7 February 2024	ITEM: 12 Decision: 110692
Cabinet	
Commissioning Report – Domiciliary Care	
Wards and communities affected: All	**Key Decision:** Key
Report of: Cllr. George Coxshall – Portfolio Holder for Health, Adult's Health, Community and Public Protection	
Accountable Assistant Director: Les Billingham - Assistant Director of Adult Social Care and Community Development	
Accountable Director: Ian Wake - Executive Director Adults, Housing and Health	
This report is Public	
Version: Final	

Executive Summary

The Council has a statutory duty under the Care Act (2014) to provide care and support to people whose needs meet the eligibility criteria detailed in this legislation.

Domiciliary care is commonly referred to as home care and the terms are used interchangeably. Domiciliary care services are regulated by the Care Quality Commission (CQC) and cover a wide range of activities, including (but not limited to) the provision of personal care such as assistance with washing/bathing, getting dressed, going to the toilet as well as support with nutrition and hydration. These services are delivered in the person's home and seek to support people to remain in the community.

Domiciliary care can also extend to reablement services (help to regain or retain skills and confidence) for people leaving hospital or seeking care and support for the first time. Reablement services seek to delay or reduce the need for ongoing care and support.

Current contracting arrangements for domiciliary care come to an end on 31 March 2025. This report seeks the agreement of Cabinet on the proposed recommendation that the procurement of these services commences in February 2024 for a contract start date of 01 April 2025.

Commissioner Comment:

Commissioner has been consulted on the content of this report and agreed the recommendations made.

1. Recommendation(s)

1.1 To approve the tender of domiciliary care services to meet our statutory requirements under the Care Act (2014). This includes both the core domiciliary care service, reablement and the Out of Hours service.

1.2 Delegate the award of the contract to the Executive Director for Adults, Housing and Health in consultation with the Portfolio Holder for Health, Adult's Health, Community and Public Protection

2. Introduction and Background

2.1 We have a statutory responsibility to meet eligible need (Care Act 2014). Although other types of community-based support such as supported living, extra care and shared lives schemes are also regulated under CQC's domiciliary care regime, these services are not included in this tender as they are commissioned separately. This tender only relates to the provision of domiciliary care in people's own homes (regardless of tenure).

2.2 Current contract arrangements for domiciliary care finish on 31 March 2025. The tender is scheduled to start in February 2024 and the proposed procurement timetable is attached as Appendix 1.

2.3 As domiciliary care provision is based on assessed need, the amount of care commissioned is variable. However, in the first quarter of 2023 approximately 8900 hours of domiciliary care was provided per week for 690 people (an average of 1.8 hours per person per day). 900 hours per week is delivered by internal services (Caring for Thurrock) and the remainder is externally commissioned.

2.4 Currently 89% of directly provided or commissioned domiciliary care services in Thurrock are rated by CQC to be of 'good' quality. This is in line with CQC's 2022 reported national average of 87% of domiciliary care services being rated as 'good' or above.

2.5 Thurrock currently pays £20.58 per hour for externally commissioned domiciliary care.

2.6 Our spend on externally commissioned home care per year is approximately £8.6million.

2.7 In addition to externally commissioned domiciliary care services, Thurrock retains in-house provision (Caring for Thurrock). As well as providing both domiciliary care (both traditional and wellbeing models) and reablement, Caring for Thurrock acts as the 'Provider of Last Resort' (PoLR).

2.8 A PoLR is in place should there be a provider failure, insufficient capacity in the market as a whole or geographical area, a client for whom all other care options have been exhausted or in a support or management role for providers who require additional assistance. A PoLR is essential to managing and controlling risk levels in externally provided care.

2.9 The Care Act places a responsibility on local authorities to ensure continuity of care for vulnerable adults should there be a service disruption such as those detailed above. Caring for Thurrock's current hours and location of care delivery has largely been shaped by a previous failure of a provider who supplied services to people utilising direct payments or their own funds to buy care. As such, internal services have grown larger than intended. Thurrock must ensure that the correct balance is achieved between what it commissions externally and what level of provision we retain in-house to manage the risk of any potential provider failure.

