Northern Health and Social Care Trust

Rural Needs Screening Template

Section 1: Define activity subject to Section 1(1) of Rural Needs Act (NI) 2016
1A. Short title describing activity being undertaken that is subject to Section 1(1) of the Rural Needs Act (NI) 2016: Northern Trust (NHSCT) proposal to purchase domiciliary care provided by non-statutory providers.
1B. Are you Developing, Adopting, Implementing or Revising a Policy a Strategy or a Plan? (Underline or Circle) **Or are you delivering or designing a public service? (Underline or Circle)** **What is official title of this Policy, Strategy, Plan or Public service (if any)?** How we propose to purchase domiciliary care provided by non-statutory providers. Consultation document 6 September 2021- 29 November 2021 –
1C. Give details of the aims and/or objectives of the Policy, Strategy, Plan or Public Service: To implement a contract model for the procurement and future delivery of non-statutory domiciliary care services across the NHSCT area. Domiciliary care is the provision of personal care and practical support that is necessary to maintain a service user in a measure of health, wellbeing, hygiene and safety as assessed by the Trust. Currently domiciliary care services are delivered by statutory and non–statutory providers to over 5000 service users in their own home. The way NHSCT purchase domiciliary care needs to change due to legislative requirements and also to ensure services provided meet the current and future needs of the NHSCT population. Approximately 25% of the population of NI live within the NHSCT, increasing to 27% when only looking at age 75+. Over the next 10 years the population of NHSCT age 85+ is expected to increase by 49%, nearly half of the population. Anticipated outcomes are: - Responsive and equitable service delivery including the timeliness of when a service will start, both following an admission to an acute hospital and when a person is assessed as needing a service whilst living in their own home. The service must also be equitable across the whole Trust locality, with no service user being disadvantaged due to their home address or any other factors. - Alignment to strategic direction as a more person centred, flexible approach will be taken to the delivery of care. - Application of robust governance arrangements for the delivery of quality domiciliary care services that provide the required assurances including, but not limited to, hours delivered and lone worker arrangements - consistency and continuity of care - EU procurement directives and legislative compliance. Domiciliary care services have traditionally been purchased on an annual basis from established non-statutory providers with contracts rolling forward each year. NHSCT procurement processes need to be compliant with Public Contracts Regulations (2015).

Northern Health and Social Care Trust

1D. What definition of 'rural' is the Trust using in respect of the Policy, Strategy, Plan or Public Service:

Population Settlements of less than 5,000

Section 2 - Understanding impact of Policy, Strategy, Plan or Public Service

2A. Is the Policy, Strategy, Plan or Public Service likely to impact on people in rural areas?

Yes ■ No ☐ If response is NO Go To Section 2E.

2B. How is it likely to impact on people in rural areas?

Research carried out for Public Health England (2017) - Health Profile Shropshire http://fingertipsreports.phe.org.uk/health-profiles/2017/e06000051.pdf identified 'two key challenges' for rural service delivery of domiciliary care:

- Lower population density impeding economies of scale resulting in higher per unit costs for service delivery.
- The penalty of distance. The distance from providers to rural service users involves higher travel costs, opportunity costs and unproductive time for staff.

It was also noted that in many rural areas the demographic and sparsity challenges of providing home care are compounded by other factors including:

- Difficulties for clients in accessing health services which are likely to be further away and often inaccessible to them by bus. This may result in first contact with social services being at a 'moment of crisis'
- An older housing stock, which may be of inappropriate design (e.g. entrance steps, narrow staircases)
- Fuel poverty which is more prevalent in rural areas due to the characteristics of the housing stock (older and often single skinned) and where mains gas is frequently unavailable
- A shortage of suitable housing options, both in terms of house types (such as small bungalows) and support (e.g. sheltered housing, supported living and extra care)
- Older people are often geographically separated from family
- Potentially hidden need
- Isolation

This proposal includes delivery of locality based services with NHSCT geography delineated into the ten historic Borough Council areas covered by the Trust. The Trust's geographical area is considered too large for any one provider to deliver services across and therefore will be broken down into localities or areas. The approach considered most appropriate is to create areas based on the 10 large towns (historic Borough Councils) across the Trust area. These are referred to hereafter as 'lots'.

