Lincolnshire COUNTY COUNCIL
Working for a better future

**Policy and Scrutiny**

**Open Report on behalf of Glen Garrod, Director of Adult Care**

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| Report to: | **Adults Scrutiny Committee** |
| Date: | **25 February 2015** |
| Subject: | **Community Support Procurement** |

**Summary:**

This item invites the Adults Scrutiny Committee to consider a report entitled Community Support which is due to be considered by the Executive Councillor for Adult Care and Health Services, Children's Services on 27 February 2015. The views of the Scrutiny Committee will be reported to the Executive Councillor, 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 Executive Councillor set out in the report.

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

## 1. Background

The Executive Councillor is due to consider a report entitled Community Support on 27 February 2015. 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 recommendations in the report and whether it wishes to make any additional comments to the Executive Councillor. The Committee's views will be reported to the Executive Councillor.

## 3. Consultation

### a) Policy Proofing Actions Required

Not applicable.

## 4. Appendices

| These are listed below and attached at the back of the report | |
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| Appendix 1 | Community Support Procurement - Report to Executive Councillor for Adult Care and Health Services, Children's Services 27 February 2015 |

## 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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Lincolnshire COUNTY COUNCIL
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**Executive Councillor**

**Open Report on behalf of Glen Garrod, Director of Adult Social Services**

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|---|---|
| Report to: | **Executive Councillor for Adult Care and Health Services, Children's Services** |
| Date: | **27 February 2015** |
| Subject: | **Community Support Procurement** |
| Decision Reference: | **I008334** |
| Key decision? | **Yes** |

**Summary:**

The Community Support Framework has been in place since October 2011 delivering home care services for older persons and people with physical disability and community supported living for learning disability services and will come to an end on 30th Sept 2015. At this point new contracts must be in place and any pre-existing packages of care must be transferred to new providers within a limited timeframe and new packages of care must be directed exclusively to the new providers. This report seeks approval from the Executive Councillor to procure new contracts for home care services (including children's home care) and community supported living services.

In addition the report seeks to advise of the national and local factors in Community Support and to update on work undertaken to review existing arrangements in line with the Council's broader strategic commissioning decision making

**Recommendation(s):**

That the Executive Councillor

1. Approves that a procurement be undertaken to deliver a set of contracts to be awarded to Prime Providers of Older Persons and Physical Disability Home Care based on (12) geographical zones priced on the basis of a specified rate of £12.76 per hour for Urban work and £13.05 per hour for Rural work alongside guaranteed volumes of work for a period of up to 5 years for each zone.

2. Approves a procurement be undertaken to deliver a contract for Home Care for Children to be undertaken through the same process as in 1 above with a specified rate of £18.67 per hour for urban work and £19.16 per hour for rural work with the option to award alongside or separately from Older Persons and Physical Disability services

3. Approves a procurement be undertaken to establish an open framework of providers to deliver Community Supported Living (CSL) services across Lincolnshire for Adults with a Learning Disability and for a period of 5 years with a maximum rate of £13.30 per hour, the actual rate to be determined at any lower figure than the maximum proposed by providers within the procurement.

4. Approves the extension of the current Childrens Services contract for home care until the conclusion of the procurement process and any subsequent award for childrens home care services.

5. Delegates to the Director of Adult Care in consultation with the Executive Councillor for Adult Care and Health Services, Children's Services the authority to conduct the procurement and determine the terms and final form of the contracts and to approve the award of contracts and the entering into of all contract and other legal documentation necessary to give effect to the said contract/s;

**Alternatives Considered:**

1. To award a framework for Home Care services

   Continuing the current model of a framework for Home Care would not properly address any of the pressing issues facing the council and care market which would result in continuing cost pressures, increased market instability and the reduction in the ability to ensure demands for care packages will be properly met.

2. To award a Prime Provider model for CSL services

   The Community Supported Living provision differs notably to the OP/PD home care element both operationally and in how the market is comprised. These two key differences allow the Council to choose an alternative route which better suits the specific requirements for CSL

3. To not establish a specified rate

   By not establishing a commercial model at the outset that offers the market a viable solution the Council would risk being in the position of there being an unsustainable provision for care if the rates offered back through competition were unaffordable given the understood levels of demand and complexity.

4. To do nothing

   For the reasons set out in alternative 1 continuing under the current model would be unsustainable due to the market's inability to meet demand based upon the existing commercial terms within the Community Support Framework. Home care and Community Supported Living are critical services which are at the front line of providing care to Lincolnshire residents. Without these services the impact on service users and the wider health system would be far reaching and highly disruptive.

**Reasons for Recommendation:**

The proposal to establish a prime provider model for Older People and Physical disability homecare services in Lincolnshire as well as a separate framework for Learning Disability Community Supported Living meets the needs of the Council and Partners.

1. By implementing a prime provider model for Older People's and Physical Disability homecare services the Council will be able to work with the sector to establish a more sustainable care market in Lincolnshire which is affordable to both the Council and providers, allows for providers to better manage demand, retain and train staff, and creates a strong foundation to work towards successfully managing future challenges.

2. In maintaining a framework of Learning Disability Community Supported Living providers care arrangements will be able to continue in a stable but competitive fashion while establishing a consistent rate for all providers

3. Completing a procurement will seek to establish a more affordable service for Children's home care services as well as a broader market with greater choice and flexibility

4. The recommendations address and supports the statutory requirements for managing the market under the Care Act 2014

## 1. Background

1.1 The Council currently contracts with c70 homecare providers for the delivery of OP/PD services across the County and these contracts are due to end on until 30th September 2015

1.2 Additionally, there are currently 8 separate extra care housing schemes within Lincolnshire with a total of 5 providers delivering the care and support services within these settings and these contracts are due to end in September 2015.

1.3 The total spend on home care for Older Persons (PD) and Physical Disability (PD) services is approximately £23 million per annum with approximately 3,500 service users receiving a service at any one time and the delivery of approximately 35,301 hours of service provision by independent sector providers per week.

1.4 The total spend on supported living for Learning Disability (LD) is approximately £17.5 million per annum with approximately 530 service users receiving a service at any one time and the delivery of approximately 22,282 hours of service provision by independent sector providers per week

1.5 Children's PD home care has been delivered by Action for Children since October 2007 with an annual spend of approximiately £760,000 with 77 service users and delivering 450 hours of service provision per week

1.6 LCC has imposed a fixed rate of £12.50 for providers on the OP/PD framework since 2010 with no inflationary or annual increases during this period. There are a number of spot contract providers within the c70 who are on rates above this level because they refused to sign up to the original framework rate

1.7 In December 2014 the Council agreed to increase the hourly rate to £12.70 until 31st September 2015 as an interim measure to help deal with the increasing pressure on the care and health system.

1.8 During this period there have also been changes to the National Minimum Wage level and requirements and the introduction of the Workplace Pension Scheme.

1.9 Children's PD is contracted separately and at a different rate. This is due to a number of factors inluding the level of volume through Children's PD being too small for the Council to be able to generate sufficient economies of scale as well as the more specialist skills required for providers in delivering children's PD care.

1.10 In the OP/PD homecare market over 20 providers represent 80% of the annual spend with the market meaning there is a 'long tail' of approximately 50 providers addressing a small proportion of available funding. This represents a high level of market fragmentation

1.11 Community Supported Living has a much more contained market with 5 providers making up 80% of the CSL market the top ten accounting for 95%.

1.12 Prior negotiations and engagement with the Homecare provider market has resulted in the position that any further extension or retender would need to be based on a new commercial model - that being a new rate, a new approach to contracting, or both.

1.13 Cost pressures within the Council mean there is very limited scope to increase rates, especially to the degree as may be desired by the market

1.14 Continuing demographic change means increased pressures and escalating challenges for the Council and the Care Sector in the future

**General Environment**

2 Home care, Extra Care and Community Supported living are critical services which are are the front line of providing care to Lincolnshire residents. Without these services the impact on the wider health system would be far reaching and highly disruptive.

2.1 There are many policy developments which are influencing the care market and commissioning activities on a national and local level which can be summarised as follows:

2.2 **Implementation of personalisation** - local authorities are required to ensure that service users and carers have more choice and control over the services they are able to access and the way in which the services are provided. Choice and control should not just be limited to those people who have a Direct Payment and who manage their own care but should also extend to those service users who request or require the local authority to arrange and manage their care package on their behalf.

2.3 **Outcomes** - one of the key components of personalisation is that services are delivered in a way which meets the identified outcomes for each service user. Currently, home care services are commissioned on the basis of the tasks that need to be completed to meet the service users' assessed needs. Providers are paid for the service they deliver based on the time the care workers spend each week delivering the care to the individual. This is a national approach with the majority of local authorities arranging their contracts in this way but as outlined in the Institute of Public Care report "Help to Live at Home", there is a call on local authorities to commission services, and to pay providers, for the outcomes they achieve for service users and carers.

2.4 **Reablement** - there is evidence nationally that where, following a period of illness, people are supported to regain and retain their independence they are less likely to need long term care services or only require a reduced amount of care. Local authorities are working with the NHS to ensure that they commission services which help people to retain their independence

2.5 **Demographic changes and the need for specialist and complex care** - as more people are helped to live at home for longer and given the demographics of an increasingly ageing population, there is an increase in the need for large and complex packages of care including health care services, end of life care and dementia care being delivered in people's own homes.

2.6 **Hospital avoidance and early discharge** - the NHS and local authorities are developing a range of community based services and initiatives to prevent the need for people being admitted to hospital and to ensure that people are discharged from hospital at the earliest opportunity

2.7 **Workforce development** – there is wide recognition that good quality care services require investment in a skilled and trained workforce which is motivated and well supported. Generally, care workers are paid at or close to the national minimum wage and are often employed on 'zero hour' contracts with no guaranteed hours. This means that providers are unable to retain staff and this adversely impacts on their ability to deliver good quality services

consistently. Last year the Equality and Human Rights Commission produced a report, 'Close to home: an inquiry into older people and human rights in home care' which recommends that local authorities should ensure that the way in which services are commissioned, procured and monitored, adheres to the Human Rights Act. This includes ensuring that services are provided in a way which promotes and maintains dignity with service users having some level of consistency in the care staff that deliver their care

2.8 **High quality care services** - In addition to the above, the Care Act requires councils to ensure that there are high quality social care services available within the local market to meet people's care needs.

**Scope**

3 The forthcoming procurements will address community based care to support Older Persons, Adults Physical Disability, Extra Care, Learning Disability and Children's Physical Disability needs, to continue to live independently within the community.

3.1 The resulting contractual arrangements will provide:

- Affordable solution that delivers a consistent and robust standard of care county-wide across Lincolnshire

- An improved and more sustainable care market in Lincolnshire with better long term prospects for providers to strengthen their business operations

- A market which is more capable of meeting and further able to meet changing/increasing need.

- Improved care/support outcomes through a closer and more strategic relationship with providers which will be greatly enhanced by reducing the current competitive and commercial inefficiencies within the sector.

- A county-wide approach to the management of a community support services backed by a re-structured Commercial and Contract Management team along with Brokerage and Operations.

- A strong foundation from which to work with home care providers to move to outcomes based working which will be explored and developed within the term of the contracts.

**Commercial Model**

4 Work to date has covered a variety of approaches in how to effectively commission the range of community care services required by the Council. The existing Community Support arrangement operates as an open framework consisting of a group of providers that have been assessed as

qualified and sufficiently capable of providing care to the Council's standards. This list has been refreshed periodically to keep the pool of available providers manageable and timely as well in order to help the Council address unmet needs. However this model along with work in contract mangement and brokerage has not been able to sufficiently rationalise the large number of providers across Lincolnshire within the homecare market.

4.1 In contrast the Community Supported Living market contains a much more consolidated market position with 95% of council spend only with 10 providers. Furthermore there are significant differences in how CSL is delivered operationally which is set out below.

4.2 These two key differences between Homecare and CSL allow the Council to explore different approaches which address the specific commercial characteristics of each element and maximise the potential benefits of both.

**Homecare and the Prime Provider Model for OP/PD**

5 Cost pressures within the Council mean that any resolution to the market's demand for change cannot be solely met by an increase to the rate. Any increase must be bound by what is affordable and economic to both the Council and the market.

5.1 A natural product of the extensive fragmentation in the market is that operating costs are replicated across every provider and in turn that cost is redistributed back to the Council in addition to the internal costs of managing so many providers across the County.

5.2 Furthermore the lack of guaranteed demand with any particular provider means that business are less able to achieve a sustainable financial footing which in turn affects their ability to retain staff and ensure they are able to meet demand. The inability of many home care providers to establish a sustainable, well-trained workforce with sufficient capacity to meet needs has been a significant factor in limiting care choice for service users. As demand increases the requirement to have a stronger, more skilled workforce with greater capacity will become more and more vital.

5.3 Continuing in a framework model will not properly address the cost pressures that result from market fragmentation. By guaranteeing a committed level of demand to a smaller number of providers many of the pressing issues faced by businesses would be addressed. In giving this certainty of income the provider can then 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.

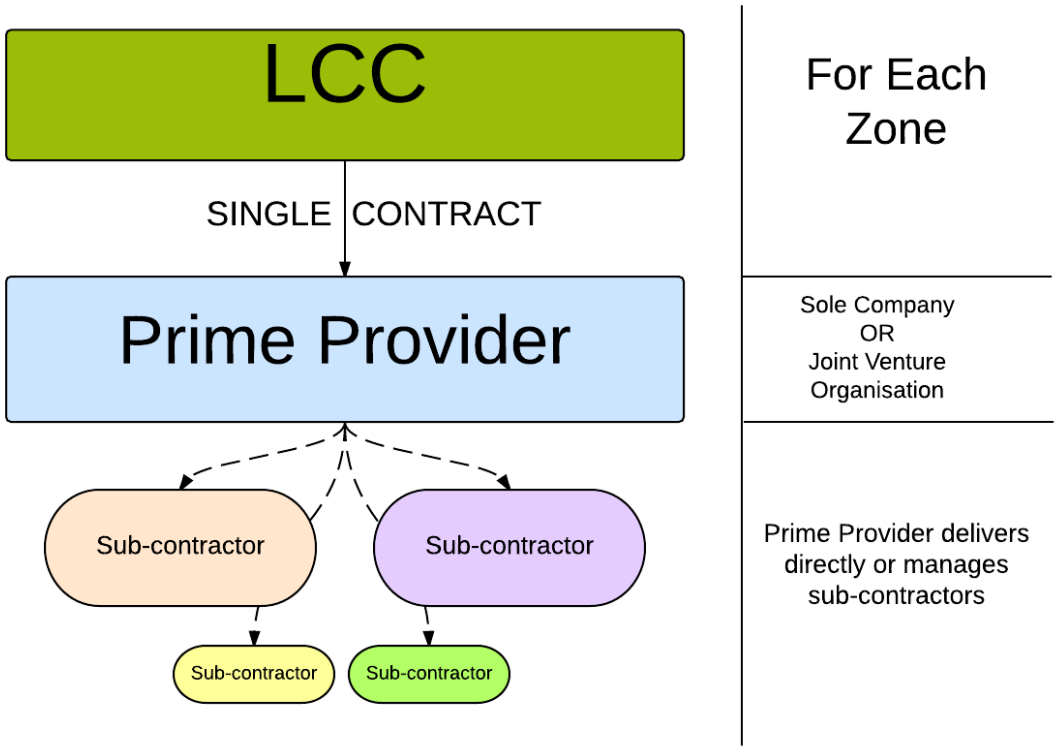
5.4 This block of guaranteed volume is set at a rate designed to be affordable to the Council and attractive to the market and has been calculated based

upon detailed modelling on the component costs of providing home care in Lincolnshire which is addressed further in section 8.

5.5 The Council must ensure that any additional demand over and above the block element is managed closely with providers to ensure as much is as possible that they are able to deliver this successfully. Any shortfall in the ability to meet additional demand will be mitigated through the construction of the contractual terms and conditions, specifically in how other prime providers or sub-contractors may be able to step-in to meet this need.

5.6 However it will be made clear from the outset that a prime provider will be contractually responsible for ensuring they are able to meet demand within their area.

**Prime provider structure**




**Prime Providers lots**

6 Providing guaranteed volume through a prime provider model will only be a viable solution for the Council and the market if the number of agreements is set at a number that in turn equates to a sufficient amount of work so as to allow providers a strong cost base to work from.

6.1 By arranging contracts into larger strategic blocks as well as providing a new rate based on an objective cost assessment of home care activities the Council will be able to achieve a position wherein it can be satisfied the new

agreements it will make with the market are fair, sustainable and will result in good quality care for service users.

6.2 In determining the number of providers for the new model depends upon a number of factors:

6.3 **Cost & Duration**

A core principle of the Prime Provider model is that greater commitment of demand creates a stronger commercial base for a provider and as such will help support them deliver better value back to the Council. Similarly by guaranteeing this demand for a longer period of time would further strengthen a prime provider's ability to establish a sound base of business. This commitment will increase economies of scale for providers as well as allow them to build better business plans, optimise resources, and the opportunity to plan care routes better thus improving efficiency and lowering costs. Furthermore the increased resource and commitment to providers will allow them to develop more sustainable workforce that will have greater strength and flexibility to meet demand.

6.4 **Operational activity**

The Council currently operates on an area team basis roughly divided into 6 main zones with 2 area teams per zone. These areas are divided up primarily by a relatively equal distribution of the number of clients receiving care and the overall population. There are differences in the sizes of each area in sq. miles as well as the mix of urban and rural areas within each zone. Taken overall this already existing operational model provides strong basis for dividing prime provider lots into zones and areas, either six zones or twelve areas (two areas per zone) See Appendix B for an overview of the zones and summary of the approximate value of each zone/area.

6.5 **Impact on the market**

An inevitable result of any rationalisation of the number of contracts the council employs to deliver home care may result in the reduction of the absolute number of providers within the market. However there is scope within the market for a significant degree of consolidation of a number of providers to join together to represent a viable bid for any potential lot which may be too large to deliver alone. Please see Appendix A for an overview of the top providers in Lincolnshire and their geographic spread.

6.6 **Risk and flexibility**

In addition to this the Council should also give regard to the resulting balance of risk that follows from awarding a too much work to a single provider. Any hypothetical award of the majority of the available lots, and therefore overall market share, may result in too few a number of remaining providers in the market. This would then limit the ability of the Council to adapt to any market factors e.g. if another prime provider were unable to continue delivering services having only a

few other available providers may lead to significant disruption. However if the number of prime providers is set at an reasonable level this should increase the Council's ability to manage risk as well as provide greater flexibility of service provision. This factor would also addresses the Council's requirement under the Care Act to effectively manage the market and address the risks of market failure.

6.7 **Service User choice**

Related to the points already raised the issue of service user choice should be properly considered. Any reduction in the overall number of providers may ostensilby appear to result in a reduction in the choice any service user may have. The Care Act states the importance of allowing a recipient of care the ability to make choices about how it is delivered. The act does not stipulate specific measure with regard to how any particular commercial arrangement must conform to or support this requirement. If, for example, the decision to be taken was to establish a single contract with one provider for the entirety of the Lincolnshire area then this level of restriction could be regarded as a de facto limitation of choice as such a monoply would very likely squeeze out other competitors. For the reasons already set out it is not recommended to enter into such a monolithic arrangement and by ensuring there are a good number of stable and high performing providers across the county service user choice may in fact increase. An important factor resulting from the heavy market fragmentation alongside the continuing difficulty to effectively meet demand there have been circumstances wherein a service user may be within the operating boundaries of many providers but none are able to fulfil this requirement due to a lack of operational capacity or it being uneconomic. By stabilising and improving the market through a stronger commercial model the service user may indeed see an actual increase in the availability of quality care options. Furthermore the Service User will continue to have the right to take a Direct Payment and choose their own care provider.

6.8 The upper and lower limit of providers that will be awarded contracts must be clear. No fewer than six and no more than twelve appears to be the bounds to which the existing market can realistically have an opportunity to be involved as well as ensuring that the rationale for moving to a prime provider model is not undermined.

6.9 As stated previously the decision as to how prime provider lots are awarded is of critical importance due to the effect it will have on the market by either the size of the opportunity being too large for any local provider and also too small so as to restrict the existing business of the larger providers.

6.10 As part of the procurement evaluation methodology there will be measures to allow the council the ability to decide as to how best the allocation of lots are awarded both in terms of value for money, the impact on the market and ensuring there is sufficient supply of services throughout the county. By establishing that there will be an upper and lower limit for number of

providers that will be awarded a contract as well as setting out clear evaluation principles in how any ultimate decision will be reached it would allow the market to offer solutions and the Council to make an informed decision as to what is the overall best make up of service delivery and value for money.

6.11 A key phase in the procurement will be in how organisations are assessed and qualified to proceed to the tender stage. As previously stated the impact of moving to a prime provider model will have a clear impact on the large number of small and medium sized providers in Lincolnshire. This impact can be mitigated through the ability of providers to offer a consortium or Joint Venture bid thus allowing those smaller providers who may collaborate with others the opportunity to tender for the contract. The Council must therefore have a clear understanding of the level of financial and business capacity a tenderer must have before being allowed to proceed to bid. This must be set at a level that represents an acceptable assessment of the level of risk involved in delivering such a large contract as well as not being unreasonably burdensome and therefore restricting SMEs and consortia bids.

