County Offices
Newland
Lincoln
LN1 1YL

7 January 2020

Adults and Community Wellbeing Scrutiny Committee

A meeting of the Adults and Community Wellbeing Scrutiny Committee will be held on **Wednesday, 15 January 2020 at 10.00 am in Committee Room One, County Offices, Newland, Lincoln, LN1 1YL** for the transaction of the business set out on the attached Agenda.

Yours sincerely

Debbie Barnes OBE
Chief Executive

Membership of the Adults and Community Wellbeing Scrutiny Committee (11 Members of the Council)

Councillors C E H Marfleet (Chairman), Mrs E J Sneath (Vice-Chairman), B Adams, Mrs P Cooper, R J Kendrick, Mrs J E Killey, Mrs C J Lawton, Mrs M J Overton MBE, C E Reid, C L Strange and M A Whittington

ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE AGENDA
WEDNESDAY, 15 JANUARY 2020

10 **Adults and Community Wellbeing Scrutiny Committee Work Programme** 131 - 140

(To receive a report by Simon Evans, Health Scrutiny Officer, which provides the Committee with an opportunity to consider its future work programme which includes a list of probable items up to and including 1 July 2020)

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Please note: for more information about any of the following please contact the Democratic Services Officer responsible for servicing this meeting

- Business of the meeting
- Any special arrangements
- Copies of reports

Contact details set out above.

All papers for council meetings are available on: www.lincolnshire.gov.uk/committeerecords

ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE
27 NOVEMBER 2019

PRESENT: COUNCILLOR C E H MARFLEET (CHAIRMAN)

Councillors Mrs E J Sneath (Vice-Chairman), R J Kendrick, Mrs J E Killey, Mrs M J Overton MBE, C E Reid, C L Strange, M A Whittington and S P Roe

Councillor Mrs P A Bradwell OBE attended the meeting as an observer

Officers in attendance:-

Pam Clipson, Alex Craig (Commercial and Procurement Manager - People Services), Simon Evans (Health Scrutiny Officer), Glen Garrod (Executive Director - Adult Care and Community Wellbeing), Theo Jarratt (County Manager, Performance Quality and Development), Tracy Perrett (Head of Hospitals and Special Projects), Katy Thomas (Programme Manager (Health Intelligence)) and Rachel Wilson (Democratic Services Officer)

36 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors B Adams and Mrs C J Lawton.

The Head of Paid Service reported that having received notice under Regulation 13 of the Local Government (Committees and Political Groups) Regulations 1990, she had appointed Councillor S P Roe as a replacement member of the Committee in place of Councillor B Adams for this meeting only.

37 DECLARATIONS OF MEMBERS' INTERESTS

Councillor M A Whittington wished it to be noted that his mother was resident in a care home in Grantham.

38 MINUTES OF THE MEETING HELD ON 9 OCTOBER 2019

RESOLVED

That the minutes of the meeting held on 9 October 2019 be signed by the Chairman as a correct record.

39 ANNOUNCEMENTS BY THE CHAIRMAN, LEAD OFFICERS AND EXECUTIVE COUNCILLOR

The Committee was advised that a new occupational therapy service had been launched on 4 November 2019, with the teams now aligned to the district councils to

improve partnership working. Councillors Mrs P A Bradwell OBE and Mrs S Woolley had received an update on the progress with the new occupational therapy service and had indicated that they were pleased with the progress so far. Additional staff were being recruited. It was a two year programme and its impact would be reviewed in the middle of 2021.

There was also a 'grow your own' programme for apprenticeships which was working very well and there were between 12 – 15 staff per annual cohort being trained as social workers or occupational therapists to work in vacant professional grades within the Directorate through this programme.

The Committee would be receiving a report on the budget in the New Year and it was recognised that there was a need to consider how these services would be funded in the future. It was highlighted that Lincolnshire was due to receive NHS funding to support mental health schemes. Lincolnshire was working well together with the NHS commissioners and Lincolnshire Partnership Foundation Trust. The Committee would be receiving updates at future meetings in relation to mental health services.

40 DIRECT PAYMENT SUPPORT SERVICE

It was reported that the Direct Payment Support Service (DPSS) was the Council's dedicated service contract that helped support service users who had a direct payment with a range of activities. The current contract had had its full extension, which meant the current provision must come to an end on 31 March 2020. A new service would have to be procured to start on 1 April 2020.

The Committee was invited to consider a report on the Direct Payment Support Service on which a decision was due to be made by the Executive Councillor for Adult Care, Health and Children's Services between 2 – 3 December 2019.

Members were provided with the opportunity to ask questions to the officers present in relation to the information contained within the report and some of the points raised during discussion included the following:

- It was queried whether there should be a KPI to encourage a lower percentage of fully managed accounts.
- There were quite a few people receiving direct payments who also received Personal Health Budgets (PHB).
- There was a need for a mechanism to allow the number of controls to be more streamlined without having to add another layer of bureaucracy. It was hoped that this was what the authority was moving towards with the pre-paid cards and virtual wallet. It would be possible to set trigger points with tolerances for spending by clients which was either too low or too high. The bank accounts did allow trigger points that would alert the finance team and social workers.
- Discussions were taking place around whether health partners would also be able to make use of the virtual wallet as they were keen to be involved as some people had social care needs and health needs, which currently needed

to be administered separately. It would be an opportunity for an individual to have one place where they could keep their money but could portion it out.

- It was noted that an annual survey had also been conducted in May 2019, and the results of this could be provided to members as a follow up. In terms of the 2018 survey, the response rate indicated 70% approval for the account set up process. This was tracked against the national picture. On average, the Lincolnshire service was performing better than the national average. The 2019 survey showed a similar trend with very similar satisfaction levels.
- In terms of KPI's which were being developed it was queried whether they should already have been in place for the existing contract. There were new requirements to focus on where people sit within the support spectrum and how often they should be reviewed. This would ensure that the money was being spent more effectively.
- It was queried whether there was still a way of ensuring that things were done correctly if people preferred to withdraw money to pay carers. Were there checks on this such as who was being paid etc.? Members were advised that the Direct Payment Policy was clear that where someone was employing a person directly, i.e. not through an agency, the DPSS was there to provide support and advice. There was also an audit function that would check that people were acting appropriately.
- Becoming an employer could be quite frightening to most people, and support would be provided by the DPSS.
- It was noted that the current budget was £485,000 and the actual spend for 2018/19 was £466,000. It was queried what the spend would be for 2019/20. It was hoped to manage all costs within £420,000.
- It was noted that around 100 new direct payments were set up every month, and around a third now chose to take the pre-paid card option.
- It was queried what would happen if more people came into the system than expected. Members were advised that the contract would cover the fixed overheads and some of the tier one activity, the rest would be paid on a by volume basis.
- In terms of the pre-paid card and the virtual wallet, it was queried what would happen if the service user passed away, and how would the authority retrieve the money. It was possible to set trigger points, such as if it was no longer needed or if there was misuse there was the ability to claw back the funds to the council's accounts. However, there was a need to ensure that this happened in the right way. There was more confidence in this method.
- It was queried how often payments were made to the pre-paid cards and virtual wallet, and it was noted that it would be the same as direct payments, so every four weeks.
- One role of the DPSS was to help people in the first few weeks to set up payments and tax etc.

(NOTE: Councillor Mrs M J Overton MBE left the meeting at 10.55am and did not return)

- The virtual wallet and pre-paid card was welcomed and it was commented that it gave audit accountability.
- There was a need to bring in the health element to strengthen it and reduce duplication.

- The new contract would evolve from the last one with better outcomes for service users.
- It was noted that there had been two cases in the last 18 months of deliberate misuse.
- A minimum of 10% of sub-contracts were to local businesses.
- The Executive Councillor commented that she was pleased the service would be receiving more support in terms of IT, and developing this had been one of the first things that the new Commercial Executive Director was tasked with. For younger people particularly, this was a good development.

RESOLVED

1. That the Committee support the recommendations to the Executive Councillor for Adult Care, Health and Children's Services as set out in the report.
2. That the following comments be passed to the Executive Councillor for Adult Care, Health and Children's Services:
    - *The proposed joint working with the NHS and the third sector is particularly welcomed.*
    - *The development of initiatives such as the virtual wallet and the pre-payment card is strongly supported, as these initiatives should support the overall up-take of direct payments.*
    - *Paragraph 1.4.2 of the report refers to a 2017-18 annual survey of users of direct payments. The Committee has suggested that a summary of the findings of this survey, and the 2018-19 survey if available, are presented to the Executive Councillor, at the time she makes the decision. (The 2017-18 survey of users from Penderels Trust is attached as an appendix to this statement.)*
    - *The Committee is pleased to see that the proposed contract will include a requirement for local sub-contractors providing a minimum of ten per cent of the service, on the basis that this would be a stimulus for other providers.*

    In addition to the above, it was also confirmed to the Committee that:
    - *The performance indicators would reflect an increase in the overall up-take in the number of people using direct payments as a positive; and*
    - *The level of misuse of direct payments was very low, and monitoring was in place to prevent this.*

41 BLOCK TRANSITIONAL CARE AND REABLEMENT BEDS RE-PROCUREMENT

Consideration was given to a report which invited the Committee to comment on a report on Block Transitional Care and Reablement Beds Re-Procurement, on which a decision was due to be made by the executive Councillor for Adult Care, Health and Children's Services between 2 and 9 December 2019.

It was reported that the procurement rounds undertaken in respect of the two separate lots of County Council beds and also on behalf of health partners (Lincolnshire's Clinical Commissioning Groups and Lincolnshire Community Health

Services NHS Trust (LCHS)) resulted in contracts totalling 86 beds (35 LCC and 51 LCHC) as of August 2019. This provision was situated within 26 care homes across the county. There was a Section 75 agreement established and since 2016 the County Council had undertaken the contract management function for both Council and health contracts.

The initial term of these contracts had expired on 7 August 2019 and had subsequently been extended until 31 March 2020 to allow adequate time to review the service and options available in respect of a re-procurement of these services.

Members were provided with the opportunity to ask questions to the officers present in relation to the information contained within the report and some of the points raised during discussion included the following:

- It was planned to re-procure the contract on the same terms. However, a new Section 75 agreement would be required.
- It was commented that the benefit of having more beds in fewer locations could be seen, but from a service user perspective it was queried whether people would need to be travelling further from home, and how much of an impact would this have or was it too early to know? It was acknowledged that it was too soon to know what the impact would be, but this was more about facilitating discharge from hospital and a temporary placement to help people regain their independence. Where possible people would be supported to be as close to their home as possible.
- It was noted that LCHS paid more than the County Council for beds, but now through joint procurement it would be better for all partners.
- It was planned that there would be four locations with up to 20 beds. The aim was to consolidate the available beds.
- There was an aim to retain the same number of beds, but through a 'block purchase' approach rather than paying for 'spot purchase'.
- There was due to be a residential rates review in the coming year, and therefore officers were not able to speculate on costs.
- It was noted that in the south of the county, a lot of residents went to Peterborough hospital, and it was queried whether there would be any issues with discharging patients in this area. Members were advised that there would not be any issues as the patients were Lincolnshire residents.
- There would be a fixed number of beds within each home, based on flexibility about prevailing needs. There was a need to know which beds would be most appropriate for people's needs as they were discharged.
- The beds would exclusively be for placements by Lincolnshire County Council and the NHS.
- It was queried whether if the room was unavailable or refused, would there be penalties. It was noted that LCC would make void payments if the bed was unoccupied. The home would be in breach of contract if it let the room to someone else.
- It was queried whether there was a danger of reducing the number of beds available for general residential use. Members were advised that these beds were for high need and were higher priority. There would still be capacity

elsewhere, but less choice. This would specifically be looked at as part of the rates review.

- The beds would be located in Lincoln, Gainsborough, Stamford, Grantham and Spalding.
- It was noted that it was the bigger homes which were being looked at. In the south of the county, it was acknowledged that there were problems with finding nursing beds. Discussions were taking place with CCG's.
- During 2020, between January and the autumn, members would have the opportunity to discuss market capacity and to also get a sense of how Lincolnshire fits into the national picture.

RESOLVED

1. That the Committee support the recommendations to the Executive Councillor for Adult Care, Health and Children's Services as set out in the report.
2. That the following comments be passed to the Executive Councillor for Adult Care, Health and Children's Services in relation to this item:
    - *a key benefit of the procurement would be avoiding unnecessary admissions to hospital and allowing for the earlier discharge of patients from hospital;*
    - *transitional care and reablement beds would be available in several locations across Lincolnshire to meet service user needs, but more information on the detailed locations would be provided to the Committee;*
    - *there would be an emphasis on improving capacity in the south of the county, where historically provision has been low; and*
    - *transferring patients from an acute hospital to a community hospital does not represent a hospital discharge, as patients in a community hospital would still be counted for the delayed transfer of care measure.*

42 LINCOLNSHIRE INDEPENDENT ADVOCACY SERVICES RE-PROCUREMENT

The Committee received a report which invited members to consider a report on the Lincolnshire Independent Advocacy Services Re-Procurement, on which a decision was due to the made by the Executive Councillor for Adult Care, Health and Children's Services between 2 – 9 December 2019.

It was reported that Lincolnshire County Council had two main contracts delivering advocacy – the Independent Lincolnshire Advocacy Services delivered by Voiceability and the NHS Complaints Advocacy Service delivered by POhWER. Both of these contracts would come to an end as of 30 June 2020.

Members were provided with the opportunity to ask questions to the officers present in relation to the information contained within the report and some of the points raised during discussion included the following:

- It was noted that the contract values listed on page 79 of the report were the current contract values. The spreadsheet attached as Appendix C gave information on the volumes of budgets going forward.
- There was an expectation that Liberty Protection Safeguards (LPS) in replacing Deprivation of Liberty Standards (DoLS) should have reduced costs. It was commented that the Council had provided the Executive Director for Adult Care and Community Wellbeing sufficient resources, to clear the back log of DoLS cases, which would be of great benefit for managing the transition to the new programme. The challenge would be in managing the budget over the next 2 – 3 years.
- The government estimated that 20% of all DoLS cases were NHS related, and so the NHS would need to resource up to 20% of the cases. There were ongoing negotiations between NHS and the government.
- It was noted that DoLS required up to seven different professionals to be involved, but the new arrangements would only require three. This could have an effect on the number of advocacy requirements that the authority received.

RESOLVED

1. That the Committee support the recommendations to the Executive Councillor for Adult Care, Health and Children's Services as set out in the report.
2. That the following additional comments be passed to the Executive Councillor for Adult Care, Health and Children's Services in relation to this item:
    - *Provision of the various advocacy services remains a statutory responsibility for the County Council and the NHS;*
    - *Unlike most local authorities, Lincolnshire County Council does not have any backlog in the processing Deprivation of Liberty Safeguard cases. and*
    - *There is an anticipation that the new Liberty Protection Safeguard requirements will incur lower costs than the existing Deprivation of Liberty Safeguards.*

43 ADULT CARE AND COMMUNITY WELLBEING PERFORMANCE REPORT - QUARTER 2 2019/20

Consideration was given to a report which presented performance against Council Business Plan targets for the Directorate as at the end of Quarter 2 2019/20. A summary of performance against target for the year was provided in Appendix A of the report and a full analysis of each indicator over the year was provided in Appendix B of the report.

Members were provided with the opportunity to ask questions to the officers present in relation to the information contained within the report and some of the points raised during discussion included the following:

- 18 of the 26 measures were either meeting or exceeding target, with three being survey measures which were reported annually. There were only five measures which were not achieving target; four within Community Wellbeing and one in Carers.

- Measure 31 – Percentage of alcohol users that left specialist treatment successfully – this had declined slightly, but was expected to fluctuate around the 35% mark. Less than 1% of people re-presented who had been through the service. This service gave good value for money.
- Measure 34 – Chlamydia diagnoses per 100,000 15 – 24 year old PHOF 3.02 – this had missed target, however officers were in the early processes of recommissioning sexual health services. It was suggested that the indicator used did not accurately represent the quality of service.
- It was queried whether success in terms of chlamydia diagnoses was measured as the number of clear cases. It was also highlighted that the testing kits were sent out on request and it was queried whether any contraception was included as a way of prevention. It was noted that the indicator measured activity instead of outcomes, and this was being reviewed at a national level.
- Measure 109 – number of health and social care staff trained in Making Every Contact Count (MECC) – it was noted that this was a collective target through the year.
- Measure 111 – People successfully supported to stop smoking – it was noted that there was a three month time lag with this data, and so this data was for the end of June 2019. Members were advised that the Integrated Lifestyle Support Service had commenced on 1 July 2019 and so an increase in performance was expected. It was considered important that the smoking indicator remained.
- It was noted that the Integrated Lifestyle Support Service was badged as 'One You Lincolnshire'. There was a need to measure what people were using the service for, and it was suggested that someone from the service come to a future meeting and give an update on progress to the Committee.
- Measure 121 – Carers who have received a review of their needs in the last 12 months – it was noted that it was unusual for this to be below target, but was believed to be due to a shift in the delivery model. It was expected that by the end of the year the target would be reached.
- In terms of 'Making Every Contact Count', cumulative performance was above target. Staff could do the training, but ultimately the success depended on whether they put it into practice.
- Carers had a right to an independent assessment, and a reasonable number wanted to be seen separately from the person they cared for, and so the authority needed to offer this. Whether it was done with the service user present, was at their discretion.
- Carers could come under a lot of stress and so sometime it was quite relevant for them to have a separate review.

RESOLVED

That the performance for Adult Care and Community Wellbeing for Quarter 2 be noted.

44 ADULT CARE AND COMMUNITY WELLBEING BUDGET 2019-20

Consideration was given to a report which provided the Committee with information in relation to the Adult Care and Community Wellbeing Budget 2019 – 20. It was reported that the net Adult Care and Community Wellbeing budget was £227.306m. For the period up to and including 31 October 2019, with the information available, the projected outturn would deliver an underspend of £0.772m for the 2019-20 financial year.

Members were provided with the opportunity to ask questions to the officers present in relation to the information contained within the report and some of the points raised during discussion including the following:

- Members commented that they were happy with the way the information had been laid out in the report.
- Concerns were raised regarding the future of the Better Care Fund as the authority was heavily dependent on it to fund social care. It was queried what would happen if it disappeared, members were advised that this was unlikely and it was generally believed that it would continue.
- It was reassuring to see demand management and projections included within the report. It was confirmed that implementation of mosaic was helping with this.

RESOLVED

That the outturn projection for 2019-20 be noted.

45 ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE WORK PROGRAMME

Consideration was given to a report which provided the Committee with an opportunity to consider its future work programme.

The following changes were suggested to the work programme:

- 15 January 2020 – the items in relation to the Better Care Fund, Rural and Coastal Communities and New Ways of Working in Social Care should be moved to the February agenda. An additional item in relation to Extra Care Housing would be added.
- Items on NHS Long Term Plan; the Lincolnshire Safeguarding Adults Board; and Transforming Care to be added to the 1 April 2020 agenda

RESOLVED

That the above changes to the work programme be noted.

The meeting closed at 12.12 pm

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Lincolnshire COUNTY COUNCIL
Working for a better future

Open Report on behalf of Glen Garrod Executive Director Adult Care and Community Wellbeing	
Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**15 January 2020**
Subject:	**Adult Care and Community Wellbeing Budget Proposals 2020-2021**

Summary:

This report details the Council's budget proposals for Adult Care and Community Wellbeing (ACCW) for the financial year 1 April 2020 – 31 March 2021.

This report details the ACCW position within the wider Council position and the assumptions made given the national context.

Actions Required:

Adult Care and Community Wellbeing Scrutiny Committee is asked to provide comments upon the proposal and note the actions and risks contained within this report.

1. 2020-21 Budget

September 2019 saw the outcome of the spending round which sets out the government's spending plans for 2020-21. This round is one year only with an expected comprehensive multi-year spending review to follow in 2020.

The spending review encompassed the following key aspects relating to social care and public health:

- an additional £1 billion for Adults' and Children's Social Care. Indicative individual authority allocations suggest a potential £14.7m for Lincolnshire County Council. This is proposed for one year only, i.e. 2020-21.

- a real terms increase of 1% to the Public Health Grant budget, which will ensure local authorities can continue to provide prevention and public health interventions.

- funding to continue at 2019-20 levels (with individual authority allocations unchanged) for the Social Care Support Grant and the Winter Pressures Grant.

- improved Better Care Fund funding will continue at 2019-20 levels and use the same methodology to allocate the funding with the Winter Pressures Grant rolled in.

All areas within the Council undertook a comprehensive budget setting process throughout the summer, culminating in a budget presentation to the Overview and Scrutiny Management Board in September 2019 and the final budget proposals will be presented to the Council in February 2020. All aspects of current spending, levels of income, council tax and use of reserves have been considered and enabled the Council to set a balanced budget for 2020-21.

The financial years 2021-22 to 2022-23 are indicating potential financial pressure as a result of growing demand across the majority of services and specific to Adult Care, a number of significant services are under contract with a renewal due.

The Council has been prudent in its income assumptions given the uncertainty of the national picture. For example the £14.7m Social Care Grant is only assumed to be received for one year, 2020-21. The pressures supported by this funding are however recurrent.

ACCW is organised into the following three delivery strategies for 2020-21 onwards:

- Adult Frailty & Long Term Conditions
- Specialist Services & Safeguarding
- Public Health & Community Wellbeing

During 2019-20 the Carer Services transferred into the Public Health division.

The table below shows the budget position for 2020-21 and compares to the 2019-20 projected outturn.

Strategy	2019-20 Projected Outturn £m	2020-21 Budget £m
Adult Frailty and Long Term Conditions	120.37	120.12
Specialist Services & Safeguarding	76.96	82.15
Public Health & Community Wellbeing *(see note)*	29.67	28.79
Better Care Funding	-46.34	-48.18
Public Health Grant	-31.80	-32.34
Adult Care and Community Wellbeing Budget	**148.86**	**150.54**

Note: This figure does not represent the full Public Health Grant received, for example it excludes Children's Public Health.

2. Adult Frailty & Long Term Conditions (AF&LTC)

The Adult Frailty and Long Term Conditions strategy brings together older people and physical disability services as well as hosting the budgets for back office functions in infrastructure budgets. The financial allocation of this delivery strategy aims to support eligible individuals to receive appropriate care and support in the most appropriate setting including community based care (including home support), re-ablement, day care and direct payments.

This strategy has managed its financial allocation effectively to enable it to report a balanced financial position over the last seven years and expects to do so again within 2019-20.

Following the detailed Budget 2020 programme, the proposed 2020-21 budget for Frailty & Long Term Conditions (excluding infrastructure) strategy is £113.05m.

AF&LTC identified £5.67m of pressures predominantly relating to demographic growth and the re-procurement of homecare services due in September 2020. In recognition of these pressures, AF&LTC identified £5.27m of efficiencies and increased income.

The proposed budget for infrastructure is £7.07m; this represents a 3.55% decrease on the 2019-20 outturn. This budget encompasses the Director's Budget, Brokerage, Business Improvement, Quality Assurance, Service Development, and the Mosaic & Performance Teams. The budget also covers contracts including Sensory Impairment & Advocacy.

The financial structure for this delivery strategy in 2020-21 is detailed below;

	2019-20 Projected Outturn £m	2020-21 Budget £m
Adult Frailty & Long Term Conditions	113.05	113.05
Infrastructure	7.32	7.07
Total Adult Frailty & Long Term Conditions	**120.37**	**120.12**

3. Adult Specialties and Safeguarding

The financial allocation of this strategy supports delivery of services for eligible adults with learning disabilities, autism and/or mental health needs.

The delivery mechanism for this strategy is primarily through partnership working predominantly with local community and residential care providers for learning disabilities and autism and Lincolnshire Partnership NHS Foundation Trust (LPFT) for community mental health care.

This strategy has managed its financial allocation effectively to enable it to report a good financial position of balanced/within <1% overspend over the last 3 years and expects to do so again within 2019-20.

Following the detailed Budget 2020 programme, the proposed 2020-21 budget for the Adult Specialties strategy is £82.15m, this represents a 6.7% increase on 2019-20 outturn.

This budget includes £6.0m of pressures relating to demographic growth and the need to invest in infrastructure to maintain the current service models. In recognition of these pressures, adult specialties were able to identify £2.05m of efficiencies and income increases.

The financial structure for this delivery strategy is detailed below:

	2019-20 Projected Outturn £m	2020-21 Budget £m
Learning Disabilities	64.19	68.32
Mental Health	8.28	9.60
Safeguarding	4.49	4.23
Total Adult Specialties	**76.96**	**82.15**

Care Delivery

The pressures reflect the annual increases we are experiencing as a result of a combination of demographic growth and eligible needs with £1.6m gross forecast for residential care and £3.0m gross forecast for home-based care.

Mental Health Community Care Services

Community mental health services are delivered by LPFT through a section 75 agreement (S75). With the S75 due for renewal in April 2020, a review of needs and delivery outcomes has been completed in preparation. It is clear that this is an area of continued growth and whilst relatively small in terms of the number of people supported the care costs are high. Delivery of the same model within 2020-21 building in the forecast demand and the staffing implications to meet national expectations will result in a financial pressure. Should Council agree with the proposal in February 2020, the financial implications are provided for within the budget.

Safeguarding

Currently LPFT deliver the Deprivation of Liberty Standard assessments with trained medical staff under contract to deliver the clinical elements. The standards are to be replaced with Liberty Protection Safeguards in October 2020. The budget for 2019-20 included £1.8m from ACCW reserves to ensure demand for assessments was met in year. The current spend is forecasting £1.5m for 2019-20. Given current demand and the likely delay to implement Liberty Protection Safeguards, £1.7m is allocated within ACCW reserves to meet 2020-21 demand.

4. Community Wellbeing

Historically this commissioning strategy has delivered services within its financial allocation and this is forecast to continue with support from the Public Health reserve.

Following the detailed Budget 2020 programme, the proposed 2020-21 budget for the Public Health & Wellbeing strategy is £28.79m, this represents a 2.9% decrease on the 2019-20 outturn.

The budget process identified a pressure of £0.5m. However this is set against the potential to generate efficiencies of £1.4m by delivering existing services in a different way predominantly through the use of technology.

