Commissioning Partnership Board/Commissioning Committee Report

Decision Maker	**Cabinet Member for Health and Social Care: Cllr Z Chauhan and Dr John Patterson**
Date of Decision:	**30th August 2018**
Subject:	**Domiciliary Care Commissioning**
Report Author:	**Vicky Walker/Victoria Wood**

Reason for the decision:	*To agree the Joint Commissioning Framework for Domiciliary Care from April 2019*
Summary:	*The purpose of the report is to agree the options for the procurement of domiciliary care services in Oldham across health and social care*
What are the alternative option(s) to be considered? Please give the reason(s) for recommendation(s):	The options are: 1. Procurement framework a) To procure all domiciliary care services under one overarching dynamic purchasing system (including health and children's). These will be separated into 4 lots: standard care based in each of the 5 clusters, extra care housing, health and complex care; children's social care b) To procure each service separately under separate tender arrangements Option a) is recommended for reasons of efficiency and consistency. As a dynamic procurement system we can add new providers onto the framework and the light touch arrangement allow us to call off the framework when required.

2. The procurement strategy -

a) We procure two main providers for standard adult care within each cluster, one borough wide provider for extra care, and specialist providers for complex care and children's
b) We procure all provision on a cluster based approach on a standard framework

Option a) is recommended as it allows for the work to be divided across 10 providers for adult social care which allows providers to deliver locally at volume. The more specialist provision will be delivered by specialist providers providing consistency in more complex cases and environments.

3. Contract length:

a) 5 years or
b) 5 years, plus an option to extend for a further 2 years

Option b) is recommended to ensure stability in the market, and allow us to work with providers to bed in changes related to cluster based working and integration. The Council will retain the ability to vary or serve notice within the contract term.

4. Payments:

a) We continue to pay providers the annually agreed fee rates for core wellbeing and individual hours. Individual hours will be reconciled on a regular basis against actual delivered hours.

Recommendation(s): *See above recommended options/decision*

Implications:

*What are the **financial** implications?* As highlighted earlier in the report the spend for domiciliary care services fluctuates daily dependent on need. We can provide an estimated pocket of spend benchmarked against previous years spends.

For care at home services delivering approximately 606,000 hours of care per year to over 1,000 individuals at an estimated cost of £9 million per annum.

For Oldham CCG Continuing Health Care for the provision of social, personal and nursing care for adults, children and young people 4,000 hours of care per annum to approximately 50 individuals at a cost of approximately £70,000.

For Extra Care Housing Services there is approximately 105,000 commissioned hours of care per annum at an approximate annual cost of £1.5 million.

Children's Domiciliary care services commission approximately £600,000 of care.

What are the ***procurement*** implications?

Strategic Sourcing supports the options in this report regarding appointing 2 lead providers per cluster for Care at Home and 1 lead provider for Extra Care. Given the nature of the services that are being procured in this commission, and the challenges within the market, Strategic Sourcing is currently undertaking an analysis with regards to the suitability of implementing a Dynamic Purchasing System utilising the flexibilities afforded by the Light Touch Regime. Strategic Sourcing will work with the services to develop a system for allocating care packages from the back up list that is in accordance with procurement obligations such as value for money and equal treatment.
Neil Clough, Sourcing & Contracts Consultant. 12th July 2018.

*What are the **legal** implications?*

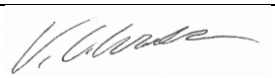
The Council has decided to use the flexibility afforded to it by the Public Contracts Regulations 2015 under the Light Touch Regime using a Dynamic Purchasing System DPS) to procure providers for the various lots outlined in the body of the report. A DPS has the advantage of allowing providers to join the system throughout the life of the contract. This has the advantage of enabling the Council to meet its duties under the Care Act 2014 to develop the market and actively manage

