

BEST VALUE REVIEW OF SERVICES FOR OLDER PEOPLE IN WEST SUSSEX:

HOME CARE

FULL REPORT

Project Director: Anna Coss, Head of Adult Services
Project Manager: Alison Boyd, Scrutiny Group
Working Group Leader and Author of Report: Mary Sinclair,
Strategic Commissioning and Performance Manager

AUG 2002

CONTENTS

Recommendations for Project Steering Group (Green)	1
Executive Summary, Conclusions and Recommendations (Blue)	2
Risk Analysis (Blue)	8
Gap Analysis (Blue)	9
Performance Improvement Plan	10
Full and Detailed Report	12
1. Introduction	
2. Background	13
3. Methodology and limitations	19
4. The in-house home care service	20
5. What do people think of the service?	57
Consultation with stakeholders	
6. How does the service compare?	74
Comparison with other LAs	
7. How does the service stand up to examination? Challenging the Best Value process	81
8. Is the service fit for the future? Competition with other providers	89
Glossary	
Appendix 1 - BVR (Home Care) Working Group Members	
Appendix 2 - Management Structure	
Appendix 3 - PEST Analysis	
Appendix 4 - SWOT Analysis	
Appendix 5 - Matching Stakeholders Views with National Care Standards	
Appendix 6 - A summary of Key Points and Issues Raised (Blue)	
Appendix 7 - Evidence File	

Recommendations for Project Steering Group

The Best Value Review Group looking at home care present the following report to the Project Steering Group on 23 September 2002 and make the following recommendations to the group:

- **The Best Value Review is accepted by members of the Project Steering Group**
- **The document is then published and shared with all stakeholders**
- **The Performance Improvement Plan forms the basis for action**
- **An update on progress is made available to members in one year's time.**

BEST VALUE REVIEW OF SERVICES FOR OLDER PEOPLE IN WEST SUSSEX: HOME CARE

Executive Summary, Conclusions & Recommendations

The central purpose of best value is to make a real and positive difference to the services local people receive from their local authority. The BVR process looked in detail at the service provided, seeking an understanding of the current position and ensuring that actions will drive improvements. Action plans need to be clear and have challenging targets and take a long term view which involves stakeholders and ensures a good quality sustainable service for vulnerable people of West Sussex.

There were five key objectives agreed for this Best Value Review and below is a summary of conclusions against each with key recommendations:

1. To develop a commissioning strategy for the in-house home care service based on the market analysis of the total market for home care in West Sussex.

This was a part of the task of the Domiciliary Care Contracting Scrutiny Sub Group which set out to examine how the development of externalising domiciliary services had been addressed in contractual terms. The process also gave the opportunity to see how the arrangements for care management had been developed and applied. Given the intention of WSSCS to outsource 60% of the home care service by 2003, both the in-house service and independent sector were examined and consideration given to the progress being made. The report of the Scrutiny Sub Group included a number of recommendations. The BVR has commented on these recommendations indicating where work has been completed, is in progress or still requires action.

The BVR originally focused on the in-house sector, this was challenged and the group then included a study of the independent sector. This built on the work undertaken by the Scrutiny Sub Group. The outsourcing of the home care service to meet the target of 60% in 2003 is on target at 53%. Sustained effort will need to be made to ensure the target is realised and those local areas where outsourcing has been low need to consider together with the contracting department how the market can be stimulated in order to achieve the 60% target.

The outcome of the benchmarking exercise indicated that most LAs are going down the route of the in-house service undertaking specialist work, short term work and caring for the hard to place people. The independent sector are generally undertaking mainstream work. There has been some expression of interest from the independent sector in specialisms such as older people with dementia and the generic care worker. Together with the difficulties experienced

by both the in-house and independent sector within, for example, the rural areas it would make sense to adopt a partnership approach.

Mainstream work could gradually be transferred to the independent sector and discussion could take place locally with those providers who have expressed an interest in providing specialist services and generic care working. This needs to be planned properly and in the interests of the service should be achieved in an incremental way that acknowledges the need for a shared vision that addresses workforce planning.

The generic care worker offers a means of providing a more seamless service that addresses the grey areas that fall between health and social care. The generic care worker tasks need to be incorporated into the role of the HCA and staff should be trained and supported. This is addressed in key recommendation 3.3.

Key recommendations:

1.1 The review supports a mixed economy for home care. An overall target of 60% outsourced by December 2003 remains reasonable, as long as quality can be assured. However, this may vary according to local circumstances particularly in some rural areas.

1.2 Each Area Manager should seek to create a local forum of in-house, independent sector/ voluntary organisation providers to work together to ensure an efficient and sustainable service for that local population. Acknowledging that though the service user will be geographically located in a particular area, the most efficient service may occasionally need to be negotiated with a service provider from another nearby area. This is part of the approach referred to in the BVR as the Modernising Partnership Approach.

2. To identify and analyse existing in house cost profiles to establish a true cost like for like comparison with the independent sector

The identification of a unit cost, both an average for the county and for each local area has been devised together with an average unit cost for the independent sector. Comparisons have been attempted with other LAs. This has proved difficult because of the different means of establishing which overheads should be included.

It is clear that work needs to be undertaken on reducing costs. Alongside the BVR a steering group has recently started looking at the management structure.

In 1999, it was recommended that work was undertaken on reducing the sickness absence percentage. Management undertook training and worked toward reducing absence. However, targets were not monitored. Realistic targets for achieving a reduction in sickness absence need to be set.

The BVR group were mindful that at the time of the Domiciliary Care Review 1998, it was agreed that the in-house home care service needed to be supported by proper scheduling and information systems. If the in-house service is to be efficient and cost effective the introduction of systems should be treated as high priority together with adequate clerical support.

Key recommendations:

- 2.1 Adult Services to ensure a review of management tasks and activity in order to reduce management costs. The review of management activity to include the role of the Domiciliary Care Commissioning Managers.**
 - 2.2 The Head of Adult Services will monitor sickness absence and take action to further reduce this as necessary and seek to maintain a maximum of 6% level across the service which is considerably better than the LAs contacted.**
 - 2.3 A bespoke IT system for home care is being progressed and the Head of Resources will ensure that the timetable does not slip from the agreed start date of July 2003**
- 3. To ensure that adequate financial controls, checks, division of duties and management control are present within the in-house home care service, to consider the impact of the business process mapping currently underway and appropriate support systems**

A systems analysis of home care pay which revealed, a number of concerns about the home care system was undertaken in 2001. The recommendations from the audit are currently being taken forward together with home care staff, managers and clerical staff.

The division of duties and responsibilities of home care staff and managers was considered as part of Shaping the Future in 2001. The need to modernise the management structure, given the various changes since the Domiciliary Care Review in 1998 has been acknowledged and is being undertaken alongside the BVR.

The business process mapping exercise is now complete and has helped inform the service specification for the in-house domiciliary care software system. Work has been undertaken on a procedure guide for the in-house service and this needs to be revised and matched against the National Care Standards.

The National Care Standards, which include specific training targets, will need to be implemented by January 2003.

Key recommendations:

- 3.1 The Group Manager (Financial Services) will ensure that the work already in progress to modify and simplify the home care payment arrangement is completed to the agreed timetable of July 2003**
- **Management rationalisation and the new IT system are referred to in key recommendations 2.1 and 2.3**
- 3.2 The Head of Adult Services will ensure that the home care service meets the National Care Standards Commission Guidelines by January 2003. The Head of Commissioning will ensure that contracts with the independent sector are National Care Standards Commission compliant.**
- 3.3 The Group Manager (Training and Development) will, with the Head of Adult Services, introduce a training programme to ensure 50% of all home care staff are qualified to NVQ 2 by 2007 and have undertaken generic care worker training.**

4. To examine the advantages and disadvantages of alternative service delivery options within the market.

The BVR gathered information as part of the benchmarking exercise which also helped inform an exercise on options for the future. The group dismissed no change as an option given the need for continuous improvement. As part of the exercise the group decided that total in-house and total out sourcing were not options as explained in section 7.5.

Little information was found on business units, something the Domiciliary Care Scrutiny Sub Group had suggested should be considered, and no information was found regarding Care Trusts where home care was already included. It was agreed that either might be options for the future subject to further information. Similarly, the Care Co-operative model might also be considered. The preferred option at this point of time being the Modernising Partnership Approach which gives the scope to build on strengths and opportunities and overcome the weaknesses and threats, working within legislation and the national guidance. The model was considered to be the best at this point in time both in terms of the potential for improvement and preparation for any future change.

Key recommendations:

- 4.1 The Head of Adult Services and The Head of Commissioning will continue to review options (Care Trust, Business Unit and Care Co-operative) for change over the next five years, ensuring both quality, sustainability and cost are the focus for the future.**
- 4.2 In the meantime the Modernising Partnership Approach also referred to in part in key recommendation 1.2 is the present preferred option.**

5. To develop a business strategy for home care which supports both the findings of the BVR and incorporates the recommendations contained within the March 2001 Domiciliary Care Contracting Report

The recommended business strategy is one that supports a Modernising Partnership Approach and sets out a clear strategy, which includes the recommendations contained within the Domiciliary Care Contracting Report, in the form of a performance improvement plan. The purpose will be to ensure Best Value is achieved through the ability to make a real difference to people's lives. An important key element will be how the recommendations are led, implemented and monitored.

Moreover workforce planning given the high number of home care staff over 50, some of whom are near retirement, recruitment problems and the need to plan for further outsourcing will be important. There are few staff from ethnic minority groups employed within home care. The recruitment policy, particularly at advertisement stage, needs to reflect that West Sussex Social and Caring Service is culturally sensitive.

The BVR addressed the objectives using the four C's of consult, compare, challenge and compete. The report describes the current in-house home care service, the strengths and weaknesses and the action that will need to be taken to make a real and positive difference to people's lives. The Improvement Performance Plan implies a huge piece of work that needs to be undertaken. However, some of that work has been started or partly achieved. The new organisational structure which brings together the provision and commissioning of home care services under one manager is a positive move. The Modernising Partnership Approach will create a framework for improvement and will assist in preparation for future change.

Key recommendations:

- 5.1 The Head of Adult Services and the Head of Commissioning will ensure that an operational performance improvement plan is confirmed, agreed and implemented.**
- 5.2 This plan to ensure that attention is given to workforce planning and also make particular reference to employing people from ethnic minority groups.**
- 5.3 That the progress of this plan is regularly monitored and a report is given to elected members at Select Committee in twelve months time.**

Risk Analysis

Risk is defined by the Audit Commission ('Worth the Risk') July 2001, as the threat that an event or action will adversely affect the organisation's ability to achieve its objectives or to successfully execute its strategies. Risk management is a process of evaluating and addressing the impact of risk in a cost effective way. It requires staff and managers with appropriate skill to identify and assess the potential for risks. Within the home care service there is an understanding that operational risk is ever present and particularly in terms of supporting independence and choice.

The BVR showed that the following risks exist within the in-house home care service:

OPERATIONAL	STRATEGIC
Recruitment	Budget confines
High number of staff near retirement age	Change of direction by Government
Training requirements in particular to meet the National Care Standards	Lack of workforce planning that addresses home care
Insufficient NVQ assessors	Best Value recommendations
Insufficient budget to make cover arrangements for staff on training	Need to reduce costs
Lack of consistency between areas.	Poor service image
Failure to prioritise	Working in competition rather than co-operatively
Remedial action not followed through	Lack of clarity about future plans
Failure to implement National Care Standards	Short term planning
Inadequate IT and management information systems	Modern ways of working e.g. partnerships and enabling
Lack of home care procedures manual	Lack of connection with performance management
Lack of leadership	Lack of leadership
Insufficient resources	Uncertain future

Gap Analysis

The BVR group identified the following gaps which include:

- Robust planning and a mid to long term strategy
- Consistency in business processes, procedures and policies between Areas
- Workforce planning group to address the shape of the workforce for the future
- Training plan to meet National Care Standards
- A domiciliary care scheduling system
- Adequate management information systems
- Revised management structure
- Modernised service which includes a 24 hour, 7 day a week provision
- Joint forum including both in-house and independent sector home care representatives
- Achievement of outsourcing targets by 2003
- Involving service users and carers in designing consultation and ensuring their participation in the process.

BEST VALUE REVIEW (HOME CARE) STRATEGIC PERFORMANCE IMPROVEMENT PLAN

RECOMMENDATION	OUTCOME	STRATEGIC LEAD	COST/ SAVINGS	TARGET
1.1. Robust programme to achieve an overall target of 60% outsourcing to be progressed.	Target of 60% achieved	Area Managers	Significant change made. Further cost detail will be part of this plan.	December 2003
1.2. Local forums of in-house and independent sector/ voluntary organisation providers to be created.	Efficient and sustainable service for the local population	Area Managers	This is a capacity issue	September 2003
2.1 Review management tasks including the role of Domiciliary Care Commissioning Managers	Reduction in management costs and greater efficiency	Head of Adult Services	Savings not yet costed but should be available in March 2003.	July 2003
2.2. Monitor and reduce sickness and seek to maintain a 6% level across the service	Reduction in cost and greater efficiency	Head of Adult Services	Reduction to 6%, savings estimated to be £115,500	March 2005
2.3 .Introduce the bespoke IT system for home care	Less reliance on manual systems and more efficient use of time.	Head of Resources	Costs included as part of E Govt.	July 2003
3.1. Modify and simplify the home care payment arrangements	Greater understanding of systems, improved accuracy and staff satisfaction.	Group Manger (Financial Services)	Greater efficiency	July 2003

RECOMMENDATION	OUTCOME	STRATEGIC LEAD	COST/ SAVINGS	TARGET
3.2. Home care to meet the National Care Standards	All providers working to the same standards	Head of Adult Services (in-house provider) Head of Commissioning (independent sector)	Cost implications not yet known	January 2003
3.3 Training programme to be introduced to ensure 50% of all home care staff are qualified to NVQ 2 by 2007 and have undertaken generic care worker training.	Skilled workforce in place as required by National Care Standards	Group Manager (Training and Development) and Head of Adult Services	Annual cost of four year programme estimated to be: NVQ: £275,000: GCW: £76,000	April 2003
4.1. Continue to review, over the next five years, options for change within home care	Best value and continuous improvement	Head of Adult Services and Head of Commissioning	Cost and quality to be constantly monitored	Ongoing 2007
4.2 Implement the Modernising Partnership Approach	Best value and continuous improvement	Head of Adult Services		December 2002
5.1 Confirm, agree and implement the performance improvement plan	Best value and continuous improvement	Head of Adult Services		October 2002
5.2. Establish a workforce planning group, with particular reference to employing people from ethnic minority groups	Right staff in the right place with the right skills	Group Personnel Manager (Social and Caring Services) with Head of Adult Services		April 2003
5.3. Progress of the performance improvement plan to be monitored and reported to elected members in twelve months time.	Action taken, monitored and revised as necessary	Head of Adult Services and Head of Commissioning.	Report to include greater level of financial detail	October 2003

BEST VALUE REVIEW OF SERVICES FOR OLDER PEOPLE IN WEST SUSSEX: HOME CARE

Full and Detailed Report

1. Introduction

The central purpose of West Sussex Social and Caring Service (WSSCS) is to make a real and positive difference to the services that local people receive. The Local Government Act 1999 places a duty on every council to deliver best value services which take into account clear standards of cost and quality by the most economic, efficient and effective means. Since April 2002, over a five year period all Local Authorities (LAs) are required to review their services against the Best Value Framework which comprises the four following drivers:

**Challenge
Compare
Consult
Compete**

A Best Value Review (BVR) recognises the importance of continuous improvement. The process involves looking in detail at the service provided, understanding the current position, having clear and challenging targets and ensuring that actions will drive improvements. It is important to have a long term view that includes both those responsible for delivering the service and the service users.

The review of the WSSCS in-house home care service is one part of a wider BVR process which examines services for older people. The home care service provides personal care, domestic and emotional support to people of all ages, the majority of whom are older people, living in the community. Generally, older people receive between two hours to fifteen hours per week, on average 5.32, a figure which is steadily increasing year on year. This may be complemented by other services such as day care and respite in a residential establishment.

The BVR working group included membership from a number of organisations (Appendix 1). The group agreed that the following objectives should be incorporated in the review:

1. To develop a commissioning strategy for the in-house home care service based on a market analysis of the total market for home care in West Sussex
2. To identify and analyse existing in-house cost profiles to establish a true cost, like for like comparison with the independent sector
3. To ensure that adequate financial controls, checks, division of duties and management controls are present within the in-house Home Care service and

to consider the impact of the business process mapping currently underway and appropriate support systems

4. To examine the advantages and disadvantages of alternative service delivery options within the market
5. To develop a business strategy for home care, which supports both the findings of the BVR and incorporates the recommendations contained within the Domiciliary Care Contracting Report March 2001 (Report of the Scrutiny Sub Group).

In order to undertake the task and produce a performance improvement plan, information was gathered about the in-house service and using the four C's, challenge, compare, consult and compete the following questions were addressed:

- What do people think of the service?
- How does the service compare?
- How does the service stand up to examination?
- Is the service fit for the future?

Best Value was regarded as a helpful framework which would assist WSSCS gain a better understanding of the home care service and the views of stakeholders in order to improve services and link these improvements to performance management arrangements. It was also regarded as an effective way of addressing the national drivers including the Government's Modernisation agenda and the National Service Framework.

Initially the review focused on the in-house provider and not the independent sector because the commissioning of and contracting with the independent sector was the subject of a Domiciliary Care Contracting Report undertaken by the Scrutiny Sub Group in 2001 as part of the re-tendering process. However, inevitably, as the review progressed it included comparisons with the independent sector and other LA providers.

Above all the purpose of the review was to make a real and positive difference to the services people receive from WSSCS.

2 Background

2.1 Home care for older people

Nationally since the 1930's the number of people over 65 has more than doubled. By 2025 the expectation is that the number of people over 80 will increase by about a half and the number of people over 90 will double. Currently, one in five of the population is over 65 and it is anticipated that this will have grown to one in four by 2020. The profound changes in demography and the age structure of society have very far reaching political, economic and social consequences.

West Sussex is a large rural county with a population of 763,000 and a higher than average proportion of older people. In 2001 there were estimated to be

151,600 older people (over 65 years of age) living in the county. The increase in the next decade is estimated to be a further 9,800 of people over 65.

Home care is a major care service which is provided to people in the community. Without the provision of regular home care many people would not be able to continue to live in their own homes. The in-house home care budget for 2001/2002 was 10.6 million and is 11.1 million in 2002/2003. The number of people receiving home care from the in-house and commissioned from the independent sector in March 2002 was 4,122, the number receiving home care over the age of 65 being 3,513 which represents 85% of the total home care hours from all services delivered. The in-house home care data collection exercise for a one week period in April 2002 indicated that the percentage was 93%.

The focus of this BVR is older people however it needs to be acknowledged that there are other groups of people receiving home care including people with learning difficulties, mental health needs, physical disabilities and children and families:

- Delivery of the home care service to the under 65s is similar in respect of the 2 hours or less
- The county average for those receiving more than 10 hours is 22% for under 65's compared with 15% for over 65's
- The highest number of hours received by a service user under 65 is 140 compared with 38 for the over 65's

The pattern of home care for older people by locality, as provided for the Spring Position Statement, indicates the following, although it should be noted at this point the actual number of people receiving intensive home care was believed to be greater than reflected in the table:

Home care hours delivered to the over 65's. (in-house and commissioned)

Locality	Total hours	No. of service users	Av no. of hours	No. 2 hours or less	% 2 hours or less	No. more than 10 hours	% more than 10 hours	Highest no. of hours per service user
Chichester	2792	524	5	102	20%	84	16%	31
Arun	3834	832	4	121	15%	95	11%	31
Adur	1815	291	6	14	5%	55	19%	35
Worthing	3151	545	6	51	9%	69	13%	22
Crawley	1595	329	5	28	9%	61	19%	28
Mid Sussex	2841	457	6	53	12%	89	19%	37
Horsham	2662	535	5	130	24%	75	14%	38
County	18690	3513	5	499	14%	528	15%	38

Source: Information Dept. March 2002

Nationally home care provides essential care for five times as many people as there are living in residential care (Community Care, 7 March.2002). From its

traditional image of unskilled workers providing domestic tasks, there has been considerable progress from a home help to a home care service. The service now provides skilled packages of care to dependent people, many of whom have complex needs, living in the community.

The LA has a duty to provide a home help service under the 1948 National Health and National Assistance Act and the 1968 Health Services and Public Health Act. In 1990 the National Health Service and Community Care Act (NHS and CC Act), which was introduced in 1993, extended the scope for LAs to either directly provide the service or purchase services from independent sector providers. This meant therefore that Social Service Departments became both commissioners and providers of services.

Access to home care as part of the care management process is through a referral to the department which is then, where appropriate, followed by a social care and financial assessment. There are no statutory requirements which determine the level of the home care service. Delivery of service can be determined by the allocated budget available and is allocated according to need in line with the department's eligibility criteria. The in-house home care service operates 7 days a week, mainly from 7am to 10pm. An in-house home care emergency out of hours scheme operates at nights and weekends. The role of home care is to support elderly and vulnerable people to live as independently as possible in their own homes.

The NHS and CC Act 1990 referred to keeping people in their own homes, maximising user choice and developing a mixed economy. This legislation encouraged the expansion of the home care service in order to provide alternatives to residential care. Since the implementation of the Act the provision of home care which is a cornerstone of community care has grown.

Nationally in recent years there has been a trend toward a greater intensity of care i.e. fewer service users overall receiving more intensive targeted services. This has meant that the traditional services, which supported people with lower level needs, are no longer available and alternative arrangements need to be made. A concern for the future is that if prevention is not addressed there is a potential for a greater number of older people requiring more intensive services.

