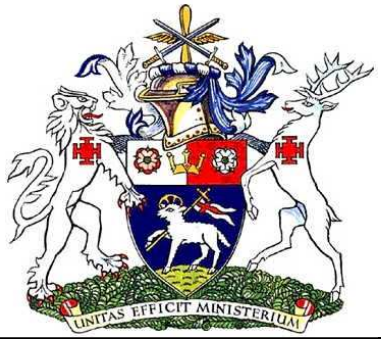
	**Adults and Safeguarding Committee** **20 November 2014**
Title	**Home and Community Support Strategy**
Report of	Dawn Wakeling, Adults and Communities Director
Wards	All
Status	Public
Enclosures	**Appendix 1: Unison's Ethical Care Charter**
Officer Contact Details	Melanie Brooks, Interim Assistant Director Adults and Communities melanie.brooks@barnet.gov.uk

Summary

Home and Community Support is a key service commissioned by all local authorities to deliver essential domiciliary support for those individuals who meet local social care eligibility criteria and need or choose support at home. The Council has a set of home and community support contracts in place which come to an end in October 2015. This report sets out the strategy for subsequent homecare provision and describes how the new model will be developed. This report addresses the mechanism for procurement of the service.

For a number of years, adult social care in Barnet has followed a strategy of supporting greater numbers of people at home, delaying and preventing admissions to residential care, promoting personalisation, direct payments and enablement. Home and community support will remain a feature of the social care offer, even as this strategy continues, as it plays a key role in preventing residential care admissions. Quality home and community support is crucial to supporting people to remain living in their own homes once a person has made full use of enablement.

Attention has been paid nationally to risks in the Home and Community Support sector concerning quality and reliability of care. The Care Act places new statutory responsibilities on Local Authorities to ensure a sustainable social care market. Locally, Adults and

Communities has reviewed the lessons learnt from two recent Home Care provider failures which are being built into the new approach to home care commissioning. The strategy for managing providers will require a strong commissioning and procurement approach with adjustment made to social work practice to move from a reactive intervention model to outcomes based commissioning. The commissioning approach will also address service sustainability through ensuring that workforce development and travel time are incorporated into the specification.

At the July Adults and Safeguarding Committee, officers were asked to consider the implications of the Unison Ethical Care Charter for Barnet and report to the Committee. This report sets out how the Charter is met in Barnet.

The Commissioning Strategy for Home and Community Services is to continue to purchase Home and Community Support Services as part of the menu of options to support people to live at home. Over time the approach is move to a mechanism that can reward and incentivise on an outcomes based commissioning approach without losing the quality and safeguarding gains from Electronic Call Monitoring. In order to prevent provider failure and to meet the requirements of the Care Act, the specifications and framework will be coproduced with providers with the aim of ensuring a sustainable market in the Borough.

Recommendations

1. **The Committee are asked to agree the strategy for re-commissioning Home and Community Support, which centres on ensuring a resilient market and to carry out a managed and safe transition to a commissioning and payment system based on service user outcomes, using a two stage procurement approach.**

2. **The committee are asked to agree that payment for travel time is included in the home and community support specification.**

1 WHY THIS REPORT IS NEEDED

1.1 Home and Community Support services, also known as home care, are part of the adult social care offer. Care Workers provide personal care, support with daily living and other help to enable a person with care needs to remain in their home. Demand for Home and Community Support is likely to increase as Barnet's population ages and as the Care Act is implemented.

1.2 The contracts for the existing Barnet services end in October 2015. The Council is required to complete a competitive tendering process to procure replacement services by this date. Given the context for these services it is not recommended that they are procured on a spot purchase basis only.

1.3 Within the contracts, providers have been paid on an activity model (i.e. volume of care delivered, with no minimum volume guarantees) drawn from a self-directed support plan (SDS) which sets out precise details of the care and support to be provided including days of the week and times of day. This is based on the service user's personal budget (PB). Whilst the support plans and contract set out expectations for quality standards and outcomes for individuals, providers are paid on time spent with the service users as opposed to delivery of outcomes for users. This report sets out the rationale for a revised approach to commissioning these services.

1.4 The current contracts were procured in 2011. The aim of this procurement was to move from eleven providers to three lead providers covering particular geographical areas to improve locality based working. This approach enabled contractual control with the lead providers and a simpler approach to brokerage of care packages.

1.5 Over the life of the contracts, the Council has terminated two of these contracts and procured alternative suppliers. The main reasons for the failure of the original providers include: performance decline following a management takeover; quality of office management (i.e. care worker rostering, business continuity systems, communications); and difficulties in staff recruitment and retention, particularly as the economy improved. The two situations have shown that the home care provider sector is not always resilient. This report sets out how the Council proposes to increase resilience in the new commissioning arrangements. Managing the transition from two failing providers to new providers has required intensive work from the Council, resulting in substantial additional cost. The priority in this work has been to ensure the safety of home care users.

1.6 This report proposes that the future strategy is to develop a sustainable home and community support (HCS) market where providers are incentivised to deliver efficient services with clear quality outcomes. Sophisticated Outcomes Based Commissioning (OBC) approaches reward and incentivises providers for delivering results for individuals – in this context for example for supporting a person to live more independently. The home care market (nationally and locally) does not have the capacity or systems to move to a payment by results approach in 2015. Other councils are developing OBC frameworks but

there are none that have proven the approach at scale in this market to date, indicating that extensive preparatory work will be required by the Council to implement this new approach.