6.12 Furthermore it is recommended to reserve an amount of work that can be delivered directly by a provider which would then be delivered by subcontractors. This would go some way to alleviating some of the pressure that small providers would have under the prime model as there will always remain a pool of work available. By implementing a sub-contracting reservation it would also increase the amount of choice and flexibility in the market. The amount that is reserved must been considered in context with the overall commercial model and that if too a large proportion is required to be subcontracted this may undermine the general principle of economies of scale that a prime provider would rely upon.

6.13 Therefore a reserved element of any prime contract for sub-contracting should be set at a reasonable level i.e. 10% of the individual annual contract value.

6.14 Meeting this target would be a primary target for prime providers and would be contract managed closely. If a prime provider consistently failed to meet this target the Council may choose to allocate any additional demand that a prime provider would normally enjoy to another prime provider.

6.15 However if a Joint Venture or Consortium comprised of SMEs were successful in winning a prime provider contract this would in principle automatically satisfy this requirement.

**Children's Home Care**

7 Childrens home care services for children with disabilities is currently delivered in a block contract of 450 hours a week to a single provider and spot contract arrangement for additional variable demand.

7.1 The current block arrangement includes service elements which will not be required in the new contracts and as such the new model realigns these costs

7.2 As part of this procurement process there is the opportunity to seek offers from the market which may result in a more affordable rate as well as new providers

7.3 It cannot be guaranteed that OP/PD home care providers can in all cases have the skills, qualification and desire to deliver childrens home care alongside the core OP/PD services therefore the procurement process will allow for bidders the option to include a childrens home care solution.

7.4 This option would also be available for specialist childrens home care providers to bid only for this element and not for OP/PD work

7.5 Work would be contracted on a spot basis based upon the geographic make up of children's home care bids and the lead provider for each zone.

7.6 By allowing the option to either award the children's homecare element as part of a prime provider contract or as a separate contract(s) the Council will be able to ensure as much is as possible that there will be a viable, county-wide, sustainable, solution for Children's home care within improved choice for the Council and service users.

**Tender process and Contracting**

8 The Home Care element of community support will procured in a two stage process similar to, but not the same, as a Restricted process with a pre-qualification stage to assess capabilty and a tender stage to evaluate and award contracts.

8.1 The PQQ process will also result in a shorter list of bidders that will then offer a tender. As bidders will state a ranked preference for the lots they wish to tender for there will be a degree of competition across lots with the ultimate decision as to which provider is awarded what based on their evaluation performance.

8.2 ITT evaluation will focus on service quality and transitional planning due to the significant risk associated with transferring packages within an appropriate timescale after contracts are awarded.

8.3 Contracts will be awarded to prime providers based upon a clear and unambiguous expectation, backed up by the terms and conditions of each agreement, that they will be responsible for ensuring that the level of demand that is guaranteed to them must be delivered either directly or by a subcontracting arrangement and there is no opportunity for them to ‘hand back’ care packages.

**Community Supported Living**

9 Community Supported Living for people with a learning disability currently operates in a different nature when compared to the homecare element of the community support framework

9.1 Applying a block contract approach to the CSL element for all service user types has been assessed as being unsuitable for a number of reasons. The main features underpinning this assessment are as follows;

- CSL provision is already structured into a quasi-prime provider model with the 'Big Five' Providers accounting for 80% of provision and the top ten providers accounting for 95%
- There is little to no over-lap between CSL and Home Care Providers
- CSL provision is currently more structured to deliver outcomes within a person centred plan
- CSL service users (and their family carers) have already exercised a positive choice over who provides their care and where they choose and continue to live.

9.2 Having discounted the block as a viable option, four other contract options were considered for a discrete 'CSL' service. The most suitable of these options was a CSL specific open framework, the main benefits of which included as follows;

- A framework approach will ensure a high degree of acceptance from providers and service users.
- Maintains good relationships which have been built up with the market and service users
- Maintains existing service provision and continuity of care for 600+ service users.
- Through being 'Open' will allow new Providers to apply, increasing choice and diversity of provision.
- Would be legally compliant with Procurement Regulations under Part current B regulations and the new light touch regimes
- Provides a platform to engage with the Market over future unit rates, which are affordable and within budgetary provision for 2015/16 and future financial years.

9.3 As set out above, the CSL market is already highly structured in comparison to OP/PD home care. There is a pre-existing consolidation on both a geographic and market share for the 'big five' and 'top ten' providers who

account for 80% and 95% respectively. Equally, the sector is capable of responding to changes in demand and has the requisite capacity and level of compeition to ensure that good quality will be borne out from operating the framework.

9.4 Early consultation, specific to existing CSL providers, has taken place in January 2015. The context/purpose of these sessions was to achieve provider buy-in as follows:

- Standalone CSL open framework for people with a learning disability
- Application process with pass/fail criteria
- Retention of existing packages of care
- Tailored LD service specification under the umbrella of the Community Support Programme
- Terms and conditions which sets out how future packages and schemes will be allocated by brokerage & mini-tender etc.
    - Also for the review of existing packages/services, which would allow migration between providers (where required) over time.
- To agree an interim arrangement in respect of Agresso billing arrangements from 1st April 2015 which will be incorporated as standard within the new framework.

9.5 Outside of the top ten there are a number of peripheral bespoke providers it would need to be determined whether, in the circumstances, that they could not agree to the above that a number of individual spot contracts will be put in place to meet the circumstances of delivery . This is in particular regard to specialist services which are delivered under NHS fully funded healthcare and are nurse/specialist led. Individual discussions would also need to be undertaken with the market in respect of reaching a mutual agreement on their future market share within Lincolnshire. Whereas, the prime provider model for OP would approximate to 8.3% provider share one of the CSL already has 28% of the market. Therefore through the operation of an open framework the council can better manage any potential restriction in the choice of suppliers available in Lincolnshire with the utlimate aim of ensuring there is a sustainable and flexible market for CSL.

**Market Rate**

*OP/PD Homecare*

10 Throughout previous negotiations with providers at extensions and new placements there has continued to be a clear message that the existing rate paid for homecare is problematic for the market.

10.1 Work has been undertaken to objectively analyse the economic basis for the rate paid for care taking into account a broad number of factors including minimum wage, travel time and overheads from a number of sources but has been specifically modelled to reflect the costs in Lincolnshire as opposed to any other proposed mechanism such as the United Kingdom

Home Care Association (UKHCA) national model for a minimum price for homecare. Indeed in most aspects both the Lincolnshire rate and those described within the UKHCA model reflect similar attributes in respect of business running costs and profitability, however differences do exist in respect of certain employee cost and travel costs attributed to the rate. The model described in Appendix G gives a detailed rationale as to how specific elements of the rate in which the contract is based was calculated.

10.2 As a result of ongoing engagement with the market and an acceptance of the fact that Lincolnshire is somewhat unusual in its geography compared to may other counties, specifically the overall size and rurality of Lincolnshire, there has been a recognition of the impact this has on providers. In introducing a separate rate for urban and rural activity the Council acknowledges the commercial reality of delivering care to remote areas is more expensive and at the same time that a provider operating in an urban environment will have reduced overheads and will therefore be able to manage cost better. This has recongised areas that have historically been designated as hard to reach and where existing provisions has been made at a premium using the visit tariff scheme where additional payments have been made by the council to provider in order to encourage take up in those hard to reach areas.

10.3 This, alongside the terms and conditions of the subsequent contracts will ensure that care providers are able to deliver agreed packages of care at an agreed quality of care as well as giving assurance that providers are able to meet the requirement to remunerate their staff in line with minimum wage legislation including travel time.

10.4 This equates to a rate of £12.76 for work designated as Urban and £13.05 for Rural work.

10.5 The council has established a methodology to help categorise areas of the county in respect of their ease or otherwise in placing service users. This methodology has identified two distinct categories "Urban" and "Rural". Urban as the term would suggest reflects areas of substantial urban density which results in the ability of the council to consistently place services users with providers and where care workers are able to travel from one location to another in a timely manner. Rural post codes however reflect areas of the county where historically it has been considered 'hard to reach/hard to place' as a result of their distance from established urban centres, and where care workers have to travel a significant distance from one location to another. In determining the total financial envelope of the service, the council established two distinct rates linked to both categories. Both rates are identical apart from the element used to establish the hourly cost of travel which is included in the overall rate. The differential between the two rates is based upon the UKHCA model that suggests 9% extra of base hourly rate on travel time be applied to costs linked to services supplied in urban areas and 13% to those provided in non-urban/rural areas.

10.6 As previously stated the new rates are not however the sole factor in constructing a more economically attractive offer to the market. Taken alongside the clear commitment of business to a prime provider over an extended period significantly improves the opportunities to providers to manage risk and costs within their business.

10.7 For each zone awarded the Prime Provider will be guaranteed a block of demand each year. The following table shows a breakdown of each area and the indicative levels of demand that would be attributed to each area and provider.

| Area | Rate Type | Total Hours Available | Block Element | Estimated Additional | Total |
|---|---|---|---|---|---|
| **Market Rasen** | Urban | 0 | £0 | £0 | £1,698,669 |
| | Rural | 131,192 | £1,369,640 | £329,028 | |
| **Louth** | Urban | 141,911 | £1,448,627 | £348,249 | £1,978,390 |
| | Rural | 14,019 | £146,355 | £35,159 | |
| **Boston** | Urban | 123,231 | £1,257,945 | £302,410 | £2,395,207 |
| | Rural | 64,477 | £673,143 | £161,709 | |
| **Skegness** | Urban | 91,624 | £935,293 | £224,844 | £2,248,142 |
| | Rural | 84,029 | £877,261 | £210,744 | |
| **Lincoln** | Urban | 128,891 | £1,315,716 | £316,298 | £1,838,066 |
| | Rural | 15,914 | £166,141 | £39,912 | |
| **Gainsborough** | Urban | 77,741 | £793,575 | £190,775 | £1,790,174 |
| | Rural | 62,235 | £649,737 | £156,086 | |
| **Hykeham** | Urban | 131,238 | £1,339,679 | £322,058 | £1,753,155 |
| | Rural | 7,060 | £73,710 | £17,707 | |
| **Lincoln South** | Urban | 47,102 | £480,814 | £115,587 | £1,565,101 |
| | Rural | 74,815 | £781,065 | £187,635 | |
| **Grantham** | Urban | 119,882 | £1,223,755 | £294,190 | £2,402,037 |
| | Rural | 68,280 | £712,845 | £171,247 | |
| **Sleaford** | Urban | 32,755 | £334,360 | £80,380 | £1,667,229 |
| | Rural | 96,732 | £1,009,884 | £242,604 | |
| **Spalding** | Urban | 90,878 | £927,686 | £223,016 | £2,787,429 |
| | Rural | 126,408 | £1,319,697 | £317,031 | |
| **Stamford & Bourne** | Urban | 165,866 | £1,693,158 | £407,035 | £2,767,661 |
| | Rural | 51,550 | £538,181 | £129,287 | |

10.8 These zones and the representative work contained within them may be subject to minor alteration and refinement at procurement.

10.9 As a result prime providers would be awarded a guaranteed level of income for the forecasted demand within that area which has been constructed from a new urban and rural rate which is higher than the current rate offered. Any additional demand over this initial block element would be offered to the prime provider at a lower rate of £12.27 for Urban work and £12.54 for Rural work.

*Community Supported Living*

10.10 A separate rate for CSL has also been constructed based upon the same analysis for the OP/PD rate but taking into consideration the more specialist nature of care involved as well as the particular market characteristics which can be seen in Appendix F.

10.11 This sets a maximum rate of £13.30 per hour within the CSL framework which providers must operate within. They in turn may take the commercial choice to offer services at a lower rate.

*Children's Home Care*

10.12 The rate for Children's home care has been constructed separately to recognise the specific nature of the service which can be seen in more detail in Appendix E.

10.13 This sets an urban rate at £18.67 per hour and a rural rate at £19.16 per hour and demand will be first offered to the provider which is awarded the respective area.

**Market Engagement**

11 A pre-tender market engagement stage is currently underway in February 2015 which shares the Council's rationale for moving to the new model.

11.1 As much as is reasonable the Council will endeavour to offer support and guidance to SMEs which may be interested in providing a joint bid. The timescales currently planned for are challenging for organisations to organise and collaborate in order to be able to achieve a Joint Venture or Consortium. However it will not be required that any prospective JV or consortia will be legally established at the outset of the procurement the expectation there being that a qualifying organisation made up of multiple providers must be able to satisfy all PQQ requirements and that if this JV subsequently is offered a lot under the contract at that point they must be able to prove that they have successfully founded the new organisation in order to be awarded the contract.

11.2 Additional support to the market has been arranged in early march to help providers who may be considering JV or Consortium bidding through two

workshops that will deliver training on the skills, requirements and steps necessary for launching a joint bid.

11.3 There has been a series of roadshow events over the last year which engaged with a majority of the homecare market on a range of issues. While the choice of a prime provider model has only recently been shared in February 2015 many of the issues previously raised have informed the design of this model namely;

- Greater recognition of the cost implications of operating in rural, hard to reach, locations.
- The need for a better, more sustainable workforce with a better retention rate
- Better management of demand and capacity across the county

**Contract Length**

12 As the one of the core principles of the Prime Provider model is that greater commitment of demand creates a stronger commercial base for a provider and as such will help support them deliver better value back to the Council. Similarly by guaranteeing this demand for a longer period of time would further strengthen a prime provider's ability to establish a sound business base.

12.1 The proposed duration for the Community Support Contracts and the CSL framework would therefore be for an initial period of 3 years with an extension period of a further 1+1 years years giving a maximum duration of 5 years.

**Transition & Mobilisation**

13 Once the prime provider model has been introduced to the market in February 2015 there will be a period of up to 6 months before new contracts are awarded wherein an existing provider may consider their ability to tender and continue operating as untenable. Given the overall number of providers in the market this is a likely to be a high probability.

13.1 Work will continue to address transitional risks throughout the procurement phase and, of equal importance, once the new contracts are awarded how care packages are continued and transferred without serious disruption. Working groups have been establish to identify and plan for the issues that may arise through transition

13.2 At contract award all new packages will be given to the prime provider and the priorty will then be for those providers to effect the transfer of all care packages from historic providers to the new arrangment within 3 months and for exceptional cases no later than 6 months from award.

13.3 CSL transfers will be more easily managed due to the nature of the framework agreement and the smaller numbers of providers. Furthermore through staggered mini-competitions the Council will be able to better manage the placement of new packages of care under the CSL thus avoiding a single stage, all-encompassing transfer.

**Legal Issues**

**Procurement implications**

14 Both home care and Community Supported Living are currently classified as Part B services and as such are not bound by the full scope of the Public Contracts Regulations 2006.

14.1 At the time of this report the Public Contracts Regulations 2015 are being passed through parliament and will come into effect on 26th February 2015 . The new change in law for the services in question relates to the publication requirements i.e. services currently classified as Part B services (i.e. Social Care) over a threshold value of €750,000 will be required to publish a contract notice in the Official Journal of the European Union. However, as with a Part B procurement under the existing Regulations, the Council will continue to have flexibility in how it structures and manages the competition as long as the EU treaty principles of equal treatment, transparency, proportionality and non-discrimination are respected

14.2 An extension to the current Children's Home Care contracts will be necessary to align with the award of any children's home care bids through this procurement.

14.3 The value of these extensions is approximately £380,000 and as such would not be bound by the full scope of the Public Contracts Regulations 2006 or 2015 as it is Part B under the former and below the forthcoming €750,000 light regime threshold under the latter. This means the Council is not required to go through the pre-contract advertising requirements of the Regulations. However, the Council is still bound by general EU Treaty obligations of transparency, equal treatment and non-discrimination. The EU Commission has issued a communication that confirms that the EU Treaty principles generally require a degree of advertising sufficient to enable the market to be opened up to competition

14.4 Even so the Treaty obligations will not require a competitive process if the Council considers that the contract would not potentially be of interest to a contractor in another EU member state. The Council must put its mind to that before embarking on a procurement exercise. A justification after the fact will not be sufficient.

14.5 The Commission communication identifies a number of considerations that the Council must take into account in forming its judgment on the point as follows

- The subject matter of the contract
- Its estimated value
- The size and structure of the market, commercial practices of the sector
- Geographic location of the place of performance

14.6 In this case the low value and the limited duration of the extension and the need for local provision mean that it is not considered that the extension would be of interest to a contractor in another EU member state

**Public Services Social Value Act**

15 In January 2013 the Public Services (Social Value) Act 2013 came into force. Under the Act the Council must before starting the process of procuring a contract for services consider two things. Firstly, how what is proposed to be procured might improve the economic social and environmental wellbeing of its area. 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.

15.1 Environmental benefits are secured by ensuring that the new model allows providers to optimise the need for travel as effective route planning will be a key element in both the expectation of the Council and as it will reduce provider overheads. Moreover it is clear that a stronger and well-resourced community support service will have the potential to deliver increased social and economic benefits to the area by;

15.2 Helping people live at home for longer; helping relieve pressure on acute hospitals, care homes, and the wider health system by assisting with front line care and preventing avoidable admissions to hospital;

15.3 Under section 1(7) of the Public Services (Social Value) Act 2013 the Council must consider whether to undertake any consultation as to the matters referred to above. The service and the value it delivers is well understood. Best practice recently adopted elsewhere has been reviewed. This and the market consultation carried out is considered to be sufficient to inform the procurement. It is unlikely that any wider consultation would be proportionate to the scope of the procurement.

**Best Value**

16 The Local Government Act 1999 imposes a “best value duty” on the Council. This creates a legal obligation on the Council to

16.1 " make arrangements to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness."

16.2 For the reasons set out in this Report, the new models for commissioning these services are considered to secure a combination of economy efficiency and effectiveness in the delivery of the services that is a significant improvement on the existing arrangements.

16.3 Section 3 of the 1999 Act places a duty on the Council, the purpose of deciding how to fulfil the above duty, to carry out consultation with specified persons

16.4 However, recent case law suggests that consultation should be on high level choices about how, as a matter of principle and approach, an authority goes about performing its functions. High-level choices would include a major outsourcing but would not extend to operational decisions about how a local authority delivers certain functions. In this case the recommendation is to continue to outsource Community Support Services on behalf of the Council. The commcerial model as set out primarliy addresses market issues and ensure that service user services are maintained and choice is not curtailed. In these circumstances the proposals are considered to be operational and not to trigger a duty to consult under section 3 of the 1999 Act. For the same reasons it is not considered that a general duty to consult arises

**Equality Act 2010**

17 The Council's duty under the Equality Act 2010 needs to be taken into account by the Executive when coming to a decision.

17.1 The Council must, in the exercise of functions, have due regard to the need to:

i. (Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
ii. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
iii. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it: Equality Act

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

i. Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
ii. 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;
iii. 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.
iv. 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.
v. 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.

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

17.4 The relevant protected characteristics are:
i. Age
ii. Disability
iii. Gender reassignment
iv. Pregnancy and maternity
v. Race
vi. Religion or belief
vii. Sex
viii. Sexual orientation

17.5 A reference to conduct that is prohibited by or under this Act includes a reference to:
i. A breach of an equality clause or rule
ii. A breach of a non-discrimination rule

17.6 It is important that the Executive is aware of the special duties owed to persons who have a protected characteristic as the duty cannot be delegated and must be discharged by the decision maker. The duty applies to all decisions taken by public bodies including policy decisions and decisions on individual cases and includes this decision.

17.7 To discharge the statutory duty the Executive must consider 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.

17.8 An Impact Assessment has been completed for both the home care element and CSL element of the reprocurement which addresses the risk of adverse impact on service users which can be found as Appendix C, Appendix D and Appendix H.

17.9 Before moving to adverse impacts, it is fair to say that the key purpose of the service is essential to enabling all those individuals who require community care services to live more independent and healthier lives. In that sense the delivery of the service helps to advance equality of opportunity. The providers ability to provide services which advance equality of opportunity will be considered in the procurement and providers will be obliged to comply with the Equality Act.

17.10 It is also true that eligibility to receive services is assessed against criteria that are neutral between people with a protected characteristic and others.

17.11 However, there are potential adverse impacts in relation to home care on older people, women and people with a disability relating principally to the possibility that although services remain the same the identity of the provider may change. This can cause distress to vulnerable people. The impact can be mitigated however by the way in which that transiiton is handled and the Council will ensure that it is plannned and carried out in such a way as to mimimise the disruption that people will experience. The impacts are considered negligible in relation to the CSL Framework as the model of delivery is not changing and many of the same providers can be expected to be on the framework

17.12 In the event of continued out-sourcing there may also be the potential for some impact on persons with a protected characteristic arising principally out of the employment impact on staff. Mitigating factors will relate to the legal protections that will be in place through TUPE and general employment laws. The contract that will be entered into will also contain clauses requiring the contractor to comply with the Equality Act.

