ADULTS AND HEALTH COMMITTEE

Thursday, 12 December 2024

Democratic and Members' Services
Emma Duncan
Service Director: Legal and Governance

10:00

New Shire Hall
Alconbury Weald
Huntingdon
PE28 4YE

Red Kite Room
New Shire Hall, Alconbury Weald, Huntingdon, PE28 4YE

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1.	**Apologies for Absence and Declarations of Interest** *Guidance on declaring interests is available in Chapter 6 of the Council's Constitution (Members' Code of Conduct)*	
2.	**Minutes - 10 October 2024**	**5 - 30**
3.	**Public Questions and Petitions**	

STRATEGIC REPORT

4.	**Adult Social Care - Accomodation for Working Age Adults - Strategic Thinking**	**31 - 44**

KEY DECISIONS

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The Adults and Health Committee comprises the following members:

Councillor Richard Howitt (Chair) Councillor Susan van de Ven (Vice-Chair) Councillor Mike Black Councillor Chris Boden Councillor Steve Corney Councillor Adela Costello Councillor Claire Daunton Councillor Anne Hay Councillor Mark Howell Councillor Edna Murphy Councillor Keith Prentice Councillor Kevin Reynolds Councillor Geoffrey Seeff Councillor Philippa Slatter and Councillor Simone Taylor Councillor Corinne Garvie (Appointee) Councillor Cameron Holloway (Appointee) Cllr Keith Horgan (Appointee) Councillor Dr Haq Nawaz (Appointee) Councillor Clare Tevlin (Appointee)

Clerk Name:	Richenda Greenhill
Clerk Telephone:	01223 699171
Clerk Email:	richenda.greenhill@cambridgeshire.gov.uk

Adults and Health Committee Minutes

Date: 10 October 2024

Time: 10.00 a.m. – 4.00 p.m.

Venue: New Shire Hall, Alconbury Weald, PE28 4YA

Present: Councillors M Black, C Boden, A Costello, C Daunton, A Hay, R Howitt (Chair), E Murphy (to 2.56pm), B Goodliffe, L Nethsingha, K Reynolds (to 3.22pm), G Seeff, P Slatter and T Sanderson (to 12pm)

From 2.00pm:
Councillors C Garvie (South Cambridgeshire District Council), K Horgan (East Cambridgeshire District Council) and C Tevlin (Huntingdonshire District Council)

264. Apologies for Absence and Declaration of Interest

Apologies were received from Councillors van de Ven (substituted by Councillor Nethsingha), Prentice (substituted by Councillor Goodliffe), Taylor (substituted by Councillor Sanderson), Boden, Howell and Dr Nawaz (Fenland District Council)

The Chair announced that Will Patten, Service Director of Commissioning, was leaving the Council and thanked him for his service on behalf of the Committee. He also thanked Healthwatch for its recent summit on health inequalities.

There were no declarations of interest.

265. Minutes – 27 June 2024 and Minutes Action Log

The minutes of the meeting on 27 June 2024 were approved as a correct record and signed by the Chair. The action log was noted.

The Chair updated the Committee on action 169 ‘Major Trauma in the East of England and the Potential Establishment of a Second Major Trauma Centre in Norwich’ and stated no response had been received from the North Norwich University Hospital (NNUH). The Acting Director of Public Health informed Members that patients would be seen at either NNUH or Addenbrooke’s depending on where there was capacity and the speciality of the hospital.

A Member questioned when the in-house services report would be presented to Committee. The Executive Director for Adults, Health and Commissioning stated that the report had been received by officers and was already in the Business Plan which was approved by Full Council in February 2024. The recommendations would form

part of future decisions for committees and would be seen by Spokes. The Chair clarified that this would include firm provisions for in-house services.

A Member queried why the charging review was not listed on the agenda plan. The Executive Director for Adults, Health and Commissioning stated that a report would be brought to the December meeting.

A Member questioned why the Right Care, Right Person (RCRP) grant was not included on the action log. He requested an update and queried what the financial implications would be. The Executive Director for Adults, Health and Commissioning stated phases two and three had been launched and actions had not resulted in additional pressures on the service. If there were any financial implications, these would be reported to Committee. Officers would circulate details regarding phases two and three to Members – **action required.**

266. Petitions and Public Questions

No petitions or public questions were received.

267. Mental Health S75 Agreement Extension

The Committee received a report which sought agreement to extend, for up to two years, the existing Section 75 Partnership Agreement to deliver Mental Health Social Work Services. The extension would enable the continuation of the service whilst a strategic review of future delivery options was completed. The presenting officer provided an overview of the services that were delivered for the growing needs for mental health issues in Cambridgeshire.

While discussing the report, Members:

- learnt that work was being pursued alongside Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) as a result of recommendations from an audit deep drive. The Executive Director for Adults, Health and Commissioning highlighted that the service had extended out the question of peer support and peer challenge specifically on Approved Mental Health Professional (AMHP) provisions to the Local Government Association and Department of Health (DoH) officers. The Chair questioned the concerns mentioned from the audit from the Council's Quality and Practice Standards Team. It was noted that an overview of the deep dive could be provided through Spokes and further details would be shared outside of Committee **– action required.**

- noted that the review would ensure the model was fit for purpose now and also in the future. The service was working towards a place based approach, which would include a review of the joint management structure as the service was currently across Cambridgeshire and Peterborough. The Executive Director for Adults, Health and Commissioning stated the review, which was being conducted in partnership with CPFT, would cover the quality of care and management.

- learnt that the two older peoples social work teams (North and South) met the demand of the county.

- questioned if officers were working with the five district councils to share local contacts including Community Safety Partnerships (CSP). Members were informed about the Care Together Programme, which involved officers working with district councils to enable people with Care Act eligible needs to access services. This might require district council support to address provision for people with accommodation challenges. There would be some variation in CSPs, but work was undertaken as part of the Accountable Business Unit (ABU) and the wider Integrated Care System (ICS) approach which would look at crisis pathways and hospital discharges. There would be a review of the pilots and district councils would be involved in this.

- queried how robust the review would be. Members learnt that the 1 + 1 contract meant the review would be undertaken within 9 months to a year. The second year would allow time to work with CPFT to deliver the recommendations and allow time if there were any significant changes.

- questioned the implications of the national decision of the RCRP partnership. It was noted that there were mechanisms, such as monthly meetings, in place to monitor any possible implications. The Executive Director for Adults, Care and Commissioning highlighted the importance of the RCRP partnership. Police would still respond to those in crisis, however the partnership aimed to ensure that the most appropriate specialist services helped those in need.

- gained assurance that progress had been made with Deprivation of Liberty Safeguards (DoLS). The figure had decreased from 1,100 in September 2023 to 800 in August 2024; additional efforts were necessary to further reduce these numbers.

The Chair highlighted the Committee's confidence in the working relationship with CPFT and welcomed the review. He noted that this was the third extension of the contract and commented that a review should have been undertaken previously. He explained that the £500k given to mental health services was used to support those in need in Cambridgeshire

It was resolved unanimously to:

a) Approve the extension of the existing Mental Health Social Work Section 75 Agreement for 2 years on a 1+1 basis from 1 April 2025 at a total value of £1,250,090 per annum. This represented £2,500,180 for the total contract period and would be adjusted for future inflationary uplifts agreed as part of the established business planning process.

b) Delegate authority for awarding and executing of any subsequent extension periods to the Executive Director for Adults, Health, and Commissioning, in consultation with the Chair and Vice Chair.

268. Drug and Alcohol Treatment Services Additional Grant Funding

The Committee received a report which detailed the impact of the potential ending or reduction in the additional grant funding for Drug and Alcohol Services at the end of March 2025. The grant had led to positive improvements in service user outcomes. The Acting Director of Public Health stated the ending or reduction in the funding would undermine these positive outcomes. The average time for people to complete treatment in the Drug and Alcohol Services was five to six years due to their complex needs. The ending or reduction in funding would mean it would be difficult for these service users to complete their treatment.

The Chair stated that he had asked for the report to be added to the agenda and had asked for a press release. He proposed an amendment, seconded by Councillor Nethsingha, to add the following recommendation, which was accepted unanimously:

> commit Cambridgeshire County Council to make full representations in support of the Association of Directors of Public Health efforts to secure central Government commitment to maintaining the additional drug and alcohol grant funding.

While discussing the report, Members:

- learnt that prevention was taught in schools in Personal, Social, Health and Economic education (PSHE). The additional funding was only for treatment and did not encompass prevention work. Members were informed about the Cambridgeshire Child and Adolescent Substance Use Service (CASUS) provided by CPFT.

- noted the importance of the additional funding as it enabled people to live independently but also alleviated pressure on health and social care services (especially in Accident and Emergency (A&E)), and other services for example the police and the criminal justice system. The Member asked officers to work with partnering services to lobby central government – **action required.** The Acting Director of Public Health highlighted the work with Cambridgeshire and Peterborough Drug and Alcohol Delivery Board and the High Harms Board. Members noted that the Integrated Care Board (ICB) had expressed concerns about the subsequent impact on A&E.

- highlighted the pressure on the criminal justice system; low level crimes were often committed to fund addiction. It was acknowledged that people needed to be offered specialised help to overcome addiction.

- learnt that Councillor van de Ven had visited Change Grow Live (CGL) projects and described the service as ‘raw and necessary’.

  The Chair stated that 3000 people used the service and the grant provided in 2024/25 approximately £2 million of a £7 million programme. Death from drugs had increased since the wave of synthetic opioids. This grant allowed the service

to be extended to try and reach hard to reach groups, especially homeless people.

The Acting Director of Public Health was asked to circulate a graph to Committee members to clearly show treatment services outcomes **– action required.**

It was resolved unanimously to:

a) Commit Cambridgeshire County Council to make full representations in support of the Association of Directors of Public Health efforts to secure central Government commitment to maintaining the additional drug and alcohol grant funding.

b) Support the proposed actions for mitigating the associated risk.

269. Finance Monitoring Report

The Committee considered a report which provided an update on the financial position of the Adults, Health and Commissioning Directorate (including Public Health) as of the end of August 2024. The presenting officer introduced a forecasted underspend for year-end. Attention was drawn to the Older People service position and difficulty in forecasting demand, debt and the use of Public Health reserves.

Members learnt that contingencies were in place for grant reductions in Public Health. 1% of the grant, £300,000, was set aside alongside some uncommitted grant money. It was anticipated some of the Public Health in year underspend of £400,000 would be set aside for the Drug and Alcohol services to continue, however this might not be needed if the grant continued.

While discussing the report, Members:

- learnt that the budget was set by the best estimates and forecasts at the time, however the trend data had shifted. Forecasting was a complicated process which included numerous factors such as the expected number of people who might enter the system. The Executive Director for Adults, Health and Commissioning explained that since the end of the pandemic, historical data could not be relied on to try and understand and predict service demands. Other local counties were facing significant adult social care pressures, so the service was testing factors affecting neighbouring counties against current assumptions to better understand the current position and to inform future projections.

- asked how easy it was for people to access services and the impact of finances on this access. The Executive Director for Adults, Health and Commissioning stated that the number of people accessing the service were consistent to previous years, however the deep dive would focus on the different pathways. It was noted that higher numbers of individuals had made initial contact compared to other local councils, indicating that other councils had a more robust early intervention programme.

- noted the challenges of forecasting were reflected in the lower number of people accessing Older People's services but a higher number accessing Children services.

- highlighted that reserves could only be spent once; while they provide security for a year, reserves were not a long-term solution.

- questioned if there was a demographic issue with older people who previously had an asset in the form of a council house which had helped them independently pay for their care, but who might need access to council social care in upcoming years. Officers agreed to look into the national data – **action required.**

- learnt the black RAG ratings usually referred to work streams for diagnostic work with no current outcomes but were expected to deliver in future years.

The Chair looked forward to the debt management report to be presented to the December meeting and wished to see the analysis of the balance of efficient and effective collection of revenue with a greater degree of sensitivity on anti-poverty measures. He reported that £17m of the £27m outstanding debt with Health partners had been agreed to be paid. He highlighted his interest, alongside the Vice-Chair, in the Care Together Vision and the work with local microenterprises to support social care at a local level. This had been a successful part of the Joint Administration's aim to localise care services, create employment and a consistent quality of care. It was the role of this Committee to ensure that older people were able to access services particularly as Age UK showed evidence of unmet needs within the county.

It was resolved unanimously to:

a) Note the Adults, Health and Commissioning Finance Monitoring Report as at the end of August 2024.

b) Endorse the use of up to £400k of Public Health reserves to support the mitigation of risks if Drug and Alcohol grants end in March 25, subject to the agreement of Strategy, Resources and Performance Committee.

270. Adults Corporate Performance Report Quarter 1 2024-25

The Committee received a report which provided an update on the performance monitoring information for the 2024/25 Quarter 1 from 1 April to 30 June. Attention was drawn to the improvement of safeguarding indicators, the successful outcomes of reablement and the continued work to improve direct payments.

While discussing the report, Members:

- learnt that the previous quarter figures were the position at the end of the previous year, which potentially could be a cumulative number so did not present the figures in the clearest way. Officers agreed to review this – **action required.**

- noted that officers were investigating why people were ending direct payments. Members were reassured that it was a small number of people, but it was being reviewed as part of the Care Quality Commission (CQC) assurance visit. The last five packages that were closed through direct payments were largely packages of support, typically for those not over 65, and it was due to the stress of not knowing if the personal assistant (PA) would turn up or what would happen if the PA was ill. Work was being done with commissioning to see how self-directed support could be moved to an alternative support to still meet people's needs.

- learnt that the indicators were part of the Performance Framework. A new Performance Framework would be presented to the next Strategy, Resources and Performance Committee which would provide the opportunity to review the indicators.

- questioned why the age 65 was chosen for indicator 235: '% total people accessing long term support in the community aged 65 and over'. Members were informed that the DoH and statutory reporting were split into working age adults and then 65 +. Officers agreed to feedback to the DoH that the working age had increased.

- questioned if the high number of contacts and low numbers of provision were due to people not receiving help when they were eligible. Members learnt there were effective early intervention services such as Adult Early Help and Technology Enabled Care so people might be getting the help they need without the need for a full care and support plan.

The Chair thanked officers for their reablement work but highlighted the continued problems with direct payments. Although the Council was underperforming compared to other counties, it was committed to making improvements. The Executive Director for Adults, Health and Commissioning reported that the service wanted to address how to make people feel more in control with direct payments. He highlighted the need to treat the figures for other councils cautiously due to differing approaches. In response, the Chair welcomed the improvement in the timetable for assessments and commended officers' honesty that there was still more work to be done. He welcomed the 2000 carers conversations but queried the quality of the conversations.

It was resolved unanimously to note the performance information and act as necessary.

271. Public Health Performance Monitoring Report – Quarter 1 2024/25

The Committee received a report on the performance of the main Public Health commissioned services for Quarter 1 2024/25. Attention was drawn to NHS Health Checks, Healthy Child programme and Stop Smoking services. The Acting Director of Public Health informed Members on the new national additional funding which had been allocated to local authorities for expanding and developing stop smoking and the wider tobacco control services. Approximately 11% of people in Cambridgeshire smoked, however rates of smoking were higher in some groups, notably the homeless, those who misuse drugs and alcohol or have a mental health condition.

Therefore, Public Health would embed stop smoking support into these services accessed by these groups.

While discussing the report, Members:

- questioned the success of the Fenland Stop Smoking programme. It was noted that the Fenland project was a pilot project, which was delivered within the Closer to Communities programme. The Fenland initiative involved the Ferry Project, a longstanding service for the homeless in Fenland. The Acting Director of Public Health hoped to have results within four to six months but emphasised that it would not be a quick process as these were challenging groups to support.

- questioned if the percentage of those who did not access the Healthy Child Programme (indicators 59 and 60) were specific groups of people. The Acting Director of Public Health stated it was difficult to capture all families and the most common cause was that some families were not at home when the check was scheduled. It was noted that how appointments were offered would be reviewed to enable access.

- queried if 'ghost patients' could be a contributing factor to the Healthy Child Programme indicator 62. The Acting Director of Public Health noted the movement of people in and out of the county which could contribute to this and would enquire if work had been undertaken to review this – **action required.**

The Chair congratulated officers on the improvements in health checks and the importance of the preventative health approach. He questioned how the service had overcome the pressure placed on GPs and asked a question on behalf of the Vice-Chair of what had been learnt from this. The Acting Director of Public Health stated that although GPs were under pressure, GP Federations had been commissioned to deliver stop smoking services in practices and this had increased NHS Health Check activity. Members learnt that a GP Federation was a group of general practices or surgeries which formed an organisation entity to work together within the local health economy to share responsibility for delivering patient-focused services. The Health Behaviour Change Services had been asked to work in a different way to help alleviate pressure on GP practices. Members also learnt about additional funding for digital technology to support health checks.

The Acting Director of Public Health continued to work with the NHS. The NHS had their own stop smoking programme, Treating Tobacco Dependency that worked within the acute units, mental health inpatients services and maternity services. Patients who smoked or started a quit attempt whilst in hospital, were referred to Council commissioned services within the community when discharged from hospital. The Acting Director of Public Health expressed concern for smoking at time of delivery rates which were higher than elsewhere in the region and reported that the ICB had been asked to do a deep dive into this.

It was resolved unanimously to:

a) Acknowledge the performance and achievements.

b) Support the actions undertaken where improvements are necessary.

272. Adults, Health and Commissioning Risk Register Update

The Committee received an overview of the risks in relation to Adults, Health and Commissioning, which also included Public Health.

While discussing the report, Members:

- questioned if there were any care home services causing concern in relation to Risk 6. The Executive Director for Adults, Health and Commissioning reported that the Council had strong relationships with care providers. It was noted that one service in Fenland had given notice to close, but support would be given to those affected and the Council was engaged with the landlord and Fenland District Council.

- expressed concern regarding Risk 10 and the lack of funding. The Executive Director for Adults, Health and Commissioning acknowledged the importance of listing this risk. The risk was monitored by comparing the directorate's performance against the budget to assess and ensure the risks were correctly evaluated.

- queried how the success or achievements would be assessed in relation to Risk 5 to change the direction of travel. Concern was also raised regarding whether this risk had been sufficiently reviewed. The Executive Director for Adults, Health and Commissioning agreed to review the risk, and the terminology used – **action required.**

- questioned if the risk rating for Risk 3 should be higher. The Executive Director for Adults, Health and Commissioning reported that there were three main unresolved areas, one of which was the future integration of the Learning Disability Partnership (LPD). He hoped to have confirmation of the integrated position by the end of the week and formal notice would be given to CPFT. The ambition would be to continue to work with CPFT with joint arrangements. Packages were fully funded under the continued health care rules for a joint funding arrangement. Joint funding arrangement reviews were challenging, and some cases would potentially be escalated to NHS England. The risk assessment focused on those joint funding arrangement cases that were in dispute after the end of the section 75 agreement. The best outcomes for those in receipt of the packages was the priority. The risk rating would be reviewed – **action required.**

- highlighted that private health care providers had asked their staff to increase their professional indemnity insurances. It was queried how the Council was indemnified. Officers agreed to clarify this in regard to social care services - **action required.**

The Chair thanked the ICB for its recent webinar. The Chair and Vice-Chair highlighted that the Council needed to be self-critical to ensure the systems were working with health partners and the Integrated Care System.

It was resolved unanimously to note the updated Adults, Health and Commissioning Risk Register, which included Public Health.

273. Adults and Health Committee Agenda Plan, Training Plan and Committee Appointments

It was agreed to add the charging review to the agenda plan for December – **action required.**

While discussing the training plan, a Member requested more notice for training sessions.

The Committee noted that the Executive Director for Adults, Health and Commissioning, in consultation with Spokes, had appointed Councillor Taylor and Councillor van de Ven to the Northwest Anglia NHS Foundation Trust Liaison Group.

Members noted that Councillors Garvie (South Cambridgeshire District Council), Holloway (Cambridge City Council), Horgan (East Cambridgeshire District Council), Dr Nawaz (Fenland District Council) and Tevlin (Huntingdonshire District Council) were co-opted for the Health Scrutiny Session.

The Chair highlighted the importance of considering strategic items at meetings. In response, the Leader of the Council suggested that it was for the Committee to decide its agenda plan. Other Members acknowledged the need for strategic, for information, reports to be included in future agendas. The Executive Director for Adults, Health and Commissioning asked for this topic to be an action so officers could better understand and be clear of the scope of papers that would be brought through the process.

It was resolved to:

a) note the committee agenda plan

b) note the committee training plan

c) note the appointments of Councillors S Taylor and S van de Ven to the North West Anglia NHS Foundation Trust Liaison Group by the Executive Director for Adults, Health and Commissioning in consultation with Adults and Health Committee Spokes on 9th August 2024.

d) appoint the following city and district councillors as non-voting co-opted members of the Adults and Health Committee for health scrutiny business only for the municipal year 2024/25:

- Cllr Corinne Garvie, representing South Cambridgeshire District Council
- Cllr Cameron Holloway, representing Cambridge City Council
- Cllr Keith Horgan, representing East Cambridgeshire District Council

- Cllr Dr Haq Nawaz, representing Fenland District Council
- Cllr Clare Tevlin, representing Huntingdonshire District Council

The meeting was adjourned between 1.00pm and 2.00pm.

Health Scrutiny

274. Maternity Services at Cambridge University Hospital Foundation Trust

The Committee welcomed Roland Sinker CBE, chief executive of Cambridge University Hospitals NHS Foundation Trust (CUHFT); Dr Kanwal Moar, Divisional Director for Women and Children's Services; and Caroline Tyrrell-Jones, Communities Programme Manager at Healthwatch Cambridgeshire. The Children and Young People Committee Spokes had also been invited to take part in the session.

The scrutiny session had been prompted by the Care Quality Commission (CQC) inspection of maternity services at Addenbrookes and The Rosie - 11 May 2023. At that time, the hospital was rated as Good overall, but with maternity services rated as Requires Improvement. The Committee had felt it was right to allow the Trust time to address the issues raised by the CQC before inviting them for public scrutiny, but had been in regular contact with Mr Sinker through liaison group meetings. The CQC's inspection of The Rosie had been carried out in the context of a national maternity services inspection programme which had identified concerns at a national level around maternity services.

Councillors Howitt, Black, Murphy and Tevlin had accepted an invitation to the committee to carry out a pre-scrutiny visit to The Rosie Hospital the previous week. The Chair extended his thanks to the Trust for offering this opportunity which he felt had been a great success, enabling an open and respectful conversation which would help inform the public scrutiny session.

Introducing the Trust's report, Mr Sinker echoed the Chair's comments around the value of the site visit. The two main areas of challenge currently facing the Trust related to urgent and emergency care and maternity services, although he judged that these were not on the scale of the challenges faced previously by the Trust in 2015/16. At the heart of the issue was the number of staff members and how they worked together to deliver the best service to patients. Significant progress had been made in relation to safeguarding training.

The Healthwatch Cambridgeshire representative advised that their organisation worked alongside Mr Sinker and The Rosie Maternity and Neonatal Voices Partnership. This was an important patient voice group and it enjoyed a productive relationship with CUHFT. They advised that the Trust was encouraging the involvement of people from diverse backgrounds

The Committee had identified four key lines of enquiry in preparation for the scrutiny session, and members' questioning focused on these areas:

1. Safety

- Appendix 1 stated that 90% of patients were seen by a doctor within four hours, and clarification was sought about whether all patients were seen by a clinician within four hours. Dr Moar stated that the CQC had offered challenge to the Maternity Unit's previous triage process. In response, a new key performance indicator (KPI) had been established of an initial response within 15 minutes. However, this remained a work in progress due to staffing levels. All delayed patients were assessed for harm, and no issues of harm had been identified. The successful recruitment of six additional junior doctors would support further improvement on this, but the issue would not be fully resolved until the consultant levels were also fully staffed.

- noted that the report stated that safeguarding training was compliant with a Trust target of 90%. However, national guidance required effective safeguarding training for all staff. Mr Sinker stated that safeguarding training rates had improved since 2023. Challenge had been offered around the rigour and depth of safeguarding training and the Trust was looking at that, including the level of the training target. He offered an update on this when the issue was resolved.

- sought clarification of the key issues which the Trust's maternity services action plan was seeking to address. Mr Sinker stated that the two main issues were speed of response, which was dependent on whether there were enough doctors and midwives to deliver timely triage, and culture and whether people were working well as a team. This could be hard to achieve if staff felt understaffed and under pressure. Subsidiary issues included training and levels of engagement with patient groups.

- noted that two 'red flag' events had occurred between October 2022 and March 2023 when a midwife was not able to provide continuous one-to-one care and support during established labour. Dr Moar stated that outcomes for the service remained strong. The hospital supported between 500-550 births per month. One red flag event had occurred around 1:1 care during labour. In response, additional staff had been added at supernumerary level since then and there had been no reoccurrence of this. Staff constantly monitored that the unit was in a safe position and patients could be diverted to other hospitals if needed.

- asked whether a lot of data was being collected, and the effectiveness of getting feedback on data and practice. Mr Moar advised that over 200 audits were carried out each year to demonstrate safe practice which generated a lot of data. Staff did feel somewhat demoralised by the level of data being collected and the Trust was trying to rationalise how data was collected and used.

- asked whether out of hours staffing was an issue. Dr Moar advised that patient flow could be predicted quite well, and staffing models were built around that. The staff establishment was at birthrate plus levels, but staff still felt under pressure so this was being looked at again. There were separate antenatal, delivery and post-natal areas and staff were assigned to each.

2. Workforce

- asked how CUHFT's vacancy rates compared with equivalent hospitals and national figures. Dr Moar explained that surrounding Trusts were experiencing similar workforce challenges. In response to high vacancy rates post-covid the Trust had looked to recruit staff both locally and from overseas. Currently, the Trust was around 7% below its establishment figure, and it was aiming to reduce this to around 5%. There tended to be higher rates of leavers in maternity services compared to the rest of Trust. Midwives required 50+ hours of training per year, and the way this was delivered had been changed to blocks of a week so that they would not be called away to fill rota gaps. Following the CQC report the Trust had reviewed its staffing model and increased its establishment baseline. Six new junior doctors had been recruited and two rounds of consultant recruitment had been undertaken to recruit six new consultants. Not all of the new consultant posts had been filled to date, but more interviews were planned and it was hoped to fill the remaining vacancies in the next three to four months.

- asked what additional steps were taken to help staff from overseas to find accommodation and acclimatise. Mr Sinker explained that a large percentage of CUH staff came from overseas. Help was provided to find their initial accommodation and to involve and celebrate them within the staff team, but while the support currently provided was solid there was scope to do more both as a Trust and collectively with partners in relation to affordable housing for key workers, transport to schools and cost of living pressures. Addressing these issues would help support staff retention.

- asked how more people could be attracted to working within maternity services at The Rosie. Dr Moar stated that it was known that medical professionals tended to practice either in the area where they trained or to return home to pursue their career. The East of England had fewer trainees within its population so there was a push to bring more training posts into the region through lobbying both Royal College of Medicine and Government.

3. Service Users' Feedback

- noted that the revised version of Appendix 2 which contained feedback scores from the Friends and Family Test (FFT) still had the figures for December 2023 missing. They were concerned that incomplete data had been submitted twice which raised concerns around oversight and supervision. The scores for 2024 also seemed to be getting worse. Mr Sinker apologised and undertook to provide the complete set of figures together with further detail around what may lay behind the deterioration in scores.

- asked what constituted satisfaction scores in relation to the FFT. Mr Sinker explained that the Trust tried find as many different indicators as possible to support a good dialogue with patients, looking not just at clinical care but more broadly at patient experience. Complaints and Freedom To Speak Up (FTSU) provided powerful forms of feedback. The Trust worked also closely with The Rosie Maternity and Neonatal Voices Partnership to identify areas of focus.

- asked about interpretation services. Dr Moar advised that this issue had been raised by the CQC. Face to face interpretation services were available for booked appointments, and staff had access to Language Line by phone and video as needed. Feedback from both service users and the midwifery team was that this was helpful to support communication.

- asked if there was space for service users who needed a bit more support to stay longer. Dr Moar stated that there was enough space at The Rosie, but it could sometimes be tricky to manage it. The Rosie did not discharge patients until they were ready to leave, and that staff looked at their wider readiness and not just medical considerations. The number of births at The Rosie had stayed broadly the same over time, but this might increase as the wider population increased. Within this number more patients were being seen who needed caesarean sections or additional medical care and the Trust was looking at transitional care for those who needed it, but this was reliant on staffing. Mr Sinker stated that there was a need to work collectively around the wider care model. Additional hospital beds were needed on the biomedical campus and improvements for patients had been seen where these were in place.

- asked how easy it was for a patient or a member of their family to complain, and how this could be done. Mr Sinker stated that there were multiple routes available to give feedback. These included responding to the Friends and Family Test, via the Patient Advice and Liaison Service (PALS), letters, patient groups, public meetings and the Board of Governors. This feedback was triangulated with the feedback received from staff, who also had multiple feedback routes.

4. Partnership working

- noted that the maternity service offered by the North West Anglia NHS Foundation Trust (NWAFT) had been rated as Good and asked what partnership working was in place to take learning from this. Dr Moar stated that CUHFT worked closely with NWAFT, and the Directors of Midwifery of both Trusts were part of an East of England group. CUHFT also benchmarked itself against other Trusts and took learning from hospitals that had good outcomes where CUHFT was experiencing challenge. Most of this engagement was at senior leadership level as it was about the implementation of process, and the learning was then shared with staff teams.

- asked about attitudes to women's health in the NHS. The committee was told that £25m had been ringfenced for women's health hubs some years ago, but that in the East of England the conversations around this had not really started. This issue sat at Integrated Care System level rather than with individual Trusts.

The Chair stated that a lot of information had been covered, and that the aim of the session was to give confidence to women and families using The Rosie. Mr Sinker stated that he would have preferred The Rosie to have been rated Good by the CQC as that was what the Trust wanted and expected for its service users, but that it welcomed the scrutiny and opportunity for learning. This included learning that there was a need to move faster and do better. The challenge was not at the scale seen in 2015/16 or of some of the issues being seen in maternity services elsewhere in the

country. However, the challenges around the two major issues of staffing and culture were being taken very seriously and there was no complacency.
The Chair commended the Trust's representatives for their openness. Summarising the discussion, he highlighted:

- the high level of complexity around maternity services, and that the efforts made by CUHFT to improve staffing levels were bearing fruit and were likely to reach target.

- the efforts being made by CUHFT to ensure patient safety across the service, and commended the now higher than average performance in relation to post-partum haemorrhage rates.

- a recommendation that the Trust adopt a target figure of 100% on safeguarding training.

- the Trust's continuing efforts in relation to the culture of team working, recognising that CUHFT staff reported that they felt that they were working under pressure.

- the importance of the timely and open transmission of data, but with a recognition of the attempts being made to balance data monitoring requirements with service provision.
- the welcome work done to date in relation to triage, but noting that 20% of patients due to be seen within 15 minutes were being seen after an hour. The Trust was encouraged to continue efforts to address this.

- the clinical training programmes already in place to train new staff, but also the need for higher numbers of students studying obstetrics and gynaecology both regionally and nationally.

- mutual objectives in relation to workforce quality and retention on issues around affordable housing, transport to school and cost of living issues and encouraged a partnership approach to learning and trying to address these issues.

- the efforts being made to increase access to interpretation services.

- that issues around satisfaction levels did not always accord with CUH's results in terms of medical outcomes, and encouraged further efforts in relation to satisfaction levels.

- the commitment to delivering services in the context of new models of care.

- the practice of ring-fencing the use of beds within the maternity services department.

- the action being taken in relation to red flag events, and recognises that there has been an extended period free from any such events.

- the findings of the Ockenden Review of Maternity Services at Nottingham University Hospitals NHS Trust, and the Trust's continued efforts. Any recommendations made by the Committee should be viewed in the context of that report and of national challenges to services.

- accepted the offer of a revised Appendix 2 containing a complete set of figures for the Friends and Family Test score and further detail around what might lay behind the deterioration in scores during 2024.

- that progress within the region and the local integrated care system in implementing women's health hubs had stalled should be re-visited in terms of providing an equitable approach to the treatment of women's and men's health.

It was resolved unanimously to delegate authority to the Democratic Services Officer, in consultation with Committee Spokes, to produce a summary of the committee's feedback and recommendations, and to send these to the relevant parties.

Councillor Murphy left the meeting at 2.56pm. Councillor Reynolds left at 3.22pm.

275. The Redevelopment of Hinchingbrooke Hospital

The Committee welcomed Deborah Lee, Senior Responsible Officer (SRO) for the Hinchingbrooke Hospital Redevelopment Programme and Louis Kamfer, Deputy Chief Executive of Cambridgeshire and Peterborough Integrated Care Board (ICB), to the meeting. Caroline Tyrrell-Jones remained, representing Healthwatch Cambridgeshire.

Councillors learned that 75% of the existing buildings on the Hinchingbrooke Hospital site were affected by reinforced autoclaved aerated concrete (RAAC). A comprehensive inspection regime was carried out to ensure that they remained safe for use. RAAC schemes did not form part of the Government's review of the hospital building programme and confirmation had been received in writing that the Hinchingbrooke redevelopment project would go ahead. The strategic outline case did not include the full vision for the campus described at the previous scrutiny session in March 2022 as that was not within the funding envelope, but work in support of that vision would continue with partners, including looking at opportunities around skills and learning and key worker housing, however, each scheme would need to bring its own funding stream. The redeveloped site would be a smart hospital and so would draw on digital innovation to advance safety and quality of care. The redevelopment team had engaged widely with patients and partners, including Healthwatch, and welcomed feedback on how best to involve councillors, patients and partners. Different ways of working were already being introduced including 192 patients currently being cared for in a virtual ward who would previously have been in an acute hospital bed. Approval of the strategic outline case had recently been received by the Trust Board and ICB and had been subsequently submitted to NHS England and the New Hospitals Programme (NHP), but the Government's aim to exit all RAAC hospitals by 2030 remained a challenging target. Significant modelling work was being undertaken around the demand pressures

anticipated over time given the population growth in Cambridgeshire and how the wider health and social care system worked together, with hospital care being just one aspect of that. This had been highlighted in the recent Darzi report.

The Committee had identified three key lines of enquiry during its pre-scrutiny preparation: safety, programme format and the consultation process and service-users' feedback. Members' questioning focused on these areas:

1. Safety:

    - asked for more information about how service delivery would be maintained during the rebuilding programme. The SRO explained that the Hinchingbrooke site was quite large, so it was possible to build on the southern corner of the site without encroaching on the existing hospital site. This meant that there would be no impact on services. Some parking provision might be lost, but staff would be supported to park off site so that parking provision for patients was maintained.

    - asked about the impact of the redevelopment on Hinchingbrooke Road and the nearby police station and ambulance services. The SRO advised that there would be a number of temporary road provisions and changes to access and egress points. Work was also being undertaken to re-think traffic movements into, out of and around the site as part of the redevelopment. Local blue light routes would be protected during the works.

    - asked about the potential impact of the expansion of Hinchingbrooke Hospital on new and existing hospitals in the county. The Deputy Chief Executive of the ICB stated that Hinchingbrooke would be treating a different cohort of patients to the planned Cambridge Children's Hospital and Cambridge Cancer Research Hospital. Across the wider integrated care system there was a significant shortfall predicted in the number of hospital beds and other health service capacity so system partners needed to work together on this.

2. Programme format:

    - asked what elements of the programme would be cut if it became necessary to reduce the scope of the redevelopment. The SRO explained that the programme submitted to the Treasury contained multiple contingencies based on extensive risk analysis. Beyond that, a system-wider conversation would be needed. At present it was planned to have more beds and larger rooms. To preserve the number of beds in a scenario of budgetary pressures, it might for example be necessary to make the rooms smaller, but they would still be a significant improvement on the current accommodation. However, provided that the hoped for funding was available they were confident the project could be delivered to the plan.

    - asked how plans to demolish the existing residential accommodation would impact on recruitment. The SRO explained that the existing accommodation would be vacated by autumn 2025. A reduced amount of temporary accommodation would be provided in the interim, but it was hoped that by

2030 additional accommodation would be available. A clear policy was in place about how the temporary accommodation would be allocated, including providing three months accommodation for new staff joining from overseas. There would be no permanent loss of provision, and they were confident that the impact could be managed.

- asked about plans to include affordable housing to support staff retention in the longer term. The SRO advised that they had been in touch with Huntingdonshire District Council about this. Models elsewhere in the country did not typically involve a capital contribution from the NHS, but was more likely to take the form of a contribution in kind in terms of excess land. Encouraging others within the wider public and private sectors to be part of the solution was very much part of the vision, but it would be important to talk to a range of stakeholders about what would add the most value to the campus. There might be alternative sites that would offer a better option for affordable housing. Around 45% of NHS staff in the region said that the cost and availability of housing was a key factor when considering where to work.

- asked what the new model of care would mean for service users in practical terms. The Deputy Chief Executive of the ICB spoke of the opportunities which now existed to understand patient risk at an individual level and to proactively mitigate this in new ways. For example, the ICB was working closely with the Public Health team around the prevention of cardiovascular disease which would preserve longer periods for individuals in better health and delay or reduce their need for acute care. It would not be possible to build enough hospital beds for the ageing demographic, so there was a need to radically shift the model of care to change the demand for healthcare. It was well known that many people in end of life care would prefer not to be in hospital, and new technology might be able to make a fundamental change to enable this. Providing new models of care offering different choices would also help address health inequalities by enabling people to engage with services in different ways.

3. Consultation process and service users' feedback

- asked how patients would be involved in the design of the new hospital, and particularly the urgent and emergency care department. The SRO stated that the value of involving patients in the design phase of the project was recognised. During RIBA stage 2 the project team would be seeking to engage patients and younger people who would be the service users of the future, as well as with the Council of Governors.

Summarising the discussion, the Chair highlighted:

- confirmation from the new Government that the redevelopment of Hinchingbrooke Hospital would proceed due to the existence of substantial quantities of RAAC.

- the proposals to make the new building a smart hospital at the leading edge of digitisation.

- the importance of continued engagement with stakeholders and local residents, and welcomed the efforts being made to engage with young people and those in hard to reach groups.

- the challenging timetable for the redevelopment of Hinchingbrooke Hospital by the target date of 2030, and encouraged the programme development team to be open and transparent around contingency planning or modifications to the programme design if that was required.

- the interim measures to try to minimise disruption to service users, staff and local residents during the redevelopment programme and to ensure their safety. This included the provision of temporary off-site accommodation for staff, protecting blue light routes and prioritising parking provision on site for service users.

- the assertion that 45% of local NHS staff said that housing was their biggest problem. The Committee encouraged efforts to identify land that could make a meaningful contribution to efforts to deliver affordable housing provision, either on the NHS estate or elsewhere.

- the wider vision around the development of the Hinchingbrooke Hospital campus.

It was resolved unanimously to delegate authority to the Democratic Services Officer, in consultation with Committee Spokes, to produce a summary of our feedback and recommendations, and to send these to the relevant parties.

276. Health Scrutiny Work Plan

Officers had been tasked by Spokes to identify a suitable topic for a second health scrutiny item at the December committee meeting. The Executive Director for Adults, Health and Commissioning advised that there were on-going concerns around urgent and emergency care within the county and this issue had been highlighted in NHS England's recent annual assessment letter to the Integrated Care Board. It was agreed unanimously with the consent of the meeting that this item should be added to the scrutiny work programme for December.

Committee members reviewed the proposed arrangements to develop an annual health scrutiny work programme for 2025/26. Officers were asked to identify a revised date for the December health scrutiny pre-meet.

