Adult Social Care Scrutiny Report

Proposed Home Care Model for Procurement 2023

Date: 24th August 2023

Lead Member: Cllr Sarah Russell

Lead Strategic Director: Martin Samuels

Leicester City Council

Useful information

- Ward(s) affected: All
- Report author: Bev White
- Author contact details: Beverley.white@leicester.gov.uk
- Report version number 2.0

1. Purpose of report

a) This report sets out a proposed model for the commissioning of home care which is based on evidence gathered through a commissioning review.

b) The report also attempts to address those issues that previous commissions have raised and is seeking views and comments with the aim of achieving acceptance of the model so that procurement can commence in the autumn (September/October) of 2023.

2 Summary

a) Current home care contracts are due to expire in October 2024 with procurement planned for autumn 2023.

b) The council currently contracts with 32 providers under a framework agreement.

c) A multi-disciplinary programme board is overseeing the review arrangements which are led by senior officers in the strategic commissioning team.

d) A comprehensive commissioning review has been undertaken by Care Analytics, an independent company engaged to analyse the home care and care home markets and support intelligence required for the council's Fair Cost of Care review and Market Sustainability Plan. This informs the modelling, demand analysis and also a separate workforce strategy.

e) In addition, staff have undertaken benchmarking with other councils and engagement with a variety of stakeholders.

f) The report provides a case to say that the present contractual model largely works and proposes that it should continue. Where we have found areas to be improved, these will be areas of focus in the next arrangements.

g) The aim of the service will be to support people to remain independent, in their own homes and delay the need for a higher level of support such as residential or nursing care. It will support the Recovery, Reablement and Rehabilitation pathway which links the NHS, local authority and community in supporting people requiring care. The model will retain its focus on achieving personal outcomes, making the most of people's strengths and assets.

h) Improvements will be introduced to address areas highlighted during engagement and which respond to intelligence identified through the Care Analytics and Skills For Care reviews.

3 Recommendations

Adult Social Care Scrutiny is recommended:

a) To note and provide comments on the proposals.

Report

Part 1

4.1 Background and Current arrangements

a) Home care or domiciliary support is a service that supports people to remain in their own home. It provides help and support with things like personal care, meal preparation, support with medication. It can also combat social isolation through support to access community facilities, through workers chatting with people in receipt of care. It can provider family carers with a break by staying with the person and doing some activity whilst the family carer gets on with something else or goes out. The service is available 24 hours a day,7 days a week including weekends and bank holidays.

b) Of the 6,500 people accessing long term social care, about 75% receive services in the community and of those over 2,000 use home care.

c) The aim of the service will be to support people to remain independent, in their own homes and delay the need for a higher level of support such as residential or nursing care. It will support the Recovery, Reablement and Rehabilitation pathway which links the NHS, local authority and community in supporting people requiring care. The model will retain its focus on achieving personal outcomes, making the most of people's strengths and assets.

d) The service for adults aged 18+ is jointly commissioned with the ICB who also contribute funding to the in-house teams who manage quality, broker packages of care with providers, and process financial payments. The council is lead commissioner.

e) The open framework contract runs from October 2017 to October 2024. It is a citywide framework with no zoning.

f) Currently there are 32 providers contracted with the council via two lots – standard and complex. 99% of provision is via the generic lot with 31 providers. Lot 2 comprises 10 providers, only one of whom is not on Lot 1.

g) There is no formal zoning arrangement in the city and providers are required to deliver care city wide. In practice, providers tend to informally zone, picking up

work to suit where their staff live (most being 'walkers'), or delivering support to specific communities, or specialising in double up care.

h) At point of entry to adult social care, people can choose a direct payment with which to arrange their own care through contracted or non-contracted providers.

i) The current contract requires staff to work in a person centred way using reablement principles, and to signpost people requiring support to community assets.

j) Quality of providers is generally good and there are good relationships with the market.

Usage

a) Of the 6,550 people supported in ASC, about 2,250 people a year have home care commissioned for them by adult social care. This equates to about 1,605,000 hours per annum. This includes a small number of health funded packages for about 100 people representing about 150,000 hours.

b) About 1260 people receive a direct payment with which to purchase home care. They can manage the direct payment themselves or choose to use one of our contracted direct payments support services. Some people using direct payments may choose to use a service with which we do not contract. This may be for many reasons, not least of which is the person's personal choice.

c) Since 2018 there has been a 54% increase in hours delivered but only a 23% increase in people drawing upon support. This means that the average size of care packages has grown considerably. Visit lengths have increased with dependency.

d) The main driver of growth has been a 76% increase in people receiving doublehanded care, compared to only a 13% increase in people receiving singlehanded care, which suggests that some of the growth in hours may have occurred as a result of reduced use of care homes or the transfer of CHC-funded people to the council. Further analysis will be done to understand this growth.

e) We are anticipating demand for home care to continue to increase year on year by around 15% with complexity of needs increasing.

f) The table below shows a snapshot of people drawing upon support on the 15th August 2023 (2060 people). The age and demographic profile is based on census categories.

Age Band	Number of People	Percentage
>18	0	0.0%
18-29	48	2.3%
30-39	54	2.6%
40-49	79	3.8%
50-59	163	7.9%
60-69	287	13.9%
70-79	466	22.6%
80+	963	46.7%
Total	2060	

Ethnicity	People	Percentage
Any other ethnic group	13	0.6%
Asian & White	3	0.1%
Asian or Asian British - Bangladeshi	6	0.3%
Asian or Asian British - Indian	820	39.8%
Asian or Asian British - other Asian origin	68	3.3%
Asian or Asian British - Pakistani	36	1.7%
Black African & White	2	0.1%
Black Caribbean & White	6	0.3%
Black or Black British - African	20	1.0%
Black or Black British - Caribbean	42	2.0%
Black or Black British - other black origin	6	0.3%
Black or Black British - Somali	10	0.5%
Chinese	5	0.2%
Information not yet obtained	78	3.8%
Other dual heritage	8	0.4%
Refused / Declined	1	0.0%
White - European	16	0.8%
White British	865	42.0%
White Irish	20	1.0%
White - other	33	1.6%
Arab	1	0.05%
Traveller of Irish Heritage	1	0.05%
Total	2060	

Cost and Spend

a) The annual spend on commissioned packages is about £27m gross a year and spend on direct payments about £24m.

b) Current hourly rates range between the following (and are determined by the rate which providers submitted during the tendering process within a financial envelope set by the council). These are uplifted annually in line with inflation and changes to pay legislation.

