# DOMICILIARY CARE

<table>
<thead>
<tr>
<th>Cabinet Date</th>
<th>10 June 2015</th>
</tr>
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<tbody>
<tr>
<td>Older People</td>
<td>Cllr Dorcas Binns</td>
</tr>
<tr>
<td>Key Decision</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Background</strong></td>
<td><strong>Documents</strong></td>
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<tr>
<td>1. <em>Care and Support Statutory Guidance issued under the Care Act 2014</em></td>
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<tr>
<td>2. <em>Emerging practice in outcome-based commissioning for social care,</em> (Institute of Public Care, April 2015)</td>
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<tr>
<td>3. <em>Growing Older in Gloucestershire</em></td>
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<tr>
<td><strong>Location/Contact</strong></td>
<td><strong>for inspection of</strong></td>
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<tr>
<td><strong>Background</strong></td>
<td><strong>Documents</strong></td>
</tr>
<tr>
<td>2. Institute of Public Care (<a href="http://ipc.brookes.ac.uk/publications/index.php?absid=807">http://ipc.brookes.ac.uk/publications/index.php?absid=807</a>)</td>
<td></td>
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<tr>
<td>3. Gloucestershire County Council website</td>
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<tr>
<td><strong>Main Consultees</strong></td>
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<tr>
<td>• Health and Care Overview and Scrutiny Committee (HCOSC)</td>
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<tr>
<td>• Officers of Gloucestershire Clinical Commissioning Group</td>
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<tr>
<td>• Domiciliary Care Providers</td>
<td></td>
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<tr>
<td>• Gloucestershire Care Providers’ Association</td>
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<tr>
<td><strong>Planned Dates</strong></td>
<td>Discussions have taken place over the last 12 months and HCOSC discussed this at its meeting on 12 May 2015.</td>
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<tr>
<td><strong>Divisional Councillor</strong></td>
<td>All</td>
</tr>
</tbody>
</table>
| **Officers**       | Margaret Willcox  
Commissioning Director: Adults and DASS  
01452 328468  
Margaret.willcox@gloucestershire.gov.uk  
Gillian Leake  
Lead Commissioner  
07813 204835  
Gillian.leake@gloucestershire.gov.uk |
### Purpose of Report

This report is presented in order to seek authority for the Director: Adults and DASS to go to market for the provision of future community based personal care services, including health care when commissioned on behalf of health partners. There are two routes to the procurement of the services, one for urban areas, one for rural:

A) Urban

(i) For the urban zone provision (60% of the total), delegated authority is sought for a formal tendering process to take place.

(ii) Delegated authority is sought for the Director: Adults and DASS in consultation with the Cabinet Member for Older People to approve the tender award decision.

B) Rural

For rural zones (40% of the total), delegated authority is sought to utilise an ‘any qualified provider’ contractual arrangement.

### Recommendations

**That Cabinet:**

1) Approves the proposed model for retendering of a range of community based services that meet the needs of people within the urban zones, including 24 hour provision, Extra Sheltered Care and a Hospital Discharge Scheme, and delegates authority to the Commissioning Directors: Adults and DASS to:

   i) carry out a compliant competitive tender process and award of contracts to up to two providers (per zone) in consultation with the Cabinet Member for Older People, for the urban zone provision of community based services as set out in this report. A single provider (per zone) may be selected but only if they can demonstrate adequate capability to deliver both health and social care services,

   ii) to enter into a contract with the next willing highest placed suitably qualified provider should the preferred provider be unable or unwilling to enter into a contract with the council

