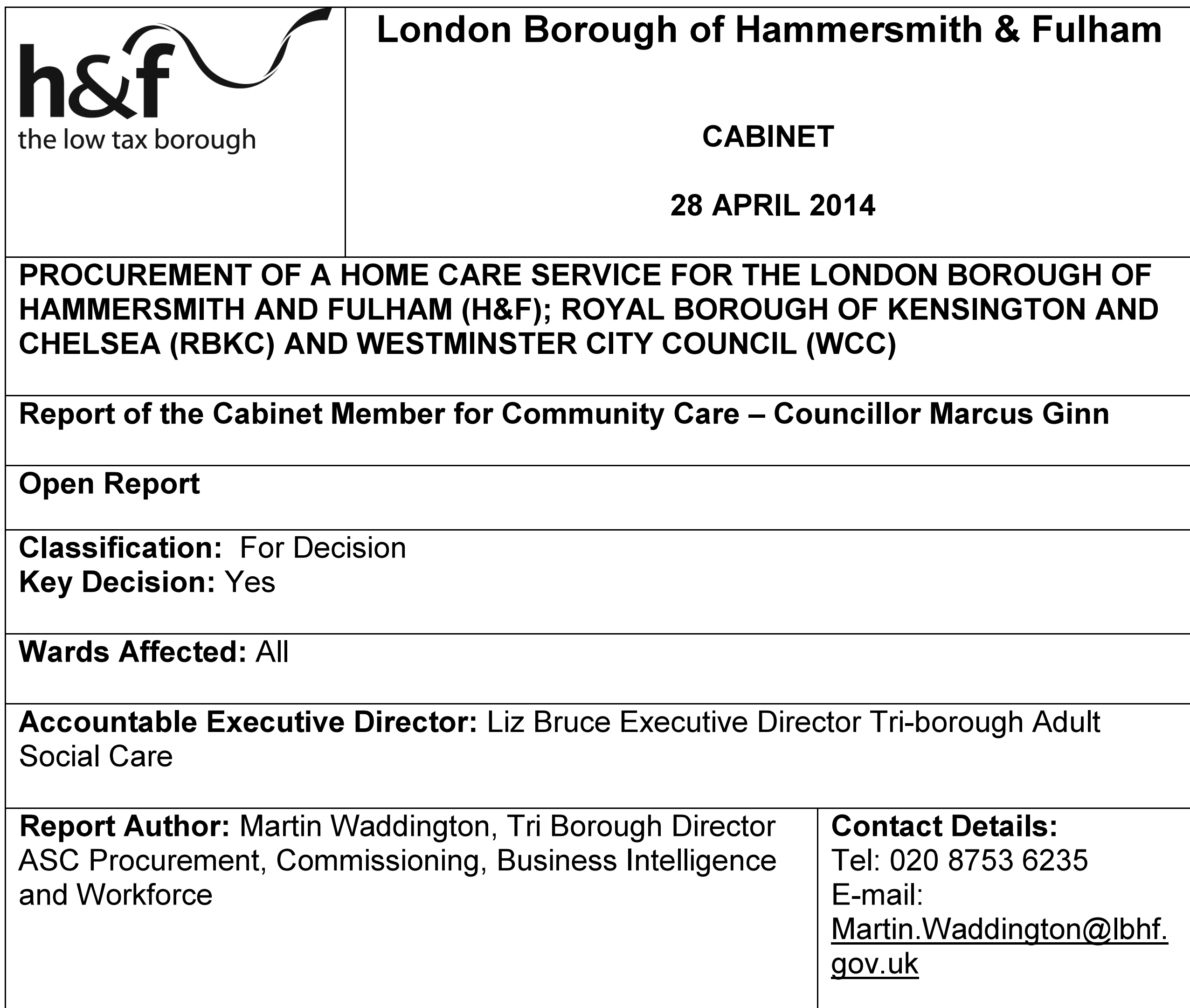

the low tax borough	London Borough of Hammersmith & Fulham **CABINET** **28 APRIL 2014**
PROCUREMENT OF A HOME CARE SERVICE FOR THE LONDON BOROUGH OF HAMMERSMITH AND FULHAM (H&F); ROYAL BOROUGH OF KENSINGTON AND CHELSEA (RBKC) AND WESTMINSTER CITY COUNCIL (WCC)	
Report of the Cabinet Member for Community Care – Councillor Marcus Ginn	
Open Report	
Classification: For Decision **Key Decision:** Yes	
Wards Affected: All	
Accountable Executive Director: Liz Bruce Executive Director Tri-borough Adult Social Care	
Report Author: Martin Waddington, Tri Borough Director ASC Procurement, Commissioning, Business Intelligence and Workforce	**Contact Details:** Tel: 020 8753 6235 E-mail: Martin.Waddington@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report sets out the proposal for new home care services for people who meet Adult Social Care (ASC) eligibility criteria in Hammersmith and Fulham (H&F), Royal Borough of Kensington and Chelsea (RBKC) and Westminster City Council (WCC). It outlines the work with the Clinical Commissioning Groups to develop and deliver joined up services and requests permission to tender for the home care service. A further report will be presented to award contracts after the procurement process is completed.

1.2. The proposal represents a significant investment of £1.8m in a vital front-line service but this can be achieved with no net increase in local authority funding. There has been a reduction in the number of people in residential care of 8.9% since April 2011. The budget pressures caused by the increased activity in home care that have supported this reduction will be met through an ongoing virement of between £403,000 and £688,000 per annum from the budget for residential care. The remaining budget

pressures of £1.4m caused by providing a better quality service will be mitigated by new ways of working in the planning, delivery and reviewing of home care and through the receipt of a contribution from the CCG towards the cost of the service.