- Lot 1 (general care) £19.23 - £20.31

- Lot 2 (complex care) £19.23 – £21.11

c) It should be noted that the exercise undertaken by the independent company Care Analytics who carried out a thorough, in-depth review of our commissioning activity concluded (in relation to the size of our home care market) that "Such growth in the market strongly implies that Leicester is paying sufficiently high rates to ensure sustainability of provision (in the local context)". Our fee rates include elements for travel time, uniform, personal protective equipment (PPE), training, sickness absence and are designed to support providers to pay their staff at least the equivalent of the National Living Wage (NLW). Rates lower than this would bring into doubt the legality of remuneration with regard to NLW.

d) The rates paid in Leicester are not the highest or lowest of our neighbouring councils and are believed to be fair to the market and value for money to the council.

e) A recent exercise to determine the hourly cost of the in-house reablement service who may be considered an alternative provider to the external market gives us an hourly rate of £35.72. This estimated hourly rate was calculated in 2021/22 and the equivalent hourly rate now is likely to be higher.

f) Leicester's present model of an in-house reablement service and externally commissioned services is common across the country. Amongst its offer, the in-house teams offer a rapid response type service, including crisis and falls support and a period of intensive reablement which aims to see people regain their previous levels of independence or at least be well on the way to regaining it.

g) Within the new 3R's model being implemented, the in-house service will receive all referrals from hospitals (it currently receives the majority anyway) and offer a period of support to enable people to Recover, be Reabled or be Rehabilitated (the 3R's). Referrals directly into externally commissioned services will reduce at this point but should still be required at different points along the pathway, with the potential for people needing ongoing support to be better optimised. It remains to be seen if the introduction of the 3R's model will significantly impact upon business levels for the external market.

h) Reasons to bring services in house are cited as greater control, fairer conditions for workers, public accountability, saving money on commissioning, procurement and managing contracts. However, under the Care Act 2014, there is a general duty for the local authority to promote diversity and quality in the market of local care and support providers. It must ensure a range of providers are available; shaped by demands of individuals, families and carers; that services are of high quality and that they meet the needs and preferences of those wanting to access services.

i) There are a number of service delivery and financial risks to consider, notably: the quality of transferred staff; equal pay legislation; and the high take-up of the Local Government Pension scheme. Practically, large numbers of staff would need to be transferred under TUPE legislation, new staff recruited (staff may choose to leave and there are staff who prefer zero hours contracts), establishing staffing structures (also increased managerial requirements) which would need to be significant to deliver in excess of £1.6m hours, training and development needs assessed and delivered, managing dynamics, responding to queries from existing customers.

j) Given the in-house indicative hourly rate (£35.72) is some 76% above the highest rate for Lot 1 (which accounts for most of the commissioned packages), a simple calculation of the in-house hourly rate multiplied by the hours delivered externally shows that should the present service be brought in-house, costs would likely rise by around £20m. This does not include the additional staffing costs required to deliver.

Quality and Sustainability

a) Generally quality of contracted providers is good although the recent QAF (Quality Assurance Framework) visits by the in-house Contracts and Assurance Team have seen a drop in quality standards but there are no major concerns at this time and concerns are being actively addressed.

b) Of the current framework providers, 29 have a rating of 'good' from CQC with four rated as 'requires improvement'. These providers are being actively supported by our Quality and Assurance team through the action planning process.

c) Feedback from a recent engagement exercise showed that people are happy with the services they receive with areas to improve cited as a need for specialist training in some conditions (LD/ASD), better communication skills and consistency of care workers for some people with certain conditions.

d) The non-contracted market in Leicester is large with many smaller organisations. It is anticipated that a large number of bids will be received for the forthcoming tender exercise.

e) Capacity is high in the market, and it is believed to be sustainable in the short – medium term with demographic changes signalling concerns for the longer term mainly because of the growth in older people which will not be matched by the growth in working age adults who may be employed to support them. These will be highlighted and addressed through our workforce strategy currently in development.

What do other councils do?

a) Benchmarking with other councils has shown that no other provider from our regional 'family' provides an in-house home care service with the exception of Derbyshire whose in-house service provides a small amount of home care in their extra care schemes only.

b) In considering our proposed model, officers reached out to other authorities in relation to the following:

Key messages from benchmarking	
Some councils use zoning	*Leicester providers informally zone*
Some councils use a prime provider model, supported by sub-contracting or a facilitated bank of supplementary providers, some of whom receive only basic quality checks	*We have discounted this because of risk of provider exit, lack of choice for people needing support and the probable need to transfer large numbers of people from unsuccessful providers when the new contract is awarded. However, a prime provider model supported by a block contract arrangement is something we will consider testing in the new arrangements in one or more 'neighbourhoods' as the 'place agenda' beds within the developing system arrangements.*
Some councils, particularly counties, pay different rates to support, for example, hard to reach areas	*We have no hard to reach areas, so enhancement is not needed*
Some councils have used block contracting but those who do are moving away from this and reverting to framework agreements, citing lack of value for money, lack of impact upon staff terms and conditions as the main reasons	*We have discounted this because it is considered too high risk for the council. Strengths of the approach include easier administration, some certainty for providers of the amount of business the council will purchase which may therefore encourage them to recruit and retain staff on more favourable terms and conditions.* *Weaknesses include setting the block too high and we pay for work not carried out, too low and we pay more through purchasing additional hours at a higher cost. There is the potential for additional hours being purchased towards the year end which may have significant impact on budgets. A block arrangement would*

