Leeds CITY COUNCIL

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Report of the Director of Adult Social Services

Scrutiny Board (Health & Adult Social Care)

Date: 18th December 2006

Subject: Homecare Commissioning 2006

Electoral Wards Affected:	**All**

Specific Implications For:	
Equality and Diversity	/
Community Cohesion	
Narrowing the Gap	

Executive Summary

This report sets out in more detail the background to the 2005/06 tendering process for Independent sector home care services within the city. The report contains data showing previous expenditure trends in regard to independent sector care provision, data showing the current reducing trend of people awaiting the provision of home care services and a detailed description of the cost and quality tests applied to the current independent sector home care providers used during the tendering exercise concluded in December 2005.

The report also contains an account of the work undertaken early in 2005 in relation to adapting Homecare service delivery models in use elsewhere in the country to the Leeds context.

1.0 Purpose of this report

1.1 This report sets out more detailed information with regard to the commissioning process in relation to independent sector home care in 2005/06.

2.0 Background

Drivers for modernising home support services

2.2 Our wish to look at a range of service models was (and remains) strongly influenced by a range of national drivers, each emphasising the need for increasingly specialist care in the home services and a much closer alignment between that which is categorised as 'healthcare' and that which is categorised as 'social support'.

2.3 National Drivers behind these changes are:

- White paper : Our Health, Our Care , Our Say(DoH-2006)
- Independence, well-being and choice: our vision for the future of social care for adults in England(DoH-2005)
- Modernization Agenda & NSF Long term conditions (New ambition for Old Age (DoH2006)
- Flexible , person-centered home care for older people (SPRU research)

2.4 An ageing population will mean that the demand for support at home will increase over the next decade. It is likely that there will be more people with long term conditions. All policy papers emphasize the importance of developing services closer to people's home and to increase the flexibility of service delivery. There is renewed emphasis on preventative interventions which requires flexibility for the provision of home care and a focus on a desired range of outcomes to be achieved rather than hours and tasks to be completed.

2.5 One of the goals in the white paper is that older people will get the support to remain active and independent in their own home. Further emphasis is put on fitting services round people and not people round services.

2.6 The resources available to deliver this are limited and efficient and effective ways of working, including the use of assistive/ new technology, have to be developed. This requires rethinking about how best to deliver home care support within the level of resources available in an efficient and effective way. New models will need to be tested to fit the local situation.

2.7 More recent government guidance further emphasises the need for Authorities to develop home care re-enablement models which are designed to improve choice and quality of life for adults who need care through the use of timely and focused intensive interventions. This approach focuses on re-enabling people so that they achieve their potential in terms of a stable level of independence with the lowest appropriate level of ongoing support or care. Various examples are reported whereby focused timely bursts of therapy, intermediate care or homecare can prevent hospital admission or post hospital transfer to long-term care, or appropriately reduce the level of ongoing home care support required.

2.8 The benefits of reducing the long-term care needs of recipients to the lowest appropriate level are obvious:

- maximizing independence
- minimizing the whole life cost of care

2.9 "The need to ensure that best use is made of limited resources will always be present within health and social care. In addition, demographic projections indicate that an increasing demand will be placed on all modes of care and so an approach needs to be established to ensure that the lowest appropriate level of intervention is provided." (DoH-CSED2006)

2.10 This kind of national evidence base points to the need to develop and evolve a range of new models of care which can be delivered cost effectively between directly provided and independent sector home care providers and their health service counterparts.

2.11 The greater majority of Local Authorities in England have either developed or are in the process of developing broadly similar patterns of care delivery to those under development in Leeds for the reasons set out above, Nottinghamshire represents a relatively early (but not unique) example of the development of such services.

Nottinghamshire County Council Homecare – service model Feb 2005

2.12 In the light of the emerging national framework and mindful of emerging local pressures officers undertook an enquiry into other Councils with similar demographic profiles to this city and identified that Nottinghamshire County Council has a population of 748.503 people (national statistics), of which 123.079 are 65 and over (57.387 >75; 13.928 >85). They have split the County in 6 Districts or Area's. This population in terms of number and age profile is very close to that of Leeds.

