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Telford & Wrekin COUNCIL

Addenbrooke House Ironmasters Way Telford TF3 4NT

HEALTH & ADULT CARE SCRUTINY COMMITTEE

Date	**Tuesday 27 February 2018**	Time	**2.00pm**
Venue	**The Wakes, Oakengates Square, Oakengates, Telford TF2 6EP**		

Enquiries Regarding this Agenda:		
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Committee Membership: Councillors M Boylan, **A J Burford (Chair)**, S P Burrell, N A Dugmore, R Mehta, L A Murray, T J Nelson, H Rhodes, and E Clare, C-optees: Mrs J Gulliver, Mrs C Henniker, Ms H Knight and Mr D Saunders

AGENDA

1. **Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes** — Appendix **A**
   To confirm the minutes of the meeting of the Health & Adult Care Scrutiny Committee held on 3 October 2017.

4. **Commissioning and Adult Social Care Cost Improvement Plan 2017-18**
   To receive the report of the Assistant Director: Governance, Procurement & Commissioning — Appendix **B**

5. **Chair's Update**

A

HEALTH AND ADULT CARE SCRUTINY COMMITTEE
Minutes of the meeting of the Health & Adult Care Scrutiny Committee held on 3 October 2017 at 2.00pm in Meeting Room G3 –G4 Addenbrooke House, Ironmasters Way, Telford, TF3 4NT

Present: Cllrs A Burford (Chair), R Mehta, L A Murray, T J Nelson, R J Sloan; Co-optees J Gulliver, C Henniker, H Knight, D Saunders

In Attendance: S Dillon – Assistant Director: Early Help & Support, R Purvis - Team Leader Projects, Policies & Quality, Early Help & Support, T Smart - Finance Manager, Finance & Human Resources TWC, J Tangye, Senior Democratic and Scrutiny Services Officer TWC

HACSC-06 Apologies for Absence

Councillors S P Burrell, N A Dugmore, H Rhodes

HACSC-07 Declarations of Interest

None

HACSC-08 Minutes

Resolved – that the minutes of the meeting of the Health & Adult Care Scrutiny Committee held on 18 July 2017 be confirmed and signed by the Chairman.

HACSC- 09 Adult Care Performance, Budget & Savings for Older People – Early Help & Support Cost Improvement Plan 2017-18

The Chair welcomed the Officers to the meeting and highlighted that the Committee had wanted to drill down and focus on specific areas of adult social care budget and performance. The Committee had agreed with Officers that they would start by focussing on older people as one of the biggest areas within adult social care. It was acknowledged that the service area had made positive progress, reducing the number of people in residential care which was encouraging in terms of client choice, support to stay at home, an increase in direct payments and had positive implications for the budget.

The Assistant Director: Early Help & Support presented the report on the progress of the Early Help and Support Service (EHS) on the provision of support for older people. The Committee heard that the approach taken by EHS was to provide early advice and guidance to individuals and focus on individual and community assets. Clients contacting the Council and the Council's commissioned advice and information service 'My Choice', were receiving earlier advice, being signposted and connected to local and community led support before statutory adult social care was necessary. The Assistant Director indicated that innovative ways of providing care were being implemented, such as assistive technology.

It was reported that older adults required the highest proportion of services. The approach to reduce the demand on statutory services meant that at the time of referral, the level of service needed was higher and the amount of services needed was greater, however people were being supported to a greater degree in the family and community setting. Particular pressures on the service were presented by the drive to avoid hospital admission, increased acuity and increased care costs. Future demand was constantly evaluated, and there was an indication that demand would be higher than average for the over 85 years age bracket. The number of people needing support for dementia was one of the areas nationally and locally set to increase. In the over 85 year's bracket, the expectation was that 800 clients would need services, set to increase to over 1000 in the next few years. For EHS this meant that the resources had to be in place to respond to the increased level of need.

Early help and prevention – Neighbourhood work was being developed to help people in their own localities and around GP surgeries. Help and information was provided earlier to address care needs. Social workers were linked with GPs for professional advice in how best to support clients, which would help to avoid hospital admissions. Teams were also tasked with reducing discharge from hospital and implementation of re-ablement. The Better Care Fund allowed for work to be done on delayed discharge particularly through the winter period. Delivery of 48 hours discharge was often over 90% and was constantly monitored by health and social care partners. The number of people referred over 65 years from 2015-16 and from 2016-17 had reduced directly through the service My Choice. The advice line was led by Citizens Advice and provided early help to people to reduce the use of Council services.