2) Authorises the Commissioning Director: Adults and DASS to issue a simplified application process to build an “any qualified provider” list for the rest of the county. This will support full participation of a mix of providers.
| Reasons for recommendations | The proposed model will ensure that personal care delivered in people’s own homes can:  
|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                             | • Maintain and, where necessary, re-able older people to live independently  
|                             | • Maximise and maintain independent living for as long as possible  
|                             | • Assist in meeting needs more quickly  
|                             | • Support the achievement of identified individual outcomes  
|                             | Full reasons for the recommendation are given in section 5.  
|                             |  
| Resource Implications       | The expected value of the contracts is circa £100 million over the life of the contract. The commissioning approach aims to enable this to grow from the circa £18 million pa at present to ensure that the Council can continue to respond to predicted demographic challenges and achieve its ambition to support more people to remain in their own homes.  
|                             | Included in the spending figures is £3 million of services currently commissioned by the Council on behalf of health partners. It is likely that there will be some increase in the range and amount of such services during the contract period. These are outlined in Section 4. The amount of services actually purchased will be dependent on outcomes of individual service user assessments and whether or not the person opts for a Direct Payment or requests the Council to commission the service on their behalf.  
|                             | The approach proposed will enable a reduction in costs associated with the focus on outcomes, more integrated and joined up services and electronic call monitoring.  
|                             | A sustainable workforce will be encouraged through ongoing support to providers. In particular the model will offer providers the opportunity to reduce their core costs and overheads in order to support better working conditions for carers.  

1. Background

1.1. There are currently approximately 124,000 people aged 65 and over living in Gloucestershire. This figure has been growing by an average of 1,500 people per year over the last 10 years. As life expectancy increases, so will the number of people who live with a long term health condition such as heart disease, diabetes, stroke and dementia, which limits their lifestyle. In Gloucestershire, it is estimated that there are 8,610 people living with dementia. That number is expected to almost double over the next 20 years.

1.2. As people are living longer and with more complex needs there is an increased demand on finite care and support resources. If the volumes of service provision are applied to the predicted demographic data there would be an expectation that over the next three years demand would rise by 9.0% in day care, 9.6% in home care and 10.4% in residential care. Alongside this, it is anticipated that the national Adult Social Care funding formulae will be significantly reduced in real terms over the same period.

1.3. The number of working age people is predicted to fall over the next ten years. This means that there will be fewer people available and able to deliver the care that may be needed.

1.4. It is important that a new approach is developed to the way in which care is commissioned and delivered so that the growing range and level of need can be met in a more cost-effective manner and with due regard to the availability of resources across communities. Jointly commissioning services with health also supports better outcomes for individuals.

1.5. The Care Act 2014 sets out the principle that the core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life. Under the Act, local authorities must carry out an assessment of anyone who appears to require care and support and focus the assessment on the person’s needs and how they impact on their wellbeing, and the outcomes they want to achieve.

1.6. In the Gloucestershire Policy document Growing Older in Gloucestershire the authority set out the following aims:
   - Making less budget support more needs;
   - Keeping people safe and independent;
   - Investing in prevention to delay or avoid more expensive care support

1.7. The following commissioning intentions have been identified to achieve these aims:
   - Significantly reduce the numbers of people in residential and nursing care and significantly increase community care and support services;
   - Focus on outcomes that enable people to maintain their independence with stronger social connectivity.
1.8. Developing a home care service which links individuals into their own communities, focuses on outcomes and increases choice and control of how and when individuals receive support is one part of delivering these aims.

1.9. Analysis of historical data suggests that practice in Gloucestershire has led to older people moving into residential and/or nursing care sooner than may be necessary. Supporting people to live independently within their own homes and communities is often more cost effective and will achieve better outcomes for individuals. Avoiding permanent placements in residential and nursing care homes is also a good measure of delaying dependency.

2. The Domiciliary Care Market in Gloucestershire

2.1. Domiciliary care may be self-funded, state funded or a combination of the two.

2.2. Since October 2005 the Council has commissioned domiciliary care for older people from an approved list of thirteen independent providers. The contracted service covers the delivery of a range of personal care and support services to individuals in their own homes. The care delivered is based on carrying out tasks to meet individual needs and can range from single or multiple daily visits through to 24 hour, live-in care.

2.3. Within Gloucestershire it is estimated that there are around 100 organisations of different sizes offering home based care services in the county. However, there is variable level of provision in service delivery and geographical coverage with delays sometimes encountered in accessing packages of care for those with high needs and/or living in rural areas.

2.4. At any one time, there are around 1,600 service users receiving domiciliary care, which equates to almost 20,000 hours per week, via services that are either directly commissioned by the Council or through individual budgets.

2.5. The approved framework of 13 providers currently delivers 80% of the overall delivery. In addition, the Council undertakes spot purchase arrangements with over 70 further providers to meet the rest of these needs.