2.13 The Nottinghamshire Fair Access to Care Services eligibility threshold was set between low and moderate (February '05) .Plans were established to raise the threshold to a level between moderate and substantial.

2.14 In terms of the local drivers for change a joint Audit Commission/ Social Services Inspectorate review took place in 1999 (reported 2000), on the basis of that review and it's recommendations a strategic outline was developed which set out the vision for the service and the shape, size, model and business direction for the Nottinghamshire directly provided service to develop. A Best Value review was used to identify the changes required

2.15 Key Drivers for change:

- to improve competitiveness
- to increase contact time and reduce cost
- departmental efficiency savings
- sustain competitiveness and commitment of staff
- sustain reputation of direct home care service
- develop distinct role for home care providers
- building on strength
- meet challenges of Best value

2.16 At that time the balance between Direct Services and Independent provision was approximately 80-20%. There was a strong feeling about the need for retention of the directly provided service in the Council. To make the required changes a whole system approach was recommended, this included working at corporate level, with direct services and independent sector, training, IT support & systems and care management staff.

2.17 A number of approaches were used with directly provided service

- reduced overhead by reducing number of layers & structures
- get best out of IT & allocate IT person to Home care to develop electronic monitoring systems
- focus on training of managers to improve staff management (absence, attendance monitoring , support)
- training strategy for staff
- Recruitment and retention drive.
- Create one point of access to all Home Care activities.
- Emphasis on differences between Direct Services and Independent sector provision and building on each other's strengths.

2.18 At the culmination of that process the following service model was adopted.

The Nottinghamshire County Council Direct Service provides the following as opposed to different services which are provided by the Nottinghamshire Independent Sector:

- Initial Response Service to new requests for Home Care services for up to six weeks, during which time the Service User is supported in regaining skills and confidence.
- Dementia Service (long term)
- Palliative Care Service (long term)
- Last resort service (when others cannot provide)
- Rapid Response Service

2.19 A review of care needs takes place between 4 and 6 weeks after commencing and recommendations about the long-term support the service user will need. Recommendations are discussed in multi-disciplinary panel and decisions made as to the longer term support needs. The brokerage service is informed about the long-term support requirements and they will make arrangements for setting up a package of care with an independent provider.

2.20 Two Rapid Response Services are provided by the direct service, their sole focus is to prevent delayed discharges and unnecessary admissions.

2.21 The service is provided between 7am and 10 PM.

2.22 The Independent sector was focussed through its contractual arrangements on longer term personal care tasks and other non-specialist care in each of the 6 districts of the Council.

2.23 Since 2000 there has been gradual change from 80-20 balance of provision towards 50-50 between the direct service provider and the independent sector. At the time, the contact hours achieved by the direct provider service were low and consequently exhibited high relative unit costs relative to the service provided.

2.24 Additional cost for the direct provided service needed to be aligned to the intensity and complexity of work undertaken and so the areas of service determined as having "Extra value" were identified to refocus the directly provided service. This enabled a different focus to be adopted for independent sector providers.

2.25 Nottinghamshire contracted 80% for "block" contracts and 20% for spot purchases. Every specific geographical area of the County has 4-6 Independent sector providers with a contract volume between 250 and 1000 hours per week (on average 365 hours per provider per area).

