



Buckinghamshire County Council

Health and Adult Social Care Select
Committee

Inquiry Report: Approved for publication on 11
August 2015

15 Minute Care Visits in Buckinghamshire



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Acknowledgments

The County Council has a critical role in supporting vulnerable residents who need our services. Hearing and understanding the experiences of people who receive our services is vital in order to ensure their needs can be met and help us improve.

We wanted to hear first-hand from service-users and front-line staff to understand their experiences of providing and receiving the domiciliary care service Inquiry

We would therefore like to express our thanks and gratitude to those who participated in this Inquiry, in particular:

- Service users who welcomed us into their homes and provided us with the opportunity to speak to them directly about the care they receive.
- Care workers we shadowed on our visits. We felt the care workers showed dedication, commitment and compassion for their work and the people they care for.
- Finally, we would also like to thank the providers and all the Council officers involved for supporting the Committee, for facilitating the visits and providing information and support.

Executive Summary

Following recent national debate and concern over the use of 15 minute home care visits, Members of the Health and Adult Social Care Select Committee undertook a scrutiny Inquiry. The purpose of this Inquiry was to check whether the Council's use of 15 minute visits is appropriate to ensure that the care needs, dignity and wellbeing of service users is being met.

The Inquiry Group gathered evidence by speaking directly to frontline carers and service users through observing 27 care visits across different locations in Buckinghamshire. Evidence was also gathered by a desktop audit of care plans to test whether the written records confirmed that the Council's current policy was implemented.

Overall our findings were reassuring. We concluded that 15 minute visits can have a place as part of a person's overall care package with care being delivered in a dignified manner. We were pleased that over the past six to 12 months the Council has taken appropriate steps to safeguard the dignity and care of service users through; firstly, the development of policy guidance for 15 minute visits (section 3) and secondly, the introduction of a more efficient process for requests for changes to care plans where time is later found to be insufficient (section 5).

The Inquiry also touched on the issue of pay for travel time (section 6) and the Council's future commissioning intentions for domiciliary care services (section 7). Although these were not the primary focus of this Inquiry (so not explored in detail), they were nevertheless raised through our evidence gathering in relation to the possible impact on the quality of service, and as such, we believed they should be addressed. HASC will ask for recommendations to be revisited in 6 & 12 months.

To provide ongoing assurance that care is always delivered in a dignified manner and meets the needs of service users, our recommendations focus on the following areas:

- Ensuring there is a clear and robust policy in place, formally validated as Council policy (recommendation 1).
- Implementing robust monitoring measures to ensure the policy is communicated and applied (recommendation 2).
- Reviewing and monitoring the change request process (where allocated time in a care plan is later found insufficient) to ensure the process is clear and timely and dignified care is not compromised (recommendation 3).
- Ensuring care workers are paid for travel time between visits to drive quality, and staff recruitment and sustainability (recommendation 4).
- Greater democratic accountability over the commissioning process at the early stages (recommendation 5).

Recommendations

- 1. Recommendation 1: The Cabinet Member agrees the “Delivering Dignified Care Policy (15 min calls)” as a key decision, as required by the Council’s Constitution and Operating Framework to formally validate it as Council policy (para 22-29).**
- 2. Recommendation 2: We recommend that there are clear monitoring and implementation arrangements in place to ensure that policy compliance is regularly reviewed. Improvement arrangements should include:**
 - a) Stronger communications of the Council’s policy to staff, providers and stakeholders.**
 - b) Improvements to the quality and detail of care plans to ensure consistency across the service**
 - c) Greater proactive utilisation of data to monitor scheduled visits which regularly exceed allocated time to ensure compliance with the policy (para 30-39).**
- 3. Recommendation 3: A monthly change request analysis report is produced as part of the Service Area Performance Scorecard, to review and monitor the impact of the process as part of the contract monitoring process. The analysis should include:**
 - The number of requests received for the period and whether they are for increases or decreases in time.**
 - Whether the requests were accepted or not (if not reason)**
 - Date that change request was received and date change was agreed and implemented**
 - Identification of delays in the process (para 40-48).**
- 4. Recommendation 4: To help drive quality of care and staff recruitment and retention, new contracts for Domiciliary Care from March 2016 should include a contract clause that requires staff to be paid for their hours of work, which should include travel time between care visits (para 49-56).**
- 5. Recommendation 5: The Cabinet Member for Health and Wellbeing should, in future, take key decisions on how services are commissioned prior to going out to tender where those contracts and services are deemed to be significant, as defined in the Council’s Constitution (para 56-61).**

1. Inquiry Context

1. The Health and Adult Social Care Select Committee (HASC) agreed to undertake a short focussed Inquiry into the Council's use of 15 minute domiciliary care visits in Buckinghamshire at its meeting on 28th April 2015.
2. This was as a result of questions being raised at a national policy level around the suitability of 15 minute calls, following the report of the Leonard Cheshire Disability Charity¹ which found that 60% of local authorities commission 15 minute visits and that their use has risen by 15% in the last five years. As such this has been a controversial topic in adult social care over recent years resulting in a divergence of views nationally.² The main concerns have been on the rise in the use of 15 min visits³, the nature of the care delivered within them and whether the time allocated risks the dignity and safety of the service users⁴ and the terms and conditions of care workers. In light of this, Members of the Health and Adult Social Care Select Committee wanted to explore the use of 15-minute visits in Buckinghamshire.
3. The Committee received updates from the Adult and Social Wellbeing Directorate in June and October 2014⁵ providing an overview of the domiciliary care services commissioned by the Council and the Council's recently implemented policy on 15 minute visits; "*Delivering Dignified Care (15 min calls)*" agreed in May 2014.
4. Following the scrutiny within Committee, Members were of the view that qualitative evidence of the frontline use and delivery of 15 minute visits was required to provide reassurance that the Council's use of such visits is appropriate and that the delivery of dignified care is not compromised.
5. The Committee appointed an Inquiry Group to conduct this focused piece of Inquiry work and report on their findings. The Inquiry Group comprised: Mrs Angela Macpherson (Chairman), Mr Roger Reed, Mrs Shade Adoh (Healthwatch Co-optee), Mrs Margaret Aston, Mr Brian Adams and Mr Noel Brown. Kama Wager, Committee Adviser from the Council's Member Services team provided the officer support for the Inquiry.

