BARNSLEY METROPOLITAN BOROUGH COUNCIL

This matter is not a Key Decision within the Council's definition and has not been included in the relevant Forward Plan

Report of the Executive Director
People) to the Cabinet
(date)

Domiciliary Care Procurement
(Support To Live at Home)

1. Purpose of the Report

1.1 To seek approval to procure a Domiciliary Care Service for Barnsley that focuses on promoting and enabling people's independence. This will also include provision for an urgent response service for end of life care.

1.2 To agree timescales for procurement and resource issues.

2. Recommendations

2.1 Cabinet approve a domiciliary care (both standard and urgent) service for the borough through a competitive tender process; to assure both quality and a best value price. The contract period is for 3 years with an option to extend for up to 2 further years.

2.2 The proposed service model is geographic – based on the area council structure - with Prime Provider in each area; with a number of assured Providers having the ability to undertake work (having successfully been through an assurance process) should service users wish to exercise their right to choice through the utilisation of a direct payment.

2.3 An Interim uplift of 2% on current fee levels will be offered to cover the period between April 2016 and the completion of new contracts.

2.4 Officers are authorised to negotiate on a case by case basis with providers who can demonstrate they are unable to absorb cost pressures within the 2% uplift.

3. Background to the Report

Background

3.1 Currently, standard and end of life domiciliary services are within the same contract. Contract prices were determined by Providers bidding within a set range of £11-14 per hour in 2010. The current contract commenced April 2010 and ends March 2016 and new arrangements need to be put into place - there is an option to put in place interim contracts for a period of 6 months with current providers to allow for a period of transition to the new arrangements. It is estimated that the new contracts will be awarded in September 2016. This provides Barnsley Council with an opportunity to commission domiciliary services that meet the

requirements of the Care Act and are supportive of the promoting independence, reablement and outcome focus ambitions of the Authority.

3.2 Activity analysis has shown that approximately 646,150 hours of domiciliary care were purchased directly by BMBC in 2014/15 from 21 Providers (on the current framework and assessed list) with costs ranging from £10 - £13.50 an hour, base line cost of £8,400,000. In total approximately 735 vulnerable adults (mainly older people) are supported - an average of each person receiving 2.4 hours a day.

Current Capacity Problems

3.3 During the life of the contract there hasn't been a formal uplift of rates and coming into the final year of the contract some framework providers have increased costs (in-line with the original tender cost thresholds). These have applied only to new packages as they have been awarded – this means that packages originally awarded in 2010 are still paid for at the 2010 prices and have not been uplifted. A number of providers have raised cost of care issues with Commissioners; this puts at risk the sustainability of the current provision. Through a transparent open book process a number of providers have demonstrated that the current prices are not meeting the cost of care.

3.4 The current arrangements are time and tasks focused and, notably more recently, have struggled to meet the demands placed upon it. Framework providers report that they receive little or no work through the mini-tender process and the majority of the new packages are awarded through phone contact with Assessment and Care Management staff. This has had an adverse affect on provider sustainability, carer employment and ultimately service quality. New packages of support are largely spot purchased from a wide range of providers from the wider assessed list. Brokers report that they can struggle to get responses from providers and services in some areas of the borough - this has led to the use of providers who do not operate in Barnsley and have not previously been commissioned by Barnsley Council. Brokers have struggled to find providers who have capacity and flexibility to meet urgent end of life care for service users; including supporting hospital discharge.

3.5 Barnsley has a clear policy direction to support people to have Direct Payments and the proposals contained within this report support the continuation of the policy direction. The current local target is that 40% of people will access Social Care support through a direct payment currently performance is in the region of 35%. This policy direction of travel is projected to continue, although the Council may choose to review it. It is therefore essential that Commissioners are able to support providers to propose pricing models for people that have a direct payment that reflect the pricing models of Council contracted services. This is currently enabled by the Resource Allocation System which is based upon the average price of domiciliary care.

3.6 The majority of people still continue to receive their support through Council contracted services. The new service model recommended in this report balances and supports both the direct payment policy direction and the need to ensure that all residents have access to safe and affordable services.

