Care Home Commissioning Strategy 2014-2017 (draft for consultation)
“I would like to live in an environment that understands me as an individual and supports me in achieving my aims.”

*Current Care Home resident*
**Glossary and Abbreviations**

Terms will be used throughout this document that may be unfamiliar or where some people have a different understanding of its meaning to others. These terms have been listed below in the order in which they appear in this document, along with any abbreviations that are used.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Bristol City Council (BCC)</td>
<td>The organisation that has overall responsibility for arranging and funding services, in this case care home services, to ensure people in Bristol receive services appropriate to their needs. BCC ‘commissions’ other organisations to deliver these services on its behalf and will be referred to as the ‘Commissioner’.</td>
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<tr>
<td>Commissioner</td>
<td>An organisation that enters into an agreement to purchase services from an organisation (provider) that the provider will then deliver. In this context Bristol City Council commissions care home services from independent providers who then deliver these services to their residents.</td>
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<tr>
<td>Care</td>
<td>This is the help that is provided to a service user by a care worker, which could be personal care or nursing care.</td>
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| Care Homes (also referred to as ‘providers’) | A Care Home is a residential setting that enabled individuals to maintain their relationships and interested with in site care services. In addition to the accommodation, they provide help and assistance with:  
  - Personal Hygiene, including help with washing, bathing, shaving, oral hygiene and nail care.  
  - Continence management, including assistance with toileting, skin care, incontinence laundry and bed changing.  
  - Food and Diet, including preparation of food and fulfilment of dietary requirements and assistance eating.  
  - Counselling and support, including behaviour management, psychological support and reminding devices.  
  - Simple treatments, including assistance with medication (including eye drops), applications of simple dressings, lotions and creams and oxygen |
therapy.
- Personal assistance, including help with dressing, surgical appliances, mechanical or manual aids, assistance getting up or going to bed.

| Care Home with Nursing | These homes provide the same help and assistance with personal care as those without nursing care but they also have professional registered nurses and experienced care assistants in constant attendance who can provide 24-hour nursing care services for more complex health needs as prescribed by physicians. In addition to being registered to provide general nursing care, many homes also offer rehabilitation services; different therapies, including physical, speech and pain therapies; and specialist health care including, dementia care, EMI nursing care, cancer care, services for younger people with physical disabilities (usually aged 18 - 64).

These homes are for people who are very frail or for people who are unable to care for themselves, who have numerous health care requirements. |

| Care Home Services | All aspects of the service that a provider delivers, and that a resident receives, in a care home. This will include the provision of accommodation (e.g. the person’s room and bed), care services (e.g. help getting out of bed) and other services (e.g. meals, laundry and activities). |

| Choice | The power, right, or liberty of an individual to choose the services and care they receive. |

| Clinical Commissioning Groups (CCG's) | CCGs are groups of GP Practices that are responsible for commissioning most health and care services for patients, working with other healthcare professionals and in partnership with local communities and Local Authorities. |

<p>| Commissioning Model | A description of all practice and processes that are set out by the commissioner and describe how care home services will be commissioned (which care homes BCC uses), arranged (the process of moving a person into a care home) and delivered (the way in which care home services are provided to residents). These arrangements are collectively known as the ‘Commissioning Model’. |</p>
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<tr>
<td>Commissioning Strategy</td>
<td>The document that considers the current Commissioning Model and describes what changes will be made to this and how they will be implemented. This will consider current levels of supply and demand, quality, future needs, requirements and best practice.</td>
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<tr>
<td>Consultation</td>
<td>The act or process of consulting, often with key stakeholders including service users, their family, friends and associates, providers and other interested parties. This is often a structured situation with a formal start and end date and pre-arranged activities.</td>
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<tr>
<td>Dementia</td>
<td>A chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning.</td>
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<tr>
<td>Dynamic Purchasing System (DPS)</td>
<td>A DPS is a completely electronic system which may be established by a contracting authority to purchase commonly used goods, works or services. It has a limited duration.</td>
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<tr>
<td>Independence</td>
<td>Independence means encouraging an individual to do as much as they can for themselves.</td>
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<tr>
<td>Lots</td>
<td>Lots are a way of managing a framework agreement and organising providers into groups.</td>
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<tr>
<td>Mini-tender</td>
<td>Describes a process that is undertaken when a care home service needs to be set up for an individual. Within the new commissioning model this will be undertaken for each placement and will be proportionate, so it will require very little time and effort from any party involved but will provide assurances about the suitability and appropriateness of the care homes wishing to be considered and will give BCC a means of identifying the best quality provider.</td>
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<tr>
<td>Needs</td>
<td>This describes what aspects of Service Users lives which they require care and support for Service Users receiving care home services will have had a formal assessment from social care staff that will consider and document exactly what these needs are.</td>
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<tr>
<td><strong>Outcomes</strong></td>
<td>The intended result for people derived from their needs assessment.</td>
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<tr>
<td><strong>People Directorate</strong></td>
<td>People Directorate provides help and support for many people aged 18 or over. This includes older people, disabled people, people with learning difficulties, those with mental health needs, people with HIV/AIDS and carers. It also takes the lead in protecting vulnerable adults from harm.</td>
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<tr>
<td><strong>Placements</strong></td>
<td>This term is sometimes used to describe a situation where a service user is living in a care home.</td>
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<tr>
<td><strong>Providers</strong></td>
<td>This term is often used to describe an organisation that owns a number of different care homes. However, within this document this term will describe a specific care home (and used exactly the same as the term ‘care home’) It will only be sued to describe an organisation that owns different homes if this is specifically stated.</td>
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<tr>
<td><strong>Reablement</strong></td>
<td>A range of [high quality] integrated (People Directorate) services (provided to individuals on a short-term basis) to promote recovery from illness, prevent unnecessary hospital admission and premature admission to long term residential care, support timely discharge from hospital and maximise independent living.</td>
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<tr>
<td><strong>Self-funders</strong></td>
<td>Self-funders are people who arrange and fund their own social care services.</td>
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<tr>
<td><strong>Tender</strong></td>
<td>A formal process that a commissioner undertakes to identify providers that it will award a contract to. These do not occur very often and will take place where a contract is coming to an end or a new commissioning model is being introduced, as in this case.</td>
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<tr>
<td><strong>Service Users (SU)</strong></td>
<td>The people that receive a social care service that is arranged and funded (at least in part) by BCC. In this Strategy, the term will specifically relate to the people that receive a home care service. The term ‘resident’ may also be used and whilst in most cases they mean the same thing, the term ‘resident’ will only be used to describe someone living in a care home, whereas the term ‘service user’ will describe anyone receiving a service even though this may not be</td>
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<tr>
<td>Stakeholders</td>
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<tr>
<td>These documents will inform service users, carers, providers of care home services, the voluntary and community sector, BCC staff and other interested parties. Stakeholders can be defined as any person or group of people who have a significant interest in services provided, or will be affected by, any planned changes in an organisation. They can be internal or external to that organisation, for example they can comprise staff, service users, families, providers, GPs and members of the public and community groups.</td>
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<th>Support Plan</th>
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<td>A plan created by the BCC social care staff, which documents the outcome of the assessment by BCC staff. This will include information on the SU, their needs, the outcomes they want to achieve and how this can be done.</td>
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Section One: Introduction

1.1 What are Care Home Services?

1.1.1 Care home services are those which are provided in a residential setting where a number of people live, usually in single rooms, and have access to on-site care services. This term is defined in the glossary. Since April 2002 all homes in England, Scotland and Wales are known as ‘care homes’, but are registered to provide different levels and types of care.

1.1.2 Care homes must be registered with Care Quality Commission (CQC) and their registration will state exactly what services they are allowed to provide.