A question was raised about the significant reduction in requests for support through My Choice and why this significant change had occurred. There was concern that this was not necessarily due to reduced demand but people finding it harder to request support, people being filtered out and only those cases that were very needy getting through to the Council. It was noted that there was better signposting and a system of triage was working to reduce the numbers. My Choice also aimed at providing early help and support and to fast track people who really needed Council services.

Hospital discharge was routinely monitored on a daily basis by partners and the report showed that the Council was broadly on track. For each Council and health economy the Department of Health set targets which had an effect on funding if targets were not met. A question was asked about the numbers of people discharged where the care package provided was not adequate and whether this was measured. It was noted that 91 days post discharge there was a review to determine whether there had been a return to hospital or a higher level of care put in place. It was a performance indicator that was difficult to monitor but it was key to monitor. Work was being done to improve on this indicator with partners. The Committee requested that this data was shared. Telford & Wrekin was achieving 3.5 discharges per day which was second best in the West Midlands. This was due to positive relationship with the CCGs and the BCF to enable continual development of the care offer,

such as a service in place overnight to turn and toilet people which was essential to prevent people going into care overnight. The Committee acknowledged that whilst there were extra pressures over the winter period, there were pressures throughout the year. The range of services, step down beds, support at night, assistive technology and frontline staff provided care at the right time in the right place for individuals.

A question was asked about what Early Help consisted of. My Choice was the first offer, local help and advice, detailed signposting. Social workers were based in the community where telephone advice did not meet need and there was signposting to what was available in the community. GPs had access to appointments with social work staff before the situation reached crisis point for a patient.

It was noted that a potential consequence of avoiding delayed discharge was that clients could be discharged from hospital to facilities far from their homes for a temporary period. The Committee was assured that the risks were weighed up, if a hospital patient was medically fit for discharge it had a negative impact if they had to stay in hospital. The situation would always be discussed with the patient and family and clinicians.

Helen Cotterell and a volunteer who helped at the assistive technology hub every Wednesday at Citizens Advice Bureau in Wellington demonstrated the new technologies to raise awareness of the tools available. The tools were being used by social workers and occupational therapists as part of care assessments and reviews. The Committee heard about reminder clocks, automated pill dispensers, pendant alarms and noted that although some tools had been around for years, the technology was much more sophisticated today.

Just Checking - was a system used for assessment to build a picture of an individual's daily routine, which detected movement in particular rooms, providing an insight into how a client was coping with their daily routine. There were several kits in each locality used for assessment purposes to inform reviews and support findings. Significant changes could be identified which helped to focus the support needed and the right amount of care at the right time to prevent over/ under caring. Assistive technology aimed to prevent long term care and reduce spend. Workshops were in place to consider best practice and ethics. The Committee requested that a report come back to Scrutiny in 6 months' time.

Members were concerned that there was not enough being done to promote such campaigns to raise awareness and demonstrate assistive technology. It was noted that the campaign would be relaunched in January 2018 with a programme of events and would include redesigned leaflets, radio promotion, and advertising in local newspapers.

Members were also concerned about access to care although it was acknowledged that the strength based approach followed the guidance of the Care Act. It was understood that the Council had to respond to need, that modern extra care had technology built in and there was a need to plan ahead at least 3 years.

The Care Act required there to be sufficiency in the market for domiciliary and residential

care, Councils were managing this so that it was affordable. The cost of care was rising, there was demand in mental health care. The domiciliary care markets were flexible and had a good range of providers. The Council supported providers to ensure there was sufficiency, managed by block purchasing and planned purchasing helped to increase the flow in the hospitals. The Care Quality Commission inspected all residential and domiciliary care to ensure if was fully on top of need and future needs which could affect providers and what they delivered. Units of extra care were purchased and reduced people having to go into residential and higher care. It was a constant challenge and solutions were being implemented all the time, such as sleep-in night support.

The Chair drew the item to a close and asked the Committee to consider its role in focussing on where Scrutiny could make a difference, be the critical friend, offer real challenge and suggestions. It was important to continue to monitor the budget and performance but perhaps to look at where the challenges were in the system.