3.7 The commissioning aims of the procurement are to achieve:

- Range of sustainable service options that are of good quality, safe and effective
- The best possible value for the public purse - both the cost and quality of services, which are fairly funded.
- A focus on achieving better outcomes for Service Users
- Secure flexible options that deliver a high level of customer satisfaction that support more Service Users to live at home
- Provision that supports and complements (any) other elements of a Service User/Carer pathway
- Recognition and reward to providers for the achievement of recovery/ progression
- Arrangements that are clear and easy to understand and implement for all
- Meeting the Authorities duty in section 5 of the Care Act to ensure a sustainable market
- Services that are commissioned in line with contract and procurement regulations
- Service Users who have Direct Payments are able to access Council quality assured services at the agreed Council rate.

4. Proposed Service Model

Standard Support

4.1 The proposed service model has a number of advantages compared to the current model, including:

- Focus on promoting peoples independence, reablement and reducing demand for social care services
- Moves away from traditional approach which may have promoted increased dependency
- Category management approach – working with fewer providers to develop better relationships and increased added value
- Potential to develop incentives for additional outcomes from year 2 (building on the 2015 John Bolton paper[1])
- Outcomes linked to priorities of service users and carers and personalised to maximise individuals potential
- Service delivery secured for the whole borough, that supports the neighbourhood and community approach direction of the Council
- Geographically based providers will support staff to promote local and sustainable social inclusion and closer links to statutory and other third sector services
- Clearer and evidence based contract monitoring
- Supports providers to plan recruitment and retention of staff

[1] John Bolton Emerging Practice in outcome based commissioning for social Care Act April 2015

- Encouraging a move away from zero hours contracts for care staff
- Increased Council and provider front-line staff satisfaction.

End of Life Care

4.2 When compared to the current provision the proposed service model offers the following advantages:

- Clear and swift pathway into service
- Continuity of care
- Staff able to meet the needs of people who need end of life care
- Service delivery secured across the whole borough.

Complex Care Needs

4.3 Demographic trends not only affect the numbers of potential service users, but also the complexity of their need. The Care Quality Commission has commented[2] that it is finding that the increasing complexity of conditions and greater co-morbidities experienced by people are impacting on the ability of care providers to deliver person-centred care that meets individual need. It also reports increasing pressures on staff, both in terms of skills required to care for people with more complex conditions and in terms of staff numbers.

4.4 Through the procurement process Commissioners will ask providers to demonstrate where they have the additional abilities to meet complex care needs. Commissioners will work with Continuing Health Care colleagues to identify the standards and types of interventions required to meet local need. These requirements will be explicit within the contract and Commissioners will implement robust contract management arrangements with providers to ensure these requirements are met. The new arrangements will help to manage this complexity of need.
This approach will support continuity of care as Service Users who require complex care interventions are also likely to need standard care.

4.5 Barnsley Council is keen to ensure that people's well-being is promoted, that they are re-abled (whenever possible) and have enough support to maintain their independence in their own communities. This is a move away from the traditional maintenance approach of domiciliary care, to one that is focused upon supporting people and promoting their independence to be able to manage as much as they care for themselves. This is reflective of the "compelling logic" within the Bolton paper "the challenges that face the domiciliary care market might be met by a more outcome-based approach… especially if this included helping the person in a positive way so that they needed less long-term care ..."

4.6 Providers will be required to utilise Electronic Call Monitoring by the end of the first year of the contract – if not sooner. This will provide Commissioners and Providers with a richness of data to support the development of the service model and a robust understanding of service usage. This will include a clearer

[2] The State of health and Social Care Act 2014 -15

evidence base of actual service delivery in peoples homes and will ensure the Authority pays for actual and evidenced (as opposed to planned) service delivered to people. Electronic Call Monitoring will also support Commissioners to understand the impact of time for travel and entry to service users homes will have on service capacity planning and hourly rates and support providers and Commissioners to move towards outcome based commissioning in future commissioning cycles.

4.7 A future requirement of providers is that all contracted Domiciliary Services will actively promote the independence and rehabilitation/ recovery of the Service Users they support. This will mean that whilst the initial demand for service from new service users is likely to continue to increase (in line with demography[3] - very large increases in the number of people over 65 years in Barnsley); the increased focus on quality and promoting independence for individuals will result in a reduced service inputs overtime – or at a minimum individual requirements should not continue to increase at the same pace. Modelling assumptions from other authorities across Yorkshire and Humber suggest that renewed focus upon independence and rehabilitation may lead (over time) to a 2% decease in packages for clients support; this will help to off-set the (inevitable) rise in the price of care. In addition, it is anticipated that the introduction of Electronic Call Monitoring will (in part) off-set any increases in hourly rates, increased demand and the impact of travel/ entry time.