¹ "Ending 15 minute care" October 2013

² See recent publications detailed in the bibliography.

³ Ending 15 min Care as in point 1.

⁴ UK Home Care Association in their publication "Care is not a commodity" July 2012.

⁵ Details of the discussion at the meetings in June and October 2014 can be found at appendix 6.

Inquiry Scope

6. The overall Inquiry aim was to examine the Council's use of 15 minute visits and the tasks allocated within them to ensure that the care needs, dignity and wellbeing of service users are being met within the time allocated. The full scope is included at Appendix 1. From this work the Inquiry Group hoped to alleviate Member concerns and provide reassurance by gathering first-hand evidence in speaking directly to both those who deliver, and those who receive the care.
7. Whilst the contract and commissioning of the whole of domiciliary care was out of the scope for this specific piece of work, we were told that current contracts are due to end in March 2016 and that there is an intention for the Council to move to a new commissioning approach. As such we touch on this area (see section 7), albeit not in detail. It is an area we may revisit in more detail within future Committee work.

Evidence

8. The Inquiry Group gathered evidence through the following stages:
 - **A desktop exercise and audit of care plans:** An initial evidence session was held on 4th June 2015 and was attended by the Council's service managers and contract managers. Members reviewed a sample of 40 care plans which included 15 minutes visits and examined the tasks allocated within them. Members also considered the Council's policy and data in relation to 15 minute visits.
 - **Members observed 27 15-minute visits first-hand:** Members shadowed six care workers⁶ to speak directly with them and observe the types of care provided in these visits and how easily this can be achieved. They also spoke directly to the 27 people receiving these visits about their views and experiences of the care they receive.
 - **Final evidence session:** Once the visits were completed the Inquiry Group held a final evidence session on the 2nd July 2014, attended by contract managers, service managers, commissioners and providers. Members discussed their findings and considered the Council's move to a new approach to commissioning domiciliary care.
9. We recognise that there are inevitably some limitations to the Inquiry's methodology as with any review. Interpretation of our findings acknowledges the context in which the evidence was derived. These include:
 - a) this was a small sample given the size of the population receiving this type of service;
 - b) visits were conducted with two of the four main care providers, thus the findings may not generalise to all providers⁷;

⁶ From across two of the four main providers

⁷ Although we do not believe that the observations and experiences shared with us would vary significantly.

c) Members' discussions with service users were conducted in the presence of the care workers, which could have enabled carers to deliver their tasks more efficiently whilst Members engaged with the service users. This said, the strength of the Inquiry's methodology is the combination of three methods of evidence gathering: auditing, observation and discussion.

10. Most importantly it utilised the participation of those both delivering and those receiving the service, in line with the Committee's objective of putting service users at the heart of all our work. Overall, we believe the value of this Inquiry is that it has provided a rich qualitative understanding of the processes inherent and outcomes achievable in the 15 minute visits.

2. Buckinghamshire Context: 15 Minute Visits

11. In Buckinghamshire the Council delivers around 20,000 domiciliary care visits each week. The Council currently commissions four providers to deliver 70% of domiciliary care on its behalf (Radian Home Support, Westminster Home Care, SevaCare and Prime Care). The remaining 30% is delivered through spot contracts.

12. The current total number of service users⁸ is 1559 across all four providers. The number of these who receive 15 minute calls as part of their care package is 689 and those who receive only 15 minute calls is 64. Approximately a third of all service users receive 15 minute calls as part of their care package. With this in mind, the significant number of service users who could be affected by inappropriate use of these visits is evident. This emphasises the importance of ensuring that these people are receiving sufficient care time to meet their needs in a dignified manner.

Budget context

13. The Council, like all local authorities is under significant budgetary pressure in this area. We were told⁹ that the total budget for 2015/16 for domiciliary care is just under £11.5 million. However, the CHASC¹⁰ Business Unit will spend approximately another £3 million to meet all the home care needs this year, which will contribute to an overall service area budget shortfall of over £7 million for 2015/16¹¹, due to the increasing complexity of people's care needs and growing demand.

⁸ As at 22/5/2015, evidence provided by the Service Area at the 4th June 2014 evidence session.

⁹ Evidence session on 4th June 2014, evidence from BCC Service Manager.

¹⁰ Communities, Health and Adult Social Care

¹¹ Details provided from Business Unit Managers.