1.3. The new service will be one that promotes and delivers more of a reablement approach, and actively reduces the number of people admitted to hospital or to residential care, thus supporting the Council and CCG strategies of increasing the number of people supported in their own homes and reducing hospital admissions.

1.4. All three boroughs have contract arrangements in place that can be terminated with three months notice and this allows the opportunity to procure an improved and more streamlined service across the Tri-borough. Hammersmith and Fulham (H&F) will be the lead procurement authority for the proposed tendering arrangements by Adult Social Care.

1.5. A financial model has been developed that allows for comparison of the budgets associated with various service delivery options with the existing budgets for home care. This enabled the Cabinet Members for each borough to consider various levels of quality and costs and based on these discussions, the jointly preferred option is one that combines:

- A mixed skills workforce
- Inclusion of an element of travel time in the unit price
- A reablement approach to delivering home care
- The use of electronic monitoring to record care delivery

1.6 Current activity and future projections show that home care services need to be able to support more people who have increasingly complex care needs. This requires greater integration with local health services, more of a focus on supporting the whole person and the making of links with the wider community, and in some cases workers who can undertake a mix of health and social care tasks.

1.7 There are risks associated with the move to this new model, but there are greater risks associated with continuing with the existing model. The model is based on a whole system change. It puts more emphasis on the person using the service as a customer and requires provider, Council and NHS staff, to adjust their practice and systems in such a way that people receive the right type and amount of support at the right time, rather than being required to fit in with services.

1.8 For example, the new system will be based on more regular reviews of whether agreed outcomes are being met. The reviews will be based on the views of the person using the service and conducted jointly by health and social care staff and involving the home care organisation

1.9 There is clear evidence from research into a number of schemes across the country, that people who receive reablement services require less

home care after the reablement period and continue to be more independent for longer. Exact figures vary but research examples are:

- 38% of people having ongoing use of home care at three months after the reablement period, compared to 95% of people when no reablement was provided
- More than 80% of people requiring no home care up to two years after the reablement period.

1.10 The proposed Tri-Borough model of home care has taken elements from the reablement service and the wider notions of self-reliance and community connection to ensure that any future system helps people do as much as possible for themselves. This would be through the combined effects of maintaining or improving mental or physical well-being, supporting people to make more use of community facilities and linking people to other sources of community support, for example those services provided by local community and voluntary sector services.

1.12 H&F have already embarked on a system wide change which has been strengthened as a result of joint working with the CCG. This has had positive impacts for people who use services as there are now fewer people using residential care and more people with more complex needs leaving hospital earlier. As a result there is increasing pressure on the home care budget and on the skills of the home care workforce. If the Council continues to provide home care in the traditional manner the CCG would be unlikely to invest in the services and the positive impacts of the reablement period will be undone by a system that creates dependency.

1.13 Alongside the procurement there will be a comprehensive workforce development plan that is being coordinated through the arrangements for implementation of the Better Care Fund projects. This includes a number of key enablers, for example the integration of both commissioning and the operational service pathways.

2. RECOMMENDATIONS

H&F

2.1. That approval be given to the proposal to begin the procurement for this service, in line with the procurement process outlined in Section 12.

RBKC

2.2. That Gate 1 (Adult Social Care Contracts and Commissioning Board) agrees the strategic direction of travel for this proposed service provision, including the financial model and risk areas involved, and notes the proposals in 4.5 for delivering home care services until such time as new contracts are awarded.

2.4 That the Cabinet Member agrees the proposal to begin the procurement for this service, in line with the procurement process outlined in Section 12.

WCC

2.5 That Gate 1 (Adult Social Care Contracts and Commissioning Board) recommends that the Tri-Borough Director agrees the strategic direction of travel for this proposed service provision, including the financial model and risk areas involved and notes the proposals in 4.5 for delivering home care services until such time as new contracts are awarded.

3. REASONS FOR DECISION

3.1. The current arrangements for the delivery of home care services will not support the Council's strategies for the delivery of efficient and effective services in the future. The Tri-borough arrangement for ASC provides an opportunity to procure a better quality home care service, based on consultation, good practice and financial modelling.

3.2. The proposed single procurement process will enable new standard specifications and contracts to be issued across the three boroughs, streamlining procurement, contract monitoring, electronic monitoring, and financial processes.

3.3. The new service will enable us to meet the strategic objective of supporting more people to live as independently as possible at home and the CCG Out of Hospital Strategy. Because of the greater focus on a skilled workforce and a reablement approach and by showing how the home care service can support the CCG Out of Hospital Strategy, the CCG have agreed to contribute financially to the budget and discussions continue about the model of future investment.

4. INTRODUCTION AND BACKGROUND

Current situation

4.1 Care at home is a key service to enable people who need care and support to remain living as independently as possible in their own homes. The current services are commissioned differently across the Tri-borough, but all services report common complaints and concerns. It is a priority at both local and national levels to improve service delivery.

4.2 The table below sets out a picture of the approximate numbers of people using home care across the Tri-borough.

	H&F	RBKC	WCC
Current **approximate** annual budget	£6,471,000	£4,501,000	£10,079,590
Home care users (average numbers)	1046	871	1149
Number of hours per year	549,448 p.a	416,000 p.a	877,000 p.a
FACS criteria	Moderate+ above	Moderate + above	Substantial + above
Number of providers used	25 on Framework – 5 Providers are mainly used 17 additional providers are used on a spot purchase basis.	2 contracted Providers 17 additional providers are used on a spot purchase basis.	5 Framework providers, 15 additional providers are used on a spot purchase basis (3 of whom are subject to formal contract monitoring).
Estimated percentage increase in people over 65 with a limiting life long illness in 2020	8%	20%	14.8%
Percentage increase in people with dementia in 2020	7%	20%	14%

4.3 Each borough has different contract arrangements for the delivery of home care. The contracts in RBKC have been extended to October 2015 but interim arrangements are being developed in H&F and WCC due to the expiry of the framework agreements they were using. The contract provision in each borough represents part of the total spend on home care. In the Tri-Borough area there are over 1200 people receiving a Direct Payment, many of whom then commission care directly from the home care provider of their choice or directly employ a Personal Assistant.