	not be supported by the current way in which people receiving a service are charged for this. In addition whilst we may hope that the certainty brought by a block contract may translate into better terms and conditions for staff, the council cannot legally mandate how organisations employ their staff and feedback from councils shows that a block approach does not translate into better terms and conditions for staff. However, a prime provider model supported by a block contract arrangement is something we will consider testing in the new arrangements in one or more 'neighbourhoods' as the 'place agenda' beds within the developing system arrangements.
Some councils require providers to have a minimum current CQC rating of either Requires Improvement or Good in order to bid for work	*We are proposing to adopt this*
Most councils have an in-house reablement team with the external market using reablement principles	*Leicester has this*
Most councils produce high level support plans with the provider building on this with the person drawing upon support	*Leicester does this*
Many councils expect providers to work with wider community and agencies to support people's independence	*Leicester does this*
Most councils use electronic care monitoring to support performance monitoring and assist with payments	*Leicester does this*
Some councils support banking of hours to give increased flexibility to people in receipt of care	*We are proposing to adopt this and will test it out in the new arrangements to understand the challenges to overcome to realise benefits.*
Some councils allow providers to decrease the amount of care delivered to individuals based upon their own assessment of the person's needs and in agreement with the person and their	*A pilot took place in 2022/23 which highlighted challenges to implementing this. Having learnt from this, we intend to revise and once again test provider led reviews which should support the*

family if appropriate, without recourse to the council	*council's pressures with outstanding reviews, be more responsive to people's changing needs and increase capacity for providers.*
Most councils commission home care for children as part of a separate short breaks service	*We will work alongside the Lead Commissioner (Children) to provide advice on the home care aspects of a holistic short breaks service.*

Engagement

a) Engagement exercises took place between 31st October 2022 and 2nd January 2023. The engagement undertaken comprised:

- Conversations with people by Care Management Officers when on visits (69 responses).
- Discussions with Social Care workers and Care Management Officers in the Duty Hub
- Use of Citizen Space survey to engage with the public - 9 responses were received from the public.
- Survey promoted on council's social media
- General request for comments to all councillors
- Provider surveys distributed to a) senior managers (29 responses received) and b) care workers (27 responses received)
- Survey to ASC and NHS staff (34 responses received)
- Discussions with providers at contracted and non-contracted forums (and ongoing)
- Use of existing intelligence held in Liquid Logic records – (84 responses)
- Extraction of relevant information from a survey sent to providers in 2022 (32 responses)

All findings from engagement have been included in the review. The model has been refined using learning from what people have told us. The procurement process (Method Statement Questions and their evaluation) includes questions directly related to what people told us was important to them.

Summary of findings from engagement

Adult Social Care Staff

- When designing the model, we should ensure language issues are considered, this is regarding strengths-based language use, literacy of staff and considerations of language requirements of people receiving support.
- It is important that some level of staff consistency can be offered. It is beneficial for the people receiving care to develop rapport with the carer. In complex cases having new carers can present a challenge.

- There is an overall view that communicating with providers is positive and they are proactive.
- Better training for carers (LD, ASD, ADHD, timekeeping, record-keeping could be sought
- More effective communications and cooperation between CAAS and Carers could improve the service.

Providers/Care staff

- According to the information submitted by providers, the average percentage of staff per provider on zero hours contracts is 75.2% (from 32 responses received - Contracts and Assurance engagement in early 2022).
- When asked about challenges faced, themes regarding staffing, process and capacity emerged.
- In terms of staff retention and staff recruitment it was often noted that better rates of pay, support with training and support with advertising would be beneficial.
- A survey was also shared with staff working in homecare. Key themes to emerge from this survey were that the work is enjoyable and rewarding, although sometimes the clients can be the biggest challenge. Majority of respondents saw care work as a career rather than a short-term job.

People Drawing upon Support

- Overall, people receiving support are happy with the care they receive
- Carers are punctual
- Carer consistency is important
- Constructive points around time and the carers sometimes rushing were noted
- The importance of choice and personalisation of care noted. The social aspect of having conversations with people when providing care should be encouraged.
- Establish better communication between carers and people drawing on support
- Some concerns regarding budgets and the need for increasing pay for carers

Soft Market Test

We held a soft market test which was distributed to our contracted and non-contracted providers. 18 responses were received. Commissioners reviewed the responses and pulled out the key themes:

- Flexibility and consistency of care challenges: some issues around managing bank hours and facilitating a consistency of care when considering staffing pressures.
- We asked about quality-of-service measuring points and it was noted that: CQC ratings should be considered as a unified approach to quality monitoring, monitoring points need to be clear to providers so they are aware of what the inspectors are measuring

- Some training could be offered to providers for the high dependency lot
- Providers expressed a preference for long contracts (at least 5 years), scheduled duration payment rather than banding and clear KPIs

A presentation was given at Leicestershire County Council's provider forum to further promote the soft market test opportunity to providers with whom we may not ordinarily come into contact

In addition, the City's contracted provider forum has been engaged with and kept updated at its monthly forum meetings since the inception of the review.

Part 2
Proposed New Arrangements

a) From the work we have done, and local and regional meetings attended to discuss the details of how other councils commission home care, it is clear that Leicester is in an extremely good position with its current home care model and commissioning practice.

b) This is supported by ongoing evidence of low numbers of people awaiting care, majority of packages placed quickly, provider market consistently reporting high capacity with few providers exiting the market, good value for money.

c) Leicestershire County Council recently recommissioned their home care service using many of the same features as ours and have seen their await care list drop significantly as a result. The recent, very detailed review of our home care commissioning and markets by Care Analytics judge our present arrangements to be "effective".

d) The current contract was extensively remodelled and introduced innovations such as requiring providers to signpost and support people to access community assets, and that carers should work using reablement principles.

e) The proposal is therefore to retain the existing framework contract arrangements with a range of providers that can bid to take on cases, working across the whole city.

