SUBJECT: A Strategy for Commissioned Domiciliary Care in Monmouthshire

MEETING: Cabinet

DATE: 22.5.24

DIVISION/WARDS AFFECTED: ALL

1. PURPOSE:

To advise Cabinet of the proposed strategy for commissioned domiciliary care 2024 – 2034 and implementation as set out within the plan.

2. RECOMMENDATIONS:

- Cabinet endorses the strategy for commissioned domiciliary care 2024-2034 and implementation plan including the procurement of block contracts and a Spot Purchasing System

3. KEY ISSUES:

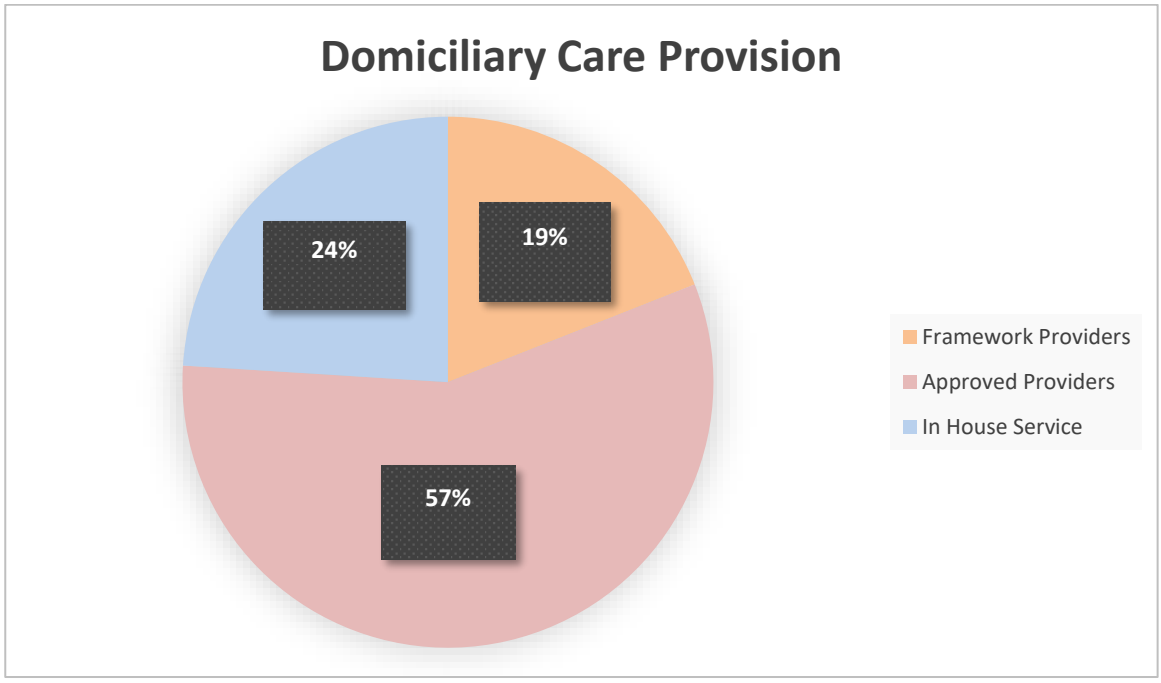
3.1 Background

3.1.1 Since 2011 the Council has commissioned its domiciliary care via a combination of framework and approved provider contracts. Framework providers are initially offered packages of support and if they are unable to deliver they are then offered out to approved providers who charge variable rates that are less cost effective. Neither framework nor approved contracts guarantee hours except for the Usk block.

3.1.2 Monmouthshire County Council's last commissioning strategy for Adult Social Care was for 2014 – 2017. Since then, we have explored potential options for improving the delivery of commissioned domiciliary care, including reorganising the commissioning of care on a small geographical patch basis, predictable payment arrangements, improved conditions for the independent workforce and outcome focused commissioning. However, with the onset of the Covid-19 pandemic this exploratory work was paused. Given the challenges we face in terms of demand and the recent worsening financial situation, it is necessary to reconsider our current arrangements and develop a strategy for the future.

3.1.3 There is a need to develop our future commissioning approach to domiciliary care within the context of key Monmouthshire County Council strategic documents, especially the Community and Corporate Plan 2022-2028 and the Socially Responsible Procurement Strategy 2023-28. Our future commissioning approach will need to support and contribute to the delivery of the C&CP's objectives especially, A Connected place where people feel part of a community and are valued. The future procurement approach will need to be consistent with and supportive of the values and objectives within the Socially Responsible Procurement Strategy to enable us to buy services that are sustainable, ethically produced, local wherever possible, and in line with our priorities and commitment to be an equitable organisation.