1.7 The Ethical Home Care Charter drafted by Unison focuses on the pay and conditions of home carer workers. The Charter states that the current rates of pay and in particular the lack of pay for travel time has adversely impacted on recruitment and retention of care workers which in turn, the Charter argues, has had a negative impact on safety, dignity and quality of care. Section 2.6 of this report sets out the current contractual position against the Charter.

1.8 The Care Act places new statutory duties on the Local Authority to ensure that the needs of people continue to be met if a provider fails, no matter what type of care they are receiving. Local authorities will have a responsibility towards all people receiving care from a provider in their area. This is regardless of whether they pay for their care themselves or whether the local authority pays for it. The Care Act places a new legal duty on the Authority to promote a sustainable provider market, including the duty not to undertake actions that threaten the sustainability of the market as a whole.

1.9 People who receive HCS state that it is important to them that they have a care worker who is reliable, is caring and respectful, arrives on time and is able to support them with what they need at that visit time. Maintaining Care Worker consistency through Council Procurement and Contract mechanism must remain a key priority. The contractual rewards and levers must be designed to ensure the person's needs are at the centre of the new arrangements.

1.10 Homecare and community support services will be commissioned within the context of changing how we deliver services and continue to support the most vulnerable people when they need it the most. The challenge for homecare and support is to improve the quality of services whilst reducing overarching care package costs through focusing on early intervention, thus delaying the need for services, developing more creative and personalised support plans, improved carer support, use of new technologies and integrating care and health services where this delivers the best outcomes. An outcome based commissioning approach will deliver services which fulfil our vision to live well, age well and stay well by focusing on those issues that are important to people who use the service.

2 REASONS FOR THE RECOMMENDATIONS

2.1 Current Home and Community Support (HCS) Service

2.1.1 HCS supported 1788 people during 2013/14, with a further 1485 purchasing their own care through a direct payment. Those who receive a direct payment may purchase HCS as well as other services. Whilst service users receiving direct payments (DP) make their own care arrangements, those who choose to buy home care as part of their DP are also reliant on the quality and sustainability of local providers. Table 1 shows the usage and cost of the

current HCS service through commissioned provision. The unit cost of homecare is lower than all other forms of commissioned care. Direct Payments and Enablement Services have a greater Unit Cost.

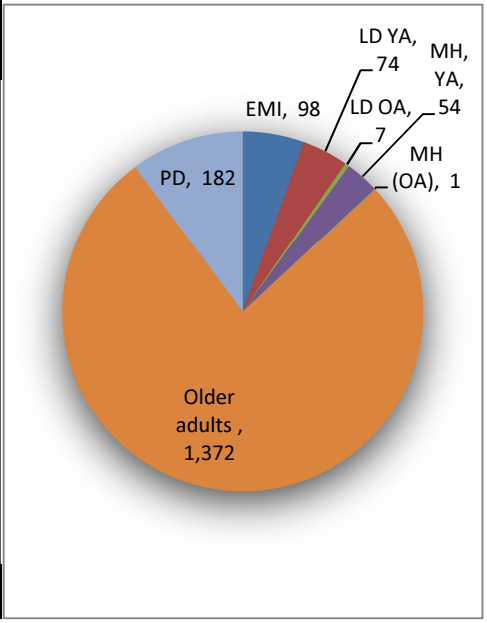
Table 1 – Service usage and cost

Period	Client count	Actual hours	Annual Spend 13/14 £000	Average length of service (in years)
13/14	1,788	484,897	7,281	2.61

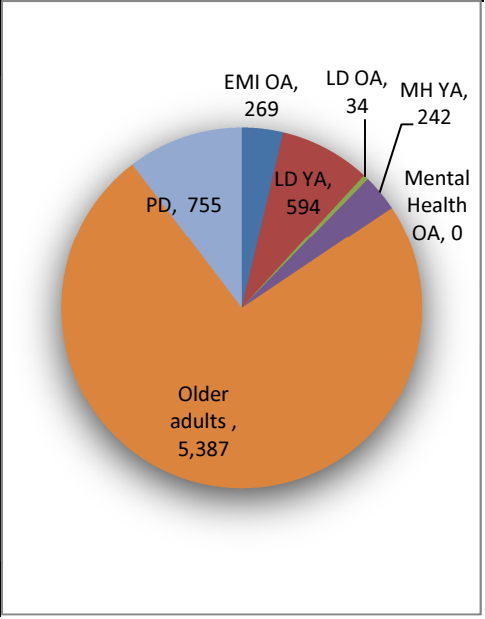
2.1.2 The volume and intensity of care packages is not standard across client care groups. A decline in the use by individuals of Council commissioned HCS services has been accompanied by an increase in the use of enablement and an increase in the number of direct payment service users. However, whilst the number of people receiving care through commissioned services has decreased, the overall numbers of HCS hours purchased has increased. This suggests that home care is being used to support people with more complex needs to stay living at home. This is further evidenced in the 5% decrease per year for the last two years in residential care admissions for older people and working age adults with care needs.

2.1.3 Demand for HCS remains the largest in the Older Adult group and this is expected to continue as Barnet's population ages. The charts below set out HCS service users and spend by client group for 2013/14. Direct Payment and Enablement figures are shown for reference and are not part of the overall figures in the chart.