2.10 Although reablement is currently provided by both internal and external providers, the specialist support and advice of therapy and nursing staff given to external agencies to enable people to regain skills sits within the Thurrock Council run joint health and social care reablement team. The council will continue to test and review our approach to the delivery of reablement, but as we try to minimise the amount of duplication of services/people going into clients, it is likely that reablement will remain an activity of all providers going forward. However, the specialist advice and support function provided by nursing and therapy staff would remain in-house.

2.11 Thurrock's in-house domiciliary care and reablement services also support with hospital discharge. External providers who supported an individual prior to admission also enable discharge by 'restarting' their package of care. In addition to this, Mid and South Essex NHS Foundation Trust also run a 'bridging' service from Basildon Hospital to enable people who are medically optimised to experience a timely discharge whilst long term care provisions are arranged.

2.12 The bridging service is funded through the Better Care Fund - BCF (a pooled budget and integrated spending plan between the health and social care system to aid integration). The Council contributes £0.216m per annum towards this service for approximately 200 hours per week. Health partners then meet the cost of any provision that exceeds this number of hours (i.e. they meet the cost at periods of higher demand).

2.13 Improving the transfer of care between the hospital and the community is a priority for the government and health and social care systems. In line with guidance, a Transfer of Care Hub (TOCH) is currently in development. A TOCH is the local health and social care systems co-ordinating centre. It is based around an Alliance (an Alliance is a strategic partnership between health, care, housing and third sector services that is responsible for the transformation of the system and developing and overseeing the deployment of the BCF in a geographical area i.e. Thurrock Integrated Care Alliance - TICA) and seeks to prevent demand for hospital services. How the TOCH develops will guide whether we need to reshape the market and how we currently operate to deliver a 'home first' approach.

2.14 Any changes to our existing hospital discharge pathways will be tested with the successful providers once they are fully embedded.

2.15 In addition to the statutory responsibility to meet eligible need and ensure continuity of care, the local authority also has a duty under the Care Act (2014) to 'shape' the market. This includes ensuring that services can meet current and future needs of people who use them and their unpaid carers.

2.16 Thurrock has seen a significant increase in the amount of domiciliary care commissioned, and it is very likely with demographic growth that this will continue.

2.17 In 2013 Thurrock commissioned 5100 hours of care per week. Today Thurrock commissions 8,900. This is partially due to the commitment to support people to remain in their own homes/communities. For example, even though Thurrock has experienced a significant increase in the number of older people with support needs over the last decade, the amount of residential based care within the Borough has not increased. Instead, resources have been redirected wherever possible away from residential care to a community setting.

2.18 Thurrock's 2021 Census data suggests that residents aged 65 years old or more have increased by almost 4000 people in the last ten years and it is estimated that one in four/five residents in Thurrock will be 65 years old or more within the next ten years. Census 2021 predicts an increase of 16,000 people aged 65 or older living in Thurrock by 2031.

Based on available data[1], the impact of these demographic changes on demand and contract value have been modelled. This is attached as a separate table in Appendix 5.

2.19 In addition to demographic pressures, the change in hospital discharge criterion during the pandemic from people being medically 'fit' to 'optimised' has created an increase in both the complexity of those requiring services and the level of care that needs to be delivered to support people effectively and safely i.e. people are coming out of hospital earlier and with more complex care needs/larger packages.

This change in criterion to medically optimised has affected all areas of provision. However, the largest impact is on the delivery of domiciliary care and accounts for a significant amount of the growth in care hours commissioned since March 2020. For example, between April 2020 to March 2022 an additional 2,700 hours per week of home care was commissioned.

2.20 Although the Council has continued to secure safe and good quality care to meet current need, doing so has been a significant challenge. With the demographic changes detailed in 2.18, the demand for this service is likely to grow over the life of the new contract. However, the domiciliary care market is fragile and faces many challenges. As such, Thurrock intends to shape the market to enable it at first to stabilise before ensuring it is sustainable long term.

2.21 Feedback shows that consistency of staff and timely visits are commonly the most important elements of a service to the client. However, retention of staff remains a fundamental challenge in Thurrock. Care work is often viewed as low status and attracts low pay. This coupled with the extremely competitive labour market in Thurrock (both in care and the wider economy) makes it difficult to achieve continuity of care for clients - this will only ever be achieved with a valued and retained workforce.