Prevention and the need for preventative services is one of the government's key targets for LAs. In response to requests for preventive services, including housework and shopping, some localities have fully or partly funded schemes including shopping schemes, Staying Put, Care and Repair, Help at Home, Disability Advice Clinic and Safe Handy Person schemes

2.2 Recent changes in the home care service

After several years of stability the in-house service has recently undergone considerable change. In 1998 a review of the home care service (West Sussex Domiciliary Care Review) was undertaken. The review considered market information, policy direction, financial constraints and workforce analysis in order to inform a business strategy for the future. To drive forward the changes, recommendations were made for a revised management structure with changes to staff terms and conditions, a formula for the allocation of clerical staff and

proposal for information technology in order to improve scheduling and information collection. Alongside this process WSSCS undertook an organisational restructuring in response to the Joint Review 1998 (Audit Commission and SSI Inspection) which had commented that insufficient attention had been paid to workforce planning, service priorities and targets. Separate to the Domiciliary Care Review but with implications for the management of the service was a requirement to achieve management efficiency savings across the department.

The recommendations of the Domiciliary Care Review needed to fit with departmental reorganisation i.e. a flatter structure with fewer managers. In addition the Single Status Agreement and Working Time Directive, which afforded manual workers, such as home care assistants, the same terms and conditions as salaried staff together with a reduced working week from 39 to 37 hours were introduced. This was followed by Job Evaluation which resulted in regradings for some staff. All three represented further cost and had implications for the unit cost of the home care service.

Following the Domiciliary Care Review the former Social Services Committee in autumn 1998, agreed that commissioning of home care from the independent sector should be developed. At that stage West Sussex was rated as one of the lowest shire counties in its purchasing of home care from the independent sector. The five year target was set whereby 60% of the home care service would be outsourced by 2003. This decision was followed by the appointment of Domiciliary Care Commissioning Managers (DCCMs) who had formerly been Home Care Managers (HCMs) and Domiciliary Care Commissioning Assistants (DCCAs) some of whom were previously Senior Home Care Assistants (SHCAs). The DCCMs manage and co-ordinate commissioning arrangements and development activities to ensure a robust and responsive domiciliary care sector in partnership with WSSCS.

Service users were transferred, as appropriate, from the in-house to the independent sector. This was followed in 2001 by tight budget confines and a requirement for greater efficiency, which was achieved through increasing the contact time between SHCAs and Home Care Assistants (HCAs) with service users, and reducing training that was not mandatory together with bi weekly rather than weekly meetings.

The BVR of home care has taken place against a background of further change. The department completed the New Directions reorganisation toward the end of the BVR process in June 2002, bringing together the provision and commissioning within separate units for children and adults. An implication for home care is a change in line management structure above Lead Manager (home care). resulting in both the in-house home care service and the domiciliary care commissioning team being managed within the same line. (Appendix 2) The conclusion drawn is that the in-house home care service has experienced considerable change and that in contrast to some other LAs that were part of the benchmarking exercise staff terms and conditions had already been subject to change.

2.3 Relevant legislation, government guidance and strategic intentions.

Reference has been made to the National Health and National Assistance Act 1948, the Health Service and Public Health Act 1968 and the NHS and CC Act 1990. Of particular relevance is the range of legislation, guidance and strategic intentions that have been introduced during the recent years. The Joint Review in 1998 commented that home care in West Sussex was less intensive and had changed less quickly than in comparable authorities

Modernising Social Services 1998, highlighted the need to promote independence, improve performance, to raise standards and improve partnerships. The Health Act 1999 enables LAs and the NHS to work more closely together. Additional funding to introduce intermediate care has been provided and is seen as a test of how well Health, Primary Care Trusts (PCTs) and Social Care work together. The WSSCS Strategy for the Development of Services for Older People 1999, placed emphasis on the need for responsive and more flexible services and specialist home care for older people with mental health needs (OPMH). The Joint Investment Plan 2000 talked about the need for a whole systems approach for Health and Social Care.

The National Service Framework for Older People (March 2001) is a key vehicle for ensuring that the needs of older people are at the heart of the reform programme for health and social services. Particularly significant are the references to person centred care, ending age discrimination, developing services which promote independence and mental health for older people.

The Carers Recognition and Services Act 1996 places a clear duty on the LAs to assess the needs of carers. Subsequent legislation and guidance emphasises the importance of taking into account the wishes and needs of carers. The Care Standards Act 2000 puts in place an independent regulatory system through the creation of the National Minimum Standards Commission. The new standards for domiciliary care will be introduced in September 2002.

The general themes from legislation and strategic intentions can be summarised as follows:

- Partnership
- Prevention
- Intermediate care
- Intensive care
- Rehabilitation
- Respite Care
- Independence

The SSI Inspection of Services for Older People in May 2001 in WSSCS concluded that:

- Some domiciliary care was not always reliable; both in-house and the independent sector

- There was some scope for more attention to developing services targeted at avoiding inappropriate admission to hospitals or residential homes through the establishment of multi disciplinary services outside hours
- Some practice could have been more sensitive to individual needs

2.4 Direct Payments

The Community Care (Direct Payments) Act 1996 permits Local Authorities to provide payments in lieu of services to meet needs assessed under the National Health Service and Community Care Act 1990. Local authorities may therefore make cash payments to service users to enable them to pay for services to meet all or some of their assessed needs. Service users are then able to make their own arrangements to meet those needs instead of using services arranged or provided by the LA.

The aim generally is to give individuals greater flexibility and cost effectiveness in the way their personal assistance is managed. Home care services may also be involved for example doing pop in services or covering for the live in carer.

Direct Payments can offer an alternative to services arranged by WSSCS and should be one of the options at the point of assessment. The scheme was originally intended for people under 65. However, since February 2000 people over 65 have been eligible. Take up has been slow both nationally and locally. Possible reasons may include:

- Older people prefer traditional services
- Older people may be apprehensive about responsibility for money and employing others

Other reasons for low take up may include:

- People, both professional and members of the public are unaware of the service
- There may be misunderstandings regarding eligibility
- Lack of advocacy or knowledge of an advocacy service

In an article on Direct Payments, 'Independence pays? – barriers to the progress of direct payments' (J Glasby and R.Littlechild. Practice Journal of BASW Vol. 14 no 1 2002) suggest that:

- Direct payments may mean a conflict re protecting/empowerment
- Confusion about what constitutes direct payments
- Demands on care managers time
- The national ban on recruiting relatives as personal assistants. The fact that direct payments are discretionary

Direct payments have grown considerably in recent years. However, scheme managers involved suggest that it may not really be embedded in the range of services. In April 2002 there were 101 people under 65 and 14 over 65 receiving

a service. A further problem is that although the service needs promotion there may be a capacity problem for the team.

Where people take up the service it may be because they are not satisfied with current services and, or, may want greater control and more flexibility. The added value is regarded as improved self-image that comes from managing a service. The service differs from the in-house and independent sector in that it not subject to police checks or the National Minimum Standards.

The managers of Direct Payments describe the scheme as cost effective. The range of service currently varies from 4 hours per week to 168 hours. The latter involves a live in carer. The unit cost includes the direct cost of the service only and is quoted as £8.80. Financial services are responsible for financial returns, receipts and time sheets. A systems review of direct payments was undertaken in December 1999 and a further audit is about to be undertaken.

In a Press release on 23 July 2002, Alan Milburn, Health Secretary unveiled a range of measures to radically reform services for older people backed up by increased investment. (Expanded services and increased choices for older people). Reference is made to:

“Increased choices for older people - following assessment of care needs all councils will be obliged to offer direct payments to older people allowing them to make their decisions about the care they need.”

3. Methodology and Limitations

3.1 Methodology

The review used the Best Value framework comprising the four C's of consult, challenge, compare and compete.

Information gathering for the reviews included:

- Data collection exercises
- Statistical information
- Surveys
- Questionnaires
- Focus Groups
- Stakeholders Groups
- Meetings
- Interviews: free flowing, semi structured and structured
- Telephone contact
- Visits to other LAs
- BVR summaries from other LAs
- Literature Review
- The Internet

Evidence files containing details of reports, consultations, meetings and benchmarking documentation are available for a more detailed study.

3.2 Limitations

The following issues are important but were outside the scope of this report:

- terms and conditions of service
- care management
- commissioning.

The main reason being that these issues had either been addressed as part of the Domiciliary Care Review in 1998, the Domiciliary Care Contracting Scrutiny Sub Group in 2001 or will be reviewed separately as part of the BVR of services for older people. The findings of this aspect of the BVR will inform other BVRs.

Information collection in some instances proved difficult because of, for instance, the different way of recording or time taken to collect the data. Given the time boundaries sample studies needed to be limited in terms of size. Other LAs were sometimes in the middle of reorganisation and were unable to respond to requests for information. WSSCS was undergoing a reorganisation as part of New Directions which included changes to locality boundaries. However, useful information was obtained from a number of different sources which informed the BVR, shaped the Improvement Performance Plan and will inform information collection for the future.

4. The in-house-home care service: the current position

The intention of this section is to give an overview of the operation of the current in-house home care service.

4.1 PEST analysis: external factors

The PEST analysis (Appendix 3) looks at the political, economic, social and technological factors that influence the current functioning and future plan for the home care service. The rapidly changing environment for the home care service needs to be acknowledged. A particular impact as illustrated in the section on legislation, government guidance and strategic intention has been the huge political agenda. The advantage is a clearer direction for future services within the framework of modernisation and partnership. Such a vision makes service users and carers the focal point and stresses the need for greater independence, organisations working in partnership and quality services.

The PEST analysis highlighted resource issues that will need to be addressed including recruitment, increased future demand for services, insufficient technology and providing services in rural areas. A number of the elements were already recognised by the in-house service and would apply equally to the independent sector.

4.2. SWOT analysis: internal factors

The SWOT analysis examined the strengths, weaknesses, opportunities and threats to the in-house home care service. (Appendix 4)

Strengths and opportunities were seen as the building blocks.

Strengths included the positive view that service users generally had about public services, the public service ethos, the ability of the in-house service to respond to the changing requirements of the organisation and loyalty of staff to service users together with the focus on promoting independence.

Opportunities included the Best Value review, new and modern ways of working such as partnerships and the drive to develop more alternatives to residential care.

The weaknesses and threats were seen as challenges to be overcome:

Weaknesses included the higher unit cost, inconsistency in business processes between localities, lack of connection between PAF indicators and service delivery, over reliance on manual systems and failure to follow through remedial action.

Threats included recruitment difficulties, pace of change and failure in some WSSCS Localities to achieve independent sector targets. As with the PEST analysis a number of these issues would apply to the independent sector and were already recognised by the in-house service.

4.3 Financial information

The report of the Domiciliary Care Contracting Scrutiny Sub Group 2001, referred to unit costs as an area that needed to be addressed in the BVR. The recommendations being:

- Comparative unit costs for home care services should be provided early in the BVR
- The department must have full information about the full unit costs for all provider services both internal and external
- The need to define what elements are included in unit cost calculations for home care in-house services
- Commissioning staff in Localities need to have access to comparative costs to support their work in allocating providers to packages of work.

An essential task therefore was to identify and analyse existing in-house profiles to establish a true cost, like for like comparison, with the independent sector.

4.3.1 Unit costs comparisons

A report by the Starfish London ADSS Benchmarking Club (The Elusive Costs of Home Care. 'Are in-house providers really more expensive than private contractors? 2002) advises caution when comparing unit costs with other LAs and the independent sector. In particular the author suggests that unit costs cannot be used as a reliable indicator of the potential savings that might be realised by externalising a service.

Specifically they identified a number of key components of unit costs that need to be carefully considered in order that a fair comparison is achieved. These are

summarised in the Table below along with an indication of their likely impact on WSSCS unit costs.

ISSUE	POSSIBLE EFFECT	WSSCS POSITION
1. Many local authorities use sample weeks to estimate annual service volumes	With seasonal fluctuations this can produce a very unreliable annual figure	The unit cost has been based upon the full year's activity of the year ending 31 March 2002
2. Some local authorities base the unit cost of the external service on care plans as opposed to what was actually delivered	Generally actual hours delivered tend to be less than planned delivery leading to an overestimate of the contact hours delivered by the external provider	Currently WSCC do not have monitoring arrangements in place to fully check the effect of variances from the care plan. As a result it is possible that the independent sector unit cost is understated.
3. Local authorities tend to treat hours invoiced by external providers as contact hours	As the hours invoiced include minimum charges, the likely effect is that they could be significantly higher than the true contact time.	Currently WSCC do not have monitoring arrangements in place to fully check the effect of minimum charges. As a result it is possible that the independent sector unit cost is understated.
4. Many local authorities fail to add a fair proportion of Management and Support Costs to the external provider	The costs apportioned to the external provider are understated resulting in an artificially lower unit cost.	WSCC has a relatively robust process for the allocation of Management and Support Costs. It is believed that these costs have been fairly attributed to the independent sector.

Source:KA July 2002

Although a relatively robust unit cost methodology has been employed in this review there is still scope for understating the cost of the independent sector.

The BVR group established a separate working group to consider the financial aspects. It was acknowledged that Best Value is not about finding the cheapest way of providing services, the aim is to achieve best quality outcomes within budget costs. Thus although the costs associated with a service are important they cannot alone satisfy the whole systems approach inherent in Best Value. However, services operate within tight budget confines and therefore cost must play an important part in determining what services can be delivered.

It is important to understand the nature of the activity in order to analyse costings. In this way the non-financial information becomes equally important. A common

method of analysing the relationship between cost and activity is the unit cost based on a contact hour. The formula being:

$$\frac{\text{Total direct costs plus overheads}}{\text{Total contact hours}}$$

Unit cost analysis allows a comparison to be made between the cost/activity relationship between different teams and different localities. The unit cost can also be broken down into its separate constituent parts – staffing, management costs, departmental overheads and corporate overheads. Furthermore if methodologies are transparent it can also be used to make comparisons between localities, constituents and other local authorities. It needs to be recognised that the unit costs on their own are not especially useful in the planning process unless they are considered in conjunction with the underlying strategy, management structure, and demographic and geographic information.

Obtaining unit costs on a comparable basis from other LAs was difficult. Other LAs as part of the benchmarking exercise identified similar difficulties. The BVR group would have benefited from WSSCS being part of a benchmarking group.

The analysis of financial information considered the full year April 2001 to March 2002. Information was collected for both on a County and Locality basis and included:

- Total service hours
- Analysis of contact percentage (Including and excluding Senior HCAs)
- Analysis of contact hours split between basic, unsocial and weekend
- Analysis of size of packages and number/lengths of visits
- Analysis of non-contact hours
- Summary of Agency cover employed by the in-house service
- Summary of overtime hours
- Unit costs
- Where appropriate comparable information for commissioned hours, those purchased from the independent sector were also included

4.3.2 Contact time

Contact time is the direct time spent with service users. The expectation is that should be 70% for HCAs and 50% for SHCAs. The results showed that following the recognition of the scale of the projected overspend of approximately £1 million in 2001/2002, contact time was highlighted as one of the key performance targets for the in-house service. As a result HCMs have concentrated much time on addressing ways that would make the service more efficient and have increased the contact time. Such measures included:

- Suspension of non-mandatory training for staff
- Reduction in frequency of meetings
- Reduction in frequency of supervision
- Changes in the way SHCAs work

As a result of this continued focus, localities have shown an average increase of 4.93% in contact time from week 1 to week 52.

The In House Contact Percentage Analysis (Localities) 2001/2002

	Adur	Arun	Chichester	Crawley	Horsham	Mid-Sussex	Worthing
Week 1	56.10%	54.60%	55.80%	58.70%	56.40%	54.60%	56.30%
Week52	61.61%	61.22%	61.44%	58.81%	59.55%	61.71%	62.70%
Increase	5.51%	6.62%	5.64%	0.11%	3.15%	7.11%	6.40%

Source: FS July 2002

When analysing contact time it was important also to understand the role of SHCAs who are responsible not only for delivering home care to individual service users but are also tasked with the major part of the day to day scheduling and work planning of the home care teams, carrying out reviews, risk assessments and quality monitoring. As a result, it was determined that it is misleading to include all of the seniors paid hours in the calculation to determine contact time.

In the previous table seniors were included, the following table excludes the SHCAs contact and paid hours and represents just the hours of the HCAs. The average increase being 5.22%

In-house Contact Percentage Analysis Excluding Senior Home Care Assistants (Localities) 2001/2002

	Adur	Arun	Chichester	Crawley	Horsham	Mid-Sussex	Worthing
Week 1	62.40%	61.20%	61.40%	66.50%	61.40%	64.20%	61.90%
Week52	67.60%	67.30%	67.50%	69.50%	64.20%	71.50%	67.70%
Increase	5.20%	6.20%	6.10%	3.00%	2.80%	7.30%	5.90%

Source: FS July 2002

Whilst this increase in contact time has been a tremendous achievement it has not been without some 'cost' to staff morale as home care staff have felt devalued particularly by the withdrawal of non-mandatory training and the reduction in the frequency of meetings which gave the opportunity to discuss care issues. The staff feel that the quality of care will be adversely affected if these measures continue in the long-term. The SHCA have expressed concern that the 50% contact time does not reflect value for money given that they are paid at a higher rate than the HCAS when undertaking direct care tasks. The requirement of The National Minimum Standards for a minimum of 50% of staff to hold NVQ qualifications by 2007 is likely to have implications for contact time.

An analysis of contact hours split between basic (weekday), unsocial and weekend showed that the profile of in-house and commissioned hours is very similar.

**Profile of Contact Hours Split Between Basic, Unsocial and Weekend:
In-house and Commissioned 2001/2002**

	Basic	Unsocial	Weekend
In-house	75.00%	7.50%	17.50%
Commissioned	74.90%	9.00%	16.10%

Source: FS July 2002

The in-house service arranges agency cover when there are staff absences. There is a marked difference in use of such cover between localities:

Profile of Agency Cover used In-House 2001/2002

Locality	Adur	Arun	Chichester	Crawley	Horsham	Mid-Sussex	Worthing
	7.80%	0.50%	7.40%	13.20%	11.00%	18.60%	3.40%

Source: FS July 2002

From the above it is evident that in some localities, Arun and Worthing the agency cover is a relatively small proportion of the total in-house care delivered. In Chichester and Adur the figures are more significant, but are still within tolerable limits. However, in three localities the percentage of agency cover is high and demanded a closer inspection to understand the issues behind the scale of agency cover being employed. The reasons for this being recruitment difficulties and cover for sickness.

An analysis was undertaken of the non-contact time:

In House Non Contact Time 2001/2002

Weeks 1 - 52	Travel	Other	Unproductive	Sick	Annual Leave	Lieu	Bank Holiday	Total
	27.00%	24.00%	0.00%	19.00	25.00	1.00	4.00	100.00

Source: FS July 2002

A summary of overtime was also undertaken which showed 1.8% of total paid hours in the first six months of the year. This analysis indicated that currently overtime represents a relatively small percentage of the in house home care wages bill and so was not considered material to the findings of this report. The BVR team were advised that the figure was higher about three years ago with some HCAs in some localities regularly working overtime. The current position would therefore suggest that the situation has been well managed by the HCMs and Lead Managers.

4.3.3 Unit Costs

The analysis of the unit cost is a critical financial indicator for the Best Value Performance Indicator for the Best Value analysis. It is also one of the most complex calculations as it has to distil both the financial and non-financial activity into a single set of results. Progress has been made in validating the methodology employed and the financial and non-financial information that underpins the unit costings (Appendix 5).

In-house and commissioned average unit cost 2001/2002

	Total direct	With Locality Overheads	With HQ Overheads	With Central Dept. Overheads
In-House	£14.21	£14.63	£14.85	£15.44
Commissioned	£10.90	£11.52	£11.83	£12.09

Source: FS May 2002

Unit Costs by Locality (Direct Costs only) 2001/2002

Adur	Arun	Chichester	Crawley	Horsham	MidSussex	Worthing
£14.24	£13.69	£14.49	£16.59	£15.24	£13.36	£13.53

Source FS July 2002

Unit Costs by Locality (All Costs) 2001/2002

Adur	Arun	Chichester	Crawley	Horsham	MidSussex	Worthing
£15.47	£14.92	£15.72	£17.83	£16.47	£14.59	£14.76

Source: FS July 2002

Key to the Unit Costings

Type of Unit Costing	Description
Total Direct	HCA's, SHCA's and managers of home care, on-costs and travel
With Locality Overheads	As above with a proportion of Locality Overheads including home care clerks
With Social and Caring Services Head Quarters Overheads	As above with a proportion of Social and Caring services Head Quarters Overheads
With Central Dept. Overheads	As above with proportion of Central Overheads

Source: FS May 2002

The above table indicates that the in-house service is more costly than the commissioned sector. The gap in the final unit cost category is £3.35 which represents that the independent sector is 22% less expensive than the in-house service. There is also a variation in unit cost between teams. For instance, Crawley is shown as having the highest unit cost. The managers suggest that the reasons for this may be reflected in the high outsourcing, the nature of the work and the size of the team. As at May 2002, Crawley had outsourced 68% and retained 32% in-house. It was estimated that 90% of the in-house work fell into the specialist category and included OPMH, Hospital Discharge Scheme (HDS), acquired brain injury and people with learning difficulties. The short term nature and, or, the intensity of the packages, assessment, reviews, ongoing monitoring, discussion with social care staff, with health and other partner organisations, briefing staff about new cases and obtaining feedback means that the work is

particularly dynamic. In addition, Crawley undertake the majority of the 15 min calls in-house

The total direct costs of the in-house home care service can be illustrated as follows:

Total Direct Costs including 50% SHCA Contact Time

HCA and SHCA	83%
Management	9%
Office costs	2%
Agency cover	6%

Source: FS July 2002

The target contact time for SHCA is 50%. Actual performance time, given their heavy involvement in operational supervision/management for 2001/02 was 40%. If this adjustment is made the figures are as follows:

Total Direct Costs including 40% SHCA Contact Time

HCA and SHCA	75%
Management	17%
Office cover	2%
Agency cover	6%

Source: FS July 2002

4.4 The shape of the service

The shape of the in-house home care service has changed. Until 1993 domestic tasks formed a large part of the service. In 2002 the service is predominantly about personal care. There has also been a movement toward the targeting of the more dependent service users, the intention being to provide a higher level of service to fewer people. This is in line with the national picture.

