Cabinet 1 December 2015	TOWER HAMLETS
Report of: Luke Addams, Interim Director: Adult's Services	**Classification:** Part Exempt (Restricted Appendix 2)
Future commissioning arrangements for domiciliary care services previously commissioned from Majlish Homecare Services	

Lead Member	**Councillor Amy Whitelock Gibbs, Cabinet Member for Health and Adult Services**
Originating Officer(s)	Karen Sugars, Interim Service Head: Commissioning and Health, Adults' Services
Wards affected	All wards
Key Decision?	Yes
Community Plan Theme	**A Healthy and Supportive Community**

Executive Summary

The council assumed, in March 2014, direct responsibility for the provision of domiciliary care services previously provided under contract by Majlish Homecare Services. This report sets out the recommended option for the future delivery of these services.

The recommended option has been identified as offering the council Best Value, utilising existing contractual arrangements, as well as providing immediate certainty for service users and employees following an extended period of uncertainty regarding the future of the service. If approved, no additional procurement process will be required to be undertaken.

The Council intends commencing, within the next two months, a full re-commissioning of all commissioned domiciliary care provision and adoption of the recommended option will ensure that the activity can be incorporated into this re-commissioning process.

Recommendations:

The Mayor in Cabinet is recommended to:

1. Approve the methodology by which the domiciliary care services previously provided by Majlish Homecare Services will be provided in the short to medium term;

2. Authorise the Acting Director of Adults' Services following consultation with the Corporate Directory of Law, Probity and Governance and Monitoring Officer to enter into any necessary negotiations and other processes

required by the Transfer of Undertakings (Protection of Employment) Regulations regarding the transfer of previous employees of Majlish Homecare Services, currently employed by the council, to those providers from whom services are subsequently commissioned.

3. Authorise the Acting Director of Adults' Services following consultation with the Corporate Director of Law Probity and Governance and Monitoring Officer the power to decide to enter into all necessary agreements and undertake any other ancillary matter to give effect to the decision referred to in recommendation 1

1. REASONS FOR THE DECISIONS

1.1 To ensure that the domiciliary care services previously provided by Majlish Homecare Services continue to be commissioned in a way that provides Best Value to the council and to provide immediate certainty for service users and employees following an extended period of uncertainty

2. ALTERNATIVE OPTIONS

2.1 The options appraisal undertaken to support identification of the Best Value option is attached to this report as Appendix 1. The six options considered are listed along with the relative strengths and weaknesses of each option. The analysis of strengths and weaknesses was based on a range of factors including impact on service users and staff, impact on the council and deliverability.

2.2 Based on these criteria only, the recommended option has been identified. However consideration should also be given to the legal advice attached at Appendix 2. The Mayor in Cabinet could, however, instruct officers to provide a more detailed analysis of one or more of the alternative options, or to pursue an alternative option altogether.

3. DETAILS OF REPORT

3.1 Majlish Homecare Services (MHS) were successful in winning a contract for inclusion on the council's Domiciliary Care Preferred Provider Framework Agreement in 2012. MHS's existing contractual relationship with the council meant that they transferred onto the new Framework with a significant volume of existing business, and accordingly were one of the largest providers of domiciliary care to the council by volume and cost.

3.2 During 2013 increasingly significant concerns were raised, both through the council's contract monitoring processes and via the regulatory activities of the Care Quality Commission, regarding the way in which MHS was being managed. These concerns were also informed and increased by

whistleblowing activity from employees within MHS. The extent of these concerns was such that the council came to the view that there was a very significant risk to MHS's ability to continue to trade as a going concern without changes to the way in which MHS was managed and run.

3.3 The council therefore sought to engage with the Board of Trustees of MHS, as well as with the existing senior managers in the organisation to effect change. Ultimately, however, this engagement did not produce a satisfactory outcome and the council took the decision, toward the end of 2013, to terminate the contract with MHS with effect from 28 February 2014.

3.4 It is important to highlight that the concerns identified both by the council and by the Care Quality Commission were primarily related to the way in which MHS was managed and run. The quality of care provided on a day to day basis by the care employees was not, and had not been previously, of particular concern.