17.13 In relation to Chidlren's Home Care Service the impacts will potentially be on young people with a disability. Again the impacts come from the possible change of provider and can and will be mitigated in the same way. Detail of mitigation is set out in the Impact Assessment.

17.14 In these circumstances it is open to the Executive Councillor to conclude that having considered the duty it considers that if appropriate steps are taken to keep matters under review and address issues as they arise through the procurement process that any potential there is for differential impact or adverse impact can be mitigated. The Executive Councillor is also entitled to conclude that when balanced against the benefits of the new arrangements it is appropriate to proceed

**Child Poverty Strategy**

18 The Council is under a duty in the exercise of its functions to have regard to its Child Poverty Strategy.

18.1 The strategy identifies that poverty is not only a matter of having limited financial resources but that it is also about the ability of families to access

the means of lifting themselves out of poverty and of having the aspiration to do so. The following four key strategic themes form the basis of

18.2 Lincolnshire's Child Poverty strategy: Economic Poverty, Poverty of Access, Poverty of Aspiration and Best Use of Resources.

18.3 The Child Poverty Strategy has been taken into account in this instance and the specific nature of the services to be provided under the proposed contracts are relevant as a small proportion of care activity will be delivered to children with disabilities which supports the key theme of Poverty of Aspiration within the strategy by increasing as much is as possible the access to services to Children with disabilities.

**Wellbeing Strategy (JHWS)**

19 The Council is under a duty in the exercise of its functions to have regard to its JSNA and its JHWS.

19.1 The JSNA for Lincolnshire is an overarching needs assessment. A wide range of data and information was reviewed to identify key issues for the population to be used in planning, commissioning and providing programmes and services to meet identified needs. This assessment underpins the JHWS 2013-18 which has the following themes:-

i. Promoting healthier lifestyles
ii. Improving the health and wellbeing of older people
iii. Delivering high quality systematic care for major causes of ill health and disability
iv. Improving health and social outcomes and reducing inequalities for children
v. Tackling the social determinants of health

19.2 Under the strategic theme of improving the health and wellbeing of older people in Lincolnshire there are 3 priorities 3 are relevant;

19.3 Spend a greater proportion of our money on helping older people to stay safe and well at home

19.4 Develop a network of services to help older people lead a more healthy and active life and cope with frailty

19.5 Spend a greater proportion of our money on helping childrern in care stay safe and well at home

19.6 The Community Support Service will contribute directly to these priorities.

**Care Act 2014**

20 The new Care Act 2014 comes into force on 1 April 2015. The new Act contains in section 5 a duty to promote the efficient and effective operation of a market in care services with a view to ensuring that any person in its area wishing to access services in the market has (i) a variety of providers to choose from providing (taken together) a variety of services; (ii) a variety of high quality services to choose from and (iii) suffcient information to make an informed decision about how to meet their care and support needs.

20.1 The section lays down a number of matters the Council must have regard to in performing its duty including ensuring sustainability of the market, best value, the importance of fostering a workforce capable of ensuring the delivery of high quality services.

20.2 Regard has been had to these matters in putting forward the above proposals.

20.3 Further statutory guidance has been issued in relation to the above duty. This identifies additonal requirements that it is worth identifying, particularly in relation to the setting of rates. These include:-

- The Council assuring itself that fee levels are appropriate to provide the delivery of agreed care packages with agreed quality of care;
- Allowing providers to meet at least national minimum wage and provide effective training for staff and retention of staff
- The Council having regard to guidance on minimum fee levels necessary to provide it with the assurance referred to above taking account of the local economic environment
- Not taking any steps that would threaten the sustainability of the market as a whole, for example by setting fee levels at a rate below a level that is sustainable for providers in the long term.

20.4 Again these matters have been taken into account. In particular in setting the proposed rates regard has been had to sustainability. The rates are set having regard to actual levels of cost in Lincolnshire and therefore in the local economic environment. Regard has also been had to shaping a market so that it is able to operate in a way to manage within the rates set. National minimum wage and staff development and retention have been central to considerations in setting the rate. The rate is not considered to be below a sustainable rate for the provision of a variety of quality services in Lincolnshire

**2. Conclusion**

Community Support Services are a fundamental part of the care system in Lincolnshire which plays a critical role in the overall healthcare system. By enabling service users to live longer at home this improves their quality of life and reduces pressures on already overburdened residential homes and hospitals.

The challenges within the homecare market alongside the financial constraints the council operates in means there are few easy options available however by rationalising the market into the prime provider model many of the issues that are affecting the sector will be addressed.

The focus of the procurements will be; to establish a network of prime providers across the county that will be able to fully meet the quality requirements set out by the council, guarantee that they are able to properly meet demand and acting as a prime provider manage the subcontractor market effectively.

The Community Supported Living Framework will continue to operate with the stable pool of providers to ensure care packages continue seamlessly and, alongside the homecare contracts, move to a consistent approach to how care is paid for as well seek to strengthen the market within in Lincolnshire.

**3. Legal Comments:**

The Council has the power to enter into the proposed contracts which are required to meet Council statutory duties.

The legal considerations are dealt with in detail in the Report including the way in which the proposals meet the market shaping duties that the Council will be required to meet when the Care Act 2014 comes into force on 1 April 2015.

The decision is consistent with the Policy Framework and within the remit of the Executive Councillor if it is within the Budget

**4. Resource Comments:**

The council has decided to procure its Home Support service for Older People via a Cost and Volume arrangement as opposed to the current framework process. This is due to increasing cost pressures within the Council that has meant that any resolution to increased demand within the home care market cannot be solely met by an increase to the existing rate. Any increases in cost must be affordable and economic to the council. It is estimated that the additional costs of the new arrangements will fall within Adults Care's budget envelope in 2015/16 and beyond. The council are also looking to increase the proposed rate it pays to providers of Community Support Living services for those with a Learning Disability, again it is estimated that the additional costs of the new rate will fall within Adults Care's budget envelope in 2015/16 and beyond.

## 5. Consultation

### a) Has Local Member Been Consulted?

Yes

### b) Has Executive Councillor Been Consulted?

Yes

### c) Scrutiny Comments

This matter is to be considered by the Adults Scrutiny Committee on 25 February 2015 and their comments will be reported to the Executive Councillor prior to the taking of the decisions

### d) Policy Proofing Actions Required

See Legal Issues section above

## 6. Appendices

| These are listed below and attached at the back of the report | |
|---|---|
| Appendix A | Appendix A - Community Support Provider Analysis |
| Appendix B | Appendix B - Lincolnshire Zones |
| Appendix C | Appendix C – Impact Analysis CS model |
| Appendix D | Appendix D - CSL Impact Analysis |
| Appendix E | Appendix E - Financial Costing Model Children's |
| Appendix F | Appendix F - CSL Rate Modelling.docx |
| Appendix G | Appendix G - Community Support Modelling.xlsx |
| Appendix H | Appendix H - Impact Analysis – Children's Domiciliary Care |

## 7. 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 Alex Craig, who can be contacted on 01522 554070 or alexander.craig@lincolnshire.gov.uk.

**APPENDIX A**

# Community Support Provider Analysis

## Prime Provider Model

The proposed model in the new Community Support re-procurement is there will be a prime provider awarded a contract for home care based on a geographical model. These zones are predicated on the Area Teams in Lincolnshire

## Provider Spend Summary

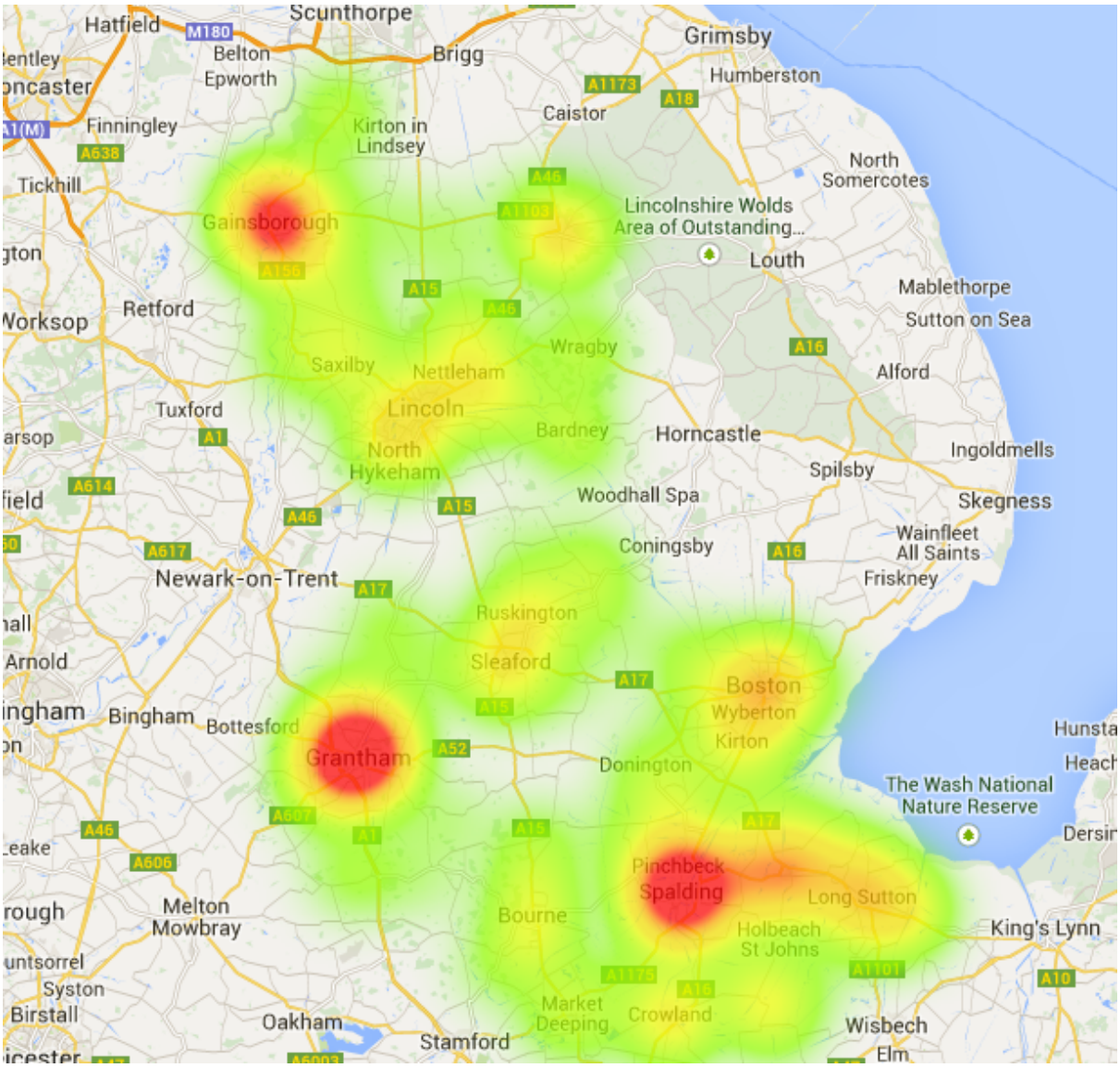
The table below shows a total of the Council's homecare spend with providers based on 29 weeks of data provided by Brokerage. Providers that have multiple bases in Lincolnshire have been aggregated and the total spends then increased by a factor of 1.79 to represent a full year of spend. The second figure represents the One Year Projection with an additional 30% to represent non-council funding thus showing an estimate of the annual turnover for any one organisation.

| Provider Spend | | |
|---|---|---|
| **Provider** | **One Year Projection** | **One Year Projection + 30%** |
| Allied | £3,182,251.51 | £4,136,926.96 |
| Walnut Care | £2,375,953.24 | £3,088,739.21 |
| Hales | £1,703,553.94 | £2,214,620.12 |
| MiHomecare | £1,625,907.89 | £2,113,680.26 |
| Compleat Care | £1,362,938.77 | £1,771,820.41 |
| Care UK | £1,112,342.28 | £1,446,044.97 |
| Care Watch | £1,028,769.90 | £1,337,400.88 |
| Bloomsbury | £803,218.16 | £1,044,183.61 |
| HICA | £718,754.58 | £934,380.95 |
| Country Court Care | £657,301.77 | £854,492.29 |
| Alderson Libertas | £643,314.17 | £836,308.42 |
| Housing 21 | £630,183.39 | £819,238.41 |
| Clarriots | £606,904.17 | £788,975.42 |
| Home From Home Care | £456,416.69 | £593,341.69 |

**National Providers not in Lincolnshire or only nominally (not exhaustive)**

- Home Instead
- Carers trust
- Caremark
- Mencap
- Voyage
- Bluebird
- Saga
- Mears Group
- City & County
- Sevacare
- Agincare
- Sterling Homecare
- Interserve

## Allied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Lincolnshire Wolds Area of Outstanding...
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Mablethorpe
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Lincoln
Tuxford
Bardney
Horncastle
A1
Ingoldmells
North Hykeham
Spilsby
A614
Woodhall Spa
Skegness
A46
A15
Wainfleet All Saints
A617
Coningsby
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Newark-on-Trent
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Friskney
Ruskington
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Wyberton
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Melton Mowbray
Long Sutton
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Holbeach St Johns
King's Lynn
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A1101
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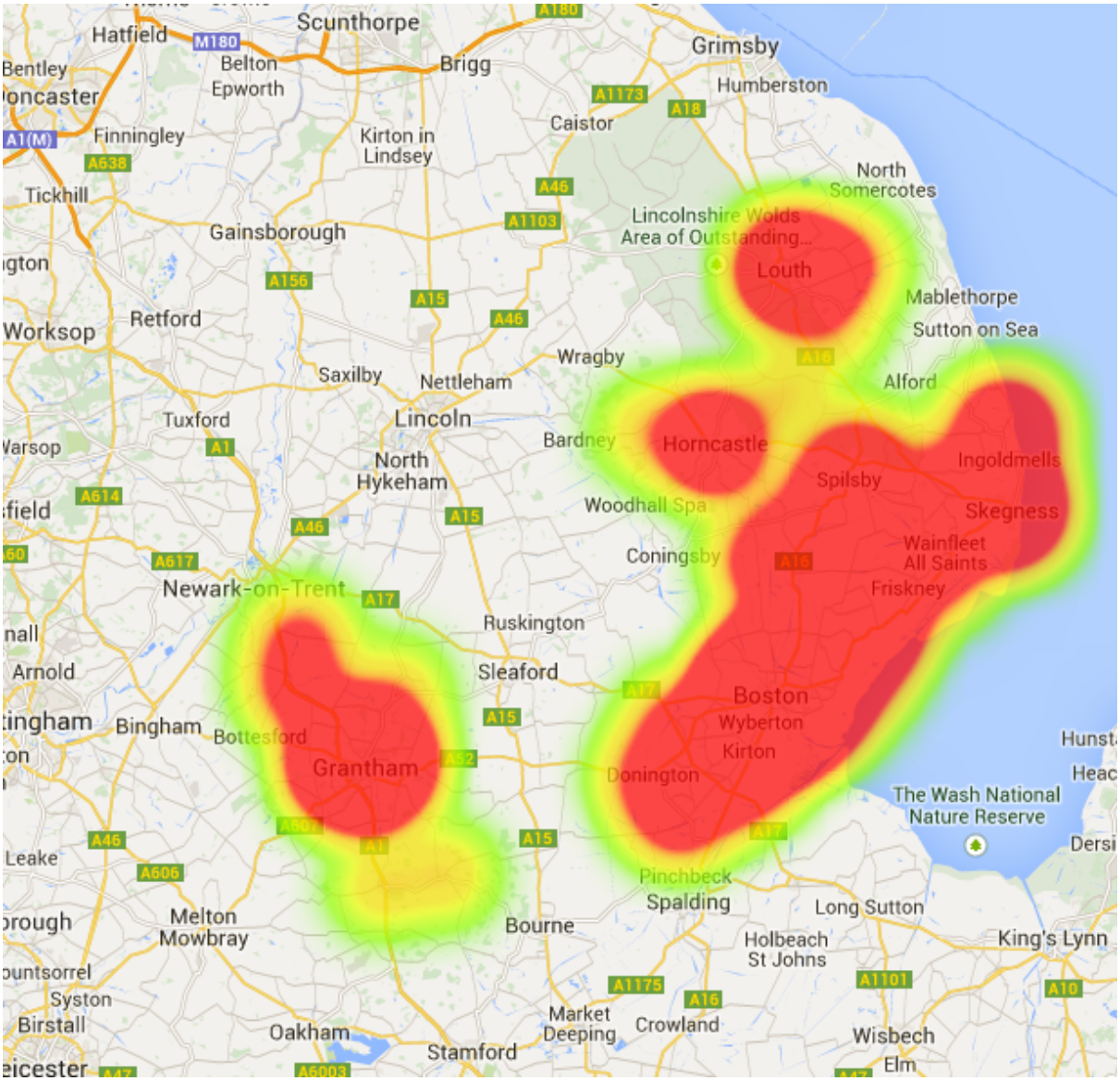
Syston
Birstall
Market Deeping
Crowland
Oakham
Stamford
Wisbech
Elm

**Walnut**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Wainfleet All Saints
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Boston
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Bottesford
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Grantham
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Melton Mowbray
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King's Lynn
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Syston
Birstall
Market Deeping
Crowland
Oakham
Stamford
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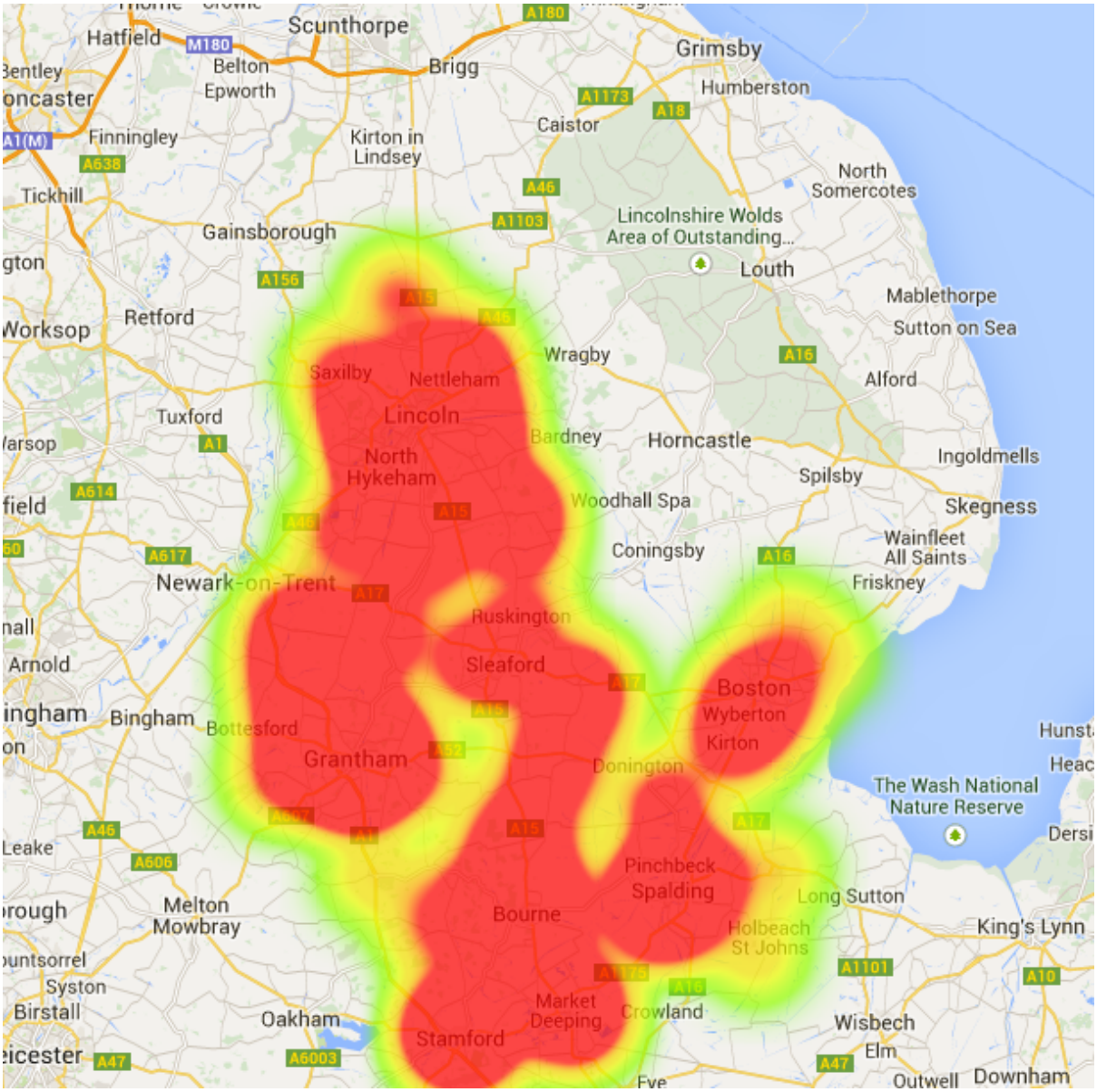
Elm
A6003

