>
</table>
Executive Summary

The scope of the select committee was to seek to answer two questions:-

- Will the steps being taken in terms of pricing and a spine provider be sufficient to support and enhance private sector care at home provision?
- Will this lessen the impact on community or hospital settings, and improve outcomes for care users?

For clarification, the spine provider is a service set up by Cormac in autumn 2015 and is named COR Care. This was established to cover a shortfall in the system.

The timing of the panel, only one month into the operation of the spine provider, meant that it was difficult to establish if there would be an enhancement in provision over a sustained period.

Evidence from the witnesses did present that the provider landscape was wary of the creation of COR Care and the impact it would have. There was however, recognition of the need for a service to act as a safety net.

The increase in pricing rate had made a difference and it was evident from the providers that this had enabled them to maintain their contracts and activity. However, due to the financial situation of commissioners, increased pricing on a cyclical basis could not be guaranteed and the market would have to consider this in their forecast modelling. There was increasing demand and financial pressure on all aspects of social care. There has to be the consideration of a levy of a social care precept which would be needed across all areas.

It was demonstrated that there was frustration by providers regarding back office functions and the resolution of these would enhance the ongoing relationship.

The creation of the framework had not established the landscape it had intended. The use of personal budgets and mistrust following the abortive initial procurement process was detrimental to its development. It has to be addressed in future commissioning of Care at Home services and within the health and social care integration plans.

The panel was unable to directly establish if the work undertaken thus far would improve outcomes for those in receipt of care at home; or in itself relieve winter pressures. The stabilisation of the Care at Home market is integral to system resilience and there is a need to address the recruitment and retention of staff in this field urgently.

The evidence gathering, including the witness days for the Select Committee, was undertaken in November and December 2015. Subsequently there has been a change in governance within Cornwall Council. This resulted in the cessation of the Health and Social Care Scrutiny Committee which initiated the review. Therefore, this report shall
be considered by the newly formed Health and Social Care Overview and Scrutiny Committee.

This Select Committee was undertaken prior to the decision of Cornwall Council to levy the Adult Care precept with Council Tax. This will begin in April 2016.

The Panel would like to take the opportunity to thank all witnesses for their attendance and evidence. Additionally thanks are expressed to all members of the public who attended the sessions.

This report was agreed as final by the Health and Adult Social Care Overview and Scrutiny Committee on 5 April 2016
The Process

At the time of the review the Health and Social Care Scrutiny Committee had a responsibility to scrutinise the delivery of health and social care in Cornwall. The committee received a request from the Portfolio Holder for Adult Care to scrutinise the area of Care at Home. This request highlighted areas of concern regarding the commissioning and provision of Care at Home services. It had been necessary for Cornwall Council to increase the payments to LOT 1 Providers on the Care Framework and there was a risk that packages of care could be ended. Additionally a spine provider, COR Care, was created in order to provide care packages for those difficult to place. Following consideration of this context it was recommended that a select committee be undertaken.

The select committee intended to seek answers to two questions –

- Will the steps being taken in terms of pricing and a spine provider be sufficient to support and enhance private sector care at home provision?

- Will this lessen the impact on community or hospital settings, and improve outcomes for care users?

And the scoping questions were defined as follows –

- Will the changes underway in the care at home framework place us in a better position to cope with the demand of winter pressures?

- Have lessons been learnt in order to inform future commissioning plans?

It is important that the recommendations are fully considered and implemented by the relevant organisations in order for Care at Home services to be provided in a coordinated and cohesive manner.
Observations, Conclusions and Recommendations

The Committee has listed its recommendations and then its observations with brief explanatory text underneath of their rationale.

Recommendations

1. Patients and families should receive clear and accurate information in hospital settings about onward care options and this should be received in a timely manner. NHS Kernow and Cornwall Council should ensure this takes place.

2. An approach and offer to staff for training and appropriate career pathways, subsidised by all areas of the sector including the NHS should be developed quickly, and existing Care at Home staff should be involved in this.

3. Cornwall Council should immediately address concerns regarding invoicing and payment times.

4. Cornwall Council should ensure that the views of those in receipt of care and their families are included in any future procurement process for Care at Home.

5. There needs to be clear evidence of continuing engagement between all providers (including COR Care) and commissioners. With greater integration and co-commissioning of services likely in the future it is vital that the lessons learnt from the framework procurement and implementation are not lost.

6. A future report(s) be received to include –
   i. Consideration of the prescription regime for patients in receipt of onward care
   ii. Potential development of a trusted assessor
   iii. The impact on current providers by the development and implementation of COR Care
   iv. The impact of the rise in hourly rate, to include information from providers
   v. Specific information demonstrating the impact on winter pressures of both the increase in funding and the creation of the spine provider
   vi. Information regarding the discussion at the Employment and Skills Board referenced by Unison
   vii. If levied, the use of the Adult Care precept and how the spend is agreed.
General Observations

The panel was grateful for the time and evidence provided by all witnesses.

There were many areas brought up in the discussion, some of which fell beyond the terms of reference for the panel. All questions and answers have been included in the minutes of the evidence gathering days that are appended to this report.

Furthermore whilst many salient points were made by all witnesses it has been difficult for the panel to establish direct impacts in all areas of finding. This includes being unable to establish a direct correlation from the evidence provided to the direct market impact of the spine provider, COR Care.

The panel considered that the evidence provided by officers from the Commissioners on the evidence days was adequate; however it was not presented in a succinct or fluid manner. This was a cause of frustration.

Thematic Observations and Conclusions

Impact on system resilience

It was too early to see the impact on winter pressures of the changes of both the increase in funding and the creation of the spine provider. It was obvious that if these changes do not work then resilience in the system would lessen. The system has to have well developed and robust plans to reduce risk, of which COR Care will form part, but not all of the solution. The panel observed that there was no explanation of what would happen if a number of providers failed and what mitigation was in place.

The system operates at full capacity and the provision of care at home packages, along with other social care options, are a vital part of patient flow. It was apparent that this was recognised by all involved but that communication has to be improved. This includes the links between NHS providers and social care providers.

Patients and families should receive clear and accurate information in hospital settings about onward care options and this should be received in a timely manner. This might enable an increase in family caring or shorter stays.

The panel was interested to hear of the development of clinical pathways with onward care, such as that in orthopaedics described by Royal Cornwall Hospitals Trust. This is an area which might be able to be developed further.

Some suggestions within the evidence such as considering the prescription regime for patients in receipt of onward care, and that of a trusted assessor should be further explored.
From the evidence received the panel was not able to establish with absolute certainty that the framework system itself has impacted on delayed transfers of care. These delays could have happened using of a preferred supplier list. However, commissioning using the framework model had caused significant anger in the system and impacts on system resilience was somewhat inevitable.

**Patient Voice**

Concern was raised that the voice of the patient and their families was not being heard in the process. This concern was heightened that the report produced by Healthwatch Cornwall had not been initiated as a result of patient concern but at the behest of providers. It had appeared to the Panel that access to patient views was predominantly facilitated by the providers, and the panel felt that this was not appropriate. Healthwatch Cornwall however did clarify that they had received contacts independently including via their website and other methods following a press release. They acknowledged in their evidence that they had found it difficult to hear the voice of people in receipt of care and their families and the Panel believe this will need to be considered in the future. Healthwatch Cornwall was created to be an independent advocate and in this circumstance elements of this were questionable. In future there should be a patient led evidence base and this should be accepted by all parties in the system and used to inform future decision making.

There should be consideration of patient views during the procurement processes. It is recognised that this may not be easy as it is predominately a financial negotiation, however with the increasing numbers of people opting for personalised budgets the views of those in receipt of care need to be heard.

**LOT 2 Providers**

There was disparity in negotiation with LOT2 providers. The Panel recognised that there was a difference in the manner of provision of care, especially around travel and transport of employees, and the insinuation LOT2 providers did not have to consider this as much as other providers. However, those cared for by LOT2 are very vulnerable and relationships with carers were likely to be steadfastly developed. Changes in carers would have a dramatic impact and with the development in LOT1 there could be impact on staffing for LOT2.

Following the evidence of Care at Home providers it was observed that there had been disparity between engagement with LOT1 and LOT 2 providers. Whilst recognising the aforementioned differences in the care that is provided it is advised that negotiations and discussions with LOT2 providers are advanced in order for there to be a recognised level of parity. There should be cognisance that any changes to LOT1 would have an impact on LOT2 and to Non Framework providers.
Development of COR Care
Whilst there was no direct evidence that there had been a demonstrative negative impact on current providers by the development of COR Care, the system is worried and this needs to be noted. The panel meetings did however take place shortly after its initiation.

There was recognition as to why the entity had been created but the anxiety that COR Care might go beyond its initial remit was palpable. It was observed that providers believed COR Care may lead to further destabilisation of the market and impact on recruitment and retention. When Commissioners look at future procurement of care at home services, and at any possible development of COR Care, this needs careful consideration and transparent explanation.

Recruitment, Retention and Pay
Throughout all of the evidence received, the one area that was overwhelming was that of employee recruitment and retention. This was linked to both pay and career aspirations. It cannot be overstated the impact this is having on all providers, whomever they are. All Care at Home providers, NHS providers and COR Care are recruiting from the same pool of potential employees. This was unsustainable and was a finite resource.

Private providers were often placed at a disadvantage due to the pay rates that were able to be offered by statutory providers and by those purchasing their own care. The Care at Home providers likened their ability to provide rates of pay akin to those offered by supermarkets as detrimental to recruitment. The decision to want to work in health and social care seemed to be driven by a societal value rather than financial and this should not be relied upon. It must also be considered the largely part time employment contracts required by employees in the sector.

Evidence from Unison explained that the Employment and Skills Board were looking into the training needs of staff and what could be implemented to ensure there is career progression within the sector. This discussion should be followed closely by those in the system and implemented where possible.

This is a national dilemma and Cornwall needs to look beyond its boundaries to help find solutions. There is no quick fix for this problem and there has to be a concerted effort from all to improve the offer for possible careers in the sector.

An approach and offer to staff for training and the development of career pathways, subsidised by all areas of the sector including the NHS would be beneficial. This could include training within settings such as community hospitals.

It is recognised that the Government has provided the ability for the authority to increase council tax with a precept for social care. This precept has to be
considered to help bolster the care at home sector, however this is with recognition that although a major part of the system there are other draws on the social care budget that also needed to be addressed. If the decision is taken to apply the precept it will need to be identified where these additional monies would be spent. Identification of this spend separately from the general budget would help in explaining to the providers and the public where the monies were directed and why.

**Unresolved mistrust**

The evidence given by some providers, and by commissioners, showed that there is still unresolved mistrust. Providers did not always appear to fully recognise the current financial constraints and pressures on local authorities and NHS commissioners and felt their own pressures were not recognised by them. There was a palpable level of hostility toward local authority officers and to some this was as a result of association to previous management structures.

The intervention by the Portfolio Holder for Adult Care appeared to be useful and welcome. However, it did not appear to have provided a forum for constructing effective partnership working but had certainly aided the airing of views. The picture painted by commissioners was that relations had improved and that all issues were being or had been addressed. This was at odds with other evidence received. Local authority witnesses appeared defensive and this would not help effective communication and discussion.

Commitment to improving relations was apparent from the commissioners but this felt linked to the concerns of the current volume and lack of resilience in the system and not to the ongoing issues being brought to the fore.

There has to be progression for all involved in relation to this. The system will not function effectively whilst it is operating in a hostile environment.

From the evidence of NHS providers it appeared that there were situations where families felt their relatives should remain in a hospital setting as they were unsure or had a lack of trust in social care options. This mistrust also requires addressing if progress is to be made. It is crucial for patients to trust the whole system to provide them with the best care.

**Integration, new models of care and care providers**

It was observed from witness evidence that there was a lack of forethought about how care at home services will be considered in the ongoing integration of health and social care. This lack of evidence caused significant concern for the select committee, and adds to the angst expressed by the providers. The lessons learnt so far should not be lost in the integration discussions and key links to providers and those on the ground such as between carers and district nurses need to be protected.
Currently there are differences in processes between the main commissioners. If services are to be commissioned from NHS Kernow this needs to be fully examined and planned although NHS Kernow implied they did not envisage a change from traditional spot purchasing and Cornwall Council seemed intent on continuing with a framework system.

There is unlikely to be any new money coming into the system and if a Council Tax precept is enabled, it is likely to be spread across all adult social care requirements.

Providers may need to acknowledge they might have to change their business models as changes take place in the future, especially if additional funding is not available. It needs to be considered that a reduction in providers might be needed in order to enhance the profitable economies of scale.

**Back office support**
Providers had a number of concerns regarding back office support for the framework within the local authority. Frustrations were evident regarding the speed of payment, processing of invoices and specified points of contact. In the short term this could begin to be alleviated by addressing concerns about invoicing and payment times.

Additional evidence received from Cornwall Council financial services provided information about how this is beginning to occur and this was welcomed but needs to continue. There has to be constructive and ongoing dialogue with providers about how that is progressed.

A single point of contact within Education, Health and Social Care for providers might be useful, but the limitations of this role would also have to be recognised.

Longer term there will need to be plans to address issues on both sides, with an agreed understanding of support and processes.

Considering the larger anxieties these areas should be addressed as a priority.

**Ethical care charter**
It was disappointing that the only organisation who had been able to sign the Ethical Care Charter was COR Care. It was felt that this was only possible due to the unique way they were set up and operated.

The panel reflected that the Charter is an aspiration for many providers, however, it would be difficult to achieve with the current contracting arrangements.
If care providers were able to sign the Charter it might provide an incentive for people considering working in the care sector.

Facilitating re-procurement and commissioning
The current price increase was shown to be helping in the interim but from the evidence received the sustainability of the services was still in jeopardy. It appears that whilst the framework model was implemented with the best of intention, there was always an underlying tension over it being a cost based system. This is difficult to avoid in times of current financial constraints. The subsequent pressure on the framework means it has been unable to cope with the demands upon it. Framework providers could not meet the demand and the Council could not enforce the contractual framework.

This was compounded by the impact of direct payments. The Council had a government set target to increase the volume of people in receipt of direct payment and this inevitably was at odds with the framework resulting in a change in volume on which the financial modelling was based. There have been a number of other national changes such as new legislation which have altered the landscape since the framework was introduced.

A perceived lack of transparency in the modelling of the framework remains an issue and this has to be addressed in future commissioning planning. There has to be clear and open modelling and pricing; national bodies, such as United Kingdom Homecare Association (UKHCA), should be consulted as part of this. Comparison to any available good practice in this area of commissioning should be included.

Likewise there should be identification of the rates provided elsewhere in the south west and possibly other comparable local authority areas. Concerns, complaints and feedback from providers who are part of the framework, and those who were not successful have to be addressed in the future commissioning of Care at Home services and within the health and social care integration programme.

There are large national providers of services who do not appear to want to operate in Cornwall. It would be useful to discuss with them why this is the case, and how that information could help develop future plans. There needs to be a commitment for robust due diligence with sufficient financial and legal support for any new procurement process. Preventing the issues that occurred in the first procurement is paramount.

LOT 2 providers gave evidence regarding to a previous procurement with regards to learning disabilities which seemed highly regarded by the market.
This should be examined to see what could be taken from this process in order to inform any future procurement. Providers should be able to provide examples of what they considered good practice.
## Terms of Reference of the Review

<table>
<thead>
<tr>
<th>Subject Name</th>
<th>Care at Home Select Committee</th>
</tr>
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| **Purpose, Question and Key Objectives** | Will the steps being taken in terms of pricing and a spine provider be sufficient to support and enhance private sector care at home provision?  
Will this lessen the impact on community or hospital settings, and improve outcomes for care users? |
| **Scope of the work** | Will the changes underway in the care at home framework place us in a better position to cope with the demand of winter pressures?  
Have lessons been learnt in order to inform future commissioning plans |
| **Not included in the scope** | Care and Nursing Home Placements and packages  
Support funded by other organisations |
| **Nature of Review (Select Committee or Inquiry Day)** | Select Committee process over 1 or 2 days |
| **Status of paperwork, i.e., is it ‘exempt, not for publication’ or can it be made public on request?** | Public unless subject to Access to Information Procedure Rules.  
**Note:** It may be necessary to add an item to each agenda regarding the status of paperwork relating to that meeting |
| **Divisions affected** | All |
| **Division Members** | All |
| **Resource requirements** | **Staff time (days)** | **Budget (£)** |
| | TBC | From within existing budgets |
| **Additional Resource Implications** | ☑ Financial  
☒ Legal  
☐ Equality and Diversity  
☐ Personnel/Trade Unions |
| Impact on vulnerable Groups | Is the work to be carried out by the group likely to have a positive or negative impact on any groups in the community? Consider the following groups
- People with disabilities
- The elderly or young people
- Men or women (gender specific)
- Gay men or lesbians
- Religion, belief or faith, or no faith
- Race
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity

If there is any impact, you should consider involving someone from the group(s)** |

| Background | Select Committee requested by Cllr Jim McKenna. |
CORNWALL COUNCIL

HEALTH AND SOCIAL CARE SCRUTINY COMMITTEE

MINUTES of a Meeting of the Health and Social Care Scrutiny Committee held in the Trelawny Room, Cornwall Council, County Hall, Truro TR1 3AY on Friday 27 November 2015 commencing at Time Not Specified.

Present: - Councillors: Eathorne-Gibbons (Chairman)
Parsons (Vice-Chairman)
P Martin, Rotchell and H Toms.

Apologies for absence:
Councillors: Burden, Gorman, Harvey, James and Nicholas.

DECLARATIONS OF INTEREST
(Agenda No. 1)
There were no declarations of interest.

SCRUTINY REVIEW OF CARE AT HOME
(Agenda No. 2)

HSC/14
10.00 - PORTFOLIO HOLDER FOR ADULT CARE
(Agenda No. 3)

By way of introduction, could you provide us with your name and details of your connection with the Care at home sector.

My name is Councillor Jim McKenna and I am the Portfolio Holder with responsibility for Adult Social Care.

Will the steps being taken in terms of pricing and a spine provider be sufficient to support and enhance private sector Care at Home provision?

The steps currently being taken were sufficient to support and stabilise the market. Prior to action being taken, Lot One Providers had indicated that they would withdraw from the Framework; however they were now working with the Council and have not withdrawn from providing care provision.

There is further work is required and there is a meeting planned with the Lot Two Providers to address the concerns they have raised in relation to the Framework.
**How do you think the system would cope with winter pressures?**

There is still an issue with patient flow. There is an increasing number of people presenting at the Royal Cornwall Hospital Trust and leaving the hospital without a suitable care package in place. If the levels of demand are as predicted then the system should be able to cope, however the system is not robust enough to address all of the issues.

The respective parties are now all working together in a more collaborative way, which is positive, and we are working on addressing the number of instances where RCHT is on black alert. Putting in place the relevant Care at Home packages will be one of the contributing factors to reducing the number of black alerts.

**What has been the impact on care users, how do we know that outcomes will improve for care users and how is the voice of the person in receipt of care (and their families) heard?**

Six to Nine Months ago, I received a lot of contact from Members and families in relation to issues being experienced with Care at Home packages. In response, I set up a Carers Forum that is designed to tease out the issues experienced by both sides and I am working closely with Health Watch as they represent the patience’s voice, to gain an understanding of the issues. There has also been an appointment made to the Head of Service (Adult Care and Support) role and these two factors combined have resulted in fewer direct complaints received.

**What is the biggest lesson that has been learnt from this process and/or what would be done differently if a similar process were to be undertaken in the future?**

Lessons have been learnt, the Framework and Contract were awarded prior to me taking up my role as Portfolio Holder. As part of the contract award there were assumptions made in relation to the hourly rate of pay to be paid to Providers and due to the issues faced following the awarding of the Framework there is now a greater understanding of what is required prior to any contracts being awarded. Two of the main learning points were that you have to work with the Providers prior to the contract specification being devised to gain an understanding of the market and sufficient resource needs to be assigned to the process. There also needs to be an understanding that the procurement of care provision is not a short-term way to achieve budget savings.

**In respect of Care at Home services, what will lessen the impact on community or hospital settings, and improve outcomes for care users?**

There needs to be sufficient staff available to fulfil the care package requirements and this is not the current situation. However, the Council has taken steps to enhance resource with the formation of the Spine Provider and this provision has been for a month.

To maintain and enhance capacity the staff currently working in the sector need to remain motivated and two steps Council has taken to support this includes
only commissioning visits that are a minimum of 30 minutes in length visits and it has implemented the living wage. There are also plans in place to provide career pathways and opportunities for carers.

**Have you any evidence to demonstrate that staff morale has improved?**

The development of the career pathways will take time. Cornwall Care staff are earning more money so the morale amongst the staff is improving and there is some evidence that staff retention is improving. The recruitment and retention of staff over future months will provide evidence of the level of morale within the workforce.

**Do you see that the implementation of the living wage will present difficulties to the providers?**

There is recognition by the Council that they need to address the issues that are being experienced in relation to the Care at Home contract and the Council will continue to work with Providers to ensure care can be delivered. There has been a recent Government announcement in relation to Councils’ being able to levy a 2% precept for adult social care provision and the Council could decide to introduce the precept and this will provide additional money to assist in meeting the growing demand for Care at Home provision.

**How will the Council fund any overspend in this area, how will it impact on other services and what has the impact been of the additional £4.5m?**

The current demand is outstripping the capacity in service provision. The ideal situation would be to receive additional grant funding. All opportunities need to be sought regarding delivering the care provision in the most efficient way. The current way care is provided to support people with learning disabilities and physical disabilities needs reviewing to ensure it is being delivered in the most efficient way. Additional funding is required to ensure that Care at Home provision can be provided at an acceptable standard.

The issue is wider than the care sector and opportunities need to be sought in other areas, for example when housing developments are proposed consideration should be given to providing supported housing within the development, which would allow people to live independently in the community for as long as possible.