To understand the shape of the service a data collection exercise was undertaken. Home care staff and managers completed the exercise in April for a period of one week. The purpose was to obtain a clearer picture of the in-house service profile and to assist in any comparisons with other LAs. The exercise was labour intensive given that recording needed to be carried out manually. In addition to the lack of home care system there was a lack of an integrated management system. These difficulties are being addressed. The exercise involved using a standard format for the week in order to gather information about:

- The HCA
- The service user
- Start time
- Planned length of the visit
- Type of care provided.

The four codes introduced to identify care categories were:

- personal care
- domestic tasks
- shopping
- meal preparation

It is acknowledged that the exercise was limited and should be regarded as a snapshot. Nevertheless the findings have proved helpful and were able to inform the BVR.

Time of visits:

After midnight to before 7am	0.2%
From 7 am to before 10am	36.7%
From 10am to before noon	21.2%
From noon to before 2pm	11.3%
From 2pm to before 5pm	3.3%
From 5pm to before 8pm	15.8%
From 8pm to before midnight	11.5%

Source: Performance and Planning. June 2002

The findings were generally felt to be representative of the service delivered. The expectation was that the hours delivered between 7am and 10am (36.7%) would be similar to those delivered between 5pm and midnight (27.3%). It was suggested that the reason for the lower percentage is that a carer may be around in the evenings to undertake tasks such as preparing a meal and assisting to bed. Equally a service user may need extra assistance in the morning to perform tasks such as washing and may be more able to cope with preparing for bed.

Activity service provided:

Personal care	77.4%
Domestic tasks	2.7%
Shopping	1.2%
Preparation of meals	18.5%
Not stated	0.2%

Source: Performance and Planning. June 2002

The low level shopping and domestic tasks was thought to reflect the change in services over the years from mainly domestic to personal care. Meal preparation was regarded as an important task and included making a sandwich, filling a flask and encouraging a service user to eat. The fact that the preparation of meals accounts for a high proportion of time indicates that it is important to review this activity to ensure that it is undertaken in the most efficient and effective way.

There was some variation between Localities which it was thought could be explained by how the information was recorded. For example, the staff were asked to record the predominant task and assisting a service user with a bath would probably be recorded as personal care but may also involve cleaning the bath and tidying up which could be regarded as domestic tasks. To be more precise this would have required a more sophisticated exercise. The subsequent discussion with HCMs and Lead Managers would suggest that the main emphasis of the current home care work is accurately reflected in the table.

Days of the week that services are delivered:

Monday	16.9%
Tuesday	15.5%.
Wednesday	15.8%
Thursday	15.7%

Friday	16.1%
Saturday	11.0%
Sunday	9.2%

Source: Performance and Planning. June 2002

The reasons given for the differences are speculative. It was suggested that a pattern of Monday, Wednesday and Friday is common. There was little comment about the weekend work other than carers are often around to assist at weekends, particularly on a Sunday. It was also suggested that service users might prefer not to have a service on a Sunday. One locality talked about particular difficulties in finding sufficient staff to work on a Sunday.

Visit duration within a range

Less than 15 mins	2.1%
15 to 30 mins	27.4%
30 to 45 mins	37.8%
45 to 1 hour	16.2%
1 to 1hr 30 mins	13.4%
1 hr 30 mins to 2 hrs	1.5%
2 hours or more	1.5%

Source: Performance and Planning. June 2002

The above table produced the most comment as managers believed that the highest percentage of hours delivered would be in the range 45 minutes to 1 hour rather than 30 to 45 minutes. A further examination in fact showed that the pattern as suggested by managers was a considerably higher proportion of 45 minutes to one hour visits during the day and in comparison a higher number of 30 to 45 minutes in the evening.

Travel time to next call

Locality	Up to 5 mins	5 to 15mins	15 to 30 mins	More than 30 mins
Arun	51.2%	46.7%	1.9%	0.2%
Chichester	27.6%	58.3%	13.7%	0.3%
Crawley	53.6%	45.4%	5.7%	0.3%
Horsham	25.9%	64.0%	9.4%	0.5%
Mid Sussex	70.0%	28.7%	1.0%	0.2%
Worthing	52.4%	46.7%	1.0%	0.0%
Adur	47.9%	51.0%	1.0%	0.0%

Source: Performance and Planning. June 2002

As anticipated, given the rural areas the longer journey of 15 to 30 minutes in respect of travel time between visits to service users are in the Chichester and Horsham Localities.

4.5 Added Value

It is a commonly held belief that in-house services are of better quality than independent sector home care and that a number of additional tasks, which are not costed, are undertaken. This would suggest that costs comparisons are not comparing like with like. Possible added value within the in-house home care service was suggested by home care managers to be:

- Involvement in care management processes and training of staff
- Joint assessment
- Chasing up financial assessments
- Attending meetings with health colleagues and other partner organisations to discuss service delivery and, or, to improve outcomes for service users.
- Service of the last resort for hard to place individuals
- Updating of the WSSCS Client Information System
- Track record of over 30 years
- Public service ethos
- Training and experience
- Specialist teams
- Existence of in-house service which assists in controlling independent sector cost.

The BVR were unable to find in the course of the review tangible evidence that the in-house service is of a better, or conversely lesser, quality. In the independent sector customer satisfaction questionnaires are completed and in-house monitoring standard questionnaires are completed. Generally little was done to monitor outcomes, user satisfaction or inputs that would allow meaningful comparisons across the sectors. Anecdotally the ADSS Starfish researchers were told that internal providers deliver a more reliable service and that staff are better trained. This was suggested in a number of different consultations as a part of the BVR, however, without robust evidence it is difficult to support this. Inputs in terms of supervision are suggested to lead to better services and greater satisfaction amongst service users, but again there was no hard evidence.

Several authorities reported that service users with higher or more complex needs are usually directed to in-house providers, for instance:

- Older People with mental health problems
- Terminally ill people
- Hospital discharge
- Intermediate care
- Rehabilitation
- Other complex needs, especially those bordering on nursing care, monitoring and feedback.

Straightforward or mainstream care is more likely to be directed to the independent sector provider, either as part of the home care strategy or when there is insufficient capacity in-house. Such difference in service provided could result in unit costs differential because of the higher level of experience or training required to provide specialist support. Crawley Locality suggested that where services are mainly specialist that this has implications for the unit cost. Comments made by other LAs, as part of the benchmarking exercise, would support this.

Some independent providers are offering or expressing an interest in specialisms. This was also the experience of some other LAs and one in particular where both in-house and the independent sector were working together on service developments.

4.6 Human resources

The in-house home care service is a large service. The majority of staff are frontline workers. The HCA may be the only person that the service user has regular contact with. The quality of the relationship between the home care assistant and the service user is crucial and cannot be understated, therefore the management of human resources is a vital element of the in-house home care service.

Help the Aged (Nothing Personal: Rationing Social Care for Older People 2002) stated that service user satisfaction was fundamentally affected by the commitment and support of their individual care worker.

4.6.1 In-house home care structure

The in-house home care structure includes Lead Managers, HCMs, SHCAs and HCAs. (Appendix 2)

Numbers of staff and managers (Full and Part Time)

Job title	Numbers
HCA	766
SHCA	95
HCM	30
Lead Managers	7

Source: PSU April 2002

The percentage of part time home care employees is as follows:

- HCAs and SHCAs : 89%
- Lead Managers and HCMs: 35%

Ratio male /female staff and managers

Job title	Male	Female
HCA and SHCA	30	831
HCM and Lead Managers	3	34

Source: PSU April 2002

The proportion of male staff is 3.7%; 3.5% being employed as direct carers. Using senior social workers, social workers and assistant social workers as a comparator, 15% of this group are male.

In 1998, the Domiciliary Care Review reported that there were a total of 46.93 Full time equivalent (FTE) HCMs. This number reduced as HCMs left or transferred across to Commissioning as DCCMs. By 2002 there were 23.08 FTE HCMs and 11 FTE DCCMs. The proposed number of SHCAs in 1998 was 103.42 FTE, in 2002 the number was 79.22 FTE.

The Domiciliary Care Review recommended the following formula:

- 1 HCM for each 800 home care hours
- 1 HCM (later DCCM) for each 1,143 independent sector home care purchased
- 1 SHCA for each 8 HCAs

By 2002 there were a number of variations across the county with some Localities working to the formula and others having greater numbers of SHCAs and, or, HCMs. As services have outsourced not all Localities have kept pace with the need to review their management structures. Given the increased outsourcing there is a need to review both the ratio of HCMs and SHCAs together with the DCCMs and DCCAs

In 2001, a group of Lead Managers, a Locality Provider Manager and the Strategic Development Manager (Adult Services) met to discuss 'Shaping the Future' which involved an examination of the following roles:

- HCM
- SHCA
- Clerical Assistant

The conclusion drawn was that a considerable amount of clerical work was being undertaken by the SHCAs. It was not clear whether additional clerical time was required or whether their time needed to be used more effectively. It was suggested that the clerks should either be managed within the home care service or 'ring fenced' in order that clerical time would be dedicated to home care rather than diverted to other tasks within the Locality office.

Shaping the Future indicated that the role of HCM had become less clear. Indeed HCMs had referred to 'feeling squeezed out'. The appointment of SHCAs has impacted on the HCM role and in many ways the role of SHCA appeared to be the clearest in the structure. It was acknowledged that the requirement for 50% of SCHAs time to be direct contact had caused tension. The findings were not developed further because they coincided with other work being undertaken on organisational change as part of the New Directions exercise.

Given the findings of Shaping the Future, the appointment of the DCCMs and the recent change in line management it would seem important to re-examine the structures within the in-house home care and the role of DCCM within commissioning. The BVR group were advised that WSSCS had recognised the need to review the management structure having expressed concern about a top heavy structure, the implications for the in-house unit cost and the domiciliary care commissioning team.

A steering group is being established to address the need to modernise the structure and ensure links are made with work to be undertaken on the National Minimum Standards and in particular the training requirements. The steering group will also be mindful of the need for IT support and adequate clerical arrangements as proposed in the Domiciliary Care Review 1998.

4.6.2 Sickness absence

The sickness absence rate for home care staff at the time of the Domiciliary Care Review (1998) was 7.25%. Work had been undertaken on managing sickness absence prior to the Review within both the Children's Service and Adult Provider Service, this was followed by new county procedures. In contact with other LAs, as part of the benchmarking exercise, the issue of managing sickness absence was raised.

Within the in-house home care service the sickness figures recorded over a two year period were approximately 7%:

- 6.46% (2000/2001)
- 7.45% (2001/2002)

Examples from other LAs included:

- Portsmouth: 8%
- Gloucester: 7.7%
- Brighton and Hove: 12.07%
- Enfield: 8.6%

The range varies across the county. A summary suggests that Littlehampton (4.98%) and Mid Sussex (4.68%) had low figures, over a two year period whereas Worthing, (8.58%), Crawley (9.47%) and Midhurst (9.98%) had higher figures. The main reason being people on long term sickness including stroke, cancer, terminal illness and stress. Localities reported that the situations were being addressed and some had been resolved, resulting in some instances in a change of job or ill health retirement. Managers reported particular problems for the smaller teams. It is difficult to be precise about these figures and they are open to possible misreporting. For example, if someone has returned from work but has not completed the absence book, he/she will continue to be recorded as being on sick leave. Similarly the actual day of return may include the two days off which inflates the sickness record and in one team compassionate leave had been recorded as sickness absence.

Monitoring sickness statistics are important and there needs to be continued action to reduce the level of sickness absence. It was noted that home care staff have felt the target of change and review for some time and that low morale could contribute to sickness. Other LAs where there had been recent organisational change and, or, changes to terms and conditions reported that sickness rates had increased.

In the paper entitled Home Care Service 1999 - 2003 a reduction of 2% in sickness absence was suggested. This does not appear to have been followed through. A planned programme of managing sickness which includes management information, team briefings, training, recruitment procedures and return to work interview would, provided it is sustained, appear to be beneficial. Both Gloucester and Portsmouth found that such a programme helped them to manage sickness levels

In comparison with the other LAs quoted the sickness absence percentage is not high. However, of concern is the fact that only 4% is built into the budget for sickness, which clearly means there are budgetary implications. Mindful of the need to continue to work on reducing the sickness absence and the need to reduce the unit cost a new target should be set and reviewed. If sickness absence reduced from 7.5% to 6.5% which was achieved in 2000/2001, savings in the region of £77,000 could be achieved. A further £38,500 could be realised by further reducing this to a target of 6%.

4.6.3 Age Profile

Job title	16-24	25-39	40-49	50-59	60+
HCA/SHCA	3%	23%	25%	38%	11%
HCM/Lead Managers	6%	14%	25%	47%	8%

Source: PSU April 2002

The majority of home care staff are over 50 years old. This fact is reflected in all the localities. Worthing and Chichester/Midhurst report a particular exodus through retirement in the next few years. It would seem sensible to address this issue. The benchmarking exercise showed that this appears to be an issue for other LAs; one LA was considering employing a male carer who was well over retirement age. The Personnel Services Unit is currently investigating the possibility of a more flexible retirement age.

Using social workers, assistant social workers and senior social workers as a comparator group it is interesting to note that 28% are over 50. The majority of staff, 72%, being under 50.

4.6.4 Staff turnover

Retention of staff is an important issue. Figures need to be monitored as there are considerable costs attached to recruitment, induction, supervision and on going training. The turnover figure for 2001/2002 in home care was 9.74%. This is very similar to the figure of 9.55% for social work staff.

4.6.5 Length of service

The countywide figures for HCAs show that:

- 5% have been employed for less than one year.
- 31% have been employed between 0 to 5 years
- 26% have been employed between 5 to 10 years.
- 24% have been employed between 10 to 15 years
- 13% have been employed between 15 to 20 years
- 6% have been employed between 20 to 25 years
- 5% have been employed for 25 years plus

All localities reflect a similar picture with some showing a more significant number of HCAs employed 1 to 2 years. Length of service for HCMs varies from 4 and 22

years. In the benchmarking exercise the impression was that generally home care staff tend to stay within the service for several years.

Interestingly, figures for the social work group are not significantly different Other than the employment figure for social workers for less than one year of 13% compared with 5% in home care and for over 20 years which is 5% as opposed to 11%, the length of service is similar.

4.6.6 Ethnicity

County wide the picture is of very few staff from ethnic minority groups. Even in Crawley where the number of ethnic minority groups is highest the number of people employed from ethnic backgrounds is very small. The 1991 census indicated that the County had a non-white proportion of 0.36%. Crawley had the largest proportion at 1.9%. This figure is out of date now however, in discussion the belief is that the number of staff recruited from ethnic minority groups is small. In the consultation exercise it was suggested that our recruitment policy needs to make it clear that the department is culturally sensitive. This is currently being addressed as a corporate issue in WSCC as part of the work on equality and the requirements of the Race Relations Amendment Act 2001.

4.6.7 Training

Modernising Social Services stresses that people who receive social care should have an assurance that the staff are sufficiently trained and skilled for the work they are doing. Staff should feel included in a framework that recognises their commitment, assures high quality training standards and oversees standards of practice. People should have confidence in WSSCS knowing that the home care service works to clear and acceptable standards.

The National Minimum Standards Commission require 50% of home care staff will be trained to NVQ Level 2 by 2007. Current figures show that:

Post	Qualified	Undertaking Training
HCM	14	4
SHCA	25	28
HCA	53	22

Source: Lead Managers (Home Care) May 2002

Currently the percentage of qualified managers and staff is:

- HCM 47%
- SHCA 26%
- HCA 7%

As at May 2002, a total of 78 SHCAs and HCAs are qualified. It is likely that of the 50 now undergoing training about half will achieve the qualification by April 2003 which will increase the total to 103. To meet the new standards 50% of the remaining staff (898 – 103 =758) 397 need to be qualified in the following four years. Allowing for a turnover of 10% and the fact that some may not achieve their qualification in the given time, it might be prudent to aim for 120

qualifications per year. This clearly has considerable impact for the in-house service both in terms of assessor time and the reduction in contact time. A costed plan needs to be produced.

Meanwhile, consideration is being given to the training needs of the generic care worker. If this is to be utilised across the county and regarded as core business there will be important training considerations which need to be incorporated in future planning. It was clear as part of both the benchmarking exercise with other LAs and in discussion with the independent sector that planning to meet the required targets is an important, time consuming and costly exercise.

In order to fulfil the training obligation links with other developments need to be considered. For example, an Intensive Support Scheme was established for people working in the residential homes for older people that are to transfer to the independent sector. The five week programme enables people who have been registered for two years or more to participate in a five week programme. The programme includes, two weeks in the place of work where practice is observed and two weeks in a training environment where they complete workbooks. The final week being used to finish off work. Training officers have worked with six candidates in each cohort undertaking the National Vocational Qualification (NVQ) assessment, delivering the training and marking the workbooks.

Once the first phase of the Intensive Support Scheme is completed, it will be possible to extend this to home care and other services. The support in terms of the assessments will need to be planned for. Meanwhile a Training and Development Assistant has been appointed to support SHCAs to achieve awards and enable them to become assessors. The department is concerned that the previous NVQ quality programme is maintained and that the new scheme is not seen as a quick fix and will therefore begin by supporting those who are already registered and for whatever reason have not achieved their award.

The department is also developing a new approach to workforce training and development within the independent sector within WSSCS. The purpose being to ensure a strategic approach to quality care NVQ training and development provision for independent care and nursing services which satisfy the pressing needs of all stakeholders to meet the TOPSS (Training Organisation for Personal Social Services) targets and reach the National Minimum Standards. Other important training includes induction, foundation, generic care and equality issues.

The Domiciliary Care Scrutiny Sub Group referred to the need to cover the costs of replacement staff. The department has secured £100, 000 from a funding bid to support the staff replacement costs for those undertaking key areas of training. This will cover a range of training including NVQ, other professional and post qualifying courses. It is regarded as a small contribution. Funding is also available to support three new Training and Development Assistants to support NVQ assessments in residential, day and home care and support the new Registered Managers Award.

The WSSCS training department has been working on a strategic partnership with the West Sussex Forum, the Registered Homes Association and the

Registered Nursing Homes Association to develop a new commissioning organisation to:

- Bid for funding for NVQ and related TOPSS training
- To commission NVQ training from training providers
- To quality assure training from NVQ providers through the creation of an Approved List of Training Providers.

The WSSCS has offered financial support to set up the staffing infrastructure and the scheme is regarded as a very positive contribution to working in partnership with the independent sector.

4.6.8 Home care systems

4.6.8.1 Systems Audit of Home Care Pay October 2001

An audit was undertaken in recognition that in 2000/2001 the home care budget needed to be adequately controlled.

The review revealed a number of home care pay system issues that needed to be addressed:

- The home care pay structure is complex. There are difficulties for the HCAs in understanding their pay entitlements and ensuring payments are made on a consistent basis.
- Guidance notes dated 1999 were being used and despite amendments to regulations there were no updates
- There were no detailed guidance notes for home care clerks or their managers
- A spreadsheet had been introduced. Key staff had left and there was insufficient documentation resulting in managers and clerks not having adequate support.
- Timesheets are signed off by HCMs who may have insufficient time and understanding of the complexities of the pay structure.
- A computerised home care pay system has been introduced. However, home care clerks still need to manually complete forms in a format acceptable to payroll. This is wasteful of staff time and allows for transposition errors.
- The complexities of the current systems are costly in terms of hours and because of the frustration surrounding the systems, are damaging to staff morale.

The recommendation was that consideration should be given to simplifying the current system. That if this was not a workable option then thought needed to be given to establishing a central home care pay team. This would facilitate greater sharing of knowledge and improved consistency and dealing with complex pay issues. A particular problem has been that the payroll system has experienced difficulty in dealing with the complexities of the home care pay system. The pay slips are complex and both HCAs and their managers have found them difficult to understand. A more straightforward pay slip needs to be developed.

Following this review a group has been set up to work on the recommendations, membership includes clerks and representatives from home care.

4.6.8.2 Information technology and systems

In 1998, the Domiciliary Care Review recommended that administrative and IT changes would be required to support the implementation of the proposals which included the demise of Divisional and Area Home Care Manager posts and the reduction of numbers of HCMs. Throughout the history of the home care service considerable effort has been invested in maintaining and developing manual systems and programming work. Following the Domiciliary Care Review a number of off the shelf home care packages were considered. A working group was formed and tasked with drawing up a service specification. This coincided with the need to replace the Client Information System (CIS) and it was agreed that a software package would be developed in house. This has proved complicated and there have been reorganisations and changes in working style, such as care management, which have necessitated a number of alterations to the service specification.

By 2000, given the planned changes in the department and care management, a domiciliary care business process mapping was proposed which was agreed by the WSSCS senior management team (SMT) in 2001. The intention being to map current business processes within in-house and commissioning of domiciliary care and to recommend changes for processes, making them more efficient, and improving consistency across localities. The process was also in recognition of the proposed new charging system, outsourcing of home care and the desire of home care to have a more business like approach. It is envisaged that the new domiciliary care system will fully support the in-house provision and commissioning of domiciliary care. The system will interface with financial systems, including Payroll, income collection, invoice payments etc. The system will provide robust management information and be able to link activity and financial data. In improving efficiency of the management of the service it is anticipated that service users and carers will receive a better service.

Representatives from home care and the domiciliary care commissioning teams have been involved. A tendering process has been agreed, with the next steps involving an evaluation of potential suppliers with recommendations for a new domiciliary care system in December 2002. As part of the implementation process consideration needs to be given to additional hardware, training and data cleaning. Experiences of other LAs would support the need to look at the processes required for the future rather than what exists now together with the need to involve Unison, staff and the independent sector in order to agree compatible systems.