Table 1 below is for illustrative purposes and shows the 10 lot locations and the NISRA population size. (This is for indicative purposes only).

Northern Health and Social Care Trust

Table 1 – Population by area 2021

Location of Lot	Trust Locality	Population size
Antrim	Antrim/Ballymena	55,541
Ballymena	Antrim/Ballymena	67,230
Carrickfergus	East- Antrim	39,340
Larne	East-Antrim	32,704
Newtownabbey	East-Antrim	87,963
Ballymoney	Causeway & Glens	32,465
Coleraine	Causeway & Glens	60,159
Moyle/Ballycastle	Causeway & Glens	17,395
Cookstown	Mid-Ulster	38,952
Magherafelt	Mid-Ulster	47,611

The table below takes the geography of NHSCT and aligns it top the categories of settlement as defined by NISRA, the categories with populations of 5000 or less are Category F(intermediate settlement), Category G (village) and Category H (open countryside). Taking the population of NHSCT at the time of the 2011 census (most recent figures available) this shows that 197,542 people out of 463,297 residing in NHSCT area (42.63% of NHSCT resident population) reside in one of these 3 categories, almost half of the population that NHSCT covers. 155,011 reside in open countryside, a category where there is significantly less likely to be economies of scale for non statutory providers in delivery of domiciliary services to these areas as there will be longer travel times and associated fuel costs along with loss of service delivery time to physically travel to the service user's home address. This table shows that there is a need to look at mitigation through a mixed economy of domiciliary care services in any model implemented to ensure that there are viable alternatives to provision by non statutory providers to ensure coverage of all areas of the NHSCT geography.

Classification	**Settlement Development Limit (SDL)**	**2011 Census Population**
BAND C - LARGE TOWN (POPULATION 18,000+)	METROPOLITAN NEWTOWNABBEY	65,555
	BALLYMENA	29,467
	CARRICKFERGUS	27,903
	COLERAINE	24,630

	ANTRIM	23,353
	LARNE	18,705
Band Total	**6**	**189,613**
BAND D - MEDIUM TOWN (POPULATION 10,000 - 17,999)	COOKSTOWN	11,620
	BALLYMONEY*	10,393
Band Total	**2**	**22,013**
BAND E - SMALL TOWN (POPULATION 5,000 - 9,999)	BALLYCLARE	9,919
	MAGHERAFELT	8,819
	PORTSTEWART	8,029
	PORTRUSH	6,442
	GREENISLAND	5,484
	BALLYCASTLE	5,238
	CRUMLIN	5,099
	RANDALSTOWN	5,099
Band Total	**8**	**54,129**
DEFAULT URBAN/RURAL SPLIT		
BAND F - INTERMEDIATE SETTLEMENT (POPULATION 2,500 - 4,999)	MAGHERA	4,217
	WHITEHEAD	3,786
	AHOGHILL	3,403
	BROUGHSHANE	2,851
	CULLYBACKEY	2,569

Band Total	**5**	**16,826**
BAND G - VILLAGE (POPULATION 1,000 - 2,499)	CASTLEDAWSON	2,292
	KELLS / CONNOR	2,053
	MONEYMORE	1,897
	GLENAVY	1,791
	DRAPERSTOWN	1,772
	KILREA	1,679
	CARNLOUGH	1,512
	TEMPLEPATRICK	1,437
	DOAGH	1,390
	CLOGH MILLS	1,309
	BUSHMILLS	1,292
	CASTLEROCK	1,287
	CUSHENDALL	1,276
	GARVAGH	1,274
	DUNLOY	1,215
	BELLAGHY	1,115
	RASHARKIN	1,114
Band Total	**17**	**25,705**
Bands A – D Total (Population 10,000+)	8	211,626
Bands E – G Total (Population 1,000 to 9,999)	30	96,660
TOTAL A – G	**38**	**308,286**
Band H - open countryside	**-**	**155,011**

Northern Health and Social Care Trust

2C. If the Policy, Strategy, Plan or Public Service is likely to impact on people in rural areas *differently* from people in urban areas, please explain how it is likely to impact on people in rural areas differently? See response at 2B above.