2.6. Ready usage of spot purchasing arrangements has allowed providers to sidestep the more complex home care packages such as multiple daily visits in rural locations.

2.7. The total current spend across all providers is £18 million per year, including £3 million of services commissioned on behalf of the Gloucestershire CCG. The current expenditure referred to includes some £2.8 million related to people under 65 years of age, mostly those with a physical disability, for whom this was the agreed appropriate service response.

2.8. The Framework contracts are due to end in April 2016.

3. Consultation and Research

3.1. Consultation with the provider market took place during 2014 and focused on several areas of development:
   - Balancing outcomes with the need to record and report outputs
• Linking service users into their communities
• Making caring a “career”
• Community based support in the short/medium/long term
• Models for purchasing community based care – Framework/Lead Provider/District Provider/Other

3.2. Discussions have also taken place with lead officers within GCC and Gloucestershire Clinical Commissioning Group to consider the scope of possible changes in the way domiciliary-based care may be commissioned. Discussions addressed potential impact on outcomes for service users, implications for the workforce and organisational development.

3.3. The message from the engagement activities was that the overall aim of domiciliary care services for older people should be “aspirational” in the same way as services for people with disabilities. Interventions should not focus on services in themselves but build on strengthening individual capabilities and support older people to being able to participate in the community.

3.4. To achieve these aims, providers identified a number of actions that could assist including:
• Changes to recruitment practices so that there is a dedicated workforce connected to the communities in which they work
• Move away from zero and short term contracts
• Greater partnership working between providers – shared training etc
• Embrace innovation and make full use of new technology
• Make full use of learning from the development of services within Housing, Learning Disability and Physical Disability services
• Co-production – providers, carers, community and service users and using connections within the communities

3.5. Providers made it clear that they considered it essential for the Council to have fully bought in to any model of delivery for it to be successful, including identifying a dedicated contract manager or link within the Council. They also stressed the importance of long term contracts to allow the necessary investment to be made into new approaches and fully imbed community connections.

3.6. Commissioners identified the following actions to support the development of domiciliary care for older people:
• Acknowledge that a joined up approach could be more expensive in the short term
• Rebrand domiciliary care, use more positive and language
• Recognise that culture change takes a long time and so investment needs to be made over a longer term
• Embrace innovation/new technology
• Make use of the learning from the development of services within Housing, Learning Disability and Physical Disability services
• Greater integration between health and social care focussing on outcomes based care, determined by individual service users.
• Establish practices that can recognise changes of need and react appropriately
• Clearer referral pathways to support early intervention – avoid crisis management, quicker access to equipment

3.7. Research into practice in other local authorities has shown that a range of models are in place to address their particular priorities and features of the local market. Whilst the supply solution should be unique to each authority area, they demonstrate what can be achieved and provide useful learning for Gloucestershire. Several councils have taken decisions to let contracts on a zoned basis. This allows them to work with providers in relation to the needs of local communities and assists with reducing overall costs associated with travel.

3.8. In the traditional way that domiciliary care is commissioned and procured, providers are required to deliver a certain number of hours of care each day/week and are paid at a rate for the agreed time they spend with each person. There is a growing trend among councils to move to “outcomes-based commissioning” whereby providers will work to achieve outcomes identified by individual service users that may reduce their need for longer term care.

3.9. This kind of approach does require close and regular measurement of performance. However, if fewer people need longer term care this will reduce the overall costs to the council.

4. Services within the Scope of this Proposal

4.1. Services that are covered by this proposal include the existing domiciliary care delivered through framework and spot purchased contracts commissioned by the Council, including 24 hour provision, Extra Sheltered Care and a Hospital Discharge Scheme. For 2014/15, these are valued at £18 million.

4.2. It is anticipated that under this proposal, services will continue to be delivered to people under 65 years of age, mostly those with a physical disability, for whom this is the agreed appropriate service response. However, it is likely this will decrease as the Building Better Lives initiative expands and people access the care and support contracts developed as part of the all age all disability approach.

4.3. A Section 75 agreement with GCCG is in place under which the Council purchases services on their behalf. The current £18 million of services purchased by the Council includes £3 million of services funded by health partners. Under these arrangements it is likely that up to a further £6 million of services could be commissioned by the Council on behalf of GCCG for Continuing Health Care (CHC).

