Department of Health & Social Care

Market Sustainability and Improvement Fund 2024 to 2025 - Qualitative Capacity Plan Template

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Contents

Use this template to complete the qualitative aspect of the capacity plan as part of the Market Sustainability and Improvement Fund (MSIF) in 2024 to 2025.

Note: local authorities are not required to publish their own MSIF capacity plan return for 2024 to 2025, as set out in the MSIF guidance for 2024 to 2025. DHSC intends to publish a report, including the data provided by local authorities, following submission and analysis of returns.

Local authorities must complete sections 1, 2 and 3. Completion of section 4 is optional.

Templates should be returned to msifcorrespondence@dhsc.gov.uk.

Deadline for submission: 11:59pm on 10 June 2024

Section 1: Capacity in winter 2023 to 2024

Give details of what measures were put in place during winter 2023 to 2024 to ensure sufficient capacity across your social care markets, and an assessment of how successful these measures were. You may wish to include information from last year's document which states what actions you planned to take in winter 2023 to 2024, with an update on how successful each was. (500 words maximum)

Sefton worked in partnership with Health to secure additional block-booked capacity in existing Intermediate Care beds in order to support with timely Hospital discharges. This included the commissioning of a further 27 beds across two facilities for a mixture of Residential and Nursing beds.

We also re-modelled beds in another existing Intermediate Care facility in order to put in place a discharge to assess bed-base which operated in partnership with community Health and therapy services in order to support people to regain their independence.

These commissioning arrangements were successful as they ensured that the level of delayed discharges were reduced and that people were assessed in these bed-based facilities for their longer-term care needs and many people were then supported to return home.

We also implemented a new commissioning framework for Domiciliary Care, which included the following model elements:

- **Provider Base** – Sefton being split into three locality areas which will have two Tier 1 Providers who are required to accept 80% of referrals between them. there will then by Tier 2 Providers that can also accept packages. The new framework was also implemented to control the number of core Providers commissioned in order to support sustainability for Providers and enable greater sufficiency in the market.
- **Revised Contractual Arrangements** - the implementation of block contracts to 'guarantee' a level of income/business for Providers and to secure dedicated market capacity to primarily support with ensuring timely acceptance of Hospital Discharge referrals (whether they be for long-term or short-term services) and to ensure capacity to accept urgent community referral cases. These block-booking arrangements also ensured that there was dedicated capacity to support with 'flow' through the additional bed-based provision we put in place, such as with respect to people who accessed the beds but who then were ready to be discharged from these beds but who required a Domiciliary Care package once they returned home. The new model also includes all Providers adopting a Trusted Assessor role in order to identify where people may require less support which in turn assists with releasing market capacity.

We also worked with our Reablement Provider to expand their capacity in order to ensure further support with timely Hospital discharges.

We also expanded our brokerage function and put in place additional Social Work Staff in order to facilitate more timely assessments of people and to ensure that both care home and domiciliary care packages could be commissioned in a more timely manner, including those into block-booking arrangements. These arrangements ensured that

the number of people awaiting a package of care either from Hospital or in the community were significantly reduced.

For care home placements we also utilised discharge funding in order to ensure that Providers were supported to accept placements of people with higher levels of acuity and to ensure that decisions on placing people could be made more quickly and not lead to delayed discharges.

Section 2: Current capacity

Give an assessment of any current capacity gaps within your markets for a) long term nursing care, b) long term residential and c) long term community care (with a particular focus on home support and supported living). Include details on what the required capacity is, the available capacity in the market, and the level of capacity that is currently affordable. (750 words maximum)

With respect to long-term **nursing care**, the current capacity gap relates to the number of beds that are available at the Council's 'standard' contracted rate. Recent analysis shows 80 vacancies but only 2 of these were in homes that do not levy a top-up. Furthermore, of these 80 vacancies only 29 of these were in homes located in South Sefton. There is therefore a particular gap for affordable placements in South Sefton.

For long-term **residential care** whilst there are 134 beds available based on recent market analysis, only 19 of these were in homes without a top-up. In terms of Service User needs, there are gaps for dementia placements and placements that can accept people with mobility needs and who may then require support from two Staff to transfer. We also have issues with making placements for people with complex needs such as Korsakoff's and autism / learning disabilities and as a result we have had to then place in out-of-borough specialist care homes due to a lack of such provision in Sefton.

For **Home Care** we have on average 20 people awaiting a package of care and based on an average number of weekly hours per package of 11.7, this equates to a total required capacity of 234 hours per week as a minimum, however it is important to highlight that our strategic aim is to increase the number of people who receive home care and reduce the number of care home placements we make, particularly general residential placements.

Based on anticipated growth of 6% this equates to additional weekly hours of 1,040, however this figure would be higher when taking into account that there may also be a growth in the number of people that utilise a Direct Payment to arrange their own Home Care service.

We do through also have capacity issues in certain geographical areas such as Formby, Ince Blundell, Hightown and Maghull. This is typically due to there being a low number of existing packages in these areas and are therefore more difficult for Providers to mobilise Staff and therefore require additional Staff travel time and mileage costs, however we have significantly increased fee rates in order to further

support Providers and implemented a new commissioning framework to establish new locality-based arrangements to support with service delivery in these areas.

Recent analysis showed that there were 2,758 weekly hours available / reported by Providers through the Capacity Tracker system, however of these, 1,630 were deemed to be hours that were potentially affordable as the remaining hours were deemed unavailable / unaffordable due to factors such as the fee rates levied by the Providers, some capacity being with Providers who state that their minimum call duration is one hour which therefore Sefton would not be able to commission for people who have an assessed need for call durations of a shorter duration than this and with Providers where there are significant quality concerns and they are currently CQC rated Inadequate so they would not be commissioned.