2D. Please indicate which of the following rural policy areas the Policy, Strategy, Plan or Public Service is likely to primarily impact on.

Jobs or Employment in Rural Areas		Community Safety or Rural Crime		Agriculture-Environment	
Education or Training in Rural Areas		Health or Social Care Services in Rural Areas	**X**	Other, please state below;	
Rural Development		Broadband/Mobile Communications in Rural Areas			
Poverty or Deprivation in Rural Areas		Rural Business, Tourism or Housing			

2E. Please explain why the Policy, Strategy, Plan or Public Service is NOT likely to impact on people in rural areas.

See response at 2B above. This is a home based service with assessment and any subsequent care delivery taking place in service user's home. The proposed non-statutory contracted service includes all locality areas (historic council areas) within NHSCT. Awards will be made in each area for long term care delivery and for short term care delivery. This should provide full coverage of the Trust geographical area.

There will also be continued availability of an in-house service – this will provide mitigation arrangements in the event of a particular geographical area not covered by the non-statutory provider. Service users can also take control of delivery of their domiciliary care needs through direct payments.

The interaction of these 3 elements should bring a positive impact to residents of NHSCT area including those who dwell rurally.

If you completed 2E above GO TO Section 6

SECTION 3 - Identifying Social and Economic Needs of Persons in Rural Areas

3A. Has the Trust taken steps to identify the social and economic needs of people in rural areas, relevant to the Policy, Strategy, Plan or Public Service? Yes ■ No ☐ if the response is NO, GO TO Section 3D

3B. Which of following methods or information sources were used by the Trust to identify these needs?

Consultation with relevant stakeholders / Survey or Questionnaire / Research / Statistics / Publications / Other methods.

Northern Health and Social Care Trust

Please provide details:

As part of the development of the proposed new arrangements for purchasing domiciliary care services, we reviewed existing research and engaged widely with service users and carers to find out what improvements could be made to domiciliary care services.

The Expert Advisory Panel on Adult Care and Support in their production of 'Power to People – Proposals to reboot adult care and support in NI', formed the Adult Care and Support Reference Group, consisting of service users and carers and which was facilitated by the Patient Client Council.

Comments and suggestions made by this group included:

- Need to see a greater acknowledgement of the needs of other populations, specifically younger people with disabilities;
- Need a 'mutual approach' to service delivery based on 3 elements – prevention, performance management and partnership working;
- Service users and carers should be empowered to determine the level of risk acceptable in their own homes and communities, for example, the current menu of services is restricted by standards and regulations

We issued a questionnaire asking eight straightforward questions covering areas of key importance to both a service user and their carer with prompts included to assist and with questionnaire completion. The analysis of returns is helped us to shape the development and delivery of our proposal. Trust care management and social worker staff carried out the survey of 133 service users and carers.

The overall results of the survey are summarised in the following table.

Feedback	% Total
Described quality of care delivered as good or very good.	85%
Strongly agreed or agreed that quality of care is the same on a weekly basis.	85%
Of very high importance or of high importance to maintain independence or improve quality of life.	83%
Strongly agreed or agreed that they felt listened to by Care Worker.	89%
Very important or important that there are the same or a small number or Care Workers.	86%

Very important or important to not feel hurried or rushed when being cared for.	96%
Communication very important or important between themselves and the Provider of care.	91%

On 26 May 2021 we held an online engagement event with service users, carers and representative groups – a summary of the feedback we received is listed below.

- Strong support for locality based services.
- A strong preference for care worker call times to be consistent.
- A strong preference for the care workers to be consistent, reinforcing continuity of care.
- Service users do not want to feel rushed or hurried by the care worker.
- Improved communication between the care worker and the service user.
- Importance of care worker training to ensure individual service user's needs are met

3C. What social and economic needs of the people in rural areas have been identified?

The issue of service availability is a valid concern in rural areas. The proposal relates to a cost/volume contract model**.** This option allows for a combination of a cost/volume contract and a spot purchase arrangement built upon current baseline volumes. Providers must also accept all referrals within the contract hours. A cost/volume contract offers the following.