	market failure. **(Elizabeth Cunningham-Doyle)**
*What are the **Human Resources** implications?*	Although there are no staffing implications for the Council, there will be staffing implications for the providers. MioCare currently undertake both extra care housing and care at home services, dependent on the outcome of the tendering process, it is highly likely that there will be TUPE transfers both in and out of the company. People Services will support this ensuring that the process is legally compliant and in accordance with the company's policies and procedures. **(Emma Gilmartin, HR Business Partner)**
***Equality and Diversity Impact Assessment** attached or not required because (please give reason)*	*Equality and Diversity Impact Assessment (EIA): Initial Screening – see Appendix A. No negative implications have been identified and therefore a full EIA was not been completed.*
*What are the **property** implications*	*None*
Risks:	*The risks identified are:* • *Current providers are not successful, and new entrants to the market impact on the ability of the sector to deliver. This should be mitigated through the diversity of the framework, including 10+ main providers, evaluation of provider capacity within the tender process, assessment of implementation plans, and the application of TUPE.* • *Some disruption for service users, providers and staff as contracts align to the new model of provision. TUPE will apply for staff which should minimise the impact on service users. There will be a three month implementation period following award of contracts to ensure the process of transfer is as smooth and effective as possible.* • *The cluster arrangements and one main provider for extra care reduces client choice. This is mitigated by ensuring there are specialist provider on the framework who can deliver to client needs, and all clients have the choice of taking a direct payment*

Has the relevant Legal Officer confirmed that the recommendations within this report are lawful and comply with the Council's Constitution/CCG's Standing Orders?	Yes
Has the relevant Finance Officer confirmed that any expenditure referred to within this report is consistent with the S.75 budget?	Yes
Are any of the recommendations within this report contrary to the Policy Framework of the Council/CCG?	No

List of Background Papers under Section 100D of the Local Government Act 1972:
(These must be Council documents and remain available for inspection for 4 years after the report is produced, there must be a link to these documents on the Forward Plan).

Title	Available from
Cabinet report re extension of Care at Home and Extra Care contracts	https://committees.oldham.gov.uk/documents/s94882/ECH%20and%20CAH%20Exemptio

Report Author Sign-off:	
Vicky Walker	
Date:	30th August 2019

Please list any appendices:-

Appendix number or letter	**Description**
Appendix A	Initial Screening: Equality Impact Assessment (EIA)

Background:

1.1 The process of integration between health and social care has identified a number of areas which should be jointly commissioned between Oldham CCG and Oldham Council. This report sets out the options appraisal for jointly

commissioning domiciliary care provision for the borough under Section 75 arrangements.

1.2 Cabinet approved the extension of this contract to 31st March 2019 to allow time to develop a single specification and contractual framework for the joint commissioning. A project group comprising of both CCG and Oldham Council colleagues have undertaken the scoping and development work to combine both organisations delivery objectives for domiciliary care.

1.3 The outcome from this scoping work has identified that the joint commissioning for domiciliary care in Oldham should comprise of one overarching framework for all domiciliary care, incorporating separate lots including:

- Care at Home;
- Extra Care Housing;
- Complex Needs (including Learning Disability and complex health needs), and
- Children's Domiciliary/Continuing Care provision.

1.4 This paper sets out the various models for operational delivery and seeks approval for the preferred options, where there is significant change.

2 Current Provision and Commissioning Approach to Care at Home within Oldham

2.1 Care at Home is commissioned in different ways at present, by three sets of commissioners: Adult Services, the CCG and Children's Services, and multiple contracts.

2.2 There is a framework and approved provider list for Oldham Council Care at Home. Oldham Council's current Care at Home contract was commissioned February 2014. The providers on the framework are delivering approximately 606,000 hours of care per year to over 1,000 individuals at an estimated cost of £9 million. Oldham Council's current Extra Care Housing (ECH) Contract was commissioned in 2015 as a mini competition from the care at home approved list for care at home. There are six Extra Care Housing schemes based in three of the GP clusters with two separate care providers, delivering approximately 105,000 commissioned hours of care per annum at a total cost of approx. £1.5 million.

2.3 The contract and service specifications for Care at Home and Extra Care Housing diverge and it can be difficult to manage a consistent approach when one element of service delivery changes.

2.4 Oldham CCG also have a separate specification and contract for the delivery of their Continuing Health Care contract with regards to social, personal and nursing care for adults, young people and children. The contract was commissioned in April 2017 by the CCG and is due to expire 31st March 2020. This contract delivers approximately 4,000 hours of care per annum to approximately 50 individuals at a cost of approximately £70,000.