Key Features of the proposed new model

- Two Lots – general and high dependency
- Delivered through a Framework Agreement
- City- wide (no zoning)
- Outcomes focused and strengths based
- The ICB supported with the delivery of health delegated tasks through a jointly commissioned service (Lot 2)

- The Joint Commissioning arrangements will cover brokering, quality assuring and payment of health packages.
- Packages will be purchased on an hourly or half hourly basis, unless there is a double up visit and 15 minutes for the second carer is paid e.g. hoisting
- The bulk of packages will be purchased through a General Lot and the proposed key features are:
    - Personal Care including Medication Management
    - Domestic tasks, including shopping, laundry and meal preparation
    - Rehabilitation/teaching of Independent Living Skills
    - Carer support, including night sitting and respite care
    - General support to meet desired outcomes e.g. assisting person to use local transport, accompanying visit to GP
    - Support to maintain and/or improve psychological and emotional wellbeing
- The High Dependency Lot requires clinical oversight and enhanced skills and qualifications
    - Delegated Health Care tasks
    - Complex and enduring mental health needs.
    - A dual sensory impairment (e.g. visual and hearing loss)
    - Behavioural, emotional and social difficulties (BESD)
    - Moderate to severe dementia
    - Moderate to severe learning disabilities
    - Hoarding behaviours
    - People with night time support needs
    - End of life/palliative care

There are some improvements and new features built in to benefit people drawing upon support, encourage better terms and conditions for staff and enhance provider sustainability.

The Proposed Model's New or Strengthened Features

Feature	Who does it benefit?	Does it incur extra cost?	Comments
The Model			
Time Banking – allowing flexibility, choice and control- new	People drawing upon support and improved staff experience	Potentially for the provider	We intend to build this in but will need to pilot this, potentially in the current arrangements. There are challenges to

			this as it does not sit easily with Electronic Care Monitoring
Provider led reviews	Provider staff will lead on reviews of the person they support and liaise with social work teams to ensure that the package of care and support plans are fit for purpose	Yes – for Adult Social Care	This will support capacity within Adult Social Care. Staff working with people on a daily basis are best placed (with the person) to understand if needs are being met in the right ways.
Increased emphasis on culturally appropriate services particularly for Leicester's South Asian communities- existing	People drawing upon support	No	This was a message from our engagement exercises. The contract requires providers to employ staff who can effectively communicate and support people from diverse communities.
Increased emphasis consistency of staff support, particularly for people with certain conditions - existing	People drawing upon support	No	The contract requires enhanced training qualifications for all staff, especially those delivering services to people with high

				dependency needs. This was a message from our engagement exercises.
	High standards of staff communication skills - new	People drawing upon support	Potentially for providers who employ overseas staff or who deliver services to people with communication needs	This was a message from our engagement exercises. The contract requires a high standard of communication skills to support Leicester's many communities.
	Enhanced training for staff supporting people with learning disabilities, dementia, complex physical needs which require double up calls	People drawing upon support Staff	No – free training and development is already commissioned for providers	This is a quality issue. Training requirements will be increased and closely monitored through the QAF process.
	Outcome focused-existing	People drawing upon support. Staff satisfaction	No - training will be provided	The rollout of ASC's Support Sequence work will require providers to work with the person drawing upon support to develop detailed support plans based on the outcomes initially identified by the social work team. Training

				will be offered to support providers to realise this.

4.8 Increased Emphasis on Quality

a) We will require that a condition of tendering is that bidders should be registered with CQC, have received an initial inspection and be rated at least Requires Improvement but with Good in the Well Led Domain.

b) We will require providers to induct new staff members in accordance with the Care Certificate (as at present) but in addition all staff providing care should be qualified at QCF Level 2 and there is an expectation that staff working at with people on the complex lot (lot 2) should be seeking qualification at QCF level 3, if not already attained. This is an increased expectation that in the current contractual arrangements. All staff responsible for the administration of medication to have completed a Level 2 accredited qualification, "Certificate in Understanding the Safe Handling of Medications" or its equivalent. Staff responsible for the management of other people who administer medication/competency, must have completed a level 3 accredited qualification, "Safe Handling of Medication Foundation and Assessors" or its equivalent.

c) We will require commissioned providers must join Inspired to Care, the organisation that supports with recruitment, retention, good practice etc.

d) We will require commissioned providers to complete the Adult Social Care Workforce Data Set to inform planning needs and completion of which secures funding for them to access training.

e) We will set the quality/price split in tender evaluation at 80/20 as the pricing envelope will be set at ITT stage. Method Statement Questions (MSQ) will have an increased emphasis on quality with people drawing upon support designing and evaluating at least two MSQs.

f) The Quality Monitoring Framework emphasises an outcome focused, strengths based approach to service delivery. The I statements formulated by Making it Real will be embedded within the refreshed QAF process that supports the delivery of this service and providers monitored on their performance in relation to these by talking directly to people drawing upon support and learning from their experiences. The relevant statements are:

1. I am treated with respect and dignity
2. I can get information and advice that is accurate, up to date and provided in a way that I can understand
3. I have people who support me, such as family, friends and people in my community

4. I have care and support that is coordinated, and everyone works well together and with me or I can choose who supports me, and how, when and where my care and support is provided.
5. I know what to do and who I can contact when I realise that things might be at risk of going wrong or my health condition may be worsening
6. I have considerate support delivered by competent people

g) The extensive use of Direct Payments within home care whilst to be welcomed as it gives people more choice and control about how they are supported does nevertheless bring some considerable challenges. Through engagement with social work teams we have learnt that many are recommending direct payments with non-contracted providers thinking erroneously that such providers have more capacity than contracted providers. This is in fact not the case as our contracted providers have significant capacity to take on new work and response times to requests for work are very quick (within hours). The challenges that the practice of placing with non-contracted providers causes are:

- The providers may have been registered with CQC as new businesses but majority are not yet inspected – this means their working practices, safety and quality are untested and as a result we are seeing safeguarding issues arising which must be dealt with by social work teams (unlike concerns raised from contracted providers which are dealt with by Contracts and Assurance team members)
- The stability of the contracted market is compromised by using non contracted providers. Also the price agreed bythe pacing workers with the non-contracted provider very often exceeds our agreed contracted and Direct Payment rate which represents poor value for money for the council and risks destabilising the contracted market.

h) We have recently started to address these issues with social work teams, given them assurances that the contracted ,market can usually meet people's needs in a safe and assured way, but we must be mindful that people needing support must still have access to providers of their choice which may require a Direct Payment.