It was felt that the right measures were being taken by the Council to enable people to stay in their homes and be supported within the community but there were things in the system that were fragile. It was acknowledged that the budget was very challenging and whilst numbers in residential care homes were falling, activity was going up and the demographics indicated older people activity. One of the suggested areas of work in the Committee's work programme was a sensitive area around care fees and it was suggested that this could be considered under the issue of resilience of the sector and how to balance costs and need, how adaptive the care market could be. The Committee felt that a closer look at the issue as a whole would be valuable rather than a focus on care fees/rates which was a market and commercial issue. It was also agreed that the particular effects of the Council's block purchasing on self-funders and people that did not qualify for care from the Council could be looked into.

Members suggested that it would be useful to unpick terms such as community support and resilience and to explore what it meant on the ground. It was particularly important to look at whether care was established in the community to support the additional level of need with the bar being raised for access to statutory care. An audit of community resilience was not needed, it could not be defined objectively nor could it be benchmarked. The Committee agreed that it would be far more useful to uncover the particular challenges within the community so that they could be addressed.

The Committee agreed to continue to monitor the cost improvement plan and delayed discharge. Quarterly reports on hospital discharge from Healthwatch could be used to triangulate the evidence provided by the Council.

Sarah Dillon, Renu Purvis, Vicky Worthington and Helen Cotterell left the meeting at 3.30pm

HACSC- 10 <u>STP Neighbourhood Work Update</u>

At the meeting in July, STP Neighbourhood work had been considered and points of interest had been agreed which included; the definition of community resilience, its limitations, the current picture in the voluntary sector (which organisations were being commissioned), clarity on what would develop into sustainable services, data on community assets, and how support provided by friends and family would be quantified. An update since the last meeting was provided by Louise Mills, Service Delivery Manager at TWC and Ruth Emery, Neighbourhood Working Programme Manager, T&W CCG. The Committee recalled that Resilient Communities was about strong and connected communities supporting people to stay well but also people with long term conditions to stay independent as long as possible. It was noted that the Neighbourhood work had not been developed at the pace it should have but with this particular approach, especially where there was little investment, the services were emerging and being shaped by the community; volunteers, the Council and partners. Dialogue with GPs had stepped up and the plans were starting to take shape. GP practices had grouped together in Neighbourhoods but it was not a one size fits all.

It was noted that the Health and Wellbeing Board had oversight of the governance and reporting structure. It was reported that there were working groups for each workstream and good representation from the Carers Forum, Healthwatch, the voluntary sector and health sector. All GP groups were represented, EHS, Shropshire Community Trust and Foundation Trust- therefore connectivity was good. It was reported that the Neighbourhood programme had fed into Future Fit Pre-Consultation Business Case and into the STP. Five year activity profiling had been completed as a result of this work. The various projects were having an impact, individual performance measures were in place. The strategy unit was currently being considered by the Neighbourhood Working Steering group, to potentially commission them to measure the impact on the health economy as a whole to support the development of a robust evaluation system.

A detailed local picture had been built from comprehensive profiling and data for implementation of programmes. Of the 40 plus projects, 28 were mobilised and delivering services that the Community was benefitting from. Examples were provided, such as Branches which provided advice and support on mental health, drug and alcohol misuse, and the TACT centre was receiving 700 visits per month. The centre was being run by volunteers; 35 volunteers had been recruited and 3000 were being trained. Community prescribing was underway in Newport Neighbourhood where GPs were helping to identify patients who could benefit from social prescribing. Community Care Co-ordinators and Link workers were in place in the Neighbourhoods, people in the communities had already assumed these roles and they were key to identifying residents that may be isolated with no family so that people could be brought together in walking groups, poetry writing and other initiatives such as a group feeding birds.

GP practices in central Telford were receiving a large number of patients for help and support on debt management and welfare issues, therefore solutions could be as simple as signposting to the right support. In this case, it was Citizens Advice drop in clinic in Donnington.

Members asked questions on the following:

- Sustainability and remuneration of the people in the Communities that were leading

groups and projects, who were being relied upon. How integration would be ensured in the future. It was noted that resources were being deployed and paid workers were being connected with volunteers, such as public health practitioners, co-ordinators/ health champions.