It was unanimously resolved to:

a) review the health scrutiny work programme for the remainder of 2024/25 (Appendix 1)

b) agree to the arrangements proposed to develop an annual health scrutiny work plan for 2025/26

277. Health Scrutiny Recommendations Tracker – October 2024

The Health Scrutiny Recommendations Tracker was reviewed and noted.

[Chair]

Adults and Health Committee – Minutes Action Log

Purpose:
To capture the actions recorded in the minutes of Adults and Health Committee meetings and report responses.

Minutes – 7th March 2024

Minute No.	Report Title	Lead officer	Action	Comments	Status
240.a	Finance Monitoring Report – January 2024	Patrick Warren Higgs	The Committee requested a specific session for the committee on workforce.	To propose this as a topic as part of Members' development sessions.	In Progress

Minutes – 27th June 2024

Minute No.	Report Title	Lead officer	Action	Comments	Status
263.b	Adult and Health Committee agenda plan, training plan and committee appointments	Patrick Warren - Higgs	The Executive Director: Adults, Health and Commissioning acknowledged that there would be further discussions on commissioning and timings at Spokes.	PWH to pick up with the Chair and Vice Chair prior to the committee meeting to update from the Chair and Vice Chair meeting.	In progress

Minute No.	Report Title	Lead officer	Action	Comments	Status
263.c	Adult and Health Committee agenda plan, training plan and committee appointments	Patrick Warren-Higgs	Officers stated that there was ongoing work on a revising the training plan. A member queried when the care together training would take place and whether this would be authority wide. They also requested some training ahead of the charges review.	PWH to pick up with the Chair and Vice Chair.	In progress

Minutes – 10th October 2024

Minute No.	Report Title	Lead officer	Action	Comments	Status
265.	Minutes – 27 June 2024 and Minutes Action Log	TBC	To circulate details of Phases 2 and 3 of the Right Care, Right Person (RCRP) grant to committee members.		
267.	Mental Health S75 Agreement Extension	Shauna Torrance	An overview of the audit deep dive should be provided to Spokes.		

Minute No.	Report Title	Lead officer	Action	Comments	Status
268.	Drug and Alcohol Treatment Services Additional Grant Funding	Val Thomas	Officers were requested to work with partner services to lobby central government on the importance of additional grant funding.	This has already been undertaken with local partners and system level groups. Letters prepared for the Chief Executive to send to relevant Government ministers	Completed
268.	Drug and Alcohol Treatment Services Additional Grant Funding	Val Thomas	To supply information to Committee members to clearly show treatment services outcomes.	This has been prepared and sent	Completed
269.	Finance Monitoring Report	Justine Hartley	The Committee questioned if there was a demographic issue with older people who previously had an asset in the form of a house which had helped them independently pay for their care, but who might need access to council social care in upcoming years. Officers were asked to look into the national data.	The finance team are continuing to investigate the issue and will report back in due course once they have a definite response back from our relevant services including the Business Intelligence team.	In progress
270.	Adults Corporate Performance Report Quarter 1 2024-25	Sarah Bye	The Committee learnt that the previous quarter figures were the position at the end of the previous year, which potentially could be a cumulative number so did not present the figures in the clearest way. Officers agreed to review this.	Updated for future reports	Completed

Minute No.	Report Title	Lead officer	Action	Comments	Status
271.	Public Health Performance Monitoring Report - Quarter 1 2024/25	Val Thomas	The Committee queried if 'ghost patients' could be a contributing factor to the Healthy Child Programme indicator 62. (take up of the 2-year development review) The Acting Director of Public Health undertook to find out if work had been undertaken to review this.	The provider records families where there are questions about whether they are still resident in the area under an 'Address not known' grouping. These records are reviewed regularly by the team to see if new information is available on NHS systems that would confirm either they had left the area or their updated local address. These families are still included in the denominator measure for these universal checks, but the numbers are very low and it don't impact significantly on the percentages accessing this check. More work is being planned by the provider over the next few months to better understand who the families are who aren't being reached by this check, including those who proactively decline the offer, to identify whether there are any health inequalities that could be addressed.	Complete
272.	Adults, Health and Commissioning	Patrick Warren-Higgs	The Committee queried how the success or achievements would be	Risk register reviewed fully and any changes to Risk 5, and direction of	Complete

Minute No.	Report Title	Lead officer	Action	Comments	Status
	Risk Register Update		assessed in relation to Risk 5 to change the direction of travel. Concern was also raised regarding whether this risk had been sufficiently reviewed. The Executive Director for Adults, Health and Commissioning agreed to review the risk and the terminology used.	travel have been reflected in the revised document.	
272.	Adults, Health and Commissioning Risk Register Update	Patrick Warren-Higgs	To review the risk rating for Risk 3: Arrangements to support people with Learning Disabilities result in poor outcomes due to uncertainty of decoupling of funding arrangements via section 75 agreement.	Risk register reviewed fully and any changes to Risk 3, and direction of travel have been reflected in the revised document. This has now been escalated and will be considered for inclusion on the corporate risk register.	Complete
272.	Adults, Health and Commissioning Risk Register Update	Sally Shaw	To clarify how the Council was indemnified in relation to the provision of social care services.		On-going
273.	Agenda Plan, Training Plan and Appointments	Patrick Warren-Higgs/ Richenda Greenhill	To add a Charging Review report to the December meeting agenda.	14.10.24: Agenda plan updated accordingly.	Completed

Adult Social Care - Accommodation for Working Age Adults: Strategic Thinking

To:	Adults and Health Committee
Meeting Date:	12 December 2024
From:	Executive Director of Adults, Health and Commissioning
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	Not Applicable for non-key decisions.
Executive Summary:	This paper provides an overview of the approach being undertaken to address adult social care supported accommodation needs for working age adults across the County.
Recommendation:	The Committee is asked to: a) scrutinise the content of the report. b) support the development of principles and next steps to expanding accommodation to meeting the current and future shortfall in accommodation for working age adults with complex needs.

Officer contacts:

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1 Creating a greener, fairer and more caring Cambridgeshire

1.1 The approach outlined in this paper supports the following Cambridgeshire County Council ambitions:

1.1.1 **Health inequalities are reduced.** Good quality housing with the right care and support enables Cambridgeshire residents to achieve good outcomes in an environment that meets their needs. A supportive housing environment reduces risk of harm, promotes social inclusion and ensures access to good quality care and support. It also helps people to maintain a healthier lifestyle or manage their health needs more proactively, enabling them to maintain the best possible quality of life for longer.

1.1.2 **People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs.** Having access to appropriate housing and support options ensures that residents of Cambridgeshire with care and support needs are able to live safely and independently in services that can flex to meet their needs, help them to maximise their quality of life and ensure they can achieve the best possible outcomes. Supported housing or independent living are particularly key in helping people to gain skills and make lasting improvements that will help them to gain confidence to live independently and achieve their goals.

1.1.3 **People and communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised.** Housing with care and support can reduce social isolation, ensure that people can play an active role in their local community and are able to access local amenities and opportunities. These services also contribute to the local economy through providing employment opportunities for local people.

1.1.4 **People are helped out of poverty and income inequality.** Those within housing with care and support are assisted with finances and maintaining a stable income. This may be through ensuring timely access to financial assessments to ensure care costs are affordable or enabling access to benefits as well as opportunities to develop skills that will aid them in accessing employment in the longer term.

2 Background

2.1 Cambridgeshire County Council has a duty under the Care Act 2014 to promote and support the wellbeing and independence of a person when it is carrying out a care and support function, or making a decision in respect of them. . Whilst the Council aims to work with people to support them to remain within their own homes wherever appropriate, this is not always possible. Research has shown that there is an intrinsic link between a person's housing and their health and wellbeing with poor quality housing costing the NHS an estimated £2.5 billion per year.[1] It is therefore important that a range of accommodation options is available to secure the best possible outcomes for the person in question as well as their informal carers and support network.

2.2 Demand for accommodation to support people with more complex care and support needs is increasing. Whilst we have successfully expanded capacity for older adults requiring a

[1] HAPPI Report, Best & Porteus 2012

care home in recent years, there is an increasing shortfall in capacity for supported accommodation to meet the needs of working aged adults with learning disabilities, autism and mental health. As evidenced within the Joint Strategic Needs Assessment, this is predominantly being driven by a rise in the number of younger adults with increasingly complex needs transitioning into adulthood and leaving education and therefore require ongoing support. This is resulting in people waiting longer to receive the right level of support to meet their needs with some people being placed in an out of county option or the Council purchasing accommodation at an increased cost. Addressing the shortfall in accommodation is therefore considered a key market shaping priority and will prove fundamental to achieving the aims set out in the corporate ambitions and The Joint Health and Wellbeing Integrated Care Strategy.

2.3 'Supported accommodation' refers to housing combined with support and/or social care services designed to help individuals live as independently as their needs allow. This can encompass various options, including nursing and residential care homes, extra care and supported accommodation arrangements. At present, the Council commissions a range of accommodation options which aim to enhance quality of life, promote independence and deliver high quality care and support to individuals but work is needed to expand and develop this.

2.4 Capital development of supported accommodation is not something adult social care can tackle alone. Whilst the District Councils handle local housing needs, including affordable housing and homelessness, the County Council is responsible for delivering statutory care and support to eligible residents. Adopting a collaborative approach is therefore essential to ensure that residents have access to an adequate choice of accommodation and that adult social care demand forms a part of the housing plans published by Districts Councils.

2.5 Internally working as 'One Council' and drawing upon the expertise and experience of other Council departments including finance, in-house services, strategic assets, public health, education and children's social care will also prove critical along with collaboration with wider independent sector providers, registered social landlords and property developers.

2.6 This paper aims to present an overview of how adult social care intends to address this challenge of expanding accommodation options for working age adults in three parts:

1) through providing an outline of demand shortfalls and current projections
2) setting out the Council's strategic intentions to meet identified accommodation needs
3) setting out the options and next steps

3 Main Issues

3.1 **Current Demand**

3.1.1 At present, there is a shortage of accommodation which satisfies the requirements of working-age adults with learning disabilities, autism, or mental health needs – often called 'Specialist' or 'Supported' accommodation. The shortage can be seen when we monitor wait times of service users who require a care placement, which also requires accommodation and compare to other groups.

3.1.2 Figure 1Figure 1: Service users waiting more than 4 weeks for shows in November 2024 the number of service users who had been waiting more than four weeks for an accommodation-based care placement. The graph shows that four in five of those people are working age adults, with supported accommodation being the most challenging accommodation to find.

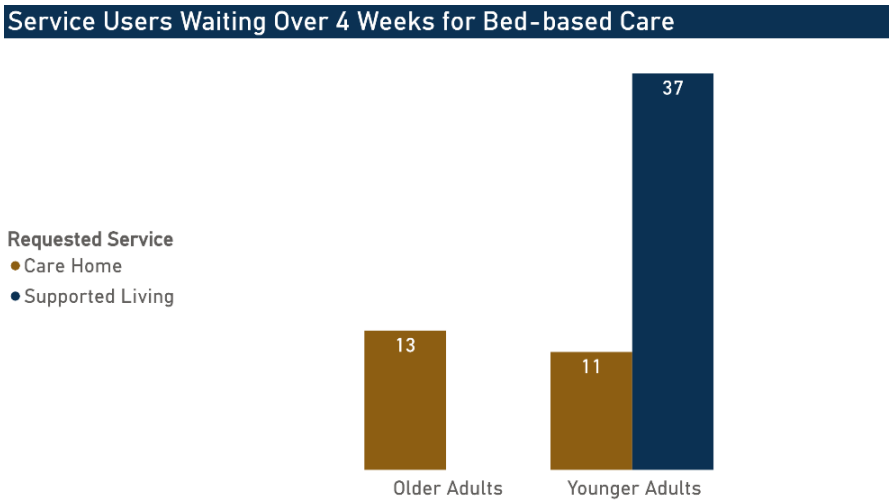

Figure 1: Service users waiting more than 4 weeks for accommodation-based care in November 2024

3.1.3 Figure 2 shows median wait times of service users seeking accommodation-based care over the past year. It shows a clear difference between the wait times of older and working-age adults, with older adults waiting an average of 12 days and working-age adults 80 days.

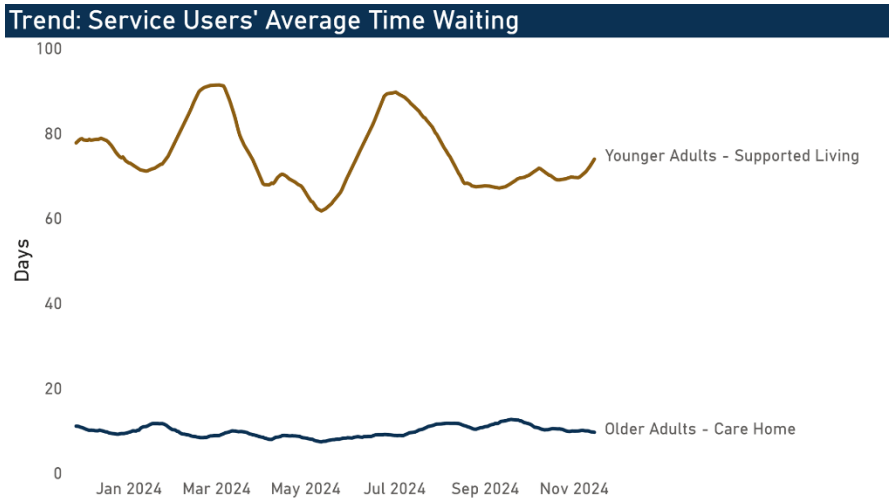

Figure 2: Median wait times for accommodation-based care placements over last 12 months

3.1.4 Working-age adults are likely to wait longer than older adults for a number of reasons including the 'socialisation period' to assess compatibility between service users and the accommodation/support package which may take several weeks. However, the size of the difference between wait times of older and younger adults demonstrates a shortfall in accommodation for the younger age group. Furthermore, while the wait times for older adults remains stable, the variance in younger adults' wait times over the period implies influence from external factors, i.e. market supply.

3.1.5 This is reinforced by the proportion of placements that have been made out of county for different types of accommodation. Figure 3 compares out of county placement percentages across cohorts.

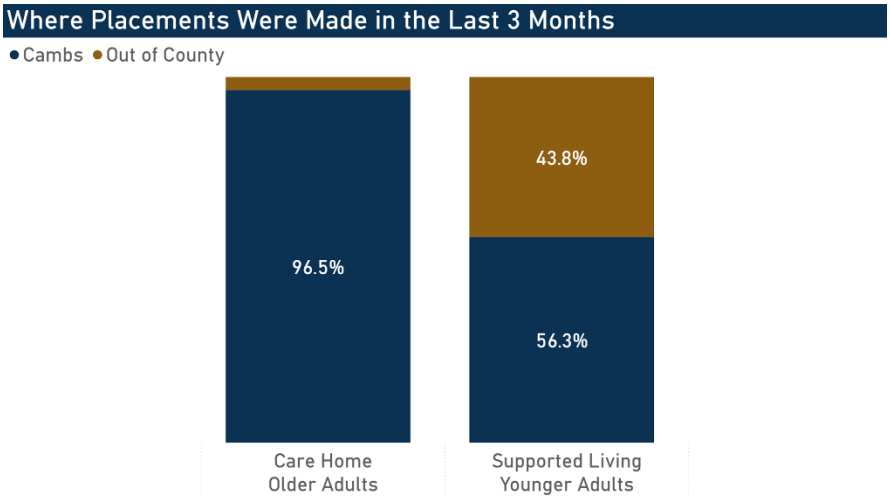

Figure 3: Percentage of placements made in or out of county over last three months

3.1.6 Over half of all placements made out of county are at the request of the service user or their family. The remaining proportion are made out of county because no suitable setting can be found which meets the service user's needs. Accounting for this, figures reveal that 1 in 5 supported accommodation placements are being made out of county because needs cannot be met in Cambridgeshire.

3.2 Future Demand is Growing

3.2.1 The demand on these accommodation-based placements will increase in coming years. In 2023, Cambridgeshire published a set of Demand Profiles which, for the first time, outlined demand forecasts for accommodation to support working-age adults at a district level. These were developed in partnership with district councils to ensure a shared view.

3.2.2 Figure 4 show estimates of additional bed capacity required to satisfy growing demand in each Cambridgeshire district. Our forecasts suggest that an additional 42 specialist placements will be required every year up to 2041 if nothing changes.

Demand Forecast: Specialist Beds

District	2022 Demand	2041 Forecast Demand	Increase Over 19 Years	Increase Each Year
City	144	242	98	5.2
East Cambs	151	247	96	5.1
Fenland	231	449	218	11.5
Hunts	250	464	214	11.3
South Cambs	191	364	173	9.1
Total	**967**	**1766**	**799**	**42.1**

Figure 4: Forecasted demand for specialist beds 2022-2041

3.3 The market is not prioritising the accommodation most needed

3.3.1 Working with local district Council partners and feedback from local property developers and providers, the commissioning team maintain an overview of accommodation which is due to be developed across all age categories and types of accommodation. At present, this extends to the next 2 years. From this, we are aware that multiple accommodation developments are due to be completed by 2026 across a range of providers, providing additional bed capacity to the Cambridgeshire market. Some of these developments are being progressed in consultation with commissions and in response to published demand profiles, others represent organic growth in the market. However, we are in contact with all developers to ensure they have a robust understanding of the type of accommodation required and affordability requirements. Figure 5 shows this 'pipeline capacity' by district and bed type for working aged adults:

Pipeline Capacity: Specialist Beds

District	Supported Living
City	24
East Cambs	2
Fenland	22
Hunts	31
South Cambs	6
Grand Total	**85**

Figure 5: Additional beds from supported accommodation developments due for completion by 2026

3.3.2 This pipeline of new developments will have a positive impact on the Council's ability to meet the growing need for accommodation to support working age adults. Figure 6 shows the remaining pipeline capacity after adjusting for increased demand over the next two years. Any developments of 'surplus' accommodation over and above the requirements of adult social care will not be directly commissioned by the Council and may be accessed by the NHS and self-funders. Commissioning arrangements will be closely monitored to ensure that we limit the number of voids being funded at any one time.

Pipeline Surplus After Two Years: Specialist Accommodation

District	Increased Supply	Increased Demand	Surplus / Deficit
City	24	10	14
East Cambs	2	10	-8
Fenland	22	23	-1
Hunts	31	23	8
South Cambs	6	18	-12
Total	**85**	**84**	**1**

Figure 6: Surplus supply of new specialist beds after two years

3.3.3 Figure 6 demonstrates that at present, new accommodation for younger adults will simply keep pace with growing demand. This will barely maintain the status quo of Supported accommodation availability, which already leads to one in five placements going out of county as detailed in paragraph 3.1.6

3.3.4 There is a need to take a longer-term view of demand to enable us to proactively and sustainably plan for a pipeline of suitable housing over a five and even ten-year timeline. Figure 7 shows for each Cambridgeshire district how the increase in future demand over the next 10 years compares with pipeline capacity from the next two years alone for working age adults:

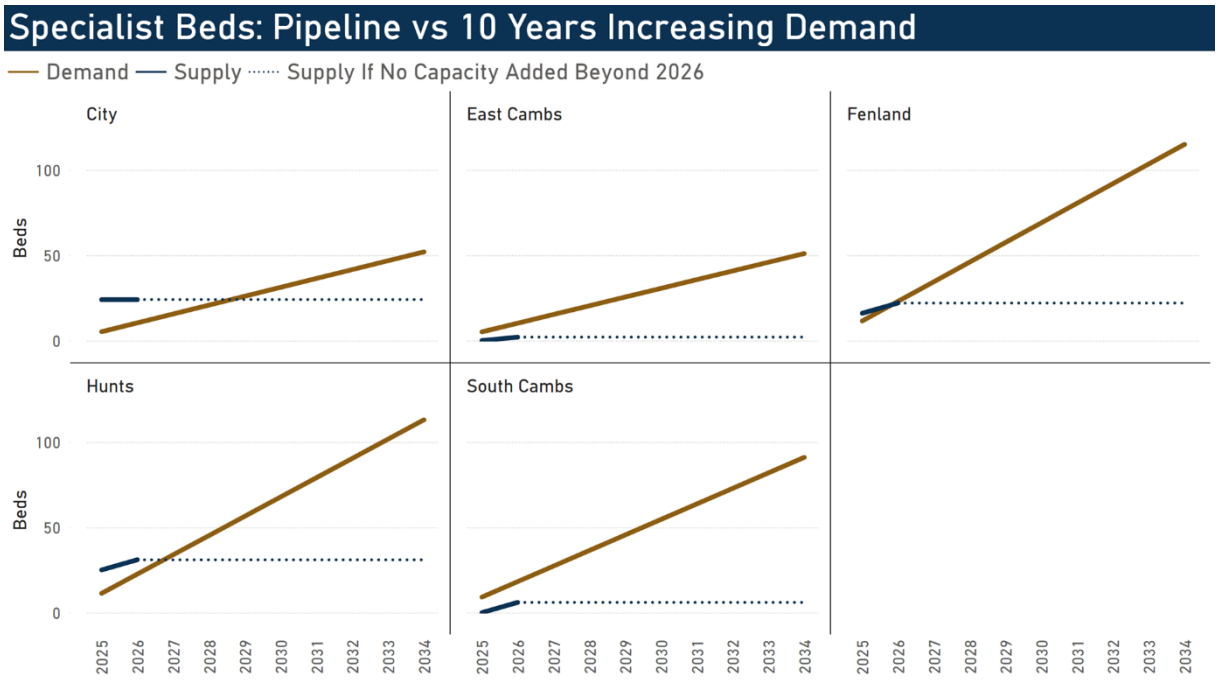

Figure 7: 2 Year Pipeline capacity of specialist beds compared to 10 years of increasing demand

3.3.5 The above shows that planned developments will merely keep pace with increased demand over the next two years and beyond that there is a significant shortfall in accommodation to meet the needs of working age adults. We must seek to encourage new provision of specialist accommodation beyond 2026 and at a faster rate.

3.4 Strategic Intentions and Priorities

3.4.1 In determining ‘what good looks like’, the Council have drawn upon a wealth of research and guidance on best practice in adult social care accommodation to inform the development of the following strategic intentions and principles:

1. **Maintain a preventative and strengths-based approach:** We will prioritise the importance of supporting people to remain in their own home, where possible, by ensuring we offer the right level and standard of preventative community which are developed and delivered in partnership across local communities. We are also reviewing our current homecare offer to ensure it uses a more enabling approach to maintaining people’s independence accounting for their wider wellbeing as well as the delivery of personal care. Where someone does require alternative accommodation and can hold their own tenancy, we help them to access appropriate long-term accommodation. With this in mind, the use of local district council housing stock for people who are eligible for social housing will be considered the Council’s primary route to sourcing accommodation for people with general care and support needs.

   Where this is not possible, we will strive to help people to remain independent through "housing with care" solutions. Whilst recognising that more traditional Care Homes options will have a part to play in supporting those with the most complex needs, we wish to explore alternative housing options for working age adults, which may offer better outcomes by allowing for greater levels of independence. This will include supported accommodation options thereby reducing the volume of people entering residential care. These arrangements will seek to ensure that the support delivered to people within these settings is managed separately to their tenancy arrangements, with all opportunities to take a more enabling approach and use technology to increase their independence harnessed.

2. **Co-production is prioritised:** We will seek to ensure that all new services are co-produced to deliver better outcomes for people, build stronger communities and enhance the value and quality of our services. Individual developments and projects will draw upon well-established networks, groups and partnership boards to do this and we will seek to continuously improve the approach taken through reviewing and sharing lessons learned.

3. **Maintain an evidenced based approach –** We will seek to build upon the work already undertaken to understand and forecast future demand for accommodation within adult social care through utilising census data, data from District Councils, and other information sources. We will ensure we maintain an up-to-date accommodation needs assessment which will be published and used to plan for a longer-term pipeline of future developments.

4. **Address gaps in capacity and increase choice and control –** There is an urgent need to address the shortfall in specialist accommodation for people with learning disabilities, autism and mental health. In doing so, we will seek to create a mixed care market comprising of a range of delivery models across in-house and independent sector services. This will aim to offer maximum choice to people, create a good balance of provision across all areas of the County and ensure that an ongoing reduction in the number of people placed out of county due to a lack of appropriate provision within County is prioritised.

5. **Ensure accommodation developed is fit for the future and appropriately located** – We recognise that the design of accommodation has a material impact on the outcomes of people accessing it and impacts on the environmental footprint of the Council. In conjunction with our partners and key stakeholders, we will seek to promote the development of housing with care solutions which include intergenerational possibilities, good design principles and adhere to best practice standards including the 9 Reach Standards[2] as well as models which have worked elsewhere.

   Additionally, the location of all accommodation will be assessed with a view to ensuring people are able to maintain links with local communities and networks of support. It is therefore important that accommodation is located in places where there are good transport links, particularly public transport and a good level of access to local services such as GP surgeries, shops, post offices and social activities. Any risks relating to recruitment and retention of support staff will also be considered.

3.4.2 Over time, we envision that the progression of these intentions will enable the Council to achieve the following outcomes:

- A reduction in average waiting time for supported accommodation for working aged adults resulting in improved outcomes for these individuals and often their informal carers.
- A gradual expansion of capacity in line with evidence of increasing demand to ensure the Council can continue to support people to achieve good outcomes and maintain choice and control.
- Expansion of a preventative approach will support the continued decrease in the number of people entering a care home setting and increase the number of people living within their own homes or a setting able to provide 'housing with care'.
- A decrease in the number of out of county placements made to ensure that wherever possible people requiring accommodation can continue to remain living within their local area and close to their community, family and network of support.
- A reduction in the number of placements made outside of established procurement frameworks resulting in a greater control of cost.

3.5 Current Position

3.5.1 To date, focus has been given to developing a robust understanding of the current shortfall in available accommodation as well as projected demand to ensure we are able to progress developments in an evidenced based way. This has led to the following being progressed:

- **New Development Pipeline** – Through the links we hold with the District Councils, we are now able to track the development of new accommodation options across the County from planning application through to completion of build and where required Care Quality Commission (CQC) Registration. This currently covers the next 2 years and enables us to have a clear overview of where and when current and future demand will be met so we can target resource to address the longer-term gap in partnership with the local market and use of capital funding.

[2] REACH Support for Living - Paradigm (paradigm-uk.org)

- **Expansion and update of existing accommodation framework** – In response to the current evidence base, proactive action has been taken to re-open and expand existing accommodation frameworks wherever possible to increase capacity available. A good example of this is the Mental Health and Autism Accommodation Framework which features within the current business plan. By engaging with the local market and re-opening the framework we not only hope to increase accommodation options for people with these needs but also achieve a projected cost avoidance saving of £400k over the course of the next two years.

3.5.2 Development of a new approach to expanding the volume and type of accommodation available in Cambridgeshire is complex and multifaceted. It requires coordinated engagement and input from a wide range of stakeholders, often a significant financial investment, proactive adjustments in response to risks arisings (e.g. impact of inflation on building costs) and a multi-year delivery plan. Many of these aspects have impacted on existing business cases and developments, challenged the current skills mix and expertise held within adult social care commissioning team and the standardised processes and procedures held within the Council. This has resulted in progress to date being slower than expected.

3.5.3 However, we have now established an Accommodation Board which will aim to kick start this process and features representation from Property Services, Finance, Policy and Insight Teams. The Board will also include the Education Capital Programme Team whom Adult Social Care have formally engaged to support with this work due to their experience of driving forward the education capital programme.

3.6 **Ongoing Development**

3.6.1 Building on this work, focus now needs to be given to meeting the current shortfall in capacity and ensuring growth in supported accommodation to meet demand projections. This will require an approach which is flexible and explores a range of different routes in a very placed based and person-centred way. Given the trends outlined above, capital funding is likely to be targeted at addressing the current and future shortfall in specialist accommodation to meet the needs of working aged adults. These include:

- **General Housing:** Work needs to be undertaken in partnership with the District Councils to understand how we ensure that those with an assessed adult social care support need can be appropriately prioritised for general housing allocation. As part of this we will need to explore whether any improvements can be made to current links and knowledge sharing arrangements across housing and social care teams and ensure there is a clear understanding across organisations and teams.

- **Development of Strategic Partnerships with local Registered Social Landlord (RSL):** The Council has taken a proactive approach to engaging with local RSL's to ensure they have a good understanding of current and projected need for supported accommodation and the opportunities that this presents to them. This could and has resulted in RSL's investing in development of supported accommodation in the knowledge that there is a waiting list of people ready to access accommodation on completion.

  However, there is also further opportunity for work to be undertaken in partnership with the Strategic Assets Team to explore whether the sale of any of the existing Council assets marked for disposal directly to an RSL at full market rate could be facilitated. If

successful, this approach would enable the Council to secure a capital receipt for these assets whilst also providing adult social care with additional placement capacity locally. The current capital allocation could be utilised here to support with the costs of developing the site rather than purchase of land subject to the approval of a business case. This could result in a much smaller capital investment being required which will support financial viability of new developments and allow adult social care capital allocation to work harder and go further

- **Release of Council estates for specialist supported accommodation:** Alternatively, Council-owned assets identified for disposal could also be reallocated to adult social care to work alongside strategic assets to re-develop the sites to meet supported accommodation requirements utilising the current capital allocation within the business plan. Whilst this wouldn't result in a capital receipt being achieved, it would enable Council owned assets to meet local need for services within the County and is something currently being pursued within Children's Services with the building of two new residential homes.

- **Redevelopment of existing adult social care or children and young people estate:** The Council currently operate several in-house services across adult and children's social care departments. In fact, the in-house learning disabilities service already provides supported accommodation and residential services. It may be that there is opportunity to expand this offer and utilise the capital allocation within the business plan to re-develop or upgrade existing buildings to either expand this service offer or meet the change in need described in paragraph 3.1.

- **Purchase and development of new sites:** The capital allocation held within the business plan can be utilised to purchase new sites, retain the land and act as landlord to potential developers, RSLs and/or care and support providers. Whilst this will enable the Council to meet the needs outlined above and retain maximum control over the asset, a much greater capital investment will be required.

3.7 Next Steps

3.7.1 Over the next 12 months, the Commissioning Team will be working in close partnership with the Policy and Insights Team, Capital Programme Team, Property Services and Finance to:

- **Refresh the current demand profiles** incorporating updated census information and looking to disaggregate care home demand projects by bed type and age to enable some more sophisticated analysis to be undertaken.
- **Build a pipeline** of developments beyond the current two-year timeframe in partnership with local district councils.
- **Develop a plan to target capital funding** allocated to address the current and projected need for accommodation identified in demand profiles.
- **Meet and engage regularly with local Registered Social Landlords and property developers** and issue an annual survey to ensure understanding of adult social care need and facilitate the work of the Accommodation Board
- **Review options for accessing Council-owned sites** marked for disposal whether that be for re-purpose or facilitating a capital receipt.
    - Undertake targeted reviews of the Learning Disability Supported Living Framework and the Mental Health and Autism Accommodation Framework to

ensure support arrangements continue to expand in line with projection of need and accommodation.

3.7.2 We expect to return to Adults and Health Committee in June 2025 with an update on the progress of this work, a business case and a plan to deliver additional accommodation utilising the capital funding allocated.

4. Alternative Options Considered

4.1 Not applicable.

5. Conclusion and reasons for recommendations

5.1 A significant amount of research, planning and engagement has taken place to build the foundations of a long-term accommodation programme which will focus on meeting the identified shortfall in accommodation both now and in the future. This approach has also helped to ensure we have the right skills mix, engagement and input from across Council departments, partners and other stakeholders to make this happen along with a sizeable capital allocation to help drive this forward where required.

5.2 Whilst a number of actions have been taken to improve and update existing commissioned arrangements to expand capacity, focus must now be given to working with identified stakeholders to adopt new and innovative ways to meet the growing demand for these services in a way which is person centred but also sustainable. Exploration of the areas outlined within paragraph 3.3 will prove key to achieving the outcomes set out within this paper.

6. Significant Implications

6.1 Finance Implications

Meeting the current and future demand for accommodation will require investment but will also bring associated cost avoidance savings some of which already form part of the business planning process as outlined within paragraphs 2.5 and 3.3.1. An investment of £12m is built into the proposed capital programme for 2025-26 and beyond for specialist accommodation.

6.2 Legal Implications

Ensuring compliance with the Council's duties under the Care Act 2014.

6.3 Risk Implications

6.4 Equality and Diversity Implications

6.5 Climate Change and Environment Implications

7. Source Documents

Homelessness and Housing Related Support

To:	Adults and Health Committee
Meeting Date:	12th December 2024
From:	Executive Director Adults, Health and Commissioning
Electoral division(s):	All
Key decision:	Yes
Forward Plan ref:	KD2024/035
Executive Summary:	This paper provides an overview of how the County Council is investing resources and working with partners to deliver essential support for the rising numbers of those with often complex support needs who are experiencing homelessness. The report highlights the positive impact this service has been having with the people being directly supported. To support the continuation of this work we are seeking an extension of the existing contracts which are facilitating the delivery of this support.
Recommendation:	The Committee is recommended to:

a) note the County Council's contribution to investing in a system-based approach to delivering support services to address the needs of those who are experiencing homelessness, and how this positively impacts this group of people.

b) approve a 2-year extension to the existing contract in line with current terms and conditions at a total value of £4,582,926 (£2,291,463 per annum) from 1st April 2025. This value will be adjusted for any future inflationary uplifts, awarded at the Council's discretion, as agreed through the business planning governance process.

c) delegate the authority to award the subsequent extension period to the Executive Director Adults, Health and Commissioning, in consultation with the Chair and Vice Chair of the Adults and Health Committee.

Officer contact:
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Post: Senior Commissioning Manager
Email: lisa.sparks@cambridgeshire.gov.uk

1. Creating a greener, fairer and more caring Cambridgeshire

1.1 The continued delivery of these services supports the following Cambridgeshire County Council ambitions:

1.1.1 **Health inequalities are reduced.** The services provide vital support to people in Cambridgeshire who are experiencing homelessness. The services provide tailored support to help people who are struggling with to maintain their accommodation for a range of reasons including addiction, poor mental or physical health. These services help people to engage in support and treatment in a way that works for them with the aim of reducing the health inequalities that the homeless population often experience.

1.1.2 **People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs.** Services help ensure that this group of people have access to safe accommodation where they can access the support they need to begin to make lasting improvements that will help them to gain confidence to live independently and achieve their goals.

1.1.3 **People are helped out of poverty and income inequality.** The services help to ensure that people have access to a stable income by enabling access to benefits as well as opportunities to develop skills that will aid them in accessing employment in the longer term.

2. Background

2.1 The number of people presenting as homeless continues to rise across the country. In Cambridgeshire we are seeing a rise in number of people approaching local district councils for support and to declare themselves homeless as well as those seeking to access Housing Related Support (HRS) services commissioned by the Cambridgeshire County Council (CCC). As people who find themselves homeless may regularly transition in and out of support services it remains difficult to calculate exact demand figures across all districts of the county. However, we do know the greatest demand for these services is presenting within Cambridge City and Fenland and the current model and level of investment in HRS reflects this. The impacts of homelessness, and particularly rough sleeping, are well documented. With this in mind, the current HRS Service was developed in 2020 in partnership with District Councils, Public Health, the Cambridgeshire Domestic Abuse and Sexual Violence Partnership, local providers and people with lived experience. The services seek to ensure that effective, preventative support and accommodation options are available to support people experiencing homelessness, and wherever possible to transition into a more permanent accommodation arrangement through helping to address and manage the reasons for this.

2.2 The HRS service commissioned by CCC plays an integral part of the local systemwide, preventative offer to support those experiencing homelessness. These contracts are complemented by an in-house Housing First service. Housing First aims to support those with the most complex needs for whom other interventions have not succeeded. Often these will be people with a history of repeat rough sleeping and homelessness, who find it hard to engage with any structured support approach. Whilst delivery of Housing First sits

outside of this contractual arrangement, it operates as part of the same pathway. The Housing First approach is jointly funded by CCC and central government rough sleeper funding with a total additional investment of £673k being used to operate the approach.

2.3 Housing Related Support (HRS) services provide dedicated staff who are able to deliver specialist support to individuals to enable them to develop independent living skills and maintain their accommodation. The support provided is tailored to meet the specific needs of each person with key examples including support to develop life skills and/or manage issues such as addiction, mental health issues and emotional wellbeing. The ultimate aim of these services is to help people to:

- Move on to fully independent living
- Feel part of their community
- Make informed decisions and choices
- Be actively involved in training, education or employment
- Engage with other relevant agencies and services
- Manage their own health and wellbeing

2.4 The funding provided for HRS services is focussed on delivering the support within a service. District Councils support with other costs such as rent or service charges through the use of housing benefit, which they administer. They also provide funding to deliver the statutory homeless functions which sit with them, such as, housing advice, assessing homelessness applications and providing access to temporary accommodation. Alongside this they also offer some discretionary services such as rent deposit schemes or helping people to clear historical rent arrears.

2.5 The Council commissioned a new co-produced model in 2020 to reflect best practice and better meet current and future needs. At the time there was extensive engagement with people with lived experience. As those experiencing homelessness are often a seldom heard group, we worked directly with the County's Counting Every Adult Team to enable us to link with their established co-production group to ensure meaningful engagement. Feedback from this engagement suggested that the reliance on shared hostel accommodation was not able to meet the wide range of needs presenting in an effective or outcome focused way. To ensure that the redesign took account of any national good practice, we also had conversations and meetings with Homeless Link, a national membership charity for organisations working with people who are homeless.

2.6 In co-production with these groups, District Councils and local providers, we sought to move away from reliance on a traditional 'hostel' model. Instead, we worked as a local system to develop a wider range of more flexible solutions that are able to respond effectively to a range of needs and demands. For example, ensuring that all contracts introduced appropriate spaces and support to meet the specific needs of homeless females who will often have experienced abuse and violence.

3. Main Issues

3.1 The services commissioned in 2022, adopted the new co-produced model resulting in;

- a move away from a focus on using ‘hostel’ type accommodation towards a more place-based approach
- ensuring a trauma informed approach to support
- a ‘Hub and Spoke’ type model that can deliver more localised solutions
- flexibility for community based ‘spoke’ units able to offer more self-contained spaces as an alternative to shared ‘hostel’ type accommodation and to provide increased ‘move-on/step-down’ opportunities for those moving through a journey out of homelessness
- an ability to meet identified support gaps e.g. support and accommodation specifically for homeless females in meeting the priorities set out in the Council’s Domestic Abuse and Sexual Violence Strategy
- simplified referral routes and a more coordinated approach to referrals
- Better access to supporting services including Drug and Alcohol Support Service commissioned by Public Health, support for mental health and employment support.

3.2 The development of this model is being shaped, delivered and progressed in two phases:

Phase	Deliverable	Timescale
1	Development, delivery and embedding of the new model outlined in paragraph 3.1 by locally commissioned providers detailed in paragraph 3.6	First contract phase (2020-2025)
2	Development of a Cost Benefit Analysis Tool and more systematic tracking of individual outcomes	Second contract phase (2025-2027)

3.3 These services have a significant impact on the ability of people to achieve improved outcomes across all areas of their lives and ultimately enable them to secure and sustain long term accommodation. The preventative nature of these services also supports the Council in managing the demand for statutory social care services. Case studies are collected from the services on an ongoing basis to evidence the difference that they are making to the individuals who use them. Some examples of these can be found at Appendix A. Overall the case studies help to demonstrate how the services positively impact on key aspects of peoples’ lives, such as:

- Regaining choice and control over their everyday lives
- Tenancy sustainment
- Improving self-esteem and self-confidence
- Being able to better manage issues they may be experience around drugs, alcohol, mental health and physical health
- Setting goals for the future
- Moving towards economic stability

3.3 Physical and mental health challenges are two of the key areas contributing to the reasons someone experiences homelessness and those accessing HRS services require immediate support with. For example, between April 2023 and March 2024, the HRS services assisted 113 people to access mental health services, 143 people to access specialised drug and alcohol support, 233 to access or engage with general health care services and 53 people were supported to engage in paid employment. These outcomes will prove integral to creating

a local support network to enable these people to increase their independence and ability to retain permanent accommodation.