The Domiciliary Care Contracting Sub Group referred to the lack of corporate support for the upgrading of information systems to support the changes within the departments. Existing systems were not delivering the information required to support managers, particularly in the context of budget management and work scheduling. The acquisition and implementation of the home care system is part of WSCC 's E government plan. Given that it is not at this stage known which package will be purchased it is not possible to identify costings. The lack of a

countywide information system was raised by the independent providers. It is important that new system is selected with the independent sector in mind.

4.6.8.3 Home care procedures

WSSCS has a number of procedures and procedure manuals. An important issue for the in-house home care service is having all the most relevant procedures in one place to ensure that all managers and staff are working to the same set of procedures thus ensuring consistency across the Localities. Work has been undertaken within home care on developing a procedure guide. This now requires a dedicated group to compare and revise, where necessary, existing procedures with those required by the National Minimum Standards.

4.6.9 Workforce planning

The NHS Plan refers to a need for a joint workforce plan that looks at how to raise the profile of social care and how to create career pathways. The advice is that we need a workforce:

- Of the right number
- With the right skills and diversity
- At the right time

An issue for WSSCS and other LAs, that were a part of the benchmarking exercise, is the fact that a high proportion of home care staff, 50%, are over 50 and a number are near retirement age. As already referred to there are concerns about the number of people who will be retiring shortly. Managers have suggested that those near retirement may not want to undertake NVQ. It was also suggested that some, including the younger age group, would be put off training if it involves study in their own time. The Intensive Support Scheme overcomes this issue by enabling staff to completed NVQ in work time.

Nationally there are concerns about the pressure on the home care service as the number of older people continues to rise. At the same time the number of younger people available to provide care is decreasing. Problems that home care services are facing include:

- Number of people of working age and available to work as a percentage of the population is decreasing.
- There are low levels of unemployment
- Competition for staff is greater, particularly in the retail trade
- Low recognition and status is afforded to home care

A number of LAs in the benchmarking exercise indicated particular difficulties in recruiting staff to work in rural areas. This is also the experience in West Sussex. There can be particular difficulties when home care assistants own transport break down and alternatives are not available. There may also be problems in employing staff effectively; travelling between calls in a rural area may involve several miles and travel time. Even greater difficulties may exist where two staff are required.

Retention is an important issue, particularly given that a high turnover of staff is very expensive in terms of induction. However, unless there is an understanding of the particular nature of the service including the future business it is clearly difficult to plan.

Key factors for the in-house home care service are:

- Home care is a highly dynamic and volatile service
- The management of home care involves particular skill in managing a dispersed workforce able to deliver services to a range of people with a variety of need.
- Given that most service users have high support needs the role of the home care assistant has changed and the tasks are very complex.
- Staff may also find themselves working hours that vary significantly from week to week.

In response to recruitment difficulties within the in-house home care service, a study was undertaken (Workforce Planning: Home Care in Mid Sussex November 2000). The research focused on this Locality because there were particular issues for managers responsible for providing services both to urban and rural areas. Problems with recruitment were being experienced nationally, particularly in London and the South East, given the continuing fall in unemployment and the increasing availability of jobs and flexible times to work. Additionally the role of the home care assistant has changed with greater attention being given to a wide range of social, creative and interpersonal skills as part of the modernising partnership approach.

The survey addressed the key aspects in recruiting and retaining home care staff:

- Major factors influencing individuals to apply to be a HCA included wishing to undertake care work and wishing to work at times 'that suit'. Other factors included support and training.
- A particular factor that seemed to have affected staff in the proceeding year, following the Domiciliary Care Review (1998) was the changes to terms and conditions which included payment of mileage. Basic hourly pay and greater personal care were also significant.
- The most important factor that made staff stay in home care related mainly to the caring role. Making a difference to people's lives, not wanting to let people down, undertaking care work and being valued by service users were all extremely important. Working in a team was also highly valued.
- Factors that might make people leave the home care service were primarily changes to conditions e.g. mileage, pay and home care becoming an independent agency.

In the follow up focus groups, team working, training and undertaking personal care were positive factors. Mileage was regarded as a big issue, particularly the non-payment of the first four miles. This has been reviewed, however no change was made, as in order to reinstate this savings had to be made elsewhere.

Other matters outside the main themes and survey results included the image of the service and that the job title home care assistant should change. Dench et al (Supporting Skills for Care Workers. University of Sussex, Institute of Employment Studies 1998) referred to the low status of home care workers suggesting that they were lower than any other group of staff. At the same time skill requirements are changing and more attention is being paid to service user's emotional, psychological and social needs which require a wide range of social, creative and interpersonal skills. In flatter organisational structures people assume more responsibilities, additionally they may be isolated and vulnerable.

Image was clearly an issue for a group of staff who recognised the importance of their job and the fact that it had changed over the years. However, the British Households Panel Study refers to home care staff as unskilled manual workers and residential staff as semi skilled manual workers. Hopkins, writing about Best Value, (Local Government Management. Issue 30 Autumn 1999. Back up for the frontline troops). acknowledges the importance of getting political commitment, strategic fit and senior managers on board but emphasises that:

"The quintessential ingredient for real, sustainable success is the wholehearted involvement and support of front line staff. Without that, its just window dressing." Home care staff and managers should be involved in discussions which focus on how to improve the image of the home care service.

The importance of workforce planning was recognised and the authors of the report were aware of other work being undertaken in the department. The changing role of HCAs had been acknowledged. The expectation being that it will continue to change particularly as social care services meet the modernisation agenda, the challenge of greater partnership and integrated working. Greater demands will be made of staff given the modern ways of working and increased skills will be required at a time of full employment with a potential for greater employment mobility. It therefore does make good business sense to plan for the workforce of the future.

The recruitment strategy which is part of the WSSCS Human Resource policy has developed a more evidenced approach to the recruitment of staff. This is in line with the aspirations of the department to focus on the competence of its staff throughout their careers in the department and to start the process of performance management from the point of entry. Recruitment focuses on competences and is closely linked to the NVQ process.

The Scrutiny Sub Group in their report (Domiciliary Contracting) commented that with the stated target for the department to outsource 60% of home care services by 2003 a number of initiatives could be developed and some training requirements which could positively engage and address in-house and external provider needs. A joint approach between in-house and the independent sector was suggested. The latter would appear to be particularly important in order that a recruitment strategy can be developed

It appears that generally LAs are becoming more aware of the need to undertake workforce planning. One LA referred to the need for a standing recruitment and retention task force, as part of workforce planning, which needs to be driven by

senior managers and owned operationally. Given the recent changes it is important to acknowledge this and appreciate staff care, culture, image and pride in what people do as important factors. To achieve a more balanced workforce WSSCS needs to monitor the composition of its workforce and use the information to inform effective recruitment and retention of staff. It will therefore be important to work with PSU to address current recruitment and retention issues and shape the workforce of the future in line with the modernising partnership approach.

4.7. Service Level Agreement (SLA)

SLAs were agreed between the home care service and the Localities and introduced to the home care service in April 2001 for the year 2001 to 2002. The SLAs have a common county core, which includes issues such as:

- Vision statement
- Service aims
- Service users
- Management arrangements
- Service tasks
- Emergency arrangements
- Response times
- Care management
- Output
- Outcomes
- Registration and Inspection

In addition each Locality has an agreement which includes

- Service user group
- Service user contact hours
- Agreed developments
- Performance indicators
- Monitoring arrangements
- Externalisation plans

LAs expect that the independent sector will have contracts with specifications but this does not necessarily apply to the in-house service. The Domiciliary Care Contracting Scrutiny Sub Group recommended that the SLAs need to be balanced with the development of the external market and that this should fit with the contracting cycle for renewal and, or, new business applications.

The in-house home care service therefore should have an agreement, such as the SLA, with the Locality which is monitored and reviewed.

4.8 Performance management

The aim of Best Value is to achieve continuous improvement in performance and excellence in services, ensuring that the needs of service users and carers are central. To successfully deliver continuous improvement it is essential to have a

robust performance management framework in place. It is important that this framework is understood and owned by everyone, not least the front line workers.

4.8.1 Performance indicators

Social Services departments are measured annually against a set of key statistical indicators which forms the performance assessment framework (PAF). The performance indicators provide a tool for managers and councillors to identify where they are performing well and where they should be focussing future effort to improve performance.

An issue in making comparisons, which was highlighted when considering the unit cost, is one of definition. This may mean that it is difficult to compare like with like.

Best Value places LAs under a duty to continuously improve, in part by setting targets which require them to aim for the best quartile of reported performance. The most relevant performance indicators for the home care service are as follows. A summary of the department's performance is given below.

Performance Indicators

PAF INDICATORS		1998/ 1999	1999/ 2000	2000/ 2001	National Average	March 2002	Latest figure June 2002
B11	Intensive Home Care as a proportion of intensive home and residential care	6.8%	10.0%	19.0%	22.0%	12.4%	15.5%
C28	Intensive Home Care	2.0	2.8	6.1	9.2	3.6	4.7
C32	Older people helped to live at home	50.0	81.7	93.0	84.0	N/A	N/A
B17	Unit cost of home care for adults and older people	£11.00	£12.80	£15.27	£11.30	£14.49	£14.49

Source: Information section March 2002

The measures for the delivery of all home care to people who are over 65 is measured in the following units:

- 2 hours or less (County average) = 14.20%
- 10 hours or more (County average) = 15.03%

Performance for year ending 2001/2002 was:

B11 Intensive home care as a proportion of intensive home and residential care

The figure dropped due to budget funding difficulties. However, the figures have improved, following Cash for Change. The figure in the above table is based on a sample week in September 2001, by March 2002 the number of people receiving intensive care packages had increased by 22%. Further work is continuing to ensure improvement is sustained. It is important to ensure all staff are aware of the PAF indicators, the target to meet and the part they will play in its achievement.

A Public Service Agreement is to be submitted with specific targets for intensive care over a three year period. The stretch target is 30% as opposed to 23%. This has implications for capacity, partnership working with health and will result in more people receiving longer and, or, more frequent visits. Links need to be made to the BVR (home care) and to the BVR (delayed hospital discharge) as part of a whole systems approach working together with partnership organisations.

C28 Intensive home care

The indicator relates to B11 and therefore reflects similar issues in relation to budget funding difficulties. It is an important indicator that is also a Cabinet target.

The figures are well below the threshold but the March 2002 figure showed an improvement and sustained improvement will be required.

C 32 Older people helped to live at home

At the time of writing this report the data was being verified.

The eligibility criteria which has raised the threshold together with the budget funding difficulties are likely to be reflected in the reduction in number of people helped to live at home

B17 Unit cost of people helped to live at home

Unit costs are considered to be an important measure of efficiency. It should be noted that the unit cost for the PAF indicators is based on a calculation of in-house, commissioned, top sliced schemes and direct payments. This is not comparable with the more focused unit cost required for the BVR. The BVR found that the difference in cost between the independent sector and in-house home care service indicated that the former was 22% cheaper.

The unit cost, as referred to, is difficult to compare with other LAs. WSSCS has a more robust unit cost in terms of the way it has been calculated. Currently it is toward high in the middle section. Options for reducing the unit costs and creating greater efficiency will be addressed as part of the Performance Improvement Plan. Such measures include reducing sickness absence, a review of the management structure and creating greater efficiency through the introduction of an IT domiciliary care system

It is recognised that there are cost implications for both the in-house and independent sector of the National Minimum Standards. It is possible that the difference in the unit cost may decrease.

Targets, comparator group average and national best performance are as follows:

Performance Targets

Older People	2001/02 Target	2001/02 Actual	2002-03 Target	2006-07 Target	Comparator Group Average 2001/02	National Best Performance 2001/01
B11	15.0%	12.4%	17.0%	23.0%*	19.0%	30<50%
C28	90	103.8	95	90	96.2	70<100
C32	82	N/A	84	92	64.2	100<140

West Sussex Performance Plan 2002 - 2003

* PSA target 30%

WSSCS are placing a greater emphasis on helping staff and managers to understand their contribution, how this impacts on service users and the work of the department as a whole. Supervision, Personal Development Plans and training programmes are an essential part of the human resource strategy. Management information needs to be accessible and user friendly.

4.8.2 Managing the performance.

Work is currently being undertaken on reshaping the strategic commissioning and performance management departments. Locality plans are performance measured in relation to the PAF on a regular basis. Managers receive feedback on local performance for instance on reducing dependency and providing flexible community services. The training department is also working with managers to develop evidence based management competencies and revising the Personal Development Plans in order to recognise the different way of working.

Home care managers and staff should to continue to develop a modern way of working in partnership with other organisations. Performance indicators for home care need to be introduced based on the National Minimum Standards and addressing areas such as reducing sickness absence, training and quality checks.

4.9 Quality

Quality at its simplest is about meeting service user and carer needs. Quality of care is more difficult to measure than, say, whether a budget target has been met. There is clearly a need to understand what the service users and other stakeholders want from the service and to hear about their experiences. WSSCS core values (Five Year Plan 1998) states that service users and carers are central to all our work.

The mission statement for the in-house home care service is defined as follows:

We aim to provide a range of high quality, good value, locally based services that promote independence and reflect the changing needs of the community.

(Adult Provider Service 1999)

The perception of the quality of a social services department may well affect its ability to recruit and retain staff. Staff morale and functioning has a fundamental impact on the quality of the service

Social care is an area of work in which the quality of service is of paramount importance. LAs may choose to externally purchase services on the basis of the cheaper unit cost, however this cost issue may carry with it a quality shortfall. For instance, in the benchmarking exercise, Enfield quoted their in-house unit cost as being £17 and the independent sector as £9 to £10, which they considered to be too low to achieve a quality service.

Help the Aged (Nothing Personal: Rationing Social Care for Older People. 2002) looked at the policies and practices in determining how older people can access social care. They found that contracting with the independent sector was being used to reduce costs. They suggested that this appeared to be opening up a gap in the quality of care as the independent sector attempt to manage with the lower fees that the LAs offered.

The home care service needs to concentrate on quality at the outset as opposed to putting things right after the event. It is also cheaper to get things right at the beginning rather than correct errors later. It is therefore important to record:

- where things go wrong
- where there are most complaints
- where there are bottlenecks.

An audit of the home care complaints in 2000 as part of the project on meeting standards in home care highlighted the following reasons for service user and carer dissatisfaction:

- Missed visits
- Timing of visits
- Change of staff
- Lack of communication
- Quality of care provided by the independent sector
- Difficulties in identifying who was providing the service.

In the benchmarking exercise with some LAs for example, Portsmouth and Gloucester, it was clear that with hindsight they wished they had paid more attention to quality as an issue and now find themselves in a position of needing to address this. The introduction of the National Minimum Standards will highlight areas where improvements are required

The in-house home care service is in the process of examining the standards in detail, highlighting where the standards are being met and where there are gaps. An action plan together with target dates can then be agreed.

Information gathered throughout the review indicated the potential for inconsistency between Localities exists and that the implementation of the National Minimum Standards will need a coordinated approach. A strong management commitment is therefore required to improve service quality, together with a system that encourages staff at every level to take responsibility for service.

In various consultation exercises with service users and carers the following quality dimensions were clearly important:

- Reliability
- Timekeeping
- Continuity of carer
- Consistency
- Changes communicated
- Dignity and respect
- Flexibility

The Social Policy Research Unit, University of York is currently looking at flexible individual centred home care for older people and how it is achieved. It is suggested that the best way to improve the quality of home care might be to address the individual concerns of service users on a person by person basis but recognises that this contrasts with the model of same quality standards for everyone. The researcher is seeking to examine how different home care teams can respond to requests for action that are important to service users. WSSCS is taking part in the research and will be able to benefit from the sharing of different practices across the country.

4.10 Quality assurance

Quality assurance fundamentally depends on the quality of staff and of staff interaction with service users and other staff. Therefore staff development is an important part of assuring quality. Investing in helping people to understand quality from the service user's point of view is key. By implication this would suggest that in order to value service users staff equally need to feel valued and that they play an important part in making a difference. In preparation for the National Minimum Standards, the in-house home care service and the independent sector were part of the Voluntary Scheme of Registration managed by the former WSCC Registration and Inspection Unit.

In September 2000 a project manager was appointed to the Adult Provider Service for nine months to undertake an exercise on meeting the standards for voluntary registration and in preparation for the National Minimum Standards. The exercise focused on one locality and involved structured interviews with 10% of service users, carers and home care assistants. The purpose was to determine what was important to service users and their carers with a view to developing good practice and guidelines for monitoring the standards.

The report indicated that there were a number of examples of good practice and satisfaction with the in-house service. It also highlighted both in the interviews with service users and their carers and with staff where practice needed to be addressed.

- Home care assistants do everything for the service user because it is quicker
- Care plan times are not always adhered to
- Service users may feel responsible when HCAs talk of being busy
- Increase in number of weekend visits. One HCA spoke of visiting 17 different households
- A number of different HCAs may visit one service user
- Service users are not always being informed of change and the names of people who would be visiting
- Home care assistants are not always given sufficient information about a service user

In May 2001, a leaflet describing the good practice standards was distributed by home care staff to households across the county. The leaflet listed the standards and asked the following questions:

- What do you like about the standards?
- What don't you like about them?
- Is there anything you would like to add?
- Is there anything you would like removed?
- How many of the standards are we meeting?

Service users, or their carers, were asked to respond by September 2001. The response was disappointing given the small number of returns and the fact that some people misunderstood the purpose of the questions and answered how they felt about the service as opposed to what they thought about the practice standards. Nevertheless, the results contained some helpful information:

What do you like about the standards?

- Good ideas.
- I hope you can carry them out
- These standards seem to cover all our requirements
- Helped me to understand the staff roles better.

What don't you like about them?

- No mention about washing or bathing the person they are caring for.
- Agencies.
- Some staff don't know about them
- Some staff feel the standards don't relate to their work

Is there anything else you would like to add?

- Why is there nothing about staff training?

- It was all covered in the leaflet.
- As people get older they need longer time in their care plan as additional tasks are added.
- Respect for carers and care of furniture in the home
- Housework. Cleaning is important

Is there anything you would like removed?

- Agencies

How many standards are we meeting?

- Meeting most of the standards
- Changes are not notified
- Some are met some are not.

Other issues highlighted included:

- They (the staff) are kind and helpful
- It is a very good service.
- You should allow more time
- Not always told when someone else is coming.

A neighbouring LA found that the following quality standards are important to service users:

- Reliability
- Continuity
- Kindness and understanding
- Cheerfulness and general manner
- Competence in undertaking specific task
- Flexibility
- Knowledge and experience of the service users and carers wishes
- Information about the service that will be provided

The in-house home care service and the independent sector were inspected annually as part of the Voluntary Scheme of Registration and will shortly be inspected by the New Commission. Understanding the new standards and working toward achieving them will be a major piece of work which offers opportunity for the independent sector and in-house home care services to work together.

4.11 Complaints and compliments

Complaints and compliments are an important way of monitoring quality. During 2001/02 the total number of complaints about home care was 117 which represented 19% of the total number of complaints for both children and adult services.

If every incident was recorded the complaints numbers would be higher. The general rule of thumb applied is that something that is instantly addressed without

the need for further investigation or response would not usually be recorded. If however, a person telephoned to say that there have been, for example, several missed calls over a period of time and the office had been previously notified and it is still happening this would be recorded as a stage one complaint. Generally any concerns put in writing would be recorded.

Home care complaint figures are recorded under three headings:

- General: about the service per se and neither in-house or independent e.g. about the assessment for the service rather than the provision.
- In-house: those about the in-house provision
- Independent: those about externally provided service

The independent numbers do not include those that were handled directly by the independent sector. Further work would be required together with the DCCMs and WSSCS Contracts Department in order that real comparisons could be made. For this exercise figures for the in-house service are:

Localities:

- General = 18
- In-house = 33
- Independent = 47

Complaints handled by the Complaints and Representation Section:

- General = 112.
- In-house = 3
- Independent = 5

Overall a breakdown of all in-house complaints, a total of 36 showed that:

- conduct of staff= 3
- financial issues= 7
- quality of care issues= 8
- assessment/ service provision= 16
- other= 2.

More detail about the three in-house complaints handled by the Complaints and representation section shows that:

- Two were to do with changes in staff, and lack of continuity, with concerns expressed that different staff turn up each day at different times
- One was to do with the home care service not meeting the needs of the service user concerned

Only headline information is available for complaints handled by the Locality offices, however from 2002/03 all complaints will be logged on a HQ system and will provide more useful management information

The SSI as part of the inspection of services for older people reported that service users routinely need to be given a copy of the complaints leaflet in order that they are sufficiently aware of their right to make complaints or make representation about council services. Following the inspection the in-house home care staff were asked to ensure that all record books kept in service users homes contained a copy of the complaints leaflet.

Complaints about home care appear low. Older people are often reluctant to complain and, or, have low expectations and therefore need to be encouraged to exercise their rights. Attention needs to be paid to how service users and carers are informed of their right to independent advocacy and how to make contact

Compliments are usually recorded if written by the in-house home care team at the Locality. Telephone or other verbal compliments are not recorded. In future compliments should be recorded and submitted together with complaints to the Complaints and Representation team.

4.12 Modern ways of working

The joint social services and health agenda requires both organisations to work with a wide range of partners to ensure that service users and carer receive the seamless care they need regardless of organisational boundaries. Health and Social Services have a long history of working together both at strategic and operational levels. Three specific areas where both have a major contribution to make include:

- Cutting health inequalities
- Mental health
- Promoting independence

Joint targets include:

- Reducing the risk of loss of independence following unplanned or unavoidable admission to hospital by reducing emergency admissions
- Improving the delivery of appropriate care and treatment to people discharged from hospital
- Reducing the number of delayed discharges from hospital

The implication for the in-house home care service is for a more modern partnership approach.