The financial structure for Community Wellbeing is shown in the table below:

	2019-20 Projected Outturn £m	2020-21 Budget £m
Community Wellbeing *	29.67	28.79
Total Community Wellbeing	**29.67**	**28.79**

** Grant awaiting confirmation of 2020-21 spending review. The table excludes Children's Public Health*

The majority of services delivered within this strategy are contracted out, 81% of funding (£24m) delivers services through awarded contracts which have varying renewal dates.

The key actions to deliver a balanced strategy whilst maintaining or improving the services offered are:-

Integrated Lifestyle Service (ILS)

This contract was awarded in July 2019 and brought together several individual services into one integrated service. The contract is for three years with the option of a two year extension to 30 June 2024.

The annual cost is £2.7m with a contribution from health of £0.5m. A section 256 agreement is in place with the Clinical Commissioning Groups (CCGs) to ensure the £0.5m annual contribution is received throughout the life of the contract. To support the cost of the contract whilst existing contracts come to an end and the new one begins, £0.58m is allocated within the Public Health 2020-21 reserve to ensure delivery of a balanced financial position.

Integrated Community Equipment Service

An additional £0.4m has been allocated to this service to enable the growth in demand for equipment to be met in 2020-21. A joint (County Council/NHS) review of the recurrent demand for this service will be undertaken given the continued forecast growth in demand and in readiness for the current contract expiry on the 31 March 2021. The service does have the option to continue the current contract through to the 31 March 2023.

Sexual Health Service

The contract for this service currently runs to the 31 March 2021. Through the Budget 2020 planning process, £0.5m efficiencies have been identified by adopting different ways of delivering the service. The service model will be worked through during 2020-21 in readiness for the re-procurement.

5. Identified Efficiencies

Each of the three strategies has plans in place to successfully deliver the efficiencies identified as part of the Budget 2020 programme. Each of the responsible lead senior officers has confirmed that the principle of identifying efficiencies without detrimental impact on service users can be achieved.

6. The Better Care Fund (BCF)

Launched through the spending review in June 2013, the BCF was highlighted as a key element of public service reform with the primary aim to drive closer integration between the NHS and Adult Social Care and improve outcomes for patients, service users and carers.

The Lincolnshire Better Care Fund is an agreement between the Council and the four Lincolnshire CCGs, overseen by the Health and Wellbeing Board. The BCF pools funds from the organisations to aid the objective of integrated service provision.

The total pooled amount in 2019-20 is £254.282m which includes £58.682m allocated to the Lincolnshire BCF from the Department of Health and Social Care. The pooled budget is made up of the minimum CCG contribution and additional improved Better Care Fund (iBCF) monies received directly from the government. All the required regional support has been given to the 2019-20 BCF Narrative Plan and the budgets have been allocated accordingly. The BCF funding is subsumed within each delivery strategy and is integral to the financial viability of both adult frailty and adult specialties.

The following table details the Lincolnshire wide Better Care Funding structure.

	2018-19 £m	2019-20 £m	2020-21 Assumption* £m
Minimum CCG Contribution	50.47	52.53	53.21
Additional CCG Contribution	74.23	79.40	79.40
Additional Local Authority Contribution	77.87	82.95	82.95
District Councils Disabled Facilities Grants	5.70	6.15	6.15
iBCF 2015 Spending Review	14.25	25.77	33.25
iBCF 2017 Chancellor Announcement	9.61	4.11	
iBCF Winter Pressures	3.37	3.37	
Total	**235.49**	**254.28**	**254.96**

**Assumed value awaiting confirmation of September 2019 spending review*

We are expecting to see a roll-over into 2020-21 of the BCF funding for a further year. The national direction would seem to indicate that 2020-21 will be used to review the components of the fund, ensure outcomes are maximised and potentially agree a three year BCF programme 2021-2024 to coincide with an anticipated Comprehensive Spending Review later in 2020.

7. Charging Policy

Section 14 of the Care Act 2014 gives Councils the power to charge adults for care and support. This applies where adults are being provided with care and support to meet eligible needs identified under Sections 18, 19 or 20 of the Care Act 2014. Councils must follow the regulations and guidance issued under the Care Act 2014.

April 2020 will see an updated Charging Policy for Lincolnshire County Council come into force. This policy will continue the journey of improving the financial assessment process and ensure that all charges and disregards are made in accordance with the Care Act.

The changes will result in a £0.5m adverse impact for Lincolnshire County Council in 2020-21, which have been built into the budget in 2020 and the Medium Term Financial Plan.

8. ACCW Capital Programme Budget

The table below details the commitments against the £12.74m ACCW Capital Programme Budget.

The budget will predominantly be spent on supporting the Extra Care Housing Programme which commenced in December 2019 with the DeWint build in Lincoln. The right type of housing in the right location enables people to maintain their independence for as long as is appropriate for the individual and provides lower cost provision than residential care.

Capital Project	County Council Total	2019/ 20	2020/ 21	2021/ 22	2022/ 23	2023/ 24
Homes for Independence, De Wint	2.80	1.40	1.40			
Homes for Independence, Nettleham	*2.60*		*2.60*			
Homes for Independence, Horncastle	*2.60*		*1.30*	*1.30*		
Homes for Independence, Pipeline	*3.39*				*1.60*	*1.79*
Disabled Facilities Grant	*0.15*					
Daycare Modernisation	*0.30*					
Learning Disabilities Building Maintenance	*0.05*	*0.05*				
Disabled Facilities Grant Central Heating Fund	*0.11*					
Total to be allocated	*0.74*					
Total ACCW Capital Reserve	**12.74**	**1.45**	**5.30**	**1.30**	**1.60**	**1.79**

Note: Those in italics are awaiting a confirmed business case / spending plan.

9. Conclusion

The Adult Care and Community Wellbeing budget proposal reflects the funding available to deliver services during 2020-21. Following a comprehensive Budget 2020 programme, the proposal reflects the priorities whilst operating within the resources available. These figures may be subject to change once we receive confirmation of the autumn 2019 Spending Review.

10. Consultation

a) Policy Proofing Actions Required

n/a

11. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Pam Clipson, Head of Finance Adult Care, who can be contacted on 01522 554293 or pam.clipson@lincolnshire.gov.uk.

Policy and Scrutiny

Open Report on behalf of Glen Garrod
Executive Director Adult Care and Community Wellbeing

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**15 January 2020**
Subject:	**Homecare**

Summary:

This item invites the Adults and Community Wellbeing Scrutiny Committee to consider a report on Homecare, which is due to be considered by the Executive on 4 February 2020. The views of the Scrutiny Committee will be reported to the Executive, as part of its consideration of this item.

Actions Required:

(1) To consider the attached report and to determine whether the Committee supports the recommendations to the Executive set out in the report.

(2) To agree any additional comments to be passed to the Executive in relation to this item.

1. Background

The Executive is due to consider a report on Homecare on 4 February 2020. The full report to the Executive is attached at Appendix 1 to this report.

2. Conclusion

Following consideration of the attached report, the Committee is requested to consider whether it supports the recommendation in the report and whether it wishes to make any additional comments to the Executive. The Committee's views will be reported to the Executive.

3. Consultation

The Committee is being consulted on the attached report and its recommendations.

4. Appendices

These are listed below and attached at the back of the report	
Appendix 1	Report to the Executive 4 February 2020 – Homecare

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Alexander Craig, who can be contacted on 01522 554070 or at alexander.craig@lincolnshire.gov.uk .

Open Report on behalf of Glen Garrod
Executive Director Adult Care and Community Wellbeing

Report to:	**Executive**
Date:	**04 February 2020**
Subject:	**Homecare**
Decision Reference:	**I019269**
Key decision?	**Yes**

Summary:

The Council currently commissions twelve, zone based, contracts to deliver Homecare across the county. These arrangements are due to come to an end on 30 September 2020

The council has statutory duty to provide homecare in the community and as such must ensure there are satisfactory arrangements in place with the market to discharge this duty. The contracts are the Council's only method of directly commissioned domiciliary care with the only other main alternative available being direct payments.

This report presents the case for re-commissioning the existing homecare contracts on a broadly similar model however with a small number of significant changes to how the service functions.

Recommendation(s):

That the Executive Councillor:

1. Approves the re-procurement of twelve zone-based Homecare contracts to establish a county-wide service effective from 1 July 2020 with services fully commencing on 1 October 2020

2. Subject to approval by full Council of additional funding sufficient to cover the additional cost identified in paragraph 2.21 of the report, approves the inclusion within each of the said Homecare contracts of:

   (i) a 30 minute minimum call duration for all personal care;
   (ii) a new 'extra rural rate' in extremely remote areas with low volumes of call activity; and
   (iii) the establishment of a Floating Support Team.

3. Delegates to the Executive Director - Adult Care and Community Wellbeing in consultation with the Executive Councillor for Adult Care, Health and Children's Services, the authority to determine the final form of the service, the procurement and the contract, to approve the award of the contract and entering into the contract, and any other legal documentation necessary to give effect to the above decisions.

Alternatives Considered:

1. Revert to a framework or Dynamic Purchasing System

2. Change the number or geographic extent of the zones

The relative merits of these alternatives are explored in the body of the Report.

Reasons for Recommendation:

The existing commercial arrangements for Homecare services have, on the whole, worked well over the duration of the current contracts. The proposed re-procurement builds on the strengths that have been developed within the local market but also proposes new recommendations to target the specific areas of increased risk that the Council faces over the near future. It is anticipated that with the approval of the recommendations within this report homecare services will not only continue to be sustainable for the future but also offers good opportunities for continued improvement.

1. Background

The Services

1.1. Homecare services are one of Adult Care's most strategically important services with over 2,500 people receiving regulated care via one of the Council's contracted providers each week totalling over 1.3 million hours of care delivered each year. With a total annual spend of over £ 24m per annum it represents approximately 10% of the total Adult Care budget and is a vital part of the wider health and care system. It is also one of the most challenging and pressurised parts of the adult care system, both locally and nationally, due to increasing overall demand, increasing complexity of care needs coupled with a market that has struggled to be able to meet demand effectively for some time now. There are no other contracts in place for Homecare with Direct Payments being the only alternative.

1.2. There are twelve 'Lead Provider' contracts in place each one taking responsibility for meeting all the demand for commissioned homecare in a specific area either directly or via sub-contractors.

1.3. Following a three month transition period from July to September 2015 the old Community Support Framework contracts of over 70 providers ended and the new Homecare Services commenced under the new Lead Provider model. This transition period was extremely challenging and led to a significant degree of disruption for service users and the market.

1.4. There were numerous reasons to move to a new model which remain absolutely relevant to the pressures facing Homecare providers now.

1.5. One of the foremost reasons was the extensive fragmentation in the market and that operating costs were replicated across every Provider and in turn that cost and inefficiency was redistributed back to the Council in addition to the internal costs of managing so many Providers across the County. The Lead Provider model addresses the cost pressures that result from market fragmentation. By guaranteeing exclusivity of demand to a smaller number of Providers many of the pressing issues faced by businesses were alleviated. In giving this certainty of income the Provider was able to better manage their costs, establish a viable operating financial model which covers their overheads, allows for profit, as well as improving their ability to retain staff which continues to be a key operational concern.

1.6. All twelve homecare contracts are due to expire on 30 September 2020 with the majority of contracts reaching the full five year term. Since the start of the contracts in 2015 where we undertook a major market restructure moving from over 70 providers to twelve, there has been a considerable degree of change within the market both locally and nationally, and following a number of reviews of the Lincolnshire homecare market the decision was taken in February by Adult Care and Community Wellbeing Executive DLT to start work on preparing for a full scale re-procurement in 2020. A series of three key reports have been presented to Adult Care Exec DLT which have summarised this work and explored a wide range of potential developments for the new contracts.

1.7. At the point of contracting in 2015 there were twelve individual providers, one per zone, but since then changes to the market has resulted in a number of contracts changing to new providers. The following table sets out the original profile of how zones were allocated and how they have changed to date.

Zone	Area	Original Provider	Current Provider	Date Transferred
1	Market Rasen	Hales Healthcare	Hales Healthcare	
2	Louth	Libertas	Libertas	
3	Boston	CRG Homecare	CRG Homecare	
4	Skegness	Walnut Care at Home	Walnut Care at Home	
5	Lincoln	Mears Care Ltd	Sage Care Ltd	June 2017
6	Gainsborough	Carewatch Care Services Ltd	Libertas	May 2018

Zone	Area	Original Provider	Current Provider	Date Transferred
7	Hykeham	Sevacare (UK) Ltd	Sevacare (UK) Ltd	
8	Lincoln South	Sage Care Ltd	Sage Care Ltd	
9	Grantham	Homecare Helpline	Fosse HealthCare	Oct 2018
10	Sleaford	Care at Your Home	CRG Homecare	April 2016
11	Spalding	Atlas Care Services Ltd	Atlas Care Services Ltd	
12	Stamford & Bourne	Bloomsbury Home Care	Atlas Care Services Ltd	Oct 2018

Contracted Hourly Rate

1.8. There are two standard hourly rates for all Lead Providers, one for urban work and one for rural. Within the first year of the contract the National Living Wage was introduced and from 1 April 2016 the hourly rate has been increased each year to reflect the National Minimum Wage change.

	2015 Rate	2016/17 Rate	2017/18 Rate	2018/19 Rate	2019/20 Rate
Urban	£13.03	£13.56	£14.23	£15.00	£15.63
Rural	£13.32	£13.85	£14.53	£15.30	£15.96

2. Service Review Activity

2.1. Due to the critical nature of the homecare contracts a detailed review exercise has been undertaken over 2019 with three main phases of work

PHASE ONE – FUNDAMENTAL REVIEW OF HOMECARE MODELS

2.2. The first phase of the review consisted of a comprehensive analysis and review of how we do business. An analysis with a focus on the commercial model, the market for homecare services and adult care in general, and operational practices that directly relate to the proper functioning of homecare contracts.

2.3. The report covered three main areas; the internal council view, how providers view the contracts and what other local authorities are doing.

2.4. Detailed interviews with stakeholders directly affected by the performance of the contracts have been conducted over the last four months. Interviews generally took two hours each and were based on a set of questions to draw out the main strategic and operational concerns of each party.

2.5. The requirement for local authority homecare services is consistent across England and as such each local authority will have similar arrangements in place. By reviewing how other councils have modelled their homecare provision it can provide a useful point of comparison when considering our options for the future model.

2.6. As there are 26 County Councils, as well as many other tier one local authorities, the decision was taken to focus on local authorities that have a similar profile to Lincolnshire i.e. a large rural county with a relatively high proportion of over 65s.

2.7. It was possible to directly interview many of the councils listed and where this has not been possible detailed analysis has been completed after reviewing published committee papers.

Nottinghamshire
Wiltshire
Devonshire
Cumbria
Norfolk
Kent
Derbyshire
Suffolk
Leicestershire
Rutland
Surrey
Staffordshire
Thurrock

2.8. After compiling the substantial volume of feedback it was then possible to analyse and consolidate many recurring issues and themes. Many of these issues relate to the fundamental challenges facing homecare systems across the country, particularly in relation to how the workforce performs.

- Finding a yes vs. being able to say no – reconciling the legal duty of the council to find care for all eligible people and the ability of the market to be able to respond to this demand safely.
- A stressed and fragile system – an account of the limited flexibility and resilience of the homecare market (nationally and locally) and the specific risk of failure events spiralling further.
- Expectations management and communication – how the council and providers can better communicate with service users to avoid unmet expectations.
- Call Times and Bandings – how to build in more flexibility around high demand call times
- Workforce capacity and capability – an account of the critical importance of the workforce in all aspects of the service and that all steps should be taken to support it.
- Alternate layer of provision – rapid response teams, insourcing or other options.
- The Rate and Funding – analysis of other local authority rates and how we can structure funding to better meet service outcomes

- Outcome Based Working – an account of a different way of working for homecare and how it would potentially solve a great deal of the challenges we face.
- Zones and geography – a review of the zone model and where changes may be beneficial
- Technology and Centralised Systems – how there is considerable available improvement in the utilisation of new technology.
- Private providers in the market – an investigation into why private providers do not bid for local authority contracts
- Market stability and provider growth – how to support the market in general
- Service transition and continuity of care – the need to avoid unnecessary disruption and damage to the market via transition
- Commercial Model – exploration of factors such as duration, performance management and incentivisation
- Integration with Health – update on joint working
- Extra Care – the need to continue to work with independent housing providers and homecare providers to ensure Extra Care works properly
- Home Based Reablement Integration

2.9. There is a large amount of additional information contained within the feedback which will also be taken into account within the new contracts.

2.10. Other findings of the phase one review were:

- Every local authority charged with providing Homecare is grappling with the same challenges as Lincolnshire. The state of the workforce, limited funding, and how to deal with travel time/rurality appear to be the biggest common challenges we all face with no obvious or easy solutions.
- In many aspects Lincolnshire appears to be in a strong position particularly around managing demand and the overall cost of the service.
- It is clear that simply paying a higher rate alone is not a straightforward solution to improving homecare outcomes and market capacity. Many other local authorities pay significantly more than Lincolnshire but experience the same, or worse, issues than we do particularly when there is evidence of weak control of the market.
- The most common commercial model in place for other councils is a type of framework or dynamic purchasing system similar to Lincolnshire contracts prior to 2015

- In some cases this is supplemented with additional block arrangements to deal with a lack of capacity in certain areas
- Use of BCF monies has not been as forward thinking or effective as has been the case in Lincolnshire.
- The prevailing, nation-wide, pressures within the system means that regardless of how much a local authority pays or how their contracts are structured there are the same problems in every county

REVIEW PHASE TWO – MARKET CONSULTATION

2.11. With the initial findings from the first phase it was then possible to develop a set of common issues and themes for more focused exploration with our local market. An early market engagement event was held at the Bentley Hotel on 26 June 2019 with attendance from twelve local and national providers. At this event the key findings from phase one were summarized and discussed in detail with providers who were also able to raise any new or additional comments for consideration. In general the market was supportive of the work completed to date and that the initial observations were representative of their own point of view.

2.12. In summary the phase two findings were:

- There is the potential for substantial improvement in technology and our processes as whole however the most beneficial area to focus on are the Council's systems.
- We would all benefit from a much greater ability to share data and communicate more effectively
- The way the system is set up at the moment (time and task) is inherently inflexible and does not support our shared goals for better outcomes and a more resilient market
- Call times are a significant issue in how day to day operations affect the bigger picture. Short calls are particularly challenging especially in rural areas, often leading to reduced quality outcomes as well as increased risk of late calls
- How the workforce operates continues to be perhaps the single most important element of how services work. Every effort should be made to improve the role of care worker including employment terms, incentives, the profile of the job, career progression, etc.
- The relationship between the council and its lead providers must continue to grow closer. With the desire to move to outcome based working as well as measures to improve operational outcomes this will require the council placing more trust in providers to act with more autonomy than currently is the case.

PHASE THREE – DEVELOPMENT OF NEW INITIATIVES FOR APPROVAL

2.13. Taking both phase one and phase two outcomes into account it was then possible to develop number of areas that were determined as in scope for further development in order to establish whether or not they are suitable for inclusion in the new contracts.

TABLE 1

	Item	Scope and aims
1	Process and technology review	Identify, map and document all processes surrounding home care (the 'as is'), from initial assessment, through to placement and all steps in between. The activity should consider physical processes and system interactions. This will help assess the impact of any proposed changes to the current model and identify potential efficiencies.
2	Improving provider flexibility and responsiveness	Review, assess and cost up the potential commissioning of a new provider led support team for each zone in the contract. This would be a small team of staff working on shifts with guaranteed hours that would deal with difficult cases, instances of staff loss, or any other factor that might undermine the stability of the provider. Where there is 'down time' for this team they would be expected to make best use of this by looking to improve service user outcomes, focusing on re-abling clients, or dealing with waiting lists.
3a	Extra Rural Rate	Review the current funding model and assess the impact of the creation of a new 'extra rural' rate.
3b	High Volume Call Times	Assess the financial implications of a payment mechanism that recognises the demand and cost for high volume call times, e.g. 7.30am.
3c	Short Calls	Assess the operational and financial impact of how we currently commission care call durations.
4	Zone Boundary Review	Review and propose changes to the existing zone boundaries to better account for more effective working areas. Particularly with regard to zone 10 which may require a fundamental change
5	Individual Service Funds Pilot and Outcome Based Working	Develop the ISF pilots across all zones in the existing contract in order to help develop a pathway to Outcome Based Working as soon as possible in the new contracts.

	Item	Scope and aims
6	Time Banding	Complete a full roll out of the time banding system to embed this practice into current contracts. Take into account any lessons learnt to date. Engagement with operational teams, brokerage and providers.
7	Domestic work	Undertake a review to identify the potential for differentiating between domestic care calls and personal care calls. Assess whether or not this could better direct resources and funding to the right areas in the new contract, whilst taking into account that separating these out may lead to increased complexity in call scheduling.
8	Care Worker Incentivisation Programme	Identify and explore opportunities to develop a meaningful incentivisation programme for care workers, e.g. PerkBox type discounts, childcare vouchers etc.
9	Joint Commissioning with Health	Actively develop joint commissioning plans with health.
10	Data Sharing Protocol	Build a data sharing portal or protocol that allows all parties to do their job better.

2.14. Over August and September a significant amount of work has since been undertaken to investigate and develop each of these items and the findings are presented below.

1. Minimum Call duration for Personal Care Calls (Item 3c in Table 1)

Overview

The volume and length of calls is a critical factor in relation to how services perform. Short calls are problematic as there types of calls are operationally challenging and often uneconomical particularly where there is extended travel time. Care workers, being only paid for the contact time they have with clients, also tend to find short calls to be very unattractive which in turn makes recruitment and retention very difficult. Most importantly though is the potential improvement to quality and service user outcomes. In all cases sub-30 minute calls for personal care adds pressure and risk to an already stressed system.

Concept

Implementing a 30 minute minimum call time for all personal care calls, excepting those cases where the service user requests a shorter call and when calls are undertaken in an Extra Care Home. This new standard would also be welcomed by CQC who's inspection regime and quality assessments are directly influenced by the amount of time given to care calls.

Summary

An additional **£1.7m** p.a. would be required to increase the minimum call duration of all personal care calls to 30 minutes. Calls that are not personal care will remain as shorter durations as will those requested by the Service User. The actual amount of this will vary depending on the current profile of service users and may in fact be lower if it can be clearly established that specific service users request short call durations as their preference. For the remaining non-personal care calls there will be further investigation into the possibility of alternative service delivery options such as new technologies to carry out medicines prompts and checks.

2. Floating Support Team (FST) (item 2 in Table 1)

Overview

Homecare is paid via an hourly rate and only for the actual commissioned call time that is required. This means that provider income is wholly based upon a relatively precise and inflexible basis as there is no surplus time built into the model. Providers are able to apply for a variation to a specific call payment if there are extenuating circumstances e.g. waiting for an ambulance, but this does not happen as a matter of course. Employment contracts also reflect the time specific nature of the work with few providers having full time salaried care staff, the majority being on 'Variable' or zero hour contracts.

The current system therefore means that that majority of provider resources are focused on meeting total demand and attending calls. Almost every facet of the system puts pressure on this goal and providers may then consider overstretching the safe limits of their capabilities leading to an increased rate of incidents of failure e.g. late calls, staff not turning up. This can have a spiralling effect on the provider as failures deepen system stress and increases the risk of even greater failure.

Based on the first phase analysis one of the proposals for consideration is establishing a new provider led floating response team for each zone in the contract. This would be a small team of staff working on shifts with guaranteed hours that would deal with difficult cases, instances of staff loss, or any other factor that might undermine the stability of the provider. Where there is 'down time' for this team they would be expected to make best use of this by looking to improve service user outcomes, focusing on re-abling clients, or dealing with waiting lists.

Concept

Establish additional capacity and responsiveness within each zone with guaranteed hours, providing availability to respond to staff loss, difficult cases and any delays

The new contract would stipulate that:

- There were named individuals on the FST (with the ability to have substitutes upon the Council's notification)
- Account for and ensure that each FST worker maintains 25 hours per week on standard commissioned work
- Account for the activities undertaken as part of the FST work
- Ensure that activities are directed on
    - Dealing with short term call round issues. This should result in less late or missed calls.
    - Dealing with reducing the waiting list. While it would not be appropriate for the FST to pick up cases that are waiting for a long period of time (as this will permanently reduce the FST capacity) they may be able to start a care package early while the provider recruits for a more permanent solution.
    - Dealing with emergencies
- If there is a persistent failure to show that FST hours are not being used effectively and the outcomes above are not improving then there will be an option to suspend or terminate this element.

Summary

Each zone requires approx.100 staff to meet demand, on average care staff work 25 hours per week. This proposal establishes a small team of 3FTE in each zone by topping up 3 workers (by an additional 12 hrs) in each zone/

Countywide equates to an additional 22,000 hours per year with an additional cost of approx. **£300,000** per year.

3. Extra Rural Rate (item 3a in Table 1)

Overview

Rurality has always presented a significant challenge in Lincolnshire. With the high number of villages and hamlets, care workers have to travel long distances. The existing rural banding covers a fairly wide parameter from hamlets with one service user to a small village with a high volume of work. These highly isolated calls are often uneconomical for both providers and care workers leading to a higher turnover of staff working in very rural areas and increased costs to providers.

Concept

Introduce an enhanced “extra rural rate” based on parameters including lowest value, highest wait and rurality to identify problem areas while continuing to have an urban and rural rate.

The new contracts would also include a contract mechanism to widen scope based upon set criteria and local authority approval eg new care package starts in a hamlet that has not previously had service users as well as turn off an extra rural rate in the instance of call volumes in an area increasing to the point it becomes more economically viable.

Summary

By applying an extra rural rate (a 5% increase to the current rural rate would be £16.76 based on 19/20 rates) to the majority of Zone 10 as well as a number of other more isolated areas in county the additional annual cost would be **£55,724**. The actual amount may vary in future based on how new service users are distributed

4. Process & Technology Review (item 1 in Table 1)

Time and capacity within the homecare system is a highly scarce resource and as such we must be able to find a way to ensure that the business of doing business is as lean as theoretically possible. Current working practices are still based on a large degree of manual work, emails, isolated spreadsheets and little over-arching governance.