**There are several pressures on the Adult Care Budget, how assured are you that the budget is adequate?**

I have concerns regarding the saving target that has been set for the next two years and the impact of failing to achieve the savings could have on other services. There has been a target of £12 million for 2016/17, which is dependent on the integration proposals and there are ongoing discussions with regard to what savings can be achieved. There is concern that if the integration does not achieve the forecast savings there will be a huge shortfall in the budget and this will impact on other service budgets.
There has been a change in leadership and key posts have been recruited to, therefore I have more reassurance that the budget will be managed appropriately.

*Is there confidence that future issues will be resolved?*

The working relationship between providers and the Council have improved, in the past there was reluctance amongst Council officers to work with the providers, however the culture is changing and partners are recognising the benefits of working together.

£20 million pounds could be put into service but this would not solve all the issues and there would still be gaps, there needs to be changes in the way we work. If I feel that there is a need for extra funding, I will put the case forward and ask for it and this was evidenced by the recent request that received support from the Policy Advisory Committee and Cabinet to use of £5 million from reserves to support the service.

*You raised a point earlier in relation to shelter housing and assisted living accommodation, is this going back what happened in the past?*

Currently there is an absence of this type of accommodation within the community including the absence of suitable housing for people with learning and physical disabilities. Care packages can be provided for these individuals, however if the property they are living in is unsuitable then they will not be able to continue living independently and will have no other option than to move into provision such as a care home.

*How do you envisage suitable housing being provided in the community?*

Local Members need to work with and lobby the Planning Service, for example, there is currently a development proposed on the former St Clare site in Penzance and I have been working with the Planning Service to negotiate the provision of supportive living accommodation on the proposed application site.

*Is there anything that you would like to add by way of summary?*

I have a question for the Committee, that I request you put to Senior Officers as part of this process, ‘When the tender process was undertaken for the Lot One and Lot Two Providers, why was the hourly rate in the contracts agreed at that level and why were no concerns raised regarding impact from the reduction in the rate?’

10.35 - LOT 1 PROVIDER REPRESENTATIVES

(Agenda No. 4)

*By way of introduction could you provide us with your name and details of your connection with Care at Home provision?*

I am Ian Williams the Project Director for Cornwall Care and I am Kevin Taylor McKale from Taylors of Grampound. Following a vote taken by Lot One
Providers, we have been chosen to attend the Select Committee to represent their views.

*Will the steps being taken in terms of pricing and a Spine Provider be sufficient to support and enhance private sector care at home provision?*

There is a consensus among the providers that the steps being taken will not address the issues. The ideas are good in principle but the care sector works with incredible low margins and the reduced rate of paid has had an impact on the ability of providers to recruit and retain staff. The hourly rate does not allow us to provide an attractive rate to pay to attract individuals to join the sector and we are working in a highly competitive jobs market where the large retailers can offer a higher rate of pay for roles that carry less responsibility than those in the care sector.

The introduction of the Spine Provider is good in principle as it allows the Council to commission care provision when other Providers do not have the capacity to provide a package. However, from the Provider’s perception the Spine Provider will be able to offer higher rates of pay to its employees. Which in turn will have a negative impact on other providers who cannot offer the same rates of pay and could result in their staff leaving to work with the Spine Provider, further reducing the capacity of Providers in the market and this could lead to the Spine Provider being required to take on more care packages. Providers have expressed concern that over time the Spine Provider will become the main care provider in Cornwall.

*You bid at a rate that you had established, what has subsequently changed in order for the system to not work effectively?*

The providers submitted a bid based upon the paperwork supplied as part of the tender documentation and the information supplied at the pre-tender meetings and this rate was £14.50.

Within the documentation, there were details in relation to volume of cases that the Framework Providers would be working with and it was reported that this information was based upon the 2012 market.

The Providers based their hourly rates in the tender bids on this volume information and believed that they would be entering into a partnership with Cornwall Council. In reality, there was no working relationship with the Council and the volume of care packages was not as outlined at the tender stage due to the approach that the Council took regarding direct payments. The Council promoted the option for care to be purchased directly rather than opting to go through the Councils Framework. This approach has led to Non-Framework Providers receiving £16 per hour and left the Framework Providers in an impossible position receiving a lower rate. In addition there has been an increase in the minimum wage, it has become more difficult to recruit and retain staff, the Care Quality Commission requirements are increasing, there are additional administration costs that are associated with being a member of the Framework such as meeting data protection legislation and collecting the data required to meet the Key Performance Indicators. All these factors have had an impact on the Care sector, however being tied into the Framework has had an unforeseen
impact on the Framework Providers, and the Council has taken far too long to respond to the issues raised by the Providers.

In the tendering process, details were requested regarding the financial modelling that the Council had undertaken to arrive at the £14.50 per hour rate. However, details of the modelling were not provided and were not seen by the Providers until the current Portfolio Holder became involved in the situation.

*How do you think the system will cope with winter pressures?*

Until the providers can recruit and retain enough staff within their organisations there is not going to be the required capacity to prevent gridlock within the system. The uplift in the hourly rate provided by the Council to Framework Providers has assisted in establishing the situation but staff recruitment and retention remains an issue.

*What impact will the requirement to pay the living wage have on Providers?*

If Framework Providers receive additional funding from the Council then there will be no issues in implementing the living wage, however if there is no uplift provided this will place a further burden on providers and they will struggle to meet their obligations.

*What is the level of staff retention and recruitment, and what is being done regarding workforce?*

We can all work together and brainstorm incentives and initiatives to recruit staff; however the issue is not related to the lack of innovation. It is about getting the required traction, working through the issues, and seeing them through to the end. There needs to be a plan put in place and some tangible outcomes achieved to put in place genuine career opportunities. The human cost of not being able to recruit and retain staff is colossal and affects those who need care, their families, and the carers.

*Currently it is believed that relatives deliver 80% of Care at Home, if this reduces what would the impact be?*

Cornwall has a higher proportion of elderly people than other areas of the country and the increasing number of people requiring care puts additional pressure on the community. The situation is further exasperated by the introduction of direct payments in that this gives individuals and families the right to choose their carer and could impact on the quality of care delivered and the number of packages available for the Framework Providers.

*How do you see the sustainability and modernisation of care at home services?*

If you are serious about addressing the issues, a full-scale regime of change is required and this may be achieved through devolution. However, the Providers need to provide, the Commissioners need to commission and the Regulators need to regulate.
The Providers currently feel that the officers commissioning the services do not have an understanding of the market. There needs to be a closer working relationship fostered and issues have to be addressed.

**What do you want the Council to do?**

The Council needs to engage with Providers at every stage as there is currently the feeling that decisions are being made without the views of Providers being taken into account and the Council needs to address this issue. In addition, there is a fundamental problem with the Council’s payment system and this is also impacting on the Providers.

**What is the biggest lesson you have learnt from the process?**

The biggest lesson learnt is that there needs to be clearer engagement between all the parties and information needs to be shared. The Council held a number of meetings with Providers who were considering tendering. At these meetings the Council presented details to suggest that following the implementation of the Framework, only the Providers who successful tendered would be offered new work through the Council. The Council also expressed a wish to work with a limited number of Providers and the notion of subcontracting by successful Providers to non-successful Providers would be positively encouraged on the basis of this information many Providers made the decision to submit their tenders.

However, this has not been the case and has caused mistrust between the Providers and the Council, and it has taken a long time for the Council to respond and take steps to resolve the issues. Time needs to be taken to ensure that all the issues are resolved and all parties need to have a true dialog and actively work together.

**What are the experiences of the discharge process in relation to Care at Home packages?**

There is a lack of timely communication between all parties. This has a direct impact on the discharge process as this reduces the time available to commission a suitable care package.

There is also an issue with the purchase order system, the purchase orders are not being issued in a timely and accurate way, which is causing a lot of additional work and they are not receiving a timely and correct payment. This means that resource is diverted from providing the care packages.

**How can communication between the parties be improved?**

The CPIC Members have tried to move forward by introducing a care passport that will provide better information about an individual and will be available to the relevant parties.

The communication issues experienced are mainly related to the processes that are in place and there is not sufficient resource in place to implement procedural
changes. The issue could be mitigated with the introduction of joint commissioning arrangements.

Is there anything you would like to add by way of summary?

In the short term the Council needs to make a decision regarding the uncoupling the CMT200 system from the system used for paying carers. The current system is very resource intensive and means time is detracted from providing care. There is a genuine feeling among Providers that they have been used to pilot the system and where mislead about the capability and ease of use of the software. By uncoupling the system, it would allow more time to focus on the recruitment and retention of staff.

In the longer term there needs to be a regime and culture change where the ethos is centred on working together.

11.20 - LOT 2 PROVIDER REPRESENTATIVES
(Agenda No. 5)

By way of introduction, could you provide us with your name and details of your connection with Care at Home provision?

I am Lyn Toman, the Area director for the Brandon Trust, and I am Tim Jones from United Response, and we are representing the views of the Lot 2 Providers.

Can you outline the difference between the Lot 1 and Lot 2 Providers?

We provide high levels of support for people with very complex needs. A lot of the support is provided in an individual’s home on a ratio of 2-1 or 1-1 and can be in place for substantial periods of a person’s life.

The support provided is more intensive than Lot 1 packages and the aim is to try to allow people to stay within their communities for as long as possible. However, this is not always possible due to the lack of suitable housing available in the county. Lot Two Providers supply support that is more intensive over a longer period for a smaller number of people.

Will the steps being taken in terms of pricing and the introduction of the Spine Provider be sufficient to support and enhance Care at Home provision?

It is difficult for us to comment, as we have not yet moved onto the higher hourly rate and in terms of the overall strategy, we have not had the opportunity to provide any input.

The Spine Provider does not provide the same packages of care as the Lot Two Providers, therefore there is minimal impact, however concern has been raised regarding the recruitment and retention of staff. Based upon the current hourly rate paid by the Council of £13.49 an hour we are unable to attract staff to work for the Providers. The national minimum wage is set at £7.20, however to recruit and retain the staff we pay a rate at £7.82 the difference is currently being funded through company reserves and this position cannot be sustained.
What is the difference since the introduction of the Framework?

Lot 1 Care providers travel from the respective homes of people they care for, and can see several individuals in a day, therefore they are transient in nature, which makes the packages more expensive.

When we entered into the Framework, it was based on the assumption that there would be a lot of growth as there would be fewer Providers able to apply for the packages.

The first tender process impacted on the subsequent tender process because the second process became more competitive and was based on the benchmarking from the first tender process.

Could you elaborate further on the comment you made in relation to the assumptions made about growth?

Prior to the Framework being introduced the Council commissioned care packages from several Providers and the Council indicated that when the Framework was implemented care packages would be commissioned through the Framework Providers. The number of Providers would be reduced in number, therefore the assumption was made that there would be a growth in the number of packages available for the Framework Providers.

In reality this was not the case due to the introduction and promotion of direct payments, which enables families to commission the care required directly, therefore they can opt to have their care package provided by Non-Framework Providers, meaning forecast growth in the number of packages available for the Framework Providers did not materialise.

What did you believe would happen after the contract had been awarded and what has been done to date to address any issues that arose?

There is a meeting scheduled to discuss the issues being raised by the Lot 2 Framework Providers and it is hoped that this will be the start of issues being addressed.

The issues that are being experienced relate to direct payments, although we fully support the principal of direct payments because this gives the individual some autonomy over their care and negates the requirement for their care Provider to tender every three years. The Lot 2 Providers are requesting more equality, the other issue for the Council to resolve relates to the payment of the direct payments to the individuals as some of them have been waiting over 12 months for payment to receive their payment.

Other issues relate to the mobilisation of the top five Framework Providers and the recruitment and retention of staff.

In the evidence presented by the Lot 1 Providers, they advised that they have collated evidence to support their request for an increase in the hourly rate paid by the Council. Do you have the same evidence to support your case?
Yes. The UK Care at Home modelling is slightly different for the Lot 2 Providers, however we are in the process of compiling the relevant information, and these details combined with the details from the CCG will support our case.

Concern has been expressed that the issues raised regarding the Lot 2 Providers will be overshadowed by the devolution and integration agenda and there is a debate as to whether Lot 2 Providers sit in the health function or was the responsibility of the Council.

*How do you see the sustainability and modernisation of Care at Home services?*

There is support required to stabilise the services and this is centred on the hourly rate paid by the Council because the current position is not sustainable and it is reaching a critical point. There is not equity between the rates paid to the Lot 1 and Lot 2 Providers and there is an issue regarding the equity between the Framework and Non-Framework Providers.

To resolve some of the issues better communication is required between all parties and there needs to be improvements in the ways all parties work together. In 2006, the tender process for care provision involved the families of people who required care, this has not been the case for the last two tenders, and there is a perception that paper and bureaucracy drove these tenders.

There is an acknowledgement that there are budget pressures and a national debate is required about care and support provision, but there are issues that can be resolved at a local level.

*What is the current turnover rate for staff?*

Up until the implementation of the Framework the turnover of staff was low, however now turnover has increase to approximately 30%. Staff that have worked for the organisation for a long time are now feeling undervalued, demoralised and are deciding to leave their roles and the rate of pay has a major impact on the recruitment and retention of staff.

*What is the biggest lesson that has been learnt from the process and/or what would you do differently if you were going through a similar process in the future?*

In hindsight, it would be better to fail to be accepted on the Framework.

Next time the Council enters into a tendering process of this nature they should look back at the process that was undertaken in 2006. This was a good experience, and involving parents and carers fostered effective partnership working.

The Lot 1 and Lot 2 procurement packages should to be treated and dealt with separately as they are different types of provision.

The procurement process was difficult to navigate through and following the failure of the first procurement, all parties were more sensitive on the second round of procurement. In addition, the recent restructure at the Council has...
caused confusion and complication for the Providers and people receiving care as there were new people to communicate with and this further impacted the culture and processes issues experienced.

As Providers, we want solutions and we would like some input into how the issues are resolved. An increase in the hourly rate paid by the Council would be a start.

12.05 - CORNWALL PARTNERS IN CARE
(Agenda No. 6)

By way of introduction, could you provide us with your name and details of your connection with Care at Home provision?

I am David Smith and I am Christine Rowbray, we are here to represent Cornwall Partners in Care, which is the trade association for the sector.

Will the steps being taken in terms of pricing and a spine provider be sufficient to support and enhance private sector Care at Home provision?

The initial guide price set out in the tender was too low and there is a sector wide issue regarding the recruitment and retention of staff, which is leading to capacity issues. The recent uplift in the hourly rate paid by the Council has helped stabilise the sector, as it has prevented Providers from going out of business, but there are wider issues that need to be addressed over the longer term.

The CPIC can understand the reason for the Council opting to set up the Spine Provider Provision however, it will be competing for the same staff and there are concerns that the Spine Provider will want to enter the direct payments market.

There is an issue with direct payments as they are currently paid at an hourly rate of £14.50 and this is not increased until the Council has reviewed the Providers and the process is currently taking up to a year.

How do you think the system will cope with winter pressures?

Cornwall Partners in Care have been engaging with the Council and NHS Kernow to look at ways of improving the process issues that are being experienced. There are various things that will improve the system, such as a retainer payment being made to Providers so that care packages can be maintained and do not need to be re-brokered following an individual’s stay in hospital. Providers could also assess their own packages rather than waiting for Council staff to undertake a full review, which would allow capacity to be released into the system, and in turn, would ease winter pressures. When a patient is in a position to be discharged from hospital, sometimes there is an issue with the information supplied by the hospital, which then impacts on the care package. By having a trusted assessor to evaluate the information and co-ordinate the equipment and support required, this could assist with the transition from hospital.

One of the other issues slowing the system down, although not directly related to the support package, relates to the prescribed medication. If the doctor
prescribes medication is to be taken three or four times a day, a more intensive care package is required, however if some regard is given to prescribing medication, the care package and the burden on the care providers can be reduced, freeing up more capacity in the system.

Better communication and co-ordination between all the organisations and the proposed integration of Health and Council services may help alleviate this issue.

What should the hourly rate paid to providers be and what evidence do you have to substantiate this rate? How does the hourly rate impact on the recruitment of staff?

The rate should be set at the UKHCA recommended rates. The sector is competing with other organisations such as retail and tourism. People who work within the care sector are paid the minimum wage, take on a lot of responsibility and work in a sector that has received a bad press. It is imperative that employers within the care sector offer a package of measures to make the role more attractive and this will assist with the recruitment and retention of staff.

Recently some providers have increased the starting hourly rate to attract people into the sector, this has been implemented for approximately four weeks, and there has been an increase in the number of applications received for advertised roles.

However to retain staff the profile of the care sector needs to be improved and there needs to be career pathways developed.

How do you see the sustainability and the modernisation of Care at Home services?

Since the introduction of the Framework agreement, the sector has taken a backward step. There was not enough input from the Providers in the sector at the pre-tender stage and the first procurement process created a lot of fragmentation within the sector.

Providers had requested details of the evidence that the Council had based their tender criteria on but the Council had not been forthcoming in providing the information.

Moving forward the Commissioners of Care at Home provision need to have more understanding of the pressures faced by Providers and there needs to be meaningful dialogue and true engagement between all partners.

What is the biggest lesson that you have learnt from the process and what would you do differently if you were to go through a similar process in the future?

In hindsight, we would not enter into the tender process, it was a costly process and unsettled staff and individuals. If we were to do it in the future the communication would need to be improved and there would need to be a greater openness.

Is there anything that you would like to add by way of summary?
There is a concern in the sector that the issues the providers have experienced with the Council, will be replicated again following the integration as there is not the confidence that lessons have been learnt.

**13.30 - NON FRAMEWORK PROVIDER REPRESENTATIVES**  
(Agenda No. 7)

*By way of introduction, could you provide us with your name and details of your connection with Care at Home provision?*

I am Tish Berriman and I am Mary Anson, we are representing the Non-Framework Providers.

*Will the steps being taken in terms of pricing and the introduction of the Spine Provider provision be sufficient to support and enhance private sector Care at Home provision?*

The increase in the national minimum wage will have an impact on the care sector as providers work to very tight margins and the increase in the hourly rate paid by the Council will not mitigate this.

There is currently some uncertainty about the rate that the Spine Provider will charge to deliver care packages and if they will be competing for care packages with the existing Providers.

One of the issues regarding being paid an hourly rate is that visits are generally ½ an hour long, in most cases, and the remainder of the time is taken up with travel, therefore the carer is not available for the full hour. In addition the employer has to pay national insurance, holiday pay, insurance, training costs and for staff uniforms. The hourly rate paid is not sufficient to cover all the costs.

The Spine Provider will not address these issues and is a sticking plaster. The rate increase to £16.00 per hour introduced in September is going to take time to filter through, as providers are only eligible for the higher rate following an assessment, which is taking the Council some time to complete. Once the assessment has been carried out the Providers are not always informed which leads to a delay in amending the billing to take into account the increase.

*Following the implementation of the Framework, what has changed in order for the system to not work effectively?*

Clients received an ultimatum in respect of their care provision, they could opt to receive a direct payment to commission their own care, or they could stay with the Council’s Framework Provider. Those that choose the Framework providers packages were moved from the Non- Framework Providers to those that were part of the Framework at very short notice. In a period of six to nine months the Non-Framework Providers business dropped by 50%. There was very little time to put mitigation in place, this unsettled the staff, and as a result, several of them left.
Can you expand on your comments regarding the tender process?

There were effectively two tender processes the first one that failed and the second process that resulted in the current situation. The Framework has been very damaging for the sector in terms of loss of money, staff, and growth in the industry.

The Council should revert to the preferred suppliers list to enable spot purchasing, as there is a finite amount of resource in Cornwall and unlike other areas of the Country, Cornwall does not have agencies to pick up the packages that cannot be delivered by the providers.

What is the level of staff retention and recruitment, and what is being done regarding the workforce?

There are a variety of issues that impact on staff recruitment and retention, the number of staff who can only work a maximum of 16 hours a week due to claiming tax credits therefore they are not available to work additional hours to cover any shortfall in resource. The shortage of affordable housing within the county has an impact on the locations where carers can afford to live. The current workforce is made up of mainly women who have children or are mature therefore there needs to be a focus on making the care sector more appealing to younger people. We are currently looking at ways to put in place a career pathway. In addition, there needs to be a more positive depiction of the sector within the media.

The recent removal of the bursary provided for nursing qualifications will have an impact on the care sector as it removal one of the potential career pathways and many apprentices are not work ready and find the transition into this type of work environment difficulty.

How do you think the system will cope with winter pressures?

Unless additional staff can be recruited and retained there will always be an issue regarding capacity.

Currently the housing stock is restricting people moving back into the community after a stay in hospital, as there are not enough suitable properties for individuals with care needs.

Care staff are choosing to leave the Providers to go and work at the hospital, agencies or in other sectors and it is increasingly hard to fill the vacancies that they leave behind.

What steps are providers taking to retain their staff?

Providers have been trying a range of measures to promote staff retention, these include providing lease cars and affordable housing to reduce the cost to employees.

Would you tender to be included within the Framework?
As it currently stands, we would not enter a tender process and commit to the Framework as we would like to see the outcome of the proposed integration programme.

**How do you believe the tender process could be improved?**

The Council needs to include the Providers in the tendering process and when developing the draft Framework, the whole sector needs bringing together. In the last tender, there were providers who opted not to bid due to the recommended hourly rate and there being floors within the rationale behind the figure. It is the view of the Non-Framework Providers that care should be commissioned through a spot purchasing process and the Framework should be abolished.

**Is there anything that you would like to add by way of summary?**

There is a wider issue when it comes to recruitment relating to management roles in the care sector. There are currently junior staff or more mature staff working in the sector that are not wanting to take on the responsibility of managing a care home due to the regulations regarding personal culpability, and the amount of bureaucracy required to fulfil the requirements put in place for Adult Social Care.

**15.00 - HEALTHWATCH CORNWALL**

(Agenda No. 9)

*By way of introduction, could you provide us with your name and details of your connection with Care at Home provision?*

My name is Debbie Pritchard and I am the Chief Executive for Healthwatch.

