

## Care Market Engagement Q&A

### **How can we give customers more control?**

People can have control of their Personal Budget through Direct Payments (DP). There may be more work to do to on this, for example to simplify the process. However, there are also ways that we can ensure that customers have more choice and control in the way their service is delivered, and we will want to work with providers on this.

### **Direct Payments- will there be a requirement for more or less of these?**

There is a will to increase number of DP's. People use in different ways, they can offer a different type of solution to meet needs that suits the lifestyle and circumstances of the customer i.e. Personal Assistants/ different service models or people may wish to choose a specific care provider outside the Council's arrangements. This is an area for more exploration. Currently 1900 Care and Support at Home customers commissioned by WSCC and around 500 older people have a direct payment

### **What are the levels likely to be for upcoming hours?**

This is something we are working on. The information presented today covers current customers and an estimate of weekly hours. However, because the new arrangements would not be transitioning existing customers, the volumes will build with new referrals from the commencement. We are currently working on identifying the average duration for customers in service and numbers of referrals to give an idea of how many customers may be referred in each area. The information we are currently looking at suggests that people utilise current services for around 14 months on average but this may change as we explore this further. More information will be provided when this has been completed.

### **If guarantee of hours is offered and a provider does not deliver hours what will happen as a result of this?**

A block gives a guarantee of a certain level of business. If the level of demand was less and there were fewer referrals than anticipated the block hours would still be paid as long as the provider has the capacity to make those hours available. However the Council would not be able to pay on a block basis if a provider were unable to deliver hours. For example, if a block of 200 hours was committed, but a provider could not recruit sufficient staff to cover and could only provide 100 hours, the Council would not pay the full block. WSCC has previous experience of phased approach to blocks. If the volumes were different in reality than expected it would be anticipated that there would be terms within the agreement to adjust volumes on block arrangements as appropriate.

**What are the terms of giving back an area?**

Generally the will is for a good relationship so for example, providers would flag up issues early before handing back customers, and to potentially avoid a position where a provider would need to give back an area. Terms and conditions will include notice periods around terminations, or suspensions, but these are not yet developed. These will be provided as part of the procurement.

**Will there be a minimum contract term?**

We have not yet agreed the contract term. We are aware that a short contract term would not be appropriate as providers will require time to implement and develop as it will take time to build with new customers. The current framework was a 2+2+2 years (6 year maximum term)

**Why did the current framework not run to the end of the last 2 year period and the new contract starting in January 21?**

This is due to the number of challenges we currently face and therefore we are keen to move to new arrangements swiftly, but also recognising that it needs a reasonable length of time to mobilise/ consult/ implement and embed.

**Are you looking for specific number of provider leads in tier one and two?**

Level 1- 1 Lead and 1 second and Dynamic Purchasing System (DPS)

Level 2- 1 Lead and DPS

We haven't determined the overall number of providers across the whole arrangement as whilst we may look at restricting the maximum number of lots that providers can be successful in, it may be that one provider is successful in more than one area. There will no restriction on numbers for the DPS.

**How may providers organise themselves to bid for areas during a time when they are not able to talk to us?**

**Provider noted that they may bid successfully for areas that they do not seek, or the outcome is different to what expected.**

Communication channels will be open and available during tender but this is a formal process, so providers questions will be responded to and available to all interested parties. We cannot facilitate providers speaking to one another. This is up to individual providers if they wish to do so. We understand there may be work to do with providers before the tender and post award as providers may develop and change their business model on the basis of the outcome.

**There is a level of uncertainty within these proposals with providers unsure of the implications of the potential payment terms.**

It is important to the Council that the approach enables viable and sustainable services and this will be a key consideration to the payment model.

Over the next 18 months it is very important that current arrangements continue and we can continue to support the current and new customers throughout that time. WSCC will continue working with and supporting current framework partners. An assurance we can offer is that we are not anticipating moving customers, and hence existing providers will continue to support their customers when moving on to the DPS.

Please use the next six weeks to provide information relating to potential costs and experiences of different pricing structures and what the impact has been on your business (e.g. are there economies of scale for volumes/blocks, will certain areas cost more etc.) and aspects for the council to consider in shaping the pricing model. We have information about current costs, UKHCA information etc. but it would also be helpful for providers to inform this by providing information to support the development of this area. Realistically it is unlikely that we will be able to present back a payment structure proposal within the next six weeks, but we can, and would like to use your information and intelligence to inform the development of this.

**If you are on DPS and are taking a lot of packages, would you become lead provider by default?**

The ambition is to work with the lead and second provider to provide the vast majority of services in the area. If they are unable to deliver required volumes, this would be managed via performance/ contract management. It is anticipated that the DPS would be used for reserve and contingency and not as the main provision in any area. DPS detail is to be worked up but it does potentially provide opportunities throughout the contract term, as for example if a lead or second moves out of area then we may look to the DPS providers to replace that lead or second provider.

**If you are on DPS do you have one price or rate per area?**

Potentially rate per area but pricing structure is yet to be developed. If provider has thoughts on this, particularly about the different costs you may have in different areas, please let us know to support the approach on this.

**Could framework rate be higher than DPS rate or vice versa?**

We are unable to answer this at this stage. Providers' information will help to shape the pricing structure.

### **How will Value for Money be evaluated?**

The procurement evaluation model has not yet been developed. However, value does not mean the cheapest price. Most tenders we look at Most Economically Advantageous Tender, which includes a mixture of quality and cost. We are looking to ensure viable and sustainable services and this will therefore need to be an achievable rate that enables a quality service for customers and outcomes for them.