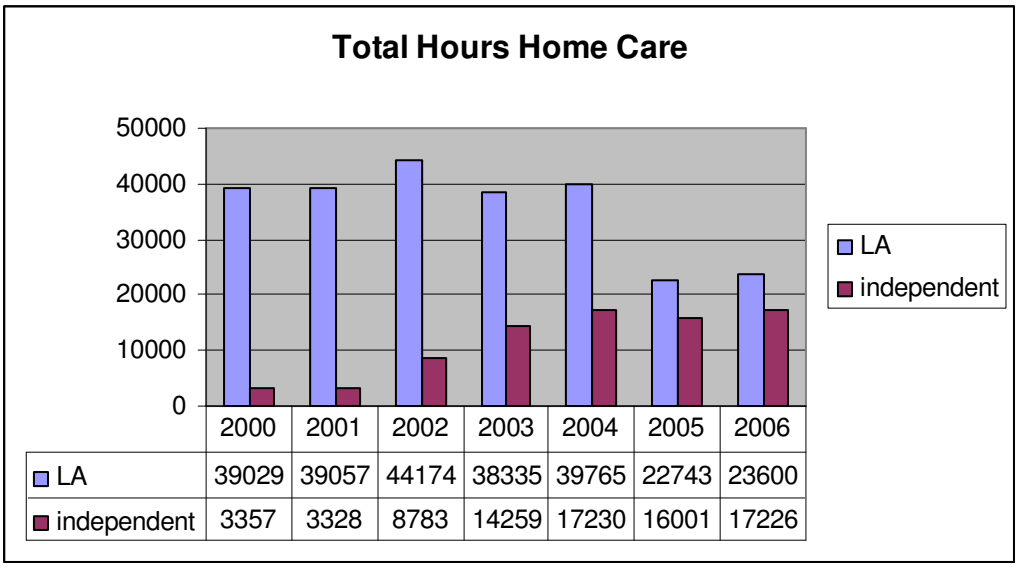
2.26 The reduction in the scale of the directly provided service has been achieved over time through the natural process of retirement and with other staff taking advantage of opportunities for redeployment into other social care functions. The change process was still going on in Feb'05 when LCC officers visited the Nottinghamshire team, clear progress in relation to the differentiated model of care had been made, but it was clear that there remained some way to go.

2.27 The manifest advantages of the model adopted were the differentiation and specialisation of the directly provided and independent sector to achieve much better value. The amplification of the training opportunities for care staff generally but specifically for the directly provided staff who were becoming much more closely aligned to fieldwork assessment teams. Finally, the adoption of electronic monitoring and support systems across both the directly provided and independent sector assisted the better management and control of this resource.

2.28 The direction adopted by Nottinghamshire had immediate and obvious resonance in relation to the position in Leeds.

3.0 Data in relation to the balance of Homecare provision

3.1 Every year the Council is obliged to submit to the Department of Health activity data in relation to both independent sector and directly provided home care services. Table 1 shows the relative activity patterns for the past number of years. The table displays the result of a one week census conducted in September each year and incorporates data relating to all adult service user groups. 80% of the hours provided by both the Local Authority and independent sector relate to homecare support to older people.



	2000	2001	2002	2003	2004	2005	2006
LA	39029	39057	44174	38335	39765	22743	23600
independent	3357	3328	8783	14259	17230	16001	17226

3.2 In the years prior to 2005 the Department reported on the basis of hours *assessed* to be provided and in the last two years has been reported on the **actual** number of hours of contact. It can be seen that although the total number of service recipients of home care services has reduced over the same period, the total number of hours of care provided has remained reasonably constant overall at around 40,000 hours a week. Clearly the intensity of the care provided continues to increase year on year.

3.3 **Table 2** (below**)** shows the expenditure on independent sector home care in the same period:

	£000
1992/93	0
1993/94	50
1994/95	452
1995/96	725
1996/97	924
1997/98	1423
1998/99	1578
1999/00	2534
2000/01	2377
2001/02	1999
2002/03	2631
2003/04	5675
2004/05	8015
2005/06	7650
2006/07 (Latest Estimate)	6530
2006/07 (Projection)	6950

3.4 It can be seen that on this basis the Council is achieving much better value from the independent sector now than was the case last year or the year before. Data of this kind provided significant impetus to the department's wish to introduce better financial management into the provision of independent sector care.

3.5 **Table 3** below, shows the how the unit cost calculations are worked out in relation to the Local Authority Community Support Service, this unit cost relates to the financial year ending 31 March 2006 and is likely to have increased in the first part of this financial year.