4.8 The key drivers for both the (draft) Adult Joint Commissioning Pricing and Value for Money Strategy and the National Audit Office (contained in appendix 1) [4] centre on value for money (not necessarily the cheapest), the Council acting as a good Commissioner, contracting with providers who are good employers and a commitment to fair fees to support this. The approach outlined in this report reflects these - together they combine to support sustainable and high quality services.

4.9 The Care Act[5] gives Local Authorities a general duty to:

- Promote an individual's well-being; choice and control.
- Intervene in the case of provider failure.
- Have market oversight; support a sustainable market.

4.10 The Market Shaping and Commissioning duty (section 5 of the Care Act 2014 and section 4 of the statutory guidance - contained in appendix 2). In summary, the principles that should underpin market-shaping and commissioning activity are sustainable, quality services that are co-produced. This means contracting

[3] https://www2.barnsley.gov.uk/media/3253723/population.pdf

[4] Successful Commissioning Guide https://www.nao.org.uk/successful-commissioning/

[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care Actre_Act_Book.pdf

with good employers who recruit and maintain a quality workforce who focus upon reablement, better outcomes and wellbeing for individuals. These principles are reflected in the commissioning approach recommended as well as the service model and financial modelling that support delivery of outcomes.

4.11 UNISON is calling for councils to commit to becoming Ethical Care Councils by commissioning home care services which adhere to the Ethical Care Charter[6]. This is broadly compatible with the requirements of the Care Act with the exception being the call for councils to support providers to pay 'living wage' (as opposed to the new national living wage). The over-riding objective behind the Charter is to establish a minimum baseline for the safety, quality and dignity of care by ensuring employment conditions. In 2014 Adult Joint Commissioning undertook a benchmarking survey of providers (appendix 3) against these requirements. This found that many of the Providers of domiciliary care in Barnsley are not compliant with either the Ethical Care Charter or Care Act in the majority of areas, notably travel time and mileage expenses.

4.12 For services to be compliant it will require the Council to commission services in which the cost of a care hour is built up to contain all the requirements; notably in relation staffing.

5 Financial and Service Model Considerations

5.1 Regional benchmarking has found that the average cost per hour is £13.91, ranging from £12.10 (North East Lincs[7]) to £16.33 (Leeds[8]). The 2013 national average cost of home care was £16.80[9]. A number of neighbouring areas have recently, or are currently procuring domiciliary services. Service models vary, including single provider across the authority area (North East Lincs.) and geographical Prime provider (Leeds and North Yorkshire). Some Authorities have determined the price they will pay for a care hour, whilst others have let the market determine price.

5.2 A geographically based service model allows for variation across the areas of the borough that have differing travel distance requirements, density of service demand and contain areas where it has been difficult to recruit and deploy care staff. This approach supports transparent and robust fee setting and allows for differing economies of scale to be reflected – as opposed to a one-fee fits all approach. Commissioners have recently and are continuing to engage with the provider market on the operational detail of this model - to ensure that the geographic model is sustainable and minimises risk to both the Authority and providers.

5.3 The pricing model is key to providers in terms of their sustainability, the quality of care they can offer and the circumstance of their workforce. However the pricing

[6] https://www.unison.org.uk/content/uploads/2013/11/On-line-Care Acttalogue220142.pdf

[7] Recently procured

[8] Range of hourly rates established by Authority based on UKHCA Pricing model assumptions. Procurement based on quality

[9] PSS December 2013

model is also significant for the Council, in term of overall affordability in the prevailing financial circumstances.

The United Kingdom Home Care Association costing model designed to assist providers in the calculation of a fair price for domiciliary care, provides an indication of the rate to be charged and is not indicative of a definitive value. Council finance colleagues have used variations of the model as a basis from which to look at the impact different assumptions may have on the hourly rate and the impact this will have on BMBC budgets and this can be found at Section 11 of this report.

5.4 Commissioners are keen to use the model to determine a competitive, fair but affordable fee structure. The procurement process will include a robust analysis of the detailed financial information submitted by providers to ensure sustainability as well as value for money. To ensure the maximum financial advantage from the market is gained by the Council, Commissioners are not recommending that a price is set prior to the procurement. Rather that the Council and providers will have an open discussion regarding the financial context for Barnsley and the necessity of a fair but affordable price for care.