Providers have stated clearly that they have to allocate a lot of staffing resource to managing the call verification and payments process. Both internal staff and providers have reported that our current practices often result in simple errors having an outsized effect on our ability to focus on the service itself.

An initial review based on the NHS pathfinder scheme has produced some high level findings however there is still a need to fully understand how each step of the process impacts on both the council and provider with a view to optimising the end-to-end process as much as possible. A separate work stream will continue alongside the re-procurement and into the new contracts.

5: High Volume Calls (item 3b in Table 1)

Overview

It is well understood that there are specific times of the day when care calls are required at higher levels (7am, 12pm and various evening times). Trying to respond to this demand puts pressure on the system and can lead to disruption to individual calls.

Concept

Following the market consultation exercise a small number of providers suggested the potential to associate the cost of the service (the hourly rate) to the relative amount of demand in the day (the volume of calls at a specific time of the day.)

However, the Council does not specify a call time when setting up a care package, this is determined at placement via brokerage in conjunction with the provider based on the service users preference & the providers capacity.

As such, the only source of data that shows specific call times sits with providers ECM information.

Providers were asked to share further evidence of this factor however there was a very limited response which was not able to show a conclusive result.

Summary

The data set is too small to draw any final conclusions and it is anticipated that the alternate proposals for call bands will alleviate some of these pressures. As such this approach is not recommended for further development.

6. Care Worker Incentivisation (item 8 in Table 1)

Overview

As previously discussed the role of the workforce is absolutely crucial to the performance of the service. Homecare is one of the largest commissioned employee groups with over a thousand personnel from providers. That being said there are serious and sustained pressures on the workforce

The job itself is a very difficult one with a low hourly wage and unsociable working hours in comparison to less challenging work. Care workers in Lincolnshire tend to earn just over the National Minimum Wage (currently £8.21 for those aged >25) at £8.50 per hour with some roles and areas attracting a higher rate, in comparison Aldi and Lidl supermarkets offer £9+ per hour and there are many other 'entry level' jobs in Lincolnshire that can offer more attractive pay and employment terms. This differential is even further exacerbated by many other factors;

- Care work is much more difficult and skilled than retail or hospitality work. Care workers have to deal with vulnerable people, emotionally distressing incidents, have to deal with service users with high complex needs such as dementia, multiple personality disorders, people going through gender transition, or even be subjected to violent behaviour. All these have to be dealt with professionally in order to just be able to do the basic care tasks that are required.
- Care workers are paid on 'contact time' with travel time being built into their hourly wage or, less often, paid additionally. This often means that depending on how an individual care worker's rota breaks down may not get paid for the full span of down time between calls thus lowering their average hourly rate. Again in comparison to retail work, or even care home employment, this is not a concern and is a more attractive offer to a prospective worker.
- Care workers rota's are often operated on a split shift basis
- The need to travel itself is a real barrier as the job frequently requires that the worker drive in order to be able to get to clients, especially in a highly rural county.
- Unemployment in Lincolnshire is very low with some areas being <1% meaning again there is a much more limited available number of potential workers to start with.
- There are very limited career development opportunities for care workers. Those that are successful almost always move into the business side of care, in fact there are many excellent examples of front line workers becoming owners or directors of businesses. However given the large

number of the workforce this single route for advancement is not suitable and does not also take full advantage of the care and health skills developed by effective care workers.

- The care worker job does not have as positive a reputation as it deserves, particularly when contrasted with Health workers.

Turnover of care workers is very high with a 30% national average rate compared to 15% in UK retail, this rate increases significantly at the start of the recruitment process with over 50% of new recruits leaving within the first 2-6 weeks. Over and above the very negative operational impact of this there is a further damage to the provider in that each failed recruitment represents an estimated loss of over £3,500 per person according to Skills for Care ("Calculating the Cost of Recruitment"). With the large numbers of failed recruits this amounts to a significant amount of lost resource, one which our providers are acutely aware of. Many of them have full time dedicated recruitment managers for each branch and have sophisticated recruitment and retention programmes to help mitigate the loss rate and to keep up with the required demand.

Concept

Implement a range of value-added options to the contract which may support the recruitment and retention of the Caring Workforce that are based on taking advantage of existing schemes.

Summary

This could include implementing; employee discount schemes, a long service award scheme, childcare co-ordinator role and/or funding childcare places, employee support and counselling service, travel schemes and car support.

The cost for this is variable and would ideally be funded by supplementary measures like BCF or other grants.

7. Zone Review (item 4 in Table 1)

Overview

The original model for zones was based on area teams being divided into 6 main zones with 2 area teams per zone.

There are differences in the sizes of each area in square miles as well as the mix of urban and rural. The classification was primarily based on ONS data

Feedback from the marketplace noted that the zone model works well but there was a limited need to review the current boundaries based on, 1) rationalising zone boundaries that span urban areas and 2) considering Zone 10, the most challenging zone with high levels of cases waiting and Poor Practice Concerns reported throughout.

Concept

For item 1) to review the main postcode area list to identify exceptions and implement a secondary layer of classifications in order to better cover whole towns.

For feedback item 2) pending the approval of the new measures presented within this report it is anticipated zone 10 will still be competitively viable. If not further negotiation will be required in order to find the best way in which to re-distribute zone 10.

Summary

No additional costs to resolve feedback items 1and 2 .

If competition fails we have recourse to negotiate with the marketplace to resolve how the zone is distributed

8. Time Bandings (item 6 in Table 1)

Overview

One of the on-going challenges for Home Care services is the high levels of demand at peak times during the day (eg early morning, lunchtime, evening time etc). To try and reduce pressure on peak times, Adult Care & Community Wellbeing Executive DLT supported a pilot introducing time bandings within the home care service on 10 November. This type of working is also closely aligned to Outcome Bases Working as it relies on there being more choice and flexibility within the system when determining call times rather than being prescriptive.

The pilot began on 19 February 2018 in two zones;

- *Zone 1, Market Rasen operated by Hales*
- *Zone 10, Sleaford operated by CRG*

The pilot was later extended to include;

- *Zone 7, Hykeham operated by Sevacare*

The pilot assigned a tiered banding to new service users depending on the assessment of their needs. The tiers were as follows;

Tier	Time Banding	Descriptor
Tier 1	07:00 – 09:30	Time critical morning call eg SU is unable to get out of bed Service user is unable to toilet themselves SU has time critical medication SU needs to be ready before a particular time
Tier 2	07:00 – 11:00	Non time critical morning call
Tier 3	11.30 – 14.00	Time critical lunch call
Tier 4	15:45 – 18.30	Time critical tea call
Tier 5	18.30 – 22.00	Non time critical evening call
Tier 6	20.00 – 22.00	Time critical evening call

The model separates the day into a series of time slots with each given a banding and a description to identify priority or standard access. The Provider is required to support the client within the time band. The flexibility to respond to calls within the wider time banding rather than a specific set time allows the provider to have greater flexibility in managing rotas and utilise staffing capacity with more fluidity. In

addition, a six week transition period following allocation to bandings, was implemented which allowed the provider to vary the delivery of support within the time period, with a view to this becoming more consistent after the six weeks had ended. The time banding makes provision for service users who require time critical calls (e.g. those requiring medication).

The feedback from the providers delivering the pilot work was positive and contributed to the following outcomes;

- greater ability to cover carer sickness and annual leave
- positively enabled quicker response particularly around hospital discharge and emergency placements
- greater flexibility
- enabled responding to a higher number of requests for support

The pilot showed the limitations of the time banding approach includes;

- during the first six weeks (the time of greatest variability) the service user is unsure as to when support will arrive which can contribute to confusion and a negative perception of time bandings
- time bandings may mean calls are too close together and not spaced out in a way which is more beneficial for service users

Concept

Implementing time bandings as standard in the new contracts to create greater flexibility during peak periods.

Trying to manage a bottleneck of calls at specific times helps manage service users expectations and staffing rotas

Within the bandings, priority status can be given to those with certain requirements (those who require medication at certain times)

Summary

Change in the approach to commissioning social care at point of care planning through to care delivery, monitoring and management of provision.

Would require internal change and change management to fully realise all the potential benefits

9. ISF and Outcome Based Working (item 5 in Table 1)

Overview

Current contracts already include the intention to move to Outcome Based Working (OBW) as a key aspiration which has been the case since 2015. Unfortunately we have only been able to make limited steps towards making OBW a reality. As things stand there is sufficient organisational clarity and capability within the market to actively pursue outcome based working and there is already an Individual Service Fund (ISF) pilot scheme underway which seeks to test some of the core concepts. Based on this initial work it appears quite possible to create a basic arrangement with the provider that means they are more responsible for

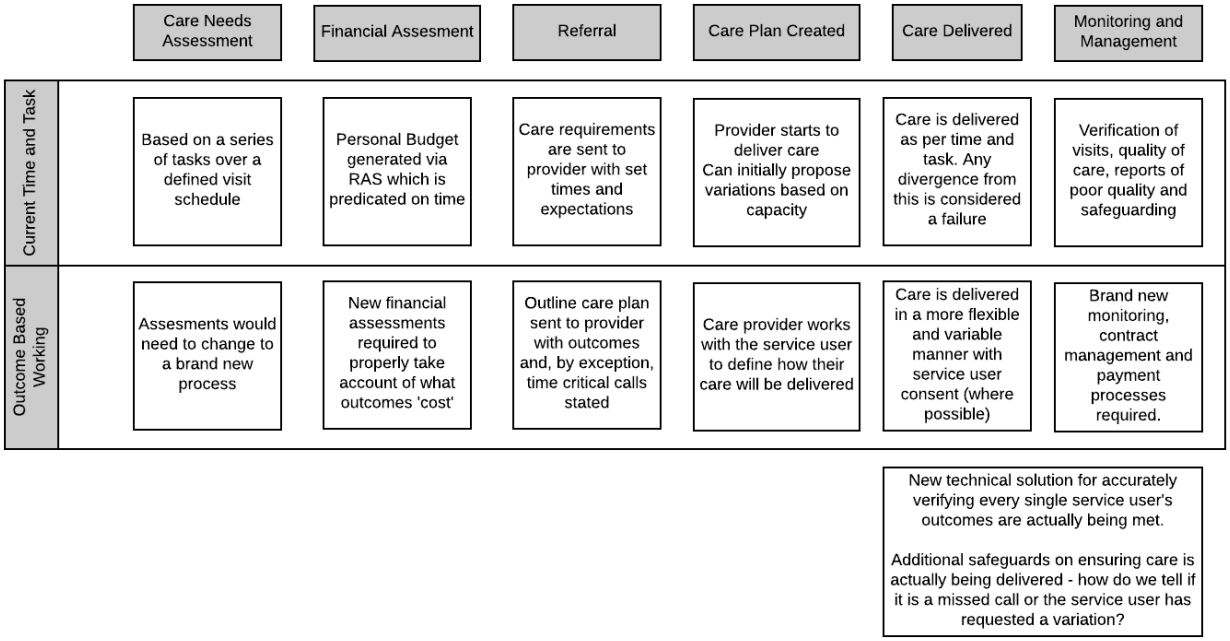
developing a person centred approach in how best to deliver and meet a service users care outcomes.

Analysis of how other local authorities have sought to implement OBW shows limited success with a few examples of substantial progress. One of the more common case studies cited in local authorities doing OBW is Wiltshire who implemented what was a full scale model that incorporated a new assessment process and contracts which linked payment to achievement of outcomes. However it has since become clear that this has not been wholly successful with the council recently deciding to revert a lot of the service functions to more traditional models, particularly as a result of the complexity of monitoring and paying providers under this regime. This also came at the cost of putting additional pressure on the relationship with the market.

Nottinghamshire have also recently sought to move towards OBW in a more incremental fashion with their new contracts having a 2.5% retention rate applied to providers with the understanding that if they meet a quality threshold then this amount will be released. While this approach is certainly closer to OBW it could also be considered akin to previous quality incentive models like the council's Quality Assessment Framework which also experienced similar issues. In this case the quality threshold is based on a customer satisfaction survey of a representative number of service users for each provider. Feedback from Nottinghamshire has stated that this approach is problematic on a number of fronts; firstly it is not sufficiently accurate or broad enough to be a suitable assessment tool, but also it has created a substantial administrative burden for the council to the point that it appears no longer sustainable.

As we can see one of the foremost issues with fully realising outcome based working is less to do with the 'front end' of creating a care plan but rather with how to practically manage and oversee these arrangements. As the core concept of outcome based working means a substantial transfer of trust and responsibility to providers this means that the council must be able to properly ensure that care is being properly delivered within this new regime. Where a time and task approach is relatively straightforward to manage (did the call take place and were the tasks completed?) the difference with outcome based working is there is much less definition on what a day or weeks' worth of care should look like. For example it may well be acceptable for a limited period of time that a service user requires less care which might then be utilised more flexibly in the future however it is difficult for the council to accurately confirm this without what would be a brand new approach to monitoring and contract management. It is also not possible to fully transfer this responsibility to providers due to the statutory duties the council holds, particularly around ensuring there are proper safeguards against individuals not receiving adequate care.

By carrying out a high level analysis of the changes required to the current system we can see that in order to fully implement OBW there would need to be a fundamental and systematic redesign of all aspects of the care journey.



Even with the significant challenges that must be faced the main rationale for moving to OBW still holds merit. As discussed it would offer much needed flexibility and responsiveness to how care is delivered, it should improve care outcomes, it would improve care worker job satisfaction as well as truly placing the service user at the centre of their care.

Concept

As with any major systems change an incremental approach provides the least risk but will take the most time. It would also provide an opportunity to optimise our own internal resources alongside a new performance management regime, rather than having to spend many hours manually processing, checking and validating call and payment data it would be possible to focus more on the fundamental reasons for the care call in the first place.

Summary

A ‘big bang’ approach to change would mean wholesale, transformational change in the approach to commissioning social care starting from care needs assessment, financial assessment and referral through to care planning, care delivery, monitoring and management of provision.

Therefore a very careful, incremental and small scale approach would be necessary for any implementation of OBW in the future contract.

10. Domestic & Social Inclusion Calls – Care Package Analysis (item 7 in Table 1)

Overview

In addition to the typical personal care tasks being carried out there are a smaller subset of calls that are commissioned for Domestic and Social Inclusion purposes. Based on analysis of commissioned care calls there is a very low frequency and low number – 1.08% of commissioned care calls are designated as such

Concept

To consider commissioning via a separate contract to carry out domestic work. Costs are not likely to be much lower to the council for non-regulated activities such as cleaning and this would also require additional overheads in procuring and managing a further contract which may not be value for money given the scale and low margins in these services.

Summary

Based on the very low proportion of Domestic and Social Inclusion calls and the complexity of implementing a separate tier it is not recommended to pursue this option.

11. Working with Health (item 9 in Table 1)

Constructive conversations with Health colleagues are ongoing but unfortunately have not progressed substantially over the last few months and at this stage it is unlikely the Council will be able to formally integrate any Health requirements for homecare for the start of new contracts. However the contract will be structured in a way that would allow for Health to buy in at a future date if possible

12. Data Portal (item 10 in Table 1)

Overview

Current systems and processes that underpin how local services operate are often time consuming and could benefit from enhanced technology. From the start of the process at assessment through to verifying the quality and cost of paying the provider, there are multiple independent systems leading to a lack of consistency as well as substantial manual input to ensure that core tasks are completed and captured. The current system includes the collation of the following information (see table one.)

Table one.

Adults Needs Assessment	Care and Support Plan Review	Adult Purchase Service Admin
• Name • Address • Mosaic ID • DOB • Telephone Number • NHS Number • Primary Support Reason • Primary Support Reason Sub-Category • Accommodation type • Consent and Capacity • Support Network • Informal Support / Carers • Advocacy • Mobility • Personal Care • Eating and Drinking • Health and Wellbeing • Engaging in local community • Health Conditions • Continuing Health Care • Risks • Eligibility	• Name • Address • Mosaic ID • DOB • Telephone Number • NHS Number • Accommodation type • Consent and Capacity • Review details • Type of Review • Prompt to consider accuracy of Care and Support Plan, Personal Budget and any changes	• Name • Address • Mosaic ID • DOB • Telephone Number • Email address • Ethnicity • Sub-ethnicity • Religion • Gender • Language • Primary Support Reason • Primary Support Reason Sub-Category • Purchasing Team • Budget Code • Overview of commissioned services including – • Rural or urban cost • Units per week • Unit cost • Number of carers • Preferred time banding • Duration • Tasks to be carried out

A more centralised system, with added layers of scrutiny, offers the potential to better embed a more timely, responsive and consistent approach across the county contributing to a more positive experience of care for both providers and the end user. The implementation of a shared data portal to host the flow to and from providers, combined with the full realisation of the Electronic Call Monitoring approach could enable the organisation to have greater control over the quality of commissioned services.

The stakeholder engagement event on 23 July 2019 at the Bentley Hotel identified that there was no appetite to develop a single electronic system used by all parties. There were concerns that this proposal would create duplication of cost and effort. Instead, establishing a simpler concept of a shared data portal would be beneficial.

By allowing all parties to share and transmit basic datasets we can then transfer data into each separate technology platform. It was suggested this may include:

1. Assessment "early notice" pipeline information which alert providers as to potential placements (whether urgent or routine)
2. Accurate referral information for required placements as soon as possible, enabling providers and requestors to speak directly
3. Variations, delays and cancellation information – a 'real time' waiting list
4. A simplified and quicker verification process to enable faster payments to providers

Please see the suggested data sets in Table Two.

Table Two

Ref	Data Set – Purpose	Content	Attachments and Date Inputter
1	To support with early warning of potential placement, enabling providers to proactively respond to emergent need	▪ *Name of client* ▪ *Mosaic ID* ▪ *Package Type (community routine/ emergency or Hospital)* ▪ *Current client location* ▪ *Key worker* ▪ *Timescale of confirmation*	• *Adults Needs Assessment* • *Brokerage* • *Hospital Co-ordinator* • *Community Care Worker*
2	To support with instigating referrals as early as possible to identify marketplace capacity and ability to respond within timescales	▪ *Name of client* ▪ *Mosaic ID* ▪ *Package Type (community routine/ emergency or Hospital* ▪ *Zone required* Hospital Data ▪ *Discharge information* ▪ *Moving and Handling Plan* ▪ *Scripts* Package Details ▪ *Start Date* ▪ *Overview of commissioned services including –* ➢ *Rural or urban cost* ➢ *Units per week* ➢ *Unit cost* ➢ *Number of carers* ➢ *Preferred time banding* ➢ *Duration* ▪ *Tasks to be carried out*	• *Adults Needs Assessment* • *Adult Purchase Service Admin* • --- • *Brokerage*

Ref	Data Set – Purpose	Content	Attachments and Date Inputter
3	To support with delays (such as hospital discharge, travel disruption etc) and cancellations	▪ *Name of client* ▪ *Mosaic ID* ▪ *Cancellation Notice / Delay Notice* ▪ *Confirmation of delay and date of effect*	Care and Support Plan Review Adult Purchase Service Admin --- Brokerage Hospital Co-ordinator Community Care Worker
4	To support with variations and temporary suspensions	▪ *Name of client* ▪ *Mosaic ID* ▪ *confirmation of variation and date of effect* ▪ *confirmation of changes to tasks or units of time* ▪ *inclusion of updated Care and Support Plan review and Adult Purchase Service Admin*	Care and Support Plan Review Adult Purchase Service Admin --- Brokerage Community Care Worker
5	To confirm payments and time bandings	▪ *Adult Purchase Service Admin with confirmed units purchased, overview of commissioned service* ▪ *Time banding allocations*	Adult Purchase Service Admin --- Brokerage
6	Providers – County Council confirmation of commencement of placement and acknowledgement of placement terms	▪ *Name of client* ▪ *Mosaic ID* ▪ *nature of placement (routine, emergency)* ▪ *planned duration* ▪ *cost and deliverables* ▪ *confirmation of total units and planned costs per week, per month, per quarter (scaled up to each period to support with invoicing process)*	Provider
6	Providers – County Council Invoice (generated from ECM)	▪ *Name of client* ▪ *Mosaic ID* ▪ *Scaled up unit costing per quarter*	Provider

A live portal system referring directly to the provider could improve efficiencies whilst enhanced reporting methods will improve accuracy of reporting by removing the human element as all referrals, along with offers of support, can be reportable through workflow. This could contribute to improved oversight of performance. The mechanism through which the data portal is hosted needs to be determined. The existing case management portal for Adult Social Care (Mosaic) could be utilised as the host, or, an alternate model of delivery commissioned from the marketplace could be considered.

Concept

A simple but effective central data sharing repository in which all relevant parties can upload vital information to be used in the proper function of the service. A data sharing protocol will also clearly set out what data should be shared, by whom, by what time, and in what format. This will enable all parties to work more efficiently with less delays and errors.

Summary

Implement a live data portal system either via the County Council website, IMP or an alternate existing system which can host and manage key service data.

2.15. Of all of the potential changes there are three areas which will have a significant impact on the budget for Homecare.

30 Minute Minimum Call Duration for all Personal Care

2.16. The initiative that has the largest overall effect is the proposal to introduce a new minimum call length for all personal care calls as the volume and length of calls is a critical factor in relation to how services perform. A prevalence of short calls is considered to be counter-productive as these types of calls are operationally very challenging & often uneconomical particularly where there is extended travel time. Care workers, being only paid for the contact time they have with clients, also tend to find short calls to be very unattractive which in turn makes recruitment and retention very difficult. With the workforce perhaps being the single most important element of provider's capability to deliver services it must be a priority to make the job financially and personally worthwhile. Additionally as we face increasing demand and a static, or decreasing workforce overall, we must also take steps to ensure the long term viability of the care workforce. Finally, and most importantly, is how service user outcomes are best met within this system and while sub-30 minute calls in certain cases are quite reasonable it is felt that in order to achieve the right level of service quality a 30 minute minimum for all personal care calls is necessary. Given the extremely high volume of homecare care required in Lincolnshire even a relatively modest increase of call durations will result in a significant increase in the cost of the services.

Extra Rural Rate

2.17. The introduction of a new 'extra rural rate' in addition to the existing urban and rural rates will directly address the challenges of providers having to meet demand in extremely remote areas with low volumes of call activity. As this measure is designed to primarily deal with areas of very low call numbers the proposed increase does not represent a large increase to the overall budget. By implementing this rate this will directly support the market and care workers more specifically when they are required to carry out highly remote work. This has been a particularly difficult problem in zone 10 which has a high proportion of small and remote villages. The incumbent provider for zone 10 has stated that without changes to how the zone operates, is funded, it will not be viable. It is hoped that with the introduction of the extra rural rate and the minimum call duration for personal care this will resolve this issue.

Floating Support Team

2.18. The proposal to establish a 'Floating Support Team' in each of the contract zones will add much need operational capacity and flexibility. As Homecare is paid via an hourly rate & only for the actual commissioned call time that is required this leaves no surplus time in the model for many inevitable issues (having to wait for ambulances, unavoidable travel delays, emergencies, etc.) which places considerable demand on the system and directly on care workers. By establishing additional capacity within each zone through guaranteed hours for a small number of staff (3 out of typically 100 care workers per zone), this will increase the ability of the provider to respond to staff loss, difficult cases & any other delays. This will then engender greater stability within the service as well as when there is “down time” within the Floating Support Team the care workers can move to focusing on waiting lists, re-abling clients, and improving service user outcomes.

2.19. It should also be noted that following detailed market engagement providers have been clear that continuing with the status quo is not sustainable in the long term and may also result in providers exiting the market.

2.20. All three of the primary initiatives are designed to direct the limited resources available to the most needed parts of the system and in doing so will:

- Allow for better outcomes for service users
- Make the care worker job better both in terms of job satisfaction and remuneration thus strengthening the entire system from the bottom up
- Introduce more flexibility and capacity to a system that is currently struggling to meet increasing demand.

Financial Impact of the New Initiatives

2.21. Based on the approval of the above three proposals there is a total of approximately £2m additional spend per annum proposed in the new contracts consisting of:

- £1.7m p.a. to increase the minimum call duration of all personal care calls to 30 minutes. Calls that are not personal care will remain as shorter durations as will those requested by the Service User. The actual amount of this will vary depending on the current profile of service users and may in fact be lower if it can be clearly established that specific service users request short call durations as their preference. For the remaining non-personal care calls there will be further investigation into the possibility of alternative service delivery options such as new technologies to carry out medicines prompts and checks.

- £300,000 p.a. to establish a 'Floating Support Team' in each zone.

- £50,000 p.a. to fund an extra rural rate designed to target the most remote areas in the county with the smallest volume of activity.

Service Users and Quality – Survey results

2.22. A telephone feedback survey was undertaken between April-June 2019 for Homecare provision using a simple response scale (1-5; 1 = poor, 5 = good).

2.23. 364 people were consulted, representing approx. 17.5% of the total number of current service users. Each respondent was asked a wide range of questions dealing with how they perceive their carer, how the care provider works, how they receive information and updates and many other factors. Overall the response was a positive one with service users having good feedback with regard to how they receive their care. However there are clear areas of improvement in how care providers manage the wider business, particularly with regard to communication with service users.

Key Findings – What's Working Well

- Many positive comments about care staff and good relationships
- A high number of respondents (4.25 out of 5) felt their carers stayed for the planned duration
- A high number of respondents (4.27 out of 5) were satisfied with their support
- A high number of respondents (4.34 out of 5) felt their carers were well trained
- A high number of respondents (4.48 out of 5) felt carers followed their care plan well

Key Findings – What's Not Working Well

- Poor communication from the office
- Poor punctuality and concerns about scheduling
- Not enough time between visits
- Lack of consistent care workers

Key Findings – What Needs to Happen

- Clearer communication to service users when delays happen
- Scheduling time to get "back on track" without taking time from people on the way
- Small stable teams, consistent & familiar care staff

2.24. These findings further support the outcomes of the prior analysis, on the whole the services are performing well but there are some key weaknesses related to how the homecare system works and how we can better improve reliability and consistency.