The home care service has a major part to play in:

- Supporting older people to continue to live in their own homes
- Reducing the need for admission to hospital
- Supporting people returning home from hospital
- Offering options to residential care through support to alternative accommodation such as sheltered housing.

4.12.1 Generic care worker project

The SSI report of the WSCC in-house home care service in 1996 highlighted the possible confusion experienced by service users about the different roles of home care assistants and district nurses. Equally, the 'grey' areas that fall between health and social care have caused concern for most LAs.

In 1999, a joint health and social services initiative was set up to begin to address the grey areas and bridge the gap between the two organisations. A steering group was established which to date has focused on four pilot sites based in Bognor, Worthing, Chancetonbury and Chichester Rural. Following a review in 2001 there was an overall endorsement for extending this way of working across the county.

At the time of the BVR, discussions were taking place about the generic care worker and how the pilot might be extended. The proposal is that the tasks performed by the generic care worker, many of which are already undertaken by some HCAs, are incorporated into the core role and staff are properly supported and trained.

4.12.2 Specialist services

There have been a number of references to developing and extending specialist services. The WSSCS Five Year Plan 1998 to 2003, referred to the need to develop specialist services for people with dementia and older people with mental health problems. The Domiciliary Care Review in 1998 acknowledged that outsourcing to 60%, as part of a five year plan would leave the in-house provider free to concentrate its expertise and skilled staff resources on developing a more specialist service within an overall framework of 'Best Value' and a shared value base with care managers.

The Strategy for the Development of Services for Older People in 1999 referred to the need to develop specialist services for older people with mental health needs. The Home Care Service 1999 –2003, recommended the development of an emphasis on specialist services and complex packages countywide by March 2001. The degree of development varying according to local need. The in-house teams across the county are involved in a range of different specialisms.

All Localities are involved in the delivery of intermediate care. The Kings Fund defines Intermediate care as

'Services designed to prevent avoidable admissions to acute care settings and to facilitate the transition from hospital to acute care settings and to facilitate the transition from hospital to home and from medical dependence to functional independence'.

Intermediate care may include:

- Fast response
- Hospital discharge
- Community rehabilitation

- Generic care working
- Step down/ rehabilitation
- Residential rehabilitation
- Hospital at home

Midhurst health workers provide a short term package of care for about two weeks for a 24 hour day. There are plans to extend the scheme to Chichester and Bognor. In Mid Sussex an Intensive Home care team provides intensive and rehabilitative support programme. Four staff (114 hours) are seconded from WSSCS, to the Mid Sussex PCT working in a team managed by the Team Leader for Intensive Care.

Other services delivered include:

- Mental health teams
- Dementia teams
- Palliative care
- Intensive home care
- 24 hour care
- Links with sheltered accommodation, respite at home and day care.

Services to those under 65 include specialist teams for:

People with physical impairment
People with learning difficulties
Children and families

4.13 Charging for home care services

Section 17 of the Health and Social Services and Social Security Adjudications Act 1983 gives LAs a discretionary power to charge for non-residential services (home and day care). A revised charging system was introduced in West Sussex in April 1985. Basically those on lower incomes pay either a standard or a discounted charge. Those with higher incomes (above £187 per week) pay an assessed charge and this assessment takes into account savings in excess of £10,000 excluding the main residence.

Payment can be made by stamps available from the Post Office, for those on standard or discounted charges, or by a four weekly invoice for those paying assessed charges. Service users who are also attending a Day Centre may choose to pay cash at the Centre.

The total number of home care service users paying a charge is 4,182, income currently received is £2,513,405 per annum. The table below gives an overall picture of the number of service users involved and income collected.

Charges paid by service users

Charge band	Weekly rate	Numbers	Amount (£)
Discount charge	£3.30	1,730	£296,982

Discounted charge with capital	£3.30	40	£63,547
Standard charge	£7.90	1,684	£726,851
Standard charge with capital	£7.90	174	£324,404
Assessed users (average payment)	£38.34	554	£1,101,621

Source: FS May 2002

Following the publication of the Circular LAC (2001) 32 – Fairer Charging Policies for Home Care and other non-residential Social Services (November 2001), WSCC has redesigned its charging system and is currently undertaking consultation. The new system involves:

- Full individual financial assessments
- Allows disability expenses to be included
- Free to the 'less well off'
- Gives Benefits advice.
- Some people will pay less
- Some people will pay more
- Cost neutral to WSSCS

A consultation process is being undertaken. Changes will be phased beginning in October 2002 and will be fully implemented in April 2003. The possibility of complaints arising as an outcome is acknowledged. It is likely that to address the needs of those people who will be expected to pay more that the changes may be introduced in a phased way.

4.14 Cross cutting issues.

West Sussex County Council set priorities for the period 2001 to 2005. Those that are particularly relevant to home care include:

- Caring for those in most need within the community
- Preventing crime and investing in public safety
- Promoting a strong and diverse economy

The council employs a total of 22,000 staff. The in-house home care service, as part of the Social and Caring Service and of the West Sussex County Council employs 4,011 staff. Throughout the BVR the group were therefore mindful of the cross cutting issues that need to be addressed.

4.14.1 Sustainability

Sustainability is about ensuring the actions and decisions taken today guarantee a better quality of life for everyone, whether economic, social or environmental, now and in the future. The in-house homecare service needs to incorporate into its strategic planning, the plans developed by the County Council.

The BVR group had a training session on sustainability and following this identified specific issues:

Social inclusion

The social inclusion strategy for West Sussex identifies minority groups, these include vulnerable people potentially at risk of exclusion from services and exclusion from society generally.

Home care plays an important part in improving life for a group of people who are vulnerable and may become socially excluded. Particular attention needs to be paid to the needs of ethnic minority groups, older people with mental health problems, and older people with learning difficulties some of whom may have mental health needs and people living in rural areas. West Sussex is a particularly rural area given that 30% of the population, compared with the national average of 20%, live in rural areas.

Promoting a strong and diverse economy

A priority of the County Council is work in partnership to sustain, regenerate and diversify the economy. This is something that has happened within the home care service as it has moved toward a mixed economy. The home care service works in partnership with other organisations.

Caring for those in need in the community

An aim is to help people to continue to live independently and to provide security for those who need care or support. The prime role for home care is supporting people to live in their own homes where feasible and to not enter institutional care unnecessarily.

Preventing crime and investing in public safety

Many older people live alone or with elderly partners. Home care has an important part to play in supporting individuals to live safely in the community.

Learning County

Skills need to be shared for example, joint training with the independent sector and other partner other organisation including health and housing.

An important target is that of creating a better basic skilled workforce and promoting lifelong learning. This is an important objective for the home care service as part of its training programme and to meet the National Minimum Standards.

4.14.2 Equity

The WSCC strategy sets out the overall aim for 2001 to 2005 as being to

‘Seek to promote the well being of the communities we serve and improve the quality of life of local people’.

There is a commitment to achieve this through targeting and promoting social inclusion and equality of opportunity. The West Sussex Social Inclusion Strategy includes:

- Customer Focus
- Policies and initiatives targeted on the right priorities and in the right areas
- A multi-disciplinary approach as the preferred way of progressing our attempts to reduce social exclusion and promote social inclusion.

The department in line with Race Relations (Statutory Duties) Order 2001 has recently published a Race Equality Scheme and has identified Equality Officers within each department. All LAs have a duty to ensure staff receive training.

All policies and procedures were examined in 2001 to ensure that they were Human Rights compatible. A similar exercise has also been undertaken as part of the NSF for Older People to ensure that people are not discriminated against on the grounds of age.

WSCC has equal opportunities in employment policy. The department is committed to providing equality of opportunity for all its employees and to eliminating unwarranted/inappropriate discrimination

4.14.3 E Government

The WSCC intention is that by 2005 citizens of West Sussex should where feasible be able to access information electronically. There are a number of projects for West Sussex of which the acquisition and implementation of the Domiciliary Care Information System scheduling package is one. WSCC is also developing as part of the electronic communication. Routes for people to access services making it easier for those with impairments to enter and find their way round county council buildings.

KEY FINDINGS

- ***The in-house home care service should address and build on the strengths and opportunities and overcome the weaknesses and threats***
- ***The unit cost should be shared and updated on an annual basis***
- ***WSSCS would benefit from being part of a benchmarking group***
- ***Recruitment needs to address the most appropriate employment patterns in line with future service delivery***
- ***Work undertaken in managing sickness absence, including setting reduction targets, needs to continue***
- ***Recruitment needs to address the gender issues, the retirement age and attracting staff from minority ethnic groups***

- *A training plan with targets to meet the National Minimum Standards needs to be drawn up*
- *The planned Domiciliary Care Information System for home care is required urgently*
- *Work undertaken on procedures for home care needs to be revised in line with the National Minimum Standards*
- *Service Level Agreements should be reinstated*
- *Performance indicators should be shared with staff and managers in home care. Data and other information should be accessible and user friendly*
- *Work on the National Minimum Standards identifying gaps and targets needs to be completed*
- *Work on the management structure alongside the BVR needs to be addressed in the light of recent changes in the wider organisation*
- *Home care managers and staff need to be briefed about the changes in the charging system for non-residential services*

5. What do people think of the service? Consultation with stakeholders

The intention of this section is to summarise the consultation exercises that have been undertaken. The process enabled the BVR group gain a better understanding of the views of stakeholders and the action required to bring about improvements.

SSI inspections of services for older people regularly show user satisfaction of 80%. More than 2/3rd of people over 65 say they are satisfied with the NHS service, compared with just over half of the 25 to 34 year olds. It is suggested that the reason for the higher level of satisfaction in people who are older is rooted in their memories of a life before the NHS and the welfare state. Those due to retire in a few years time are likely to have higher expectations of the public services and therefore be less satisfied.

A study undertaken in Sweden with mainly older people (Low expectations: Margareta Lindelof; Community Care 20-26 June 2002) reported that: 92% said they were politely treated by home helps and 80% said they were either content or very pleased with the help they received.

The writer suggested that older people had low expectations of the home care service based on extensive discussion in the media about national economic constraints. Lindelof referred to 'disciplined satisfaction'.

Best Value guidance suggests that reviews are most effective when they are wide ranging, service user focused and address questions about what service is

required before considering who can provide it most effectively. The BVR group therefore designed a consultation process that would include a wide range of stakeholders.

Exercises undertaken prior to the review and by other LAs were included. Research involved a number of different methods including individual interviews, focus groups, team meetings, postal questionnaires, telephone calls and stakeholder meetings. Regular meetings were held with managers of the home care service and in turn they were required to ensure that home care teams were kept advised.

5.1 Survey undertaken with 10% of the service users, carers and staff: Adur Locality. Spring 2000

The background to this survey is reported in greater detail in section 5.10 headed Quality Assurance

Main themes that concerned service users and carers were:

- Missed visits
- Change of staff
- Lack of communication re changes
- Quality of care in the independent sector
- Difficulties in identifying who was providing the service, i.e. in-house or independent sector.
- Care plan times not being adhered to
- A number of different HCAs visiting

5.2 West Sussex Disability Network Consultation. Summer 2000

The report indicated that:

- Some people receive consistently good services, some consistently bad and most a mixture of both
- Reliability and communication about changes are important
- Continuity of carers is fundamental
- Respect for individuals and their property is crucial
- Staff need to stay for their allocated time
- The use of agency has resulted in a down turn in service
- Better training needed for managers and staff

5.3 The Personal Social Services Survey in 2000 – 2001

Feedback included:

- Home care staff should be allowed to clean, shop and cook not just come in to dress and wash people
- Preference for the same team of workers and the same number of visits at the weekend as during the week
- Direct services are providing a good service, some of the agencies are not.

5.4 Survey undertaken in Chichester Locality with 43% of the service users.

Reported that:

- All service users had a care plan
- 36% commented that the service was not so reliable when regular staff were on annual or sick leave.
- 15% commented on the fact that they did not always know the name of the HCA, nor whether that individual came from the independent sector or from Social Services.
- 85% said that they received the time as set out on the care plan, but commented that this did differ sometimes when staff were on annual or sick leave
- All service users felt that the service was value for money and valued the support that enabled them to stay at home
- Carers commented that the service from home care supported their caring role.

5.5 A stakeholders meeting. January 2002

The meeting included service users and carers, District/Borough Councils, voluntary organisations, independent home care sector, health, academic sector, elected members, managers and staff.

Attendees were asked their opinion about:

- What is good and bad about the in-house home care service?
- What changes would you like to see to the in-house service?
- What alternative ways are there of meeting the home care needs of older people?
- What are the most appropriate developments for the future of the in-house service?

Responses suggested that:

- Time allocated for visits may be insufficient
- Service can be inflexible, e.g. bed times
- Need consistent services; continuity of care is very important
- Social services is better at consistency than the agencies.
- The status of home care is low
- Training is very important
- Need to communicate any changes
- Social services and health need to work closely together
- Preventive services are important; low level needs are not being met
- People may be afraid to complain
- Not always sure who to contact
- Services should be 24 hours a day, 7 days a week
- Stress and strains of carers needs to be recognised.

5.6 Meetings with staff and managers. February to July 2002

Throughout the process managers and staff were kept informed and involved. Staff developed a paper entitled frequently asked questions, with answers, for home care staff. The BVR group also recognised that in achieving continuous improvement it was important that staff had an understanding of Best Value. Unison and PSU have been involved in communication with staff. Meetings were held with Lead Managers (Home Care) and Locality Provider Managers.

Focus groups were also held with staff and managers. The focus group with staff gave both the opportunity to describe the purpose of the BVR, the process and progress. The group also looked at critical success factors, barriers and opportunities in the future delivery of the service. These were reported as:

Critical success factors

- Good communication.
- Development of specialist teams including generic care workers
- Promoting independence
- Trained staff
- Responding to commissioners needs, e.g. provider of last resort and crisis intervention

Barriers

- Service users feeling rushed
- Lack of communication with health staff
- Inadequate implementation plans
- Budget
- 'Home help' image
- Lack of career path
- Age profile of workforce
- Lack of NVQ assessors
- Training, e.g. generic working
- Lack of quality monitoring in in-house and independent sector.

Opportunities

- Develop generic working across West Sussex
- In-house service user focus group
- Recruit 'bank' staff to reduce agency cover.

Representatives were required to feed back to their localities. Managers also had the same information and were responsible for ensuring that Best Value was discussed in regular staff meeting forums. In addition a question and answer paper was produced in consultation with staff, Unison and the working group.

5.7 The Domiciliary Care Contracting Scrutiny Sub Group. 2001

The group carried out extensive consultation with service users and carers and through visits to Locality offices met with staff from WSSCS and the independent sector.

A questionnaire was sent out to 210 service users and carers with a balance between in-house and independent sector. The response rate was 58%. Consistency, reliability and good communication were the features most valued in the provision of services, from both in-house and external agencies. Most concerns were about unreliable staff and the inability of agencies to communicate changes, brief staff properly and offer reassurance to service user and carers about consistent service delivery. There were also requests for more flexible, appropriate times for services and individual packages of care.

5.8 Black and ethnic minorities groups. April/May 2002

Both the National Service Framework for Older People 2001 and the Race Relations (Amendment) Act 2000 aim to improve the standards of care for older people, providing them with services that are free from discrimination. An audit tool has been prepared by the DOH (2002) as practice guidance.

The majority of LAs have an ethnic minority population of less than 2%. A recent inspection by the SSI ('They look after their own don't they') DoH 1998 indicated that many of the people who migrated to Great Britain in the 1950's and 1960's when in their twenties or thirties are now older people. The report also refers to the fact that these people would not have expected to have stayed in the country and that they have as a group suffered from the results of racism, low incomes, poor housing, isolation and comparatively poor health.

The SSI report also evaluates the extent to which Social Services Departments arrangements for planning and delivering services adequately address the needs of ethnic minority older people. The report identifies the need for the following:

- Effective joint planning
- Research into need
- Equal access
- Effective assessment, care management and service delivery
- Mechanisms for delivering specific services.

The SSI report of services for older people in West Sussex in May 2001 referred to:

'The lack of understanding of the needs of people from ethnic minority communities. WSCC needs to develop a clear analysis of the needs of those communities. This should help them understand the take up of services and manage the necessary changes in culture as service users from these communities become included.'

Crawley Locality has a number of communities of diverse ethnic origin, different religions, languages and cultural values. The 1991 census showed that nearly 8% of the population were from ethnic minorities compared with a county average

of about 2%. It was estimated that by 2002 the population would have increased to over 10%. Added to this there is an Asylum seeker population. Crawley has already undertaken some work, for instance a number of visits to groups to explain about care management and find out about the needs of these local communities. They have looked at gaps in provision and how best to deliver services sensitively. It is recognised that the take up for services is not proportionally representative of the percentage population in the older age group who meet the eligibility criteria.

As part of the BVR, and the group's intention to meet with ethnic minority groups, Crawley Locality set up two separate day visits which included meetings with:

- Hindu Group
- Muslim Women's group
- Muslim men's group
- Sikh women's group
- Individual service users
- Staff meeting with those involved in ethnic minority work and developments

The consultation days in Crawley highlighted the following:

- Younger people want to work, which has implications for the extended family culture
- Services need to be reliable
- Information about services needs to be accessible
- Confidentiality is important
- Services need to be culturally sensitive
- Personal care may be an issue e.g. same gender care
- Staff should be able to communicate in the same language
- Women may feel guilty about requesting care
- People can feel 'used' if they are asked at repeated meetings to discuss their needs but there are no changes or improvements as a result

Information from staff included:

- Difficult to attract staff from ethnic minority groups
- Being unable to communicate using the same language is a disadvantage
- Personnel procedures do not take into account the needs of staff from ethnic minority groups
- There is a need for education
- Carers need training e.g. manual handling

Generally ethnic minority groups had little awareness of home care. It was suggested that the LA might not be offering the services that people want. There was consistent reference to transport, day care and grants. It was also clear that there were other needs such as health, education and housing. It is also important to recognise that there are a number of diverse groups each with different values and attitudes.

Crawley Locality is in the process of developing a template to assist in consultation. Other Localities can learn from their experience in order to address the need for all services to be culturally appropriate and accessible for those who do not have English as their first language.

5.9 People living in rural areas. May 2002

20% of the population of England live in rural areas. In West Sussex approximately 30% live in rural areas of which 30% live in small towns of over 3000 with the remainder living in villages, hamlets and isolated dwellings. (1991 Census). They have the same varied and wide ranging needs as people living anywhere else. However providing care in the country poses particular problems associated with equity, access, isolation and geography. The need for collaboration and partnership is even greater in rural areas because of the reliance on transport and the scarcity of resources.

The SSI Inspection of Community Care in Rural Communities 1999, pointed out that the geographic isolation of many rural communities may mean that even the smallest communities present service users with considerable difficulty in getting services. Equally those who support them often have considerable problem getting services to service users in their own homes. The difficulty in gaining access to some homes based in very remote areas was highlighted by managers who expressed concern about issues such as the safety of staff.

Issues for rural communities may include:

- Lack of choice
- Less accessible services
- Higher costs in providing services
- Transport problems.
- Recruitment issues

In Further Afield (Community care 9 –15 May 2002) Antoinette Ward describes an innovative approach to establishing and meeting support needs of people in sparsely populated areas. She suggests that in many rural areas needs are invisible to the statutory agencies. In the course of research the key needs of carers were reported to be:

- Practical help
- Respite care at home
- Information
- A chance to talk

The Rural Development Commission showed that the population of rural areas tends to be older, and there tends to be a larger proportion of those over 65 whose need for social care support is greater than that of younger people.

There can be particular difficulties in recruitment of staff. Transport and transport costs is a particular issue, not just in terms of mileage and access but also in bad weather. There can be additional problems where it is necessary to have two staff working together. In terms of cost and knowledge of the area it is sensible to look

for local staff, however this may not be acceptable to service users who may be known to the home care staff and therefore raise issues of confidentiality.

A small telephone survey of service users living in rural areas in Horsham and Chanctonbury Locality in May 2002 set out the main themes from consultations, asked for opinions about whether or not they were important, asked for additions, the type of service that should be provided and anything else people wanted included.

Generally, the responses indicated agreement by the participants with the themes arising from other consultation exercises. Where there was a variation it was about flexibility. One respondent indicated that flexibility could be difficult, for instance assisting someone to bed at the time they would like may not be practical given that it would be difficult to put to bed a number of people at one time. 'The flexibility must be within reality'. Another service user did not feel that if care time was not adhered to it was important. The small sample indicated an understanding of the difficulties in delivering services and people were therefore tolerant provided that information about delays and changes was communicated.

Comments made included:

- The service helps keep people in their own homes
- It should be the in-house provider giving service to all in need.
- Times of arrival may vary due to travelling and distance involved
- Delays are not a problem if they are communicated
- Problem with weekend independent cover sometimes not arriving and sometimes in a rush
- Proper standard of training needed.
- Carers who spend the allocated time with us are very thorough
- Service should be controlled by social services. If senior managers had to use the service they would see the difference between their own staff and that of agencies.

The issue of transport, which is outside the scope of the BVR, has a substantial impact on older people living in rural areas and their ability to access services and facilities.

5.10 Older men living alone. May 2002

The proportion of male HCAs employed by WSSCS is small, they represent 3% of the total HCA workforce. Inevitably few people will be able to receive care from a male HCA even if this is their preference. Given that home care users are predominantly female the male service users over 65 were believed to be a minority group. Semi structured one to one interviews were undertaken with a small group of male service users. Service users were encouraged to discuss the service that they received, asked how they felt about receiving a service from a female carer and whether a choice had ever been given of a male or female carer.

All were receiving care from female home care assistants. None had been offered a choice and all were satisfied with the service. All those interviewed said

that they felt more comfortable with a female carer as their perception was that females should undertake a caring role as opposed to male HCAs.