- Community care, support and resilience was not a free resource nor cheap; for the medium/ long term this resource had to be nurtured and funded, particularly where Future Fit relied on Neighbourhood services to keep people out of hospital and reduce demand on acute services. Social prescribing was one element that the Committee felt could improve people's mental and physical health but this was not as accessible for people with long term conditions and people at crisis point. For conditions such as diabetes, there were national targets. The CCG has commissioned structured education for the management of diabetes and tailored support to GPs. There was an incentive scheme to encourage GPs to hit targets to help people to manage the condition and prevent surgery such as amputation. Diabetes specialists and teams were working in the communities with GPs. An audit of patient numbers attending GP practices for wounds identified that healing rates and outcomes can be improved and therefore the CCG is commissioning a dedicated wound healing service.
- It was confirmed that the CCG and Local Authority is working with the whole health economy, integrating pathways and being more flexible with resources. The CCG is working with the Local Authority, Community Trust and Foundation Trust to develop integrated teams. Early Help and Support workers were supporting GP surgeries which allowed for better access for patients.
- Estates planning is an element of the Neighbourhood Working Programme that is identifying the estates assets in the area including NHS and Council buildings, in addition to other assets such as leisure centres, community owned buildings etc.
- There was an overarching communication and engagement strategy currently being developed.

The Committee expressed their intention to look at the detail of the projects to try to gain an insight in to the implementation of projects on the ground and the impact for residents and clients of the services. The Officers agreed to share further detail around projects. Members were also interested in taking an overview of the programme and expressed their intention to understand what the programme was achieving. How much could be quantified, how it was supporting the Future Fit Programme and how it was meeting the huge demand on acute services and primary care, and helping to reduce this demand. The Committee considered that it would be useful to consider the 5 Year Forward View for Primary Care. The Committee sought the high level picture to understand how much of a contribution the Neighbourhood work would make to the STP and FFP and sought assurance that the work would sustain the reconfiguration of hospital services.

Louise Mills and Ruth Emery left the meeting 4.40pm

HACSC- 11 Chairs Update

The Committee considered items for the next meeting and how scrutiny should proceed with the work programme. The Committee agreed that it would be valuable to drill down into services and community/ Neighbourhood projects under the STP; to take evidence from residents, patients and their families, and voluntary organisations such as CAB and Age UK. The Committee felt it was important to establish as far as possible, how effective the

changes were as described by Officers.

The Chair provided an update on a briefing he had had with Christine Morris, T&W CCG Lead for Quality, Nursing and Safety on the Midwife Led Unit Service Review. SaTH had raised concerns about the sustainability of the MLU clinical model of service delivery. A review was being undertaken by Shropshire CCG on behalf of T&W CCG. A recommendation would be made about the future model of MLU for decision by the CCGs. The review would look at clinical sustainability; safety and clinical outcomes, quality concerns, staffing of units and workforce plan, rural access, financial sustainability of the 5 existing MLUs, value for money in terms of cost and rural access.

There was also a national programme based on the 2016 Maternity Review Report – Better Births: Improving Outcomes of Maternity Services in England. This was a five year forward view for maternity care which detailed how maternity services needed to change. The CCGs were developing plans to achieve the five year forward view as required by NHS England.

The meeting ended at 4.50pm

Signed: .....

Date: .....

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TELFORD & WREKIN COUNCIL

HEALTH AND ADULT CARE SCRUTINY COMMITTEE – 27 FEBRUARY 2018

COMMISSIONING AND ADULT SOCIAL CARE IMPROVEMENT PLAN 2017-18

REPORT OF THE ASSISTANT DIRECTOR: GOVERNANCE, PROCUREMENT & COMMISSIONING

1. PURPOSE

1.1. To enable the Health and Adult Care Scrutiny Committee to consider the management of price in the Council's commissioning strategy for the provision of care and support in adult social care.

2. RECOMMENDATIONS

2.1. **That the Committee consider the report and agree any recommendations or further actions.**

3. INTRODUCTION

3.1. Managing price on the context of commissioning

Price is just one element of the commissioning role. The Commissioners base their work-plans around 4 key strategic objectives:

- Sufficiency – a statutory duty in the Care Act 2014;
- Quality – externally assessed – Care Quality Commission;
- **Price** – the focus of this report**;** and
- Innovation – service development – not reported here.

4. What are the services?

4.1. In this report care and support includes the provision of well-being care (for example, day care services), personal care (for example, domiciliary care) and the provision of accommodation. Within these broad headings the market can be more specifically defined as follows:

4.2. Well-being care

- Day care services
- Supported living/ enablement services for those living at home, in supported living accommodation and extra care housing
- Community support (not a commissioned service/ not reported here)

4.3. Personal Care

- Domiciliary care
- Specialised/ more complex care
- Rehabilitation and intermediate care

4.4. Accommodation

Residential	Older people, Adults with Learning Difficulties, mental health issues and physical disabilities
Residential EMI	Older people only
Nursing	Older people, Adults with Learning Difficulties, mental health issues and physical disabilities
Nursing EMI	Older people only

The way that the markets for these services operate are different and, accordingly, strategies for managing price are different. This report outlines the different approaches to managing **price** in those different markets.