4.4 The upcoming Care Bill will require Councils to provide Personal Budgets to everyone who uses adult social care services and will emphasise the importance of supporting more people to use Direct Payments. Over the life of the new contracts there will be a range of initiatives to develop a better system for Direct Payments. The increasing popularity of Direct Payments will ensure there is a healthy market of home care providers for people to choose from and enable smaller organisations to continue providing services. This will allow people a choice of providers to use should they not wish the Council to commission a service on their behalf.

4.5 In H&F, home care provision is delivered as part of the West London Alliance (WLA) contract which ends on 30 September 2014. When the Tri-Borough arrangement was agreed H&F decided not to continue as a paying member of the WLA and discussions are continuing on the preferred model of contract to use until the new contracts can be awarded. If there is to be an extension to the Framework or if a spot

purchase arrangement is made at the time, any necessary reports will be done separately.

4.6 In WCC, there are five providers on a home care Framework awarded in January 2010 and further extended in May 2012. The Framework agreement ended in February 2014. In an effort to reduce costs and rationalise care provision due to capacity issues on the Framework, services are also spot purchased and work is currently ongoing to streamline this provision. A proposal has been developed for Cabinet Member approval to extend existing contracts in WCC until February 2016 to enable a managed transition to the new contracts.

4.7 In RBKC, contracts were awarded to two home care providers on 27th October 2008 and these have been extended until October 2015 with break clauses.

4.8 RBKC has an electronic monitoring system that tracks care worker visits and that can be viewed by ASC staff. This allows payment to be made based on the actual level of service delivered rather than the level of service ordered, thus enabling savings to be achieved by only paying for care that has been delivered. Although it cannot measure the quality of the service being delivered, it does provide information on who has delivered the care. It also acts as a backup to confirm whether visits have been undertaken on time or at all, so safeguarding users. H&F and WCC wish to work with RBKC to procure a new electronic monitoring system for the new service to enable similar efficiencies to be achieved in these boroughs. This will be subject to a separate procurement.

Why the system of home care needs to change

4.9 There is a national and local consensus that the current system of home care is not fit for purpose and cannot meet the increasing levels and complexity of need. The population of people that are being supported to live at home now have a range of complex needs and this population is increasing, for example those living with a diagnosis of dementia, people with long term conditions including increasing health needs and people with challenging behaviour.

4.10 The CCG investment in the H&F Community Independence Service has seen activity levels rise, with just under 1000 referrals in 2013. This has helped increase the discharge of people from hospital and is considered a best practice model. As a result of the increasing complexity of need, nearly 18% of people require more than the standard six week period of reablement, with the associated pressure on home care budgets. The current system fails to capitalise on the health and well-being gains during the reablement period by providing a service that supports people by doing tasks for them.

4.11 There are also more people being supported to continue living at home because of the success of Rapid Response Nursing to prevent hospital admissions and in reach into hospitals to speed up discharge.

4.12 While the current provision of home care differs, levels of dissatisfaction are perceived as similar across the Tri-borough according to reports undertaken by user focused groups.

4.13 As part of a co-production approach, people who use services gave clear messages on what they expect from a home care service and these have formed the basis for the development of the new model. People said they wanted:

:

- To direct their own care
- To have a consistent care worker
- To be treated with dignity and respect
- To have a streamlined approach to their care
- Improved conditions for care workers
- To be connected with the wider community.

4.14 This information was used to conduct further consultation and discussions with providers. There was also a review of best practice examples, legal advice on options and discussions with assessment and care management staff.

4.15 Healthwatch have managed a Tri-borough home care subgroup throughout this work and they made sure people who use services and family carers attended the consultation and were heard. Healthwatch continue to support people to be involved in commenting on the specification for the service and in helping develop questions that will be used as part of the tender award process.

4.16 In conjunction with this work, a financial model was developed which looked at options for providing different levels of care provision and different levels of care worker remuneration. This allowed the development of a number of scenarios and ensured that Cabinet Members could make informed decisions about issues of cost and quality.

4.17 The three borough ASC Cabinet Members have already agreed that this will be managed as a Tri-borough project and have approved the main elements of the service proposal in principle.

5. PROPOSAL AND ISSUES

Service proposal

5.1 The service to be procured is one which is based on:

- Achieving outcomes for people using services, moving away from ‘time and task’ focused provision
- Providers working more directly with people using services to agree the details of their care and how the outcomes will be achieved
- Ensuring dignity and compassion are core values in the service
- A more consistent service provision

- A reablement approach as part of care provision with people being enabled to do as much for themselves as possible.
- A measured integration of health and social care tasks over the life of the contract
- People being helped to feel a part of their local community.

5.2 Care Managers and people who need a service will agree a support plan which will be based on the outcomes that need to be met and the four weekly budget needed to achieve this. There will be a workforce development plan for health care assistants and District Nurses to support their involvement in this system. Referral information will be sent to Providers through a Brokerage Team, as detailed at 5.18.

5.3 Providers will agree with the person using the service how their outcomes will be achieved, i.e. what they will do and when they will visit, it will not be specified by the Council. If the person doesn't have mental capacity, this will be agreed with their carer or advocate on their behalf.