Users of Home & Community Support services 2013/14	
Client Group	**No. of users**
Elderly Mentally Ill Older Adults (OA)	98
Learning disabilities Younger Adults (YA)	74
Learning disabilities OA	7
Mental Health YA	54
Mental Health OA	1
Older adults	1,372
Physical Disabilities	182
Total – Homecare	**1,788**
Enablement	1,593
Direct payments (DP)	1,485
Total	**4,866**



Spend on Home & Community Support services 2013/14	
Client Group	**Annual cost £s**
Elderly Mentally Ill Older Adults (OA)	269
Learning disabilities Younger Adults (YA)	594
Learning disabilities OA	34
Mental Health YA	242
Mental Health OA	
Older adults	5,387
Physical Disabilities	755
Total – Homecare	**7,281**
Enablement	1,093
Direct payments (DP)	11,522
Total	**19,896**



2.2 Current Contractual Performance

2.2.1 Home and Community Support was procured in 2011 for a three-year contract term (the Contracts end in November 2015). The model was to procure a lead provider for each of 3 localities, south, west and north. Each provider charged a slightly different rate for the service, having been set through their response to the tender specification. Whilst the two lead providers that have now had their contracts terminated experienced different management problems, there are key themes which Adult Social Care will address in order to learn the lessons from these events. Poor management practice was a prevailing factor. The internal management and ability to lead the operations effectively

led to a lack of control for scheduling and sub-contracting arrangements. Providers also reported that they were experiencing staffing difficulties, both in recruitment and retention. There is evidence that remuneration for one provider was an issue in their recruitment and retention. This led to a lack of resilience in day to day care cover and ability to deliver care packages consistently.

2.2.2 The evidence also suggests that efficiency and care worker consistency, as well as quality of staff working life, increases where providers know the geography of their locality extremely well and can plan care rosters with this knowledge. One of the providers that failed was based outside the locality they served and this appears to have caused problems in setting efficient routes for care workers.

2.2.3 Finally, given the size of Barnet, it should be noted that each of the localities served patches of over 120,000 residents. This created challenges in terms of knowing the patch in detail and each provider had to undertake sub-contracting in order to fulfil the care requirements of the whole locality. The Council will therefore review the three locality arrangements and increase the number of localities in the new specification.

2.2.4 The existing contracts are based on activity delivered against an agreed support plan. It should be noted that the contract only reimburses for the time spent on the visit itself. Providers invoice through Electronic Call Monitoring (ECM), based on time spent in the service user's home. All calls are over 30 minutes (with very few exceptions where indicated as part of a support plan for monitoring/engagement of hard to engage users). The implementation of ECM and the current contractual model has enabled improved business process between LBB and providers and delivered greater transparency of activity and contractual performance. ECM is a key tool in ensuring appropriate payment of providers, but more essentially, providing a tool for safeguarding adults through the exposure of missed calls.

2.3 Proposed Future Service Model

2.3.1 There is an opportunity through the retender to develop a model which rewards providers for the outcomes they deliver with people and the quality of the visit. The intention would be to incentivise for increased independence and wellbeing of the service user, in contrast with payment for time spent with them. The strategic intention will be to move, over time, to a full outcome based commissioning (OBC) of home care. Moving to this approach will involve the development of sophisticated monitoring and reporting arrangements within the Council and providers. The ability to monitor home care delivery against the agreed individual user outcomes contractually would need to be tested locally prior to roll out across the borough, based on experience from other councils. This will in turn need a structured change in support planning practice in social work teams.

2.3.2 It should be noted that whilst OBC is attracting a lot of interest as a commissioning approach, to date very few councils have adopted this

approach at scale. Those which have commenced implementation have reported significant complexities in embedding OBC, given the degree of change it involves for providers and for Council's purchase to pay systems. For this reason, the recommended approach to commissioning is to implement OBC in a staged approach with providers.

2.3.3 Although it is clear that the number of localities should increase from three, the exact division of localities and hence number of providers is yet to be determined. Work has taken place to map service users by postcode in terms of hours and numbers of existing service users and this will be further developed in the dialogue stage of the procurement. This will continue to provide a tool to ensure the Council is comfortable with the level of risk the provider manages operationally as well as a tool for maintaining oversight of the effectiveness of rostering, one of the factors in the two provider failures described above.

2.3.4 Outcomes based commissioning of home care will be a crucial element to the Council's strategy of supporting people with dementia and their carers in the community. The commissioning intention is to develop provision that can both support people with dementia as part of the contract and integrate with mental health services and the Better Care Fund integrated care model, to support people with dementia at home, providing support to carers as well as direct care to service users. The aim will be to ensure more complex dementia care can be provided in the community and to develop innovative ways of working to manage the increasing needs in Barnet that relate to dementia and older age.

2.3.5 In the current contracting arrangements, the Council has needed to procure specialist home care on a spot purchased basis for service users with complex needs, over and above the three lead providers. The commissioning intention behind OBC is to develop the ability of lead providers to provide effective homecare for those with more complex needs, through its focus on individual outcomes. This will be explored further in the dialogue stage.