3.1.4 The data within the strategy is at a point in time in July 2023, which shows approximately 8000 hours per week of domiciliary care being delivered. The chart below shows the breakdown of hours between Framework and Approved Providers and In House Provision.



3.1.5 In October 2023 we began an analysis of our existing commissioned domiciliary care arrangements, an assessment of future need and an exploration of options for the future. The work has culminated in the development of a 10-year strategy, which is attached as Appendix 1 and an executive summary as Appendix 2.

3.1.6 The data within the strategy was obtained from FLO and relates to planned hours and not actual hours. Where spend data is shown this has been derived from calculations of planned and has not been validated against the Council's spend. All data is based on an hour of care and does not take in to account the varying costs of part hour care calls. All figures are based on a point in time in July 2023.

3.2 Findings

3.1.1 The strategy sets out in detail the findings on both a county wide and locality basis. The key issues of note are summarised below:

3.1.2 The county has seen a 26% increase in over 65's (2011 - 2021 Census Data), which is the largest increase in Wales. The Gwent Region Needs Assessment predicts a rise in the older population of 97.1% between 2013 and 2035 in Monmouthshire.

3.1.3 The current commissioning arrangements are do not provide sufficient capacity to meet current need. This presents a further risk to our ability to meet growing demand up to 2035.

3.1.4 The framework arrangements are no longer fit for purpose, only delivering 24% of commissioned care. There is an overreliance on approved providers, a key risk, as costs are higher.

3.1.5 The impact of these arrangements is common to all three locality areas. However, the extent varies in each locality and in addition there are issues which are relevant in some of the localities but not all.

3.1.6 In the North 71% is purchased in the lowest cost band. In comparison in the South 61% is purchased in the highest cost band. Average hourly costs vary significantly.

3.1.7 In-house domiciliary care provision is consistent in the North and South (24% & 22%), in the Central area 67% is delivered by our in-house services.

3.1.8 The number of providers operating in each of the locality areas varies:

- The North has 9 providers with no dominant provider.
- Central area has 10 providers, most have low hours. No dominant provider, the provider with the highest number of hours has 19% of the market. 36% of care has average care rates in the highest cost bracket.
- South area has 6 providers with average rates in the highest cost bracket.

3.1.9 The average weekly care hours per person (commissioned and in house) are consistent in the North (13.9) & South (13.2) but are 35% less in Central (9.6).

3.1.10 The brokerage arrangements provide a fragmented structure, care is offered and accepted on an individual and siloed basis. Providers aren't always able to respond to the bigger picture. It has limited financial controls built in; teams broker individual packages at any of the available rates. There is no requirement to procure lowest cost, outside of the framework being offered work first.

3.1.11 Feedback from the people using the service obtained via community care questionnaires, complaints and quality assurance activity has been taken into consideration in the development of the strategy. This feedback indicates in the main people are happy with the current care they receive. We receive very few complaints in regard to domiciliary care where people have expressed concerns this usually relates to inconsistency of carers and late call times. As we move forward with the implementation of the strategy and the procurement process, we will seek to ensure the voices of people receiving the service are heard and incorporated into service design.

3.1.12 The views of existing providers have been sought in regards to the existing arrangements, what works well and doesn't work well, and what would improve things for the future. As part of the procurement process, we will be seeking further views from both potential new and existing providers, as well as people who receive the service.

3.2 Conclusions

3.2.1 The independent sector has shown remarkable resilience over recent years, managing the pandemic, recruitment and retention issues and growing costs.

3.2.2 Current contractual arrangements are not conducive to maximising capacity to meet demand, offering insufficient security to either the Council or providers. They are fragmented with a large number for providers competing for business.

3.2.3 To meet the current challenges and future demand, contractual arrangements need restructuring to support greater resilience, flexibility, and capacity.

3.2.4 The challenges are common to all areas, but the extent and degree vary.

3.2.5 Brokerage arrangements are fragmented and time consuming often resulting in lengthy delays in securing care. More robust arrangements are needed.

3.2.6 Care costs differ considerably across the county. Approved provider dominance in certain areas, at higher rates, is impacting on overstretched budgets.

3.2.7 The current financial situation is unprecedentedly challenging, the existing arrangements do not maximise cost effectiveness and control.

3.3 Future Strategic Objectives

3.3.1 The strategy has three strategic objectives to effectively respond to the current challenges within the domiciliary care sector in Monmouthshire. There is a need to change the procurement and management of domiciliary care to meet current and future predicted demand.

1. **Provide sustainable high quality domiciliary care to those with an assessed need within Monmouthshire.**
   - Increase capacity and resilience with the domiciliary care sector.
   - Improve outcomes for individuals who need or may need care in the future, through target reablement and best use of capacity.