5.4 The boroughs will be divided into nine 'patches' (geographical areas) based on an approximate number of care hours delivered in that patch. H&F will have three patches, RBKC two patches and WCC four patches, a total of nine patches in all. Each patch will equate to a contract and thus all nine contracts will each be of approximate equal financial value. The concept of organising home care into patches is based on best practice models. The benefits are:

- Providers can schedule their work in a defined area and ensure home care workers do not have unreasonable travel time between visits.
- There can be more emphasis on people being recruited from the local community.
- Providers get to know the local community and voluntary sector services in their patch so that they can assist people to make the most of what is available in their area.
- Referral agencies across health and social care will be clear who the provider is for each area.
- There will be stronger relationships to help improve services as there will be fewer contracted providers.
- More consistent application of the safeguarding policy.

5.5 Providers can bid for and be awarded a maximum of two patches across the Tri-borough, but these must not be in the same borough. There will be one Provider per patch who will be awarded all the home care work commissioned by ASC in their patch. Providers will have to accept 100% of referrals in their patch.

Moving to an integrated model

Purpose

5.6 The effect of the CCG Out Of Hospital Strategies and the Council's reduced use of residential care, is that homecare providers will be caring

for more people with complex health and social care needs. People are also likely to be receiving multiple health services, for example from district nursing, GPs and other health professionals. There will be a much more joined up approach, where a team of health and social care professionals care for an individual holistically, rather than many separate professionals attending to the different needs of one individual.

5.7 The potential benefits of this are:

- A better patient experience where people only tell their story once.
- Better outcomes for the individual through a collaborative approach between professionals who share knowledge and problem solve together.
- A more responsive service where the whole team of professionals are aware of the changing needs of the individual, and can respond with the most appropriate care.
- Efficiencies through reducing the total number of visits and ensuring tasks are allocated to the most appropriately skilled staff.

5.8 Homecare will be an integral part of delivering this vision for people who receive both health and social care. It is therefore important that we consider what opportunities there are in this procurement to move towards this vision.

5.9 In order to fully maximise the potential of the new service, Public Health have been involved in looking at the health and well-being opportunities and will continue to be involved in shaping the specification, the tender evaluation process and performance monitoring.

Process

5.10 ASC Cabinet Members and the CCG Chairs decided that Tri-borough and the CCGs should work together to explore opportunities for the wider system changes needed to support an improved system and the specific requirement of adding a hybrid component to the homecare tender. In practice this would mean that homecare workers would be trained to deliver basic health tasks. Potentially including:

Oral Medication Prompting	Catheter Care
Ear Drops Administration	Stoma Care
Eye drops Administration	Compression hosiery
Applying Creams	Mouth Care
Simple Dressings	Equipment support
Dementia Support	Inhaler Technique Support
Pressure Relief/Care	Nutritional Support

5.11 These are tasks that are predominantly carried out by the district nursing services at the moment. The CCGs are working to gather data on the volume of the tasks that are carried out and could be delegated to non-qualified staff.

5.12 This could also mean that homecare workers have a much greater role in liaising with other health professionals around an individual's care and

changing needs. The CCGs aim to have a clearer specification and activity data by the end of March 2014. There are a number of other issues that would need resolving, for example, clinical governance arrangements, managing and altering care plans, charging and invoicing.

Options

5.13 In terms of the involvement of the CCG in the procurement, the options are:

- A fully specified service, including the hybrid aspect, with an estimate of service volume and clear governance arrangements.
- A basic specified service, with the stated intention to negotiate with the successful provider for the provision of health tasks to be specified at a later date.

5.14 More detail on these options is presented in Appendix B and a report will be prepared for the joint leadership at the end of March for a decision on the way forward.

Electronic monitoring

5.15 An electronic monitoring system based around the one currently provided by RBKC will be used for the new contract. The contract variations and new procurement that will be needed to include H&F and WCC are currently being confirmed. This system will be the subject of a separate procurement process.

5.16 The system will ensure people who use services and their families, and Tri-borough contract monitoring and finance staff, have information on when care workers have visited, overall monthly hours and consistency of care worker.

5.17 The electronic monitoring system will allow electronic invoicing to be giving accurate billing and automated payments, a key efficiency saving for the service.

5.18 A central Brokerage team across the Tri-borough will be developed from within existing resources to manage referrals, maintenance of services, monitoring of quality and payment of invoices. This will be based on learning from the RBKC e-monitoring team and a business case and separate proposal are being developed.

Assessing and monitoring for outcomes

5.19 The main difference with the current arrangements for home care delivery will be the move to a system-wide focus on the outcomes that have been achieved as a result of the support delivered, rather than the current focus simply on activity levels.

5.20 Assessment staff will agree the identified needs and the agreed outcomes in such a way that the future monitoring arrangements can demonstrate whether the outcomes have been achieved.

5.21 There will be more regular reviews of individuals, jointly undertaken with health where needed, and these will be targeted to ensure that every opportunity is taken to control cost pressures, avoid crisis trigger points and to look for evidence of improvements. As people become more confident and more connected to community and voluntary sector services the level of care needed will decrease, or increase more slowly.

5.22 Contract monitoring will be tailored to the new model with key performance indicators reflecting the main priorities, for example continuity of care worker, people report being treated with dignity and compassion.

Social Value

5.23 The new model will require home care providers to develop greater links with the local community and voluntary sector organisations in order to help connect customers to those organisations that will assist in decreasing isolation and improving health and wellbeing.

5.24 There will also be an emphasis on encouraging local employment wherever possible, both to improve chances for local people and also to improve local knowledge. It will also assist with reducing travel time, a key challenge for home care providers.

5.25 Best practice is not to specify exactly what social value is required but to make it clear that the evaluation of quality aspects of the bid will include reference to this area.

6. OPTIONS AND ANALYSIS OF OPTIONS

6.1 There is an option to continue with a time and task approach and to procure new services based solely on the lowest unit price per hour. With this model there would be no incentive for home care providers to encourage independence and the Council's would face increasing budget pressures as more people with more complex needs are supported to continue living in their own homes. This model also offers limited opportunities for integration with health services or for the delivery of health tasks. For reasons of quality of service, whole system integration, customer satisfaction and budgetary control this option is not recommended.