4.10 Unison's Ethical Charter

a) Here in Leicester we have embedded the core principles of the charter in our contractual arrangements and invested to ensure that homecare workers are paid for a minimum of 30 minutes for all calls. The rate we pay includes payment for travel time, holidays, uniform, PPE, training and are set at national living wage rates. We will continue to strongly encourage providers to offer guaranteed hours contracts and aim to reduce the proportion of zero hours contracts over the life of the contract.

b) The Council has also reviewed and increased the hourly rate it pays to providers in an effort to boost wages towards the real living wage rate, offered staff bonus

schemes in winter 2021/22 and 2022/3 to support staff, and implemented a provider hardship fund which offers providers support to improving conditions for staff. We also disseminate information about various staff benefit/discount schemes to agencies and support events such as the Care Awards Ceremony.

c) In respect of the recommendations made under the Unison's Ethical Charter, we are able to partially comply with only the following recommendations unmet (or partially met):

- Zero hours contracts and occupational sick pay beyond the first 5 days.

d) Our providers still recruit staff on zero hours contracts but increasingly, there are trends towards guaranteed hours (usually 16 per week) and full time hours for overseas recruits. Some staff prefer to work on the zero hour basis as this suits their personal arrangements. We continue to have dialogue with providers about how this can be improved and learn from other areas and it will feature strongly in our workforce strategy currently under development. We will test a different contractual arrangement (block contract and potentially a prime provider model) within one or two neighbourhoods and require the provider/s to not use zero hours contracts in these pilots to learn from this and apply the learning appropriately.

e) A more detailed assessment of the current provision of the home care market in relation to compliance with the Unison Ethical Charter recommendations is set out in Appendix 2.

4.11 Responding to the Adult Social Care Scrutiny Task Group Report on Workforce

a) In 2020 the Adult Social Care Scrutiny Commission presented its report "Adult Social Care Workforce Planning: Looking to the Future" which sets out its recommendations to better support staff to secure better outcomes for them and the people they care for.

b) The table below sets out how we have considered these recommendations within this commissioning review.

Task Group Recommendation	Commissioning Review Response
Paying the Real Living Wage to all staff on Leicester City Council adult social care contracts to properly value those staff working in the sector. This would cost an estimated £3.9m for 2020/21 for residential care, domiciliary care and supported living. Not all organisations complete the Adult Social Care Workforce Data Set, so the actual cost will be higher, and even more so if we implement other working rights, such as occupational sick pay.	As part of the work we do to set fee rates for domiciliary care, we will consider the cost of applying the Real Living Wage. Since the Task Group's work, the cost of this is likely to exceed the previous calculations. This will be taken through the appropriate senior governance bodies when complete.

We expedite our 2019 Manifesto commitment to sign up to the Ethical Care Charter	Although some councils have achieved a 'partial sign up' status, the local branch approach was not supportive of this.
Join up the silos to create a clear, simple and desirable apprenticeship route funded using unspent levy funds to encourage newer people to join the sector permanently, particularly younger people	Further exploration of this will be picked up in the developing workforce strategy.
Work with those in the workforce to try and find community and cooperative solutions, such as employee buy outs or a grouping together of micro providers, which ensure staff are invested stakeholders in care organisations	This can be explored through our developing workforce strategy.
When commissioning, require that providers give access to the unions to their workforce so that they can collectively lobby for improvements in their workplace.	This can be encouraged but not required through our commissioning approach.
Also, to require and to ensure that providers complete the Skills for Care National Minimum Data Sets (NMDS) so that they are able to access funding for training but also so that we can better follow trends across the workforce locally.	We are setting this as a contractual requirement in the new model.
Create our own internal agency for existing LCC staff rather than working with external agencies to offer more flexibility for our own team by creating a pool of people and additional work.	This is outside of the scope of this commissioning review
Retention is key in terms of boosting quality of work and quality of care for those receiving it. We need to work with providers around this specific issue. Recommendations to increase retention rates include improved training and development routes; improved pay and conditions; and proper recognition and valuing of the role of carers.	We have commissioned Inspired to Care who provide free support in relation to recruitment and retention to members. Membership is free and it is a contractual requirement within the new arrangements that providers become members. Furthermore, free training and development is offered through the Leicestershire Social Care Development Group – signing up to

	this is also a contractual requirement in the new arrangements. We will monitor take up of both these offers through our QAF process. During the winters of 2021/22 and 2022/23 we used NHS discharge monies to provide bonuses to staff who stayed with an employer over these periods when retention is often an issue. This was particularly so last year when the cost of living crisis was particularly acute. Learning from this can be applied in the future.

4.12 Governance and High Level Timescales

a) This work is overseen by a multi-disciplinary board chaired by the Director of Adult Social Care and Commissioning, and which includes representatives of the ICB and the Midlands and Lancashire Commissioning Support Unit. The work has been drafted and agreed by them.

b) In order to have new contracts in place for 7th October 2024 and to allow a good amount of time for contracts to be mobilised, people drawing upon support to be reviewed and if necessary moved from unsuccessful providers to new providers or onto a Direct Payment, we are aiming to award new contracts on 4th April 2024.

c) This means that we must have all documents agreed and signed off by 5th September 2023 to enable us to publish the Invitation to Tender documents on 12th September 2023.

d) This procurement is likely to attract a lot of bids and we wish to allow providers sufficient time to prepare and submit their bids (about 40 days- 30 days being the minimum) and avoid the pressures of the winter period and Christmas holidays for both tender submission and officer evaluation.

e) Should slippage occur, then the 6 month mobilisation period will be eroded. In anticipation of this, we are intending to rationalise the number of tasks that need to be done so some can be brought forward into the procurement process (e.g. key policies and documents checked off), and if existing providers are successful, it is expected that mobilisation will be simpler.

