A Strategy for Commissioned Domiciliary Care in Monmouthshire.

2024 - 2034

May 2024

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INTRODUCTION

This document provides an assessment of the current arrangements within Monmouthshire for commissioned long term domiciliary care and sets out Monmouthshire County Council's strategy for the next 10 years.

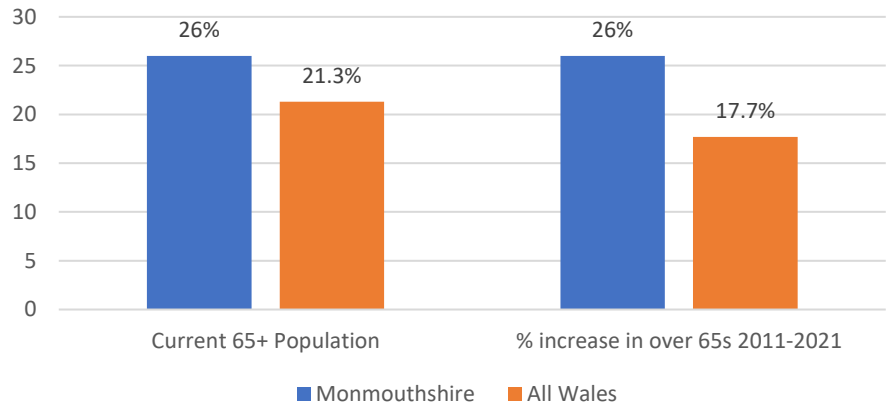
1. BACKGROUND

1.1 Demographics

Monmouthshire is a primarily rural community with an approximate population of 93,000 people, ONS Census Data shows a 1.8% population increase between 2011 and 2021, this is slightly higher than the overall increase for Wales.

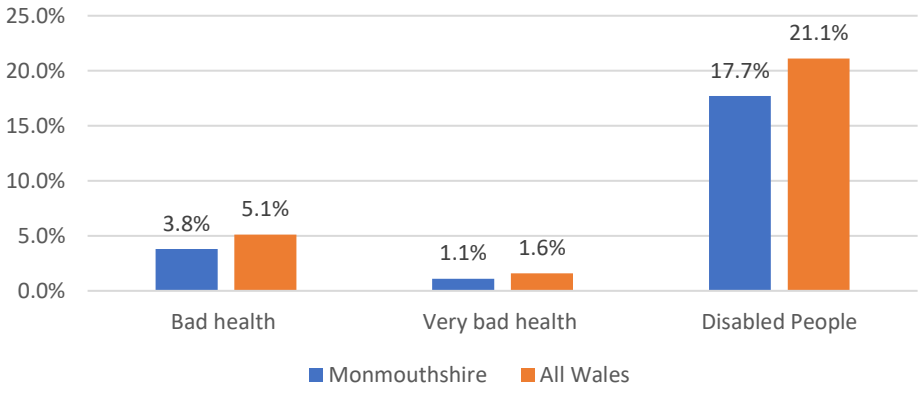
The ONS 2021 Census survey illustrate rises in the older population in Monmouthshire, with further increases predicted up to 2035. Please see table 1 below.

Table 1: Over 65s Population Monmouthshire and All Wales



ONS Census Data 2021 provides information about the number of people living in Monmouthshire who identify as having bad or very bad health, and/or a disability. Table 2 shows the Monmouthshire and all Wales position.

Table 2: People Identifying as having bad health or disabled Census Data 2022



Monmouthshire has the lowest percentage of disabled people in Wales (ONS Data 2021) and the Gwent Population Needs Assessment (2022-23) shows it has the lowest rate of life limiting long-term illness per 100,000 in the Gwent region.

The increasing ageing population in Wales, and society presents a set of unique challenges, including how this population should be supported to live fulfilled lives and in the context of this strategy particularly how individuals should be supported once they reach the point of needing care.

Monmouthshire is an affluent area, it has no 'small areas' in the most deprived 10% in the Welsh Index of Multiple Deprivation (WIMD) 2019. This contrasts with Newport which has the highest proportion of 'small areas' in the most deprived 10% in Wales.

It is possible to assume that because Monmouthshire is not considered a deprived area, that there are no areas of deprivation. This however is not the case, Cantref 2 (a smaller area in Abergavenny) is in the 10-20% most deprived overall (WIMD, 2019), and both Llanover 2 and Thornwell 1 are in the 20-30% most deprived areas of Wales. The Monmouthshire Tackling Poverty Action Plan (2021) states that the relative affluence of the county can often mask the day-to-day experience of its residents who may be experiencing poverty that may not be immediately visible. Data within the plan also shows that access to services and hardship grants peaked following Covid.

1.2 Current Service Provision

Monmouthshire County Council commissions long term domiciliary care from independent sector providers supplemented through in-house reablement and domiciliary care services. Analysis of current service provision, including spend data, has been undertaken by using data contained within existing management information systems. The data within the system relates to planned hours of care and not actual hours delivered. Where spend data is shown this has been derived from planned hours of care within Flo and has not been validated against the Council's spend. All data is based on an hour of care and does not take in to account the varying costs of part hour care calls.

Monmouthshire County Council currently provides approximately 8000 hours per week of long-term domiciliary care this includes independently commissioned and directly delivered care.

Directly Delivered Care

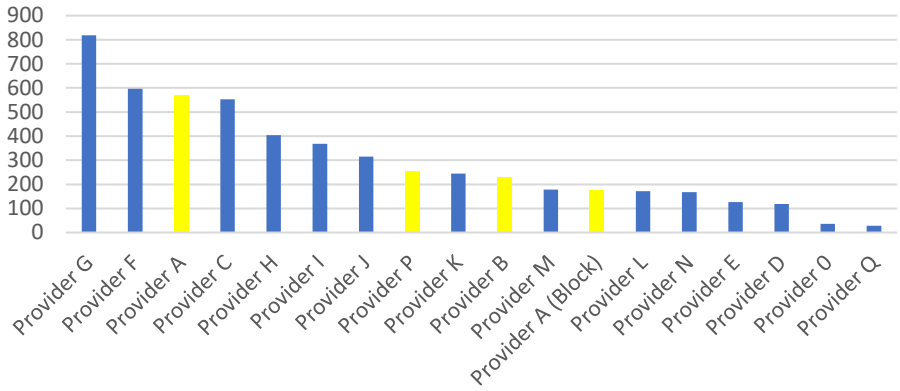
The in-house domiciliary care service's focus is on the provision of reablement and specialist support such as dementia. In recent years the service's ability to deliver reablement has been adversely impacted by the need for it to deliver long term care in parts of the county where it has proved difficult to secure independently commissioned domiciliary care. Approximately 24% are provided by in house reablement and domiciliary care services. In house domiciliary care services are organised on a locality bases, with a team in each of the three localities which is sub divided into patch based teams. Although overall 24% is provided by the in house service the position varies between each of the localities in the North and South area

it provides between 22% and 24%. In contrast, in the Central area it provides 67% of all domiciliary care.

Independently Commissioned Care

There are 17 core independent sector domiciliary care providers with whom Monmouthshire County Council commissions. Generally, the sector has remained relatively stable over the last 2-3 years with only 1 provider withdrawing from the county. There have been a few new entrants to the market. The Council has matured, good working relationships with all of its providers. Table 3 shows all providers and weekly hours.