- A mixture of guaranteed/block volume and spot purchasing arrangement, to offer sustainability of service.
- A guaranteed/block volume of hours per week across all programmes of care
- The remaining volume to be utilised using a spot purchase arrangement
- The guaranteed/block volume is proposed to be divided across geographical areas and from those areas the Trust will create lots (Table 1). There will be separate contracts within the lots for short-term and long-term services
- At least two contracts will be awarded per lot – one short term and one long term, however a higher number of contracts will be created in lots with the highest populations
- Providers awarded a contract within a lot will be expected to provide contingency within the lot for other providers delivering services within the same lot.
- The providers will be required to provide additional spot-purchased hours where demand for services within their geographical area exceeds the guaranteed/block hours.

- A contract term of 3 years with the option of 2 x 12 month extensions which offers the opportunity for a more stable and sustainable environment for providers, enabling better continuity of care for service users and carers
- Includes services for older people, people with a physical, sensory or learning disability, people with a mental health condition and children and young people.
- Providers could be successfully awarded a number of lots although they will not be able to be the sole provider within any lot to ensure contingency arrangements/support is available.
- A Provider can be successful in being awarded contracts within a lot for both short-term and long-term services provided the lot requires at least 3 contracts and thus another provider will also be operating in the lot for the purpose of contingency.
- A provider can only be successful in being awarded a maximum of one long-term and one short-term service within a lot
- It is anticipated the number of awarded contracts/providers will range from 20 - 40.
- We will have monitoring officers who will undertake both planned and unplanned checks to ensure the services are delivered appropriately.

Arrangements will be factored into the contract model to manage the situation in the unlikely event that the provider of a lot is unable to fulfil the contract terms in delivering the domiciliary care service. These will include the following.

- Each lot will have a minimum of two providers. A provider cannot be awarded all contracts within a lot to ensure at least one contingency provider exists.
- The lots will be awarded based on the number of hours of service delivery available with the highest number of lot hours being awarded first, the second highest awarded second, and so on. Once a provider has won the maximum number of contracts available to them within a lot, they will be removed from the lot to ensure at least one contingency provider exists within each lot. Lots will be re-marked in respect of pricing.
- Potential providers can bid for all lots but once they have been awarded the maximum contracts available within a lot will be removed from the tender process.

The proposed model will support the following benefits.

- A more sustainable service that will provide greater continuity for the Trust, service users, carers and their families.
- The creation of geographical areas/lots that will enable providers to create robust infrastructures and contingency arrangements.
- Guaranteed levels of activity that will promote provider sustainability, stability and increased efficiency.

3D Please explain why no steps were taken by the Trust to identify the social and economic needs of people in rural areas?

Northern Health and Social Care Trust

Not applicable

SECTION 4 - Considering Social and Economic Needs of Persons in Rural Areas

4A. What issues were considered in relation to the social and economic needs of people in rural areas?

Service availability across the Trust geographical area, service user choice in relation to delivery of service, the benefits of continuing to have a mixed economy of care including statutory in house provision and direct payments

SECTION 5 - Influencing the Policy, Strategy, Plan or Public Service

5A. Has the policy, strategy, plan or public service been changed by consideration of the rural needs identified?
Yes ■ **No** ☐ **if the response is NO, GO TO Section 5C**

5B. If yes, how have rural needs influenced the policy, strategy plan or public service?

This is a service delivered in the service user home environment with the aim of maintaining their ability to continue to live in a community setting. It is therefore important to cover all geographical areas of the Trust and this has been achieved by splitting the Trust into locality areas aligned to the historic councils. There will be awards on a long and short term basis for each identified locality.
Mitigation to ensure spread of service delivery includes continued statutory in house provision and the use of direct payments to allow service users to take control of their own domiciliary care delivery**.**

5C. If no, why have the rural needs identified not influenced the policy, strategy, plan or public service? Not applicable

Section 6: Documentation:

6A. Please tick below to confirm that the RNIA Template will be retained by the Trust and relevant information on the Section 1 activity compiled in accordance with paragraph 6.7 of the guidance.

I confirm that the RNIA Template will be retained and relevant information compiled

Approved by:	Trust Board		
		Date:	26 August 2021