Commissioning approach

14. The Council's current model of commissioning for domiciliary care is structured on the delivery of the tasks within a certain time window, commonly known as "time and task", i.e. the completion of tasks to meet eligible needs within a specific time slots (e.g. 15, 30 to 60 minutes). Under this model the Council defines the tasks and timings to be delivered by the providers delivering care on behalf of the Council and pays the providers for the time care is provided.¹² The care plans completed by adult social care managers with service users, identify the areas where people need help to remain living safe and well in their homes. Once a provider agrees to take on a new service user, a senior care coordinator, employed by the provider will visit the service user at home and agree with them the details of their support plan.
15. There is growing critique of the time and task model of commissioning for social care. For example, the view of Jane Harris, Director of the charity Leonard Cheshire describes the time and task approach as "*A service focused on time and task is a coping service, not a caring service*". This view would suggest that there is a conflict between current time and task commissioning practice used by the Council and achieving good care from a service user perspective.
16. However, we were told¹³ that the current contracts between the Council and the four main providers of domiciliary care in Buckinghamshire are due to expire on 31st March 2016 and that the procurement process is underway and will be completed by the end of the year.
17. We heard that it is the intention of the Council to move away from 'time and task' to a more 'outcomes-based approach' to the commissioning of domiciliary care which will be built into the new contracts. An outcomes-based service involves agreeing a set of measurable outcomes and a budget for the hours of support required (based on eligible needs). The council will still define the maximum number of hours available to deliver the outcomes, however under this model the service user (family and informal carers) and supplier work together to agree on what outcomes can be achieved and when the care is to be delivered. The aim is to put the service user at the centre of their care with a more enabling service, giving service users more control over the choice of support and when to use it.
18. This approach has emerged nationally over the last five years with the benefits being highlighted¹⁴ and many local authorities exploring its potential implementation. Wiltshire has successfully adopted this approach over the past six years and has had it fully embedded for the past three years. Other

¹² Evidence session on 4th June 2015.

¹³ By Service Manager at our evidence session on 4th June 2015.

¹⁴ IPC report; Emerging practice in outcomes based commissioning, April 2015.

neighboring Councils have recently gone out to tender adopting this new approach (e.g. Hertfordshire County Council and Royal Borough of Windsor and Maidenhead).

19. Recent national publications¹⁵ on the commissioning of home care services make clear the importance of the service commissioning role in ensuring that the problems identified about home care are dealt with. This is especially emphasised by the EHRC¹⁶ and ADASS¹⁷ reports, and forms the basis of Unison's Care Charter for Ethical Care Councils. The EHRC report concludes that the problems identified with home care could be resolved if local authorities made more of the opportunities they have to promote and protect care recipient's human rights through the way home care is commissioned and the way in which home care contracts are procured and monitored.

20. With this overall recommendation as the basis for improved service, the recent national publications make the following specific recommendations for commissioners to demand of agencies providing the service:

- Allow sufficient time for care workers to care properly for people, to talk with them and form a relationship. Match the time allocated to the service recipient to their needs.
- Schedule visits so that the worker does not have to rush the time with each service recipient.
- Allocate the same worker to service recipients wherever appropriate.
- Pay care workers for time spent travelling between visits; time spent training and other necessary expenses such as mobile phone costs.
- Pay care workers the National Minimum Wage or preferably the Living Wage.
- Take steps to deal with zero hours contracts (as outlined in the report "Zeroing In")¹⁸.
- Improve recruitment, training and monitoring of care staff. See home care as a skilled career.

21. Although we did not explore all of these issues in detail within this particular Inquiry scope, the issues were raised by Members and touched upon when carrying out the evidence gathering (we cover staff travel time in section 6). We hope that the new contracts and commissioning approach will go some way to addressing these areas. Future scrutiny may revisit the transition to an outcomes based approach to commissioning for domiciliary care and the shaping of the new contracts (see final section of the report).

¹⁵ See Bibliography

¹⁶ Equalities and Human Rights Commission: Inquiry into Older People and Human Rights – Home Care.

¹⁷ Association of Directors of Adult Social Services: Tips for Directors: Commissioning and Arranging Home Care Services.

¹⁸ Report on zero hours contracts: Zeroing In, by the Resolution Foundation.

3. Policy Context for 15 Minute Visits

22. As mentioned, there is a national divergence of views on the use of 15 minute visits, however it appears to be accepted that 15 minute visits can be appropriate for some people and for some specific care tasks. The president of the Association of Directors of Adults' Social Services (ADASS), Sandie Keene, is quoted as saying "it is totally wrong to believe that all tasks need more than 15 minutes to carry out". ADASS conducted research which found that 88% of Councils who commission 15 minute calls did so to give medication or check welfare only and not to deliver personal care. In a statement from the ADASS dated 4th October 2013, directors argued that "in some cases, 15 minute visits to older people at home are fully justified and fully adequate". Even the Leonard Cheshire Disability Charity who called for a ban on 15 minute visits state themselves that 15 minute calls are appropriate for some tasks, including administering medication.
23. We were told¹⁹ that the Council developed and agreed a new key policy for 15 minute visits; "*Delivering Dignified Domiciliary Care (15 min calls) in May 2014*".²⁰ The policy was developed to ensure that Buckinghamshire County Council set out clearly what its position is with regard to the commissioning of 15 minute calls and to communicate this to Care Managers and Providers to ensure that service users' needs are met in a dignified way in order to promote their independence and wellbeing.
24. The policy provides care managers with guidance on the use of 15 minute visits, and sets out how the Council will ensure that service users have dignified care that fully meets their assessed needs, how this will be achieved and in what circumstances these visits are usually or typically appropriate. It states they are only appropriate for simple tasks such as medication/welfare checks, or providing a drink/heating (with a max of one-two tasks dependent on the individual's level of independence/capacity). It states that personal care should not be delivered within a 15 min call.
25. The care workers we spoke to confirmed that, in their view, 15 minute visits can be appropriate as part of a person's overall care package. They confirmed that in their experience these visits were suitable for welfare and medication checks or for delivery of one, possibly two simple tasks only in order to ensure that care is delivered in a dignified way and that this was dependant on the service user (e.g. their mobility, independence, capacity etc.). A carer told us "any more than this and we have to really rush the client and quality of care may be compromised". They also confirmed that, in their view, personal care tasks were

¹⁹ October 2014 committee meeting see link to committee papers is appendix 6

²⁰ The full policy can be found at appendix 2

not appropriate for 15 minute calls, as they would be too rushed and result in care being delivered in an undignified manner.