3.4 The model and investment are also supporting local HRS providers to manage a significant increase in demand for these support services within the context of a rising complexity in need. Overall, services have seen a 14% increase in the number of referrals received since the contract started and the number of adults with complex needs[1] being supported by services has increased by 27% from 89 being supported at the end of 2022-23 to 122 at the end of 2023-24.

3.6 Table one below provides an overview of the providers and services operating within each District area across Cambridgeshire. The number of units represents the level of temporary accommodation available within service, with the HRS Services wrapping around the person residing within each unit. Lot 1 is delivered by an established Fenland based charitable provider. Lot 2 is a partnership of providers which includes larger organisations as well as local charitable organisations.

Lot	Provider		Service	Units
Lot 1 – Fenland	The Ferry Project		The Ferry Project	37
Lot 2 – Cambridge	Riverside Group are the lead Provider and contract holder, but work with the other Providers and Partners listed to deliver the contract.	Jimmys Cambridge	Jimmy's Assessment Centre and move on units	24
		Jimmy's Cambridge	451 Newmarket Road	6
		Riverside Group	Willow Walk	20
		Riverside Group	222 Victoria Road	54
		CHS Group	Corona House	6
		Cambridge Cyrenians	Dispersed and Move-On Houses	73
		Cambridge Cyrenians	Jubilee Project	10
		Change Grow Live (CGL)	Street Outreach & Homeless Prevention Offer	Variable
		Wintercomfort	Learning and Development (excluded adults)	Variable

Table 1: List of commissioned Adult HRS services

3.8 Based on current service capacity, the average annual cost of each unit is £8,582 (£165.00 per week). However, in reality prices will vary across the provisions to reflect the differing levels of support being provided. Due to the transient lifestyle and engagement in services by people accessing these services, systematic tracking of performance is challenging. However, we are confident that the data reflected in paragraph 3.4 and 3.5 reflects delivery across the service.

[1] For this contract complex needs are defined as someone who has three or more of the following; history of repeat homelessness, substance misuse, mental health issues, domestic abuse, contact with the criminal justice system.

3.9 Wider impact:

In addition to the services provided within these contracts, providers also use grant funding, charitable means and their own volunteers to deliver a range of additional services which users of contracted services can benefit from. These include things such as access to onsite mental health support, counselling, art therapy, cookery classes, smoking cessation interventions, social activities, additional options for move-on accommodation, assistance with furnishing a new home and initial resettlement support for those moving on.

3.10 To ensure a more robust approach to evidencing wider benefits, providers are working with commissioners to develop and implement a new Cost Benefit Analysis (CBA) Model across all HRS Services to better understand the real value added. The model is based on the nationally recognised 'Manchester Model'[2], and will help to demonstrate the wider impact of HRS services in delivering savings to the public purse by preventing, or reducing higher cost interventions needed from other public sector services. Some initial testing of the model is being undertaken with the aim of it being piloted within these contracts from January to March 2025, and then fully implemented from April 2025.

3.11 Details of extension request:
The report is seeking extension approval for all the services detailed in table 3.2. The contracts for Lots 1 and 2 were procured following Adults and Health Committee approval in June 2021. The committee approved the award of a 7-year contract (3+2+2). The initial contracts for both Lots end on the 31st March 2025 and this is the first request to extend for an initial period of 2 years. It should be noted that there is a standard 6-month break clause built into the contract for these services which means the Council holds the right to vary or terminate arrangements should they not deliver to expectations, outcomes or value for money requirements during the next extension period.

The value of the requested contract extensions are set out below.

Lot	Annual Value
Lot 1 – Fenland	£278,036
Lot 2 – Cambridge	£2,013,426
Total per annum	**£2,291,463**
Total for 2 year extension	**£4,582,926**

Table 2 – Annual values

The contract value for Lot 2 includes the following contributions from Public Health and Cambridge City Council who are both partners within the current contract arrangement.

Third Party	Contribution per annum
Cambridge City Council	£395,000
Public Health	£182,000

Table 3 – Third Party contribution per annum.

[2] Research: Cost Benefit Analysis - Greater Manchester Combined Authority

4. Alternative Options Considered

4.1 The alternative options that were considered alongside this recommendation are outlined in the table below.

Option	Rationale
Let the contract expire	Whilst these are non-statutory services, they are supporting some of the most vulnerable residents in Cambridgeshire. Ceasing these services would lead much poorer outcomes for this group and would generate increased levels of economic disadvantage, increased health inequalities and divert people into higher cost crisis and statutory services.
Re-tender the services	The original decision to allow a contract period of up to 7 years was to enable providers to make the changes needed to move towards the new model of service delivery. Providers have made good progress in this area and are continuing the develop the services. The contract is delivering good outcomes for individuals and there is a good working relationship between the council and the providers. Re-procurement would be costly, divert provider and council resources away from service delivery and lead to disruption for service users.
Deliver the support in-house	The providers of these services are specialists in their fields. Their comprehensive knowledge and understanding of homelessness and housing is an essential element of the support they deliver. As third sector agencies they are often able to also access additional resources and grants which are not available to statutory services. Many of those supported by these services also have a reluctance to approach or work with statutory services, therefore an in-house option would be more likely to deter people from accessing the support they required.

5. Conclusion and reasons for recommendations

5.1 By commissioning these services the county is supporting the commitments made within its strategic ambitions and is helping to deliver positive outcomes for some of the most vulnerable residents of Cambridgeshire, many of whom have complex needs, are economically disadvantaged and socially excluded.

5.2 Providers have proactively worked with the Council to align with the new model and current monitoring data is demonstrating the very positive impact that the services are having, as well as the difference they are making to the lives of individuals.

5.3 By supporting individuals within these services, the Council is also helping to prevent people's needs from escalating to a level where they would require crisis or higher need services, thus increasing pressure on statutory services and resources.

5.4 Extending the contracts will allow the council to continue working with the providers and wider partners to deliver further improvements and innovations, starting with the planned implementation of the new Cost Benefit Analysis approach will also help to evidence the wider benefits of the service.

6. Significant Implications

Report authors should evaluate significant implications using the sub-headings below. Each specific implication must be signed off by the relevant officer within the Council (or external advisors) and included in the table below for the Executive Director to review before the final report is submitted to Democratic Services (who will delete the table) for publication.

You will also need sign off by the Corporate Clearance Group (CCG) at the relevant CCG meeting.

Further guidance and a checklist containing prompt questions are included at Appendix 1.

6.1 Finance Implications

What are the finance implications?
Please see section 3.9 of the report

6.2 Legal Implications

What are the legal implications?
No legal implications identified.

6.3 Risk Implications

What are the risk implications?
These are highlighted in Sections 2.1, 3.3 and 4.1

6.4 Equality and Diversity Implications

What are the equality and diversity implications?
These services support significant numbers of people experiencing multiple disadvantage, rough sleeping and repeat homelessness. Removal or reduction of these service would impact on their access to support and lead to much poorer outcomes for them and contribute to increased rough sleeping.

6.5 Climate Change and Environment Implications

What are the climate change and environment implications?
None identified.

7. Source Documents

None

Appendix A – Case studies

Example One

Name of provider and service:

The Ferry Project

Contact person for any queries:

Keith Smith

Client identifier (e.g. initials, code etc):

LM

Background/Crisis/Issues (Where was the client before, what was the situation that led to them needing this support service, what needs are you supporting them with?

LM is a 44-year-old lady who was referred to our service following on from a discharge from Hospital.

Client had been smoking heroin heavily prior to admission and had been taken into hospital.

Client was admitted to hospital with Liver swelling, and was treated for Sepsis, thrombocytopaenia and heart failure.

Her Mobility was severely impaired due to acute swelling in both of her legs and was unable to walk without the use of crutches.

Client had been staying with her son however due to overcrowding could not return there.

Client had been known to our service historically and had successfully enjoyed a sustained period of both work and managing her tenancy.

This came to an end after approximately 2 years as she returned to substance misuse.

Whilst LM does have family connections in the area these cannot always be relied upon as a trusted network of support.

Her drugs misuse historically has meant she has served custodial sentences and has been abused sexually.

Actions/Support (what have you done to support them and how have you helped them access other support?)

Client has been supported to register with local drug recovery service and has been assisted with booking and attending appointments.

We liaise weekly with LM's assigned recovery worker on progress and updates.
At time of writing LM has been abstinent totally on drugs misuse since discharge from hospital and appears to be enjoying this abstinence and the support she is receiving.
LM attributes her determination to successfully recover from misuse to recently becoming a grandmother and sees this as a responsible role.

LM has engaged well in her health recovery, and this can be visibly seen in her improved mobility and general presentation.

Client is assisted with booking medical appointments and attending them where appropriate.
Whilst many of her medical conditions will be lifelong by providing this support, we are able to ensure that her needs are met as best as they can be.
Evidentially we have provided support to gain asthma inhalers, non-opiate pain killers to under pin her drug tests at recovery services in addition to support with ordering other medication.

From a financial perspective we have supported LM in maximising benefits by putting in for both PIP and WCA considerations and her journey will be health orientated.

LM has displayed that she can when abstinent from Drugs misuse budget and manage her income and expenditure well.

LM also is upskilling on her spoken English by attending weekly ESOL courses.

Comments (what difference or impact has the service made to the person's life? Have any potential scenarios been prevented or delayed as a result of support received e.g. hospital admission, recall to prison etc?)

Criminal convictions have been avoided, thanks to hub staff intervention.
Engagement with the appropriate health services has been coordinated, meaning LM may recover in the future, or there may be a way to manage her symptoms long term.

Street homelessness was prevented by managers and the key worker agreeing to bring LM back into a supported living environment and work in a bespoke way.

Pressure from the DWP has been eased, meaning LM will not be forced back into employment while so unwell; there were many risks associated with that scenario.

LM may see an increase in her income if the PIP and WCA applications are successful.

LM now has an identifiable pathway back to accommodation and can receive our support for a prolonged period.

LM has been able to build a solid relationship with her key worker and is able to be open and honest about challenges she faces.

Example Two

HRS Monitoring Case study template

Name of provider and service:

CHS Group – Corona House

Contact person for any queries:

Client identifier (e.g. initials, code etc):

AR

Background/Crisis/Issues (Where was the client before, what was the situation that led to them needing this support service, what needs are you supporting them with?

AR moved into Corona House after a period of homelessness. She had a difficult family background, resulting in her being taken into care as a child and through her late teens and twenties, experiencing nearly a decade of unstable housing with periods of homelessness, living in hostels and living in her partners' homes. AR received a diagnosis of EUPD shortly before moving into Corona House, she experienced extreme emotional states that she felt completely overwhelmed by, and this appeared to have contributed to her housing situation. AR had also self-medicated since her mid-teens, with alcohol and later cocaine, and to this day, is reliant on cannabis to regulate her mood. AR had been unable to work, had difficulty trusting **o**thers including professionals, and difficulties with regulating her emotions and behaviour. She had a court date coming up because of an incident resulting in two charges of assaulting a police officer.
AR found all relationships challenging due to her past experiences and emotional health needs. She has tendencies to view others and their actions as good or bad and therefore found it difficult to accept honest mistakes and occasions when things might not turn out the way she imagined they would.
This resulted in intense relationships that could be stormy and disruptive; hurtful for those in them and difficult for others witnessing the disruption. A's friendships

and intimate relationships were fraught with arguments, cold wars and sometimes physical violence. Several times at Corona House, A's partner was banned for several months due to the severe disruption caused by their incidents of conflict. AR was good at looking after her flat and kept it very clean and tidy. She had pets that were very important to her and took good care of them. She did not like having debts but found budgeting an enormous challenge. She felt she needed to collect items for her future to feel safe, and thus shopped compulsively. This also meant that she had to be very organised in her flat – because there was very little space remaining!
She was very anxious about interaction with others, and needed support with phone calls, appointments, attending activities etc.
While living at Corona House, A had a stroke resulting in partial sight loss and brain injury impacting her memory and concentration and causing regular fatigue and headaches. This also led to her being diagnosed with a heart condition and a decision to carry out heart surgery in the near future. This was a devasting blow for her as a young woman (26 years old) and her mental health deteriorated as a result of this for a period of time. A was angry at what had happened to her and keen to place blame somewhere. This resulted in many episodes of extreme anger towards health professionals and staff at Corona House.
Following her stroke, A did not feel confident to go out alone and required staff or a friend/family member to go with her to the shops and all appointments. The stroke also delayed her moving on, so she lived at Corona House for around one year with significantly increased support needs, particularly as she felt she could not do things independently.

Actions/Support (what have you done to support them and how have you helped them access other support?)

- **Support to access and attend courses and activities:** A enjoyed coming to some of the Corona Community sessions and would come if a member of staff she trusted would be there with her. A also undertook a few online courses whilst at Corona House. Some of these were completed as part of her probation requirements.
- **Referrals to financial support and foodbank vouchers:** A struggled to make her money last and frequently needed some support planning her spending or accessing grants to top up her income**.**
- **Support to make and access medical appointments:** A had many health issues before she had the strokes, including asthma and IBS. The stroke caused lots of health complications and A had various teams she had to meet with and required staff to attend these appointments with her.
- **Support to manage reminders for medication and appointments: T**he strokes affected A's capacity to remember details and she needed help to diarise appointments and remember to look at her calendar**.**
- **Support to access legal aid and communicate with the courts:** This was with regards to the assault case.
- **Referral for a free laptop**
- **Funding for a punchbag to support emotional regulation:** This was accessed through the CHS support fund.

- **Support with social interactions:** A would regularly show us text messages and get support with how to respond and reflect on what was reasonable in her relationships.
- **Support to apply for a provisional driving licence**
- **Support with relationships and boundaries**
- **Support with claiming benefits**
- **Support with managing sexual health and contraception**
- **Funding to get bike mended**
- **Support with moving on to permanent independent accommodation**

Comments (what difference or impact has the service made to the person's life? Have any potential scenarios been prevented or delayed as a result of support received e.g. hospital admission, recall to prison etc?)

Corona House and the support offered provided A with a stable home for the first time since she was 16. A was supported and worked hard to manage and regulate her emotions; at times it was extremely difficult for A and the staff team to manage her outbursts, but over time she learned to deal with her fluctuating emotions well. This helped her to cope with moving on from Corona House which had really become a safe haven for her and to move into permanent independent accommodation, avoiding the revolving door of homelessness that she had previously experienced. A was very devoted to her pets and has now got 5 cats and a dog.

When A had her stroke the support that was offered prevented her needing hospital admissions, staff managed and supported her with all her appointments, helping with travel to keep her numerous appointments.

When A moved in, she was involved with the courts and probation, staff supported her through the entire process, dealing with her high anxiety and emotional regulation, which then prevented her becoming involved in any more altercations and further involvement with the criminal justice system

Agenda Item No: 6

Extra Care Contract Extensions

To:	Adults and Health Committee
Meeting Date:	12th December 2024
From:	Executive Director Adults, Health and Commissioning
Electoral division(s):	Cambridge City, East Cambridgeshire and Huntingdon
Key decision:	Yes
Forward Plan ref:	KD2024/006

Executive Summary: This paper provides an overview of how the County Council are investing resources to deliver essential care and support to those in Extra Care Housing. It seeks support for the continuation of this work through delivering an extension to 5 existing Extra Care contracts.

Recommendation: Committee are being asked to:

a) approve a 2-year contract extension from 1st April 2025 at a value of £1,662,354 (£831,177 per annum) for Ditchburn Place, which will be adjusted for any future inflationary uplifts and awarded at the Council's discretion. This includes formal contract variation to reflect the need to harmonise Terms and Conditions for TUPE staff.

b) approve a 3-year contract extension from 1st April 2025 at a value of £3,578,556 (£1,192,852p per annum) for Baird Lodge, Eden Place, Millbrook House and Ness Court (Baird Lodge et al), which will be adjusted for any future inflationary uplifts and awarded at the Council's discretion.

c) delegate the authority to award the subsequent extension periods and contract variations on both contracts to the Executive Director Adults, Health and Commissioning in consultation with the Chair and Vice Chair of the Adults & Health Committee.

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1. Creating a greener, fairer and more caring Cambridgeshire

1.1 The continued delivery of these services supports the following Cambridgeshire County Council ambitions:

1.1.1 **Health inequalities are reduced.** Extra Care schemes offer equitable access to care and support services. The support service commissioned by the Council is provided for those with an assessed care need and predominantly accessed by older age adults across Cambridgeshire. The services allow for the Cambridgeshire population to receive care and support in a more enabling environment than other traditional models of care, i.e. residential care homes. Extra Care schemes aim to achieve a balanced community of tenants and reduces health inequalities for those who are at risk of social isolation by creating a community that is able to support them.

1.1.2 **People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs.** Extra Care schemes ensure that tenants are able to live safely and independently in services that can flex to meet their care and support needs as and when is appropriate. This ambition is central to the ethos of Extra Care and to ensuring the best possible outcomes for tenants.

1.1.3 **People and communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised.** Extra Care schemes provide a community for those who may become isolated in their homes. Most schemes are well located and have access to local amenities allowing for tenants to remain active parts of their communities. Schemes also employ local people and therefore contribute to an inclusive economy.

2. Background

2.1 Extra care housing schemes are specialist housing schemes for older people that have been specifically designed to maximise independence for tenants. All tenants have their own apartment with a front door and also benefit from the availability of the onsite care and support service. The supportive environment in extra care enables older people to live independently for longer. It is an important aspect of the prevention agenda as people's health and wellbeing are maintained thereby delaying or preventing the use of residential care.

2.2 The model of Extra Care Housing offers tenants self-contained accommodation with their own front door but also provides a significantly higher level of support than other options available for older adults such as sheltered accommodation. This is an integral feature of the Extra Care model and there are additional facilities (for example, larger bathrooms to accommodate any necessary equipment) for the less mobile. Communal areas tend to include social and practical facilities such as lounges and laundries and a meal service is usually on offer. Extra Care aims to provide greater independent living whilst also being capable of providing care and support. The kind of care and support delivered in Extra Care services is a step down from those seen in residential and nursing care.

2.3 The extra care model aligns with the Council's market shaping approach which seeks to ensure a vibrant and sustainable provider market which is able to deliver appropriate accommodation options with care and support. The strategic importance of Extra Care in meeting the accommodation and support needs of older people is also reflected within the Older People Demand Profiles.[1] The demand profiles highlight a clear need for the continued need for Extra Care Housing as an option for Cambridgeshire's ageing population, the graph below outlines the projected additional supply of Extra Care Housing required between 2021 – 2026 to meet this demand. Extra Care Housing presents as an attractive option for those looking to enter into a flexible model of home ownership as a number of schemes in the County offer leasehold properties as well as tenancy. to meet this demand. To meet our current project demand, we would need to double the number of extra places currently available within the County.

2.4 The Council's market shaping approach acknowledges the need to significantly increase access to Extra Care so that people can be supported at an earlier stage in their care journey and have a higher likelihood of being independent for longer, supporting Cambridgeshire's prevention agenda. Plans to increase access to Extra Care are in development and Commissioners are working, as part of the Adults Social Care Accommodation Board to develop a pipeline and will explore a number of options and approaches to increasing capacity within this area. The care and support provided in Extra Care Housing prevents or delays the need for further intervention e.g. residential or nursing homes.

2.5 **The Cambridgeshire Extra Care market**

Cambridgeshire currently has 18 Extra Care Services as detailed in Table A. The extension request being issued today covers the delivery of 240 extra care units representing just under 32% of capacity available across the County. All services are operated by an independent housing provider responsible for tenancy arrangements and any building related queries with a separate care provider delivering the 24/7 care and support.

[1] Demand profiles forecast - Cambridgeshire County Council. Please note that this document is a shared CCC and PCC paper and therefore and action Is required to review following the Council's decoupling.

District	No. of EC schemes	Unit numbers	Scheme
Cambridge City	4	126	Ditchburn Place Dunstan Court ++ Richard Newcombe Court Willowbank ++
East Cambs	3	149	Baird Lodge (Ely) Millbrook House (Soham) Ness Court (Burwell)
Fenland	4	184	Doddington Court (Doddington) Jubilee Court (March) Somers Court (Wisbech) Willow Court (Whittlesey)
Huntingdonshire	3	123	Eden Place (St Ives) Park View (Huntingdon) Poppyfields (St Neots)
South Cambs	4	175	Bircham House (Sawston) Mill View (Hauxton) Moorlands (Melbourn) Nichols Court (Linton)

Table A: Extra Care Schemes in Cambridgeshire
++: Dunstan Court and Willowbank in Cambridge City also have 17 and 13 sheltered housing flats respectively.

2.7 **Outcomes**

Case studies highlighting the positive impact of the care and support delivered at the schemes can be found at Appendix A. In addition to this, a new Extra Care monitoring form has also been developed to feedback on the outcomes delivered at each scheme. Part of the new monitoring form, to be provided to the Contract Management Team quarterly, is related to the outcomes delivered. This will provide a tangible data set to complement extra care case studies. The information gathered from these monitoring returns will help to highlight how extra care housing aligns with the council's strategic framework i.e. to reduce health inequalities.

2.8 To monitor performance, the Contract Management Team have maintained oversight of the current provider of services as part of the risk-based monitoring approach used across the market and there are currently no concerns about either the quality of performance of the contract outside of developments specifically referenced in the report.

3. Main Issues

3.1 The contract for Ditchburn Place was directly awarded for a period of 10 years (5+3+2). The initial contract period runs from 24th February 2020 to 23rd February 2025. The contract for Baird Lodge and the other schemes was awarded for a period of 10 years (5+1+1+1+1+1). The initial contract period runs from 1st April 2020 to 31st March 2025.

3.2 Both contracts were let prior to the use of the current wording pertaining to the delegated authority to extend being granted to the Executive Director of Adults, Health and Commissioning.

3.3 **Somers Court**

3.3.1 When the Baird Lodge et al contract was procured in 2019, Somers Court in Wisbech was also included in the tender.

3.3.2 In late August 2024, the landlord of Somers Court, Housing 21, informed Cambridgeshire County Council of their intention to close the service by the 31st March 2025. It had been the intention of Housing 21, who took over the scheme in 2023, to operate the service until a new larger, and updated scheme was developed by Fenland Futures Limited nearby to the current scheme. However, due to delays in the building of the new services, the increasing complexity of delivering a service with shared facilities and growing maintenance required on the building, Housing 21 have concluded that Somers Court can no longer operate in a safe and sustainable manner.

3.3.3 CCC colleagues are part of a small project group, together with Housing 21 and Fenland District Council to manage the decommissioning safely, sensitively and effectively. Local members have been briefed, and the project group is working on the required next steps to ensure all tenants are supported with securing alternative accommodation, with care and support where required. This process is currently ongoing but on completion a report detailing the outcome and impact of the approach will be issued to Adults and Health Spokes meeting. If any implications require a key decision to be taken they will be tabled on the agenda for a future committee meeting.

3.3.4 Somers Court held a total contract value of £408,898 per annum. This is not included in the budgetary figures outlined in Table C below as the service is not being included in the extension request.

3.4 **Ditchburn Place**

3.4.1 Care within Ditchburn Place extra care scheme was previously provided by Cambridge City Council. A competitive tender process was undertaken to award a new contract when the arrangement with Cambridge City ended, but no bids were received. This was predominantly due to financial risk associated with high levels of local authority staff transferred across to the new provider, and the fact that the service was supporting those people living here who had higher levels of care than an extra care scheme, would normally be expected to support.

3.4.2 As no bids were received, a request to directly award the contract to Radis was taken to Adults Committee as a confidential decision in April 2019 and approved. It was acknowledged that a higher level of block hours than needed was contracted for to ensure that additional costs around TUPE would be covered.

3.4.3 There was an expectation that during the initial 5 year contract term that the provider would look at harmonisation of staff terms and conditions and also consider how the service could be brought back into line with standard extra care services. However, this was not formalised and there has been very limited progress on this, mainly due to the fact the number of TUPE staff remains significant. To move this forward the Contract Management Team are working with the provider to address this through development of a clear plan to harmonise the staff terms and conditions and realign the care balance within the scheme which will be agreed by both the provider and Social Care teams. This will be formalised through delivery of a contract variation incorporating requirements to harmonise staff terms and conditions. Any further extension beyond April 2027 offer would be contingent on demonstrable progress in these areas.

3.5 **Utilisation**

3.5.1 Services across the county are well utilised and vacancies are generally filled quickly. For most schemes, including those we are seeking to extend in this paper, waiting lists are in operation. Utilisation of the contracts is regularly monitored and over the period of 07/0/2024 to 25/08/2024 the average weekly care hours were as follows:

- Baird, Millbrook, Ness and Eden Schemes = 453 hrs per week
- Ditchburn Place = 378 hrs per week

This means that whilst there are minimal vacancies, the care hours being delivered at Ditchburn Place are falling significantly below the allocated block of 600 support hours. This will be addressed through the harmonisation work summarised in paragraph 3.4.3.

3.5.2 Monitoring and market feedback suggests that our approach to commissioning extra care may no longer be the most cost effective or efficient way of ensuring appropriate delivery of care within these services. Currently all schemes have a block amount of hours and can claim for additional hours of care and support if required. However, this is proving to be a rigid approach that does not allow for flexibility when block hours are over or underutilised. To assist with this in the short-term contract terms & conditions will be amended to enable us to review the block hours annually and renegotiate based on actual usage across the year. Alongside this, alternative future delivery models will also be explored.

3.7 **Extension request**

3.7.1 This is the first request to extend the care and support contracts for all at the above schemes. During this extension periods, Commissioners will continue to work with Contracts colleagues to understand the utilisation of the block hours, which are regularly monitored. This will help to establish the viability of any future extensions or re-tendering of the services should any re-balancing of block hours be required. Please note, that whilst Somers Court is included in the current contract for Baird Lodge et al, as the service is due to close from March 2025, we are not requesting an extension to this element of the funding and the associated contract value outlined in paragraph 3.3.4 has been removed.

Table C below details the Extra Care schemes seeking contract extension.

Scheme	District	Care Provider	Annual Contract Value	Total extension value
Ditchburn Place	Cambridge	Radis	£831,177	£1,662,354 (2 years)
Baird Lodge	East Cambs	Radis	£1,192,852	£3,578,556 (3 years)
Eden Place	East Cambs	Radis		
Millbrook House	East Cambs	Radis		
Ness Court	Hunts	Radis		

Table C – Annual contract value with proposed 24/25 uplift applied. This is based on current rates and would be adjusted if services are eligible for an uplift.

3.7.2 The block usage will continue to be regularly monitored by the Contract Management Team for all services. For Ditchburn Place the council will be seeking reductions in hours over the 2 year period as a result of harmonisation. For Baird Lodge et al, it has been agreed with procurement to seek a contract variation which alters the extension periods from a +1 year arrangement over 5 years to a 3+2 year arrangement. This is on the basis that the total duration and the financial value is the same.

4. Alternative Options Considered

4.1 The alternative options that were considered alongside this recommendation are outlined in the table below.

Baird, Millbrook, Ness & Eden		**Ditchburn Place**	
Option	Reasons this was not considered	Option	Reasons this was not considered
Do not extend the contracts	Contracts are utilised and providing positive outcomes for service users therefore there is no reason not to extend the contracts for a period of 2 years.	Terminate the current contract and re-tender	Original tender received no bids due to high financial risk as a result of the large number of local authority staff who would be transferring under TUPE. As the TUPE implications have not been addressed during the initial contract period, it is extremely likely that we would again be in a position where no bids are received due to financial risk posed by the TUPE transfer.
		Arbitrarily reduce block hours to reflect current care hours and extend for full 3 years	Reducing the hours to match care package hours would not take account of the additional TUPE costs which additional hours were put in place to offset. Reducing to this level would make the contract financially unviable for the Provider and therefore there would be a significant risk the contract could not continue.
		Set up as an 'in-house' service	The recent review of in-house service delivery undertaken by Red Quadrant has highlighted a need to address some recommendations around delivery of current in-house services before considering expansion of in-house delivery. The review also suggested that any future expansion should be targeted to meet specific market needs or gaps, rather

			than market areas with good coverage such as Extra Care.

Table G – Options considered

5. Conclusion and reasons for recommendations

5.1 In commissioning these services the Council is supporting the commitments made within its ambitions and helping to deliver positive outcomes for older people and those with additional care and support needs.

5.2 By supporting individuals within these services, the Council is also helping to prevent people's needs from escalating to a level where they would require emergency or higher need services e.g. residential or nursing homes.

5.3 Extending the contracts will allow the Council to continue to meet the needs of service users, and to review the current commissioning approach and consider other potential options for the future. This will be informed by any recognised best practice and through discussions with other local authorities who have already successfully implemented different approaches elsewhere.

5.4 Over the next 6 months, commissioners will: -

- Engaging with other local authorities about the way they commission extra care housing
- Obtain views and thoughts from providers/landlords/service users on the current approach
- Workshop and test out new approaches and models with stakeholders and partners.

6. Significant Implications

6.1 Finance Implications

The financial implications are the outlined in Section 3 of the report.

6.2 Legal Implications

The requested contract alteration for Baird Lodge et al is on the basis of the duration and the financial value of the extension periods remaining the same. Providers will have the opportunity to challenge this during the standstill period.

6.3 Risk Implications

If required outcomes are not delivered in relation to the Ditchburn Contract, then the County Council would need to review our position. Whilst this will not impact on the level of service people will receive, it will delay the financial efficiencies associated with realigning the terms and conditions.

6.4 Equality and Diversity Implications

The EQIA's remain the same from the original committee papers.

6.5 Climate Change and Environment Implications

N/A

7. Source documents

None

Appendix A – Case studies

Example One

We support a lady (B) who has lived at Eden Place for the last 8 years. She lives with Dementia, which has gradually been getting worse. She is now not visiting the dining room, forgetting to eat, does not attend activities and is spending a lot more time in bed. Family are concerned about B having to move out of Eden Place, and have made it clear that they want B to remain at Eden Place, even though B's condition is deteriorating.

To ensure that we are able to continue to support and meet B's needs, we have put additional monitoring in place including:

- Where staff have any spare time, they will carry out extra checks on B, where they will sit, talk and interact with B
- B loves music and singing, so where B is feeling up to it staff will take B to accessible activities such as singing, coffee mornings, or to watch the entertainers. When B is having a bad day staff will put music on in B's room
- Where the family have visited B and raised with staff that B is having a down day, we will ask the waking night staff to do some additional checks overnight to reassure the family and alleviate their anxiety
- In addition to attending activities staff will take B around the garden or to the dining room for a cup of tea in any spare time. This has resulted in B going to bed less as she is less socially isolated and more active
- Staff will prepare breakfast for B first, so they are able to encourage and monitor B's eating during their visit. This has resulted in B eating more
- We have records in place so staff record what B is eating and drinking
- Staff have completed training in addition to Care Certificate requirements, including Lewy Body and Dementia Awareness
- Consistent staff who know B well has meant that staff are able to understand B's body language and facial expressions, including if she is happy or not, so they are able to swiftly respond if required.

Example Two

Radis have supported K, an 97 year old lady, for just over 3 years after she moved in Ness Court following the Covid pandemic. K has lived in various settings over the years including sheltered accommodation and a care home. She has told staff that is fed up with moving, that she wants to settle at Ness Court and this is to be her final home.

K's health has recently declined. K has been deemed as having full capacity and has decided not to inform Radis staff, nor her son of her diagnosis/prognosis. We have noticed that she has stopped eating and drinking due to her inability to swallow, meaning that she is a high risk of choking. K's breathing has also changed and she has a constant pain in her chest.

Paramedics were called and had advised that K would need to be admitted in to hospital as she may need a PEG fitted. K refused to go into hospital as she felt that if she did get admitted that she would die there, which was not her wish and said that she would rather suffer.

Our Service Manager, Toma, has instead liaised with K's GP and local District Nurses to discuss the possibility of having a PEG fitted during day surgery to reduce the amount of time K spends at hospital and therefore, can recover at home as per her wish.

Specialist training is being sourced to continue to meet K's new nutritional needs and also to ensure K's pain medication can be administered to keep her comfortable. Staff have already completed End

of Life training so staff are able to provide appropriate support and care to K at Ness Court, if she continues to choose to die at her home.

Example three

Mr X moved into Ditchburn in 2023 following an accident he had while living abroad. This resulted in him suffering a head injury (Neurological trauma), and his mobility and continence being affected. Mr X also lived with Bi-polar disorder. Following the accident, his marriage also broke down, although he and his wife remained good friends.
Mr X moved back to England and lived with his sibling. His siblings were struggling to cope with Mr X's care needs and enquired about him coming to live at Ditchburn Place with this being close to them. Mr X came to visit and agreed to move in.
Mr X's goals were to be as independent as possible following his accident and to have a good quality of life. To support this staff would carry out welfare checks on Mr X, ensure he came to the dining room for his meals and prompt him to take his medication. This helped him to be engaged with staff and other residents as well as ensuring he did not self-neglect.
Mr X is at high risk of falls, so staff carried out a falls risk assessment, and ensured Mr X used his stick and provided gentle encouragement while mobile to help him to move independently. Staff also ensured support was available when Mr X needed extra support with his continence.
Staff also made Mr X aware of any activities/events that were on at the scheme, encouraging attendance to reduce his isolation. Mr X seemed to really enjoy these and became a regular participant and really enjoyed engaging with other people.
An email from his sister (25/9/24) stated '*I am happy to report that Mr X seems to be flourishing at Ditchburn, so thanks to all for looking after him so well.'*

Adults, Health and Commissioning Business Planning Audit

To:	Adults and Health Committee
Meeting Date:	12th December 2024
From:	Executive Director for Adults, Health and Commissioning
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	Not applicable

Executive Summary: The outcomes of this report are to update Committee in relation to the following:

- An overview of the recommendations from Internal Audit in relation to the Adults Health and Commissioning Business Planning 2024/25 Process.
- Progress to implement the agreed remedial actions

Recommendation: The Committee is asked to note the contents of the audit report and remedial actions undertaken.

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1. Creating a greener, fairer and more caring Cambridgeshire

1.1 This report supports delivery of the Council's ambition to ensure People enjoy health, safe and independent lives through timely support that is most suited to their needs.

2. Background

2.1 The Executive Director for Adults Health and Commissioning requested internal audit to conduct a review of the governance and planning processes carried out as part of the development of 2024/25 business planning proposals within the directorate.

2.2 The audit was completed in September 2024. The outcome was that there was limited assurance in place around the adequacy of system and compliance, but that the organisational impact of these findings was minor.

2.3 The audit resulted in six recommended actions. Three high priority and three medium priority in nature.

2.4 The Audit and Accounts Committee discussed the Adults Directorate Business Planning Review and Challenge Audit at its meeting on 31 October 2024. The Committee resolved unanimously that the report should be submitted to the Adults and Health Committee for consideration.

3. Main Issues

3.1 The aim of the internal audit review was to undertake a 'critical friend' role to scrutinise two individual proposals in depth (Learning Disability Deep Dive and All Age Locality Review) and undertake a review of the business planning programme as a whole, and to make any recommendations to strengthen proposals, programme governance or subsequent planning and implementation of business planning actions.

3.2 The audit was commenced in January 2024, with the final report being published in October 2024. The timing of the audit meant that it was undertaken at the tail end of the 2024/25 business planning cycle, prior to full Council approvals for the business plan being in place and implementation of plans commencing. As such, the audit report notes that the systems and governance structures for delivery of the proposals were still at an early stage of development at the time the audit was undertaken.

3.3 The findings of the audit report were that Adequacy of System had 'limited' assurance and compliance had 'limited' assurance, whilst the organisational impact was 'Minor'. The key reasons were:

- At the time of audit, there was no clearly defined and documented overarching governance structure in place to provide oversight and assurance across the entire range of Adults business planning proposals. However, it was noted that these arrangements were under development at the time, including oversight and accountability mechanisms for savings and transformation programmes.

- There was a lack of consistency in the level of detail regarding benefits realisations, delivery plans and risk assessments associated with business planning proposals.
- The implementation and communication of a clear corporate project management framework and change board system across the organisation would provide further guidance and support for the implementation of proposals.

3.4 The audit report made a set of six recommendations. Three of these are risk rated as high and the remaining three as medium. The recommendations have been actioned as outlined below:

3.4.1 Completed Actions

	Recommendation	**RAG**	**Update**
1A	Establish a comprehensive governance structure	High	**Completed** • Central Adults, Health and Commissioning directorate change board established and meets monthly to oversee implementation of all proposals. • Organisational requirements for the oversight of directorate change programmes are in place • Project and programme boards and delivery governance and reporting lines established. • Power BI reporting dashboard has been developed providing overview of all projects. • Red RAG projects reported monthly to corporate change board. • Risk management process established.
2A	Learning Disability Deep Dive: Develop comprehensive and well-defined project proposals	High	• Proposal documents have been enhanced to ensure clear scope, objectives and action plans are in place. • Savings are monitored monthly and verified by Finance for reporting into published savings tracker. • Programme board is aligned with central Adults Health and Commissioning Change Board, with reporting and governance oversight established.
2B	Learning Disability Deep Dive: Develop and embed risk identification, register, mitigation	Medium	• Risk register and savings tracker in place for all projects. This includes inclusion of more robust risk mitigation plans.

	strategies and sufficient details in highlight reports.		• Consistent highlight reporting implemented, reporting up to directorate change board.
3B	All Age Locality Review: Implement robust risk identification and managements processes and clear project plans.	Medium	• A comprehensive risk register has been implemented. • Project oversight board has been established • Regular reports are feeding into the directorate change board and associated governance.

3.4.2 In Progress Actions

	Recommendation	**RAG**	**Update**
1B	Improved planning/refinement of implementation plans, savings and costs and procurement processes prior to execution	Medium	• Corporate business planning process has been refined for 2025/26 to ensure more robust proposal development and testing, including finance testing. • For initiatives involving consultancy support, we are progressing procurement plans and have clear timelines in place. • Review of resourcing to support the co-ordination of the central portfolio overview for adults, health and commissioning underway.
3A	All Age Locality Review: Develop detailed proposals, investment plans, alignment with existing governance and monitoring mechanisms.	High	• Consultancy support has been commissioned and work is underway with detailed milestone plan in place. The outcomes of this will inform future opportunities and plans. • Clear governance for the project has been established, ensuring robust oversight and accountability.

3.5 The findings and implementation of recommended actions has had a positive impact on the process for the 2025/26 business planning cycle, as the Adults, Health and Commissioning Directorate have embedded the learning and developed more robust processes to support delivery, risk management and governance.

3.6 The Executive Director for Adults, Health and Commissioning will be attending Audits and Account Committee in January 2025 to provide assurance to the Committee regarding the effectiveness of governance arrangements and compliance within the Directorate in line with the Committee's Terms of Reference.

4. Conclusion and reasons for recommendations

4.1 Committee is being asked to scrutinise and comment on the contents of this report.

5. Significant Implications

5.1 Finance Implications

Implementing the findings and recommendations from this internal audit will ensure robust processes and governance supporting effective development of business planning proposals and delivery of associated financial benefits.