6.2 To take account of the feedback from customers, organisations that deliver home care and the NHS, various models have been assessed in the development of this new service. These have both cost and service implications and have been presented to Cabinet members, jointly and separately to enable decisions to be made.

6.3 These options have included consideration of various rates of pay, allowance for travel time and the use of a mixed-skills workforce to provide more complex support.

6.4 The recommended option informally agreed by all ASC Cabinet Members was to offer the new service using a mixed skills workforce and including an element of travel time. This would be supported by scoring of elements of the unit price in the tender submissions, including the rates of pay of staff.

7. CONSULTATION

7.1 At the start of the proposal to retender services for home care, a series of consultation events to find out people's views on how a good and compassionate home care service can be achieved. Four events were held in the summer of 2012, attended by 184 people, 17% of whom were people using services and carers of those using services.

7.2 A consultation report was produced by Frameworks 4 Change, an independent provider who facilitated the consultation events on behalf of the Tri-borough. Please see Report Appendix C.

7.3 People felt that the key features of any new service would be:

- Consistency of care worker.
- A service which looks more widely at people's lives including outcomes for them.
- A more streamlined assessment process.
- Integrated care provision.
- Support for people to lead good lives.

7.4 Discussions with existing providers and a soft market testing exercise broadly supported the direction of travel and the key elements of the new service model.

7.5 There has been feedback from care management staff throughout this process and they will continue to be involved in the development of the whole systems changes and in the procurement process.

7.6 There have been ongoing meetings with the Tri-borough Healthwatch home care group to ensure the voice of people using services and their carers is heard and incorporated in developing the model.

7.7 The main issues raised by Healthwatch include:

- People being treated with dignity
- Consistency of care worker
- Pay for workers
- Timekeeping/travel
- A more streamlined assessment process
- Helping people link with their local community

7.8 Each Council Scrutiny Committee has also heard details of the problems associated with the current arrangements and there is broad support for plans to improve the quality of care at home.

7.9 In addition to the soft market testing, a provider information event was held on 17 February 2014. Representatives of over 100 provider organisations attended to hear details of the proposed model and procurement process. Although the contracts for each patch are over 3000 hours per week, it was made clear that consortium or sub-contract arrangements would be welcomed. As each contract includes a range of services previously considered as specialist, there should be opportunities for small and medium sized organisations to be involved in delivering services.

7.10 ASC Cabinet Members of each Council are also keen to ensure that the procurement process is sufficiently detailed to ensure scoring of submitted tenders takes account of the pay and other terms and conditions of the work force delivering these services and this has been reflected in the financial modelling presented to them.

8. EQUALITY IMPLICATIONS

8.1 Please see attached Equalities Impact Assessment Appendix E

8.2 There are no negative equality impacts as a result of this proposal. The Equality Impact Assessment will be updated with detail from the successful organisations and included in the report to award contracts.

9. LEGAL IMPLICATIONS

9.1. Bi-borough legal services has been advising the client department to date and will continue to do so throughout the procurement process.

9.2. Implications verified/completed by: Catherine Irvine, Senior Solicitor (Contracts) 020 8753 2774.

9.3. Westminster City Council - There are no particular legal implications arising from this report.
Rhian Davies, Corporate Lawyer, Westminster City Council
020 7641 2729

10. FINANCIAL AND RESOURCES IMPLICATIONS

Comments of Executive Director of Finance and Corporate Governance

10.1 This report seeks approval to commence the procurement of a Tri borough home care service.

10.2 The financial model has been developed to demonstrate the approximate anticipated spend within different scenarios. Cabinet Members have agreed to follow the model which proposes a mixed skills workforce with an element included for travel time.

10.3 In each borough the impact of the proposed model is different, based on differences in the current unit costs, different impacts of population change and different impacts of the new arrangement for electronic monitoring. The proposed financial impact for Hammersmith & Fulham ASC is outlined in detail in appendix A.

10.4 The Hammersmith & Fulham 2014/15 home care budget is £6,471,000. Based on this model, the net annual effect for H&F would be a projected budget pressure of £395,000. This has to be seen against the reduction in the use of residential care, the savings in this budget area and the virement of funds of £400,000 from residential placement budget to support the increased activity in home care. The remaining pressure will be managed within existing Adult Social Care budgets and through a contribution from the CCG, so will not adversely affect the existing MTFS plan.

10.5 The full financial modelling implications of the procurement of the new service will be detailed in the contract award report, when prices from prospective providers are known.

10.6 The current home care contracts are due to expire on 30 September 2014. Discussions are ongoing with the WLA regarding the implications of the contracts ending and the possibility of moving to spot purchasing for home care as detailed in sections 4.3 and 4.5 of this report. A separate Cabinet report will detail the financial implications of the interim arrangements.

11. RISK MANAGEMENT

11.1. Risks can be broadly categorised as those associated with
- The interim operational arrangements.
- The procurement process
- The viability of the proposed service model.
- Budget.
- The delivery of joint health and social care tasks.

11.2. The risks associated with negotiating extensions to the current framework contracts used by H&F and WCC are less than those associated with moving to spot purchase arrangements. There is a risk to commencing the procurement associated with agreeing the new model. However the procurement timetable itself is considered to be realistic and there will be a clear project plan and allocation of staff resources to ensure the timetable is adhered to.

11.3. The ASC department is responsible for ongoing risk identification and mitigation of risks (risk management), such as they may arise, that are associated with the procurement. Should any significant risks materialise they must be communicated across the three councils and inform an Adult Social Care Department level Risk Register. A project register has been completed and is kept under review that follows the Tri-borough risk management approach.