Commercial Approach

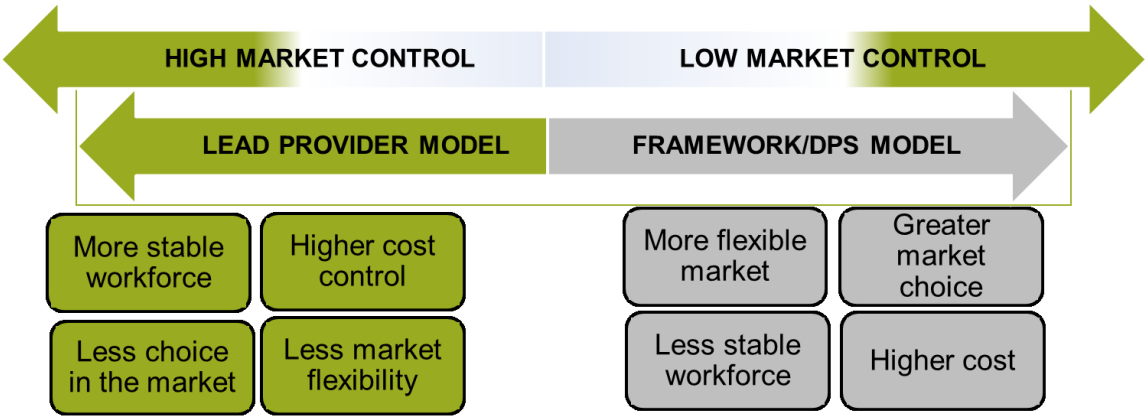
2.25. The current commercial model is fit for purpose and provides the necessary stability and control for managing the homecare market. While there have been significant changes to individual zones within the life of the current contracts it is evident that in the majority of zones services have performed well overall and in many cases very well. Therefore it is clear that the characteristics of the commercial model are sufficient for good providers to do well and where there are difficulties in the future with specific providers there will continue to be a range of performance management tools available to the commercial team to manage this risk.

2.26. The existing twelve zone approach also works well overall with only minor changes required for future contracts. This is likely to only extend to a very small degree wherein existing zone boundaries span a town.

2.27. It is recommended that the existing block guarantee payment is no longer necessary in the new contracts with exclusivity being sufficient for providers. Service volume estimates will be clearly communicated to bidders who will then be in a position to be able to plan accordingly.

2.28. Following the introduction of the contracts in 2015 there was a significant degree of disturbance to the local market and services which resulted in a period of time wherein the waiting list reached uncomfortably high levels. Given the relative fragility of the market it will be a priority to minimise disruption wherever possible. While changes of providers are, and have been, necessary this almost always results in a weakening of local systems. The evaluation of bids will therefore focus on ensuring that the new providers can deliver a quality service but also that existing strength in the local market is not undermined.

2.29. An alternative approach, discussed earlier, might be to revert to a framework model which was in effect pre-2015. The framework model is also prevalent in many other councils however there are significant drawbacks to considering this as a viable alternative. Firstly we would lose almost all of the strength and stability that has been built up over the last five years. Secondly it the local market is not well aligned to this type of contracting model as it relies on a large number of smaller providers. More fundamentally though, the reasons why the Council chose to move to the current model are still wholly relevant. The lead provider model provides a higher degree of stability, control, and resilience than a framework.



2.30. Operating a lead provider model offers the highest degree of assurance as to ensuring that we can “find a yes” in the market. A framework model tends to result in cases being 'handed back' when circumstances are not ideal for providers and historically this often occurred just before each weekend. These handback events were highly disruptive and in some cases led to many late or missed calls. In order to mitigate the impact of these types of events the only option available to councils tends to be entering into another type of agreement with any available provider at a higher rate. This was evident in the findings of the first phase analysis wherein many local authorities operating frameworks were forced to operate with a higher tier of providers that dealt with difficult care calls at a much higher premium. The lead provider model makes it clear that there is no ability to hand back cases and in fact all demand in each zone must be met by the provider. This not only provides greater clarity and stability to the market but also ensures a high degree of cost control too.

2.31. However it is acknowledged that even within the lead provider model there is still limited capacity and flexibility to meet demand. This one of the main reasons in recommending the new changes to the future contracts. The introduction of the Floating Support Team is particularly apposite in this case.

2.32. The proposed contract duration for the new Homecare contracts is an initial term of five years with the option to extend by a further three years (5+1+1+1). This increase from the current duration (3+1+1+1) takes into account clear feedback from all stakeholders that in many cases it is accurate to say that it has taken the full duration of the existing contracts for providers to fully stabilise and establish themselves. Therefore increasing the duration will allow the council, the market and service users a greater opportunity to reach a more stable and sustainable position.

2.33. The new contracts shall be awarded to start on 1 July 2020 at which point there will be a three month transition in which the old contracts and new contracts run side-by-side. Within the transition period the old provider will work with the incoming provider to transfer all service users and staff affected by TUPE in a manner that results in as little disruption as possible. On 1 October 2020 the old contracts will have ceased entirely and the new providers will be solely responsible for meeting all demand for commissioned homecare within their zone.

3 Tender Process

3.1 The market for homecare services continues to operate under significant pressure, and we have seen locally the market shrink over the last five years following a wider national trend of some providers withdrawing from local authority contracts. . Based upon the prevailing market conditions and the experience of re-tendering zones 9 and 12 it is recommended to undertake a single 'Open Process' tender exercise. This will provide sufficient scope to enable effective competition as well as allow for additional time for the critical transition phase over summer.

3.2 In order to properly ensure there is a good level of competition for the contracts the commercial team will undertake proactive, enhanced market engagement as was the case in the 2018 re-procurement. This resulted in a significant increase in the number of new bidders to the local market.

3.3 Provisional Tender Timeline

Issue the ITT	14 February (approx.)
Evaluation period	24 April
Contact Award	3 July
Mobilisation period	3 July – 30 Sept
Go Live	1 October

4. Legal Issues:

Equality Act 2010

Under section 149 of the Equality Act 2010, the Council must, in the exercise of its functions, have due regard to the need to:

* Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act
* Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
* Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The relevant protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; and sexual orientation

Having due regard to the need to advance equality of opportunity involves having due regard, in particular, to the need to:

* Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic.
* Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it.
* Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to tackle prejudice, and promote understanding.

Compliance with the duties in section 149 may involve treating some persons more favourably than others.

The duty cannot be delegated and must be discharged by the decision-maker. To discharge the statutory duty the decision-maker must analyse all the relevant material with the specific statutory obligations in mind. If a risk of adverse impact is identified consideration must be given to measures to avoid that impact as part of the decision making process.

The key purpose of the service is to improve the health and wellbeing of the most vulnerable people by ensuring access to support; to prevent their needs escalating to more costly statutory service thresholds, and to help them access and maintain stable, settled and appropriate accommodation.

An Impact Assessment has been completed and copy of is appended to this report at **Appendix A**. No adverse impacts have been identified.

5. Joint Strategic Needs Analysis (JSNA and the Joint Health and Wellbeing Strategy (JHWS)

The Council must have regard to the Joint Strategic Needs Assessment (JSNA) and the Joint Health & Well Being Strategy (JHWS) in coming to a decision.

Adults Health and Wellbeing is a core themes of the JSNA, with a key priority being to improve health and reduce health inequalities for individuals. Homecare is one of the councils primary services that is required to meet its statutory duties and ensure service users are able to live in their own homes for longer.

6. Crime and Disorder

Under section 17 of the Crime and Disorder Act 1998, the Council must exercise its various functions with due regard to the likely effect of the exercise of those functions on, and the need to do all that it reasonably can to prevent crime and disorder in its area (including anti-social and other behaviour adversely affecting the local environment), the misuse of drugs, alcohol and other substances in its area and re-offending in its area

This service is unlikely to contribute to the furtherance of the section 17 matters.

7. Conclusion

7.1. To consider the proposals for the new homecare contracts and the financial impact of their inclusion. Establishing a new minimum call duration for personal care calls, while the most expensive initiative, perhaps holds the best overall chance to materially improve the conditions of the whole homecare system. The inclusion of a new extra rural rate and Floating Support Teams are targeted measures which are also important to further strengthen the homecare system at a time when it is facing serious and sustained challenge. With these major changes as well as retaining the strength and stability that has been built up in the local market the proposed new contracts offer a strong foundation for the future of homecare services in Lincolnshire.

8. Legal Comments:

The Council has the power to enter into the contract proposed. The legal considerations to be taken into account in reaching a decision are dealt with in the Report. The decision is consistent with the Policy Framework and within the remit of the Executive.

9. Resource Comments:

It is recognised that the funding needed to deliver the improved scope is above current budget. This is being addressed through the budget 2020 process which full Council will receive in February 2020. A deep dive across adult frailty is underway reviewing efficiency and effectiveness of budgets.

10. Consultation

a) Has Local Member Been Consulted?

N/A

b) Has Executive Councillor Been Consulted?

Yes

c) Scrutiny Comments

The decision will be considered by the Adults and Community Wellbeing Scrutiny Committee on 15 January 2020 and the comments of the Committee will be reported to the Executive.

d) Have Risks and Impact Analysis been carried out?

Yes

e) Risks and Impact Analysis

See the main body of the Report and Appendix A

11. Appendices

These are listed below and attached at the back of the report	
Appendix A	Equality Impact Assessment

12. Background Papers - No background papers within the meaning of section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Alexander Craig, who can be contacted on 01522 554070 or at alexander.craig@lincolnshire.gov.uk

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Equality Impact Analysis to enable informed decisions

The purpose of this document is to:-

I. help decision makers fulfil their duties under the Equality Act 2010 and
II. for you to evidence the positive and adverse impacts of the proposed change on people with protected characteristics and ways to mitigate or eliminate any adverse impacts.

Using this form

This form must be updated and reviewed as your evidence on a proposal for a project/service change/policy/commissioning of a service or decommissioning of a service evolves taking into account any consultation feedback, significant changes to the proposals and data to support impacts of proposed changes. The key findings of the most up to date version of the Equality Impact Analysis must be explained in the report to the decision maker and the Equality Impact Analysis must be attached to the decision making report.

****Please make sure you read the information below so that you understand what is required under the Equality Act 2010****

Equality Act 2010

The Equality Act 2010 applies to both our workforce and our customers. Under the Equality Act 2010, decision makers are under a personal duty, to have due (that is proportionate) regard to the need to protect and promote the interests of persons with protected characteristics.

Protected characteristics

The protected characteristics under the Act are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

Section 149 of the Equality Act 2010

Section 149 requires a public authority to have due regard to the need to:

- Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by/or under the Act
- Advance equality of opportunity between persons who share relevant protected characteristics and persons who do not share those characteristics
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The purpose of Section 149 is to get decision makers to consider the impact their decisions may or will have on those with protected characteristics and by evidencing the impacts on people with protected characteristics decision makers should be able to demonstrate 'due regard'.

Decision makers duty under the Act
Having had careful regard to the Equality Impact Analysis, and also the consultation responses, decision makers are under a personal duty to have due regard to the need to protect and promote the interests of persons with protected characteristics (see above) and to:-

(i) consider and analyse how the decision is likely to affect those with protected characteristics, in practical terms,
(ii) remove any unlawful discrimination, harassment, victimisation and other prohibited conduct,
(iii) consider whether practical steps should be taken to mitigate or avoid any adverse consequences that the decision is likely to have, for persons with protected characteristics and, indeed, to consider whether the decision should not be taken at all, in the interests of persons with protected characteristics,
(iv) consider whether steps should be taken to advance equality, foster good relations and generally promote the interests of persons with protected characteristics, either by varying the recommended decision or by taking some other decision.

Conducting an Impact Analysis

The Equality Impact Analysis is a process to identify the impact or likely impact a project, proposed service change, commissioning, decommissioning or policy will have on people with protected characteristics listed above. It should be considered at the beginning of the decision making process.

The Lead Officer responsibility
This is the person writing the report for the decision maker. It is the responsibility of the Lead Officer to make sure that the Equality Impact Analysis is robust and proportionate to the decision being taken.

Summary of findings
You must provide a clear and concise summary of the key findings of this Equality Impact Analysis in the decision making report and attach this Equality Impact Analysis to the report.

Impact – definition

An impact is an intentional or unintentional lasting consequence or significant change to people's lives brought about by an action or series of actions.

How much detail to include?
The Equality Impact Analysis should be proportionate to the impact of proposed change. In deciding this asking simple questions “Who might be affected by this decision?” "Which protected characteristics might be affected?" and “How might they be affected?” will help you consider the extent to which you already have evidence, information and data, and where there are gaps that you will need to explore. Ensure the source and date of any existing data is referenced.
You must consider both obvious and any less obvious impacts. Engaging with people with the protected characteristics will help you to identify less obvious impacts as these groups share their perspectives with you.

A given proposal may have a positive impact on one or more protected characteristics and have an adverse impact on others. You must capture these differences in this form to help decision makers to arrive at a view as to where the balance of advantage or disadvantage lies. If an adverse impact is unavoidable then it must be clearly justified and recorded as such, with an explanation as to why no steps can be taken to avoid the impact. Consequences must be included.

Proposals for more than one option If more than one option is being proposed you must ensure that the Equality Impact Analysis covers all options. Depending on the circumstances, it may be more appropriate to complete an Equality Impact Analysis for each option.

The information you provide in this form must be sufficient to allow the decision maker to fulfil their role as above. You must include the latest version of the Equality Impact Analysis with the report to the decision maker. Please be aware that the information in this form must be able to stand up to legal challenge.

Background Information

Title of the policy / project / service being considered	Homecare Services	**Person / people completing analysis**	Alexander Craig
Service Area	Adult Care	**Lead Officer**	Alexander Craig
Who is the decision maker?	Councillor Bradwell	**How was the Equality Impact Analysis undertaken?**	Desktop
Date of meeting when decision will be made	01/02/2020	**Version control**	V1
Is this proposed change to an existing policy/service/project or is it new?	Existing policy/service/project	**LCC directly delivered, commissioned, re-commissioned or de-commissioned?**	Re-commissioned
Describe the proposed change	Lincolnshire County Council (LCC) has twelve contracts delivering Homecare Services. All of these contracts come to an end as of 30th Sept 2020. A review has been completed looking at the performance of the current contracts and expectations in terms of future demand. It is recommended that a set of new contracts are procured based on the recommendations set out in the report to the executive.		

Evidencing the impacts

In this section you will explain the difference that proposed changes are likely to make on people with protected characteristics.
To help you do this first consider the impacts the proposed changes may have on people without protected characteristics before then considering the impacts the proposed changes may have on people with protected characteristics.

You must evidence here who will benefit and how they will benefit. If there are no benefits that you can identify please state 'No perceived benefit' under the relevant protected characteristic. You can add sub categories under the protected characteristics to make clear the impacts. For example under Age you may have considered the impact on 0-5 year olds or people aged 65 and over, under Race you may have considered Eastern European migrants, under Sex you may have considered specific impacts on men.

Data to support impacts of proposed changes

When considering the equality impact of a decision it is important to know who the people are that will be affected by any change.

Population data and the Joint Strategic Needs Assessment

The Lincolnshire Research Observatory (LRO) holds a range of population data by the protected characteristics. This can help put a decision into context. Visit the LRO website and its population theme page by following this link: http://www.research-lincs.org.uk If you cannot find what you are looking for, or need more information, please contact the LRO team. You will also find information about the Joint Strategic Needs Assessment on the LRO website.

Workforce profiles

You can obtain information by many of the protected characteristics for the Council's workforce and comparisons with the labour market on the Council's website. As of 1st April 2015, managers can obtain workforce profile data by the protected characteristics for their specific areas using Agresso.

Positive impacts
The proposed change may have the following positive impacts on persons with protected characteristics – If no positive impact, please state *'no positive impact'.*

Age	The homecare service is an adult age service but the vast majority of service users are 65+. The homecare service is a critical frontline service that helps people with social care needs stay at home for longer.. .
Disability	The service also provides support to a small number of people with a primary need stemming from a physical disability.
Gender reassignment	There is no specific positive impact relating to gender re assignment.
Marriage and civil partnership	There is no specific positive impact relating to marriage or civil partnership
Pregnancy and maternity	There is no specific positive impact relating to pregnancy and maternity
Race	There is no specific positive impact relating to race.
Religion or belief	There is no specific positive impact relating to religion or belief.

Sex	As the vast majority of homecare workers are female the proposed improvements to the contracts will hopefully increase employment opportunities and the overall quality of the career locally.
Sexual orientation	There is no specific positive impact relating to sexual orientation.

If you have identified positive impacts for other groups not specifically covered by the protected characteristics in the Equality Act 2010 you can include them here if it will help the decision maker to make an informed decision.

Adverse/negative impacts
You must evidence how people with protected characteristics will be adversely impacted and any proposed mitigation to reduce or eliminate adverse impacts. An adverse impact causes disadvantage or exclusion. If such an impact is identified please state how, as far as possible, it is justified; eliminated; minimised or counter balanced by other measures.
If there are no adverse impacts that you can identify please state 'No perceived adverse impact' under the relevant protected characteristic.

Negative impacts of the proposed change and practical steps to mitigate or avoid any adverse consequences on people with protected characteristics are detailed below. If you have not identified any mitigating action to reduce an adverse impact please state *'No mitigating action identified'*.

Age	'No perceived adverse impact'
Disability	No perceived adverse impact
Gender reassignment	'No perceived adverse impact'
Marriage and civil partnership	'No perceived adverse impact'
Pregnancy and maternity	'No perceived adverse impact'

Race	'No perceived adverse impact'
Religion or belief	'No perceived adverse impact'
Sex	'No perceived adverse impact'
Sexual orientation	'No perceived adverse impact'

If you have identified negative impacts for other groups not specifically covered by the protected characteristics under the Equality Act 2010 you can include them here if it will help the decision maker to make an informed decision.

Stakeholders

Stake holders are people or groups who may be directly affected (primary stakeholders) and indirectly affected (secondary stakeholders)

You must evidence here who you involved in gathering your evidence about benefits, adverse impacts and practical steps to mitigate or avoid any adverse consequences. You must be confident that any engagement was meaningful. The Community engagement team can help you to do this and you can contact them at consultation@lincolnshire.gov.uk

State clearly what (if any) consultation or engagement activity took place by stating who you involved when compiling this EIA under the protected characteristics. Include organisations you invited and organisations who attended, the date(s) they were involved and method of involvement i.e. Equality Impact Analysis workshop/email/telephone conversation/meeting/consultation. State clearly the objectives of the EIA consultation and findings from the EIA consultation under each of the protected characteristics. If you have not covered any of the protected characteristics please state the reasons why they were not consulted/engaged.

Objective(s) of the EIA consultation/engagement activity
The service is informed by statutory requirements for advocacy in: • Care Act (2014) • Mental Health Act (2007) • Mental Capacity Act (2005) • Children and Families Act (2014) • Health and Social Care Act (2012) Engagement activity has been undertaken with a wide range of key stakeholders, including existing and potential service providers, users of the existing commissioned services, other Councils, care quality commission, and service users.

Who was involved in the EIA consultation/engagement activity? Detail any findings identified by the protected characteristic

Age	No specific feedback identified
Disability	No specific feedback identified
Gender reassignment	No specific feedback identified
Marriage and civil partnership	No specific feedback identified
Pregnancy and maternity	No specific feedback identified
Race	No specific feedback identified
Religion or belief	No specific feedback identified

Sex	No specific feedback identified
Sexual orientation	No specific feedback identified
Are you confident that everyone who should have been involved in producing this version of the Equality Impact Analysis has been involved in a meaningful way? The purpose is to make sure you have got the perspective of all the protected characteristics.	Yes
Once the changes have been implemented how will you undertake evaluation of the benefits and how effective the actions to reduce adverse impacts have been?	The Equality Impact Analysis will be a live document, regularly reviewed by commissioning leads and commercial colleagues. There will be regular implementation meetings with the successful providers as part of awarding the contracts. These meetings will review whether there are any impacts against individual service users, particularly those who are protected under the Equality Act 2010. A review of any adverse impacts will be carried out six months after the new service has been implemented. Following implementation there will be quarterly contract management meetings, again these will review the service delivery and will identify any protected groups or individuals who may be impacted either in a positive or negative way.

Further Details

Are you handling personal data?	Yes If yes, please give details. Service will hold personal data regarding individual cases they are dealing with.

Actions required Include any actions identified in this analysis for on-going monitoring of impacts.	**Action**	**Lead officer**	**Timescale**
Signed off by		**Date**	Click here to enter a date.

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Policy and Scrutiny

Open Report on behalf of Glen Garrod
Executive Director Adult Care and Community Wellbeing

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**15 January 2020**
Subject:	**Re-Procurement of Community Supported Living Services**

Summary:

This item invites the Adults and Community Wellbeing Scrutiny Committee to consider a report on the re-procurement of Community Supported Living services, which is due to be considered by the Executive on 4 February 2020. The views of the Scrutiny Committee will be reported to the Executive, as part of its consideration of this item.

Actions Required:

(1) To consider the attached report and to determine whether the Committee supports the recommendations to the Executive set out in the report.

(2) To agree any additional comments to be passed to the Executive in relation to this item.

1. Background

The Executive is due to consider a report entitled Re-procurement of Community Supported Living Services on 4 February 2020. The full report to the Executive is attached at Appendix A to this report.

2. Conclusion

Following consideration of the attached report, the Committee is requested to consider whether it supports the recommendation in the report and whether it wishes to make any additional comments to the Executive. The Committees views will be reported to the Executive.

3. Consultation

The Adults and Community Wellbeing Scrutiny Committee is being consulted on a proposal being submitted to the Executive on 4 February 2020.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Report to the Executive – Re-procurement of Community Supported Living Services

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Carl Miller, who can be contacted on 01522 553673 or carl.miller@lincolnshire.gov.uk.

APPENDIX A

Lincolnshire COUNTY COUNCIL *Working for a better future*

Executive

Open Report on behalf of Glen Garrod
Executive Director Adult Care and Community Wellbeing

Report to:	**Executive**
Date:	**04 February 2020**
Subject:	**Re-procurement of Community Supported Living Services**
Decision Reference:	**I019199**
Key decision?	**Yes**

Summary:

The Community Supported Living - Open Select List is a framework agreement of approved providers who can meet care and support, and if appropriate, accommodation needs for vulnerable adults across Lincolnshire. The current framework has 38 providers approved to deliver services; there are 21 active at this time.

The current contractual arrangement ends on the 31 May 2020. The service has been reviewed and recommendations made to ensure future demand can be met across Lincolnshire and in particular, for those who have needs of a highly complex nature.

This report gives an update on progress to date, and seeks approval for the re-procurement of the Community Supported Living - Open Select List.

Recommendation(s):

That the Executive;

1. Approves the procurement of a framework of Care Quality Commission registered Community Supported Living providers who can meet care and support needs across Lincolnshire.

2. Delegates to the Executive Director of Adult Care & Community Wellbeing, in consultation with the Executive Councillor for Adult Care, Health & Children's Services, the authority to determine the final form of the contract and to approve the award of contract(s) and the entering into of contract(s) and other legal documentation necessary to give effect to the decision.

Alternatives Considered:	
1.	Extend the current provision The 5 year contract term ends 31 May 2020, with no provision to extend. In any event, extending current contracts would fail to address the challenges and opportunities for improvement identified in the service review and noted below: o Gap in provision to meet need for those with particularly highly complex needs and/or behaviour that challenges o Opportunity to enhance and strengthen service provision, clarifying contractual requirements to ensure consistent operational practice from commissioners and providers, strengthening contract management tools and introducing person-centred outcome reporting. o Opportunity to mitigate risk that future tenancies in established Lincolnshire CSL schemes go to those from out of county NHS organisations or local authorities, reducing valuable provision for those in county, by introducing nominations agreements in appropriate circumstances.
2.	Not to commission the service at all The CSL services address and support statutory requirements under the Care Act 2014 which require local authorities to provide or arrange for the provision of services, facilities or resources, or take other steps, which they consider will contribute towards preventing or delaying the development by adults in its area of needs for care and support. . This service is one of a range of options to ensure there is a choice of high quality care and support services available for vulnerable adults. Not to have a framework of approved providers in place would mean a requirement to spot contract for each and every situation which would be both ineffective in terms of time and costly. This option would also be likely to have an adverse impact to the effectiveness of contract management.
3.	Bring services in-house The Council has commissioned these services and developed the market for care and support provision for vulnerable people across Lincolnshire over a number of years. This is aligned to current government policy and the personalisation agenda, the Council does not have the infrastructure or budget available to bring these services in-house.

Reasons for Recommendation:

1. The proposed model will allow the Council continued access to approved providers who offer good performance and quality, committed to meeting the care and support needs for vulnerable adults across Lincolnshire. It will also allow access to new providers who can meet future demand, particularly where need is of a highly complex nature.

2. The established delivery model is flexible in meeting need, capable of offering the best value, in terms of price and quality, to the Council. All providers are effectively contract managed with strong working relationships developed and support given proportionate to current risk ratings and provider knowledge.

3. A framework offering a choice of approved providers with the ability to meet wide ranging levels of client needs is advantageous to commissioners.

4. Where new accommodation is part of the requirement, a mini-competition process enables value for money and specific outcomes for the individual(s) concerned to be established at the point of contract call-off.

1. Background

1.1 The Council currently commissions care and support in the community for vulnerable adults, and where appropriate, access to accommodation through the Community Supported Living (CSL) - Open Select List (OSL) framework agreement. CSL services provide care and support to individuals who live in a variety of settings including dedicated single or shared supported living schemes, rented accommodation, owner occupied property, extra care schemes or live with family, carers or friends.

1.2 Where rented accommodation is required, suitable vacancies within existing and established schemes are utilised wherever possible. Where existing schemes are fully occupied or unsuitable, care and support providers may work with housing providers in order to meet a requirement to establish new dedicated community supported living schemes. The person supported has their own tenancy agreement, and the accommodation always remains separate from the provision of care and support, enabling a level of independence not possible in a residential care setting.

