Help to Live at Home Programme

Full Business Case for the Joint Commissioning of Personal Care Services Provided in the Home

Status: Final

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Contents

1. Executive Summary

This business case recommends that NHS and Local Authority partners in Leicestershire jointly commission a new model of personal care at home for Leicestershire residents with effect from 2016/17.

The business case is the culmination of a detailed programme of joint work completed between January and August 2015.

Partners have developed and assessed a range of options for commissioning the new service and the work programme has included:

- Engaging in productive dialogue with service providers about the options and future needs for this service.
- Understanding and analysing the detail of the activity currently being commissioned across Local Authority (LA) and NHS partners, and modelling future demands.
- Reviewing the overall model of care, especially how personal care at home connects to other pathways within the health and care system such as hospital discharge.
- Shedding light on operational and technical barriers and improvements that need to be addressed for this service to succeed.
- Considering how personal care at home will connect to other preventative and wellbeing services in Leicestershire's communities.
- Assessing opportunities to integrate back office services in support of joint commissioning between NHS and LA partners, and release efficiencies.
- Testing financial aspects such as payment mechanisms.
- Understanding citizen needs and expectations.
- Seeking the advice and challenge of a scrutiny review panel.

The business case
- Sets out the case for adopting a new service model which has been designed to deliver an improved pathway of care when personal care and support is needed at home and the options considered for achieving this
- Assesses the capacity of, and demand for, the service, the associated costs, risks and benefits of the proposed model and the commissioning approach from the perspective of:
    - o the needs of the service user
    - o the strategic drivers of commissioners; and

o the readiness of the provider market

The total financial envelope of the services in scope for this business case is £36.3m representing approx. 49,230 care hours per week across 11,763 packages of care. These packages are currently being commissioned separately by NHS and LA organisations and are being delivered by up to 150 providers.

The service specification and contractual arrangements will be based on delivering against the strategic objectives for the new model of service, focusing in particular on incentivising the providers of home care to deliver person-centred reablement.

A new joint approach to commissioning is proposed from 2016/17, which will entail (via the procurement strategy), rationalising the number of providers and commissioning the new model of care in new locality based Lots[1], with one specification, and one contract.

HTLAH services will be delivered on a lead contract basis via a section 75 agreement. The Council will lead the contracting on behalf of all partners with integrated back office functions, so that providers interface with one point of contact, supported by joint contractual and performance management systems across NHS and LA commissioners.

The benefits that are expected from the proposals are:

- Improved outcomes for service users

- Home care delivered as a core element of the wider integrated care and support being developed in Leicestershire localities

- Greater security and sustainability for providers in the market

- Improved market management/market development from a commissioning perspective

- A more resilient market to meet the changing shape of health and care services/demands, given our local demography, and that more care will be delivered in the community in the future

- Achieving (£1.9m) savings, per the medium term financial plans of NHS and LA commissioners

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[1] A geographical area for which a provider will bid in the procurement process

While the development of this business case represents a critical milestone in this programme of work there are significant elements of work ahead. The next steps and milestones for the programme, including the resources needed to deliver this effectively, are also set out in this document. These elements of work are concerned with undertaking a successful procurement and transition to the new model of care in 2016/17.

At this stage NHS and LA statutory bodies are being asked to approve the proposed model of care to be commissioned via this business case, and support the further work required to prepare for procurement and transition.

Formal approval to procure will be sought in Q4 2015/16 from each statutory body, and a further report will follow to seek this approval at that time.

2. Introduction

Over the next five years the health and care system across Leicester, Leicestershire and Rutland will be transformed through the ***Better Care Together*** programme.

More health and care will be delivered in community settings in the future with all partners focused on reducing unnecessary admissions to hospitals and care homes, reducing delayed discharges from hospital, and providing a much stronger platform of integrated and preventative community services.

The Help To Live At Home (HTLAH) Programme is an essential component of the 5 year plan to transform health and care in LLR and will be targeted to two specific groups of people:

- Those in need of support at home following a hospital stay

- Those in the community whose needs have changed meaning they need more support to stay at home

The HTLAH Programme has been designed to help service users achieve maximum possible independence at home, by moving to a service model which is focused on reablement and maximising independence.

The HTLAH Outline Business Case produced in July 2015 assessed a range of strategic options, recommending which of the options should progress to Full Business Case stage.

This Full Business Case recommends that NHS and Local Authority partners in Leicestershire jointly commission a new model of personal care at home for Leicestershire residents with effect from 2016/17.

3. Strategic Context

The integrated service model for HTLAH has been designed based on a range of national and local drivers for transforming health and care. The main drivers are highlighted below:

Ageing Population and Disease Trends

The HTLAH service will need to address the predicted rising demands of older people, people with long term conditions and complex care per the analysis contained within Leicestershire's JSNA, which in turn underpins the case for change in LLR's *Better Care Together* Five Year Plan

The Sustainability and Resilience of the Local Health and Care Economy

The LLR health and care economy has been experiencing a rising demand in acute care over a number of years, and remains a national outlier in this regard.

Significant demand pressures and operational problems were experienced in 2014/15 across the whole health and care system. The impact of this was seen in a range of metrics, with ongoing poor A&E performance being symptomatic of wider system problems.

One of the consequences was the saturation of Leicestershire's home care market, resulting in a sizeable "await care" list when peaks of activity occurred and packages of care could not be sourced.

The lack of flow into packages of care in the community had adverse effects on the ability of the acute system to discharge patients, as well as knock on effects into the wider flow of patients through the whole system.

Attempting to seek more provision, (even at a premium) within the LA's existing provider framework was no longer a sustainable commissioning strategy.

With a planned recommissioning of the home care service pending for the LA in 2016, during the winter of 2015/16 Ernst & Young provided initial strategic advice on a range of potential service model options, based on their experience of working with other councils.

At the same time, due to escalating problems within the system generally, through joint working between all health and care partners at the LLR Urgent Care Board, a combined action plan was implemented to drive measurable change in 3 categories of activity:

- reducing the demands flowing into acute hospitals

- improving the flow and throughput of people once in hospital to achieve optimum medical management and length of stay

- improving the pathways for hospital discharge, and the coordination needed across all agencies required to achieve safe, effective and timely hospital discharge

By January 2015, the outputs of the Ernst and Young analysis, coupled with the Urgent Care Board's system wide work indicated a fundamental review of the model of home care was needed. Over the last 8 months, the HTLAH programme has undertaken this fundamental review resulting in

a) implementing some interim solutions to release capacity in the market in 2015/16 (already achieving high impact)

b) developing a medium term solution for the joint re-commissioning of home care from 2016/17 (the subject of this business case)

Achieving Greater Integration

In common with other elements of Leicestershire's Integration Programme, the proposed service model for HTLAH has been designed in line with the National Voices principles and King's Fund principles for integrated, person centred care. E.g.

- The involvement of the service user in care planning;
- Common models of delivery;
- Single care plans;
- Joint care pathways;
- Simplified discharge pathways;
- Reduction in delayed bed days;
- More people benefitting from targeted reablement on discharge

Addressing Missed Opportunities for Reablement and Incentivising Reablement

It is clear from the analysis undertaken for this business case that we are missing some opportunities for reablement, and/or not maximising the effectiveness of reablement, due to the way services are currently designed and commissioned.

The HTLAH programme has considered in some detail how more reablement can be driven through the pathway and model of care locally, and how a consistent reablement offer can be made for all hospital discharges including NHS Continuing Healthcare patients.

The programme of work has also considered how the market can be incentivised to promote reablement in their service offer and the mechanisms by which this can be achieved between commissioners and providers.

<u>Personalisation and the Implementation of the Care Act</u>

There are a range of statutory duties on local authorities including Personalisation and the Care Act that have been taken into account in designing the HTLAH model. For example, the Care Act requires that the public sector gives consideration to ensuring that there are improved employment terms for staff working in the care industry, particularly when renegotiating contracts with the care sector.

<u>Public Sector Financial Context</u>

All partners continue to face challenging financial targets including medium term saving requirements. The programme has therefore considered the contribution that can be made by the new HTLAH service to achieving commissioner financial plans. The financial model that has been designed for this service has also set out the return on investment assumptions if more effective reablement is achieved for specific groups of people.

4. Programme Scope

Leicestershire County Council (LCC) currently commissions close to £25.37m personal care from external providers, mainly through spot purchase style contracts, for circa 4,600 service users. In addition, a further £11m (approximate) is spent jointly by East Leicestershire & Rutland CCG (ELRCCG) and West Leicestershire CCG (WLCCG), on personal care for approximately 1,000 recipients of Continuing Healthcare (CHC). This combined spend on external provision forms the financial envelope for the scope of the new outcomes based integrated service model.

The HTLAH project team has considered a number of other services and budgets which have been agreed as out of scope for this programme. However, activity to facilitate the successful implementation of a new model of personal care will require some focused actions on functions which interface with the HTLAH scope, and therefore this re-design activity is included within the scope of the programme.

5. Data Analysis – Key Findings

Analysis of Activity and Spend

A significant volume of data has been analysed as part of the work undertaken by the programme, and a summary can be found below.

Table 1 shows a simple comparison of cost and activity between the partner agencies. As expected this shows that the volume lies within LCC, however the cost and intensity of packages comes from the CHC patients, e.g. there are 48 health cases receiving in excess of 100 hours per week. Historically, social care interventions follow a crisis resulting in an acute episode whereas health needs have been managed as long term conditions and / or chronic episodes. This has led to a mismatch in commissioning with packages often being built on projected need by nature of condition/episode rather than a period of reablement, leading to a return to independence and subsequent reduction in need for care approach.

Table 1

Current Activity	LCC	NHS
Number of Clients	4,593	1,014
Spend	£25.4m	£10.9m
Number of care packages	10,189	1,574
Av. Care hours per week	33,732	15,498
Average hours per package	12 hours per week	48 hours per week
% clients over 70 years old	81%	65%

*Source: GEM raw data provided March 2015, representing non-audited contracts paid April 1st 2014 onwards. **Note:** There are more packages than service users for a variety of reasons, such as one service user having more than one package of care – this could be because successive packages commenced and finished within the period, or because packages have been set up separately rather than as a single enhanced package.*

Currently LCC commissions almost six times the number of care packages as those commissioned through CHC, to four and half times the number of people. This is to be expected as LCC cases tend to be higher volume, lower need/acuity level packages, which is demonstrated when broken down into average weekly care hours. This shows LCC commissioning just over twice the number of hours commissioned through CHC, which is indicative of the longer times allocated for care for CHC than

are traditionally commissioned for social care. This should not however be interpreted as a reflection of differing qualities of care commissioned or provided. In fact, whilst some core staff will differ in relation to nursing needs, much of the personal care is provided by the same, or differing arms of the same provider, which would indicate that it will be the same staff delivering care of the same quality, regardless of the source of funding. It should be noted however that the differences in terms of size of package may be attributable to the nature of the needs of CHC patients, although it is also acknowledged that some over-prescribing of required care is also known to occur.

CHC Data Constraints and Caveats
The data analysis undertaken for the full business case for the CHC cohort of patients has been based on a data set provided by the Arden GEM Commissioning Support Unit. This covers cases between 1 April 2014 – 31 March 2015 with data provided on the following fields: CHC service provider, hours worked/year and expenditure/year, in each of the 18 Lots and in each of the 7 Locations.

In order to receive the data set in the format needed, work was required within the CSU to collate the information. There was a significant delay in accessing this data over a period of 12 weeks between December 2014 and March 2015. The was escalated via the HTLAH programme Risk Register up to the Integration Executive. In order to unblock this situation, the HTLAH Programme Board had to pay for this work to be carried out and set a series of delivery deadlines.

It is recognised by CCG and LA partners that the CHC data set has a number of constraints and caveats associated with it which include the following:

- The current system for managing CHC commissioning records involves a combination of manual and IT based data within Arden GEM, although there is a stated intent to move to electronic records in the future.
- Data quality and completeness is therefore difficult to assure. The data set received was reviewed by the LCC HTLAH analyst and the Research & Insight Team analyst and this identified a number of validation issues some of which were resolved by the local authority in the finalisation of the data set however it has not been possible to validate the data set fully in terms of the fields of data required for this business case, and the Programme Board has accepted the data provided is in places incomplete. It has been agreed however that the data is good enough on which to base our modelling assumptions and the risks noted on this.
- Due to the difficulties in terms of timelines and costs in getting the initial data set, it was not feasible to re-run this data set later in 2015, nearer the time of the production of the final full business case, so assumptions have continued to be made based on the original data set.