1.1.3 A home registered as a ‘care home providing personal care’ can only provide personal care, which includes help staff helping residents with washing and dressing.

1.1.4 A home registered as a ‘care home providing nursing care’ will have staff that provide personal care, but will also have qualified nurses on duty 24 hours a day to carry out nursing tasks. These homes are typically for people who are physically or mentally frail and / or need regular attention from a nurse.

1.2 Context

1.2.1 Bristol City Council (BCC) currently commissions care home services from over 170 care homes, most of which are in Bristol. Of the other care homes commissioned by BCC, the majority are in South Gloucestershire, Bath and North East Somerset or North Somerset, with the remainder spread across the UK. There are approximately 1,800 people in care homes that have their care arranged and (at least partly) funded by BCC and in a typical month approximately 50 BCC service users will move into a care home.

1.2.2 The total annual cost of care home services purchased by BCC is approximately £59 million. Of the total amount that BCC spends on purchasing adult social services from independent providers, approximately half of this is spent on care home services.

1.2.3 Everyone that receives a care home service will have a financial assessment, which is undertaken by BCC to assess if the service user is in a position to contribute to the cost of their own care. Most service users do make a contribution and the total annual value of these ‘service user contributions’ is approximately £11m per year, which is paid directly to BCC. These figures do not include service users that privately arrange and fund their own care in a care home and are known as ‘self-funders’.

1.2.4 BCC is responsible for setting out how care home services are commissioned (which care homes BCC uses), arranged (the process of moving a person into a care home) and delivered (the way in which care home services are provided to
residents). These arrangements are collectively known as the ‘Commissioning Model’.

1.2.5 BCC has received a lot of information that points to problems with the current commissioning model and the need for change. This has come in the form of service user feedback (e.g. complaints), national and local policy (e.g. Care Bill), information from providers (e.g. difficulties with BCC standard rates for payment) and information relating to the context in which services are delivered (e.g. reduced budgets for Local Authorities).

1.2.6 Having analysed and considered this information, BCC acknowledges that there are many aspects of the current commissioning model that can, and need to be, improved.

1.3 BCC vision for care home services

1.3.1 BCC has a clear vision for these services, from which all aspects of how the services are commissioned, arranged and delivered will flow from this vision, which is that:

1.3.2 “People who need care and support in Bristol will have access to suitable and appropriate residential and nursing accommodation and services, real choice in the help they receive and maximum control over the way they live their lives”.

1.4 Purpose of the Commissioning Strategy

1.4.1 A Commissioning Strategy is a document/s that sets out plans and intentions for the future commissioning of services. This is particularly important for services that have a lot of key stakeholders who will be affected by these plans, such as for the care home services commissioned by BCC. This Commissioning Strategy’s main purpose is to support and facilitate the delivery of BCC’s vision for care home services.

1.4.2 BCC will share this Strategy widely and undertake a 12-week consultation to ensure that all stakeholders are fully informed about BCC’s plans and intentions and have the opportunity to share their views on the proposals being put forward.

1.4.3 The Strategy will outline BCC’s approach to care home services (residential and nursing) for adults including, but not limited to, those with mental health needs, learning difficulties, physical/sensory impairments, that are vulnerable and that have dementia.

1.4.4 The Strategy will be used to outline relevant feedback, evidence and information about how care home services are currently commissioned, arranged and delivered. This will then be used to assess the suitability of the current model and, if required, inform the design of a new commissioning model. The final part of the document will contain a detailed description of a proposed new commissioning model, how it will operate and what it will achieve.

1.4.5 More specifically, this document will inform key stakeholders of:
a. The evidence, information and feedback on the current commissioning model  

b. The changes that will be made to existing commissioning arrangements  
c. How BCC will select the providers that it will commission care home services from in the future.  
d. The type and level of services BCC expects care home providers to deliver.  
e. The standards of service delivery that BCC expects from care home providers.  
f. The expectations BCC has of the market and individual providers.  
g. The expectations that stakeholders can have of BCC.

1.5 Objectives of the Commissioning Strategy

1.5.1 This Strategy sets out the changes that will be required to the current BCC commissioning model and as a result the way in which the market operates, in order to deliver BCC’s vision for care home services.

1.5.2 BCC has set some specific objectives that it seeks to achieve through the completion of the Commissioning Strategy and the implementation of a new commissioning model. Some of these seek to improve how these services are delivered and their value to the resident (1.5.3 – 1.5.5) and others seek to improve the way in which these services are arranged and commissioned (1.5.6 – 1.5.8).

1.5.3 Better access to care home service most suitable to people’s needs – Including the type and level of provision and other factors such as their preferred location, layout and environment. A specific aspect of this is that BCC hopes to reduce the number of people living in care homes outside of Bristol because the services they want and require are not available within the City.

1.5.4 Increased choice for service users – This includes choice for a person about which care home they live in. It also includes choice for a person about the service they receive whilst living in a care home, such as in relation to food, activities and other aspects of their lifestyle.

1.5.5 Increased independence for service users – This focuses on the way services are delivered and should lead to people living as independently as they can / want to in the home. For some people this could be about them being able to move out of the care home.

1.5.6 Services offer value for money – There is clarity, transparency and shared expectations about the fees paid to care home providers and the services delivered to residents.

1.5.7 An effective and sustainable care home market – The care home market and the commissioners and providers within it, will be able to operate effectively and the commissioning model will achieve the right balance between the needs and requirements of all parties to ensure the market is sustainable for the long term.

1.5.8 Implement a new joint contract with Bristol Clinical Commissioning Group (BCCG) – This will give providers greater clarity and consistency about many aspects of the practice and processes that the commissioners will require of them.
1.6 Principles of the Commissioning Model

1.6.1 In delivering the BCC vision for care home services and the objectives that sit beneath this, BCC will remain focused on the specific and significant impacts these services have on people’s lives. It is acknowledged that when services are described as being ‘high quality’, ‘suitable’ or ‘appropriate’ that this will mean different things to different service users. Therefore, work has been done to understand the very personal feelings that these services can affect (positively or negatively) to identify the principles on which the commissioning model must be based.

1.6.2 Using this information, BCC has agreed a set of principles that will guide future work to improve care home services. The services an individual receives must support them to feel, experience or achieve:

a. **A sense of security** – Individuals’ feel safe and secure, feel free from threat or harm, but not to the extent that positive risks are denied.

b. **A sense of belonging** – Individuals’ feel ‘part of things’, both within the home and the wider community, and are able to maintain existing relationships and form new ones.

c. **A sense of continuity** – Individuals’ life history and individuality are recognised and valued, and their interests, hobbies, passions and social networks are brought into the home.

d. **A sense of purpose** – Individuals’ are supported to have valued goals to aim for and lives that are valuable.

e. **A sense of achievement** – Individuals’ are able to set and achieve their goals and feel satisfied with their efforts.

f. **A sense of significance** – Individuals’ feel that they ‘matter’, that their life has importance and that other people recognise them and who they are.

1.7 Development of the Commissioning Strategy

1.7.1 BCC has undertaken detailed work to consider the value of the current commissioning model and how this model can be improved. This includes obtaining feedback from service users, care home providers, BCC staff and other stakeholders on what currently works well and not so well in Bristol. This also includes work to understand the alternative models of delivering care home services, the local and national context in which these services are provided and the challenges that BCC face. The results have been used to shape the strategic approach that BCC will take to meet future needs, provide high quality care and ensure there are suitable and cost effective care home services for our residents in Bristol.