2.22 Skills for Care estimates that nearly half (46%) of Thurrock's adult social care workforce are on a '0' hour contract compared to a regional average of 24% i.e. we have double the number. Thurrock also has an older workforce - with nearly one third (30%) of people working in the local adult social care sector expected to retire within the next 10 years.

2.23 In addition to workforce, the Kings Fund has also identified rurality as a problem when securing supply of domiciliary care. This is due to the travel time and cost involved in a low number of visits over a large geographical area. Thurrock has similarly experienced difficulty

[1] We are still awaiting census 2021 population estimate data. As such, the modelling was based on ONS Population projections – local authorities: SNPP Z1 data release March 2020.

in securing care in its villages (Orsett, Horndon and Bulphan) and in areas where demand is low, and travel can be affected e.g. East Tilbury (past the railway crossing).

2.24 If Thurrock is to secure care over the next ten years, some things need to be done differently. For example, addressing how unattractive a career in care is, moving away from the role being low status, low pay and with low job security. There is also a need to commission differently. Short term contracts focusing on time and task activities do not assist with the challenges faced both now or in the future, nor do they assist in helping Thurrock to meet its aspirations.

2.25 To address this, in Thurrock we have adopted a Human Learning System (HLS) approach as a framework for delivering the change required. HLS is about "*building relationships with real people – the people we're trying to help…….and responding to the complex reality of people's lives - their strengths and needs*"[2].

2.26 Utilising an HLS approach, the council will move away from fixed ideas on how we support people and will instead accept that the model of care will continuously adapt and change over time in response to need. The council will 'experiment' in partnership with providers and those that use services to shape support and care to better meet outcomes.

2.27 The council accepts that not all experiments will be successful. However, it will use the learning and if something doesn't work or stops meeting need, change it. In essence, the council will commission for learning. As such, the specification has been designed to evolve and change in response to learning. An example of how learning may change what is delivered is the Wellbeing Teams (please see 2.30 and 2.31)

2.28 Better Care Together Thurrock – The Case for Further Change, Thurrock's integrated care strategy, details the (HLS) approach being used to transform, integrate and improve care. Chapter 8 details how the approach is being used to transform care delivered in the home.

2.29 Engagement work with residents has demonstrated that those in receipt of homecare want a service that is flexible, treats them as a whole person, is based on long-term relationships and is joined up, minimising the number of people coming into their home.

2.30 How Thurrock currently commissions, organises and provides care does not support service user aspirations. In response to this, Thurrock has developed Wellbeing Teams to test delivering home care differently. These teams are based on the Dutch Buurtzorg model which are small neighbourhood-based teams who are able to respond to the needs of the whole person and can link with other professionals to provide a joined-up response. Because they work on a neighbourhood level, they can have a detailed knowledge of the community assets and networks available to them and connect service users to these.

2.31 The Buurtzorg model was proven to be efficient and to deliver much better outcomes for people. However, it was based around health interventions (community nursing) and not social care. As such, Thurrock has been piloting Wellbeing Teams based on the same principles as Buurtzorg but applying them to people in receipt of social care. This pilot and its evaluation are ongoing and will be used to support the future development of the model of care provided in the Borough.

2.32 Although initial results are positive, the pilot is currently too small to be able to draw wider conclusions. It is currently unclear whether this approach inspired by the Buurtzorg model will have the same positive outcomes as experienced in the Netherlands when limited to social

[2] https://realworld.report/

care needs. As such, when more robust evidence becomes available, in line with a HLS approach, Thurrock will adapt its external model to take account of that learning (see section 3. Options).

2.33 As part of this pilot, work has been taking place to explore blended roles for Wellbeing Workers. This means upskilling existing staff to be able to undertake certain health tasks (e.g. diabetes management) to improve continuity of care and reduce duplication. It is hoped that this will also improve the status of care workers, resulting in higher retention. This is at an early stage, but again the results of this work will support the development of the external model.