Community Support	**Hours**
Supervisors	124,800
Assistants	1,497,600
Total Hours	**1,622,400**

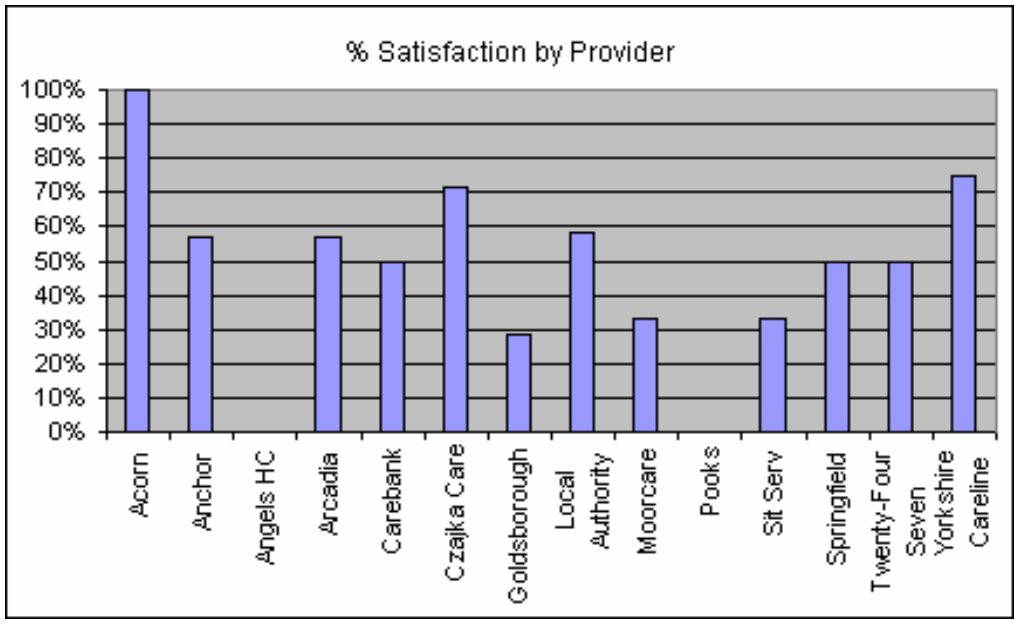
FTEs		843
Annual Leave	25 days	111,429
Bank Holidays	11 days	49,029
Bank Holiday Cover	*2	49,029
Saturdays *1.5	3 days out of 42(7%)	56,784
Sundays *2	3 days out of 42 (7%)	113,568
Nights (8-10pm)	180 staff * 2 hrs *5 days *1.20	360
Sickness	21 days per FTE	131,040
Travel	Nos * 234 days * 1hr	185,997
Meetings	Nos * 2hrs *12 mos	33,384
Contact Hours		**891,781**

		£
Budgets		16,792
Overheads		
Management	955	
Support	1,810	
	2,765	2,642
Total Costs		**19,434**