The interviewer suggested that it might be useful to sample male service users of different age groups to establish whether or not they hold the same views as the sample group. It seems important that while there may be difficulty in accommodating choice this should be explained and the service users views about preference should be respected.

5.11 Domiciliary Care Commissioning Managers. May 2002

A focus group was held with the DCCMs to address the following:

What makes your service (independent sector commissioned service) Best Value?

- Competition between Agencies
- Small organisations
- More effective decision-making
- Gives choice to DCCMs according to individual circumstance

What makes the in-house Best Value?

- Staff retention
- Terms and conditions
- Guaranteed hours
- History and public image

Improvements to achieve Best Value: Independent sector

- More clerical support in order that DCCAs can monitor service users
- Better software and hardware.

Improvements to achieve Best Value: in-house

- More flexible workforce
- Issues that apply to the independent sector, i.e. more clerical support and IT

How is the role of the Home Care Manager different to Domiciliary Care Commissioning Manager?

- DCCM not as involved in provision of direct care
- Less stressful but more responsibility
- There is a large difference between SHCA and DCCA.

Generally it was felt that roles were not fully understood and should be explained. The main problem was the 'them' and 'us' between in-house and commissioning teams in some Localities. An improvement would be closer working which might be helped by the organisational change. One line manager (Service Manager) will now manage both the in-house service and the DCCMs.

5.12 Care management staff. June 2002

The views of the individuals involved in undertaking the assessment and setting up the care plan is crucial. A questionnaire was designed and forwarded to representatives of each locality. Respondents were asked their views about strengths and weaknesses and improvements for both the independent sector and in-house home care service.

Results showed that:

In-house strengths

- Closer liaison and greater communication
- Flexibility in provision and response
- Specialist services
- Reliability
- Better management
- Better training
- Committed and enthusiastic toward service users
- Professional boundaries maintained
- Perseverance with 'tricky' situations
- SHCAs

In-house weaknesses

- Care plans not fully read
- Lack of availability
- Flexibility to suit service user need
- Not able to stay for as long as we would like e.g. befriending/ conversation

In-house improvements

- More staff
- Night services
- Medication given
- Joint working
- Attendance at reviews
- Specialist services

In-house innovations

- Respite at home
- Specialisation
- Initial home care review before social work review
- Joint training

Independent sector strengths

- Flexibility

- Availability: unsocial hours, urban areas, short notice

Independent sector weaknesses

- Commissioning process isolates care managers from providers of service
- Communicating change
- Availability: rural areas
- Missed calls.
- Calls not provided at times agreed
- Do the minimum
- Lack of specialisms
- Can pick and choose

Independent sector improvements

- Direct links to providers
- Additional training e.g. empowerment
- Better communication
- Joint training with in-house.
- Change of attitude toward service users

Independent sector innovations

- Respite at home
- Night care
- Learn from in-house staff
- Specialist training
- More contracts in rural areas
- Penalties for poor practice

5.13 Health consultation 1999/2002

5.13.1 District Nurse Survey. Worthing 1999

The survey involved face to face interviews with fifteen District Nurses, chosen at random. The aim was to gain their views on the in-house home care service and the independent sector service.

Differences between the two types of provider were identified. However, it was realised that much was dependent on the individual delivering the service. One person said she had been working as a District Nurse for many years and had not been able to tell the difference between independent sector and WSSCS staff

The in-house home care service was regarded as generally offering better trained staff and it was suggested that the use of agency was most appropriate for the less complex work. One person felt that guidelines for home care staff were excessive and rigid and that they tend to make unnecessary contact resulting in increased pressure for District Nurses. It was believed that there were more complaints about missing calls and being late in the independent sector than in-house

The conclusion drawn was that the majority of service users are satisfied with the service they receive irrespective of the provider. It was recognised that complex packages of care mainly involves working in partnership with other organisations and that services might best be delivered in-house.

5.13.2 Community Mental Health Team for Older People. Bognor May 2002

Discussion about the in-house service highlighted the following:

- Frustration regarding the length of time it can take to get the help desk to start home care
- Preference for the in-house service rather than from the independent sector given the team meet regularly with the in-house service
- Confidence in communication, feedback and trained staff

5.13.3 District Nurses, Community Psychiatric Nurses and Housing Scheme Managers. Mid Sussex 2002

Discussion focused on the best and worst things about the in-house home care service and the independent sector:

Best things about in-house home care

- Easier to contact
- Continuity of staff
- Trained carers
- Reliability and flexibility

Best things about the independent sector

- Client can choose what they want and when
- High level of continuity
- Can include shopping and housework

Worst things about the in-house service

- Lack of funds
- Staff shortage
- Staff need more time to support and enable people
- Delay in care starting because of the panel

Worst things about the Independent sector

- Don't take the same responsibility
- Contact point can be difficult
- Service users complain about lack of time
- Training needs

5.13.4 Locality consultation

Home care staff in the Localities meet regularly with District Nurses, and in some Localities, Hospital Discharge scheme managers are based in and, or, work closely with hospital based staff. The specialist mental health and the dementia teams have regular contact with CMHTs and consultants. In Littlehampton geographical teams have been linked to GP surgeries.

Opportunities are used for joint working, e.g. generic care worker, intermediate care, rehabilitation and attendance at training and case discussions. Partnership working at all levels has developed significantly.

5.14 Older people with mental health needs. 2001/2002

Between November 2001 and March 2002, work was undertaken on a service plan for older people with mental health needs. The study included a section on home based services and included semi-structured interviews with about forty individuals.

It is recognised that to live successfully in the community, service users and carers require a variety of home based support which need to be jointly planned, coordinated and accessible from one point. Services need to be flexible, responsive and available 7 days a week, 24 hours a day.

The comments made by respondents were in line with the Forget Me Not Mental Health Services for Older People (Audit Commission Jan 2000) and also reflected National Service Framework for Older People (March 2001). Nationally approximately 80% of people with dementia are still living in their own homes and approximately 30% live alone. (T.Kitwood) The NSF states that support should be available to help older people with mental health needs to live in the familiarity of their own homes.

The Alzheimer's Society has indicated that over 90% of people with dementia living in the community, or their carers, have problems concerning medication. A major difficulty being remembering to give or to take medicines. A 'grey area' for health and social care has been the administration of medicines. For example home care staff have not been permitted to give medication. Recent protocol as part of the generic care worker project has begun to address this issue. Future changes in practice should enable people to stay in the community by reducing risks associated with mismanagement of medication.

Forget Me Not referred to home care as a key service in supporting people in their own homes, whether living alone or with a carer. In some of the localities there are specialist home care teams for older people who have mental health needs, generally focusing on people with dementia. Where teams exist they are highly regarded by care management staff, CPNs and consultants. Staff are referred to as having an empathy with and understanding of older people with mental health needs, given they have the advantage of some training and knowledge of the problems that both service users and carers may encounter.

An important issue in supporting people at home is that of a flexible, responsive service. Currently home care is not a 24 hour service. In addition to specialist

teams the role of Community Support Worker who would be available 24 hours a day has been suggested. At the start of Community Care in 1993 a night care team existed in Littlehampton which proved to be successful, however, cost was given as a reason for terminating the service.

In recent years managers in some Localities have responded creatively to the need for an over night service. Reference has also been made of the need for a crisis response service. The hospital discharge team is regarded as an important means of getting to know someone's needs in greater detail before finalising the care plan.

5.15 Older people with learning difficulties. 2002

The opinions of managers and policy /project officers were sought. People with learning difficulties receive home care, although the amount and nature of the care delivered may vary across the county. For example in Arun there is a dedicated team offering home care to people with learning difficulties both under and over 65, with the additional provision of a half day per week 'club' run by the home care service for people with learning difficulties. All the home care for people with learning difficulties is co-ordinated by one home care manager. In Worthing, a manager who is also responsible for mental health services delivers approximately 100 hours. The Worthing scheme was established as a pilot for the development of a community support service under the management of the home care service. In Mid Sussex there is good co-ordination between the home care service and day and residential services and roles overlap. Elsewhere the provision is more patchy and on a smaller scale.

The county strategy for older people with learning difficulties is driven by Valuing People which points to a significant increase in the need for community support services. The expansion of housing choice and modernisation of day services are reliant on good community support being in place. A strategy for the commissioning and provision of these services is being developed.

Since June 2002, as part of New Directions, provider services for people with learning difficulties are managed within a discrete learning difficulty service. The place of the specialist home care provision, which seems to be more the role of a community support worker needs to be considered. The reorganisation of services for people with learning difficulties includes residential, care management and day care services but not home care.

As part of developing the service plan for older people with mental health needs 2001/2002 older people with learning difficulties who also have mental health problems were acknowledged as a group whose needs should be addressed. People with learning difficulties have shared in increased life expectancy arising from improvements in health and social care. People with Downs Syndrome show premature ageing and are particularly susceptible to Alzheimer's disease; about one third will have dementia. A further factor is that where individuals remain at home their carers are often older and in poor health themselves. The implication being that their combined needs should be explored.

5.16 Carers: Open session March 2002

The main points arising from the session held with carers under the heading 'Quality of Home Care' were:

- Concern about home care being unreliable
- Poor communication
- Agency staff often have had little or no training
- Service does not always match care plan; less time given
- Quality of service is critical

Carers suggested that there should be improved management, co-ordination and communication together with improved monitoring that included service users and carers. The consultations with carers emphasised the need for carers to have a feedback on where their comments have been taken and any action which results from them.

5.17 Housing Schemes. 2002

Contact varies between Localities and housing and housing associations. In most there are either informal meetings for instance home care staff and scheme managers, or more formal meetings with housing associations, housing scheme managers and other organisations.

Currently some managers and staff are involved in supporting existing schemes in Horsham, Crawley and Mid Sussex or developing Extra Care projects including a partnership development with a WSSCS residential home in Selsey. . Work is also being undertaken in Worthing looking at the most efficient way of providing home care from the in-house and independent sector service to sheltered housing schemes. The possibility of regular meetings with home care, health colleagues and scheme managers is currently being considered. Home care staff are regularly involved in providing support to sheltered housing and extra care services.

5.18 Policy and Development Group (Older People). March 2002

The purpose and progress of the BVR was discussed at the quarterly meeting of the group in March 2002. Membership of the group includes County Councillors, voluntary organisations, the independent sector, service users, carers, health and social care and a pensioners action group.

Comments made included:

- Help at home schemes are invaluable as part of preventative services
- Older people cannot get home care and when they can they cannot afford it
- Sometimes a less satisfactory standard of care is offered by the independent sector
- There are good and bad providers in both the in-house and independent sector,

5.19 Consultation exercises in other LAs. 2000/2

Information from other home care BVRs in Northamptonshire and Southampton showed that key issues in consultation with service users were:

- Availability of the service (can my needs be met?)
- Reliability (will the carer turn up?)
- Punctuality (will the carer turn up on time)
- Consistency (will it be my regular carer?)
- Quality (is care provided in the way I would wish?)

5.20 National Research: Rowntree Foundation: Getting Older Peoples Views on Quality Home Care

The research referred to the following issues:

- Need help to keep the home clean and undertake small tasks e.g. changing light bulbs
- Notification of tasks to be undertaken and any changes in carers
- Flexible service that reflects need
- Training
- Regular carers
- Services to enable older people to get out of their homes.

5.21 Study undertaken in Sweden Community Care June 2002

The study which involved telephone interviews with mainly older people using home care suggested that many service users felt that:

- They did not get help at the time agreed
- The quality of service differed owing to who came to help
- Help was provided by a number of different HCAs

5.22 Comment

The BVR consultation process was fairly extensive, although it was acknowledged that in some instances the samples were small. What was clear throughout was that people did not just want to be involved, they wanted their involvement to make a real difference. Comments were made both about tokenism and consultation fatigue. Peter Beresford (MCC. Building knowledge for integrated care Volume 10 Issue 3 June) suggests that service users and carer are suspicious of dominant managerialist/consumerist approaches to user involvement, based on information seeking and data collection.

Beresford suggests that there is a need for a more democratic and empowering approach to participation which changes the balance of power and involve service user directly in the decision making process. To be meaningful future consultation needs to involve stakeholders at an earlier stage. However, the main issue is that there needs to be a real change in how older people are seen in terms of their ability to participate and contribute Current 'emancipating research'

is currently involving and, in some instances, paying older people to be involved in undertaking research.

The Social Policy Research Unit at York is currently looking at flexible individual care and how LAs respond to what individuals regard as important to their quality of life. The National Minimum Standards will expect LAs to build in to their annual planning mechanisms for consultation with service users. Both at county and local level, plans for consultation and involvement need to be developed with service users and carers.

The majority of issues raised by stakeholders during consultation will be addressed as part of the implementation of the National Minimum Standards. (Appendix 6).

KEY FINDINGS

- ***Future consultation with service users and carers need to be designed in partnership to ensure meaningful consultation and involvement.***
- ***The needs of minority groups should be addressed.***
- ***Consultation on the in-house home care service needs to include feedback and ensure that those consulted have evidence that their views have been heard and have made a difference***
- ***Localities need to plan for annual consultation as required by the National Minimum Standards.***
- ***Most of the points raised by those consulted can be addressed by proper implementation of the National Minimum Standards (Appendix 5)***
- ***Preventative services models used in some Localities can help address the need for lower level services.***
- ***Workforce planning needs to address the status of the service by ensuring clarity about the business, clear procedures, training plans, business plans and appropriate job titles***
- ***The need for a 24 hour, 7 days a week service should be addressed***
- ***The future role of the in-house service needs to include specialist teams e.g. older people with mental health problems***
- ***Discussions should be held with the County Team for People with Learning difficulties to agree the best way of delivering services.***

- ***Culturally sensitive services need to be available to all across the county. Links can be made with the Equality Champion for Adults and Crawley Locality***

6.How does the service compare? Comparison with others LAs.

The intention of this section is to give an overview of the contacts made with other LAs as part of the benchmarking exercise.

In order to consider the question how the service compares the BVR group chose to compare WSSCS in-house home care service with other LAs.

The comparisons were a key part of the review, illustrating the value of benchmarking. The Local Government Act 1999 refers to benchmarking as improving ourselves by learning from others.

The purpose of the benchmarking was to identify the possibility for efficiencies by looking at processes which help deliver better performance and outcomes. It was also important to identify good practice.

A questionnaire for the benchmarking exercise with other authorities was agreed by the BVR group. The BVR team approached a selection of 12 authorities using the four PAF indicators (B11, B17, C28 and C32). Selection focused on the high performers, and in addition, other authorities were added to give a wider cross section. Initial contact was by telephone at which stage initial questions were asked, then agreement was sought to complete a written questionnaire.

Of the twelve contacted, five were unable to respond. Seven responded giving information over the telephone and returning partially or fully completed questionnaires. One offered to do a presentation rather than complete the questionnaire. The results were included in a matrix and a decision was made to visit three LAs: Portsmouth, Gloucester and Hertfordshire.

Findings were as follows:

6.1 Portsmouth

- Recruitment issues with high numbers of home care staff over 50 years of age
- Good relationship with the independent sector, joint forum. training and day to day contact
- Working toward 30% in-house and 70% independent sector
- Concentrating on short term and specialist work i.e. OPMH and rehabilitation, Developing a 24 hour service
- 45% of services delivered are less than one hour
- Current IT system inadequate and not suited to short term work
- Investigating electronic monitoring.
- Sickness absence: 8%
- Higher unit cost (£11.04) in comparison with independent sector, differential 23%
- Developing annualised hours, may cause budget problems for staff
- With hindsight would put greater emphasis on quality.

Issues including recruitment, sickness absence and the unit cost differential between in-house and independent sector, although not the actual unit cost, and inadequate IT system are similar to WSSCS. The co-operative relationship with the independent sector indicated good practice

6.2 Gloucester

- Recruitment issues with high numbers over 50 years of age
- Dedicated County Manager and quality Development Manager
- Open relationship with independent sector, joint forum and training
- 60% independent sector/ 40% in-house
- Mainly short-term work e.g. rapid response, intermediate care, hospital discharge and those with challenging needs
- Night care system supported by mainstream out of hours service
- Inadequate IT system
- Electronic monitoring not successful
- Sickness absence: 7.7% (increased during reorganisation)
- Unit cost £12.40/ £12.50 (direct cost overheads)
- Independent sector charges £8.50 to £11.50
- Working on (admin aspect) ISO 9000
- Centralised brokerage
- With hindsight would have put greater emphasis on quality.

Issues including recruitment, high numbers of staff over 50, proportion of independent sector and in-house service, sickness absence and inadequate IT system are similar to WSSCS. The relationship with the independent sector indicated good practice.

6.3 Hertfordshire

- 100% outsourcing
- Intended 80% independent sector, Leonard Cheshire made successful bid for the other 20%
- Providers are expected to collaborate
- Monitoring of providers important. Providers are compared with each other.
- Contracts awarded on a 40% price and 60% quality basis
- All providers have electronic monitoring
- Outsourcing had costs attached, process included review team and took about 4 to 5 years to complete
- Award won for contracting process
- Savings not achieved. e.g. LA staff part of TUPE, new staff on less favourable terms and conditions and are not staying
- Any savings will be long term
- Process for service innovation and service development was unclear

The service delivery differed significantly from the WSSCS in-house home care service. The award won for the contracting process indicates good practice. Savings not yet achieved.

6.4 Cambridgeshire

- Recruitment problems with a 20% vacancy despite innovative recruitment programme
- Independent sector responsible for high volume, less tailored services
- In-house service includes rehabilitation, hospital discharge, rapid response, complex and high dependency clients and developing integrated teams
- In house unit cost is about £16.03, different rates are calculated for 15 mins (£4.86), 30 mins (£8.58) and 45mins (£12.30)
- In house unit cost is £2 to £4 more than independent sector
- Staff to work on 2 weekly rotas
- Do not anticipate problems in meeting training targets
- About to introduce in-house home care IT system
- Early stages of electronic monitoring
- Focus groups being set up to inform planning of services for older peoples
- Central broker system determines which provider to use

Issues such as range of services, higher unit cost and being at the point of introducing an IT system are similar to WSSCS. Focus groups to inform planning of services for older people indicates good practice.

6.5 Derbyshire

- Recruitment problems in rural areas
- Staff need to change style of working to enablement rather than doing for
- Generic care worker pilot in CMHTs, specialisms are not yet well developed
- In-house service is 70%, independent sector is 30%
- Operating electronic monitoring/time sheets involving calls from clients homes
- In house unit cost is £11 and £12; independent sector charge is £7 and £8 per hour

Issues including recruitment problems in rural areas and generic care working are similar to WSSCS

6.6 Enfield

- Recruitment problems in more rural areas
- Independent sector experiencing recruitment problems
- In-house work with vulnerable service users. Independent sector do mainstream work
- High proportion of staff are over 50
- Sickness absence is 8.6%
- Guaranteed hours operated
- In-house unit cost (estimate) £17.
- Independent sector charge is £9 to £10 per hour but considered too low to achieve a quality service
- In house provides about 47% in-house, 53% independent sector.

Issues including recruitment problems, sickness absence, guaranteed hours and high proportion of staff over 50 years are similar to WSSCS

6.7 Oxfordshire

- Recruitment and retention problems
- External providers tend to pay staff more in difficult to recruit rural areas
- Independent sector provide 60% of service but this varies across the county
- Differential charge for urban and rural areas
- Currently undertaking market research regarding specialist services to inform future planning. Meanwhile undertaking rapid response and reablement
- In-house unit cost is higher than the independent sector
- Independent sector undertaking mainstream work
- All providers undertake a large number of 15 minute calls
- Outsourcing of the shopping service has decreased flexibility in the in-house home care service and anticipated savings have not been achieved

Issues including recruitment. Large number of 15 minute calls and proportion of independent sector provision are similar to WSSCS. Outsourcing shopping has not achieved anticipated savings. Oxfordshire has as part of a benchmarking exercise found it virtually impossible to determine why their unit cost was high.

6.8 Information from other LAs not included in the benchmarking.

6.8.1 East Sussex

- In-house 55%, independent sector 45%
- Providing short term intensive and rehabilitative care service across the county.
- Some limited capacity for hard to place service users or those with complex needs for whom independent sectors have been unable to provide a service.
- Plan that standard personal care will be undertaken by the independent sector
- Joint training with the independent sector being developed.

Issues including proportion of independent sector provision similar to WSSCS and service delivery similar to other LAs

6.8.2 Brighton and Hove

- Recruitment problems
- Good relationship with the independent sector, forums with in-house/independent sector
- Mainly short term work, more vulnerable and hard to place people
- New grade of HC support worker being established
- IT systems inadequate as it was planned with long term service in mind.

Issues including inadequate IT system and recruitment problems similar to WSSCS

6.8.3 Norfolk

- Plan to reduce in-house/independent sector ratio from 70:30 to 60:40

Out sourcing proportion similar to WSSCS.

6.8.4 Dorset

- Moving the balance of care which has been more heavily weighted to the in-house service to the independent sector
- Focusing the in-house service on a more specialist service
- Considering re-negotiating terms and conditions of home care staff

WSSCS reviewed terms and conditions for staff in 1998. Issues about specialist services and mixed economy similar to WSSCS.

6.8.5 Bromley

- In-house service to reduce, independent sector proportion to increase
- Considering refocusing in-house services to a more intensive rehabilitative service
- Terms and conditions of employment being considered

Issues including reviewing terms and conditions for staff in 1998/1999 and reducing in-house activity similar to WSSCS.

6.8.6 Newcastle

- Was providing 50/50 in-house/independent sector.
- Intends moving domestic support to the independent sector
- In-house service to re-focus on post hospital care rehabilitative work

Domestic support in WSSCS has reduced following the introduction of Community Care in 1993.