2.34 In addition to Thurrock's core domiciliary care service, the Authority also commissions an Out of Hours (OOH) service which operates between 11pm and 7am. Prior to this service being put in place over a decade ago, there was no option for people with this level of need to remain in their own home. This service has enabled people to remain independent for longer, avoiding residential care and hospital admissions.

2.35 The service consists of three 'runs' which incorporates planned activity and an emergency component (i.e. able to respond to issues that arise such as a fall or continence issue – this part of the service is usually accessed via a 'lifeline' pendant alarm). Planned care activities are largely concerned with continence and skin integrity including repositioning/turning for those who are cared for in bed.

2.36 Due to the complexity of service users, the need to respond to emergencies and to keep staff safe during unsociable hours, each 'run' is staffed by two workers. The cost of each 'run' is currently £97,368 per annum. One of the three 'runs' is funded by Continuing Healthcare (CHC) partners i.e. the NHS. The OOH service is in addition to the 8,000 externally commissioned core domiciliary care hours detailed in 2.3. This will be a separate contract opportunity in the tender and will operate on a Thurrock wide basis. Unlike the core offer, there is insufficient demand in some localities to operate this service on a place/locality basis. The two 'runs' commissioned by the council are built into existing budgetary commitments.

3. Issues, Options and Analysis of Options

There are three main options. The preferred option is 2.

3.1 **Option 1 – Re-commission on the same basis as has been done historically i.e. time and task, priced per hour over a short contract period**.

3.1.1 Although it could be viewed as a low-risk option to go out to tender on the same basis as before, by doing so the council would not address the significant risk it faces in attracting a sufficient workforce to secure enough high-quality care to meet projected demand.

3.1.2 Due to the nature of the support required, people who use these services have an intimate relationship with the person supporting them and as such they want consistency in their care worker.

3.1.3 Current commissioning activity does not address long term recruitment and retention issues. As already explained, Thurrock has experienced difficulty in securing supply and is expecting both significant demographic growth and for 30% of its workforce to retire over the next 10

years. Recommissioning on the same basis – short term contracts, time and task etc will not address these issues.

3.1.4 As part of the Integrated Care Strategy (The Case for Further Change), Thurrock has organised its health and social care systems into localities to enable greater integration and to take advantage of community resources and natural networks of support that exist in each area. Continuing to commission in a traditional way does not support locality working. What is proposed will see care delivered on the same geographical 'footprint' as primary and social care, moving the relationship away from commissioner/provider to one of a partner who works jointly and equally alongside health and social care services.

3.1.5 This 'zoning' of care delivery cuts down on travel between visits and reduces the frequency of visits starting late.

3.1.6 As stated in 2.18, demographic pressures have been modelled alongside assumed levels of inflation – please see Appendix 5. These pressures result in an inflated cost, for the 10-year life of the contract of £114m.

3.2 **Option 2 – Preferred Option – Work with providers as partners to test, learn and shape services over the life of the contract.**

3.2.1 This option provides the opportunity to move towards a sustainable model, co-produced with service users and providers.

3.2.2 The recommendation is that the tender is at first for a traditional home care service albeit with some alterations to the current model. During the life of the contract, Thurrock's Adult Social Care Commissioning Team will experiment with providers, testing new models of delivery. Based on this learning, users views and the outcome of financial modelling/cost benefit analysis the service will be adapted over time.

3.2.3 Appendix 2 shows the locality boundaries and current delivery of care.

3.2.4 To allow providers to really embed in each locality, understanding the assets and networks unique to each area, care in this contract will be arranged around the existing Social Care Locality Team/Primary Care Network footprints. One provider will be sought for each of the four localities. The expectation is that potential providers must have the capability and capacity to meet all arising need for domiciliary care within their locality.

3.2.5 To mitigate the risk of any future quality or contract failure in the external market, potential providers cannot bid for more than one area (although they can also bid for the Out of Hours contract in addition to one locality contract). Should the designated provider for the locality be unable to meet demand, the package of care will be offered to the providers operating in other localities. Should we still be unable to secure care, need will be met by the use of spot provision. Ultimately, we retain Caring for Thurrock as a PoLR.