4.5. Managing the cost of the provision of adult social care

There are 4 factors that can deliver savings and directly impact on the Council's purchasing budget, these are:

- The numbers of people being provided with care and support - operational;
- The nature of the care and support provided – commissioning/ operational;
- The length of time that care and support is provided for – commissioning/ operational; and finally
- The **price** of that care and support – commissioning

4.6. In accordance with the Council's Commitment Statement 2017-18 , refreshed in March 2017 and the main focus of the cost improvement plan, as previously reported, the key focus is on either managing demand away from high cost services or supporting the review of existing placements and providing alternative provision.

4.7. The Council does not forget or take for granted the support provided by unpaid Carers, who are the backbone of the Care Provision for vulnerable adults within the community. We continue to review and re-commission services for our unpaid Carers to ensure we offer as much assistance and support as possible to support them.

4.8. Some numbers

The Council's purchasing budget for adult social care for 17/18 is:

Gross position	£44,453,400
Net position	£34,723,346 (including financial contributions from CCG for health funding and contributions from clients)

Table 1-Budgets and associated client numbers 2017/18

	Older People		ALD		Phys Dis		Mental health	
	£m	Nos	£m	Nos	£m	Nos	£m	Nos
Personal Care								
Domiciliary care	3,243	294	2,609	59	1,251	63	457	29
Well-being								
Day care services	187		142		92		13	
Accommodation								
Residential Care	2,202	85	3,432	45	264	6	621	16
EMI Residential	2,019	70						
Nursing Care	3,812	104	183	5	375	9	211	6
EMI Nursing	806	23						
Direct Payments	1,474	109	2,134	136	1,643	150	104	27
Total	13,743	685	8,500	245	3,625	228	1,406	78

4.9. Well-being

4.10. Day Care Services

The vast majority of this expenditure is with the Council's in-house service, My Options. Depending upon the success of the community resilience projects we would expect, and it is forecast in future planning that the expenditure against this budget is going to reduce. Even within existing business planning the teams are talking to the My Options teams to develop re-ablement / independent living focussed provision to achieve encourage better outcomes for service users – enabling volunteering/ paid employment and independent living.

4.11. Supported living/ extra care

We are re-considering the way that this service is provided in the context of the developing community support, assistive technology and lower level preventative services provided by the landlord

For example there is a bid submission to explore a Smart House; offering all client groups the opportunity to test and see how assistive technology solutions can assist them and reduce the cost of care provided by replacing where appropriate people providing care by using AT solutions for example, giving people more privacy and reducing the cost of night care provision.

4.12. Personal Care

4.13. Domiciliary Care – General

Care is predominantly procured via a Dynamic Purchasing System, ("DPS"), meaning that service providers apply to join a framework. There are some basic quality requirements that the provider must evidence including robust quality and safety policies that are thoroughly checked at the outset of any business with them and annually as part of their contract management. Once on the framework any provider can bid for work against a capped cost, currently fixed at £14.10.

There are currently 40 providers on the DPS Framework (52% are local registered providers and 90% already employ within the Borough). The current DPS is due to be re-commissioned in 2019. The price is capped in the contract.

The Council are currently implementing an Electronic Call Monitoring system, ("ECM"), initially for providers with more than 10 care packages for older people. The system records the care actually provided, in 7 minute blocks, as opposed to the care actually commissioned. Beta testing has identified differences in the care commissioned and the care provided. Once fully operational this will ensure that the Council only pays for actual delivered care and will assist providers in managing their business.

However, it is important to note that there is also a statutory responsibility on the Council to ensure sufficiency of supply in the market: Last year, 2016/17, no inflationary uplift was provided. This coming year, from April 2018, there is, excluding any other inflationary pressure, the impact of the cost of the living wage which, at 50 pence per hour roughly equates to a 4% uplift on the ceiling cost of £14.10. We will be working with the providers to agree a reasonable, and mutually agreed uplift to support them manage this cost pressure. (We do expect the providers to make efficiency savings as well – there are efficiency savings from the detailed data provided through the implemented ECM system, see above.) By ignoring this pressure there is a risk that we jeopardise the sufficiency and stability of the market.

