

## Scotland: Collaborative Commissioning of Care at Home Services

### Part 1: General Information

Publication on EIP on AHA Portal	Yes
Copyright	Yes
Verification of the Good Practice	Yes
Evaluation of the Good Practice	No
Type of the Good Practice	Notable practice

### Part 2: Description of the Good Practice

Name of the Good Practice	Collaborative Commissioning of Care at Home Services
Short name (Acronym)	Collaborative Commissioning of Care at Home Services
URL of the Good Practice	<a href="https://www.youtube.com/watch?v=LEi6A0xfMXk">https://www.youtube.com/watch?v=LEi6A0xfMXk</a>
Geographical scope	Local level
Country	Scotland
Region(s) involved	Highland
Status of the Good Practice	On-going
Stakeholders involved	<ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Primary care centres</li> <li>• Home care centres</li> <li>• Private companies</li> <li>• Micro-sized industry</li> <li>• Regional public authorities</li> </ul>
Size of population covered	1,000-9,9999
Targeted audience	65-79 Years

### Summary of the Good Practice

Since integration, NHS Highland has been implementing a strategic commissioning approach towards the development and delivery of services. Key to this activity has been the perception that whilst the formal partnership agreement instituting the lead agency arrangements for delivery of adult care are between the NHS and The Highland Council, the concept of “integration” being pursued reflects a belief that true integration takes place across sectors, and allows the full contribution of the community to the design and delivery of services.

The objectives were to establish a sustainable; accessible; high quality Care@ Home service within a fixed financial envelope.

It was out of this work, that Highland engaged in a Programme Budgeting Marginal Analysis (PBMA) pilot to better understand a structured approach to priority setting. (paper submitted for publication with Glasgow Caledonian University)

The outcomes have been the achievement of the objectives, plus the unforeseen development of a new community driven model of care@home.

The route for achievement were new collaborative commissioning approaches and mechanisms (currently receiving considerable national interest/acclaim)

The transferrable aspects are:

- Principles of engagement
- Commissioning methodology
- Care delivery models

**Key words:** Care at Home, Commissioning, Cross-sector, Community

### Good practice being part of the larger programme

Yes.

Integration of Health and Social Care. The Highland integration pre dates national integration via the Public Bodies Act by 4 years.

### Challenges / problems addressed by the good practice

The challenge of improving Care@ Home provision is critical to future provision for an ageing population. Unavailability of Care @ Home:

- Increases dependency by delaying hospital discharge
- Increases Care Home utilisation in terms of lower age on admission and increased length of stay

- Deprives people of a choice, and a chance for continued independence •  
Confines choice to expensive residential and institutional options
- Reduces the quality of experience, whilst driving up system costs.

**Importance of the challenges / problems before starting to implement good practice**

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**Environment before the good practice was implemented**

Initially, the behaviour of the statutory sector in this setting was procurement, rather than commissioning and very traditional in setting terms and driving down price. It is also important to note that, as a purchaser /provider, the statutory sector protected and prioritised use of the “in house” service, at the expense of the stability of the Sectors.

Market facilitation (or lack of) requires to be seen in this context. Due to a position as a 60% provider of care@home, the statutory sector made available those hours that they did not have capacity/logistics to provide themselves. Provision was not jointly planned and forward planning to allow sector expansion was minimal.

The fee structure was set by establishing the level of increase that could be borne by the budget, based on existing configurations of activity.

This “hand to mouth” approach was further exacerbated by the ability of the in house service to offer better terms and conditions to staff. The result was that the independent and voluntary providers trained up new staff, only to see them attracted away to the in house service due to better terms and conditions, resulting in staff shortages which destabilised independent provision, resulting in the return of packages to the in house service, “proving” that the sector could not be relied upon to deliver sustainability.

This vicious cycle was further amplified because the lack of a consistent or sustained flow of hours/work meant that the Sector could not recruit in advance, as there was no assurance that the trained up staff would be deployed despite a shortage of care@home.

The resulting context was poor and distrustful relationships; a dysfunctional market and an adversarial and acrimonious liaison meeting. However this approach did help to foster a cooperative approach from all non-statutory providers under the coordination of Scottish Care, which became a crucial aspect of the subsequent changes.

**Key innovative elements of the good practice and how the good practice improved situation compared to previous practice**

There was an upward shift in quality;

- More people are able to live independently at home
- Delays in receiving care @ home were reduced or eliminated in the project area and Hospital bed days lost awaiting Care@ Home were reduced
- Remote areas previously described as impossible to provide care now have thriving provision
- A sustainable “fair rate” is paid for care@home hours and a collaborative commissioning environment has been achieved.
- A joint recruitment strategy for the Sector was implemented and was successful and the living wage was paid to Care@ Home workers across sectors from 2014 (two years ahead of the national initiative)

Reference to Self-Directed Support is also important. Through the process of collaboration, it became apparent that there were localities where no provider was able to operate successfully, but where the community wished to support provision. In these (principally rural) areas, a partnership approach between the community and the independent sector was taken forward to establish “pop up” care@home which knitted together existing provision with community capacity to create reliable care at home where there had previously been none. This model may be particularly applicable to the very rural North and West of Highland as we move to this approach in 2016/17.