3.2.6 However, prior to contract commencement the council will work with one village (Bulphan) and one difficult to access area (East Tilbury beyond the railway crossing) to grow an alternative response. Thurrock has experience in developing community-based solutions and has grown a vibrant and diverse Micro Enterprise market (a Micro Enterprise is small social business providing support in a bespoke way – most commonly as a sole trader). Since 2015 Thurrock

has supported the development of over 100 micro providers to operate in the area to support people.

3.2.7 As part of this model, to enable all partners to build strong relationships and to give greater assurance, allowing providers in turn to give more security and to invest in those they employ, it is proposed that the contract is for a period of 10 years. However, to minimise risk there will be a break clause at 5 years in addition to the usual termination clauses. A significant change in the relationship with providers or a reduction in the reliance on '0' hour employment contracts will not be achieved by continuing to issue short term contract agreements. Recurrent tenders are time consuming, costly and do not foster joint working between providers but instead puts them in competition with each other. As Thurrock declares the rate for care, this frequent procurement activity adds little benefit or value for money for either the Authority or the user of commissioned services.

3.2.8 Based on the current hourly rate and demand levels for home care a 10-year contract would be approximately £89 million. The table in Appendix 5 models the estimated cost of the contract on a year-by-year basis incorporating both demographic and inflationary growth.

3.2.9 Legal and procurement advice has been obtained on the ability to change the model during the life of the contract without attracting challenge. Based on this advice, Adult Social Care Commissioners will set out within the specification the areas of service delivery that could alter over time e.g. introducing the principles of the wellbeing model externally, blended roles, reablement and hospital discharge etc. This allows for incremental change to occur over the life of the contract.

3.2.10 As providers move to the role of partner, the commissioning approach will also adapt to reflect this. The possibility of moving the commissioning of services from an hourly basis to allocating a set amount of core hours per area will be explored – allowing the provider to operate as a trusted assessor, staffing with some security and having inherent flexibility to adapt and deliver care to people whose needs may fluctuate/change over time e.g. reductions as people re-able/recover, increases in response to an episode of illness.

3.2.11 An implementation timetable of this option is attached as Appendix 4. As service developments will be shaped by learning, this is subject to change. However, the timeframes show when the learning outcomes should be available and how and when we will work alongside the successful providers. As stated in 3.3.4, the current provider market is currently not at the point that it could deliver our aspirations and services in a different way. The tender will be used to test and secure future partners who understand what the Alliance plans to achieve and have the capability to adapt over time.

3.2.12 As can be seen from Appendix 4, the implementation of domiciliary care contracts is complex. As such, it is recommended that delegated authority to award the contract is given to the Executive Director of Adults, Housing and Health, in consultation with the Portfolio Holder for Health, Adult's Health, Community and Public Protection. This will allow a sufficient window of time between contract award and contract commencement, during which the necessary handover and onboarding activity can take place to ensure a smooth and effective transition of care to the new service model and possibly new providers (depending on outcome of the tender). Risk in the delivery of care is at its highest during a period of change, as such delegated authority will allow a longer handover period, which in turn will mitigate some risk.

3.3 Option 3 – Go out to the market with a new but untested model of care.

3.3.1 Although the existing model of care is flawed and early results from the Wellbeing Team experiment are positive, going to the market with a largely untested model poses significant risk for the local authority.

3.3.2 The wellbeing model appears to deliver better outcomes for individuals and the system as a whole (i.e. less g.p. and hospital visits) but due to the additional costs involved with delivering this model (although again there is some evidence that these additional costs are recouped elsewhere in the system), the benefits need to be replicated with a much wider cohort of people before the reshaping of all externally commissioned services should be considered.

3.3.3 There is also uncertainty about what the delivery of wellbeing principles in externally commissioned home care would look like and this will need to be robustly tested in partnership with providers.

3.3.4 In addition, there is a significant risk that the market would not be able to respond to this new way of working without support. As such, this option is not seen as viable.

The preferred Option 2 allows the Council to make the incremental change required.