1.3 The framework was established on 1 June 2015 and concludes on 31 May 2020. It has 38 providers, 21 of which are actively delivering services in the form of call off contracts. Across Lincolnshire 903 people are currently supported (excluding those who access services via direct payment), 569 of whom are supported within a dedicated accommodation setting and 334 are supported at home. Over 90% have a primary diagnosis of learning disability. Support for a wide range of needs is in scope of the framework, so an opportunity exists for greater utilisation to support other primary support needs, including Mental Health and Physical Disabilities in future.

2. Duty to Deliver

2.1 CSL services address and support statutory requirements under the Care Act 2014 which require local authorities to provide or arrange for the provision of services, facilities or resources, or take other steps, which it considers will contribute towards preventing or delaying the development by adults in its area of needs for care and support. . This service is one of a range of options to ensure there is a choice of high quality care and support services available for vulnerable adults.

3. Compliance with Legislation, Policy & Guidance

3.1 There has been a policy shift to utilise supported living schemes that have a focus on enablement and independence in order to meet care and support needs and outcome expectations.

3.2 In reviewing the service and updating the service specification, national legislation and the principles, guidance and standards outlined in the following key publications have been considered;-

- Valuing People (DOH 2001)
- Our Health Our Care Our Say (DOH 2006)
- Valuing People Now (DOH 2009)
- Health and Social Care Act (2012)
- Care Act (2014)
- Mental Capacity Act (2005)
- The Building the Right Support nine core principles and golden threads in the national service model published in October 2015 to support commissioners of health and social care services
- Registering the Right Support 2017
- NICE Guidance published in March 2018
- Transforming Care guidance

3.3 It is expected providers will deliver high quality services that will recognise and promote the rights of the people they support as citizens and encourage their independence, choice and inclusion through a person centred approach.

4. Service Performance

4.1 The service is performing well. The performance metrics available demonstrate improvement when comparing an extract of data two years apart.

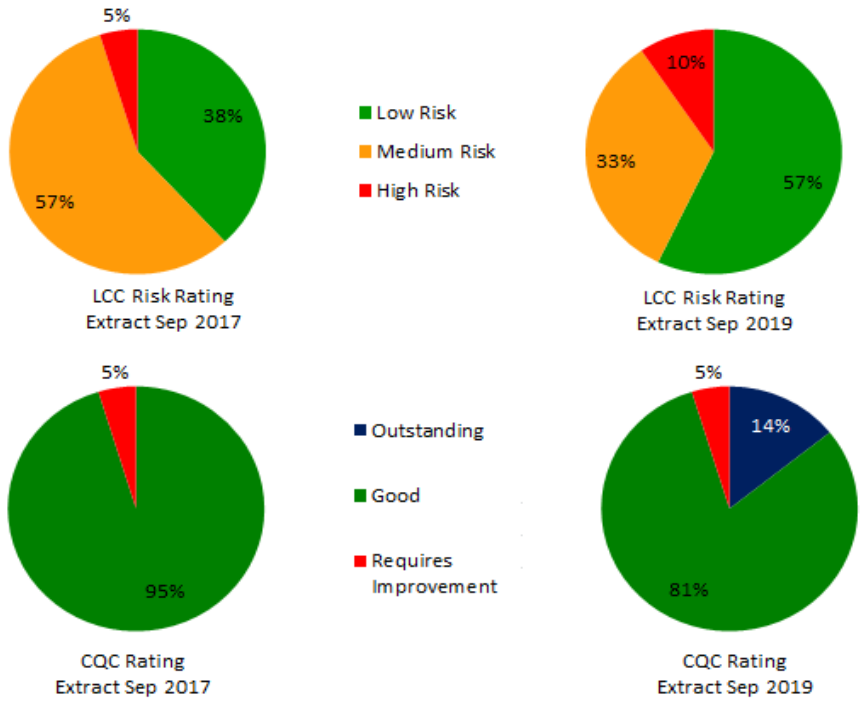

Figure 1: LCC Risk Rating & CQC Rating Sep 17 v Sep 19

4.2 The risk rating is the Council's own internal measure and encompasses the CQC rating, safeguarding concerns, poor practice concerns as well as current intelligence related to key areas which are thought to impact providers i.e. staff turnover, management changes, financial situation. The Council's contract management support is proportionate to the providers' CQC rating. The current CQC ratings demonstrate an improvement with 3 (14%) achieving an outstanding rating by September 2019 though it is recognised that some suppliers still require improvement.

4.3 The approach to comprehensive contract performance and risk management of care and support providers on the current framework will continue under the new framework; and will be supplemented by the use of service credits, KPI's based on outcomes for individuals, a strengthened service specification and a contract call off document which improves clarity of expectation for delivery in all packages of care and support. These are all tools to enhance contract and performance management in supporting provider excellence.

5. Future Demand

5.1 Projecting future demand for Adult Social Care is challenging. As well as estimating how many new people will be assessed as eligible for care and support it is also necessary to estimate attrition. Whilst the overall net number of people eligible for CSL is increasing year on year the complexity of needs is also increasing. The 2019-20 budget for Learning Disability Services (which represents 90% of the current CSL activity) was based on 67 new placements and 40 discharges. Latest activity levels still suggest that these figures will hold true for 2019-20. Similar activity levels will also inform the 2020-21 financial year.

5.2 A service review has been undertaken by the Commercial Team in relation to future demand and estimates that 200 people currently known to Adult Care may require CSL services at some point in the future (12 transforming care; 42 children transitioning to adult services; 146 where they may be in own home, family home or residential care). However, it is difficult to predict with certainty when estimated demand will become need, as many factors impact this. In recent years, existing and established dedicated accommodation settings have met the majority of the accommodation need.

5.3 Of the 200 people who may feed into future demand, there are twelve individuals under S.75 through transforming care and 40 leaving educational / residential settings who are likely to fall into a highly complex need category over the next 5 years though at this stage, it is unknown if all will require community supported living. The review established that several providers on the framework had the ability to meet highly complex need, but only one willing to do so within our current ceiling rate. Therefore, the new framework needs to address the barriers of the current ceiling rate payment mechanism.

5.4 Additional demand may also come through future integrated working opportunities, such as teams supporting those with physical disability or mental health accessing the CSL framework.

6 Current Contract Call Off Process

6.1 There are three current methods of contract call off from the framework

1) **Direct by Practitioner:** where care and support need is identified at the family or own home, and where the support requirement is less than 24/7, practitioners select a provider who can meet need.
2) **Brokerage into Existing Setting:** Where accommodation is part of the requirement, placement into a suitable vacancy from existing scheme accommodation options is brokered wherever possible. The care and support provision will usually already be in place in this scenario.
3) **Mini Competition:** Where there are either no vacancies or no suitable vacancies in existing CSL settings, providers are invited to participate in a mini competition according to geographical area, capability and

specialism. Mini competitions may require providers to identify suitable new accommodation solutions as part of the proposal.

6.2 There have been occasions when it has not been possible to establish a call off from the framework by one of these routes. This occurs when providers are unable to meet the needs of the individual(s) concerned because of a lack of capability or capacity, or because they are unable to do so within the constraints of the framework pricing mechanism. In these circumstances an exception route is used to commission services from a provider outside of the framework, utilising a spot contract, often at a price point above that of the framework. Whilst this does work in the small number of cases in which it is necessary, it is also challenging in the context of constrained timescales, choice, control and leverage for the Council. Given the predicted higher future demand for highly complex needs, a clear pathway to manage these cases within scope of the new framework is proposed to help to address the associated challenges.

7 Pricing

7.1 The framework operates with an hourly rate for provision of care and support, determined by providers subject to a cap or ceiling rate, currently set at £16.01 p/h. This has been very successful in managing service delivery costs. For the majority (99.98%) of care and support needs, the current rate is sufficient with just 13 exceptions above the current ceiling rate. When compared with other local authorities, the current ceiling rate is comparative in meeting general need, but other local authorities engaged through the review process have identified similar issues in meeting highly complex needs. Recognising this, some have started to introduce a higher tier rate.

8. Sleep in Support

8.1 In April 2017 the CSL-OSL framework was varied to account for an emerging risk about the qualification of 'sleep-in' support as working time and payment of the National Minimum Wage. The variation introduced an "Enhanced Sleep In Rate" equal to the minimum wage for sleep in support. This move was welcomed by providers; a proportion of whom were already, or were intending to voluntarily pay the minimum wage for sleep in. In part this was to avoid any future potential liability related to this issue and followed the outcome of employment tribunal rulings.

8.2 On Friday 13 July 2018, in the case Royal Mencap Society v Tomlinson-Blake and Shannon v Rampersad (t/a Clifton House residential Home), the Court of Appeal ruled that workers who 'sleep-in' at or near their place of work are not entitled to the minimum wage for the time they spend asleep. This overturned previous employment tribunal rulings.

8.3 Although the Court ruled in their favour, Mencap now pay the minimum wage for sleep in to their workers.

8.4 There remains uncertainty on this position, Unison applied for an appeal to the Supreme Court which was granted, the date set for this hearing is the 12 and 13 February, 2020. The decision is expected by July 2020.

8.5 Subject to the final decision reached by the Supreme Court in this appeal case, the Council may need to review its sleep in payment and arrangements. The intention to review sleep in arrangements and associated payment following this decision will be described within the procurement documentation and service specification, to ensure the provider market is aware of this eventuality.

9 Market Engagement & Feedback

9.1 A prior information notice was published on 9th September, 2019. This initiated a process of pre-tender market engagement. Feedback gained from this process has provided an understanding of the market's preferred approach to a number of important issues affecting the commercial model, including contract duration, market capacity and resource, ability to manage highly complex individuals within the current cost model. The results of the engagement exercise are summarised below:

- A preference that the contract duration of five years is not reduced, and includes an option(s) to extend.
- A theme of being unable to meet highly complex need within the current ceiling rate was identified, which is in line with experience of operating the current framework. This will be addressed with the introduction of a 'highly complex' pathway, as described in section 9, point (a).
- A desire for full transparency and fairness of opportunity in the way that the Council allocates new placements was identified. This is acknowledged and will be addressed with the proposal for centralised oversight of all new placements under this contract as part of the new framework (section 9, point d).
- Comments about limited opportunities to deliver new placements. This is acknowledged and improved clarity in the new framework regarding future demand projections and mechanisms for call off and the allocation of new placements are intended to help to address this.

10 Scope and Proposed Changes to Current Arrangements

10.1 The framework mechanism has proved successful and it is proposed to maintain this approach when re-commissioning services, with only a small number of relatively minor but important changes identified following the review of the service. These are intended to support the Council to improve transparency and control, strengthening the specification in support effective contract management, allowing for the potential of further integrated working with health, and meeting the full range of care and support needs for vulnerable adults over the next contract term through the framework. The proposed changes are:

a) Introduction of a highly complex pathway where, if required, there is the ability to go above the ceiling rate within scope of the framework. This is intended to attract more suppliers who specialise in meeting this type of highly complex need to join the framework, offering the Council more choice and leverage. This will replace the current exception route and is necessary because future demand shows that there is increased demand in the area of those who will fall into a 'highly complex' category where it is likely we would need to use an exception route. The mechanism proposed is to first seek to place within the ceiling rate for the framework, and where that is not possible, to use a mini-competition to establish a bespoke rate for the individual or group. The pricing requirements for such a competition will give full transparency of rate calculation to ensure value for money is maintained.

b) The second recommendation is that providers are incentivised to bid lower than the ceiling rate at the point of joining the framework, with ongoing centralised oversight for all new opportunities, by making cost a consideration in all new placement requirements. This should help to mitigate the risk that existing and potential new framework providers bid to join the new framework at the maximum ceiling rate, and ensure ongoing value for money. If all existing providers were to re-join the framework at the ceiling rate, based on current year costs and care packages, the resulting additional cost would be £135k per annum.

c) The Council establishes a nominations agreement whereby it secures first refusal for a period to be determined for new accommodation settings. The precise terms could be negotiated according to the characteristics of the setting, but a general principal of exclusivity on nominations a reasonable period is proposed. It may be necessary to share the risk of void costs with the provider during this period, and the Council's appetite for this could be determined on a case by case basis according to prevailing demand, and the costs and quality of the setting This is intended to address a risk whereby Lincolnshire County Council loses vacancies in existing schemes to competing local authorities. Engagement with providers has shown that out of county commissioners placing in Lincolnshire are willing to pay higher rates. On occasion, the Council has lost potential tenancies in dedicated accommodation settings. This change will also give clarity to providers of the potential maximum vacancy period expected prior to accepting referrals from elsewhere.

d) Strengthen the specification in the specific areas identified through review, engagement and analysis. These are described at Appendix 1, and include the introduction of service credits, clear detailing of processes for contract call-off, creating outcome focussed and person centred KPI's, setting clear expectations of support hours, options for flexibility and associated payment, and inclusion of health partners named as potential commissioners.

11 Budget and Cost Implications

11.1 The 2019/20 budget for Community Supported Living – Open Select List contract is £32m; with a projected spend of £31.8m. Budget setting for 2020/21 is underway and will take account of inflationary cost increases applied to the ceiling rate (average 4.7% annual increase over current framework period), and estimated net increases in service utilisation (an average net growth of 6.4% p.a. over the last three years).

11.2 A risk has been identified in the financial exposure of existing providers all bidding at the ceiling rate in the forthcoming tender process, as noted at section 9.1(b). This is quantified as £135k per annum based on current year costs and volumes. Having identified this risk we are seeking to mitigate as described in that section.

11.3 The proposal to add a 'highly complex' pathway will allow the Council greater choice of highly specialised provider. Whilst this will enable prices for services to exceed the ceiling rate mechanism, this will remain a small proportion of total service utilisation and is therefore not anticipated to have a significant impact on overall service costs. Additionally, there will be controls in the pricing requirements for such cases, giving full transparency of rate calculation to ensure value for money is maintained.

11.4 The CSL-OSL framework has been used primarily for those with Learning Disability and/or Autism. The budget relates to the use of this framework for those individuals. As the framework is intentionally wider in scope i.e. refers to care and support for vulnerable adults; a wider group of commissioners could use this framework to engage providers e.g. LPFT mental health teams, physical disability teams. Initial conversations indicate this is desirable as the flexibility of this framework represents value for money and it will establish clear pricing at the level of provider. Individuals with other primary support needs will already be supported by, or be entitled to support from the Council in a variety of support settings. However those currently supported to live in the community will be, in the main, utilising direct payments, so the opportunity for the Council to directly commission support through the CSL framework more widely should have the effect of increasing choice and improving control over costs.

12 Procurement Implications

12.1 The procurement is being undertaken in accordance with regulations 74-76 of the Public Contract Regulations 2015 under "Light Touch Regime" utilising an open procedure method.

12.2 It is the intention to issue an OJEU notice for publication week commencing 3 February 2020 and a contract notice award will be issued to bidders who are successful in being admitted onto the framework.

12.3 In undertaking the procurement the Council will ensure the process complies fully with the EU treaty principles of openness, fairness, transparency and non-discrimination.

12.4 All time limits imposed on bidders in the process for responding to the OJEU notice and invitation to tender will be reasonable and appropriate.

13 The Invitation to Tender (ITT) document

13.1 The ITT will include the following

- A revised specification drafted incorporating key findings and input from stakeholder consultation
- Revised contract terms and conditions
- Clarity of award and evaluation criteria in relation to becoming an approved provider via this framework
- Clarity for the subsequent contract call-off process
- Clear requirements for submission of evidence in relation to quality and performance with the development of key performance indicators

14 Competition

14.1 Exposing the service to the open market has generated a high level of interest. Following the publication of the Prior Information Notice in September 2019, over 100 organisations have expressed interest. This will encourage improved value for money in terms of quality and price. It will also open up the option of attracting those providers who can address the identified gaps in provision (geographical area; specialism) in this market. It offers the Council flexibility of provider to meet future care and support requirements.

15. Contract Commencement and Duration

15.1 The existing CSL OSL come to a conclusion on 31st May 2020, with the new framework (if approved) commencing on 1st June 2020. Call off contracts created under the existing framework are separate contracts in their own right and will continue unless and until they expire or are terminated under their own terms. Continuity of provision is therefore preserved for existing recipients of services.

15.2 The proposed term for the new Open Select List framework is five years, in line with existing arrangement, and it is further proposed to include an option to extend by up to a further two years (5+1+1). Evidence from market engagement feedback suggests that this is an acceptable term for the arrangement and would provide sufficient financial assurance for the provider.

16. Contract Structure

16.1 The aim for CSL services will be to have multiple providers to ensure full coverage and capacity geographically and in terms of service specialisms, enabling vulnerable adults to access the services they need. This is also intended to enable continuity of care for individuals already in receipt of CSL services wherever possible.

16.2 Service providers will deliver high quality CSL provision to the eligible population, and will be required to work in collaboration with the Council and other stakeholders and partners to ensure effective and high quality services are delivered and maintained.

16.3 In order to achieve this, an Open Select List (OSL) will be re-established. This is a flexible framework approach which ensures that the market can remain dynamic by periodically giving new providers to opportunity to join. This will help to ensure that the market remains sustainable in the long term, and enable the Council to ensure that all providers are suitably qualified based on consistent application of Lincolnshire County Council requirements and policies.

17. Payment and Performance Management

17.1 The OSL will continue to operate with an hourly rate for provision of care and support, determined by providers at the point of joining the framework, subject to a cap or ceiling rate. The rates will then be subject to an annual inflationary cost review, with any uplift determined by the Council. This has proved effective in the current service contracts and remains a cost effective solution, enabling a flexible approach to changing user needs.

17.2 Comprehensive contract performance and risk management of care and support providers will also continue. This proposal adds the use of service credits, user outcome linked KPI's, a strengthened service specification and a contract call off document which improves clarity of expectation for delivery in all packages of care and support. These are all tools to enhance contract and performance management in supporting provider excellence.

18. Public Services Social Value Act

18.1 In January 2013, the Public Services (Social Value) Act came into force. Under the Act the Council consider during the pre-procurement phase how they can secure wider social, economic and environmental benefits. This is consideration of how what is proposed to be procured might improve the economic social and environmental wellbeing of Lincolnshire. Secondly, how in conducting the process of procurement it might act with a view to securing that improvement. The council must only consider matters that are relevant to the services being procured and must consider the extent to which it is proportionate in all the circumstances to take those matters into account. In considering this issue the Council must be aware that it remains bound by EU procurement legislation which itself through its requirement for

transparency, fairness and non-discrimination places limits on what can be done to achieve these outcomes through a procurement.

18.2 This framework agreement will allow Lincolnshire County Council to improve the social wellbeing of vulnerable citizens across Lincolnshire. Related to this, the council has engaged with those supported to develop 5 statements shown below that providers are expected to provide outcome for. This will demonstrate how this framework is enhancing the social wellbeing of those supported.

1. "I am supported to exercise choice and control in all aspects of the care I receive and my quality of life is enhanced"
2. "My health and wellbeing are promoted at all times and I am supported to maintain my independence wherever possible"
3. "I am included and have the support required to join in activities and social events and be part of my local community"
4. "I feel safe – protected from avoidable harm and free from any kind of abuse, harassment and discrimination"
5. "My staff team are experienced, well trained and effectively supported to meet my needs"

18.3 Under section 1(7) of the Public Services (Social Value) Act 2012 the Council must consider whether to undertake any consultation as to the matters referred to above. The framework has been operational since 1st June 2015; therefore, there the market is well understood. As part of the pre-procurement work, a wide ranging market engagement and stakeholder consultation have been undertaken. A wider consultation would be unlikely to be proportionate to the scope of this procurement.

19 Legal Issues:

Equality Act 2010

Under section 149 of the Equality Act 2010, the Council must, in the exercise of its functions, have due regard to the need to:

* Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act
* Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
* Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The relevant protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; and sexual orientation

Having due regard to the need to advance equality of opportunity involves having due regard, in particular, to the need to:

* Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic

* Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it

* Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low

The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities

Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to tackle prejudice, and promote understanding

Compliance with the duties in section 149 may involve treating some persons more favourably than others

The duty cannot be delegated and must be discharged by the decision-maker. To discharge the statutory duty the decision-maker must analyse all the relevant material with the specific statutory obligations in mind. If a risk of adverse impact is identified consideration must be given to measures to avoid that impact as part of the decision making process

19.1 An Equality Impact Assessment (EIA) has been completed (Appendix 2). The re-commissioning of this service will have a positive impact on those with disability. This service will apply to adults, where the threshold to have needs met is placed on the local authority by the Care Act 2014, and will be open to all in line with the Equalities Act 2010.

Joint Strategic Needs Analysis (JSNA and the Joint Health and Wellbeing Strategy (JHWS)

The Council must have regard to the Joint Strategic Needs Assessment (JSNA) and the Joint Health & Well Being Strategy (JHWS) in coming to a decision

19.2 Health & Wellbeing are two of the core themes of the JSNA. There is a key priority to reduce health inequality and improve health for individuals. The CSL service provides care and support which helps those supported to achieve these outcomes.

19.3 Successful providers will be expected to understand Lincolnshire, rurality and demographics. They will be expected to have a local presence appropriate to the service delivery.

Crime and Disorder

Under section 17 of the Crime and Disorder Act 1998, the Council must exercise its various functions with due regard to the likely effect of the exercise of those functions on, and the need to do all that it reasonably can to prevent crime and disorder in its area (including anti-social and other behaviour adversely affecting the local environment), the misuse of drugs, alcohol and other substances in its area and re-offending in its area

19.4 This service is unlikely to directly impact section 17 of the Crime and Disorder Act 1998. Providers', who deliver CSL services, have a responsibility to deliver successful outcomes for individuals. In some cases, this may result in a lowering the risk and/or instances of anti-social behaviour in communities.

18.5 For individuals in receipt of CSL services, providers have a responsibility to meet their outcome of "feeling safe – protected from avoidable harm and free from any kind of abuse, harassment and discrimination" which has relevance to section 17 of the Crime and Disorder Act 1998.

20. Conclusion

20.1 CSL services address and support statutory requirements under the Care Act 2014. They form a critical element of a range of service options to ensure there is a choice of high quality care and support services available for vulnerable adults, supporting and enabling them to live as independently as possible in the community.

20.2 The conclusion of the existing CSL Open Select List framework at the end of June 2020 means a procurement process needs to commence in February 2020. The service has been reviewed, and engagement undertaken with key stakeholders to help to ensure that a sustainable and high quality service for vulnerable adults requiring care and support in the community continues. The recommended changes and improvements are intended to ensure future demand can be met across Lincolnshire, in particular for those who have needs of a highly complex nature. The key principles of future service delivery are summarised below:

a) Meeting the care and support needs for vulnerable adults in a range of settings including their own home, family home, rented accommodation and/or dedicated accommodation settings.

b) Invitation of framework providers for future opportunities to deliver care and support, and if required, accommodation that will meet outcomes detailed within an agreed care plan for those individuals supported.

c) To develop a highly complex placement pathway, to allow the Council greater choice of provider, replacing the current 'exception route', ensuring contract compliance and value for money.

d) To include tender scoring as part of future provider selection, incentivising existing providers to bid lower than the ceiling rate and maintain value for money.

e) To establish nominations agreements in appropriate circumstances, to ensure that eligible Lincolnshire residents benefit from services established in the county.

f) To make improvements to the current specification to improve oversight and offer greater clarity of expectations for the provider market, including; the introduction of service credits, clear detailing of processes for contract call off, creating outcome focussed and person centred KPI's, examples of tailoring hours to achieve outcomes, clear expectations of support hours, options for flexibility and associated payment, and ensure health partners are named as potential commissioners.

21. Legal Comments:

The Council has the power to commission and enter into the Open Select List framework as proposed.

The decision is consistent with the policy framework and within the remit of the Executive.

22. Resource Comments:

This report seeks to present the case for the commissioning of a Community Supported Living (CSL) service. I can confirm that the changes proposed are not anticipated to have any significant impact on overall costs, however it should be noted that the following factors will influence budget allocations over the next five year contracting period:-

1) Population growth in demand, particularly for highly complex individuals
2) Inflationary cost pressures, in particular wage inflation
3) Continued impact of the policy shift to utilise supported living schemes that have a focus on enablement and independence in order to meet care and support needs and outcome expectations.

This is being addressed through the budget 2020 process which full Council will receive in February 2020. I can also confirm that current commissioning intentions and delegated approvals recommended within this report meet the criteria set out in the Councils published financial procedures.

23. Consultation

a) Has Local Member Been Consulted? - N/A

b) Has Executive Councillor Been Consulted? – Yes

c) Scrutiny Comments

The decision will be considered by the Adults and Community Wellbeing Scrutiny Committee on the 15 January, 2020 and the comments of the Committee will be reported to the Executive.

d) Have Risks and Impact Analysis been carried out? Yes

e) Risks and Impact Analysis

See body of report and Appendix 2 Equality Impact Assessment. A summary project risk analysis is also included below.

Risk Description	Mitigating Action
Re-procurement may result in higher costs. Two providers indicated during engagement they would increase their standard hourly rate to ceiling. Potential £135k per annum additional cost if all providers increase to ceiling.	Implement incentive for providers to come in at lower rate, tiered for new opportunities.
Level of Interest – interest overall is high confirmed by expressions of interest in prior information notice and return of market engagement questionnaires. Also current lack in some geographical areas of providers, particularly meeting moderate to high needs.	Implement a cap on no. of providers admitted based on application form
Established care and support providers do not meet the minimum standard required for new framework.	In this event, following extended contract support transitional arrangements will be implemented to support continuity of care in the short term and until alternative support is established.

24. Appendices

These are listed below and attached at the back of the report	
Appendix 1	Specification Gap Analysis
Appendix 2	Equality Impact Assessment

25. Background Papers

No background papers within the meaning of section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Eilidh French, who can be contacted on 01522 553670 or eilidh.french@lincolnshire.gov.uk.