*Describe the methodology and learning from the work that you have undertaken?*

In undertaking its work, Healthwatch based 40% of its findings on feedback received from the Freephone line, information submitted through the website, emails and details received from partner organisations. The other 60% of the information was gained by seeking active feedback through our outreach work. This involved collating anonymously details of real life experiences, details of single examples raised and collating information regarding the small issues. Through this work, it was deemed that the level of concern expressed warranted a formal project.

There was concern raised about Care at Home issues in Autumn 2014 and following these concerns being raised by the organisation, Healthwatch meet with NHS Kernow and the Cornwall Council Commissioners to advise them of the findings.

Healthwatch undertook further investigations and arranged and attended a variety of meetings, forums, and sessions with the Providers where they were asked a series of specific questions. In addition there was a survey circulated to clients to enable a picture to be developed. There was a meeting held with the
Portfolio Holder for Adult Social Care and Healthwatch approached the media to request a public response regarding Care at Home provision. As a result, a report was drafted and sent to the Commissioners in the first instance to allow them to address the issues and promote action.

In May 2015, a final report was produced and the report acknowledges that the Council had undertaken various actions to start rectifying the issues.

*How do you validate the information that you receive?*

There was feedback gathered from over 70 people and there is no validation of the information gained as it is treated in an open and candid way. We also gather information from all parties involved to obtain a rounded perspective.

*What were the learnings from the work undertaken?*

There were several areas of concern that were raised as part of the project which included lack of capacity within the sector to provide the required care packages with some evidence of packages being handed back to the Commissioners and serious concerns regarding the pay and conditions of the staff delivering the care resulting in staff leaving the sector. There was also an issue with the two-way communication between the Providers and Cornwall Council.

The Framework Providers had not been given the required information regarding care situations, the Non-Framework providers secured contracts with the NHS and post the implementation of the Framework the Council continued to use Non-Framework Providers to carry out care packages. Providers were experiencing cash flow problems due to invoicing issues, direct payments, and service user contributions.

Healthwatch noted that there was still a good level of care being provided but concern was raised regarding the training provided for younger carers. The findings were reported to the Portfolio Holder for Adult Social Care and he acted quickly to improve the situation.

*Are there any plans to follow up the work undertaken?*

There are no current plans in the immediate future to follow up the work as Healthwatch are happy with the core care set up, a lot of progress has been made through the Framework Group and there has been an improvement in response to the issues raised.

*Have Healthwatch nationally looked at the matter?*

The purpose of Healthwatch is to respond to issues that arise locally and the issue raised in relation to Care at Home provision has not formally been escalated to the national level, however we have shared the report nationally. There has not been the same sort of issues experienced nationally.

*Is there a vehicle to share the lessons learnt for the work?*
There is an online Healthwatch Forum where work can be shared and it can act as a source of information.

*How is the voice of the person in receipt of care (and their families) heard?*

In the course of this piece of work, we found it quite difficult to hear the voice of the people in receipt of care and their families. Where the families had been badly affected, they would present their views, however it was more difficult to reach others receiving care packages. We are not sure if the reason for not sharing the information related to data protection issues, however, the issue may have been improved if there had been a closer working relationship with the Council.

The meeting ended at 15.20pm.

[The agenda and reports relating to the items referred to above are attached to the signed copy of the Minutes].
CORNWALL COUNCIL
HEALTH AND SOCIAL CARE SCRUTINY COMMITTEE

MINUTES of a Meeting of the Health and Social Care Scrutiny Committee held in the Trelawny Room, Cornwall Council, County Hall, Truro TR1 3AY on Friday 4 December 2015 commencing at 9.15 am.

Present:- Councillors: Eathorne-Gibbons (Chairman)

Also in attendance: Councillors: Margaret Abban, Nicholas, Rotchell and H Toms.
Apologies for absence: Councillors: Burden, Gorman, Harvey, James, P Martin and Parsons.

DECLARATIONS OF INTEREST (Agenda No. 1)
HSC/21 There were no declarations of interest.

SCRUTINY REVIEW OF CARE AT HOME (Agenda No. 2)
HSC/22 09.15 - UNISON REPRESENTATIVE (Agenda No. 3)
HSC/23 By way of introduction could you provide us with your name and details of your connection with Care at Home provision?

I am Stuart Roden and I am here to represent the Employee representatives.

Are there concerns regarding the recruitment in the care sector?

Unison has a long-standing relationship with Cornwall Care and they had indicated that they were considering not providing care at home packages, however they have negotiated a temporary reduction in the hourly rate pay to staff. This has now increased to £7.60 after a period of six months and has not quite reached the level of the Living Wage yet.
A number of staff have left the care sector reluctantly, and there is concern amongst the remaining staff that care packages are being removed due to the lack of resource and this has had an impact on the individuals providing and receiving the care.

Are you aware of any measures being taken to address the concern raised in relation to workforce recruitment and retention?

There are short-term steps being taken including the introduction of the Spine Provider to step in where no other Provider is available to fulfil the care package.
there is also work being undertaken within the sector to achieve the guaranteed ethical standard charter. The Employment and Skills Board are currently looking into the training needs of staff and what can be implemented to ensure there is career progression within the sector.

All parties within the care sector are being brought together to develop a wider training strategy. The number of people requiring care is increasing with the ageing population and there needs to be an adequate number of staff to deliver the care, therefore action is required now.

_How do the employees feel about the Framework contract?_

The employees have a limited understanding of the bid process and the contractual arrangements associated with it and as such blame their direct employers for the issues.

_Has there been any improvement in communication?_

The Council has made the decision to become a living wage employer for both directly employed staff and contractors alike, staff need to be paid for their travel time between clients and have paid time to attend training but there are a variety of pressures on the Councils budgets and in turn this pressure is placed on the Provider.

The first Ethical Care Standard charter has been signed within the South West with the Council Providers and it is hoped that this will be a catalyst to set and increase the standards within the industry. However it is onerous on providers and there is a perception that the Council are treating its own Provider differently to the external Providers.

_What is your view on the communication between parties?_

The Unions had very little input into the Framework contract despite having a good relationship with the Council. We attend weekly informal and monthly formal meetings with the Council, however there was no information shared regarding the contract.

There is now a different Portfolio Holder responsible for Adult Social Care and we believe that the Council is a more open to work with the Providers, however, the Unions would like a greater involvement in commissioning as they have a relationships with a large number of employees across the sector.

_Do you think the process has put people off the sector?_

The people who were employed at the time did not fully understand the process, and the Non-Framework Providers and Framework Providers have all been impacted directly by the implementation of the Framework and this in turn is impacting on the people who are receiving care.

_What do you think could be done to improve the sustainability of the workforce within the sector?_
An increase in the rates of pay would assist, the people in the care sector do not do it for the remuneration, as it is primarily a moral choice. However, the care sector is competing with other industries that can pay better wages for less responsible positions.

In the future, there is a requirement to recruit a large number of people in the sector and the Council needs to look at setting the standard and make it a career that people want to enter into and progress in.

All organisations within the sector are experiencing issues with recruitment and this coupled with the increases in agency fees as led to the sector recruiting people from outside the UK, however this is a short term stop gap and we should be looking at growing the workforce within the UK and making it a more attractive proposition.

What is your view of a single integrated approach and how can you aid the understanding of the single approach?

In my view, the principle of Commissioners and Providers does not work, as it is over complicated. There needs to be an integrated approach to commissioning and a reduction in the number of Providers. Currently there are many small Providers competing for the same pool of staff and care packages, which means there are no economies of scale.

There needs to be more cooperation between providers and the Health and Wellbeing Board could assist in supporting the sector.

The big challenge is combining the constituent parts of Health and Social Care, what involvement have the Unions had in the process currently being undertaken?

The Unions have been involved at the initial stage through the Case for Cornwall on an informal basis, however, there has been no subsequent involvement.

Is there anything that you would like to add by way of summary?

The issues within the care sector are broader than issues that relate to the Council. The care sector currently absorbs most of the training costs for its staff, and a proportion of these staff that will enter the care sector as a stepping-stone to nursing and other roles within the NHS. The situation will be further impacted by the removal of the bursary available for nursing course.

There needs to be a sector wide approach to staff training and the development of career pathways that are subsidised by all areas of the sector including the NHS.

10.00 - ROYAL CORNWALL HOSPITALS TRUST
(Agenda No. 4)

HSC/24 By way of introduction could you provide us with your name and details of your connection with Care at Home provision?

Health and Social Care Scrutiny Committee – Select Committee Review of Care At Home
December 2015
I am Paul Bostock and I am the Chief Operating Officer for Royal Cornwall Hospital Trust.

*How do you think you will cope with winter pressures, and will the changes being made in the Care at Home Framework impact on this?*

The Treliske Site struggles to meet the current emergency demand, however the proposed changes in the Framework should allow more patient flow, and if the proposals are delivered the situation should be improved.

*Do you believe the system to be more robust this year when compared to previous years?*

We are much more aligned with other agencies and are aware of the issues. There is still an issue with capacity, however there has been an improvement due to the better working practices.

*Has the process for people flowing through the hospital improved?*

The Emergency Department now has an acute General Practitioner assessing the patients coming into the department, which is assisting with the patient flow at the front end of the process. To improve the patient flow at the back end of the hospital there patients need to be discharged at the earliest opportunity and this is not always possible due to there not being a suitable care package in place. Communication between all partners needs to be improved to enable care options to be discussed and put in place at an early stage reducing the number of delayed discharges.

*Is there a structure in place for arranging onward care to allow patients to be discarded from hospital?*

There are issues of our own making, which we are trying to resolve regarding the time that patients are discharged and there are issues in relation to capacity of care Providers that is not within our control. We now have a more robust process in place and are interfacing with our partners to improve the patient flow.

*In your evidence you referred to an acute GP being based in the Emergency Department, is this part of a wider strategy and is RCHT having an impact on flow issues?*

There is a Multi-Provider Group that meets to review the pathways and look at the ways people can be treated by other parts of the NHS. The strategy is about ensuring that the right expertise is accessible at the right time in the patient journey. It is felt that the acute GPs fit into this strategy as they have the relevant experience to assess people when they first present to the Emergency Department.

*How much do you involve carers and families in discharge decisions?*
Every patient that comes into the hospital is assessed and given an expected discharge date. To date we have not been good at informing families at an early stage about the care options especially where the preferred option is not available. We are currently focusing on working with our staff to promote early conversations with all parties and are looking at bringing forward discharge dates for more simple cases.

As NHS providers, what do you think is your role in Care at Home?

Our role is to communicate and brief patients about the options available for their care to prepare them for their transition back to the community and to work with our partners to put in place a suitable care package.

Do you believe the process was better prior to the Framework?

On face value, it looks like there has not been any improvement as there are 56 people currently in hospital that could be transferred and this is double the national average. There is a plan in place that will come into effect in January and it is anticipated that this will reduce the number of patients who cannot be transferred. The question is, ‘What are the issues impacting on discharge across the totality?’ The Royal Cornwall Hospital Trust deals with people with complex care issues and these people require more complex care packages when they are discharged into the community and currently not all of the packages can be provided at the point of anticipated discharge due to resource issues. The other issue is with the families of the patients receiving care, that believe that the best place for their relative is in hospital as they do not have confidence in the alternative options.

Are there differences between how you liaise with those receiving long-term complex packages of care and those receiving a ‘traditional ‘care at home package?

Cases that are more complex can now be treated within the community so finding Providers who can deliver the right level of care can be an issue and these cases often require a bed in a nursing or care home prior to going back to their own home. The number of beds are limited which adds an additional complexity to the case as it is not just about the package of care but locating suitable accommodation.

What changes have there been in the discharge process where Care at Home might be needed?

The discharge process is one of the many steps in the patient journey and there are number of things that can be done to make this process as smooth as possible. Assessing the patient at an early stage in the process to ascertain their requirements following there discharge is the first step and a specialist nursing team work with vulnerable patients and case manager their care throughout their hospital journey.

There has been significant work done in relation to the discharge process and now there is an expectation that all patients have a date for discharge, which is reviewed throughout their journey. In addition, there is a twice-daily review of
all discharge dates and any patients that are identified as being due to be discharged are prioritised to ensure that everything is in place to support them when they leave the hospital.

There is a piece of work currently being undertaken that will move patients ready for discharge from the hospital bed into a discharge lounge which will allow the hospital to use the beds for other patients, while giving the patients awaiting discharge a safe place to stay until they can go to the agreed place within the community.

The Hospitals performance on the length of stay is good in comparison to other hospitals, however it is recognised that early communication with patients, their families and partners in the hospital journey with regard to care options and expectations for the patient discharge can reduce the length of stay in hospital. Ongoing communication with all parties and the sharing of accurate details throughout the process is the key to achieving a timely discharge.

What changes have there been and do you think they have gone far enough?

There have been two recent inspections, one relating to the business side of the Emergency Department, and one that looked at the discharge of patients. In my view, it is all about the speed and pace of change. My concern is whether the changes are radical and rapid enough. There is a real risk to care from the business of the hospital and we have to look at why the changes are not improving the overall performance.

Do you think integration will help improve the issues?

Integration needs to be the vehicle to change the whole way of working and improve the experience of care for the patient. It comes down to a question of money, budgets are being reduced and this requires us to look at how we work in all areas and by looking at care as a whole without focusing on who delivers it presents an opportunity to tackle budget issues and review how care is delivered.

Have NHS Providers been proactive in resolving situations where able?

We have taken some proactive steps to support the ongoing care of patients for example, when a stroke patient is discharged from hospital a team is assigned to provide therapy at the home of the individual and we are looking to extend this to other areas, such as orthopaedics.

How long do you provide this care for and what process is in place for the handover of the care to another provider?

For orthopaedic patients the handover takes place around three or four day after discharge. We are currently looking at how this approach can be adopted for other pathways.

When bed blocking arises are you proactive to help?
When planning for the winter pressures we look at measures that can be put in place to mitigate the issues that cause bed blocking. One of the measures we are looking at is identifying other areas where we can extend the acute care at home.

We meet weekly with Care at Home Providers to ensure we are all working together. We also review the work that is going on around the country to alleviate the issues and investigate any options that may be suitable for Cornwall.

*How has communication been between those involved?*

A lot of the community and Care at Home staff from the Peninsula Trust are based on the hospital sites, which aids good communication between the parties. We are now working from one list with the PCT, which has also been an improvement.

There are inherent frustrations with communication with staff working in the rural locations, however this is partly due to capacity in these areas.

*Are you involved in the training of carers?*

I think that the biggest step forward has been in the area of training support workers, as there is a lot of bedside care provided by support workers. There is a wider piece of work being undertaken that involves, partners to identify training opportunities and career pathways for carers.

*Do you have concerns about the pool of resources being shared between yourselves and care Providers and the impact this might have?*

The integration of services for our care workers needs to sit with the Care at Home Providers and does not necessary sit with us, however a flexible skilled workforce will be of benefit to us.

*Who is to lead on the integration?*

There is an agreed workforce plan that has identifies senior officers who have been assigned to lead on the work. There is a piece of ongoing work to scope what Health and Social Care integration looks like.

RCHT are providing input and making suggestions of areas where we can make improvements across the integrated services and we are relying on other partners to have input in the areas where they provide specialist services. For the integration to work there needs, to be strong and clear leadership and the work needs to take place at pace.

*Where should the drive and lead come from?*

For the integration to progress, there needs to be buy in and engagement from staff, patients, their families and the wider public. The leadership needs to come from the top of the organisations with Social Care and all other partners leading on their areas of speciality.
By upskilling your staff do you believe there is an impact on other areas providing care?

This is an example of where we need to look at sector wide career pathways. We would be happy to discuss this issue with Adult Social Care to identify a way we can work with staff to reduce the impact on resources. We need to move from the current competitive approach and focus on what is best for the community.

In your view, does the Living Board set up in the Penwith area help with providing care in the Community?

Small-scale community projects of this nature help break down the barriers and unlock some of the budget and money constraints as well as fostering accountability in the local area.

Is there anything that you would like to add by way of summary?

To resolve the issues that are being encountered, we need to have a robust plan in place that we can all put into action and deliver the care in a joined up way.

10.45 - PENINSULA COMMUNITY HEALTH
(Agenda No. 5)

HSC/25 By way of introduction could you provide us with your name and details of your connection with Care at Home provision?

My name is Steve Jenkins and I am the Chief Executive of Peninsula Community Health (PCH).

How do you think the system will cope with the winter pressures, and will the changes being made in the Framework impact on this?

The position of the PCH and the overall system has improved over the past year. The PCH has now established an onward care team and have developed one list of patients requiring care that is also used by RCHT.

We have daily communication with the hospital to discuss cases and the requirements of care packages for individual patients to enable them to be discharged into the community at the earliest opportunity.

The acute GPs that are now working in the Emergency Department at Treliske, allow patients to be triaged effectively at the first point of contact within the hospital and the increased capacity of the onward care team assists with the early discharge of patients, aiding patient flow throughout the hospital.

There is a lot of work going into addressing the length of time that a patient spends in hospital and we are pleased to see an increase in the money going into the Care at Home sector and this has established the market however, it has not resolved the issues.

Health and Social Care Scrutiny Committee – Select Committee Review of Care At Home December 2015
As NHS providers, what do you think is your role in Care at Home provision?

I think that the identification at an early stage of patients requiring ongoing care when they leave hospital is important and to support this the onward care team are assessing the needs and liaising with the Adult Social Care team to ensure they are aware of the care needs.

There are currently 1000 district nurse visits every day, they have a very good relationship with care homes, and these relationships need to be built upon and used effectively.

Our involvement is across the board and we have offered staff to work in the Steps Team, which will hopefully be in place from January onwards.

Do you believe the process was better before the Framework was put in place?

I personally have only been in post since 2013, therefore am unable to comment beyond that. We are seeing the amounts pay to Providers reducing but the pressures are increasing, including the increased amount of management time spent on dealing with complaints, which is taking time away from the providing of care. I do believe that the cost effectiveness of providing Care at Home can be increased by reducing the number of Providers, as it currently stands there are too many providers competing for work and resources on reduced profit margins.

Are there differences between how you liaise with those receiving long-term complex packages of care and those receiving a ‘traditional’ care at home package?

There has been no difference in the way we liaise, as each person’s care needs are different and they should be seen as individuals.

What changes have there been in the discharge process where care in the home might be required?

We have improved our own systems, including working from the same list as RCHT, the development of the Living Well Programme and strengthening the onward care team. There has also been more involvement from the voluntary sector as they can provide support to get people back into their homes, specifically providing support such as a befriending service.

What will lessen the impact on community or hospital setting, and how will this improve the outcomes for care users?

The whole Care at Home system is under a huge amount of pressure. The addition money that is been provided to the Lot One Providers has helped to stabilise the situation, however there is an issue with the recruitment and retention of staff and we need to work on providing career pathways and a clear career progression structure within the sector.
Community hospitals are a good place for training people in the care sector as they can learn the skills needed in an environment where there is the required support before they go out to provide care in the wider community.

**Have NHS providers been proactive in resolving situations where able?**

Over the last year, there have been some very creative solutions to assist in mitigating the issues that have been encountered. The Council have agreed to block book beds at the Community Hospital that builds more flexibility in the whole system.

There is a resource issue, which means it can be difficult to get care packages in place and the district nurses have been used in some circumstances, which has an impact on other areas.

The working relationships between all parties are much improved and to fill the gap there is a strong desire across all parties to put the care of patients first and the introduction of the Living Well Programme has provided more scope for improvement.

**How has the communication been between those involved?**

Two years ago, the communication was dire and there was a blame culture between the organisations. However over the last two years there have been significant improvements and an appetite from all parties to make improvements, for example, the NHS has taken the lead on communication with people about making the right choices when considering where to seek their care from and this is reducing the impact on the front end of the Emergency Department.

Partners now have respect for each other and are able to provide constructive challenge and a shared responsibility as it is now accepted that the whole system needs to work well to improve patient flow.

**Are you involved in the training of carers?**

We do provide a lot of training already, where Care Homes require their staff to be trained, we make Practitioners available to provide this training and provide advice and support in relation to end of life care. However, we do not currently provide training to the wider Care at Home sector in a formal way.

**Is there a way that we can rebrand the caring profession?**

The role of home carers is important and without them there would be a lot more pressure on hospitals, therefore it is in the interest of the whole sector to find a way of promoting the role and making it more attractive.

**Do you have concerns about the pool of resources being shared between yourselves and care providers and the impact this might have?**

Cornwall requires a five-year Strategy that links a variety of areas, for example, we do not currently work with housing, however the lack of suitable housing in
the community will have an impact over the longer term on the length of time it takes to discharge from hospital. Having a clear strategy and standards in place will allow the partners to prioritise the aspects that they need to deliver on and ensure there is a joined up approach.

*Who do you think should provide the leadership for this strategy?*

The PCH has been the glue holding the sector together and we have been instrumental in moving things forward. All parties need to undertake the work at pace utilising the good work that has already been done.

*Is there anything you would like to say in the way of summary?*

We need to look at the issues we have experienced in the past and use the learning from them to deliver the best care possible in the longer term.

**11.30 - CORNWALL PARTNERSHIP FOUNDATION TRUST**
(Agenda No. 6)

HSC/26  *How do you think you will cope with winter pressures, and which of changes made could make the biggest difference?*

The time of day that a patient is discharged from hospital can make a huge difference, for example, discharging a dementia patient at night can mean that they have to go into a nursing home to gain support rather than being released from hospital into their own homes, which would happen if they were to be discharged during the day.

More capacity on the ground is required to avoid the situation were care Providers are unable to provide care packages. We currently attract home care staff to our organisation because we pay higher rates than the other Providers can pay, however we are aware that we are all competing for the same staff and there needs to be some consideration given into how this is going to be sustainable in the future.

There needs to be an opportunity for carers to progress their careers where they want to, and for the carers who are happy with the role they perform they need to be recognised for their work and for their work needs to be valued. The approach needs to be joined up throughout the sector and we need to be more creative around issues such as staff training.

*As NHS providers, what do you think is your role in Care at Home?*

We have a Section 75 resource agreement. Predominantly patients will have physical conditions, however, there are some patients who have dementia or other mental health conditions, can require care that is more complex, and our role is to support the Care at Home delivered through the district nurses etc.