6 Procurement Model

6.1 All providers will be required to compete competitively in the new contract arrangements and will be subject to an evaluation of quality and price. Commissioners are looking at procurement processes that permit an additional 'best and final offer' element of competition with negotiation into the procurement process. There will be a parallel but separate procurement process for each of the geographic areas of the borough for domiciliary care service. This would allow the Council to maximise value for money opportunities, whilst balancing provider need for sustainability. It would also provide additional assurance to the Council that the price paid reflects the local circumstances of each geographic area. The integration of standard and urgent (end of life) services will ensure continuity of support, as well as ensure that most effective use of resources is made.

6.2 This will ensure that the Council has the assurances primarily of quality whilst maximising financial resources. This balance of quality and price will help prevent the downward spiral of service quality that some authorities have experienced and indeed that has contributed to Barnsley's current difficulties in provision and continuity of services currently. A robust analysis of provider pricing structures will provide assurance against compromises in employment, quality of care and provider sustainability.

7. Timescales

7.1 Pre- Procurement Period – May 16

Further market engagement
Further Service user/ Carer engagement
Back office processes aligned– service user records and payments
Activity modelling
Tender documentation

Prior Information Notice publication

7.2 Procurement Period – May - September 16

PQQ and evaluation
ITT and evaluation
Notification to providers
Contract award
Awareness raising and development for Service Users/ Carers (as necessary)

7.3 Implementation Period September - December 16

Detailed system implementation - service user records and payments
Contract Management
TUPE implications
Communications - Service User/ Carer/ A&CM staff/elected members
Sensitively manage (any) necessary transfers of provision or provider.

7.4 This remains a very challenging timescale to meet. The full impact will only become clearer when the number of providers who express an interest and progress to the next stage is known. In addition, the complexity of implementation can only be fully appreciated once the successful providers are notified and the full market effect is understood. This has been logged and managed as a risk.

8 Implementation

8.1 Following procurement an implementation team will develop a detailed and phased implementation plan to ensure seamless and sensitive implementation. Key elements will include:

Communication Plan

8.2 There will need to be further and sensitive communication with individual service users (and their families) regarding (any) implications for them and the support they receive. This will include the options available to them and support (if necessary) to make these. Following procurement only providers that Barnsley Council contracts with will be able to provide publically funded domiciliary care in Barnsley. This may mean some existing packages are required to transfer to another provider; although this may not require a change in front-line care staff for individuals as TUPE may apply to sections of the workforce.

Providers

8.3 The Authorities commissioning and contracting staff will also be a need to work closely with (any) incoming and outgoing providers – to ensure stability and continuity (as far as possible) of support and staffing. There are likely to be some TUPE implications for the provider workforce and it may be necessary to communicate directly with certain staff groups.

BMBC Staff

8.4 Clear information regarding the new arrangements will need to be shared with a range of BMBC staff; this will include front line care management, Customer Access Team, business support and finance.

Other Stakeholders

8.5 Clear information regarding the new arrangements will need to be shared with a range of stakeholders, including Healthwatch, advocacy providers, Elected Members and Area Councils.

9 Consideration of Alternative Approaches

Service Model Options

9.1 An options appraisal has been undertaken by Commissioners to support the development of the recommended service model. This has been informed by stakeholders and the experiences of other Councils in the region.

Single Prime Provider

9.2 A single Prime Provider covering the whole borough – increased risk if the provider fails. Lack of choice for service users. Maximum economies of scale; although these are likely to be offset by the requirement to provide coverage across the whole borough.

Multiple Providers

9.3 Multiple providers for the borough – this is essentially the current mechanism. Difficulties around coverage for the whole borough and the process for providers accepting packages. Multiple unit costs can cause difficulties for back office functions. Maximum choice for people. Very limited economies of scale. Limited assurances of quality. Difficult to manage market and engage with providers. May result in unintended consequence of driving down price below sustainable levels.

Small Number of Prime Providers

9.4 Covering the whole borough – manages risk if a single Prime fails. Some efficiency of Council back office functions and some economies of scale. Supports provider sustainability and market engagement/ development.

Financial Envelope Options

Reverse Auction

9.5 Following quality thresholds being met a reverse auction could be held for each geographic area. This would drive down providers principle (staffing) costs and reduce profit margins. The Bolton paper does not support the use of reverse auctions and there has been adverse media coverage. It could also have an adverse effect on service quality, spending locally and the reputation of the Council.