Table 3: Providers and weekly hours delivered (July 2023)



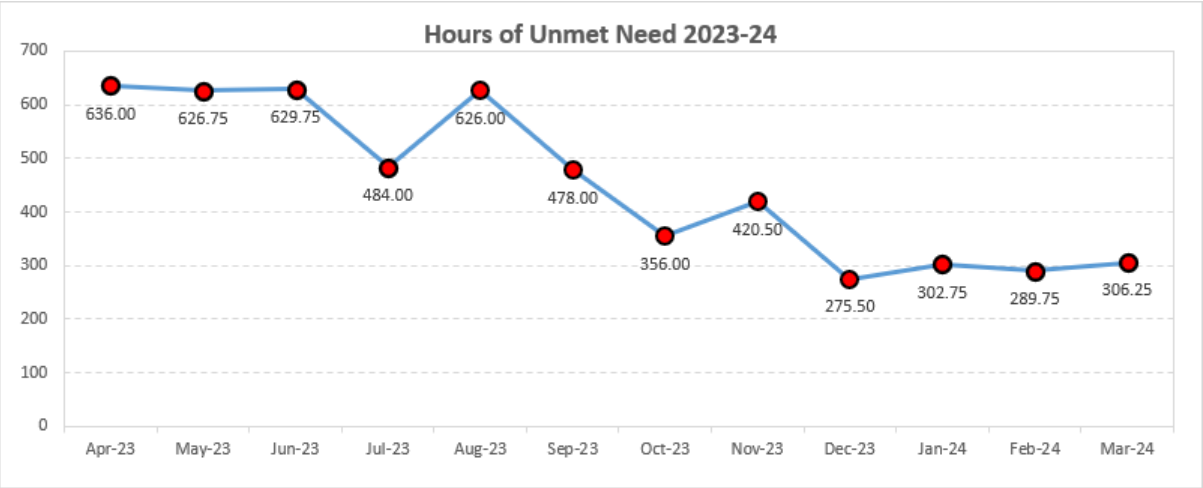
*The chart above has framework providers plotted in yellow

The Gwent Market Stability Report 2022 showed that there was insufficient capacity in the sector across the region to meet demand. The report also stated staff are leaving the sector at an unprecedented rate due to issues around terms and conditions, cost of Social Care Wales registration, driving and other factors. This has led to the hand back of packages across the region, particularly complex packages where providers have been unable to find the staff to cover. Local data shows package hand backs in Monmouthshire have been limited to date.

The Gwent Market Stability report 2022, showed Monmouthshire as having the highest level of unmet need across the Gwent authorities. Our data shows that it is more difficult to find care in the South and Central areas, particularly in Chepstow, Monmouth, and some of the more rural areas. Providers have reported the longstanding challenges they face in recruiting in these areas. Other contributing factors could include the relative affluence of these areas, and the rural nature of their surrounds. This is in contrast to the North of the county where population is more mixed, and people travel from Torfaen and Caerphilly for work.

Following a peak in unmet need during 2022 capacity within the market has improved. Table 4 shows the number of hours of domiciliary waiting to be brokered county wide between April 2023 and March 2024

Table 4



76% of all domiciliary care in Monmouthshire is purchased from the independent sector. 24% is purchased from a small framework of three providers and the remaining 76% from approved providers.

Providers who form part of the framework are our providers of first choice. Approved providers have different contractual terms and rates are generally higher. We do not guarantee any of our providers work, except for the Usk block. See table 5.

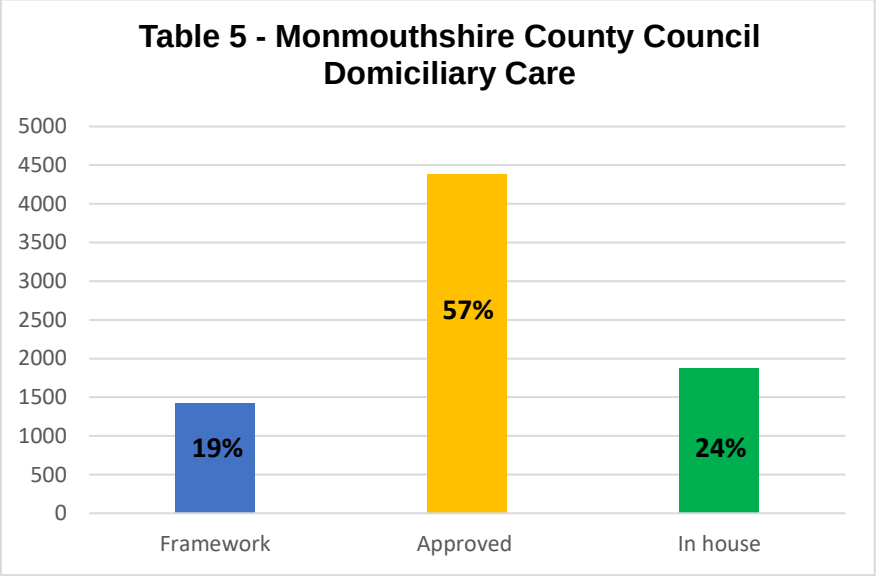


Table 5 demonstrates an overreliance on approved providers which varies in degree across the county. Table 6 shows hours provided in each area of the county.

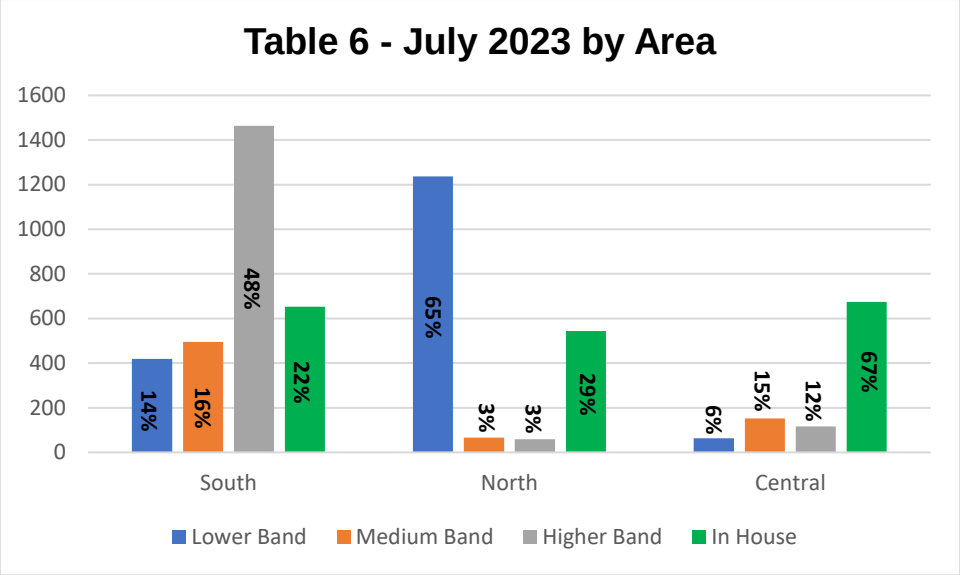
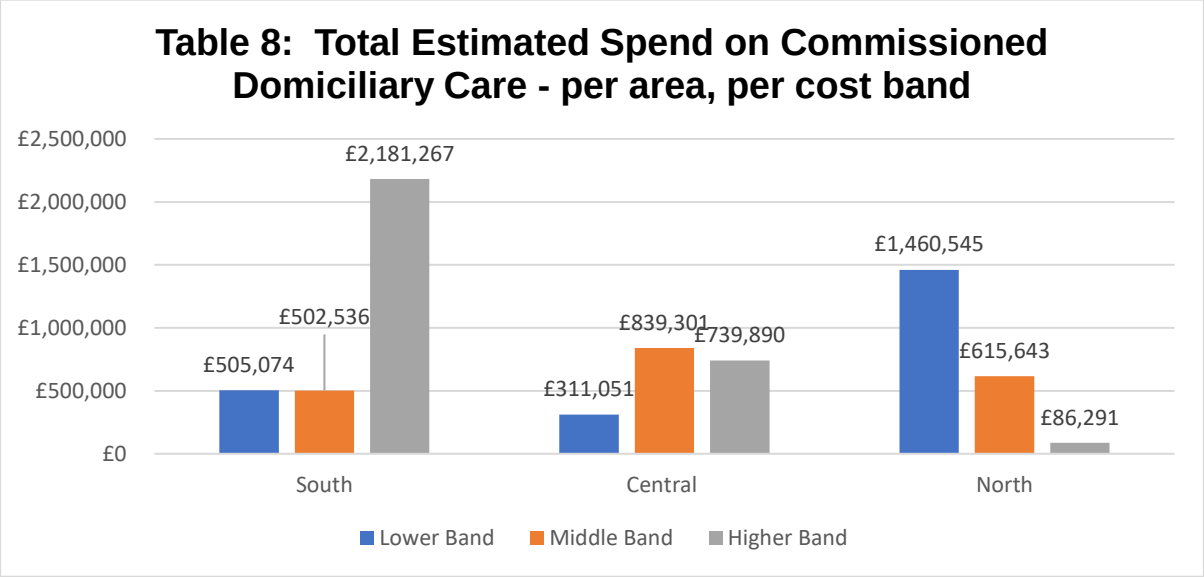