5. Financial, legal and other implications

5.1 Financial implications

This report does not suggest any significant changes to the current arrangements for home care, other than the potential for 'banking' unused care hours for use in a later period. The practicalities of this in terms of charging need to be explored in detail and whether or not there are sufficient benefits for the person receiving care to warrant implementation.

The existing cost model for home care will be used to establish the maximum framework rates allowable.

Martin Judson, Head of Finance

5.2 Legal implications

The retendering of this service which is to be jointly commissioned with NHS Partners, early legal and procurement engagement has been sought to advise on the model and ensure compliance with the Public Contract Regulations 2015 (as amended) and the Authority's standing orders. Any collaborative working will need to be underpinned with appropriate agreements to capture responsibilities of contract management, decision making and governance of the service contract and ensure economies of scale. In respect of any existing obligations under any existing joint working agreement these will need to be considered and complied with where relevant.

In respect of issues which have arisen in the existing/previous procured services the Authority should ensure a robust specification is devised to achieve the desired outcomes and appropriate monitoring of the same.

As the report states the proposed [existing] model is not changing, should this proposal change then further legal advice to be sought and whether it may trigger any duty to consult or otherwise.
Ongoing legal support to be obtained as required.

Mannah Begum, Principal Solicitor (Commercial) Ext. 37 1423

5.3 Climate Change and Carbon Reduction implications

Following the council's declaration of a climate emergency and ambition to reach net zero carbon emissions for the council and the city, the council has a vital role to play in addressing carbon emissions relating to the delivery of its services, and those of its partners, including through its procurement and commissioning activities.

Carbon emissions from commissioning and delivery of services should be managed through use of the council's sustainable procurement guidelines within tendering exercises, by requiring and encouraging consideration of opportunities for reducing emissions. This could include areas such as the use of low carbon and energy

efficient buildings to deliver services, enabling use of sustainable travel options for staff and service users and reduced consumption and waste of equipment and materials, as relevant and appropriate to the service.

Aidan Davis, Sustainability Officer, Ext 37 2284

5.4 Equalities Implications

Under the Equality Act 2010, public authorities have a Public Sector Equality Duty (PSED) which means that, in carrying out their functions, they have a statutory duty to pay due regard to the need to eliminate unlawful discrimination, harassment and victimisation, to advance equality of opportunity between people who share a protected characteristic and those who don't and to foster good relations between people who share a protected characteristic and those who don't.

Protected Characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

The report seeks approval for the re-procurement of domiciliary home care services which if agreed should lead to positive outcomes for people from across a range of protected characteristics. In order to demonstrate that the consideration of equalities impacts have been taken into account as part of the re-procurement and as an integral part of the decision-making process, it is recommended that an Equality Impact Assessment is undertaken.

Carrying out an equality impact assessment is an iterative process that should be revisited throughout the decision-making process and updated to reflect any feedback/changes due to consultation/ engagement as appropriate. The findings of the Equality Impact Assessment should be shared, throughout the process, with decision makers in order to inform their considerations and decision making.

Where any potential disproportionate negative equalities impacts are identified in relation to a protected characteristic/s, steps should be identified and taken to mitigate that impact. The EIA findings should continue to be used as a tool to aid consideration around whether we are meeting the aims of the PSED, and to further inform the work being progressed on the re-procurement.

Sukhi Biring
Equalities Officer
454 4175

5.5 Other Implications (You will need to have considered other implications in preparing this report. Please indicate which ones apply?)

None

Appendices:
Appendix A – Supporting Information
Appendix B – Comparison of commissioning practice against Unison's Ethical Charter

Appendix A – Supporting Information

Improvements to be brought in

In the commissioning review, we took the opportunity to review how we could improve what currently does not work or to consolidate what does work, and covered the following points:

Aspect	Works?	Somewhat Works?	Does not work?	Comment
Sufficiency of providers	√			An open framework allows for additional providers to be brought in when needed; there are a great many registered providers in the city (170 at time of writing).
Ability of providers to pick up work quickly	√			Providers consistently report capacity and all areas of the city have coverage.
Low awaiting care lists	√			Capacity in the market is consistently high and providers are responsive Consistently low awaiting care numbers.
Quality of work	√			93% of contracted providers have a CQC rating of Good; greater focus on CQC registration status at ITT stage; development work with providers
Workforce recruitment & retention		√		Recruitment into the sector is challenging; presently there are sufficient staff to deliver care, but providers report recruitment exercises are constant. Inspire to Care membership supports providers with recruitment, retention and training; LSCDG membership offers free training. Workforce strategy being finalised.
Workforce terms & conditions		√		Use of zero hours contracts in the city is very high. Many workers like the flexibility that zero hours contracts bring. Zero hours contracts are often used when a business requires flexibility from a subset of their workforce to help them navigate

				fluctuations in workload while keeping costs low. Zero hours workers are entitled to: • The National Minimum Wage • Paid holiday • Maximum of 48 hrs of work a week (and the right to opt out) • Protection against discrimination • Whistleblowing protection • Statutory sick pay We wish to see a reduction in the number of zero hours contracts and will signal this in the specification and work with providers to reduce these. Our payment rates will be set at a level that supports this reduction.
Geographic reach of providers	√			All areas of the city have coverage; providers informally zone themselves as most workers are walkers
Ability of providers to meet specific needs	√			No needs go unmet; greater focus on language skills and specialist training for complex needs identified. Recent increases in demand for support for people from South Asian communities has been noted – demand is being met. All these needs will be highlighted in the new specification.
Value for Money	√			The council's rate is not far off the rate calculated as 'median' through the Fair Cost of Care exercise. It supports the business models in place in the sector. The existing cost model for home care will be used to establish the maximum framework rates allowable; achieve a

				balance between VFM for the council, paying fees that enable providers to have a stable business and employ staff with better terms and conditions
Sustainability of market		√		The overall market is large with a mixture of small, medium and larger agencies. New businesses frequently open. Many providers have been active locally for many years. Current economic conditions are impacting adversely, and we are closely monitoring this and offering support where we can
Provider relationships	√			Continue to maintain our good relationships and look to build
Flexibility of model		√		Explore and introduce time banking
Strengths based approach		√		Continue to promote and pilot approaches; evaluate current pilot
Outcomes focused		√		Greater emphasis on outcomes focused support plans and provider training to deliver, flexing payment bandings to support staff