Tender at a fixed price determined by the Council

9.6 This would afford the Council absolute certainty regarding the financial envelope and would ensure that it was affordable to the Authority. The price may not attract bidders if it is set too low and if demonstrated it is unsustainable maybe challenged legally. Conversely, if set too high the Council would not achieve best value for scarce resources. If the price is too low it may adversely affect quality of provision - call cutting, poor recruitment retention and training and supervision. Barnsley is already a low payer for domiciliary care (by comparison) and has an insecure set of providers. Sustainability of service provision may be assured (assuming the fee level is correct).

Tender for a fixed price determined collaboratively with the market

9.7 This would afford the Council absolute certainty regarding the financial envelope and would ensure that it was affordable to the Authority. A negotiated price may be able to be reached at an acceptable level for majority of providers. It would require significant time to undertake negotiations, which may not achieve consensus for all providers and the Council (as the current market has variable prices within a range depending on individual business models/scale etc.). This option may cost the Council more than necessary as it will not be able to use the competitiveness of the market to achieve best combination of quality and price. Sustainability of service provision is assured and the risk of legal challenge to the council is minimised. This option could support effective business relationships with Providers and joint working to develop approaches, including a focus on outcomes.

Open tender

9.8 This gives the Council the opportunity to test the market for quality and price and select the best option to deliver. In addition there is the potential to negotiate on price as part of the procurement process. Sustainability of service provision is assured (fewer providers with larger volumes of work and economies of scale) the risk of legal challenge to the council is minimised. This option could support effective business relationships with providers and joint working to develop approaches, including a focus on outcomes. The price and total cost to the council is known following the conclusion of the tender process.

10. Proposal and Justification

10.1 Barnsley Council secures domiciliary care services (both standard and urgent) for the borough through a competitive tender process; to assure quality and price.

10.2 The service model is geographic – based on the area council structure - with Prime Providers in each area; with a number of assured providers having the ability to undertake work (having successfully been through an assurance process) should service users wish to exercise their right to choice through the utilisation of a direct payment.

10.3 An Interim uplift of 2% on current fee levels will be offered to cover the period between April 2016 and the completion of new contracts.

10.4 Officers are authorised to negotiate on a case by case basis with providers who can demonstrate they are unable to absorb cost pressures within the 2% uplift.

11. Implications for Local People and Service Users

11.1 The implementation of the new service model will secure sustainable, quality domiciliary care services for vulnerable adults across the borough. This will support people to improve (where possible) and maintain their own independence in their homes and communities as long as possible. For people requiring end of life care it will enable service users at the end of life to be cared for and die in the place of their choice.

11.2 The geographic service model with a Prime Providers may require some current packages of care will need to transfer to a different provider. The full impact this may have cannot be assessed until the outcome of the procurement process is known. There maybe some current or future service users who do not wish to transfer to a new provider or receive support from the Prime Provider. In this situation the Brokerage or Customer Access Teams would need to offer additional information and support to enable the individual to purchase their own care using a Direct Payment or Individual Service Fund from an assured alternative provider. Self funders will have access to the information regarding service availability and hourly rates to enable them to make their choices.

12. Financial Implications

12.1 There are 21 different providers (on current framework and assessed list) delivering the current baseline standard (Tier 1) domiciliary care hours of 646,150 across all client groups. This does not include Tier 2 and 3 specialist provision. The current baseline cost of domiciliary care is £8.4m per annum, with an average hourly rate of £13.00 (although current provider rates ranges between £11 to £14 per hour). Comparative information (source: ADASS Y&H regional finance officers survey) indicates that Barnsley's hourly rate is lower than the regional Y&H authorities average rate of £13.91 and South Yorkshire authorities average of £13.56 – see table below.

12.2 The current contract for domiciliary care ends March 2015, with new contracts expected to be in place within the 2016/17 financial year (with anticipated implementation date likely to be from September 2016). An extension of existing contract with agreed financial uplift in rates may have to be considered and put in place as an interim measure during the transition period leading to the new procurement contract coming on board in September 2016.

Key considerations for determining an affordable provider rate

12.3 The following are the main drivers or considerations in terms of determining the baseline cost of an hour of domiciliary care under the proposed procurement contract:

- From April 2016 a new mandatory National Living Wage for workers aged 25 and above will come to effect at £7.20. This is expected to rise to £9.00 by 2020. The impact of this on provider hourly fee and therefore on the likely contract cost to the Council will need to be considered;

- The trade union (Unison) is calling for Councils to commit to becoming Ethical Care Councils by commissioning homecare services which adhere to the Ethical Care Charter. Therefore, the extent to which the Council wishes to embrace the principles within the published Unison's Ethical Care Charter and to incentivise compliance by Providers through the procurement contract would have a significant impact on the hourly cost of care. The Unison Ethical Care Charter seeks to ensure the safety, quality and dignity of care by ensuring that homecare workers: are paid for their travel time / cost; will be regularly trained; and will be paid at least the living wage. These requirements are now also embodied in the Care Act and compliance is being enforced by HMRC.