3.5 Once the decision to terminate the contract had been taken various options for maintaining service delivery from 1 March 2014 onwards were considered. The safest option identified at the time was to bring the service under the direct management of the council for a period of time in order to allow for a more considered exploration of the Best Value option for the service. In pursuance of this, employees of MHS who were directly involved in providing the care delivered by the service as well as first line supervisors were offered the opportunity to transfer, under the terms of the Transfer of Undertakings (Protection of Employment) Regulations, to the council's employment on their existing terms and conditions with effect from 1 March 2014. This transfer involved a total of approximately 120 employees the majority of whom worked part-time hours. New management arrangements were put in place by the council to ensure that the service would be effectively managed and run on a day to day basis.

3.6 The transfer to the council took place on schedule, with the council assuming direct responsibility for the provision of the service with effect from 1 March 2014. Since that date the focus has been on maintaining and improving the quality of care provided; ensuring that all staff are properly trained; ensuring that terms and conditions of employment are appropriate and equitably applied; and ensuring that documentation relating to all employees is up to date and complete. This documentation includes proof of right to work as well as up to date Disclosure and Barring Service checks.

3.7 The transfer in of the service was always intended to be a temporary measure until such time as the service had been stabilised and put back on a sound footing. Various options for the future delivery of the service have been analysed and these options are set out in the options appraisal included as appendix 1 to this report. The length of time that has now elapsed since the service was transferred to the Council means that there is an increasingly pressing need to provide certainty and reassurance for service users and employees.

3.8 The preferred option identified by officers and recommended for approval by the Mayor in Cabinet, is that the volume of business currently provided by the service is commissioned via the existing Preferred Provider Framework Agreement. This will be achieved by offering the business to the top ranked provider on the Framework in the first instance and then to subsequently ranked providers until all of the activity is allocated. Employees will also transfer, on existing terms and conditions, to the receiving provider or providers. This option is judged to provide the optimum means of providing the certainty needed for service users and employees as well as offering good value to the Council.

3.9 In summary, the six options considered are:

- Allocate to providers on the existing Preferred Provider Framework by the same method as would be used for new packages of care commissioned via the framework. This option will ensure that the activity is then incorporated into the planned re-tender of the Preferred Provider Framework;
- Retain in-house until such time as the planned Preferred Provider Framework re-tender is completed (November 2016), and allocate to successful bidders as part of the contract mobilisation process;
- Retain in-house for an initial period and initiate the process of setting up a new entity, using the Public Sector Mutual model. Once the new entity is set up, the Council to retain a majority stake for an incubation period of between two and three years to allow the service to become commercially viable prior to being exposed to competition law requirements to competitively tender for business;
- Tender for the necessary volume of activity as a single (reducing) block contract;
- Tender for the necessary volume of activity via a new Preferred Provider Framework (separate to the currently planned process);
- Retain in-house on the same basis as the previous Longer Term Homecare service i.e. reducing over time as packages cease.

3.10 The following factors have been taken into account when considering the relative strengths and weaknesses of these options in order to determine the recommendation:

- Speed of delivery (achievability);
- Resources required to deliver (achievability and impact);
- Impact on service users and carers (impact);
- Impact on front line employees of Fides (impact);
- Impact on wider domiciliary care market locally (impact);
- Impact on LBTH, including reputational (impact);
- Cost (achievability and impact)

3.11 Before effecting any transfer, officers will undertake a detailed risk analysis to ensure that the financial and operational sustainability of the receiving provider or providers is not adversely impacted by the additional volume of

activity to be commissioned from them and by the number of employees to be transferred with the activity. A detailed action plan will be put in place to ensure that all identified risks have suitable mitigation measures in place.

3.12 Senior Managers have undertaken two consultation meetings with employees of the service, on the 11th and 19th of November 2015 in order to seek their views on the different options. Across the two sessions approximately 70 of the workforce of 120 attended, and a Trade Union representative was also in each session. It is clear from the outcome of these sessions that there are significant divisions within the staff group about the preferred way forward, and arguably the most consistent message to come from the sessions is that what matters most is security of employment. All of the options under consideration mean that employees will transfer to new employers with terms and conditions protected by the TUPE regulations.