4. Reasons for Recommendation

4.1 It is a statutory requirement to meet eligible care and support needs.

4.2 It is a statutory requirement to shape the market to meet current and future demand.

4.3 The preferred option (option 2) minimises risk, seeks immediate improvements but secures long term flexibility to shape services in response to learning/user feedback.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 As part of Adult Social Care's quality improvement work and its commitment to co-production by ensuring people who use domiciliary care can also shape the services they receive; a survey was sent to all existing users seeking their views of the current service and its impact on their life. As part of this, people who use home care were asked to come forward to be part of an independently run focus group so that more in-depth discussions could be conducted.

5.2 During September and October 2023, Thurrock's User Led Organisation (ULO) ran focus groups with those people who have volunteered to participate.

5.3 In addition, Public Health colleagues continue to assess the impact of the wellbeing model on service user outcomes.

5.4 Also, to make use of existing contacts with domiciliary care service users, between August and October 2023 Contract Officers as part of their quality monitoring visits asked anybody in receipt of home care 3 additional questions.

5.5 A provider engagement event for existing and potential providers was held on 27 November 2023. This event allows the Council to have early discussions with providers about the HLS approach and the proposed model of care including the expectation that the successful

partners will adapt and shape their service over the life of the contract based on evidence from learning and user engagement.

5.6 This report was presented at the Health Overview and Scrutiny Committee on 11 January 2024.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The domiciliary care contract impacts on the following Council Priority;

People – a borough where people of all ages are proud to work and play, live and stay.

Specifically, the delivery of 'high quality, consistent and accessible public services which are right first time'.

7. Implications

7.1 Financial

Implications verified by: **Michael Jones**
Head of Corporate Finance

15 January 2024

An assessment of the annual costs, for the duration of the contract, are detailed in **Appendix 5**. This has been used as the basis to demonstrate an indicative value, which incorporates predicted demographic and inflationary impacts.

This is based on indices and assumptions consistent with the Councils medium term financial strategy.

Actual annual fee uplifts to providers are subject to consultation, and external market and economic factors which could alter that value of the annual contract totals.

The annual estimated expenditure of £8.6m, used as the starting point for external homecare services is consistent with the 2023/24 base budget.

Budget provision of £0.216m, to finance the Councils contribution to the Bridging service (para 2.212) is included in the base budget. This is in addition to the £8.6m for external homecare services.

7.2 Legal

Implications verified by: **Kevin Molloy**
Team Leader Contract Team

15 January 2024

Following issue by the Council of a s114 notice, the Council must ensure that its resources are not used for non-essential spending. The contract at issue here is essential and the provision of it a statutory duty under the Care Act. In procuring the services outlined, the Council must observe the obligations upon it outlined in national legislation and in its internal procurement rules. Officers should ensure Legal Services are kept informed as they progress through the procurement.

7.3 **Diversity and Equality**

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

15 January 2024

All information regarding Community Equality Impact Assessments can be found here: https://intranet.thurrock.gov.uk/services/diversity-and-equality/ceia/

Due to the nature of the services under discussion in the report, older people will be disproportionately impacted by any change/activity in this area.

However, the approach detailed in the report seeks to address the key risks to the long-term sustainability of domiciliary care and details how we as a council (working in partnership with providers and people who use this service) will mitigate these risks.

As such, the development of the domiciliary care service model and the application of the HLS approach in commissioning, should have a positive impact on older people (and all service users) in that it should secure sufficient services to meet needs both now and in the future. It is also hoped that it will improve workforce retention and improve service users' outcomes.

There have been no adverse outcomes identified, however as the service evolves ongoing evaluations of the impact of these changes will be undertaken through the completion of a Community Equality Impact Assessment (CEIA).

7.4 **Risks**

Adult Social Care Demand, Stability and Market Failure is a corporate risk. Although this risk is wider than just domiciliary care, a driver behind this tender and the development of a new domiciliary care model is to help mitigate this identified risk. The instability of the care market, increased demand and potential failure to meet need due to workforce recruitment and retention issues have been addressed by our preferred option – 2 (please see section 3.2).