26. In total we shadowed six carers and observed the care being delivered in twenty-seven 15-minute visits to understand the types and level of tasks that could be delivered in a dignified way. We were pleased to find that where simple tasks (in line with the policy outlined above) were allocated (in 21 of the 27 visits), the care was always delivered in a dignified manner. Our observations were supported by the positive feedback we received from those receiving the care in these visits, they felt they were treated with dignity and respect and spoke highly of their care workers.
27. With the above in mind, we were assured that 15 minute visits can be suitable in the circumstances outlined in the policy and that they can have a place as part of the overall care package for some people. However we would emphasise, that to ensure the Council's use is in line with the national use highlighted above (ADASS findings), we strongly believe that: they should predominately be used for welfare/medication checks only; in some circumstances, (dependant on the level of dependence of the person), they can be suitable for the delivery of a simple task such as heating a meal/making a drink; they should not include more than two simple tasks; and personal care should never be delivered in a 15 minute visit.
28. We were pleased to find that our observations supported the policy and therefore consider the new policy fair and accurate. If the Council ensures it is fully implemented and complied with, we believe that it will ensure that only those tasks that can be delivered in a dignified way will be allocated to a 15 minute visits and will be on par with accepted practice on the use of 15 minute visits nationally.
29. This said, we were informed that the policy was agreed by the Cabinet Member and Service Director at the Adults and Family Wellbeing Business Unit Board meeting. In order to be validated as a working policy, it should be agreed by the Cabinet Member as a key decision as stated in the Council's Constitution and Operating Framework, documents which have been agreed by Full Council and Cabinet respectively. Business Unit Boards are internal advisory boards only they are not a decision making body and therefore the policy as it stands is not validated. Therefore:

Recommendation 1: The Cabinet Member agrees the “Delivering Dignified Care Policy (15 min calls)” as a key decision, as required by the Council’s Constitution and Operating Framework to formally validate it as Council policy.

4. Is Policy Translating into Practice?

30. We were told that the new policy was developed with care management representatives and providers. The service area held two “Policy into Practice” sessions with providers and adult social care staff in November and December 2014 which were attended by 35 people. The intention was that information from these sessions would be cascaded through regular team meeting updates and through communication of the policy via the policy watch bulletin monthly (used to promote and launch policies).
31. However, we heard from contract managers that, in their view, the policy has still not fully embedded within the care management teams and the wider teams who undertake the initial assessments (allocating lengths of visits and task to be completed). They felt that more needed to be done to communicate the policy wider to foster a change in culture and fully implement policy on the ground. This said, we recognise that the policy has only been communicated among the wider workforce for the past 6 months so will take time for the culture change to fully materialise.
32. A core objective of this Inquiry was to test whether current 15 minute visits are appropriate (in line with the policy outlined above). As mentioned in the previous section, we were pleased to find that the majority of the visits we observed (21 one of the 27 visits) had simple tasks allocated to them, were in line with the policy and care was delivered in a dignified way. We did however observe a few examples (six 15 minute visits), where we believed carers struggled to complete the level of tasks in the time allocated. We must emphasise however, that despite the time being exceeded, service users were treated caringly and with dignity.
33. What the visits brought home to us, is the complexity in defining care. Being able to stick rigidly to the plan is difficult as people will always need help with other things on occasions which may cause the visit to overrun. Care workers will not leave someone in need. They will always stay longer if required to complete the tasks; we were assured of this. Where carers are regularly struggling to keep to time, we were told that providers can make a request to the Council for a change to the time allocated (see next section) to ensure that the dignity of care is not compromised.
34. In addition to our visits, we reviewed a sample of 40 current care plans which included 15 minute visits to check and assure ourselves that the tasks allocated within them are in line with the policy outlined above (i.e. that the policy has been effectively communicated and implemented).

35. As a result of this review we questioned the level of tasks allocated within 14 of the total 40 care plans reviewed, (9 of these care plans were post policy implementation). We also highlighted some inconsistency in the detail of some of the care plans, specifically in relation to missing detail on the tasks to be delivered within the 15 minute visit (in 7 of the care plans we couldn't find the detail of the tasks to be carried out so were unable to come to a view). Contract Managers also confirmed that there is still inconsistency in the quality and detail of the initial assessments carried out, which may cause delays in the process when commissioning providers, and/or for providers/carers knowing what tasks to deliver.
36. We referred these cases to the service area who reviewed this information. Both the Service Director and an Operational Service Manager reviewed the cases and stated that in their professional judgement the majority of these cases they believed the tasks allocated were appropriate for 15 minute visits. They did however, agree that there was a small number (4) (of those identified by members) where the tasks allocated may not be appropriate for a 15 minute visits. This was due to: possibly too many tasks allocated or because personal hygiene tasks were listed in the support plan for the 15 minute visit (which would not be appropriate). As a result, these particular cases are being reviewed further by the managers. They will be cross referenced with care managers, providers and carers to check and assure themselves that the time is sufficient and changes made if required.
37. This audit and review process was a valuable exercise for both Members and the service area. It tested the application of and compliance with the policy. The difficulties with this exercise as a mechanism for monitoring policy compliance were found to be:
- a) It was difficult to come to an accurate judgement by simply looking at the tasks allocated alone. This required further detailed investigation, and a professional assessment of the individual circumstances of a particular service user to identify whether time was in fact sufficient.
 - b) Where the detail recorded in the care plans was incomplete or difficult to locate, it meant the Inquiry group were unable to reach a firm conclusion on whether the policy had been complied with.
38. The value in this process was that it resulted in a number of key learning points and areas for improvement being highlighted. These include:
- A need for stronger communication and clarification over the use of the policy guidance to ensure compliance with it.
 - A need for clarity over how the service area will measure and monitor compliance with the policy going forward.