Children Facing Transition

There are a total of 681 known young people who will transition between Children's Services and Adult Services over the next three years. While the vast majority of these children will go on to need some level of service from Adult Social Care and Health, there are only a small number of these that may require services through HTLAH, and others that may look to using personal budgets for an equivalent service. The exact number who may need an ongoing service at this stage is not known, as it is determined at the point the transitions assessment is carried out. Table 2 shows the known numbers of children coming through transition in the next four years:

Table 2

Year	Known Number of children transitioning.
2015	115
2016	166
2017	234
2018	166

Analysis of the Current Marketplace

- There are up to 150 providers currently operating across Leicestershire who provide services for either LCC and/or CHC. This number varies at any given time due to dynamic nature of the market (i.e. mergers, acquisitions or withdrawals).
- The largest market share of any one of these providers represents 9.6% of the total market.
- There are 29 providers who deliver less than 20 hours of care per week on behalf of social care or health.
- The Hinckley and Bosworth CCG Locality has the highest value of local business at £8m per annum.
- The largest provider in Hinckley and Bosworth CCG Locality holds 13% of the market. They are the second largest provider across the whole of Leicestershire.
- There are two CCG localities that share the lowest value of business with £4.1m each, these are Oadby & Wigston and North Charnwood respectively. Just over 5,000 hours per week are delivered in both of these localities, a figure that was highlighted as minimum provider viability in the Ernst & Young paper.
- Between them, the largest 10 providers (in terms of commissioned hours) represent 38% of the total market.
- Population projection data for the 75+ years population of North West Leicestershire locality highlights an increase of over 30% between 2014 and 2021. The smallest increase over the same period, of less than 10%, is projected for the Oadby and Wigston locality.

Key Facts

The current annual financial envelope for this programme is £36.3m[2].

This currently delivers of a total of 49,230 hours care per week across 11,763 Health and Social Care packages to 5,607 service users.

We are seeking to commission from a smaller number of providers in order to develop stronger strategic relationships.

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[2] Combined budget for commissioned care.

6. HTLAH Model Overview

The Reablement Offer

'Reablement can be described as an 'approach' or a 'philosophy' within home care services – one which aims to help people 'do things for themselves', rather than 'having things done for them'.'

(Care Services Efficiency Delivery programme (CSED), Homecare Reablement, Prospective Longitudinal Study, Interim Report 1 of 2, CSED, Department of Health, Oct 2009)

The key underlying principles of an effective reablement offer are the ethos of working proactively with service users over a defined period of time, to achieve goals set by the service user and the reablement team together, with the overall aim of maximising service users' independence, choice and quality of life, and reducing their future need for support.

National research has shown that through a reablement intervention, 50% of service users may have the potential to improve and regain independence, managing with a significantly reduced package of care or no need for a long term package of care. LCC's HART reablement service matches national best practice (50% of those being provided with reablement having 'no further needs', 22% 'admitted' to hospital or residential care, 22% requiring ongoing maintenance care and 6% ending for other reasons). Building on these outcomes, the HTLAH model requires all personal care providers to adopt a reablement approach while promoting independence as a priority, to prolong service user's ability to live at home and remove or reduce the need for commissioned care hours in comparison with current levels of personal care.

HTLAH Target Operating Model

The model has been developed in two stages, firstly to cover all service users who are transferring from hospital (step-down), and secondly to cover all service users who may experience an acute episode within the community which puts them at risk of hospital or residential admission (step-up).

The aim of both models is to return people to the normal functional base they enjoyed before their crisis and prevent unnecessary admissions to hospital or long stay residential care.

Step Down Reablement – Facilitating hospital discharge (figure 6a)

LCC's current reablement service, HART, will be redesigned to form the Core Reablement offer supported by Community Health Services, in order to support transfer from all hospital settings for all service users requiring reablement. Any eligibility assessments required will be carried out in the community during the reablement period. It has been recognised that this could mean an increase in those people being eligible for social care funding as those that may have been CHC recipients' transition away from being eligible for health funding. The financial

modelling section of the business case describes the principles and methodology that has been agreed between the Council and both of the CCGs in respect to managing this risk.

Following Core Reablement, the Independent Sector will receive those service users who have been assessed as having ongoing support needs.

Current HART activity, generated from community based referrals, will in the new model be undertaken by independent sector providers in line with the new HTLAH Step Up provision (see below).

Help to Live at Home Care Pathway – Step Down

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MCA completed if required at any stage through the pathway by the integrated team

1. Patient medically stable to transfer care.

2. Initial assessment inc minimal basic equipment required to be safe at home

3. Min. Data Set [*1]

4. Coordination triage by Integrated team. Suitable for Pathway?

No [*3]

Leaves Pathway

5. Transferred Home

6. Trusted Assessment: Goals agreed and Integrated reablement delivered

7. Stepping Down Integrated Reviews

No Further Eligible Needs (NFEN)

8. Fin. Assessment & Ind. Care Account

9. Integrated Joint Support Plan written[*2]

10. Integrated Delivery of Support Plan

11. Package & reviews completed

NFEN

12. Integrated ongoing support plan & RAS completed

SP starts ongoing care with updated MDS

STEP UP

*1: process already defined & mapped elsewhere
*2: Realignment Integration Programme (Brian Jopling)
*3: Rapidly deteriorating patients should not be reabled, but integrated assessment team need to decide this following assessment. Care package anticipated to be slightly higher than maintenance level, roughly 10 hours care inclusive of assessment and review. Leaves Pathway to Pathway 4

17

Step Up Reablement – Preventing avoidable admission (figure 6b)

New episodes that occur in the community will be provided with a period of intensive reablement commissioned from the Independent Sector Provider in order to avoid the need for either hospital or residential care admission.

Independent sector providers will deliver the initial intensive reablement for the community based referrals in the same way as the Core Reablement Step Down service model.

For those transferring from the Step Down service and for community based referrals requiring longer term support the external market will provide support using the ethos of ongoing reablement rather than maintenance support.

Figure 6b

VERSION CONTROL: DRAFT: HTLAH model design v26.vsd   09/07/2015

STEP UP (IN THE COMMUNITY)

Only move to 1a if required (complex case, safeguarding

1a Locality work trays (Urgent, Planned): further ASC assessment needed (*1) following the CPW Rules of Engagement

NFEN

CSC review work tray for 2wk review (sooner if needed)

3. Schedules initial review of care needed

Allocate Package (*2)

Named SP for Zone, banded hours, Outcomes

1. CSC: screening, assessment, challenge(*5)

AT Comm Eqpt Intermediate Care Team

4. SP Assessment, then initial reablement

Step Down to maintenance with revised Banding(*3)

NFEN

6. Review Team: review at max of Wk2, sooner where possible. (*3)

7. Ongoing reab't agreed (Wks 3 & 4)

5. Provide minimum AT and equipment needed to meet eligible needs

NFEN

AT provider Comm Eqpt with PIN Refer via SPA for ICT (therapeutic needs, physio, OT) or for SALT assess't. Refer: CSC again if safeguarding

SP asks & Review Team agrees to extend reab't to Wk5/6

8. Review: Pay't Mech step down to Low £/hr (*3, *4)

NFEN

Wk4 review, agree eligibility & ongoing POC.

NFEN

In any case: move to low £/hr rate after end Wk4

9. Review Team: refer POC to CCF for Fin. Assess't & Ind. Care Account

10. Joint Support Plan written [*2] by SP + SU

11. Review Team: sign off support plan & do the RAS

Allocate budget via:
- cash card
- Direct Pay't
- managed service
- PMA (check if these will still exist)
- ISF

Step Down Entry Point

13. Regular scheduled reviews

NFEN

14. SP starts ongoing maintenance level care (*5)

SP asks for a review

NFEN

Continual review and step down process between discharge and a maximum of 6 weeks for reablement

*1: social worker retains responsibility for case re safeguarding. *2: only if required. *3 CHC checklist done at point of review where stepped down to maintenance *4 Banding reviewed at same time. Check eligibility to national criteria
*5: Minimum Data Set to be done/updated, for CHC patients stepping down from hospital or Stepping Up in the community.

7. Alternative Community Pathways and HTLAH

Transfer to Assess (T2A) Pathway

The T2A pathway commenced in March 2015 within UHL. It is a joint scheme between Health and LCC's Adult Social Care Services to enable patients to be transferred home whilst awaiting eligibility assessments (Decision Support Tool for Continuing Healthcare Funding).

A UHL Discharge Specialist Sister acts as the Case Manager working alongside a County Social Worker. The cohort of patients subject to the pathway is 15 patients at any one time. Patients are initially transferred home with a health funded package of care, with the aim of a pathway length of stay of no longer than 6 weeks. The patients then get joint case management support and their DST is aimed to be completed around week 2/3 of their stay on the pathway.

The principle of reablement is currently not a feature of the T2A pathway.

Under the new HTLAH service the T2A patients will go through the Step Down pathway and benefit from the reablement approach.

Enhanced Intensive Community Support (ICRS2) Offer - BCT Bed Reconfiguration

The LLR bed reconfiguration work, which is taking place as part of Better Care Together, indicates that a proportion of patients may leave hospital in the future on the proposed new ICRS2 pathway.

This additional element of the LLR discharge pathways is being designed to discharge certain patients from hospital within 10/11 days, and is likely to be implemented within 2015/16 . This means their care will continue intensively in the community instead of hospital.

The HTLAH programme board is currently working with the LLR Better Care Together programme to establish the exact cohort of patients this will affect, and at what stage this pathway will be introduced.

It is clear that once this new pathway is being introduced there will need to be a clear process to review each patients' needs at the point of discharge from ICRS2, to determine if they have ongoing needs and that the safe minimum transfer data set will be used to communicate these requirements with other agencies.

Patients leaving ICRS2 who have ongoing needs may have clinical needs, social needs or a combination of both. In terms of the implications for the HTLAH full business case, at this stage we are noting this development is pending, and that clear processes and protocols will be needed in order to transfer patients into ongoing care and support.

Ongoing support could therefore be either step up HTLAH domiciliary care provided by the independent sector or step down statutory reablement (e.g. via HART). This is captured on the HTLAH risk register.

8. Effectiveness of Reablement and 2 Week Reviews

The following analysis is a snapshot of cases currently going through HART, the T2A pathway and the 2 week review team. It is intended to demonstrate the impact and outcomes that are being achieved across the various approaches that are being deployed:

		BEFORE REVIEW Care hours per week				Average days from care start to POC review 1	Average days from care start to POC review 2	AFTER REVIEW Care hours per week			
		POCs	Max	Average	Min			POCs	Max	Average	Min
HART	Community referrals	2	10.5	9.0	7.45	24	n/a	2	7.45	7.2	7
HART	Hospital discharges	5	12.25	9.24	3.5	11	n/a	5	6.45	1.29	0
CHC T2A	Hospital discharges	21	52.5	23.7	5.25	10	20	21	52.5	21.6	0
SPs	Community referrals	56	40.3	13.0	0.8	16	n/a	56	40.2	7.1	0
SPs	Hospital discharges	56	43.6	14.5	2.2	20	n/a	56	36.9	7.8	0

Currently the only reablement pathway that is in place is via HART.

The two week reviews of care packages delivered by the independent sector for both community referrals and transfers from hospital (cases that are not able to go through HART due to capacity constraints) are already achieving a reduction in the number of care hours per week despite there being no formal reablement requirement in the current independent sector offer.

By standardising the new HTLAH Step Up offer to include both a reablement focus and a two week review process it is expected that outcomes seen should be at least on par with those currently being achieved by HART, thus widening service user access to consistent reablement support across Leicestershire.

9. Identified Critical Success Factors (KPI)

- All avoidable 'awaiting care' cases are eliminated in line with the Await Care action plan targets and trajectory.

- A successful procurement is achieved. This will be met where full coverage is achieved in all areas and delivery is made by providers that are compliant with all contractual requirements and meet all staffing, quality of delivery and service user outcome requirements. The successful bids must also be affordable, as defined by the envelope stated in this Full Business Case, on behalf of the commissioning organisations.