3.13 The total volume of activity to be recommissioned via the Preferred Provider Framework Agreement is 129,311 hours per annum, delivered to 143 individual service users, and the forecast cost of providing the service in 2015/16 is £1.73m[1].

3.14 A delivery plan is in the process of being developed in order to ensure that if the recommended option is agreed, the necessary arrangements to transfer the activity to a receiving provider or providers can be effected in as timely a manner as possible, while at the same time ensuring that service users and employees experience as little disruption as possible. It is intended that all transfers will be complete by 31 March 2016.

3.15 In particular, the delivery plan will include specific actions to ensure that employees of the service are treated fairly and equitably, and are appropriately supported through the transfer process. The delivery plan will also include various actions to support the receiving provider or providers to incorporate transferred employees into their existing workforce.

3.16 MHS did also provide services on behalf of NHS Tower Hamlets CCG and a small number of other London Boroughs on a spot purchased basis and these services have continued to be provided since the council assumed direct control of the service. Those purchasing authorities will therefore need to make alternative arrangements to have these services provided if the recommended option is pursued. Officers will work closely with those purchasing authorities to ensure that is achieved in the least disruptive manner possible for service users.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The predicted cost of providing the service previously managed by MHS is £1.73m for this financial year. The unit cost of providing the current service is £14.64 per hour which is outside the average rate charged by our external providers of between £13.92 and £14.50 per hour. The rate has increased

[1] Based on a unit cost of £14.50 ph

recently as the unit cost in April 2015 for MHS was £13.94 per hour. By redistributing the clients to the existing preferred provider framework the Council will avoid the risk of subsidising a potentially costly in-house service.

5. LEGAL COMMENTS

5.1 Detailed legal advice on the risks relating to each of the options is provided in **restricted** Appendix 2

5.2 The Council has a duty to ensure that all its services provide for Best Value in accordance with Section 3 of the Local Government Act 1999. In order to comply with this duty it is accepted practice that local authorities should tender services and award a contract based on the bid that provides the most economically advantageous tender judged on a blend of quality and price.

5.3 The services that are the subject of this report are of the type that are subject to Schedule 3 of the Public Contracts Regulations 2015. Therefore, these regulations will apply to any new tender but in a limited way. In effect, the Council should tender these services in a manner that is only compliant with the Council's general duties of fairness openness and transparency required by the Treaty For the Operation of the European Union. However, such a tender process would still take a significant amount of time (9 months to a year) during which the levels of uncertainty for service users and employees alike would be exacerbated.

5.4 The Council had previously tendered for these services when Majlish won a bid and it was at that point the frameworks for the placement of further new packages of care were formed. However, Majlish's service provision failed but the Council still owes a legal duty to the service users to provide these services under the Care Act 2014. Therefore, the use of the previously tendered frameworks could comply with this duty should the services be recommissioned using this route.

5.5 A pragmatic approach is to transfer the services to the previously tendered frameworks to provide short to medium term certainty for service users for a period of time long enough for the Council to tender the whole of its domiciliary care provision

5.6 The intended approach is to allocate provision of the services between the remaining framework providers by first offering the opportunity to provide these services to the provider who scored best under the original evaluation. Then when that provider has reached its capacity the second placed provider will be offered the opportunity and so on until all the service users have been allocated a service provider. This is the correct methodology for allocating services to particular framework members where the framework does not provide for a separate mini competition exercise. This is also consistent with the Council's best value duty and its duty to purchase services in accordance with the original tender results.

5.7 It could be seen that the presentation of these services to a particular provider or provider's amounts to the award of a new contract. However, the original

contract and procurement process envisaged the Council having the ability to request further services to be provided by a provider throughout the contract period, and in fact this is necessary in order to provide efficacy to the frameworks. Therefore, the reallocation of these services is consistent with the original intention of the frameworks when they were tendered.