- A need for improvements and further guidance around the quality and detail expected within care plans (including when, what and where to record care plan information) to ensure consistency across the service.
- More proactive utilisation of data to monitor scheduled visits which regularly exceed the allocated time to ensure compliance with the policy.

39. With the above in mind, to ensure the service area is compliant with the new policy, we believe that measures should be put in place to address the above areas for improvement, and regular spot checks of care plans should be carried out. This will provide service managers with the assurance that what they believe is happening is translating into practice. It will ensure that the level of tasks allocated to visits, and the quality and detail of the initial assessments are sufficient to ensure that people's care needs are being met in a dignified manner, therefore:

Recommendation 2: We recommend that there are clear monitoring and implementation arrangements in place to ensure that policy compliance is regularly reviewed. Improvement arrangements should include:

- a) Stronger communications of the Council's policy to staff, providers and stakeholders.**
- b) Improvements to the quality and detail of care plans to ensure consistency across the service**
- c) Greater proactive utilisation of data to monitor scheduled visits which regularly exceed allocated time to ensure compliance with the policy.**

5. The Change Request Process

40. In speaking about the use of 15 minute visits, the president of ADASS said “we must never be complacent...sometimes time allocation is insufficient ...where the time needed to carry out certain tasks is underestimated...And where that happens adjustments really have to be made”. We considered whether the Council has an effective and efficient process in place for changes to be made to a person’s care plan where the commissioned time is found to be insufficient to meet their care needs²¹ in a dignified manner or where quality of care may be compromised.
41. We were told that the Council implemented a new change request process on the 18th May 2015. Improvements were made to address an historic lack of a clear and efficient process, which had resulted in too many referrals being dealt with in an untimely manner. The new process means that there is now one form and one email, with each request recorded and tracked through to conclusion. There is an escalation process if the request is unresolved after 4 weeks, and the data will become part of the performance suite.
42. The change request process means that at any time during the year a Client, their family member (on their behalf), the Care Provider or a member of Adult Social Care team can identify the need for and request a change to Domiciliary Care. Changes can be temporary or long-term and can be requested to increase, or reduce or change (timing etc.) level of care. Changes need to be agreed by a Care Management worker and changes will be implemented as soon as possible.
43. We requested data on the number of referrals received for change requests. The service area carried out this analysis and told us that between January and May 2015 there were 724 requests for changes to care packages; of these 193 (26.7%) were for decreases, 107 (14.7%) for variations/one offs and 424 (58.6%) for increases in care. With over half of all requests and 424 people over a 5 month requesting increases, this highlighted to us the significance in the number of people whose quality of care could be impacted by an inefficient process and delays to changes being made.
44. To understand how efficiently these requests were dealt with we requested further analysis to be carried out on the above data to consider the length of time it took for these requests to be agreed and implemented (the service user receiving the change they require). The results of this data can be found at Appendix 4. The analysis appears to show that the system is working, with the majority of referrals being dealt with within two weeks. Where the request is

²¹ (whether by provider, carer, family or person receiving care).

urgent, due to the needs of the client being high risk, care providers are able to implement a change immediately and complete a change request retrospectively. However the first chart at Appendix 4 shows that there are still some cases (approximately 40) that are taking longer and approximately 60 that the time is unknown/not traced within the analysis.

45. We did hear evidence that suggested there may still be some instances of delays in the process. For example, we heard from carers we spoke to that sometimes it still took too long for a change to be made having informed their managers that task time was insufficient. Two of the carers we spoke to quoted timescales of up to 2 months. We were also told by one of the providers that, whilst the system is working and providers are able to request changes, “there are still some cases which take longer than they should” and that the process still needs to be “far quicker and responsive to changing care needs of our service users”.
46. We acknowledge that it appears that these cases are the exception to the norm, (they may predate the new process and be a result of historic inefficiencies) and that from the evidence provided by the service area it appears that, on the whole, the new process is working. The analysis which identifies the time lapse between referrals and implementation of changes has not previously been analysed in this way by the service area prior to it being requested by this Inquiry.
47. We were pleased to hear of the improvements to the process and receive the data which appears to demonstrate that the system on the whole is working. It is our view that a quick change process is paramount to ensuring that a person receives the care they need in a dignified way.
48. With the above in mind, as this is a new process (agreed 18th May 2015), and given the significant number of referrals received for increases to care packages (i.e. people who could negatively be impacted by delays), we believe that the service area should proactively use the data they collect to monitor and review the impact and effectiveness of the new change request process on a regular basis. This will ensure that it continues to work effectively and delivers the outcomes our service users expect in a timely manner. It will ensure the instances we heard about are the result of transition to the new process and not ongoing delays in the system. This will act as a safeguarding mechanism to identify any future delays in the process and resolve them quickly. Therefore:

Recommendation 3: A monthly change request analysis report is produced as part of the Service Area Performance Scorecard, to review and monitor the

impact of the process as part of the contract monitoring process. The analysis should include:

- **The number of requests received for the period**
- **Whether they are for increase/decrease in time**
- **Whether the requests were accepted or not (if not reason)**
- **Date that change request was received and date change was agreed and implemented**
- **Identification of delays in the process.**