5.2 Legal Implications

There are no significant legal implications.

5.3 Risk Implications

There are no significant risk implications, as these have been addressed through implementation of the audit recommendations.

5.4 Equality and Diversity Implications

There are no significant equality and diversity implications.

6. Source Documents

None

Finance Monitoring Report – December 2024

To:	Adults and Health Committee
Meeting Date:	12 December 2024
From:	Executive Director: Adults, Health & Commissioning Executive Director: Finance and Resources
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	N/A
Executive Summary:	The report provides an update on the financial position of the Adults, Health and Commissioning Directorate (including Public Health) as at the end of October 2024.
Recommendations:	Adults and Health Committee is recommended to: 1) note the Adults, Health and Commissioning Finance Monitoring Report as at the end of October 2024. 2) note the update on Adult Social Care debt.

Officer contact:
Name: Justine Hartley
Post: Strategic Finance Manager
Email: justine.hartley@cambridgeshire.gov.uk

1. Creating a greener, fairer and more caring Cambridgeshire

1.1 This regular financial monitoring report provides the consolidated management accounts of the Adults, Health and Commissioning Directorate and the Public Health Directorate, enabling members to be aware of, and to scrutinise, the delivery of the business plan for 2024-25 and the corporate vision and ambitions within it.

2. Background

2.1 Finance Monitoring Reports (FMR) are produced monthly, except for April, by all services. They report on a range of financial information to enable a view of each service's financial position to be taken.

2.2 Budgets for services are agreed by Full Council in the business plan in February of each year and can be amended by budget virements. In particular, the FMR provides a revenue budget forecast showing the current projection of whether services will be over- or under-spent for the year against those budgets.

2.3 The presentation of the FMR enables Members to review and comment on the financial position of services within the committee's remit.

2.4 Generally, the FMR forecasts explain the overall financial position of each service and the key drivers of any budget variance, rather than explaining changes in forecast month-by-month.

2.5 The contents page of the FMR shows the key sections of the report. In reviewing the financial position of services, members of this committee may wish to focus on these sections:

- Section 1 – providing a summary table for services that are the responsibility of this committee and setting out the significant financial issues (replicated below).
- Section 5 – the key activity data for Adult Services provides information about service-user numbers and unit costs, which are principal drivers of the financial position.
- Appendices 1-3 – these set out the detailed financial position by service and provide a detailed commentary for services projecting a significant variance from budget.
- Appendix 4 – this sets out the savings for Adults, Health and Commissioning and Public Health in the 2023/24 business plan, and savings not achieved and brought forward from previous years that are still thought to be deliverable.
- Appendix 5 – contains information on earmarked reserves, grant income and budget virements.

3. Main Issues

3.1 Adults, Health and Commissioning overall revenue position

3.1.1 The overall position for Adults, Health and Commissioning budgets to the end of October 2024 is a forecast underspend of £5,388k (equivalent to 2.3% of the annual budget). This includes a forecast underspend for Public Health of £248k (equivalent to 0.6% of the annual budget) which is assumed to be transferred to Public Health reserves at year end.

Forecast Outturn Variance (Previous) £000	Service Area	Gross Budget £000	Income Budget £000	Net Budget £000	Actual to date £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
3,113	Executive Director	21,580	-54,503	-32,923	-30,973	978	-3.0%
1,504	Learning Disability and Prevention	155,600	-37,137	118,463	69,592	1,543	1.3%
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-274	Public Health	41,695	-38,792	2,904	-9,555	-248	-0.6%
-4,355	**Total Expenditure**	**417,574**	**-183,653**	**233,921**	**111,908**	**-5,636**	**-2.4%**
274	(Drawdown from) / Contribution to Public Health reserves	-2,903	0	-2,903	-982	248	9%
-4,081	**Total**	**414,671**	**-183,653**	**231,018**	**110,926**	**-5,388**	**-2%**

3.1.2 Net growth in the early months of the year for Older People services was significantly below budget, and whilst growth has now returned to closer to expected levels, a significant forecast underspend remains. This is largely driven by higher numbers of packages ending rather than by lower numbers of new packages starting, and represents a shift from the trends we had been seeing during, and in the period immediately following, the covid pandemic. A deep dive into this area continues to further understand the changes to flows of service users in recent months to inform both the in-year forecast and future demand projections.

3.1.3 The forecast underspend against the budget for Older People services is partially offset by pressures in services for people with learning difficulties and for mental health care costs, some of which relate to Older People. Plus, some of the savings built into the Business Plan for 2024-25 need further work to deliver.

3.1.4 The key factors that will impact the forecast position as the year progresses include:

- demand is difficult to predict and can vary significantly from month to month. This can be reflected both in numbers accessing services, and higher acuity of need of those accessing services;
- the Directorate has a challenging set of savings targets to deliver against in 2024-25. Progress against these targets is reported quarterly and whilst many are on track to deliver, in other areas the work to finalise delivery plans is still underway putting at risk the chances of full delivery of savings in the current financial year;
- recruitment remains challenging and vacant posts can lead to underspends against staffing budgets;
- staffing risks are particularly pertinent for the Public Health team in the short term as the separation from Peterborough City Council takes place; and
- pressures with the provider market continue to be felt, particularly related to increasing fee rates. Inflationary negotiations are ongoing with over 90% of package uplifts agreed to date. Providers are continuing to report cost pressures related to both workforce issues and the current cost of living crisis. The impacts of inflationary pressures are seen both in the uplifts required for existing care packages, and the price at which new packages are sourced; and
- the position of the care market, particularly around specific types of provision and location, is making some placements more difficult to source, particularly at the more complex end of provision.

3.1.5 As a result of these issues, close attention will be paid to changes in demand, costs and income as the 2024-25 financial year progresses, and forecasts will be updated accordingly.

3.1.6 There is further commentary on overdue debt with Health partners in section 3.3.1 below. Adults, Health and Commissioning overdue debt (excluding debt with Health partners) stood at £22.3m at the end of August, up from £21.7m at the end of July. Although the large majority of client contributions are paid on time, the complexity of people's individual care needs and personal finances will mean that some amounts are not immediately collectable: this can include amounts secured against properties or subject to probate. . The Council has established a focused programme of work to ensure that activity to collect amounts owed as client contributions keeps pace with increased levels of billing and that levels of aged and overdue debt are decreased with improved customer experience.

3.1.7 Adults, Health and Commissioning overdue debt (excluding debt with Health partners) stood at £20.9m at the end of October, down from £21.6m at the end of September. In addition, overdue debt with Health partners stood at £10.6m at the end of October down significantly from £27.6m at the end of September following the partial payment of a number of outstanding invoices in relation to the Learning Disability Partnership. Actions continue following a deep dive into some of the factors resulting in the levels of debt, along with additional resources to work on backlogs of financial assessments. Debt over 90 days old was £17.0m at the end of October, down marginally from £17.1m at the end of September. The level of aged debt has a knock-on impact on the bad debt provision and likelihood of write offs which will be monitored as the year progresses.

3.2 Update on Adult Social Care debt presented to Audit Committee in October 2024

3.2.1 Audit and Accounts Committee received an update on debt as at the end of September 2024 at its meeting on 31 October. The elements related to Adult Social Care debt are replicated below.
Background

3.2.1 The balance sheet health metrics, that are reported in the Integrated Finance Monitoring Report at each meeting of the Strategy, Resources and Performance Committee record that there is a significant exception with the level of debt outstanding (91 days+) for Adult Social Care (client contributions to care costs). Although metrics for percentage of income collected within 90 days is still meeting the target level, the absolute amount of overdue debt has risen by approximately £2.4m over the last 12 months. This reflects the rising levels of client contributions billed by the Council from £45.9m (2022/23) to £52.5m (2023/24), and £31.4m during the first half of 2024/25.

3.2.2 It is positive that overall more income is being collected due to increases in billing, however a part of the increase relates to retrospective back dated charges as a result of clients being charged a provisional amount for an extended period of time. This follows significant progress with reducing the backlog of financial assessments over the last 18 months. Delayed billing can lead to debt building for clients, which can prove more difficult to collect, especially where clients have become used to paying a lower provisional charge over a prolonged period, or where charges are billed a significant period after death and the estate has been distributed.

Overall Debt position

3.2.3 The main areas impacting the current debt position are:

• Significant increase in Integrated Care Board (ICB) debts which stood at £28m on 1 October compared to £3.8m at the same point in 2023/24. During October, payments of £16.6m have been secured, which is welcomed, and reduces the ICB debt balance to £11.4m.

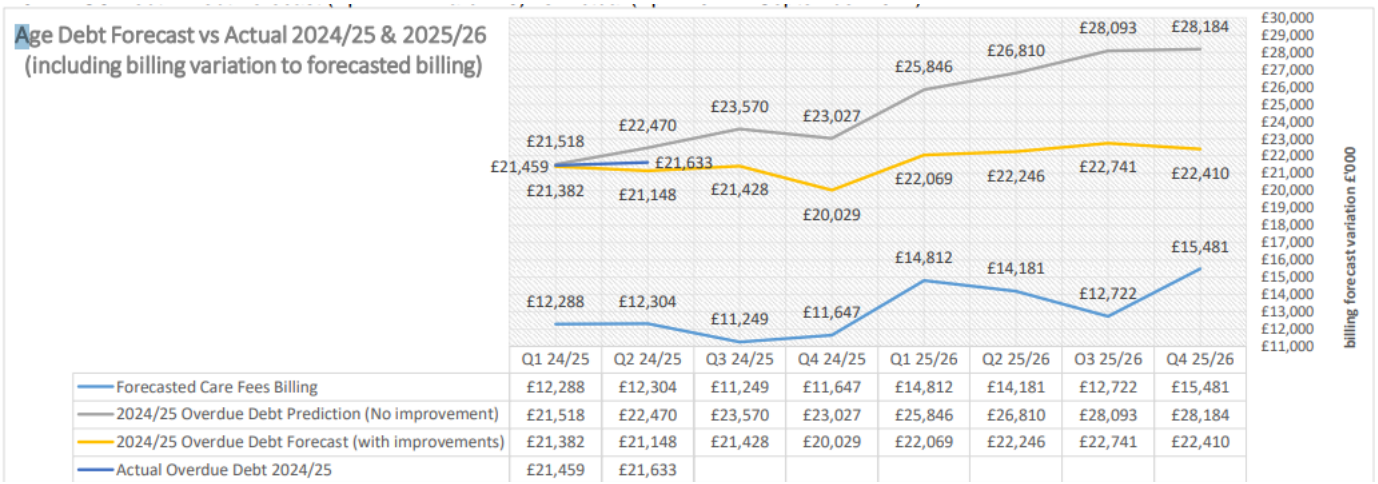
• Increased ASC debt billing of £6.6m in 2023/24 and a further £5.6m in the first half of 2024/25. £10.1m over the same 18-month period relates to back dated charges, with some charges back dating by more than a year. Such debts become increasingly difficult to collect.

3.2.4 ASC Age Debt Analysis – Headlines

• ASC Debt increase has slowed, and age debt (debts six months) have started to reduce over the last two months by circa £868k, as a result of improvements implemented.
• Revenue raised is higher than 2023/24 forecast which is positive from an income perspective but has resulted in increased debt where payment not fully collected.
• Backlog in Financial Assessments has been reduced and is moving towards business-as-usual levels.
• Wide ranging process improvements have been identified and implemented or in the process of being implemented.

• Improved staff performance within Debt Team, which has significantly increased number of accounts actioned from average of 1,070 in last half of 2023/24 to 1,701 average in 2024/25, with September 24 peak of over 2,000.
• Digitalisation advances considered and several options have been identified and progressed such as Paperless Direct Debits, SMS reminders.
• Increased resources have been funded and are either in place or currently being recruited.
• Increase in use of third-party services to support recovery process have been procured and are being embedded.
• Increase training, support and guidance across teams (Debt, Financial Assessment and Practice).
• Improved communication and workflow tracking due to be implemented between Adults Finance Team & Debt Team during October 2024, following successful testing during September 2024.
• Issues identified and improved processes being implemented to better manage Court of Protection debts within both Adult Social Care and the Debt team, which should have a positive impact on related debt.

3.2.5 ASC Debt – Debt forecast (April 24 – March 26) vs Actual (April 24 – September 24)



	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26
Forecasted Care Fees Billing	£12,288	£12,304	£11,249	£11,647	£14,812	£14,181	£12,722	£15,481
2024/25 Overdue Debt Prediction (No improvement)	£21,518	£22,470	£23,570	£23,027	£25,846	£26,810	£28,093	£28,184
2024/25 Overdue Debt Forecast (with improvements)	£21,382	£21,148	£21,428	£20,029	£22,069	£22,246	£22,741	£22,410
Actual Overdue Debt 2024/25	£21,459	£21,633						

3.2.6 Finance modelling has been undertaken to forecast the revenue through 2024/25 and 2025/26, which shows an upward trajectory in respect of income generated through billing compared to previous billing in 2023/24.

• 2023/24 – Actual billed revenue £52.5m (£44.6m care fees).

• 2024/25 – Forecasted billing revenue £55.4m (£47.5m care fees), representing a £2.9m increase from 2023/24. Actual billing P1-P5 was £3.5m up on forecast.

• 2025/26 – Forecasted billing revenue £65.2m (£57.2m care fees), representing an increase of £9.8m increase over 2024/25.

3.2.7 Debt Forecast has been modelled taking into consideration the increased income as well as expect impact in respect of performance.

• Debt Forecast shows that Debt levels would be circa £28.2m based on increase revenue if normal levels of recovery were achieved, increase of £7.7m from April 2024.

• Debt Forecast with improvements in ASC Service & Debt Team reduce the expected balance in March 2026 to £22.4m which represents an increase of £900k over two years, against the backdrop of £15.6m more being raised, representing circa 94% collection on the additional income, and improving significantly the Debt vs. twelve months billing ratio.

3.2.8 ASC has seen a £2.4m increase in debt over the last twelve months across all age brackets, with £636k in aged debts (6+ months) and £1.8m in debts that are in age brackets of less than 6 months. Over the same period the level of Income generated through billing for ASC has been increased by £8m (Oct22-Sept23 = £50.1m vs. Oct23-Sept24 = £58.1m), representing increased income collection of circa £5.6m.

• £1m increase in debts allocated to our solicitors or an external debt collection partner. The increase in this category of debt is following work undertaking by Debt Team to progress more quickly once internal recovery actions have been exhausted.
• £850k increase in debts requiring support from ASC – Due to the vulnerable nature of the customer base these debts can be quite complex.
• £700k increase in debts awaiting Court of Protection (COP) decisions – These debts are where Service Users have lost capacity to manage their financial affairs and applications are made to the COP for a family member, Advocate or the council through Client Funds to take over responsibility for property and affairs decisions. Debts within this category can take a significant period of time before there is someone appointed through the Courts or DWP. There is material level of debt in this category which is likely to be overstated as the client has been assessed as full cost until their finances can be assessed.
• £386k increase within Deceased Debts which has been impacted in the main by the clearing of Financial Assessment backlogs over the last 18 months, again there is a level of debt overstatement within this category as well as a raised likelihood of bad debt write-offs where retrospective billing may have occurred.
• £270k Increase in Secured Property related debt, where clients have passed away and the deferred payment agreement, they had with the council has ceased. These debts are secured but will take a period of time before funds are realised pending probate and subsequent sale of property.
• £868k reduction has been seen in aged debts, those older than six months over the last two months as improvements implemented start to impact.

2023/24 – Collection Performance

3.2.9 Collection rate for 2023/24 shows that 92.5% of all revenue billed has been collected as shown in the below table with 83% being secured within the first 90 days, performance would have been higher if not for the disputed ICB charges during 2023/24, which have continued into 2024/25.

Combined 90 Day Performance

				Income Collected [£]			Performance - % Collected		
Financial Year	Period	No. of Invoices	Invoiced Amount'000	3 Months	6 Months	Total to Date	3 Months	6 Months	Total to Date
2023/24	Apr-23	5,757	£12,779	£10,746	£11,379	£12,442	84.1%	89.0%	97.4%
	May-23	7,331	£12,167	£10,270	£10,860	£11,494	84.4%	89.3%	94.5%
	Jun-23	7,329	£18,129	£16,721	£17,080	£17,583	92.2%	94.2%	97.0%
	Jul-23	5,692	£18,772	£14,525	£17,080	£18,304	77.4%	91.0%	97.5%
	Aug-23	7,429	£10,373	£7,752	£8,990	£9,609	74.7%	86.7%	92.6%
	Sep-23	7,286	£31,144	£28,324	£28,832	£29,864	90.9%	92.6%	95.9%
	Oct-23	5,966	£13,614	£11,749	£12,237	£12,810	86.3%	89.9%	94.1%
	Nov-23	7,739	£19,554	£17,162	£17,790	£18,833	87.8%	91.0%	96.3%
	Dec-23	5,783	£15,277	£11,629	£12,985	£13,598	76.1%	85.0%	89.0%
	Jan-24	5,696	£28,708	£20,434	£20,736	£20,976	71.2%	72.2%	73.1%
	Feb-24	8,001	£21,928	£18,253	£19,218	£20,852	83.2%	87.6%	95.1%
	Mar-24	5,633	£33,619	£27,966	£31,903	£32,094	83.2%	94.9%	95.5%
		79,642	£236,063	£195,532	£209,090	£218,460	82.8%	88.6%	92.5%

2024/25 – Collection Performance

3.2.10 Collection rate for the first quarter of 2024/25 is currently at 75%, which is suppressed by £8.3m of NHS / ICB charges raised during the same period, excluding the performance would be 91%. This position will be improved once the NHS income received in October is applied.

3.2.11 Improvements implemented in late 2023/24 in respect of staff performance is ensuring that debts are actioned promptly, with monthly accounts actioned during the first half of 2024/25 averaging at 1,701 accounts compared to 1,070 in the last half of 2023/24. September 2024 saw a peak achieved of over 2,000 actions.

Improvements Implemented / In Progress

3.2.12 The improvement work in this area is overseen by a project board co-chaired by the Service Director: Finance and Procurement and the Service Director: Adult Social Care. Actions have been assigned to both Debt and Adult Social Care teams.

Systems & Digital		
• New Call Management System implemented for Debt Team • HALO communication / workflow system put in place between AFT & Debt. • SMS Reminder system being procured / implemented • Paperless Direct Debit Solution being procured / implemented • Increased E-Billing		• Improved Call management • Better Customer Experience • Reduced complaints • Improved internal communication / workflow between teams • Improved cashflow and reduction in debt levels. • Reduction in postal and print costs • Reduced carbon footprint • Printed percentage reduced from 77%(Nov21) to 60% (Sept 24)
Improved Team Management		
• Portfolio changes & Team Performance • Improved Team Guidance in place within the Debt Team, with staff training provided • Enhanced reporting by category / subcategory (further granularity) in place to better track / understand debt. • Changes in Financial Assessment Process, maximising resource and improving productivity.		• Raised Team performance, increase in actions from monthly average of 1,070 to 1,701 (59% improvement) • More consistent approach and one that looks to achieve outcome or move to the next stage of recovery sooner. • Improved more granular debt data which facilitates next recovery actions and where debt is in a process outside of the council's immediate control (Probate, Court of Protection, Property Sale etc) • Maximising revenue through more timely and increased billing. • Reduction in Financial Assessment backlog from 1037 (Aug23) to 64 (Sept24)
Detailed Reviews & Process improvements		
• Detailed Court of Protection (COP) review & process improvements implemented. • Detailed review of Deceased Cases, process changes implemented. • Legal review undertaken, changes implemented, and additional services procured. • Customer correspondence review completed, revised dunning letters and template letters produced including behavioural science nudges.		• Reduced timeframe over the end-to-end COP process once all changes implemented. • Deceased Debt reviewed and tackled at earliest opportunity. • Identify toxic debt more quickly and take actions to resolve or write-off timely. • Reduce Debt write-offs in the longer term. • Increased options to improve recovery through external legal / trace services.
External Debt Recovery Agents		
• Debt Recovery Agents procured to handle ASC cases with a softer approach with the council remaining in control. • Referral of cases to Finders International and associated solicitors		• Maximise collection (21% of first trance referred paid & 50% of customers made contact where they had not previously engaged) • Identify non-recoverable debts quicker and reduce bad debt write-offs • Decrease Legal costs in the longer term

Resources		
• Review Debt Team operating model to ensure the right level / skill level is effective. • Recruitment to vacant / additional funded posts within Debt & Client Funds teams. • Increase training and development of staff to deliver high performing team. • Right-Size Client Funds Team to reduce / remove waiting list		• Increased skill and knowledge of staff to maximise opportunities to secure income and reduce Bad Debt. • Improved cashflow and assurance within the council in respect of debt management.
Process improvements / New ways of working / Improve Customer Experience		
• Direct Debit Campaign (Increase Take-up) • Promotion / switch towards digital where possible (Paperless Billing & Communications [email / SMS]) • Pilot changes to dunning process and analysis the effectiveness of different options. • Implement changes identified within Audit report. • Review and update corporate Income Strategy, and guidance documents. • Identify debt write-off root cause(s) and implement changes to minimise		• Improved customer experience through use of modern technology and improved processes. • Reduction in councils costs and carbon footprint • Maximising return through use of costeffective third-party services. • Improved controls in respect of debt management. • Policies that align with effective debt recovery and the councils wider ambitions.

3.3 Latest position on Adult Social Care debt

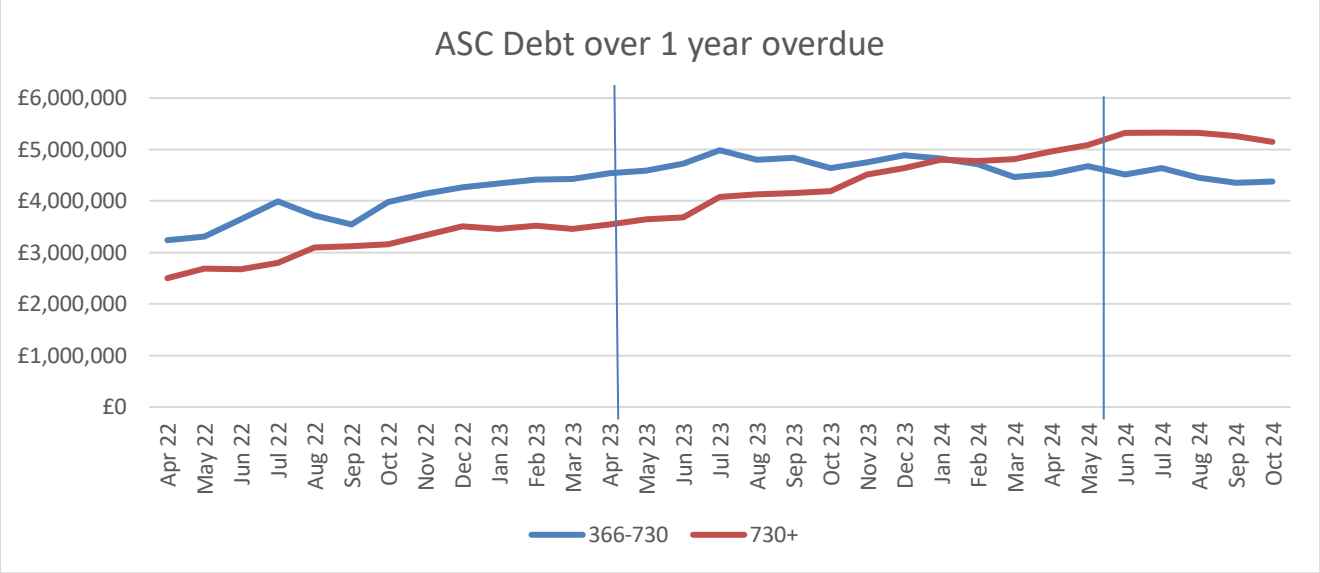
3.3.1 Adult Social Care debt at the end of October with trend performance is set out below.

Overall Age Debt Position - By Directorate

Directorate	Overdue			Trend Performance	
	Current Month	Previous Month	Last Year	Monthly	Yearly
Adults, Health and Commissioning	£ 20,900,223	£ 21,633,031	£ 18,843,256	↑	↓
Public Health	£ -	£ 6,840	£ 11,472	↑	↑
NHS Services (mainly AHC)	£ 10,637,199	£ 27,984,961	£ 5,693,195	↑	↓
	£ 31,537,422	£ 49,624,832	£ 24,547,923		

3.3.2 This reflects an improved position across the Adults, Health and Commissioning Directorate compared to the September position presented to Audit and Accounts Committee. In particular the October position reflects the significant payments received from Health partners during October 2024.

3.3.3 In addition to an improved overall position we are also seeing older debt starting to reduce slowly having been consistently grown for many months. As shown in the graph below. This reflects the actions from the debt deep dive.



3.3.4 Further information is also being collated for Audit and Accounts Committee is relation to backdated charges and the impact these have had on debt levels. This will be brought to the next Adults and Health Committee for information.

4. Significant Implications

4.1 Finance Implications

This report provides the latest financial information for the Adults, Health and Commissioning and Public Health Directorates and so has a direct impact on scrutiny and on wider decision making.

4.2 Legal Implications

There are no significant implications within this category.

4.3 Risk Implications

There are no significant implications within this category.

4.4 Equality and Diversity Implications

There are no significant implications within this category.

5. Source Documents

5.1 None.

6. Accessibility

6.1 The information contained in this report and appendix is available in an accessible format on request from the report author.

Directorate: Adults, Health and Commissioning

Subject: Finance Monitoring Report – October 2024 (period 7)

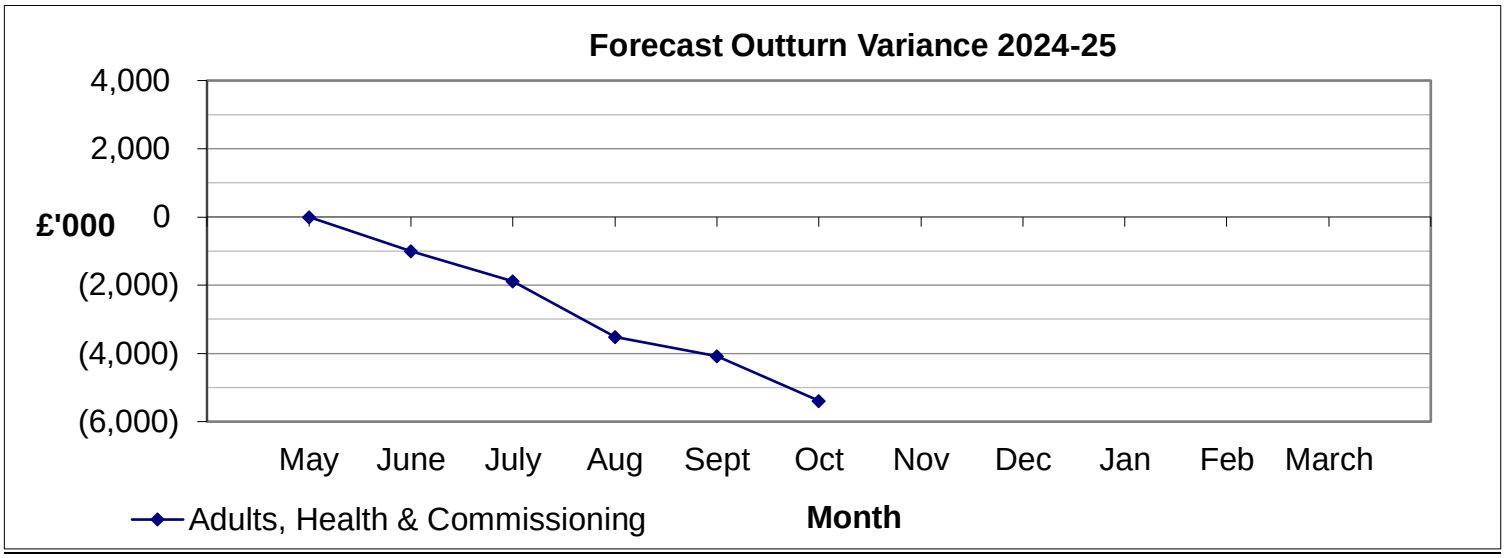
Contents

1. Revenue Executive Summary

1.1 Overall Position

At the end of October 2024, Adults, Health and Commissioning is projecting a forecast underspend of £5,388k. This includes the position for the Public Health service. There are a range of factors that will impact the forecast position as the year progresses which are set out in this report, but movements in the early months of the year are reflected in these forecasts. Close attention will be paid to changes in demand, costs and income as the 2024-25 financial year progresses, and forecasts will be updated accordingly.

1.2 Summary of Revenue position by Directorate



1.2.1 Adults, Health and Commissioning

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-4,355	**Total Expenditure**	**417,574**	**-183,653**	**233,921**	**111,908**	**-5,636**	**-2.4%**
274	(Drawdown from) / Contribution to Public Health reserves	-2,903	0	-2,903	-982	248	9%
-4,081	**Total**	**414,671**	**-183,653**	**231,018**	**110,926**	**-5,388**	**-2%**

1.3 Significant Issues

The overall position for Adults, Health and Commissioning budgets to the end of October 2024 is a forecast underspend of £5,388k (equivalent to 2.3% of the annual budget). This includes a forecast underspend for Public Health of £248k (equivalent to 0.6% of the annual budget) which is assumed to be transferred to Public Health reserves at year end.

Net growth in the early months of the year for Older People services was significantly below budget, and whilst growth has now returned to closer to expected levels, a significant forecast underspend remains. This is largely driven by higher numbers of packages ending rather than by lower numbers of new packages starting, and represents a shift from the trends we had been seeing during, and in the period immediately following, the covid pandemic. A deep dive into this area continues to further understand the changes to flows of service users in recent months to inform both the in-year forecast and future demand projections.

The forecast underspend against the budget for Older People services is partially offset by pressures in services for people with learning difficulties and for mental health care costs, some of which relate to Older People. Plus, some of the savings built into the Business Plan for 2024-25 need further work to deliver.

The key factors that will impact the forecast position as the year progresses include:

- demand is difficult to predict and can vary significantly from month to month. This can be reflected both in numbers accessing services, and higher acuity of need of those accessing services;
- the Directorate has a challenging set of savings targets to deliver against in 2024-25. Progress against these targets is reported quarterly and whilst many are on track to deliver, in other areas the work to finalise delivery plans is still underway putting at risk the chances of full delivery of savings in the current financial year;
- recruitment remains challenging and vacant posts can lead to underspends against staffing budgets;
- staffing risks are particularly pertinent for the Public Health team in the short term as the separation from Peterborough City Council takes place; and
- pressures with the provider market continue to be felt, particularly related to increasing fee rates. Inflationary negotiations are ongoing with over 90% of package uplifts agreed to date. Providers are continuing to report cost pressures related to both workforce issues and the current cost of living crisis. The impacts of inflationary pressures are seen both in the uplifts required for existing care packages, and the price at which new packages are sourced; and
- the position of the care market, particularly around specific types of provision and location, is making some placements more difficult to source, particularly at the more complex end of provision.

As a result of these issues, close attention will be paid to changes in demand, costs and income as the 2024-25 financial year progresses, and forecasts will be updated accordingly.

Adults, Health and Commissioning overdue debt (excluding debt with Health partners) stood at £20.9m at the end of October, down from £21.6m at the end of September. In addition, overdue debt with Health partners stood at £10.6m at the end of October down significantly from £27.6m at the end of September following the partial payment of a number of outstanding invoices in relation to the Learning Disability Partnership. Actions continue following a deep dive into some of the factors resulting in the levels of debt, along with additional resources to work on backlogs of financial assessments. Debt over 90 days old was £17.0m at the end of October, down marginally from £17.1m at the end of September. The level of aged debt has a knock-on impact on the bad debt provision and likelihood of write offs which will be monitored as the year progresses.

2. Capital Executive Summary

At the end of October 2024, the capital programme for Adults, Health and Commissioning is forecast to underspend by £616k in 2024-25. This is largely due to delay in the Ely Independent Living Service capital scheme. We continue to wait for the NHS to approve the Heads of Terms before considering our next steps and as there has been no progress in the past months, the planned capital expenditure in 2024-25 has been rephased to 2025-26.

Further details of the capital position can be found in Appendix 3.

3. Savings Tracker Summary

The savings trackers are produced quarterly to monitor delivery of savings against agreed plans and the second quarterly tracker is included at Appendix 4.

4. Technical note

On a quarterly basis, a technical financial appendix is included as Appendix 5. This appendix covers:

- Grants that have been received by the service.
- Budget movements (virements) into or out of the directorate from other directorates, to show why the budget might be different from that agreed by Full Council.
- Service earmarked reserves – funds held for specific purposes that may be drawn down in-year or carried-forward – including use of funds and forecast draw-down.

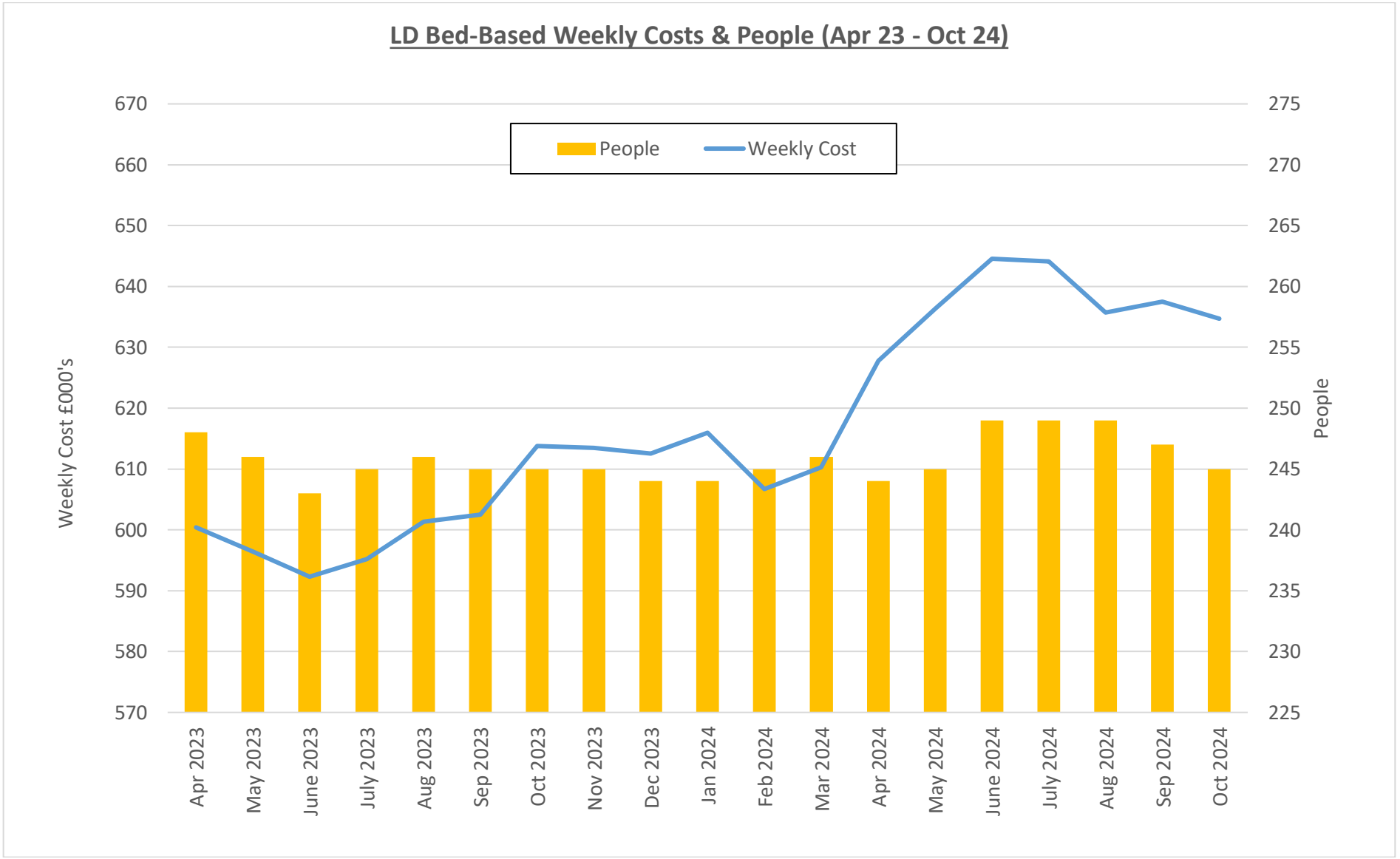
The second quarterly appendix is included within this Finance Monitoring Report.