5.8 It should be noted that throughout the transition the Council should also comply with its consultative duties with the Service Users in line with the Care Act 2014.

5.9 It is highly likely that the Transfer of Undertakings (Protection of Employment) Regulations will apply to any transfer of the service. Where they do apply the Council should be aware of the duty to consult with the transferring employees and should take part in the process as well as making the framework providers aware of the potential staff transfer.

5.10 When making any alterations to the services the Council should ensure that it has full knowledge of the effect such changes may have on people who have a protected characteristic as compared with those who don't for the purposes of the Equality Act 2010 and has taken all necessary steps to properly understand the position including consultation where necessary.

5.11 Should the Council elect to set up a public sector mutual, this would be subject to further detailed legal advice. However, for the purposes of this report and the determination of timescales it should be noted that the consent by the Secretary Of State would be required. In any event this is a lengthy process and is also complex and would therefore, provide little short to medium term certainty for service users and employees.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 The receiving provider or providers are subject to the same contractual terms and conditions as those previously in place with MHS and these cover a range of factors including compliance with the Public Sector Equality Duty.

6.2 The significant majority of the individuals to whom a service is provided are from the Bangladeshi community. Ensuring that receiving providers are capable of providing a service that is culturally appropriate and that the first language preferences of individuals can be respected will be a critical component of the delivery plan.

7. BEST VALUE (BV) IMPLICATIONS

7.1 The options analysis that informs the recommendation to Cabinet was undertaken in order to identify the Best Value option for the future delivery of the service. Best Value has been determined by considering the following factors in the options appraisal:

- Speed of delivery (achievability);
- Resources required to deliver (achievability and impact);
- Impact on service users and carers (impact);
- Impact on front line employees of Fides (impact);
- Impact on wider domiciliary care market locally (impact);
- Impact on LBTH, including reputational (impact);
- Cost (achievability and impact)

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 There are no sustainability implications arising from the subject of this report.

9. RISK MANAGEMENT IMPLICATIONS

9.1 As noted in paragraph 3.8 above, prior to any transfer of activity to receiving provider or providers a detailed risk analysis will be undertaken to ensure that the receiving provider or providers are not adversely impacted by the additional volume of activity to be commissioned from them and by the number of employees to be transferred with the activity. A detailed action plan will be put in place to ensure that all identified risks have suitable mitigation measure in place.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 There are no crime and disorder implications arising directly from the subject of this report.

11. SAFEGUARDING IMPLICATIONS

11.1 The service provides care to vulnerable individuals who have been identified as being eligible for provision of services in accordance with the council's duties under the Care Act 2014. A critical component of the process put in place to effect the transfer will, therefore, relate to ensuring that those individuals are fully safeguarded during the transfer process itself and subsequently once care is being delivered by the receiving provider or providers.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE.

Appendices

- Appendix 1: Option Appraisal
- Appendix 2: Legal advice (exempt, Paragraph 5 of Part 1 to Schedule 12A to the Local Government Act 1972).

Background Documents – Local Authorities (Executive Arrangements)(Access to Information)(England) Regulations 2012

- NONE

Officer contact details for documents:
N/A

Appendix 1

Future commissioning arrangements for services previously provided by Majlish Homecare Services: Option Appraisal

Prepared: **09 November 2015**

Version: **05**

1. The options for regularising the commissioning arrangements for the domiciliary care activity previously provided by Majlish Homecare Services (MHS) are outlined below.

2. The options are presented in ranked order. This ranked order has been determined by considering the following criteria:
   - Speed of delivery (achievability);
   - Resources required to deliver (achievability and impact);
   - Impact on service users and carers (impact);
   - Impact on front line employees (impact);
   - Impact on wider domiciliary care market locally (impact);
   - Impact on LBTH, including reputational (impact);
   - Cost (achievability and impact)

3. For each of the options a simple 'strengths and weaknesses' appraisal, based on the above criteria, has been undertaken in order to evidence and substantiate the ranked order in which they are presented.