More and more expenditure is taking the form of direct payments to individuals to enable them to secure the care and support that suits them best. There are some efficiency savings from reduced administration and some savings in the cost of care, although these are not expected to be significant.

More specialist domiciliary care is commissioned on an individual basis against specific need.

4.14. Accommodation

4.15. Older People – Price levelling

As has been previously detailed we commission residential based accommodation which varies in price according to need.

This provision, and the market, is split between over 65s and 24 – 64 year olds. Residential and nursing care is provided across these groups and, for over 65's, further care is provided for those with extra frailty, EMI support.

There is an active market in Telford & Wrekin and the wider, but still local area. The Council commissions these types of service from 19 providers, varying from large providers with 80 beds down to much smaller providers who have less than 10 beds.

See Table 1 above from more details on the numbers of service users.

Traditionally this provision has been purchased either through block or spot contracts. Block contracts guarantee price and are generally discounted against the price of an individual bed but of course for savings to be delivered need to be fully utilised all the time. Spots, you only pay for beds when you need them, but they are subject to the exigencies of the market and historical circumstance – i.e. some spot prices were agreed some years ago and do not reflect the price of a bed and associated care costs.

Recognising the diversity of providers in the markets we have been negotiating individually with the providers to agree price "levelled" beds for a fixed term, giving both the Council and the provider certainty, enabling both to manage costs more easily and, as a corollary of this, ensure greater sufficiency. This is enabling the Council to model better for future years' costs.

It should be noted that we continue to engage regularly and positively with SPIC – who are briefed on this approach.

4.16. 24 – 65 year old levelling

In respect of 24 – 65 year old services we are in the early stages of a regional piece of work with a similar objective; individual Council's do not purchase sufficient beds to give them any real power/ influence over price however, when operating together we might reasonably expect to be able to secure more competitive rates from the suppliers

An added factor that is more relevant for this cohort is that costs are informed by individual circumstances, which vary more than for older people.

4.17. Risks

This approach requires positive engagement from the providers. This is our experience to date. Where we do not agree we are only referring as a last resort where no other accommodation is available.

Depending upon the agreement the cost trajectory can lead to increased cost up front

4.18. The implementation of the national living wage is undoubtedly a cost pressure for all providers, but particularly for domiciliary care providers

4.19. 3rd Party top up Policy

In light of recent ombudsman reports, our 3rd Party Top up policy is being reviewed to ensure that it is transparent for the family or friends supporting a vulnerable person and appropriately monitored.

4.20. Travel Assistance

We have an all age travel assistance plan in place which aims to increase independence for all and deliver cashable savings where possible. In terms of Adults, this will mean:

- Ensuring that people's mobility allowance which is part of their Disability Living Allowance is appropriately maximised,
- Exploring viable options for future use of Fleet transport
- The optimisation of shared transport
- Our Future Leaders Group is looking at how we introduce a voluntary car and drivers scheme and is working with the market place to progress this
- Optimise travel training across appropriate ALD groups.

4.21. KEY INFORMATION

This report focuses on the management of price for services for vulnerable adults people. Specific information is detailed earlier in the report

4.22. FINANCIAL/VALUE FOR MONEY IMPACT

The increasing price of care has had a significant impact on care expenditure in recent years. The Council has in the past had a table of agreed Older People accommodation rates, with uplifts applied as appropriate and in agreement with providers and SPIC. However, there a significant number of providers of care who have not adhered to the rates agreed and have charged fees at higher and arguably "Market rates". This has added a significant cost to the service particularly in recent years to Nursing and Nursing EMI accommodation and care because of the specialised nature of the service and the economics of supply and demand. Implementing the framework agreement for Domiciliary care has had an impact in reducing the volatility and mainly upward cost of purchasing homecare. The implementation of a system of price levelling should have the same effect although it is expected to increase costs in the first instance. The budget strategy for 2018/19 has taken account of a Five Year model developed to determine the impact of known pressures and opportunities around the delivery of Adult Social Care. This includes a determination of the impact of the proposed price changes on the cost of care described in this report, and the estimated impact of the introduction of the ECM system.

5. LEGAL ISSUES

This is an information report so there are no legal issues for members' consideration

Report prepared by Jonathan Eatough, Assistant Director, Governance, Procurement & Commissioning