11.4. The PQQ will examine prospective tenderers in areas of organisational structure, financial standing, experience of delivering a quality service, insurance cover, health and safety and quality assurance procedures, contractual matters and technical and professional ability. PQQ's will be evaluated by the Tender Appraisal Panel (TAP). The Tender Appraisal Panel will therefore have a central role in ensuring that prospective service providers are sufficiently robust with their internal risk management arrangements.

11.5. The proposal to proceed with a Tri-borough procurement through the new E-procurement system contributes positively to the Strategic Bi-borough Risk Register entry number 1, Managing Budgets

11.6. The model represents a change from current practice and requires a number of different elements of a complex system to change, including Council staff and systems. A project plan has been established to manage these changes and their interactions along with a stakeholder engagement and communication plan.

11.7. The financial model has highlighted a potential budget pressure in H&F. Work will continue on the financial modelling of the new service and this will be developed in the context of the proposed application for the Better Care Fund. As the Out of Hospital strategy delivers more change, the demand for home care will change. More detailed financial modelling will be included in the report required to approve the award of contracts.

11.8. There could be a potential risk of a variation to price (hourly rate) if information is received later regarding any TUPE information that may affect terms and conditions. This may be the case if care workers previously employed internally have been outsourced on local authority terms and conditions which would still apply with a further TUPE transfer.

11.9. A further potential risk of variation to price will arise if there is a decision to include the delivery of health tasks within this specification. There may be TUPE implications in respect of the existing community health provider organisation. Any risk identified would be the responsibility of the appropriate CCG.

11.10. There is a risk that in aiming to achieve a fully integrated health and social care service, there is insufficient regard for the complexity involved and the project timetables are compromised. There is an initial agreement to allow a fixed period of time to evaluate a range of health data, after which

a decision will be made on future involvement of specific health tasks in the procurement.

Business Continuity

11.11 Resilience in providing Home Care Provision is essential as an interruption to the service could have far reaching consequences. Resilience is best achieved by looking at viable options to remove any risk associated with the provider, plus having robust and workable strategies that are able to continue the service offered.

11.12 While providers should have their own business continuity plans, council officers need to be aware that the total loss of the provider would make their response null and void.

11.13 The Care Bill will make reference to Council's having greater responsibility for predicting and managing any consequences of provider failure. For example this could include regular reviews of an organisations financial standing. The detailed guidance to support the Bill has not yet been issued. A Resilience strategy will be developed as part of the project group work. This will involve a range of stakeholders, including commissioning officers, contracts officers, care management as well as external providers such as CQC and other local providers.

11.14 The Resilience strategy will be referenced in the award report.

11.15 Comments provided by Ian Cairns, Bi-borough Business Continuity Manager MSc, Emergency Planning and Disaster Management MBCI and lead auditor BS25999 and ISO22301.

12. PROCUREMENT STRATEGY IMPLICATIONS

12.1. It is proposed to let nine roughly equivalent Home Care Contracts based on nine geographical patches, three in Hammersmith and Fulham, two in Kensington and Chelsea and in Westminster. Contracts of this size will generate a lot of interest from the market and enable successful providers to achieve economies of scale without being overly large and resulting in providers regularly experiencing difficulties in meeting service delivery requirements.

12.2. Guidance will be issued with the Pre Qualification Questionnaire to ensure organisations are aware that consortium and sub-contract arrangements are welcomed. This will offer opportunities for smaller organisations to be involved and ensure contracted organisations are able to accept all referrals.

12.3. The procurement will be led by H&F and will use the restricted tender process. It will be conducted in accordance with the Public Contracts Regulations 2006 (as amended) and H&F's Contract Standing Orders.

The procurement process will be conducted electronically using the Bravo Solution ‘capitalEsourcing’ portal.

12.4. An advertisement will be placed on each of the Tri-borough’s websites inviting Expressions of Interest. As Home Care is a Part B service there is no requirement to place a notice advertising the opportunity in the Official Journal of the European Union (OJEU). Prospective tenderers will be required to complete and submit a Pre Qualification Questionnaire (PQQ). The PQQ will examine prospective tenderers in areas of organisational structure, financial standing, experience of delivering a quality service, insurance cover, health and safety and quality assurance procedures, contractual matters and technical and professional ability. PQQ’s will be evaluated by the Tender Appraisal Panel (TAP).

12.5. Prospective tenderers will be required to indicate which of the nine contracts their PQQ relates to and rank these in order of preference from one to nine. Prospective tenderers can submit a PQQ for any number of the nine contracts but will only be shortlisted to proceed to Invitation to Tender (ITT) stage for a maximum of two contracts, which will not be within the same borough. They will be asked to indicate whether they wish to apply for one or two contracts. It is anticipated that in order to maximise their tendering opportunities the majority of tenderers will express an interest in tendering for all nine contracts at PQQ stage.

12.6. Five tenderers will be shortlisted to proceed to ITT stage for each contract. This will result in a minimum of 23 and a maximum of 45 tenderers proceeding to ITT stage. All prospective tenderers who pass all parts of the PQQ will be ranked in order of their overall marks. The tenderer ranked highest will proceed to ITT for their first two choices, on the basis that these are not in the same borough. If they are in the same borough the tenderer will proceed to ITT for their first choice contract and for their subsequent first choice of contract in a different borough. This process will continue until five tenderers have been shortlisted to proceed to ITT for all nine contracts. This could result in a tenderer who expresses an interest in less than all nine contracts not proceeding to ITT for any contracts while a tenderer with a lower score but who expresses an interest in a different combination of the nine contracts could proceed to ITT for two contracts.

12.7. This procedure has been discussed and agreed in the project group and with legal representation and is considered to be the best way to achieve the procurement aims.

12.8. Returned tenders will be evaluated by the TAP on a Price: Quality ratio of 50:50. The evaluation of quality will be based on the written responses of tenderers to questions related to the delivery of the Service Specification, including those questions developed with Healthwatch.