6.8.7 Wandsworth

- Externalised housework only service in 1995
- Personal care put out to tender in 1997, contract won in-house
- In-house market share of 48% is to reduce to 25%
- Major changes made to staff terms and conditions
- Significant problems for staff and managers
- Continued discontent re different annual and sickness leave entitlement. Further tendering in 2001.
- In-house unit cost about 15% higher than independent sector cost
- Savings made by the in-house ceasing to use a number of 'corporate services'

Service differs from WSSCS. Savings made by ceasing to use a number of corporate services.

6.8.8 Durham

- Recruitment is a problem
- Moving from 50:50 to in-house 25%, independent sector 75%
- Offering specialist care which includes people with dementia, physical disability and children.
- There are no hospital discharge services
- Mainstream care is provided by the independent sector
- Unit costs quoted as Monday to Friday £10.22, Saturday £14.00 and Sunday £18.00
- Unsuccessful negotiation to change staff terms and conditions

Issues including recruitment and specialist services are similar to WSSCS

6.8.9 Cumbria

- Staff retention is a problem. Lack of guaranteed hours is regarded to be a weakness
- In-house service is 75%, independent sector 25%
- Staff morale described as low
- Management structure described as thin.

Services differ from WSSCS

6.8.10 Kent

- Difficulties in further outsourcing envisaged because of difficulty in covering rural areas e.g. recruitment
- In-house service proportion is 19%, independent sector is 81%

Issue of rural cover is similar to WSSCS

6.8.11 Suffolk

- In house service 45%, independent sector 55%
- Terms and conditions changed several years ago as part of budget confines. Deal struck which gave a guarantee of at least 40% of service in-house
- Return to county wide conditions of service planned with the implementation of single status and job evaluation

Outsourcing proportion similar to WSSCS

As indicated in the section on finance and illustrated in the benchmarking exercise there is a variation between LAs in terms of unit costs. Clearly there needs to be some caution given there are different ways of calculating the cost. The Audit Commission /SSI Report Getting the Best from Social Services found that across 12 local authorities the unit cost for in-house services varied

from £7 per hour to £15 per hour, whilst there were also considerable variations in relation to independent sector costs. The report noted the different ways in which costs were allocated within local authorities presented them with a key difficulty in drawing meaningful comparisons.

East Sussex found that without exception those authorities that had completed BVRs identified a significant additional cost to them of retaining the in-house home care service. A number of authorities have taken steps to reduce current costs through efficiency measures, which have included reviewing staff terms and conditions.

The Domiciliary Care Review in 1998 looked in detail at the terms and condition of home care staff and made a number of changes. The new structure required staff to be more flexible in their hours worked in acknowledgement of the changed needs of service users and the consequent requirement for greater weekend and evening work. The budgetary confines in 2001/2002 resulted in further changes to work patterns as targets for SHCA and HCA contact time with service users were increased.

KEY FINDINGS

- ***Several local authorities experience recruitment problems with a high number of staff over 50 years old***
- ***Unit cost vary considerably as do the methods for calculating them; it is difficult to compare like with like***
- ***Most LAs favoured a mixed economy with the balance being higher in the independent sector***
- ***Most LAs were outsourcing mainstream work and in-house services were doing short term work, specialisms and working with hard to place people***
- ***Electronic monitoring has been considered and introduced in some areas. Success rates vary.***
- ***Most LAs have examined terms and conditions of staff in the run up to, as part of, or, following the BVR***
- ***IT systems were often not meeting changed requirements***
- ***The importance of quality was generally highlighted***
- ***Good practice included the relationship between the in-house and the independent sector with a sense of co-operation as opposed to competition***

7. How does the service stand up to examination? Challenging the Best Value process.

The intention of this section is to describe how the home care BVR process was challenged.

The challenge was to consider whether or not WSSCS should provide the service, if so how it should be provided in order to ensure continuous improvement.

7.1 Groups that challenged

The BVR was challenged throughout the process by a number of groups which included the BVR working group, the core group, the Challenge Panel, the Project Steering Group and the Project Group. Membership of the various groups was wide ranging and included county councillors, officers, staff and representatives from partner organisations including the private and voluntary sector and health. The BVR was discussed in other forums which included the Policy and Development Group for Older People and a number of meetings and focus groups with frontline staff and managers. Various consultation exercises were also seen as providing a challenge. The BVR group identified a critical friend from another LA part way through the review. Unfortunately the work was not undertaken. The BVR group in future would wish to gain commitment at the start of the review process.

7.2 The Challenge Panel

A Challenge Panel which included representation from a pensioners group, health community, district/borough councils and independent sector providers was established. In reality the core membership was primarily the independent sector. The group acted as an adviser and ensured independent challenge of the best value process.

The group challenged the fact that the focus of the home care BVR was on the in-house sector and that the independent sector had not been included. The original scoping exercise was amended to include a study of the independent sector. A work plan was agreed with the Challenge Panel.

A review of the challenge panel with recommendations for the future to ensure best use of this important resource is planned.

7.3 SSI Inspection of Social Care Services for Older People May 2001

The BVR group were also mindful of other challenges to the home care service which included the SSI Inspection of Social Care Services for Older People 2001. As mentioned earlier, the report referred to the fact that:

- Some domiciliary care was not reliable (in-house and independent sector)
- There was not an inclusive approach to assessing and responding to the needs of older people from ethnic minority groups
- Complaints leaflets were not handed out to all service users as a matter of routine

- The independent sector needs further engagement if West Sussex is to reach its aspirations to outsource 60% of home care by 2003.

An action plan was developed in November 2001 and a review of action taken was submitted to the SSI in June 2002.

7.4 Improving Older People's Services. SSI November 2000

The report stated that service users and carers most valued personalised care that reflected individual needs and gave people opportunities to live life as they wanted. The implication being on home care with an emphasis on enabling not just doing for. Future induction, foundation, NVQ and other training needs to incorporate the need for a modern, partnership approach.

7.5 Alternative ways of providing a home care service

As a part of challenge, the BVR needed to consider different ways of providing a service.

During the course of the review the BVR group considered five options, the pros and cons of each, and which option or options seemed most appropriate at this point in time. The main options for the home care service were agreed as:

- Total in house
- Total outsourcing
- Modernising partnership approach
- Business Unit
- Care Trust

The BVR group examined and discussed the options having collected information as part of the benchmarking exercise and using contacts with other LAs, periodicals and the Internet.

When considering the options the group were mindful of the SWOT and PEST analysis, consultation with stakeholders and the study of the independent sector as part of the section on competition and the challenges made.

OPTION	PROS	CONS	JUSTIFICATION
Total In-House	Retains management control. Confidence in the public sector.	Lack of innovation. High unit costs Less choice. Rigidity of employment conditions together with possible consequent inflexibility of staff. Further change of provider for some service users. Capacity issue in terms of being able to provide	Against Government directive to promote a flourishing independent sector within a mixed economy. No evidence found of other LAs that have fully retained the

OPTION	PROS	CONS	JUSTIFICATION
		the service in-house. Difficulties in providing a service in rural areas Service user wishes not to change care workers.	service. Politically unacceptable. Recruitment issues would make this difficult to achieve. NOT CONSIDERED TO BE AN OPTION
Total Outsourcing	More flexibility because of less rigid employment conditions. Reduced cost of service. Market now more mature.	At behest of market e.g. cartels. Risk, particularly if small number of providers. Increased contracting and monitoring costs. Reduced competition. Move away from a mixed economy. Innovation with different partners e.g. health may be difficult. Service users may lack confidence in a fully outsourced service. Change of provider for service users. Savings may take some years to achieve.	Hertfordshire considered, some positive factors such as monitoring and contracting arrangements including the geographic arrangements. However, it took four to five years to arrange, Savings not transpired and will take several years to achieve. Starfish/ADSS Report suggest outsourcing may not achieve savings. Innovation can be problematic Against Government directive to create a mixed economy. NOT CONSIDERED TO BE AN OPTION
Modernising Partnership Approach	Period of consolidation for staff Stability and continuity Best use of	Higher unit cost. Lack of radical change might be interpreted as 'tweaking' rather than genuine improvement. Getting different cultures	The benchmarking exercise showed that a number of LAs are adopting a similar route

OPTION	PROS	CONS	JUSTIFICATION
	available resources. Partnership working with independent sector and other organisations e.g. health and housing. Work co-operatively with the independent sector, outsourcing mainstream work and negotiating other work e.g. specialisms. Opportunity to improve by building on strengths and opportunities and overcoming weaknesses and threats. Good basis for preparing for future. Incremental improvement. Synergy of best practice. Ensuring critical mass in balance between independent and in-house sector.	to work together. Partnership working e.g. setting up forums, training takes time Low base point in terms of IT, procedures etc. Investment needs to be made in staff training and introducing IT.	Allows for immediate improvement using the Performance improvement Plan. Gives time to do further work, if required, on other possible options e.g. Care Trusts and prepare for further change CONSIDERED TO BE THE PREFERRED OPTION
Business Unit	Clearly sets out vision statement and objectives. Clear management accountability. Reduced central and social and caring services overheads.	May involve initial set up costs. Knowledge and skills e.g. Financial and HR will need to be transferred and may incur additional costs. Synergy is seen as an added value but if separate from the	Limited Information on which to base a decision. Would require further work. A positive aspect being that the unit is not buffeted about by the

OPTION	PROS	CONS	JUSTIFICATION
	In-house can openly tender. Retains some LA control. Can develop niche market.	organisation this could be lost. Failure rates in new businesses can be high Energy directed to setting up a business might detract from modernisation agenda and creating partnerships. Investment in IT system required. Outstanding work would need to be completed e.g. in-house home care procedures, National Minimum Standards, training. Relationship with the independent sector is competitive rather than co-operative.	budget and can plan ahead. Changes may involve cost in terms of finance and poor staff morale Greater investigation of a number of models would be necessary in order to make an informed decision. CONSIDERED TO BE A POSSIBLE OPTION FOR THE FUTURE SUBJECT TO FURTHER INVESTIGATION
Care Trust	Partnership with health. Opportunity to work collaboratively e.g. generic care, intermediate care. Single line management	A model which currently included home care was not found. Care Trusts are new and untested at present. Staff may feel 'taken over' by another organisation. Newly integrated organisations may experience deterioration in staff morale and stress. Takes time to settle in, good joint working needs building up over a period of time. Training e.g. how to work in partnership needs to be in place. Systems need rationalising and bringing together. Cultural issues. Charging issues for different organisations.	The modernisation agenda requires greater emphasis on working in partnership and work is being undertaken which will pave the way for the future. Currently insufficient information is available on which to make a decision. Feedback on future models, which will include home care, awaited e.g. Brighton and Hove. CONSIDERED TO BE A POSSIBLE OPTION FOR

OPTION	PROS	CONS	JUSTIFICATION
		Recent structural change in both social care and health organisations.	THE FUTURE SUBJECT TO FURTHER INVESTIGATION

The BVR group recognised that the evidence gathered on which to base a recommendation about the most appropriate option could be considered to be limited. However, what was clear was that there were a range of common issues within the benchmarking exercise and in other contact with LAs that indicated that the Modernising Partnership Approach would enable the issues raised in consultation and during the examination of the service to be undertaken. This would both improve the service and help prepare for any future change

One LA based their reconfiguration of services for the future on the belief that the independent sector does not have the infrastructure to take on the development role and that this was best placed in the in-house service. They proposed that the in-house service should focus on niche services such as rehabilitation, hospital discharge, protection, mainly short term intervention and promoting independence. Another LA reported that they were unable to find another LA that had fully outsourced. The same LA also discounted the possibility of a business unit on the basis that it maintains the in-house service in competition rather than in co-operation with the independent sector. They stressed the need for a complementary rather than a competitive relationship with the independent sector.

The BVR group therefore recommends that:

The following two are not considered to be options:

- Total in-house service
- Total outsourcing

The benchmarking exercise did not reveal any LAs that were retaining the home care service in-house. The model for full outsourcing was Hertfordshire, given the many positives in terms of its contracting and monitoring on balance the additional costs of project management, the time taken and the inability to achieve anticipated savings in the short to mid term were seen as distinct disadvantages.

The following were considered to be possible options that might be considered in the future.

- Business Unit
- Care Trust

There was little information about business units. The theory suggested that there were some advantages that should be considered. There was no information as part of the benchmarking exercise. However some information

was collected about Wandsworth. Similarly there was no information about Care Trusts which had included the home care service. Detail that was available highlighted both the advantages in working together under a single management to create seamless services as well as the disadvantage in a lowering of staff morale, lack of preparation etc.

It is understood that Brighton and Hove, as a pilot area, will be considering moving the home care service into the Care Trust and further news is awaited. Meanwhile, the generic care worker model, intermediate care, hospital discharge and other specialist ways of working were regarded as excellent opportunities in line with national requirements and in preparation for the future.

In addition to the above options information was gathered on social firm and care co-operative models.

OPTION	PROS	CONS	JUSTIFICATION
Social Firm	It is a business created for the employment of people with a disability or other disadvantage in the labour market. (More than 25% of the paid workforce to be people with disabilities or disadvantage and 50% of income to be achieved through sales)	A supportive but not a care environment. Costly in terms of time, money and energy	No evidence found of LAs using this model. Recruitment issues would make this difficult to achieve. NOT CONSIDERED TO BE AN OPTION
Care Co-operative	Co-operatives are jointly owned and democratically controlled enterprises. Membership is based on participation. Co-operative members own their business and elect a board made up of service users and staff.	May involve initial set up costs. Failure rates in new businesses can be high. Energy directed into setting up a business may detract from the modernisation agenda Investment in IT system required.	A number of models of co-operatives providing home care service on behalf of LAs exist. The London Borough of Croydon have a multi stakeholder co-operative. CONSIDERED TO BE WORTHY OF FURTHER INVESTIGATION

OPTION	PROS	CONS	JUSTIFICATION
	Co-operatives are based on values of self-help, self-responsibility, democracy, equality and social responsibility. They provide the middle ground between the public and the private sector. Focus is on provision of quality services which meet the needs of the community. Profit is put back into the business.		AS PART OF A BUSINESS UNIT OPTION/

The preferred option was considered to be:

- Modernising Partnership Approach

The Modernising Partnership Approach was seen as immediately giving the scope to build on the strengths and opportunities, and overcome weaknesses and threats within the in-house service. Such a model would need properly supporting in terms of a performance improvement plan. It was recognised that this might not address immediately the higher unit cost; indeed no other models appeared to assure a reduction. It would give a period of continuity and enable a concentration on modernising the service and in particular the partnerships whilst at the same time ensuring improvements in areas such as the National Minimum Standards, reviewing the current structure, introducing new technology together with good management systems and consider how best to deliver services.

The choice of option would be comparable with many other LAs who have also been required to demonstrate why they have selected their preferred choice and how this is most likely to deliver Best Value. In addressing the SWOT analysis the in-house service is in a good position to modernise services and introduce improvements that make a difference.

KEY FINDINGS

- ***A number of different groups and consultation exercises have challenged the BVR group.***

- *The options considered as part of the sample point the way forward showing that there are similarities between many other LAs and the direction for the future.*
- *Total in-house and total outsourcing are not considered to be viable options*
- *Possible future options include business units and care trusts, subject to further investigation.*
- *The Care Co-operative is worthy of further investigation as part of the business unit option.*
- *The preferred option is the Modernising Partnership Approach which would give the scope to build on the strengths and opportunities and work toward overcoming the weaknesses and threats.*
- *The Modernising Partnership Approach is considered to be the option currently most likely to ensure the improvements that make a difference.*

8. Is the service fit for the future? Competition with other providers

The intention of this section is to set out the work undertaken in comparing in-house and independent sector services. Reference is made to the report of the Domiciliary Care Contracting Scrutiny Sub Group and the study of the independent sector referred to in the challenge section.

The BVR group recognised the importance of embracing fair competition as a means of securing efficient and effective services. The original scoping had not included the independent sector and, as referred to, a decision was made that this should be part of the review. The team therefore looked at other LAs as part of the benchmarking exercise, previous work undertaken as part of a home care survey which looked at both the in-house and the independent sector, the Domiciliary Care Contracting report produced by the Scrutiny Sub Group and a specific study of the independent sector as part of the BVR.

8.1 The SWOT analysis

The SWOT analysis of the in-house service (Appendix 4) set out the strengths and opportunities to build on and the ability weaknesses and threats that would need to be overcome:

8.2 Survey of in-house and independent sector home care. Worthing Locality 1999

The cross agency study looked at services being provided by the in-house service and the independent sector. In 1999 the in-house provision was 70% and independent sector was 30%.

Three surveys undertaken included:

- Service users previously receiving home care from in house services and now receiving services from the independent sector
- Service users receiving home care from the in-house service
- Service users receiving services from the independent sector

The result showed that generally service users felt that

- Care workers from both in-house and the independent sector have a friendly caring manner. Less than 2% said this was the case only sometimes and one service user said the twilight service from the agency was never caring.
- Over 85% said that their care workers were able to finish their work in the time allocated. That they were punctual and stayed for the time allocated.
- Service users said that their care workers were trustworthy.
- 50% of service users said they were told beforehand if their usual care worker would not be calling. Both the in-house service and independent sector scored badly in this area.
- 95% of service users irrespective of who provided their care said that they would recommend the service.

Research undertaken by South Gloucestershire in November 1999, showed that 89% of the in-house service users rated the service as good or very good compared with 82% of independent home care users. Both studies showed similarities between the in-house and the independent sector.

8.3 Domiciliary Care Contracting Report: Scrutiny Sub Group of the Social and Caring Services Select Committee. March 2001

The group examined how the development of outsourcing domiciliary services was being addressed in contractual terms. Given the stated intention of the WSSCS to progress towards 60% of home care being outsourced by 2003. County Councillors had the opportunity to examine both the in-house service and the independent sector, to consider how contractual requirements are being met, to look at the market for home care services and note the differences in urban and rural areas in relation to our contracting service provision both by in-house and external providers. References made included:

- The need to develop more block contracts
- The need to move away from spot purchases
- The need to encourage smaller providers
- The need to consider variations in the 60:40 split when taking into account the different nature of rural and urban areas

Recommendations from the Domiciliary Care Contracting Report that related specifically to the home care service included:

- The department should make strenuous efforts to ensure that the practice where packages of care are split between agencies or agencies and the in-house provider should be discontinued.

Localities report that progress has been made in this area.

- The department should take steps to ensure that better communication is established with service users and carers when staff or service changes are necessary to support the service.

The results of surveys indicate that this has been a problem and continues to be a problem.

- When there is a change of home care assistant or a temporary substitution, the replacement staff need to be better briefed about the service user's individual care needs and the importance of adhering to the care plan.

The results of the consultation exercise suggest that this is still a problem and HCA's indicate that information is not always available.

- The department needs to develop a strategy for covering the additional costs for training in-house provider staff to the relevant NVQ standards to meet the requirements of the Care Standards Act.

Work is currently being undertaken as part of preparing staff in line with the National Minimum Standards.

- The Department must have full information about the unit costs for all provider services, both internal and external.

Unit costs for the year ending 2001/2002 are now available for the home care service and have been included in this report

The report also included a number of recommendations that are being addressed by the care management teams and the Contracts Department.

8.4 Independent sector study May 2002

At the point of the Domiciliary Care Review in 1998, 75% of the home care service was provided in-house:

Commissioned Home Care.

Adur	Arun	Chichester	Crawley	Horsham	MidSussex	Worthing	Average
19%	14%	10%	43%	32%	41%	27%	25%

Source FS 1997/1998

The decision, by the then Social Services Committee in autumn 1998, was that the in-house home care service should manage 40% of the service and the

independent sector 60% and a target set to achieve this by 2003. By 1999 the in-house share was 69% and expenditure in the independent sector was as follows:

Commissioned Home Care

Adur	Arun	Chichester	Crawley	Horsham	MidSussex	Worthing	Average
26%	12%	11%	53%	48%	52%	32%	31%

Source: FS Wk 16 1999/2000

By May 2002 the outsourcing has increased to:

Commissioned Home Care

Adur	Arun	Chichester	Crawley	Horsham	MidSussex	Worthing	Average
56%	31%	36%	68%	60%	62%	55%	53%

Source: FS May 2002

The figure does not include the in-house agency cover. In the week 10 May 2002, 2.4% of total hours were purchased by Localities from agencies.

West Sussex is characterised by a number of different domiciliary care markets, the coastal strip is very different from north of the Downs and Crawley is very different again. There are many small domiciliary care organisations with not the same large corporate presence as in some other LAs.

Currently 53% of the home care hours are delivered by the independent sector. The expectation is that the target reached will be 60% in 2003. The department has illustrated that effective action has been taken to develop the market. Action is still required to increase outsourcing in some Localities.

The Domiciliary Care Contracting Scrutiny Group suggested that the 60/40 split should be regarded as an overall County target, with each Locality being given individual targets which take account of local market variations but which contribute to achievement of the overall target. This seems sensible however if this were to imply a larger increase in some areas then the balance might not be achievable in terms of a mixed economy. For instance moving Crawley from 68% to 100% would almost achieve the County target. While accepting that there may be some imbalance between Localities it might be preferable to encourage growth in areas where outsourcing is low.

To reach the required 60% a possible model, given that attention would need to be given to workforce planning to ensure appropriate staffing numbers, might be:

Commissioned Home Care

Adur	Arun	Chichester	Crawley	Horsham	MidSussex	Worthing	Average
60%	55%	55%	68%	60%	62%	60%	60%

In 1998 there were a total of 21 providers being used on a regular basis. Currently there are 62 approved providers with 45 regularly used. All localities with the exception of Chichester and Mid Sussex have block contracts. Both are in the process of negotiating contracts.

The total number of block contract providers is 10 and usage per locality varies from one to five. Spot contracts vary from 4 to 16. Currently there are eight residential or nursing homes that have diversified and are offering care in the community to older people. The actual volume of home care work is unknown. However, there is potential for the most efficient use of staff time assuming staff are able to work flexibly in the residential home and in the community. The resource centre model adopted by some other authorities and being developed in two residential homes in WSSCS offers the same potential.