APPENDIX 1

SPECIFICATION GAP ANALYSIS SUMMARY

Area	Reason
Introduction of Service Credits	Financial incentive to help to drive good performance, helpful tool to support effective contract management and aligned with other similar contractual mechanisms
Housing	Greater clarity of expectation of housing providers to meet the requirements of the Mental Health Act, separation of care and support, and guidance on fair rental charges
Contract Call Off Process	Greater clarity on the process for placement call off and further competitions covering all circumstances for award of new opportunities
Contract Call Off – Specific Outcomes	Set expected outcomes relevant to new packages of care and support, supporting contract management and care management.
Mencap sleep in ruling	Review sleep in payment in light of decision expected by Supreme Court expected July 20
Sharing of Core Hours & 1:1 Support	Provide example and expectation that supported living care and support is a flexible and responsive service within service specification
Tiering Providers	Include how providers will be tiered based on their application to the framework, requires scenario planning
Clear Nomination Rights	As an appendix for providers to return to formalise process that vacancies are offered to LCC first for an agreed length of time
Key Performance Indicators	Move to an "outcome focused & person centred" KPI expectation that providers will submit as part of their annual reporting; also strengthening reporting arrangements for providers on workforce statistics e.g. vacancy rates, turnover rates and recruitment and retention rates
Payment schedules	Ensure providers are signing for hours delivered. Clear expectation they do so defined in the specification.

Equality Impact Analysis to enable informed decisions

The purpose of this document is to:-

I. help decision makers fulfil their duties under the Equality Act 2010 and
II. for you to evidence the positive and adverse impacts of the proposed change on people with protected characteristics and ways to mitigate or eliminate any adverse impacts.

Using this form

This form must be updated and reviewed as your evidence on a proposal for a project/service change/policy/commissioning of a service or decommissioning of a service evolves taking into account any consultation feedback, significant changes to the proposals and data to support impacts of proposed changes. The key findings of the most up to date version of the Equality Impact Analysis must be explained in the report to the decision maker and the Equality Impact Analysis must be attached to the decision making report.

****Please make sure you read the information below so that you understand what is required under the Equality Act 2010****

Equality Act 2010

The Equality Act 2010 applies to both our workforce and our customers. Under the Equality Act 2010, decision makers are under a personal duty, to have due (that is proportionate) regard to the need to protect and promote the interests of persons with protected characteristics.

Protected characteristics

The protected characteristics under the Act are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

Section 149 of the Equality Act 2010

Section 149 requires a public authority to have due regard to the need to:

- Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by/or under the Act
- Advance equality of opportunity between persons who share relevant protected characteristics and persons who do not share those characteristics
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The purpose of Section 149 is to get decision makers to consider the impact their decisions may or will have on those with protected characteristics and by evidencing the impacts on people with protected characteristics decision makers should be able to demonstrate 'due regard'.

Decision makers duty under the Act
Having had careful regard to the Equality Impact Analysis, and also the consultation responses, decision makers are under a personal duty to have due regard to the need to protect and promote the interests of persons with protected characteristics (see above) and to:-

(i) consider and analyse how the decision is likely to affect those with protected characteristics, in practical terms,
(ii) remove any unlawful discrimination, harassment, victimisation and other prohibited conduct,
(iii) consider whether practical steps should be taken to mitigate or avoid any adverse consequences that the decision is likely to have, for persons with protected characteristics and, indeed, to consider whether the decision should not be taken at all, in the interests of persons with protected characteristics,
(iv) consider whether steps should be taken to advance equality, foster good relations and generally promote the interests of persons with protected characteristics, either by varying the recommended decision or by taking some other decision.

Conducting an Impact Analysis

The Equality Impact Analysis is a process to identify the impact or likely impact a project, proposed service change, commissioning, decommissioning or policy will have on people with protected characteristics listed above. It should be considered at the beginning of the decision making process.

The Lead Officer responsibility
This is the person writing the report for the decision maker. It is the responsibility of the Lead Officer to make sure that the Equality Impact Analysis is robust and proportionate to the decision being taken.

Summary of findings
You must provide a clear and concise summary of the key findings of this Equality Impact Analysis in the decision making report and attach this Equality Impact Analysis to the report.

Impact – definition

An impact is an intentional or unintentional lasting consequence or significant change to people's lives brought about by an action or series of actions.

How much detail to include?
The Equality Impact Analysis should be proportionate to the impact of proposed change. In deciding this asking simple questions “Who might be affected by this decision?” "Which protected characteristics might be affected?" and “How might they be affected?” will help you consider the extent to which you already have evidence, information and data, and where there are gaps that you will need to explore. Ensure the source and date of any existing data is referenced.
You must consider both obvious and any less obvious impacts. Engaging with people with the protected characteristics will help you to identify less obvious impacts as these groups share their perspectives with you.

A given proposal may have a positive impact on one or more protected characteristics and have an adverse impact on others. You must capture these differences in this form to help decision makers to arrive at a view as to where the balance of advantage or disadvantage lies. If an adverse impact is unavoidable then it must be clearly justified and recorded as such, with an explanation as to why no steps can be taken to avoid the impact. Consequences must be included.

Proposals for more than one option If more than one option is being proposed you must ensure that the Equality Impact Analysis covers all options. Depending on the circumstances, it may be more appropriate to complete an Equality Impact Analysis for each option.

The information you provide in this form must be sufficient to allow the decision maker to fulfil their role as above. You must include the latest version of the Equality Impact Analysis with the report to the decision maker. Please be aware that the information in this form must be able to stand up to legal challenge.

Background Information

Title of the policy / project / service being considered	Community Supported Living – Open Select List re-commissioning	**Person / people completing analysis**	Eilidh French
Service Area	Adult Care and Community Wellbeing	**Lead Officer**	Joanna Tubb
Who is the decision maker?	Executive	**How was the Equality Impact Analysis undertaken?**	There has been extensive stakeholder consultation and pre-market engagement alongside a service review.
Date of meeting when decision will be made	04/02/2020	**Version control**	1.1
Is this proposed change to an existing policy/service/project or is it new?	Existing policy/service/project	**LCC directly delivered, commissioned, re-commissioned or de-commissioned?**	Re-commissioned
Describe the proposed change	The existing service is countywide, meeting the care and support needs for vulnerable adults, fundamentally this is a continuation of the service with some important, but minor changes described in the Executive Report.		

Evidencing the impacts

In this section you will explain the difference that proposed changes are likely to make on people with protected characteristics.
To help you do this first consider the impacts the proposed changes may have on people without protected characteristics before then considering the impacts the proposed changes may have on people with protected characteristics.

You must evidence here who will benefit and how they will benefit. If there are no benefits that you can identify please state 'No perceived benefit' under the relevant protected characteristic. You can add sub categories under the protected characteristics to make clear the impacts. For example under Age you may have considered the impact on 0-5 year olds or people aged 65 and over, under Race you may have considered Eastern European migrants, under Sex you may have considered specific impacts on men.

Data to support impacts of proposed changes

When considering the equality impact of a decision it is important to know who the people are that will be affected by any change.

Population data and the Joint Strategic Needs Assessment

The Lincolnshire Research Observatory (LRO) holds a range of population data by the protected characteristics. This can help put a decision into context. Visit the LRO website and its population theme page by following this link: http://www.research-lincs.org.uk If you cannot find what you are looking for, or need more information, please contact the LRO team. You will also find information about the Joint Strategic Needs Assessment on the LRO website.

Workforce profiles

You can obtain information by many of the protected characteristics for the Council's workforce and comparisons with the labour market on the Council's website. As of 1st April 2015, managers can obtain workforce profile data by the protected characteristics for their specific areas using Agresso.

Positive impacts
The proposed change may have the following positive impacts on persons with protected characteristics – If no positive impact, please state *'no positive impact'.*

Age	The community supported living open select list is a framework of providers who can meet care and support needs, with accommodation where appropriate, for vulnerable adults.
Disability	The community supported living open select list applies to vulnerable adults in order that they can access care and support provision. This service supports those people who have a disability which is likely to have substantial, adverse, and long-term effect on ability to carry out normal day-to-day activities, therefore, it will result in a positive impact for this group.
Gender reassignment	No positive impact.
Marriage and civil partnership	No positive impact.
Pregnancy and maternity	No positive impact.
Race	No positive impact.
Religion or belief	

No positive impact.

	No positive impact.
	No positive impact.

If you have identified positive impacts for other groups not specifically covered by the protected characteristics in the Equality Act 2010 you can include them here if it will help the decision maker to make an informed decision.

Adverse/negative impacts
You must evidence how people with protected characteristics will be adversely impacted and any proposed mitigation to reduce or eliminate adverse impacts. An adverse impact causes disadvantage or exclusion. If such an impact is identified please state how, as far as possible, it is justified; eliminated; minimised or counter balanced by other measures.
If there are no adverse impacts that you can identify please state 'No perceived adverse impact' under the relevant protected characteristic.

Negative impacts of the proposed change and practical steps to mitigate or avoid any adverse consequences on people with protected characteristics are detailed below. If you have not identified any mitigating action to reduce an adverse impact please state *'No mitigating action identified'*.

Age	No perceived adverse impact
Disability	No perceived adverse impact
Gender reassignment	No perceived adverse impact
Marriage and civil partnership	No perceived adverse impact
Pregnancy and maternity	No perceived adverse impact

Race	No perceived adverse impact
Religion or belief	No perceived adverse impact
Sex	No perceived adverse impact
Sexual orientation	No perceived adverse impact

If you have identified negative impacts for other groups not specifically covered by the protected characteristics under the Equality Act 2010 you can include them here if it will help the decision maker to make an informed decision.
N/A

Stakeholders

Stake holders are people or groups who may be directly affected (primary stakeholders) and indirectly affected (secondary stakeholders)

You must evidence here who you involved in gathering your evidence about benefits, adverse impacts and practical steps to mitigate or avoid any adverse consequences. You must be confident that any engagement was meaningful. The Community engagement team can help you to do this and you can contact them at consultation@lincolnshire.gov.uk

State clearly what (if any) consultation or engagement activity took place by stating who you involved when compiling this EIA under the protected characteristics. Include organisations you invited and organisations who attended, the date(s) they were involved and method of involvement i.e. Equality Impact Analysis workshop/email/telephone conversation/meeting/consultation. State clearly the objectives of the EIA consultation and findings from the EIA consultation under each of the protected characteristics. If you have not covered any of the protected characteristics please state the reasons why they were not consulted/engaged.

Objective(s) of the EIA consultation/engagement activity
Engagement conducted to explore if change to service is necessary and if it would provide positive or negative impact for people. The engagement process supports the procedure for providing Equality Impact Assessments, which will allow LCC ASC to check that new services are being introduced fairly and have evidence of wide ranging and appropriate community engagement.

Who was involved in the EIA consultation/engagement activity? Detail any findings identified by the protected characteristic

Age	A sample of those supported by the service, existing and potential providers, practitioners, contract officers and health colleagues
Disability	A sample of those supported by the service, existing and potential providers, practitioners, contract officers and health colleagues
Gender reassignment	A sample of those supported by the service, existing and potential providers, practitioners, contract officers and health colleagues
Marriage and civil partnership	A sample of those supported by the service, existing and potential providers, practitioners, contract officers and health colleagues
Pregnancy and maternity	A sample of those supported by the service, existing and potential providers, practitioners, contract officers and health colleagues
Race	A sample of those supported by the service, existing and potential providers, practitioners, contract officers and health colleagues
Religion or belief	A sample of those supported by the service, existing and potential providers, practitioners, contract officers and health colleagues

Sex	A sample of those supported by the service, existing and potential providers, practitioners, contract officers and health colleagues
Sexual orientation	A sample of those supported by the service, existing and potential providers, practitioners, contract officers and health colleagues
Are you confident that everyone who should have been involved in producing this version of the Equality Impact Analysis has been involved in a meaningful way? The purpose is to make sure you have got the perspective of all the protected characteristics.	Proposed changes to the service are based on engagement with all stakeholders, a sample of those supported by the service, existing and potential providers, practitioners, contract officers and health colleagues.
Once the changes have been implemented how will you undertake evaluation of the benefits and how effective the actions to reduce adverse impacts have been?	The changes will be evaluated regularly through contract monitoring as well as annual reviews into the service, which will involve appropriate engagement with users of the service.

Further Details

Are you handling personal data?	Yes If yes, please give details. The service providers (suppliers) who are delivering call-off contracts from the framework hold personal data regarding the individuals they support

Actions required Include any actions identified in this analysis for on-going monitoring of impacts.	**Action**	**Lead officer**	**Timescale**

Version	Description	Created/amended by	Date created/amended	Approved by	Date approved
1.0	Version issued as part of procurement documentation	ES	01/12/19		
1.1	As above. Minor amend to Positive Impacts – Disability section wording	CM	06.01.2019		

Examples of a Description:
'Version issued as part of procurement documentation'
'Issued following discussion with community groups'
'Issued following requirement for a service change; Issued following discussion with supplier'

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Lincolnshire COUNTY COUNCIL Working for a better future

Policy and Scrutiny

Open Report on behalf of Derek Ward, Director of Public Health

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**15 January 2020**
Subject:	**Presentation on the Director of Public Health Annual Report**

Summary:

The Director of Public Health Annual Report is an independent statutory report on the health of the people of Lincolnshire. This year's report is on the burden of disease in Lincolnshire.

Actions Required:

The Committee is asked to receive the report and presentation, and to note its contents.

1. Background

One of the statutory duties of each Local Authority Director of Public Health is to produce an independent report on the state of the health of the people they serve on an annual basis. Local Authorities have a statutory duty to publish the report. As the reports are aimed at lay audiences, the key feature must be their accessibility to the wider public.

The 2019 Director of Public Health Annual Report, attached as Appendix A, is focused on the burden of disease in Lincolnshire. The report uses the Global Burden of Disease (GBD) methodology. The GBD is a study into how disease affects populations in terms of both morbidity and mortality. It also provides the ability to look at the major risk factors behind the causes of morbidity and mortality. This can be used to drive change in order to improve the population's health.

The full Annual Report document is available on the Council's website. To support the published document, a video and slide deck has also been published and these will be presented to the Committee at the meeting.

2. Conclusion

The Director of Public Health has a statutory duty to produce an annual report on the health of the people of Lincolnshire. The Adults and Community Wellbeing Committee is therefore asked to note the contents of the presentation.

3. Consultation

a) Have Risks and Impact Analysis been carried out?

No.

b) Risks and Impact Analysis

This a professional independent report produced by the Director of Public Health.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	The Director of Public Health Annual Report 2019 - The Burden of Disease in Lincolnshire

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were use in the preparation of this report.

This report was written by Aiden Vaughan, who can be contacted on 01522 550657 or aiden.vaughan@lincolnshire.gov.uk.

The Burden of Disease in Lincolnshire

The Director of Public Health Annual Report 2019

Lincolnshire COUNTY COUNCIL

Working for a better future

Contents

Foreword

It is a great pleasure to present my first annual report as the Director of Public Health (DPH) for Lincolnshire. This report covers the period of mid 2018 through to 2019 as a transition year from the previous DPH, Tony McGinty. I would like to pass on my thanks to Tony for doing an excellent job and supporting me in my new post. I also want to thank the team who did a lot of the work on this report. Although this is the DPH report, it is very much a team effort and I am immensely grateful to everyone who has contributed.

In this, my first report, I very much wanted to describe the health and illness experienced in Lincolnshire, but in a different way. This is important for two reasons. Firstly, as the new DPH I want to fully understand the diseases that are causing death and disability in the county, in order to tackle them. Secondly, the health and care system has become a victim of its own success. Over the past 50 years, we have seen a fundamental shift in how we support people with disease. Conditions that would once have killed are now treated as chronic diseases and people can expect to live a long time with multiple conditions. But the way we describe disease at a population level is still very much focussed on what people die from. We talk about mortality rates or life expectancy.

We need to change how we measure illness at a population level to reflect the changes that we are experiencing. We need to refocus on how we can help people to live for as long as possible in good health – "healthy life expectancy".

For the first time at a Lincolnshire level, the Global Burden of Disease (GBD) gives us an opportunity to describe illness and mortality using a standard measure. For the first time we can ask ourselves does cancer cause more ill health and years of life lost than heart disease? For the first time we can measure just how big an impact mental ill-health has on the people of the county and compare that to the impact of early deaths from stroke. This is the challenge we have tackled in this report. And it has thrown up a few surprises.

Whilst measuring ill-health and mortality in a different way is important, acting on the causes of the ill-health is vital. I have included a section in the report describing how we can address these causes. I have also included a section on the key risk factors that drive the burden of disease. I will work with partners across the county to tackle the causes and risk factors. I will report back on progress in the DPH report for 2020.

Finally, we have produced some videos to accompany this report. I would be interested in comments on whether you find these helpful and useful in describing the findings we report here, which can be emailed to PublicHealthDivision@lincolnshire.gov.uk

Derek Ward,
Director of Public Health

1. Introduction

An individual's view of their own health and the impacts of illness is very personal. It is influenced by a wide range of factors including the support of friends and families, the health and care services they receive, and the wider environment within which they experience their illness. In contrast, measures of overall population health or illness must be objective and numerical in nature in order to understand patterns and trends, to benchmark geographic areas or cohorts of the population, and to evaluate the impact of interventions and services on health outcomes.

Most commonly, these measures are based upon the causes of death and measures of premature mortality within the population. Over the last 100 years in England, medical breakthroughs and improved living conditions and behaviours have seen people living longer than ever before. However since 2011, improvements in mortality rates and life expectancy have slowed (Source: Public Health England). The current life expectancy at birth (2015-17) in Lincolnshire is 79.4 years for males and 82.9 years for females, broadly similar to the England values of 79.6 years and 83.1 years respectively (Source: Public Health England).

Nationally, the leading cause of death has also changed over time, with a decrease of around 50% in deaths from heart disease and stroke over the last 15 years, and increases in Alzheimer's, dementia and suicide (Source: Public Health England). In Lincolnshire, the leading causes of death in under 75s are cancer (41%), cardiovascular disease (CVD) (24%) and respiratory disease (9%). In the 75 plus population they are CVD (29%), cancer (22%), then respiratory disease (14%), with CVD and cancer switching positions between these two age groups. (Source: Civil Registration data)[1]

Although mortality-based measures are useful in understanding causes of death and inequalities in life expectancy, they do not describe the impacts of living with ill-health, or conditions which may severely limit everyday life but which do not necessarily cause early death. Measuring healthy life expectancy goes some way to bridging this gap. Healthy life expectancy describes the number of years a person can expect to live in good health, without disability or

1. Civil Registration Data, 2018/19, NHS Digital

life limiting illness. In Lincolnshire, healthy life expectancy at birth for males is 61.7 years and for females is 62.4 years. Looked at another way, this means that men can expect to live for 17.7 years with one or more serious health conditions before they die and women will live for more than two decades (20.5 years) before they die. Nationally the difference is 16.2 years in males and 19.3 years in females. (Source: Public Health England)

Keeping people fit and healthy for as long as possible is important to the individual, the economy and wider society. Ill-health causes disengagement with the labour market and with activities such as volunteering and caring roles. This impacts upon personal income, self-worth and can result in isolation, which themselves contribute further to ill-health, as well as meaning that others, including public services, may need to fill the gap. Measures of health which consider years lived with ill-health and disability, as well as life expectancy, start to describe the 'burden' of disease.

The NHS Long Term Plan sets out how the NHS will strengthen its contribution to prevention and health inequalities and make improvements in quality and outcomes across a number of major conditions. The Plan highlights how the Global Burden of Disease (GBD) study has guided the renewed prevention priorities (for example, smoking and obesity) and the major conditions to tackle (for example, cancer and cardiovascular disease).

The GBD was created in 1991 and is devised through epidemiological research. The aim is to produce measurable and comparable health outcome data, known as Disability-Adjusted Life Years (DALYs). DALYs are calculated by adding together the number of years lost due to premature mortality (YLL) and the number of years lived with a disability (YLD), using a standard life expectancy age, in this instance derived from Japanese life expectancy.

In 2016, local authority data for GBD was introduced, making it possible to compare Lincolnshire nationally and globally. The data in this report is from the most recent iteration in 2017.

2. Lincolnshire's Burden of Disease

The GBD is divided into four tiers of hierarchy, with level 1 being the broadest grouping and level four breaking conditions down into specific illnesses recognised in the International Classification of Disease (ICD) Version 10. An example for ischaemic stroke is shown below:

- Level 1 – non communicable disease
- Level 2 – cardiovascular disease
- Level 3 – stroke
- Level 4 – ischemic stroke

For this report, level 3 data is used as this provides policy makers and health professionals with sufficiently detailed, but meaningful and robust, intelligence upon which to make decisions.

2.1 Mortality (Years of Life Lost)

Years of life lost (YLL) is the estimated difference between age at death and standard life expectancy. For a whole population it is generally presented as a rate per 100,000 people so that data can be compared for areas with different sized populations.

In Lincolnshire, the rate of all cause, age and sex YLL is higher than regionally and nationally. Whilst it decreased from 21,001 per 100,000 people in 1990 to 14,893 per 100,000 in 2012, the trend reversed, increasing to 15,932 per 100,000 by 2017. This can be seen in Figure 1.

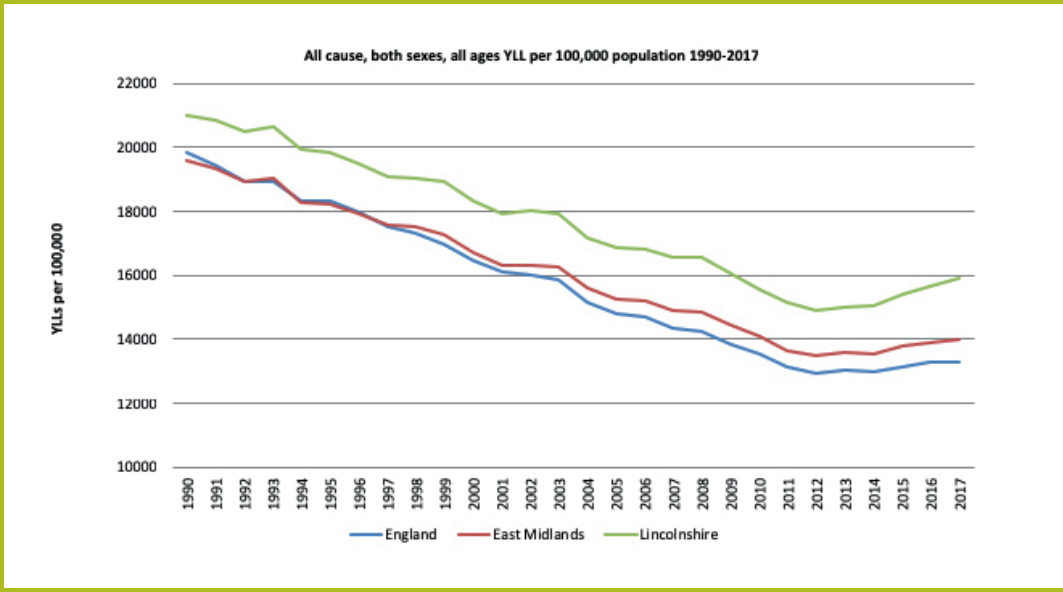

Figure 1: All Cause, Age and Sex YLL per 100,000 People, 1990 – 2017

Table 1: Main Causes of YLL in Lincolnshire, 2017, and Percentage Change over Time
All age and sex YLL per 100,000 people

Condition	Rate	Percentage	YLL	% Change from 1990	% Change from 2010
Ischemic heart disease	2,331	14.6%	17,737	-60.1%	-2.4%
Lung cancer	1,161	7.3%	8,833	-16.2%	2.5%
Stroke	933	5.6%	7,092	-46.6%	-3.6%
Chronic obstructive pulmonary disease (COPD)	909	5.7%	6,917	11.7%	6.5%
Alzheimer's	906	5.7%	6,894	58.4%	14.1%
Lower respiratory infection	628	3.9%	4,778	-0.2%	11.6%
Colorectal cancer	591	3.7%	4,493	-18.0%	1.4%
Breast cancer	486	3.1%	3,701	-30.5%	1.3%
Self-harm	370	2.3%	2,814	-15.4%	10.2%
Pancreatic cancer	353	2.2%	2,689	28.8%	9.1%

Table 1 shows, that in 2017, ischemic heart disease (IHD) was by far the highest cause of YLL in Lincolnshire. In terms of change, a negative figure shows a decrease in YLL and a positive one shows an increase. The main conditions that result in YLL have remained largely unchanged since the GBD was first published, with the exception of Alzheimer's disease, which has increased and been in the top five conditions from 2002 onwards. Since 1990, YLL from ischemic heart disease has decreased by over 60% however Alzheimer's has increased by nearly the same proportion. There are also some differences between males and females; for example, the rate for Alzheimer's in females is much higher, at 4,204 per 100,000, than in males, where it is 2,690 YLLs per 100,000. YLL for lung cancer is higher in males, at 5,819 per 100,000, than it is in females, at 3,644 per 100,000.

2.2 Morbidity (Years Living with Disability)

Years living with disability (YLD) is calculated by multiplying the prevalence of each cause and its consequences, by a disability weighting, corrected for comorbidity. Local data on YLD are more difficult to evaluate because they are similar for many important conditions across local areas, and uncertainty around weights also reduces the accuracy of YLD. (Source: The Lancet). Despite these limitations, for the first time, YLD allows us to compare the burden of disease across different conditions using a standard measure. It also allows us to compare how much burden of disease is due to people living with disabling conditions to how many years of life are lost from those conditions.

YLD shows a steady increase from 13,117 per 100,000 people in 1990 to 14,788 per 100,000 people in 2017, and Lincolnshire's rate is increasing more quickly than regionally and nationally, as shown in Figure 2.