2.3.6 There are a number of factors that need to be properly resourced to deliver a procurement and contract change that moves the current arrangements on; TUPE considerations, transition, market engagement and systems development. The market needs to be supported to develop a clear foundation within a reasonable time period whilst at the same time we ensure consistency for service users. It is proposed that an approved list of providers is established for a two year period with effective performance measures, contract management arrangements and plans for building partnership relationships with providers (within this we can also explore the linkages with the WLA framework). The establishment of the approved list will demonstrate a stepped change to the current commissioning of home care and will enable market preparation for the development of the outcomes approach with those providers with the least burden on the market. It is recommended by Corporate Procurement to award contract for the Approved List for two years with an option to extend for two years. This is a two-stage procurement to

allow the Authority and Market to move to an Outcomes Based Approach in a managed way.

2.3.7 This will run alongside the delivery of a robust Options Analysis that considers alternative service delivery models, opportunities arising from the work to integrate with Health and the development of an outcome focused commissioning model. This would enable the service to establish the mechanism and culture change required to deliver outcome focused commissioning within this market and to ensure the linkages with Enablement and Continuing Health Care are made.

2.3.8 The contract award for the Approved List will be made on a two year basis with the option to extend for a further two years which will allow the first two years to run the contract as business as usual, whilst developing the outcomes based model running alongside the delivery of the new contract. The latter years would be for the procurement of the outcomes based contract (1 year) and transition phase if required (1 year), followed by full operation of the Outcome Based Contract. Consultation for the outcomes based model will take place prior to the procurement for the outcomes based model starting. Of optimum importance is the work to build partnership relationships with providers with sustainable pricing and workforce development plans to develop an effective joint workforce strategy. Internally, systems will develop to address the relationship between frontline staff and providers, as well as the contract management framework and strategic supplier relationship management.

2.3.9 The proposed Approved List will allow for providers to be removed (due to performance issues) and appoint new providers if need be.

2.4 Future Service Demand Projections

2.4.1 The likely demand for future home care services in Barnet will be affected by parallel service developments, much of which seeks to prevent the need for ongoing care or acts as an alternative. The Council is investing in enablement provision which seeks to support residents to live as independently as possible, with no or lower levels of traditional home care support. Enablement adopts a ‘doing with’ rather than ‘doing for’ approach to develop the service users’ confidence and ability to take care of themselves again. The Council is also promoting direct payments, telecare and equipment. The outcome of this has been to reduce the use of home care over time and increase use of direct payments.

2.4.2 The Council has now adopted a ‘community offer ‘approach, which was subject to public consultation last year. This forms part of the Adults and Communities savings plans within the medium term financial strategy (MTFS). The community offer ensures that informal support, telecare, enablement and equipment are considered and offered if appropriate, before traditional care is provided. This work will continue to progress and investment is being made in the telecare offer to ensure packages of care support independence and with clear plans for reducing care where this is appropriate.

2.4.3 Home from hospital services work with those who require short term social care support to enable them to recover from a health issue. These services typically support people with lower levels of need than those who would benefit from enablement. Home from hospital service development will be an important element of the implementation of the Better Care Fund model. The new HCS model will work alongside services which can respond to acute illness exacerbation, such as the Better Care Fund Rapid Response team provide intensive support when needed to maximise a person's potential to stay at home. The new HCS services will also work alongside end of life clinical care, to support people in the palliative care stage.

2.4.4 The Direct Payment strategy will continue to increase the numbers of people who purchase their care directly and maximise the use of Personal Assistants (PAs) who support independent living. A separate project to increase the number of PAs working in Barnet has been developed as part of the priorities and spending review (PSR). This work will also reduce demand for Council Commissioned HCS provision where a person's needs and choices can best be provided through Direct Payment and employment of a PA who supports the person in a different way with wider aspects of daily living.

2.4.5 Whilst the service developments described above will decrease requirements for home care, demographic projections indicate that the number of people potentially needing a service is due to increase significantly over the next twenty years. Barnet's population of older people is due to rise by approximately 15% between 2013 and 2015. A significant increase in the number of people with dementia is also anticipated.

2.4.6 The Council's modelling also indicates that increased numbers of residents will come forward requesting social care support from the Council as a result of the enhanced duties on councils arising from the Care Act. Residents who would fund their own care would also be able to request that the Council arranges care for them, likely to be at the rate the Council pays. As a consequence it is anticipated that HCS providers are likely to raise their prices to councils in order to compensate for the loss of income from people paying at often higher private market rates. Council modelling indicates that a further 6,000 people living in their own homes will come forward requesting an assessment for social care support as a result of the Care Act. Whilst it cannot be determined how many of this 6,000 will meet eligibility criteria or what their precise social care needs will be, it is clear that this will lead to increased numbers of service users, some of whom will use home care.

2.4.7 There is some evidence that an outcome based approach to home care can decrease the use of home care both through a reduction in annual hours and length of package. Evidence suggests that other Local Authorities have found that the OBC approach has reduced annual home care packages by 2-5% each year. These levels will not automatically translate to the Barnet context, as the Council has already been doing other work to reduce dependency on home care. However, it is reasonable to assume that the OBC approach will reduce home care packages for individuals as they are supported to regain

independence. The OBC approach is therefore seen as a key part of the future strategy to enable people to age well in Barnet, whilst managing statutory duties within resource limits.