*Do you believe the process was better before the Framework?*
On the face of it, the Framework was a good idea but there was concern expressed regarding it being structured on a cost-based system. As a trust we did not believe that it was viable to provide care based on the specification of the tender therefore we did not bid for inclusion in the Framework.

Following the implementation of the Framework, the Framework Providers have not been able to meet the demand for care packages therefore the Council has not been able to enforce the terms of the Framework and as such, the Framework is not working effectively.

Do you think that there are things that could be done to prevent patients from being moved from care facility to care facility?

We need to be better at providing nighttime support for dementia care and when people are moved out of their home and into a care setting they can be caught in a vicious circle. The introduction of the Living Well Programme may contribute to improving this issue.

Are you involved in the training of carers?

A cross agency approach to training would be welcomed. Currently the dementia nurses that work within the Trust provide informal training to care homes and we provide guidance and support to mental health units. There are plenty of jobs in the care sector however, there are not enough people wanting to take up the roles.

There are many students taking Health and Social Care courses at the college but concern has been raised that there are not enough work experience placements available, could you provide comment?

As far as I am aware the CPFT have not been formally approached by the education providers to discuss work experience placements.

Do you have concerns about the pool of resources being shared between yourselves and care providers and the impact this might have?

We need to work together within the sector and look at how we can all work more efficiently. There needs to be a place based approach to provision and there should be an element of control over the provision from the local community. Post April we are looking at working with clusters of GP practices to identify where demand for care is and are looking to engage and support the voluntary sector. The wider challenge is to make communities more resilient and to put in place a structure that is right for local communities.

Who do you think should provide the leadership?

We have a plan of work to do up until April, in addition, we have a transformation team in place that are working on drawing up plans and working with providers to agree actions to deliver care effectively.

12.15 - KERNOW HEALTH
(Agenda No. 7)
By way of introduction could you provide us with your name and details of your connection with Care at Home provision?

I am Peter Stokes and I am the Chief Operating Officer for Kernow Health. I represent 165 Doctors practices in Cornwall and the organisation was forms to ensure that the voices of practices were heard and that they are sustainable for the future.

How do you think you will cope with winter pressures, and will changes being made in the Care at Home Framework impact on this?

There is currently a crisis in GP practices, there are not enough GPs, and there is a shortage of practice nurses. 65% of GPs aged 55 or older have indicated that they will be leaving their jobs in the next 5 years. The workload of GPs has significantly increased and one of the contributing factors is providing care in the home. It is acknowledged that older people respond better to care when they receive the care in their own homes, however this type of care can impact on GPs.

There is a realisation that there is not a silver bullet to resolve the issues and things need to be done differently.

How can the issue of sustainability be improved?

Kernow Health are providing a strategic voice, sit on the System Resilience Board and are working more closely with partners at a senior level.

We have been successful in bidding to become a community education provider network and will be delivering this jointly with Devon.

Partners are pooling resource and working in a portfolio model, which is allowing GPs to gain more skills and work in different areas for example, working for 2 days a week in acute care within the Emergency Department.

Are the Care at Home Services sustainable?

Currently, if a care package cannot be delivered it has a direct impact on GPs, for example if a patient requires eye drops and there is not a carer available to provide this care, GPs have been asked to do this. Unscheduled GP visits, due to the lack of a care package, place an additional burden on practices. Therefore, it is crucial that the home care provision is strong.

The Care Provider needs to be encouraged and supported to provide care training and the GPs have a role to wrap around this training.

When do you see that a plan will be in place for the provision of care and who should lead on it?

I see that the Deal for Cornwall and the integration of Health and Adult Social Care will be the driver for this and we welcome the combining of resources. This will allow people from the various partners to work more closely together and
the Providers are now more receptive to joint working, which will impact on the way care is delivered, and the collation of GPs is leading the debate in relation to effective partnership working.

*What will lessen the impact on community of hospital settings, and improve outcomes for care users?*

All the right things are being put in place, the most immediate thing we are doing is investing in staff training and looking at where the various roles fit into the overall care picture. Well trained staff will help reduce the current issues in the longer term.

*How is the communication been between those involved?*

Communication at the strategic level and on the ground was good. There could be some improvement in the communication between multi discipline teams and operational teams, however the relationships are now much stronger and there is more trust between all parties.

*Are you involved in the training of carers?*

The NHS had put money into creating more opportunities for community education, which will allow us to act as a vehicle for the delivery of more joined up training. We are working with Exeter and Plymouth Universities and other education providers to develop the training.

*What role do GP's have in Care at Home provision?*

We need to ensure that there is sufficient resource and skills available to deliver the care required in the community. If the resource is not maintained it will put further pressure on the GPs service, which is already under pressure.

*Do you think there is the required capacity within GP Practices to undergo the radical changes that are required?*

GPs have recognised the need to change and there is a mandate amongst the Doctors. Not all of the 65 GP Surgeries are on the same page as some of them are very traditional but they are in the minority. The majority are embracing the change and providing the required leadership in their practices. Although it is going to be challenging to keep business as normal progressing while the work to transform the service is taking place.

**13.40 - NHS KERNOW**  
(Agenda No. 8)

HSC/28 I am Trevena Doyle and I represent the Kernow Commissioning Group and we are responsible for systems resilience, safety, and patient flow, which includes the capacity of Care at Home provision.

*How do you think the system will cope with winter pressures, and will changes being made in the Care at Home Framework have an impact?*
Anticipating some of the periods of pressure and being realistic about the demands on provision I believe that overall, the system can perform well. The 4-hour target is consistently being met in Minor Injury Units, system partners meet on a regular basis to develop plans to meet the needs of patient flow, and the respective regulators sign these off.

The key objective is to maintain the patient flow system. Long stays in hospital are a large contributory factor to the deterioration in the ability of a person remaining independent in the community. The needs to be the required capacity in the Care at Home provision to enable people to leave hospital with the right care in place at the earliest opportunity. The introduction of the Steps Service combined with Care at Home provision will assist in meeting the winter pressures.

What examples are there of national good practice and would the models in Cornwall compare with examples?

There are a variety of initiatives that are taking place in Cornwall such as the Living Well Programme, which is helping assess people’s needs at an early stage. The Programme is centred on getting people the right support in their community and the Steps Service, that provides short-term support that is goal orientated and where this service has intervened there has been an increase in the number of people staying in their own homes.

However, there is a lack of capacity in the Steps Service, which means that the service is unable to take on all the referrals and requires domiciliary care to input more resource.

Integration with the rapid response services is required as the evidence shows that this reduces the requirement for long-term care.

There has been a change from long hospital stays to providing more care in the person’s home. Acute care can now be delivered in the home and the processes to facilitate this can be put in place but to make them work there needs to be a change in culture and thinking.

What procedures are in place for when people leave hospital and are not sure whether they can cope in their own home?

The best practice is for someone to come into hospital who had not previously required a care package and there would be an assessment done while they were in hospital to assess their care needs and a package would be put in place for when they leave hospital. This package would be assessed after 24 hours of their arrival home to ensure that it meet the needs of the individual.

In the evidence that you have provided, you advised us that where there is a greater intervention from the Steps Service there is less reliance on domiciliary care, please could you provide further clarification on why you believe this is the case?

Where there has not been enough capacity in the Steps Service the care package is provided by domiciliary care, the domiciliary care service provide less
intensive care, however the Step Service provision is more intensive and focuses on rehabilitation therefore the patient outcomes are different.

*How do you see the sustainability and modernisation of care at home services and your role in it?*

The key element is working to balance the day-to-day services with the transformation work, as these will have to be done in parallel. Patients want more choice and control over how their care is delivered and with the introduction of direct payments, the way services are Commission’s needs to change and be modernised.

*How do you make it sustainable?*

To make it sustainable we need to look at using our resources better, ensuring that the workforce is not fragmented across the providers and that the work is not duplicated. The integration of teams and services will assist with this and avoiding duplication, in addition to helping to achieve the required savings.

*Will you be altering from spot purchasing packages in foreseeable future?*

Spot purchasing has been done for a number of years by frontline staff. The question is what model of care do we want to Commission? This will drive how we will purchase the care but in the meantime, we will continue to spot purchase.

*What was the NHS approach to contracting Care at Home packages in 2012-2014 and what is it now?*

The Providers applied for individual packages of care and recently, there has been an introduction of the health buyer session, which looks at the length, and hours of staff service, we are now looking at a whole picture model. As it is a bidding process, we do not set a fixed rate for care packages.

*Will the steps being taken in terms of pricing and a Spine Provider Provision be sufficient to support and enhance private sector Care at Home provision?*

There is some nervousness about the delayed transfer and to date there has not been any improvement. The price increase paid to Providers by the Council has created some resilience in the sector and there is an expectation that improvements will be seen in January.

*Have you concerns about the recruitment and retentions of the workforce involved in care and if so, how will you help with this?*

The System Resilience Group has been looking at this issue for a long time. One of the issues is how to introduce Steps and Core Care provision without taking resource and disabling other Providers.

There is a requirement for the whole sector to work together, and look at training people to carry out roles, and have the flexibility to allow people to do
work placements or rotations in a planned way to present the maximum amount of opportunities for the workforce to develop.

Is there an agreed action plan for this approach?

The current focus has been on the here and now. We need to map out what we currently have and understand where the skills gaps exist and start addressing the issues.

How has the communication been between those involved?

The communication is good and consistent and I have received some good feedback. There is support between the partners and they provide each other with a high amount of challenge. The Chief Officers are meeting on a weekly basis and the focus is centred on providing the best care for the patient.

Is there something that you would like to add by way of summary?

The key question is about how we commission care in the future to meet the growing demand in a way that is efficient and effective.

15.10 - CORNWALL COUNCIL (EDUCATION, HEALTH AND SOCIAL CARE MANAGEMENT)
(Agenda No. 10)

HSC/29 I am Anna Mankee-Williams the Head of Service (Commissioning, Performance and Improvement), I am Maria Harvey, Senior Manager, Contracts and Service Improvement, and I am Liz Nichols, Senior Commissioning Manager.

How do you think you will cope with winter pressures, and will changes being made in the Care at Home Framework have an impact?

One of the key things that the Council and its Partners need to do is to analyse and address the demand. The situation in Cornwall in relation to demand is similar to the national picture and we are working to put in place mitigation to deal with the here and now and reduce the impact of the demand. There are a variety of measures that we are looking to put in place that include, conducting soft market testing for a welcome home service that would be done in conjunction with RCHT. We are looking to improve processes and work more closely with RCHT to develop a common process methodology and a clear plan has been developed to support this with the Council taking the lead. We are currently looking at bringing in a single line management model with the CCG and are looking at introducing a trusted assessor role, which would mean that an independent person would assess patients care needs and feed into the care package requirements.

We are working with the voluntary sector to provide support for people when they leave hospital to ensure they have day to day support with tasks such as shopping and pastoral support.
To reduce the immediate pressure, the Council has opened a four bedded care provision for the Christmas and New Year period to alleviate some of the issues when the demand is at its highest.

We are working more closely with the Providers and are listening to suggestions they put forward and taking on board the issues.

With the introduction of direct payments, people are able to select Non-Framework Providers to provide their care and the Council is working through checking all new Providers for quality.

We also have the provision of two flats that can be utilised and need to communicate the details with partners so this provision can be used effectively when required.

*Is there good communication, and are partners joined up on the back door provision?*

There has been a plan developed for all partners and in addition to the work being done on the back door provision a cross agency group is working on reducing hospital admissions, which will reduce the pressure on the back door provision.

There has been investment in equipment with a view that some double care packages can be reduced to single packages to free up capacity.

*What is the impact on care users and how do we know what will improve outcomes for care users?*

The first thought when providing care provision is with the services users, we conduct questionnaires, hold focus groups and gain feedback on a face-to-face basis. The tender included questions regarding the ethical care charter and asked bidders to provide a method statement feedback from their service users. In addition, we have an electronic monitoring facility and are in contact with the people who received care as they telephone the Council on a daily basis.

*Will the steps being taken in terms of pricing and the Spine Provider Provision be sufficient to support and enhance private sector Care at Home Provision?*

The Spine Provider has been established in response to the issue of demand outstripping the capacity of the Providers and will help meet the need from more complex care packages. This provision has only been in place for a short amount of time, therefore will take some time to have an impact.

The pricing has established the market and will help in establishing the workforce, however there is still work required to look at ways to attract people to work in the sector.

Currently the Health Care Assistant roles attract more applicants than there are roles while other roles in the sector do not attract applicants, and the reasons for this need to be understood so we can address the situation.

*How will the variations between Lot One and Lot Two be addressed?*
The setting that the care is delivered in is different and there is the additional travel element with the Lot One packages, however the transactional process is the same for both Providers Lots.

In your view, are there substantial differences in the care packages provided by the Lot One and Lot Two Providers?

The Providers were split into two lots, as they are different due the nature of care they provide, however, there are minimal specific differences between the two.

How is the voice of the person in receipt of care (and their families) heard?

The Council has an engagement officer who works with the care providers. Historically the engagement has been with the same people and there is recognition that the Council needs to engage with a larger number of people in receipt of care and there is a specific piece of work being undertaken to look at how this can be achieved.

What is being done to help Providers regarding workforce training, recruitment, and retention?

There has been £10,600 of funds put into a recruitment campaign, we are working with colleagues within the sector, and with the LEAP to attract European Funding, we have held work force development sessions to promote good practice and have developed a strong relationship with Job Centre Plus.

There is work being undertaken to develop career pathways with clear case studies to illustrate the opportunities available, and linking with qualifications that are now requiring a year of experience in the care section. Job Centre Plus has care sector champions within their offices to provide quality advice for job seekers. Training has been commissioned to train managers and provide the mandatory training required in the sector.

There are wider things that are happening such as an award ceremony for people within the wider sector to recognise the positive achievements, providing support with accommodation and developing a scheme of discounts for staff within the sector.

Do you foresee a return to a method to a method of spot purchasing packages rather than commissioning care through a Framework?

The Framework is in effect a formalised way of spot purchasing. The option of block purchasing care has been looked into, however with the introduction of direct payments this option would not have the flexibility to meet the care requirements.

14.25 - CORNWALL COUNCIL (LEGAL AND FINANCE)
(Agenda No. 9)
By way of introduction could you provide us with your name and
details of your connection with Care at Home provision?

I am Julian Kitto, Assistant Head of Governance and Information - Legal Services
and Wayne Rickard - Assistant Head of Finance at Cornwall Council.

What are the main issues legally that were raised by the initial challenge to the
Framework and how were they addressed?

The issues that arose related to the unpublished sub set of data in the scoring
matrix that was designed as guidance for the tender process and informed the
weighting. Once the tenders had been scored, the bidders were informed of the
outcome and the unsuccessful bidders requested feedback as to why they had
not been successful.

Following the feedback there was a challenge to the tender during the standstill
period regarding transparency of the process, which specifically related to the
publication of the criteria, and the challenge was lodged in court, which halted
the appointment of successful bidders.

The challenge put forward, claimed that as the weighting criteria was not
published, the process was not transparent, and it was alleged that if the
information had been made available it would have impacted on the bids
submitted. The view was taken that the chances of defending the Councils
position in court was poor and therefore the decision was made to agree to a
consent order and settle the case.

The Council could have then chosen to go back to the pre-qualification question
stage of the procurement, however it was felt that there had been learning that
could be applied to the process and the Council put out a new tender.

How was the guide price set and how can the Council seek to support the market
who now finds that unviable?

There was a guide price of £14.50 set and this was not presented as a ceiling
rate of pay. The information gained during the first procurement and the prices
obtained from domiciliary care invoices paid across the county were used to
calculate the range and formulate the guide price. The information was also
combined with the requirement to make efficiency savings.

Since the Framework procurement, the Providers have made representations to
the Council regarding the rates and sustainability of the contract. Regular
meetings have been held with the Lot One Providers to discuss the issues they
were experiencing with the Framework and there was a range of measures put
forward to mitigate the issues. One of the main issues that the Providers put
forward related to the volume of care packages that they were receiving from
the Council. The number of packages fell far short of the projective number
suggested in the tender process and this had an impact on the Providers as they
could not make the required economies of scale to meet business costs.
Moreover, various Providers had indicated that they would withdraw from the
Framework and the sector.
Following the concerns being raised regarding Lot One Providers and the evidence produced to support their case, Cabinet agreed additional funding of £4.5 million pounds to fund an increase in the hourly rate to £16.00.

*Do you believe that the increase is sustainable and how will the Spine Provider impact on the Providers?*

The Spine Provider has been establish as a Provider of last resort, therefore it is not envisaged that they will be completing for the care packages with the Framework Providers and not impacting on the economies of scale and meaning the uplift in the hourly rate would be more sustainable.

*When the Council agreed to increase the hourly rate paid to the Lot One Providers, was the introduction of the living wage taken into consideration?*

The report to Cabinet looked at all the latest information available regarding an hourly rate for Domiciliary Care and the current rate paid in the South West was on average £15.85 so in setting the rate at £16.00 takes the rate that the Council pays to the Lot One Providers above the average.

In announcing the introduction of the National Living Wage, the Government stated that there would be tax breaks in place to support businesses in making the transition to the new wage and envisaged that there will be future challenges that will need addressing including the volume of care packages available to the Lot One Providers.

*What due diligence took place in the contracting/procurement of the Framework?*

There was consideration given by Adult Social Care as to what other Councils were doing in relation to the domiciliary care provision and there were supplier events held where the Council engaged with the representatives from the market. Assessments were made at the pre-qualification stage of the tender process, there was engagement with solicitors throughout the process and they was legal support available at the contract-signing event.

Following the signing of the contracts there was an implementation meeting and a contract review meetings were held. Throughout the process, the Council provided and shared responses to all the clarification questions posed by the Providers.

*How will the Council fund any overspend in this area and how will it impact on other services?*

There is a requirement for the Corporate Directors to fund any overspend from within their Directorate, however in this case the decision was made corporately to add £4.5 million pounds to the budget to resource the year on year demand. A longer-term strategy will be required to address the budget issues going forward and this will have an impact on other services in the directorate, as domiciliary care was a priority service provision.

*Could the Council share the list of providers and bid rates?*
The list of Framework Providers was in the Public domain and detail could be supplied to the Committee in writing. Each of the Providers submitted an hourly rate of pay during the tender process, therefore each one is paid at a different rate, and this information was not available in the public domain.

*Have lessons been learnt in order to inform future commissioning and budgeting plans?*

An annual business plan and annual accounts are produced by the service and the information from these help the Council gain an improved understanding of the market and ensures that the Council is conforming to Act One of the Care Act.

Lessons have been learnt with regard to staffing, at the outset of the procurement the Council requested details of the employees working for the Providers with the view that TUPE arrangements could be put in place. This is not information that the Council can compel the Providers to supply and as the domiciliary care market in Cornwall was underdeveloped the engagement and the relationship with companies was not established enough for them to share the information. In future tenders the market will be more developed and the relationship will be more established which would resolve the issue.

Due to the current amount of capacity within Care at Home provision, there is no way to enforce a default escalation process and the Council is not able to exclude any of the Providers from the Framework.

*Will the steps being taken in terms of pricing and a Spine Provider be sufficient to support and enhance private sector Care at Home provision?*

It is too early to assess the impact of the increase but it has established the situation. The hourly rate paid to the Provider is only part of the issue. The private domiciliary care market in Cornwall is relatively immature and small and medium companies deliver care provision in the main, which makes the market very sensitive to external and market changes and changes in the workforce. The increase in the hourly rate has assisted in building a better relationship with the Providers and in the ever-changing market, the Spine Provider will help provide more stability especially in the event that a Provider is unable to provide care packages or exits the market.

*Was there adequate legal and finance involvement in the development of the Framework?*

Legal and finance support was provided throughout the procurement process, however in hindsight the first unsuccessful procurement had not received the right level of support. There was only a small amount of support provided, a senior solicitor reviewed the details in the draft contract and there was limited ad hoc support and this had contributed to the failure of the procurement as legal had not been aware of the sub criteria used to weight tendered bids.

As the first procurement had not been successful, this placed more importance on the second procurement being successful and it had to be carried out at pace to ensure that there was a Framework in place. The Council commissioned
external solicitors to draft the paperwork, there was a lot more internal resource from legal, and finance assigned to the process. The Council dealt with the threat litigation internally and the Head of Governance and Information chaired a project board that meet on a weekly basis and helped to ensure that the focus was maintained and that there was an overview of the identified risks. For future procurements, there is a recognition that the Council needs to obtain a better understanding of the market and the pressures that the providers face.

*If the modelling had been done at an earlier stage to the procurement, do you think the guide hourly rate would have been set at the current rate of £16.00.*

The lower hourly guide rate was set based on the evidence collated at the time and to meet the budget pressure being face by the service, therefore the modelling would not have had too much impact on this. It is also in part an issue with the maturity of the market in that when the Providers submitted their bids there was the option for them to put in a higher rate based on their business models.

The meeting ended at 4.20 pm.

[The agenda and reports relating to the items referred to above are attached to the signed copy of the Minutes].
Witnesses
The Health and Social Care Scrutiny Committee would like to place on record its gratitude to all the witnesses that attended the review and who provided evidence in a coherent and comprehensive way. Their evidence has enabled the Committee to gain a broader understanding of the issues and make recommendations.

The list of witnesses is set out below, in the order in which they appeared before the Committee.