4. The six options identified (and the order in which they are ranked) is as follows:
   a) Allocate to providers on the existing Preferred Provider Framework by the same method as would be used for new packages of care commissioned via the framework. This option will ensure that the activity is then incorporated into the planned re-tender of the Preferred Provider Framework;
   b) Retain in-house until such time as the planned Preferred Provider Framework re-tender is completed (November 2016), and allocate to successful bidders as part of the contract mobilisation process;
   c) Tender for the necessary volume of activity as a single (reducing) block contract;
   d) Retain in-house for an initial period and initiate the process of setting up a new entity, using the Public Sector Mutual model. Once the new entity is set up, the Council to retain a majority stake for an incubation period of between two and three years to allow the service to become commercially viable prior to being exposed to competition law requirements to competitively tender for business;
   e) Tender for the necessary volume of activity via a new Preferred Provider Framework (separate to the wider re-commissioning exercise that is being planned currently);
   f) Retain in-house on the same basis as the Longer Term Homecare service was i.e. reducing over time as packages cease.

5. Option appraisal

Option and brief description	Appraisal of strengths and weaknesses
A Allocate to providers on the existing Preferred Provider Framework by the same method as would be used for new packages of care commissioned via the framework. This option will ensure that the activity is then incorporated into the planned re-tender of the Preferred Provider Framework The 16 providers on the current framework are ranked, and the 'rules' which govern the operation of the Framework mean that unless an individual expresses a preference for a particular provider on the list then new packages must be offered to the top ranked provider in the first instance. If the top ranked provider is not able to take on the package it is then offered to the second ranked and so on until allocated. The provided hours can be treated in the same way.	**Strengths** • Significantly quicker than other procurement based options; • Requires significantly less resource to manage and deliver; • Consistent with current commissioning arrangements; • Consistent with the way that care commissioned from other failing providers has been reallocated; • Likely to deliver savings as unit costs of top ranked provider are lower; • Minimises LBTH exposure to single status issues and associated risks relating to the workforce; • Likely (subject to TUPE consultations) that the existing workforce would transfer to one, or a small number of, providers.
	Weaknesses • The Framework was not explicitly set up to manage large scale transfers such as this, so there is a (low) risk of challenge from other providers not offered the business. The hours commissioned from MHS were, however, all included in the original volumes advertised when the Framework was tendered, or have been commissioned via the Framework since it was established, so the Council can robustly defend any such challenge. • Timing is now a significant issue, given that the existing Framework will be subject to a competitive procurement process over the next 9 to 12 months. This creates the possibility that individual

	service users will experience two transfers to new providers in a short space of time. • Following on from the above bullet point, employees would face the possibility of two TUPE transfers in a short space of time.
B Retain in-house until such time as the planned re-tender of the Preferred Provider Framework tender is completed (November 2016), and allocate to successful bidders as part of the contract mobilisation process.	**Strengths** • Does not require any additional authorisations to be secured from Cabinet / Mayor, or any additional advertising; • Would utilise the planned tender process so less likely to create wider market turbulence than the option above; • Mobilisation issues would be contained within the wider mobilisation process for the new contracts, rather than the Council having to manage two separate mobilisation processes.
	Weaknesses • An extended period of uncertainty for service users, families and employees; • Increased risk to the Council of a challenge relating to the differing terms and conditions of employees as compared with other LBTH employees in equivalent roles; • May mean existing staff group is more widely dispersed across multiple providers. • Higher cost to the Council as the services would remain in house for an extended period and unit costs are currently higher than for commissioned providers.
C Tender for the necessary volume of activity as a single (reducing) block contract	**Strengths** • Tender process would be

	straightforward; • TUPE transfer would be to a single provider; • Mobilisation would be relatively easy to manage.
	Weaknesses • Given the value of the business to be tendered, there would need to be a Cabinet decision to enable the tender to proceed; • The tender, once advertised, would take a minimum of five moths to reach contract award stage (although an abbreviated procedure could reduce this to perhaps four months, but with concomitant increase in risk of challenge); • The likely level of interest would be very high and significant resource would therefore be required to evaluate tenders; • There is no guarantee that the price achieved via the tender process would be lower than currently offered by the service, so a cost pressure risk exists; • An extended period of uncertainty for service users, families and employees; • Increased risk to the Council of a challenge relating to the differing terms and conditions of employees as compared with other LBTH employees in equivalent roles; • Risk of creating wider turbulence in the domiciliary care market locally if we are seen to be proceeding with this tender separately from the wider re-commissioning exercise that is being planned currently; • Experience has shown that block contracts create difficulty in terms of ensuring proper compliance with the council's Electronic Home Care