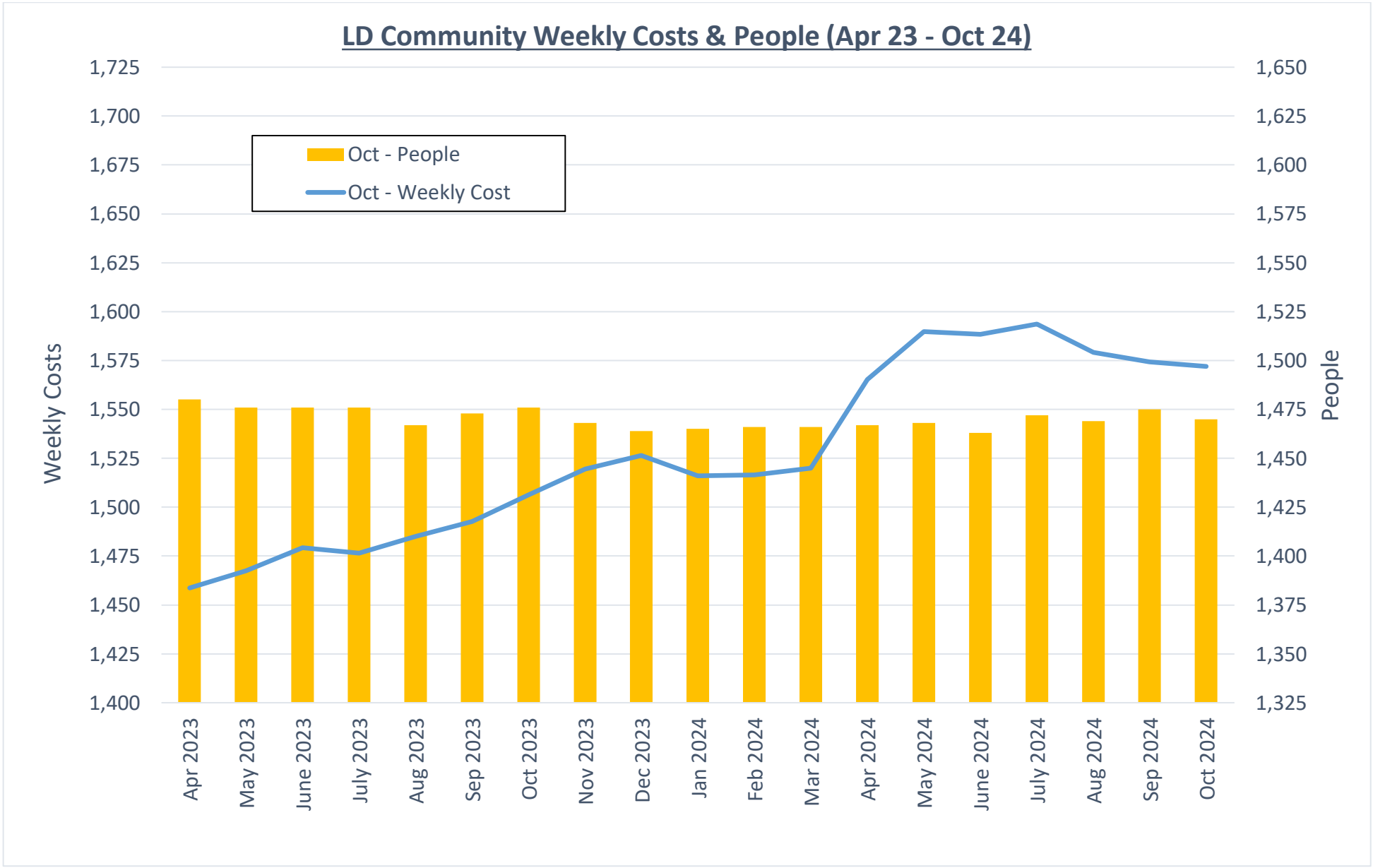
5. Key Activity Data

5.1 Key activity data to the end of October 2024 for Learning Disability Partnership is shown below:

Learning Disability Partnership	BUDGET			ACTUAL (October 2024)				Forecast Outturn		
Service Type	*Expected No. of Care Packages 2024-25*	*Budgeted Average Unit Cost (per week)*	*Annual Budget*	*Current Care Packages*	*DoT*	*Current Average Unit Cost (per week)*	*DoT*	*Total spend/ income*	*DoT*	*Variance*
Accommodation based										
~Residential	240	£2,602	£31,318k	237	↔	£2,528	↑	£32,743k	↑	£1,425k
~Nursing	10	£4,504	£2,352k	8	↑	£4,736	↓	£2,203k	↓	-£149k
~Respite			£403k		↔		↔	£438k	↑	£35k
Accommodation based subtotal	**250**	**£2,678**	**£34,073k**	**245**		**£2,600**		**£35,383k**		**£1,310k**
Community based										
~Supported Living	607	£1,760	£50,057k	596	↓	£1,806	↑	£52,475k	↑	£2,417k
~Homecare	407	£575	£12,059k	361	↑	£577	↓	£11,704k	↓	-£356k
~Direct payments	406	£608	£11,395k	408	↑	£571	↓	£11,003k	↓	-£392k
~Live In Care	7	£1,926	£303k	7	↔	£1,762	↔	£303k	↓	£k
~Day Care	652	£224	£5,575k	644	↑	£216	↑	£5,777k	↑	£202k
~Other Care	290	£132	£3,029k	298	↑	£128	↓	£2,910k	↑	-£119k
Community based subtotal	**2,369**	**£737**	**£82,419k**	2,314		£738		£84,172k		£1,753k
Total for expenditure	**2,619**	**£923**	**£116,492k**	**2,559**		**£916**		**£119,555k**	↓	**£3,063k**
Care Contributions			-£5,750k					-£5,929k	↔	-£179k

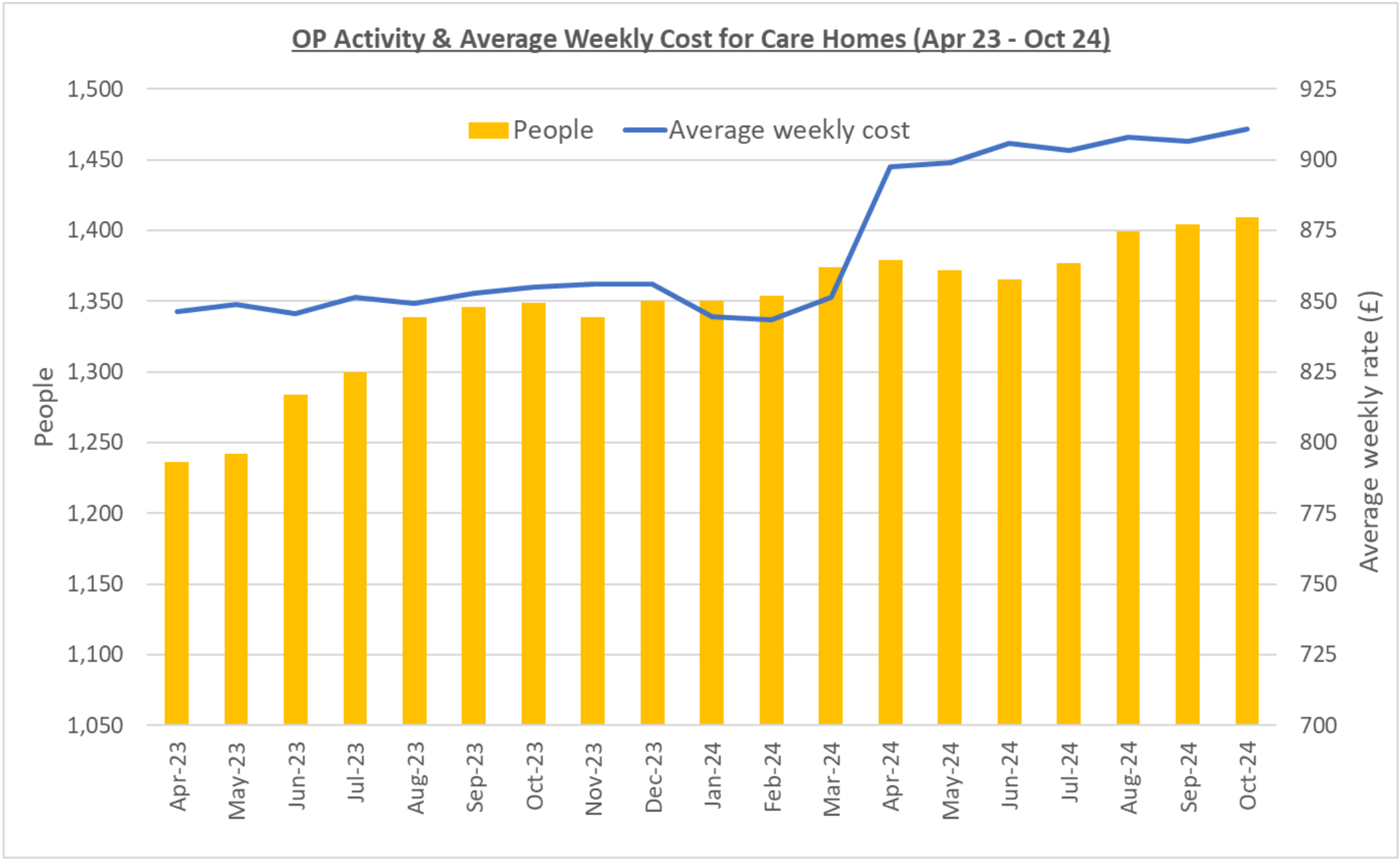
The LDP includes service-users that are fully funded by the NHS, who generally have very high needs and therefore costly care packages.

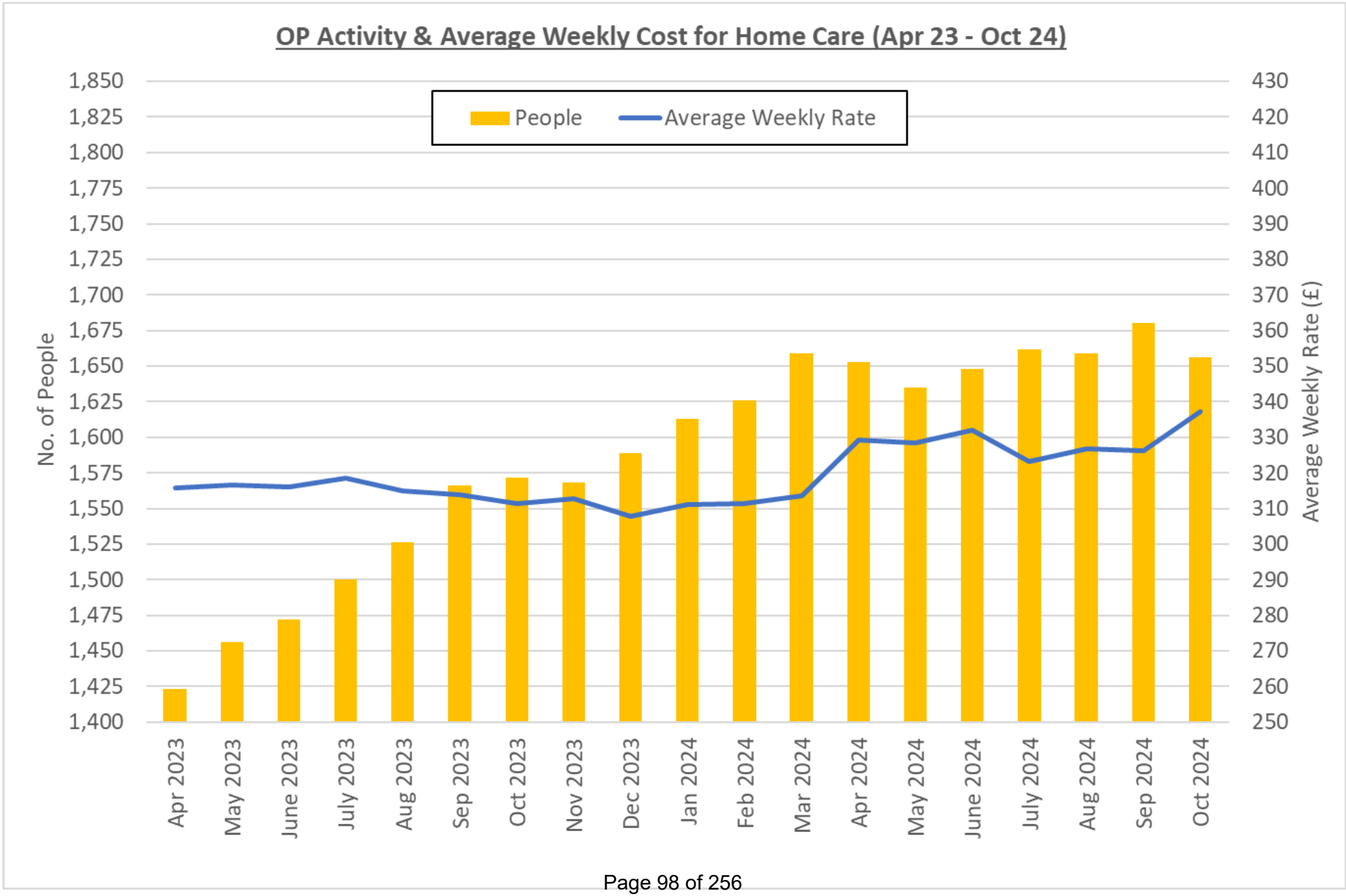

LD Bed-Based Weekly Costs & People (Apr 23 - Oct 24)
People
Weekly Cost
Weekly Cost £000's
People
670
660
650
640
630
620
610
600
590
580
570
275
270
265
260
255
250
245
240
235
230
225
Apr 2023
May 2023
June 2023
July 2023
Aug 2023
Sep 2023
Oct 2023
Nov 2023
Dec 2023
Jan 2024
Feb 2024
Mar 2024
Apr 2024
May 2024
June 2024
July 2024
Aug 2024
Sep 2024
Oct 2024


LD Community Weekly Costs & People (Apr 23 - Oct 24)
Oct - People
Oct - Weekly Cost
Weekly Costs
People
1,725
1,700
1,675
1,650
1,625
1,600
1,575
1,550
1,525
1,500
1,475
1,450
1,425
1,400
1,650
1,625
1,600
1,575
1,550
1,525
1,500
1,475
1,450
1,425
1,400
1,375
1,350
1,325
Apr 2023
May 2023
June 2023
July 2023
Aug 2023
Sep 2023
Oct 2023
Nov 2023
Dec 2023
Jan 2024
Feb 2024
Mar 2024
Apr 2024
May 2024
June 2024
July 2024
Aug 2024
Sep 2024
Oct 2024

5.2 Key activity data to the end of October 2024 for Older People's service is shown below:

Older People's Service	BUDGET			ACTUAL (October 2024)				Outturn		
Service Type	*Expected No. of Care Packages 2024-25*	*Budgeted Average Unit Cost (per week)*	*Annual Budget*	*Current Care Packages*	*DoT*	*Current Average Unit Cost (per week)*	*DoT*	*Total spend/ income*	*DoT*	*Variance*
Accommodation based										
~Residential	425	£873	£20,509k	380	↓	£853	↑	£18,454k	↓	-£2,054k
~Residential Dementia	564	£883	£27,609k	559	↑	£860	↑	£27,365k	↑	-£245k
~Nursing	264	£1,003	£16,142k	258	↓	£979	↑	£14,901k	↑	-£1,241k
~Nursing Dementia	222	£1,091	£14,882k	212	↓	£1,063	↓	£13,289k	↑	-£1,593k
~Respite			£775k	73		£120		£727k	↑	-£49k
Accommodation based subtotal	**1,475**	**£933**	**£79,917k**	**1,482**		**£911**		**£74,735k**		**-£5,182k**
Community based										
~Supported Living	433	£127	£6,711k	414	↑	£118	↓	£6,191k	↓	-£520k
~Homecare	1,845	£342	£30,633k	1,656	↓	£337	↑	£28,282k	↓	-£2,350k
~Direct payments	144	£497	£3,843k	170	↑	£450	↑	£3,521k	↑	-£322k
~Live In Care	38	£1,063	£1,740k	27	↑	£1,007	↓	£1,435k	↑	-£305k
~Day Care	67	£64	£206k	54	↓	£78	↓	£148k	↓	-£58k
~Other Care			£108k	12	↑	£45		£146k	↑	£38k
Community based subtotal	**2,527**	**£318**	**£43,241k**	**2,333**		**£307**		**£39,724k**		**-£3,517k**
Total for expenditure	**4,002**	**£545**	**£123,158k**	**3,815**		**£541**		**£114,458k**	↑	**-£8,699k**
Care Contributions			-£40,211k					-£42,699k		-£2,488k


OP Activity & Average Weekly Cost for Care Homes (Apr 23 - Oct 24)
People
Average weekly cost
People
Average weekly rate (£)
1,500
1,450
1,400
1,350
1,300
1,250
1,200
1,150
1,100
1,050
925
900
875
850
825
800
775
750
725
700
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24


OP Activity & Average Weekly Cost for Home Care (Apr 23 - Oct 24)
People
Average Weekly Rate
No. of People
Average Weekly Rate (£)
1,850
1,825
1,800
1,775
1,750
1,725
1,700
1,675
1,650
1,625
1,600
1,575
1,550
1,525
1,500
1,475
1,450
1,425
1,400
430
420
410
400
390
380
370
360
350
340
330
320
310
300
290
280
270
260
250
Apr 2023
May 2023
June 2023
July 2023
Aug 2023
Sep 2023
Oct 2023
Nov 2023
Dec 2023
Jan 2024
Feb 2024
Mar 2024
Apr 2024
May 2024
June 2024
July 2024
Aug 2024
Sep 2024
Oct 2024

5.3 Key activity data at the end of October 2024 for Physical Disabilities Services is shown below:

Physical Disabilities	BUDGET			ACTUAL (October 2024)				Outturn		
Service Type	*Expected No. of Care Packages 2024-25*	*Budgeted Average Unit Cost (per week)*	*Annual Budget*	*Current Care Packages*	*DoT*	*Current Average Unit Cost (per week)*	*DoT*	*Total spend/ income*	*DoT*	*Variance*
Accommodation based										
~Residential	27	£1,227	£1,780k	28	↓	£1,234	↑	£1,746k	↓	-£34k
~Residential Dementia	6	£940	£297k	7	↔	£987	↑	£349k	↑	£52k
~Nursing	23	£1,308	£1,444k	24	↑	£1,384	↑	£1,661k	↑	£217k
~Nursing Dementia	0	£0	£k	2	↔	£1,215	↔	£121k	↓	£121k
~Respite			£52k	11	↔	£63	↔	£78k	↓	£26k
Accommodation based subtotal	**56**	**£1,229**	**£3,574k**	**72**		**£1,264**		**£3,955k**		**£381k**
Community based										
~Supported Living	39	£558	£724k	37	↔	£517	↓	£620k	↓	-£104k
~Homecare	453	£301	£6,406k	353	↓	£309	↓	£5,682k	↓	-£724k
~Direct payments	168	£470	£3,823k	175	↑	£441	↓	£3,786k	↓	-£38k
~Live In Care	21	£1,112	£1,191k	23	↑	£1,079	↓	£1,235k	↓	£44k
~Day Care	24	£110	£129k	21	↓	£153	↑	£158k	↓	£29k
~Other Care			£1k	7	↑	£149	↑	£16k	↑	£15k
Community based subtotal	**705**	**£373**	**£12,274k**	**616**		**£381**		**£11,497k**		**-£777k**
Total for expenditure	**761**	**£436**	**£15,848k**	**688**		**£473**		**£15,452k**	↓	**-£396k**
Care Contributions			-£1,870k					-£2,021k		-£151k

5.4 Key activity data at the end of October 2024 for Older People Mental Health (OPMH) is shown below:

Older People Mental Health	BUDGET			ACTUAL (October 2024)				Outturn		
Service Type	***Expected No. of Care Packages 2024-25***	***Budgeted Average Unit Cost (per week)***	***Annual Budget***	***Current Care Packages***	***DoT***	***Current Average Unit Cost (per week)***	***DoT***	***Total spend/ income***	***DoT***	***Variance***
Accommodation based										
~Residential	38	£794	£1,302k	40	↑	£805	↑	£1,568k	↑	£266k
~Residential Dementia	50	£859	£1,820k	43	↓	£853	↑	£1,786k	↓	-£34k
~Nursing	35	£988	£1,492k	36	↑	£980	↑	£1,674k	↓	£182k
~Nursing Dementia	88	£1,158	£4,606k	87	↑	£1,147	↑	£4,735k	↓	£129k
~Respite	2	£82	£31k	1	↓	£86	↓	£4k	↑	-£27k
Accommodation based subtotal	**213**	**£993**	**£9,252k**	**207**		**£990**		**£9,767k**		**£516k**
Community based										
~Supported Living	8	£244	£72k	9	↑	£278	↑	£222k	↑	£150k
~Homecare	77	£297	£1,090k	70	↑	£292	↓	£1,057k	↓	-£33k
~Direct payments	8	£1,376	£610k	8	↑	£1,401	↑	£597k	↓	-£13k
~Live In Care	10	£1,100	£521k	10	↑	£1,066	↓	£600k	↑	£79k
~Day Care	6	£60	£3k	8	↑	£81	↑	£5k	↓	£1k
~Other Care	4	£11	£2k	4	↓	£51	↑	£3k	↑	£1k
Community based subtotal	**113**	**£418**	**£2,297k**	**109**		**£419**		**£2,483k**		**£186k**
Total for expenditure	**326**	**£794**	**£11,549k**	**316**		**£793**		**£12,250k**	↓	**£702k**
Care Contributions			-£2,011k					-£1,396k	↑	£615k

5.5 Key activity data at the end of October 2024 for Adult Mental Health (AMH) is shown below:

Adult Mental Health	BUDGET			ACTUAL (October 2024)				Outturn		
Service Type	*Expected No. of Care Packages 2024-25*	*Budgeted Average Unit Cost (per week)*	*Annual Budget*	*Current Care Packages*	*DoT*	*Current Average Unit Cost (per week)*	*DoT*	*Total spend/ income*	*DoT*	*Variance*
Accommodation based										
~Residential	58	£998	£3,046k	59	↔	£951	↔	£3,044k	↑	-£2k
~Residential Dementia	1	£690	£35k	1	↔	£1,071	↔	£58k	↑	£23k
~Nursing	9	£1,083	£508k	9	↔	£1,120	↔	£534k	↑	£25k
~Nursing Dementia			£k	1	↔	£1,685	↔	£89k	↑	£89k
~Respite			£k	1	↔	£10	↔	£15k	↓	£15k
Accommodation based subtotal	**68**	**£1,005**	**£3,590k**	**71**		**£985**		**£3,740k**		**£150k**
Community based										
~Supported Living	152	£701	£4,741k	145	↔	£611	↔	£5,609k	↑	£868k
~Homecare	180	£140	£1,942k	202	↑	£154	↓	£2,500k	↑	£558k
~Direct payments	21	£241	£255k	20	↔	£238	↔	£246k	↑	-£9k
~Live In Care	2	£2,035	£210k	3	↔	£1,586	↔	£247k	↑	£36k
~Day Care	7	£70	£29k	7	↔	£86	↔	£30k	↓	£1k
~Other Care	5	£970	£2k	5	↔	£33	↔	£34k	↑	£31k
Community based subtotal	**367**	**£398**	**£7,180k**	**382**		**£340**		**£8,665k**		**£1,485k**
Total for expenditure	**435**	**£493**	**£10,769k**	**453**		**£441**		**£12,404k**	↑	**£1,635k**
Care Contributions			-£539k					-£500k	↓	£39k

5.6 Key activity data at the end of October 2024 for Autism is shown below:

Autism	BUDGET			ACTUAL (October 2024)				Outturn		
Service Type	*Expected No. of Care Packages 2024-25*	*Budgeted Average Unit Cost (per week)*	*Annual Budget*	*Current Care Packages*	*DoT*	*Current Average Unit Cost (per week)*	*DoT*	*Total spend/ income*	*DoT*	*Variance*
Accommodation based										
~Residential	1	£1,409	£115k	**0**	↔	**£0**	↔	£96k	↑	-£19k
Accommodation based subtotal	**1**	**£1,409**	**£115k**	**1**	↑	**7**	↑	**£96k**	↑	-£19k
Community based										
~Supported Living	38	£1,165	£2,172k	32	↑	£914	↑	£1,825k	↓	-£347k
~Homecare	50	£231	£554k	41	↑	£238	↑	£488k	↑	-£66k
~Direct payments	55	£234	£690k	43	↑	£250	↓	£571k	↓	-£119k
~Day Care	38	£65	£119k	16	↓	£96	↑	£91k	↓	-£29k
~Other Care	10	£284	£134k	9	↑	£204	↓	£172k	↓	£38k
Community based subtotal	**191**	**£387**	**£3,669k**	**141**		**£377**		**£3,147k**		-£522k
Total for expenditure	**192**	**£393**	**£3,784k**	**142**		**£374**		**£3,243k**		-£541k
Care Contributions			-£138k					**-£152k**		-£14k

Appendix 1 – Adults, Health and Commissioning Detailed Financial Information

Forecast Outturn Variance (Previous) £000	Committee	Note	Budget Line	Gross Budget £000	Income Budget £000	Net Budget £000	Actual to date £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
			Executive Director						
2,838	A&H	1	Executive Director - Adults, Health & Commissioning	18,191	-54,485	-36,294	-32,914	684	2%
275	A&H	2	Performance & Strategic Development	2,775	-17	2,758	1,545	300	11%
0	A&H		Principal Social Worker	614	0	614	396	-6	-1%
			Service Director – LDP and Prevention						
28	A&H		Service Director – LDP and Prevention	388	-92	296	-207	40	13%
-40	A&H		Prevention & Early Intervention	11,035	-410	10,626	7,160	-4	0%
0	A&H		Transfers of Care	2,008	0	2,008	1,220	0	0%
-617	A&H	3	Autism and Adult Support	4,280	-175	4,105	1,802	-627	-15%
		4	**Learning Disabilities**						
0	A&H		LD Head of Service	6,815	0	6,815	3,262	-23	0%
1,872	A&H		LD - City, South and East Localities	52,908	-2,991	49,917	33,337	2,365	5%
1,849	A&H		LD - Hunts and Fenland Localities	49,286	-2,310	46,976	30,369	1,678	4%
-1,072	A&H		LD - Young Adults Team	18,391	-278	18,113	10,042	-1,369	-8%
130	A&H		LD - In House Provider Services	10,489	-206	10,283	5,613	129	1%
-645	A&H		LD - NHS Contribution to Pooled Budget	0	-30,675	-30,675	-23,006	-645	-2%
2,134			**Learning Disabilities Total**	**137,889**	**-36,460**	**101,429**	**59,618**	**2,134**	**2%**
			Service Director – Care & Assessment						
0	A&H		Service Director - Care & Assessment	919	0	919	483	25	3%
0	A&H		Assessment & Care Management	5,100	-44	5,056	2,823	0	0%
0	A&H		Safeguarding	1,531	0	1,531	849	0	0%
58	A&H		Adults Finance Operations	1,917	0	1,917	686	56	3%

Forecast Outturn Variance (Previous) £000	Committee	Note	Budget Line	Gross Budget £000	Income Budget £000	Net Budget £000	Actual to date £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
		5	**Older People's and Physical Disabilities Services**						
-5,510	A&H		Older Peoples Services - North	56,219	-19,485	36,734	20,684	-5,186	-14%
-5,348	A&H		Older Peoples Services - South	64,313	-20,862	43,451	25,175	-5,002	-12%
29	A&H		Physical Disabilities - North	7,656	-1,048	6,608	3,939	-132	-2%
-106	A&H		Physical Disabilities - South	8,078	-1,076	7,002	4,491	-169	-2%
-10,935			**Older People's and Physical Disabilities Services Total**	**136,267**	**-42,472**	**93,795**	**54,288**	**-10,490**	**-11%**
			Service Director - Commissioning						
177	A&H	6	Service Director - Commissioning	726	0	726	475	177	24%
0	A&H		Adults Commissioning - Staffing	2,720	0	2,720	1,584	0	0%
0	CYP		Children's Commissioning - Staffing	1,348	0	1,348	862	0	0%
-58	A&H		Adults Commissioning - Contracts	9,276	-3,947	5,330	1,804	-58	-1%
-97	A&H		Housing Related Support	6,825	-596	6,229	3,014	-106	-2%
18	A&H		Integrated Community Equipment Service	5,015	-2,777	2,238	863	-240	-11%
		7	**Mental Health**						
-78	A&H		Mental Health - Staffing	3,846	-58	3,788	1,429	-78	-2%
-123	A&H		Mental Health Commissioning	3,141	-532	2,609	1,521	-123	-5%
1,133	A&H		Adult Mental Health	8,713	-629	8,084	5,351	1,693	21%
1,204	A&H		Older People Mental Health	11,354	-2,168	9,186	6,813	1,235	13%
2,136			**Mental Health Total**	**27,053**	**-3,386**	**23,667**	**15,114**	**2,727**	**12%**

Forecast Outturn Variance (Previous) £000	Committee	Note	Budget Line	Gross Budget £000	Income Budget £000	Net Budget £000	Actual to date £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
			Public Health						
0	CYP		Children Health	14,937	-4,416	10,521	5,216	0	0%
0	A&H		Drug & Alcohol Misuse	6,747	-1,804	4,943	1,983	0	0%
25	A&H		Sexual Health & Contraception	7,356	-1,867	5,489	2,198	0	0%
-3	A&H		Behaviour Change Services	3,961	-900	3,060	1,521	-3	0%
0	A&H		Smoking Cessation	1,631	-886	745	-410	0	0%
0	A&H		NHS Health Checks	854	0	854	200	0	0%
0	A&H		Other Health Improvement	150	0	150	85	2	1%
0	A&H		General Prevention Activities	1,026	0	1,026	-150	0	0%
0	A&H		Adult Mental Health & Community Safety	351	-107	244	-9	0	0%
-296	A&H	9	Public Health Service	4,683	-28,812	-24,129	-20,190	-247	-5%
-274			**Public Health Total**	**41,695**	**-38,792**	**2,904**	**-9,555**	**-248**	**-1%**
-4,355			**Overall Adults, Health & Commissioning Total before Use of Reserves**	**417,574**	**-183,653**	**233,921**	**111,908**	**-5,636**	**-2%**
0			**Drawdown from Adults reserves**	0	0	0	0	0	0%
274			**Drawdown from Public Health reserves**	-2,903	0	-2,903	-982	248	9%
-4,081			**Overall Adults, Health & Commissioning Total**	**414,671**	**-183,653**	**231,018**	**110,926**	**-5,388**	**-2%**

Appendix 2 – Service Commentaries on Forecast Outturn Position

Narrative is given below where there is a forecast variance greater than 2% of net budget or £100,000 whichever is greater for a service area, or where there is significant risk in delivery to budget for the year.

Note	Commentary vs previous month	Service Area / Budget Line	Net Budget £000	Forecast Outturn Variance £000	Forecast Outturn Variance %	Commentary
1	Updated	Executive Director - Adults, Health & Commissioning	-36,294	684	2%	The Executive Director policy line holds a range of budgets applicable across the Directorate. This includes the following budgets with forecast variances: i) the savings target for review of in house provision for which the review work is underway but no firm plans are yet in place to deliver savings or additional income creating a £1m pressure in year; ii) the Council's share of Learning Disability funding held outside of the pooled budget shared with Health. This includes a budget for an additional £2.6m of funding from the NHS as a contribution to LD costs. The work to confirm revised contributions to LD costs is progressing but no changes in funding arrangements will now take place until 25-26; iii) the vacancy factor budget for the Adults, Health and Commissioning Directorate is forecast to over recover by £400k based on vacancies in the first half of the year; iv) priorities around the use of external grant funding have been revisited to reflect latest spend estimates which has released £1,031k of grant monies to contribute to care pressures; and v) £1m of the contingency budget held back awaiting the outcome of inflation awards has now been released; and vi) the staff pay awards have now largely been finalised releasing an underspend of £340k across Adults, Health and Commissioning.

Note	Commentary vs previous month	Service Area / Budget Line	Net Budget £000	Forecast Outturn Variance £000	Forecast Outturn Variance %	Commentary
2	Updated	Performance & Strategic Development	2,758	300	11%	Current progress on the digital innovation savings strategy suggests that the saving linked to this project will be delayed and will under-deliver in 24-25. Work is ongoing to understand the size of the savings opportunity and some mitigation in year may be possible. This will be reflected as it is identified.
3	Updated	Autism and Adult Support	4,105	-627	-15%	The 24-25 budget for the Autism and Adult Support Service included additional demand funding in recognition of the fact the service has been clearing its substantial waiting list. However, the assessments and reviews completed so far indicate that fewer people on the waiting list will require placements than was originally anticipated. Therefore, the projections for new demand in 24-25 have been revised down by £328k. Additionally, a number of placements have ended since the budget was set in February 2024, delivering a saving of ~£220k. The forecast also assumes a £63k increase in repayments of unused direct payments.
4	Updated	Learning Disabilities	101,429	2,134	2%	Learning Disability service is currently forecasting an overspend of £2.1m. The budget is pooled between the council and the NHS, with shares of 77% and 23% respectively. The service is currently going through the process of dissolving the pooled budget which could cause short term financial pressures. There is significant risk around the savings targets attached to the budget of £2.9m all of which have active workstreams and this is adding an estimated £500k to cost pressures at the current time. Cost pressures are also being shown through increase in complexity of need of current people receiving care over and above that expected, while demand for new people coming into service has also started to increase following a reduction during last year and the beginning part of this year. Pressures within the provider market continue to be seen through some requests for higher than budgeted uplifts, negotiations are being managed with these providers on an individual basis.
5	Updated	Older People's and Physical Disabilities	93,795	-10,490	-11%	Older People's and Physical Disabilities services are forecasting an £10.49m underspend. Demand increased significantly during 2023-24, and this was reflected in the budget set for 2024-25.

Note	Commentary vs previous month	Service Area / Budget Line	Net Budget £000	Forecast Outturn Variance £000	Forecast Outturn Variance %	Commentary
						However, net activity levels are significantly lower than expected for the year to date, especially for care homes and domiciliary care. This is the main component of the reported underspend position. The budget assumes in-year savings delivery of £2.3m. Current progress suggests we will underachieve against this savings target by £850k. There remains uncertainty regarding income from clients contributing to the cost of their care, which increased considerably over the past year. This appears to be continuing in the current year and we are forecasting an underspend of £2.6m. However, uncertainties remain regarding the potential impact of increasing levels of adult social care debt.
6	Existing	Service Director - Commissioning	726	177	24%	Timescales for the delivery of savings linked to the all age locality strategy have been updated in line with current progress. We are forecasting a £177k under-delivery against the savings target in 24-25. Further development of plans is required, based on an independent review being undertaken. Progress will be monitored closely and the forecast updated accordingly.
7	New	Housing Related Support	6,229	-106	-2%	Housing Related Support Services are forecasting an underspend of £106k. £40k of underspend is due to the ending of an historic funding arrangement in relation to HRS at Huntingdonshire travellers' site, as this support is now being delivered by other means. The remainder of the underspend is due to 24-25 contract increases being successfully negotiated below the level that was anticipated when the budget was set, and income from partners increasing in line with contract increases.
8	New	Integrated Community Equipment Service	2,238	-240	-11%	The Integrated Community Equipment Service is forecasting an underspend of £240k. This is largely due to an over-accrual for spend in March 2024, which was lower than estimated.
9	Updated	Mental Health	23,667	2,727	12%	Mental Health services are forecasting an overspend of £2.727m for October. This is being driven by an increasing number of high-cost, complex community-based cases within Adult Mental Health. This includes a significant number of transition cases coming through from Children's. Demand pressures on Older People Mental Health bed-based care have reduced this month, but a residual overspend from higher numbers of placements in the first

Note	Commentary vs previous month	Service Area / Budget Line	Net Budget £000	Forecast Outturn Variance £000	Forecast Outturn Variance %	Commentary
						half of the year remains. There is an additional pressure of £192k following closure of a supported living unit where clients were not able to be supported in similar provision due to complexity of need. The budget assumed £0.5m in-year savings delivery; an expected under-achievement of £386k is reflected in the forecast. There is a forecast overspend of £654k against income from clients contributing to the cost of their care, reflecting the expected impact of increasing levels of adult social care debt.
10	Updated	Public Health Service	-24,129	-248	1%	The reported underspend for the public health service is due to in year vacancies following the recruitment pause during the restructure consultation and further staffing changes as a result of the separation of public health from a shared service. Internal processes have been followed and recruitment for essential roles is underway. The newly appointed Director of Public Health, who takes up post in January 2025, will be reviewing the requirements and structure within the Public Health service. In addition, £96k of the 2024/25 grant uplift is committed in 2025/26 but remains unallocated for 2024/25 on a one off basis.

Appendix 3 – Capital Position

3.1 Capital Expenditure

Original 2024-25 Budget as per Business Plan £000	Committee	Scheme Category	Total Scheme Revised Budget £000	Total Scheme Forecast Variance £000	Revised Budget for 2024-25 £000	Actual Spend (Oct) £000	Forecast Outturn Variance (Oct) £000
10,384	A&H	Independent Living Service: East Cambridgeshire	22,200	-473	500	-	-500
5,070	A&H	Disabled Facilities Grant	55,300	-	5,530	5,060	-
400	A&H	Integrated Community Equipment Service	3,600	-	400	-	-31
185	A&H	Capitalisation of interest costs	940	-	185	-	-160
-1,558	A&H	Capital variations	-	-	-75	-	75
14,481		**TOTAL**	**82,040**	**-473**	**6,540**	**5,060**	**-616**

The schemes with significant variances (>£250k) either due to changes in phasing or changes in overall scheme costs can be found below:

Ref	Directorate / Committee	Commentary vs previous month	Scheme	Scheme Budget £m	Budget for 2024-25 £m	Forecast Outturn Variance £m	Cause	Commentary
1	Adults & Health	New	Independent Living Service: East Cambridgeshire	22,200	500	-500	Rephasing	We continue to wait for the NHS to approve the Heads of Terms before considering our next steps in the Ely Independent Living Service project. As there has been no progress in the past months, the planned capital expenditure in 2024-25 will be rephased to 2025-26. Additionally, updated estimates for the construction costs have reduced the total scheme budget by £473k.

3.2 Capital Variations Budget

Variation budgets are set annually and reflect an estimate of the average variation experienced across all capital schemes, and reduce the overall borrowing required to finance our capital programme. There are typically delays in some form across the capital programme due to unforeseen events, but we cannot project this for each individual scheme. We therefore budget centrally for some level of delay. Any known delays are budgeted for and reported at scheme level. If forecast underspends are reported, these are offset with a forecast outturn for the variation budget, leading to a balanced outturn overall up to the point when rephasing exceeds this budget.

3.3 Capital Funding

Original 2024-25 Funding Allocation as per Business Plan £000	Source of Funding	Revised Funding for 2024-25 £000	Forecast Spend (Oct) £000	Forecast Variance (Oct) £000
5,070	Grant Funding	5,530	5,563	33
9,411	Prudential Borrowing	1,010	521	-649
14,481	**Total Funding**	**6,540**	**6,084**	**-616**

Appendix 4 – Savings Tracker

4.1 Adults, Health and Commissioning Savings Tracker 2024/25 Quarter 2

					-17,286	-11,389	5,897	34%		
Directorate	**Committee**	**Type**	**Business Plan Reference**	**Title**	**Planned Savings 2024-25 £000**	**Forecast Savings £000**	**Variance from Plan £000**	**% Variance**	**RAG**	**Forecast Commentary**
AHC	A&H	2023-24 cfwd	A/R.6.188 (2022-23)	Micro-enterprises Support	-103	0	103	100%	Black	Initial estimates of cost savings were based on early capacity hours from a small-scale pilot undertaken. However, the ability to achieve these savings has been limited by the reducing uptake of direct payments which act as an access point to these services. Mitigations have been agreed in October 2024 to address this with the aim of realising savings from 2025/26 onwards
AHC	A&H	2023-24 cfwd	A/R.6.195 (2022-23)	Increased support for carers	-24	-24	0	0%	Green	Expecting to deliver to target
AHC	A&H	2023-24 cfwd	A/R.6.200 (2023-24)	Expansion of Direct Payments	-6	-6	0	0%	Green	Savings to be realised Q3 - Q4
AHC	A&H	2023-24 cfwd	A/R.6.206 (2023-24)	LD mid-cost range placement review (links to A/R.5.025)	-53	-53	0	0%	Green	Expecting to deliver to target
AHC	A&H	2024-25 saving	B/R.6.002	Expansion of Direct Payments	-32	-32	0	0%	Green	Savings to be realised Q3 - Q4
AHC	A&H	2024-25 saving	B/R.6.003	Decommissioning of block contracts for car rounds providing homecare	-2,473	-2,473	0	0%	Green	Delivered
AHC	A&H	2024-25 saving	B/R.6.004	Mental Health section 75 vacancy factor	-50	-50	0	0%	Green	Delivered
AHC	A&H	2024-25 saving	B/R.6.005	Learning Disability mid-cost range placement review	-264	-352	-88	-33%	Blue	Expecting to over deliver and contributing to other LD savings that are not forecast to deliver in full. Saving shared with the ICB
AHC	A&H	2024-25 saving	B/R.6.006	Mental Health supported accommodation	-137	-34	103	75%	Amber	There has been a delay in re-opening the framework which means the saving will only be partially delivered in 2024/25.
AHC	A&H	2024-25 saving	B/R.6.007	Learning Disability Voids Saving	-300	-320	-20	-7%	Blue	Expecting to over deliver and contributing to other LD savings that are not forecast to deliver in full. Saving shared with the ICB
AHC	A&H	2024-25 saving	B/R.6.008	Reduction in 1 day of care	-456	-456	0	0%	Green	Occurred February 2024. Saving shared with the ICB.