7.5 **Other implications** (where significant) – i.e. Staff, Health Inequalities, Sustainability, Crime and Disorder, or Impact on Looked After Children

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- ***Better Care Together Thurrock – The Case for Further Change,*** https://democracy.thurrock.gov.uk/documents/s34501/Appendix%20B%20-

%20Better%20Care%20Together%20Thurrock%20-%20Further%20Case%20for%20Change%20-%20Full%20Version.pdf

- ***Market Sustainability Plan 2023***, https://www.thurrock.gov.uk/adult-care-strategies-and-plans/adult-social-care-local-account

- ***Skills for Care - Thurrock Summary***, https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/Local-authority-area-summary-reports/Eastern/2022/Thurrock-Summary.pdf

9. Appendices to the report

- Appendix 1 – Procurement Timeline
- Appendix 2 – Heat Maps of care delivery with locality boundaries identified.
- Appendix 3 – Community Equality Impact Assessment
- Appendix 4 – Option 2 (Preferred Option) Implementation Timetable
- Appendix 5 – Predicted Inflationary and Demand Pressures on contract value.

Report Author:

Sarah Turner

Commissioning Manager

Adult Social Care

Appendix 1 – Procurement Timetable

Activity	Start Date	End Date
Market Engagement Event	Nov 23	-
Cabinet approval to tender	07 Feb 24	-
Selection Stage (SQ)	19 Feb 24	22 Mar 24
SQ Evaluation	25 Mar 24	19 Apr 24
Tender Stage (ITT)	22 Apr 24	07 Jun 24
Evaluation of written tenders	10 Jun 24	28 Jun 24
Tender Interviews	01 Jul 24	19 Jul 24
Service User Visits	22 Jul 24	16 Aug 24
Notification of Outcome	19 Aug 24	-
Standstill	20 Aug 24	29 Aug 24
Award	30 Aug 24	-
Handover/TUPE	02 Sep 24	31 Mar 25
Contract Start	01 Apr 25	-

Appendix 2 – Localities and current care delivery – please see separate PDF.

Appendix 3 – Community Equality Impact Assessment – please see separate report.

Appendix 4 – Preferred Option Implementation Timetable – please see separate report.

Appendix 5 – Predicted Inflationary and Demand Pressures on contract value.

Appendix 5 – Predicted Inflationary and Demand Pressures on contract value.

		Per Client		Total		Inflation					Annual Budget Impact		
Financial Year - Stating 2024/25	Number of Clients	Average Weekly Home Care Package (Hours)	Average Annual Home Care Package (Hours)	Total Home Care Hours per week (Hours)	Prior Year Hourly Rate £	Staffing Element - 70% of Contract %'age	£	Non Staffing Element - 30% of Contract %'age	£	Uplifted Hourly Rate £	Annual Hours (Hours)	Annual Growth Requirement £m's	Annual Cost - Budget Requirement £m's
Base Year 2023/24	690	11.59	605	8,000						**£ 20.58**	417,143		8,585
Year 1	695	11.59	605	8,058	£ 20.58	5%	£0.72	7%	£0.43	£ 21.73	420,166	546	9,131
Year 2	700	11.59	605	8,116	£ 21.73	5%	£0.76	3%	£0.20	£ 22.69	423,189	470	9,602
Year 3	705	11.59	605	8,174	£ 22.69	5%	£0.79	2%	£0.14	£ 23.62	426,212	465	10,067
Year 4	710	11.59	605	8,232	£ 23.62	5%	£0.83	2%	£0.14	£ 24.59	429,234	487	10,554
Year 5	715	11.59	605	8,290	£ 24.59	5%	£0.86	2%	£0.15	£ 25.60	432,257	510	11,064
Year 6	720	11.59	605	8,348	£ 25.60	5%	£0.90	2%	£0.15	£ 26.64	435,280	534	11,598
Year 7	725	11.59	605	8,406	£ 26.64	5%	£0.93	2%	£0.16	£ 27.74	438,303	559	12,157
Year 8	730	11.59	605	8,464	£ 27.74	5%	£0.97	2%	£0.17	£ 28.87	441,325	586	12,743
Year 9	735	11.59	605	8,522	£ 28.87	5%	£1.01	2%	£0.17	£ 30.06	444,348	613	13,356
Year 10	740	11.59	605	8,580	£ 30.06	5%	£1.05	2%	£0.18	£ 31.29	447,371	642	13,999

10 Yr Contract Value	**114,270**