- The remodelled HART service, working alongside Community Health Services (Core Reablement offer) provides the Step Down service for all hospital service users needing reablement and does not have to 'hold' any standard personal care packages due to lack of personal care capacity in the independent sector.

- Growth in demand for long term care is mitigated, with the 2014 levels, being used as a baseline for measurement purposes.

- The focus of delivery is on reablement, outcome based support planning, and long term support.

- LCC savings target of £250k in 2016/17 and £1m in 2017/18 are achieved.

- An increase in percentage of those service users who are satisfied with the care and support they receive. This increase will be measured against the 2013/14 baseline of 60.1%.

- The new community reablement offer must match the levels currently achieved by HART. The baseline for this to be at least as effective as the current HART performance over a timescale to be agreed in development of service specification KPI measures.

- Contain growth in spend to levels in the MTFS and NHS growth assumptions.

- Support BCF outcome metrics to:
  o Reduce delayed transfers of care per 100,000 population per month from 361.98 at 31/03/2014 to 350.48 by 31/03/2016.
  o Reduce 754.53 permanent admissions per 100,000 population per year to 670.39 by 31/03/2016.

- Length of Stay for patients is less than 10 days – both shortening length of stay, and removing the "stranded patient". The rationale for this is to reduce the decompensation of patients staying in hospital and to maximise their chances of reablement.

- Reduction in CHC overspend/resource pressure achieved.

- Packages of care are appropriately commissioned at the first point of opportunity.

Key Facts:

- **Target operating model has been jointly developed based on the ethos of reablement**
- **There is a clear and defined model for both Step Up and Step Down pathways**
- **The cohort of service users both for LCC and CHC has been defined**
- **Critical Success Factors have been identified which will form the basis of**

KPI development for the service specification and performance management

10. Demand Profiling for the Independent Sector

Demand profiling for the independent sector activity will be used to confirm the affordability of the HTLAH programme over the proposed contract term.

The model we have developed for the full business case contains a number of policy, activity and financial assumptions as at September 2015. It is recognised by the HTLAH Programme Board that these assumptions represent a point in time and will inevitably be affected by the changing landscape of health and care nationally, and locally via the Better Care Together 5 year transformation plan. The model will therefore be a live and dynamic tool which is refreshed as needed to keep pace with these developments.

The demand profiling will be refined for the procurement stage of HTLAH to show the effect on levels of business for each Lot. This will then be reflected in future iterations of the business case in order that the Programme Board can monitor the ongoing viability and effectiveness of the programme.

Further information will be shared with providers at key stages during the procurement process. In terms of the selected providers in 2016 we will continue to work very closely with them during the life of the contract so that any future adaptations required (e.g. to the activity levels or model of care) are planned collaboratively and coproduced.

11. Financial Modelling

Detailed financial modelling has been undertaken by both the local authority and CCGs and consolidated into the full business case.

Leicestershire County Council Position
The County Council's Medium Term Financial Strategy 2015/16 to 2018/19 includes an efficiency saving target linked to HTLAH of £250k in 2016/17 which increases to £1m from 2017/18. As the Council has been providing reablement to service users for a number of years through the in-house HART service, it is not anticipated that the effectiveness of reablement will substantially change as a result of this programme. Instead, the calculated savings come from other areas:

- Reduced hourly rate paid to independent sector providers through the consolidation of existing service provision.

- Reduced unit costs of community reablement when this service is provided by the independent sector rather than HART.

In the County Council's Medium Term Financial Strategy, there is an additional savings requirement of £1m, commencing in 2017/18 against the HART service. At this point those savings have not been incorporated into the financial modelling but it is anticipated that these additional savings will have a reduction in ongoing costs for HTLAH, particularly for CCGs.

Health Position
CCG operational plans include an annual savings target of £1m to be achieved in 2017/18 (with a part year effect of £0.3m in 2016/17) on personal care costs for continuing healthcare patients at home.

Savings to health are on the basis of an improved offer to ensure that CHC patients are reabled to the point where ongoing support needs are reduced. Reablement packages will complement existing commissioned services including, ICS, night nursing, proactive care, Marie Curie and domiciliary therapies.

There are some services that are out of scope of HTLAH, these include:
- Specialist services, eg brain and spinal injury
- S117 patients
- Learning Disabilities, where the package of care is commissioned through the LD Pooled budget. In these cases, the costs and activity have been included in the LA modelling

Pricing
The recent announcement made in the Chancellor's Summer Budget concerning the introduction of a National Living Wage has been incorporated into the financial modelling. The exact financial impact of the living wage will not be known with any certainty until the procurement process is complete, whereby we can confirm assumptions about the market price, and contracts are then awarded.

For the purposes of a consistent approach in financial modelling, both the local authority and health have used the same assumptions on rates for personal care.

The rates calculated and used in the financial modelling are indicative and further refinement will be required which may have an impact on final costs and savings. It is planned to take an upper and lower rate approach to pricing in the tender as this will prevent abnormally low / unviable bids whilst ensuring that costs are capped at an affordable rate.

Continuing Healthcare
As a consequence of improved commissioning and reablement outcomes for health patients, it is anticipated that we can increase the number of cases where CHC eligibility criteria are not met. Some of these patients will still have continuing

support needs which will be funded from other areas, including social care. Based on the health financial modelling, by 2020/21, it is expected that the cost of these patients to social care will be in the region of £0.2m.

One of the objectives of HTLAH is to design a pathway into the service that has been designed jointly between health and social care with the aim of maintaining patients at home for as long as possible, and reducing demand through a more effective service offer based on reablement.

The impact of this could be viewed as increasing the risks of cost shifting between organisations. However, the Programme Board recognises that the new model of care may mean adjusting the costs between organisations but these adjustments will be transparent and managed jointly through the section 75 agreement and this process is needed in order to support NHS commissioners reducing their overall CHC costs in the medium term.

Consolidated Savings
Combined health and social care savings are summarised in the table below:

	16/17 £'000	17/18 £'000	18/19 £'000	19/20 £'000	20/21 £'000
CCG Reablement cost / -savings	28	180	-440	-746	-1,058
LA Community Reablement saving	-254	-829	-790	-758	-758
LA Procurement Savings	-69	-275	-275	-275	-275
CHC Cost transfer to social care	20	64	119	185	234
Total Savings	**-275**	**-860**	**-1,386**	**1,594**	**1,857**
PMO Costs	236				
Transitional Costs	288				
Net Savings	**249**	**-860**	**-1,386**	**-1,594**	**-1,857**

*Excluding cost of back office functions

Back Office Support Functions
As part of the ongoing delivery of an integrated service there needs to be an efficient back office support function, this includes making payments to providers and contract compliance.

In the medium to long term, savings are anticipated for both the LA and CCGs, this would come through efficiencies of payment processes and reduced number of providers. In addition to this, under the new pathways, there is an additional saving as the existing brokerage function provided by the LA will not be needed.

For the local authority, annual savings are estimated to be £100k. This arises from no longer having the need for a brokerage function as packages of care will be allocated to the care provider for that specific zone. The exact timing of when this saving can

be achieved will depend on when the new model of care commissioning becomes fully operational.

Due to the complexities in the current Service Level Agreement (SLA) that the CCGs hold with the provider of back office functions no savings are anticipated in the short term. This because the SLA includes funding for a consolidated team that offers a full back office support to the three LLR CCGs for all CHC services. Furthermore some of these functions will be transferring back in house at some point this year. As such, in the interim period, the CCGs will have to invest into the project a sum circa £100k to fund the additional resource required to undertake the health back office functions. It is expected that in future negotiations there will be opportunities to review and make adjustments to the SLA from which savings could be realised.

The business model for back office support functions is currently being designed. To providers this will have the look and feel of a fully integrated service, the actual implementation will be on a phased basis with the business critical functions taking priority.

Implementation Costs
To ensure the programme is successfully implemented, a number of other costs will be incurred. These will be non-recurrent in nature and include:

- Programme Costs – This relates to the cost of running the overall project and includes project management, engagement, procurement, IT requirements and other administrative items of expenditure. These costs total £356k in 2015/16 and a further £236k in 2016/17. These costs are being shared between the LA and Health.

- Transition Costs – Once the contracts have been awarded, there will be a substantial piece of work to ensure that service users transfer, where appropriate, to their new provider. In some cases service users / patients may opt for a direct payment or personal health budget. This will require careful planning and will need to be resourced appropriately to ensure that delivery of the programme remains on track. The estimated cost of transition is £182k in 2015/16 with a further £288k in 2016/17.

Financial Governance
Financial governance will be underpinned by a section 75 agreement. The agreement will clearly detail financial related matters including:
- Financial processes and controls
- Funding flows
- Risk and benefits sharing

Work has commenced on writing the agreement and will be refined further as the detailed processes are worked through.

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Key Facts

Anticipated ongoing savings (LA & CCG) potential (LA & CCG) by 2020/21: £1.9m broadly in line with MTFS and Operating Plan requirements

National Living Wage implications have been taken account in the financial modelling

Financial governance will be addressed in the section 75 partnership agreement

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12.   Strategic Option appraisal

Background

In November and December 2014 the HTLAH programme worked with Ernst & Young to develop initial strategic options for recommissioning Leicestershire's domiciliary personal care services, and to consider the opportunities for partners to improve service quality and outcomes and achieve efficiencies and cost savings.

Advice was sought from Ernst & Young due to their work with other authorities, as well as both commissioners and providers of similar services within the NHS. Ernst & Young's work for LCC provided a starting point for developing the methodology for modelling the potential costs and savings.

The strategic options fell into three main categories:

1. Provider payment mechanisms- how the market can be incentivised to deliver outcome and reablement focussed services

2. Provider delivery models- how the market can be structured (number and type of provider organisations).

3. Provider organisation by zone – how the market can be organised by defined zones across Leicestershire County.

A long list of initial strategic options in each of these categories were assessed by the Integration Executive which had been given the mandate for the HTLAH programme to be developed jointly by the two county CCGs and LCC.

The mandate was for the development of a business case based on an agreed short list of strategic options as approved by the Integration Executive. This business case needed to be supported by a much more detailed options appraisal and robust financial modelling to assess benefits, savings, implementation implications and overall affordability of the preferred option.

Due to the impending expiration of the LCC's existing contracting framework for domiciliary care providers, the outputs of this work needed to be produced rapidly, to allow for business case production (and approval) by late autumn of 2015. Procurement will start early 2016, followed by contract award and transition to the new service later in the same year.

In addition to the procurement timescale pressure, LCC also have a financial dependency on an assumption of £1m savings in 2017/18 (as stated in the Council's medium term financial strategy, 2015-19) which need to be achieved through the remodelling and re-procurement of this service.

Having examined the strategic options with regard to a number of key criteria the optimum combination that was put forward as the recommended model for HTLAH is:

- Payment mechanism- Stepped Unit Cost
- Provider delivery- More than one provider per area with a fixed upper limit
- Geographical zone- Align to current CCG/LPT localities

The supporting rationale for this was:

- The HTLAH Programme Board scored each option through the strategic options appraisal matrix, giving scores for strategic fit, ease of implementation (IT systems & processes), ease of implementation (market readiness), benefits (financial), benefits (outcomes) and implementation timescale.
- The provider delivery & payment mechanism was based on an evaluation of commercial viability and the drive towards incentivising the delivery of reablement outcomes
- Provider engagement strongly indicates that the Market is more likely to be able to respond to the recommended strategic options within the chosen timescale for procurement and implementation

Provider Payment Mechanism

Chosen Option - Stepped Unit Cost
The principle of the chosen payment mechanism centres on the ambition of commissioners to make the fundamental shift to an outcomes based contract, rather than a traditional time and task inputs/outputs contract, and to build in mechanisms to incentivise and remunerate providers through front end loaded payments.