1.7.2 This document sets out proposals for what changes will be made and how they will be implemented. This document, and the proposals within it, will then be the focus of a formal 12-week consultation period. This consultation will be undertaken in a thorough and meaningful way to ensure that people’s views on this strategy are heard, understood and used to shape BCC future plans.
Section Two: Description of current commissioning model

2.1 Introduction

2.1.1 This section describes how care home services are currently commissioned arranged, delivered and reviewed. This is intended to provide an objective description of what currently happens. This section will not provide any judgments on how well these arrangements are working, or are perceived to be working, as this will be provided in section 3.

2.2 How care home providers are accredited by BCC

2.2.1 Care home providers who want to offer services on behalf of BCC must sign up to a contract with BCC and undergo a series of initial checks. The first stage of this process is registration with the Care Quality Commission (CQC).

2.2.2 BCC will then carry out a series of checks that include:
   a. A review of the latest CQC inspection report to ensure the home is compliant with the regulatory requirements of the Health and Social Care Act 2008
   b. A check with the local Safeguarding Team to ensure there are no current concerns
   c. A check with the local Commissioning Team to ensure there are no current concerns

2.2.3 Once BCC is satisfied that the home is registered with CQC and that there is no current quality concerns, a contract is set up between the Provider and BCC.

2.3 How individuals needs are assessed

2.3.1 Service users are assessed for care home services by a social care professional and a long term care home service will only be agreed after all reasonable alternatives have been explored and where it is clear that none of these are suitable for the service user and they must live in a care home.

2.3.2 The Self Directed Support assessment process will help to establish whether the service user can continue to live in the community with additional care and/or reablement services.

2.3.3 If the service user requires a short or long term care home service, the assessment process will determine the type of home that is required. For nursing homes, a separate health needs assessment will be completed by a relevant health professional to confirm whether 24 hour nursing care is required, or not.

2.3.4 The social care professional will develop a Support Plan with the service user and other people involved in caring for them. The Support Plan will describe various aspects of the service user’s needs and wishes, including:
   a. Their health and social care needs
b. The outcomes they wish to achieve

c. The care and support they will require to achieve these outcomes.

d. The type of care home required

e. Their choice of care home and / or the area of Bristol they wish to live in

f. Any other needs, preferences or wishes (e.g. Cultural and religious needs)

2.4 Identifying and arranging a care home service

2.4.1 Once completed, the Support Plan is shared with another BCC function called the Support Planning and Brokerage Team. The allocated Broker will check through the details on the document and start to identify suitable care home placements. The decision about which care homes will be approached is determined by the information on the Support Plan and the Broker's knowledge of different providers.

2.4.2 Once the Broker has identified vacancies in a care home suitable for the service user, they will share the Support Plan with the Home Manager. If the Home Manager/s believes the service user's needs can be met in their care home then they will confirm this to the Broker and the allocated social care professional who will then inform the service user and/or their family. This will be done with all homes that are suitable and have vacancies.

2.4.3 A visit will then be arranged to the care home/s and a decision will then be made by the service user and their family / friends. The Home Manager will also complete their own assessment at this stage to ensure that they can meet the service user's needs. Once all parties are satisfied that the care home is suitable, a final weekly cost will be negotiated between the Provider, the Broker and the social care professional.

2.5 Reviewing care home services

2.5.1 Long term placements should be reviewed by a social care professional approximately 4 weeks after the service user has moved in. The purpose of the review is to ensure that their needs are being met by the care home staff, they are settled in their new environment and the placement is safe and suitable for them. Further ad hoc reviews are carried out as appropriate and can be requested by the Provider, the service user or any other person involved in the care or support of the service user in addition to BCC identifying the need for a review.
Section Three: Suitability of current commissioning model and case for change

3.1 Introduction

3.1.1 This section assesses the suitability of the current care home commissioning model. To do this, BCC has obtained and will use feedback, information and evidence from key stakeholders, national and local policy and knowledge of the challenges facing BCC in the delivery of care home services. This section will highlight the areas of the current commissioning model that are felt to be working well, but more importantly, focus on those areas where improvements need to be made.

3.2 Feedback from people that receive care home services

Overview

3.2.1 BCC has spoken to many people who currently use care home services, as well as those who may require them in the future, to understand their views and incorporate them into the design of a new commissioning model on what. As part of this, BCC has used 1000 survey responses and over 100 individual experiences that were received from 2012 – 2014 from people that receive care home services. Information has also been obtained from events, workshops and meetings that BCC has arranged for stakeholders to discuss the current commissioning model. These have included:

a. Consultation events throughout Bristol, which informed the BCC Cabinet report of 26th July 2012 on the future of BCC owned care home services.

b. A Citizens Panel Questionnaire undertaken in January 2012 on the future of BCC owned care homes, which was completed by over 750 Bristol citizens.

c. An annual Department of Health ‘User Experience Survey’ completed by over 100 people currently in receipt of care home services.

d. A review of complaints received by BCC in 2013 about care home services.

e. Workshops with service users, carers and people representing Equalities Groups across Bristol (one in October 2012 and one in April 2013) to inform key documents, such as Equalities Impact Assessments.

3.2.2 The significant amount of quality feedback from people who receive care home services provides a helpful evidence base for assessing the suitability of the current commissioning model.

3.2.3 The overall message from this feedback is that, for most people, most of the time, things work well, but there is significant room for improvement in a number of areas.

3.2.4 The feedback was varied, very personal and covered a huge range of concerns and problems. However, during the analysis of this information some key themes began to emerge about what was important to people. This was not about pigeon holing people or there concerns, or ignoring the often very different and unique
personal experiences. It was about ensuring that this information could be used to inform the design of a new commissioning model and ensure that it led to improvements in the areas most important to service users. The key themes were:

a. Quality
b. Safety
c. Choice
d. Independence / Social involvement

3.2.5 These key themes will be referred throughout the rest of this document. This will reflect that much of the feedback has covered these areas, but it won’t be at the expense of other concerns that people have raised and these will also be included as appropriate.

Key Findings

3.2.6 Service User survey information that has informed this Strategy

a. **Satisfaction:** This was generally very high with; 40% of respondents saying they are extremely satisfied, 28% very satisfied, 26% quite satisfied, 1% dissatisfied and 5% gave a neutral response.

b. **Quality:** 81% of respondents gave a positive response (Good to Excellent)

c. **Safety:** 78% of service users gave a positive response. 22% had room for improvement.

d. **Choice and control:** 80% of respondents gave a positive response

e. **Independence / Social involvement:** 57% did not or could not leave the care home

3.2.7 Complaints information that has informed this Strategy

a. **Quality:** 41% of complaints relate to poor standards of care.

b. **Safety:** 39% of complaints relate to concerns over the health of service users and their safety.

c. **Communication:** 35% of complaints relate to poor communication from care staff and poor recording in care plans.

3.2.8 Focus Group feedback that has informed this Strategy

a. **Quality:** There was a general concern around a lack of staff training and understanding in dealing with service users with specialist needs, e.g. behaviour that may challenge staff as a result of their dementia.

b. **Choice:** Service users are not always given a choice of the gender of staff that would assist them with intimate personal care routines, which compromises their sense of dignity and respect.

c. **Communication:** Service users experienced communication issues caused by; language barriers, difficulties as a result of the physical, cognitive or sensory impairment of the service user and the culture amongst particular groups meaning that service users may be less willing to open up to others about problems or issues they might experience. This may also affect the access people, especially those with dementia or a learning difficulty, have to health promotion, prevention and primary care services due to difficulties in communications with staff.

d. **Discrimination or barriers:** Members from the Older People Partnership Forum had concerns that older people sometimes face this in care home
settings, where their views, opinions are not obtained or respected and where assumptions are made about their individual preferences and tastes, for example ‘all elderly people like listening to war time music’.

e. **Dignity and respect:** People who are Lesbian, Gay and Bisexual had concerns that their sexuality would not be respected in a care home setting either by staff or other residents. This has been backed up by national research by the Equalities and Human Rights Commission. People who are Transgender had concerns that understanding by staff and other service users on gender reassignment and transgender issues would not be respected or understood.