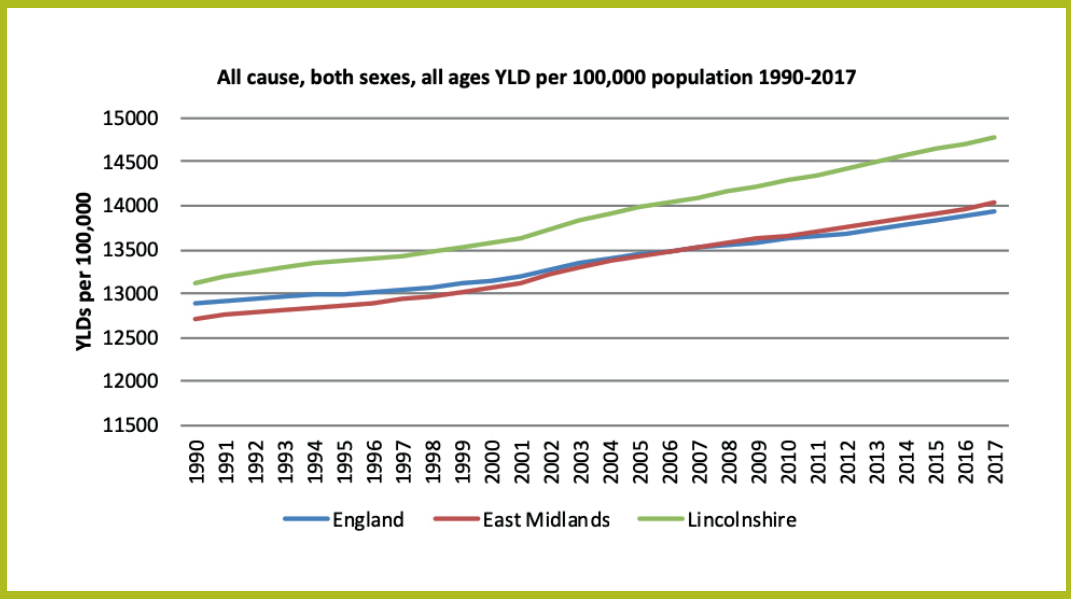

Figure 2: All Cause, Age and Sex YLD per 100,000 People, 1990 – 2017

Table 2 shows the main causes of YLD in Lincolnshire and the percentage change from 1990 - 2017. The top five conditions are unchanged since 1990, but again there are some interesting differences between males and females, for example, diabetes is the second highest cause of YLD in males (666 per 100,000) but only the eighth highest in females (554 per 100,000).

Table 2: Main Causes of YLD in Lincolnshire, 2017, and Percentage Change over Time
All age and sex YLL per 100,000 people

Condition	Rate	Percentage	YLDs	% Change from 1990	% Change from 2010
Low back pain	1,932	13.1%	14,702	18.7	6.4%
Headache disorders	881	6.0%	6,705	-1.7%	-1.3%
Depressive disorders	718	4.9%	5,459	-4.4%	0.1%
Neck pain	714	4.8%	5,429	32.5%	6.4%
Age-related hearing loss	628	4.2%	4,780	27.9%	6.6%
Diabetes	608	4.1%	4,628	77.6%	21.5%
Chronic Obstructive Pulmonary Disease (COPD)	585	4.0%	4,450	32.9%	-4.0%
Falls	569	3.8%	4,326	39.2%	8.8%
Anxiety disorders	407	2.8%	3,093	-0.4%	-1.3%
Oral disorders	388	2.6%	2,952	-6.9%	9.0%

2.3 Overall Burden of Disease

Disability-adjusted life years (DALYs) compare the overall burden of disease in populations, viewing mortality and morbidity in equal measure and underpinning the GBD. DALYs are calculated by adding together the number of years lost due to premature mortality (i.e. years of life lost) and the number of YLD, as shown in Figure 3. They can also be used to compare the burden of individual diseases and conditions in the population.

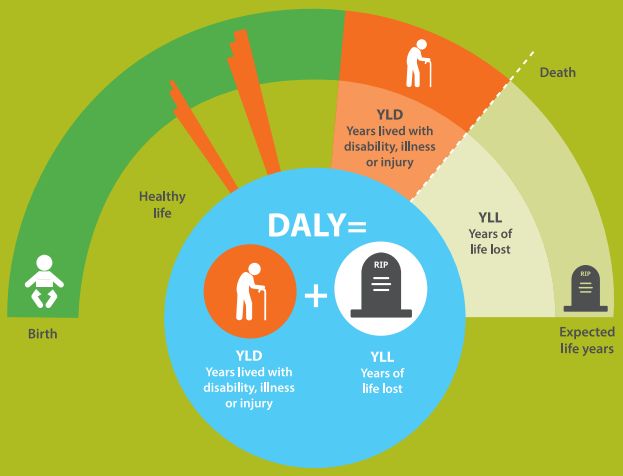

Figure 3: Measure of Disease Burden (DALYs)
Source: Public Health England

Since inception of the GBD in 1990, Lincolnshire's DALY rate has slowly reduced from 34,117 per 100,000 people, to 29,307 per 100,000 in 2012. However, the trend started to reverse and in 2017, Lincolnshire had a DALY rate of 30,721 per 100,000 people, higher than the East Midlands and England, as shown in Figure 4. This equates to a total of nearly a quarter of a million (233,716) DALYs experienced by the people of Lincolnshire in 2017.

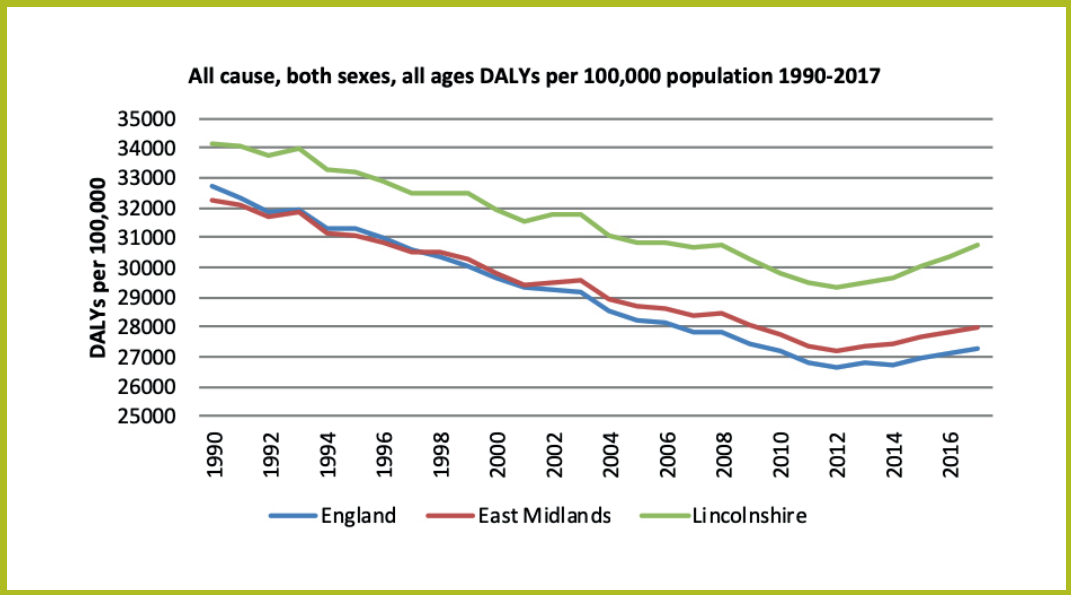

Figure 4: All Cause, Age and Sex DALYs per 100,000 People, 1990 – 2017

The main causes of DALYs in Lincolnshire and the percentage change from 1990-2017 and 2010-2017 are provided in Table 3.

In 2017 the greatest cause of DALYs in Lincolnshire was IHD with 2,455 per 100,000 people. This accounts for 8% of all Lincolnshire DALYs. The top five causes of DALYs have remained unchanged in Lincolnshire since the GBD began in 1990; however there have been decreases in lung cancer, stroke and ischemic heart disease. Increases have been seen in low back pain and COPD.

Table 3: Main Causes of DALYs in Lincolnshire, 2017, and Percentage Change over Time
All age and sex YLL per 100,000 people

Condition	Rate	Percentage	DALYs	% Change from 1990	% Change from 2010
Ischemic heart disease	2,455	8.0%	18,678	-59.0%	-2.1%
Low back pain	1,932	6.3%	14,702	18.7%	6.4%
Chronic obstructive pulmonary disease (COPD)	1,494	4.9%	11,367	19.1%	2.1%
Stroke	1,212	4.0%	9,221	-38.8%	0.3%
Lung cancer	1,183	3.6%	9,004	-15.6%	2.7%
Alzheimer's	1,309	3.7%	8,666	55.4%	13.2%
Headache disorders	881	2.9%	6,705	-1.7%	-1.3%
Diabetes	763	2.5%	5,805	23.6%	16.7%
Depressive disorders	718	2.4%	5,459	-4.4%	0.1%
Neck pain	714	2.31%	5,429	32.5%	6.4%

Again, there are some differences between the sexes. Notably, males have more than double the number of DALYs for ischemic heart disease (3,379 per 100,000) than females (1,581 per 100,000), and whilst low back pain is the second highest cause of DALYs overall, it is the highest cause in females (2,100 per 100,000).

In order to understand the causes of all conditions, GDB data is best depicted in a treemap, as shown in Figure 5. This uses colour representation: blue - all non-communicable diseases; red - communicable, maternal, neonatal, and nutritional diseases and injuries; and green - external causes. The shade variation further represents how much each condition has changed since 1990, with a darker shade indicating an increase in the condition. The area of the rectangle denotes the total burden of the condition in Lincolnshire.

The treemap shows that the Lincolnshire burden is largely comprised of non-communicable diseases (in blue) with a smaller proportion of communicable, maternal, neonatal, and nutritional diseases and injuries. The greatest burden is seen to be a non-communicable disease, IHD, and this is a very similar picture to nationally.

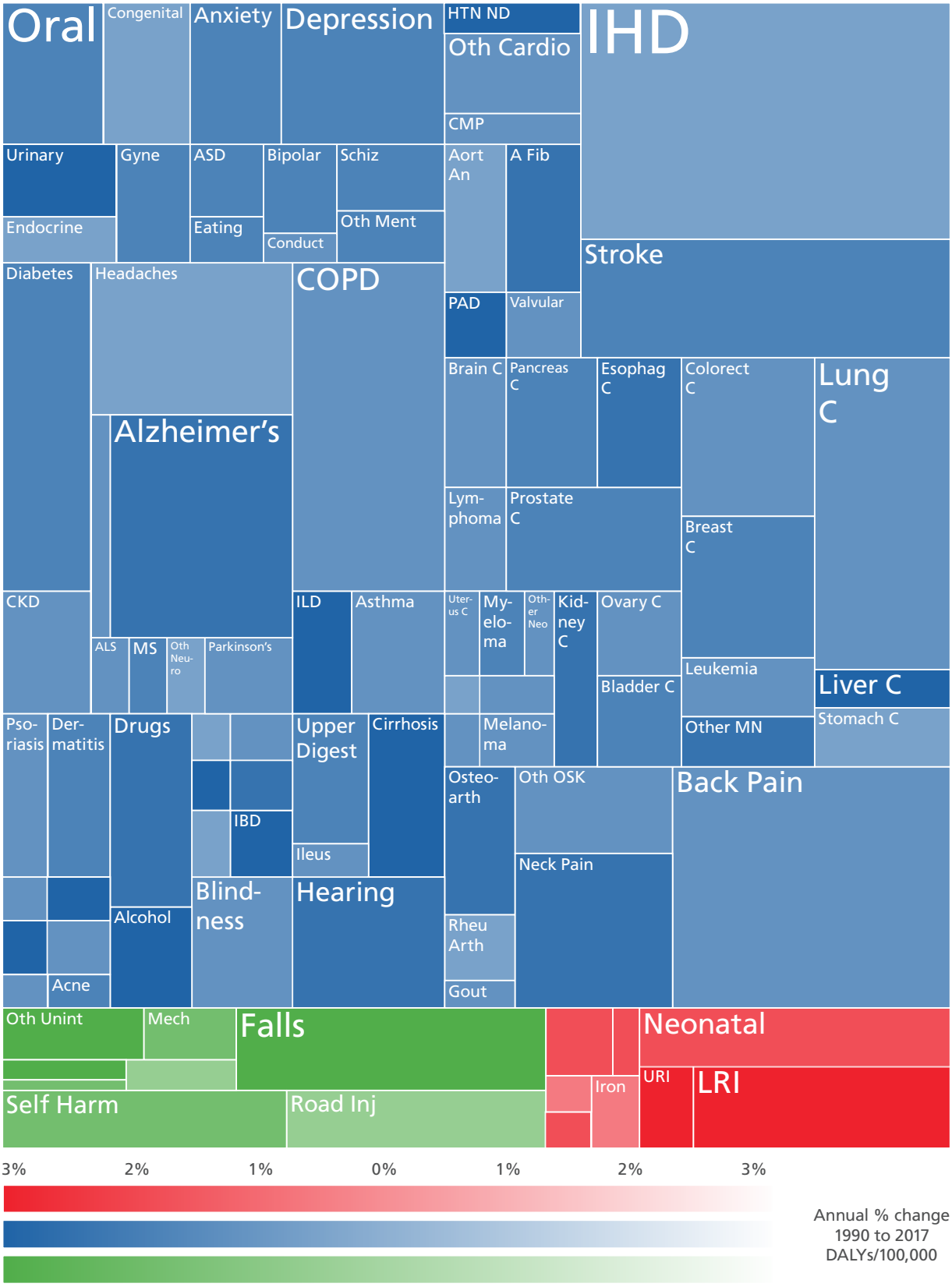

Figure 5: Level 3 GBD data for Lincolnshire, All age and sex DALYs, 2017

2.4 Risk Factors for Disease Burden

The GBD analyses risk factor exposure and attributable risk across three broad areas: behavioural, environmental and metabolic risks. Table 4 shows the specific risks that are within each category. It should be noted that not all disease burden has an attributable risk.

Table 4: Risk factor breakdown		
Behavioural	**Metabolic**	**Environmental**
Malnutrition, dietary risk, tobacco, alcohol use, unsafe sex, drug use, low physical activity, domestic violence and childhood maltreatment	High blood pressure, high fasting glucose plasma, high body mass index, high cholesterol, impaired kidney function and low bone mineral density	Air pollution, Unsafe water, unsafe sanitation, handwashing, occupational risks and other

For the overall burden of disease, the majority of Lincolnshire's risk factor exposure and attributable risk is classified as 'behavioural' at just over 50%. This is important in shaping prevention and intervention activities. Figure 6 shows the total number of DALYs (in 2017) for the three main risk factors.

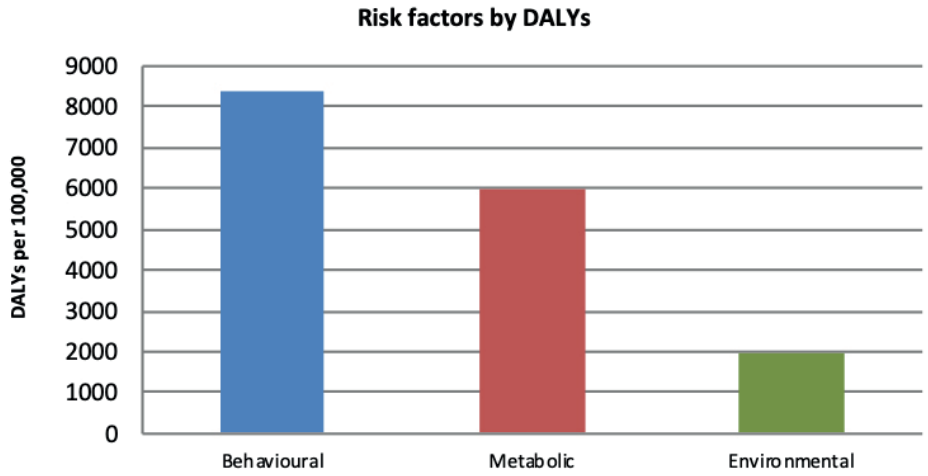

Figure 6: Total DALYs by Risk Factor for Lincolnshire, 2017

DALYs can be attributed to one risk factor or to a number of combined risk factors, and Figure 7 shows a more detailed picture. For attributable risk factors in DALYs, behavioural factors have the highest proportion of the risk attributable burden, with just over 40%. Next highest is metabolic factors alone, followed by risk that is attributable to behavioural and metabolic factors combined. Only 6.9% of DALYs have been attributed to environmental factors alone.

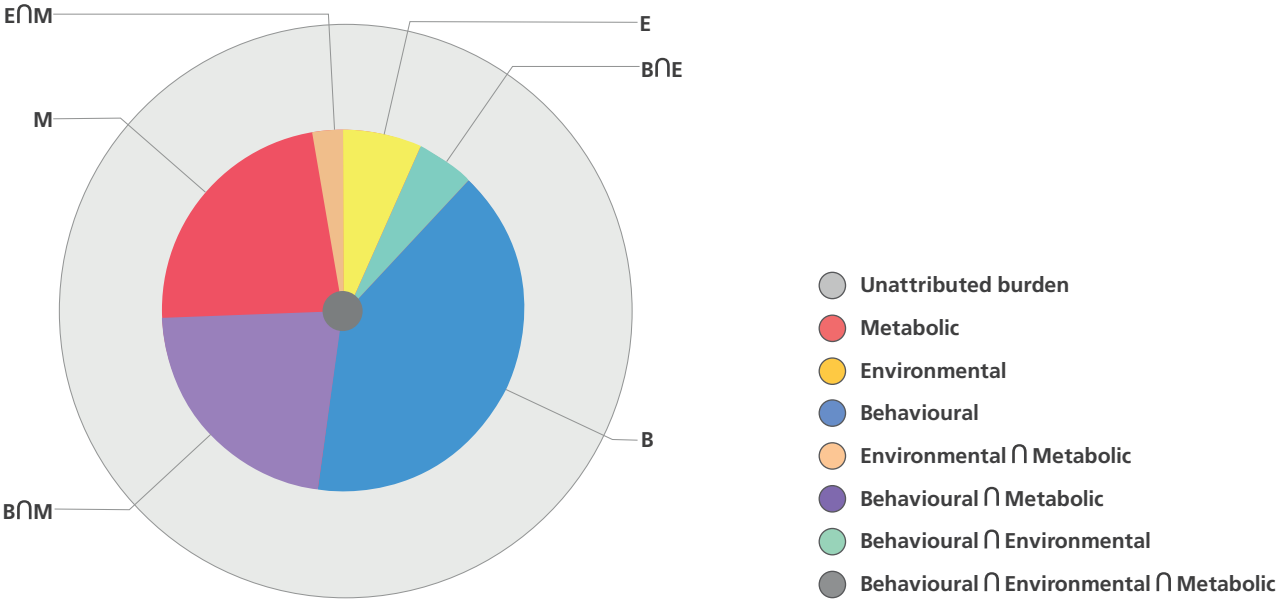

Figure 7: All Cause, Age and Sex DALYs Attributable to Risk Factors, 2017

It should be noted that only 40% of the burden of disease for DALYs has been attributed to any risk factor for many different reasons, such as a lack of research and the limitations of the modelling used. The grey circle around the chart represents the amount of unattributed risk.

With CVD being the main cause of DALYs in Lincolnshire, a similar in depth analysis has been carried out for this condition. Figure 8 shows that behavioural and metabolic risk factors combined are the primary drivers of this condition. It also shows that the unattributable risk is considerably lower for CVD than for all causes of DALYs, due to the amount of research that is available on the condition.

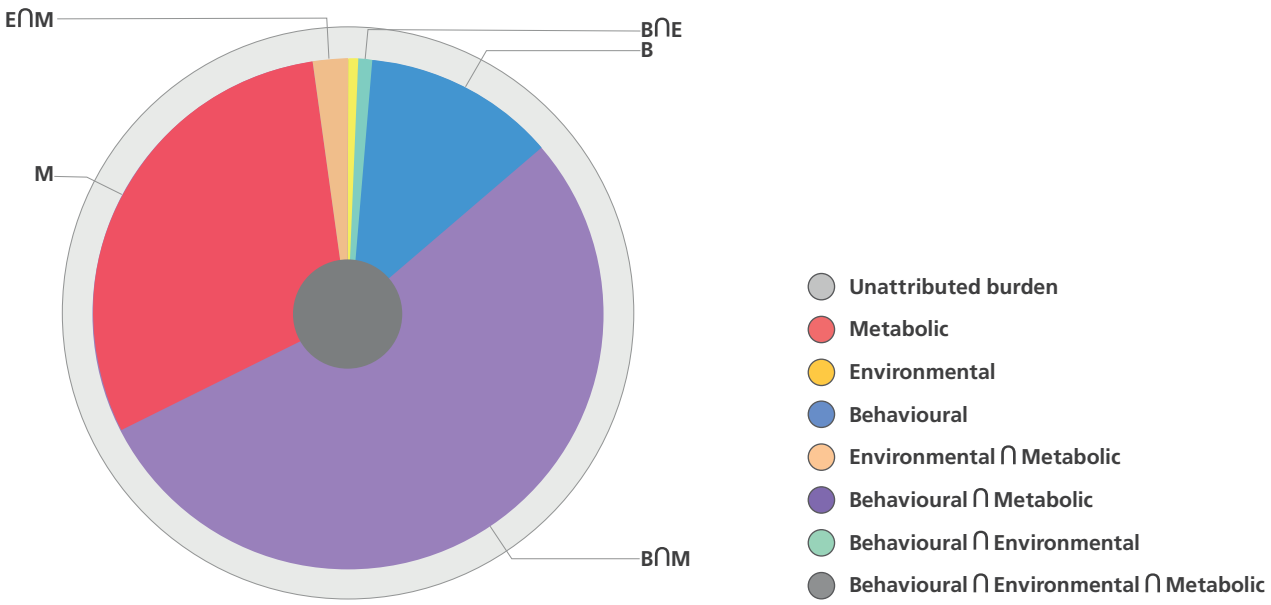

Figure 8: Cardiovascular Disease, all Age and Sex DALYs Attributable to Risk Factors, 2017

Examining individual risk factors more specifically; Figure 9 shows a breakdown of the greatest specific risk factors and their impact on burden of disease. The top five risk factors for DALYs in Lincolnshire are smoking, high blood pressure, high body mass index, high fasting plasma glucose and high cholesterol. Just these five factors account for 40% of all attributable risk, equating to 12,266 DALYs per 100,000 people, and 94,316 DALYs for the population in total.

Whilst the number of DALYs attributed to smoking in Lincolnshire has reduced by nearly half (47.9%) since 1990, it still remains the greatest risk factor (at 3,488 DALYs per 100,000 people). Smoking is the largest contributor to cancer, CVD and respiratory disease. For CVD alone, the greatest individual risk factor is high blood pressure.

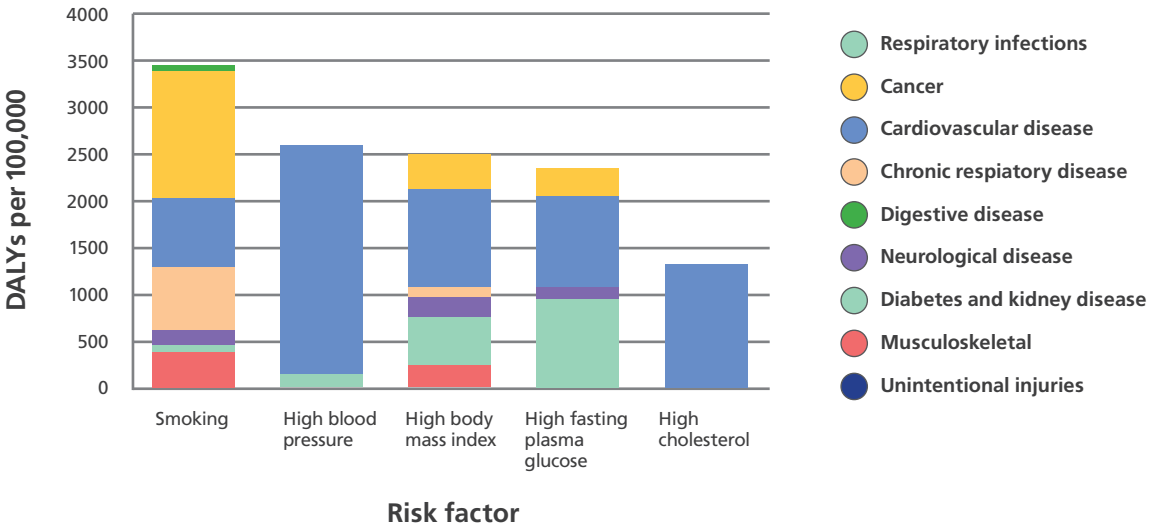

Figure 9: Attributable Risk Factors and their Impact on Burden of Disease, Lincolnshire, 2017

3. Implications of the GBD Study for the Health and Care System in Lincolnshire

The GBD study provides a unique perspective on health and identifies the need to address those conditions that not only contribute to the main causes of mortality, but are also causing the greatest overall burden of disease.

Whilst life expectancy has increased for the people of Lincolnshire, those extra years of life are not always spent in good health. An increasing proportion of people are living with multiple long term conditions, some for decades. There is a national ambition to improve healthy life expectancy, whilst closing the gap between the richest and poorest (Source: Dept. of Health and Social Care). The gap between overall life expectancy and healthy life expectancy has been identified as the 'window of need' and the aim of preventative interventions is to extend the period of healthy life expectancy, therefore reducing this window of need (Source: Public Health England).

Having an understanding of the risk factors that contribute to the disease burden enables interventions to be focussed on these, using the evidence on interventions that will have most impact. The GBD shows the contribution that addressing behavioural, metabolic and environmental/occupational risk factors can make in reducing the conditions which cause the greatest burden to our population. It will require a radical approach to prevention to have a real impact on reducing the occurrence of problems in the first place and, when they do arise, to support people to manage them as effectively as possible. This new approach is a key element of the national NHS Long Term Plan which is reflected in the development of the Lincolnshire Long Term Plan. The NHS Long Term Plan has a commitment to prevention, with a move away from a system that simply treats illness, into one that helps to keep people healthier for longer. Smoking, obesity, diet, alcohol and air pollution are some of the public health priorities in the plan.

The Lincolnshire GBD data does not enable identification of health inequalities at the local level, however the overall GBD data does show inequalities that take place across England and those areas experiencing poorer health, lower life expectancy and earlier onset of chronic disease and disability (Source: Public Health England). The Lincolnshire Joint Strategic Needs Assessment (JSNA) provides additional intelligence on health inequalities across many of the diseases causing the greatest burden for example, diabetes, CVD and COPD, as well as on the main risk factors, for example, smoking and physical inactivity.