Table 7 – Average Weekly Number of Hours per person

	Purchased Externally	Provided by In House	Purchased and in house
South	15.1	9	13.2
North	14.8	11.8	13.9
Central	10.5	8.3	9.6

The average weekly hours per person is similar in the South and North whilst the Central area provides lower average hours per person and can be attributed in part to lower levels of market sufficiency and high service demand.



The estimated spend is based on planned hours of support at the hourly rate at a point in time in July 2023, and is for illustrative purposes. Actual spend would include the actual units of hours and part hours provided.

The current brokerage system entails individual packages of care brokered out by an administrative brokerage officer, first to framework and subsequently to approved where capacity doesn't exist within the framework. Offers of capacity are then sent to social workers who make the final decision and confirm with the successful provider.

Over the last few years, as the council explored and implemented Place Based and localised systems to make best use of capacity, care management teams have often made direct contact with providers themselves to secure care. Whilst this approach has many benefits, it has also led to less oversight as to how care packages are brokered, cost of packages and a two-tier system of brokerage which can lead to some providers not receiving equitable access to care packages.

Direct Payments and Micro Carers

As well as receiving domiciliary care from commissioned and in house providers, people in Monmouthshire are able to have their care at home needs met through other options which include micro carers and direct payments.

Micro Care

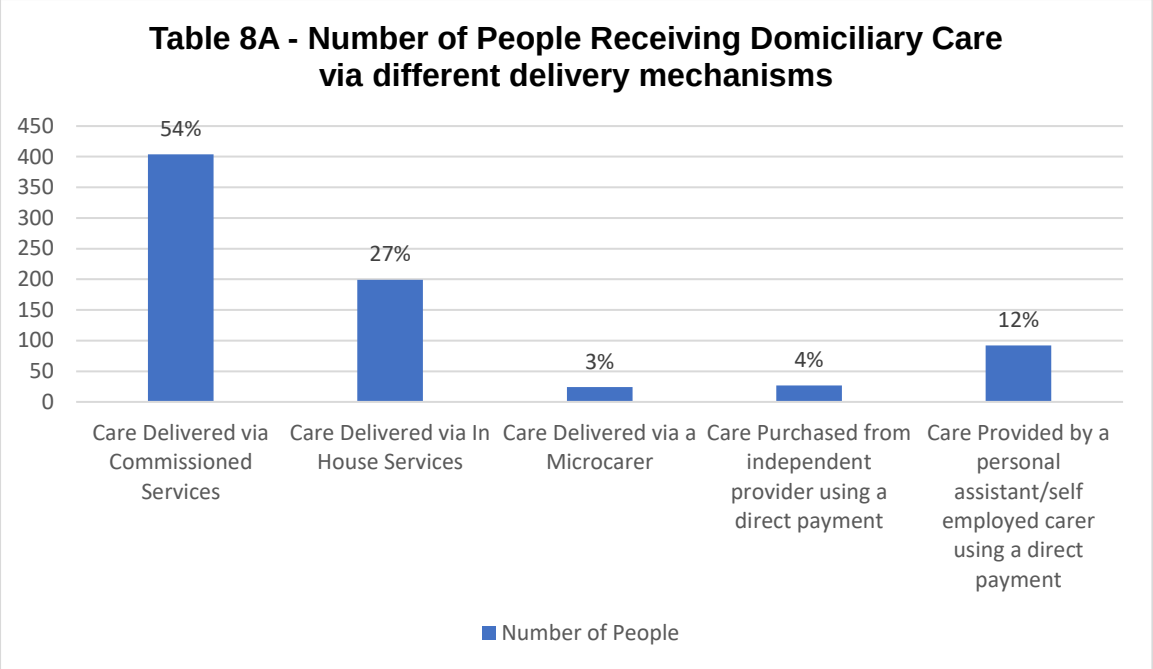
In 2022/23 the Council developed and implemented a micro care platform. The number of micro carers operating in Monmouthshire has steadily gained momentum providing alternative employment options in care and supporting choice and capacity within the provision of care.

Micro carers are self-employed individuals who offer personalised support and care to citizens who live in their local area. This means that the support services they offer can be delivered at times and in ways that suits the needs of the individual, offering greater continuity of care and flexibility. Micro carers aim to offer a tailored service that is responsive and imaginative in its delivery.

Recruiting home care workers in rural areas has historically proven a challenge. The development of the micro care directory looks to address this issue by offering an additional, viable solution to the availability of care services across Monmouthshire, providing greater choice to its residents.

Direct Payments

The Direct Payment Scheme is designed to give people more independence, choice, and control and to help them manage their lives in their own homes. The scheme can provide assistance with personal care, everyday living tasks, support in people's caring roles, with purchasing equipment or any other type of support that enables people to live independently. People are provided with a budget through a Direct Payment which they can use to purchase the types of support they need privately this may include employing a personal assistant or contracting with an independent domiciliary care agency directly.