**DAY 1 –**

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<th>Witnesses</th>
<th>Organisation</th>
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<tr>
<td>Cllr Jim McKenna</td>
<td>Portfolio Holder Adult Care, Cornwall Council</td>
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<td>Ian Williams (Cornwall Care)</td>
<td>LOT 1 Providers</td>
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<td>Kevin Taylor – McHale (Taylors of Grampound)</td>
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<td>Lyn Tomen (Brandon Trust)</td>
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<td>Tim Jones (United Response)</td>
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<td>David Smith</td>
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<td>Christine Rowberry</td>
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<td>Tish Berriman</td>
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<td>Mary Anson</td>
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<td>Debbie Pritchard</td>
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**DAY 2 –**

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<td>Stuart Roden</td>
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<td>Paul Bostock</td>
<td>Royal Cornwall Hospital Trust</td>
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<td>Steve Jenkins</td>
<td>Cornwall Partnership NHS Trust Peninsula Community Health</td>
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<td>Phil Confue</td>
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<td>Peter Stokes</td>
<td>Kernow Health</td>
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<td>Tryphaena Doyle</td>
<td>NHS Kernow</td>
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<td>Julian Kitto</td>
<td>Legal Services, Governance and Information, Cornwall Council</td>
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<td>Wayne Rickard</td>
<td>Finance Services, Business Planning and Development, Cornwall Council</td>
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<td>Anna Mankee - Williams</td>
<td>Education, Health and Social Care - Cornwall Council</td>
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<td>Maria Harvey</td>
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<td>Liz Nichols</td>
<td>Education, Health and Social Care - Cornwall Council</td>
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1 / Will the steps being taken in terms of pricing and a spine provider be sufficient to support and enhance private sector care at home?

No, the steps being taken are good ideas in their own right but they will fail at the point of delivery. Care at home providers have no choice other than to work on a high volume, low margin business model and the limiting factor that the majority of providers are battling with is their ability to recruit and retain enough carers to be able to run sustainable services.

The UKHCA state in their ‘a minimum price for home care’ guidelines that providers need to be paid £16.16 per hour for care in order for them to be able to pay the current national minimum wage (£6.70 per hour), which will increase to £16.70 per hour in April 2016 in order for them to be able to pay the new national living wage (£7.20 per hour).

The Council are currently paying providers on the framework agreement £16.00 per hour, which is not enough to enable them to pay their staff what is deemed to be the market rate of £7.10 an hour. It is also not enough for providers to recruit and retain sufficient numbers of carers to enable them to run sustainable services in what is in practice, a highly seasonal and low unemployment market place in the county.

The Council’s spine provider Corcare is currently paying its carers £7.85 per hour (the same rate the STEP’s team were being paid) and care at home providers are already experiencing carers transferring across to them due to the higher wages and associated benefits. Also, new and existing supermarkets are paying their staff up to £9.00 per hour for roles with considerably less responsibility, which will mean that carers will leave the sector.

2 / How do you think the system will cope with winter pressures?

The system will not cope with winter pressures. It is only a matter of time before our hospitals go back onto a back alert status and one of the main reasons why this will happen is that the Council have not put enough resources into care at home (despite repeated efforts from providers to address the issue) to enable providers to recruit, train and retain enough carers.
3 / You bid at a rate which you had established, what subsequently changed in order for the system to not work effectively?

Care at home providers based their bids on the information provided by the Council in the meetings that took place leading up to the tender process and in the tender process paperwork.

Providers were given a guideline rate of £14.50 on which to base their bids; some care package volume information dating back to October 2012; an understanding of how the 6 month mobilisation process work in practice and a sense that the Council wished to work with a smaller number of providers and that they would put steps in place to enable this to happen.

The Council stated that their finance team had modelled the £14.50 figure and determined that it was sufficient to meet all statutory requirements in respect of the national minimum wage, despite the UKHCA’s view that the cost of care at this point in time was £15.19. This led providers to believe that the Council would work them to enable this to work, which did not materialise in practice.

The care package volume information turned out to be misleading as it included care packages that were delivered by the EIS team, which was confirmed by a Council Officer as not being relevant to the process. The care package volume information also completely ignored the Council’s intentions to talk to clients about what they later described to be their preferred option, which was for clients to go onto direct payments, which had a significant impact on the number of care packages available.

The Council decided to continue to pay non framework providers the rates they were being paid prior to the framework agreement (£16.28), which had the impact of enabling them to pay their carers higher rates than framework providers and once combined with the fact that providers were unable to TUPE transfer carers across with care packages, ground the mobilisation process to a halt.

Over and above this care at home providers have experienced three increases in the national minimum wage; a low unemployment market place; competition for staff from both inside and outside of the sector; unexpected increases in costs due to the new CQC regulations and the Care Certificate and higher than expected administration costs relating to the seemingly never ending issues providers have experienced with the ECM (CM2000) system, data protection audit and KPI requirements.

4 / How did you respond to packages of care pre June 2014?
Care at home providers would receive a phone call from the brokerage team and would be asked whether they could deliver a care package based on the tariff of prices they had in place at the time.

5 / What issues did you have prior to the framework contract?

Comparatively few, there were and continue to be issues with purchase orders and the timeliness of payments. In the main though, providers had more sustainable services, operated in a market driven environment and experienced far fewer issues with recruitment, training and retention. Carers felt valued, motivated and rewarded and there was a myriad of people who were willing to recommend care at home as a potential career to both their friends and family members.

6 / What are the experiences of discharge processes with care at home packages?

Care at home providers are not able to bid for as many care packages as they would like to due to their inability recruit, train and retain as many carers as they need to in order to run sustainable services. When providers are able to take packages on they can often experience inaccurate contact details, limited to no care planning information and limited to no purchase order information, all of which have the impact of causing providers further problems down the line.

7 / What is the level of staff recruitment and retention and what is being done regarding workforce?

Care at home providers are experiencing unprecedented issues wrt the recruitment and retention of carers, they have tried many innovative methods to recruit and retain carers throughout this period but are limited in terms of what they can do/offer due to the amount they are being paid by for the services they deliver by the Council and the cost of the associated activities.

This has involved newspaper adverts, magazine adverts, radio adverts, working with recruitment agencies, job sites, banners, billboards, bus stop posters, text campaigns, flier campaigns, demographic profiling, postcode lists, direct mail, open days, job fairs, ex carers letter, carer referral incentives, college presentations, job centres, women’s institutes and rotary club talks.

It has also involved rewards and recognition schemes, enhanced holiday entitlement, help with child care, enhanced pension schemes, long service awards, training and development, stepped pay bands, procurement deals, car lease purchase deals, free DBS checks and uniforms, paid for training and training time, paid for travel time between clients and attractive mileage rates.
8 / How is the voice of the person in receipt of care (and their families) heard?

The voice of the person in receipt of care (and their families) is heard through conversations with care at home carers, these conversations are captured in the client’s care plan as well as in the carer’s supervisions, appraisals and team meetings. Many providers put further mechanisms in place to support these processes including client surveys and discovery interviews.

The voice of the person in receipt of care (and their families) is also heard through Healthwatch, Commissioners, regulatory bodies and other partner organisations both local and national. Care at home providers continually hear that clients are confused about the current arrangements in the county, especially when they relate to invoicing and outstanding moneys.

9 / How do you see the sustainability and modernisation of care at home services?

Care at home providers are finding it harder and harder to address the combined wants and needs of their clients, carers, commissioners and regulatory bodies. If as a county we are serious about addressing this issue, then care at home providers believe that we will have to go through a complete regime change in order to make this happen.

This could be achieved through the prospect of joint commissioning but will be wholly dependent on the associated success criteria and the individuals who are appointed into key roles.

Care at home providers believe that providers should provide care, commissioners should commission care and regulatory bodies should regulate care. Care at home providers also believe that they will really need to be listened to and understood, before working relationships can be rebuilt, sustainable services can be supported and enabled and long term plans can be put into place.

10 / What has been your biggest lesson from this process and / or what would you do differently if going through a similar process?

Care at home providers believe that the biggest lesson they have learnt from this process is that they have a better opportunity to influence outcomes by working together and that if they are going to influence change in a positive way for their clients and their carers, then the only way to do this is through meaningful dialogue with commissioners and regulatory bodies.

11 / How has the communication been between those involved?
The communication between care at home providers has never been better. The communication between providers and some Council Officers remains difficult due to the fact that providers feel down by some key individuals. As a result of this, providers are left feeling disappointed and disillusioned and as a group are finding it harder than they expected to, to trust the individuals concerned. Indeed some providers have highlighted the need for an independent investigation into the situation.

12 / Recognising the difference in scales, is there anything else that could be learnt from national providers or national representative organisations?

Care at home providers felt the need to involve Healthwatch, the UKHCA, Care England, Local Councillors and Local MP’s to help address the issues they have been facing with the Council. Some of these issues have been addressed but the overall situation will never truly be resolved, until a competent project team is put into place, the framework agreement is bought to an end and a level playing field is created, by moving towards a more NHS based style of commissioning.

Second Submission

Health and Social Care Scrutiny Committee - Care at Home Select Committee

Submitted on behalf of Lot 1 Provider Representation:

Pre Contract

In preparation for the PQQ and ITT in respect of the current Framework a number of meetings were held by the Council for Providers who were considering tendering. During these meetings the Council presented a number of key suggestions in advance of the PQQ and ITT and it is our belief that many Providers decided to tender based on the information presented in these meetings.

Key suggestions presented by the Council include but are not limited to the following:

Following implementation of the Framework only successful Providers would be offered new work from the Council; the Council indicated that they wished to work with a limited number of Providers and the notion of subcontracting by successful Providers to non-successful Providers was positively encouraged.

Response to Packages of Care Pre June 2014

Prior the current contract Providers were mainly contacted by telephone. There was a greater emphasis on ensuring appropriate placement of packages with greater detail of information being provided in relation to the service needs.
Initially, under the current process full post code information was not provided in email correspondence which made it difficult for Providers to appropriately place packages efficiently. Providers repeatedly requested full postal code information from the Support Brokers but were advised that this was not possible. After many requests, the full post code information was eventually provided making the potential allocation of work easier. Under the current process, where bid details are provided by email, detail around package needs are sparse and in some cases inaccurate. Providers have advised that when full support plans arrive after winning a bid they contain additional and important information that should have been provided with the initial details. The additional information in some cases will mean having to deliver a different type of support than anticipated at the point of bidding.

As discussed, there were issues with Purchase Order Provision prior to contract but these issues had been occurring for many years despite Providers raising concerns with the Council on many occasions.

**Recruitment:**

A concern amongst Providers who intended tendering for a position on the Framework was that their ability to bid for work would be dependent on their ability to recruit. The Council indicated that throughout the 6 month mobilisation period Service Users would be moved from Non Framework Providers to Framework Providers and it was suggested that this would encourage staff mobilisation because volumes of work would shift from the many to the few. The Council discussed at some length the need to be aware of TUPE issues and tried to encourage the sharing of staff information in this respect and it was suggested that the Council’s intention was to enable successful Providers to grow their businesses.

The general assumption by both Providers and the Council was that because of the reduced number of Providers the Council was going to work with, successful Providers would attract the necessary staff to provide the additional volume of services needed and many Providers submitted Tender Prices based on their ability to uplift in numbers of hours delivered in order to counter the reduction in charges.

Most Framework Providers have reported having lost staff as a result of being a part of the Framework with reports of halving in size at worst with some remaining static and one smaller Provider reporting that they had increased in size.

Providers have been advised by the Council that National Providers have no interest in delivering services in Cornwall. Cornwall is unique in respect of its geography (not surrounded by numerous other Counties therefore difficult to draw in staffing from neighbouring Counties) and its mix of rural and urban locations makes it more difficult to provide a one size fits all model of provision.

Reports from some Providers have suggested that recruitment and retention was effected at the start of the contract (and continues to do so) as a result of the introduction of Electronic Call Monitoring (ECM). As discussed, Non-Framework Providers are not subject to ECM and some Framework Providers have advised...
that they have either lost existing staff to Non-Framework Providers or when new staff apply one of the first questions they ask is “do you use Electronic Call Monitoring” some applicants have withdrawn from the process once this has been established.

Processes around recruitment are also hampered as DBS applications can be held by the Local Police Force for up to 60 days before anything can be done to progress these applications.

This means that up to three months after initially offering a position and putting an applicant through training and shadowing can pass before they allowed to work solo.

There appears no rhyme or reason as to why some applications are held up whilst others go through quite quickly, however, in the main it appears to be down Local Police Force’s resource issues – they simply do not have the time or personnel to sift through the process quickly.

Because of this, some Providers have reported that applicants have withdrawn from the application process due to the wait involved. It is a great pity that such an administration issue can result in loss of staff to this industry as just one additional applicant added to a pool of staff could potentially mean the ability to support 6-8 new Service Users.

**Charge Rates:**

The current rate of £16.00ph is not sufficient for Providers to pay rates in line with a living wage. This is one issue facing existing Providers as they are unable to compete with the likes of supermarkets and other non-care related business that can support wages higher in line with a living wage. Front line staff working in the domiciliary Care Sector face many challenges throughout their working day including early starts, travelling between clients and late finishes. There is a feeling that the role of Care Worker is not recognised for the skilled role that it entails and until both local and central government are able to fund appropriate charges it will not be possible to pay a sufficient and deserved wage equal to a living wage or higher.

Reduced rates were encouraged by the Council throughout the lead up to the Tender and their inclusion of a guide rate of £14.50 per hour for Care Services and £12.00 for Domestic Services confirmed their intention to drive charges down.

Indeed, prior to the Contract questions were submitted to the Council relating to the Council’s guide rate Clarification log as follows:

**Clarification log number 009 asked the following question:**

"Using the UKHCA guidelines of 11.4 minutes travel time and 4 miles between service users and assuming the majority of calls are 30 minutes. If a company carried out all the indicative hours for Lizard and Helston of 1902 hours paying current minimum wage of £6.31, the annual employment costs would be £1,399,946. The income from CC based on the guide price of £14.50/hour would..."
be £1,434,108 leaving £34,162 for rent, utilities, admin, supervision etc. It is clearly not possible to provide high quality care on that basis.

Please clarify how the guide price was derived and confirm that it includes provision to ensure that providers meet their obligations under minimum wage legislation.”

The response provided by the Council was:

“The guide price has been modelled by the Council’s finance team and agreed by the Adult Care Health and Wellbeing directorate as being appropriate to meet all statutory requirements in respect of the National Minimum Wage. However Bidders are reminded that the guide price is simply that, a guide price. Therefore Bidders are free to respond to this opportunity according to their own business policies.”

Additional questions were asked as follows:

"a) Is it legal (Care Bill Act in Parliament) moral or ethical for the Council to seek to procure services at a target price of £14.50 when accepted evidence from the UKHCA states that the minimum rate for providers only paying the current Minimum Wage is £15.19, not taking into account the Low Pay Commission’s recommendation of a 3% increase to £6.50?  
b) Can the Council recommend how, with the target rate of £14.50, service providers can provide a quality service and recruit and retain staff without paying in excess of the National Minimum Wage and moving towards paying the Living Wage. The Council’s strategy appears to be forcing Service Providers to pay low wages which does not assist in its Sustainable Communities Strategy”

During the recent costing exercise carried out by the Council Providers asked for the ‘modelling’ as indicated in the Council’s response above to be provided so that it could be included in the discussions but this request was denied.

In addition, a report produced by one the Council’s own Finance Officers was produced after visiting and speak with a number of Providers in March 2015. The purpose of the visits was to gather evidence from Providers relating to their current financial positions as a result of Framework inclusion and Providers involved were advised that the report was to be submitted for use during the costing exercise. Providers were advised by that Officer that the report had been submitted to the Council but when Providers requested sight of this the Council denied its existence.

At this stage we would ask once again for the Council to produce the information relating to the modelling carried out prior to Tender given that subsequently it has been acknowledged that the suggested guide rate is simply not sustainable, as well as the report produced prior to the costing exercise which subsequently led to the uplift to £16.00 ph.

A number of Providers have advised they applied due diligence in terms of developing economies of scale models in line with suggested future availability of work provided by the Council.
Data Inaccuracy and Misleading Information around Procedural Matters:

Data provided by the Council relating to the number of hours available within the geographical zones was out of date and subsequently found to be an inaccurate summary of the actual hours available. This was confirmed by one of the Council’s Finance Officers who visited some Providers prior to the costing exercise.

Many providers were unable to achieve the economies of scale necessary to achieve a sustainable financial model due to the lack of movement of staff within the Market Place, which many Providers believe was as a direct result of the Council continuing to pay (from the beginning of the Framework Agreement) Non Successful Providers at their old rates of pay (i.e. a mainly higher rates than successful providers – later confirmed by the Council to be on average £16.50ph).

This matter was compounded by the fact that the Council began commissioning new work from Non Framework Providers within six months of the contract, who were not under the same restrictions as Framework Providers, could charge higher rates, did not have to use Electronic Call Monitoring or deal with its associated administratively heavy processes and were not obliged to meet KPI requirements of successful Framework Providers. At month 17 into the Contract, the Council continues to work with Non Framework Providers who do not have any of the above mentioned restrictions and, as has been confirmed by the Council charge on average £16.50 per hour for services, which is 50pence higher than even the recently uplifted rate of £16.00 for Framework Providers.

A further compounding issue was that Framework Providers were expected to reduce their charges to the new contracted rates less than one week after signing the contract in June 2014 whilst Non-Framework Providers continued to charge their existing rates.

Many Framework Providers have indicated that this came as a surprise as they had expected their new ‘charge rate’ to begin following the six month mobilisation period. Given that Non Framework Providers were able to continue providing services throughout the first six months of the contract (and some continue to do so) at their existing rates (£16.28) whilst Framework Providers had their rate cut immediately, it is felt that this directly impacted on movement of staff within the market place. Whilst Framework Providers ran into a steady decline Non Framework Providers continued to thrive with some reports from Non Framework Providers advising that the introduction of a Framework was the best thing that had happened to them as they had not had their services taken away from them as advised by the Council prior to the contract but had continued to provide services and had managed to retain their existing rates.

Experience of Discharge Processes:

In respect of procedures around discharge Providers have indicated that often when they are advised that a Service User is to be discharged and a date of commencement/recommencement of service is agreed Staff will arrive at the
Service User’s home at the agreed time to discover they had not been discharged.

The Provider had not been contacted to advise of any delay and often this occurs out of hours adding further complexity to the process.

**Sub-contracting:**

A number of Framework Providers attempted to engage with Non-Framework Providers prior to and during the early stages of the contract. However, because charge rates for many Framework Providers had dropped significantly as a result of the joining the Framework, and therefore any agreed sub contracted rates would need to be lower, the general response from Non-Framework Providers was that they would hold off on any decision to sub contract until the Council began reassessing their own clients. The rationale being, why would Non-Framework Providers agree to sub-contract at lower rates when they were still continuing to work with the Council at their existing rates which were higher?

**Electronic Call Monitoring and Billing using CM2000:**

Prior to Contract Providers were led to believe by Council Officers that Electronic Call Monitoring (ECM), had been fully piloted but concerns were raised by a number of Providers involved with the Piloting who explained that the financial model of this process had never been completed during the Pilot. This resulted in Framework Providers being subjected to the use of a partially functioning and administratively heavy billing system and despite very many promises from Project leaders within the Council of the implementation of full finance manager system the system Framework Providers are working with is still only partially functioning at month 17 into the contract. Indeed there is a feeling that current Framework Providers are acting as a Pilot for this system and had they been made aware of this prior to contract this may have had an impact on their decision to Tender.

Electronic Call Monitoring (ECM) was introduced in August 2014 and the introduction of minute by minute billing in October 2014.

Council Officers have maintained that the primary purpose for introducing ECM was to monitor quality and to ensure missed visits were captured. Many Providers have indicated that they are fully supportive of the use of ECM for these purposes and believe that some form of monitoring is a useful process. However, the use of CM2000 and ECM for billing has caused problems for Providers and the Council since its inception in October 2014 and at month 17 into the Contract the process is still not accurate.

At the time of its introduction it was clear that the Council were unable to ensure payments to Providers under the minute by minute billing structure as it was not fully operational. This resulted in the introduction of an interim billing period, which hugely disadvantaged Providers in terms of administrative duties and was inequitable across the delivery of services, as it was known that not all Providers were billing the Council under the requested process but were still being paid for the services they delivered on a planned visit basis.
The Council indicated 3 times throughout the initial introductory period that unless Providers submitted invoices based on actual delivered services, as opposed to planned visits, they would not be paid and eventually this led to ‘bonus’ payments based on percentage delivery being made to those providers who had managed to make the partially functioning systems work.

This resulted in further inequitably as the way in which these bonus payments were calculated did not appear to take into account the number of Client Contributions each Provider had to process nor the weighting of multi-rate vs single rate clients which caused a great deal if additional administration. In addition, those Providers who were not able to bill as requested were still faced with the same difficulties around billing which took many months to resolve and it is felt that this could have been avoided had the Council Officers listened to Providers at the time of the billing introduction instead of ploughing ahead with such an inadequate and untested process. In essence, the provision of a bonus payment was viewed as process by which the Council could justify such a poorly implemented process. It did not help those Providers who were struggling to implement the system and given the system was flawed, untested, and partially functioning this compounded the efforts of Providers to get the system to work for them.

No information relating to the process of ‘interim billing’ was presented by the Council as part of Tender Process, nor was it indicated by the Council prior to Tendering, it is believed that no Provider could have factored in the additional costs relating to the introduction of interim billing by the Council and on this basis it is suggested that interim billing and all that it entails should not have been introduced in the manner it was. This is confirmed by the fact that the full system has still not been introduced over a year and a half into the contract. In sum, the Council has struggled for at least 16 months to get its billing system to work, it did not fully test the system prior to the contract beginning and because of this it is felt that Providers were misled prior to the contract over the requirements of ECM and the use of CM2000 system.

**Purchase Order Provision:**

Prior to the Framework concerns were also raised with regard to the Council’s inability to provide Purchase Orders on time and containing accurate information – this has always been an issue and for years prior to the current Framework Providers have brought PO provision to the attention of Council Officers.

The Council Officers involved in meetings prior to the current Framework indicated that this was something they were aware of and would have to ensure that appropriate processes were in place to deal with such issues when the Framework began.

As we enter month 17 of the contract the issue of timely and accurate Purchase Order provision has yet to be resolved resulting in much additional work for Providers from both a delivery and payment point of view.

The Council was made aware again of issues around non receipt of Purchase Orders at the time of Commissioning from the start of the Contract. However,
Despite being asked about this on very many occasions and despite being promised a responses there was no change.