6. Staff Travel Time and Rostering

49. The UKHCA²² have calculated that the recommended minimum hourly rate that statutory commissioners should pay homecare services to ensure a good quality and sustainable service is £15.19 per hour. In Buckinghamshire the Council currently pays an average of £17.85 per hour to providers, so above the national recommended hourly rate. The rate the Council pays is even higher in more rural areas to account for increased travelling times and payments to carers.
50. Staff terms and conditions (including pay for travel time) is an area of concern identified within recent national reports on delivery and commissioning of home care services.²³ Through our evidence gathering we found that in line with the national divergence, there is a difference across the Council's main providers in how they pay staff for travel time (for example, we heard that two of the main providers do pay travel time). Their pay models reflect the different basic rates dependent upon whether they pay travel time and what mileage rate they apply as part of the overall remuneration package. We recognise that this was not the primary focus of the Inquiry however it was a line of questioning that arose from the Inquiry in relation to the correlation between staff terms and conditions and possible impact on service quality. Therefore, we believe we needed to highlight it within this report.
51. We were told that there is no single contract across the County Council that stipulates how providers should address terms and conditions; however the Council does stipulate that all contracts must be legally compliant in all regards (including relation to the minimum wage). We were told that stipulating specific contract terms and conditions could potentially increase the costs for the Council (with providers increasing their rates) and be over burdensome for contract monitoring.
52. We observed some of the carers we shadowed working up to an extra 2.5 hours in a day in travel time for which they were not being paid. In looking at the staff rotas on a ten hour shift this would equate to a quarter of their shift not being paid for. Whilst we acknowledge that this was a limited sample of carers, we believe that this is likely to be a common result of many care worker's terms and conditions locally, as found nationally. It was our view that this could be counterproductive to improving staff retention and recruitment in what is a very difficult, yet fundamentally essential profession.

²² United Kingdom Homecare Association

²³ See national reports highlighted within the bibliography.

53. We also observed little flexibility in the travel time allowance between visits within the carer's daily rotas, with time allocated being very limited. In the visits we observed, it was clear that service users were aware of how rushed carers are as the majority of service users we spoke to commented on this. Whilst we were impressed with the carers who often go over and above and stay longer than required, this impacts on the subsequent visits and the impact of crammed rotas, in our view, results in the carers having to work in a very task focussed way rather than a person-centred approach. We hope that these issues will be addressed through the new outcomes based approach being piloted which will explore a local area team approach to delivering care. This should reduce travel time of individual carers (see section 6).
54. There are areas that do stipulate such matters within their contracts. For example, Hertfordshire County Council has adopted an outcomes based approach to commissioning and went out to tender on this approach over the last year. It require that all contracts are let on the basis of paying living wage as a minimum, offering staff travel and training time, employers paying for uniforms and staff receiving full checks etc.²⁴ The Committee encourages the service area to investigate this approach further as a best practice approach which addresses some of the concerns raised nationally around the terms and conditions of care staff which could impact on care delivery.
55. Whilst we did not explore the differences between the providers in detail, in our view there appeared to be a significant gap between the hourly rate we pay providers and what those delivering the care receive. We believe that the Council pays the providers enough to be able to cover travel of their staff.
56. We acknowledge that it would require further detailed discussions and possibly have an impact on contract monitoring (which can be addressed through forthcoming contract renewal). However, we believe that as a nationally recognised issue, it is one of political choice and it is our firm view that the Council should be ensuring that care staff are paid for their hours of work. We believe this will help improve staff sustainability and recruitment, which will drive quality of care as highlighted in recent national reports.²⁵ Therefore:

Recommendation 4: To help drive quality of care and staff recruitment and retention, new contracts for Domiciliary Care from March 2016 should include a contract clause that requires staff to be paid for their hours of work, which should include travel time between care visits.

²⁴ Institute of Public Care; Emerging practice in outcomes based commissioning for social care April 2105.

²⁵ E.g. Burstow key to care and other reports highlighted in Bibliography.

7. Moving Forward

Pilot: Outcomes Based Approach to Commissioning

57. As previously mentioned, the Council's current domiciliary care contracts come to an end in March 2016 and the Adult Social Care Service Area is looking to move to an outcomes based approach to commissioning, an approach that is emerging as best practice nationally (see section 2).
58. We heard that the Council will be exploring how an outcomes based approach could work in Buckinghamshire through a pilot which will begin mid July 2015 and run for six months. The pilot is designed to trial the delivery of an outcomes based service in conjunction with moving to a locality based delivery model (focussing on local area care teams). Three of main four main providers have volunteered to trial the new model. Each provider has selected approximately 20 service users in close geographic locations and assigned 4/5 carers to the cluster.
59. We were told that the aim of the pilot is to establish:
- How the Council will deliver an outcomes based service and if by setting up local teams with local staff we can deliver a better quality service that meets the needs of local people and gives carers greater job satisfaction leading to better retention. The carers will be able to make decisions with customers on a daily basis, to adjust the service to meet individual needs delivering the right service at the right time for each customer. It is hoped that travel for carers will be reduced significantly.
 - It will assess the impact of moving to an outcomes based service on suppliers, service users and their families. Moreover it will help the Council understand the advantages and difficulties in implementing and delivering a different style of service, test out the new approach, and identify and unpick the challenges in order to identify solutions.
60. We were told that the within the new contract the council will be taking a phased approach to outcomes based commissioning with a transition phase taking place over the first 18 months of the new contracts. We support a move towards an outcomes based approach and look forward to seeing the results of the pilot. We will be monitoring the new contracts and the transition to an outcomes based model for domiciliary care through future scrutiny and Committee updates, to ensure that it results in positive benefits for service users and the extent to which it addresses operational issues and issues around staff retention and recruitment in the drive to improve the quality of care received.