2.5 Home care cost implications

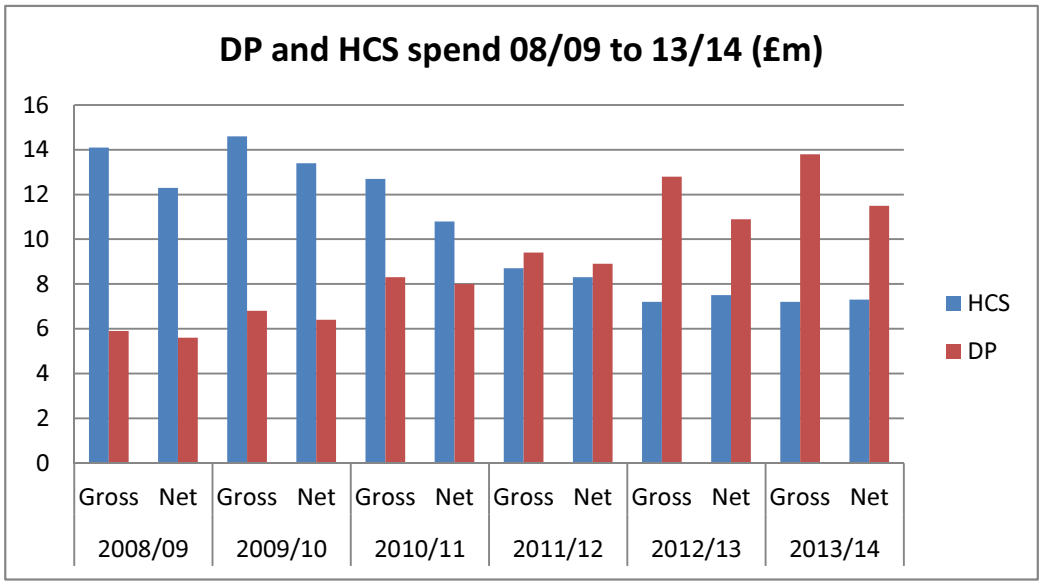
2.5.1 Within the current contracts, the Council pays a range of hourly rates for Home and Community Support. These are set out below. These rates are an average rate and include all contracted and spot purchased rates for all home care packages.

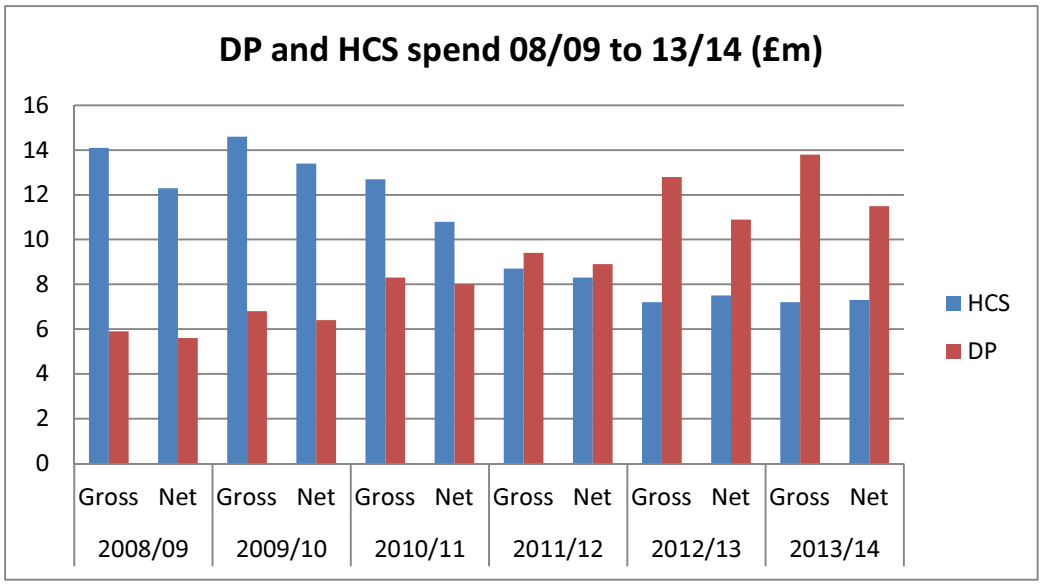
Current Hourly Rates

Current average Lead Provider rate – excludes Bank Holidays	£12.87
Current average spot purchase rate	£14.16
Current average West London Alliance rate for Providers willing to work in Barnet (2014) Standard rate only	£13.74
Enablement Service Rate	£18.64

2.5.2 The prices were secured through a competitive tender process using the most economically advantageous tender (MEAT) methodology, with a scoring system based on a mixture of price and quality aspects. The current contract price does not specify for travel time and neither do the WLA rates. The current contract stresses the requirement for the right numbers and calibre of staff to carry out the duties specified but states that the Supplier shall be entirely responsible for the employment and conditions of service of its staff employed in the provision of the Services. Existing providers are required by law to pay workers the minimum wage and deliver other statutory workforce requirements. In addition, the contracts state that staff shall be suitably trained (at the providers' cost) and have access to occupational sick pay schemes. The contracts also set out minimum standards for care worker consistency and to plan efficient home carer routes. The contracts do not include a requirement to adopt the Unison Ethical Home Care Charter.

2.5.3 The financial outturn figures for HCS and direct payments for the past 6 years are shown in the graph below. (NB in 2 cases, the net figure is higher than gross. This is due to bad debt provision.)