**Hales**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Bingham
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Pinchbeck
Spalding
Long Sutton
Bourne
Holbeach St Johns
King's Lynn
Syston
Birstall
Oakham
Market Deeping
Crowland
Stamford
Wisbech
Elm
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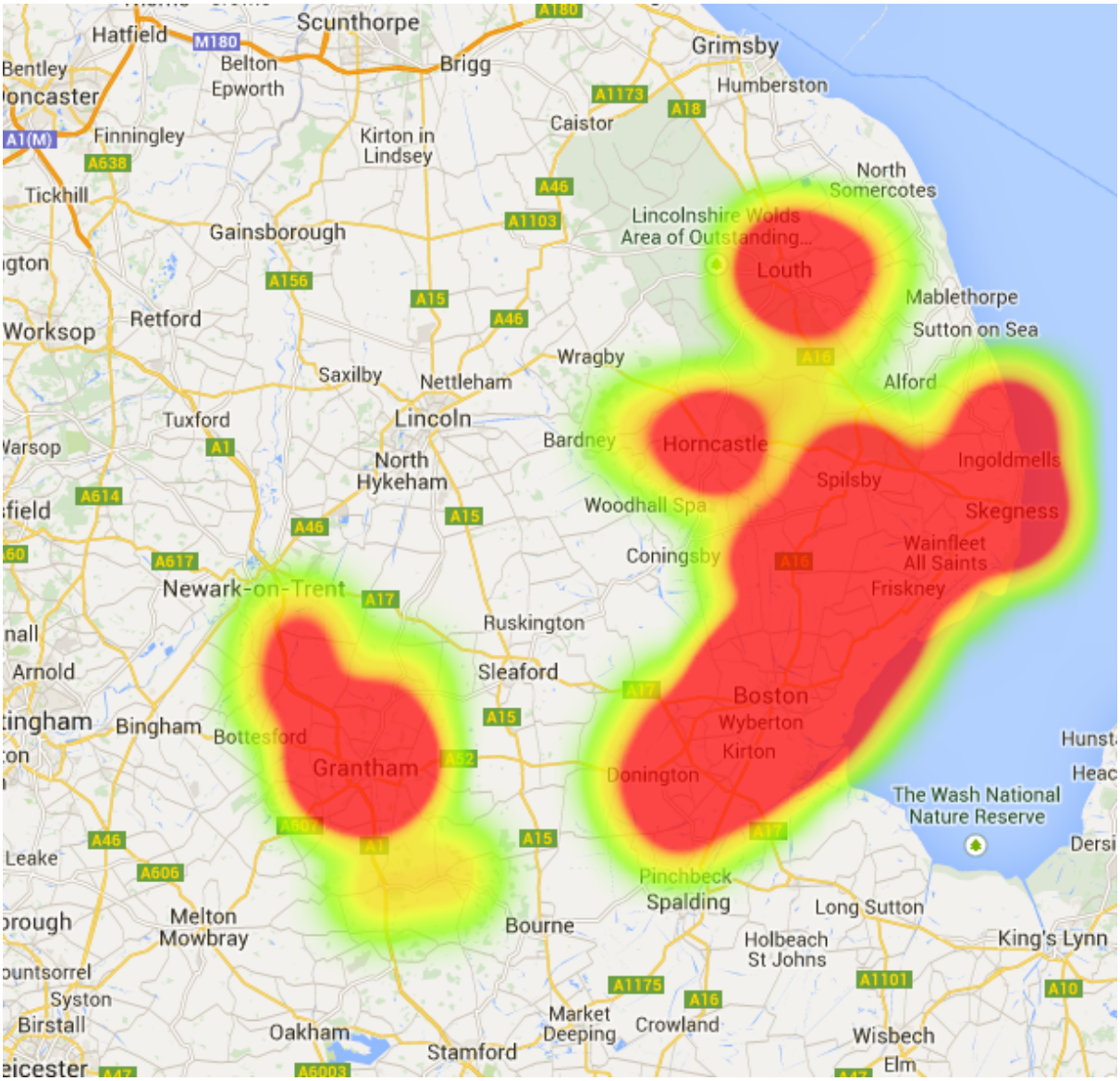
Downham

**MiHomecare**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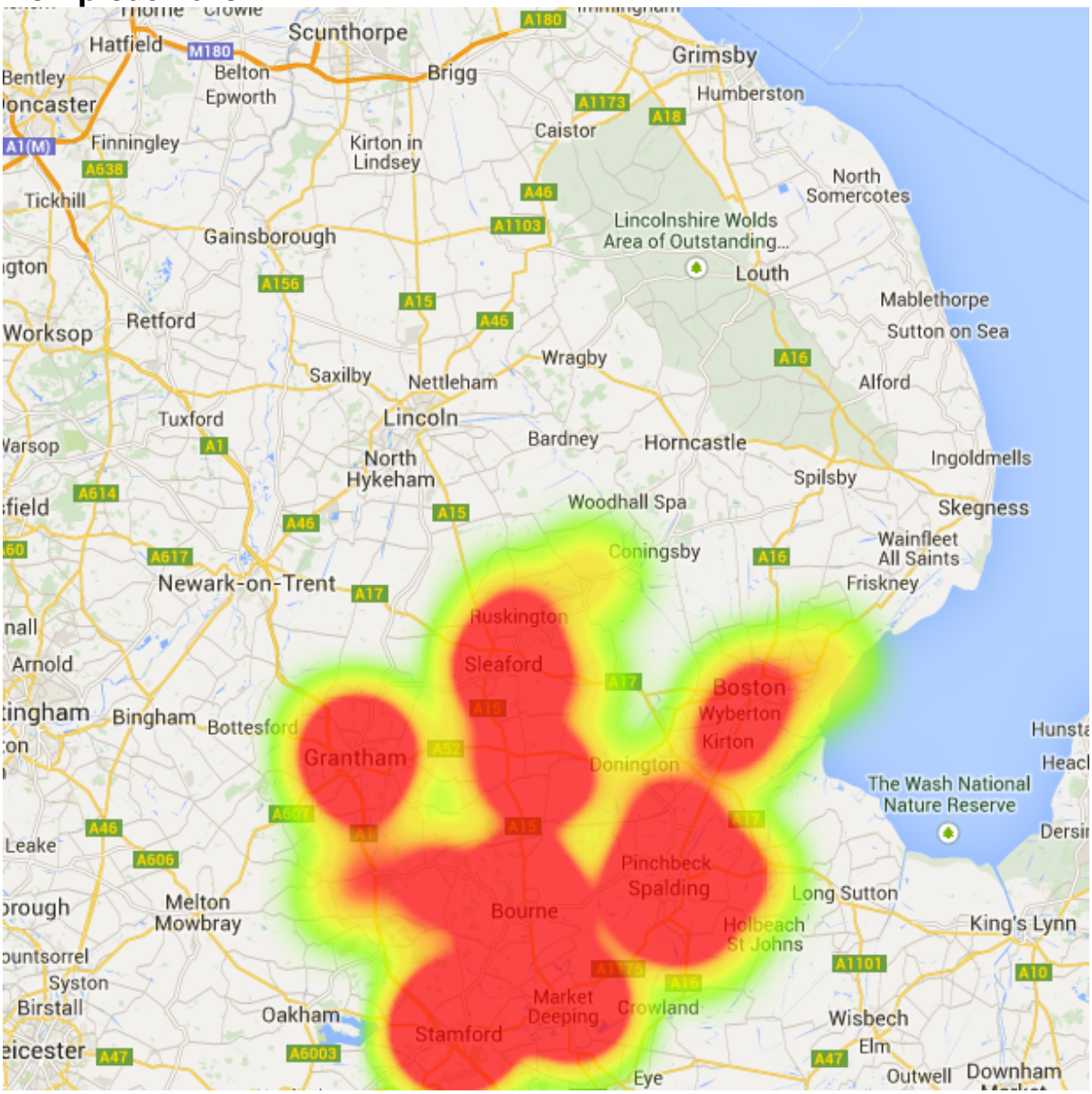
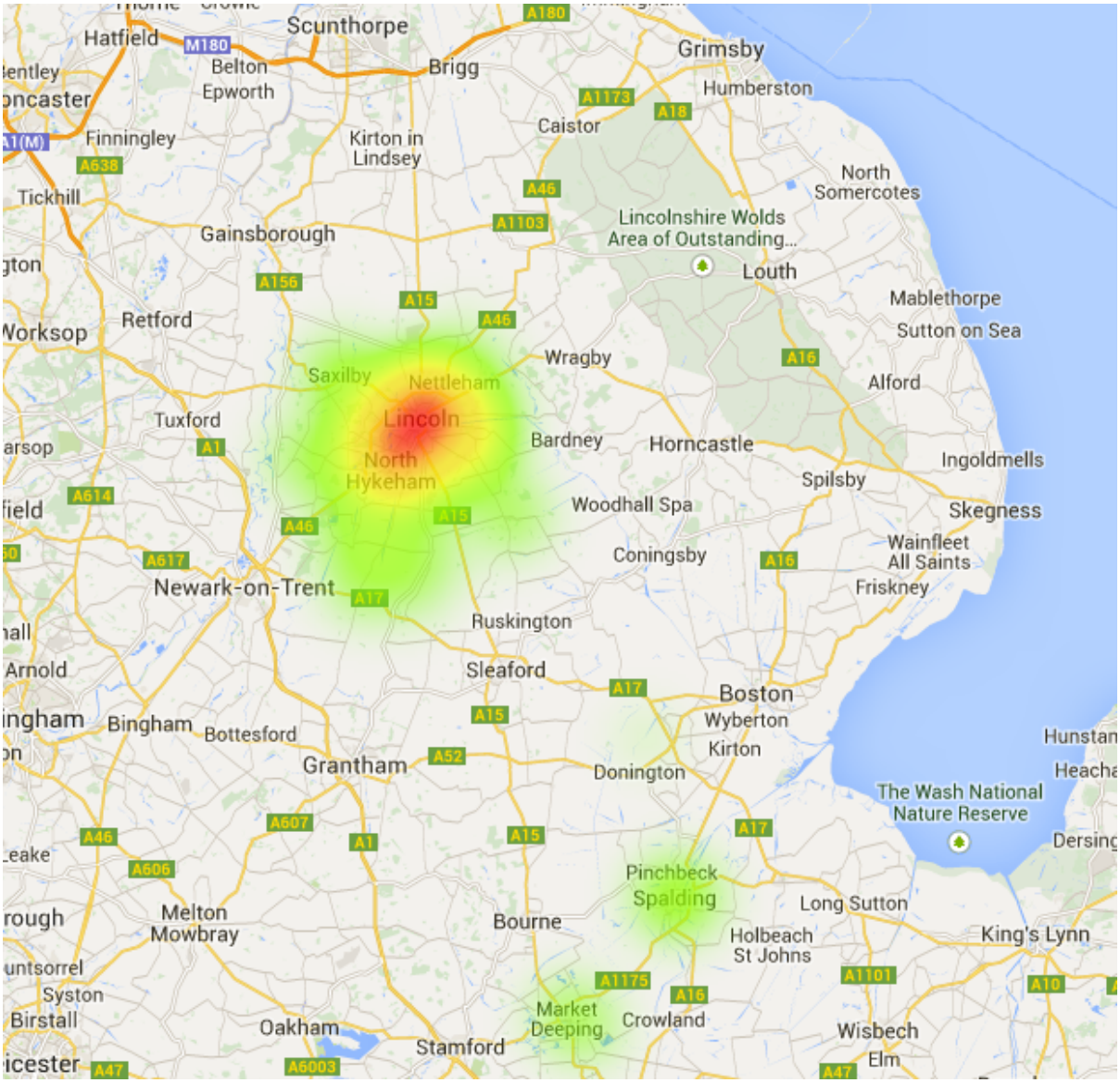
## Compleat Care



**Care UK**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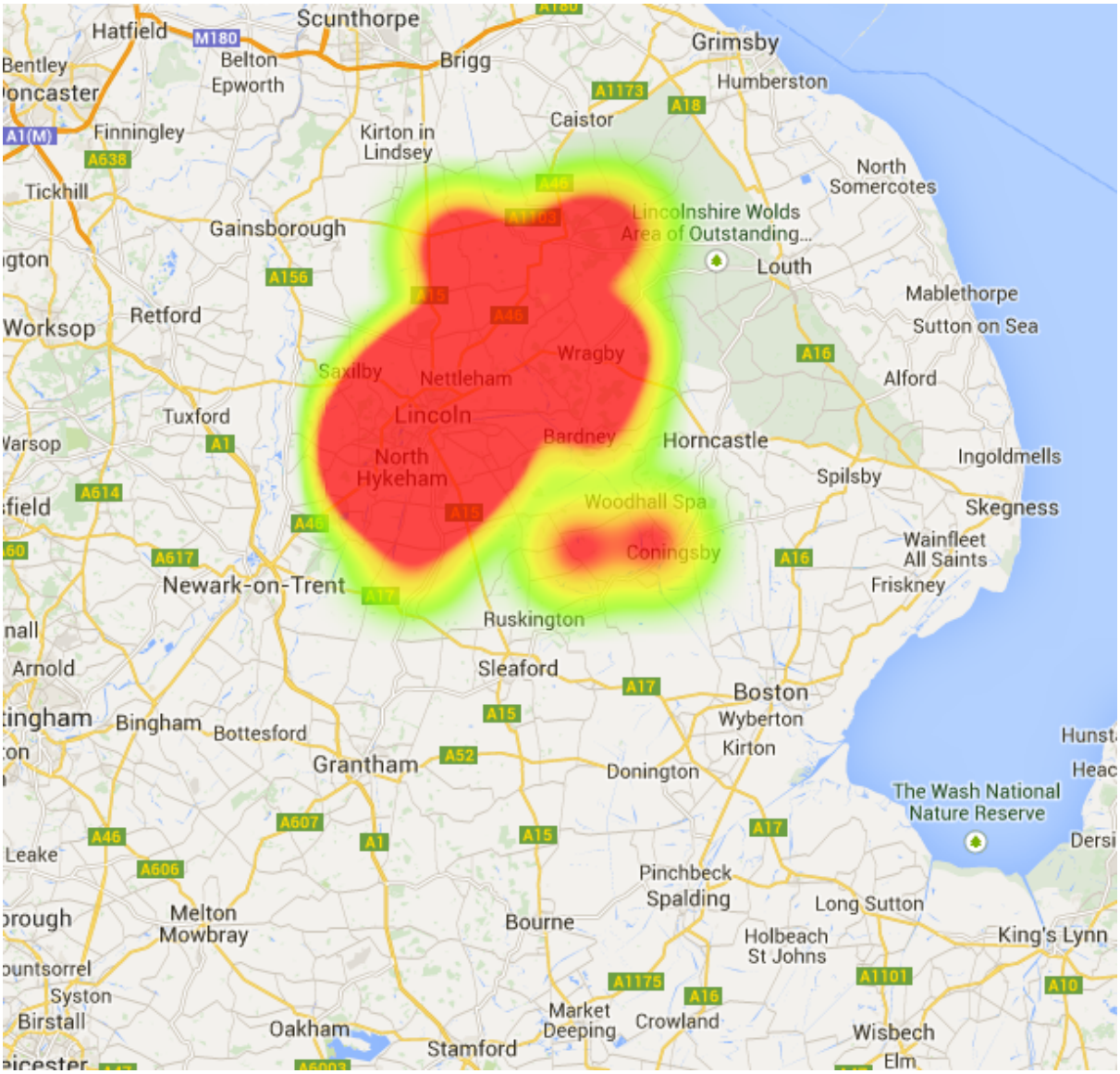
## Care Watch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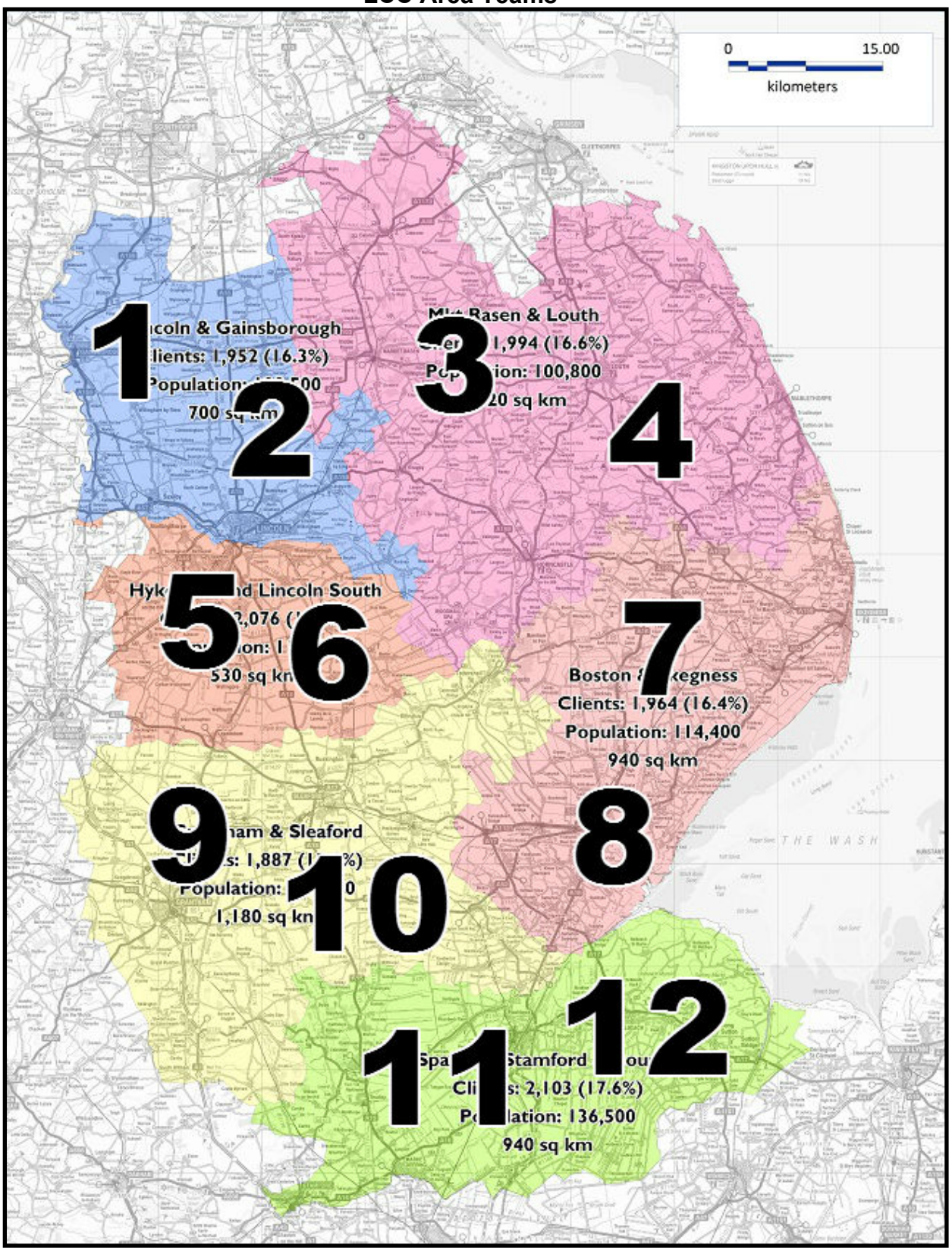
## LCC Area Teams



| Zone | Area | Rate Type | Annualised Hours | Growth @ 4% | Total Hours Available | 80% | 20% | 80% | 20% | Total Cost |
|---|---|---|---|---|---|---|---|---|---|---|
| Zone 1 | Market Rasen | Urban | | 0.00 | | 0 | 0 | £0.00 | £0.00 | |
| | | Rural | 126 | 5045.83 | 13119 | 104953 | 26238 | £1,369,640.04 | £329,028.47 | £1,698,668.51 |
| | Louth | Urban | 136 | 5458.11 | 14191 | 113529 | 28382 | £1,448,626.82 | £348,249.43 | |
| | | Rural | 13 | 539.18 | 1401 | 11215 | 2804 | £146,354.81 | £35,158.80 | £1,978,389.86 |
| Zone 2 | Boston | Urban | 118 | 4739.67 | 12323 | 98585 | 24646 | £1,257,945.44 | £302,409.69 | |
| | | Rural | 61 | 2479.90 | 6447 | 51582 | 12895 | £673,142.89 | £161,709.04 | £2,395,207.05 |
| | Skegness | Urban | 88 | 3523.98 | 9162 | 73299 | 18325 | £935,293.28 | £224,844.21 | |
| | | Rural | 80 | 3231.88 | 8402 | 67223 | 16806 | £877,260.66 | £210,744.23 | £2,248,142.38 |
| Zone 3 | Lincoln | Urban | 123 | 4957.33 | 12889 | 103113 | 25778 | £1,315,715.56 | £316,297.61 | |
| | | Rural | 15 | 612.07 | 1591 | 12731 | 3183 | £166,140.80 | £39,911.99 | £1,838,065.96 |
| | Gainsborough | Urban | 74 | 2990.02 | 7774 | 62192 | 15548 | £793,575.35 | £190,775.27 | |
| | | Rural | 59 | 2393.67 | 6223 | 49788 | 12447 | £649,737.18 | £156,086.29 | £1,790,174.09 |
| Zone 4 | Hykeham | Urban | 126 | 5047.62 | 13123 | 104991 | 26248 | £1,339,679.03 | £322,058.42 | |
| | | Rural | 6 | 271.55 | 706 | 5648 | 1412 | £73,710.08 | £17,707.36 | £1,753,154.89 |
| | Lincoln South | Urban | 45 | 1811.60 | 4710 | 37681 | 9420 | £480,813.62 | £115,587.44 | |
| | | Rural | 71 | 2877.49 | 7481 | 59852 | 14963 | £781,064.75 | £187,635.10 | £1,565,100.91 |
| Zone 5 | Grantham | Urban | 115 | 4610.84 | 11988 | 95906 | 23976 | £1,223,754.93 | £294,190.30 | |
| | | Rural | 65 | 2626.16 | 6828 | 54624 | 13656 | £712,845.38 | £171,246.76 | £2,402,037.38 |
| | Sleaford | Urban | 31 | 1259.80 | 3275 | 26204 | 6551 | £334,360.12 | £80,380.07 | |
| | | Rural | 93 | 3720.47 | 9673 | 77386 | 19346 | £1,009,884.48 | £242,604.43 | £1,667,229.10 |
| Zone 6 | Spalding | Urban | 87 | 3495.32 | 9087 | 72703 | 18176 | £927,686.46 | £223,015.53 | |
| | | Rural | 121 | 4861.84 | 12640 | 101126 | 25282 | £1,319,696.76 | £317,030.60 | £2,787,429.35 |
| | Stamford & Bourne | Urban | 159 | 6379.45 | 16586 | 132693 | 33173 | £1,693,158.39 | £407,034.75 | |
| | | Rural | 49 | 1982.69 | 5155 | 41240 | 10310 | £538,180.67 | £129,287.08 | £2,767,660.88 |
| **Totals** | | | **1872** | **74916.47** | **194782** | | | **£20,068,267.51** | **£4,822,992.87** | **£24,891,260.37** |