3.2.9 The information obtained from the various sources has been analysed and the key headlines have been shared in section 2.2. This has been translated in some key areas for improvement, which are:

a. **Quality:** Improve the consistency and quality of care across all homes and reduce the number of concerns relating to poor standards.

b. **Safety:** Ensure all service users feel safe, and their lives are free from fear, abuse and neglect.

c. **Choice:** Ensure service users are afforded choice and control over their daily life. This may be in relation to the time they wake up or go to bed, their food preferences or how they would like to spend each day. Providers should recognise what service users would like to, and can do for themselves.

d. **Independence / Social involvement:** Ensure that service users can maintain their relationships with families, friends, carers and advocates and that they are supported in a way that allows these relationships to enhance service users’ quality of life. Providers should establish and build links with the local community, promoting social inclusion and placing the care home as an active part of the community, utilising local services to enhance the quality of life of service user.

3.3 **Feedback from health and social care professionals**

3.3.1 Feedback was obtained from those who work with vulnerable people to identify their needs and arrange care and support services for them. This was done through an online survey in May 2013.

3.3.2 The key issues raised by professionals were:

a. **Level of provision** – There are gaps in the provision of some types of services and to meet the needs of particular service user groups and situations.

b. **Quality of provision** – The quality of services delivered to people, in some homes and for some service user’s needs to improve.

Level of provision

3.3.3 When asked whether the variety of care homes in Bristol is sufficient to meet the needs of individuals 45% of respondents felt that the current range of services are insufficient.
3.3.4 The survey results highlighted a specific need for greater provision of these types of services:
   a. Planned Respite Care
   b. Emergency Respite Care
   c. Reablement Care
   d. Step up / Step down Care

Quality of provision

3.3.5 Quality
   a. There is a general need for higher quality provision.
   b. Stronger links should be created between care homes and local communities

3.3.6 Choice
   a. Service user’s wishes should be acknowledged and wherever possible acted upon, especially with regard to the location of the home.
   b. Services should be diverse and tailored towards individuals’ needs and choices, not generic, institutional, and stereotypical care and support.
   c. Providers should be supported and offered incentives to provide more person centred services.
   d. There should be more support for couples to live together in care homes
   e. Services should be more sensitive to cultural needs and those of Lesbian, Gay, Bisexual and Transgender residents.

3.3.7 Independence
   a. Providers should always be focussed on maximising service user independence and culture change is needed in some homes to make this happen.
   b. There should be an integrated approach between BCC and Health organisations.

3.3.8 Service user groups: In addition to improving standards across all aspects of provision, social care professionals identified specific circumstances and needs that were not fully being met and where specific improvements are required. These relate to:
   a. Asperger’s
   b. Dementia, including those who also have a Learning Difficulty
   c. Autism
   d. Bariatric Care needs
   e. Acquired Brain Injuries
   f. Complex Neurological Conditions
   g. Alcohol and drug dependency
   h. Sensory impairments (BSL / Deaf / blind)

3.4 Feedback from providers of care home services

3.4.1 Quality
   a. There is significant pressure from many sources regarding quality, particularly since the exposure of inadequate care at Winterbourne View.
b. There is a tension between promoting social inclusion with the acceptance of society for people with a disability or dementia.

3.4.2 Choice
a. Service users should have full choice about which home they go into, as long as it is suitable.
b. Social Workers and Providers must involve service users and their families in support planning.
c. Direct Payments could increase choice and improve quality of life for residents.
d. BCC must secure more capacity to meet the needs of service users with complex needs.

3.4.3 Independence
a. Service users should be encouraged and supported to be as independent as possible.
b. Some people living in care homes could live in a more independent setting.
c. There needs to be a shift in thinking to ensure that people are supported to be more independent and that any associated risks are well managed.

3.5 Financial Situation

3.5.1 BCC currently use ‘standard rates’ to purchase care home placements. These rates set out what BCC expects to pay for care home services and there are slightly different rates to reflect the different complexities (e.g. different rates for residential and nursing and for complex needs).

3.5.2 These standard rates are paid in approximately 50% of existing placements. For the remaining 50%, the rate is agreed through negotiation between the provider and BCC. Where a fee is agreed above the standard rate, the top up is referred to as the ‘Exceptional Special Needs’ (ESN’s) payment. ESN’s were introduced to address situations where a service user has needs that require extra input from the provider, over and above what we would expect from them. The ESN would fund this additional support. However, many of the current ESN’s are in place because the provider will not deliver care home services at BCC standard rates.

3.5.3 Every provider delivers service in a slightly different way and every service user has different needs. However, there are very clear similarities in the inputs from providers (e.g. numbers of staff, quality of food) and the requirements of service users (e.g. 2 care staff to help them out of bed in a morning).

3.5.4 Where these similarities exist BCC would expect that the rates charged by these providers are also similar. This is not the case. It is common for there to be significant difference in the cost of care home services, where there is no apparent difference in the cost to deliver service and most importantly, the quality of the service an individual receives and the extent to which this helps them live the lifestyle they want. The current commissioning model offers little transparency about why a particular rate is being paid and what service is provided for this rate.
3.5.5 Graph 1 (in 3.5.8) compares the average gross weekly cost of a care home placement made by BCC, compared to Local Authorities with a similar socio-demographic profile to Bristol.

3.5.6 The graph shows that based on these rates, BCC paid a fee above the average of these other Local Authorities for approximately 90% of its placements. BCC pays above the average figure for; residential care for people with a physical disability, nursing care for people with a physical disability, nursing care for people with a learning difficulty and residential care for older people.

3.5.7 There are 2 groups where BCC pays a lower rate (residential care for people with mental health needs and nursing care for people with mental health needs) but of the 1800 people in care homes funded by BCC, only approximately 100 are in these categories.

3.5.8 Graph 1

### Unit Costs (Source: PSS EX1)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>2012/13</th>
<th>2011/12</th>
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</thead>
<tbody>
<tr>
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<td></td>
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<tr>
<td>Physical Disability (18-64)</td>
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</tr>
<tr>
<td>Nursing Care (18-64)</td>
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<tr>
<td>Mental Health (18-64)</td>
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<tr>
<td>Learning Disabilities</td>
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<tr>
<td>Nursing Care (Older People)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential Care (Older People)</td>
<td></td>
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</tbody>
</table>

3.5.9 Feedback from Health and Social Care Professionals on Value for Money is that:

a. The weekly rates that BCC pays for care home places are escalating in some areas.
b. There is a need for increased competition.
c. There is a need for better transparency about what service needs to be provided and what rate should be paid to the provider for delivering this.

3.5.10 Feedback from Providers of Care Home Services on Value for Money is:

a. The current model is not effective, with standard rates being too low and rarely used.
b. The use of ESN’s to top up standard rates is inconsistent and some Providers have benefitted more than others.
c. The annual Inflationary uplift mechanism is not effective.
3.6 The Case for Change

Quality is variable and in some cases low

3.6.1 Quality is by far the most important factor for service users and carers and at the moment this is variable across different homes in Bristol. BCC acknowledges that it needs to be clearer with providers about what it expects and requires from them. An example of this is related to the independence and social involvement of service users. There is evidence that some providers see this as secondary to ensuring a person is safe and cared for and actions and documents from commissioners may have reinforced this. However, the information received by BCC from service users, their families, social care professionals and even care home providers highlighted that for many service user their level of independence can be the biggest difficulty they face in their life. The new commissioning model will need to address this.