4.4. This proposal does not cover the current Reablement Service provided through Gloucestershire Care Services. However, providers will be invited to indicate their ability to provide rehabilitation and improvement services in order to be able to supplement current provision.

4.5. Electronic Call Monitoring is to be introduced to cover home based care. This will allow the Council to exercise greater control over costs of care delivered as well
as supporting the monitoring of working practices including consistency of carer and timeliness of visits.

5. Proposed Service Changes

5.1. Following due consideration of the engagement and research activities, it is proposed that a new service model be developed to ensure that home based care delivered in people’s own homes can:

- Maintain and, where necessary, re-able older people to live independently
- Maximise and maintain independent living for as long as possible
- Assist in meeting needs more quickly
- Support the achievement of identified individual outcomes

5.2. Shifting to an integrated health and social care model has been recognised as providing a better base for flexible community support that aims to stabilise people in crisis (within their home) as well as reducing the risk of a crisis occurring. It is proposed, therefore, that contracts be issued which can cover both health and social care home care support. Contracts will be outcomes-focussed and person centred.

5.3. Working with a large number of providers can make it difficult to take forward changes in the shape or focus of the service, unless managed. Nevertheless, it is important to support a healthy mix of providers including large national companies as well as SMEs.

5.4. Encouraging providers of all sizes to work together as clusters is seen as an important factor in achieving greater effectiveness of cover across the whole county but particularly the more rural locations.

5.5. In order to deliver an outcome-based, flexible and sustainable model it is proposed that a differential approach to commissioning be introduced in the county. It is proposed that the county be divided into 6 zones covering urban and rural areas. The exact placement of the boundaries of each zone will be based on District Council boundaries and alignment with Integrated Community Teams.

5.6. Two urban zones will be established to cover the main urban areas of the county – Cheltenham and Gloucester. These 2 areas represent 60% of the current delivery of assessed need and usage of this service in the county, equating to approximately 200,000 hours per annum.

5.7. Recognising the concerns raised by providers, contracts for the urban zones would be issued for 5 years (plus 2). This would allow them to invest in changes that may be required for new ways of working and develop more effective practices. The contract would set out clear requirements in terms of performance and quality against which the provider would be monitored and held to account.

5.8. Contracts for the two urban areas would be delivered by one or two prime providers for each area, ensuring there is adequate capability to deliver both health and social care services. In exchange for having exclusivity for all placements within their zone, prime providers will be responsible for ensuring the delivery in that area. There would be a fixed hourly fee, inclusive of travel, for the
services provided in the urban areas. This approach will support improved rostering of care staff to maximise operational efficiency and make best use of resources.

5.9. For the rest of the county, a more developmental approach is suggested. It is proposed that a simplified application process be issued to build an “any qualified provider” list. This would support a mix of providers and allow the full participation of smaller organisations that may, effectively, be excluded from an onerous procurement process.

5.10. Zoning of the rural areas will provide a platform for managing market shaping and offering support to providers and communities. Providers will also be encouraged to engage fully with local communities to support people in their own homes for longer. Within each rural zone, providers will be invited to set their maximum usual price which will include travel (time and mileage). This supports better working practices and allows a greater proportion of carers’ time to be spent delivering care.

5.11. It is further proposed that the Council will work actively with providers in the rural zones to facilitate and support greater collaboration and co-operation and improve outcomes for service users. It is anticipated that this will, in turn, improve training and development opportunities for care staff and support the sharing of best practice.

5.12. In order to support this model, it will be necessary to collect and review performance information which can be shared with providers. This information will need to identify how well outcomes are being met for individual service users as well as how effectively providers are fulfilling the requirements of the contract.

5.13. In the urban zones, the prime provider will be required to identify solutions to any issues that performance information highlights, where this is within their capability.

5.14. In the rural zones, performance information will be considered by the whole group of providers within that zone with the expectation that they will find collaborative solutions to address difficulties.