2.5.4 Our experience of the home care market both in Barnet and other authorities shows that there is not a simple correlation of wage rates with carer motivation and the quality of care delivered. Other significant factors are management style, training opportunities, allowances for travel time and the rigour of candidate selection. It should be noted that guaranteed hours suit some, but not all care workers. The take up when this was recently offered by one of LBB's largest providers was around 45% of its carers. It should also be noted that excellent quality care is being delivered by the majority of LBB's care providers, none of which is believed to be paying LLW.

2.5.5 Workforce recruitment, retention and development remain key concerns in the social care market. Carers will be paid around minimum wage levels and as a workforce home carers are not professionally qualified, work locally, typically work long hours and will have other caring responsibilities. The workforce can be transient and temporary, and agencies will compete with other local employers such as supermarkets for labour. Terms and conditions are therefore an element of ensuring workforce sustainability. An efficient home care service will roster care schedules so that home care travel time is kept to a minimum and face to face time with clients is maximised. However, the effect of only paying for home care calls has the effect of reducing home care wages for their full working hours and this is considered to be a factor in the exit of workers from this market. Workforce development is included in the current lead provider specification. Travel time payment and training are considered to be important factors in ensuring service sustainability alongside effective office management. It is recommended that travel time is added to the specification and bidders be asked to include this in their responses.

2.5.6 A robust and sustainable market in Barnet would be typified by a core set of strategic partners and a number of smaller providers who are able to deliver capacity as required. A good provider would have sound business and operational management and be able to engage with LBB to develop future models of care whilst delivering safe and reliable services to residents. The provider would be able to assure a workforce who are suitably trained and qualified to undertake homecare. A sustainable provider would need to balance cost and profit to be able to attract and retain sufficient numbers of carers to provide care which at times can fluctuate in terms of volume and complexity.

2.6 The Unison Ethical Home Care Charter

2.6.1 At their meeting on 2 July 2014, the Adults and Safeguarding Committee agreed to consider the Ethical Care Charter along with other relevant considerations within an Officer report later this year to assist the Committee to address Homecare contracts from 2015 as part of the commissioning plan.

2.6.2 The Charter was published by Unison in 2013 and is reproduced below with a current and future position statement. The main elements of the charter and how the Council's current home care contracts relate to them are set out in the table below. From this it can be seen that the main areas of change were the Council to adopt the Charter in its entirety would be: the requirement for providers not to use zero-hours contracts; payment of LLW; and payment of travel time and expenses.

Ethical home care charter statements	Current contracts	Commissioning Intention
Level One		
Commissioning of visits will be based on client need and not minutes or tasks.	Care Schedules are based on an agreed support plan which meets users' eligible needs. Care schedules set out duration of call, frequency of calls and tasks to be undertaken for the user (personal care and daily living tasks)	Care Schedules will include outcomes for the Service User to be met through Home Care and performance against these will be monitored through the Outcomes Based Approach. These outcomes may well include task and call frequency/duration.
15-minute visits will not be used as they undermine the dignity of the clients.	The Council's policy is not to commission 15 minute calls and the vast majority of calls are at least 30 minutes. Exceptions can be made if there is a need for engagement with the service user on a brief basis but not to carry out personal care or daily living tasks. (these calls are less than 1% of total hours)	The Care Schedule will be outcome and needs based. This may well include setting out a call duration or frequency. The current policy position on 15 minute calls will not change.
Homecare workers will be paid for their travel time, their travel costs and other necessary expenses such as mobile phones	Providers are responsible for the terms and conditions of their staff under the current contract. Within the current contract and within the WLA contracts the majority of providers do not cost this into their rates.	Providers will be invited to set out in their pricing schedule a price for service including travel time
Homecare workers will be regularly trained to the necessary standard to provide a good service (at no cost to themselves and in work time)	This forms part of the current contract specification for lead providers	This will continue.

Visits will be scheduled so that homecare workers are not forced to rush their time with clients or leave their clients early to get to the next one on time	The services are currently provided on a locality basis with the intention to ensure efficient route planning and hence that all visits are carried out in full. Use of ECM ensures that call duration is monitored to ensure calls are not cut short.	This will continue in the revised specification.
Those homecare workers who are eligible must be paid statutory sick pay	This forms part of the current contract specification.	This will continue in the revised specification.
Level Two		
Clients will be allocated the same homecare worker(s) wherever possible	The current Performance Framework requirement for Support Worker consistency is: for packages of <10 hours: maximum of 3 workers and for >10 hours: maximum of 5 workers. There is a procedural requirement in the current contract for matching staff skills, training and proficiencies with Service Users' needs, including requirements related to gender and religious and ethnic background.	Continuity of care will remain a key outcome for the contract. Requirements regarding Care worker consistency and matching skills and diversity needs will continue.
Zero hour contracts will not be used in place of permanent contracts	The current contract stresses the requirement for the right numbers and calibre of staff to carry out the duties specified but states that the Supplier shall be entirely responsible for the employment and conditions of service of its staff employed in the provision of the Services. Current providers employ staff using a variety of contractual mechanisms.	The Outcomes Based Contract will be specified to ensure the provider operates a sustainable model of staff employment that assures continuity of care for the service user and enables a skilled and reliable workforce to be developed.