3.6.2 In most cases, care home services are good and the majority of service users are satisfied. However, the individual experiences of when things go wrong demonstrate the significant impact this can have on people’s lives. The new commissioning model needs to minimise the extent to which problems occur, but ensure that when they do they are identified and addressed as quickly and effectively as possibly. This improvement will only be achieved if the there is a connection between the requirements of care homes, the way providers identify and address problems, the way that BCC quality assures providers and the way commissioners and providers work with service users and their families to empower them to raise any concerns they have.

Costs are high and transparency is low

3.6.3 The current commissioning model is financially unsustainable, with the cost of care and demand for care increasing. There needs to be a greater clarity about what rate is being paid for services, what type and level of service this is paying for. The new model will seek to increase the transparency between service provision and costs and this is linked to the level of independence.

There are gaps in service provision

3.6.4 BCC is looking to secure access to more care home beds in Bristol. These beds will need to be suitable for people with all different needs, but especially those with complex or challenging behaviors. BCC has no desire for lots of empty care home beds in the City, but there does need to be greater supply than at present to avoid lengthy delays for people (often waiting in hospital) whilst a suitable care home bed can be found and to offer greater choice to service users about where they live and how they live. BCC is taking direct steps to address this shortage and is in the early stages of working with external partners to build and operate 3 care homes in the City, particularly for people with dementia. BCC will also build features into the new commissioning model that seek to improve its access to care home beds across the City. The request of care homes is that they also consider
these gaps and look to develop more care homes, and different types of services across the City.

Services do not focus on maximising service users independence

3.6.5 The focus of the current commissioning model is on caring for people and keeping them safe and well. There is little emphasis on providers working with service users to improve their independence and involvement in social groups. This statement is not being used to criticise providers and some do take on this responsibility and work with residents in a way that does maximise their independence. The point is being raised to acknowledge that all parties and all parts of the commissioning model need to recognise the importance of increasing independence if this is to become a reality in care homes.

3.6.6 This is particularly important because there are a proportionately higher number of people in care homes in Bristol than elsewhere, which suggests that a new commissioning model from BCC needs to do more to avoid people going in to care homes, to do more to support people to move from care homes to more independent living and to ensure that people in care homes can live as independently as possible. This will mean reversing the culture and approach that currently sees services being provided in a way that leads to people being de-skilled and more dependent.

Conclusion

3.6.7 The information, evidence and feedback obtained during this work, and shared in this document, gives a clear message that improvements can and need to be made to the way that care home services are commissioned, arranged and delivered in Bristol. The current arrangements are not providing the type, level and quality of service that BCC wants to offer the Bristol residents. The current practice and processes are not encouraging and supporting providers to deliver the best service they can. Service users are left with too little choice about the type of care home service they want and are not receiving the services that will help them live the lifestyle they want.

3.6.8 As a result, BCC has made the decision to introduce a new commissioning model. This will be described in section 4 of this document.
Section Four: National & Local Policy: Context & Drivers

4.1 Introduction

4.1.1 This section will describe the current policy and legislation that will guide any new commissioning model that BCC introduces. This section will be structured around the key themes that service users identified as being most important to them; quality, safety, choice and independence. Under each theme, the legislation and policy aimed at improving services will be described. This will lead to some repetition as some of the national and local policy is aimed at delivering improvements across different themes.

4.2 Quality

4.2.1 **The Care Bill** – introduces a duty for local authorities to promote diversity, quality and sufficiency of local services through “market shaping”. This approach intends to deliver improved and sustainable services which focus on the needs and outcomes of individuals, families and carers.

4.2.2 **BCC practice and policy** – BCC uses the Joint Strategic Needs Assessment and feedback and information from key staff to establish what service provision is needed in Bristol now and in the future. BCC uses statutory procurement frameworks to ensure that it commissions services fairly and selects providers on the basis of demonstrable high quality and value for money. BCC also uses a Quality Assurance Framework to obtain feedback from people that come into contact with care home services, to help understand the quality of care and support people receive.

4.3 Safety and Dignity

4.3.1 **Transforming Care: A National Response to Winterbourne View Hospital (2012 Department of Health Report)** – the Government’s response to an investigation into the abuse of residents at Winterbourne View in South Gloucestershire. It highlights that the warning signs were not picked up by commissioners or other stakeholders and that there are several lessons to be learnt by commissioners and providers. The response also identified clear gaps in the care regulatory framework that the Government intends to address.

4.3.2 **The Care Bill** – aims to improve the quality of care and introduce new standards as part of the Government’s response to the Mid-Staffordshire Hospital and Winterbourne View inquiries. This includes the introduction of a new Care Quality Commission (CQC) rating system for hospitals and care homes. CQC are planning changes to the way they inspect, monitor and regulate care services, and implement more robust registration requirements. The Care Bill will also establish the first statutory framework for adult safeguarding. This will define local authorities’ responsibilities, and those of their local partners to protect adults at risk of abuse or neglect and place a duty on local authorities to set up Safeguarding Adult Boards.
4.3.3 **The Commission on Residential Care (2013)** – A year-long Commission that will assess how residential care can become a more valued part of the care system, develop into positive choice for older people with high support needs, and deliver personalised and empowering care.

4.3.4 **Local Context: BCCs Quality Assurance Framework** – states that everyone is responsible for ensuring that all vulnerable people in Bristol receive high quality care and support. It is important to know that services are delivered in a caring and empathetic way and with dignity and respect in order to uphold the diversity, values and human rights of the people using the service. BCC check this happens through its Quality Assurance framework and plan. BCC recognise that quality should underpin everything it does.

4.4 **Choice**

4.4.1 **Putting People First (2007)** – provides a commitment to ‘Personalisation’ based on the principles that service users should be enabled to have more choice and control over their social care, and that care services should reflect the aspirations and needs of those who use them.

4.4.2 **The Care Bill** (due to be implemented in 2015/2016) – sets out to achieve the vision of the 2012 white paper ‘Caring for our Future’. It extends personalisation and; places a legal responsibility on Local Authorities to provide a care and support plan, provides people with a legal entitlement to a personal budget, and enhances people’s rights to ask for direct payments to meet their needs.

4.4.3 **Local Context** – Personalisation is one of BCC’s service delivery principles and a key priority is to enable service users to have real choice about the support they receive and have maximum control over the way they live their lives. This is reflected in Bristol’s Health and Wellbeing Strategy 2013.

4.5 **Independence**

4.5.1 **Care Bill** – emphasises the need for Local Authorities to work with their communities to arrange services that help people to maintain their independence, prevent the development of care needs, or delay an increase in care needs.

4.5.2 **Bristol's Health and Wellbeing Strategy 2013** – emphasises that individuals should be able to remain independent for as long as possible, with access to support and advice when needed. Bristol also has a joint Rehabilitation & Reablement project.
Section Five: Description of the future commissioning model

5.1 Introduction

5.1.1 BCC has used the information shared in sections 1, 2 and 3 to consider the different features of a new commissioning model and the different options for how this would work. This section contains a series of proposals that have been developed that will form the new commissioning model. These proposals are just that and nothing is set in stone.

5.1.2 The proposals will give an overview of all aspects of the commissioning model. They are intended to be specific enough to allow people to consider the impact on the care home services they receive, provide and commission, yet broad enough to offer a lot of scope for discussion and agreement on the specific details of how this will work.

5.1.3 There are many aspects of this model that will benefit from feedback and suggestions from people involved in arranging, delivering or receiving these services. To help with this feedback process, a series of grey boxes have been included in this section to highlight key information, or where there is a proposal that BCC is particularly keen to hear feedback on.

5.1.4 BCC will use a 12 week consultation with stakeholders to go through a robust process of checking the document, challenge the proposals within it and refining the details of how services will be commissioned, arranged and delivered.