The changing epidemiology evidenced in the GBD study presents a challenge to health and social care systems. The GBD identifies some conditions where the burden of disease has increased, for example, musculoskeletal (MSK) conditions (back and neck pain), Alzheimer's and diabetes. A fundamental shift is required in the system to support population level interventions to address the causes and effects of these conditions, which may have previously received less focus. The development of new Integrated Care Systems (ICS) provide opportunities to develop a system wide approach to prevention and health and social care provision for those conditions causing the greatest burden within our population.

The Joint Health and Wellbeing Strategy (JHWS) for Lincolnshire aims to inform and influence decisions about the commissioning and delivery of health and social care services. This helps to ensure that they are focused on the needs of the people who use them and tackle the factors that affect everyone's health and wellbeing. The aims, themes and priorities of the JHWS, as shown in Figure 10, all support actions to address the main causes of disease burden for the Lincolnshire population.

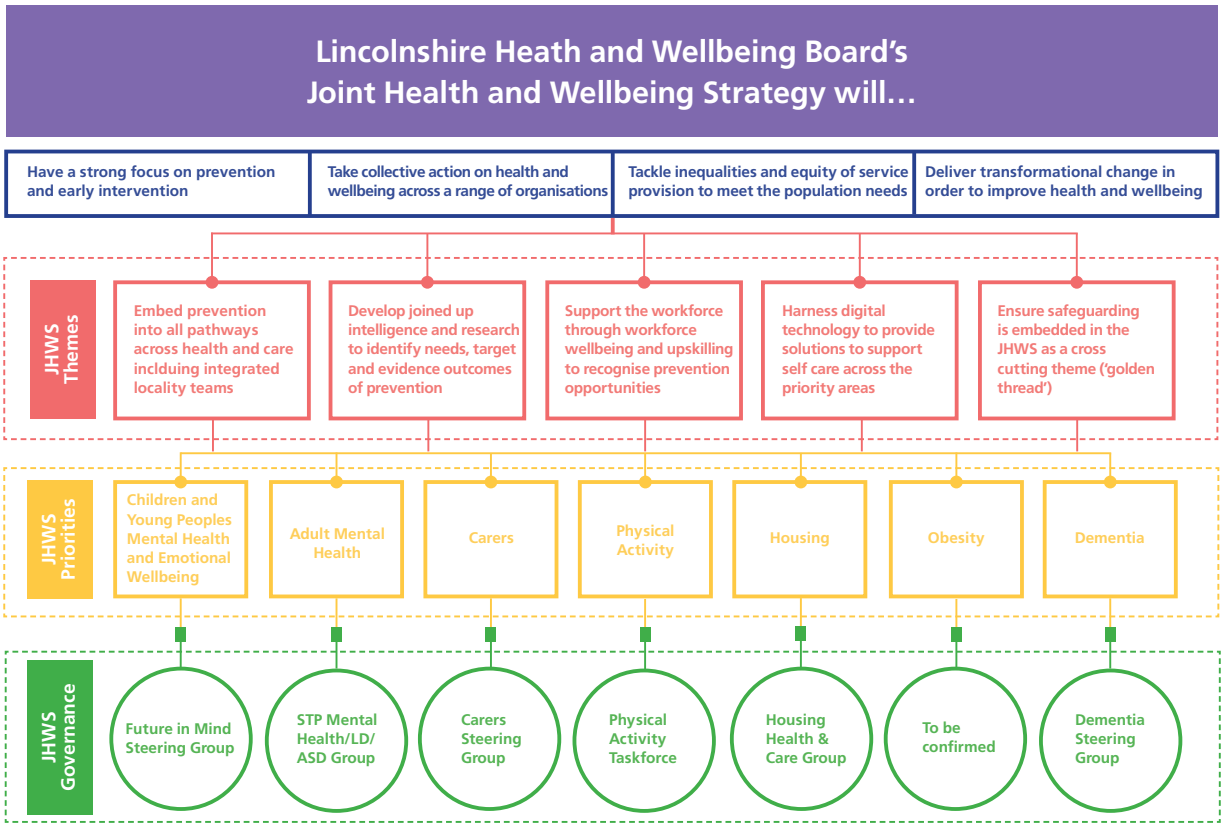

Figure10: Overview of Lincolnshire's Joint Health and Wellbeing Strategy (2018)

3.1 Addressing the Causes of Disease Burden

3.1.1 Cardiovascular Disease

CVD (heart disease and stroke) continues to dominate in the GBD and shows the need for ongoing systematic programmes to reduce CVD risk factors, especially behavioural (for example, smoking) and metabolic (for example, high blood pressure). Whilst given less of a focus in this annual report, the importance of addressing environmental risk factors is also essential, for example, air quality.

Whilst mortality from CVD has almost halved over recent decades, it still causes a quarter of all deaths. The condition is strongly associated with health inequalities, and those living in England's most deprived areas are almost 4 times more likely to die prematurely from CVD than those in the least deprived. There are a number of contributing factors associated with CVD, many of which are considered modifiable lifestyle risks, including, high blood pressure (hypertension), smoking, high cholesterol, obesity, physical inactivity, excessive alcohol consumption and a poor diet. The impact of CVD on the health and social care sector is significant. The NHS Rightcare CVD prevention pathway is an evidence-based, prevention and treatment pathway that identifies a number of high impact interventions in addition to cross cutting interventions to prevent CVD. Some of these include:

- Maximise NHS Health Check uptake and follow up.
- Embed CVD prevention within health and wellbeing initiatives.
- Challenge unwarranted variation and drive quality improvement in detection and management of the high risk conditions, for example high blood pressure
- Ensure interventions and referral pathways specifically target communities with historically poorer outcomes.

Further information is available in the JSNA Cardiovascular Disease topic.

3.1.2 Musculoskeletal Conditions

MSK conditions, for example, low back pain and neck pain, together cause the greatest disease burden in Lincolnshire. There are multiple risk factors that can increase susceptibility to MSK problems, including age, being overweight or obese, lack of physical activity and smoking. Two factors that often coincide are increasing age and reduced physical activity.

The evidence for providing cost-effective interventions for preventing and treating MSK conditions is overwhelming (Source; Public Health England), and includes:

- Physical Activity – The Chief Medical Officer has set guidelines for physical activity. Adults should aim to be active daily and should include muscle strengthening activities on at least two days a week, but any strengthening activity is better than none.
- Maintain a healthy weight and balanced diet – This can reduce the risks of developing conditions such as back pain and osteoarthritis of the knee.
- Smoking - Smoking has a negative impact on bone mineral density.

Further information is available in the JSNA Musculoskeletal (MSK) Conditions topic.

3.1.3 Chronic Obstructive Pulmonary Disease

COPD is a progressive disease, with symptoms including breathlessness and persistent coughs, and is a leading cause of disease burden in Lincolnshire. Like many long term conditions, it is known that there is a proportion of the population living with COPD, but not yet diagnosed. Smoking is the biggest risk factor for COPD.

A number of the NHS Rightcare pathways support work on COPD. This includes a number of opportunities, for example, in relation to early detection/accurate diagnosis of COPD and long term condition management. In addition to detection, management and treatment, prevention is essential, which includes interventions in relation to physical activity, smoking and air quality.

Further information is available in the JSNA Chronic Obstructive Pulmonary Disease topic.

3.1.4 Alzheimer's disease

Alzheimer's disease is the most common cause of dementia, affecting around six in every 10 people with dementia. Alzheimer's may also occur with other types of dementia, such as vascular dementia (Source: Alzheimer's Research UK). Some of the risk factors for Alzheimer's are the same as for CVD. Therefore addressing some of the behavioural (e.g. smoking) and metabolic preventative interventions for CVD (e.g. management of high blood pressure), will also address the prevention of Alzheimer's disease.

Further information is available in the JSNA Dementia topic.

3.1.5 Headaches

A headache is a common symptom associated with many conditions. Headaches can be categorized into primary headaches, which are not associated with an underlying condition, for example, tension type headaches and migraines; and secondary headaches which occur as a result of other causes, for example, trauma, infection. The majority of headaches are primary. Most people self-manage their headaches but it is one of the most common reasons for primary care consultations (Source: NICE).

Although limited, some information on headaches is provided in the JSNA Neurological Conditions topic.

3.1.6 Depression

Depression is characterised by persistent low mood and/or loss of pleasure in most activities and a range of associated emotional, cognitive, physical, and behavioural symptoms. The cause of depression is unknown but is likely to result from complex interaction of biological, psychological, and social factors. Depression can exacerbate the pain, disability, and distress associated with a range of physical diseases. Depression can impair a person's ability to function for example, in employment and relationships (Source: NICE). The NHS Every Mind Matters resource provides some tips on how to look after our mental health and wellbeing.

Further information on depression is provided in the JSNA Mental Health (Adults) topic.

3.2 Addressing the Risk Factors

The identification of risk factors linked to disease burden emphasises the importance of a broad approach to enable behavioural, metabolic and environmental risks to be addressed. Interventions for one risk factor will address multiple causes of disease burden, for example, addressing high blood pressure will impact on heart disease, stroke and Alzheimer's. There is a need for an approach that prevents the onset of risk factors/disease (primary prevention), whilst also diagnosing and managing risk factors/disease (secondary and tertiary prevention).

Apart from smoking, metabolic factors account for the leading causes of overall DALYs. High blood pressure is second to smoking.

3.2.1 Smoking

Smoking remains the greatest single contributor to health inequalities, accounting for half the difference in life expectancy between those living in the most and least deprived communities. Lincolnshire's smoking prevalence in adults is gradually reducing and continues to mirror the trend across England. There are geographic differences across the county in terms of prevalence and diseases/ deaths attributable to smoking, along with inequalities relating to factors such as deprivation, mental health and pregnancy.

A range of interventions are needed to address the health consequences of smoking. These include prevention (particularly in young people and pregnant women), supporting people to quit, eliminating the variation in smoking rates (for example, the higher rate amongst people with a serious mental illness) and effective enforcement.

Further information is available in the JSNA Smoking Reduction in Adults topic.

3.2.2 Physical Inactivity

Physical inactivity contributes to many diseases and premature deaths, including heart disease, strokes, diabetes and certain cancers. Regular physical activity can help to prevent and manage many chronic conditions and has an important role in good mental health. Within the county's adult population, Lincolnshire is identified as one of the most inactive areas in England. The Blueprint for Creating a More Active Lincolnshire focuses on four main areas that will have the greatest potential to change physical activity levels across Lincolnshire.

Further information is available in the JSNA Physical Activity topic.

3.2.3 High Blood Pressure (hypertension)

High blood pressure is amongst the top risk factors for years of life lost in England. It is the second highest attributable risk factor causing overall burden of disease in Lincolnshire. Improving the detection and treatment of hypertension is one of the national ambitions to prevent CVD. Achieving these ambitions requires a whole system approach across Local Authorities, Clinical Commissioning Groups, General Practice, Pharmacists and Community settings.

Nationally, those in the most deprived communities are 30% more likely to have high blood pressure. It is essential that interventions to reduce a person's risk of developing high blood pressure continue to take place across the health and care system, i.e. primary prevention. This includes interventions on diet, alcohol, weight, physical activity and smoking.

The role of secondary prevention, detecting disease and risk factors to prevent deterioration, is critical. Optimally managing people with identified high blood pressure is a key intervention for CVD prevention. The 'Size of the Prize in CVD Prevention in Lincolnshire' identifies the heart attacks and strokes averted, and money saved, by optimizing treatment in hypertension.

Initiatives like, 'Know your Numbers!' (the Blood Pressure UK awareness campaign), encourages adults to know their blood pressure and take the necessary actions to maintain healthy blood pressure. Promotion of this campaign across the health and social care system can help to achieve the CVD prevention ambitions.

The NHS Rightcare CVD Prevention Pathway identifies interventions across a number of the leading risk factors, including hypertension. High Value Interventions include identifying and targeting people with possible undiagnosed and untreated hypertension. Maximising the NHS Health Check Programme uptake and follow up is a key intervention.

4. Conclusion

For the first time we have been able to use Global Burden of Disease methodology to create new intelligence, helping us to understand the greatest burdens of disease in Lincolnshire. This has allowed us to compare the impacts of diseases and conditions that people die from, with those that people can live with for many years.

The picture which has emerged is one which is recognised, in part. Whilst life expectancy has increased, the period of time that people live with disabilities has also increased. The biggest killers are ischaemic heart disease, lung cancer, stroke, and COPD. However, close behind these is Alzheimer's, accounting for nearly 6% of all Years of Life Lost in Lincolnshire. When it comes to Years Lived with Disability the picture is very different. Low back pain, headache disorders, depressive disorders, neck pain and age related hearing loss are the top five causes. Diabetes and COPD also rank highly, as do falls, anxiety disorders, and oral disorders.

When premature mortality and disability data are combined to compare the overall burden of disease, the greatest single burden in Lincolnshire is ischaemic heart disease, and second is lower back pain. However, when lower back pain and neck pain are combined they become the greatest cause of Disability Adjusted Life Years in Lincolnshire.

So whilst heart disease and cancers are the big killers, lower back and neck pain (MSK), mental health issues and Alzheimer's disease are all key challenges we have to tackle at a Lincolnshire level because of their overall impact.

A fundamental shift is needed to refocus our shared efforts, requiring an emphasis on prevention and early detection, and informed by evidence of the most common risk factors driving ill-health. Unsurprisingly, the single greatest risk factor is smoking, and other key factors are high blood pressure, high body mass index and high cholesterol, which are all risks that we can do something about and which we have discussed in this report.

We will use the Health and Wellbeing Board and the NHS Long Term Plan to tackle the causes and risks of illness in Lincolnshire, and will report back on our progress in next year's Director of Public Health report.

Lincolnshire COUNTY COUNCIL

Working for a better future

Lincolnshire COUNTY COUNCIL
Working for a better future

Open Report on behalf of Andrew Crookham
Executive Director - Resources

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**15 January 2020**
Subject:	**Adults and Community Wellbeing Scrutiny Committee Work Programme**

Summary:

The Committee is also requested to consider its future work programme, which includes a list of probable items up to and including 1 July 2020. The report also includes a schedule of previous activity by the Committee since June 2017.

There is a plan to hold up two workshop meetings to consider the topic of health inequalities in rural and coastal communities in Lincolnshire, and also to invite members of the Health Scrutiny Committee to the workshops.

The Committee is requested to note the three decisions made by the Executive Councillor for Adult Care, Health and Children's Services on 2 December, following consideration by this Committee on 27 November 2019

Actions Required:

(1) To review the Committee's future work programme, highlighting any activity for possible inclusion in the work programme.

(2) To make arrangements for up to two workshop meetings to consider the topic of rural and coastal communities; and to invite members of the Health Scrutiny Committee to the workshops.

(3) To note that the following decisions were made by the Executive Councillor for Adult Care, Health and Children's Services on 2 December 2019 following consideration by this Committee on 27 November 2019:

- Direct Payment Support Service (Minute 40)
- Block Transitional Care and Reablement Beds Re-Procurement (Minute 41)
- Lincolnshire Independent Advocacy Services Re-Procurement (Minute 42)

1. Rural and Coastal Health Inequalities - Workshop Proposal

It is proposed that up to two workshop meetings are arranged to consider the details of the topic of health inequalities in rural and coastal communities in Lincolnshire. This approach would allow a detailed focus on this important topic and involve the Executive Councillor for Adult Care, Health and Children's Services and representatives from Public Health England in the discussions on this topic, together with the Council's own officers.

It is also suggested that members of the Health Scrutiny Committee for Lincolnshire be invited to the workshops. The plan is that the first workshop would be arranged on a date in February.

2. Current Items

The Committee is due to consider the following items at this meeting: -

15 January 2020 – 10.00am	
Item	*Contributor(s)*
Adult Care and Community Wellbeing Budget Proposals 2020-21	Pam Clipson, Head of Finance, Adult Care and Community Wellbeing
Home Care Service *(Executive Decision – 4 February 2020)*	Alexander Craig, Commercial and Procurement Manager – People Services
Home-Based Reablement Service *(Executive Decision – 4 February 2020)*	Alina Hackney, Senior Strategic Commercial and Procurement Manager Carl Miller, Commercial and Procurement Manager – People Services
Re-Procurement of Community Supported Living Services *(Executive Decision – 4 February 2020)*	Carl Miller, Commercial and Procurement Manager – People Services
Annual Report of the Director of Public Health	Derek Ward, Director of Public Health

3. Future Items

Set out below are the meeting dates up to July 2020, with a list of items allocated or provisionally allocated to a particular date. The items in the published forward plan of executive decisions within the remit of this Committee are listed in Appendix A.

26 February 2020 – 10.00am	
Item	*Contributor(s)*
Adult Care and Community Wellbeing Performance Report - Quarter 3 2019/20	Katy Thomas, County Manager - Performance & Intelligence, Adult Care and Community Wellbeing
Adult Care and Community Wellbeing Budget Monitoring 2019/20	Pam Clipson, Head of Finance, Adult Care and Community Wellbeing
Better Care Fund	Pam Clipson, Head of Finance, Adult Care and Community Wellbeing
New Ways of Working in Social Care	Glen Garrod, Executive Director, Adult Care and Community Wellbeing
Care Quality Commission Update *(To be confirmed.)*	Andrew Appleyard, Inspection Manager, Care Quality Commission
Agreement with Lincolnshire Partnership NHS Foundation Trust under Section 75 of the National Health Service Act 2006 (Executive Decision – 3 March 2020) *REPORT TO CONTAIN EXEMPT INFORMATION*	Justin Hackney, Assistant Director, Specialist Services and Safeguarding

1 April 2020 – 10.00am	
Item	*Contributor(s)*
Extra Care Housing *(Executive Decision – 7 April 2020)*	Kevin Kendall, Assistant Director, Corporate Property
Lincolnshire NHS Long Term Plan	Glen Garrod, Executive Director of Adult Care and Community Wellbeing
Day Opportunities	Justin Hackney, Assistant Director, Specialist Services and Safeguarding
Mental Health – Community Based Model	Justin Hackney, Assistant Director, Specialist Services and Safeguarding
Transforming Care	Justin Hackney, Assistant Director, Specialist Services and Safeguarding
Lincolnshire Safeguarding Adults Board – Annual Plan	David Culy, Lincolnshire Safeguarding Adults Board Business Manager

13 May 2020 – 10.00am	
Item	*Contributor(s)*
Team Around the Adult – Update on Developments	Justin Hackney, Assistant Director, Specialist Services and Safeguarding

1 July 2020 – 10.00am	
Item	*Contributor(s)*
Adult Care and Community Wellbeing Performance Report - Quarter 4 2019/20	Katy Thomas, County Manager - Performance & Intelligence, Adult Care and Community Wellbeing
Adult Care and Community Wellbeing Budget 2019-20 – Outturn Report	Head of Finance, Adult Care and Community Wellbeing

Items to be Programmed

- National Carers Strategy
- Alcohol Harm and Substance Misuse Services
- Managed Care Network for Mental Health (C*onsidered 11 April 2018)*
- Long Term Funding of Adult Social Care
- Homes for Independence

4. Previously Considered Items

All items previously considered by the Committee since June 2017 are listed in Appendix B.

At the Committee's last meeting on 27 November 2019, three statements were submitted to the Executive Councillor for Adult Care, Health and Children's Services in advance of her decisions on 2 December 2019. In each case, the Executive Councillor made the decision as proposed in the report. These decisions are listed below and further details are contained in the relevant minutes:

- Direct Payment Support Service (Minute 40)
- Block Transitional Care and Reablement Beds Re-Procurement (Minute 41)
- Lincolnshire Independent Advocacy Services Re-Procurement (Minute 42)

5. Conclusion

Members of the Committee are invited to review, consider and comment on the work programme and highlight for discussion any additional scrutiny activity which could be included for consideration in the work programme.

6. Consultation

Not applicable

7. Appendices

These are listed below and set out at the conclusion of this report.

Appendix A	Forward Plan – Items Relevant to the Remit of the Adults and Community Wellbeing Scrutiny Committee
Appendix B	Adults and Community Wellbeing Scrutiny Committee – Previously Considered Items

8. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Simon Evans, Health Scrutiny Officer, who can be contacted on 01522 553607 or by e-mail at Simon.Evans@lincolnshire.gov.uk

APPENDIX A

FORWARD PLAN OF KEY DECISIONS WITHIN THE REMIT OF THE ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE

From 3 February 2020

DEC REF	MATTER FOR DECISION	DATE OF DECISION	DECISION MAKER	PEOPLE/GROUPS CONSULTED PRIOR TO DECISION	OFFICERS FROM WHOM FURTHER INFORMATION CAN BE OBTAINED AND REPRESENTATIONS MADE (All officers are based at County Offices, Newland, Lincoln LN1 1YL unless otherwise stated)	DIVISIONS AFFECTED
I018998	Home Base Reablement Service Procurement	4 Feb 2020	Executive	Adults and Community Wellbeing Scrutiny Committee	Senior Commercial and Procurement Officer Tel: 01522 550744 Email: Helen.Johnston@lincolnshire.gov.uk	All
I019199	Procurement of Community Supported Living Services	4 Feb 2020	Executive	Adults and Community Wellbeing Scrutiny Committee	Commercial Team People Services Tel: 01522 553670 Email: Eilidh.French@lincolnshire.gov.uk	All
I019269	Home Care Re-Procurement	4 Feb 2020	Executive	Adults and Community Wellbeing Scrutiny Committee	Senior Commercial & Procurement Officer Tel: 01522 554978 Email: Catherine.Southcott@lincolnshire.gov.uk	All

DEC REF	MATTER FOR DECISION	DATE OF DECISION	DECISION MAKER	PEOPLE/GROUPS CONSULTED PRIOR TO DECISION	OFFICERS FROM WHOM FURTHER INFORMATION CAN BE OBTAINED AND REPRESENTATIONS MADE (All officers are based at County Offices, Newland, Lincoln LN1 1YL unless otherwise stated)	DIVISIONS AFFECTED
I018573	New Lincolnshire Partnership NHS foundation Trust Section 75 Partnership Agreement	3 Mar 2020	Executive	Adults and Community Wellbeing Scrutiny Committee	Assistant Director – Specialist Adult Services Tel: 01522 554259 Email: Justin.Hackney@lincolnshire.gov.uk	All
I019235	Extra Care Housing	7 Apr 2020	Executive	Adults and Community Wellbeing Scrutiny Committee	Assistant Director - Corporate Property Tel: 01522 552933 Email: Kevin.Kendall@lincolnshire.gov.uk	All

APPENDIX B

ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE
PREVIOUSLY CONSIDERED ITEMS

	2017				2018								2019								2020				
KEY ✓ = Item Considered = Planned Item	15 June	26 July	6 Sept	29 Nov	10 Jan	14 Feb	11 Apr	30 May	4 July	5 Sept	10 Oct	28 Nov	16 Jan	27 Feb	10 Apr	22 May	3 July	4 Sept	9 Oct	27 Nov	15 Jan	26 Feb	1 Apr	13 May	1 July
Meeting Length - Minutes	135	170	146	150	245	120	200	185	135	135	210	185	130	170	190	135	194	150	140	132					
Adult Care and Community Wellbeing Corporate Items																									
Advocacy Services																				✓					
Better Care Fund		✓																							
Budget Items			✓		✓				✓		✓		✓	✓			✓			✓					
Care Quality Commission				✓																					
Commercial Team																✓									
Contract Management					✓																				
Integrated Community Care															✓										
Introduction	✓																								
IT Updates					✓							✓													
Joint Strategic Needs Assessment	✓																								
Local Account				✓																					
Multi-Purpose Block Beds																				✓					
Social Care Working																									
NHS Long Term Plan														✓											
Quarterly Performance		✓	✓	✓			✓		✓	✓		✓		✓			✓	✓		✓					
Strategic Market Support Partner			✓																						
Winter Planning										✓						✓			✓						
Adult Frailty, Long Term Conditions and Physical Disability																									
Activity Data 2018/19																		✓							
Assessment and Re-ablement															✓										
Care and Support for Older People – Green Paper												✓				✓									
Commissioning Strategy											✓														
Dementia											✓				✓										
Direct Payments Support Service																				✓					
Home Care Service																									
Homecare Customer Survey									✓																
Residential Care / Residential Care with Nursing - Fees						✓			✓																
Review Performance									✓																

	2017				2018								2019								2020				
KEY ✓ = Item Considered = Planned Item	15 June	26 July	6 Sept	29 Nov	10 Jan	14 Feb	11 Apr	30 May	4 July	5 Sept	10 Oct	28 Nov	16 Jan	27 Feb	10 Apr	22 May	3 July	4 Sept	9 Oct	27 Nov	15 Jan	26 Feb	1 Apr	13 May	1 July
Adult Safeguarding																									
Commissioning Strategy										✓															
Safeguarding Board Annual Plan																							■		
Safeguarding Scrutiny Sub Group				✓		✓		✓		✓															
Carers																									
Commissioning Strategy											✓														
Community Wellbeing																									
Director of Public Health Report								✓													■				
Director of Public Health Role								✓																	
Domestic Abuse Services			✓																						
Healthwatch Procurement								✓																	
Integrated Lifestyle / One You											✓								✓						
NHS Health Check Programme							✓																		
Rural and Coastal Communities																									
Sexual Health Services													✓												
Stop Smoking Service					✓																				
Wellbeing Commissioning Strategy											✓														
Wellbeing Service												✓						✓							
Housing Related Activities																									
Extra Care Housing						✓											✓					■			
Homes for Independence Strategy																									
Housing Related Support																		✓							
Memorandum of Understanding															✓										
Supported Housing						✓																			
Specialist Adult Services																									
Autism Strategy															✓										
Commissioning Strategy										✓															
Community Supported Living																						■			
Day Opportunities																							■		
Learning Disability – Short Breaks																	✓								
Managed Care Network Mental Health							✓																		
Mental Health Community Based Model																							■		
Section 75 Agreement – Mental Health																						■			
Section 117 Mental Health Act Policy																	✓								
Shared Lives							✓																		
Team Around the Adult																			✓					■	
Transforming Care																							■		

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