1.3 Commissioning of Domiciliary Care in Wales

During July/August 2022 a short piece of research was carried out by Monmouthshire County Council across the other 21 local authorities in Wales to understand what and how they commissioned their domiciliary care services, and to help shape our strategy going forward. Some high-level findings are shared in tables 9 and 10:

Table 9: Current Model of Care

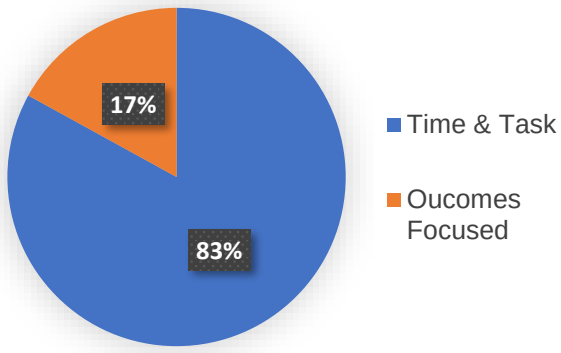
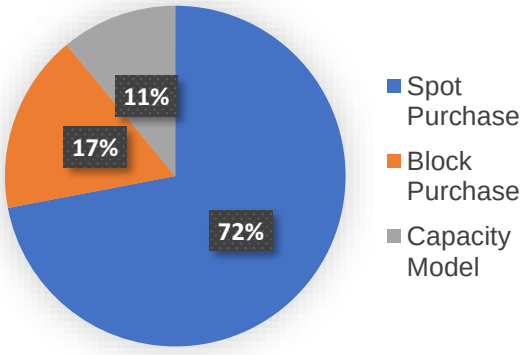


Table 10: Purchasing Method & Payment



Whilst 83% of respondents (15/18) still commission a time and task model of care, there was some innovation within this group. There were a smaller number of areas including two in Gwent who felt that the current time and task, traditional method of commissioning was working for them and so didn't feel the need for any innovation.

Half of the authorities spoken to referred to some sort of innovation, the scale of innovation varied quite significantly from area to area with most at the stage of small-scale pilots to test out innovative ways of working. The key themes in terms of innovation were:

- Patch-based working; from very micro patches to larger scale areas.
- Use of block contracts to improve working conditions and guarantee hours in areas where capacity is an issue.
- Mandating minimum employment terms within contracts, including paying RLW or higher, 45p per mile, fixed hours, and flat rates of pay for all hours worked including travel time.
- Restructuring of packages to make best use of the in-house workforce in areas with limited capacity, rural areas and for complex packages.
- Increased rates, which varied across areas.
- Outcomes based commissioning is a small but growing area.

Monmouthshire has been similarly innovative, we have made use of a block contract in specific areas where capacity has been a particular issue and was one of the first Councils to trial place based, patch-based care which has led to the identification of some of the key operating principles conducive to more sustainable domiciliary care.

Whilst there is a variety of innovation occurring across Wales, most areas are still operating a time and task model of care. Most require hours delivered to be monitored by an Electronic Care Monitoring System so that commissioner can maintain some oversight of hours delivered and reconcile to payments. Almost all areas, regardless of levels of innovation reported issues with recruitment, retention, and capacity; although newer and more innovative models of provision were in their early stages and as such impact was hard to measure at this stage. The challenges Monmouthshire faces are not unique and are being experienced across Wales.

1.4 Local Strategic and Policy Context

This assessment of the existing arrangements for domiciliary care and future delivery strategy have been developed and informed by key local strategic priorities and policy objectives. These include:

Monmouthshire County Council's Community and Corporate Plan 2022-2028

The plan sets out the ambition for the council and county of Monmouthshire. The purpose is clear. Monmouthshire will be: "a zero carbon county, supporting well-being, health and dignity for everyone at every stage of life".

The plan articulates the challenges and opportunities facing the Council and county and sets out how these will be addressed. It has clear high-level objectives that are measurable, Monmouthshire will be:

- A Fair place to live where the effects of inequality and poverty have been reduced;
- A Green place to live and work, with reduced carbon emissions, and making a positive contribution to addressing the climate and nature emergency;
- A Thriving and ambitious place, where there are vibrant town centres, where businesses can grow and develop;
- A Safe place to live where people have a home and community where they feel secure;
- A Connected place where people feel part of a community and are valued;
- A Learning place where everybody has the opportunity to reach their potential.

The objective of A Connected place where people feel part of a community and valued relates to health and wellbeing including access to social care, and seeks three specific achievements:

- High quality social care which enables people to live their lives on their terms,
- A healthy and active Monmouthshire where loneliness and isolation are reduced, well-being is promoted, and people are safeguarded,
- A professional and passionate social care workforce.

Monmouthshire County Council's Socially Responsible Procurement Strategy 2023-28

Our financial position is challenging and must use every penny we have wisely. However, procurement also plays a vital role in achieving societal benefits through enabling the delivery of progressive policies like decarbonisation, achieving social value, securing fair work and delivering community benefits that can play a significant role in bringing about a more fairer society.

Our Socially Responsible Procurement Strategy 2023-28 will enable us to buy goods, services and works that are sustainable, ethically produced, local wherever possible, and in line with our priorities and commitment to be an equitable organisation.

This approach to procurement will achieve financial value but equally, if not more importantly. It will also achieve equitable community benefits and social value for current and future generations. This approach will underpin our future procurement activity for domiciliary care.

Social Care and Health Directorate strategies

The Social Care and Health Director's report 2022/23 provides an overview of progress against the social care priorities. The value-base of the Social Care and Health Directorate aligns to Social Services and Well-being (Wales) Act 2014 where putting individual people at the centre of what we do and practising with care and compassion is what really counts. Supporting citizens to live their own best lives has been the mantra for Monmouthshire Social Care and Health over many years and is still at the heart of what we do.

Adult Social Care and Health services in Monmouthshire support people to live their own lives as independently as possible. Key to this is the ability to understand what matters to people and to identify the right support required to find solutions to the issues they face. The services are wide ranging and varied but share a common

purpose to 'support people to live their own best lives' as defined by what matters to them as individuals. This is a holistic, value based approach aligned with the principles of the SSWBA.

A priority action for 2023 is to further develop strategic and locality-based commissioning and seek to expand choice for how individuals receive the care they need, the production of this Strategy for Commissioned Domiciliary Care is a key foundation stone of this.

Welsh Government Health and Social Care Climate Emergency National Programme

The Welsh Government established the health and social care climate emergency national programme in Autumn 2021. The aim of the programme is to provide strategic oversight for the health and social care response to the climate emergency. Within the programme there are 5 national project boards one of which is social care. The programme has funding for over 3 years to support projects across the sector that contribute to reducing emissions and help the sector adapt to the impacts of climate change.

The Social Care in Wales – Decarbonisation Route Map towards Net Zero by 2023 sets out how this will be achieved, there are a number of key steps which will need to be considered in the commissioning and delivery of domiciliary care into the future, which will include promoting active travel, education and carbon literacy programmes and the way in which we procure care to appraise providers' sustainability credentials.

2. ASSESSMENT OF EXISTING ARRANGEMENTS

2.1 General Features

The framework contract was introduced in April 2011 with the intention of securing sufficient capacity and maximising cost effectiveness. The 23/24 framework rate is more cost effective. Only 24% of our overall commissioned care is purchased via the framework, this low take up has remained relatively static for the last 5-6 years.

76% of all commissioned support is purchased from approved providers whose rates vary considerably from low to high. The reliance on approved providers varies across each of the 3 localities and therefore the impact of these rates is different in each area.

Both the framework and the approved provider contracts offer us no guarantee of hours, and equally we provide no guarantee of hours in return. Whilst the absence of a guarantee of hours minimises the risk to the Council in terms of paying for care which is not needed, demand is outstripping capacity and has done for many years. The Council also has no contractual assurance that the hours that are needed will be delivered and are dependent upon providers choosing to pick up new packages of support. The only exception is the Usk Project where a capacity model is in place with a framework provider guaranteeing us 250 care hours.