Under the chosen option providers are incentivised to drive reablement outcomes in the early stages of the package of care for all new community referrals by receiving an agreed higher rate for an initial period, up to a maximum duration of six weeks. As part of the throughput model it is anticipated that by building in formal reviews of assessed need at week 2 as standard it will result in the number of cases that continue through the reablement pathway reducing, and where packages do continue on the pathway it is anticipated that the vast majority will do so on a reducing scale of

need releasing capacity back into the independent sector to take on the new cases. Where a change in need is identified by the commissioner or provider a review will take place ahead of the scheduled 2 week review and the package of care will be adjusted accordingly. Likewise reviews can be completed at any point in time during the period of reablement.
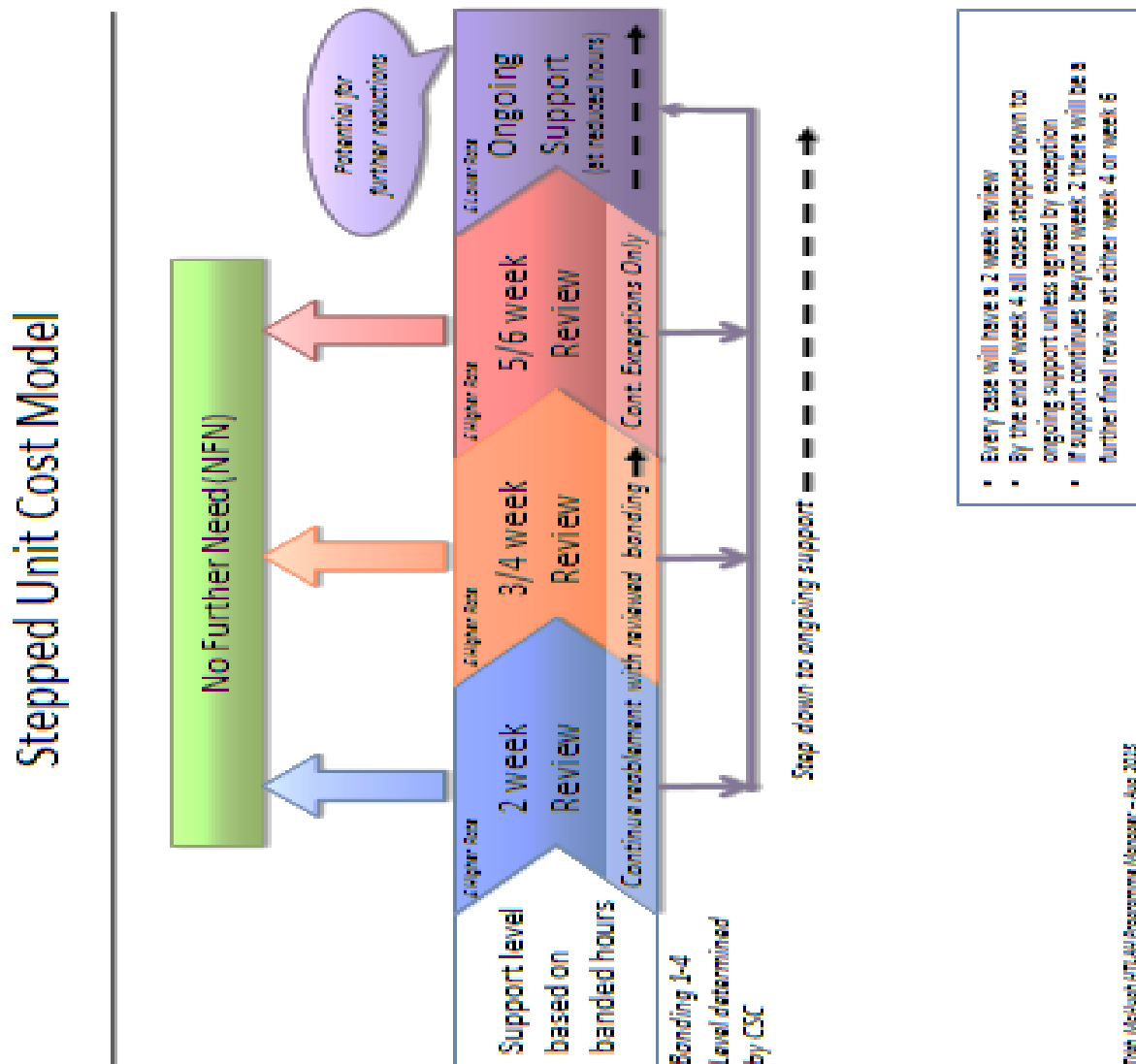
Geographic Market Divisions

Chosen Option: Align to Current CCG/LPT Localities

The geographical zones for the HTLAH providers will be aligned to fit with the existing health and social care localities.

Health and care integration is being developed on a locality footprint whereby Community Health Services, Primary Care and Adult Social Care are already working together in specific geographical areas/hubs.

These are being used as the basis for case management for vulnerable people, with further service developments such as those in our unified prevention programme being wrapped around the locality hub – e.g. first contact, our housing offer (lightbulb), carer support, assistive technology, and local area coordination.

By organising personal care providers in the same locality 'footprints' as other core services it meets the wider strategic requirements and service configuration of the integration programme in Leicestershire. It maximises opportunities for providers to interact and use the full range of available support and resources in the community to support the service user to maintain independence at home for as long as possible.

Provider Delivery Model

Chosen Option: More than one provider per Area but with a fixed upper limit

The strategic aim is to rationalise the provider market in Leicestershire, from up to 150 providers to up to a maximum of 18 in order to provide a stronger platform for commissioner / provider relationship management and performance management.

In moving to an outcomes based specification for this service, LCC and NHS commissioners are keen to drive the maximum reablement outcomes from the service and work closely with providers on all aspects of service quality and delivery, which can be achieved more consistently, efficiently and systematically with fewer providers. Outcomes commissioning will be less complex with providers and commissioners sharing an increased commitment to one another.

As set out in the Outline Business Case recommendations, the agreed delivery model is to have more than one provider per area (CCG locality) with a fixed upper limit on the number of providers per area. However refinement of lotting strategies for the final procurement may identify alternate mechanisms for capping the amount of business a single provider can hold in order to maintain market diversity, an option that will need subsequent ratification with the Programme Board.

Business resilience and the ability of providers to absorb all the required activity within the designated geographical zone(s) were important considerations in the development of the chosen provider delivery model.

Lessons learned from other recent national and regional domiciliary care procurements have also been examined where reliance has been placed on one provider; provider failure has subsequently occurred and led to business continuity risks/service gaps.

It is essential for the whole health and care system that the HTLAH service functions effectively and can support the flow of patients across the system.

The model that has been developed is based on having geographically specific Lots within each CCG locality. This modelling was facilitated by the Data and Business

Intelligence Sub Group who analysed the current allocation of hours and cost for health and social care personal care across each of the localities to inform the proposed Lots into areas, combining an urban and rural mix wherever practicable. The challenge for this work was to achieve proposals where all individual "Lots" are as equal as possible thereby reducing the risk of unattractive Lots in terms of volume of hours for providers, in order to mitigate the risk of having no tenders for specific areas.

In the analysis undertaken for the Outline Business Case it was identified that only the largest provider in Leicestershire currently delivers more than 3000 hours of care per week. It was therefore decided that, as part of the procurement of HTLAH services, Lots based on a level of activity from approximately 2,000 to 3,500 per week would represent a more attractive and feasible business model for current providers at this stage. It is also anticipated that this sizing will offer sufficient leverage to attract new providers into the county.

Taking Oadby and Wigston as the smallest locality in terms of personal care delivery, and in order to have at least two providers in this locality, the only rational approach was to split the area in half as two Lots. Building on these principles each of the seven localities have been split into suggested Lots – the smallest lot being 50% of Oadby and Wigston at just over 2,300 average hours per week in each lot and the largest being just over 3,200 average hours per week in the first of three Lots in Hinckley and Bosworth.

This delivery model reduces the risk of market failure due to capacity, and retains a level of resilience in the market. This addresses a specific concern of the Scrutiny Review Panel in relation to market resilience and the risk of contracting with a small number of providers.

Commissioners are also required to ensure that choice is preserved in the future configuration of the market to support self-funding and cash payment options, whatever the number of providers within a locality contracted to provide managed services.

Commissioners recognise that any rationalisation of the market will entail further support and shaping if the market is to come forward in smaller groupings or engage in lead provider/sub-contractor or consortia arrangements in the future. Provider engagement is well established in the HTLAH programme and resources to deliver against this element of the programme will continue to be directed in support of achieving a successful outcome with the market for the preferred provider configuration option.

This approach recognises the need to significantly reduce the number of providers that commissioners contract with, acknowledging that a reduction from the current 150-plus health and social care providers to 18 or less, would represent a reduction of more than 80%, in a single procurement process. This provides a basis then for further rationalisation in the future.

Proposed Lots within CCG localities

HELP TO LIVE AT HOME

CCG LOCALITY	CONTRACT LOT (draft)
N W Leicestershire	1 Castle Donington & Whitwick
N W Leicestershire	2 Ibstock & Measham
N W Leicestershire	3 Ashby de la Zouche & Coalville
North Charnwood	4 Loughborough East
North Charnwood	5 Loughborough West & Shepshed
Melton, Rutland & Harborough	6 Melton Mowbray
Melton, Rutland & Harborough	7 Market Harborough
Melton, Rutland & Harborough	8 Thurnby & Syston
Oadby & Wigston	9 Oadby
Oadby & Wigston	10 Wigston & South Wigston
Hinckley & Bosworth	12 Hinckley & Twycross
Hinckley & Bosworth	13 Groby & Market Bosworth
Hinckley & Bosworth	14 Broughton Astley & Burbage
Blaby & Lutterworth	11 Blaby & Countesthorpe
Blaby & Lutterworth	15 Glenfield & Braunstone Town
Blaby & Lutterworth	16 Narborough & Lutterworth
South Charnwood	17 Birstall & Anstey
South Charnwood	18 Mountsorrel & Quorn
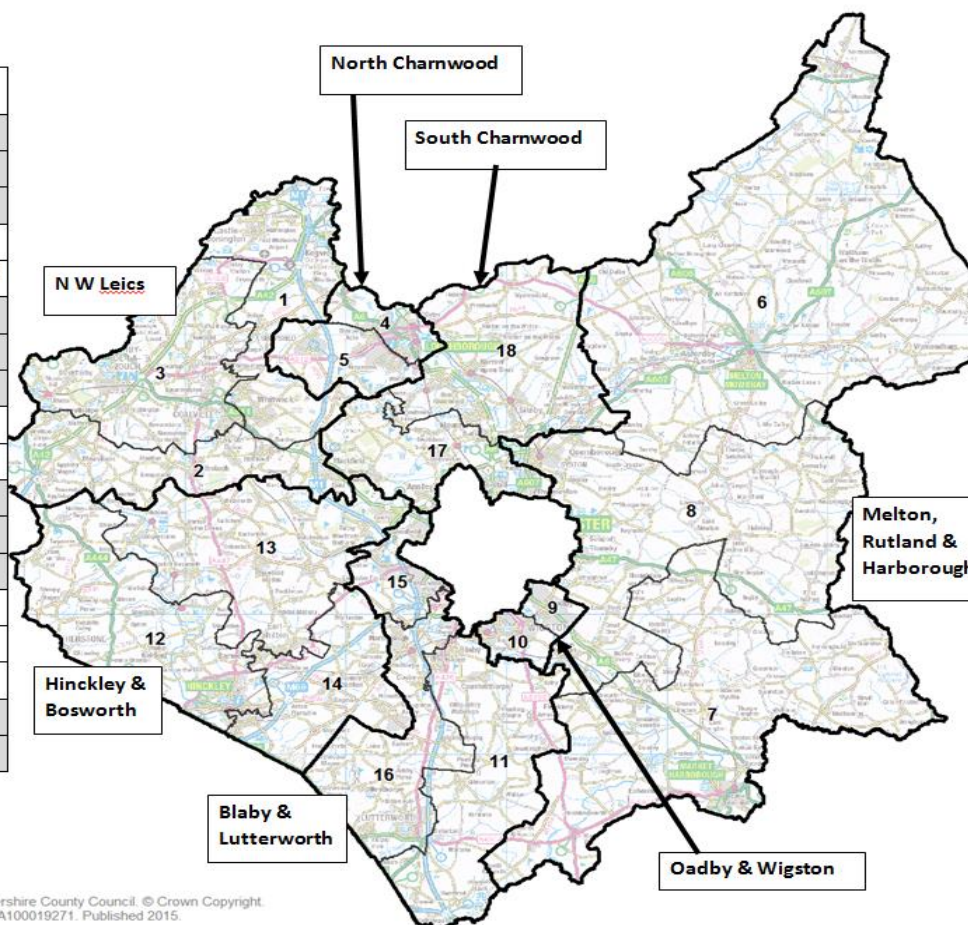
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. LA100019271. Published 2015.