- The development of an affordable financial model would need to give consideration to the Home Care Association (HCA) costing model – aimed at assisting providers / Councils in determining the fair price for Domiciliary Care. The issued template is designed to highlight financial factors to be considered and incorporated in establishing an hour cost of care. It should be noted that the HCA calculated rate based on its model is by no way indicative of best value nor are Councils under any legal obligation to adopt such rate or use the model. The HCA modelled template has been used as a framework under 2 of the options put forward for consideration. Commissioners are keen to use the model to determine a fair but affordable fee structure.

- It is imperative that the baseline cost of an hour of care as determined should be affordable to the Council and within available resources (and financial constraints). The duty under the Care Act relating to market sustainability mean that regards would need to be given as part of the fee setting process to preventing provider failure, the quality of care they can offer and the circumstance of their workforce.

Calculating 'cost of an hour' care

12.4 A number of costing options have been undertaken to determine the baseline hourly rate that is affordable and at the same time allows service providers to meet anticipated inflationary cost pressures, e.g. wage increases. Table 1 builds on the analysis at 3.18 of this report and summarises the annual budgetary impact (FYE) for the options Finance colleagues have modelled (Appendix 5).

Table 1 <u>Annual Budgetary Impact</u>

	2016-17	2017-18	2018-19	3 year

	£m	£m	£m	£m
Option 1 – national living wage uplift	0.452	0.290	0.291	1.033
Option 2 – NLW uplift plus fair fee (1)	0.715	0.771	0.592	2.079
Option 3 – NLW uplift plus fair fee (2)	1.230	1.194	0.648	3.073

12.5 The following assumptions underpin the above annual costs:

- It is based on a baseline gross spend of £8.4m and an assumed total annual hours of domiciliary care provision of 646,150 (it is likely that actual commissioned hours might be different to reflect demographics / needs);

- Specialist domiciliary care provision (e.g. learning disabilities supported living) that are provided at a higher average hourly rate are excluded from the costings – not part of the standard procurement contract;

  An effective commencement date of Sept 2015 was assumed under all the options. As the procurement process is anticipated to take until August to complete, it is envisaged that the existing contract would be extended for 5 months. Therefore, an interim uplift (of 2%) for all providers is recoomended. For providers who are able to demonstrate they are unable to absorb cost pressures commissioners are authorised to negotiate an anadditional uplift. The new rates (would apply from April to August 2016, with the new hourly rate coming into effect from Sept).

Option 1: national living wage uplift

12.6 Under this option a standard average 5.4% inflationary uplift would be applied to existing domiciliary care hourly rates from April 2016. The 5.4% increase represents the effect of an increase by the NLW of the staff cost element within the existing hourly rate.

	Hourly rate	Cost increase (£m)	Annual cost (£m)
2015-16 (baseline)	£13.00		8.400
2016-17	£13.70	0.452	8.852
2017-18	£14.14	0.290	9.142
2018-19	£14.59	0.291	9.433
		1.033	

12.7 This would have the impact of increasing the average hourly rate from £13 to £13.70, with a full year cost of £0.452m for 2016/17. The estimated total cost over the 3 years to 2018/19 is £1.0m.

12.8 There is the risk that the uplifted rate may not be perceived as reflecting the 'true' cost of care as it has not been derived using the UK HCA modelled template. There is also the risk of legal challenge / judicial review if the hourly rate is perceived as low and unstainable by Providers.

Option 2: National living wage uplift plus fair fee (1)

12.9 The UK HCA modelled template has been used to determine the hourly cost of domiciliary care by reflecting and making assumptions on an array of costs faced by Providers such as staffing, travelling, pension, training, holiday pay, management overheads and profitability margin. Under this option the following assumptions have been incorporated within the template:

- National living wage increase on staffing costs
- Pension increase relating to workplace pension enrolment
- Travel time / travelling costs (as recommended in the Ethical Charter)
- Management overheads - 16% (NB level recommended by UK HCA is 27%)
- Profit margin – 3% (NB level recommended by UK HCA 3 – 5%)

	Hourly rate	Cost increase (£m)	Annual cost (£m)
2015-16 (baseline)	£13.00		8.400
2016-17	£14.40	0.715	9.115
2017-18	£15.30	0.771	9.887
2018-19	£16.22	0.592	10.479
		2.079	

12.10 Option 2 reflects a management overhead of 16% and a Provider profitability margin of 3% within the template. Under this option an increase in costs of £715k (full year effect) in 2016/17 – including the uplift for the interim 5 months period. The estimated total cost over 3 years to 2018/19 is £1.0m. The average hourly rate is expected to increase from £13 to £14.40 in 2016/17.