Flexibility of care delivered – a proposed pilot

a) People who use home care and support sometimes need to flex their package of care to better meet their needs by bringing forward or banking hours to be used for certain circumstances, for example, when someone is out or away, and use them another time, for example when additional support is required. We have been exploring a model used in Rotherham where they have applied this flexible approach to their commissioned home care. We hope to pilot this in the new service.

b) In Rotherham they call this Envelopes of Time. This home care and support model moves away from the rigid 'time and task' model to a model which accesses allocated envelopes of time over a defined time period e.g. 80 hours over 4 weeks. This allows more flexibility and encourages innovation. Home care and support service interventions will have a strong focus on supporting people accessing home care and support to achieve positive outcomes to optimise their independence. Although in its early days and negatively impacted by Covid and now workforce issues within the market, this model was adopted

following consultation with people and staff in Rotherham and where it is used, feedback is positive.

Provider led reviews

c) Learning from work elsewhere and from our own work within residential care, it is intended to test the concept of provider led reviews within home care. The benefits of provider led reviews include:

- people have a faster response to changes in their needs. This enables better risk management and improves safety.
- Reduction in 'over-prescription' which can lead to greater dependency.
- Impactful work by providers who know their clients (people) well.
- More autonomy and trust around the people who care for that person.
- Release of capacity within adult social care

The parameters of the test will be scoped out and it is intended to co-produce this work with providers and with people who draw upon support.

Workforce and sustainability challenges

d) This is a very significant challenge and not something that can be fixed in the short term. We intend to address the challenges that have been highlighted with recruitment and retention of staff through this model, our workforce strategy and market sustainability plan currently being drafted, and which consider the challenges facing the sector. This is not just an issue for Leicester, nor its features particularly confined to Leicester; it is a national problem.

e) The care sector is already facing major recruitment challenges, at least in part caused by low pay relative to the demands of the job roles. The work currently being done to set fee rates will set the pricing envelope used by providers during the tender process will be mindful of the dynamic and variable costs of running a business which allows providers to recruit, retain and pay staff an appropriate and legal wage. It will include elements such as National Living Wage, covering costs of travel, uniform, PPE, holiday, sickness and training time. Provision for an annual consideration for an inflationary uplift will be built in.

f) Care Analytics report that in their extensive work in other council areas, there is a great deal of variability in terms of higher fees from councils translating into higher pay for care workers so any increase in rates will have to be carefully monitored to ensure this has the desired effect. It is important to note that the council cannot legally oblige providers to employ staff in certain ways, for example not use zero hours contracts. We will ensure our pay rates are fair (see e above) and signal our desire to see a reduction in zero hours contracts within our specification. We will work with providers to reduce these and continue to

engage with other councils to learn what they do to discourage use of zero hours contracts.

g) Skills for Care report that about 9,300 staff are employed in home care roles in Leicester (2021/22) 89% of whom are employed in the independent sector. The age profile of the workforce is steadily ageing with an average age of 43, and an ethnicity profile of 40% white and 60% from black and ethnic minority communities. 79% of staff were female and 21% male. 30% hold a qualification relevant to social care but 63% either have or are working towards the Care Certificate. The staff turnover rate was 25.4% and the vacancy rate 15.1%. 44% of staff are recruited from within the sector.

h) In the long term, demographic pressures will further reduce the workforce available to support care work. This is because the elderly population is growing in Leicester at a greater pace than the working age population and the ratio of potential workers to people likely to need care and support is going to markedly fall.

i) Letting the contract for 5 years with the ability to extend for up to a further 24 months offers some certainty to providers and allows them to build up their business. It also allows us to build relationships with them, support with development and work with the market to ensure that care delivered is the highest quality. The usual termination clauses will apply.

Quality of providers

j) We will place a greater emphasis on quality in bid evaluation to ensure that only the very best providers are selected, this includes:

k) We will set a bar at ITT stage that only those providers rated at least Requires Improvement but with Good in the Well Led domain are allowed to bid. They must achieve an overall Good rating at the time of contract award (should they be successful) or submit a self-assessment statement as evidence that they are currently working towards a rating of 'Good' via a CQC improvement plan. Their contract may be delayed until they have satisfied this. Consideration was given to requiring a CQC rating of Good across all domains, but this is felt to be too risky with supply potentially compromised as a result. Presently 87% of our contracted providers are rated good but this figure is lower in the non-contracted market.

l) We will require bidders to have had prior experience of delivering personal care as a company and to be registered with CQC at the time of bidding for the contract and to have had at least 1 inspection.

m) We intend to award contracts to around 30 providers as at present to allow closer working and development with them and release capacity within the

CaAS Quality Assurance team to work with the non-contracted market to improve quality. This allows a balance between sufficient choice for people needing support, sufficient capacity should a provider exit the market and what is manageable to allow us to work with and develop the market.