Further analysis will be undertaken on the indicative number of hours per Lot prior to procurement to determine the potential impact, during the lifetime of the contract, on demand for care of factors such as take up of cash budgets, any known changes in eligibility criteria and significant, localised demographic or other demand pressures.

At the time of writing this business case feedback is also being sought from CCG localities and federations on the lotting arrangements, which will also be fed into the final lotting configuration prior to procurement.

13.   Back Office Integration for HTLAH

Phase 1 of the back office integration for HTLAH will focus on delivery of an interim solution for day one of the new HTLAH service. This will provide a single system and point of contact with commissioners, from a provider perspective.

The agreed principles of the interim solution are:

- That LCC will hold the provider contracts
- That there will be business process integration
- No transfers of staff between organisations
- No IT system integration

Agreed functions for Phase 1 are:

- Placing of orders with providers;
- Making provider payments;
- Receipt of activity returns from providers, linked to KPIs/metrics;
- Contract and quality monitoring of HTLAH providers

Efficiencies against this stage:

- for commissioners, is in how we manage the providers
- for providers, is reduced back office costs

Links will be made between the Back Office workstream and the Specification and Procurement sub group to ensure there is a cohesive approach to the contract development i.e. the contract monitoring process and the KPI framework and submission requirements are aligned, tested and confirmed ready for when the tender documents are released in early 2016.

Further, the development of the S75 agreement linked to HTLAH will be informed by the interim solution design for the back office integration.

Further work on back office integration forms a wider project within the Integration Executive work plan for 2016/17, whereby NHS and LA commissioners will consider other potential areas of joint commissioning, as such this wider work is outside of the scope of the HTLAH programme but the HTLAH programme provides an early test case upon which to build further assumptions.

14. Outcome Benefits

The table below summarises the perceived benefits of this programme:

	Benefit Description	Benefit type	Benefit category	Value	Baseline
B1	£250k Cashable savings	Financial	Cost reduction	Decrease A&C budget by £250k	2016/17 budget (HTLAH in-house and Independent sector)
B2	£1m Cashable savings	Financial	Cost reduction	Decrease A&C budget by £1m	2017/18 budget (HTLAH in-house and Independent sector)
B3	Contribute to a reduction in await care for people in hospital (DTOC)	Financial	Cost reduction	Support BCF DTOC outcome metrics to reduce delayed transfer of care per 100,000 population per month	From 361.98 at 31.3.14 to 350.48 by 31.3.16 (National Target)
B4	Reduction in await care for people in the Community (step up) Reduction in await care for people in hospital (step down)	Financial	Cost reduction	Reduction or removal of current Brokerage requirements	2016/17 value of Brokerage
B5	Contribute to a reduction in avoidable admissions/readmissions	Financial	Cost reduction	Reduction in bed days.	Not currently captured. Possible baseline from

	to hospital				audited sample of 2015/16 referrals from case narrative
B6	Reduced need for ongoing social care (post-reablement)	Financial	Cost reduction	Decrease in A&C budget	Initial commissioned hours
B7	Reduced need for ongoing CHC (post-reablement)	Financial	Cost reduction	Decrease in CCG budget	CCG budget for CHC
B8	Contribution to fewer avoidable permanent admissions to residential homes	Financial	Cost reduction	Reduction in A&C budget	Reduce 754.53 permanent admissions per 100,000 population per year to 670.39
B9	An increase in numbers of those service users that are satisfied with the care and support they receive.	Non-financial	Customer (Non-financial)	This increase will be measured against the 2013/14 baseline of 60.1%.	
B10	Length of Stay for patients over 75 is less than 10 days – removing the "stranded patient". The rationale for this is to reduce the	Financial Non -financial	Reduction on XBS Quality	 Reduce by 10% the	

	decompensation of patients staying in hospital and to maximise their chances of reablement.		improvement for over 75's	number of spells in excess of 10 days. (baseline April 2015-April 2016)	
B11	Reduced Bed days used by the over 75's (baseline still in development) as defined and in line with BCF targets.	Provider cost saving	Improvement in rehab outcomes for the over 75's	Home First supports reduction in access to permanent care settings Reduction in re-admission improvement in people remaining in discharge destination 31 days post discharge.	

In additional to the Benefits identified above, the integrated HTLAH programme will generate a number of positive outcomes across the four key stakeholder groups;

- People who use the service
- Commissioners
- Service providers
- The wider Workforce

For People Who Use Home-Based Social Care Services And Carers	**For Commissioners**
-Focus on outcomes not 'time and task' inputs -Greater independence to continue to live at home -Seamless care when arranging care or when moving from hospital to home -More consistent service quality and patient experience across the county -Care decisions and outcome setting made with the customer and those closest to them -Fewer people awaiting care (in hospital, in the community) -Fewer delayed transfers of care -Improved service provision leading to better outcomes for customers -Fewer avoidable admissions/ readmissions to hospital More help with signposting to other community based support, information and services, as part of improved integrated care	-Reduced levels of need for ongoing care due to more proactive reablement -Better outcomes for patients and citizens in terms of achieving independence/quality of life goals -Increased flexibility and improved outcomes -Fewer avoidable admissions/ readmissions to hospital -Improved Partnership working with providers, operationally and strategically -Advantages of scale through joint commissioning -Reduced waste, delays and duplication in the commissioning process -Early reviews to ensure packages of care following hospital discharge are set/re-set at correct levels -Better integration of home-based personal care with other commissioners community services -Better management of demand for care -Integration of back office support systems
For Service Providers	**For The Workforce Who Provide The Care**
-More security of activity levels within the Lots, allowing medium/longer term service planning/service development -Better communication and fewer handovers between organisations involved in the care and wellbeing of customers -Certainty of core operating area based on designated lot(s) for commissioned services and private customer base -Co-production and partnership working with commissioners and other providers of community support -Empowerment to design/ redesign packages of care to meet the changing needs of each individual customer -More stable workforce, lower turnover rates, improved retention rates -Flexibility to meet service user outcomes via drawing upon local preventative/support offers	-Focus on delivering person-centred care and support to optimise the health and wellbeing of citizens -Better terms and conditions of employment More stable workforce, lower turnover rates -Increased contact time with patients/service users, less travel -Joined up home-based personal care for health and social care patients/service users -Knowledge and links with community resources within clear locality delivery model. More integrated working with other local providers including community nurses, social workers and GP practice

15. Procurement Process and Contractual Mechanism

Procurement Process
Eastern Shires Purchasing Organisation (ESPO) has been engaged to assist with the procurement process.

The service specification for which tenders will be invited will comprise the following:

- The 'step up' community reablement service (designed to promote and improve people's ability and confidence to live independently in their own home)

- Long term maintenance care (which includes transferring social care and continuing health care packages)

- Waking and sleeping nights

- 24/7 provision (for those people who require this in the short or longer term)

A Lead Provider will be appointed for each of the Lots. A proposal on the configuration of how bidders will be permitted to tender is the responsibility of ESPO and the HTLAH Specification and Procurement Sub Group. Risk management and commercial viability will be key considerations balancing market diversity against the need to attract the calibre of providers required to meet the full range of presenting needs within all of the Lots.

The HTLAH Specification and Procurement Sub Group will lead the operational work and the HTLAH Programme Board will be accountable for ratifying the procurement approach and tender rules including the lotting strategy

It is proposed that a two-stage procedure will be followed:

- Stage 1: Pre-qualification Questionnaire (PQQ)

- Stage 2: Invitation to Tender (ITT)

This contract will fall within the new 'light touch regime' introduced in the 2015 Public Contracts Regulations which will present additional flexibilities within the procurement process. Further advice will be sought on this matter by the HTLAH Programme Board.

The details of the procurement process, including the evaluation aspects will be finalised and confirmed by the date at which the contracts are formally advertised.

All documents will be issued through the E-Procurement Portal; bidders are therefore required to register and use the portal for submission of bids and clarification of any queries.

An internal, but independent Pre-procurement Review Panel will meet in October 2015 to approve the overall approach. This will involve officers from both of the CCGs and the Council.

The procurement will commence early January 2016, with completion anticipated by the end of May 2016. The contract(s) will commence between May and August 2016, dependant on any TUPE due diligence requirements prior to service commencement.

There will be a phased transition of service users from the existing contracts to any new contracts awarded as a result of the procurement exercise.

Service providers awarded contracts will commence all new service provision from the date at which it is determined they are business ready (TUPE dependant) and will work with LCC and the CCGs to transition existing care from exiting providers, so that contracts will be fully operational by the end of December 2016.

The programme will incur ESPO fees (to be confirmed) as a result of ESPOs involvement in the procurement process, which will be apportioned across partners.

Quality Assurance
The HTLAH service aims to deliver improved outcomes for service users and will rationalise the number of providers of personal care within the Leicestershire area. The joint commissioning approach will entail the following aspects of assuring the quality of the services commissioned:

- Assurance at the point of selection for providers, including due diligence concerning their track record in delivering quality and their regulatory status
- Specific quality assurance metrics will be set out in the service specification, including the provider data requirements for these
- Delivery against these metrics will be monitored jointly by NHS and LA partners as part of the joint quality and performance management framework to be applied throughout the life of the contract
- The delivery of person centred outcomes in terms of reablement, based on individual care plans of service users, will be subject to a systematic review process (at 2,4 and 6 weeks), as set out in the operating model for HTLAH, with provider payment mechanisms linked to delivery of reablement outcomes

Expert advice from the CCG Chief Nursing Officers will be sought in developing and delivering the above aspects of quality assurance.

Indicative Procurement Timetable

	Stage/Activity	Target Date
1	Issue date of the Application Form (PQQ) Return date 4 weeks from issue date (Initial Bidders' Day to be facilitated during this period)	Early January 2016
2	Evaluation of Application Forms (Need to allow 2 weeks)	Early February 2016
3	Invitation to tender issued to firms included in select tender list (tender out for 6 weeks)	Mid-February 2016
4	Bidders Forum for tendering organisations	End of February 2016
5	Closing date for return of tenders	End of March 2016
6	Evaluation of tenders (Allow 2 weeks including sign off processes ESPO and LCC/CCG's)	Mid-April 2016
7	Contracts awarded + standstill (min 10 working days)	End of April/Early May 2016
8	Contracts commence	Early/Mid May-August 2016*

*If TUPE applies this will need to be built into the transition period.

Social Value Considerations

In line with legal requirements and best practice, Social Value considerations (the potential for capturing added value during the commissioning process) will be appraised during pre-procurement, and embedded in the specification and final tender process.

The Programme Board is working with the Centre for Citizenship, Enterprise & Governance (CCEG) who will provide advice and support regarding the identification of Social Value opportunities.

By applying Social Value requirements to the procurement, commissioners will ensure that the final service design not only meets HTLAH programme objectives, but also demonstrates added value.

The HTLAH Programme Board is currently exploring how Social Value can be embedded in the commissioning approach, how it can be measured efficiently, and the scale of added value that can be achieved.

Contracting Mechanism

The cost-benefit analysis determined that cost and volume contracts will be used to commission HTLAH services. The contracts will give providers a guaranteed minimum level of hours for each Lot, likely to be risk based per Lot rather than a blanket minimum applied to all Lots.

Demand profiling will provide the anticipated levels of business of each Lot over the term of the contract, based on applying a range of assumptions to current levels of demand.

This approach will give Providers the ability to plan for service delivery, in terms of investment in workforce development and back office infrastructure, over the lifetime of the contract, something they are unable to commit to under the current contractual framework arrangements.

A contract term of 3 +1 +1 years has been determined as offering the optimum duration in terms of allowing sufficient time for the new HTLAH model to become fully embedded into providers' working practices and organisational structures, while at the same time allowing the market to stabilise, and enabling commissioners and providers to enable commissioners to appraise the introduction of a PbR system.

It has been determined that the LCC contractual framework will be used for HTLAH since they will be invoiced for all payments

16. Key Constraints and Delivery Assumptions

There are a number of important considerations listed by category below:

Programme Delivery

- Constraints:

    o Availability of key resources and subject matter experts to deliver the project across NHS and LA commissioning teams.