5.2 Overview of proposed commissioning model

How will it work?

5.2.1 The proposed commissioning model will be a ‘framework agreement’ between commissioner and providers.

5.2.2 There will be a formal tender process to decide which providers get on to the framework and all providers that want to be on it must submit a tender bid.

5.2.3 BCC will produce a Core Service Specification (CSS) that lists the different care home services (e.g. one to one care, food, accommodation) that BCC expects a provider to deliver.

5.2.4 Tender bids will require information from the provider on the quality of the services they will deliver in the CSS and the price they will charge.

5.2.5 The information submitted by providers will be used to assess their bids and rank providers according to their quality and cost in relation to the CSS.

5.2.6 Providers that are successful in this tender will be on a framework and ranked according to their bid score.

5.2.7 When looking for a care home for a service user, BCC will undertake a mini tender to identify suitable and interested providers.

5.2.8 The providers that respond will be ranked (as per their tender score) and the highest ranked providers put on a short list that will be offered to the service user.

5.2.9 The service user will then select the home they want to move to, from this shortlist.
Key information for providers

5.2.10 Providers that do not participate in the tender, or who do so and do not meet BCC’s minimum criteria, will not be on the framework. These providers will not have the opportunity to provide care home services for BCC-funded service users.

5.2.11 This new commissioning model will apply to new placements.

5.2.12 BCC is also looking to apply this model, or key parts of it, to existing placements.

Feedback prompt:
What aspects of this model do you think will work well?
What aspects do you think should be changed and how?
Which aspects of the new model could be applied to existing placements?

5.3 Overview of tender process and assessment of providers

5.3.1 BCC will issue a draft Commissioning Strategy (this document) and undertake a 12-week consultation with key stakeholders. At the end of this consultation period, BCC will produce a final Commissioning Strategy. This document will reflect feedback received during the consultation and will give full details of BCC’s firm plans for the tender process and the ongoing service delivery requirements on providers. The sharing of these documents and the start of the tender process will occur at the same time.

5.3.2 All Providers that wish to be on the framework will be required to participate in the tender process. The process will begin with BCC sharing information (through its web based portal) that sets out what is required of providers in their bid and the service that BCC expects to be delivered. This will include full information about the CSS (which is provided at Appendix 1), so providers know what they will be expected to deliver and can respond to this with appropriate information on their quality and price.

5.3.3 The information in each bid will be assessed by BCC against the evaluation criteria in two areas; quality and price. Each question in the tender will be assessed and scored against a set of criteria. All scores to all questions will be added together to come up with the final score for each bid. Providers will then be ranked according to their score.

5.3.4 There will be some questions in the tender that will require a provider to achieve at least a minimum score, or fulfill a minimum requirement in order to be on the framework. There will also be minimum overall score that a provider must exceed. Failure to achieve any of these requirements will mean that provider does not get on the BCC care home framework and no BCC funded service users will be placed in their care home.

5.3.5 The purpose of this tender process is to understand more about the care home services that a provider offers and the quality and price of these services. By undertaking a tender that will obtain information about various aspects of service delivery and by using a CSS to set a consistent requirement of all providers, BCC will be able to reach a more objective assessment of the quality and price of care.
home services, than at present. BCC’s decision making process will also be much more transparent and providers will be much clearer than at present about why they have or haven’t been asked to provide care home services for an individual. As a result, it is expected that these changes will strengthen the relationships BCC has with each provider and the market as a whole.

5.4 Quality

5.4.1 The information that BCC requires from providers will cover all aspects of service delivery, such as; organisational infrastructure, staff training and management, quality and preparation of meals, health and safety and provision and management of medication. This will help BCC understand; the services the care home offers, the type of needs and outcomes they are able to meet and how well they do this. As described in 4.4.2, a score will be given for each question in the tender and these will contribute to the overall score. BCC will use these scores to rank providers according to their service offer.

5.4.2 During the mini-tender, BCC will use an additional step to ensure that the short list includes providers that are the most suitable and appropriate for that service user and offer the type and quality of services required to meet their needs and outcomes. All providers will be required to register their interest in this placement and will also be required to submit brief information about how they would meet the needs and outcomes of the service user, as set out in the Support Plan. BCC will review these submissions and approve those that demonstrate they are suitable and appropriate for that service user. Providers that BCC does not believe are suitable and appropriate for the service user, will be eliminated. BCC will then create a short list based of those providers that are suitable and appropriate and based on their ranking in the tender.

Feedback prompt:
What information would stakeholders want BCC to obtain to ensure that care homes are suitable and appropriate for service users?

5.4.3 The tender will be the main opportunity for providers to share information about the quality of their service. The mini-tender will then give providers the opportunity to share brief information about how they will meet the specific needs and outcomes of that service user. Providers will not have any other opportunities to share information about the quality of their service, or any opportunity to change their ‘quality’ score.

Feedback prompt:
Should providers be given other opportunities to change their ‘quality’ submission to BCC and if so when and how?

5.4.4 BCC will continue to use a Quality Assurance Framework and Safeguarding Policies to identify poor practice. These will be used in a similar way in the future as they are at present, making use of placement bans where necessary.
5.4.5 All stakeholders should be aware that this model seeks to identify the most suitable care home service for a service user, at a price that is directly linked to what is needed and being provided. BCC will not pay for any extra care home services that are not specifically set out in the care documentation as being needed by the service user.

Expected benefits of new commissioning model

5.4.6 This commissioning model has been structured so that these statements and assurances can be made in relation to quality:
   a. BCC will only consider using providers that have demonstrated their services are of high quality, as the result of a thorough assessment of all aspects of their organisation and service delivery
   b. BCC will not consider using providers that have not had this assessment, or where they have and BCC is not satisfied that their services are of sufficient quality.
   c. BCC will only recommend a care home to a service user that is suitable and appropriate AND are one of the highest ranked providers in that lots
   d. BCC will give the service user the final choice of which care home they live in.

5.5 Price

5.5.1 BCC will not set a price, but all providers wanting to be on the framework will be required to complete a pricing schedule and submit a price they would charge to deliver services. There will be a single price to deliver the CSS and separate prices for additional care home services not included in the CSS (e.g. price per hour of one to one care). BCC has set up the CSS so that it covers the type and level of services that most service users will require.

5.5.2 The decision by BCC to follow this approach and not set a price, is in recognition of the differences in how providers operate and the various factors that could affect the price they would want to charge. These include their; method of service delivery, cost base, organisational ethos and additional costs and income streams. This will also ensure that BCC is paying that provider the ‘true cost of care’, or certainly a price that each provider has put forward and is happy to accept.

5.5.3 In the final Commissioning Strategy, BCC will give some guidance to providers on the rates that BCC expects to pay for the CSS.

Feedback prompt:
What changes would stakeholders want BCC to make to how the quality of care home services is assessed on an on-going basis?

Feedback prompt:
What type of guidance do providers want on price (e.g. banding, upper limit)? How do providers want to be involved in informing BCC price guidance?
5.5.4 Providers will have set points at which they can, if they want, change their pricing schedule. The first opportunity to set their price will be during the tender and then at regular intervals afterwards. As already stated, there will be no opportunity for providers to change their price ad hoc or to look to negotiate with BCC for the rate they will charge to deliver the CSS.

5.5.5 The assessment of the service user, and the BCC care documentation, will:
   a. Identify the service user’s needs and the outcomes they want to achieve.
   b. Confirm if the input required from the care home is within the CSS
   c. State any specific requirements the service user has that the providers should be aware of and that might affect the home they move to (e.g. location of care home)

5.5.6 If the care home service requirements are within the CSS there will be no negotiation on price. Once a provider has been selected to deliver the care home services the price that BCC will pay is the ‘standard price’ for that provider.