Unit Cost	**21.79**

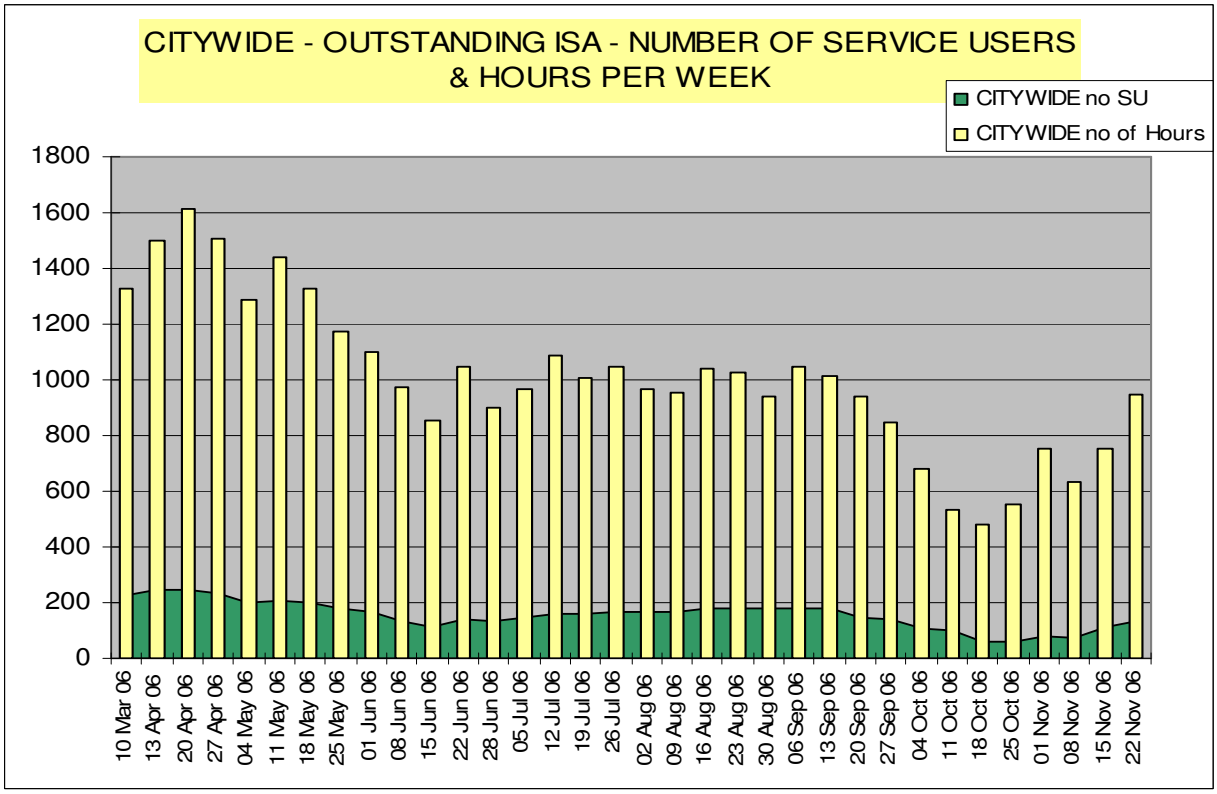
3.5 Quality – PSS Survey February 2006

3.6 **Table 4** (below) shows the percentage satisfaction rating in relation to home care providers operating in the City in February 2006, immediately before the introduction



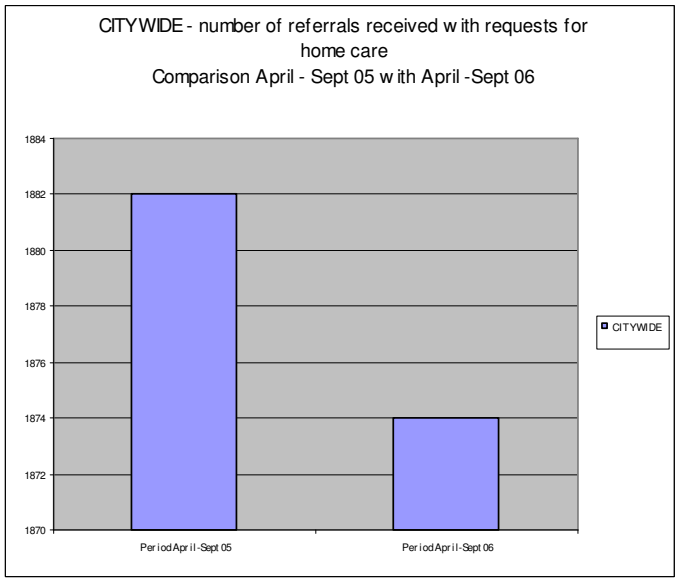
of the new contracts. The overall satisfaction result is 57.6% and has gone up from 51% (1*) since 2003, this puts Leeds in the 3* banding with 5* set at achieving an overall 63.21% rating.