Providers will have a clear and accountable procedure for following up staff concerns about their clients' wellbeing	It is a requirement under the current contract staff are familiar with, and work under the 'Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse 2011.' There is also a requirement to have a robust complaints procedure. The Barnet's Safeguarding Adults Competency Framework 2012 also makes clear the responsibilities of support staff (Group A).	This will continue to be in place.
Homecare workers will be given the opportunity to regularly meet co-workers to share best practice and limit their isolation.	Under the current contract, there is a requirement for continual staff monitoring through regular supervision sessions on at least a 6-weekly basis and that there is a clear process to enable staff to refer concerns outside of the usual supervision structure when necessary.	This will continue to be in place.
All homecare workers will be paid at least the Living Wage	No provider pays staff at this level as part of the current contracts.	Providers will be required to price the service at a level which sustains a trained, reliable and consistent workforce. Requirement to set a particular level of pay will not form part of the specification.
Level Three		
All homecare workers will be covered by an occupational sick pay scheme	Sickness is not excluded in the current schedule. Contractors operate different models of staff employment.	Providers will be required to meet legal requirements.

2.6.3 The costs of adopting payment for travel time and the Living Wage are set out in the table below, with the current median price (average of lead provider and spot price) used as the base hourly rate for the purposes of modelling.

	2015	**2016**	**2017**	**2018**	**2019**	**2020**
Options	£'m	£'m	£'m	£'m	£'m	£'m
Median rate with travel time	£0.566	£0.586	£0.607	£0.628	£0.649	£0.674
Living Wage	£1.939	£2.008	£2.079	£2.151	£2.224	£2.673

3 ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Do nothing. This is not recommended.

3.2 Home care services could be retendered on "as is" contract and specification with no review of delivery. The prices for care would continue to vary from provider to provider. There would an incentive to increase service volumes without improving quality. This option would not be consistent with the Council's strategy.

4 POST DECISION IMPLEMENTATION

4.1 Following a decision on setting a sustainable rate for HCS in Barnet and adopting the move to a staged introduction of Outcome Based Commissioning, the service specification which is currently being developed will include the elements which Committee sets out. The current commissioning plan includes a programme of work to develop a sustainable specification as well as a clear procurement timetable. Service users, staff members and providers will be involved in this programme. This will be tested and refined through a dialogue stage with providers, with Invitation To Tender (ITT) (restricted tender) to go out at the beginning of February 2015, with contract award scheduled for July 2015. This would be followed by a programme of preparation for the implementation of the new contracts, addressing staffing, contract preparation and purchase to pay systems. Retaining consistency of allocated care workers for service users will be a priority. All service users will be reviewed and should users wish to stay with providers no longer part of the Council's contracts, this will be facilitated by taking a direct payment.

4.2 Alongside this, a programme of change management will commence to prepare all parties for the transition to the new outcome focussed model, addressing the cultural and behavioural change aspects described earlier in this report.

5 IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 This approach will enable delivery of the 2013/14 Corporate Plan objectives: "Support families and individuals that need it – promoting independence, learning and well-being"; and "Promote a healthy, active, independent and informed over 55 population in the borough so that Barnet is a place that encourages and supports residents to age well".

5.1.2 This approach is consistent with The Health and Well-being Strategy 2012-15 supporting people to remain independent and well, and remain connected to the community. In addition the strategy will support the delivery of the Better Care Fund integrated care model.

5.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.2.1 The funding for this is from the Adults and Communities base budget. The total spend on home care in 2013/14 was £7.3m (gross). The projected spend for homecare for 2014/15 is £7.4m, which represents a net increase of £100k. The Adult Social Care Budget has reduced from £110m (net) in 2010 to £85m (net) in 2014, with a further £8.4m savings identified for MTFS 2015/16 and £12m for the PSR period.

5.2.2 To consider the financial envelope required for the service in future years, it is important to consider two key drivers:

- Future demand for the service
- Future price increases

5.2.3 As set out in paragraph 2.1.1 the current hours provided for homecare services is 484,897. It is forecast that through to 2030 this will increase to 562,480, representing 77,583 hours. If the current average unit price of £14.29 per hour (based on the core contract with the three lead providers and other spot services) remains as, this would increase the financial commitment by £1.109m.

The breakdown by financial year is set out below from 2015/16 for the public spending review period.

Year	Forecast Hours	Movement from Previous Year	Hourly Rate £	Financial Impact £'000
2015/16	497,019	12,122	14.29	173
2016/17	506,717	9,698	14.29	139
2019/19	526,113	9,698	14.29	139
2019/20	535,811	9,698	14.29	139
			TOTAL	**729**

5.2.4 There are a number of initiatives contained within both the medium term financial strategy (MTFS) and public spending review (PSR) which are aimed at reducing the demand for homecare services and therefore this pressure is likely to be reduced by these initiatives. However, it is also expected that spend on Direct Payment will increase as a result of these initiatives.

5.2.5 The current procurement approach doesn't assume that we shall procure at a fixed spot rate for the contract.

5.2.6 Modelling indicates that payment for travel time will have the following cost implications, set out in the table below. However it should be noted that this will be dependent on the results of the tender process. It is the view of the commissioner that any additional cost pressure arising from the payment of

travel time will be contained within the adult social care budget through targeted use of enablement to reduce care package costs among current service users; prioritising the transfer of spot purchased care packages to new lead provider rates, managing inflationary pressures and use of Care Act new burdens funding, when made available.