Providers were advised in early 2015 that a ‘legal’ problem relating to Purchase Order Provision had been identified which meant that these could not be emailed to Providers.

Notwithstanding the fact that Providers were led to believe PO provision issues would be resolved prior to contract, emailing of POs was eventually introduced by the Council approximately six months later and there was a suggestion by some Officers that this had now resolved the issue. However, this has still not addressed the provision of timely and accurate provision of these orders as timely provision is dependent on assessment and re-assessment information being entered onto the Council’s own systems then disseminated to Providers at the point of entry. This still does not happen and Providers are still faced with additional administration as a result of the Council not having resolved this issue.

Invoices are returned unpaid advising that because assessments have taken place resulting in new Purchase Orders being raised containing changes to charges the invoices are incorrect. The invoices are incorrect because the new information was not provided to the Providers quickly enough for them to update their own systems with some new information still only arriving 4 – 6 weeks after the changes had occurred.

Information relating to the introduction of Client Contributions following the Council’s financial assessment of Service Users does not reach Providers in time for them to include this information on invoices, which consequently results in numerous invoice returns for amendment resulting further in delays in payment. And, often Service Users appear to have been assessed incorrectly and this results in further delays in payment to Providers whilst discrepancies are investigated.

Services Users appear confused and concerned at receiving invoices and will say that they simply do not understand the process of client contributions. Unfortunately, explanation of such issues falls to the Providers as the Council’s default response is that the Service Users are provided with all the necessary paper work at the time of assessment.

**Mistrust of Council Officers:**

Within the first six to nine months of the contract the Council did not acknowledge the disparity across the Market in terms of how work was being commissioned and did not appear to recognise the impact that this inequitable process was having on successful Providers. Many Providers tried to inform Council Officers within the first six months of the contract that they were experiencing problems and whilst Officers would meet with Providers to discuss such issues many were told that they were the only Provider who had raised these matters. However, it soon became apparent that this was the default response from Council Officers as many Providers had become aware that they were being told the same thing.
This led to Provider suspicion of Council Officers and a feeling that when concerns were raised these concerns would either be completely ignored or lip service would be paid with no resultant resolution being provided.

Because of this, Providers contacted Cllr Jim McKenna to discuss their concerns in early January which subsequently led to the formation of a Framework Representative Group being formed in an attempt to address the numerous concerns Providers felt were not being appropriately responded to by Council Officers.

**CORMAC AND CorCare – Council Spine Provider:**

Existing Providers have been advised by the Council that to address the issue of capacity CORMAC’s Cor Care has been created in an attempt to cover shortfall within the sector however, there is a feeling amongst existing Providers that an inequitable process has been supported by the Council.

When Providers became aware, through media coverage of this service, that a living wage was to be a starting point for those working within the service this caused considerable concern amongst existing Providers as it was felt that in order to support such a wage, costs to the Council for such a service would inevitably exceed the recently authorised uplift figure of £16.00.

Providers have tried to establish whether the charges they have been capped at are equal to or at least close to those agreed with CORMAC but neither CORMAC nor the Council have been willing to discuss this.

Existing Providers have previously been advised by numerous Council Officers and Cabinet members that CORMAC’s COR Care domiciliary and STEPS service has simply been formed to pick up cases in the event that existing Providers (both Framework and Non Framework) are unable to service.

However, this position seems contrary to information presented [here](http://www.cormacltd.co.uk/latest-news/2015/october-2015/new-care-services-for-cormac/)

in which it states "*The new home care agency will initially run as a pilot project and will be up and running to offer support services to people who wish to use their personal budget or private payers from April 2016.*"

To clarify, Providers fully support any quality service that will be in a position to assist with capacity issues across the County and fully recognise the Council’s need to take action to address such issues.

Providers have been advised that COR Care is treated as an external provider in the market and Cornwall Council are holding them to account through robust contract monitoring and performance management processes as with other providers in the sector. However, whilst, COR Care may be subject to the same requirements in terms of monitoring and performance management existing Providers have questioned whether Cor Care is expected to deliver these same
services at the same hourly rate of £16.00ph at which current Providers are expected to deliver and develop their services.

A higher hourly rate would clearly enable any business to develop their services at a more rapid rate and whilst CORMAC has initially indicated that they are in the market simply to cover current unmet demand their literature suggests that this is not the ultimate aim.

Indeed, Simon Deacon Director of Operations for CORMAC has said the following about their new service: "This wasn’t something that was on our horizon and we did not have plans to enter the care sector, but we are happy to use our commercial and service driven ethos to help the Council find a solution to fill some of the gaps and help individuals receive the care they need. In the long term we are hoping to further develop the service in a way that we have done with other areas of business.

To clarify matters with current Providers it has been requested that a meeting be held between the lead commissioner and Providers, which would allow CORMAC the opportunity to allay any concerns existing Providers may have in respect of its current and future services and hopefully enable an ongoing positive and solution focussed dialogue with the aim of addressing issues of capacity across the County. Unfortunately, this suggestion has not been taken up by the lead commissioner.

Ultimately, it is felt that the Framework Agreement no longer appears fit for purpose based on the current market and as we move towards joint commissioning decisions to continue with such onerous and partially functioning systems required under the current contract seems nonsensical.

KCCG has made no clear commitment to the future use of ECM or the use of CM2000 ECM for billing and as KCCG work with many more domiciliary Providers than the current 23 involved with the Framework it is not clear whether continued use of the system for all would either be practical or cost efficient. And the fact that over half way through the current Framework contract issues around ECM and billing have still to be resolved it begs the question as to why KCCG would want to pursue a system that is not fully functioning and only serves to cause many Providers increased administration.

It is clear that the ability to recruit is having a serious impact on the Sector as a whole and this is unlikely to resolve quickly in what has turned into an inequitable Market where ‘Successful’ Framework Providers are working hard to meet the many requirements and restrictions of a Framework Agreement whilst non Framework Providers continue to supply the Council with Services without such restrictions and responsibilities.

In addition, existing Providers fear that they will soon be in competition with the Council’s Spine Provider who appears to sit outside of the process in terms of a restricted charge rate of £16.00ph and as such could potentially build their service at a more rapid rate than existing providers.

A number of Providers have advised that if it were not for injections of personal cash or for the ability to use monies from additional services (i.e. Care Homes)
to prop up their domiciliary care provision they would have had to close their doors within the first 6 to 9 months of the contract. Despite such matters being brought to the attention of Senior Officers within the Council it was not until the intervention of Cllr Jim McKenna that these issues were taken seriously and if it were not for his intervention and subsequent application to Cabinet for an uplift in charges some businesses would no longer be here today. The ramifications a number of mid to large organisations being left in the position of no longer being able to provide care for such reasons are that lack of capacity could increase to in excess of 3000 to 5000 hours per week within a very short period of time.

In sum, it is felt that the current Framework Agreement is no longer tenable due to the fact that the landscape has so demonstrably changed since June 2014 and the agreement only serves to hamper efforts to deliver Care Services within the County of Cornwall. The Framework in its current form has not resolved capacity issues despite the best efforts of all Providers involved (whether Framework or Non-Framework) and it is felt that the unwieldy nature and overly administrative complexity of the Contract has obstructed the process of Care delivery by placing additional, unnecessary and untested, burdens on Providers who struggle daily to meet the demands of delivering a quality service in a grossly underfunded industry.

Lot 1 Provider Representation
Written Evidence Submission from Cornwall Partners in Care

A lot of the questions contained within the key purpose and scope of the Care at Home inquiry are directed at me as a single framework provider but, as Chairman of CPIC, I have arranged for the answers to be representative of the sector as a whole.

1/ Will the steps in terms of pricing and a spine provider be sufficient to support and enhance private sector care at home provision?

- The uplift was a good idea in principle, but was not sufficient to make things work. It is a “sticking plaster” which will not address the additional costs associated with the introduction of the living wage in April. Although the UKHCA costing model was used in the costing exercise and CPIC were instrumental in bringing the relevant parties together, the Council adapted the model to establish a rate of £16.00. Had the Council used the specific model a higher rate would have been achieved.

- The spine provider will not solve the capacity issues and should not have been necessary had existing providers been paid at a rate which would allow recruitment and retention of staff. The spine provider, having more generous terms and conditions, could make the situation worse by drawing staff away from existing providers and could become more than a “safety net” provider if the current “uneven playing field” is not addressed.

- The Direct Payment rate has not been uplifted and remains at £14.50 until cases are re-assessed which could take up to a year, and many providers are working in the dark as to when these assessments are due.

2/ How do you think the system will cope with winter pressures?

- Providers need to be paid at rates which enable them to recruit, train and retain staff.

- CPIC Committee members have been engaging with the Council and NHS Kernow to look at how the sector can assist in reducing bed blocking, and we are happy to continue with this engagement - although it needs to happen in a more coordinated way. Some other issues need to be considered - such as the payment of retainers to providers so that Service Users do not have to be “re-brokered” when they are admitted to hospital. Providers assessing the timings of their own packages - rather than waiting for Council staff to undertake a full review - could also release some capacity into the system.
3/ You bid at a rate which you had established, what has subsequently changed in order for the system not to work effectively?

- Bids were based on the Council guide price of £14.50 which was set too low, and we have been given no evidence as to how this guide price was set, and so we have no indication if due diligence was undertaken. Many providers chose not to bid because they realized that the contract would be unsustainable.

- Since the introduction of the framework agreement, the whole marketplace has changed beyond recognition as a direct result of the following factors:

  1. Care Act
  2. Care Certificate
  3. CQC – higher level requirements
  4. Pensions
  5. Minimum/Living wage
  6. CHAS
  7. Data Control requirements
  8. Administrative burdens such as CM2000 and KPIs
  9. High employment
  10. New higher wages paid eg by Lidl and Aldi
  11. Sub-contracting arrangements proving to be unworkable.

4/ How did you respond to packages of care pre June 2014?

- Spot purchasing - whereby over 100 Approved Providers put in bids which reflected market rates and the true cost of care. There was a healthy competitive market which involved all providers of care who were on the Approved list.

- NHS Kernow are still using spot purchasing arrangements.

5/ What issues did you have prior to the framework contract?

- There was a healthy diverse market prior to 2007, but from 2008/09 there was a process of destabilization due to a downward pressure on pricing, which conflicted with increased costs due to Working Time Directives, the minimum wage and increases to National Insurance.

- Spot Purchasing was more flexible, and allowed the above factors to be taken into account and, where necessary, higher rates could be paid to staff to recruit, train and retain staff, as care workers were beginning to exit the sector.

6/ What are the experiences of discharge processes with care at home packages?
• There is little communication/interface between hospitals and Care at Home providers, and discharge planning needs to be improved and “bridges built”.

• 7 day per week brokerage would assist with capacity issues.

• The list of Council packages awaiting placement with providers is not always updated in a timely fashion.

7/ What is the level of staff retention and recruitment, and what is being done regarding workforce?

• The fundamental issue of recruitment and retention in the Health and Social Care sector has been made worse through the introduction of the framework agreement.

• In times of full employment the problem becomes more acute, and because of Tax Credits a large percentage of the workforce will only work part time, requiring more personnel to cover the same hours.

• New living wage uplifts will improve staff terms and conditions but they will still see themselves on the “minimum”, and therefore we will have to pay substantially more than this “minimum” because people can get the same money in jobs which have far less responsibility, and are more flexible and family friendly.

• These problems are not helped by the low profile of the sector - which is not helped by the “blame culture” directed at providers and associated negative media attention.

• Job Centre Plus have provided evidence to demonstrate that job seekers are unwilling to take up posts within the health and social care sector because of low pay and unsociable working hours.

8/ How is the voice of the person in receipt of care (and their families) heard?

• Our staff speak to them every day and feedback is encouraged so that Team Leaders and Managers are aware of any issues.

• Families and interested parties are involved in the assessment process.

• Quality Assurance questionnaires and Health Watch ensure that the voice of the Service User is heard.

9/ How do you see the sustainability and modernization of care at home services?
• Since the introduction of the framework agreement the sector seems to have gone backwards.

• The sector has been put through a process which was both costly, onerous and extremely stressful. It should be recognized that the capacity issues currently facing the sector could have been far worse had providers of all types not used personal reserves to keep them sustainable until the uplift was received.

• Commissioners of care do not seem to understand the pressures facing providers.

• Providers need to be treated as equal partners through meaningful dialogue and true engagement.

• National evidence from the Kings Fund regarding demographic and cost pressures facing the sector do not seem to have been taken into account.

10/ What is your biggest lesson from this process and/or what would you do differently if going through a similar one in the future?
• The first tender was challenged and acknowledged as being flawed. The evaluation process was compromised – “scoring” was the area of the challenge which was successful. If it were not for this failure, we would not be where we are today, and significant costs would not have been incurred by the Council and individual care providers.

• The tender fragmented the market, and a “divide and rule” philosophy has damaged relationships

• The second contract was put together in a legalistic way with significant input from solicitors and accountants with no due diligence to ensure that the measures contained within the contract were practical

• Linked to the above point, sub-contracting arrangements have proved to be unworkable, despite attempts to make the arrangements work.

• There have been huge administrative burdens placed on providers due to the cumbersome nature of the contract. For example, Key Performance Indicators which have not been equally applied to all providers

• Despite initial consultation with providers on the introduction of Electronic Care Monitoring, the pilot scheme was halted with no proper evaluation and agreement on matters such as minute by minute invoicing.
• Health not being part of the tender was a major shortcoming as it has enabled some non framework providers to thrive. It was always assumed by the Council that staff would move from non-framework to framework providers although this never happened in practice. The Council were not conversant with TUPE requirements as they assumed it would be relevant to Lot 1 providers which was not the case. All providers were asked to submit TUPE information which further destabilized the market. The size of the contract was over estimated as Health data was included.

• There appears to have been insufficient expertise within the Council to introduce the framework agreement. A lack of leadership, provider engagement, and project management has hampered the process.

• A lack of accountability has meant that problems have not been addressed in a timely manner.

• A report prepared by Angela Stevens from the Councils’ Audit Department reviewing some of the shortcomings of the framework agreement was never shared with providers.

11/ How has the communication been between those involved?
• There was no opportunity for providers to have a say in what would or would not work - even after the failure of the first contract when there was a request for dialogue which was ignored. During the two tender processes there was a complete block on provider engagement which lasted for 18 months.

• There seemed to be a lack of accountability with a perceived reluctance to engage with the sector at the start of the contract when problems became apparent, and this continued until Councillor McKenna as the Portfolio holder agreed to get involved.

• Communication with non framework providers was only initiated when capacity issues and “black alerts” were apparent.

• The tone and approach of council communication has appeared to be defensive and patronizing with no vision, plan or solution when providers presented problems. This lack of real and meaningful engagement has undermined Council credibility and working relationships, and is a key issue which needs to be addressed if the sector is to move forward in a positive way.

12/ Recognising the differences in scales, is there anything that could be learnt from national providers or national representative organizations?
• From the onset of the tender process, providers were in touch with UKHCA and Care England – the problem was that the Council would not acknowledge this input.

• The recent pricing uplift was based on a UKHCA costing model and CPIC were instrumental in bringing the relevant parties together.

• The current UKHCA costing tool specifies rates which flex according to new cost pressures such as the living wage, new pension requirements etc, and needs to be acknowledged by the Council as a tool by which the true cost of care can be recognized.

DLS
25/11/15
Written Evidence Submission from LOT 2 Providers

Lot 2:
We provide 24/7 care in line with Cornwall Councils key commissioning strategies which are aimed at improving individual and strategic outcomes and supporting people to live in their own homes for as long as they wish to.

We achieve this by delivering high quality services that are flexible and responsive and give people choice and control over how their care and support is provided.

Whilst we are here today representing the Lot 2 Sector our own individual organisations deliver in excess of 14,000 + hours per week (United Response 6,000+ hours – Brandon Trust 8,000 +hours)

Processes Undertaken:

Framework for Care at Home - Implementation 1st July 2013.
The first process undertaken in 2013 was based on ‘Quality’ and as long as providers met the quality standards they would retain their existing business. Providers quoted the rates that they were prepared to bid for any new business that was offered through the Framework.

The Guide Rate was quoted as £15.00 per hour.
Whilst we recognise that the failure of this process had a financial impact on the Council we would like to remind all concerned that there were also costs incurred by all contributing Providers. The costs to United Response were in the region of £54,000. This was similar to the costs for Brandon trust resulting in an overall cost in the region of around £100,000+ for both organisations.

Framework for Care at Home - Implementation June 2014.
The second process held an element of quality but was heavily weighted as cost competitive. Providers were now disadvantaged, as through the first process the Council had the previously disclosed hourly rates that organisations were prepared to bid for new work.

The Guide Rate was quoted as £14.50 per hour.
Our businesses were now at greater risk with the second process as it was very evident that there was a general theme of reducing providers and moving to sub-contracting and no agreement to retention of existing business leading to the potential risk of losing ALL of their provision in the County. Throughout the Tender process a recurring theme was that there was to be a drastic reduction of Providers across Cornwall, with unsuccessful Providers potentially sub-contracting to Framework Providers. Provider bids were based on economies of scale due to major growth.

The above factors led providers to come forward with their best possible price. Both tenders were predicated on growth.

Expectations of Growth for Successful Providers.
Framework Providers were called upon to present their Business Implementation Plan at a face to face meeting at the Council. United Response implemented a structure which cost £84,000 in order to position themselves for rapid growth. This was welcomed and complimented by Council officials, who expressed their gratitude that we had positioned ourselves so well. At no point was it stated that this was excessive or that there would not be a mass mobilisation.
At a United Response meeting in August 2014 with family members a senior commissioner advised that there were 183 people in receipt of support in Lot 2 who’s provider had been unsuccessful in the tender process and that there had been a significant increase in the number of Direct Payments across the County. There in reality, was very little growth in business across the county.

**Savings Given to the Council**

In 2008 the average rate for Care was £22.00 per hour (allowing us to facilitate expensive TUPE transfer staff from NHS). The cost of contractual change for Brandon trust in order to support a sustainable workforce was £1million pound which was found from organisation reserves.

In 2013 this reduced to £15.69, followed by our Framework rates being applied in June 2014.

For United Response based on an average of 6,000 hours delivery this equates to **Savings to the Council of just under £2.5 million**. For Brandon Trust this figure is in the region of **£3 million giving a combined total of £5.5 million**

With each rate reduction this has meant extremely costly re-structuring and hence redundancy payment costs etc. which further extends our losses.

**The inequitable treatment of providers in Cornwall leading to some, like UR and Brandon being put at severe commercial disadvantage.**

For the Councils ‘Successful’ Framework Providers their new reduced rates were implemented with immediate effect in June 2014. **For United Response this meant a reduction of £425,000 from their budgets and for Brandon Trust this was an even higher figure of £650,000.**

For ‘non-successful’ providers they were allowed to continue on their previous rates for a further 6 months+ and were then almost 100% supported to move across to the Direct Payment rate of £14.50 which has now been increased to £16.00 with the recent uplift that has been afforded to Lot 1 and those with Direct Payments. This has very clearly skewed the recruitment market place and forced us to have to uplift our rates of pay in order to attract staff. This has meant a substantial investment from reserves for both organisations. This cost is year on year.

There was a **very clear timeframe and Mobilisation Plan to support families of ‘non-successful’ providers to move to Direct Payments.** This was achieved within the first 6-9 months of the new Framework.

There has been **no Mobilisation Plan to support the families of the ‘Successful’ Framework Providers to be moved across to Direct Payments**, which has the added benefit of providing ‘peace of mind’ for families and people supported from potentially losing their provider at the next Tender process.

**Conclusion**

We understand the climate we are currently working in is extremely financially challenging and **we are not asking for ‘preferential treatment’ – just equality.**

We have been involved in on-going negotiations and discussions within Jim McKenna’s Meetings with Care Provider Group for almost 12 months and completely understand the pressures on Lot 1 with bed blocking at the Royal Cornwall Hospital, but the question is now about sustainability.

We have been committed to Cornwall and continue to enjoy an excellent relationship with commissioners but **our organisations have been commercially disadvantaged by our success on the Framework** and both
our organisations are now having to supplement our income from our organisations reserves. The financial situation is now critical, to the point where serious consideration is being given by each organisation with regards the ability to continue to operate in Cornwall.
Written Evidence Submission from Non Framework Providers

Submission by Mary Anson – non framework provider.
Responses compiled from both personal experience and from information given during various consultations with other non-framework providers.
Prepared November 2015

1. Will the steps being taken in terms of pricing and a spine provider be sufficient to support and enhance private sector care at home provision?

Unlikely now the new NLW has been announced. This has been set at a very high level. Traditionally care providers (in Cornwall) have always strived to pay above the NMW in order to try to attract staff into the sector and away from other, less challenging jobs such as retail, supermarkets, tourism, etc. I really doubt we will be funded well enough to continue to have this ‘edge’ on other local employment sectors which, if we can only match, rather than better, the pay rates in supermarkets (for example) will make the situation for care even worse, not better, despite the welcome increase in the new minimum (the Living) wage, which is on its way. Our carers will now be bumping along the new, albeit higher ‘bottom’ instead of just above it, as now. The spine provider is advertising and competing for staff at higher rates of pay and attracting staff away from ourselves.

2. How do you think the system will cope with winter pressures?

Without a significant tranche of new care staff coming into the sector, we will not be able to make much if any impact on the winter pressures; it will not be helpful either, if the domiciliary care market improves pay so that it draws carers away from the residential care sector, as this will only move the problem around- and vice versa.

3. You bid at a rate which you had established, what has subsequently changed in order for the system to not work effectively?

There are different types of non-framework provider, and who are generally in different positions now:

1. Those who were never interested in tendering at all and did not attempt PQQ – so did not bid at any rate
2. Those who failed at PQQ so were not eligible to tender (and were not allowed to see the tender details) so could not bid at all
3. Those who passed PQQ but decided the terms of the tender requirements were not something they felt they could work with so did not continue on to submit a tender – they did not bid at any rate
4. Passed PQQ but failed at the tender (ITT) stage – these did put in a bid, but failed to get through for varying reasons, not necessarily related to the bid rate.