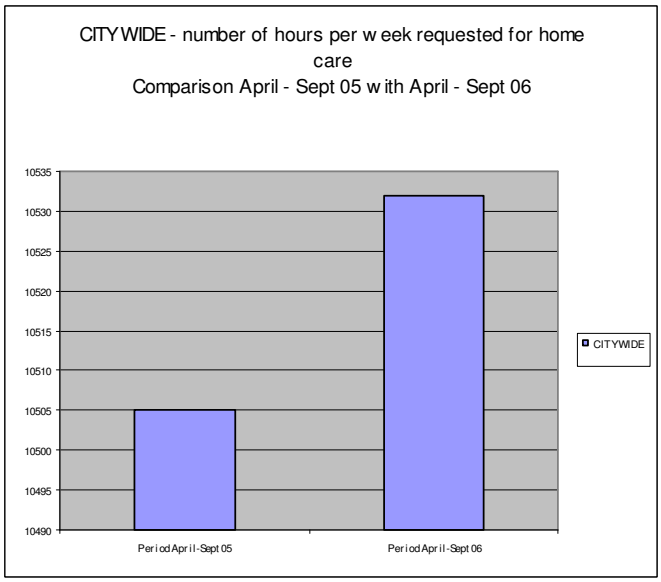
3.7 **Table 5** (below) shows the way in which the numbers of people awaiting new packages of home care has fluctuated in the last 18 months. A discernable downward trend is apparent showing that people are waiting for shorter periods to be provided



with home care support.

Table 6 a 7 b (below) shows how the referral patterns for home care have shifted in a similar





period, in April to September 2005 many referrals were made for comparatively small packages of care whereas by September 2006 the position had been reversed with a much smaller number of referrals for much more intensive care packages.

The Tender Process

3.8 An invitation for tender was sought under the restricted procedure (EC Part B Service). This contract was initially advertised for expressions of interest in August 2003 in the Yorkshire Post, Yorkshire Evening Post and the Councils' tendering website. A further advertisement for expressions of interest was sought in June 2005 in the same media/publications stated above. Note – Companies who expressed an interest in August 2003 and met the Council's evaluation criteria were included on the Council's select tender list and notified not to re-submit their interest.

3.9 After the additional expressions of interest and short listing criteria, thirty four domiciliary care providers were invited to tender having been identified by using the restricted procedure.

Evaluation of Tenders

3.9 Each tender was scored against a tender evaluation model containing Quality and Price criteria with the total available points as follows:

Quality	400 points (40%)
Price	600 points (60%).
Total	**1000 points (100%)**

3.10 Quality criteria were measured against 6 scenarios:-

- Understanding the Social Model of Disability
- Service & staff monitoring and evaluation arrangements
- Arrangements to ensure customer satisfaction
- Staff recruitment, appraisal and training
- Approach to joint working with Leeds City Council staff
- Delivery of outcome focused Home Care

3.11 The evaluation process began on 11th November 2005 with twenty seven organisations returning their tender submission, however, one organisation later withdrew their offer. As part of that process two separate groups were established, one to evaluate the quality element of the tender submission (involving users and carers) worth 40% of the total score, a separate group involving financial specialists to evaluate the pricing element of the submission, worth 60%.

3.12 This decision was in direct response to the scale of financial difficulties facing the department in relation to budget overspends on independent sector home care in the financial year 2005/05.

3.13 Table 2 indicates that the final out-turn for expenditure in that financial year was £8.05 million, some £3.0 million more than had been budgeted for. It was clear to officers that cost efficiencies could be made in the way services were contracted and the scoring system for the award of contracts was formulated accordingly.

3.14 Each of the 27 tender submissions was scored on the basis of 1000 available points, a maximum of 600 being available for the tendered price of the cost element of the contract. Providers were advised that the Local Authority expected that they would wish to cover all their fixed costs in the cost element of the contract. Surveys conducted by the Authority in advance of the tender submissions revealed the range of prices paid by other neighbouring, core and comparable Authorities paid for one hour of independent sector home care. This was compared to the range of prices paid in Leeds at that time and a matrix devised.

3.15 At the upper end of the matrix a tendered price of £20.00 per hour would have attracted a score of 0 points. Proceeding through 10p increments to the point where a price submission of £10.00 would attract a maximum score of 600 points.