12.9. The award of the contracts will be made by the boroughs which they relate to and will be undertaken in accordance with each borough’s own

officer and member governance requirements. Each contract will have a term of seven years with a break clause after five years.

12.10. Following the award of contracts there will be a 3-6 month mobilisation phase during which time a Contract Implementation Group (CIG) will work with both the outgoing and incoming providers to ensure a smooth transition to the new service arrangements. This will include the transfer of both Service Users and those staff who have rights under the Transfer of Undertaking (Protection of Employment) ("TUPE") Regulations 2006.

12.11. If people want to continue using their existing care provider rather than moving to the newly contracted care provider they can be supported to take a Direct Payment and to purchase their care directly.

12.12. The CIG will continue to work closely with the incoming providers for the first six months of each contract. The client side management of the contract will then be undertaken by the Tri Borough Adult Social Care Procurement and Contract Monitoring Team.

Staffing Implications and Consultation:

12.13 These services are currently provided by external provider organisations. The process will be subject to the Transfer of Undertakings (TUPE) of external to external Providers. Information on this will be collected as part of the procurement process in the normal way.

12.14 The issue of TUPE is complex, especially if each of the nine contracts has a phased implementation date or phased start date. The Council cannot control the date of the TUPE transfers. They occur when the transfer of undertaking is deemed to have taken place. The issue will be addressed at the time it is determined whether each contract has a phased start date.

12.15 There are implications for Council staff in establishing a central brokerage and electronic monitoring team and this will be the subject of a separate decision report after a full consultation with staff affected.

12.16 Bi-borough and WCC HR will be consulted as appropriate and as needed.

12.17 The proposed procurement timetable is expected to be as follows

Action	Timescale
Governance process starts	March 2014
Procurement process starts -Pre Qualification Questionnaire	April 2014
Return of Tenders	September 2014
Contract Award	November 2014
Implementation	December 2014 – April 2015

Supplier Relationship Management and Monitoring

12.18 The contracts will be monitored by the ASC Contracts monitoring team. Data will be requested on a monthly basis and the contract will be monitored on a quarterly basis.

12.19 As this is a new service model, there will be ongoing work with all providers, singly and as a group, to look at how the service model is developing; the involvement of people using the service in monitoring performance, potential service development pilots over the life of the contract and to ensure good practice is encouraged. The workforce required to deliver these contracts is different from current contracts and proposals are being developed for a joint approach to workforce development for the first 12 months of the contracts.

12.20 There will be more regular contact and feedback with customers at an early stage to evaluate the service and whether it is working. There will be input from Healthwatch who will continue their role of working with people using services to provide feedback into how the service is meeting their needs and outcomes.

12.21 Key performance indicators will be set and monitored quarterly to ensure that the service is developing as is expected. There will supported by basic monthly data collection which will confirm overall service delivery activity.

12.22 The contracts will require joint meetings between all providers to share experiences, learning and good practise. This will support a more collaborative approach and provide another mechanism for addressing some of the larger system issues that affect both the quality and outcomes of a home care service.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	None		

Appendices:

Appendix A – Finance projection for H&F
Appendix B – Analysis of procurement options
Appendix C - Risk Summary
Appendix D - Frameworks4Change Consultation report
Appendix E - Equality Impact Assessment (available electronically)

Appendix A – Finance projection for H&F

HAMMERSMITH AND FULHAM		Yr 1 2015/16	Yr 2 2016/17	Yr 3 2017/18	Yr 4 2018/19	Yr 5 2018/20
Projected Commissioned Hours per annum		549,448	554,953	560,595	566,377	572,302
DO NOTHING OPTION WITH DEMOGRAPHICS		**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Current annual budget	**£12.51**	6,471	6,471	6,471	6,471	6,471
Projected annual spend including demographic impact		6,874	6,942	7,013	7,085	7,159
Difference between planned and actual	-2%	-137	-139	-140	-142	-143
Variance to budget		**403**	**471**	**542**	**614**	**688**
NEW HOMECARE MODEL WITH DEMOGRAPHICS		**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Projected annual spend including demographic impact	**£15.06**	8,275	8,358	8,443	8,530	8,619
Variance to Budget-pre virement		**1,804**	**1,887**	**1,972**	**2,059**	**2,148**
Virement from res care		**403**	**471**	**542**	**614**	**688**
Pressure due to new contract-post virement		**1,401**	**1,415**	**1,430**	**1,444**	**1,459**
Cost Mitigation						
Additional Impact of Non- delivery	-2%	-28	-28	-29	-29	-29
Impact of electronic monitoring	-4.50%	-372	-376	-380	-384	-388
Impact Reablement approach	-2%	-157	-159	-161	-162	-164
Health and Social Care Integration reviews	-3%	-248	-251	-253	-256	-259
Reduction in Residential and Nursing placements by supporting people at home	-2%	-200	-200	-200	-200	-200
Total	**-14%**	**-1,006**	**-1,014**	**-1,022**	**-1,031**	**-1,040**
Net effect after impacts of cost mitigation activity		**395**	**401**	**407**	**413**	**420**
Projected income from CCG		**395**	**401**	**407**	**413**	**420**
Net effect		**0**	**0**	**0**	**0**	**0**