	2015	2016	2017	2018	2019	2020
Options	£'m	£'m	£'m	£'m	£'m	£'m
Median rate with travel time	£0.566	£0.586	£0.607	£0.628	£0.649	£0.674

5.2.7 The procurement has TUPE implications for staff working for current providers. Tenderers will be provided with all TUPE information as part of the tender process.

5.2.8 The procurement process will follow a two stage approach. The first to procure the 2 year framework agreement and the second to commission to outcome based approach. The second stage will be subject to a robust options analysis, in order to ensure successful implementation and to ensure learning from other areas implementing outcomes based commissioning. Value for money will be determined by evaluating the quality of each bid against the tender criteria including a pricing schedule. This process will ensure that the providers who can provide the highest quality services as well as maximising the resources available. With the two stage procurement process, it is expected that this will provide better value for money, but as this is currently at concept stage, there is a risk that undertaking two procurements could create an additional cost.

5.3 Legal and Constitutional References

5.3.1 The responsibilities of the Adults and Safeguarding Committee are contained within the Council's Constitution - Section 15 Responsibility for Functions (Annex A). Specific responsibilities for those powers, duties and functions of the Council in relation to Adults and Communities including the following specific functions:

- Promoting the best possible Adult Social Care services.

5.3.2 The Adults and Safeguarding Committee is responsible for the following:

- Working with partners on the Health and Well-being Board to ensure that social care interventions are effectively and seamlessly joined up with public health and healthcare, and promote the Health and Well-being Strategy and its associated sub strategies.
- Ensuring that the local authority's safeguarding responsibilities are taken into account.

5.4 Risk Management

5.4.1 The proposals being put forward within this report describes a major change in the way officers and contractors interact and will require considerable efforts on both parts to change culture and processes. An outcome focussed approach to contracting and payment by results rather than by the number of hours is a departure from the current way of working. Tasks to deliver this will be set out in the project plan.

5.4.2 Measuring outcomes as the basis for payment will require strong audit trails to ensure appropriate use of public money. As part of the implementation plan, the Council will review its approach to contract management to ensure high levels of assurance.

5.4.3 The Care Act, demographic growth and increasing complexity of need could lead to growth in users of home care. This is being mitigated through a focus on prevention and early intervention, information and advice, enablement, equipment and telecare. This will partly mitigate the demand and financial pressures that will continue to be faced by adult social care.

5.4.4 The Project will develop a risk management strategy in line with the Corporate Risk Management Framework.

5.4.5 The Care Act will bring new duties for Authorities to develop a sustainable provider market and to be directly responsibility for provider failure even where the service is not commissioned through the Council. Furthermore, the cost of taking a reactive approach to the Council of provider failure is approximately £250K per failure. Service User continuity of care is placed at risk when a provider fails unexpectedly. The development of a sustainable market will partly mitigate against these risks.

5.4.6 Allowing the market to determine the rate for a service specified with clear quality outcomes may result in the submission of tenders with prices that exceed the budget.

5.5 Equalities and Diversity

5.5.1 The 2010 Equality Act outlines the provisions of the Public Sector Equalities Duty which requires Public Bodies to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people from different groups
- foster good relations between people from different groups

The broad purpose of this duty is to integrate considerations of equality into day business and keep them under review in decision making, the design of policies and the delivery of services

5.5.2 On 1 October 2012, new provisions in the Equality Act came into force

banning age discrimination in health and social care. This is in line with the duties incumbent on all public bodies through the Equalities Act 2010. Adult Social Care works within LBB's policy framework for equalities, offers services to users within this framework, and undertakes relevant positive action to ensure social care is accessible to groups with different equalities characteristics; for example, producing easy-read information for people with learning disabilities and offering interpreters for service users.

5.6 Consultation and Engagement

5.6.1 Adults and Communities have robust partnership and engagement structures. From this and regular surveys, there is a large evidence base that Service Users want two key things from Home and Community Support - the same carer visiting regularly and for that care to be timely.

5.6.2 Consultation will take place before the procurement process. There is a shift in emphasis on service delivery as set out from set hours to outcomes, clearly this is in line with the ethos of the Care Act but the specific method being devised by Barnet for how providers will be commissioned is not prescribed and is a new process for Barnet which potentially impacts all service users. The new commissioning is clearly a change in policy which will require consultation with providers but because of the potential to affect the Servicer User as well they should be consulted. The pilot project will be part of the consultation process as will direct engagement with Service User and Carer Groups in Barnet.

6 BACKGROUND PAPERS

6.1 Cabinet Resources Committee 29 September 2011, approval of contract award for three Lead Providers for the provision of Home and Community Support (HCS) services which commenced 1 November 2011.

6.2 Cabinet Resources Committee 19 July 2010, approval of contract award for eleven framework contract providers for Home and Community Support services which commenced 1 November 2010 and authority to proceed to the next stage of the procurement approach to appoint 3 Lead Providers after a pilot period.

6.3 Adults and Safeguarding Committee 2 July 2014, agreed to consider the Ethical Care Charter along with other relevant considerations within an Officer report later this year to assist the committee to address Homecare contracts from 2015 as part of the commissioning plan.

Appendix 1: Unison's Ethical Care Charter