As a care provider who failed, on very spurious and ill-informed judgements, to even get as far as the tender (as at Point 2 above), I was one who was therefore not in a position to tender at all. So nothing has changed (as per
your question) for me. My failure to qualify at PQQ was because the process indicated that my financial gearing was wrong and therefore my dom care service was not viable, something that is patently not true (bank letters of support were subsequently offered). The process failed to take into account that my ‘gearing’ included capital debt for four residential care homes. This was particularly inept of the people who wrote, approved and evaluated the tender document. My dom care service is not a stand-alone limited company, so the accounts as requested involved my whole service. This was not understood by council. However, there have in any event been many changes which have affected all agencies since the tender process began. These are: The Care Act; Auto-enrolment of pensions; implementation of the National Living Wage; tax credits. Certain supermarkets, and STEPS (now Cor Care) were (and still are) paying considerably more than is possible for many of the rest of us. In times of labour shortage, the ability to reward staff is crucial.

4. How did you respond to packages of care pre June 2014?

Speaking from a personal perspective only, I (and at least one other that I am aware of) were held back from taking council funded work due to the council’s own bureaucratic processes which, although registered with CQC, could not enter onto the former ‘preferred provider’ list. Consequently these agencies had to wait – for years in some cases – with a service the council’s conditions meant it was not allowed to use. Your loss!! The agencies thrived without council funded work. Several agencies set up in Cornwall having achieved CQC registration since the start of the last ‘preferred provider’ list several years ago. The council excluded itself from using these agencies by its own bureaucratic processes, by excluding new entrants into the market. These agencies established their own market position, operating successfully with heath- and privately-funded clients. Some of these saw no reason to tender for council funded work when the opportunity to apply (the tender) took place; others, at not inconsiderable expense, passed the first tender process, both at PQQ and at ITT, only to have this disregarded when the council’s own flawed process resulted in the first tender being abandoned after a legal challenged.

This resulted in considerable disillusionment with the council as a ‘partner’ it was safe to do business with, let alone tie themselves into any sort of onerous contract with. The second tender was badly designed, as it ruled out some agencies at PQQ stage for spurious reasons where the council literally failed to understand ‘gearing’ (as in my own case), ruling my service as financially non-viable – the council had set criteria which were unable to take into account the accounts where another service (a care home with a totally different capital debt structure) required a significantly different financial structure to that of a stand-alone domiciliary care agency. Another (not for profit) provider failed at the same point by missing a deadline by 24 hours, having omitted in error to supply a copy of the insurance certificate – again, at a considerable loss of potential capacity to the council. Non-framework providers now tender for work at what is a viable rate for them, and are only restricted in capacity due to the availability of staff. Many of these agencies now pay their staff considerably more than agencies
on the framework. Non-framework providers are generally able to operate at rates and conditions which are better, and therefore more viable, than those who were successful at getting onto the framework. Surely, a state of affairs which the council has brought on itself, but which is divisive within the sector itself and which risks the loss of framework providers who are considering exiting the market, leaving a situation where non-framework providers could be the more likely to survive than the ‘successful’, framework, providers.

5. What issues did you have prior to the framework contract?

An inability to make my viable service available to the council; hence I did not recruit staff in sufficient numbers which would allow us to take on council funded work at a time when recruitment was actually easier than it is today. We only carried out work for health- and self-funded clients, usually end of life care or other short term packages. As it is, our service continues to run well without having to depend on the council, but our staffing levels restrict our ability to take on much current council funded work.

In actual fact, the sector worked reasonably well until somewhere around 2008/09 when the council employed an officer (called [REDACTED] I believe) whose activities in preparing the ground in order to implement a tender process began to pull the sector apart. While she did not stay for long, it was long enough to commence the unravelling of the sector into the capacity crisis the council is experiencing now.

6. What are the experiences of discharge processes with care at home packages?

Common to all services - framework, non-framework, and care homes too - are some major problems which occur all too frequently, and which put service users at risk, thanks to frequent inaccurate or lack of information being supplied by the various NHS and social care personnel. This is presumably due to the pressures to get someone out of hospital regardless, it seems, for what might happen to them after an ill-informed and inaccurate handover to the provider who is often left without the right information which would allow them to provide safe care. This has led to a lack of trust by agencies and care homes alike. These errors include, but are by no means exclusive: failure to notify providers about a relevant medical condition; failure to inform about the need for pressure relieving equipment; late transport for discharges; generally poor communication; inaccurate or no medication coming out with the client; no discharge summary; to list just a few.

7. What is the level of staff retention and recruitment, and what is being done regarding workforce?

The social care workforce in Cornwall ‘recycles’ around different providers, often returning more than once to providers they have already worked for previously; and a percentage exits the sector altogether. Different providers are working on this in different ways; given the challenges of recruitment I do not intend to share my own solutions which I am trialling at this time. The problems vary anyway, from area to area: transport, cost of driving lessons and car ownership, the impossibility of using public transport, as well
as the difficulty in paying travel/mileage costs at a level which maintains a car in a reliable condition at all times. Even training requirements, when other employment sectors do not have such onerous conditions, is a factor, as is the potential but real risk of criminal prosecution for omissions and failures such as those which might be caused by the need to ‘rush’ to the next client, are all deterrents to seeking this sort of employment. Media coverage of care headlines, together with the perception that this is low status work for poor pay, is enough for some potentially very good candidates to feel that a career in care is something they do not wish to be associated with – the impression often being that carers and care providers, are generally considered uncaring, if not actually abusive. These things all affect recruitment, and while appropriate training and robust exposure of poor practices are vital, at times of labour shortage, these compound the recruitment challenges.

8. How is the voice of the person in receipt of care (and their families) heard?

We ask them!

9. How do you see the sustainability and modernisation of care at home services?

At the moment it is going backwards.

10. What is your biggest lesson has been from this process and/or what they would do differently if going through a similar one in the future?

Probably not to engage with council funded work at all, without much greater transparency in the process, and less penalties attached where matters are outside our control (eg recruitment difficulties), and without adequate funding which would enable us to attract the best calibre staff.

I think the council has more to learn than the sector. For example, it was very naïve to believe that staff could be TUPE’d across from non-framework to framework providers. That would assume that non-framework providers did not provide any other care, such as to either health or self-funders, or domestic and other unregulated support. It also assumed that staff had no loyalty to their employers and would be happy to be ‘transferred’ to another. Some exited the sector at this time. Unless the business itself was taken over, or the service users themselves were the employers, a TUPE transfer could never have applied, and was something CPIC tried to warn about, but was not listened to, at the time.

11. How has the communication been between those involved?

Not straightforward! Lack of meaningful engagement during the tendering process, presumably because of fears of legal challenges.
12. Recognising the differences in scales, is there anything that could be learnt from national providers or national representative organisations?

The differences are not just in scale; Cornwall is predominately rural and carers largely need to be car drivers. Plymouth, Exeter, other cities, can have care ‘runs’ where many carers can be non-drivers. That has nothing to do with scale.

Cornwall’s challenge includes a number of factors: as a historically low-wage economy there are relatively more people on HB (housing benefit) and tax credits, than better off parts of the country. This means our existing carers are less able to take on more hours as it is not to their advantage to lose tax credits or HB. More are therefore part time from choice (which also makes childcare arrangements more manageable/affordable). This requires Cornwall to have more ‘numbers’ of staff to cover the same hours of care than other areas where more fulltime personnel are available.

Cornwall is the ‘longest’ county in England but has a relatively low population (the population of the entire county matches just the Exeter travel to work area, where service users are concentrated in a far easier to reach geography, as are the carers – and where even there, they have recruitment challenges; ours are just that much worse). The Cornwall working population has other options open to them, and potential staff are not located in areas of density in sufficient numbers that makes it economically viable to meet the care needs of the disparately located service user population – and certainly not at the funding levels currently provided.

Second Submission of Written Evidence – Non Framework Providers

Non-Framework Providers answers

Produced by Tish Berriman
Trelawney Domiciliary Care

Questionnaires were sent to many Non-Framework providers for input into the questions. Where providers’ responses have been included their responses are in the boxes.

It is important to be aware in the first instance that the majority of providers applied to the Pre-Qualifying Questionnaire [PQQ] to enable them to be able to tender. However, even if they had been successful at PQQ when the tender was put out, many providers then made the decision not to tender. Some of the reasons given by these providers are as follows;

"decided against applying mainly because put off by the implied consequences of what would happen if unable to provide capacity, plus doing the sums felt being held to a precise financial figure which gave no room for movement to accommodate for future expenses set by legislation/own business plan. Was totally unrealistic and unsustainable and therefore we just couldn’t commit"
"I got through the PQQ but decided, because we were only small, I would be unable to do sufficient bidding of packages. This has subsequently been changed and if I had not had to bid on 90% of everything would have submitted a bid for lot 1."

"I choose not to go forward with the second tender after being successful in the first tender and second PQQ as I knew that the fixed pricing tool could not sustain the standard of care provided. Also did not take into consideration of any forward planning, now living wage, pensions, and training”

My service – at not inconsiderable expense - passed the first tender process, both at PQQ and at ITT, only to have this disregarded when the council’s own flawed process resulted in the first tender being abandoned when it was legally challenged.

"We got through the PQQ, but were unsuccessful due to our bid price in the tender” this was the reply from many non-framework providers

Many providers who did apply to the tender were not successful and this they feel is because they went in at a price that they felt was sustainable for their business but was failed because the figure was too high.

Many providers feel that the system prior to tender was working well, with packages being put out to all providers to be bid on. Many providers feel that the Council has “brought this on themselves” with regard to some of the problems in the sector.

When the tender began, over the next 6 months or more, non-framework providers were being contacted by brokerage on a weekly basis to inform them that one or more clients had been assessed, their package put out to successful bid on the Framework, and that our care would finish with only a few days’ notice without any prior knowledge that this was happening. This culminated in destabilising the market due to the following reasons

Clients’ removal from runs left gaps in runs which could not be filled as we were not being offered any other work.

Staff were having gaps in their runs and were left wondering where things were going

Staff were with clients who were distraught at losing their staff who they had become reliant on and this upset many of them greatly. This left providers in a very difficult position, and most providers at that time just saw a large abyss and they were going down it financially. Businesses that had been built up over many years were disappearing in front of provider’s eyes and there was nothing that providers felt they could do about it. Providers were still legally needing to pay staff who had contracted hours, many agencies do not use zero hours contracts, but alongside this, they were finding that their businesses were reducing by a third to a half in a few months, no businesses can sustain this. This put many businesses in severe debt or forced them to close completely.

This did not persuade staff to move to framework providers, but to leave the sector completely as they were too upset with the system. TUPE which had been suggested as an option by the Council does not happen in the Care at Home sector, staff are very much loyal to their provider and to the clients.
Some providers tried sub-contracting but not many. It was not financially viable for providers to sub-contract as they were going to get even less than the £14.50 as charges would be taken out before payment made. Those that did try found it was unworkable.

During this time there was no communication with the non-framework providers in the sector for at least 12 months from the Council. The only way that many providers actually managed to keep going was because of the Health packages that were still being offered to all providers and to take on clients at the £14.50 rate with direct payments. So even though we were not on the framework, our businesses were suffering the same as many framework providers. However, many providers stated that their businesses suffered greatly during this period and some providers businesses are still only 50-75% of what they originally were prior to the tender.

Since this time, and when the Council was then forced to return to the non-framework sector to cover capacity, many providers felt that they did not want to work with the Council due to distrust that they would be put in a similar position. There is also a view of, the Council did not want to work with us then so why should providers now work with the Council, and the only thing to override this view is the vulnerable clients who need care. Clients were being offered direct payments and many had little understanding of what these involved resulting in many refusing to take them and even if they had family members they were also confused as to the situation. We expressed concern on many occasions to the Council regarding how clients could be put in a situation where they were being visited and told that the only way they could keep their agency was if they had a personal budget/direct payment. A stark decision to be made within a short period of time, which many clients and families could not manage. After assessors had left the clients, we would often get phone calls, or our staff would go into the client, and find them distressed as they did not understand what was going on. I and many of my fellow providers as well as our staff were extremely distressed by this situation and when we challenged officers about it, they would inform us that they had communicated with the clients all along and that they had been given all the information. The communication in the beginning from the Council was letters that were sent to clients, with the Council saying that they had identified clients who had disabilities to be able to read them. **WRONG** many of the clients have visual problems, memory problems, which are not identified on a council database of disabilities if there is one; only personal knowledge of clients would have identified these issues which the Council did not have on posting out block letters. We as providers also tried to help clients with visiting them and trying to help them understand the situation. Some have family who look after the post and they may have not even seen the letters or even had the situation discussed with them, and we were aware of this also, especially where the family had made the decision that they did not want to deal with the budget... We were well aware that many clients were informing us that they had not had prior notice of this as far as they were aware. They were in our opinion being given information by assessors who had no clear knowledge of direct payments, and due to this, ended up frightening many clients. Basically these clients in the period 6 months post framework were being told that if they wanted to keep their agency they had to have a direct payment, or they had to be transferred to a framework provider. Imagine a relative or even you being given that ultimatum and how you would feel losing the very people that had been coming to your home over a period of years in many cases and people with whom you had a personal and
trusting relationship to be told they would not be coming by the end of the week !!!!!.
If the client made the decision to have a direct payment, the provider was rang while the council officer was at the house. This was often the first time we would be aware that the client was being assessed. We would be asked if we would continue with the client on direct payments and what was our charge. When we would give the price of £16.28 we would be told that the client had no money to top up and the provider had to make a decision there and then regarding if we would drop our price to £14.50 to continue the care for the client or it would go out to be bid on.
Providers felt that the Councils attitude to these clients was disgraceful and upsetting that the vulnerable people of Cornwall could be treated like this! It went against everything that providers felt were important and it was strongly felt among providers that the client’s rights to dignity and respect were not given.

1. **Will the steps being taken in terms of pricing and a spine provider be sufficient to support and enhance private sector care at home provision?**

The general view is no. The sector suggests that this is a sticking plaster. The pricing increase has not been reflected for clients in receipt of direct payments who are based on £14.50 per hour whereas the framework providers have been getting the £16.00 uplift for their clients from the 5th Sept. Non-framework providers have been informed that this will be done when the clients have their next annual review however, in our opinion this has made a two tier system for clients who the Council place being paid for at a higher rate than those who appear to be penalised for wanting to have a direct payment being given the lower rate of £14.50 for the unknown future at this time. All providers that provide services to these clients are unaware of when that assessment is due as these clients deal with the money themselves, so providers are left in a position where do they increase their prices to the £16.00 and put clients who have not had the uplift at risk of debt or wait another 12 months for the uplift which is not a feasible option for many providers. I was told by a Council official for providers to monitor when clients with direct payments went past their revue date, which we are obviously unable to do!!!

There are many elements that affect the sector and have not been taken into account.
Meeting Regulations;-
Care Act
Care Certificate
Does not allow providers to be able to pay the National Minimum Wage [NMW] let alone the National Living Wage [NLW]
Pension contributions
CQC Inspection Regime
Proposed Increase of CQC registration over the next 2-4 years of over 300%.
There is a proposed increase over 2 to 4 years of CQC Registration fee in
a single location of Domiciliary Care of £2491.00 [2015 = £796.00, Estimated 2018 = £3,287.00].

This does not allow for the provision of a robust and responsive service. Most providers are unable to compete with the wages offered by the Spine provider Corcare and this provider also will run out of capacity also and not fulfil its role. Many providers are now suspicious that Corcare is getting a higher rate than the Framework providers as it is difficult to see how they can sustain these higher pay rates. Providers are unable to compete with local supermarkets who are now offering NLW and there are more moving in to the area.

The pricing set is not sufficient to allow for providers to be able to provide a safe service with the capacity of well trained staff that will stay in the sector and be given a professional path to follow but will continue to have staff who are being paid a low rate of pay for doing an extremely important role in our society. There needs to be a consultation regarding pricing with the whole sector.

Opinions from the sector are;-

Although the uplift is welcome it has already been top sliced by the council. The UKHCA suggested figure was nearly £1 more. Add to this is the fact that this calculation was made before we were aware of the chancellor’s plan for a living wage and this uplift is in my opinion a sticking plaster for an arterial wound.

The spine provider Core care are recruiting staff from within the existing social care staff pool. They are able to provided significantly higher wages and travelling time and are therefore attracting staff from other private care companies. The people they are recruiting are not new to the care sector, they are simply poached from another agency. This will then cause further capacity issues in the sector and will lead to Corcare becoming a main provider rather than a last resort.

2. How do you think the system will cope with winter pressures?

Again, the consensus of opinion is an overall no. Given that we as providers in our experience feel that the sector has not hit the real winter pressures yet, when the really cold weather sets in, and that as capacity is not being managed now, then it is very likely that the system will not cope, and the sector and the NHS will be in a far worse state than it is now, but with vulnerable members of our society and their families being the ones that suffer.

Providers, both framework and non-framework have repeatedly been telling the Council over and over again that there would be capacity problems. The sector needs new blood, decent wages and a career structure to enable us to try to encourage staff into the sector. If this does not happen, we will continue to lose staff to higher paid jobs with less stress, no unsocial hours and going out in all weathers. The low number of care staff left will only continue to move around the sector between various providers and homes looking for job satisfaction and liveable wages as they are doing now causing high turnaround in staff, and the sector will continue to decline even further.

Without a significant tranche of new care staff coming into the sector, we will not be able to make much impact on the winter pressures; it will not be helpful either, if the domiciliary care market improves pay so that it draws
carers away from the care home sector, as this will only move the problem around.

I think the system will struggle to cope with winter pressures. Winter pressures are no longer simply isolated to the winter months. There have been significant pressures on the sector throughout the year. If we have a particularly bad flu season these difficulties will be exacerbated.

3. You bid at a rate which you had established, what has subsequently changed in order for the system to not work effectively?

Comments relating to this question relate very much to the Guide Price and the Pricing Tool that was in place which restricted the price that could be generated and many non-framework provider’s did not even go further with the tender at this point due to the reasoning that they would be unable to provide a quality service or even meet the terms being placed in the Framework Contract.

Many feel that although they did not sign a tender agreement, they have also been forced to take a loss of 13% based on the UKHCA recommendations by being forced to take a £14.50 rate for direct payment which for many of these clients the rate is still £14.50 even though the framework providers have now been offered £16.00 per hour since last September which still does not meet the UKHCA guidelines which Care England also agree with. Direct payments have not been automatically uplifted and will not be until their next assessment, which should be annual, and as we are only two months in to the increase, and assessments are very behind, non-framework providers could have to wait another 10 months before they receive an uplift. Many providers will not be able to continue at those rates and will give up or be forced to close, culminating in more clients needing care urgently alongside the clients already not placed. This is a very real situation for many providers that the Council does not seem to want to take on board.

The Framework agreement was structured in a manner which in my opinion was guaranteed to fail. One of the primary reasons the system failed was that the guideline price was not sustainable and provided insufficient allowance for sub-contracting.

I choose not to go forward with the second tender after being successful in the first tender and second PQQ as I knew that the fixed pricing tool could not sustain the standard of care provided. Also did not take into consideration of any forward planning, now living wage, pensions, and training.

I was not in a position to tender (bid) at all. My company was failed at PWW because the process indicated that my financial gearing was wrong and therefore my Care at Home service was not viable, something that was patently not true (bank letters of support were subsequently offered). The process failed to take into account that my ‘gearing’ included capital debt for four residential care homes. This appeared to me to be particularly inept of
the people who wrote, approved and evaluated the tender document. My Care at Home service is not a stand-alone limited company, so the accounts requested involved my whole service.

My Care at Home business failed at ITT because of missing a deadline by 24 hours, I was moving business premises at the time, did not have access to WiFi and did not receive the E-Mail from Procurement asking for a copy of an insurance certificate that had been omitted in error even though I tried to explain as soon as I was able to access my e-mails again.

My company got through the PQQ and however, because I felt the rate was unsustainable I chose not to Tender. I felt that the guide price of 14.50 was unsustainable. I knew I would be unable to continue to provide a quality service and meet all the many statutory requirements as well as be able to offer an attractive wage for staff at this price. I chose to gamble with the possibility that I may lose my business rather than provide a substandard service and betray my staff by cutting wages.

4. How did you respond to packages of care pre June 2014?

Many companies would bid for packages when they became available and dependent on where their capacity was. Many companies felt that there were not so many problems prior to the tender. Recruitment was still a problem but not quite so much as it is now. However, providers were receiving a higher rate for most packages than the guide price of £14.50 at this time, which was nearly three years ago, so were able to at least try and keep pay rates on a par with other businesses outside of the sector which is a situation they feel they are not in now.

Many companies had a higher ratio of staff than they do now. Companies state that the decline in the staff that they now employ post-framework is due in general initially by a de-stabilising of the market by the Council with the tender process and the effect it had on non-framework staff with the moving over of clients to the Framework companies and no apparent stability in the market.

This was not a problem prior to the tender and most staff were settled in their roles and with their companies although recruitment was always a problem.

Clients appeared to have more accurate assessments, and when a package was bid on, there was more concise information given to the provider about the client either by the case worker or brokerage, which enabled better support for the client initially. Unfortunately, information about these vulnerable clients is now scant and can often be mis-leading and important areas not identified properly, such as Moving and Handling needs, support needs, packages not sufficient to meet the clients’ needs in time allowed. Many providers feel that these vulnerable people are being treated a numbers with no real concern for their welfare sometimes.

It was felt that with the bidding process prior to the tender this allowed a free market which would have reflected in the true cost of Care at Home. It was also felt that there was more joint working with the Council teams and this
provided a better service for the vulnerable clients of Cornwall with better outcomes for them.

We were very selective about which packages we took to ensure they were sustainable.

I (and at least one other company that I am aware of) had never been allowed to respond to required packages (nor was I offered any) because my Care at Home service, although newly registered with CQC in 2010, could not enter onto the former “preferred provider” list which had already been set up and was a closed list. Consequently it is only since the Council are now asking, it appears, all providers to take up packages, that I am receiving them, even though I apparently failed at PQQ!!