2.5 Children's services have a separately commissioned range services known as 'Short Breaks' of which one element provides for domiciliary care and respite service. It is this element that will be included in the Joint Commissioning arrangements. The individual commissioned provision for domiciliary care

provision for children's were commissioned by Children's Services Commissioners in October 2017, with a contract end date of 31st March 2019. The value is approximately £600,000 per annum.

2.6 The current payment approach for care at home of paying by minute on actual delivered hours was developed to minimize the cost of care at home services and ensure that payment was only made for delivered care hours only. This was facilitated through an electronic call monitoring (ECM) system. The current ECM system is no longer fit for purpose and will cease to be supported from December 2018. Separate approval has been sought to de-commission the current system with a view to scoping alternative options. It is also worth noting that the CCG do not use an ECM system and pay on a manual invoice basis.

2.7 The current payment approach for extra care is based on a sixty hour weekly core amount per scheme to pay for the presence of a senior care worker. Care staff are paid per care run in a similar way to care at home. The model has been reviewed for the new tender process and we have consulted with our current providers. It has been found that as carers are not paid per shift, but by number of calls, there are times where they are on site but are not being paid, leading to little flexibility, and staff waiting on scheme between peak periods but reluctant to do any additional ad hoc work, helping with activities etc. as they are not being paid.

2.8 The night service is paid separately using funding from the Better Care Fund based on 2 carers and a mobile night van.

Proposals:

3. Procurement Approach

3.1 To maximise efficiencies and resources it is proposed that we combine the NHS and Oldham Council contracts through Section 75 arrangements. The packages of care delivered through Care At Home, Continuing Health Care, Continuing Care Extra Care Housing, and Children's Care are very similar in nature, albeit delivered to different client groups in different contexts. Combining the contracts provides the opportunity to streamline provision and the contract monitoring approach. This would allow services to be commissioned together under one purchasing system.

3.2 It is proposed that the NHS standard short form contract is used and any additional requirements are added to this via schedules. The rationale for this is due to legal considerations where some of the work commissioned under this arrangement would be clinical in nature and NHS terms and conditions taking precedence.

3.3 A single specification and tendering process for the delivery of care would ensure consistent requirements for the delivery of care in the community. This would assist with improving quality through a shared understanding of expectations and quality standards. This process would also reduce duplication and time constraints through the tendering process for the local authority, Oldham CCG and providers alike.

3.4 Through a framework commissioning approach, a joint set criteria for delivering domiciliary care will be identified through a single overarching specification in Oldham. A lotting strategy will identify the specific service delivery requirements with additional service requirements outlined in the procurement of each Lot.

3.5 The price per hour for the delivery of care will be consistent across health and social care and set at a fixed price relating to each service lot so the evaluation of the bids will be based on quality, outcomes and social value.

4 Procurement and Lotting Strategy

4.1 It is proposed that under this particular framework the lotting strategy would be as follows:

- Lot 1 – Adults Domiciliary care at home (inclusive of continuing health care, and with the a night sitting service option to increase capacity/complement the Marie Curie service)
- Lot 2 – Extra Care housing
- Lot 3 - Complex care: including Learning Disability, complex health needs, and for individuals with domiciliary night care needs (rather than overnight sitting)
- Lot 4 – Children's domiciliary care

4.2 Provider and stakeholder consultation and a benchmarking exercise with neighbouring authorities, have informed our proposals for the different lots:

Lot 1: Adult Domiciliary Care (standard) delivered at scale

4.3 As we continue on the integration journey between health and social care, the delivery of services is now focused around the five GP clusters. For future delivery of care at home services it is envisaged that the cluster based approach would allow better neighbourhood working and integration with our health colleagues. It is proposed that we have a lead provider(s) for each cluster who can drive innovation and quality. The provider would work effectively with the community based health and social care teams providing a joined up approach, and maximising the use of all community assets.

4.4 The focus on two providers per cluster, provides a more vibrant market, with providers having a guaranteed level of hours, which will help stabilise the market. It will support providers to recruit and retain staff who can work locally, have consistent hours and the introduction of new tasks/responsibilities will provide opportunities to learn new skills. Learning taken from other GM authorities taking the two provider per cluster approach has shown that this creates capacity within the system. The providers would work on a rota basis: one week on, one week off. This would mean the care arrangers would place packages of care with the provider when it was their week on rota.