Governance and Democratic Accountability

61. It is worth noting, that in the final stages of our Inquiry, we were made aware that an invitation to providers to tender for the new contracts was published on the 13th July 2015. Given that the contract involves a significant budget and is for frontline delivery of services to vulnerable people, it highlighted some key learning points around enhancing democratic accountability and transparency in relation to the tender process going forward. The four main issues it highlighted are:

- a. **Democratic Accountability in Future Shape.** As a significant area of Council expenditure and with direct impact on public, we were concerned that a key decision was not taken by the Cabinet Member prior to going out to tender. The real political choice is on what services are commissioned and how, and this is set out in the contract specification which is published when the tender invitation is issued. It is at this planning stage where a democratic mandate is needed to ensure political accountability for decisions about how the Council allocates its resources. After going out to tender there are strict legal procurement processes that must be followed. Significant decisions should be taken by Members not Officers.
- b. **Ensuring the right professional advice to the Cabinet Member prior to a decision.** Such a high value contract requires input from a range of professional officers (e.g. legal, procurement, finance), as well as understanding the impact on all Council services. The key decision process ensures that there is a clear audit trail for the Cabinet Member receiving this advice to ensure value for money.
- c. **Project Governance.** Within the Council's Operating Framework there is a requirement for projects to progress through a Project Gateway process. The criteria for registration include, but not exclusively: savings of above £500k; have multiple complex options; is a politically sensitive area and has a significant reputational risk. The first two stages, of the five stage process, are to ensure that the project has full Member support prior to progression to tendering. The Domiciliary Care contract was of high value with significant savings identified, highly complex and with significant potential for reputational risk and yet was not registered for the Project Gateway process.
- d. **Lack of transparency to all Members.** We were not made aware of the details of the tender process or the tender specification prior to it going out, so were unable understand how and when we could influence it through our Inquiry. In addition, as the decision to go out to tender was not taken as a key decision there was no opportunity for all Members to see that a key decision was coming up on the statutory forward plan and provide an input.

62. Given the points above, it is our view that the current approach can be improved across the whole Council going forward to support good governance. Therefore:

Recommendation 5: The Cabinet Member for Health and Wellbeing should, in future, take key decisions on how services are commissioned prior to going out to tender where those contracts and services are deemed to be significant, as defined in the Council's Constitution.

Appendix 1: Inquiry Scope

Title	15 Minute Domiciliary Care Visits
Signed-off by	Select Committee Chairman, Angela Macpherson
	Head of Member Services, Sara Turnbull
Author	Kama Wager, Committee Advisor
Date	To be agreed by committee on 28 th April
Inquiry Group Membership	Ms Angela Macpherson (Chairman), Ms Shade Adoh, Mr Nigel Shepherd, Mrs Margaret Aston, Mr Roger Reed, Mr Brian Adams, Mr Noel Brown.
Member Services Resource	Member Services will provide the following officer support: <ul style="list-style-type: none"> • Sara Turnbull, Head of Member Services – Policy Advice and Report Quality Assurance • Committee Adviser – Policy Lead & project management 15 hours per week over 2-3 months. • Committee Assistant – Administrative support (as needed)
Lead Cabinet Member	Mike Appleyard
Lead HQ/BU Officer	Alison Bulman, Service Director- Service Provision
What is the problem that is trying to be solved?	Members want to be assured that the care needs, dignity and wellbeing of service users are appropriately met within the time allocated for 15 min visits.
Is the issue of significance to Buckinghamshire as a whole?	Yes – This is an issue being raised nationally and will affect all residents who receive domiciliary care services in Bucks.
Is the topic of relevance to the work of BCC?	Yes
Is this topic within the remit of the Select Committee?	Yes – specific to Health and Safeguarding of vulnerable adults.
What work is underway already on this issue?	<p>The committee received an update in October 2014 but concerns still remain, therefore they want to carry out a short, focussed Inquiry to examine specific areas in more detail to alleviate concerns and/or identify areas of recommendation to share with the Cabinet Member.</p> <p>A project is being scoped with Quality Care Team and Health Watch looking at dignity of care in care homes. Although this appears to be on a different issue (care homes), the Inquiry group will consider the proposal when it is drafted and consider if there are any opportunities for the pieces of work to complement each other, and avoid duplication.</p>
Are there any key changes that might	NO

impact on this issue?	
What are the key timing considerations?	<ul style="list-style-type: none"> • Inquiry takes place after May elections due to member availability. • Service area capacity only available from May.
Who are the key stakeholders & decision-makers?	<p>Patricia Birchley, Cabinet Member for Adult Social Services Susie Yapp, Service director adult social services Alison Bulman, Service Director Service Provision Graham Finch, Contract Manager Service users/Families Carers, frontline staff</p>
What might the Inquiry Achieve?	<p>The Inquiry will aim to;</p> <ul style="list-style-type: none"> • Address and gather further evidence on outstanding concerns members have in relation to 15 minute visits. • To enable voices of service users and carers to be heard. • Improve member understanding of the service and how it works by speaking to people who receive as well as those who deliver the service. • Enable members to observe front line services in action and understand first-hand the service user experiences of the service provided and the complexities of service delivery. • Ensure that 15 minute visits are meeting peoples care needs and considering them in the context of the overall care package. Gathering sufficient evidence to assure members that the process is effective (views of the service user, what does it feel like to get 15 min visit, what are the impacts of this? • Further evidence and information on instances of 5 min visits or less than 15 mins. Members would like to be assured through further evidence that these shorter visits are balanced out over the course of other visits within the care package and that all needs are being met. (Audit trail of care plans). • Understanding staff views and all stakeholders (visits)
What media/communications support do you want?	<ul style="list-style-type: none"> • Press release to launch Inquiry evidence-gathering • Social media to promote member activity on the Inquiry (photos, tweets, and comms activity). • Press coverage linked to the visits • Videoing support to capture the first hand stories of carers/service users (where appropriate with agreement) • Press release to promote the report once published.