- Delivery Assumptions:

    o That the HTLAH model is adopted by Health and Social Care as a shared vision, and that the information, resources, processes and systems required for design, specification, procurement and implementation are made available in a timely manner.

- o That during the HTLAH programme lifecycle the impact of changes to processes and IAS improvements that could impact when they go live are fully understood

- o That the outputs of the remodelling of the existing HART reablement service are planned and delivered in conjunction with the HTLAH timeline/assumptions

Commercial

- Constraints:

  - o Current contracts that are in place and the re-commissioning timelines for those contracts.

  - o Access to robust and timely data on cost and performance across all commissioning partners.

- Delivery Assumptions:

  - o There will be a single service specification.

  - o There will be single contract underpinned by a Section 75 agreement.

  - o Development will be on a lead contracting basis i.e. single provider payment mechanisms; single contract monitoring system.

  - o There will be clearly defined clinical versus non-clinical activities and transfer to an appropriate agency/provider to meet clinical needs in relevant cases.

  - o That a provider portal will be developed and in place for selected HTLAH providers to document support planning and changes.

  - o The service received from ESPO is timely and comprehensive

  - o Social Value elements are designed and agreed by the Programme Board in line with programme timescales

Marketplace

- Constraints:

  - o The acknowledged risk that the capacity of the external market to be able to respond to the new specification may impact on delivery and achievement of full benefits on time.

  - o Attendance of key stakeholders at meetings and workshops.

- Delivery Assumptions:

  o That the domiciliary care market is willing and able to engage with the proposed HTLAH model, including the premise of a limited number of providers operating within defined zones and potentially entering into robust sub-contractual arrangements with third party providers.

  o That the independent sector providers intensive reablement will provide a consistent offer across the county, with achieved outcomes no less than the current in-house performance.

  o That the market will engage in a series of market shaping and supporting workshops throughout the period of the HTLAH programme and that these facilitate the delivery of the market response required.

  o That the HTLAH model will enable independent sector providers to stimulate the social care labour market, ensuring the stable supply of a skilled and motivated workforce able to deliver the specified outcomes.

Financial

- Constraints:

  o Delivery within the defined budget, including managing demand within the required levels

- Delivery Assumptions:

  o That the market value of a 'step-up' community based reablement service will attract a lower unit cost than existing in-house services.

  o Assessing funding for CHC, or assessing for eligibility boundaries will be made clear, while ensuring that patient expectations are managed appropriately.

  o Existing eligibility arrangements will apply for CHC, NHS and Social Care.

  o The existing LA system of paying providers will be used, CCGs will then be recharged for their costs.

Stakeholders

- Constraints:

  o Avoidance of negative impact on the delivery of front line services and performance

- o That Integrated Reablement joint working agreements will be resourced in line with projected 'step-down' volumes that are referred through to the In-house reablement service (i.e. CHS Nursing and Therapy).

- Delivery Assumptions:

  - o Exclusions on pathways will be clearly documented, and patient/family expectations will be managed appropriately.

  - o Existing service users may opt to purchase services from an alternative provider using a Direct Payment.

Key Facts

There are a number of significant constraints and delivery assumptions that are key to planning for the successful delivery of this programme

These have been summarised in the FBC. Further detail and the mitigation being applied has been reflected in the HTLAH PID, programme plan and risk register

17. Programme Governance

HTLAH Programme Board
The HTLAH programme is governed by a dedicated Programme Board which has been in place since December 2014. The Board meets monthly, chaired by Sandy McMillan, Assistant Director Adult Social Care, LCC and has senior level representation from both County CCGs and the LA, including the Director of Health and Care Integration and a representative from Healthwatch.

The HTLAH programme plan ensures that the milestones and processes are in place both for reporting progress and seeking approvals (such as for the Outline Business Case, Full Business Case and procurement related decisions) and that the HTLAH programme outputs feed into the appropriate governance tiers of the collaborative arrangements and individual statutory agencies.

The Programme Board reports into the Council's Transformation Delivery Board (where HTLAH is known as Transformation Programme T2) and into the Integration Executive, the Director level group leading the delivery of the Integration Programme across the LA and NHS partnership.

Both these groups meets monthly and receive joint highlight reports as well as reviewing key outputs such as the Outline and Full Business Case as part of the process to seek final assurance and approvals from LCC's Cabinet and CCG Boards.

HTLAH Programme Task and Finish Sub Groups
The HTLAH Programme Board has two sub-groups supporting the commissioning of the new service model:

- Design, Finance and Technical
- Specification and Procurement

Each sub group operates on a task and finish basis and is jointly sponsored by a CCG and LA lead from the HTLAH Programme Board.

The sub groups have led the development of the HTLAH model design, the work undertaken to analyse the options, including financial analysis, and the work to prepare for procurement including market development and producing the outline service specification.

A further sub-group will be in place from Q3 2015/16. This will focus on planning and supporting the transition and implementation into the new service following procurement.

The table below outlines the existing sub-groups, the joint leadership for each group and summarises the key activities undertaken in support of the full business case:

Sub-group	Programme Board Leads	Function
Model Design/ Finance & Technical	Caron Williams **Assistant Director Strategy and Planning, WLCCG** Sue Wilson **Head of Service, Strategic Commissioning & Market Dev't, LCC** Richard George **Business Partner Team, LCC** Connie Atugonza **Head of Finance, East Leicestershire & Rutland CCG** Sarah Rogers **Financial Analysis & Information Team, LCC**	Detailed development of the HTLAH model based on the option recommendations in the Outline Business Case. High level process mapping of care pathways for hospital discharge and community referrals. Financial modelling. Input to inform model feasibility and development timescales and costs of technical system and process changes.
Specification & Procurement	Gill Newton **Market Development, LCC** Joyce Bowler **(Hosted) Project Manager Personal Health Budgets (Adults) & Continuing Healthcare, ELRCCG**	Development of the provider delivery model locality lot approach. Development of the joint service specification , including Social Value requirements. Input to inform the contractual mechanisms and procurement approach. Development of procurement timeline. Market engagement events.

HTLAH Programme Steering Group

Due to the complex nature of this programme and the tight timescales that are in place, the HTLAH Programme Team have implemented weekly steering group meetings since November 2014 to ensure the programme of work is delivered and barriers and risks to delivery are swiftly addressed. The weekly Steering Group is chaired by the Director of Health and Care Integration.

The Steering Group oversees day to day responsibility for

- The development and delivery of the programme plan
- Programme resources
- Programme risks
- Contributing to the options appraisal, in particular in terms of testing the feasibility of implementing the proposed options
- Supporting the Programme Board in analysing and scoping three other supporting strands of work that are dependencies for the HTLAH programme

These are:

- Section 75 development for HTLAH;
- Remodelling of Core Reablement offer in line with the new HTLAH model;
- Back Office contracting and payment integration for HTLAH

The Steering Group have also been responsible for ensuring the wide ranging communications and engagement plan for HTLAH with evidence of how the findings have influenced programme.

The engagement plan has included:

- Working with Healthwatch
- Working with the Council's Scrutiny Review Panel for HTLAH resulting in the production of the scrutiny review report in June 2015
- Engagement with CCGs Executive Teams and Boards
- Engagement with LPT and UHL Executive Teams
- Engagement with the VCS
- Services User Focus Groups
- Market Development Engagement Events

HTLAH Programme Resources

The Programme currently has the following dedicated resources:

1.0   Full time equivalent Programme Manager
1.0   Full time equivalent Business Analyst
1.0   Full time equivalent Project Manager
1.0   0.6 Full time equivalent Project Support Officer

All of the above are currently funded by the County Council through existing funding arrangements.

The programme also draws heavily on existing strategic, finance, commissioning support and procurement resources from the respective teams in the two CCGs and the Council.

Communications support is provided by the communications lead for the Integration Programme who is funded from the BCF.

Additional fixed term project capacity, (specifically targeted in support of CCG liaison during the design and options analysis work leading into the business case), has been provided and funded from the BCF over the period April to July 2015.

A review of HTLAH programme resource requirements beyond completion of the full business case phase has been undertaken by the Programme Manager in conjunction with the Assistant Finance Business Partner, Adults & Communities. This is intended to support all agencies in understanding the ongoing commitment needed through the procurement and transition phases, into implementation.

The process and timescales to secure the funding will be agreed as part of the authorisation process to proceed to procurement. Details are summarised in the financial analysis section of the business case.

Key Facts

The HTLAH programme has a dedicated programme board with supporting programme infrastructure

The HTLAH programme is jointly owned and delivered by the Council and CCGs

The HTLAH programme reports through to the Integration Executive and Council Transformation Delivery Board, as well as into the individual CCG Boards and the County Council's Cabinet

Programme resource requirements are being kept under close review

18. Programme Approach

Programme Overview:

An indicative governance timeline for the Full Business Case is shown below:
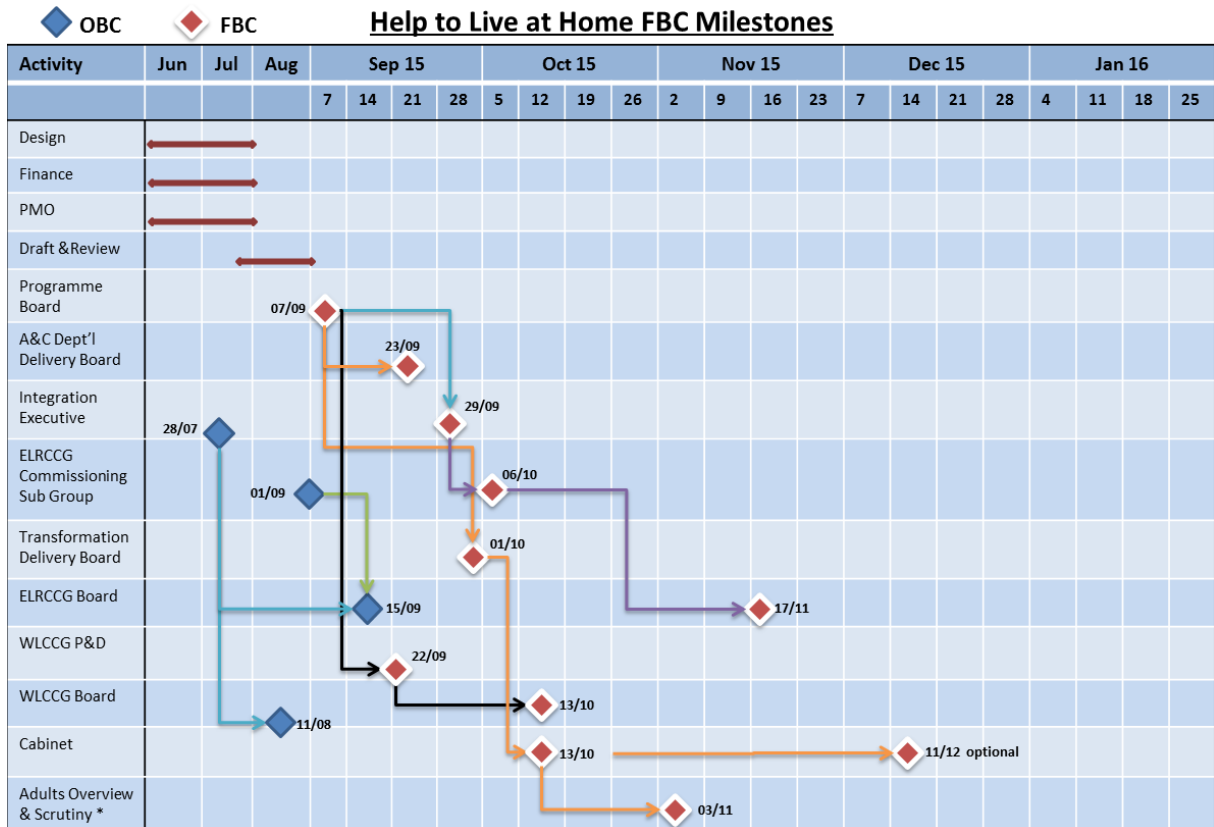
* Programme Board sign off on 07.09.15 - TDB will need to have considered the business case prior to circulation for formal approval by Cabinet. Due to the timings of A&C OSC meetings there will be no opportunity to present ahead of it going to Cabinet on 13th Oct. Will therefore require informal briefing to OSC Chair in advance of Cabinet and/or sending copy of Cabinet report to Scrutiny members at same time it is circulated to Cabinet members.