### **A criticism of the 2015 framework tender award was that there was no recognition of those providers already delivering in areas.**

We will be looking to see evidence of how providers can achieve the requirements. For existing providers established within the area you will have an evidence base of how you do and can provide services that you can demonstrate. We can't restrict providers from outside of area bidding. The evaluation criteria is not set yet and we would want to apply lessons learned from other procurement processes.

### **If non-current WSCC provider will they be able to bid?**

Yes, evaluation criteria yet to be set, but all providers will have the opportunity to bid for the DPS initially which will be the starting point for providers to get on to the arrangements and to respond to opportunities for lead and second providers.

### **Will lead provider deliver for WSCC and Continuing Healthcare (CHC)?**

CHC have given a view that they are keen to work with us on the commissioning of Care and Support at Home, and if they continue to want to be included, then the lead would deliver for both WSCC and CHC. End of Life unlikely to be included in this and they are looking at separate arrangements for this.

### **Three providers engaged in tech project consultation. Is there requirement for providers to use specific system?**

Learning from the work and engagement we have done on electronic call monitoring previously is that it would be unhelpful for the council to state the use of one particular system. We are looking at the potential for a provider portal which providers can enter information direct on to the system or through which their systems can import information into the system and hence it is the interface between systems. We are not anticipating requiring providers adopt a specific electronic call monitoring system.

Further to this market engagement event, please contact us via the email address [adultscommissioning@westsussex.gov.uk](mailto:adultscommissioning@westsussex.gov.uk), to offer feedback on the commissioning approach and the potential model.

Provider survey to be distributed, within the next week. Particularly seeking views on payments structure.

## **Hospital Discharge Care Service Questions**

### **Talking about moving assessment away from hospital to home how will providers know what services are required before a health or social care assessment?**

A short evaluation of an individual's suitability to be supported on the Home First pathway will be undertaken in hospital. Each hospital will have a multi-disciplinary team to co-ordinate discharges. An initial assessment will be carried out by Sussex Community NHS Foundation Trust (SCFT) when a patient has returned home which will determine their immediate care and support requirements.

### **Do you envisage service requirements will be larger than what is currently required for each customer per day per week?**

Potentially customers may require more support at the start of service following a discharge from hospital that may reduce as they recover and settle back at home. Likewise, customers may have reduced support needs.

### **Strange that provider not approached on model as delivered Home First service in Brighton and Hove- short sighted.**

The Council is aware that a previous pilot was operated in the coastal area, and is working closely with Clinical Commissioning Group colleagues and Sussex Community NHS Trust regarding learning from the pilot in the development of the future for home first. Will liaise with procurement on whether there are opportunities to develop this further, although noted timescales are tight. We will look to continue to embed learning going forward with the home first approach.

### **Why is the HDC model different to the Care and Support at Home geographical split?**

HDC and Care and Support at Home are distinct services with different requirements. There is an emphasis on the provider liaising closely with the multi disciplinary team and therefore a number of providers covering smaller areas may not suit this approach. HDC services need to cover the whole of the county including areas where there is likely to be very little regular demand for services.

The interim service has split the county into two service lots. For the full service from April 2020 we are looking at potentially three geographical areas. The

lower volumes in the interim service would reduce the viability of splitting the Coastal area into two separate lots.

**Bigger geography- alters workforce requirements/ skill set re working with MDT and so not for all Care and Support at Home providers.**

**How if current providers not covering all geographical area will anyone be able to deliver the interim arrangement?**

This may present a challenge to a number of providers who may not feel able to cover all areas. However, some providers may take the view that number of customers in certain areas maybe small so we may adapt business to cover, other providers may look to diversify into this type of service and deliver in a slightly different way. If there are no providers able to deliver then we would look to review the approach.

**What are the volume hours made up of? Is this contact time?**

Yes. The volume of hours represents the projected required hours for contact time delivery

**What if it emerges that a customer requires residential care before the assessment is completed what are the risks and whose responsibility is it if there are greater needs than can be managed or risks for the customer ?**

Before people leave hospital it will be determined whether they are suitable for the pathway. If they have 24 hour care needs they would not be considered suitable and will follow a different pathway. There will also be daily multiple disciplinary team meetings for all involved (with the expectation that the HDS providers will be actively involved in these) to discuss and manage risks and ensure services suitable to meet the needs of the customers.

**Will the Home First Care provider need to be the HDS provider when the full arrangements come into effect?**

The current tender opportunity available to contracted providers is for the interim service and is in relation to the Home First Care function only. The interim service will operate from October to March 2020.

The full Hospital Discharge Care service that will deliver from April 2020 onwards will deliver both the Home First Care and the Bridging Care functions in each area. The awarded provider will need to deliver both of the functions.

Procurement for this service will take place in the Autumn this year following a key decision in line with the Council's approval processes.

The interim and full services have separate procurement arrangements.

**Would be helpful for the provider to know how assumed Home First hours in the tender?**

The HDC service volumes are determined by historic data in relation to social work activity from hospital teams and projected throughput. Information on this will be provided as part of the tender.

**If accepting different model to traditional model how will current providers be able to deliver?**

This model continues to require personal care and so the majority of the service actually provided may be the same. However it will be a different approach with very quick response, a re-abling ethos and different service requirements. Recognise however that this is a different approach to the Care and Support at Home service and therefore not all providers may wish to bid.

Please submit any questions or comments to [adultscommissioning@westsussex.gov.uk](mailto:adultscommissioning@westsussex.gov.uk)