**Part 3: Transferability of the Good Practice**

<b>Cost-effectiveness of the good practice (including all kind of costs and outcomes such as better health, quality of life or other resources)</b>	Lower costs, improved outcomes
<b>Resources required for the deployment of the good practice (personnel, equipment, facilities, ICT and other resources required)</b>	
Resources required were limited to the extent that £0.5m was made available to cover fixed at one year double running costs. All other resources were existing management time being directed to supporting the project.	
<b>Total budget of the Good Practice</b>	€100.00 - €499,999
<b>Source of funding</b>	Local funding
<b>The main actions that have to be done to deploy the Good Practice</b>	
In reflecting on the path that has been followed by the Care at Home Sectors within Highland, it is important to recognise that whilst there have been practice,	

process and system changes, the real underlying changes have occurred within behaviours and culture. Key to these are:

- Building trusting relationships Firstly this refers to the relationship between the NHS and the non-statutory providers: evidencing that we mean what we say about working together, and that we are intent on doing this at scale, rather than making change at the margins to demonstrate Good Practice, whilst continuing to protect the 60% of inward commissioning to the in-house service. Secondly, this refers to the development of a (possibly unique) local arrangement whereby the Provider base adopts a collaborative approach towards coordination of recruitment and allocation of work. The importance of this cooperative culture cannot be understated, not least as entrants to the Highland “market” require understanding the behaviours expected of the members of that market. The upshot of the above is that there is an unusual level of trust between the commissioner and providers; and between providers.
- Alongside the development of trust has been a relinquishing of power to allow the sector, as a whole, to develop the new arrangements, rather than the NHS imposing conditions on them. This has resulted in the attached conditions to the Tariff, which are the statements developed by the providers, of “what they think the NHS should be expecting” to achieve the outcomes we have agreed to pursue. It is probably fair to say that the resultant conditions are probably both better owned and more robust than the NHS might have otherwise hoped for. • Changing expectations. The above changes have raised expectations of both behaviour and levels of provision. We have moved from a traditional approach to monitoring and compliance to a point where the Development Group considers challenges and jointly promotes improvement, rather than the Commissioner challenging a provider in isolation. The expectation within the Highland environment is that the Sector (including the in-house provider) will suggest and implement solutions to maintain a “self-healing” provider base.
- Acting with integrity. This expectation cuts both ways. At the start, there was much that had been negative about the way that the Purchaser/Provider split operated; and we needed to be honest about that and to try and fix it. We can now say that both the NHS and the Sector are prepared to critically appraise our own approaches and to openly seek solutions. This has been as much about being honest about what we can’t do, as it has about what we can.

#### **Issues during the implementation of the Good Practice**

- Shifting activity and developing a market is difficult in a period of escalating, unmet need.

<ul style="list-style-type: none"> <li>• All parties are looking for assurances on big financial and operational risks that cannot be provided in such a developmental context.</li> <li>• A major system change which is predicated on cultural change takes time that we did not have. The result was a brinkmanship that the project would “come good” in the end. Which it did.</li> <li>• Being prepared to take the bold step and holding our nerve that we were doing the right thing, is harder than accepting a “safe” but deteriorating status quo.</li> </ul>
<p><b>Additional resources required to scale up Good Practice</b></p> <p>No</p>
<p><b>Basis to support sustainability of the Good Practice</b></p> <p>As described above. The key resource transfer is from high cost, in house provision to lower cost (but still the highest rate paid in Scotland) better quality provision. This enables the in-house service to be redeployed to provide an intense rehabilitation service, which has been seen to reduce dependency, creating a virtuous cycle which reduces demand.</p>
<p><b>Evidence to observe the Good Practice</b></p> <p>The good practice is observed via the report - <a href="https://www.youtube.com/watch?v=LEi6A0xfMXk">https://www.youtube.com/watch?v=LEi6A0xfMXk</a></p> <p>Study visit can also be accommodated.</p>

#### Part 4: Viability assessment of the Good Practice

<p><b>Time needed to deploy the Good Practice</b></p> <p>Between one year and three years.</p>
<p><b>Investment per citizens / patient / client in terms of financial resources</b></p> <p>No available calculation.</p> <p>The project does not require an additional investment per person, the investment is the care cost that varies dependent on need @ £18.99 per hour of delivered care.</p>
<p><b>Evidence behind the Good Practice</b></p> <p>Apparent evidence. Evidence is based on qualitative success stories.</p> <p>Principle evidence is the reduction of bed days delayed in hospital attributable to Care@ Home delays (these can be costed) and the emergence of provision in previously unreachable rural areas.</p>

<p><b>Maturity of the Good Practice</b></p> <p>There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use.</p> <p>The practice is now firmly established in the Inner Moray Firth area of Highland (previously named South and East) and is being migrated to the North and West, where it is at an early stage of a likely slower rate of development.</p>
<p><b>Estimated time of impact of the Good Practice</b></p> <p>Medium impact - e.g. shortly beyond the pilot project period</p>
<p><b>Impact observed</b></p> <p>Better quality of life (societal).</p>
<p><b>Transferability of the Good Practice</b></p> <p>The innovative practice has been transferred within the same region.</p>

## Part 5: Your organisation

<b>Name of the organisation</b>	NHS Highland
<b>Address of the organisation</b>	Assynt House Beechwood Park Inverness IV2 3BW
<b>Type of organisation</b>	Local public authorities
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