In terms of **Extra Care**, we have identified that there are capacity gaps, given current supply and the identification of the need to develop more Extra Care Housing as a viable alternative to residential care. At present we have two schemes (95 units) and both are reporting 100% occupancy. Our Extra Care Housing Prospectus identifies the aim to deliver 1,306 extra care units by 2036 then this would further enable us to reach our ambition to approach the national best quartile for residential admissions. This would require us to divert a total of 842 placements per year. At present we have plans for six new schemes to be operational by 2026/27 providing up to an additional 560 units.

For **Supported Living**, there are currently 543 bedspaces in commissioned services in Sefton and 508 (96%) of these are occupied. As a result, at present there are not any significant capacity issues as the available capacity is deemed affordable given they are voids in existing Sefton commissioned services, however there are gaps to place people with complex needs, such as S117 cases and additional dedicated capacity is in the process of being commissioned to address this issue.

We have also identified that there is a required capacity for less intensive services including services that provide a lower level of care/support to people as opposed to solely having schemes that operate on a 24/7 model.

Section 3: Future capacity

Give an assessment of any future capacity gaps within your markets for a) long term nursing care, b) long term residential and c) long term community care with a focus on winter 2024 to 2025. Include a detailed plan on how these capacity gaps will be addressed. (750 words maximum)

For **nursing care** we have assessed that there are future gaps for dementia placements, particularly in South Sefton. As part of our proposed new commissioning framework we will be working with current Providers to re-categorise their services so that they can support this cohort.

A further gap is with respect to placements which are available that are affordable. To meet this gap we continue to pay enhanced rates / top-ups where necessary and to support this we have implemented a new 1:1 policy and process to be used when commissioning additional care and support for people in care homes.

For **residential** care we have assessed that whilst there are no gaps in terms of current placements available and the fact that our strategic aim is to support more people to remain in their own home for longer, there are gaps with respect to placements that can support people with higher acuity levels.

For winter 2024/25 we continue to work with Health partners, including on the delivery of schemes under the Better Care Fund, and these include re-modelling and expanding Intermediate Care bed-based services in order to support with timely Hospital discharges and to then ensure that more people are rehabilitated which then results in where they then require long-term residential or nursing care, the care homes are better placed to support them and meet their needs.

We have also had approval to implement a new care homes commissioning framework to better manage the market and to provide a mechanism for further integration and working with the market to re-model services so that they can meet our longer-term needs.

For both residential and nursing placements we are also assessing the need to block-book some beds to ensure further dedicated capacity over the winter period.

For **home care**, we are further implementing our new commissioning framework in order to put in place more capacity including through issuing new 'lead' provider contracts with two providers in North and South Sefton. These contracts will ensure that there are additional contractual arrangements in place with providers to accept packages in a timely manner and who will receive more structured contractual arrangements, including block-booking of hours to ensure dedicated capacity, especially during winter so as to ensure that there is capacity in place for them to accept hospital discharge cases. These new arrangements will seek to secure an additional 400 block-booked hours per week across Sefton.

We are also exploring the re-opening of our commissioning framework to attract new applicants, including those Providers that are current spot purchased but who levy rates higher than our contracted rates, but who now may wish to apply in order to be on the framework to regularly receive more referrals. This in turn will enable us to access additional capacity reported by these providers, as outlined in section 2 of this template.

A key issue affecting capacity is the lack of reablement service capacity to ensure that people initially receive a phase of reablement in order to maximise their independence and therefore reduce the level of long-term care required. To meet this gap, we are commissioning additional reablement providers to deliver up to 500 hours per week each and seeking to expand the 'intake model' of reablement so that as many people as possible receive it before longer-term home care is arranged.

Our new commissioning model also requires all providers to adopt a trusted assessor role whereby they regularly review people and make recommendations on the potential to reduce their existing care package which in turn then releases market capacity.

For **supported living**, we are securing additional capacity (up to 9 units) of capacity to support people with complex needs (including S117 cases) and which can also be utilised for people awaiting discharge from Hospital. We are also continuing to utilise

a new Liverpool City Region procurement framework to expand our provider bases, including those providers that can support complex people.

Section 4 (optional): Methods of commissioning

Give any additional information or context regarding the proportion of care commissioned using different methods that you provided banding for in question 6 of the quantitative return. (300 words maximum)

For **residential and nursing care**, the level of long-term placements commissioned under structured and/or block arrangements is negligible, however as part of future commissioning arrangements there will be more structured arrangements including the potential to block-book some beds especially for people with complex needs and to support some care homes with their ongoing viability and to reflect that certain categories of beds will always be required.

There have been block-booking arrangements, commissioned in line with our winter plans, however such beds are primarily for short-term placements.

For **home care**, our new commissioning framework has outlined to providers that we remain committed to the further expansion of block-booking arrangements in order to support providers with their viability and to put in place dedicated staffing teams. Currently bloc-purchasing is only with respect to the delivery of short-term services which primarily support with ensuring timely Hospital discharges, however.

Our new framework also includes more structured commissioning arrangements with Tier 1 providers who between them are required to accept 80% of referrals and then us having Tier 2 providers who can also accept referral. The figures reported in question 6 of the quantitative return are lower as these new arrangements are still being embedded.

For **supported living**, we do have some block contracts but we are further exploring the expansion of these arrangements, as linked to our future work outlined in section 3 of this template.

For **extra care** services these two contracts are both block-booked for daytime and nighttime hours provision in order to ensure that there is a dedicated staff team in place.