	Monitoring solution.
D Retain in-house for an initial period and initiate the process of setting up a new entity, using the Public Sector Mutual model. Once the new entity is set up, the Council to retain a majority stake for an incubation period of between two and three years to allow the service to become commercially viable prior to being exposed to competition law requirements to competitively tender for business. This option relies on the employees of the organisation being willing to take collective ownership of the business (the best known example of an organisation of this type is John Lewis). To achieve this a new Public Sector Mutual, constituted as a Community Interest Company, charity or Limited Company would be created by the Council. The rules governing the setting up of Public Sector Mutuals allow a degree of flexibility in exposing the new entity to the full requirements of EU / UK competition law. Essentially this means that for an 'incubation period' of up to two years from the date of the new entity being constituted it can carry on its existing business without the need to competitively tender prior to being 'spun-out' fully and becoming subject to competition law requirements. Initial legal advice on this option suggests that the process of constituting the new entity is complex and will take around six months to complete. Further detail on Public Sector Mutuals can be provided as required.	**Strengths** • Provides the existing workforce with the opportunity to exercise a high degree of control over the running of the business; • Will not require any commissioning effort during the set up / incubation period (but see weaknesses below); • Provides assurance of continuity for service users and staff for a period of two to three years (covering set-up and incubation); • Provides assurance to the Council regarding the cost of service delivery during the set-up / incubation period; • Although during the incubation period the Council must remain as the service's primary customer, the service can begin to take on work from other customers (cash Personal Budget holders, Self-funders, other public bodies). This is part of the process of becoming self-sustaining post the incubation period; **Weaknesses** • The domiciliary care market is extremely dynamic and highly competitive. There is, therefore, a very real and significant risk that the service would struggle to win new business (and to retain existing business post spin-out). This would render its medium term sustainability in very real doubt. • Initial legal advice on this option suggests that the process of constituting the new entity is complex and will take around six months to complete; • Will require the service to be resourced to a level that enables it to manage its

	business in a self-contained way on a day to day basis as well as to provide the leadership and specialist expertise both in developing the Mutual model and in building the business to maximise the likelihood of sustainability in the longer term; • The exemption from EU / UK procurement law only extends to the set-up and incubation phase. Once that expires the service will have to tender to continue providing services under contract to LBTH in exactly the same way as any other service provider. This creates a medium-term risk regarding sustainability; • management tensions, instability and strongly divided opinions on this option within the staff group would jeopardise success of the Public Sector Mutual meaning it is very unlikely to be a viable option
E Tender for the necessary volume of activity via a new Preferred Provider Framework (separate to the currently planned process)	**Strengths** • Tender process would be straightforward.
	Weaknesses • As for the option C above, plus; • TUPE transfer (to multiple providers) would be more complicated; • Mobilisation process (involving multiple providers) would be more complicated; • Incongruity between running a new Framework tender, while the existing one remains in progress would be more marked than for running a block tender as above, leading to increased risk of reputational damage.

F Retain in-house on a long term basis on the same basis as the previous Longer Term Homecare service i.e. reducing over time as packages cease.	**Strengths** • Immediate certainty for service users and existing employees.
	Weaknesses • Inevitable cost pressures arising from assimilation of existing employees onto LBTH terms and conditions; • Increased likelihood of challenge from other recipients of commissioned domiciliary care seeking to have that care also transferred to being directly provided by LBTH; • Would be inconsistent with the decision to close down the Longer Term Homecare service, thus creating the potential for reputational damage to the council.