Appendix B – Analysis of procurement options

Option	Benefits	Risks
We fully specify the hybrid aspect of the service when we go out to procurement in April, with estimations of the volumes of activity and clear governance arrangements	We can ask providers to submit tenders for the hybrid aspect of the service and take into account the quality and price of this when awarding contracts. We are therefore more likely to get value for money on the hybrid aspect.	If we specify the service without fully understanding the detail, we may end up specifying the service incorrectly/inaccurately and having to renegotiate with providers later on. If we aren't fully sure of the tasks/activity that can be transferred across, we may place too much emphasis, in the tender, on the hybrid aspect and later find that it is hardly used. This would mean we may not get the best value for money.
We specify that the service will be extended to include low level health tasks during the life of the contract, and that we will negotiate with providers to agree an appropriate price at that point.	We will have a better understanding of how a hybrid service will work by the time we specify and therefore will be able to give more detail to providers, enabling them to price more accurately.	If we negotiate partway through the contract, we will be asking existing providers to submit prices for a hybrid service. There will be no open market competition in the pricing which could mean that providers submit higher hourly rates. To mitigate this risk we can specify the mechanism for pricing to an extent. CCGs would still have the facility to use their district nursing contracts if the pricing was unreasonable. Tri-borough contracts lawyers felt that the financial risk was relatively low. The second risk is that if we are not scoring for healthcare in the tender, we will not be assessing providers on their ability to deliver this service so we may not be appointing the most appropriate providers for the job. Having said this, Tri-borough would be one of the first places to roll out a hybrid service, so very few providers are likely to have experience of delivering this already.

Appendix C - Risk Summary

Risk area	Detail	Action/mitigation
Interim operational risks	In the original timetable we expected to have new contracts in place by April 2014. Due to unforeseen delays this has been revised to January 2015. This means: - - Interim solution will need to be developed following LBHF framework end in October 2014. Providers are unlikely to maintain current prices as there has been no uplift during the life of the contract so there is a high likelihood of increased cost pressures. - - Westminster has been running an interim solution using a combination of spot purchase arrangements and a framework agreement. This was agreed on the basis that we would be going out to procurement in 2013. There is a risk of legal challenge if there are further delays to the procurement. There are also risks to the quality and cost of current provision as the interim solution does not allow much control/monitoring of the provision. - - The RBKC contract with 2 providers has been extended to October 2015. There is no immediate risk to provision here.	1) Interim arrangements will need to be developed in LBHF. Advice from legal representatives is that we could extend the current WLA framework. However, these are unlikely to be at the same cost as at present. 2) We will need to model the impact of this likely cost increase on LBHF budgets 3) We will need to develop new interim spot purchase arrangements in Westminster which give improved financial control and quality assurance.
Risk to the future model	The model in itself represents a whole system change in the way care is commissioned and delivered, and shifts more responsibility onto the provider. - - there is a risk that providers are not geared up to deliver this kind of service at present. - - There is a significant internal change in both process and culture required to deliver this. This is dependent on other projects such as the customer journey work. If the internal change isn't delivered, the benefits of the homecare model may not be realised. - - A continued reablement approach is well supported nationally, but the impact is not well evidenced. There is a risk that we may have overstated the impact this will have on the number of homecare hours. - - The success of the model is dependent on having sufficient capacity within contract monitoring to support the development of providers/the service once implemented. It is also dependent on	1) Soft market testing showed that some providers were already delivering some parts of the model, and that there was a willingness to move in this direction. Other local authorities such as Wiltshire have already developed similar models. 2) The project team are working with business analysis to develop a robust evaluation method that will measure the new model on service use, customer satisfaction and finances. 3) The project team will look at the required resource for contract monitoring in the future and feedback to

	having sufficient capacity in operations to review regularly. If there isn't capacity the benefits of the model may not be realised. - - Conversely, there are also risks associated with *not* adopting the model, and continuing with a traditional model of homecare. These are - - loss of credibility (with both the market and the public) - - the service would become increasingly unfit for purpose in the context of whole systems care and the out of hospital strategies - - The service would struggle to cope with people with complex health and social care needs, which would probably result in an increase in purchasing specialist care which is more costly.	ALTT/the commissioning review.
Financial risk	IT should be noted that the financial model is an attempt to estimate how much a provider might charge to deliver the service. The accuracy depends on how close this is to the actual bids that are submitted. It also takes into account demographic changes, and the impact that the new model might have on total number of hours commissioned. Again these are estimates and it is important that this is recognised when making decisions based on these predictions. - - there is a risk to the finances because it is difficult to predict the combined impact that the model, as well as other changes in the system (e.g OOH strategies) and changing demographics, will have on service use. - - Some of the benefits of this service model are likely to be seen elsewhere in the system, for example in use of health care services. This is difficult to monitor and may require some significant resource to evaluate properly as well as buy in and co-operation from our health colleagues to support data collection.	1) Finance officers should look at ASC budgets as a whole, rather than the homecare budget in isolation and develop contingencies for increase in spend and how this would be managed. 2) A robust evaluation should be planned for partway through the contract, at which point there should be a benefit realisation report and a decision as to whether the service should be continued. 3) Even if the new model was not adopted, there would still be significant impact on the budgets as there would be an inevitable uplift in hourly rate for LBHF, and increased hours due to demographic change in all three boroughs. 4) The overall financial risk should be considered in the context of the proposed application for Better Care Fund.
Risk associated with a	There are a number of risks relating to the addition of a hybrid (health and social care) component to the model	1) We have been given clear deadlines for work with health

hybrid model	- - Increased delays to the tender. The impact of this will be an extension to the interim arrangements which may impact quality and budgets as outlined above. Delays also impact the Tri-borough's credibility with the provider market, and with the public. - - risk to the tender because the pricing and scoring mechanism will become a lot more complicated, thereby reducing the chances of successfully awarding the contracts to the best providers, at a price which is both sustainable and represents value for money. - - Risk to the success of the model because in addition to asking providers to deliver a completely new homecare service, we are asking them to develop a new integrated component as well.	colleagues to develop an integrated model, which should reduce delays to the tender. 2) We will need to develop an agreement with health to fund some ongoing resource to support providers in their development of this service as it will involve significant change for local authorities, health organisations and homecare providers.