5.15. To support this model, it is proposed that 4 dedicated Outcome Manager roles be established with clear responsibility for market development. These officers will work with providers – 1 for each of the 2 urban zones and 2 for the rural zones. They will be responsible for the monitoring of the performance information and addressing issues directly with the providers. They will also assist providers to work together to develop new services and acquire skills and capacity to respond to changing demands. In the rural zones, these officers will facilitate groupings within the zones and support the development of longer term relationships between providers.

5.16. This approach aims to provide a platform for the development of small and medium enterprises in rural or more isolated areas, provide support for smaller businesses which reflect the communities they work with and start the process of
connecting domiciliary care with existing community support, thereby facilitating the move away from time and task based delivery.

5.17. It is intended that a full review of the rural model will be undertaken after 2 years to assess its effectiveness. The review will take into account also experiences within the urban zones.

5.18. Tailoring the method of delivery in the different areas of the county aims to protect the more commercially viable markets in the two urban areas, both of which provide sufficient mass/numbers to deliver efficiencies due to the size and density of the current and potential market. Containing the size of the urban zones ensures that the offer of a fixed price including travel will support more effective rostering of care staff and allow the Council greater control over costs.

5.19. Making use of Electronic Call Monitoring (ECM) offers further potential savings and will be introduced to support this model. Experience from work within Disability services indicates that this will further support improved rostering of care staff and reduce costs for the Council. The information that can be generated through ECM will also assist work with providers to highlight quality issues and improve the experience of service users.

5.20. It is possible that TUPE may apply between providers. The Council will ensure that the successful provider(s)’ transition plan embraces this possibility.

6. Other Options

6.1. **Retain the Status Quo**

The current framework arrangement will expire in April 2016. Replacing it with the same model would mean that support would continue to be based on a time and task output basis rather than being tailored to individual needs and outcomes. There would be no incentive for providers to make links with local communities that could enhance support and enable people to remain living independently within their own home. There would be a risk that gaps in support would lead to an increase in demand for more expensive social care and health services.

6.2. **Introduce a new Outcomes-Based Framework**

This approach would not allow for the required level of engagement with providers to introduce different approaches at local level. Without a defined and discrete area on which to focus, opportunities for providers to develop wider community capacity and an understanding of the resources that may be available to support their outcome framework may be lost.

6.3. **Introduce a Lead Provider model for the entire county**

Given the size and diversity of the county, it would be very difficult for a provider to be able to achieve the understanding of community resources to be able to actively network and integrate their service users with existing local resources.
This option also represents significant risks of a lack of flexibility and of having no service at all in the event of the provider failing.

6.4. **Introduce Lead Provider for specific zones or areas.**

This option would be limiting for the more rural areas of the county. Analysis of current delivery suggests that those living in rural areas and requiring more than one visit a day are more likely to have to wait for a home care service to start. They are also more likely to be served by a smaller local provider. A mixed market in more rural areas will assist in addressing such issues by maximising the potential number of providers who are obliged to respond to the need.

7. **Risk Assessment**

7.1. The commitment of providers – both existing and potential – will be important in taking forward a developmental contract which aims to change the shape and focus of this service. Extensive consultation with the market will be vital during the tender preparation. Ongoing engagement and support of providers is a key part of the proposed model.

7.2. The absence of this commitment from providers would challenge the reshaping of existing services and may not result in the savings or outcomes that we need to achieve.

8. **Officer Advice**

8.1. It is recommended that Cabinet agree to the tendering for community based support services that meet the needs of older people within the urban zones, and an “any qualified provider” approach for the rest of the county, as described in section 4. This would make a significant contribution to realising the aims set out in the Gloucestershire Policy document *Growing Older in Gloucestershire* and the commissioning intentions that support their achievement.

8.2. Procurement of these services in the way outlined above would also achieve some of the aims outlined in the *Active Communities* and *Active Individuals* strategies. The proposed model will support contracts that connect providers to the communities in which they deploy their staff. Providers will be encouraged to extend resources to assist service users to make individual connections with their communities. In addition, providers will be able to take full advantage of existing local opportunities to develop the service capacity.

8.3. The model proposed supports the development of caring as a career. The tendering process and evaluation of providers seeking to join the Any Qualified Provider list will address a range of quality standards to ensure that services can be delivered by an appropriately trained and sustainable workforce.