Brokerage

The current system works on the brokering of individual packages, for example one 30min morning call 7 days a week. This means that providers are usually looking for space within their current provision to accommodate hours. It can prove challenging for existing providers as the low volume of hours being offered make it very difficult for them to grow capacity. Equally for new providers entering the area, it can prove challenging to pick up sufficient volume needed to be viable. The overall outcome is the Council is ultimately totally reliant on the hourly rate of whichever provider offers to provide support.

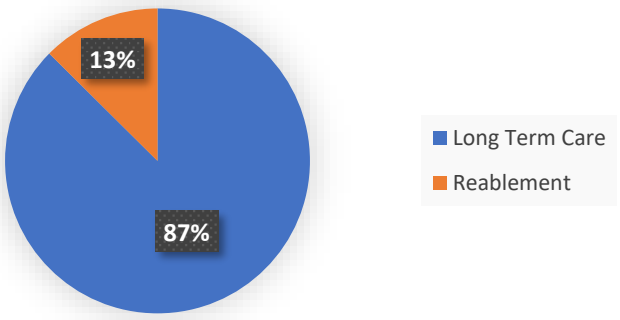
Whilst some work has been done in some areas to look at coordinating the brokering of individual packages to create volume rather that the traditional piecemeal offering; this isn't consistent across the county.

Current brokerage arrangements provide a fragmented structure, where care is offered and accepted on a largely individual and siloed basis. This means that providers aren't always able to respond to the bigger picture, for example if they knew there were 70 hours in a specific area, they may be able to recruit to meet this need. The current brokerage system has limited financial controls built in; teams are able to individually broker packages at any of the available rates. There is no requirement to procure lowest cost, outside of the framework being offered work first. Anecdotally the care management teams are often balancing the need to have care provided quickly and may therefore approach providers with whom they have a good working relationship with first. This doesn't always secure the most cost-effective option.

In House

The in-house Care at Home service was transformed some years ago to focus on the provision of short term reablement support and specialist support such as dementia. However, over recent years the ability of the reablement team has been reduced due to the need to subsidise a lack of capacity within the long-term domiciliary care market. The current split between long term care and reablement can be seen in table 11.

Table 11: In House Domiciliary Care Jan 24



The intention is to refocus the in-house provision, so it returns to its original purpose of being a small specialist in house service that is dedicated to reablement and specialism.

The split is approximately 75% purchased domiciliary care and 25% directly provided. While this split is seen in the North and South, in the Central area there has been a long-term dependency on the in-house service to meet the demands of long-term care which has been difficult to commission; approximately 67% of all care is provided by the in-house service in this area. The need to provide this longer-term care and support negatively impacts upon the reablement capacity of the in-house service.

Summary of Key General Features and Observations

- 26% increase in Monmouthshire's over 65 population between 2011 and 2021, the largest in Wales, with a further predicted increase up to 2035.
- Current supply is insufficient to meet need - unmet need and significant risk of being unable to meet growing demand up to 2035.
- Current spot purchase arrangements are commercially risky for new entrants to the market.
- Under supply of external provision within the County means that in house provision is diverted from the reablement and specialist support model.
- A future tender process may encourage new entrants to the market.
- The framework contract is no longer fit for purpose with only 24% of care provided through it and generally an overreliance via approved providers.
- Longer term contracts (10 years) would offer greater stability and encourage real partnership in the delivery of outcomes-based delivery.
- Opportunity to flex capacity within the contractual term.
- Opportunity for providers to bid for block and spot contracts.
- The position varies considerably across all 3 localities with significant differences in average hourly rates, average weekly hours of care per person and significant differences in the bands in which care is purchased.
- Approved provider rates vary considerably from low to high.
- The position varies across the three localities, in the North most of the care is purchased from the lowest cost band 71%, contrasted to the South where 61% of care is commissioned from the highest cost band. The Central area is reliant on in-house provision.

2.2 Local Features

The impact of the current domiciliary care arrangements explored in section 2.1 above, are common to the three locality areas of the North, Central and South. However, the extent varies in each locality and in addition there are issues which are relevant in some of the localities but not all. In the section below the impact and issues are set out on a locality-by-locality basis. All data relates to July 2023.

South

The South encompasses Caldicot, Chepstow, the Gwent levels and surrounding rural areas, it borders Newport and Gloucestershire. Table 12 shows the spread of commissioned domiciliary care provision by cost bracket as well as in house provision. (Table 12) and commissioned care only (Table 13).

Table 12: South Domiciliary Care - July 23 - including In House

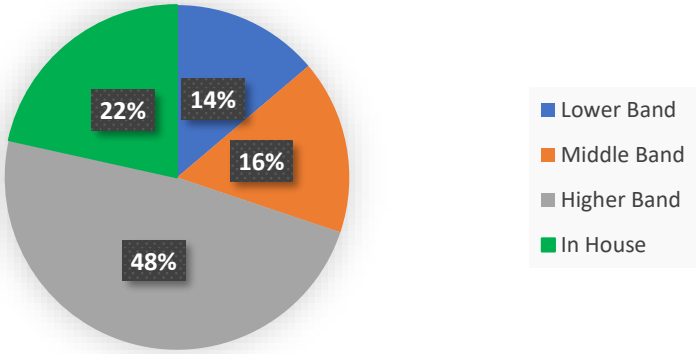
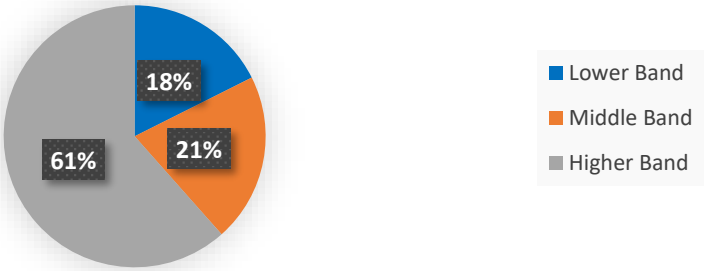


Table 13: South Domiciliary Care - July 23 - excluding In House



Key Factors:

- Lowest percentage (22%) of in-house compared to commissioned care.
- Highest number of commissioned care hours in the county.
- Highest level (61%) of commissioned care in the highest cost bracket.
- Very low percentage (18%) of commissioned care bought within the lowest price bracket.
- Second highest level of unmet need in October 2023
- Based on July 2023, 36% of care in the South is delivered by one provider at a high rate.

Central

The Central encompasses Monmouth, Raglan and Usk. Outside of the main township of Monmouth and Usk, the area is very rural. Table 14 and 15 show the spread of domiciliary care provision in this area by cost bracket.