Based upon this timeline, an indicative programme delivery plan has been developed.

Help to Live at Home Delivery Milestones

ACTIVITY	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17
Programme Board Mandate to deliver	◆																
Full Board/ Cabinet approval		───	◆														
Section 75 Agreement	────	────	────	◆													
Communications	────	────	────	────	────	────	────	────	────	────	────	────	────	────	────	────	
Develop Spec'n & Contract	────	────	────	◆													
SU & Provider engagement	────	────	────	────	────	────	────	────	────	────	────	────	────	────	────	────	
Transition planning/ preparation	────	────	────	────	────	────	────	────	────	────							
PQQ, ITT & Award					◆		◆		◆								
Go Live – new SUs									◆────	────	────	────					
TUPE between Providers									────	────	────	────					
Provider mobilisation									────	────	────	────					
Existing SU transfers									────	────	────	────	────	────	────	◆	
Business as usual																	◆

◆ Existing service users all transferred – scenario modelling to be completed to inform final timeline

A full programme plan is maintained by the Project Management Office (PMO). TUPE consultation may extend the pre contract award procurement phase. This will be brought to each Programme Board as part of the Governance arrangements.

Key Facts

There is a clearly defined governance structure for the HTLAH programme with named representatives from each member organisation

A structured programme plan is in place, monitored and reviewed at each Programme Board

There is a detailed risk register in RAIDOL format, governed by the Programme Board, that is also discussed at each Board

There are clearly defined reporting routes into local authority and CCG governance structures for the HTLAH programme

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19. Programme Engagement

Provider Engagement

Extensive provider engagement has been carried out with the aim of:

- Helping the programme in understanding if there are different views on the options from small and large providers
- Contributing to informing feasibility of implementation of the options
- Helping to develop the approach to support market readiness for the new way of working, including gauging provider interest in the proposed options.
- Shaping market understanding of Reablement and working to Outcomes.

The most recent engagement events aimed to:

- Help the programme in understanding if Lots are commercially viable and likely to attract bids in the procurement phase
- Contribute to informing the development of the provider delivery model as part of the Full Business Case
- Help to develop the approach to support market readiness in respect of Lead Provider, Sub-contracting and Consortia arrangements

Service User Engagement

Engagement with service users has taken place through a series of facilitated workshops. Output from these workshops has been used to inform the development of the HTLAH model and underpinning principles.

Further detail of engagement activity can be seen in **Appendix One.**

Key Facts:

- **A comprehensive engagement plan is in place for staff, patients and providers that will continue throughout the life of the programme**

- **We have used the findings and insight from provider engagement and service user engagement as well as the advice of the Scrutiny Review Panel to inform the analysis and recommendations in this business case**

20. Risks and Issues Management

The new processes to support the HTLAH operating model have only been designed at a relatively high level, building on the integrated service model principles of integrated teams and professionals in health and adult social care working together seamlessly. It is recognised that there is still significant work needed to ensure that the detail of these processes is fully designed, and that behavioural and delivery pressures are considered at each point in order to protect the service user's journey through the pathway, and to ensure that no blockages or misuse of the pathway in terms of inappropriate discharge can occur.

The HTLAH Programme uses the LCC corporate RAIDOL (Risks, Actions, Issues, Decisions, Opportunities, Lessons-learned) framework for management of risks and issues.

The risk score determines the expected actions by the risk owners in terms of frequency of monitoring & reporting, escalation routes and contingency plans.

Risks and Issues are reported and reviewed on a monthly basis at the HTLAH Programme Board. They cover strategic and operational programme risks. The summary of the risks (current, and if mitigated) are:

Status of all risks	Current risk	Mitigated risk
Status: **Red**	29	6
Status: **Amber**	29	45
Status: **Green**	1	8

This indicates that the HTLAH Programme carries a significant level of risk.

Top 5 Risks (Mitigated scores)

Risk ID	Risk Detail	Current RAG status	Comment – provide details of why risk has improved or remained unchanged and further mitigations
R22	Insufficient lead in time or support to allow providers to form necessary partnerships and sub-contracting arrangements.	RED 16	More detailed engagement with the market; more benchmarking. Facilitated workshops with SPs to help them form new arrangements.

Risk ID	Risk Detail	Current RAG status	Comment – provide details of why risk has improved or remained unchanged and further mitigations
R03	Service provider fails	RED 15	Plans in place for robust Service Specification (Spec & Proc't Group). Now refining Delivery Model (Design Group). Effective evaluation and due diligence before award.
R41	Risk of limited or poor access to data. (Cause: Lack of an integrated health and social care information system. GEM's data system has problems for transparency & quality.)	RED 15	Data provided for OBC & FBC; but data awaited + data validation still from GEM but looking unlikely in time for FBC.
R46	Transition arrangements not sufficiently resourced or planned for.	RED 15	Transition and Implementation sub-group set up to plan transition period and provide operational support. But group has only met once.\n\nFBC: selected option on basis of feasibility, fitness for purpose & savings.
R55	Insufficient resources allocated within the Programme plan to progress a Section 75 agreement to point of completion within Programme delivery times.	RED 15	Independent legal advice stated the BCF consultation does suffice for s75 also (no need to do a separate consultation).\n\nCurrent pace of progress means s75 may not be done for Nov CCG Board cycle. To bridge the gap to next CCG cycle (Jan 2016 [after PQQ launch]) we could do a MOU but that too would require work. A further meeting 14.9.15 may resolve points that are not yet clear.

The full risk register at Programme level can be seen in **Appendix Three.**

21. Equality & Human Rights Impact Assessment

An initial Equality and Human Rights Impact assessment was completed (January 2014). Following a review in February 2015 it was determined that this remained fit for purpose for the Outline Business Case.

A joint Equalities Impact Assessment is required in order to ensure an integrated approach. A joint equalities impact assessment is currently being undertaken as part of the development process and will be completed prior to commencement of procurement. This joint assessment will ensure that we can demonstrate how service user groups and providers have been engaged into the final design and delivery model.

22. Recommendations

Members of the CCG Board/LCC Cabinet are requested to review the contents of this document to assure themselves that the work undertaken and governance arrangements are in line with expectations for proceeding to a decision, and to consider the recommendations made below:

1. Approve this Full Business Case, including the proposed service and financial models, the step down payment mechanism and the indicative locality Lots.

2. Note that the full details of the procurement including the final lotting strategy are subject to further work and will form a further report to the Cabinet and CCG Boards at the time of seeking approval to procure.

3. Note that final approval and instruction to procure will entail authorisation by both CCG Boards and Cabinet at the time of procurement.

4. Support the continuation of the HTLAH programme plan, so that key activities continue with a view to procurement and transition in line with the programme plan through to 2016.

23. Glossary

AQP	Any Qualified Provider
Arden & GEM	See entry for GEM
ASC	Adult Social Care
AT	Assistive Technology
Await Care	A situation in which a person needs care but no SP agrees to provide the care, so the SU has to wait until the situation changes
BCF	Better Care Fund
BCT	Better Care Together, a 5-year integration programme of health and social care in the LLR area
CHC	Continuing Health Care
Compliance	LCC's Compliance service ensures that SPs adhere correctly to the terms of their contracts
ContrOCC	LCC's computer system that reconciles commissioned care with EHCM bills, and instructs Oracle to pay
CPLI	Care Package Line Item: an instruction in LAS Protocol that sets in motion the provision of care
CSC	Customer Service Centre
Data Sharing Agreement	A legal document in which a CCG and LA agree to share between them data containing patient confidential items (e.g. name, address, postcode, date of birth, diagnosis, treatment, etc.).
DSA	See Data Sharing Agreement
DST	Decision Support Tool
DToC	Delayed Transfer of Care
EHCM	Electronic Homecare Monitoring System that tracks in real time the hours of care actually given to each SU
ELRCCG	East Leicestershire & Rutland Clinical Commissioning Group
EMSS	East Midlands Support Services: the 3rd party used by LCC to send out payments to SPs
GEM	Arden & Greater East Midlands Commissioning Support Unit
HART	Homecare Assessment & Reablement Team, an in-house service provided by LCC
HTLAH	Help To Live At Home a joint procurement of home-based social care for ASC service users and CHC patients
HWBB	Health & Well Being Board
ICS	Intensive Community Support
ICS2	Enhanced Intensive Community Support (ICS2) Offer - BCT Bed

	Reconfiguration: an expanded and enhanced ICS offer in LPT which will support the out of hospital shift supporting patients in the community
IS	Independent Sector service providers
LA	Local Authority
LAS Protocol	LCC's computer system for commissioning care
LCC	Leicestershire County Council
Left Shift	A process through which hospital in-patients are discharged or transferred as early as possible out of the intensive clinical treatment environment
LLR	Leicester City, Leicestershire, Rutland
Locality	Any of the 7 Localities used to divide the CCG areas. WLCCG (4): NW Leicestershire, North Charnwood, South Charnwood, Hinckley & Bosworth. ELRCCG (3): Melton, Rutland & Harborough; Oadby & Wigston; Blaby & Lutterworth
Lot	A sub-division of a Locality, dividing each Locality into 2 or 3 areas. Each Lot will have a contract and a contracted SP once HTLAH has been procured. There are 10 Lots in WLCCG, 8 Lots in ELRCCG.
LPT	Leicestershire Partnership NHS Trust
MTFS	Medium Term Finance Strategy
NFN	No Further Needs; i.e. care is no longer required at all from care organisations
Oracle	LCC's computer system that actually send payment to SPs for care given
POC	Package of Care
Provider portal	A new computerised portal that shall be introduced through which SPs will be able to see a certain level of information and will also be able to send and receive information relating to the care they are giving
Reablement	A process through which a person is assisted to regain skills they once had, so that they are able to self-care more, and need less or nil care support
Reviews	A process operated by LCC in which the design of a POC is reviewed with a view to: adjusting the amount and type of care to match more precisely the SU's current needs; ending the POC if there are NFN.
s75	Section 75: a legal agreement between a LA and a CCG agreeing to share or outsource some aspects of health and social care. The s75 Agreement is the legal document that gives precise details of

	which services are affected, who will do what, how the new arrangements will be managed (governance, commissioning, operations, performance management, costs, etc.).
SBS	The 3rd party provider used by NHS organisations to make payments to SPs
SP, SPs	Service Provider (s)
Step Down	A process of helping people who are being discharged from hospital so that they are reabled to live at home without needing to be readmitted to hospital or residential care. When HTLAH is procured all Step Down reablement work will be done by HART.
Step Up	A process of helping people living at home to continue to live at home without needing to be admitted to hospital or residential care. When HTLAH is procured all Step Up reablement work will be done by SPs.
SU	Service User
T2A	Transfer To Assess pathway
Time & Task	A way of working in which SPs are given a list of care tasks to complete and a prescribed time allowance in which to complete the tasks
UHL	University Hospitals of Leicester (Leicester Royal Infirmary, Glenfield Hospital, Leicester General Hospital
WLCCG	West Leicestershire Clinical Commissioning Group

Appendix 1: Programme Engagement

 Provider Engagement

February 2015

Two market engagement events were undertaken, providing an opportunity to explore with both existing and prospective Service Providers the benefits and challenges of the range of strategic options considered in the development of this business case. 112 participants attended the events from 61 organisations.

The February 2015 engagement events were supplemented by an online questionnaire that was made available to all delegates (including those unable to attend facilitated events) with the aim of:

- Helping the programme in understanding if there are different views on the options from small and large providers
- Contributing to informing feasibility of implementation of the options
- Helping to develop the approach to support market readiness for the new way of working, including gauging provider interest in the proposed options.

May 2015

Two further events were held May 2015 to explore the delivery of Reablement through the independent sector, commissioning for outcomes and developing the role of providers in coordinating support for individuals from community resources and assistive technology. These events provided an opportunity to appraise the Market of the delivery model under development, compared and contrasted to the current model, and supported the development of the new model utilising the knowledge and expertise of the Market.

 Topics discussed were:
- Reablement in practice; Assistive Technology; Social Capital and developing community resources.
- Outcomes commissioning: the current market experience; delivering to outcomes, putting the service user/patient at the heart of support planning

July & August 2015

Two market engagement events were undertaken in July and August 2015, providing an opportunity to explore with both existing and prospective Service Providers the benefits and challenges of the chosen strategic options considered in the development of this business case.