Independent sector providers cover a wide range of service groups but few specialise. Packages tend to be managed on a local geographical basis whereas most specialist teams tend to cover larger areas involving greater travel time and mileage and consequent higher unit costs. There has however been some interest in dementia services and the generic care worker pilot. 55% of the intensive home care (10 hours with 6 or more visits) is undertaken by the independent sector.

Localities report that the concern about shared packages amongst providers, which was highlighted in the Domiciliary Care Contracting Report, has been addressed and in May 2002 the total number of part packages was 26.

In the financial section (5.3) reference was made to the need to view unit costs with some caution. The span in the charges made to WSSCS for spot contracts varies from £9.25 to £13.90, with additional enhancements for weekends and bank holidays. Charges for part hours also vary quite considerably. For instance a 15 minute call could be quoted at a special rate or the equivalent at a 30 minute rate. The cost of four 15 minute calls can vary from £16.44 to £29.00. The hourly rate for block contacts remains the same and part hours are paid pro rata.

This would suggest that the most efficient way of delivering short calls should be investigated given the additional cost. Questions should include is this really necessary, should it be undertaken in-house, the independent sector or a mixture of both. Short calls are usually undertaken for the following reasons:

- Making beds
- Emptying commodes
- Prompting medication
- Check calls
- Making up flasks

One Locality reported that it had stopped accepting 15 minute calls, the implication being that 30 minute visits might be requested when 15 minutes would be sufficient. Conversely another Locality suggested that 15 minute calls were requested when in fact visits of a longer duration were required. Generally it was thought that 15 minute calls play an important role in keeping people in the community. The particular example of older people with dementia who may need several prompt medication and check calls was mentioned. Equally an older frail person may be able to manage their own personal care but would not, for example, be able to empty a commode.

Actual numbers of 15 minute calls by Locality varies considerably, in the sample the lowest number was 40 in Arun and 707 in Worthing. Given the high use and cost involved it would be sensible to look at this in further detail and agree the most cost effective way of providing what has been argued to be an important service. Oxfordshire have reduced the number of 15 minute calls by developing alternatives e.g. checks by telephone.

Number of 15 Minute Visits during One Week in May 2002

Locality	Number of 15 min. visits
Crawley	221
Worthing	707
Arun	40
Adur	437
Bognor	92
Mid Sussex	237
Horsham	627
Chichester	121
Total	2,482

Source: DCCMs 2002

A criticism in some of the home care consultation exercises, both in WSSCS and other LAs, has been unreliability and a failure to deliver a service. The SSI Inspection of Services for Older People referred to services, both in-house and independent sector, as not always being reliable.

General references in some of the consultation exercises to the independent sector suggested that they might be less reliable than the in-house service. At the start of the outsourcing in 1998 there was a belief that the independent sector were unreliable, and that they would need to refer back to the in-house service when unable to meet a commitment because of sickness or unavailability of staff. In the first six months of 2002, using their quarterly monitoring report the DCCMs found that there had been 'very few incidents'.

Similarly, following the Domiciliary Care Review 1998, managers in home care referred to the number of out of hours calls made by the independent sector or their service users. In a sample week in April 2002, nine calls were received from the independent sector. The majority of these were calls requesting advice, five were from the same agency, one was a complaint from a District Nurse and another from a service user who thought the care worker had taken her TV magazine! The calls represent 9% of the total calls. The DCCMs believe that the independent sector arranges its own emergency cover and if necessary will contact the DCCM should there be a need to subcontract which they suggest is rare.

All DCCMs undertake quarterly monitoring; independent sector providers have to meet the standards in the WSSCS contract for Domiciliary Care. The independent sector providers are monitored against the standards and quarterly monitoring reports which incorporate:

- Activity levels
- Reasons for sub contracting
- Number of failed visits and reasons
- Number of NVQ trained staff
- Quality assurance, complaints and customer satisfaction surveys.

The National Minimum Standards will mean that both in-house and independent sector home care services will be subject to the same standards and the same inspection process. There are likely to be cost implications for the independent sector which could mean that they will need to review and raise their charges.

Bill McClimont UKHCA Chairman (Standards your views are crucial: The Home Carer Jan 2002) suggests that the new measures will inevitably increase the costs for home care.

“I estimate by at least £1.25 per hour. I have heard a local authority commissioner suggest up to £3.25 per hour.”

The main costs relate to training of care workers, but other significant factors include supervision and quality assurance. McClimont suggests that the additional costs will be difficult to absorb because most home care purchased by the independent sector is at break even level or below.

The DCCMs reported that from their knowledge of the independent sector they believed that the providers appeared to be proactive in introducing, or working toward introducing the National Minimum Standards and they agreed that there likely to be additional costs. One independent sector provider reported that it was estimated that the increase could be 20% or 25%.

Particular concerns for the independent sector in managing a service included:

- Recruitment and retention
- Rural areas. (Health and safety issues, terrain and cost of provision)
- Lack of information technology in WSCC
- National Minimum Standards

The relationship between the DCCMs and the independent sector is described by the latter as good. The process used by DCCMs to communicate with the independent sector varies. Meetings are generally on a one to basis with the independent providers and are used to discuss service user issues, invoicing, contracts and quality standards.

Some Localities have joint meetings on a quarterly basis. In-house providers are not routinely involved in meetings. All DCCMs meet regularly with the Lead Managers. The positive experience of other LAs who hold regular joint meetings which gives the opportunity to work in a more co-operative way sharing information and experience should be emulated. It is recommended that countywide meetings are held with representatives from the in-house and the independent sector.

In contrast to the in-house service, with the exception of the smaller providers, the independent sector have the appropriate hard and software to assist with programming. Some providers are considering call-monitoring systems, but none has a system at present. Future plans for IT within the in-house home care service should include discussion with the independent sector. The SSI Inspection of Services for Older People recommended that WSSCS should work more closely with the independent sector to further develop a shared vision about service development across the county.

KEY FINDINGS

- ***A WSSCS study of in-house and independent sector services showed that 95% of service users would rate services as good or very good irrespective of who provided the care***
- ***Both the in-house and independent sector scored badly on not informing service users of change***
- ***A survey in another LA showed that 89% of in-house service users and 82% of independent sector service users rated the service as good or very good***
- ***The Domiciliary Care Contracting Scrutiny Sub Group made recommendations for the in-house service, care management and contracts department. Some have been acted upon others require further work***
- ***The target for outsourcing to be met by 2003 is 60%; currently the figure is 53% with variations between Localities. There needs to be growth in Localities where outsourcing has been slow.***
- ***Most of the specialist work is undertaken in-house with some interest being shown by some independent sector providers***
- ***15 minute calls by both the in-house and independent sector need further investigation to ensure that these are being delivered in the most cost effective way***
- ***The National Minimum Standards will have cost implications for the independent sector, which may result in higher charges to the LA***
- ***The National Minimum Standards will have some implications for the in-house service particularly in meeting the training requirement.***
- ***Current concerns for both the in-house and the independent sector include recruitment and retention and providing services to rural areas.***
- ***To improve partnership and cooperation meeting forums should include both in-house and independent sector providers on a regular basis.***

- *The in-house sector does not have an adequate IT system. Most independent providers have systems and should be included in discussions about future in-house systems.*
- *The in-house home care service and the independent sector should be represented in regular joint forums.*

Please refer to the first section of this report for the Executive Summary, Conclusions and Recommendations.

END

GLOSSARY

APPENDICES

Appendix 1: Membership of Working Group

Appendix 2: Management Structure

Appendix 3: PEST

Appendix 4: SWOT

**Appendix 5: Matching Stakeholders Views with the National
Minimum Standards**

Appendix 6: Summary of Key Points and Issues Raised

Appendix 7: Evidence File

APPENDIX 1

BVR (HOME CARE) WORKING GROUP MEMBERS

NAME	ORGANISATION/ROLE
Mary Sinclair	Strategic Commissioning Manager/ Working Group Leader WSSCS
Alison Boyd	Project Manager (Scrutiny Group) WSCC
Mandy Farnham	Performance Manager WSSCS
Rebecca Eborn	Project support WSSCS
Jenny Daniels	Locality Provider Manager WSSCS
Helen Ellis	Senior Home Care Assistant WSSCS
Martin Sherred	Operations Manager (Adults) WSSCS
Rob Allen	Management Audit WSCC
Nicola Mardell	Home Help UK
Lesley Strong	Mid Sussex PCT
Chris Scanes	Area Manager WSSCS
Sarah McGreal	Unison
Yvette Butterworth	PSU
Kevin Armstrong	Financial Services WSCC
Elaine Spurdle	Contracts WSSCS
Susan Thompson	Information Section

APPENDIX 2

August 2002

MANAGEMENT STRUCTURE

Jan 1999 – June 2002

June 2002

Head of
Adult Provider
Services

Head of
Commissioning

Locality Manager

Locality Provider
Manager

Operations
Manager

Lead Manager
(Home Care)

Home Care Manager

Domiciliary Care
Commissioning
Manager

Senior
Home Care
Assistant

Domiciliary Care
Commissioning
Assistant

Home Care Assistant

Head of Adult Services

Area Manager

Service Manager

Lead Manager
(Home Care)

Home Care
Manager

Domiciliary
Care
Commissioning
Manager

Senior
Home
Care
Assistant

Domiciliary
Care
Commissioning
Assistant

Home Care Assistant

----- Denotes supervisory role

APPENDIX 3
PEST ANALYSIS
IN-HOUSE HOME CARE SERVICE

POLITICAL	ECONOMIC
NHS and Community Care Act 1990 Mixed economy Best Value Review 2002 Joint Review 1998 WSSC 5 year Plan 1998 Modernising Social Services NHS Plan Health Act 1999 National Service Framework 2001 Care Standards Act 2000 Government grants Performance framework Domiciliary Care Contracting Scrutiny Group 2001 Human Rights County Council Plans	Minimum wage Single status/reduced working week Job evaluation Best value Competition Organisational restructuring Domiciliary Care Review 1998 Unit cost Market share Ageing population TOPSS agenda Inspections Other County Council Departments Care Standards Act 2000 Specialist services Government grants
SOCIAL	TECHNOLOGICAL
Increasing numbers of older people Higher dependence Demography Higher expectations Best value Core competencies High employment Greater choice of employment Older workforce Large rural areas	Absence of software system Insufficient hardware Few communication aids Inadequate management information Training needs

APPENDIX 4

SWOT ANALYSIS OF IN-HOUSE HOME CARE SERVICE AS AT APRIL 2002.

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
• Positive view of service users of the in-house service. • Tradition that public services are safe - public service ethos. • In-house service can direct according to the changing requirements of the organisation. • Not for profit organisation. • Staff commitment-retention, responsiveness, generally low staff turnover. • Good strategy for recruitment, induction, training and supervision. • Clear career progression. • Large public service employer which contributes to the local economy.	• Lack of robust contracts and improvements for business planning subject to cuts in response to budget crisis. • Inconsistency in business processes between localities. • Part of a large bureaucratic organisation. • The resolution of certain personnel issues e.g. long term sickness, can be time consuming • Complicated pay structures and processes e.g. enhancements. • Apparent high price/ cost of service. • Short termism- lack of consistent long-term strategy.	• New ways of working e.g. partnerships, pooled budgets • Best Vale Review. • Government grant, Cash for Change • Huge growth market potential, government pressure to develop more non-residential care services. • Development of intermediate care. • Public/private partnership. • New opportunities for areas of work e.g. generic care. • Achieved a fully qualified, trained work force. • Single assessment. • Inspection of services. • Change of image.	• New ways of working e.g. Partnerships, pooled budgets. • Care Standards Act. • Demand outstripping supply. • Poor perception of the home care role. • Management by a different organisation. E.g. Health • Recruitment difficulties. • Lack of strategic planning leaving services vulnerable. • Pace of change. • Best Value Review. • Instability of service.

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
• Service has a role as a safeguard against independent cartels. • Focus on enabling people, promoting independence e.g. hospital discharge, rehabilitation and intermediate care schemes. • Holistic view of care i.e. awareness of other services we provide e.g. day care. • Integrated into department e.g. Care management • Experience of change • Experience of audits and reviews. • Several years experience of delivering home care. • Guaranteed working hours.	• Lack of connection between PAF actions and service delivery. • Failure to follow through remedial action, e.g. review recommendations. • Lack of IT systems - low tech and over reliance on manual records. • Inadequate management information and support systems. • Lack of clarity over reliability of unit costs. • Average age of staff is high-50 years. • Difficulty in recruiting young people to the service. • Lack of uniformity in application of policies and procedures. • Guaranteed working hours rigidity.		

APPENDIX 5

Matching Stakeholder Views with the National Care Standards

STAKEHOLDER VIEW	NATIONAL CARE STANDARD
Trained staff	Standard 19/20
Skilled staff	Standard 3
Changes communicated	Standard 6
Quality of service	Standard 27
Quality monitoring	Standard 27
Stay full time as per care plan	Standard 6
Reliability	Standard 6
Continuity and consistency	Standard 6
Respect and dignity	Standard 8
Information	Standard 1
Clarity about who to contact	Standard 4
Flexibility	Standard 6
Complaints information	Standard 26
Promoting independence	Standard 9
Adequate care plans	Standard 7
Confidentiality	Standard 5
Culturally sensitive services	Standard 3/8

APPENDIX 6

A Summary of Key Points and Issues Raised.

1. The Best Value Review (BVR) of home care is part of a wider BVR which examines services for older people in West Sussex. The prime purpose of the BVR was to make a real and positive difference to the home care services that people receive from West Sussex Social and Caring Service. (WSSCS)

2. The review gathered information for the review under the headings of **consult, compare, challenge** and **compete**.

2.1 Consult

2.1.1 Best value guidance suggests that reviews are most effective when they are wide ranging and service user focussed. The BVR designed a consultation process that included a cross section of stakeholders. Exercises undertaken prior to the review and information from sources such as other LAs was included.

2.1.2 Regular meetings were held with managers within the home care service. In turn they were expected to ensure that home care teams were kept informed. Staff suggested that critical success factors to ensure improvement included the development of specialist teams, generic working and provider of the last resort.

2.1.3 Issues which concerned service users and carers included missed visits, changes of staff and lack of communication. Surveys indicated a sense of greater confidence in the in-house service as opposed to 'agencies' on the one hand, and a feeling of not knowing who staff are employed by on the other hand.

2.1.4 Consultation with ethnic groups highlighted the need for services to be accessible, reliable, communicated in their language and culturally sensitive.

2.1.5 People in rural areas have the same varied and wide ranging needs as others. Providing care in the country can pose problems associated with equity, access and isolation. The in-house and independent sector need to work collaboratively at a local level.

2.1.6 Care management staff considered the strengths of the in-house service to be close liaison, flexibility in service provision, specialist services and commitment to service users. Weaknesses included not having fully read care plans, limited availability, and lack of flexibility to respond to service user need.

2.1.7 Health staff were confident in communication with and feedback from in-house home care staff but were frustrated with the time it can take for the help desk to arrange home care.

2.2 Compare

2.2.1 In order to compare the in-house home care service a benchmarking exercise was undertaken with other LAs. Generally LAs favoured a mixed economy of home care with the independent sector having the higher proportion. Most LAs were outsourcing 'mainstream work' and in-house services were undertaking short term work and specialisms.

2.2.2 Examples of good practice in other LAs included the positive relationship between the in-house and the independent sector. The approach being one of co-operation as opposed to competition.

2.3 Challenge

2.3.1 The work of the BVR group was challenged throughout by a number of different groups with a cross section of stakeholders. The Challenge Panel challenged the fact that the BVR focussed on the in-house home care service only. The original scoping exercise was revised to include the independent sector.

2.3.2 The SSI Inspection of Services for Older People had referred to the fact that some domiciliary care, both in-house and in the independent sector, was not reliable.

2.3.3 Alternative ways of providing a home care service were considered during the course of the review. Possibilities included total in-house service, total outsourcing, a Modernising Partnership Approach, a Business Unit and a Care Trust.

2.3.4 The BVR group considered that both bringing home care services back in-house or totally outsourcing services were not viable options

2.3.5 The BVR group were unable to find sufficient information of a model of a Care Trust that included home care and of a business unit. It was considered that this is worthy of further investigation, together with care co-operatives, as possible future options.

2.3.6 The preferred model is the Modernising Partnership Approach, which gives an immediate opportunity to build on strengths and work toward overcoming the weaknesses and threats. This approach is comparable to other LAs in the BVR study. The BVR group considered this currently to be the most likely model to deliver Best Value.

2.4 Compete

2.4.1 The BVR group recognised the importance of embracing fair competition as a means of securing efficient and effective services.

2.4.2 The Domiciliary Care Contracting Report 2001 examined the development of outsourcing. Recommendations of the Review included discontinuing care packages split between agencies or agencies and in-house providers and ensuring changes are communicated with service users.

2.4.3 Since 1998 outsourcing has increased from 25% to 53%. The target for 2003 is 60%. There is a variation in outsourcing between local areas ranging from 31% to 68%.

2.4.4 Generally it will make sense to outsource mainstream work, however, some independent sector providers have shown an interest in specialisms and generic care. Areas need to work in partnership with the independent sector to agree how to work co-operatively at a local level.

2.4.5 The National Care Standards will mean that both in-house home care service and the independent sector will be subject to the same inspection process. The National Care Standards will have cost implications for the independent sector which may mean that it will be necessary to review charges.

2.4.6 Meetings between Domiciliary Care Commissioning Managers and the independent sector are generally on a one to one basis. Good practice from other LAs would suggest that there is value in including both in-house and the independent sector in regular meetings. Local forums are recommended.

3. A true 'like for like' unit cost comparison with the independent sector and other Local Authorities (LAs) is difficult to achieve. However, WSSCS has developed a robust and transparent unit cost which allows for a comparison to be made of cost and activity between teams and different local areas.

4. The unit cost for the in-house service is higher than the independent sector. This needs to be addressed by revising the management structure, reducing sickness absence and increasing efficiency through the introduction of a domiciliary care scheduling system.

5. The role of Domiciliary Care Commissioning Manager was introduced following the Domiciliary Care Review. Given the recent changes and the growth of outsourcing to the independent sector, the role needs to be reviewed.

6. Workforce planning given the high number of home care staff over 50, some of whom are near retirement, recruitment problems and the need to plan for further outsourcing will be important. There are few staff from ethnic minority groups employed within home care. The recruitment policy, particularly at advertisement stage, needs to reflect that the department is culturally sensitive.

7. The National Care Standards Commission require 50% of home care staff to be qualified to NVQ Level 2 by 2007. A training programme which addresses the need for sufficient assessors and verifiers needs to be in place by 2003.

8. Areas developed Service Level Agreements in 2001/2002. The independent sector work within service specifications. The in-house service should develop similar agreements with Areas.

9. Social Services departments are measured annually against a set of key statistical indicators which form the performance assessment framework. The BVR examined four of the indicators that are particularly relevant to older people receiving home care services: B11, C28, C32 and B17.

10. Figures for Intensive care as a proportion of intensive home and residential care had dropped following budget confines. However, the figure has and is continuing to improve. Achieving the targets will require more intensive packages of home care.

11. The quality of the home care service is of paramount importance. Service users and carers are particularly concerned about reliability, timekeeping, continuity of carer and consistency. The National Care Standards are to be implemented in January 2003. The in-house home care service needs to ensure that the service is ready and a plan in place, with targets, to meet any gaps.

12. The joint social care and health agenda requires both organisations to work with a wide range of partners to ensure that service users and carers receive seamless services.

13. Home care is a crucial part of the modern partnership approach. The generic care worker service offers an opportunity to work across organisational boundaries. The tasks performed by the generic care worker should be incorporated into the home care assistant role (HCA) and reflected in the training programme.

14. The Improvement Performance Plan sets out the actions that are required to make a real and positive difference to the services people receive from the WSSCS in-house home care service. The actions contained in the Improvement Performance Plan will need to be properly managed and monitored to ensure continuous improvement.

APPENDIX 7

EVIDENCE FILE

- Domiciliary Care Contracting Report (Scrutiny Sub Group) 2001
- Domiciliary Care Review 1998
- SSI inspection of Services for Older People May 2001
- National Care Standards; Domiciliary Care
- The Elusive Costs of Home Care. Starfish London ADSS Benchmarking Club Report 2002
- BVR Scoping Document 2002
- Financial Report: 2002 K. Armstrong
- Data Collection Exercise April 2002 M.Farnham
- Shaping the Future: May 2001 J.Daniels/ MN Sinclair
- Systems Audit of Home Care October 2001
- Workforce Planning in Home Care 2000. S.Burns. A.Lane. M N.Sinclair
- Meeting the Standards for Voluntary Registration. 2001 J.Lawrence
- Complaints information 2001/2002 S.Glover
- Information on Charging 2002 C.Campbell/ N Stringer
- Sustainability check list 2002 R.Eborn. A .Boyd
- Consultation Plan 2002. A Boyd
- Copies/summaries of consultation exercises 1999/2002
- Notes of meetings, focus groups, working and core group, project and project steering group, Challenge Panel, Lead Managers (home care)and Away Days.2002
- Best Value :Frequently Asked Questions: home care staff 2002
- Survey of in-house and independent sector home care.1999 A Godley
- Service Plan OPMH 2001/2002 MN Sinclair

- Home care BVR Questionnaire for Benchmarking.2002 M Farnham
- Benchmarking Matrix 2002 M Farnham/ MN Sinclair
- Work plan, Independent sector 2002 MN Sinclair
- Independent Sector Analysis. May 2002 A.Godley
- Home Care Service 1999-2003 M.Bamford
- Strategy for the Development of services for Older People 1999 M E Griffiths
- Best Value review summaries: other LAs
- Briefing paper on Best Value
- Statistical information: financial, personnel and training
- A New Approach to Workforce Training and Development in the Independent Sector within West Sussex 2002
- Articles
- Glossary of terms. R Eborn