We were asked by the Case Co involved or telephoned by the brokerage team. This way of commissioning was more informative of the Client’s needs and discharge requirements [this was prior to the very first tender]

I responded to packages previous to June 2014 through a system of spot purchasing which worked. If we found we had capacity we would often contact social services ourselves to advise them of the fact we had space in a particular area at a given time. This is now a system that we use with our health partners.

5. What issues did you have prior to the framework contract?

The general consensus is that the market was working fairly well, not necessarily ideal, but it was felt to be fairer and that with market force it would be self-ceiling itself with regards to hourly rates. Many providers were still reeling from the very first tender not going ahead. Some providers had invested in leasing properties on the strength that they had been accepted on to the first tender and at the higher rate. Some of the buildings were to be used for housing learning disability, some for expansion within a business such as training rooms. These buildings were taken on leases after confirmation of being accepted, so many companies started to struggle with the extra expense that they were now having without the expected increase in work.

Rates were not sustainable, invoices were not getting paid, and ACHW were not listening to client wishes. There was a lack of transparency. Now it is worse. The current £16/hour is not sustainable for rural areas. We don’t accept packages at that rate. We are still having issues with invoices, especially when funding is withdrawn as the client is assessed able to pay. The issue arises in that neither the client nor the provider is informed until after the event. When determining private budgets, ACHW do not work with the providers to provide the appropriate level of care. We see these as the realities of doing business with the Council and adjust our business model accordingly.
As I was not on the provider list as that had been closed before I began my business, an inability to make my viable service available to the council; hence I did not recruit staff for council funded work at a time when recruitment was actually easier than it is today. We only carried out work for health- and self-funded clients, usually end of life or other short term packages. Had I been able to develop my service at the time, I believe I would have been able then to recruit more carers, and would now have been in a better position to take on packages from the council than is the case today.

The change in Case Co now not being based at the G.P surgery’s which gave us more up to date information about the Client and any changes needed, and having the other persons as District Nurses, G.P., Community Matron, working under one roof in some cases stopped some hospital admissions.

Although recruitment has always been a problem to some degree I would say the ability to recruit staff has deteriorated since the introduction of the framework. Care has always been an area of work that is looked down upon and is not regarded as a career once again this is something that has continued to worsen. There were continued issues with getting purchase orders in a timely manner, this has only worsened.

6. What are the experiences of discharge processes with care at home packages?

When clients are admitted to hospital, there is no forthcoming communication with the providers until the client is ready to be discharged. It is expected that providers keep the space for that client, and this could be many weeks with no payment whatsoever, not even a retainer. The first a provider will usually know that a client is ready for discharge is when the discharge team ring and ask the company to restart the package at the next available visit, often a phone call at lunchtime to restart at teatime. This client may have been in hospital for a few days or even weeks. The presumption is that the provider will restart straight away at the time slot the client had always had. Many providers try to track their clients whilst they are in hospital, but this brings its own problems as the ward staff do not recognise providers as being allowed to know information about the client due to confidentiality, although if the client was asked if they minded their care company being involved many would readily agree. If the client is a big package and could be double handed four times a day, it is impossible for providers to keep that slot open for any length of time. Staff cannot have gaps in their runs; providers cannot pay them for clients that are not there as the providers are not getting paid for the clients as well as the fact that that space could be utilised for another client who urgently requires a service. Providers are financially not able to keep staff in a cupboard ready to restart immediately. There needs to be more acceptances of providers being part of the team and being incorporated within the discussions around the proposed discharge for clients. Clients are often being sent home as back to the ability they were prior to admission, however, mobility becomes a big issue with many clients on returning home. Walking to the end of a ward on a twice daily basis often is
insufficient for when they return home and their needs then are completely different. Many providers have had situations where clients have been returned home as supposedly being able to mobilise with one carer and transfer when in fact that is not the case. Providers often go to a client in the evening, post discharge, and that person cannot stand or turn. The carers and the client are then at risk as there is no equipment to be used and you are faced with being unable to even get the client into bed without physically man handling them. The ambulance service cannot be used in this situation, because they also have a position where they are not a lifting service, so providers are left with difficult situations. When equipment is recognised as being required post discharge, it is normal that it cannot be delivered by the loans department for many days and we are informed that we need to care for the client in bed, this then brings its own problems with continence, tissue viability as well as dignity and respect for that client.

Often you will put a restart into the rotas for your staff to go to the client, only for the staff member to ring and say that the client is not home. This is a waste of money and time for the sake of a telephone call.

Discharges are often chaotic. There is very little communication between the discharge team to us. It is a regular occurrence that we are informed a client will be returning home and so we restart a package, only to discover that that individual has not been discharged after all and we simply have not been informed of the change of plans. Similarly, we have had many phone calls asking us if we have an individual as a client because discharge cannot find out who their care package is with. There is a lengthy delay with medication and transport. There is also a delay with discharge returning phone calls and contacting family members. Care plans are often say “provide personal care” and the mobility, health etc. are often markedly different from what we had been told to expect. This impacts upon our care plan, our ability to inform our staff as to what to expect when visiting a client and risk assessments.

Many clients discharged from hospital are new to the service and will be discharged home in the short term through EIS or Health. However, the problems begin to arise when the clients are transferred over to the Council with their care package from either of the above if they become long term. The providers are often not made aware that the client has been transferred over to the Council for longer term care, or that they have been assessed by a case worker, assessed by the financial team and then, when the invoice is passed through to the original supplier for payment, lo and behold it then begins to bounce between the provider and the various suppliers as all tend to claim they know nothing of it, and then inform the provider that two months prior, the provider should have been issuing an invoice to the client as they had been assessed to have a direct payment, or to the Council but no one had actually got around to producing a purchase order. This then leads to delayed payment and many providers have had to resort to invoice payment release options to free up cash flow to pay wages and bills, which is all extra expense.
We take on packages at short notice, in good faith only for invoices to be rejected as the client is assessed as paying for their own care, however neither the client or the provider are informed of this.

Not personally applicable to my home care service as I do not take many (exception being a few health and self-funded; most being at home anyway before they come to me), but anecdotally, inaccurate information being supplied by the various NHS and social care personnel is a major concern (something which is a serious issue in respect of discharges to care homes too); failure to supply required loan equipment in a timely way; late transport for discharges; inaccurate or no medication coming out with the client; no discharge summary; among a few ......

Discharges can be very bad, medication sometimes Double Handed needed, the client is assessed at home as not being single, lack of clear information.

7. What is the level of staff retention and recruitment, and what is being done regarding workforce?

New blood is required in the sector, but until the sector can shake off the bad publicity it has and is able to offer the right level of pay for this responsible role, training and future prospects to new staff, this will not happen. The UKHCA suggest that to maintain paying the Living Wage of £7.20 in April 2016, then providers need to be paid a minimum of £16.70, far more than providers are receiving or will I’m sure receive in April 2016.

Staff retention and recruitment is very poor. This is not because providers are not looking after their staff, but because staff are not seeing any career structure or future in Social Care. Many providers are losing staff to the Hospital as they feel they have a better career progression there, as well as better pay and better working conditions, [not having to go out in all weathers or drive their own car at work, being paid for unsocial hours]. The hospitals are snapping staff up from the care sector because they are getting an already well trained applicant and it is beneficial for them to have already had experience in care. Providers are also regularly feeding staff into Nurse training where again their previous experience is most advantageous. Many staff leave to go to other unconnected jobs, or into homes as they are fed up with poor pay, being out in all weathers and having to use their cars, which in many cases are older cars that consistently are breaking down as the staff we employ are not able to afford decent cars. This role does not attract many full time or male carers and relies on a workforce made up mainly of working mothers who are part time, and older workers who are now dropping their hours as they get older and will be retiring in the next few years, with no prospect of replacing them.

Many providers find that the astronomical cost of recruiting in papers or on the radio are out of their reach and rely on internet vacancy pages, but very few people come through and they will go through various agencies interviews to see who pays the most at the end of the day as that is important to them. There has been so much bad publicity about how providers do not pay travel time, zero hours contracts paying under NMW, which in fact are in most cases not true at all, that this also prevents people applying. These are the first questions that...
providers are often asked at interview. Adverts on the job centre website also providers say, do not bring people who are interested in the role, they are tick boxing because of receiving benefit money. Therefore, interviews are set up and often the person does not turn up or it is obvious that they are not interested. This wastes a lot of valuable time for providers.

There has been a change in who we are recruiting. Some of our new staff comes from outside of the sector but many are experienced care staff who are looking for better wages and better working conditions. When staff leave us it has been to take up nursing training, to work in the hospital or to leave the sector entirely.

By setting sustainable rates we are able to improve wages and ensure supervision is in place which is improving our recruitment and staff retention. A structured pay scale is undermined by ACHW and Government policy. We are committed to paying the living wage.

The social care workforce in Cornwall ‘recycles’ around different providers often returning more than once to providers they have already worked for previously; and a percentage exits the sector altogether. Different providers are working on this in different ways; given the challenges of recruitment I do not intend to share my own solutions which I am trialling at this time. The problems vary anyway, from area to area, transport, cost of driving lessons and car ownership, the impossibility of using public transport, as well as the difficulty in paying travel/mileage costs at a level which maintains a car in a reliable condition at all times. Even training requirements, when other employment sectors do not have such onerous conditions, is a factor, as is the potential but real risk of criminal prosecution for omissions and failures, is a deterrent to seeking this sort of employment. Media coverage of care headlines is enough for some potentially very good candidates to feel that a career in care is something they do not wish to be associated with – the impression often being that carers and care providers, are generally abusive. These things all affect recruitment, and while appropriate training and robust exposure of poor practices are vital, at times of labour shortage, these compound the recruitment challenges.

Staff retention recruitment is very difficult when the supermarkets offer £9.00 an hour, when we are asked to work in all winds and weathers early mornings late nights and more and more complex Care needed.

8. How is the voice of the person in receipt of care (and their families) heard?

The main way voices of the clients are heard is by the staff visiting them, feeding back to providers, and also providers themselves being in contact with them. It has caused many problems with clients not having allocated workers, and when a problem is identified with a client, there is a big gap between a worker being allocated to that client and the problem can escalate. There does not appear to be much follow up with case workers until they are due for an

Health and Social Care Scrutiny Committee – Select Committee Review of Care At Home
December 2015
assessment unless providers highlight a problem or a need, and often the assessments are long overdue. It is even worse since clients were given direct payments as we are now informed they are 'private'!! Clients and families do not understand the system and say that they have not had things explained to them.

The client is heard by us. We talk to all of our clients regularly, I know them all, and their families, their living conditions, and health issues even their pets. We have constant contact with our clients, we signpost and arrange help from other services, we pick up their prescriptions (at no extra cost) and we advocate on their behalf. I have personally assisted many of the clients with paperwork and form filling.

We see evidence that they are not heard and any evidence to the contrary appears to be case workers ticking boxes without fully informing clients and their families of their options.

We work close with the person and their families to ensure best personal-centred Care.

We ask them!

9. How do you see the sustainability and modernisation of care at home services?

Many providers feel that Cornwall is a special case, being surrounded on two sides by the sea and no other counties except Devon. This means that there are no other resources to pull from. Agencies from outside Cornwall are not interested in coming down as they realise the cost viability of providing services in this area. With small towns and hamlets spread out over large areas and many areas of moorland, the costs are prohibitive at the rates offered by the Council and this is another reason there can be capacity problems as vulnerable clients in outlying areas cannot get cover as agencies cannot afford the travel costs and mileage at the rates being paid. We have a higher than average elderly population with a small care workforce that has been made worse by the diabolical systems that have been put in by the Council starting with the first tender which could not even be got right, and the second tender exercise which has culminated only in making the sector smaller than it was and a local hospital that cannot discharge clients into the community. Although this may also be a nationwide problem, some of the problems in Cornwall have come about due to council officers putting into places ideas that they had not thought through and did not understand the consequences of as they did not have enough understanding of the sector. These officers really should not be allowed to do anything similar to this again, and only people who understand the sector on the ground should assist the Council to take things forward in a way that acknowledges Cornwall’s uniqueness.

But this would also need to be a partnership exercise with a council that assists the sector, does not try to break it up and set up a two tier system.
The tender was based on personalisation for the client, but providers are at a loss to see where the Council has brought this in to their own work or the way that the tender was enforced.

\textit{Without a paradigm shift in ACHW thinking the system will remain unsustainable. A modern system would encourage true person centred care based on a model which encourages payment of a living wage and rewards enlightened systems. Cost effective care is not care at the lowest price.}

\textit{The sustainability of the care sector is a huge worry. With our unique geography, population density and disproportionately elder population the sector in Cornwall faces some huge challenges. Without investment the problems experienced over the past year will only continue and worsen. There is continual demand for our services and less and less people who want to enter the care sector due to the low wages. Why would someone work in care with the long hours, split shifts and often challenging work when they can be paid more to stock shelves in a supermarket with far less responsibility and far less training required?}

\textit{At the moment it is going backwards}

\textit{To increase the charge using quality services, more dialogue with the Council on a way forward, involving all providers for Home Care, some of who are not members of CPIC are not aware of what is happening.}

10. What is your [the] biggest lesson [that] has been [taken] from this process and/or what they [do you think should be done] would do differently if going through a similar one in the future?

For a start this question does not make sense. I have made a presumption of how I think the question should be read!! Providers will be very cautious, and I believe that some will not take up any more tenders. Some providers have managed to set their businesses back up doing private work. The cost to providers for two tenders has been prohibitive, many paying up to £4000 per tender for advice from Consultants, and providers will not want to be paying those amounts out again with no benefit to their businesses.

Some Council officers appeared to not have the knowledge or authority to make decisions. There appears to be not a single person who is able to take the lead in decision making.

I believe, and many other providers believe, that the Council needs to go back to a provider list as before, and that the market should be allowed to manage itself within a marketplace environment but starting at a higher rate.

Instead of just talking to the sector, the Council needs to show that it is listening to the sector, Council officers must admit to their lack of knowledge in many areas and we should all be able to work together using each other’s knowledge and experience. Many providers have many years of experience in the sector and this should be taken and worked with and utilised.
When the Care at Home system moves over with the NHS, the system must not stay as it is now, but follow the more successful and more welcomed system with providers which is the NHS buying scheme.

**We have learnt to treat ACHW with extreme caution, they are not interested in being open and working with providers for the best interests of those needing care. Without change we will limit the number of ACHW packages we take on as the risks to the business are too great.**

**Probably not to engage with council funded work at all, without much greater transparency in the process, and less penalties attached where matters are outside our control (e.g. recruitment difficulties). I think the council has more to learn than the sector. For example, it was very naïve to believe that staff could be TUPE’d across from non-framework to framework providers. That would assume that non-framework providers did not provide any other care, such as to either health or self-funders, or domestic and otherwise unregulated support. It also assumed that staff had no loyalty to their employers and would be happy to be ‘transferred’ to another. Some exited the sector at this time. Unless the business itself was taken over, or the service users themselves were the employers, a TUPE transfer could never have applied, and was something CPIC tried to warn about, but was not listened to, at the time.**

**Working with providers to try and find common ground with regular communication, as some provides feel they are not valued.**

**The biggest lesson I have learnt was that I trusted my instinct when I chose not to take part in the tender exercise. My company has gone from predominately social services clientele to predominantly private and personal buffet within the last year. We rarely take social service packages now. Unfortunately the trust between the private care sector and the council has been severely damaged by this whole process. We have felt ignored and bullied by many within the council's commissioning team. Our very real concerns about the tender were pushed aside and our years of industry experience were belittled.**

**11. How has the communication been between those involved?**

Many providers have felt that the only time there was communication with non-framework providers was when things started to go wrong and Council officials then came asking for help from Non framework providers. As they had been left out in the cold for 12 months the feeling was decidedly cold, but what overrode this was purely helping the vulnerable clients of Cornwall. I and many other agencies at the end of last year beginning of this year were receiving telephone calls from relatives of clients needing care who were in hospital, desperately trying to get them home and offering to pay privately if we could help even though there direct payments had not been sorted out. None of us want to go through that again.

There have been meetings set up with CPIC committee members and the Portfolio Holder alongside other providers and Council officials. Although it is
felt that some smaller problems and niggles have been helped, and it has been an opportunity to bring things to the table, there are other concerns that have not been dealt with or seem not to have been taken on board as important.

Provider meetings and non-framework meetings, again providers feel that although suggestions are put forward to how to help prevent capacity issues, the providers feel that they are just being given lip service because they do not seem to see anything happening regarding their suggestions. At the last two non-framework meetings the officials wanted to discuss a contract for the non-framework providers, ideas and information was sought by the officers with the proviso that the contract would be discussed with providers before implementation. There was talk of the contract coming out end of December, and unfortunately many providers feel that this contract is just going to be sent out for us to sign, in which case, there is the possibility that providers will just hand back the Council clients that they look after which will implode the capacity position that is in place.

**Very poor from ACHW, there is a systematic lack of transparency. ACHW were advised on numerous occasions that the Framework agreement was not sustainable. The impression is that ACHW were wanting to influence the market without the vision or knowledge to do so.**

**Communication has been very poor with none Framework provides until recently when the capacity issues became greater.**

**Not straightforward!**

Communication has been one sided. We are talked at rather than to. It is only in the last 4 months that non framework providers have been engaged with and I feel this was simply because they desperately needed our services. However, this communication was not true communication because our suggestions and questions are often ignored. Too often it feels like a tick box exercise rather than meaningful dialogue.

**12. Recognising the differences in scales, is there anything that could be learnt from national providers or national representative organisations?**

I believe and many providers believe that Cornwall needs to listen to the UKHCA and Care England with reference to commissioning rates that are needed to enable providers to pay the National Living wage, without paying the Living Wage although in Cornwall, with the number of outside supermarkets moving in to the area who are paying the Living Wage of £9.00 plus [the National Minimum Living Wage from April 2016 is £7.20, the Living Wage at present is £7.85 which will go up in April 2016. The care sector in Cornwall is made up of many part time working mothers and not many full time staff. We need to encourage full time staff into this role so we are not reliant on workers who are restricted by the benefits they receive with the hours and pay they can receive, this puts the sector under many restrictions. To enable this the sector needs to encourage staff into the**

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Health and Social Care Scrutiny Committee – Select Committee Review of Care At Home
December 2015
sector, higher pay being one way, but also professional pathways, and Cornwall is very poor at having courses available to staff where they can mix with care staff from other areas doing more specialised work which could enthuse them.

We have insufficient evidence to comment.

The differences are not just in scale; Cornwall is predominately rural; carers largely need to be car drivers. Plymouth, Exeter, other cities, can have care ‘runs’ where many carers can be non-drivers. That has nothing to do with scale.

Cornwall’s challenge includes a number of factors: as a historically low-wage economy there are relatively more people on HB (housing benefit) and tax credits, than better off parts of the country. This means our existing carers are less able to take on more hours as it is not to their advantage to lose tax credits or HB. More are therefore part time from choice (which also makes childcare arrangements more manageable). This requires Cornwall to have more ‘numbers’ of staff to cover the same hours of care than other areas where more fulltime personnel are available.

Cornwall is the ‘longest’ county in England but has a relatively low population (the population from the entire county matches just the Exeter travel to work area, where care users are concentrated in a far easier to reach geography, as are the carers – and where even there, they have recruitment challenges; ours are just that much worse). The Cornwall working population has other options open to them, and potential staff are not located in areas of density in sufficient numbers that makes it economically viable to meet the care needs of the disparately located service user population –and certainly not at the funding levels currently provided.
Written Evidence Submission from Cornwall Council Finance Services (Business Planning and Development) and Legal Services (Governance and Information)

9. How are issues regarding payment and purchase order delays being addressed?

This is really a question for the Adult Care Service who is responsible for the payment and purchase order process. However, there have been significant changes to the processes for payment and purchase orders following feedback from the providers:

- simpler less detailed purchase order was developed and implemented;
- timeframes for the processing of orders was streamlined and regularly reviewed;
- brokers and charging assessment team have tried to ensure the process is as smooth as possible but as with any complex system sometimes this is not as timely as it should be; and
- early this financial year we reduced a delay in postage and sometimes non receipt by e-mailing Purchase orders and not posting (as cryptshared for security these have a time limited life for download and must be retrieved within 10 days).

Alongside the changes and simplification of the system we have developed the Finance Manager Module within Callconfirmlive. This sends data twice a day from MOSAIC our case management system to the provider’s electronic call system. The data is matched and reconciled for payment before being sent back into MOSAIC for payment. This reduces the risk of purchase orders not being received in a timely manner. There are 5 providers live on Finance Manager with a further 5 providers going live in this finance period. Another group of providers are being trained this week for them to start using the system in the New Year. The payments will be significantly quicker than the current 30 day term and much of these are fully automated.

10. What was the cost difference from before the framework to the last 12 months?

This is difficult to look at in isolation as there are a number of factors that influence the overall spend on packages of care, these include:

- Increasing trend of personalisation of budgets meaning the Council commissions less packages of care;
- Significant changes to EIS service in 2014/15 i.e. effectively the Council stopped commissioning new EIS packages of care;
- Change in the charging policy in 2014/15 which meant more people had to pay higher contributions or drop totally out of the Council’s commissioning responsibility; and
- Significant backlogs of reviews were undertaken in 2014/15.

The overall spend on packages of care and personal budgets (before client contributions) for the last two financial years are:
2013/14 - £53,563,233. No. of services users at 31/3/14 – 5,110
2014/15 - £50,842,428. No of services users at 31/3/15 – 4,303
The reduction of £2,720,805 between years cannot be solely attributed to the framework because of the points mentioned above, including the overall reduction in number of service users from 5,110 to 4,303.

11. Have legal challenges been warranted in your opinion?

Yes, the grounds for challenge in respect of Care at Home 1 were sound. We should not have used the evaluation matrix document it constituted unpublished sub-criteria and it rendered our procurement process unlawful.
There were no formal challenges made in respect of Care at Home 2.