Directorate	Committee	Type	Business Plan Reference	Title	Planned Savings 2024-25 £000	Forecast Savings £000	Variance from Plan £000	% Variance	RAG	Forecast Commentary
AHC	A&H	2024-25 saving	B/R.6.009	Mental Health residential and community	-357	-171	186	52%	Amber	There has been a delay in establishing the new model of residential care and good homecare market capacity has meant that very limited off framework placements are being made reducing the in year savings opportunity
AHC	A&H	2024-25 saving	B/R.6.010	Block beds void management	-380	-320	60	16%	Green	Our improvements from Q2 are starting to deliver which is why savings projection has increase. Further improvements are expected during Q3.
AHC	A&H	2024-25 saving	B/R.6.011	Reablement surplus following restructure	-91	-91	0	0%	Green	Saving delivered
AHC	A&H	2024-25 saving	B/R.6.012	Historic saving from ending of Lifelines service	-70	-70	0	0%	Green	Saving delivered
AHC	A&H	2024-25 saving	B/R.6.013	Prevent, reduce and delay needs presenting - reablement	-525	-330	195	37%	Red	The element of this saving that relates to services for Older People is expecting to deliver to target. However, further work is required on the element of the saving related to Learning Disabilities which is a saving shared with the ICB
AHC	A&H	2024-25 saving	B/R.6.015	Prevention Agenda - Digital Innovation	-300	0	300	100%	Black	Further development of plans required to deliver saving
AHC	A&H	2024-25 saving	B/R.6.016	Learning Disability Low Cost placement review	-169	-361	-192	-114%	Blue	Expecting to over deliver and contributing to other LD savings that are not forecast to deliver in full. Saving shared with the ICB
AHC	A&H	2024-25 saving	B/R.6.017	Learning Disability Vehicle Fleet Reduction	-50	-150	-100	-200%	Blue	Forecasting overdelivery
AHC	A&H	2024-25 saving	B/R.6.018	Learning Disability Respite Utilisation	-247	-156	91	37%	Amber	Saving shared with the ICB; Revised process being co-produced with providers, improved utilisation will begin in Q2. Utilisation has risen to over 70% and on track to meeting the business case target.
AHC	A&H	2024-25 saving	B/R.6.019	Learning Disability Negotiation with providers	-585	-400	185	32%	Red	Saving shared with the ICB; the volume of negotiations increased in Q2 as expected, however the transaction work is taking longer than planned. Expectation that additional benefits will be realised the next quarter.
AHC	A&H	2024-25 saving	B/R.6.020	Learning Disability Cambridgeshire Outreach	-260	-57	203	78%	Amber	Saving shared with the ICB; Approach is being finalised, updated forecast savings will be available in the next quarter.

Directorate	Committee	Type	Business Plan Reference	Title	Planned Savings 2024-25 £000	Forecast Savings £000	Variance from Plan £000	% Variance	RAG	Forecast Commentary
AHC	A&H	2024-25 saving	B/R.6.021	Learning Disability Enablement	-391	0	391	100%	Black	Pilot is due to start in September, initial pilot will be evaluated at the end of January 2025 to enable forecast savings going forward, which will be available in Q4. Saving shared with the ICB. Other LD savings which are overdelivering are in part setting off the shortfall in delivery of this saving.
AHC	A&H	2024-25 saving	B/R.6.024	Prevention Agenda - All Age Locality Strategy	-177	0	177	100%	Black	Further development of plans required based on an independent review being undertaken.
AHC	A&H	2024-25 saving	B/R.6.025	Mental Health Recommissioning Supported Accommodation	-75	0	75	100%	Black	The cost of alternative placements has outweighed the original saving identified due to level of assessed complexity.
AHC	A&H	2024-25 saving	B/R.6.027	Review discharge pathways - Pathway 3, Reduce bed based care	-400	0	400	100%	Black	Delivery of savings has been delayed and further work is required to secure the delivery of this saving. Forecast savings will be updated as work progresses.
AHC	A&H	2024-25 saving	B/R.6.028	Review discharge pathways - Pathway 3, Reduce homecare	-400	0	400	100%	Black	Delivery of savings has been delayed and further work is required to secure the delivery of this saving. Forecast savings will be updated as work progresses.
AHC	A&H	2024-25 saving	B/R.6.029	Review discharge pathways - Pathway 2, Reduce bed based care	-400	0	400	100%	Black	Delivery of savings has been delayed and further work is required to secure the delivery of this saving. Forecast savings will be updated as work progresses.
AHC	A&H	2024-25 saving	B/R.6.030	Review in house services - Cost avoidance / efficiencies and new opportunities	-300	0	300	100%	Black	Review of in house services is underway and expected to complete shortly. Forecast savings will be updated based on the outcomes of the review work.
AHC	A&H	2024-25 saving	B/R.6.031	Review in house services - supported living	-400	0	400	100%	Black	Review of in house services is underway and expected to complete shortly. Forecast savings will be updated based on the outcomes of the review work.
AHC	A&H	2024-25 saving	B/R.6.032	Review in house services - Respite / residential	-300	0	300	100%	Black	Review of in house services is underway and expected to complete shortly. Forecast savings will be updated based on the outcomes of the review work.
AHC	A&H	2024-25 saving	B/R.6.033	Extra Care	-350	-700	-350	-100%	Blue	Delivered additional savings to plan
AHC	A&H	2024-25 saving	B/R.6.034	Advocacy contract recommissioning	-128	-128	0	0%	Green	Delivered
AHC	A&H	2024-25 saving	B/R.6.035	Care Home Trusted Assessor service	-69	-69	0	0%	Green	Delivered

Directorate	Committee	Type	Business Plan Reference	Title	Planned Savings 2024-25 £000	Forecast Savings £000	Variance from Plan £000	% Variance	RAG	Forecast Commentary
AHC	A&H	2024-25 saving	B/R.6.036	Adults, Health and Commissioning vacancy factor	-560	-960	-400	-71%	Blue	Vacancy factor expected to exceed target in 2024/25
AHC	A&H	2024-25 saving	B/R.6.037	Day Opportunities	-260	-101	159	61%	Amber	Saving shared with the ICB; Approach is being finalised, forecast savings have started in Q2 from using current under-utilised capacity.
AHC	A&H	2022-23 cfwd	A/R.7.113 (2022-23)	Learning Disability Partnership Pooled Budget - cost share	-1,125	0	1,125	100%	Black	For this year this saving will not be achieved as the end date of the Section 75 Agreement is end of March 2025
AHC	A&H	2024-25 income	B/R.7.005a	Learning Disability Partnership Pooled Budget - cost share	-1,469	0	1,469	100%	Black	For this year this saving will not be achieved as the end date of the Section 75 Agreement is end of March 2025
AHC	A&H	2024-25 income	B/R.7.005b	Increased ICB contributions - share of demand, inflation, investments and savings	-2,420	-2,420	0	0%	Green	Forecasting delivery against plan
AHC	A&H	2024-25 income	B/R.7.006	Increased income from reducing Financial Assessments backlog	-931	-931	0	0%	Green	Savings achieved. Procurement complete to outsource financial assessment activity which has delivered saving to plan.
AHC	A&H	2024-25 saving	F/R.6.001	Health in all Policies	-125	-125	0	0%	Green	Complete
AHC	A&H	2024-25 saving	F/R.6.002	Public Health savings	-27	-27	0	0%	Green	Complete
AHC	A&H	2024-25 saving	F/R.6.003	Savings from recommissioning of contracts	-22	-22	0	0%	Green	Complete
AHC	A&H	2024-25 income	F/R.7.200	Increased contribution from PCC	-25	0	25	100%	Black	Increased contribution will not be achieved following separation from PCC but nor will additional costs be incurred which it was due to fund.

Key to savings tracker:

Total saving	Over £500k	£100-500k	Below £100k
Black	100% non-achieving	100% non-achieving	100% non-achieving
Red	Percentage variance more than 19%	-	-
Amber	Under-achieving by 14% to 19%	Percentage variance more than 19%	Percentage variance more than 19%
Green	Percentage variance less than 14%	Percentage variance less than 19%	Percentage variance less than 19%
Blue	Over-achieving	Over-achieving	Over-achieving

APPENDIX 5 – Technical Note

5.1 The table below outlines the additional Adults, Health and Commissioning grant income, which is not built into base budgets.

Grant	Awarding Body	Amount £'000
Grants as per Business Plan		
Public Health	DHSC	28,442
Improved Better Care Fund	Department for Levelling Up, Housing & Communities (DLUHC)	15,171
Market Sustainability and Improvement Fund	DLUHC	10,168
Disabled Facilities Grant	DLUHC	5,530
ASC Discharge Fund	DLUHC	3,545
Supplementary Substance Misuse Treatment Grant	Office for Health Improvement & Disparities (OHID)	1,098
Local Stop Smoking Services and Support Grant	Office for Health Improvement & Disparities (OHID)	886
Accelerating Reform Fund	DHSC	577
Rough Sleeping Drug and Alcohol Treatment Grant	DLUHC	515
Social Care in Prisons Grant	DHSC	331
Individual Placement & Support grant	Office for Health Improvement & Disparities (OHID)	122
Total Non-Baselined Grants 24-25		**66,384**

5.2 Virements and Budget Reconciliation (Adults, Health and Commissioning)

(Virements between Adults, Health and Commissioning and other service blocks)

	Eff. Period	£'000	Notes
Budget as per Business Plan		**230,361**	
Post Business Plan, pre initial budget load adjustments		931	Post BP, pre initial budget load adjustments
Children's Advocacy	May	-194	Move of Children's advocacy budget from Adults, Health and Commissioning to Children's, Education and Families
Transfer of staffing budget to CEF	May	-73	Transfer of staffing budget to CEF following separation in 2023/24 of AHC and CEF
Transfer of budget to Learning & Development team	July	-7	Transfer of budget to Learning & Development team to cover cost of Deprivation of Liberty Standards Signatory Training 24/25
Budget 24-25		**231,018**	

5.3.1 Adults, Health and Commissioning Earmarked Reserve Schedule

£000	2024-25 Opening Balance	Movements in 2024-25	Balance at end Oct	Forecast at year-end	Remarks
Corporate risk reserves relating to services in this directorate:					
Adults Risk Reserves	7,511	-500	7,011	6,661	Includes Learning Disability and Debt reserve as well as main risk reserve held against the risk of demand for ASC services outstripping budget available.
Ringfenced Reserves:					
COMF grant reserve	1,070	-1,070	0	0	Was required to be fully utilised by end September 2024
PH Grant reserve	4,912	-983	3,929	2,256	See further detail below
Earmarked Reserved Relating to AHC	**13,493**	**-2,554**	**10,939**	**8,917**	

5.3.2 Public Health Grant Earmarked Reserve

£'000	2024-25 Opening Balance	Movements in 2024-25	Balance at end Oct	Forecast at year-end	Reserve Description
Children's Public Health:					
Best Start in Life	116	-40	77	22	Contribution to Best Start in Life programme
Public Health Children's Manager	8	-8	0	0	Additional Staffing Capacity
Public Mental Health:					
Public Mental Health Manager	37	-21	16	0	Additional Staffing Capacity
Support for families of children who self-harm.	26	-21	4	0	Rolling out pilot family self-harm support programme across Cambridgeshire
Training Programme Eating Disorders	10	0	10	5	Training Programme Eating Disorders

£'000	2024-25 Opening Balance	Movements in 2024-25	Balance at end Oct	Forecast at year-end	Reserve Description
Adult Social Care & Learning Disability:					
Falls Prevention Fund	494	-4	490	173	Partnership joint funded falls prevention project with the NHS, plus Enhanced Falls Prevention -
Public Health Manager - Learning Disability	42	-21	22	0	Additional Staffing Capacity
Improving residents' health literacy skills to improve health outcomes	250	-150	100	100	Additional funding to existing Adult Literacy programme
PHI and Emergency Planning:					
Quality of Life Survey	216	0	216	112	Annual survey for 3 years to assess long term covid impact
Public Health Emergency Planning	9	0	9	0	Additional funds to respond to Health Protection incidents
Prevention and Health Improvement:					
Stop Smoking Service	27	-27	0	0	Additional Staffing Capacity - Focused on post to reduce smoking during pregnancy
Smoking in pregnancy	168	0	168	91	To fund work to decrease smoking in pregnancy
NHS Health checks Incentive Funding	407	-150	257	257	Funding to increase the number of health checks that can be undertaken to catch up with some of the missed checks during the pandemic.
Psychosexual counselling service	34	0	34	17	
Tier 2 Adult Weight Management Services	137	0	137	47	
Tier 3 Weight Management Services post covid	1,058	-289	769	308	To increase capacity of weight management services over 3 years
Social Marketing Research and Campaigns	293	0	293	53	Social marketing research and related campaigns
Support for Primary care prevention	400	0	400	0	Anticipated spend over 2 years
Service improvement activity for Stop Smoking Services and NHS Health Checks	80	0	80	80	Additional service funding for stop smoking and health checks
Children's obesity	339	0	339	339	New request approved by S,R&P Committee in December 23

£'000	2024-25 Opening Balance	Movements in 2024-25	Balance at end Oct	Forecast at year-end	Reserve Description
Traveller Health:					
Gypsy Roma and Travelers Education Liaison officer	1	-1	0	0	Additional Staffing Capacity
Health in All Policies:					
Effects of planning policy on health inequalities	139	-31	107	9	
Training for Health Impact Assessments	45	-19	26	22	
Miscellaneous:					
Health related spend elsewhere in the Council	200	-200	0	0	Agreed as part of 2022-23 Business Plan to be spent over 3 years to 2024-25
Public Health contingency	375	0	375	375	Contingency held against reducing Supplementary Substance Misuse Treatment grant and Rough Sleeping Drug and Alcohol Treatment Grant. Contingency will allow a smoother transition to new service model if the grant is ended. To be topped up to £400k at year end from in year underspends.
Uncommitted PH reserves	0	0	0	0	
Year end transfer of underspend to PH reserve	0	0	0	248	Assumed transfer of in year forecast underspend to reserves at year end
TOTAL EARMARKED RESERVES	**4,912**	**-983**	**3,929**	**2,256**	

(+) positive figures represent surplus funds.
(-) negative figures represent deficit funds.

5.3.3 Adults, Health and Commissioning Capital Reserve Schedule

£'000	2024-25 Opening Balance	Movements in 2024-25	Balance at end Oct	Forecast at year-end	Reserve Description
Head of Integration	33	0	33	0	Capital grant funding for AHC IT Systems
TOTAL EARMARKED RESERVES	**33**	**0**	**33**	**0**	

(+) positive figures represent surplus funds.
(-) negative figures represent deficit funds.

Application of Adult Social Care Charges Review

To:	Adults and Health Committee
Meeting Date:	12 December 2024
From:	Executive Director: Adults, Health and Commissioning
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	Not applicable.

Executive Summary: This report outlines the findings and proposed recommendations of the review of Cambridgeshire County Council's Adult Social Care Charging Policy and application of associated legislation and guidance.

Committee is asked to scrutinise the contents of the paper, providing a view that the Adult Charging Policy is legally compliant through interpretation and application of the Care Act 2014 and supporting guidance, and that the review confirms the application and use of the policy is consistent with other councils in the comparator group regionally and nationally.

Committee is asked to agree the proposed recommendations to enhance the Council's transparency, information and advice it provides to its residents.

Recommendations: The Committee is recommended to:

a) support the 17 recommendations set out in Appendix 2 and summarised in Section 3 of the report.

b) provide regular updates through Spokes meetings on the implementation of the recommendations.

1. Creating a greener, fairer and more caring Cambridgeshire

1.1 This report relates to Ambition 5: People enjoy healthy, safe and independent lives through timely support that is most suited to their needs.

2. Background

2.1 As part of the Business Planning process to support the Council's financial position, officers commissioned an independent review of the charging policy, and its interpretation of legislation and guidance, alongside its application against care and support provided by the Council. A specific aspect of the review was to take an anti-poverty view of the approach to charging, considering the impact on people because of the cost-of-living crisis, and ongoing financial pressures of many within Cambridgeshire.

The overall purpose of the review was:

- To provide assurance that the Cambridgeshire County Council's Adult Social Care Charging Policy is compliant with the Care Act 2014, equitable and in line with national policy, and describe where there is flexibility or choice in the interpretation and application of the legislation.

- To provide a clear rationale for those Adult Social Care services which are chargeable or not, the levels of fees set for each service and the impact of any changes including the financial cost and impact on levels of charges raised on both individuals and the Council as a whole.

- To consider any proposals and viability of such to support an anti-poverty approach on individuals and cost-of-living challenges they may face.

2.2 In September 2024, an external consultant was commissioned and commenced the review, with the scope agreed with the Chair and Vice-Chair. The outcome was to produce a full report of their findings, conclusions and any recommendations arising; to demonstrate critical challenge and external assurance of the Council's approach to charging for Adult Social Care services.

3. Main Issues

3.1 The Care Act 2014 (the Act) provides the legal framework for charging for adult social care and support. Section 14 of the Act enables local authorities with adult social care responsibilities, to charge a person in receipt of care and support services where it is permitted to charge, and Section 17 of the Act permits local authorities to undertake an assessment of an individual's financial resources to determine the amount, if any, that they will be required to pay towards the cost of their care.

3.2 The Care and Support (Charging and Assessment of Resources) Regulations 2014, and Care and Support Statutory Guidance (and annexes) (CASS) issued by the Department of

Health and Social Care under the Care Act 2014 set out much of the detail regarding charging for care.

3.3 The relevant parts of the Statutory guidance are Chapter 8: Charging and financial assessment, Annex A: Choice of accommodation and additional payments, Annex B: Treatment of capital, Annex C: Treatment of Income, Annex D: Recovery of debts, Annex E: Deprivation of assets and Annex F: Temporary and short-term residents in care homes.

3.4 The external review formed nine lines of enquiry on current arrangements, which included:

- Which services are chargeable, along with Council's application and interpretation of Section 14 and Section 17 of the Act, in respect of charging for services.
- Those services charged for and how rates are established, including full cost recovery and benchmarking against other comparator councils.
- The implications of the Charging Policy on individuals and the alignment to Cambridgeshire's anti-poverty work, to help understand the impact of the current Charging Policy on residents and the Council.

3.5 A detailed report following the agreed lines of enquiry was produced, (summary report in Appendix 1) that provided the assurance that the Charging Policy is compliant with the Care Act 2014, applied equitably and in line with legislation and guidance. The report also described where there is flexibility or choice, when shaping the charging policy, in the interpretation and application of the legislation.

3.6 Examining through an anti-poverty lens, the review also considered various proposals and viability of application, that might support a reduction in an individual's client contribution, that may offer some possible relief toward meeting the costs of their care and support, in the context of the cost-of-living challenges they may face.

3.7 Whilst there were 28 recommendations (Appendix 1) arising from the review, after consideration, officers recommend that 17 be presented to Committee for a decision to progress, with timescales as set out in Appendix 2, of which the key are as follows:

(a) As the Adult Social Care Charging Policy meets legislation and is compliant with the Care Act 2014, there is no requirement for a further review for the financial year 2025/26. A full review will be undertaken in advance of 2026/27, to ensure the Policy continues to meet legislation and the needs of the Council.

(b) That no changes are made to scope of chargeable and non-chargeable services for 2025/26. Rate increases for these charges will still be subject to review and to reflect movements in operating cost/inflation.

(c) The annual fees and charges report will be broadened to include charges for services, to evidence costs for care and support, to help people understand the costs against the charges that the outcome of their financial assessment is applied against.

(d) To ensure greater openness and transparency, the annual review of charges will form appendices within the Adult Social Care Charging Policy, including a list of indicative costs of care paid to providers, to better support decision making for self-funders.

(e) To produce additional online information and advice and promote transparency of fees and charges outside of the charging policy, typical rates for care and support for those with issues with paying for care already received.

(f) To consider the options and potential for the introduction of a financial assessment 'appeal and waiver' process, ensuring compliance with regulation and financial scheme of delegation; and understanding the financial implications of any such process.

(g) To consider options to finance an increase in the capacity of Welfare Benefits Advisors, to focus on maximising welfare benefit take up, given the current waiting list for this service, to better support an operating model for benefits maximisation and welfare support. To include in this review ongoing work from Cambridge City and South Cambs Low Income Family Tracker (LIFT).

(h) Some of the other recommendations proposed not to be progressed at this time may have financial implications for the council, so will be considered during the business planning session for 2026/27.

3.8 The 11 recommendations that officers did not recommend be presented to Committee, are in the main regarding investment into business analytics and insights, for example development of a contributions forecasting tool to aid informed decision making based on accurate impact data, and Policy and Insight Team to provide analytic and statistical analysis of property/capital/income and assessed expenditure. Officers did not recommend these to be taken forward, as they do not provide value to those people who use services.

4. Conclusion and reasons for recommendations

4.1 The recommendations are made as they meet the outcome objectives of the review:

(a) To provide assurance that the Cambridgeshire County Council's Adult Social Care Charging Policy is compliant with the Care Act 2014, equitable and in line with national policy, and describe where there is flexibility or choice in the interpretation and application of the legislation.

(b) To provide a clear rationale for those adult social care services which are chargeable or not, the levels of fees for set for each service and the impact of any changes including the financial cost and impact on levels of charges raised on both individuals and the Council as a whole.

(c) To consider any proposals and viability of such to support an anti-poverty approach on individuals and cost-of-living challenges they may face.

5. Significant Implications

5.1 Finance Implications

No direct financial implications from the recommendations proposed.

Recommendations with potential financial impact will be subject to business planning work during 2025/26 and if supported, for subsequent implementation in 2026/27.

5.2 Legal Implications

Section 9 of the Act states that where it appears to a local authority that an adult may have needs for care and support, the authority must assess whether an adult has needs for care and support, and, if so, what those needs are. Subsequently, Section 18 of the Act confers a duty on the Council to meet the eligible needs of individuals ordinarily resident in their area.

When providing such services, Section 14(1) of the Act confers a power upon the Council to make a charge for meeting needs under section 18 of the Act. However, by section 14(7) of the Act, the Council may not make a charge under section 14(1) if the income of the adult concerned would, after deduction of the amount of the charge, fall below such amount as is specified in regulations (the Minimum Income Guarantee).

Section 17(1) of the Act provides that, where a local authority considers that it would charge the adult under section 14(1) for meeting at least some of his eligible needs, it must assess (a) the level of the adult's financial resources, and (b) the amount (if any) which the adult would be likely to be able to pay towards the costs of meeting the needs for care and support.

The current Adults Charging Policy was reviewed by the Council's legal representatives and Kings Counsel in March 2024 as part of an ongoing Judicial Review. The review in preparation for the case determined the Adult Charging Policy to be compliant with the Care Act 2014, applied equitably and in line with legislation and guidance.

The Judicial Review itself is currently stayed until the appeal judgement of R (YVR by YUL) v Birmingham City Council [2024] EWHC 701 (Admin) which addresses the same issues as the current claim.

The Policy continues to be compliant with relevant legislation including the Care Act 2014 and associated Regulations and Statutory Guidance as outlined in section 3 above and is pursuing a legitimate aim of considering a person's eligible needs and finances on an individual basis taking into consideration the income that they may have with ensuring that the Council can set a balanced budget and maximising funds available to discharge the Council's duties under the Act.

The external independent review that has been commissioned by the Council has investigated the impact of individuals who could be affected by the lines of enquiry to

change the Charging Policy, whilst balancing this impact with the financial position of the Council (Appendix sections 1.3, 1.5 and 1.6).

While findings set out in Appendix 2, section 1.5 makes reference to the impact on people who use services and outlines the impact of the financial pressures associated with that line of enquiry, this needs to be expanded to review specifically the impact on people who use our services who cannot work and then outline how any mitigation of discrimination against this cohort would impact any financial pressures on the Council. For example, if the Council was not to charge those individuals for services it would lose a significant amount of income, but the services would still need to be provided to the individual.

5.3 Risk Implications

There are no risks arising from the recommendations contained in this report.

No health & safety implications.

No staff consultation. If the subsequent business case investment in additional Welfare Benefits Advisors is approved this will result in additional recruitment; approvals for such will follow the normal business planning and workforce approval process at that time.

5.4 Equality and Diversity Implications

If the proposed recommendations are agreed, then no new EDI or EQIA implications will arise. Outputs from the agreed actions will themselves be subject to EQIA.

Further exploration into the cohort of clients who are unable to work and potential changes to the Charging Policy will have EDI or EQIA implications and will be addressed at that time with its individual EQIA.

6. Source Documents

6.1 The Care Act https://www.legislation.gov.uk/ukpga/2014/23/contents

6.2 Care and support statutory guidance (“CASS”) https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-supportstatutory-guidance

6.3 Cambridgeshire County Council Adult Social Care Charging Policy https://www.cambridgeshire.gov.uk/asset-library/Adult-Social-Care-charging-policy-April2020-updated-July-2023.pdf

CLT Paper: Application of Adult Social Care Charges Review – Appendix 1

Application of Adult Social Care Charges Review - Summary

To: Corporate Leadership Team and Members
Date: 6 November 2024
From: Kirstin Clarke - Service Director Adult Social Care and Richard Gibson, Head of Service: ASC Finance Operations

Purpose: To undertake a review of the charging arrangements, set by the Council's Adult Social Care Charging Policy, within the statutory framework of the Care Act 2014; for residential and non-residential charging. This review will incorporate a specific anti-poverty view and the implications of the cost-of-living crisis on people who use our services.

1. Background

1.1 The review remit was set out in the proposal to the Chair and Vice Chair, Adults and Health Committee, Cambridgeshire County Council on 13 June 2024. It was "To undertake a review of the charging arrangements, set by the Council's Adult Social Care Charging Policy, within the statutory framework of the Care Act 2014, for residential and non-residential charging. This review will incorporate a specific anti-poverty view and the implications of the cost-of-living crisis on people who use our services." Details of the lines of enquiry were subsequently set out and are addressed individually below.

2. To review the Cambridgeshire County Council's Adult Social Care Charging Policy, comparing the interpretation and application of the Care Act and Statutory Supporting Guidance, against other council's both regionally and nationally.

2.1 Comparison was made against the Cambridgeshire County Council (CCC) Local Government Association (LGA)/Chartered Institute of Public Finance Accountants (CIPFA) comparator group. The group consists of the county councils of Oxfordshire, Staffordshire, Warwickshire, Worcestershire, Leicestershire, Hertfordshire, Gloucestershire, Suffolk, Surrey, Nottinghamshire, Essex, Kent, Hampshire, Somerset and West Sussex. The comparator group was extended to include the neighbouring councils of Norfolk County Council and Peterborough City Council for further regional comparison.

2.2 The review found that CCC and comparator councils are principally aligned with respect to chargeable and non-chargeable services where a financial assessment is required to determine a contribution (or charge) toward a person's cost of care and support. In respect of chargeable services, where a financial assessment is undertaken, all councils in the comparator group have exercised their discretion to charge for services where Care and Support Statutory (CASS) Guidance allows. The current CCC Charging Policy is compliant and consistent with the comparator group, of seventeen councils, in its interpretation and application of the regulations and guidance.

2.3 There are variances in how councils apply Disability Related Expenses (DRE) in a financial assessment and what and how councils set associated fees and charges, including for administration of care and support for self-funders and Deferred Payments Agreements (DPA). The DRE rates established by CCC are in the middle to high bracket compared with the comparator group councils.

2.4 The charging policies themselves vary in content and detail. Most of the councils have a standalone policy complimented by online information that is often more detailed. CCC follows this principle. CCC can enhance its

current published policy and supporting information with further content and detail to more clearly demonstrate that the charging system is fair, transparent, and supportive of individuals' needs and circumstances.

2.5 In conclusion, CCC is legally compliant in its charging policy through its interpretation and application of the CASS regulations and guidance.

2.6 Recommendations and Action Plan

2.6.1 The following recommendations/actions are made with a priority level and indicative timeline:

Ref	Description	Priority	Timeline
1.	That the charging policy is reviewed, approved, and republished for the next financial year after consideration of the recommendations arising from this review.	High	January 2025 to March 2026
2.	That separately to any changes to the body of the Charging Policy itself, further detail is included as appendices in the policy and reviewed annually or as required on: • General Charging Principles including fees and charges • Disability Related Expenses (DRE) • Recourse to support for non-payment including right of appeal against financial assessment outcomes and the waiver process	High	January to September 2025
3.	A review, against the comparator group, is undertaken of supporting information available to people in documented and digital form on paying for care be carried out to establish a refreshed and expended set of leaflets and factsheets.	Medium	September 2025
4.	That a review of the type and level of expenditure considered in an enhanced (full) DRE assessment be undertaken and any output be set out in supporting documentation and online content.	Low	September 2025

3. A review of regional and wider national comparators which will compare what services (other) councils charge for, what services do they not charge for, and any rationale for why.

3.1 In respect of chargeable services, where a financial assessment is undertaken to determine contributions towards a package of care and support, all councils in the comparator group have exercised their discretion to charge for services where CASS guidance allows. The rationale amongst the comparator group for this would appear to be purely financial. The reduction in funding to local authorities over a number of years has not seen councils looking at options to relax charging policies but has conversely required local authorities to strengthen their charging policies whilst remaining in compliance with CASS regulations and guidance.

3.2 Hammersmith and Fulham Council is unique for councils in England by not charging residents for community care. The decision made in 2015 required the council to cover all the costs for care provided at home and their financial position allowed, and continues to allow them, to do this. In April 2024, the London Borough of Tower Hamlets promised to become just the second council in England to "abolish all charges for care and support for 'disabled people in their own homes...". This has not been implemented yet and appears to be a commitment without an approved and funded implementation plan.

3.3 In the comparator group there are minor variances to chargeable and non-chargeable services. Staffordshire CC have discretionally set a higher limit, £5,000 instead of £1,000, for the provision of equipment and minor adaptations free of charge and Nottinghamshire CC do not stipulate a 6-week period for free of charge reablement giving discretion to extend this target period if deemed appropriate. Staffordshire and Nottinghamshire are two of the seventeen councils exercising this discretion.

3.4 The types and levels of fees and charges for certain services (not classed as chargeable and non-chargeable) that councils provide and have discretion to charge for vary in scope and cost. This includes transport, telecare and assistive technology, meal provision and administration charges for Deferred Payment Agreements (DPA), self-funder brokerage and management of Direct Payment accounts. CCC charges are in the low to middle range of the comparator group except for self-funder brokerage costs in the middle to high bracket. Some of the comparator group councils levy the full set up charge when a DPA is not finalised on the part of the applicant even though the council has incurred costs. Reputationally it is advisable for CCC to more clearly set out their fees and charges based on the neutral cost recovery principle set out in CASS regulations and guidance. For example, fees and charges are published on the council website but are not published in the Adult Social care 'Paying for Care' webpages; the advice is to publish fees and charges information in multiple locations to promote sharing of information.

3.5 The CASS guidance on chargeable and non-chargeable services has been followed by CCC in line with virtually all English councils. In summary, the key principles of charging for care, outlined in the Care Act 2014, and applied by CCC can be assessed as:

- **Affordability**: People are not charged more than it is reasonably practicable for them to pay. Support is in place for those who have issues in paying including a right of appeal against any financial assessment and a planned waiver scheme for charges.
- **Comprehensiveness**: The systems and processes in place reduce variation in how people are assessed and charged.
- **Transparency**: Whilst the current policy is a good baseline, fees and charges could be more clearly set out, digitally and documented, so people know what they may/will be charged and what indicative costs for services are.
- **Well-being and Inclusion**: The approach does promote well-being, social inclusion, and support personalisation, independence, choice, and control. As preventative services develop especially assistive technology (TEC enabled care) CCC should be planning to establish a policy on whether such services are charged for.
- **Support for Carers**: There is support for carers to contribute towards them looking after their own health and well-being and to care effectively and safely. The policy of not charging for carer services supports this.
- **Person-focused**: The system reflects the variety of care journeys and options available to meet individual needs.
- **Equality**: Charging rules are applied equally so those with similar needs or services are treated the same but attention through processes and staff training should be paid to how couples are treated.
- **Encouragement of Employment and Education**: The system would appear to encourage and enable those who wish to stay in or take up employment, education, or training to do so. Earnings, where appropriate, are correctly disregarded in the financial assessment.
- **Sustainability**: The current approach contributes to a CCC balanced budget and appears sustainable in the long term.

3.6 In conclusion, CCC chargeable and non-chargeable services are in line with 99% of councils in England but it could improve how it sets out its full list of associated fees and charges. There is also opportunity to strengthen charges for Deferred Payment Agreements to recoup incurred costs when an agreement does not proceed due to the action of the applicant.

3.7 <u>Recommendations and Action Plan</u>

3.7.1 The following recommendations/actions are made with a priority level and indicative timeline:

Ref	Description	Priority	Timeline
1.	That all Fees and Charges, including for Direct Payment Managed Accounts, be detailed as an appendix to the Charging Policy and updated annually.	High	January to March 2025
2.	That a decision is made on whether to annually include alongside the charging policy a list of indicative costs of care paid to providers.	Medium	December 2024
3.	That consideration be given to amending the CC charging and DPA policies that the set-up fee is payable even if the DPA is not finalised due to the action of the applicant.	Medium	January to March 2025
4.	That ASC consider how future TEC enabled care is treated with reference to the CASS regulations and guidance.	Low	April 2026 onwards

4. To consider the options to charge or not for specific services, the implications this will have on the person and the council's Adult Social Care financial position.

4.1 Any decision to change the current charging policy in respect of services will affect the council's financial position. The income from charging forecast for 2024/25 for residential and non-residential care is £52.5 million. The latest forecast with an increase in contributions will be reflected in the current budget setting process. It includes a sizeable backdating of charges that are one-offs and not recurring. Research shows that local authorities are not looking to stop or reduce charging levels but are looking to increase income from chargeable services and/or contributions. In the CCC comparator group this can be evidenced by the recent decision of Norfolk CC to reduce their enhanced MIG levels to that of the annual advised Government levels.

4.2 The forecast contributions income for 2024/25 for community-based services is £19.6 million. Whilst people can receive multiple community care services, about 80% of this income can reasonably be attributed to care at home. A decision to stop charging for this type of care would result in lost income of around -£19.6 million. As well as the need to find a replacement for this lost income there is the question of equitability especially for those being charged for residential care.

4.3 There is a right of appeal for people and support is in place if they wish to challenge their financial assessment or are unable to pay their contributions to care. The resources put in place by the council around welfare benefits maximisation and cost of living crisis support, discussed later in this report, also provide support. It should be noted that not only the charging policy, but the level of future fees paid to providers will have an impact on contributions to care, especially for full cost payers and not just the elements (benefits levels, MIG, disregarded income etc.) of the financial assessment process.

4.4 In conclusion, the financial position of the council does not lend itself to any significant change in its charging policy. Any changes to the policy done in isolation could result in legal challenge based on equitability and fairness.

4.5 Recommendations and Action Plan

4.5.1 The following recommendations/actions are made with a priority level and indicative timeline:

Ref	Description	Priority	Timeline
1.	That no changes are made to scope of chargeable and non-chargeable services for 2025/26. i.e. Element/charging lines Deferred Payment Agreements, Self-Funder Arrangement Fees, Meals and Transport. Rates for these fees will be changed each year to reflect changes in operating cost/inflation.	High	December 2024

5. To provide insight across the diverse range of people who use our services, the outcome of their financial assessment and their typical incomes, of the (financial) impact of the current Charging Policy.

5.1 Insight into service users is available from the ASC statutory SALT Return for 2023/24. Further detail is available in the ADASS self-assessment report currently being refreshed.

5.2 CASS regulations and guidance implicitly set out for councils the detail of how individuals paying for care must be left with sufficient monies to live on and ensure they are not financially compromised as a result of any financial assessment. This includes income disregards, expenses to be considered including allowances for any disability related expenses and for those receiving care at home the Minimum Income Guarantee levels set by the Government. CCC in comparison with the comparator group is in the middle to high bracket for the level of non-assessed disability related expenses allowed.

Residential Financial Assessments

5.3 The financial assessment takes assessed Income (including tariff income) and deducts the total of income disregarded, expenditure allowed and other allowances to give the contribution to care:

Level of Weekly Contribution	No. of Clients	Clients as %
Nil Charge	8	0.58%
Up to £100/week	22	1.61%
£100 - £200/week	567	41.42%
£200 - £300/week	352	25.71%
More than £300/week	229	16.73%
Full Charge	191	13.95%
Total	**1369**	**100.00%**

5.4 The majority of those undertaking a full financial assessment have an outcome resulting in a charge due to the nature of the financial assessment ensuring those in care are principally paying towards the accommodation element of the service received. Any change to income disregards and/or increased allowances will have a positive impact on the vast majority, but not self-funders, of those paying a contribution towards their residential care. There would be a virtually like for like negative impact on the council finances as a result of any such change.

5.5 Analysis of income considered during the financial assessment shows the complexity and variety of income sources for individuals in residential settings, with many having multiple income sources and a significant reliance on pensions and benefits. The most common income types are Occupational Pension or Annuity, State Pension, DLA/PIP Mobility and Pension Guarantee Credit.

Non-Residential Financial Assessments

5.6 The financial assessment takes assessed Income (including tariff income) and deducts the total of income disregarded, expenditure allowed, disability related expenses and other allowances/Minimum Income Guarantee (MIG) to give the contribution to care:

Level of Weekly Contribution	No. of Clients	Clients as %
Nil Charge	615	18.56%
Up to £60/week	709	21.41%
£60 - £100/week	276	8.33%

Level of Weekly Contribution	No. of Clients	Clients as %
£100 - £150/week	827	24.95%
More than £150/week	416	12.56%
Full Charge	470	14.19%
Total	**3313**	**100.00%**

5.7 The most financially vulnerable clients are 'nil costers' (18.56% of clients); whose income is so low that they are not required to contribute toward their care. Therefore, any discretionary change to retained income and/or allowances would not benefit these clients, as they are already assessed as 'nil cost'.

5.8 21.41% of contributors to care pay up to £60 per week and could still be classed as financially vulnerable. Any increase to income retention through increased benefit or allowances levels/rates permitted would have a more significant impact than those in higher contribution brackets.

5.9 Analysis of income considered during the financial assessment mirror that of the residential financial assessments with many having multiple income sources and a significant reliance on pensions and benefits. The most common income types are Occupational Pension or Annuity, State Pension, DLA/PIP Mobility and Pension Guarantee Credit. There is also significant instances of Employment and Support Allowance (ESA).

5.10 In conclusion, CCC follows the CASS regulations and guidance on ensuring that those paying for care have sufficient income for day to day living costs. The council has support in place for those in financial difficulty.

5.11 Recommendations and Action Plan

5.11.1 The following recommendations/actions are made with a priority level and indicative timeline:

Ref	Description	Priority	Timeline
1.	A dataset and agreed periodic analytical and statistical output be agreed with the Policy and Insight Team to provide an insight into the demographics and financial aspects of those contributing to care to assist in informed decision making.	Low	September 2025

6. A review of the current approach for Adult Social Care and the Council, with an anti-poverty approach, to understand the application of such, comparing other councils both regionally and nationally to understand alternative options and the financial impact on the county council of any changes.

6.1 Councils regionally and nationally are strengthening their focus on the impact of the cost-of-living crisis and all forms of poverty on their residents and what support they can offer in response. Whilst Adult Social Care (ASC) has its part to play in addressing these issues at all contact points with residents this focus needs to be corporately lead with a strategy that ASC contributes to and supports.

6.2 With the cost-of-living crisis, and in September 2021 the setting up by the Government of the Household Support Fund, councils have administered that scheme and provided resources for those affected by the cost-of-living crisis. The approach taken by CCC and councils in the comparator group is remarkably similar in offer and detail. Digital content is principally provided through standalone resource hubs or specific web pages. CCC have their 'support with the cost of living' landing page accessible under the Communities channel. The content across the comparator group is principally the same as that for CCC whose content, locally and nationally, looks comprehensive and is benefited by being tagged as a popular topic on the CCC landing page.