**APPENDIX C**

| Impact Analysis to Enable Informed Decisions | | | | | | |
|---|---|---|---|---|---|---|
| **Background Information** | | | | | | |
| **Directorate** | **Assistant Director Area** | **Service Area** | **Lead Officer** | **Person / people completing analysis** | **Date of workshop / meeting** | **Version** |
| Adults | Pete Sidgwick Assistant Director Frailty and Long term conditions | Adult Care | | Sue Blakemore-Quality Assurance Manager | November 2014 | V1.1 Updated January 2015 |

| | | |
|---|---|---|
| **Title of the policy / project / service being considered** | Community Support Model – re- procurement | |
| **General overview and description** | To consider the impact of the proposed model of delivery for the future delivery of community support services:<br>This analysis particularly focuses on the impact of the re-commissioning of community support for older people and people with physical disabilities; this includes home support including as part of extra care housing. | |
| **Current status** | Existing | To be re-commissioned |
| **Timescales for implementation** | November 2014- June 2015 | |
| **Analysis** | | |
| **1. What is the current situation?** | • Adult Social Care has a strategic direction to enable people to remain living independently in their own home for as long as possible and community support services contribute a fundamental role to achieving this<br>• The current framework agreement was implemented in 2011 and sets out a model of tiered service delivery for community support. It was introduced to support delivery of the personalisation agenda encompassed within Putting People First and the drive for personalisation and choice.<br>• In Lincolnshire there are currently 53 active home support providers in Lincolnshire who primarily support the needs of older people and people with physical disability. Although there is a high number of providers this does not equate to a wide choice for people about their provider as that is primarily based on capacity of providers at the point of brokering the | |

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| | person's package care.<br><br>• There are 4 providers who provide home support services within 8 extra care housing schemes<br>• There have been 2 extensions to the framework agreement and during that time there has been no increase in the current generic rate of £12.50 per hour rate. Since August 2014 a visit tariff of £1 per visit has been paid to support delivery of care packages in postcode areas where it has been difficult to deliver packages<br><br>The current agreement is due to expire on 31st May 2015<br><br>The details set out in section 2 highlight the need to review the current model of delivery |
| **2. What are the drivers for change?** | • The number of people aged 65 and over is projected to increase nationally by 23% from 10.3 million in 2010 to 12.7 million in 2018**.** More people are living alone in old age and can access less informal care than in the past and the cost of homecare is forecast to rise from 1% of the UK's Gross Domestic product ( GDP) now to between 2and 4% by 2050. People are living longer and a higher proportion of older people receiving homecare are now considered to have complex needs. ***( Source SCIE commissioning home care for older people June 2014)***<br>**2.1 Lincolnshire demographics:**<br>• Lincolnshire is a large county, 95% of the land is rural. In England 18% population live in rural areas in Lincolnshire it is 48%; its population centres around 1 city, several large market towns and the remainder in sparsely populated in rural locations and the transport infrastructure is poor<br><br>• The over 65's represent 52% of people living in rural areas and in those rural areas older people represent 23% of the population as opposed to 19% in urban areas ( source Lincolnshire research observatory). This highlights the need for home support to be delivered effectively in rural locations<br>• The proportion of people over 75 is predicted to increase by 101% between 2012-2037 (*source population trends in Lincolnshire 2013*) and this is above the national average. There has also been an increase of 43% (5,900) in people in the 85+ age group since 2003<br><br>• **A growing complexity of need**: An aging population means that people are remaining at |

home with more complex needs. There are increasing numbers of people living with comorbidities, an increased number of people living at home with dementia and more people who choose to receive end of life care in their own home.

- Adult social care supports people whose eligibility criteria are substantial or critical. The biggest age group which ASC supports is aged 85 +. **There is a further breakdown of people currently in receipt of home support services by protected characteristics in section 6**
- Analysis of the home care schedule 2011-2013 indicated the % of active schedules including 2 or more carers is increasing which corresponds to increased complexity of need

**2.2 Care Act 2014**

- The Care Act, and its implementation guidance, includes reference to commission activity which focuses on outcomes and well- being of people using services

- The Act also sets out the need to ensure choice through an effective market which offers genuine choice to meet the needs and reasonable preferences of local people.

- It sets out that local authorities must encourage a variety of different providers and promote a market which offers a sustainable and diverse range of care and support and different types of service.

- The market also needs to be able to respond to the care options for those people who self-fund or who arrange and manage their own care through Direct Payments

- In the future there will be an increased need to develop services which will provide 24/7 availability and contribute to reducing avoidable hospital admissions and support prompt hospital discharges.

- In considering market development models there is a need to manage the risk of market failure

**2.3 Financial considerations**

- Currently there is immense pressure on the public sector finances. All local authorities have had their funding reduced by central government and this is to continue going forward for the period of the next Spending Review. For Lincolnshire County Council this means that it must achieve further savings of £90 million over the next 4 years as a consequence the Council through its commissioning is looking to reduce inefficiency whilst maintaining quality

**2.3 Quality:**

- ASC defines quality as services which are safe: effective and that people have a positive experience of their care.
- Adult Social Care's strategic direction is to support people to remain at home for as long as possible. There have been a series of recent national reports relating to the quality of home support; these have all led to increased media interest about home support and much of that has been negative.
- These include the Equality and Human Rights Commission report 'Close to Home ' in 2011: The Leonard Cheshire Disability report ' Ending 15 minute Calls' and CQC published a national overview in February 2013 ' Not just a number'.

- In November 2013 the Quality Assurance team visited a statistically significant sample of people in their own homes to find out their experience of home support. This included people whose support included 15 minute calls. The work was undertaken in response to increased media interest in the quality of home support, and in particular the use of 15 minute calls. This built on some previous work which had already been undertaken with people and has helped us to understand better the things which are really important to people about their home support services

- People told us very clearly that the most important thing to them is continuity of carers.

- People want to know who is coming into their home and undertaking their care, familiar carers were particularly important to people receiving personal care. The responses from people suggest that people tended to receive better quality care where they knew who their carers would be, before they arrived. Our evidence shows that people do not routinely

receive this continuity.

- People also told us that their carers are often late but that when they do arrive they generally stay for the allocated time. Some people commented that one of the reasons carers arrived late was a lack of adequate travel time between visits.

- We also identified some evidence of missed calls.
- Many people told us that when there are changes to their carer or if someone is going to be late they would like to know in advance.

- It is fundamental that what people have told us feeds directly into the current revision of the community support framework, particularly for people in receipt of personal care. By specifying quality expectations contract management can be strengthened, including a greater emphasis on how the provider evidences how it assesses and monitors the quality of its own provision, including how it encourages people to give feedback and how it applies the learning from that feedback.

**2.4 Current market**:

- All agencies in England that provide personal care to people in their own home must be registered by CQC and this is the providers' responsibility. The way CQC regulate services is changing and from October 2014 they have begun to introduce a rating system for providers under the Key Lines of Enquiry ( KLOE) of safe: effective: caring: well-led and responsive to people's needs.

Based on the previous compliance rates for the home support market in Lincolnshire compliance is high 18% of the 53 services were CQC non-compliant as at 3.10.14. None of our providers currently have any enforcement actions.

- There have been increasing pressures on the current market provision in Lincolnshire

- During the last year and half the demand for new home support packages has risen by 8.4%. This has been accentuated by an increasing demand for transfers and variations and peaks during the winter period. We have evidenced the highest demand for new packages in the south of the county and a decrease in the west. The demand for variations is having the most impact in the East but has decreased in the South. The demand for transfers is

having the most impact in the West.

- The assessed hours delivered each week has increased by approximately 7%. Since August 2014 a visit tariff has been paid for packages of care in certain hard to place areas of the county. There has also been an increase in packages waiting over 7 days; transfers of care are the most likely activity to take more than 7 days, with lack of offers as the main delay.

- The numbers of hand backs is also increasing and it can be evidenced that small providers tend to hand- back the highest % of packages. It should be noted from analysis of hand backs in November 2014 main reasons were i. Loss of carers ii service user request iii provider no longer to meet needs

**2.5 Workforce:**

- There are national, as well as local, concerns about the workforce in the care sector.

- Overall the recruitment and retention of a skilled and trained workforce for the home support sector, as part of the wider care force workforce , is problematical

- Care workers are low waged with most being paid around the minimum wage. Current information indicates that pay is around £7 per hour in Lincolnshire; many care workers are currently on zero based contracts. Some providers have said anecdotally that they do not pay travel time.

- In Lincolnshire there are vacancies across the county. This is highest in the east and the highest turnover of staff is in the south of the county. Overall the turnover is higher than that experienced in residential care.

- Issues which have been identified as contributing to this include staff who decide the job isn't for them, people moving to other jobs in the care sector with better incentives benefit rules changes mean people prefer not to take a job with variable hours or a long recruitment process, and the calibre of applicants coming through. There is more difficulty recruiting in rural areas and providers have told us that many applicants or staff who can't drive.

- There are increasing numbers of people eligible for ASC who now receive a direct payment and, where people have a personal budget, there has been increased demand for personal assistants. Initial research indicates that the wages for personal assistants in Lincolnshire are higher than those paid by a provider organisation. This again can have a further knock on effect on the stability of the workforce.

**2.6 Integration with Health**

- The direction of the Care Act and the integration of Health and Social care will increasingly lead to the joining up of commissioning arrangements and highlights the need to join up service provision to align with the neighbourhood team model.
- There are drivers to reduce admissions into acute hospitals and also to reduce the delays in discharging people from hospital back into the community and their own home. This can impact on the complexity of need and the level, and type of care required.

**2.7 In conclusion:**

- The current Community Supported Living framework agreement is open to a large number of providers to provide tiered levels of support. Tier 3 includes services which provide personal care to people in their own home.

- This framework has meant that there is potentially no limit to the number of care providers who may be operating in a particular area but it has not delivered real choice to people; there have been instances where care providers have been unable to sustain service delivery. This and other issues identified are also impacting on the stability of the home support market in Lincolnshire.

- There is a clear need to address these issues and respond to what people have already told us is important to them about their home support in how we procure a future model of delivery for community support

- The recruitment and retention of a skilled, competent and compassionate workforce needs to underpin the stability of the market

- We need to commission a model which removes inefficiency and which complies with Care Act guidance

**3. What difference will we make?**

- The proposal being considered for tender sets out a different model for the future of delivery community support
- It proposes a 5 year cost and volume contract in 6 zones which cover postcodes which are mapped to the current CCG areas: The average cost per zone would be £1million per annum
- Table 1 below indicates the current numbers of providers operating in locations (June 2014 )

Table 1

| Row Labels | Number of Providers | Number of Service Users | Service Users per Provider |
|---|---|---|---|
| Boston | 9 | 309 | 34.3 |
| Gainsborough | 19 | 262 | 13.8 |
| Grantham | 12 | 277 | 23.1 |
| Hykeham | 18 | 300 | 16.7 |
| Lincoln Central | 18 | 243 | 13.5 |
| Lincoln South | 22 | 252 | 11.5 |
| Louth | 9 | 256 | 28.4 |
| Market Rasen | 16 | 258 | 16.1 |
| Skegness | 12 | 312 | 26.0 |
| Sleaford | 20 | 257 | 12.9 |
| Spalding | 15 | 373 | 24.9 |
| Stamford/Bourne | 12 | 358 | 29.8 |
| Grand Total | | 3457 | |

Table 2: This indicates the proposed zones where a prime provider would operate

| **Lincolnshire East CCG:** | **Lincolnshire West CCG** | **South West Lincolnshire CCG** | **Lincolnshire South CCG:** |
|---|---|---|---|
| Zone 1 : Market Rasen and Louth | Zone 3 Lincoln and Gainsborough | Zone 5: Grantham and Sleaford | Zone 6 Spalding and Stamford and Bourne |
| Zone 2: Boston and Skegness | Zone 4 Hykeham and Lincoln South | | |

- It is proposed that each Zone would have a ' prime provider' based in these locations. This would remove the current inefficiency where all providers can compete for the same work wherever it is within the County delaying the placement of care packages and extending travel time between placements.

- This model stipulates that % business in a locality should be subcontracted and contract managed by the prime provider

.

- The contract would delegate the brokering of care in each zone to the prime provider.

- We are moving to outcomes based commissioning. The service specification will set out clearer quality expectations, including what people have already told us is important to them, robust KPIs and dedicated contract management by senior contracts officer. The prime provider would then be responsible for ensuring the required quality expectations and standards are replicated, delivered and managed when there are subcontracted providers

- The service specification and financial modelling will include consideration of travel times and wage rates in line with current best practice guidance, together with findings from the Laing and Buisson market report

- The contract can set out clear expectations for improved terms and conditions for the

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| | workforce to help address concerns<br><br>• The proposed model will stipulate the use of electronic call monitoring |
| **4. What are the assumptions about the benefits?** | • There is a clear need to address current stability and sustainability of providers in the current market place and likewise the variable quality standards of provision.<br>• It is anticipated that a move to fewer providers, with clear expectations for service delivery, will help stabilise the market and improve quality of service.<br>• With fewer providers it will be easier to monitor the consistency and quality of service and for the prime provider to build relationships and partnerships in areas, e.g with neighbourhood teams so that there is a more integrated approach and focus on improving outcomes for individual service users<br>• By having a % of the business subcontracted within a locality it offers some choice of provider in line with Care Act<br>• The performance measures for delivery will include those to capture performance against what people have told us is important to them.<br>• The new model will stipulate the use of electronic call monitoring system with the intended benefit of being able to monitor any missed or late calls.<br>• It is envisaged that a 5 year contract would offer providers greater financial stability<br>• It will allow them to invest more in recruitment and retention and staff development, and also to be able to offer them better terms and conditions , including a reduction in zero hours contracts.<br>• This should in turn start to improve continuity of carers for service users, which people have told us is the most important thing to them.<br>• It is envisaged that care staff from unsuccessful providers will be transferred to the prime provider under TUPE regulations<br>• However it should be noted that these benefit assumptions must be considered with regard and acknowledgement of the underlying issues of workforce recruitment and retention which exist nationally<br>• Fewer providers would mean a reduction in overhead costs and offer economies of scale |

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| | • It would result in fewer contract monitoring meetings, which potentially reduces internal costs, but allow more focused and robust contract management.<br>• This is a model which has already been introduced in other authorities e.g Nottinghamshire and Wiltshire |
| **5. How are you testing your assumptions about the benefits?** | • The findings from national and local research are informing the development of the service specification and the quality standards we are aiming for, which ultimately should lead to improved outcomes for service users.<br>• We are ensuring that what people have already told us is most important to them will be included in the quality standards and performance measures<br>• The feedback we have from service users is about their experience of their current care packages ***however it should be noted that there has been no dialogue with service users or their carers about the proposed model of home support delivery***<br>• Analysis has been undertaken to look at the number of packages within the geographical locations of the proposed zones (see table 1).<br>• When this was shared with providers at an event held 3rd June 2014 there was recognition that there is large number of providers competing for the business in locations and that fragmentation can make it difficult for businesses to be economically viable.<br>• The event was attended by 15 providers (28% of current providers) plus Linca.<br>• In subsequent discussions providers have suggested an optimum of 5 providers in operating in a post code area<br>• We have looked at some early evaluation of this model following its introduction in Wiltshire and it is worth noting that more people than anticipated decided to remain with their previous providers and take a direct payment. This resulted in some providers still remaining operational in the county with local offices, and their staff not transferring to the prime provider to provide a ready- made workforce |

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| **6. The assumptions about any adverse impacts. Could it have a negative impact on anyone?**<br><br>If Yes, go to 6.1 and 6.2<br>If No, please explain how you know this is the case | Yes<br><br>• The model which is being proposed would result in contracts which have a prime provider operating in a zoned location, potentially with a number of sub contracted providers<br><br>• The use of a cost and volume block contracts does offer benefits as set out previously which contribute to managing public funds and delivering efficient services, but it does reduce providing real choice or control to the person on the receiving end<br><br>• One effect is that some smaller providers may go out of business<br><br>• This means that some people will need to have their care packages transferred to another provider when the service user was happy and confident with their original provider and carers<br><br>• It will result in fewer providers and therefore a reduction of choice in providers available. Although the way that care packages are currently brokered, which is based on carers availability, does not provide real choice for most people **the Care Act guidance is actively encouraging choice and diversity in the market.**<br><br>• Once we enter the procurement timeframes and the model is shared widely with the sector some providers may give notice to hand back packages which will need to be re-brokered.<br><br>• Potentially those people this affects may need to transfer again post June 2015.<br><br>• A reduction in providers will also mean that there are fewer options should care need to be re-brokered.<br><br>• The use of call monitoring has benefits which address the issues of missed and late calls but may unintentionally perpetuate the focus on length of time of a visit rather than the flexibility of more personalised and flexible support<br><br>• The proposed model makes the assumption that care staff from unsuccessful providers will transfer under TUPE to the prime provider and therefore provide a ready- made workforce |

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| | for the extra volume of care packages. It should be noted that in Wiltshire many people choose to remain with their care company via the use of a direct payment<br><br>• If this was to happen in Lincolnshire it could impact on the transfer timeframes to the new model |
| 6.1 Which groups / individuals could it have a negative impact on? | ASC in Lincolnshire supports people who meet the eligibility threshold s of substantial and critical needs. The eligibility thresholds are determined regardless of the protected characteristics set out in the Equality Act 2010<br>ASC supports approximately 4244 people with home support. ( source performance team extract from client record database September 2014). This includes people who receive home support at home or as part of extra care housing.<br>The figure also includes 581 people with learning disabilities who are based in community supported living,<br>Community supported living is being considered as part of the overall re-procurement exercise, but as a discreet part of that, and there is a separate impact analysis being undertaken for that work.<br><br>Therefore this change to the proposed model of service delivery for home support will affect to some extent all 3663 people who are currently in receipt of service and people who become eligible in the future. For those people in receipt of services the prime provider model will mean that their package of care may transfer to another provider with potentially a change to their paid carer.<br>There is an option for people to take a direct payment and use this to remain with their current provider but it is unclear how sustainable some smaller services may be.<br>There will also be some people currently in receipt of services, and those who will become eligible in the future, who lack capacity to manage a direct payment and therefore their choice will be limited to that of the prime provider. There are no figures available to give an estimation of this number.<br><br>The re-procurement exercise does not mean that we are decommissioning home support services, but the reshaping of the market does mean that people may have their care support delivered by a different provider |