2. **Maximise the cost effectiveness of the care purchased, with less diversity of cost between providers.**

3. **Improve and standardise terms and conditions for the domiciliary care workforce, supporting with stability of workforce within providers**.

3.3.2 Section 4.2 within the strategy sets out some of the key changes that we want to put in place to deliver these strategic objectives. The key elements of the strategy are:

- Implement Block Contract arrangements as the primary delivery mechanism for all commissioned care.
- Implement spot purchasing contractual arrangements as a secondary arrangement for commissioning specialist and/or complex packages, which cannot be delivered through the block contract arrangement.
- An open procurement process, to enable existing and new providers to tender for both the block contracts and the spot purchasing contract.
- Contracts will include the requirement to deliver outcomes for people.
- Implement a new brokerage system and invoice validation process.
- Develop specific implementation plans for each of the three localities to account for local variation/need, including volume of hours.
- Include within the block contract terms and conditions a fair and reasonable hourly rate (flat rate with no premiums for part hours)
- Introduce the requirement for electronic call monitoring systems in both the block and Spot Purchasing contracts.
- Include within the block and spot purchasing contract terms and conditions for staff to include payment of RLW, mileage rate, payment for travel time, holidays, and contract terms.
- Ensure providers are employing staff in line with agreed contract terms and conditions.

3.4 Options Appraisal

3.4.1

Option 1: Continue with existing framework and approved provider arrangements.	
Opportunities	**Risks**
• Overall existing arrangements meet demand moderately well. • Stable sector – longstanding arrangements and good working relationships • Continuity of Care retained. • No impact on existing independent workforce i.e. TUPE.	• Unmet need continues to be problematic especially in the South and Central areas. • Insufficient capacity to meet current demand and predicted growth. • Recruitment and retention is not improved. • Too many providers competing for business with a negative impact. • Framework and approved contracts offer no guarantee of hours, piece meal brokering of individual support packages offers little opportunity for growth. • Little centralised oversight of brokering of packages. • The framework contract is no longer fit for purpose, only 24% of care provided through it and an overreliance on commissioning care via approved providers. • Some localities have considerable challenges in securing care and are either over reliant on high-cost providers and or in house. • The current brokerage arrangements aren't effective for either the Council or providers and offer little financial control or oversight. • Significant variation in hourly costs.
Option 2: Bring all commissioned domiciliary care in house.	
Opportunities	**Risks**
• Direct control through operational management of all domiciliary care. • Enhanced terms and conditions for the workforce. • Ability to reorganise operations without contractual variation/negotiation.	• No alternative method of provision if in house service is unable to meet demand. • Local and national businesses would lose a significant proportion of, if not all their work. • Mass TUPE transfer of existing provider workforce into MCC. • Loss of expertise and specialism in the independent sector e.g. learning disability and brain injury. • Costs will be considerably higher due to employment terms and conditions.

Option 3: Implement new contractual arrangements including block and spot purchasing.	
Opportunities	**Risk**
• Effective management processes to maximise capacity and flexibility. • Greater sustainability and resilience for providers. • Better cost effectiveness – less variation in rate range. • TUPE will apply which will ensure continuity of care. • Improve recruitment and retention of social care workforce. • Quality Assurance mechanisms confirm care is at the required standard. • Improved capacity to meet current and future demand. • Improved recruitment and retention of social care workforce through consistent terms and conditions. • Efficient oversight of use of hours. • Improved financial controls. • More efficient invoice payment system.	• Destabilisation of providers and market, existing providers may lose business. • Mass transfer of staff (TUPE) • Potential loss of continuity of Care • Lack of interest in the tender from providers • Opposition from people receiving services. • Phased approach may impact on other areas. • Destabilisation of the market due to change in one area.

3.4.2 Option 3 is the preferred option for the future of commissioned domiciliary care as it provides an opportunity to ensure the future arrangements are fit for purpose and cost effective.

3.5 Next Steps

<u>Implementation Approach</u>

3.5.1 The challenges we face over the next 10 or more years are complex and multi-faceted. To meet these challenges and realise the three strategic objectives, a systematic and targeted plan of action is needed. The scale of the challenge will necessitate a prioritised implementation approach. The South needs to be addressed first due to their reliance on high-cost provision.

3.5.2 The issues are common to all three areas but vary in degree and impact. The manner in which these issues will be bespoke to the individual locality; the objectives will be common to all, but the specific actions may differ.

3.5.3 Phase one of the two phased action plan will focus on implementing a range of targeted key actions for the South. Work will be ongoing during phase one to identify the key actions needed to address the Central. Phase two will be implementation for Central and identifying and implementing key actions for the North.