Table 14: Central Domiciliary Care - July 23 - including In House

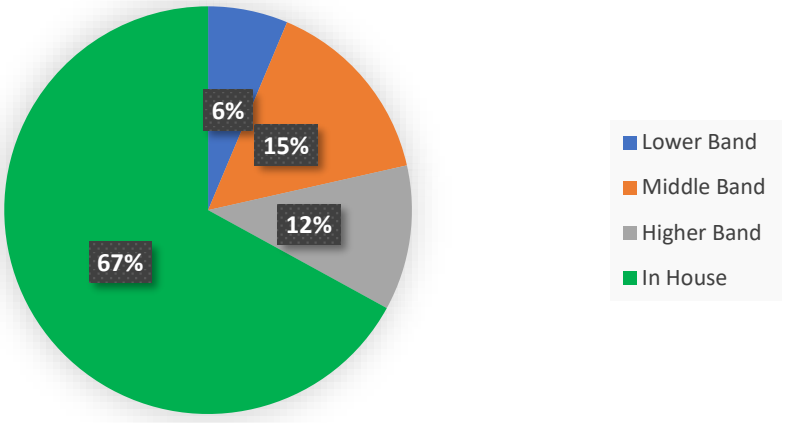
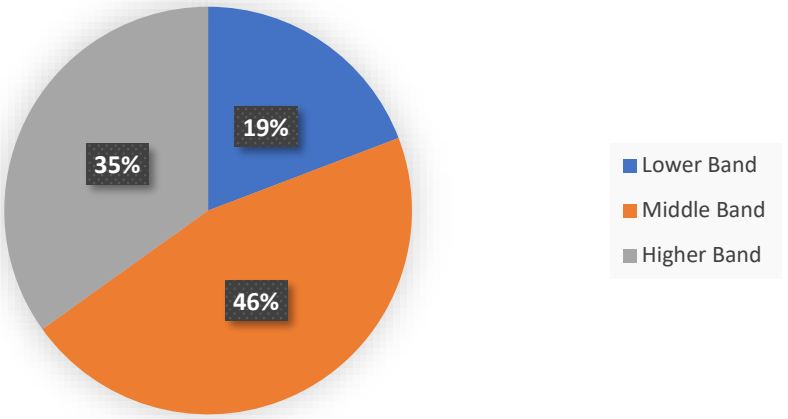


Table 15: Central Domiciliary Care - July 23 - excluding in House



Key Factors:

- Highest percentage (67%) of in-house provision compared to commissioned care. Overreliance on in house, to plug gaps in commissioned provision and reduces the ability of MCC to provide specialist reablement short term interventions to increase and maintain independence.
- Lowest number of commissioned care hours in the county.
- Highest level (45%) of commissioned care in the middle cost bracket. 36% of care purchased in the highest price bracket.
- 10 providers operate with weekly hours ranging between 17.5 and 354. There is no real dominant provider, the provider with the highest number of hours only supports 19% of the market.
- Highest level of unmet need in October 2023 (second highest in July 2023).

North

The North encompasses Abergavenny, Govilon, Gilwern, Llanfoist, Llanelly Hill. Tables 16 and 17 show the spread of care provision in this area by cost bracket only.

Table 16: North Domiciliary Care - July 23 - including In House

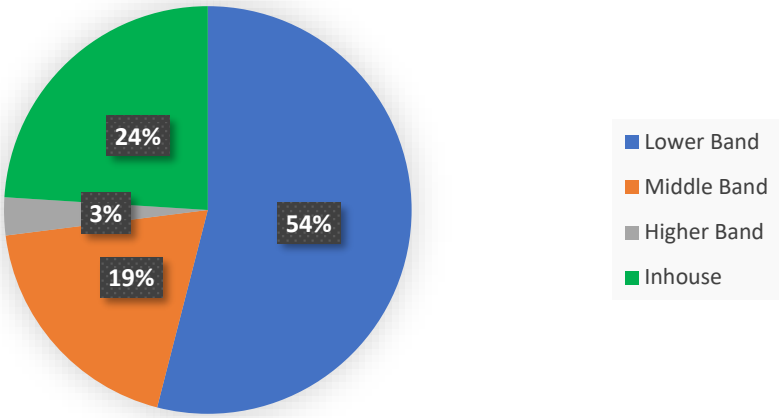
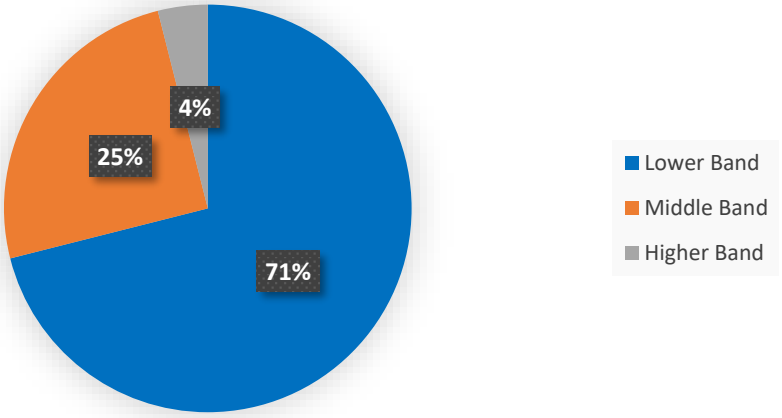


Table 17: North Domiciliary Care - July 23 - excluding In House



Key Factors:

- Second lowest percentage (24%) of in-house provision compared to commissioned care (lowest percentage 22%)
- Highest level (71%) of commissioned care in the lowest cost bracket.
- Lowest average hourly rate for commissioned care.
- No dominant provider and has a good level of choice.

2.3 Feedback from Stakeholders

Existing Providers

An important aspect of the assessment of the existing arrangements is capturing the experience and views of our existing providers.

In March and April 2024, an initial engagement exercise was undertaken, with all existing providers in Monmouthshire invited to participate in a survey. 25 providers of domiciliary care were invited to take part, this included the 17 core providers of long-term domiciliary care and a further 8 who provide more specialist services such as supported living. The survey sought views on what works well and doesn't work well in the way it is commissioned and the way they deliver it currently.

Responses were received from 8 providers (32% response rate).

What Works Well?

- Good working relationships with the commissioning and social work teams.
- Fair brokerage system.
- Timely invoice payments.
- Spot purchasing with no requirement to deliver specified number of hours.
- Locality working/Geographical split.

What doesn’t work so well?

- Recruitment and retention including staff leaving the sector, movement between agencies and ability to recruit.
- Geographical spread and rural nature of areas of the Council.
- Hourly rates.
- Currently only able to offer staff zero hours contracts.
- No guarantee of hours, making it difficult to build volume and develop runs.
- Too much competition.
- Difficulty in recruiting drivers, and walking runs not always possible.
- Delays between bidding on packages and final decisions.
- Delays in finance being informed of packages, with delays in invoice payments.
- No enhancements for bank holidays or retainers for absences e.g. hospital.

What would improve things in the future?

- Guaranteed hours.
- More parity in rates and fees.
- Predictable payments.
- Improved Terms and Conditions for the workforce.
- Improved spot purchasing systems.
- Continued joint working.
- Rural runs that pay travel time
- Block Contracts and guaranteed hours.

People Receiving the Service

An analysis of feedback from the people using the service obtained via community care questionnaires, complaints and quality assurance activity indicates in the main people are happy with the current care they receive. We receive very few complaints in regard to domiciliary care where people have expressed concerns this usually relates to inconsistency of carers and late call times.

As we move forward with the implementation of the strategy and the procurement process we will seek to ensure the voices of people receiving the service are heard and incorporated in to service design.

We understand the potential change in a domiciliary care provider may be worrying for people receiving services, and we will seek to mitigate their anxiety and possible disruption as far as possible. It is likely that TUPE (Transfer of Undertakings Protection of Employment rights) will apply to any future procurement exercise which would offer existing carers the right to transfer their employment to the newly awarded provider. This will ensure continuity of carer for people receiving the service.