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| 6.2 Please state how it could have a negative impact on these groups / individuals? Please refer to the list of protected characteristics to assist your answer. | The proposed model for home support services will be implemented for service delivery subject to a contract which incorporates current Equality and Human Rights legislation.<br><br>As the eligibility threshold criteria for Adult Social Care Support are determined nationally they are applied to an individual's care needs regardless of the protected characteristics of age : gender re-assignment: pregnancy or maternity: race : disability: religion or belief: sex: sexual orientation : marriage & civil partnership . However a people's individual care needs and therefore eligibility for ASC support correlate to groups identified by protected characteristics.<br><br>We have identified people currently using services under the framework agreement which is due to expire on 31st May 2015, and therefore will be affected by the changes either directly or indirectly, although we cannot determine until after the procurement exercise exactly which individual service users will need to transfer their packages of care.<br><br>The following represents a breakdown of the current service users broken this down by the protected characteristics of Age: Sex: Disability and Ethnicity:<br><br>Breakdown of people receiving home care: ( source performance team extract from client record database September 2014)excluding learning disabilities)<br><br>**Age Group 18-24**: Total 15: female 7: male 8: 14 = White British (93%)<br><br>**Age Group 25- 34**: Total 29: female 17: male 12: 29 = White British (100%)<br><br>**Age Group 35-44**: Total 65; female 36; male 29: 62= White British ( 95%) 3=other ethnic groups<br><br>**Age Group 45- 54:** Total114 : female 69: male 45: 109= White British (96%) 5= other ethnic |

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| | groups<br><br>**Age Group 55-64:** Total 233: female 136; male 97: 218= White British ( 94%) 6= other ethnic groups<br><br>**Age Group 65- 74:**Total 522: female 300: male 222: 513 = White British ( 98%) 8=other ethnic groups<br><br>**Age Group 75-84:** Total 1181: female 776: male 405: 1149= White British ( 97%) 30= other ethnic groups : 2= not stated<br><br>**Age Group 85+:** Total 1503: female 1110 : male 393: 1461 = White British ( 97%) 35=other ethnic groups; 7 not stated<br><br>Overall the characteristics of the people who will be most affected by these changes are older people aged<br>i. 85+<br>ii. 75-84<br>and a larger percentage of females, which correlates to a longer life expectancy for women.<br><br>The largest ethnic group it will affect are service users who are recorded as White British. This does reflect the demographic in Lincolnshire, however it can also be seen that the numbers of service users from other ethnic groups also increases in the 75-84 and 85+ age groups.<br><br>There are concerns that any communication received and/or rumours heard by service users and their carers from across all groups could cause them great worry and stress. This could be compounded if they need to change their provider twice as a result of this |

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| **7. How are you testing your assumptions about adverse impacts?** | Should approval be given for the re procurement exercise to commence in 2015 using this model, the transition group, reporting to the programme board, will need to consider and recommend and implement ways to take forward how we engage/communicate with service uses and their carers. |
| 7.1 What further evidence do you need to gather? | |
| **8. Who are the stakeholders and how will they be affected?** | **Primary** (those directly affected, either positively or negatively by the organisation's actions) |
| | Care providers<br>People in receipt of services/ their carers<br>ASC Care management staff<br>Brokerage team<br>Neighbourhood teams and other agencies |
| | **Secondary** (intermediaries, people or organisations who are indirectly affected by the organisation's actions) |
| | Other local authorities because of changes in market share |

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| **9. How are you assessing the risks and minimising the impacts?** | • Our assessment of risk includes undertaking this impact analysis<br>• What people have already told us is important to them will be built into the service specification and will be subject to more robust contract management<br>• It is proposed that there is a working group within ASC to manage the transition planning of service delivery to the new model<br>• **This transition planning working group will to set out a clear programme of engagement and communication/ messages to service users and their carers so that it is clear to people what we are doing and the reasons why and how we can work to minimise their worry and concern**<br>• The invitation to tender and its evaluation criteria will include how the provider will manage any staff TUPE and the smooth and seamless transfer of care packages<br>• The provider events planned for early 2015 , subject to approval of the model, will include representation from economic development to offer advice to smaller businesses<br>• There needs to be robust contract management of all existing providers during the procurement period to make sure that services are maintained |
| **10. What changes will the Council need to make as a result of introducing the policy / project / service etc?** | • There is a clear need to shape the market going forward so that there is sufficient provision and capacity in the market to meet the growing demands. This does need to be underpinned by a capable and caring workforce who can then deliver the continuity of care which is so important to people.<br>• |
| **11. How will you undertake evaluation once the changes have been implemented?** | • Ahead of the re-procurement exercise the quality team are currently finalising work undertaken work to establish a baseline of our current home support market ahead of a re procurement exercise<br>• It has included desktop analysis and telephone survey to benchmark people's experience of their current home care support.<br>• This gives us up to date direct customer insight from people using all current providers in the county (November 2014) proportionate to the packages of care they deliver.<br>• This will allow us to benchmark current customer experience against what people have already told us is important to them, and therefore what we want to address and improve in |

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| | the future service delivery model<br><br>• This benchmark will allow comparison over time to evaluate the impact of the new model following its implementation, with people's experience as a key measure where we would expect to see improvements against these measures | | |
| **Further Details** | | | |
| **Are you handling personal data**? If so, please give details. | Part of the analysis has been undertaken using information taken from our client record database | | |
| **How was this analysis undertaken?** Facilitated workshop? Who attended? | This analysis has been completed collating the information and input from a variety of sources and relevant staff within the ASC | | |
| **Are you confident that everyone who should have been involved in producing this version of the Impact Analysis has been?** If No, who needs to be involved? | | | |
| **If this is new, or requires a decision by Councillors to revise, has this impact analysis been included with the committee report?** | Yes | | |
| **Actions required** Including any actions identified in this analysis for monitoring in the relevant service area work plan? | **Action** | **Lead officer** | **Timescale** |

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| | This impact analysis will be updated during implementation of project plan and will inform implementation<br><br>The timescales of project plan will be incorporated once available following the decision to proceed with this model.<br><br>This will include the work to be undertaken by 3 groups<br>1. Service specification for home community support for Older People and those with Physical Disability<br>2. Transition planning for the above i.e the change from the old to new model)<br>3. Service specification and transition for learning disabilities community supported living<br>These working groups will report to a Community Support programme Board | | In line with agreed project timelines |
| **Signed off by** | | **Date** | January 2015 |

* Cells of the form with shading will help you form your consultation plan, should you need to carry out a consultation as a result of Impact Analysis discussions.

**APPENDIX D**

| Impact Analysis to Enable Informed Decisions | | | | | | |
|---|---|---|---|---|---|---|
| **Background Information** | | | | | | |
| **Directorate** | **Assistant Director Area** | **Service Area** | **Lead Officer** | **Person / people completing analysis** | **Date of workshop / meeting** | **Version** |
| ASC | Justin Hackney AD Specialist Services | ASC | | Sue Blakemore Quality Assurance manager | | V0.1 for Executive DMT 9/12/2014 |

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| **Title of the policy / project / service being considered** | Community Support Model – re-procurement | |
| **General overview and description** | To consider the impact of the proposed model of delivery for the future delivery of community support services:<br>This analysis particularly focuses on the impact of the re-commissioning of community support living for people with Learning Disabilities | |
| **Current status** | Existing | To be re-commissioned |
| **Timescales for implementation** | November 2014- June 2015 | |
| **Analysis** | | |
| **1. What is the current situation?** | • The Community Supported Living services are provided through the Community Support Framework. This agreement is due to end on 31st May 2015<br>• Community Supported Living currently supports 581 people with learning disabilities to achieve and maintain their independence in a community. The service is provided by a smaller number of providers those service providers on the framework for Older people and those with Physical Disabilities. There 14 providers who deliver services at approximately 90 locations across the county.<br>• 80% of the current provision is provided by the top 5 providers and 95% by the top 10 providers<br>• These specialist services are structured around the delivery of person centred plans and outcomes for the individuals. | |

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| **2. What are the drivers for change?** | • Since 2011 the findings of the Winterbourne View Serious Case Review ,and subsequently the Cheshire West judgement, influence and impact on service delivery for people with learning disabilities.<br>• Valuing People Now, which sets principles of rights, independence, choice and inclusion for people with learning disabilities, has been incorporated in the Care Act 2014.<br>• There is a strategic direction to enable people with learning disabilities to achieve independent living in the community with a range of housing and support solutions, including those with more complex needs.<br>• If this is to be achieved there is a need to reshape and upgrade the housing stock available for people with learning disabilities over time.<br>• The Joint Strategic Needs Assessment for Lincolnshire clearly shows that the numbers of people with learning disabilities will increase. It is projected that the numbers of people with learning disabilities over 65 will rise from 3,432 in 2014 to 3,926 by 2020. Likewise numbers in the 18-64 age group will also increase from 10,434 in 2014 to 3,926 by 2020.<br><br>• As the wider community support framework approaches re-procurement timelines consideration has been given to incorporating CSL for people with learning disabilities into the proposed model of prime providers in 6 zones and locations across the county.<br>• Because of the distinct differences in the nature of specialist CSL provision home an option appraisal was looked at which considered 5 options of contract model for community supported living services<br>• This was considered by senior managers for Learning Disabilities and it was agreed that the re-commissioning for this support would not form part of the wider proposed for a prime provider model for community support across 6 locality zones<br>• The preferred option for a contract model for this service is an open framework<br>.<br>Financial constraints: Currently there is immense pressure on the public sector finances as a consequence the Council is continually looking to reduce inefficiency through more effective commissioning . |

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| **3. What difference will we make?** | • The continuation of a similar model of delivery for community support will provide continuity of service provision for the people currently using those services.<br>• It will also provide the opportunity to allow time to engage and consult with people with learning disabilities , their families and carers, providers and other stakeholders to shape the market as the Adults Specialities commissioning strategy develops<br>• The current service specification needs to be revised and updated in line with current legislation and good practice guidance –re-commissioning provides the opportunity to do this<br>• As an open framework it will allow new providers to enter the market and expand choice<br>• This will include reshaping and upgrading housing stock for people with learning disabilities |
| **4. What are the assumptions about the benefits?** | • This model of an open framework allows for new providers to enter the market thereby increasing choice which is in keeping with Care Act guidance<br>• Maintaining the current service model means continuity for existing service users with the current provision of their choice<br>• Based on the availability of contract management information for 5 current providers there is evidence of high satisfaction rates from people using their services<br>• The current providers , including those who have a large % of the market in Lincolnshire will continue to provide services and it is envisaged that this continuation will help build relationships and contribute to a collaborative approach in shaping the market going forward<br>• A revised service specification will set out clearer expectations for quality and improved outcomes for service users |
| **5. How are you testing your assumptions about the benefits?** | There has been an options appraisal for the contract model option |

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| **6. The assumptions about any adverse impacts. Could it have a negative impact on anyone?**<br><br>If Yes, go to 6.1 and 6.2<br>If No, please explain how you know this is the case | • ASC in Lincolnshire supports people who meet the eligibility threshold s of substantial and critical needs. The eligibility thresholds are determined regardless of the protected characteristics set out in the Equality Act 2010<br>• Community Supported Living is for people with the main protected characteristic of learning disability.<br>• It is recognised that any changes to CSL would affect service users and their families who are in receipt of services by providers under the current framework<br>• However the option for an open framework contract option type should result in no immediate changes in the provider market and therefore no direct impact for current service users and their carers<br>• There is still financial modelling work being undertaken and the payments rates for future financial years and this may impact on the market |
| 6.1 Which groups / individuals could it have a negative impact on? | ASC in Lincolnshire supports people who meet the eligibility threshold s of substantial and critical needs. The eligibility thresholds are determined regardless of the protected characteristics set out in the Equality Act 2010..<br><br>Although it is anticipated that the contract option model for CSL will have no immediate impact of current services users we have considered the numbers of current service users with learning disabilities under the other protected characteristics of age, sex, and ethnicity<br><br>Based on client record data for September 2014 ( source performance team) there were 581 people with learning disabilities in receipt of community supported living further broken down by the protected characteristics of age: sex; ethnicity<br>Age 18-24= 64: female 24:male 40; ethnicity 95% White British 3% ( number 2) Black African<br>Age 25-34 = 103: female 40: male 63: ethnicity 96% White British 2% White other 0.9% (1) Asian<br>Age 35-44 = 102: female 47:male 55 : ethnicity 100% White British<br>Age 45-54= 135: female 62: male 73 ; ethnicity 100% stated White British<br>Age 55-64= 94: female 50: male 44<br>Age 65-74= 62: female 29: male 33; ethnicity 99% White British 1% White Irish<br>Age 75-84= 17: female 10: male 7: ethnicity 100% White British<br>Age 85+ = 4: female 2: male 2: ethnicity 100% White British |

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| 6.2 Please state how it could have a negative impact on these groups / individuals? Please refer to the list of protected characteristics to assist your answer. | As noted above the impact on services users will be negligible as the model of delivery is not changing |
| **7. How are you testing your assumptions about adverse impacts?** | • There has been an options appraisal for a contract model and the option of an open framework would make no significant changes to the current care providers and therefore the continuity of care for people in those services<br>• The customer satisfaction information we have from service users, although it is limited to a few of the providers, suggests that there is a high satisfaction rate with current services<br>• The financial modelling is still in progress |
| 7.1 What further evidence do you need to gather? | We will need to gather further feedback from existing service users on the experience of their current services to inform any further developments over time |
| **8. Who are the stakeholders and how will they be affected?** | **Primary** (those directly affected, either positively or negatively by the organisation's actions) |
| | People with learning disabilities currently living in community supported living<br>Their families/ carers<br>CSL providers<br>District Councils<br>Housing providers |

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| | **Secondary** (intermediaries, people or organisations who are indirectly affected by the organisation's actions) |
| | |
| **9. How are you assessing the risks and minimising the impacts?** | • Part of mitigating any risk is undertaking this impact analysis to inform any decision making<br>• The preferred contract options for CSL will not make changes in the short term and provide continuity of care.<br>• The length of the next framework will be 5 years and this will allow time to full engagement with service users and other stakeholders about the future shape of specialist services |
| **10. What changes will the Council need to make as a result of introducing the policy / project / service etc?** | |
| **11. How will you undertake evaluation once the changes have been implemented?** | There will be improved contract management against the revised service specification- this will include collating and reviewing peoples experience of their care as a measure of quality |

| **Further Details** | |
|---|---|
| **Are you handling personal data**? If so, please give details. | Part of the analysis has been undertaken using information taken from our client record database |
| **How was this analysis undertaken?** Facilitated workshop? Who attended? | The impact analysis includes information from relevant staff in specialist services |

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| **Are you confident that everyone who should have been involved in producing this version of the Impact Analysis has been?**<br>If No, who needs to be involved? | | | |
| **If this is new, or requires a decision by Councillors to revise, has this impact analysis been included with the committee report?** | Yes | | |
| **Actions required**<br>Including any actions identified in this analysis for monitoring in the relevant service area work plan? | **Action** | **Lead officer** | **Timescale** |
| | This impact analysis will be undated during implementation of project plan and will inform that plan<br><br>• The timescales of project plan will be incorporated once available following the decision of Executive DMT<br>• There is a working group in place for Service specification and transition for learning disabilities community supported living<br>• The working group will report to a Community Support programme Board | | In line with project timeframes once finalised |
| **Signed off by** | | **Date** | 5.12.2014 |

* Cells of the form with shading will help you form your consultation plan, should you need to carry out a consultation as a result of Impact Analysis discussions.

# Children's Domiciliary Care Rate Modelling

Analysis has been completed to understand the make-up of the hourly rate for Children's Domiciliary Care with the view of establishing a rate that represents a viable and legally compliant position and also is at a point that is acceptable to the market. The foundation to this work was the baseline established within the OP/PD rate construction and this has been adapted to reflect the specialist nature of Children's Domiciliary Care.

The first point was in establishing a suitable hourly salary rate for Children's Domiciliary Care workers based on the knowledge that specialist skills are required and the attendance/contribution to Local Authority meetings such as Child In Need Meetings, Child Protection Conferences and Education Health Care Plans can be a key component of this role. Also review of regional and national unit rates and analysis of information compiled by Personal Social Services Research Unit indicated that the hourly rate identified was in line with average unit costs.

This justified a higher hourly rate than an Adult's Domiciliary Care worker and the Children's Specification mandates a minimum of 50% of staff having a relevant Health and/or Social Care qualification. Once an hourly rate had been identified, associated staffing costs were applied to reach a final Payroll Cost.

Continuing the adaption of the Adult Care financial modelling tool, it was felt that an increase in the training costs would be required due to the highly specialist and individual training requirements for each Domiciliary Care case. Using the calculations identified by Adult Care as a baseline and using experience within the CWD team and from training records submitted by the current Provider, an increase was felt necessary to ensure high quality provision.

In terms of mileage costs, office based staff costs and management costs – again the Adult Care financial model gave a baseline and from knowledge of the local market, it can be assumed that there will be significantly less Providers interested/able to provide Children's Domiciliary Care so an uplift in these costs would be required to make provision viable throughout Lincolnshire.

The operating margin calculation remained consistent with Adult Care.

The final unit costs for Children's Domiciliary Care are:

Urban Rate - £18.67
Rural Rate - £19.16.

This should realise savings of over £10 per hour in comparison to the unit cost currently paid as part of the existing Domiciliary Care block contract. Any savings should assist with increased volume of delivery and reduce waiting times.

# CSL Rate Modelling

Analysis has been completed to understand the make-up of the hourly rate for Community Supported Living with the view of establishing a rate that represents a viable and legally compliant position and also is at a point that is acceptable to the market.

The foundation to this work was the baseline established within the OP/PD rate construction to ensure a level of remuneration that recognises the costs of business and meets minimum wage legislation and other requirements. The next point was in establishing a smoothed average rate for the 16 top mainstream CSL Providers within the market, who account for 96% of current CSL provision. A number of Providers were specifically excluded from this average rate, due to the specialist nature of the services provided.

In determining the smoothed average, the average rate was determined firstly for each individual provider. A number of the top 16 providers currently charge on the basis of multiple rates, which are a result of legacy commissioning arrangements. Therefore, all the charges were multiplied through and divided by the total number of hours delivered in order to get the smoothed average.

Through this modelling, the average hourly rate across the providers was £12.92. This was then compared to the work already undertaken in building the hourly rate for OP/PD community care and verified that the necessary costs and legal requirements have been properly recognised within that rate.

Once establishing this foundation further work was done to model the impact of a series of rate increases based on a 1, 2 and 3% uplift. The resulting hourly rates are as follow

| Increase | New Rate |
|---|---|
| 1% | £13.05 |
| 2% | £13.18 |
| 3% | £13.30 |

Each of these rates has a different effect on each CSL provider due to the specific nature of the blend of rates they currently have. When applied to the rates each provider has, at the 1% and 2% uplift the negative impact is broader than at 3%. At the 3% level it is a positive impact for almost all providers. Spot contracts may be issued in respect of the specialist packages of care, leaving a positive impact on the remainder.

In respect of the small number of providers who may not enjoy the same level of improvement there will need to be a commercial decision by them in rejecting any offer at £13.30. Work could be done with them as individual providers to encourage them to accept the rates; in any event there are a small number of packages identified (26) which may be affected by this scenario and would be managed carefully to ensure, if necessary, a smooth transition.

The incentives which will attract them and the other providers include:

- Standalone CSL model for LD
- Retention of existing packages
- An open framework with an application and mini competition process compared to a full tender process
- Ability to place themselves in a favourable position, for future commissioning intentions and new packages of care.

In respect of the last point, the £13.30 has been described as a ceiling rate, which would allow providers to submit lower rates and position their price point at a competitive level. This cost criteria would then form part of the wider criteria of the future shaping of CSL provision.