3.5.4 The implementation approach is ambitious, with demanding timescales which assume the smooth running of the process. The benefits of a phased implementation approach include the opportunity for iterative learning, learning from successes and difficulties.

Provisional Implementation timetable

3.5.5 The strategy (see appendix 1) has a phased implementation plan. The key action areas for Phase 1 (February 2024 – February 2025) are set out below:

- Implementing a new contract in the South offering fixed blocks of hours.
- Implementing a new system for spot purchasing of specialist or ad hoc domiciliary care in the South.
- Implementing a new brokerage system for the new block and spot purchasing contracts
- Enhancing monitoring of delivery hours and improving payment processes
- Developing a locality specific plan for the Central area for phase 2.

3.5.6 The key considerations and risk associated with phase 1 are:

- Procuring appropriate providers to fulfil the block arrangements.
- Ensuring the block rate is reasonable, financially viable & cost-effective.
- Significant change for providers, workforce & people receiving services.
- The resources which will be required for many areas of SCH to deliver the plan i.e Commissioning, Care Management and Finance Team.

3.5.7 The timeline for phase one is as follows:

- Feb - May 2024: Gain Approval (DMT, SLT and Informal Cabinet)
- By August 2024: Develop Procurement Paperwork for Block and Spot Purchasing Contractual arrangements (South)
- September - October 2024: Procurement Process for Block and Spot Purchasing Contractual arrangements (South)
- September-October 2024: Identify commissioning need for Central.
- November 2024: Develop future commissioning approach to meet need for Central.
- November 2024: Award for Block and Spot purchasing
- November 2024 – January 2025: Implementation
- December 2024/ January 2025: Produce Contractual and procurement documentation (Central)
- 1st February 2025: Contract fully implemented.
- 1st February 2025: Implement Revised Brokerage Arrangements and greater oversight of call times and delivery.
- February 2025: Gain approval for Central implementation plan

3.5.8 Phase two, February 2025 – February 2026 will be the implementation of new arrangements in the Central area and identifying the required future contractual arrangements to address the specific geographical challenges.

4 EQUALITY AND FUTURE GENERATIONS EVALUATION (INCLUDES SOCIAL JUSTICE, SAFEGUARDING AND CORPORATE PARENTING):

4.1 An Integrated Impact Assessment has been undertaken and is attached as Appendix 3 and a summary from Section 8 of the Integrated Impact Assessment identifying the significant positive and negative impacts is detailed below.

Positive Impacts:

- The proposed changes to the way in which we commission domiciliary care should improve capacity and resilience in the sector, whilst ensuring best use of public funds. This will ensure there is as far as possible sufficient quality care at the right cost to meet the individual's needs. The Spot Purchasing arrangements (which will run alongside block contracts) will also provide a way in which very specialist care and support can be purchased.
- The new commissioning model will enable a cost effective, secure and resilient model of care commissioning and delivery which will seek to provide best possible outcomes for individuals who require care in Monmouthshire.
- Longer term the mandating of common employment terms will improve equity in the sector, improve consistency and also provide greater security to the workforce.

Negative Impacts:

- Individuals who currently receive care and support may be impacted by changes in care provider. This may cause some anxiety and uncertainty.
- Providers and who are not successful in winning the tender will be impacted, with the workforce potentially being transferred under TUPE regulations.

5 REASONS:

5.1 Analysis of the existing commissioning domiciliary care arrangements clearly evidences that there is a need for change to meet the current challenges of growing demand and growing costs, and to be fit for purpose for the future.

5.2 Specific implementation plans are required for each locality to positively influence the arrangements without losing the benefits of the current arrangements.

6 RESOURCE IMPLICATIONS:

6.1 Expenditure on commissioned domiciliary care is one of adult services biggest spend areas, circa £6m in 2022/23.

6.2 At this stage it is not possible to calculate the costs of implementing the new block contract and spot purchasing arrangements as the rates will not be confirmed until the procurement process begins.

6.3 The implementation of new arrangements in the South has the potential to deliver cost savings.

6.4 As work proceeds in regard to the procurement process and the hourly rates/costs are clearer, a further report will be brought to DMT to advise of implementation costs.

7 CONSULTEES:

- SLT
- SCH DMT
- Integrated Service Managers
- Head of Adult Services

8 BACKGROUND PAPERS:

Appendix 1: A Strategy for Commissioned Domiciliary Care in Monmouthshire
Appendix 2: A Strategy for Commissioned Domiciliary Care in Monmouthshire – Executive Summary
Appendix 3: Integrated Impact Assessment

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