5.5.7 In some cases, the care documentation will state that additional care home services will be required to those in the CSS. Where this is the case, the prices the provider has put forward for these additional services will be included and BCC will pay the provider’s standard price, plus their rate for the additional services.

5.5.8 BCC will only pay for care home services that are identified in the Support Planning process undertaken by BCC social care staff and included in the care documentation. These will be the services required to meet the needs of the service user and help them achieve their outcomes. The rate BCC pays will be the provider’s standard price for the CSS (plus the cost of additional services if they are required)

5.5.9 Under the current commissioning model, price negotiation has occurred for approximately 50% of existing placements and different factors are brought into these negotiations that are separate to the service user’s needs and that sit outside of the Support Plan. These include requests for a higher price because “the service user has challenging or complex needs and may need extra care” or “we only have a large room left and we charge a bit more for this extra space”.

5.5.10 Under the new commissioning model, BCC will not:
   a. Enter into negotiations with providers on a case by case basis.
   b. Consider factors that are not directly stated into the care documentation and relate directly to the service user’s needs and outcomes

5.5.11 This approach will bring greater predictability to BCC and the providers about the rate that will be paid / received and greater transparency over the link between what is needed, what is being provided and what price is being paid.

Expected benefits of new commissioning model

5.5.12 This commissioning model has been structured so that these statements and assurances can be made in relation to price and finances:
a. Providers will know exactly what price they will receive to deliver the services in the CSS, and any other services that are required.
b. BCC will know exactly what price it will pay any given provider to deliver the services in the CSS, any other services that are required.
c. All parties will have been party to agreeing the rate and remove the need for any negotiations or concerns that BCC is not paying the true cost of care.

5.6 Lots

5.6.1 Any commissioning model must have structure and bring clarity and certainty for those involved. However, there are many complexities with care home services and the new commissioning model must reflect the very different and specific needs of service users and restrictions on providers around location, registration and services they can provide. It is not an open market in that many of the providers, regardless of the quality of the service they offer, will be totally inappropriate and unsuitable for a particular service user. This may be because they are not registered to deliver the services that person needs, or because they are based at the other end of Bristol to where that service user wants to live.

5.6.2 BCC wants to ensure that this model is sustainable and believes that ‘lots’ will help achieve this. Lots are a way of managing a framework agreement and organising providers according to how suitable and appropriate their home is for different groups of service users. The Lots will operate within the overall structure around price and quality that has been described, but offers the flexibility to ensure the new commissioning model has efficient practice and processes.

5.6.3 It is most common for lots to be organised around client group (e.g. service users with learning difficulties) or service type (e.g. residential care homes), but they could also be arranged according to geography (e.g. separate lots for the south Bristol and north Bristol).

Expected benefits of new commissioning model

5.6.4 Lots should ensure that:
   a. BCC is comparing like with like – Providers that deliver the same types of services to people with the same types of needs are ranked against each other.
   b. Providers only receive referrals that are relevant to them – Limitations on the type of services care homes can provide and the importance of factors such as location in a person’s choice about which home they move to, mean that there would be no point in a home receiving all referrals.
   c. BCC can manage capacity within lots and across all lots – BCC will understand exactly what capacity is available and who this would be suitable for.

5.6.5 Lots should also make the tender process simple and focused, as providers can concentrate on demonstrating their ability to meet the needs of a particular group. Providers will be able to bid for more than one lot.
5.7 Independence

5.7.1 All care home residents should be supported to maximise their independence. At present, the culture within care home services, reinforced by BCC’s requirements of them, is such that many daily living tasks are done for service users, rather than supporting them to do things for themselves. This can create a circle of increasing dependency where residents come to rely on, and expect, this type of help.

5.7.2 For many service users this will be absolutely appropriate, but the new commissioning model must encourage, facilitate and require a different way of working with people that want the opportunity to recover, recuperate and develop / their independent living skills. These are people who want to live more independently within the care home, or that want to move into accommodation that offers more independent living, which may be back to their own home.

5.7.3 In December 2012, BCC and BCCG jointly agreed a set of outcomes in a service specification that care home providers are required to work towards with service users. These outcomes are based on maximising independence using a ‘reablement approach’. Providers will be required to adopt a reablement approach where all aspects of how they set up and deliver services will need to consider maximising the independence of the service user. There is no requirement on providers to bring in additional expertise (e.g. physiotherapists) or to install extra facilities in the home (e.g. gymnasium). The requirement is that the default for all providers must be to ask “what can I do to maximise the independence of this person?”

5.7.4 This Commissioning Strategy seeks to further embed this reablement approach within care home services, using the outcomes defined in the service specification and working with an ethos of supporting service users to maximise their independence.

5.7.5 The expectations and requirements of care home providers are set out in the Joint Care Home Specification (between BCC and Bristol Clinical Commissioning Group). This gives full details about what providers are required to do and to achieve. Here are some of the inputs and outcomes that BCC expects from providers:
   a. Care tasks – Provider is required to establish what part the service user wants to play in their care and then work with them to achieve this. An example of this could be for the service user to feed themselves, rather than have a care worker do it for them.
   b. Lifestyle – Provider is required to establish how the service user wants to spend their time and to help them achieve this. An example could be that the service user wants to get a newspaper from the local shop, rather than have it brought to him. The provider should do what they can to facilitate this.

Feedback prompt:
Do you think Lots should be used as part of the commissioning model? If so, what should the lots be (e.g. service user group, geography)?
c. **Independent living** – Provider is required to identify people that have moved into their home but with the right type and level of support, could be helped back to a situation where they can move back into their own home. The provider could get the service user much more involved in how they structure their day and in the personal care (e.g. getting in and out of bed) and daily living tasks (e.g. doing laundry) to increase the skills and confidence of the service user.

5.7.6 As well as needing to ensure that the culture within care homes follows a reablement approach, BCC must also ensure the right services are in place to support this. BCC is currently reviewing and improving the reablement services it offers across the City, which includes a project involving BCC, BCCG and the Acute Health Trusts aimed at improving the reablement pathway in Bristol. The outcomes and deliverables of this project will inform the way care home services are commissioned in the future.

**Expected benefits of the new commissioning model**

5.7.7 The service user will have many more opportunities than at present to continue to live their life in the way they have become accustomed. The fact that they now live in a care home should not force them to change their lifestyle or to become de-skilled as a result of their situation and surroundings. Instead, it should encourage and facilitate them to continue living the life they want, in a way that reflects, but is not restricted by their current circumstances.

5.8 **Choice**

5.8.1 This starts with their choice about if a care home is the right place for them to be and this is discussed, where appropriate, during the social care assessment. This assessment will also identify any specific needs and requirements that service user has in relation to their future care home service and this will inform the care documentation shared with providers. BCC will use this information to create a shortlist of potential care, following a process already described in this section using ranking and lots. This short list will be shared with the service user, who will be supported to make the decision about which home is most suitable and appropriate to their needs, requirements and preferences.

5.8.2 Under this model, once in the home the service user must continue to be given choices and supported to make decisions. As with all other aspects of this model, this is about suitability and appropriateness, not about a one size fits all approach. This works two ways. It is not appropriate for BCC to demand that all providers offer all service users’ choice about every aspects of their care. Equally, it is not appropriate for providers to make assumptions about a person’s wishes, or their ability to make decisions, based on a service user’s medical diagnosis or the provider’s experience of how other people in the same situation react.