4.5 <u>Alternative options are to:</u>

- Have one provider per cluster which would reduce administration, but reduce the capacity in the market, and cause more risks around seeking alternatives for individuals care packages in the event of dealing with provider failure.
- Continue to commission services as currently, but capacity is an issue with many providers, and provision can be scattered across the borough with no clear link to cluster arrangements and local assets.

Lot 2: Extra Care

4.6 It is proposed that under the new service delivery model for Extra Care Housing one lead provider operates borough wide.

4.7 The borough wide approach would allow us to commission an experienced extra care provider, ensure consistency, and retain our focus on the development of the extra care service. Extra Care is a different service to Care at Home as it is a 24/7 service, requires site management skills and partnership working with the housing provider and contractors. One point of contact for care delivered within an Extra Care setting, will reduce the time health and social care staff need to spend communicating and developing relationships and services.

4.8 We have recently developed extra care night provision, which operates across different schemes/providers. By including this provision formally within one contract, we can reduced the number of providers delivering different elements of the service, which promotes better communication and management.

4.9 Having one lead provider for the delivery of Extra Care Housing does cause some risks which are associated with provider failure. However the Extra Care Housing provision is usually more stable than the home care market. The payment model for Extra Care Housing will support stability in the market place.

4.10 The alternative options are to continue to have multiple providers delivering extra care, based on a split of schemes, or delivered by a cluster lead. Extra Care provision is currently only based in three of the five clusters (three schemes based in the Central Cluster, two schemes based in North Cluster and one scheme based in East Cluster) which would skew the number of hours delivered by the cluster lead providers, and a decision would have to be made regarding which lead cluster provider is allocated extra care. If decisions regarding who was commissioned to provide extra care is based on experience, a care at home cluster based approach for extra care would also limit the number of providers who could bid, as there are fewer specialist providers within this market.

Lot 3: Complex Care including Health and Learning Disability

4.11 Complex care including health and learning disabilities are specialist areas and have lower demand in terms of volume. As a result we are proposing a separate lot to include specialist providers providing domiciliary type care, who can work across the borough. Care at night, outside of extra care, will also be included within this lot as this is more effective as a borough wide service, as the volume is

small and therefore it would not be an efficient use of resources to have six separate services running per cluster.

4.12 The alternative option is to separate out the commissioning for specialist provision, so we have separate tenders for health provision, learning disability, night services etc. This would potentially dilute our ability to co-ordinate contractual changes and develop services consistently across domiciliary care type provision.

Lot 4: Children's Domicillary Care – short breaks

4.13 Again the volume of children receiving domiciliary care services is smaller, with around 70 receiving directly commissioned care, and these children will be scattered across the borough. In order to ensure those providers working with children have the specialist skills and adhere to the appropriate regulations we have separated this into a different lot and are looking for providers who can operate across the borough. It is envisaged that the service may by delivered by one of the providers delivering in a cluster, or by another specialist provider in Lot 3, as long as they can also deliver this service borough wide.

4.14 The alternative option is to separate out the commissioning for children's social care into a separate tender. However this would miss the opportunity to commission social care consistently and link with health Continuing Care provision, and for providers to gain some economies of scale.

4.15 NB: The understanding is that the Oldham Care's provider The Mio Care Group would be the 'provider of last resort' should there be any provider / market failure, in circumstances where:

- There is a failure of another provider that is of such short notice that alternative longer term arrangements cannot be made, or
- The Council is unable to secure, within the required timescales, any other provider to deliver a service, or
- There is an identified need to offer short term support to another provider to enable them to continue to provide a service where the assessed needs of service users cannot be met in a safe way.

This will mitigate any associated risks with provider / market failure.

5. Contract term

5.1 In order to create sustainability for the market, and effectively embed the new cluster based approach and the joint service delivery specification between health and social care, it is proposed that a longer length contract be created to help facilitate this. It is proposed that the new joint contract should be for the maximum that a framework agreement allows which is seven years, based on a five years plus the option to extend for a further two years. This will give us the time to stablise the market, develop best practice and evolve future ways of working. The advantage of having an option to extend are; if things are going well, there is no need to scope, commission and procure a new service at the end of the five year period.

5.2 It should be noted that at any time during the contract period, should any issues arise, the contract obligations can be brought to an end by virtue of material breaches etc. However, if contract clauses are invoked this does bring an element of risk via way of legal challenge.