12.11 This option balances the risks identified in option 1 and provides an increase in fee over and above the NLW increase. This should result in a better quality provision as T&Cs for workers will be improved along with training and supervision which in turn will attract and retaining better staff. Retaining a good core domiciliary care workforce will help to achieve sustainable services that provide good outcome focussed support.

Option 3: National living wage uplift plus fair fee (2)

12.12 This is a variation of option 2 above and is based on the use of the HCA modelled template, but with a slight change to the cost assumptions built into the model. Under this option, allowance is made for NLW increase as well as other costs such as pension, travelling, training, etc. However, the recommended 27% management overhead rate has been assumed plus a profit margin of 3% (the lower end of the recommended guide)

	Hourly rate	Cost increase (£m)	Annual cost (£m)
2015-16 (baseline)	£13.00		8.400
2016-17	£15.76	1.230	9.630
2017-18	£16.75	1.194	9.887

2018-19	£17.76	0.648	10.479
		3.073	

12.13 Option C will result in an increase in expected costs of £1.230M in 2016/17 with the newly contracted hourly rate of £15.76. The estimated total cost over 3 years to 2018/19 is £3.073M.

This option is the most expensive and is unaffordable to the Council. Commissioners' views are that tenders are expected to be returned that are competitively priced and possibly be below these hourly rates.

13. Affordability assessment

13.1 The level of fee increase must be considered in the context of the Council's resource constraints. Whilst the flexibility to increase Council Tax precept by 2% mean that there is some additional resources available (estimate = £1.6m) in 2016/17, it should be noted that this is insufficient to mitigate all known cost pressures within Adult Social Care – currently projected in the region of £4m (such as NLW / contract fee, demographic growth pressures, etc.).

13.2 There is no doubt that the introduction of the national living wage comes with an expectation by Providers that such cost pressure is reflected in the fee level. To this end it is proposed that the current domiciliary care fee is uplifted to reflect the full NLW increase in 2016/17. This would go some way in ensuring that Providers can manage this additional cost pressure. The impact is an additional cost of £452k in 2016/17 rising to £1.0m in 2018/19 (see option 1) and can be funded from the additional precept funding.

13.3 Given the need to constrain overall cost pressures within available resources any further increase to reflect fair fee would be unaffordable. In such event a number of options would need to be explored, mostly through the contract procurement / negotiation process, to ensure that the agreed hourly rate is within the affordable envelope. There is the risk that in the event that this is not possible there would likely be an overspend against budgets in 2016/17. This risk may be partially mitigated by improved outcomes leading to 2% reduction in activity from year 2 of the contract.

14. Employee Implications

14.1 None directly for Barnsley Council staff.

14.2 There maybe implications for unsuccessful provider employees in that their employers may not longer operate in the borough or they may continue in a more limited manner.

14.3 However, Service Users will continue to receive the support they need and on this basis it is anticipated that TUPE will apply and they will be offered the opportunity to transfer to the successful provider organisation on at least the same terms and conditions. TUPE is a provider to provider responsibility, although Commissioners would facilitate the process in a planned way. Some

employees may choose not to TUPE to a new employer.

14.4 The full impact of any possible implications for provider employees cannot be understood until contracts have been awarded and current Service Users have made their choices regarding their preferred support provider.

15. Communications Implications

15.1 None at this stage

16. Consultations

16.1 Consultation has taken place with providers, Assessment and Care Management Staff and Service Users. The findings can be found at Appendix 4.

16.2 In summary, providers have told us about the things they would like to see improved/changed in the next contracting round. These are mainly to meet the requirements of the Care Act, notably around employee terms and conditions. They are also supportive of a focus on outcomes, geographical model and electronic call monitoring.

16.3 Assessment and Care Management staff feedback mainly focused on the need to be able to secure service across the borough and improving the ease of back office functions. They also wanted to see improvements in the arrangements for fast track packages.