5.8.3 The expectations and requirements of care home providers are set out in the Joint Care Home Specification (between BCC and Bristol Clinical Commissioning Group). This gives full details about what providers are required to do. Here are some of the choices that BCC believes residents should be given:
a. Care tasks – The provider should give service users choices about how and when this care is delivered. Wherever possible this programme of care will be agreed as the result of discussions with service users. An example of this could be for the service user to state what time they want to get out of bed.

b. Lifestyle – The provider should work with the service user to establish how they want to live their life in the home and what is important to them. An example of this would be if a person wants to spend time with other residents or on their own, if they want to leave the home and if so, what do they want to do, how and when. It is acknowledged that any discussion will need to take focus on what can be achieved within the structure of the care home (e.g. what activities are available and the staffing rota’s), but this must improve on the current situation. An illustration of the current situation is that in a recent survey response, 24% of respondents reported they never leave the care home, with a further 33% reporting they are unable to, or find it difficult to get to all the places in their local area that they want.

5.8.4 The option of Direct Payments (DP) also remains open to service users as an alternative means of taking greater choice and control. BCC has been successful in becoming a Pilot site for a trial in the use of DP in care homes and this is an opportunity to ensure that service users within care home settings are afforded the same level of choice and control as those living in their own homes.

Expected benefits of the new commissioning model

5.8.5 As with service user independence, this new model will require all parties to consider how they can improve the service user’s situation. The outcome should be that the service user takes a much more active role in the decision making process, where they are can and want to be.
Section Six: Next Steps

6.1.1 Once this document has been seen and agreed by BCC senior management and political leadership, it will be issued to all stakeholders and form a key part of a formal 12-week consultation. The proposals in this document will be considered, discussed, challenged and more than likely changed, during this consultation. This will be done through a series of events for service users, providers and BCC staff. The views of key people will also be obtained in other ways (such as surveys) to ensure that no stone is left unturned in our attempts to ensure that all those affected by these changes have their opportunity to contribute. BCC will then make the best use of this information to design the best possible commissioning model for care home services in Bristol.

   a. 12-week Consultation Period begins: 6th August 2014
   b. 12-week Consultation Period ends: 29th October 2014
   c. BCC shares ‘You Said We Did’ document: By end of December 2014
   d. BCC produces final Care Home Commissioning Strategy: By end of January 2015.
Appendix 1: Core Service Specification

7.1.1 Listed below is the Core Cost Specification on services which must be included in your standard weekly price.

7.1.2 Some of the services included in the Core Cost Specification may not be included in your own standard placement prices; however you must quote for the provision of all the services in the Core Cost Specification below so please ensure you have adjusted your quote from your usual prices if appropriate.

7.1.3 In bidding for these services, the Provider agrees to provide the following services within their standard weekly price:

<table>
<thead>
<tr>
<th>1. 24 Hour Personalised Care and Accommodation including Administration Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Safe, high quality care which meets the individual’s needs:</td>
</tr>
<tr>
<td>&gt; 20 hours per week per resident</td>
</tr>
<tr>
<td>• All home cooked meals and refreshments; SU’s have access to a range of foods and drinks that meet their nutritional, cultural and ethical requirements and reasonable adjustments are made where necessary.</td>
</tr>
<tr>
<td>• Private, furnished bedrooms which can be personalised</td>
</tr>
<tr>
<td>• a full laundry service</td>
</tr>
<tr>
<td>• a daily cleaning service</td>
</tr>
<tr>
<td>• bed linen and towels</td>
</tr>
<tr>
<td>b. Work with Providers and statutory/non-statutory agencies to meet the Care and Support Plan</td>
</tr>
<tr>
<td>c. Medical Supplies (including medical equipment rental)</td>
</tr>
<tr>
<td>d. Continence Products</td>
</tr>
<tr>
<td>e. Utility Bills including:</td>
</tr>
<tr>
<td>• Gas</td>
</tr>
<tr>
<td>• Oil</td>
</tr>
<tr>
<td>• Electricity</td>
</tr>
<tr>
<td>• Water</td>
</tr>
<tr>
<td>• Telephone</td>
</tr>
<tr>
<td>• Television Licence</td>
</tr>
<tr>
<td>• Internet Access</td>
</tr>
<tr>
<td>• Council Tax</td>
</tr>
<tr>
<td>f. Insurance</td>
</tr>
<tr>
<td>g. Registration Fees (including Disclosure and Barring Service (DBS))</td>
</tr>
<tr>
<td>h. Recruitment</td>
</tr>
<tr>
<td>i. Direct Training (net of grants and supplies)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Initial and on-going assessment of need</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Conduct assessments of the individual throughout their placement, including written assessments</td>
</tr>
</tbody>
</table>
3. **Staff Costs (including ‘on-costs’)**
   a. Qualified Nurses
   b. Care Assistants
   c. Cleaning, Catering and Laundry
   d. Management, Administration, Receptionists, Activity Workers
   e. Agency Staff
   f. Maintenance and Gardener

4. **Activities**
   a. Any outings / activities to be included in the standard price – The Provider will ensure that a range of meaningful activities and events within / outside the home are available to meet social need.
   b. Activities will provide intellectual stimulation, focus on life stories, and enable SUs to re-establish lost skills and to develop new skills.

5. **Contact**
   a. Based on risk assessment and as specified in the Support Plan the Provider will facilitate, transport, host and promote contact with the SUs support network.

6. **Transport**
   a. The Provider ensures that provision is made to support all SUs in attending their screening and clinic appointments at the GP practice or hospital (e.g. eye screening, hearing tests, mammography or annual health checks). In order to ensure equality of access to Health provision, in the event of support being otherwise unavailable, the Provider will ensure that a staff escort is provided on request to enable SUs to attend appointments relating to their Health Care.
   b. SUs that require inpatient admission to hospital are accompanied by staff for a detailed handover, including necessary documentation, appropriate to their health needs (e.g. Traffic Light Assessments or Communication passports). It is not expected for staff to remain with the SU during their inpatient admission.

7. **Moving on**
   a. The Provider will ensure staff support the SU in planning for their future from the time they start using the service. This will form part of the Provider Care and Support plan and SDS Support plan / CHC Care Plan. In doing so, the Provider will ensure the SU is involved in all meetings to discuss their future move.
   c. SUs can visit the place they are moving to and keep their current accommodation while they make a decision about moving. The Provider will facilitate this process to ensure it happens smoothly.
   d. SUs who move on must have the opportunity to keep up friendships made during their time at the home. The Provider will facilitate this process, where practicable to ensure it happens smoothly.

8. **Religious and Cultural Beliefs**
   a. SUs are given the opportunity and support they may need to practise their beliefs, including keeping in touch with their faith community and having access to resources relating to religious and cultural needs.

9. **Equipment**
   a. The Provider will make sure that aids, adaptations and equipment are suitable.
available and properly maintained and will ensure that appropriate care is given safely, according to the individually assessed needs of each SU in order to maintain and promote SUs’ independence.

b. The Provider will carry out pre-admission assessments in order to identify potential SUs’ current and likely future need for equipment which will be met by the Provider and may include equipment not normally provided by the home which will be added as an additional service.

c. In line with ‘Bristol Community Equipment Service Policy for the Provision of Equipment in Care Homes’ September 2012.

10. Repairs and Maintenance / Capital Costs

a. Land
b. Buildings and equipment meeting National Minimum Standards
c. Maintenance capital expenditure
d. Repairs and Maintenance
e. Contract Maintenance
f. Surplus / Profit

Additional Services Costs:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Fee</th>
<th>Per Hour</th>
<th>Per Day</th>
<th>Per Week</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Care 1:1</td>
<td>£</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Care Worker 1:1</td>
<td>£</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Equipment</td>
<td>£</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Physiotherapy</td>
<td>£</td>
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<td>Occupational Therapy</td>
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<tr>
<td>Speech Therapy</td>
<td>£</td>
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<td>Other (please provide description)</td>
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<tr>
<td>Other (please provide description)</td>
<td>£</td>
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