Appendix 2: Delivering Dignified Care (15 min calls) Policy

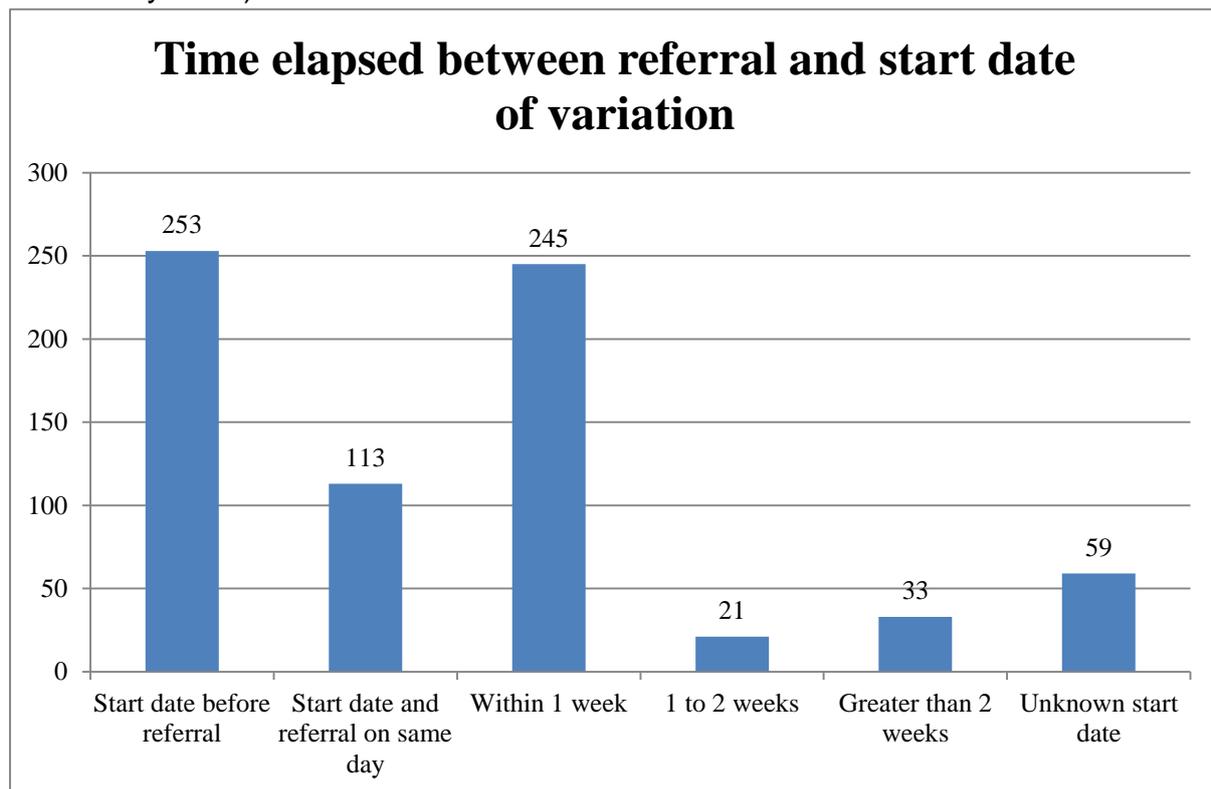
The full policy can be found here:

<https://democracy.buckscc.gov.uk/documents/s53085/DIG%20DOM%20CARE%20FINAL%20POLICY.pdf>

Appendix 3: Results of Change Process Analysis

This chart identifies the timescales between the change request form being received by Care Resource Team (who makes the changes on Swift to the commissioned care package) and they also identify on Swift the date that the change is to be or already has been implemented.

However, this data does not explicitly capture and count the time during which this request is being discussed with care managers, although it should be noted that these conversations can and do often happen on the same day as the request form is submitted. Data captured from June 2015, will capture this timescale separately, so we can report on it. (Data received from the service area at the evidence session on 2nd July 2015).



Appendix 4: Background Committee items on Domiciliary care

- Details of the committee meeting covering Domiciliary care in June 2014 can be found here:
<https://democracy.buckscc.gov.uk/ieListDocuments.aspx?CIId=137&MIId=5744&Ver=4>
- Details of the item covered at the October 2014 committee meeting can be found here:
<https://democracy.buckscc.gov.uk/ieListDocuments.aspx?CIId=137&MIId=5746&Ver=4>

Bibliography

The concerns around 15 min visits have been put into closer focus by recent national publications about the commissioning and provision of home care by independent / private agencies. These include:

1. Unison Report [Time to Care](#)
2. [Charter for Ethical Care](#), Unison
3. Leonard Cheshire Disability Charity [Ending 15 minute Care](#)
4. [Inquiry into Older People and Human Rights - Home Care](#) Equalities and Human Rights Commission (EHRC))
5. Report: H.M Revenue and Customs (HMRC) [National Minimum Wage Compliance in Social Care Sector](#)
6. Survey: Main Challenges in Home Care (Guardian / Department of Health)
<http://static.guim.co.uk/nl/1383067901570/Homecare-survey-full-result.pdf>
7. [Tips for Directors: Commissioning and Arranging Home Care Services](#) Association of Directors of Adult Social Services (ADASS)
8. [Zeroing In](#) : Report on zero hours contracts; The Resolution Foundation
9. [Key to Care](#) Report of the Burstow Commission the future of the home care workforce, 2014.
10. Institute of Public Care, Discussion paper; [Emerging Practice in Outcomes Based Commissioning](#) 2015.