United Kingdom Homecare Association
The professional association for homecare providers

Equality Unit
Route Complex
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Co. Antrim
BT53 6BP

30 January 2018

Dear Sirs,

Expert Advisory Panel on Adult Care and Support Call for Evidence

Thank you for the opportunity to respond to the Northern Health and Social Care Trusts consultation on future procurement practices for domiciliary care, which I have the pleasure to do on behalf of the United Kingdom Homecare Association (UKHCA).

We have written a short response outlining our main concerns over the proposed changes. Please do contact me if you require any additional information.

Yours faithfully,

James Whynacht

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Question 1.

Do you agree with the reasons and the need for change outlined in the document?

We broadly agree with the Trust's stated reasons and need for a change from its current contracting arrangements as outlined in the document, and we recognise that the Trust has committed to communicating its intentions in the consultation document. We also commend the Trust's intentions to help prospective bidders to quantify their obligations under TUPE. Not all commissioning bodies take this into account and it will allow providers to adequately assess risks in the transfer and submit prices which reflect their obligations.

Question 2.

Do you agree with the Trust's proposed model for purchasing services from non-statutory providers?

As a general principle, UKHCA encourages commissioners to implement zoning of large geographic areas. Dividing the contract into Lots, in this case, can be beneficial in a number of ways, which we will cover in the next question. However, we do have a number of concerns over the Trust's proposed purchasing model.

We fully support the stated aim of creating a more flexible and responsive provider model for people who use homecare, however, we believe that some of the of the measures outlined in the document actually run counter to that stated aim. We believe that the Trust is intending to adopt a "time and task" focus on services through a very prescriptive approach to how care will be purchased, including the very high use of short visits that are 30 minutes or fewer. This is

an exceptionally high use of short visits by UK standards, and is unlikely to give providers, or their care workers, little ability to meet service user's fluctuating needs.

This inflexibility will be compounded by the proposed time bands for daily support tasks. Not only do the bands themselves appear to be inflexible, but they also have two and a half hours built in where no care will be delivered between 11am and 12pm, and 3pm to 4.30pm. We understand that there are peaks and troughs in demand for care throughout the day, but this is economically inefficient for both the Trust and providers to have prescribed times where no care is being delivered. Care workers are therefore likely to have significant spare capacity during these times. This is an economically inefficient use of the workforce. Given that Northern Trust (along with the other Trusts in Northern Ireland) are paying some of the lowest hourly rates for homecare in the UK, we find it unlikely that a rate will be being paid which enables employers to have spare capacity, and providers will need to reflect this down-time within their assessment of the price required to remain viable.

We also believe that the "service start times" (the notice periods given to begin or re-start a package of care) are also ambitious given the care workforce shortages in Northern Ireland. It is therefore likely that there will be a high number of contract defaults if this system is imposed as a contractual obligation.

We have previously mentioned the over-reliance on "time and task" services that last 30 minutes or fewer; it is also of great concern to see the very high proportion of visits commissioned by the Trust that last 15 minutes or fewer. Although we recognise that NICE guidelines are not applicable to Northern Ireland, they do state that "Home care visits shorter than half an hour should

only be made if the home care worker is known to the person and the visit is part of a wider package of support and the purpose of the visit can be properly undertaken in that time."[1]

It is therefore concerning to see that 45% of calls lasted between 0-15 minutes. In our view, the Trust should satisfy itself that such purchasing patterns are in the interests of an effective homecare service and have a rationale to explain why it purchasing is so different to NICE recommendations.

We note that the Trust has included a section in the document on Electronic Call Monitoring Systems (ECMS) during the life of the contract. The Trust has not indicated whether it intends to link the introduction of ECMS with the generation of invoices, but we assume that this is the Trust's intention (based on previous experience with other authorities throughout the UK) and we wish to warn in the strongest possible terms that the introduction of invoicing to ECMS times, unless it is accompanied by a review of contract price at the same time, is likely to affect the commercial viability of contracted providers. It is our view that the Trust would be irresponsible to introduce such a system (ie. Linking ECMS times to invoicing) particularly if it fails to explain its intentions *in full* at the point of invitation to tender.

We also have concerns about the requirement for providers to accept additional spot-purchasing where demand exceeds the guaranteed hours in their primary lots. It may exceed the capacities of the primary care provider, or force providers into taking on commercially unviable tasks without being adequately remunerated by the Trust.

[1] https://www.nice.org.uk/guidance/ng21

Finally, the requirement that successful bidders must be able to provide care to all the named service user groups means that only "generalists" can apply. Not only will some of these providers possibly lack the required skills to properly fulfil specialist care, it is also likely to exclude providers that deliver specialist services from bidding.

Question 3.

Do you agree with the creation of geographical areas or lots within the Trust area?

As stated previously, we generally support the zoning of contracts. Zoning can encourage a more efficient use of the available workforce, and generally reduces travel time between call visits which can help to reduce costs for providers. It is also likely to improve continuity of care for service users.

However, we believe that the Trust is taking a high-risk in appointing a single primary provider to each Lot, such providers may or may not be able to deliver all of the necessary hours demanded by the contract. This could be exacerbated by the uncertain level of spot-purchased hours that the provider may also be required to deliver.

Although we were pleased to see some thought given to contingency planning in the event of provider failure, we do have some concerns. There are no guarantees that the appointed contingency provider will have the required capacity to provide cover if they are already at maximum capacity providing the primary contract in another Lot. If there was any disruption in service it could have potentially dire consequences for both Lots in this case.

Question4.

An outcome of initial equality screening considerations is available on the Trust website. Do you agree with the outcome of this screening?

We have not assessed this question.

Question 5.

The Rural Needs Act NI 2016 places a duty on public authorities, including government departments, to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans and when designing and delivering public services. Do you have any evidence to suggest that the proposal within this document would create an adverse differential impact?

We do not have a comment on this question at this time.