6.3 ASC can effectively use all of its 'front door' entry points and subsequent contacts with people to provide information, advice and guidance on options to address all forms of poverty and specific resources under the council's response to the cost-of-living crisis. This means ASC has effective access routes to the Welfare Benefits team across the service to support people maximising their personal and household income. To ensure transparency ASC needs to clearly set out in its charging policy and also digitally:

- The details and process for the right of appeal against the outcome of financial assessments
- The details and process for the council to waive any charges made for care and support be that for future service provision and/or outstanding charges accrued
- The debt recovery policy specific to ASC

6.4 Resolve Poverty is working with Cambridgeshire County Council and the Poverty Strategy Commission to meaningfully engage with local people who are living in, or are at risk of living in poverty.

The Cambridgeshire Poverty Strategy Commission is a new, independent initiative to explore how the local system serves those experiencing the consequences of poverty, and how improvements can be made to this system. Initially facilitated by Cambridgeshire County Council, the Commission will draw on the experiences of its commissioners, as well as evidence gathered from people with lived experience of poverty.

Resolve Poverty is facilitating the lived experience elements of this effort, by hosting workshops over the next month in communities across Cambridgeshire. They are looking to engage with a diverse range of people across Cambridgeshire, to listen to their experiences, priorities and ideas for influencing the anti-poverty policies and strategies that are likely to affect them and others. Participants will be compensated for their time, as well as the VCFSE sector organisations that refer them.

6.5 5 out of the 17 councils in the comparator group have a waiver scheme in operation for those who are unable to pay for their care charges. Of those 3 state a waiver will only be granted in exceptional circumstances. Those councils that have no dedicated waiver scheme instead talk about a right of appeal or advise people to contact the council if they are in financial difficulty when paying for care.

6.6 In conclusion, ASC actively supports the corporate initiatives on anti-poverty and the cost-of-living crisis at all contact points with those seeking its support and services. As stated it offers support to those with issues in meeting their contribution to care commitments.

6.7 Recommendations and Action Plan

6.7.1 The following recommendations/actions are made with a priority level and indicative timeline:

Ref	Description	Priority	Timeline
1.	All ASC staff are provided with regular updates on the councils' anti-poverty strategy and cost of living response and how they can ensure available support is provided where necessary for use at all contact points.	Medium	April 2025 onwards
2.	ASC sets out clearly and transparently to future and current contributors to care costs in the charging policy the details of appeal against the outcome of the financial assessment, any implemented waiver scheme and the CCC debt recovery policy.	High	January to September 2025

7. Impact assessment of disregarding different levels of benefits, people receive, including higher rate of disability living allowance (DLA), Personal Independence Payment (PIP) or Attendance Allowance (AA) from the Financial Assessment.

7.1 The CASS guidance sets out that councils may take most of the benefits people receive into account as part of the financial assessment. The guidance fully details what such income must be fully disregarded and what must be considered. Certain allowance rates are set out annually by the Government (DHSC and DWP) with increases supposed to address inflationary and cost of living pressures. Within certain allowances the mobility component must be fully disregarded, and the DLA Care lower rate is a legacy allowance so the only option allowable really to CCC under the guidance would be make changes to how it treated the 'assessed income' of PIP Daily Living and Attendance Allowances. The external consultant supporting the fees and charges review has set out a number of changes to rates which could be considered by the Council and has estimated the financial impact of each. These are set out in the paragraphs below. Further consideration of the issues arising from any of these changes and validation of the financial impact is needed and will inform any future proposals feeding into 2026/27 Business Planning.

7.2 If CCC decided to apply a single rate of DLA/PIP/AA of £72.65 thereby disregarding the higher rate of £108.55 this would have the following impact on contributions income across the allowance types:

Decrease in Contributions Income	**Numbers**	**Full Year Cost £**
DLA Care – Higher Rate (Community)	216	-393,660
PIP Daily Living – Higher Rate (Community)	896	-1,971,096
Attendance Allowance – Higher Rate (Community)	468	-849,331
Attendance Allowance – Higher Rate (Residential)	11	-20,535
Total	**1,591**	**-3,234,622**

7.3 If CCC decided to apply an enhanced Personal Expenses Allowance (PEA) for those in residential care of £60.30 per week up from the current rate of £30.15 then this would affect some 1,159 people reducing contribution income by -£1.92 million per annum.

7.4 From the comparator group the treatment of DRE varies. CCC apply two rates for DRE, based on disability benefits/allowances received, for those not having a full DRE assessment. As at 31 March 2024 rates were £20 and £28 per week. The following options used by other councils in the comparator group could be considered:

- A self-assessment banded scheme (such as Leicestershire CC) that increases the current allowed levels – Introducing two self-assessed bands of £30 and £38 would impact just over 2,000 individuals resulting in a reduction of contribution income by just over -£1 million per annum.
- A single flat rate minimum allowance (such as Surrey CC, Hertfordshire CC, Suffolk CC, Nottinghamshire CC, Kent CC) higher than that of the current higher level – Introducing a single flat rate of £35 would impact just over 2,000 individuals resulting in a reduction of contribution income by circa -£942k per annum.
- An indicative allowance based on 35% of a person's Disability Benefit (such as Oxfordshire CC) – This could impact on 90% of individuals going through a financial assessment resulting in a reduction of contribution income by circa -£4.9 million.
- All claimants are assessed on an individual basis with allowances linked to an expenses table, the impact cannot be quantified financially as we do not possess the detailed expenses information for the majority of current service users. However, the resources required to undertake such assessments would probably be prohibitive as to administer this would require a dedicated DRE assessment team.

7.5 As with any change made in isolation there is the prospect of legal challenge that the change is not fair and that all those contributing to care not affected by this isolated change are not being 'fairly' and 'equitably' treated.

7.6 In conclusion, the complexity of the financial assessment process means changes made in isolation to income disregarded, be they allowances and/or benefits, would have a significant impact on the council's finances and could be legally challenged on the basis of equitability and fairness.

7.7 Recommendations and Action Plan

7.7.1 The following recommendations/actions are made with a priority level and indicative timeline:

Ref	Description	Priority	Timeline
1.	That no changes to any allowances are made in the Charging Policy.	High	December 2024

8. Impact assessment of adopting a locally agreed Minimum Income Guarantee (MIG), higher than that set nationally by the Department of Health and Social Care (DHSC), setting out the financial, legal, reputational, and political implications.

8.1 The legal position on the level of MIG applied, for charging for care and support in other (not residential care home) care settings including a person's home is explicitly set out in CASS regulations and guidance. "Local authorities must ensure that a person's income is not reduced below a specified level after charges have been deducted. The amounts are set out in the Care and Support (Charging and Assessment of Resources) Regulations. However, this is only a minimum, and local authorities have discretion to set a higher level if they wish". In addition, "The purpose of the minimum income guarantee is to promote independence and social inclusion and ensure that they have sufficient funds to meet basic needs such as purchasing food, utility costs or insurance. This must be after any housing costs such as rent, and council tax net of any benefits provided to support these costs – and after any disability related expenditure…."

8.2 All the comparator group, including Norfolk CC as of November 2024, apply the Government set multiple MIG rates. Reputationally CCC can be seen to be following guidance and regulations correctly but politically the option to go beyond this standard would be appealing if financial circumstances allowed. However, as stated before, those contributing to care but not affected by this discretionary change could challenge the council on fairness and equitability grounds.

8.3 Analysis of Community-based clients contributions show:

Level of Weekly Contribution	No. of Clients	Clients as %
Nil Charge	615	18.56%
Up to £60/week	709	21.41%
£60 - £100/week	276	8.33%
£100 - £150/week	827	24.95%
More than £150/week	416	12.56%
Full Charge	470	14.19%
Total	**3313**	**100.00%**

8.4 From an anti-poverty perspective the most financially vulnerable clients are 'nil costers' (18.56% of clients); whose income is so low that applying the Government set MIG means they are not required to contribute toward their care. Therefore, a discretionary change to the MIG would not benefit these clients, as they are already assessed as 'nil cost'.

8.5 From an anti-poverty perspective the next most financially vulnerable clients are those contributing up to £60/week (21.41% of clients), who would directly benefit by a change in the MIG; their weekly contribution would decrease equal to the discretionary increase in the MIG.

8.6 A discretionary change to the MIG would benefit all community-based clients, except for the most financially vulnerable ('Nil Costers') and the most affluent (Full Charge) clients, as a discretionary change would need to be applied to all MIGS to avoid legal challenge of discrimination.

8.7 The financial impact of options to increase the MIG levels have been estimated by the external consultant to be:

- MIG rates raised by £10 would result in a decrease of contributions of circa -£1.15 million per annum
- MIG rates raised by 5% would result in a decrease of contributions of circa -£1.19 million per annum

8.8 CCC would need to carefully consider applying changes to individual MIG rates as to do so, rather than a consistent change to all rates, would likely be legally challenged on equitability and fairness grounds.

8.9 In conclusion, CCC applies the same MIG rates as all of its comparator group councils and any change would have significant financial impact to the council especially as all rates would need to change to mitigate challenge.

8.10 Recommendations and Action Plan

8.10.1 The following recommendations/actions are made with a priority level and indicative timeline:

Ref	Description	Priority	Timeline
1.	That the council continue to use the MIG levels as set by the Government, and not to use its discretion to increase any MIGs.	High	December 2024

9. Opportunities for strengthening the welfare benefit advice available, to support residents to maximise their personal entitlement, and that of household income.

9.1 Welfare benefits advice is provided through a dedicated Welfare Benefits Team as part of Adult Early Help (AEH) and through a commissioned service provider, P3. There is also non-council support available through the likes of the Citizens Advice Bureau (CAB).

9.2 All those being supported who see positive financial impact of benefit maximisation with the result that those with increased eligible benefits increase their contribution to provisioned care and support. Care and support costs borne by the council will reduce accordingly.

9.3 The Welfare Benefits Team sees demand outstrip capacity. This has an impact on ASC referrals as they are not prioritised ahead of residents who can self-present for support. If the team had additional resources including a dedicated IT system, they could expand their offer so the numbers the team support, and the positive impact on the council's finances, could be increased.

9.4 In conclusion, there is an opportunity for ASC to enhance the welfare benefits of those it supports with the subsequent positive financial impact on the council by expanding the Welfare Benefits Team to enable a focus on those in contact with ASC services.

9.5 Recommendations and Action Plan

9.5.1 The following recommendations are made along with a proposed Action Plan showing a priority level and indicative timeline:

Ref	Description	Priority	Timeline
1.	An invest to save proposal is developed to increase the capacity of the Welfare Benefits Team.	High	February 2025

Ref	Description	Priority	Timeline
2.	That priority consideration be given for IT to supply a database for team activity and outcome recording and reporting.	Medium	April 2025
3.	That the operating model for benefits maximisation and welfare support be determined with consideration being given to the Welfare Benefits Team setting resources aside for ASC referrals and focus on Attendance Allowance take up by existing service users.	Low	February 2025

10. Support with Cost-of-Living: Explore production of a visual guide to demonstrate the ways in which the council is supporting client and wider residents with cost-of-living crisis and our anti-poverty focus.

10.1 The provision of such a resource setting out numerous sets of information in a schematic or visual guide that is easily understandable is difficult. If provided in printed form, it is hard to version manage as the information can quickly change or become redundant and managing old versions in circulation is impossible. That said, the LGA do provide a resource list of examples of cost-of-living policy and strategy documents that contain visual aids that CCC may wish to follow.

10.2 Recommendations and Action Plan

10.2.1 The following recommendations/actions are made with a priority level and indicative timeline:

Ref	Description	Priority	Timeline
1.	ASC requests that CCC Anti-Poverty Strategic Lead develop through the work with Resolve Poverty and the Poverty Strategy Commission a visual aid that shows the response of CCC to the cost-of-living crisis that includes all principal support offered to residents is produced for use at all ASC contact points.	Low	July 2025

11. Conclusion

11.1 In conclusion members are requested to note that the CCC Adult Charging Policy is:

- Legally compliant through interpretation and application of CASS regulations and guidance
- Consistent with other councils in the comparator group regionally and nationally
- That ceasing to charge for community-based services would cost the council around -£20 million per annum
- That changes in policy such as variations to benefits and allowances such as the MIG or DRE are estimated to cost the council between -£1.0 million and -£4.9 million in lost income per annum, and could risk challenge on the grounds of inequity and fairness if done in isolation
- There are areas for improvement principally around printed and online information and advice, such as transparency of fees and charges outside of the charging policy, typical rates for care and support for those with issues with paying for care already received

Appendix A – Other Recommendations

The following are recommendations in addition to the those contained against each line of enquiry.

Ref	Description	Priority	Timeline
1.	The annual Fees and Charges list should be available on the appropriate ASC web pages.	Medium	April 2025 onwards

Ref	Description	Priority	Timeline
2.	That further detail is included in the Charging Policy on the: • Levels of provider care costs paid, how they are agreed plus any effect on annual contributions uplifts • Flat rate fees to distinguish between contributions and other fees and charges	Medium	April 2026 onwards
3.	That a detailed analysis of how the DRE banded allowances were calculated and a review of the allowances and how they are applied be undertaken.	Low	September 2025
4.	How couples are treated in the financial assessment process should be reviewed and documented for staff to ensure adherence to CASS regulations and guidance and consistency of approach.	Medium	December 2024 onwards
5.	Development of a contributions forecasting tool to aid informed decision making based on accurate impact data.	Low	April to September 2025
6.	That the Policy and Insight Team be requested to provide analytic and statistical analysis of property/capital/income and assessed expenditure.	Low	April 2025 onwards
7.	Ensure that any approved waiver scheme financial implications have been determined and the scheme is in compliance with financial regulations.	Medium	April 2025 onwards
8.	CCC uses appropriate forums so that the Government provides detail on how annual MIG levels are calculated and set.	Low	April 2025 onwards
9.	That a review of ASC dashboards/reports be undertaken in respect of financial assessment and contributions and a development plan be put in place to prioritise those that would meet business needs and to inform decision making and address FOI, members queries and public challenge.	Medium	April 2025 onwards

LINES OF ENQUIRY: OFFICER RECOMMENDATIONS & TIMESCALES

1.1 To review the Cambridgeshire County Council's Adult Social Care Charging Policy, comparing the interpretation and application of the Care Act and Statutory Supporting Guidance, against other council's both regionally and nationally.

Conclusion: The council's Adult Charging Policy is legally compliant through interpretation and application of CASS regulations and guidance; the policy is consistent with (17) other councils in the comparator group regionally and nationally.

Recommendation(s):

Ref	Description	Priority	Timeline
1.1.1	That CLT supports that the charging policy has been reviewed, approved, and republished for the next financial year, whilst acknowledging the recommendations arising from this review.	High	Jan 2025 to March 2026
1.1.2	That CLT support the recommendation that further detail is included, as appendices, in the charging policy on: • General Charging Principles • Disability Related Expenses (DRE) • Recourse to support for non-payment including right of appeal against financial assessment outcomes and the waiver process (subject to further investigation and decision)	High	Jan to Sept 2025
1.1.3	To review introduction of financial assessment appeal and waiver process, ensuring compliance with regulation and financial scheme of delegation.	Medium	Jan to Sept 2025
1.1.4	That CLT supports a review of the type and level of expenditure considered in an enhanced (full) DRE assessment be undertaken and any output be set out in supporting documentation and online content.	Low	September 2025

1.2 A review of regional and wider national comparators which will compare what services (other) councils charge for, what services do they not charge for, and any rationale for why.

Conclusion: That Cambridgeshire's chargeable and non-chargeable services are in line with 99% of councils in England but it could improve how it sets out its full list of associated fees and charges. There is also the opportunity to strengthen charges for Deferred Payment

Agreements to recoup costs incurred when an agreement does not proceed due to the action of the applicant. The review notes that only Hammersmith and Fulham Council is unique for councils in England by not charging residents for community care. The decision made in 2015 required the council to cover all the costs for care provided at home and their financial position allowed, and continues to allow them, to do this.

Recommendation(s):

Ref	Description	Priority	Timeline
1.2.1	That all Fees and Charges, including for Direct Payment Managed Accounts, be detailed as an appendix to the Charging Policy and updated annually.	High	January to March 2025
1.2.2	That a decision is made on whether to annually include alongside the charging policy a list of indicative costs of care paid to providers.	Medium	December 2024
1.2.3	That consideration be given to amending the CC charging and DPA policies that the set-up fee is payable even if the DPA is not finalised due to the action of the applicant.	Medium	January to March 2025

1.3 To consider the options to charge or not for specific services, the implications this will have on the person and the council's Adult Social Care financial position.

Conclusion: The financial position of the council does not lend itself to any significant change in its charging policy. Any changes to the policy done in isolation could result in legal challenge based on equitability and fairness.

Any decision to change the current charging policy in respect of services will affect the council's financial position. The income from the charging forecast for 2024/25 for residential and non-residential care is £52.5 million.

Research shows that local authorities are not looking to stop or reduce charging levels but are looking to increase income from chargeable services and/or contributions. In the CCC comparator group this can be evidenced by the recent decision of Norfolk CC to reduce their enhanced MIG levels to that of the annual advised Government levels.

A decision to stop charging for community-based services would result in lost income of around -£19.6 million.
Recommendation(s):

Ref	Description	Priority	Timeline

1.3.1.	That CLT support no changes are made to scope of chargeable and non-chargeable services for 2025/26. i.e. Scope of Element/charging lines remain as Deferred Payment Agreements, Self-Funder Arrangement Fees, Meals and Transport. Rates for these fees will be changed each year to reflect changes in operating cost/inflation.	High	December 2024

1.4 A review of the current approach for Adult Social Care and the Council, with an antipoverty approach, to understand the application of such, comparing other councils both regionally and nationally to understand alternative options and the financial impact on the county council of any changes.

Conclusion: ASC actively supports the corporate initiatives on anti-poverty and the cost of living crisis at all contact points with those seeking its support and services; it offers support to those with issues in meeting their contribution to care commitments. ASC has effective access routes to the Welfare Benefits team across the service to support people maximising their personal and household income. Consideration of the introduction of financial assessment appeal and waiver process, ensuring compliance with regulation and financial scheme of delegation, may further enhance the support provided.

Recommendation(s):

Ref	Description	Priority	Timeline
1.4.1	CLT to support that all ASC staff are provided with regular updates on the wider councils' anti-poverty strategy and cost of living response and how they can ensure available support is provided where necessary for use at all contact points via the corporate center.	Medium	April 2025 onwards

1.5 Impact assessment of disregarding different levels of benefits, people receive, including higher rate of disability living allowance (DLA), Personal Independence Payment (PIP) or Attendance Allowance (AA) from the Financial Assessment.

Conclusion: The complexity of the financial assessment process means changes made in isolation to income disregarded, be they allowances and/or benefits, would have a significant impact on the council's finances and could be legally challenged based on equitability and fairness.

Any change made in isolation there is the prospect of legal challenge that the change is not fair and that all those contributing to care not affected by this isolated change are not being 'fairly' and 'equitably' treated.

If the council decided to apply a single rate of DLA/PIP/AA of £72.65, thereby disregarding the higher rate of £108.55, this would result in lost income of around -£3.2 million.

Recommendation(s):

Ref	Description	Priority	Timeline
1.5.1	That no changes to any allowances are made in the Charging Policy in 2025/26.	High	December 2024

1.6 Impact assessment of adopting a locally agreed Minimum Income Guarantee (MIG), higher than that set nationally by the Department of Health and Social Care (DHSC), setting out the financial, legal, reputational, and political implications.

Conclusion: The policy applies the same MIG rates as all (17) of its comparator group councils and any change would have significant financial impact on the council especially as all rates would need to change to mitigate challenges. For example:

- If MIG rates were raised by £10, it would result in a decrease of contributions of circa £1.15 million per annum
- If MIG rates were raised by 5%, it would result in a decrease of contributions of circa £1.19 million per annum
- Any increase in the MIG would not benefit the most financially vulnerable, who will already have been financially assessed as “Nil Cost” (zero contribution toward their care)

Recommendation(s):

Ref	Description	Priority	Timeline
1.6.1.	That CLT supports the council continue to use the MIG levels as set by the Government, and not to use its discretion to increase any MIGs.	High	December 2024

1.7 Opportunities for strengthening the welfare benefit advice available, to support residents to maximise their personal entitlement, and that of household income.

Conclusion: There is an opportunity for ASC to enhance the welfare benefits of those it supports with the subsequent positive financial impact on the council by expanding the Welfare Benefits Team to enable a focus on those in contact with ASC services.

Welfare benefits advice is provided through a dedicated Welfare Benefits Team as part of Adult Early Help (AEH) and through a commissioned service provider, P3. There is also non council support available through the likes of the Citizens Advice Bureau (CAB).

The Welfare Benefits Team sees demand outstrip capacity. This has an impact on ASC referrals as they are not prioritised ahead of residents who can self-present for support. If the

team had additional resources including a dedicated IT system, they could expand their offer so the numbers the team support, and the positive impact on the council's finances, could be increased.

Recommendation(s):

Ref	Description	Priority	Timeline
1.7.1	CLT to note an invest to save proposal is being developed to increase the capacity of the Welfare Benefits Team. To include in this review ongoing work from Cambridge City and South Cambs Low Income Family Tracker (LIFT).	High	February 2025
1.7.2	CLT to support that the operating model for benefits maximisation and welfare support be determined with consideration being given to the Welfare Benefits Team setting resources aside for ASC referrals and focusing on Attendance Allowance take up by existing service users.	Low	February 2025

1.8 Supplemental: Support with Cost-of-Living: Explore production of a visual guide to demonstrate the ways in which the council is supporting client and wider residents with cost-of-living crisis and our anti-poverty focus.

Conclusion: The provision of such a resource setting out numerous sets of information in a schematic or visual guide, that is easily understandable, is difficult. If provided in printed form, it is hard to version manage as the information can quickly change or become redundant and managing old versions in circulation is impossible.

Recommendation(s):

Ref	Description	Priority	Timeline
1.8.1	ASC requests that CCC Anti-Poverty Strategic Lead develop a visual aid that shows the response of CCC to the cost-of-living crisis that includes all principal support offered to residents for use at all ASC contact points.	Low	Autumn 2025

1.9 Further supplemental recommended actions.

The following are recommendations in addition to those contained against each line of enquiry and are for CLT to note.

Ref	Description	Priority	Timeline

1.9.1	The annual Fees and Charges list should be available on the appropriate ASC web pages.	Medium	April 2025 onwards
1.9.2	That a detailed analysis of how the DRE banded allowances were calculated and a review of the allowances and how they are applied be undertaken.	Low	September 2025
Ref	Description	Priority	Timeline
1.9.3	Ensure that any approved waiver scheme financial implications have been determined, and the scheme is in compliance with financial regulations.	Medium	April 2025 onwards

Agenda Item No: 10

Corporate Performance Report

To:	Adults and Health Committee
Meeting Date:	12 December 2024
From: Executive Director:	Adults, Health and Commissioning
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	Not Applicable
Executive Summary:	This report provides an update to the Committee on the performance monitoring information for the 2024/25 quarter 2 period, covering July 1st to September 30th
Recommendation:	The Committee is asked to: Note performance information and act, as necessary.

Officer contact:
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1. Creating a greener, fairer and more caring Cambridgeshire

1.1 This report analyses the key performance indicators (KPIs) which directly link to Ambition 4: People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs. Due to the complex nature of KPIs, some indicators may also impact other ambitions.

2. Background

2.1 The Performance Management Framework sets out that Policy and Service Committees should:

- Set outcomes and strategy in the areas they oversee.
- Select and approve the addition and removal of Key Performance Indicators (KPIs) for the committee performance report.
- Track progress quarterly.
- Consider whether performance is at an acceptable level.
- Seek to understand the reasons behind the level of performance.
- Identify remedial action.

2.2 This report, delivered quarterly, continues to support the committee with its performance management role. It provides an update on the status of the selected Key Performance Indicators (KPIs) which track the performance of the services the committee oversees.

2.3 The report covers the period of Quarter 2 2024/25, up to the end of September 2024.

2.4 The most recent data for indicators for this committee can be found in the dashboard at Appendix 1. The dashboard includes the following information for each KPI:

- Current and previous performance and the projected linear trend.
- Current and previous targets. Please note that not all KPIs have targets, this may be because they are being developed or the indicator is being monitored for context.
- Red / Amber / Green (RAG) status.
- Direction for improvement to show whether an increase or decrease is good.
- Change in performance which shows whether performance is improving (up) or deteriorating (down).
- The performance of our statistical neighbours. This is only available, and therefore included, where there is a standard national definition of the indicator.
- KPI description.
- Commentary on the KPI.

2.5 The following RAGB criteria are being used:

- Red – current performance is 10% or more from target.
- Amber – current performance is off target by less than 10%.
- Green – current performance is on target or better by up to 5%.
- Baseline – indicates performance is currently being tracked in order to inform the target setting process.
- Contextual – these KPIs track key activity being undertaken, to present a rounded view of information relevant to the service area, without a performance target.
- In development - KPI has been agreed, but data collection and target setting are in development.

3. Main Issues

3.1 Current performance of available indicators monitored by the Committee is as follows:

An overview of the current performance monitored by the Committee is as follows:

- New contacts for Adult Social Care remain high per 100,000 of population but the conversion rate to people requiring formal care and support is low indicating an effective prevention, information and advice offer.
- Safeguarding continues to be an effective area of practice with higher than national and statistical neighbour averages for making safeguarding personal and reducing or removing risk.
- Reablement performance has reduced slightly in this quarter but this is still an effective intervention achieving a high percentage of successful outcomes ensuring people are able to regain or maintain their independence and reducing the number of people requiring longer term care and support.
- The number of people who have not received a review of their long-term care and support needs within the last 12 months remains at a lower level then statistical or national comparators but there is a declining trend which will be monitored
- A high proportion of adults aged 18-64 continue to be supported within the community but there is a slight declining trend in community support for adults over 65 years old.
- The rate of carers assessed or reviewed per 100,000 population in Q1 and Q2 2024/25 has improved compared to the first two quarters of last year
- The number of people receiving a Direct Payment improved slightly this quarter following a period of static or declining trends. Work continues to improve this area of performance with a range of initiatives.

3.2 There are 5 indicators that have improved this quarter.

Indicator 230: Number of new client contacts for Adult Social Care per 100,000 of the population

The rate of new client contacts per 100,000 population has been slightly higher in the first two quarters of 2024/25, compared with Q1 and Q2 last year.

Although the level of new contacts remains at a relatively high level many of the contacts are managed through prevention and early intervention services or through the provision of information, advice and guidance to support people to access universal and community services in their communities. The conversion rate of contacts to formal care and support remains low. Work continues to identify ways in which the Council can continue to improve its information and advice offer and that practitioners have the resources they require to support individuals to access a wide range of universal services to meet their needs.

Indicator 231: % of new client contacts not resulting in long term care and support

This indicator is important to look at in line with indicator 230 as it shows whether change in contact numbers are from people needing long term care, or people whose needs could be

met with preventative or low level community support. It helps us understand what might be driving a growth or reduction in contacts

Performance of this indicator improved throughout the last financial year and has continued to improve in Q1 and Q2 of 2024/25. In Q2 2024/25 the proportion of new client contacts not resulting in long term care and support rose above 90% for the first time in the last three years.

Indicator 233: Number of carers assessed or reviewed in the year per 100,000 of the population

The rate of carers assessed or reviewed per 100,000 population in Q1 and Q2 2024/25 has improved compared to the first two quarters of last year. Although the rate is significantly lower than the national average, and that of our statistical neighbour due to the way carer activity is recorded in Cambridgeshire we have seen an improvement in this quarter compared to the same period in 2023/24. A move away from carers assessments by default to a more constructive and timely conversation accounts for the lower volume of carers assessments. Activity by teams supporting carers can be recorded as carers conversations, which are not counted in the above measure.

During Q2 2024/25 (YTD cumulative) we have completed:
- 190 carers assessments
- 17 carers reviews
- 3760 carers conversations considering the carers needs while supporting the person being cared for

Indicator 126: Proportion of people using social care who receive direct payments

The percentage of people receiving direct payments has increased marginally in Q2 2024/25 from 17.2% in Q1 to 17.4% but continues to be low, reflecting the challenge in making direct payments an attractive solution. The decrease in percentage compared to 2022/23 is predominantly due to increasing service user numbers, whilst the number of clients with direct payments has remained relatively stable.

There is a programme in place which is focussed on supporting improvements to the proportion of people receiving direct payments and the outcomes people achieve through self-directed support. The programme is focussing on improved training, information and process to encourage direct payment performance and we hope to build on the improving trend over the next 6 months of 2024/25. We continue to develop our approach to community micro enterprises to build more opportunities for people to use direct payments to access care and support opportunities local to them.

Indicator 229: Percentages of safeguarding enquiries where risk has been reduced or removed

The proportion of safeguarding enquiries where the risk was reduced or removed has increased slightly from 91.4% in Q1 to 91.6% in Q2 2024/25. The improved performance

from the 2023/24 financial year is due to an amendment to the methodology to align more closely with the year-end statutory return.

Detailed commentary and summary of each indicator can be found in Appendix 1.

3.3 There are 6 indicators that have declined this quarter. Below are some examples.

Indicator 232: Proportion of people receiving long term support who had not received a review in the last 12 months, % of all people funded by ASC in long-term

In Q1 2024/25, 28.4% of clients had not received a review in the last 12 months, and Q2 2024/25 has seen a decline in performance to 30.24%. However, performance remains above the latest published data (2022/23) for England (43%) and statistical neighbours (34.6%). Further focus on the number of overdue reviews will continue.

Indicator 105: Percentage of those able to express desired outcomes who fully or partially achieved their desired outcomes

The % of enquiries where outcomes have been partially or fully achieved fell marginally in Q2 2024/25 to 95.24%. However, performance has remained consistent for the last 5 quarters, between 95% and 96%, and remains above the national and regional averages from 2022/23 which are 94.9% and 91.9% respectively.

Indicator 140: Proportion of people receiving reablement who did not require long term support after reablement was completed

The percentage of people who did not require long term support after reablement has decreased from 88.1% in Q1 to 85.2% in Q2 2024/25. This is significantly higher than the England average of 77% but we will continue to monitor the trend for this indicator to ensure that the proportion of people in Cambridgeshire who do not require long term support remains at a high level.

Indicator 236: Percentage of Cases where Making Safeguarding Personal (MSP) questions have been asked

Performance has remained consistent, with outcomes being asked in just under 94% of enquiries in both Q1 and Q2 2024/25. This is well above the national and statistical neighbour averages for 2022/23 which are around 81%, but slightly lower than local performance in Q1 and Q2 2023/24. The high % of enquiries where outcomes were asked suggests the making safeguarding personal approach is fully embedded into working practise.

Indicator 234: % total people accessing long term support in the community aged 18-64

The percentage of clients aged 18-64 accessing long term support in the community was fairly static throughout 2023/24 and has remained close to 91% in Q1 and Q2 2024/25. Although showing a slight decline between quarters of 0.3% this indicator remains higher than the national average and statistical neighbours average for 2022/23.

Indicator 235: % total people accessing long term support in the community aged 65 and

over

The percentage of clients aged 65+ accessing long term support in the community increased during the course of 2023/24, but fell slightly to 62.36% in Q1 2024/25. The percentage has fallen further to 61.42% in Q2 2024/25, which is marginally lower than during the same quarter last year. This could be reflective of the increasing complexity of needs for individuals accessing care and support.

Community settings include sheltered housing and extra care housing as well people being supported in their own homes.

Detailed commentary and summary of each indicator can be found in Appendix 1.

4. Survey of Adult Carers

4.1 Every two years NHS Digital, the analytics function in Department of Health and Social Care, directs Local Authorities to conduct a national survey of adult carers. The latest survey took place in Autumn 2023 and the results were published nationally in late June 2024.The previous survey took place in the Autumn of 2021, after being postponed a year due to Covid.

4.2 We sent out 1365 surveys to Adult Carers across Cambridgeshire and received 500 responses, a response rate of 37%.

4.3 The survey result provided a demographic breakdown of our Adult Carer population. 67.9% of carers in Cambridgeshire were female and 32.1% were male, which is similar to national proportions (68.6% female and 30.7% male). The biggest group of carers were aged 55-64 (26.4%), followed by those aged 75-84 (21.0%), and those aged 65-74 (20.4%). These three age bands were also the largest nationally. 91.5% of carers in the sample were white British. This has reduced from 2021 (94.9%) but remains much higher than the proportion of white British carers nationally

4.4 Appendix 2 of this report provides a full analysis of the survey results but some of the key findings are listed below:

- The number of carers who 15.35% of carers indicated that they were not in paid employment because of their caring responsibilities fell from 26.3% in 2021 to 15.35%. Of those who were in employment 16.6% felt supported by their employer which is an increase from 11.1% in the previous survey.
- The proportion of carers who stated they had a health condition or disability decreased in all categories (compared with 2021. Nationally the proportion of carers declaring no health condition or disability was 38.9% which is lower than in Cambridgeshire (44.6%).
- The most common reason for the cared for person requiring support was due to a physical disability. This was the same in 2021, however the proportion has decreased from 53.1% to 49.3%. The percentage with dementia rose significantly from 26.6% in 2021 to 40.3% in 2023, as did the percentage with problems connected to ageing (35.4% in 2023 compared with 25.4% in 2021). The percentage

with a learning disability or difficulty fell steeply to 20.0% from 45.7% in 2021; however, it this is more in line with survey results in 2018 (19.4%) and 2016 (20.5%).

- 56.7% of the people cared for received funding from the Council, up from 24.2% in 2021.

4.5 There are some key improvements for Carers which the survey responses highlight:

- **Overall satisfaction with services received by the cared for person -** Of those who received support from Social Services in the last 12 months, the percentage who were "extremely satisfied" increased slightly to 13.6%, from 13.4% in 2021. The percentage who were "very satisfied" also increased, from 21.0% to 25.7%. The percentages of people who were "quite dissatisfied", "very dissatisfied" or "extremely dissatisfied" with support services all decreased from 2021.
- **Having control over daily life –** The percentage of carers who reported having as much control over their daily life as they wanted increased from 19.4% in 2021 to 24.9%. Those who stated they did not have enough control over daily life fell from 63.6% to 59.4%. This improvement may be in part due in part to Covid; however, the figures are also an improvement on the 2018 survey results
- **Helpfulness of information and advice** – the results in respect of the helpfulness of information and advice have improved from 2021. A similar proportion of carers (69%) sought out information and advice. Of those who sought advice, 25.9% found it "very helpful" compared to 24.6% in 2021. The percentage who found it "quite helpful" rose from 55.0% to 57.6%. The percentage who found the advice "quite unhelpful" or "very unhelpful" has fallen
- **Social contact –** A greater percentage of carers felt they had as much social contact as they wanted with people they liked, 34.0%, up from 27.6% in 2021
- **Loneliness –** This year a new question was asked: "How often do you feel lonely?". Responses indicate that carers in Cambridgeshire felt less lonely that carers nationally: 11.4% felt lonely "Often or always" (13.3% nationally), and 28.2% felt lonely "Some of the time" (30.8% nationally). 16.6% of carers reported never feeling lonely, compared with 14.5% nationally.

4.6 There are also areas of performance which could be improved based on the survey results and the support that Adult Carers receive:

- **Access to information and advice** – Although a similar proportion of carers sought advice in 2023 compared to 2021, about 69%. Of those who sought advice, the percentage who found it "very easy to find" fell from 13.5% in 2021 to 12.6% in 2023
- **Carers feeling consulted with –** Questions in relation to carers engagement with care and support planning for the person they supported were not as positive as in 2021. The proportion of carers who said they "always felt involved or consulted" fell from 42.4% to 40.4% and those who "usually felt involved or consulted" fell from 33.2% to 32.0%.

4.7 Results of the Survey of Adult Carers will be shared with the Council's Carers Partnership Board and Adult Social Care Forum. The results have also been aligned to the delivery of the All-Age Carers Strategy and initiatives such as the introduction of an app for Carers which provides tailored information and advice as well as co-production events to involve carers in determining priorities have been introduced which aim to address some of the areas where the Council can improve its performance.

5. Refreshed Performance Management Framework

5.1 A refreshed Performance Management Framework has been approved at Strategy, Resources & Performance committee on the 31st October. The refreshed framework looks to create a clearer performance process that links from individual services' performance all the way through to strategic decision-making, supporting the council to embed performance at the heart of everything it does.

5.2 Creating a clearly defined hierarchy for performance allows the right stakeholders to see the right Information at the right time. This will be achieved through having a clear golden thread for performance, as well as consistency across the organisation in how performance is approached.

5.3 Having a consistent approach across the organisation not only provides structure to how we manage performance as an organisation, but it also provides transparency in how we work, and the results achieved across all services and directorates. The Operational KPI section of the scorecard will allow for each directorate to have KPIs across all of their services in one place, allowing performance to be scrutinised by officers as well as linking performance across a whole directorate more effectively.

5.4 Through the directorate scorecards, directorates' Strategic Key Performance Indicators (SKPIs) will feed up to create an organisation-wide balanced scorecard. SKPIs link directly to our corporate ambitions set out within the Strategic Framework. They help our elected members and Corporate Leadership Team ('CLT') to understand performance across the entire council. SKPIs aim to tell the story of the council as well as giving a clear position on performance against the council's Strategic Ambitions.

5.5 In the context of this committee there will be a refinement of indicators that will be presented compared to previous iterations of the Corporate Performance Report. As part of this refresh, both Public Health and Adults, Health and Commissioning will be reported through one corporate report. This focus on SKPIs alongside reviewing papers on risk, finance and change together will result in an increase in scrutiny and understanding of overall performance.

5.6 The initial indicators which will be presented to the Adults & Health committee would include the following:

- New client contacts, rate per 100,000 population
- Requests from new clients where the outcome was short term support to maximise independence per 100,000 population
- Long-term support needs of adults (18-64) met by admission to residential and nursing care homes per 100,000 population
- Long-term support needs of adults (65+) met by admission to residential and nursing care homes per 100,000 population
- Total people accessing long term support in the community aged 18-64 per 100,000 population
- Total people accessing long term support in the community aged 65+ per 100,000 population
- % of people in receipt of long-term support for more than 12 months that have received a review in the last 12 months

- % of safeguarding enquiries where risk has been removed or reduced.
- Number of carers assessed or reviewed per 100,000 population
- Average number of carers conversations carried out per month
- % of care users who receive direct payments
- Social Care Quality of Life Score
- % ASC locations rated good or outstanding by CQC

These indicators have been selected to enable members of this committee to have the best overview of performance in line with our strategic ambitions. These indicators will, where possible, be benchmarked against national and regional performance and set appropriate targets to allow fair scrutiny.

6. Conclusion and recommendations

6.1 5 indicators have seen an improvement in performance from this quarter to last quarter.

6 indicators have seen a decrease in performance from this quarter to last quarter.

6.2 The results of the Survey of Adult Carers have shown some key areas of improvement compared to the previous survey alongside some highlighted areas for further development.