**APPENDIX G**

## SUMMARY

| Zone | Area | Rate Type | Annualised Hours | Growth @ 4% | Total Hours Available | 80% | 20% | 80% | 20% | Total Cost |
|---|---|---|---|---|---|---|---|---|---|---|
| Zone 1 | Market Rasen | Urban | 0.00 | 0.00 | 0 | 0 | 0 | £0.00 | £0.00 | |
| | | Rural | 126145.74 | 5045.83 | 131192 | 104953 | 26238 | £1,369,640.04 | £329,028.47 | £1,698,668.51 |
| | Louth | Urban | 136452.82 | 5458.11 | 141911 | 113529 | 28382 | £1,448,626.82 | £348,249.43 | |
| | | Rural | 13479.48 | 539.18 | 14019 | 11215 | 2804 | £146,354.81 | £35,158.80 | £1,978,389.86 |
| Zone 2 | Boston | Urban | 118491.67 | 4739.67 | 123231 | 98585 | 24646 | £1,257,945.44 | £302,409.69 | |
| | | Rural | 61997.39 | 2479.90 | 64477 | 51582 | 12895 | £673,142.89 | £161,709.04 | £2,395,207.05 |
| | Skegness | Urban | 88099.58 | 3523.98 | 91624 | 73299 | 18325 | £935,293.28 | £224,844.21 | |
| | | Rural | 80796.92 | 3231.88 | 84029 | 67223 | 16806 | £877,260.66 | £210,744.23 | £2,248,142.38 |
| Zone 3 | Lincoln | Urban | 123933.30 | 4957.33 | 128891 | 103113 | 25778 | £1,315,715.56 | £316,297.61 | |
| | | Rural | 15301.80 | 612.07 | 15914 | 12731 | 3183 | £166,140.80 | £39,911.99 | £1,838,065.96 |
| | Gainsborough | Urban | 74750.51 | 2990.02 | 77741 | 62192 | 15548 | £793,575.35 | £190,775.27 | |
| | | Rural | 59841.69 | 2393.67 | 62235 | 49788 | 12447 | £649,737.18 | £156,086.29 | £1,790,174.09 |
| Zone 4 | Hykeham | Urban | 126190.53 | 5047.62 | 131238 | 104991 | 26248 | £1,339,679.03 | £322,058.42 | |
| | | Rural | 6788.80 | 271.55 | 7060 | 5648 | 1412 | £73,710.08 | £17,707.36 | £1,753,154.89 |
| | Lincoln South | Urban | 45290.05 | 1811.60 | 47102 | 37681 | 9420 | £480,813.62 | £115,587.44 | |
| | | Rural | 71937.15 | 2877.49 | 74815 | 59852 | 14963 | £781,064.75 | £187,635.10 | £1,565,100.91 |
| Zone 5 | Grantham | Urban | 115271.10 | 4610.84 | 119882 | 95906 | 23976 | £1,223,754.93 | £294,190.30 | |
| | | Rural | 65654.05 | 2626.16 | 68280 | 54624 | 13656 | £712,845.38 | £171,246.76 | £2,402,037.38 |
| | Sleaford | Urban | 31494.92 | 1259.80 | 32755 | 26204 | 6551 | £334,360.12 | £80,380.07 | |
| | | Rural | 93011.76 | 3720.47 | 96732 | 77386 | 19346 | £1,009,884.48 | £242,604.43 | £1,667,229.10 |
| Zone 6 | Spalding | Urban | 87383.05 | 3495.32 | 90878 | 72703 | 18176 | £927,686.46 | £223,015.53 | |
| | | Rural | 121545.90 | 4861.84 | 126408 | 101126 | 25282 | £1,319,696.76 | £317,030.60 | £2,787,429.35 |
| | Stamford & Bourne | Urban | 159486.37 | 6379.45 | 165866 | 132693 | 33173 | £1,693,158.39 | £407,034.75 | |
| | | Rural | 49567.18 | 1982.69 | 51550 | 41240 | 10310 | £538,180.67 | £129,287.08 | £2,767,660.88 |
| **Total** | | | **1872911.767** | **74916.47** | **1947828.238** | | | **£20,068,267.51** | **£4,822,992.87** | **£24,891,260.37** |

| **Suggested Rates @ NMW** | 80% Rate | 20% Rate |
|---|---|---|
| Urban | 12.76 | 12.27 |
| Rural | 13.05 | 12.54 |

# POSTCODES TO LRO DATA

| Lincolnshire East CCG | | | | Lincolnshire West CCG | | | | South West Lincolnshire CCG | | Lincolnshire South CCG | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Zone 1 | | Zone 2 | | Zone 3 | | Zone 4 | | Zone 5 | | Zone 6 | |
| Market Rasen | Louth | Boston | Skegness | Lincoln | Gainsborough | Hykeham | Lincoln South | Grantham | Sleaford | Spalding | Stamford & Bourne |
| DN20 8 | LN9 9 | PE20 1 | PE22 7 | LN1 1 | DN21 1 | LN6 0 | LN4 1 | NG13 0 | LN4 4 | PE11 1 | PE6 0 |
| DN20 9 | LN11 1 | PE20 2 | PE22 8 | LN2 1 | DN21 2 | LN6 3 | LN4 2 | NG23 5 | NG34 0 | PE11 2 | PE6 8 |
| DN36 5 | LN11 7 | PE20 3 | PE22 9 | LN2 2 | DN21 3 | LN6 4 | LN4 3 | NG31 0 | NG34 4 | PE11 3 | PE6 9 |
| DN37 0 | LN11 8 | PE21 0 | PE23 4 | LN2 3 | DN21 5 | LN6 5 | LN5 0 | NG31 6 | NG34 7 | PE11 9 | PE9 1 |
| DN37 8 | LN11 9 | PE21 1 | PE23 5 | LN2 4 | DN21 9 | LN6 7 | LN5 7 | NG31 7 | NG34 8 | PE12 0 | PE9 2 |
| DN38 6 | LN12 1 | PE21 6 | PE23 9 | LN2 5 | LN1 2 | LN6 8 | LN5 8 | NG31 8 | NG34 9 | PE12 2 | PE9 3 |
| DN41 8 | LN12 2 | PE21 7 | PE24 4 | LN3 4 | LN1 3 | LN6 9 | LN5 9 | NG31 9 | PE11 4 | PE12 6 | PE9 4 |
| LN7 6 | LN12 9 | PE21 8 | PE24 5 | LN3 5 | LN8 2 | NG23 7 | | NG32 1 | | PE12 7 | PE10 0 |
| LN8 3 | LN13 0 | PE21 9 | PE25 1 | LN5 5 | | | | NG32 2 | | PE12 8 | PE10 1 |
| LN8 5 | LN13 3 | PE22 0 | PE25 2 | | | | | NG32 3 | | PE12 9 | PE10 9 |
| LN8 6 | LN13 9 | | PE25 3 | | | | | NG33 4 | | PE13 5 | |
| LN8 9 | | | PE25 9 | | | | | NG33 5 | | | |
| LN9 5 | | | | | | | | | | | |
| LN9 6 | | | | | | | | | | | |
| LN10 5 | | | | | | | | | | | |
| LN10 6 | | | | | | | | | | | |
| LN11 0 | | | | | | | | | | | |

Urban

Rural

Both but predominantly rural

Both but predominantly urban

## ZONE SPLIT

| Postcode | Location | Total | Rate Type |
|---|---|---|---|
| PE20 1 | Boston | 7373.22 | Rural |
| PE20 2 | Boston | 5902.47 | Rural |
| PE20 3 | Boston | 5069.67 | Rural |
| PE21 0 | Boston | 14588.77 | Urban |
| PE21 6 | Boston | 822.82 | Urban |
| PE21 7 | Boston | 10183.70 | Urban |
| PE21 8 | Boston | 11536.46 | Urban |
| PE21 9 | Boston | 10592.16 | Urban |
| PE22 0 | Boston | 6624.82 | Rural |
| DN21 1 | Gainsborough | 12331.44 | Urban |
| DN21 2 | Gainsborough | 5817.96 | Urban |
| DN21 3 | Gainsborough | 6219.45 | Rural |
| DN21 5 | Gainsborough | 7286.43 | Rural |
| LN1 2 | Gainsborough | 8035.80 | Rural |
| LN1 3 | Gainsborough | 11957.25 | Urban |
| LN8 2 | Gainsborough | 2560.27 | Rural |
| NG23 5 | Grantham | 4945.51 | Rural |
| NG31 6 | Grantham | 4601.22 | Urban |
| NG31 7 | Grantham | 15732.23 | Urban |
| NG31 8 | Grantham | 13781.74 | Urban |
| NG31 9 | Grantham | 12311.60 | Urban |
| NG32 1 | Grantham | 4267.79 | Rural |
| NG32 2 | Grantham | 4738.74 | Rural |
| NG32 3 | Grantham | 3533.77 | Rural |
| NG33 4 | Grantham | 5560.33 | Rural |
| NG33 5 | Grantham | 3396.80 | Rural |
| LN6 0 | Hykeham | 11053.79 | Urban |
| LN6 3 | Hykeham | 1961.02 | Urban |
| LN6 4 | Hykeham | 51.26 | Rural |
| LN6 5 | Hykeham | 2448.33 | Rural |
| LN6 7 | Hykeham | 13618.64 | Urban |
| LN6 8 | Hykeham | 10348.51 | Urban |
| LN6 9 | Hykeham | 13842.76 | Urban |
| NG23 7 | Hykeham | 234.68 | Rural |
| LN1 1 | Lincoln Central | 5216.87 | Urban |
| LN2 1 | Lincoln Central | 1360.23 | Urban |
| LN2 2 | Lincoln Central | 17287.85 | Urban |
| LN2 3 | Lincoln Central | 4262.71 | Urban |
| LN2 4 | Lincoln Central | 15491.44 | Urban |
| LN2 5 | Lincoln Central | 5960.75 | Urban |
| LN3 4 | Lincoln Central | 4411.54 | Rural |
| LN3 5 | Lincoln Central | 1751.44 | Rural |
| LN5 5 | Lincoln Central | 335.75 | Urban |
| LN4 1 | Lincoln South | 8618.20 | Rural |
| LN4 2 | Lincoln South | 8894.36 | Rural |
| LN4 3 | Lincoln South | 7265.07 | Rural |

| | | | |
|---|---|---|---|
| LN5 0 | Lincoln South | 4195.90 | Rural |
| LN5 7 | Lincoln South | 1594.86 | Urban |
| LN5 8 | Lincoln South | 8242.54 | Urban |
| LN5 9 | Lincoln South | 8403.70 | Urban |
| LN11 7 | Louth | 5429.02 | Rural |
| LN11 8 | Louth | 8319.35 | Urban |
| LN11 9 | Louth | 10674.92 | Urban |
| LN12 1 | Louth | 6895.76 | Urban |
| LN12 2 | Louth | 15209.98 | Urban |
| LN13 0 | Louth | 6477.10 | Urban |
| LN13 9 | Louth | 7380.88 | Urban |
| DN36 5 | Mkt Rasen | 6884.34 | Rural |
| DN38 6 | Mkt Rasen | 199.49 | Rural |
| DN41 8 | Mkt Rasen | 1599.00 | Rural |
| LN10 5 | Mkt Rasen | 860.28 | Rural |
| LN10 6 | Mkt Rasen | 4786.93 | Rural |
| LN11 0 | Mkt Rasen | 7608.08 | Rural |
| LN7 6 | Mkt Rasen | 7155.68 | Rural |
| LN8 3 | Mkt Rasen | 6679.78 | Rural |
| LN8 5 | Mkt Rasen | 4018.18 | Rural |
| LN8 6 | Mkt Rasen | 2474.95 | Rural |
| LN9 5 | Mkt Rasen | 5237.82 | Rural |
| LN9 6 | Mkt Rasen | 3302.16 | Rural |
| PE22 7 | Skegness | 1470.71 | Rural |
| PE22 8 | Skegness | 3481.89 | Rural |
| PE22 9 | Skegness | 4555.92 | Rural |
| PE23 4 | Skegness | 2560.47 | Rural |
| PE23 5 | Skegness | 7277.69 | Rural |
| PE24 4 | Skegness | 5429.10 | Rural |
| PE24 5 | Skegness | 7766.13 | Rural |
| PE25 1 | Skegness | 10393.52 | Urban |
| PE25 2 | Skegness | 17263.70 | Urban |
| PE25 3 | Skegness | 7825.93 | Urban |
| LN4 4 | Sleaford | 5151.55 | Rural |
| NG34 0 | Sleaford | 7972.92 | Rural |
| NG34 4 | Sleaford | 108.18 | Urban |
| NG34 7 | Sleaford | 12576.77 | Urban |
| NG34 8 | Sleaford | 7392.23 | Rural |
| NG34 9 | Sleaford | 10925.43 | Rural |
| PE11 4 | Sleaford | 6019.45 | Rural |
| PE11 1 | Spalding | 11323.94 | Urban |
| PE11 2 | Spalding | 14731.60 | Urban |
| PE11 3 | Spalding | 9139.01 | Urban |
| PE12 0 | Spalding | 8635.46 | Rural |
| PE12 6 | Spalding | 9748.76 | Rural |
| PE12 7 | Spalding | 9764.66 | Rural |
| PE12 8 | Spalding | 4080.29 | Rural |
| PE12 9 | Spalding | 15804.41 | Rural |
| PE13 5 | Spalding | 920.47 | Rural |

| | | | |
|---|---|---|---|
| PE10 0 | Stamford/Bourne | 10788.80 | Rural |
| PE10 9 | Stamford/Bourne | 22408.44 | Urban |
| PE6 0 | Stamford/Bourne | 6049.64 | Rural |
| PE6 8 | Stamford/Bourne | 14038.78 | Urban |
| PE6 9 | Stamford/Bourne | 2840.21 | Urban |
| PE9 1 | Stamford/Bourne | 17891.14 | Urban |
| PE9 2 | Stamford/Bourne | 7056.45 | Urban |
| PE9 4 | Stamford/Bourne | 3125.33 | Rural |
| Grand Total | | 754364.56 | |

# MODEL

| | | | |
|---|---|---|---|
| **DIRECT PAYROLL COST** | | | |
| Basic Salary | | £ 6.50 | **M1** |
| Employer NI | | £ 0.33 | **M2** |
| Employer Pension cost | | £ 0.07 | **M3** |
| Holiday Pay | | £ 0.80 | **M4** |
| Estimated Sick Pay Cost | | £ 0.18 | **M5** |
| **Basic Payroll cost (weekdays)** | **Sub Total 1** | **£ 7.88** | **M6** |
| **Extra pay for weekends and antisocial hours** | **Sub Total 2** | **£ 0.33** | **M7** |
| **Direct Payroll Cost** | **Sub Totals 1 & 2:** | **£ 8.20** | **M8** |
| **OVERHEADS** | | | |
| Standby Staff Cost | | £ - | **M9** |
| Uniform , gloves etc. | | £ 0.02 | **M10** |
| Training | | £ 0.66 | **M11** |
| Travel cost | **Rural** | £ 0.89 | **M12** |
| Recruitment cost | | £ 0.02 | **M13** |
| ECM Cost | | £ - | **M14** |
| Office Based staff e.g. co-ordinator / schedulers. | | £ 0.41 | **M15** |
| Establishment cost. Rent, Utility, Communication, insurance, fixtures and fittings. | | £ 0.26 | **M16** |
| Management costs | | £ 2.08 | **M17** |
| **Total Overheads** | **Sub Total 3** | **£ 4.34** | **M18** |
| **TOTAL COSTS** | | | |
| **Total Cost (Payroll + overheads)** | **Sub Totals 1,2 & 3** | **£ 12.54** | **M19** |
| **OPERATING MARGIN** | | | |
| Operating Margin % | | 4.00% | **M20** |
| Operating Margin £ | **Sub Total 4** | **£ 0.50** | **M21** |
| **TOTAL CHARGEABLE TO COUNCIL** | | **£ 13.05** | **M22** |

| DIRECT PAYROLL COST | | | |
|---|---|---|---|
| Basic Salary | | £ 6.50 | M1 |
| Employer NI | | £ 0.33 | M2 |
| Employer Pension cost | | £ 0.07 | M3 |
| Holiday Pay | | £ 0.80 | M4 |
| Estimated Sick Pay Cost | | £ 0.18 | M5 |
| **Basic Payroll cost (weekdays)** | **Sub Total 1** | **£ 7.88** | M6 |
| **Extra pay for weekends and antisocial hours** | **Sub Total 2** | **£ 0.33** | M7 |
| **Direct Payroll Cost** | **Sub Totals 1 & 2:** | **£ 8.20** | M8 |
| **OVERHEADS** | | | |
| Standby Staff Cost | | £ - | M9 |
| Uniform , gloves etc. | | £ 0.02 | M10 |
| Training | | £ 0.66 | M11 |
| Travel cost | **Urban** | £ 0.61 | M12 |
| Recruitment cost | | £ 0.02 | M13 |
| ECM Cost | | £ - | M14 |
| Office Based staff e.g. co-ordinator / schedulers. | | £ 0.41 | M15 |
| Establishment cost. Rent, Utility, Communication, insurance, fixtures and fittings. | | £ 0.26 | M16 |
| Management costs | | £ 2.08 | M17 |
| **Total Overheads** | **Sub Total 3** | **£ 4.07** | M18 |
| **TOTAL COSTS** | | | |
| **Total Cost (Payroll + overheads)** | **Sub Totals 1,2 & 3** | **£ 12.27** | M19 |
| **OPERATING MARGIN** | | | |
| Operating Margin % | | 4.00% | M20 |
| Operating Margin £ | **Sub Total 4** | **£ 0.49** | M21 |
| **TOTAL CHARGEABLE TO COUNCIL** | | **£ 12.76** | M22 |

Sources for the costs included in this model are available in the "Rationale" tab below, each figure in the model is labelled with a M* tag next to it which correlates to a rationale for that particular costing.

Clicking on the Pink tab in Cell C16 and selecting between "Urban" and "Rural" will give two different final rates for covering travel time in urban and rural settings respectively.

Documents used in the preparation of this model are labelled on the Rationale tab as R*. These are available for validation.

# RATIONALE

| Model Cell Number | Notes | Calculation | Formulae | Reference Documentation |
|---|---|---|---|---|
| M1 | £6.50 Minimum Wage level | | | **R1** |
| M2 | Based on a worker on minimum wage at 37 hours per week, the 4 weekly cost to the employer for NI contributions is £48.30, for an hourly cost of £0.33 to 2dp - taken from HM Revenue and Customs NI Calculator. http://www.hmrc.gov.uk/calcs/nice.htm | £48.30 / (37 hours x 4 weeks) = 0.3263 = £0.33 to 2dp | 0.33 | - |
| M3 | New regulations require a minimum 1% contribution of an employee's gross pay, taking the value of £6.50 per hour, minimum contribution is £0.07 to 2dp | £6.50 x 1% = £0.065 = £0.07 to 2dp | 0.07 | - |
| M4 | Based on generating the costs of 28 days (5.6 weeks) statutory holiday entitlement over a year (52 weeks). This was an under-estimate. The costs of statutory holiday pay can only be earned while the employee is actually working and is therefore 52 weeks less the 5.6 weeks that the worker takes as leave. The calculation for holiday pay expressed as a percentage should therefore be (5.6 ÷ 46.4) × 100 or 12.07%. For more information on holiday pay see: www.gov.uk/holiday-entitlement-rights.for holiday pay | (£6.50 x 7.5 hours x 28 days) / (37 hours x 46.4 weeks per year) = 0.7950 = £0.80 to 2dp | 0.80 | **R2** |
| M5 | Mean sick days per year in the domicillary care sector is 7 to the nearest day, Table 6.9 , Pg 31 State of the adult Social Care Workforce 2012, NMDS. Cost as a per hour fraction of replacing the member of staff with a comparable member is £0.18 per hour. | (£6.50 x 7.5 hours x 7 days) / (37 hours x 52.14 weeks per year) = 0.1768 = £0.18 to 2dp | 0.18 | **R2** |
| M6 | Sum of M1 through M5 | | | |
| M7 | Laing and Buisson report from 2011, on what local authorities pay for a homecare hour. Assuming all increases are solely due to paying for extra hourly cost, and working out a week at the enhanced plus standard against a fully standard week gives a 5.4% increase per hour on costs | See "Costing for M7" Tab below | | **R7** |
| M8 | Sum of M6 and M7 | | | |
| M9 | These costs should not be borne by LCC, we have no current block contracts and would expect service providers to keep a small surplus of hours available as part of their business continuity. | | | - |
| M10 | There is no available data on the costs of uniform and PPE clothing available for the domicilliary care market therefore the amount calculated as a per week cost for the residential framework has been used divided by the number of working hours per week. | £0.91 / 37 hours per week = 0.02459 = £0.02 to 2dp | | **R8** |

| Model Cell Number | Notes | Calculation | Formulae | Reference Documentation |
|---|---|---|---|---|
| M11 | The NMDS SC Briefing 2 - Skills for care gives the cost of training a care worker at £980, assuming that staff stay for 2 years (90% of care staff have been delivering for 2 years or more - State of the Adult Social Care Sector and Workforce in England, 2012 Pg 32, Table 6.12), the cost per hour to recoup the training costs is 0.2539 = £0.25 to 2dp.<br>The NMDS SC Briefing 12 - Skills for care also gives a turnover rate of 20.9% for domiciliary care staff, so allowing 20.9% on top of the above costs, for retraining new members gives another £0.21 per hour<br>There will be further CPD training needs across a carer's employment for refresher courses and package specific training, in the absence of further information the average figures from the Extra Care tender have been used = £0.20 per hour.<br>Total for training costs = £0.66 per hour | £980 / (2 years x 52.14 weeks x 37 hours per week) = £0.25 to 2dp. Adding 20.9 % of this amount is = £0.21 to 2dp. Plus £0.20 for additional refresher costs.Total cost £0.66 per hour | | **R2 / R3 / R6** |
| M12 | UKHCA model dictates 9% extra of base hourly rate on travel time in urban areas and 13% in non urban. This rate does not take into account paying mileage to Providers, but does include travel time. Paying mileage would require a systematic mapping of homecare calls within the county and investigation into Provider's care rounds. | | | **R5** |
| M13 | There is no available data on the costs of recruitment available for the domicilliary care market therefore the amount calculated as a per week cost for the residential framework ahs been used divided by the number of working hours per week. | £0.83 / 37 hours per week = 0.02243 = £0.02 to 2dp | | **R8** |
| M14 | Providers have traditionally borne the cost of any Electronic Call Monitoring System that they utilise, this will continue to be the case | | | **-** |
| M15 | From Local Authority Area Profile - Lincolnshire, NMDS-SC, Table 7, employee job roles, 80% of care staff employed in the domiciliary care sector are employed as carers. Taking the figures for registered managers at 1%, senior carers at 7% and grouping the other management staff to 7%, roughly 5% of staff will be back office.<br><br>Costings per hour are taken from the Local Authority Area Profile - Lincolnshire, NMDS-SC, Table 24, Worker Pay and Conditions: Gross Hourly Salaries. | See "Costing for M15" Tab below. Note: On costs for back office staff have been included in rate for M17. | | **R4** |

| Model Cell Number | Notes | Calculation | Formulae | Reference Documentation |
|---|---|---|---|---|
| M16 | Average cost for Rent, etc. based on Extra Care costings from previous tender, all 5 providers used in the calculation are CSF providers and the Extra Care schemes utilise the same staff members that deliver under the community support framework. | | | **R6** |
| M17 | From Local Authority Area Profile - Lincolnshire, NMDS-SC, Table 7, employee job roles, 80% of care staff employed in the domiciliary care sector are employed as carers. Taking the figures for registered managers at 1%, senior carers at 7% and grouping the other management staff to 7%, roughly 5% of staff will be back office.<br><br>Costings per hour are taken from the Local Authority Area Profile - Lincolnshire, NMDS-SC, Table 24, Worker Pay and Conditions: Gross Hourly Salaries. Sickness rates have been taken from Table 6.9 , Pg 31 State of the adult Social Care Workforce 2012, NMDS. NI Costs per 4 weekly period are taken from HMRC NI Calculator: http://www.hmrc.gov.uk/calcs/nice.htm | See "Costing for M17" Tab below | | **R4 / R2** |
| M18 | Sum of M9 through M17 | | | |
| M19 | Sum of M18 and M8 | | | |
| M20 | Average profit margin based on Extra Care costings from previous tender, all 5 providers used in the calculation are CSF providers and the Extra Care schemes utilise the same staff members that deliver under the community support framework. | See "Costing for M20" Tab below | | **R6** |
| M21 | M20 expressed as a cost in £ | M19 x M20 | | **-** |
| M22 | Sum of M19 and M21 | | | |

