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.

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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

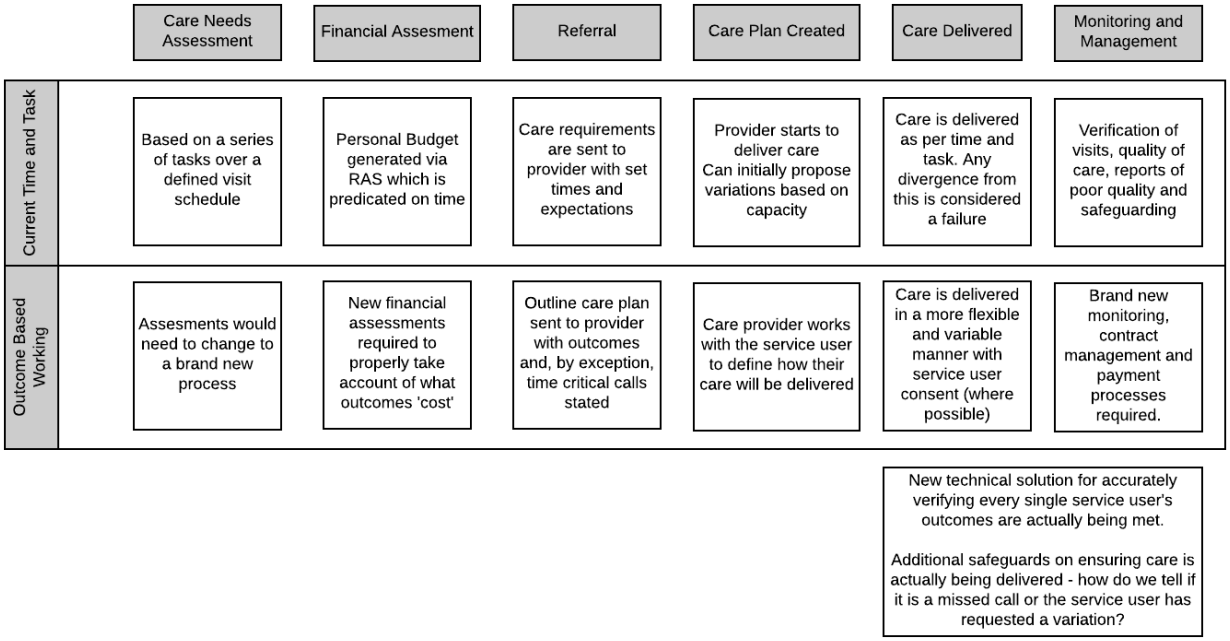
developing a person centred approach in how best to deliver and meet a service users care outcomes.

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

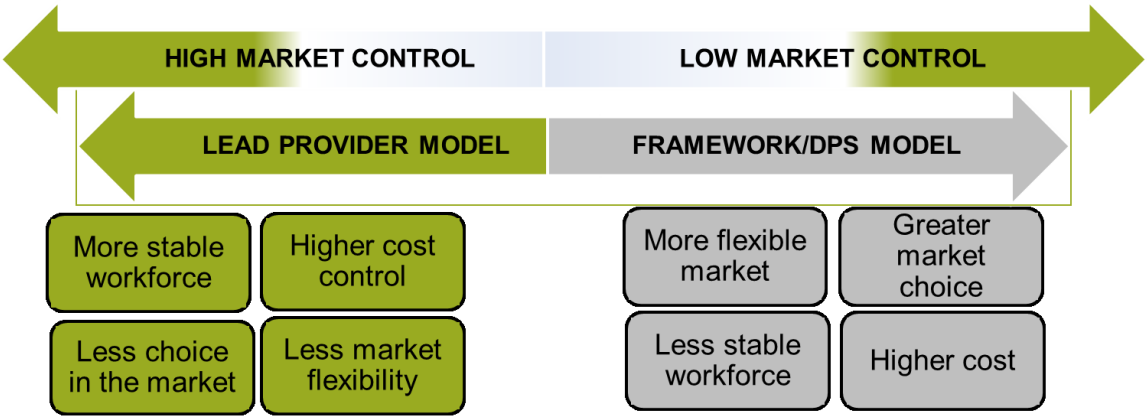
2.25. The current commercial model is fit for purpose and provides the necessary stability and control for managing the homecare market. While there have been significant changes to individual zones within the life of the current contracts it is evident that in the majority of zones services have performed 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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