Other considerations

n) Locally work is being undertaken on pathway improvements which will see all patients discharged from hospital offered a period of Recovery, Reablement or Rehabilitation (3 R's) through the in-house Home First service. The impact of this may be a decrease in referrals to home care from hospital with people with ongoing support needs having packages commissioned for them following their 3 R's input. The impact of these pathway changes will have to be closely monitored.

o) Night care support is already available through our current specification but as part of our support to the ICS, we have Winter Discharge funds to pilot a night time home care service which uses a block contract arrangement to ensure support is readily available and avoid an inappropriate discharge into bedded provision. This service offers eligible patients discharged from hospital a period of night time waking and sleep-in support to aid their recovery and allow a realistic period of assessment for any ongoing needs. The pilot lasted from 30th January 2023 to 31st March 2023 and was very successful. Plans are in place to recommission this from the autumn of 2023 and over the winter of 2024.

Bring the service in-house

p) Costs would increase because of local government terms and conditions and as the council does not use zero hours contracts, there would be a risk of staff down-time (unused hours) as most home care is delivered around what might be termed 'breakfast, lunch and tea time' calls. In 2021/22 work was done on an hourly rate of the in-house reablement team whose work is comparable to externally commissioned services. This showed that the hourly rate was 86% greater than the current commissioned rate.

Appendix 2
Unison's Ethical Charter

a) This charter is part of the Union's Save Care Now Campaign and was developed to support the conditions and quality of home care services nationwide, benefiting care workers and the people they support. There are commitments within the charter to include guaranteed hours for staff rather than using zero hours contracts and a target of paying the living wage.

b) Adherence to the charter includes a number of practical recommendations, and commits the Council to ensure that carers travel time is funded, that they do not have to rush from one client to the next, and that residents should keep the same carer as far as possible.

c) There are also commitments within the charter to include guaranteed hours for staff rather than using zero hours contracts and a target of paying the living wage. The Living Wage is a rate based on the real cost of living for employees and their families.

d) Our assessment against all the Charter's Recommendations is below:

	Stage 1 - Key Elements	Yes Please tick if Agreed by the Local Authority	Notes (including reasons why a LA will not accept an element)
1	The starting point for commissioning of visits will be client need and not minutes or tasks. Workers will have the freedom to provide appropriate care and will be given time to talk to their clients	Yes	The LA currently starts an assessment by looking at the outcomes someone wants/needs to achieve. This guides the assessment, which results in the commissioning of time and task to achieve the outcome. Increasingly there is less prescription with regard to time and more flexibility afforded to how people choose for their outcomes to be met.
2	The time allocated to visits will match the needs of the clients. In general, 15-minute visits will not be used as they undermine the dignity of the clients.	Yes	Since October 2014, no 15 minute calls have been commissioned, unless for example, 2 carers are needed to hoist a person or where help is offered to walk people to the dining hall in Extra Care schemes.
3	Homecare workers will be paid for their travel time, their travel costs and other necessary expenses such as mobile phones.	Yes	Payment for staff travel time is included in the fee rate paid by the council and providers are required to set out their costs in regard to this when they bid for work.

4	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.	Yes	The ASC Quality Assessment Framework (QAF) requires providers to evidence that care is not rushed and that time is allocated to allow for a task to be completed in the way that the client wishes. All providers are subject to the QAF process. We are reviewing how our time bandings can be altered to prevent the need for care workers to rush calls and ensure they are not disadvantaged financially.
5	Those homecare workers who are eligible must be paid statutory sick pay.	Yes	An element of statutory sick pay is included in within our financial calculations. The review will determine if this can be increased but this will have cost implications.

	Stage 2 Key Elements	Yes Please tick if Agreed by the Local Authority	Notes (including reasons why a LA will not accept an element)
1	Clients will be allocated the same homecare worker(s) wherever possible	Yes	The ASC QAF requires existing providers to evidence that there is continuity and consistency in staff matched to service users and is the method used by the Authority to ensure contract compliance. Electronic Care Monitoring Data is analysed by the Council to ensure compliance.
2	Zero hour contracts will not be used in place of permanent contracts	Agree to work towards this	There is currently no contractual mechanism to prevent providers from taking this approach. However, the current provider engagement is asking again how common this approach is in the home care market. Some are suggesting staff prefer the flexibility of this approach. We have seen increasing numbers of minimum hours contracts and full time contracts and we will continue to monitor this and seek further improvements through our dialogue with providers, learning lessons from elsewhere too.

3	Providers will have a clear and accountable procedure for following up staff concerns about their clients' wellbeing	Yes	The specification and contract require providers to identify and meet health, nutritional, cultural, religious and lifestyle needs and make provision for them. This is monitored through the QAF process.
4	All homecare workers will be regularly trained to the necessary standard to provide a good service (at no cost to themselves and in work time)	Yes	The QAF requires providers to evidence compliance against a core list of training requirements. Providers currently determine their own procedures around whether staff are paid to attend and/or whether this is in work time, but an allowance for staff time in this respect is included within our costings for fee rates. We have updated and enhanced our training requirements for the new model.
5	Homecare workers will be given the opportunity to regularly meet co-workers to share best practice and limit their isolation	Yes	The QAF requires providers to evidence compliance against this contractual requirement. The new model requires enhanced training and qualifications and this will be monitored through the QAF.

	Stage 3 Key Elements	**Yes** **Please tick if Agreed by the Local Authority**	**Notes (including reasons why a LA will not accept an element)**
1	All homecare workers will be paid at least the Living Wage If Council employed homecare workers paid above this rate are outsourced it should be on the basis that the provider is required, and is funded, to maintain these pay levels throughout the contract	Yes	All providers are legally required to pay the National Living Wage. The Council is committed to awarding contracts on the basis of providers paying the Foundation Living Wage, but is aware that some contracts will present a huge financial challenge, including domiciliary care.
2	All homecare workers will be covered by an occupational sick pay scheme to ensure that staff do not feel pressurised to work when they are ill in order to protect the welfare of their vulnerable clients.	Agree to work towards this	There is currently no contractual mechanism to require providers to have an occupational sick pay scheme. However, our provider engagement with providers shows that some of them, particularly the larger players, do have this in place. Our fee rates include an element of statutory sick pay.