9. **Equalities considerations**

9.1. An equality impact assessment has been undertaken and a Due Regard statement is attached for consideration. Changes to the way home based care is contracted for and delivered have been assessed as having a positive or
beneficial effect. This is because the changes proposed will move from a time and task focus to a more tailored response to the individual and their particular assessed outcomes. The new arrangements also take account of the individual’s community and how services help them to connect more fully with this.

9.2. Cabinet Members should read and consider the Due Regard Statement in order to satisfy themselves as decision makers that due regard has been given.

10. Performance Management/Follow-up

10.1. Each contract will include specific and measurable standards and outcomes. We are proposing dedicated named Contracts /Market Development Officers especially during the initial implementation period and change process. These officers will work with Quality Assurance to ensure the delivery follows the intended direction of travel and supports the achievement of individual outcomes. Contract performance will be managed through the collation and analysis of key performance indicators and regular meetings with the providers.
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<thead>
<tr>
<th>Report Title</th>
<th>Domiciliary Care</th>
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<tbody>
<tr>
<td>Statutory Authority</td>
<td>Care Act 2014</td>
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<tr>
<td>Relevant County Council policy</td>
<td>Growing Older in Gloucestershire</td>
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<tr>
<td>Resource Implications</td>
<td>The expected value of the contract is circa £100 million over the life of the contract. The commissioning approach aims to enable this to grow from the circa £18 million pa at present to ensure that the Council can continue to respond to predicted demographic challenges and achieve its ambition to support more people to remain in their own homes. The approach will enable a reduction in costs associated with the focus on outcomes and electronic call monitoring. A sustainable workforce will be encouraged through ongoing support to providers. In particular the model will offer providers the opportunity to reduce their core costs and overheads in order to support better working conditions for carers.</td>
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<td>Sustainability checklist:</td>
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<td>Partnerships</td>
<td>Joint Commissioning Partnership Executive and Board Better Care Fund Forum Gloucestershire Care Providers Association</td>
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<td>Decision Making and Involvement</td>
<td>Joint Commissioning Partnership Executive and Board</td>
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<tr>
<td>Economy and Employment</td>
<td>The proposed model supports the development of improved working conditions for people employed as carers. Extending home based care for more people will require increased recruitment to the care sector.</td>
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<tr>
<td>Caring for people</td>
<td>The proposed model will focus on achieving individual identified outcomes and will support people to remain in their own neighbourhoods and communities</td>
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<td>Social Value</td>
<td>A key feature of the proposed model is the establishment of zones and development of care consortiums. These will support engagement with communities and facilitate links with local resources and services in order to enhance provision.</td>
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<tr>
<td>Built Environment</td>
<td>N/A</td>
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<td>Natural Environment' including Ecology</td>
<td>N/A</td>
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<tr>
<td><strong>(Biodiversity)</strong> Education and Information</td>
<td>N/A</td>
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<td><strong>Tackling Climate Change</strong> Carbon Emissions Implications?</td>
<td>Improved rostering should negate the impact on overall mileage of an increased number of journeys by care staff</td>
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<tr>
<td>Vulnerable to climate change?</td>
<td>No</td>
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<tr>
<td><strong>Due Regard Statement</strong> Has a Due Regard Statement been completed?</td>
<td>Yes</td>
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<tr>
<td>Yes - considerations included in main body of report</td>
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<td>Alternatively a hard copy is available for inspection from Jo Moore, Democratic Services Unit, e-mail: <a href="mailto:jo.moore@gloucestershire.gov.uk">jo.moore@gloucestershire.gov.uk</a>.</td>
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<td><strong>Human rights Implications</strong> A number of the Articles of the Convention apply to the commissioning of home based care services. Of particular relevance are Article 3 (freedom from torture and inhuman and degrading treatment or punishment) and Article 8 (the right to respect for private and family life, home and correspondence). These have been considered in the development of the model proposed within this report.</td>
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<td><strong>Consultation Arrangements</strong> Consultation has taken place with providers and commissioners as described in Section 3 of this report. Following Cabinet agreement, further consultation, in association with GCC’s Consultation Team, will take place with providers and more specifically with service users. The focus of the work with service users will be to inform the structure of the outcome targets within the resulting tender documentation.</td>
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