These engagement events included live voting to ascertain the market view of chosen strategic options. This was supplemented by an anonymised survey of indicative bidding intentions against the 18 draft Lots across 7 localities. This was made available to all delegates with the aim of:

- Helping the programme in understanding if Lots are commercially viable and likely to attract bids in the procurement phase
- Contributing to informing the development of the provider delivery model as part of the Full Business Case
- Helping to develop the approach to support market readiness in respect of Lead Provider, Sub-contracting and Consortia arrangements

Headline Responses (live-voting):
- 61% of Providers indicated that they were ready to provide a reablement service now, with or without minimal additional support.
- A further 25% indicated that they were ready to provide reablement with substantial additional support.
- 84% of Providers indicated that they were confident or very confident about delivering an integrated service to a blend of people (Health and Social Care)
- 76% of Providers indicated that they considered the draft 18 Lots to be commercially viable, with no or minor concerns.
- 87% of Providers indicated that they would like to attend additional events to explore the role and function of Lead Provider, Sub-contractor and Consortia

Indicative bidding intentions

The anonymised questionnaire asked for indicative bidding intentions across the 18 Lots with no commitment on their part.

Responses were received from micro through to large sized organisations[3] and indicated bidding interest across all Lots. Where bidding intentions were expressed through smaller organisations, these could potentially be supported through consortia bids.

It should be noted that whilst large organisations would be likely to have the back office infrastructure to manage a large influx of care, including undertaking a local recruitment campaign if required, it remains likely that any organisation undertaking a Lead Provider role would be reliant, at least in part, on TUPE transfers in order to meet it's staffing requirements. This reliance could be reduced, however, by sub-contracting.Conversely, smaller organisations operating collectively within a Lot under

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[3] A large organisation is one that self-declared in excess of 250 employees (not necessarily in Leicestershire). There were 24 respondents across the two events who fell into this category.

a consortia arrangement may satisfy their staffing requirements without being reliant on TUPE transfers.

The chart below illustrates the indicative bidding intentions received:
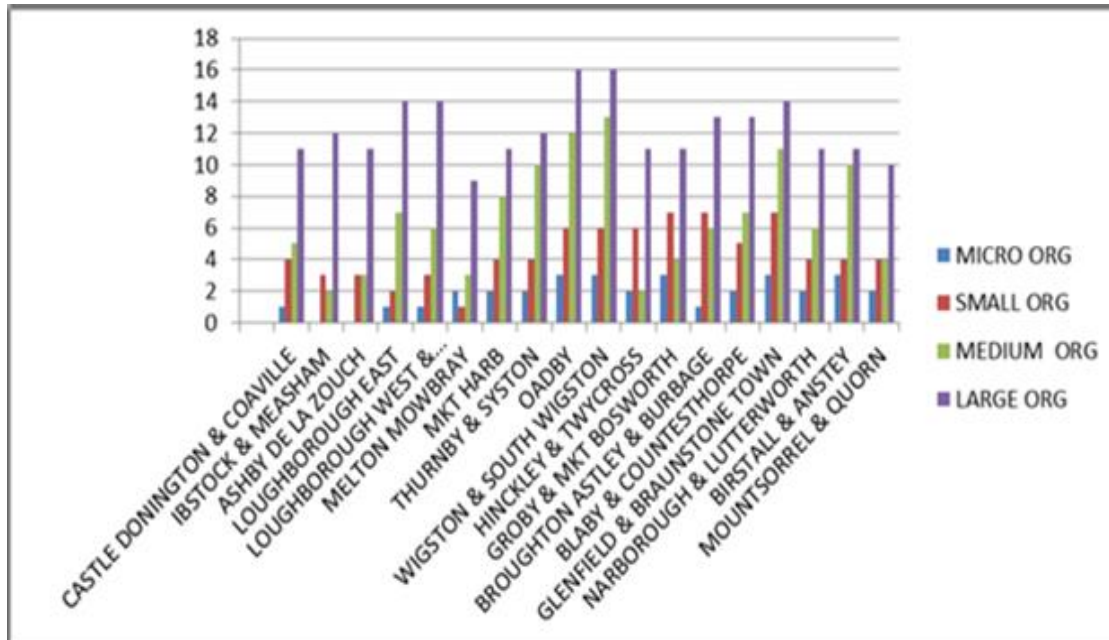
All of the events were notified to existing contracted providers of Domiciliary Care and CHC. Additionally, invitations have been published externally on Source Leicestershire and Pro-contract to ensure national exposure exposure..

Events were well attended throughout.

Next Steps for Provider Engagement

Planning for the next phase of market readying/support for providers has started. This will be in the form of networking events for providers with an interest in collaborating and working with other providers as well as signposting to advice and information regarding bidding as a lead or sub-contrator or as part of an alliance or consortia

Service User and Carer Engagement

Three discussion groups took place with residents aged from their 60s to their 90s in May 2015. Following discussion of what was important to them, they considered potential 'I statements' both in their groups and in their post-discussion questionnaires about their expectations of the proposed HTLAH service. The development of 'I statements' will be used to support the Service Specification development in relation to Outcomes.

Participants were very positive about the proposed new service. Better co-ordination and collaboration between health and social care services was a recurrent theme of the discussions. Participants were specifically supportive of helping people to live at home. In their pre-discussion questionnaires, the great majority thought it was 'very important' that people should be supported to live in their own homes, rather than in a care home or hospital.

They cited the need for independence; the importance of memories of the past and of friends and families; the ability for people to do what they want, when they want to, on their own terms; and a perception that people can deteriorate once outside their familiar environment. There was a general perception that not only would the 'Help to Live at Home' service facilitate a better quality of life but it would also help older people retain their dignity and self-respect, and could also help extend life expectancy. And it seemed to them that, in many cases, this must be a more cost-effective approach to care than institutional alternatives.

> *'I want to remain as independent and in control as long as possible because that is good for my health and for my emotional wellbeing. And I want the support which ties in to all the help that I need in order to live independently and so I can retain personal control to make the choices which are right for me.'*
>
> Statement from HTLAH engagement event

Further Engagement Work

Further engagement work is planned from September 2015 as part of the joint stakeholder communications and engagement plan. It is recognised that this will run through the whole life of the programme, including the critical transition and implementation phase.

The next phase of engagement, to be delivered from September 2015 onwards, will

1. Progress service user engagement with people with physical disability, learning disabilities and mental health issues via the LCC Research and Insight Team and existing forums such as the Learning Disabilities Partnership Board.

2. Build upon previous engagement work with a view to developing the HTLAH awareness message between model development and service specification through to procurement and implementation.

Appendix 2: Strategic options

Provider Payment Mechanism

Chosen option - application of stepped payment

Customer orders (CPLIs) will be set in IAS with an end date at 4 weeks for the initial reablement period. This is to ensure there is continuity of support for the service user and continuity of payments for providers. During this 4 week period, where a review has taken place and there is a reduction or increase in the package of care the CPLI will be adjusted to reflect this. The end date for any revised CPLI will be set at 4 weeks from the initial start date of the package of care.

By the end of week 4 of reablement, all cases will be stepped down to ongoing support or care will cease if no longer required, this will be the case for all packages of care unless agreed by exception, in which case the final review can occur at week 5 or week 6. Following the reviews at weeks 5 or 6 cases again cases will be stepped down to ongoing support or care will cease if no longer required,

On transfer to a maintenance care package a lower hourly rate will be applied. The expectation is that reablement outcomes will continue to be worked on with service users so that they have the opportunity to achieve their desired goals.

The payment mechanism behind HTLAH has been designed to optimise the technical configuration within the current payment system whilst reflecting the commissioners' intentions to incentivise good performance and achievement of outcomes.

A banding approach based on the number of hours of reablement support a week will be rolled up to give a maximum number of hours of care to be provided over a 4 week period, the use of the bandings to allow flexibility in service delivery may be extended for up further 2 weeks or until the end of the reablement period whichever is sooner. These bandings for individual packages of care will be subject to adjustment should a review indicate that a lower or higher volume of support is needed. I revised CLPI will be entered onto IAS to reflect this. Four bandings have been designed based on evidence from a sample of typical packages of care (Band 1: 0 – 5; Band 2 >5 – 15; Band 3 >15 – 28; Band 4 >28 – 35+).

In agreement with the service user the provider will be able to flex the level of support each week to best meet the individual's needs. For example:

Band	Weekly Hours	4 week period	Week1	Week2	Week3	Week4	TOTAL
1	0 - 5	Up to 20 hrs	9 hrs	5hrs	3 hrs	2 hrs	19 hrs

Currently if one week during a four week payment period exceeds the tolerance limit, the payment for that Service User for those four weeks is suspended to the Provider. Altering the way that the current tolerance levels operate will support the new flexible way of working for reablement. Testing is currently in place to utilise an existing ContrOCC system feature with nil cost, which is also conducive to the project implementation plan, to enable tolerances to continue to apply over each four week payment period.

A contingency option has also been determined which would enable tolerance levels to be changed for the different types of care package (e.g. one level for reablement, another level for each service type within ongoing maintenance care), this too would enable greater flexibility particularly during the reablement phase.   To do this, and move tolerances from contract level to a CPLI level, technical development will be needed for IAS, with an estimated cost at £27k for 30 days development work. All developments require a 12 week period to complete, followed by 4 weeks of testing. Therefore the last date when any developments can be requested so that the new features are available at Contract Start is Jan 2016.

Provider visibility of CPLIs will be via the Provider Portal[4].

Payments to providers will be based on actuals for both the reablement period and the ongoing maintenance care.   Data will be submitted by providers through the Electronic Home Care Monitoring (EHCM) system via the Provider Portal.

Commissioners have assessed the technical system changes and associated finance administration developments needed to support the new payment mechanism. In broad terms it is recognised that recoding within the system will be essential to enable LCC to host transactions for CHC service users. Investigations have concluded that this is feasible, recognising that a period of user acceptance testing across the associated systems will be critical.

System capability to be able to handle the combination of different reablement and maintenance rates at a locality lot level, both at the start of the contracts, as well as incorporating any changes during the life of the contract should this apply, can be managed by the Compliance Team.

The chosen option delivers direct benefits by moving towards an outcomes based approach, whilst mitigating the significant implementation risks of moving from the current approach to a full payment by results payment model at this stage.

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[4] Subject to implementation

This was seen as the prudent option, given the risk assessment including the need for development, testing and implementation of robust infrastructure arrangements for the monitoring and management of payments by results and the shorter lead time to procure and transition into the new service.

All commissioners, feel that the move to a full payment by results system should be the ultimate destination for this service, however achieving this in one step was not seen as a practical solution that could be implemented successfully by 2016. This recommendation was supported by the scrutiny review panel.

Commissioners also assessed that further market development and innovation with providers should be undertaken within the life of the contract so that the move to a full outcome based approach could be achieved in the medium term and that the specification should reflect the requirement that the selected provider(s) engage fully in this development.
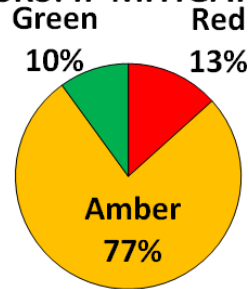
Appendix 3: Risk Register at Programme level

	Current risk	Mitigated risk
Red	29	8
Amber	30	46
Green	1	6

RISKS: CURRENT
Green 2%
Red 48%
Amber 50%
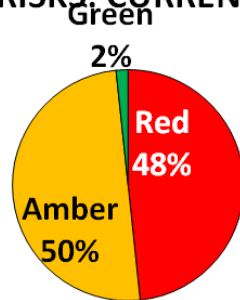
RISKS: IF MITIGATED
Green 10%
Red 13%
Amber 77%

Programme Phase	Current risk	Mitigated risk
Design	14.1	10.4
Validation	12.3	9.6
Procurement	14.4	10.1
Transition	12.7	9.8
BAU/ business continuity	16.5	12.3

KEY for average risk scores

1-2	
3-5	
6-12	
>12, <13.5	>13.5, <15
15-25	

Actions	Open	16	78	Closed
Issues	Open	2	1	Closed
Decisions	Agreed	31	0	Rejected
Opportunities				
Lessons learned				