16.4 Barnsley Service Users and Carers have previously identified the following key messages in relation to domiciliary care:

- The importance of having the same workers with continuity.
- The importance of staff been training to meet the service user's individual needs.
- The need for improved communication between provider and service user and/or carer
- The need for service users to not feel hurried or rushed when care is been provided
- The importance of flexibility and the changes in needs of the service user i.e., it is not always possible that the service user wants to have a bath at the same time each day, week etc.
- To arrive on time or if not possible to be told its not and contacted with a time when they can call.
- To be polite and listened to and not be patronized by talking loud or in a child like manner.
- To be consulted at all times to do with their care needs and any changes required.

These messages are consistent with national themes and recent informal feedback.

16.5 Further engagement is planned with service users and carers and providers.

This will be centred on the key quality characteristics for service users as well as how best they can be involved in the procurement process and developing further operational detail of the service model with providers. Assessment and Care Management staff are involved within the project board and subgroup of this work stream.

16.6 The Commissioner expectation is that Service Users, Carers and local community members will be engaged in the procurement process and support has been arranged to enable this.

17. Key Policy Considerations

17.1 Barnsley Health and Well Being Strategy

18. Tackling Health Inequalities

18.1 The procurement of a sustainable new service that has clear outcomes and contract monitoring arrangements which is accessible to Service Users across the borough will support the reduction of inequalities in health.

18.2 The Equality Impact Assessment is contained at Appendix 5.

19. Climate Change and Sustainable Energy Act (2006)

19.1 None direct

20. Consideration of Risks

20.1 The assessed list of non-prime providers reduces the risk to the Council of having fewer providers. This will also enable direct payment /individual service fund holders a choice of provider as well as supporting options for self-funders.

20.2 The national living wage (implemented from 1st April 2016) presents a risk to both service delivery and also a financial risk to the Council. From April 2016, the national living wage will be £7.20 an hour for workers aged 25 and older. The minimum wage will still apply for workers aged 24 and under. Currently the minimum wage is £6.70; this is an increase of 7%.

20.3 The risk to providers of the current services is that current hourly rates do not reflect the wage increases that are required to meet the living wage. The risks to the Council centre around sustainability of service delivery and the financial uplift to providers required to meet the living wage.

20.4 There are additional risks to the Council linked to the financial implications of the uplift on current arrangements.

20.5 The procurement and implementation timetable is challenging to achieve and will be subject to review and possibly increasing. Unknown variables at this point are the number of providers who will apply for the procurement. The full impact of the new service model cannot be known until successful providers are notified. Managing (any) TUPE implications may require up to 90 days.

20.6 Across the Yorkshire and Humber region a number of authorities are or have recently tendered for domiciliary services. There have been a number of successful legal challenges to the process and a neighbouring authority has withdrawn the tender and is currently reviewing its approach.

20.7 Should significant numbers of Service Users opt to take a Direct Payment and stay with their existing provider this may have an impact on the volumes of work and the viability of the new contract arrangements and providers.

20.7 A project risk log has been developed and risks are identified, recorded and managed and mitigating actions identified.

21. Health and Safety Implications

21.1 None direct

22. Compatibility with the European Convention on Human Rights

22.1 The requires local authorities to take into account their 'positive obligations' to actively promote and protect the rights of people as described in the Convention and therefore maintains that all providers of publically funded home care should consider themselves bound by the HRA. Organisations should consider their call schedules to ensure they do not conflict with public service values of dignity, choice, fairness and equality.

23. Promoting Equality, Diversity and Inclusion

24. Reduction of Crime and Disorder

24.1 None direct

25. Conservation of Biodiversity

25.1 None direct

26. Glossary of Terms and Abbreviations

27. List of Appendices

27.1 Appendix 1 – Adult Joint Commissioning Pricing and Value for Money Strategy (draft)

27.2 Appendix 2 – Care Act 2014 – market shaping and commissioning duty

27.3 Appendix 3 - Barnsley Ethical Care Charter Analysis

27.4 Appendix 4 – Consultation Feedback

27.5 Appendix 5 – Equality Impact Assessment

28. Details of Background Papers (including contact details of officer holding them and who, if

necessary, Can arrange for inspection)

Officer Contact: (Name of Alison Rumbol, Senior Commissioner)
Tel. No. (775607)
Date: (February 2016)

Financial Implications/ Consultation …… *(to be signed by senior Financial Services officer where no financial implications)*