# COSTING FOR M7

Average homecare fees 2009/10

| Weighted average price for an independent sector homecare hour provided for social services by time and region, UK 2009/2010. | | | | |
|---|---|---|---|---|
| **Region** | **Daytime Weekday** | **Daytime Weekend** | **Night-time Weekday** | **Night-time Weekend** |
| East Midlands | £12.79 | £14.66 | £13.34 | £14.80 |

Source: Laing & Buisson, Domiciliary Care UK Market Report 2011.

| **Daytime Weekend** | **Night-time Weekday** | **Night-time Weekend** |
|---|---|---|
| % increase on standard daytime week day rate per hour | % increase on standard daytime week day rate per hour | % increase on standard daytime week day rate per hour |
| 1.146207975 | 1.043002 | 1.157154027 |

| | | Hours per week | Cost at £5 per hour |
|---|---|---|---|
| Night time weekend | 10pm -7am sat sun | 18 | £ 104.14 |
| Night time weekday | 10pm - 7am mon - fri | 45 | £ 234.68 |
| Day time weekend | 7am - 10pm sat sun | 30 | £ 171.93 |
| Rest of week | | 75 | £ 375.00 |
| Total cost of a full week with enhanced rates | | | £ 885.75 |
| Total cost of a full week at standard rate | | 168 | £ 840.00 |
| Percentage increase in cost spread across the week | | | 1.054 |

(we are only interested in the % change so the cost per hour doesn't matter)

# COSTING FOR M15

| | Percentage of Organisation | Cost per Hour | |
|---|---|---|---|
| Registered Manager | 1% | £ 12.50 | |
| Other Management | 7% | £ 8.50 | Assumption that other management are paid at senior carer rate |
| Senior Carers | 7% | £ 8.50 | |
| Office Staff | 5% | £ 6.50 | Assumption that office staff are paid at standard carer rate |
| Carers | 80% | £ 6.50 | |

| | |
|---|---|
| 5 staff @ £6.50 per hour | £ 32.50 |
| If there are fewer carers, there will be conversely fewer office workers required, therefore dividing the cost per hour by the percentage that carers make up of the staff team to allow costs to be scaled so the number of staff is not required for the calculation of the rate. | £ 0.40625 |
| Cost per hour for Office Staff to 2dp | **£0.41** |

# COSTING FOR M17

| | Percentage of Organisation | Cost per Hour | |
|---|---|---|---|
| Registered Manager | 1% | £ 12.50 | |
| Other Management | 7% | £ 8.50 | Assumption that other management are paid at senior carer rate |
| Senior Carers | 7% | £ 8.50 | |
| Office Staff | 5% | £ 6.50 | Assumption that office staff are paid at standard carer rate |
| Carers | 80% | £ 6.50 | |

**Payroll Costs**

| No of Staff | Staff group | Cost per hour for each staff group | |
|---|---|---|---|
| 1 | Registered Manager | £ 12.50 | |
| 7 | Other Management | £ 59.50 | |
| 7 | Senior Carers | £ 59.50 | |
| | | £ 131.50 | total cost per hour for all non carer/admin staff |

Dividing this by 80 for the precentage of frontline care staff in a standard agency

| | |
|---|---|
| £ 1.64 | per hour to cover management staff wages |

**NI Contribution**

| No of Staff | Staff group | NI Cost Per Person per 4 weekly period | Total cost NI cost per group per 4 weeks |
|---|---|---|---|
| 1 | Registered Manager | 170.84 | £ 170.84 |
| 7 | Other Management | 89.15 | £ 624.05 |
| 7 | Senior Carers | 89.15 | £ 624.05 |
| 5 | Office Staff | 48.30 | £ 241.50 |
| | | | £ 1,660.44 |
| | | | £ 11.22 |
| | | | £ 0.14 |

4 weekly cost for back office and management staff NI contribution.

dividing by (37 hours x 4 weeks) to get a NI cost per hour if paid for by one member of staff

dividing this by 80 to get the split between the percentage ratio of care staff to management/back office staff for a per hour rate to pay for NI contribution

**Pension**

| No of Staff | Staff group | Cost per Hour | Total cost per hour per group |
|---|---|---|---|
| 1 | Registered Manager | £ 12.50 | £ 12.50 |
| 7 | Other Management | £ 8.50 | £ 59.50 |
| 7 | Senior Carers | £ 8.50 | £ 59.50 |
| 5 | Office Staff | £ | £ |

| | | | | |
|---|---|---|---|---|
| | | 6.50 | 32.50 | |
| | | | £ 164.00 | total cost per hour of 'other' staff |
| | | | £ 1.64 | 1% pension contribution for 'other' staff |
| | | | £ 0.02 | split between 80% care staff |

**Sick Pay** 6 days sick on average per year for back office staff

| No of Staff | Staff group | Cost per Hour | Total cost per hour per group | |
|---|---|---|---|---|
| 1 | Registered Manager | £ 12.50 | £ 12.50 | |
| 7 | Other Management | £ 8.50 | £ 59.50 | |
| 7 | Senior Carers | £ 8.50 | £ 59.50 | |
| 5 | Office Staff | £ 6.50 | £ 32.50 | |
| | | | £ 164.00 | total cost per hour of 'other' staff |
| | | | £ 7,380.00 | cost across the year for sick pay |
| | | | £ 3.83 | split across the working hours of one member of staff |
| | | | £ 0.05 | split further across 80% care staff |

**Holiday Pay** Assuming 28 days holiday pay per staff member

| No of Staff | Staff group | Cost per Hour | Total cost per hour per group |
|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| 1 | Registered Manager | £ 12.50 | £ 12.50 | |
| 7 | Other Management | £ 8.50 | £ 59.50 | |
| 7 | Senior Carers | £ 8.50 | £ 59.50 | |
| 5 | Office Staff | £ 6.50 | £ 32.50 | |
| | | | £ 164.00 | total cost per hour of 'other' staff |
| | | | £ 34,440.00 | cost across the year for holiday pay |
| | | | £ 17.85 | split across the working hours of one member of staff |
| | | | £ 0.22 | split further across 80% care staff |

| | | |
|---|---|---|
| **Management staff costs and total on costs per hour** | **£** | **2.08** |

# COSTING FOR M20

| | £(Hourly rate) | | | | | | |
|---|---|---|---|---|---|---|---|
| **Category** | Provider 1 | Provider 2 | Provider 3 | Provider 4 | Provider 5 | Provider 6 | Average |
| Staffing | 9.54 | 9.01 | 9.25 | 10.38 | 9.32 | 10.43 | 9.66 |
| Basic Pay | 7.56 | 6.63 | 7.33 | £6.58 | 6.69 | 7.89 | 7.11 |
| NI | 0.83 | 0.51 | 0.32 | £0.96 | 0.74 | 0.39 | 0.63 |
| Pension | | | | | | | 0.00 |
| Other Costs | | 0.87 | 0.88 | £0.98 | 0.84 | 1.08 | 0.78 |
| Travel Expenses | 0.08 | | | | | 0.24 | 0.05 |
| Training Expenses | 0.37 | 0.14 | 0.36 | £0.09 | 0.2 | 0.04 | 0.20 |
| Premises & Equipment | 0.53 | 0.55 | 0.36 | £0.62 | 0.45 | 0.79 | 0.55 |
| Administration | 0.17 | 0.31 | | £1.15 | 0.4 | | 0.34 |
| Overheads | 0.55 | 1.23 | 0.44 | 1.23 | 1.84 | 0.73 | 0.26 |
| Management Costs | 0.3 | 0.51 | 0.37 | £1.06 | 1.5 | 0.73 | |
| IT Support | 0.07 | 0.11 | 0.07 | £0.03 | 0.01 | | 0.05 |
| Finance Support | 0.05 | 0.24 | | £0.03 | 0.2 | | 0.09 |
| HR | 0.05 | 0.21 | | £0.03 | 0.1 | | 0.07 |
| Legal Costs | 0.04 | 0.06 | | £0.03 | | | 0.02 |
| Insurance | 0.04 | 0.1 | | £0.05 | 0.03 | | 0.04 |
| Other Related Costs (Please Specify): | | | | | | | |
| Profit | 1.44 | 0.56 | 1.2 | £1.28 | 0.92 | 0.83 | 1.04 |
| TOTAL EXPENDITURE | 11.53 | 11.61 | 10.88 | £12.89 | 12.08 | 11.99 | 11.83 |
| Based on estimated activity (hours per week) | 105 | 105 | 180 | 105 | 105 | 205 | 134.17 |
| Percentage Profit | 12% | 5% | 11% | 10% | 8% | 7% | 9% |

**APPENDIX H**

| Impact Analysis to Enable Informed Decisions | | | | | | |
|---|---|---|---|---|---|---|
| **Background Information** | | | | | | |
| **Directorate** | **Assistant Director Area** | **Service Area** | **Lead Officer** | **Person / people completing analysis** | **Date of workshop / meeting** | **Version** |
| Children's Services | Stuart Carlton | Children's Commissioning | Andrew Mclean | Becky Harrison | Updated 12 Feb 15 | Draft V5 |

| | | |
|---|---|---|
| **Title of the policy / project / service being considered** | Review of the Domiciliary Care Service | |
| **General overview and description** | The contract for this service comes to an end on 31 March 2015 and is being reviewed as part of the commissioning process. Approval is being sought for a contract extension to 30 September 2015 to allow the joint re-commissioning of this service with Adult Social Care to be undertaken.<br><br>The decision to commission this service jointly with Adult Social Care seeks to ensure any future service continues to meet the needs of children and young people. Integral to this decision is the consideration and impact of continued budget pressures on future services with the need to demonstrate the most efficient use of resources and value for money.<br><br>A joint project group with Adult Social Care has been developed to ensure development of this service is undertaken in a consistent way that meets the needs of all service users, with Adults taking the lead role in procurement of the future service.<br><br>Six areas, comprising of two zones per area, have been identified as geographical service delivery areas and the commissioning intention is to contract with between four and twelve "prime providers" to allow market stimulation and development. | |
| **Current status** | Existing | **<u>Commissioned</u>** |
| **Timescales for implementation** | The outcomes of the review of this service, and decisions around any future commissioning were made by the Executive on 2 September 2014. | |

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| | There has been a slight delay to the tendering of this service with the new contract award date scheduled for 01 July 2015, and the contract to start 01 October 2015. |
| **Analysis** | |
| **1. What is the current situation?** | The current service is run by Action For Children (AFC) and they have held the Domiciliary Care contract since October 2007.<br><br>The Contract is due to end in March 2015, with decisions around commissioning intentions and recommendations approved by the Executive on 2 September 2014.<br><br>Children and Young People with Disabilities are children in need as defined by The Children Act 1989 section 17 (10) and as such are entitled following an assessment of need to receive services designed to improve outcomes and their life experiences.<br><br>This service supports the Local Authority duty in respect of the Breaks for Carers of Disabled Children Regulations 2011, part of the Children Act 1989, whereby in performing their duty LA's must:<br>• Have regard to the needs of those carers who would be unable to continue to provide care unless breaks from caring were given to them; and<br>• Have regard to the needs of those carers who would be able to provide care for their disabled child more effectively if breaks from caring were given to them to allow them to-<br>i) Undertaken education, training or regular leisure activity<br>ii) Meet the needs of other children in the family more effectively, or<br>iii) Carry out day to day tasks which they must perform in order to run their household. |

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| **2. What are the drivers for change?** | The contract is coming to an end in March 2015, with the approval being sought to extend up to 30 September 2015.<br><br>Impact of continued budget pressures on any future service and the need to demonstrate the most efficient use of resources and value for money. There is an opportunity to realise savings and efficiencies by delivering this service by collaborating with Adult Social Care to realise savings offered by volume of delivery/locality of delivery.<br><br>It is also anticipated that a collaborative service may assist transition from Children's services to Adult's services. |
| **3. What difference will we make?** | All commissioning processes are moving towards an outcome based service delivery model; the service specification will ensure that the experiences of the service user are heard and taken into account in the delivery.<br><br>Any future service shall demonstrate that it is providing value for money and realising maximum efficiencies whilst targeting the maximum amount of families. |
| **4. What are the assumptions about the benefits?** | The voice of the child and their families will be heard by understanding their experiences, with service delivery being tailored to their needs and aspirations as part of ongoing communications with families at time of service delivery.<br><br>Parents and stakeholders have been consulted and will continue to be included to ensure services are being delivered in line with need and striving for continual improvement.<br><br>Services will be delivered in locations where they are needed and ensure that children who require these services have access and any waiting list will be managed accordingly.<br><br>That collaboration with Adult's will lead to contract efficiencies and improved economies of scale, potentially resulting in smoother transition to Adult Care and greater numbers of users receiving service. |

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| **5. How are you testing your assumptions about the benefits?** | The service will be monitored and contract managed using a suitable monitoring toolkit identified by Adults who are the lead for this collaboration, with input/feedback provided by Children's Services.<br><br>The contract management process ensures that stakeholder feedback is sought and outcomes from this are incorporated into service delivery. |
| **6. The assumptions about any adverse impacts. Could it have a negative impact on anyone?**<br><br>If Yes, go to 6.1 and 6.2<br>If No, please explain how you know this is the case | YES |
| 6.1 Which groups / individuals could it have a negative impact on? | • Children and their families<br>• Parents/Carers<br>• Current Providers of services<br>• Stakeholders of Domiciliary Care services |
| 6.2 Please state how it could have a negative impact on these groups / individuals? Please refer to the list of protected characteristics to assist your answer. | • Children and their families have built up relationships with the current Provider of the service which could end depending on the outcome of the tendering activity and this has been identified through consultation as being very important to families.<br>• A change in Provider may result in reduced or increased quality, value for money and provision. Consultation has also indicated that a high proportion of service users are already receiving the the full care package they require and consideration must be given to this in the new contract to ensure there is no decrease in quality/service.<br>• Collaboration with Adult Social Care may result in the standard of domiciliary care for children being reduced if the successful Provider does not ensure the specific needs for |

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| | children/young people are accounted for. A robust specification has been developed with the need for specialised, individual and timely delivery of care emphasised throughout.<br>• Loss of business for the current Provider if they are unsuccessful in securing this contract following the procurement process. The current Provider have been kept aware of the current situation and relevant information has been shared. A number of market engagement events have been facilitated and the current Provider has attended these to receive up to date contract/future intentions.<br><br>The list of protected characteristics has been reviewed and the following groups of people may be impacted:<br><br>• Age – children aged 0-18 years who currently access the domiciliary care services will be impacted by any change in Provider. There will also be scope for those children/young people affected by transition to adulthood to be impacted by any change of Provider/change in service delivery.<br>• Gender re-assignment – N/A<br>• Pregnancy or maternity – N/A<br>• Race – N/A<br>• Disability – user group is wholly made up of children/young people with disabilities and any cessation/change will have an impact on those who use these services.<br>• Religion or belief – N/A<br>• Sex – N/A<br>• Sexual orientation – N/A<br>• Marriage and civil partnership – N/A |

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| **7. How are you testing your assumptions about adverse impacts?** | The experience of the Commissioning Team from running previous tender exercises allows us to assume that the outgoing Provider can be impacted by a retender and they have been informed of the decision to re-tender in November 2014. The current Provider has been involved in the development of our commissioning activities in respect children with disabilities services and has attended market engagement events and has been updated regarding the procurement process at suitable points.<br><br>A consultation process has been completed to gain the views and opinions of parents/carers and work is being undertaken with parents/carers and relevant stakeholders to communicate the final decision about the future service and how best to support anyone affected by any changes. A Communications Plan has been developed by the Project Team including letters to users and Providers, staff briefings and the compilation of FAQ's for staff receiving queries. Queries are also being monitored to identify common themes of concern and these will be incorporated into Project Risk Log if appropriate.<br><br>A visit to Nottingham City Council was undertaken to identify lessons learnt and enable project team to develop mitigating actions where necessary – Project Risk Log updated.<br><br>Robust cost modelling has been undertaken to ensure that the unit rate is consummate with market expectations and regional/national averages and has been adapted from the Adult's cost modelling. The final unit cost is comparable with Nottingham City's successful rate and has been shared with relevant colleagues.<br><br>Feedback from consultation has been included in the development of the specification to ensure that any gaps in provision are addressed and user views are represented. |
| 7.1 What further evidence do you need to gather? | |
| **8. Who are the stakeholders and how will they be** | **Primary** (those directly affected, either positively or negatively by the organisation's actions) |

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| **affected?** | Children and Young People, Current Providers of CWD commissioned services |
| | **Secondary** (intermediaries, people or organisations who are indirectly affected by the organisation's actions) |
| | Parents/ Carers |
| **9. How are you assessing the risks and minimising the impacts?** | As part of the review process we have engaged with our current Providers, parents, carers, children and young people to gain their views and opinions and incorporated these into the recommended option for future delivery as much as possible. Communication will be on-going as part of wider Project Team communication plan.<br><br>If possible children/young people and/or their families and carers will be involved in the tender process.<br><br>The new Providers will have in place appropriate policies and procedures in relation to Equality and Discrimination. These will be based on legal responsibilities and recognised good practice. They will be reviewed on a regular basis by the Provider and checked as part of the contract monitoring function of LCC.<br><br>See previous points regarding visit to Nottingham City Council.<br><br>All project risks are logged and reviewed in project risk register. |
| **10. What changes will the Council need to make as a result of introducing the policy / project / service etc?** | The Council will not need to make any changes. All stakeholders will be informed of the decisions agreed by the Executive following the meeting.<br><br>A Communications Plan is in place and has been approved by appropriate officers. |

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| **11. How will you undertake evaluation once the changes have been implemented?** | Through regular review of outcomes as part of the commissioning process / contract monitoring.<br><br>By stakeholder surveys which have been included as a mandatory KPI for the new Provider.<br><br>Through regular contact with service users by CWD team. |

| **Further Details** | | | |
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| **Are you handling personal data**? If so, please give details. | No | | |
| **How was this analysis undertaken?** Facilitated workshop? Who attended? | Analysis based on current information held including consultation information from parents/families and project information developed between Service Lead, Commissioning Lead and wider project team. | | |
| **Are you confident that everyone who should have been involved in producing this version of the Impact Analysis has been?** If No, who needs to be involved? | YES - all views from consultation with providers, children/young people and their families have been considered in development of this Impact Analysis. | | |
| **If this is new, or requires a decision by Councillors to revise, has this impact analysis been included with the committee report?** | | | |
| **Actions required** Including any actions identified in this analysis for monitoring in the relevant service area work plan? | **Action** | **Lead officer** | **Timescale** |

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| **Signed off by** |  | **Date** | 16 February 2015 |

* Cells of the form with shading will help you form your consultation plan, should you need to carry out a consultation as a result of Impact Analysis discussions.

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