3. KEY OBSERVATIONS AND CONCLUSIONS

3.1 Observations

Strategic resilience:

- Overall existing arrangements meet demand moderately well – although it fluctuates
- Unmet need is more problematic in the South and Central areas.
- Insufficient capacity to meet current demand and predicted growth.
- Recruitment and retention is a key issue with a resultant impact upon capacity – the situation has deteriorated even more since the pandemic.
- Stable sector – longstanding arrangements and good working relationships
- Too many providers competing for business with a negative impact.
- Framework and approved contracts offer no guarantee of hours, piece meal brokering of individual support packages offers little opportunity for growth.
- Little centralised oversight of brokering of packages.
- The framework contract is no longer fit for purpose, only 24% of care provided through it and an overreliance on commissioning care via approved providers.

Operational effectiveness:

- The challenges are common to all localities but the extent and degree to which they are impacted varies.
- Some localities have considerable challenges in securing care and are either over reliant on high-cost providers and or in house.
- The South locality has the greatest dependency on higher cost providers 61%.
- The Central area has 67% of in-house provision compared to commissioned care with an overreliance on in house, to plug gaps in commissioned provision.

- Arrangements in the North work well, with the highest level (71%) of commissioned domiciliary care in the most competitively priced lowest cost bracket.
- The current brokerage arrangements aren't effective for either the Council or providers and offer little financial control or oversight.

Cost effectiveness:

- Significant variation in hourly costs
- The existing arrangements for commissioned domiciliary care do not maximise the opportunities for greater cost effectiveness and control.

3.2 Conclusions

The independent sector in Monmouthshire has shown remarkable resilience over recent years, managing the impact of the pandemic, coping with deteriorating recruitment and retention levels and growing costs.

The current contractual arrangements are not conducive to maximising capacity to meet demand. They do not offer sufficient security to either the Council or providers. They are fragmented with a large number of providers competing for business.

To meet the current challenges of demand and the future predicted increases, contractual arrangements need restructuring to secure and support greater resilience, flexibility, and capacity. We will need to work with current providers through effective market engagement to ensure models for the future support local provision and provide opportunities for effective care delivery. This will include giving consideration to lot areas which allow for best use of existing provision and staff and minimises market disruption. This will include ensuring block contracting opportunities are open to provider consortiums, social enterprises, not for profits and other business models.

Though operationally the challenges are common to all localities, the extent and degree to which they are impacted varies. These challenges are seen in terms of difficulty in securing care, over reliance on high-cost providers and or in house.

The Usk Capacity model is one of the ways in which we have been able to meet the challenges within the sector. Commissioning hours as a block from a framework provider, guaranteeing payment at an affordable level and allowing the provider to plan delivery has provided guaranteed care (up to 250 hours) in an area where care was previously difficult to secure. This model enables us to manage capacity, closely monitor quality and develop an outcomes focused service model, through effective partnership working with a provider. To ensure the effective and efficient operation of the block delivery against paid hours has been consistently monitored and flexed up and down when needed.

The Usk model has greatly influenced this strategic commissioning plan as it provides experience of overseeing an arrangement that differs from traditional spot contract methods of commissioning. The decision to further expand this model is therefore based on sound learning achieved through operational success.

The current brokerage arrangements are fragmented, some packages of support are commissioned directly by the care teams and other via the brokerage system operated via the commissioning team. It is cumbersome, time consuming and often results in lengthy delays in securing care. A more robust approach is needed.

There are considerable differences in the cost of care across the county. The predominance of the approved provider supply in certain areas, at high hourly rates, is having a considerable impact on already overstretched budgets.

The current financial situation is one of unprecedented challenge, the Council is facing budget deficits and high levels of overspends particularly in adult social care. The existing arrangements for commissioned domiciliary care do not maximise the opportunities for greater cost effectiveness and control.

There are a number of Quality Assurance mechanisms in place to provide assurances around the delivery of good quality care across Monmouthshire. This includes Care Inspectorate Wales who provide Welsh Government with assurances around quality and safety of service, through inspection and registration of new services. Internally, the Social Care and Health Directorate Commissioning Team operate a robust accreditation process for approving new providers, considering their financial standing, insurance, and track record (through references, visits, and inspection reports). All domiciliary care providers receive annual quality assurance visits, to check contract compliance including: Safe recruitment practices, care management and records, training, and care quality. Whilst these visits provide assurances around quality of care, further scrutiny around call monitoring will be needed in the future. In addition, we also have Safeguarding, Community Care questionnaires and complaints processes in place to ensure any quality or safety issues are identified and responded to quickly and effectively.

4. THE FUTURE

4.1 Strategic Objectives

To respond to the current challenges within the domiciliary care sector in Monmouthshire there is a need to change the way in which we procure and manage domiciliary care to ensure we meet current and future predicted demand. The steps we take going forward will be guided by the following strategic objectives.

1. **Provide sustainable high quality domiciliary care to those with an assessed need within Monmouthshire.**
   - Increase capacity and resilience within the domiciliary care sector both now and into the future.
   - Improve outcomes for individuals who need or may need care in the future, through targeted reablement and best use of capacity.

2. **Maximise the cost effectiveness of the care purchased, with less diversity of cost between providers.**

3. **Improve and standardise terms and conditions for the independent sector domiciliary care workforce supporting with stability of workforce within providers.**

4.2 How we will achieve the strategic objectives.

The approach we will take to address the current and future challenges and deliver the strategic objectives will require some key changes to be put in place, these are set out in the table below.

What we want to achieve	The actions we will take	How we will measure progress
Provide sustainable high quality domiciliary care to those with an assessed need within Monmouthshire. Desired Outcome: People in Monmouthshire receive high quality domiciliary care, which enables them to live their lives on their terms.	County Wide: • Implement Block Contract arrangements as the primary delivery mechanism for all commissioned care. • Implement spot purchasing contractual arrangements and systems for commissioning specialist and/or complex packages, which cannot be delivered through the block contract arrangement. • Use an open procurement process, which enables existing and new providers to tender for both the block contracts and the spot purchasing contract. • Contracts will include the requirement to deliver outcomes for people. • Implement a new brokerage system. Localities: • Develop specific implementation plans for each of the three localities to account for local variation/need, including volume of hours.	• % of care provided via the block contract arrangements • % of care provided via spot purchase • % of unmet need • Number of people waiting for discharge from hospital due to awaiting domiciliary care packages. • Feedback from people in receipt of domiciliary care (Community Care Questionnaire). • Use quality assurance framework to measure progress on individual outcomes.
Maximise the cost effectiveness of the care purchased, with less	• Include within the block contract terms and conditions a fair and reasonable hourly rate (flat rate with no premiums for part hours)	• Monthly analysis of costs of care. • Number of hours of care delivered against planned.

diversity of cost between providers. Desired Outcome: Care is purchased in the most cost-effective way.	• Include within the Spot Purchase contract terms and conditions a fair and reasonable minimum and maximum rate. • Introduce the requirement for electronic call monitoring systems in both the block and Spot Purchasing contracts. • Implement a robust verification process for the validation of invoice payments.	• % of invoices paid at actual level of delivered hours.
Improve and standardise terms and conditions for the independent sector domiciliary care workforce supporting with stability of workforce within providers. Desired Outcome: A stable independent sector domiciliary care workforce with harmonised terms and conditions.	• Include within the block and spot purchasing contract terms and conditions for staff to include payment of RLW, mileage rate, payment for travel time, holidays, and contract terms. • Ensure providers are employing staff in line with agreed contract terms and conditions.	• % staff turnover in providers • % of staff leaving the sector • % of staff moving between providers

5. NEXT STEPS

Analysis of our existing commissioning domiciliary care arrangements clearly evidences that there is a need for change if we are to meet the current challenges of growing demand and growing costs, and to be fit for purpose in meeting the future challenges of increased demographics.