3.16 No provider scored 600 points, the highest scoring provider with 570 points was not selected, and the lowest scoring provider with 126 was not selected. Companies invited to further negotiation scored between 342 and 520 on price scores.

3.17 Quality was assessed on the basis of the tender submission where a series of questions relating to the provision of personal home care services (devised by service recipients, their carers and care managers) were marked by a panel consisting of service users, carers and care managers. Again the maximum mark was 400.

3.18 No provider scored 400 points. The highest scoring company with 360 points was not elected (failed financial assessment examination), selected providers scored in the range 224 – 335. The highest aggregate score was 818 and the lowest aggregate score was 689.

3.19 The threshold for shortlisting was set at 600 points combined from the two scores. Shortlisting was followed by interviews, the interviews were followed by assessment of financial viability, references from other Authorities, checks with the Commission for Social Care Inspection, background checks (due diligence), further interviews and final selection. The process was independently audited and approved by the Council auditors.

3.20 Complaints Case Studies. Providers have furnished us with details of various complaints which they have brought to resolution. However, all the accounts contain extensive amounts of personal information relating to the service user and or/carer. Officers are seeking ways to summarise these accounts in ways which preserve the anonymity of the individual service users concerned whilst preserving the interest of the case study. These will be tabled at the Board meeting.

Christmas Cover Arrangements

3.21 All the providers have been required to confirm that they have contingency arrangements in place for the Christmas period.

3.22 Goldsboro have confirmed that they have arrangements in place to provide cover over both Christmas and New Year holidays, they are in the process of confirming with their service users those who will require a service during this time as many people spend the festive seasons with family or friends and do not require a service for the whole period. This means that organisations are able to amend their rotas accordingly.

3.23 Care UK have restrictions in place for staff leave over the holiday period they too are in the process of contacting each of their service users top determine their exact requirements and will then staff their rota's accordingly with appropriate standby arrangements.

3.24 Springfield report that they have already commenced this process of matching care staff to service users who will require services over the holidays.

3.25 Jay's have also completed a similar process and, in addition have advised us of their standby and supervisory arrangements over the period.

3.26 Anchor Trust intend to cover rota's as normal over the holiday period and will employ two care teams to cover the Christmas and New Year holidays respectively. Their service users have been asked to give early indications of calls that they would wish to be cancelled.

3.27 Claimar have written to all staff and service users asking for them to confirm their wish to work/ need for care over the holiday period. Once they have this information they will match carers to service users, they report this is a system which has worked well for their organisation in previous years.

3.32 We are satisfied that at this stage (29th November) providers have taken/ are taking reasonable steps to ensure cover and are clearly implementing contingency planning. We will seek further assurance in early December to ensure that the matching process described has been finalised.

4.0 Implications for Council Policy and Governance

4.1 The policy direction was set out and agreed in the Executive Board reports previously referred to and there are no implications for Council governance arising in consequence.

5.0 Legal and Resource Implications

5.1 The legal implications of the tender process were considered by the Corporate Procurement Unit and the Council auditors, the process followed was deemed to be open, fair and transparent. The resource implications are set out at table 2 (above). (

6.0 Conclusions

6.1 The tender process undertaken in relation to the procurement of independent sector home care in 2005 was set in the context of national policy drivers, considerations of appropriate service delivery models and local best value considerations.

6.2 Care has been taken to research each element of the process and to engage and consult with current users of services, their carers and care providers to seek to determine the most appropriate means of addressing current and emerging needs in the city.

6.3 Among a number of Authorities, Nottinghamshire was identified as having the closest demography to Leeds and its service models were investigated in that context. Learning gained in that context and others has been applied to the Leeds approach.

6.4 The tendering exercise that followed in late 2005 sought to address the need to introduce differentiated models of care between directly provided and independent sector providers as well as ensuring that the spiralling costs of independent sector care were brought under control. The scoring system for selection being predicated on that basis.

7.0 Recommendations

7.1 Members of the Scrutiny Board, Adult Health & Social Care are asked to note the contents of this report.