5.3 The alternative option would be reduce the contract period but it could be argued that the shorter time frame of a contract does not provide stability within the market place as once the contract is up and running, it would soon be time to review and scope service delivery again and commence once again with the commissioning cycle. Not only does this create excessive resources within commissioning and procurement, it also causes lack of uncertainty for providers, and employees staff thus de-stabilising an already fragile market. It also reduces the ability to provide continuity of care for service users, as staff can choose whether to TUPE or stay with the outgoing care provider.

6 Future changes to the payment models:

6.1 As the contracts for care at home come together through the joint commissioning arrangements it is important that finance arrangements between both organisations are understood. A separate working group for financial arrangements has been devised and both parties are satisfied with the manual invoicing approach on actual delivered care hours as an interim basis.

6.2 It is proposed that moving forward, care at home providers within the clusters would be paid based on a minimum commissioned hours approach. We anticipate that this will help stabilise the market by providing more security to providers. It will also assist with any future recruitment issues that might be faced when moving over to a lead provider cluster based model. Finance will be consulted to ensure the right balance of payment is implemented, and this will be finalized prior to commencement of the procurement process.

6.3 As Extra Care schemes have now matured in terms of a balance of need, we are proposing the following payment model to support the ability of providers to:

- To pay a 360 hours per week core block payment (average 60 hours per scheme) to provide wrap around care, supervision and additional building and care management tasks.

- To pay a block for the night service, which is based on a 11pm-7am mobile availability across schemes, addressing short term and emergency care needs.

- To pay a monthly amount based on a balance of need in schemes. This will be calculated based on current commissioned hours, and the ideal balance in schemes based on high, medium, low/no need. However, payments will be reconciled against individually delivered hours, and any overpayment or underpayment will be addressed on a quarterly basis.

6.4 The block amount will address the fixed elements of the service which provide the wrap around care 24 hours per day. The provider can choose to use the block core payment flexibly to meet the needs of each scheme, as it may vary according to the arrangement of building, the number of people on temporary step up, and

the vulnerability of tenants. The expected senior staffing of the building (7am to 11pm) will continue to be part of the care specification. The block for the night service could be included within the payment, reducing administration.

6.5 The stable monthly payment for individual care hours will ensure that there can be core shift paid staff, and there is capacity to pick up new packages of care and any restarts of packages of care following a stay in hospital. This approach would allow for dedicated extra care staff paid per shift rather than care hours delivered which reduces issues with recruitment and retention and creates stability for the provision. There would also be greater scope to promote good working relationships across housing and care through joint activities, enabling them to focus on the wider extra care roles of social inclusion and re-enablement and to work with providers to develop enhanced services.

6.6 By separating the two elements of the payment will allow for the option that tenants a degree of choice. Tenants in receipt of care will continue to be responsible for paying the weekly wellbeing charge for the wrap around care service delivered by the on-site contracted provider, as this is part of the 'extra care' provision they have chosen to move into. However, they can choose to opt for an off-site provider for their individual care hours.

6.7 The CCG already use Council standard fee rates for providers, with additional slightly higher rates for more complex health care. Children's services pay different rates. By procuring services together we can look at standardising all the fee rates, based on complexity of care rather than client group.

Conclusions:

7.1 We are recommending that all the domiciliary care services are commissioned together under one joint Council and CCG overarching specification and purchasing system. The different specialisms and differences in arrangements will be addressed within the four separate lots. Services will be jointly monitored, reducing duplication and ensuring consistency across services, pricing and outcomes.

7.2 The key recommendations are then:

- Procurement through a dynamic purchasing system/light touch to allow for call off arrangements for specialist services

- To separate services into four lots to account for different deliver arrangements and regulation frameworks. These will be:
  - Standard care delivered by two providers within the five cluster areas
  - One borough wide provider for Extra Care
  - Specialist providers to deliver complex care including health, night care and learning disability
  - Specialist providers to deliver social care services to children

- To set up the contract for a term of five years, with the option to extend for a further two years. This will ensure stability and allow for development of key partnerships and delivery arrangements.

- Payments will be based on delivered hours at agreed annual fee rates, and at a level of commissioned service. This will be reconciled against delivered hours on a regular basis.