In considering how best to meet these challenges it has been paramount to understand how we can positively influence our arrangements for the future without losing the benefits of the current arrangements. For example, the current arrangements clearly result in a much higher cost of care in the South whilst in the North of the county the opposite is true. Affecting positive change will require diligent, meticulous and iterative management.

This is a complex area, the proposals for the future are equally complex. However, the aspirations and actions for the future offer a way forward which is both ambitious and deliverable and will ultimately deliver the strategic objectives for commissioned domiciliary care.

The challenges facing domiciliary care in Monmouthshire over the next 10 years are both complex and multi-faceted. To meet these challenges and realise our three strategic objectives, a systematic and targeted plan of action is needed. The scale of the challenge will necessitate a prioritised implementation approach. The South is the area which needs addressing first due to the significant reliance on high-cost provision.

The issues currently faced whilst common to all three geographical areas, vary in degree and impact. It is therefore logical that the manner in which these issues are addressed is bespoke to the individual localities; the objectives will be common to all, but the specific actions may differ.

Phase one of the two phased action plan will focus on implementing a range of targeted key actions for the South. Work will be ongoing during phase one to identify the key actions needed to address the Central. Phase two will be implementation for Central and identifying and implementing key actions for the North.

This phased implementation approach is ambitious, the breadth and depth of work required to deliver it cannot be overestimated. The suggested timescales are demanding and assume the smooth running of the process, which may be subject to change as the project progresses. The benefits of a phased approach include iterative learning; learning from successes and difficulties as it progresses.

5.1 Summary of Phase 1 Implementation

At the end of document there is an overview of the actions, timescales, and risks for each phase. A detailed project plan will be developed for the implementation phases. It is anticipated that Phase 1 will begin in February 2024 and conclude by February 2025. The key areas of focus for this phase are:

- Implementing a new contract in the South offering fixed blocks of hours.
- Implementing a new contracts and systems for purchasing of specialist or ad hoc domiciliary care in the South.

- Implementing a new brokerage system for the new block and spot purchasing contracts
- Enhancing monitoring of delivery hours and improving payment processes
- Developing a locality specific plan for the Central area for phase 2.

Key considerations/risks:

- The need to attract sufficient and appropriate providers via tendering process to fulfil the block arrangements.
- Ensuring the agreed rate for the block contracts is fair, reasonable, and financially viable whilst at the same time securing care at the most cost-effective rate.
- Significant change for providers, the workforce and people receiving services.
- The resources which will be required for many areas of SCH to deliver the plan i.e. Commissioning, Care Management and Finance Team.

6. PHASED IMPLEMENTATION PLAN

Phase 1 February 2024 – February 2025					
Area	**Actions**	**Detail**	**Timeframe**	**Desired Outcomes**	**Risks**
South	Implement three geographical lots with guaranteed block hours.	• Guaranteed hours at a set rate. • Annual uplifts set by MCC. • Mandated common contractual terms for staff to improve terms and conditions	• Approval Feb - May 2024 • Develop necessary paperwork and procurement documentation by August 2024 • Procurement September-October 2024 • Award November 2024 • Implementation November 2024 – January 2025 • Contract fully implemented 1st February 2025	• Effective management processes to maximise capacity and flexibility. • Greater sustainability and resilience for providers • Better cost effectiveness • Improve recruitment and retention of social care workforce. • Quality Assurance mechanisms confirm care is at the required standard.	• Destabilisation of providers and market. • Existing providers may lose business. • Mass transfer of staff (TUPE) • Loss of continuity of Care • Lack of interest in the tender from providers • Opposition from people receiving services. • Insufficient resource within commissioning and care management teams to deliver this piece of work. • If the rate is too low it may be unviable and unattractive to providers, too high and it could result in an overall increase in costs.
	Implement new spot purchasing contractual arrangements.	• Smaller number of approved providers to pick up specialist/ad hoc cases.	• Approval Feb - May 2024 • Develop necessary paperwork and procurement documentation by August 2024	• Improved capacity • Better cost effectiveness – control of rates. • Improve recruitment and	• Some loss of continuity of Care • Lack of interest in the tender from providers • Opposition from people receiving services.

		• Set a minimum and maximum cost level. • Annual uplifts set by MCC. • Mandated common contractual terms for staff to improve terms and conditions	• Procurement September-October 2024 • Award November 2024 • Implementation November 2024 – January 2025 • Contract fully implemented 1st February 2025	retention of social care workforce	• Insufficient resource within commissioning and care management teams to deliver this piece of work. • If the rate is too low it may be unviable and unattractive to providers, too high and it could result in an overall increase in costs.
	Implement revised and refined brokerage arrangements.	• Process for management of the block contract. • Process for use of the spot purchasing systems. • Centralised oversight and reporting arrangements.	• Design July/August 2024 • Obtain additional staffing resources if needed August-October 2024 • Fully implemented 1st February 2025	• Maximise cost effectiveness. • Ensure best use of capacity. • Efficient oversight of use of hours.	• Perceived loss of control/decision making by care management teams. • Potential need for additional resources. • Insufficient resource within commissioning and care management teams to deliver this piece of work.
	Greater contractual oversight – compliance monitoring of call times and payments	• Process for monitoring of call times and call delivery; implementation of call monitoring system. • Robust process for invoice payments.	• Design July/August 2024 • Obtain additional staffing resources if needed August-October 2024 • Fully implemented 1st February 2025	• Improved financial controls. • More efficient invoice payment system.	• Possible resistance from providers due to increased scrutiny. • Insufficient resource within commissioning and care management teams to deliver this piece of work.
Central	Identify the required future contractual arrangements to address the specific	• Understand further the specific challenges faced in the Central area.	• Identify commissioning need September/October 2024	• Clarity of approach specific to this locality.	• Two tiered contractual arrangements in place. • Potential for some providers to move to the

	geographical challenges.	• Consider overreliance on in house services. • Develop appropriate future approach.	• Develop future commissioning approach to meet need November 2024. • Produce Contractual and procurement documentation December 2024/ January 2025 • Approval Feb 2025		South, because of attractiveness of new contractual arrangements there. • Destabilisation of the market due to change in one area. • Insufficient resource within commissioning and care management teams to deliver this piece of work.
Phase 2 February 2025 – February 2026					
Area	**Actions**	**Detail**	**Timeframe**	**Desired Outcomes**	**Risks**
Central	Implement agreed commissioning approach	• Commence procurement	• Procurement March 2025 • Fully Implemented 1st August 2025	To be confirmed	• Two tiered contractual arrangements in place. • Potential for some providers to move to the South, because of attractiveness of new contractual arrangements there. • Destabilisation of the market due to change in one area. • Insufficient resource within commissioning and care management teams to deliver this piece of work.
North	Identify the required future contractual arrangements to address the specific geographical challenges.	• Understand further the specific challenges faced in the North area.	• Identify commissioning need April/May 2025 • Develop future commissioning	• Clarity of approach specific to this locality.	• Two tiered contractual arrangements in place. • Potential for some providers to move to the South, because of attractiveness of

		• Develop appropriate future approach. • Commence procurement	approach to meet need June 2025. • Produce Contractual and procurement documentation July/August 2025 • Approval September 2025 • Procurement October 2025 • Fully Implemented 1st February 2026		new contractual arrangements there. • Destabilisation of the market due to change in one area. • Insufficient resource within commissioning and care management teams to deliver this piece of work.