6.3 This Corporate Performance paper is a monitoring paper. There are no recommendations for this quarter.

7. Significant Implications

7.1 This report monitors quarterly performance. There are no significant implications within this report.

8. Source Documents

8.1 None.

Produced on: 28 November 2024

Performance Report

Quarter 2

2024/25 financial year

Adults and Health Committee

Governance & Performance
Cambridgeshire County Council
governanceandperformance@cambridgeshire.gov.uk

Key

Data Item	Explanation
Target / Pro Rata Target	The target that has been set for the indicator, relevant for the reporting period
Current Month / Current Period	The latest performance figure relevant to the reporting period
Previous Month / previous period	The previously reported performance figure
Direction for Improvement	Indicates whether 'good' performance is a higher or a lower figure
Change in Performance	Indicates whether performance is 'improving' or 'declining' by comparing the latest performance figure with that of the previous reporting period
Statistical Neighbours Mean	Provided as a point of comparison, based on the most recently available data from identified statistical neighbours.
England Mean	Provided as a point of comparison, based on the most recent nationally available data
RAG Rating	• **Red** – current performance is off target by more than 10% • **Amber** – current performance is off target by 10% or less • **Green** – current performance is on target by up to 5% over target • **Blue** – current performance exceeds target by more than 5% • **Baseline** – indicates performance is currently being tracked in order to inform the target setting process • **Contextual** – these measures track key activity being undertaken, to present a rounded view of information relevant to the service area, without a performance target. • **In Development** - measure has been agreed, but data collection and target setting are in development
Indicator Description	Provides an overview of how a measure is calculated. Where possible, this is based on a nationally agreed definition to assist benchmarking with statistically comparable authorities
Commentary	Provides a narrative to explain the changes in performance within the reporting period
Actions	Actions undertaken to address under-performance. Populated for 'red' indicators only
Useful Links	Provides links to relevant documentation, such as nationally available data and definitions

Indicator 230: Number of new client contacts for Adult Social Care per 100,000 of the population

Return to Index November 2024

Pro Rata Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	2323.5	1188.6	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
4498.8	4471.4	In Development

Indicator Description

Effective community prevention and information services should minimise the number of people needing to contact adult social care directly. A marked growth in the number of contacts might show that universal community services are not meeting need. Conversely a marked reduction might suggest that we are not providing the right pathways into adult social care for those who do need it.

This measure only includes requests for support relating to new clients. In line with statutory reporting guidance, the definition of "new" is that the client is not in receipt of any long term support at the time the contact was made.

Calculation:

(X/Y)*100,000

Where:

X = Total number of new requests for support from people aged 18+ as defined by SALT guidance (tables STS001 1a and STS001 1b)

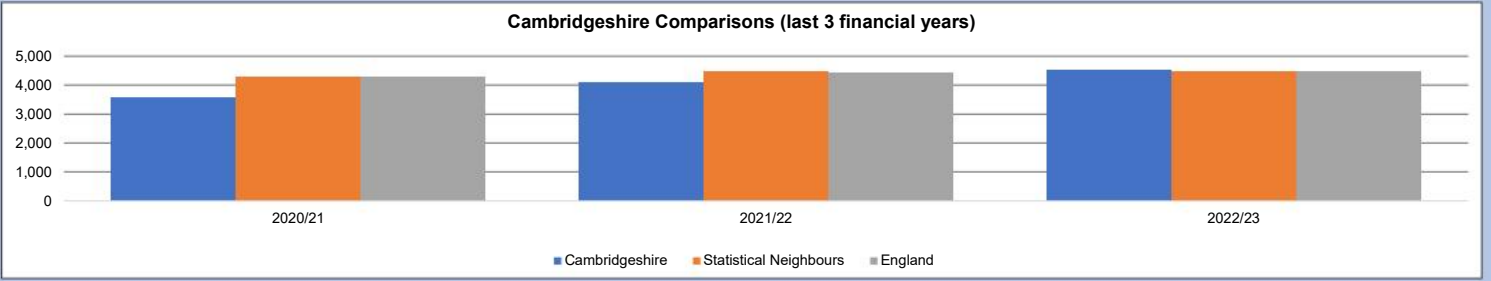
Y = 18+ population

Useful Links

F

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:



Commentary

Please note, quarterly data reflects local reporting methods used to produce figures throughout the year. Year end data for Cambridgeshire and comparator groups is produced from the latest published statutory return data. Please note that the CIPFA nearest neighbour comparison group for Cambridgeshire changed from the 2022/23 financial year.

The rate of new client contacts per 100,000 population has been slightly higher in the first two quarters of 2024/25, compared with Q1 and Q2 last year.

Actions

Indicator 231: % of new client contacts not resulting in long term care and support

Return to Index November 2024

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	90.4%	89.5%	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
91.4%	91.5%	In Development

Indicator Description

This indicator is important to look at in line with indicator 230 as it shows whether change in contact numbers are from people needing long term care, or people whose needs could be met with preventative or low level community support. It helps us understand what might be driving a growth or reduction in contacts.

This measure only includes requests for support relating to new clients. In line with statutory reporting guidance, the definition of "new" is that the client is not in receipt of any long term support at the time the contact was made.

Calculation:

(X/Y)*100

Where:

X = Total number of new requests for support from people aged 18+ as defined by SALT guidance (tables STS001 1a and STS001 1b) that do not result in the need for long term care and support

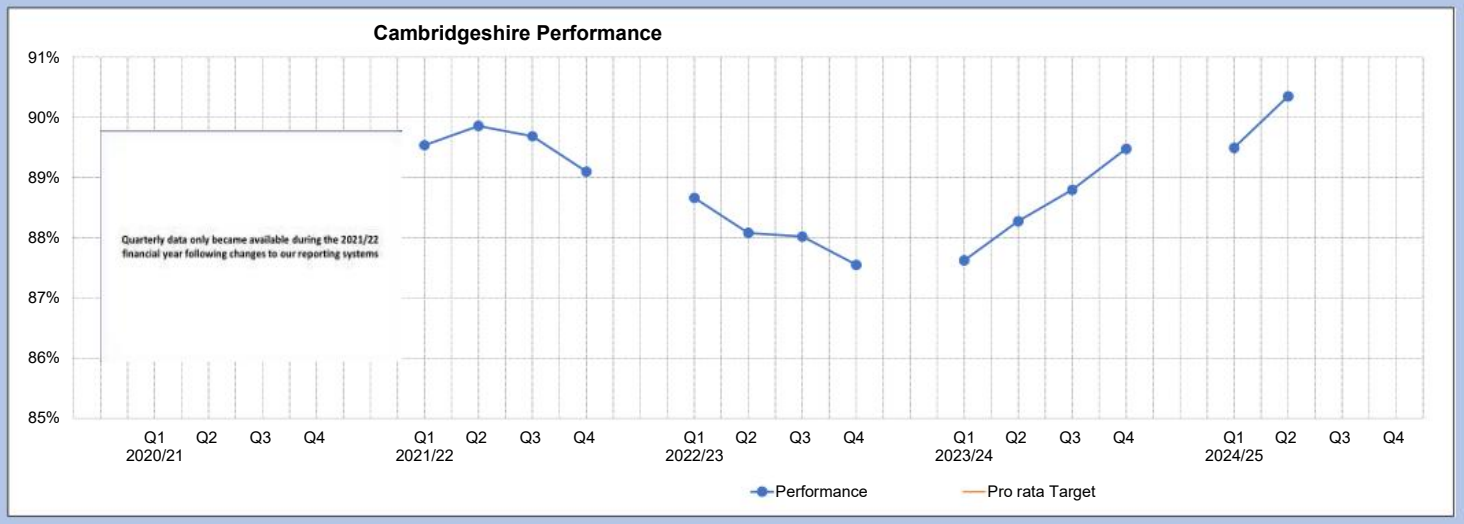
Y = Total number of new requests for support from people aged 18+ as defined by SALT guidance (tables STS001 1a and STS001 1b)

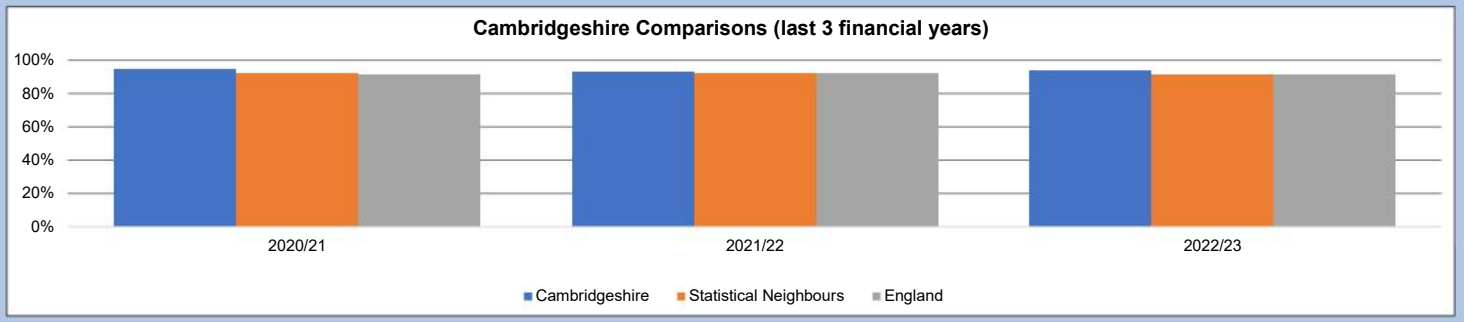
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, quarterly data reflects local reporting methods used to produce figures throughout the year. Year end data for Cambridgeshire and comparator groups is produced from the latest published statutory return data. Please note that the CIPFA nearest neighbour comparison group for Cambridgeshire changed from the 2022/23 financial year.

Performance improved throught the last financial year, and has continued to improve in Q1 and Q2 of 2024/25. In Q2 2024/25 the proportion of new client contacts not resulting in long term care and support rose above 90% for the first time in the last three years.

Actions

Indicator 232: Proportion of people receiving long term support who had not received a review in the last 12 months, % of all people funded by ASC in long-term Return to Index **November 2024**

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↓	30.2%	28.4%	Declining

Statistical Neighbour Mean	England Mean	RAG Rating
34.6%	43.0%	In Development

Indicator Description

It is a statutory duty to review long term care and support plans at least once a year. Regular reviews can help safeguard from risk, but also support personalisation by continuing to support people to connect to their communities and make the most of the local assets.

Calculation:

(X/Y)*100

Where:

X = Number of people receiving long-term support for over 12 months who had not received a review in the last 12 months

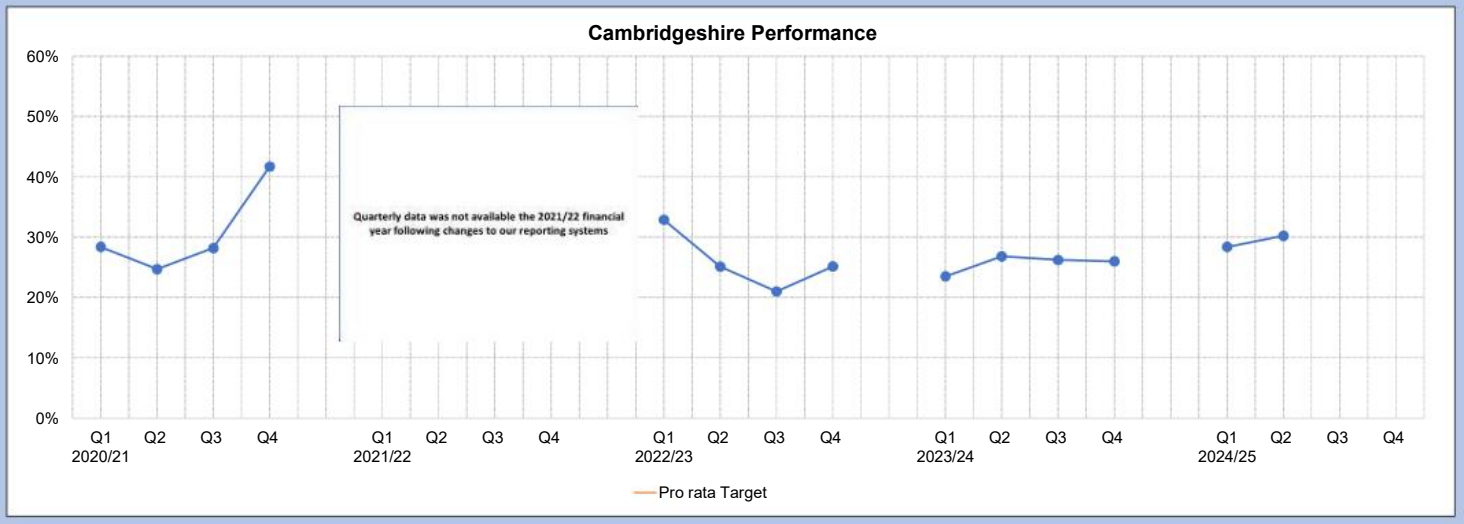
Y = Total number of people receiving long-term support for over 12 months at the end of the period

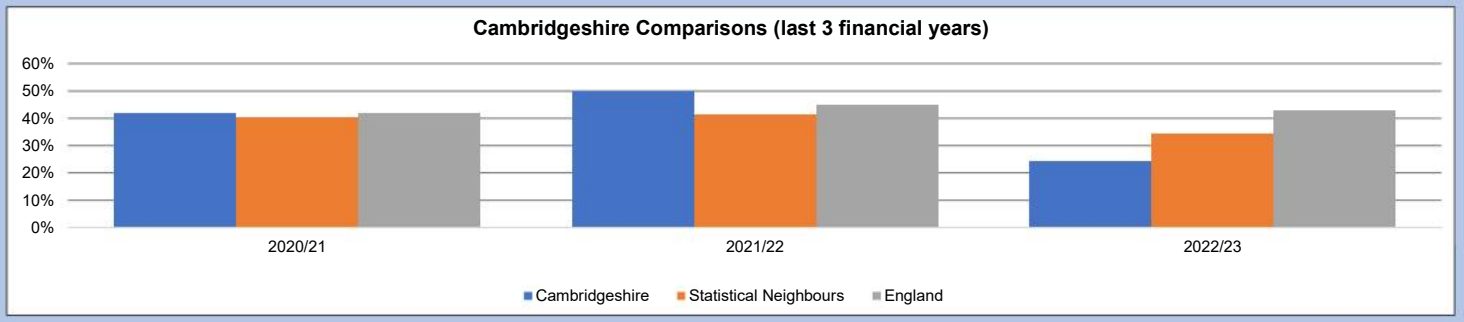
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, quarterly data reflects local reporting methods used to produce figures throughout the year. Year end data for Cambridgeshire and comparator groups is produced from the latest published statutory return data. Please note that the CIPFA nearest neighbour comparison group for Cambridgeshire changed from the 2022/23 financial year.

During 2022/23, there was a significant level of activity undertaken to clear review backlogs that built up during the pandemic. An external agency was commissioned from March 2022 to work through the backlog of reviews for clients receiving long-term services. This additional capacity significantly increased the number of reviews being completed; in 2021-22 there was an average of 294 reviews completed per month, increasing to an average of 472 reviews for the completed financial year 2022-23. During 2023/24, there were 474 reviews completed on average per month, partly due to the continued involvement of the ASC external team. This increase in reviews led to a comparatively low percentage of clients who had not received a review in the last 12 months at year-end 2023/24.
In Q1 2024/25, 28.4% of clients had not received a review in the last 12 months, and Q2 2024/25 has seen a further decline in performance to 30.24%. However, performance remains above the latest published data (2022/23) for England and statistical neighbours.

Actions

Indicator 233: Number of carers assessed or reviewed in the year per 100,000 of the population

Return to Index November 2024

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	37.3	19.2	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
487.3	478.0	In Development

Indicator Description

Reviews are also an important time to make contact with carers to check that they remain able to offer their critical support. Assessments and reviews can be done jointly or separately from the cared for person. It is an opportunity to support carers to continue their caring role but also to plan for the future.

Calculation:

(X/Y)*100,000

Where:

X = Total number of carers with a carers assessment or review in the period

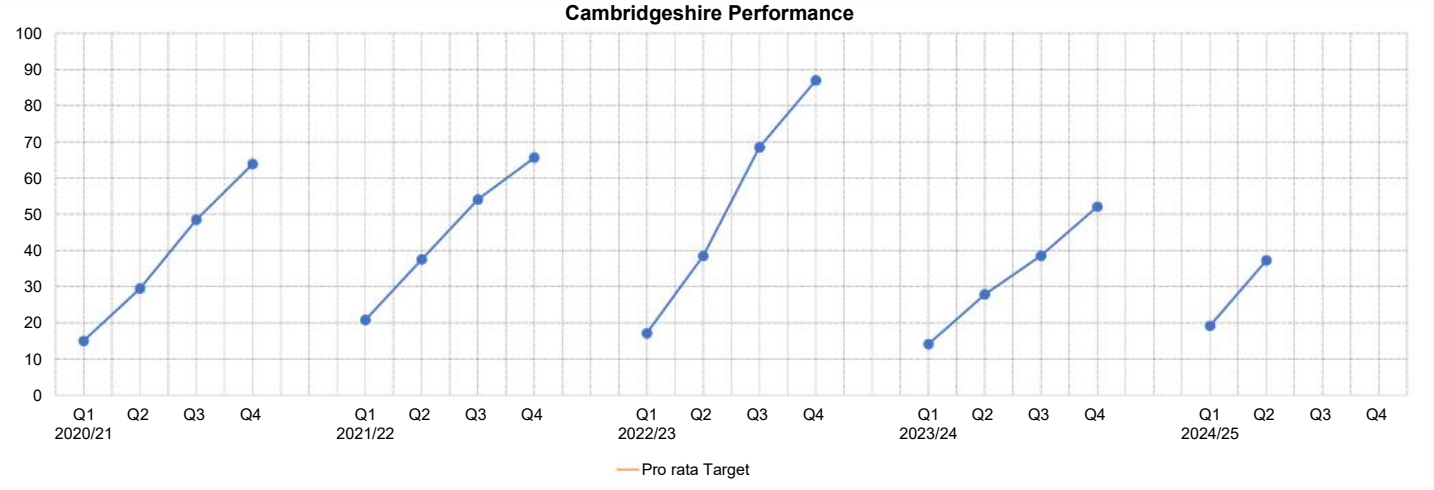
Y = 18+ population

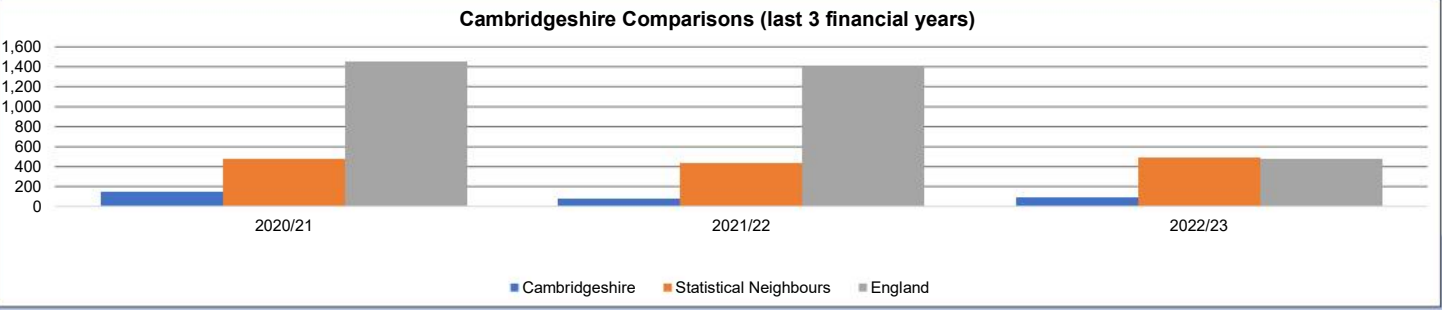
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, quarterly data reflects local reporting methods used to produce figures throughout the year. Year end data for Cambridgeshire and comparator groups is produced from the latest published statutory return data. Please note that the CIPFA nearest neighbour comparison group for Cambridgeshire changed from the 2022/23 financial year.

The rate of carers assessed or reviewed per 100,000 population in Q1 and Q2 2024/25 has improved compared to the first two quarters of last year. The rate is significantly lower than the national average, and that of our statistical neighbours. This is due to the way carer activity is recorded in Cambridgeshire and is a reflection of our process. A move away from carers assessments by default to a more constructive and timely conversation accounts for the lower volume of carers assessments. Activity by teams supporting carers can be recorded as carers conversations, which are not counted in the above measure.

During Q2 2024/25 (YTD cumulative) we have completed:
- 190 carers assessments
- 17 carers reviews
- 2075 carers conversation steps (often completed when assessing the cared-for service user - see bullet point below)
- 3760 carers conversations considering the carers needs while supporting the person being cared for

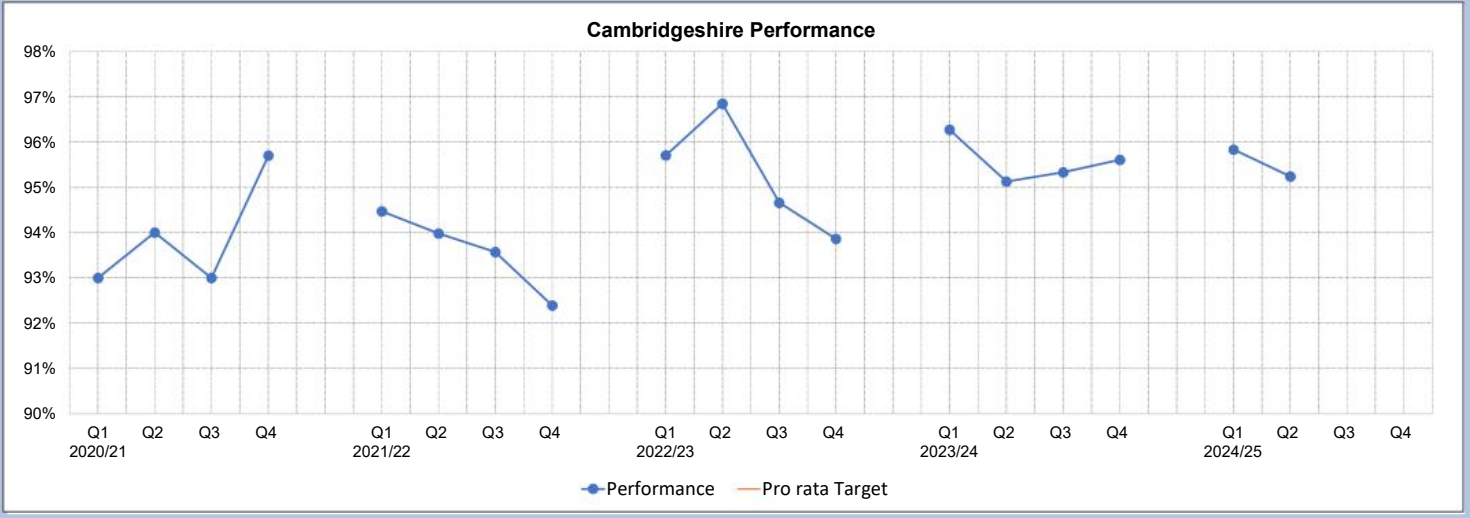
Actions

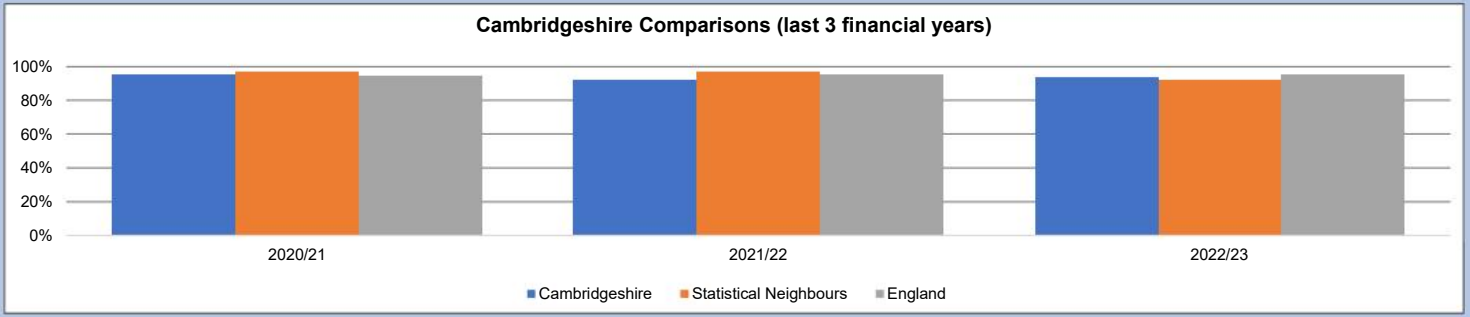
Indicator 105: Percentage of those able to express desired outcomes who fully or partially achieved their desired outcomes

Return to Index November 2024

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	95.2%	95.8%	Declining

Statistical Neighbour Mean	England Mean	RAG Rating
91.9%	94.9%	In Development





Indicator Description

The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

As part of the statutory reporting of safeguarding cases, those adults at risk may be asked what their desired outcomes of a safeguarding enquiry are. Where desired outcomes have been expressed, after completion of the safeguarding enquiry, the achievement of these outcomes is reported. This data is collected as part of the statutory Safeguarding Adults Collection.

This indicator links to indicator 236 and monitors how well we have been able to support the person to achieve the outcomes they wanted from the safeguarding enquiry.

Calculation:

(X/Y)*100

Where:

X = The number of concluded enquiries where outcomes were either achieved or partially achieved.

Y = The number of concluded enquiries where the adult(s) expressed desired outcomes.

Commentary

Please note, quarterly data reflects local reporting methods used to produce figures throughout the year. Year end data for Cambridgeshire and comparator groups is produced from the latest published statutory return data. Please note that the CIPFA nearest neighbour comparison group for Cambridgeshire changed from the 2022/23 financial year.

The % of enquiries where outcomes have been partially or fully achieved fell marginally in Q2 2024/25 to 95.24%. However, performance has remained consistent for the last 5 quarters, between 95% and 96%, and remains above the national and regional averages from 2022/23.

Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:

Actions

Indicator 126: Proportion of people using social care who receive direct payments

Return to Index November 2024

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	17.4%	17.2%	Improving

Statistical Neighbour Mean	England Mean	RAG rating
27.1%	26.2%	In Development

Indicator Description

Direct payments provide people with more choice and control over how they meet their care and support needs.

The scope of this indicator is limited to people who receive long term support only. These include people whose self directed support is most relevant. This will better reflect the council's progress in delivering personalised services for users and carers.

Both measures for self directed support and direct payments have also been split into two. They will focus on users and carers separately. This measure reflects the proportion of people who receive a direct payment either through a personal budget or other means.

Calculation:

(X/Y)*100

X = The number of users receiving direct payments and part direct payments at the end of the period.

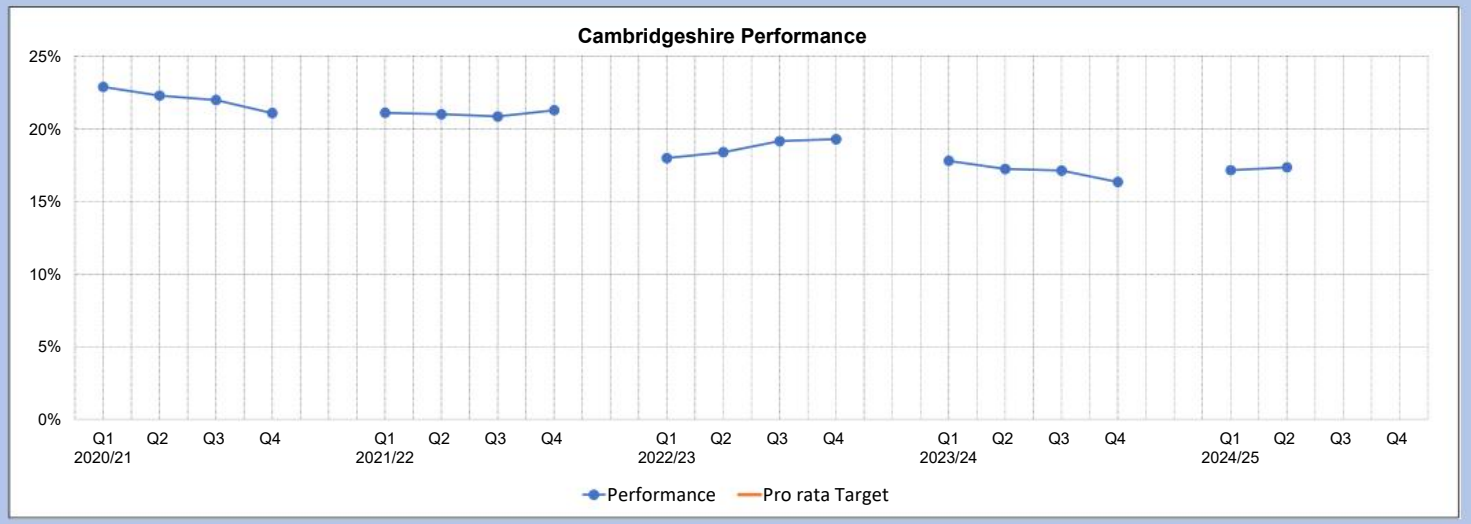
Y = Clients aged 18 or over accessing long term support at the end of the period.

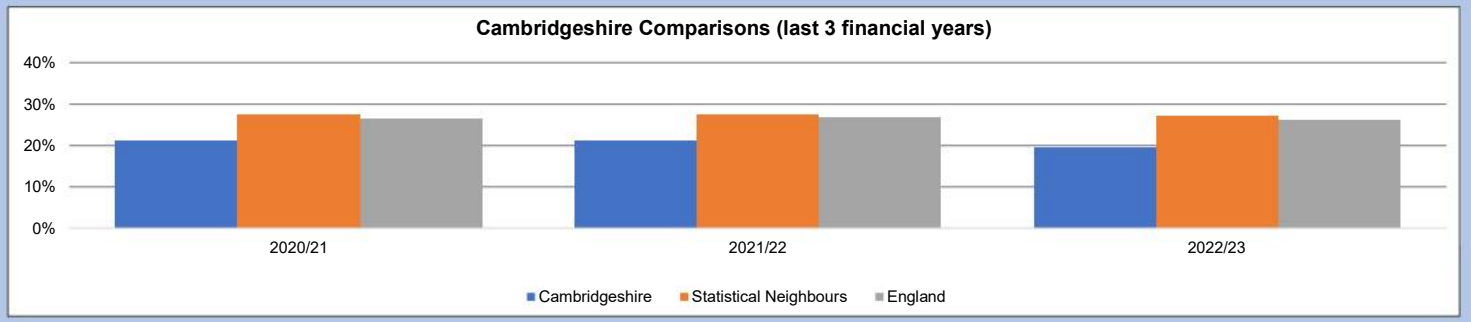
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, quarterly data reflects local reporting methods used to produce figures throughout the year. Year end data for Cambridgeshire and comparator groups is produced from the latest published statutory return data. Please note that the CIPFA nearest neighbour comparison group for Cambridgeshire changed from the 2022/23 financial year.

The percentage of people receiving direct payments has increased marginally in Q2 2024/25 but continues to be low, reflecting the challenge in making direct payments an attractive solution. The decrease in percentage compared to 2022/23 is predominantly due to increasing service user numbers, whilst the number of clients with direct payments has remained relatively stable.

Our work with Community Catalyst around micro enterprises seeks to build more opportunities for people to use direct payments to access care and support opportunities local to them.
The council has recently introduced Individual Service Funds, a personal budget managed by a provider of the persons choice rather than held by themselves. This alongside the work to develop place based micro-enterprises within the Care Together programme should help to build on the range of options available.

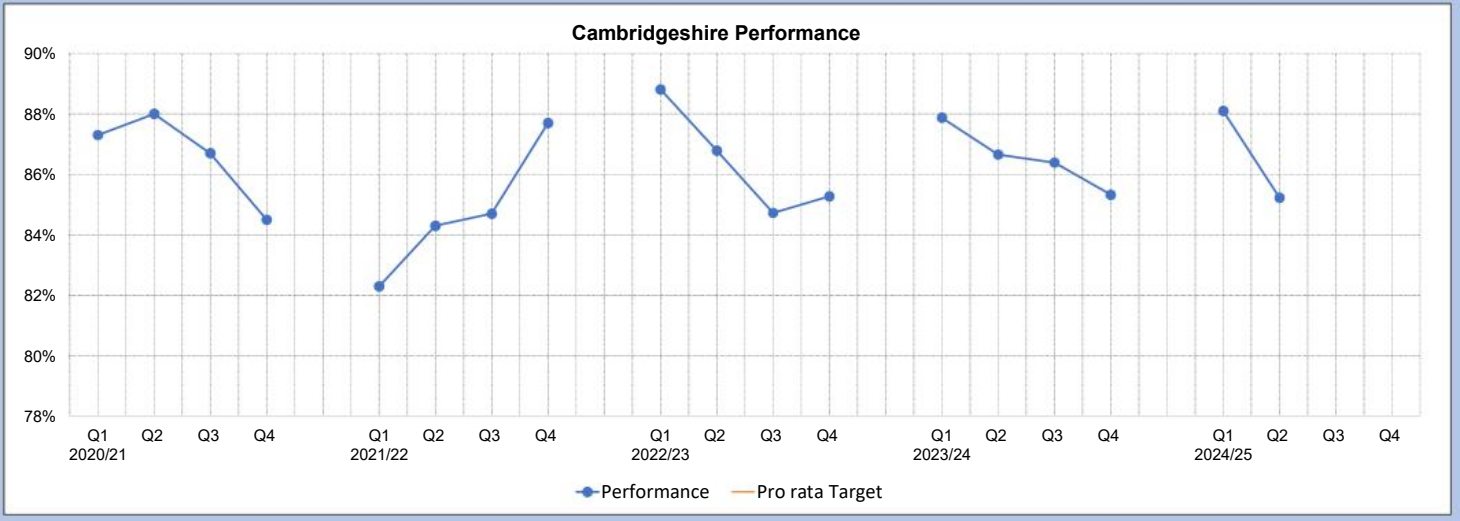
Actions

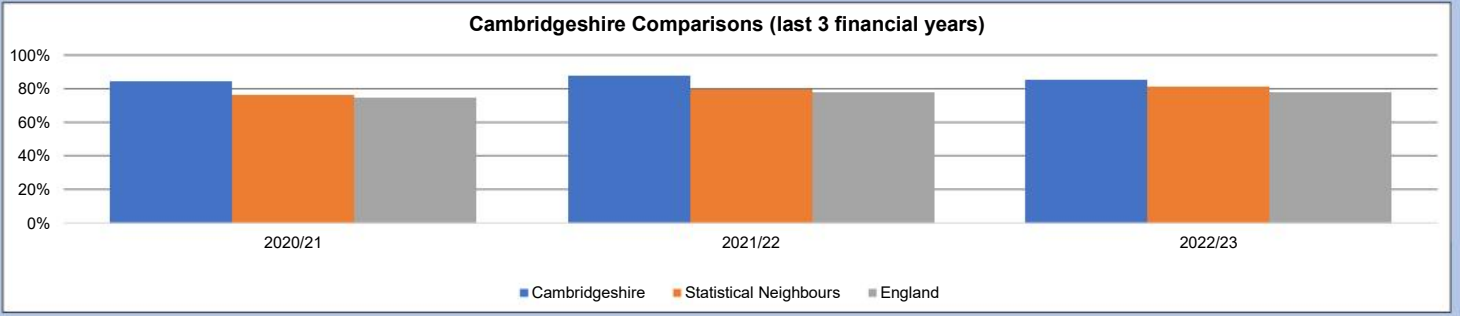
Indicator 140: Proportion of people receiving reablement who did not require long term support after reablement was completed

Return to Index November 2024

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	85.2%	88.1%	Declining

Statistical Neighbour Mean	England Mean	RAG Rating
81.3%	77.5%	In Development





Indicator Description

This indicator shows the proportion of new clients who received short term services during the year, where no further request was made for ongoing support. Reablement support has best results for those who can be prevented from requiring long term care and support. However, it can also benefit people in receipt of long-term care and support by supporting improvement and enhancing their level of independence. Setting a target too high on this indicator can be a perverse incentive to reduce the service for those with more complex needs. A target should be set that reflects a balance of use. This indicator can be viewed alongside the trends on new clients with long term service outcomes (indicator 231) to ensure that more complex cases are not being diverted straight into long term care.

Short term support is designed to maximise independence. Therefore, it will exclude carer contingency and emergency support. This stops the inclusion of short term support services which are not reablement services.

Calculation:

(X/Y)*100

Where:

X = Number of new clients where the sequel to "Short Term Support to maximise independence" was "Ongoing Low Level Support", "Short Term Support (Other)", "No Services Provided - Universal Services/Signposted to Other Services", or "No Services Provided - No identified needs".

Y = Number of new clients who had short term support to maximise independence. Clients with a sequel of either early cessation due to a life event, or who have had needs identified but have either declined support or are self funding are not included in this total.

Commentary

Please note, quarterly data reflects local reporting methods used to produce figures throughout the year. Year end data for Cambridgeshire and comparator groups is produced from the latest published statutory return data. Please note that the CIPFA nearest neighbour comparison group for Cambridgeshire changed from the 2022/23 financial year.

The percentage of people who did not require long term support after reablement has decreased from 88.1% in Q1 to 85.2% in Q2 2024/25.

Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:

Actions

Indicator 236: Percentage of Cases where Making Safeguarding Personal (MSP) questions have been asked

Return to Index November 2024

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	93.9%	93.9%	Declining

Statistical Neighbour Mean	England Mean	RAG Rating
81.8%	81.2%	In Development

Indicator Description

It is important when undertaking a safeguarding enquiry that the person to whom it relates is engaged and is able to say what they want as an outcome, where they have capacity to do so. This indicator monitors how well we are involving people in this way.

Calculation:

(X/Y)*100

Where:

X = The number of concluded enquiries where the adult or adult's representative was asked what their desired outcomes were

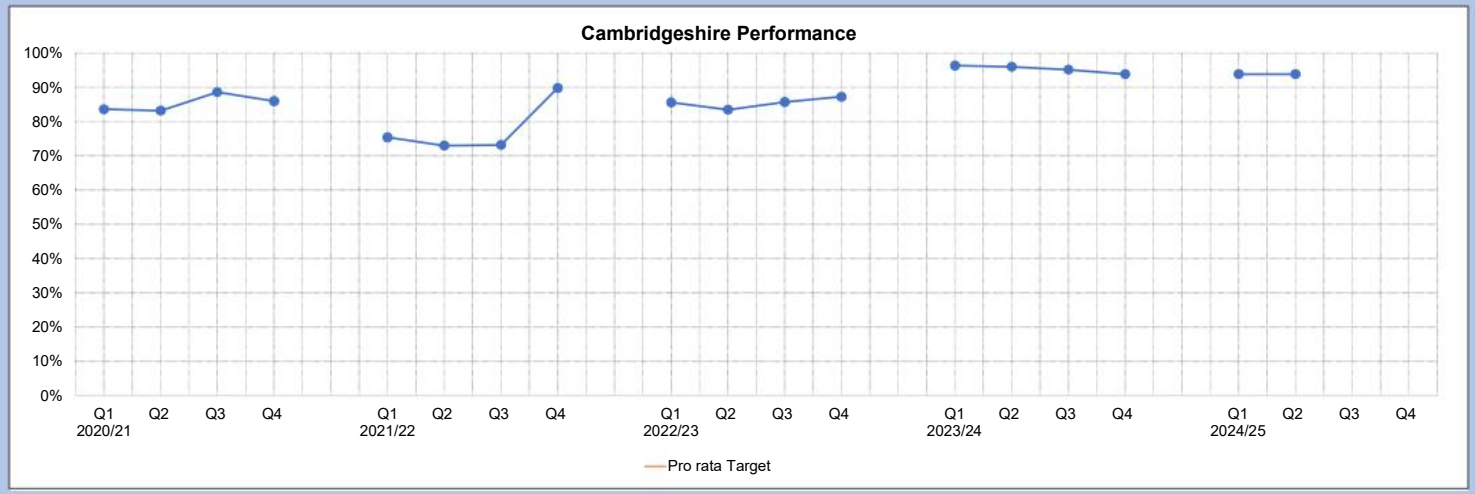
Y = The number of concluded enquiries

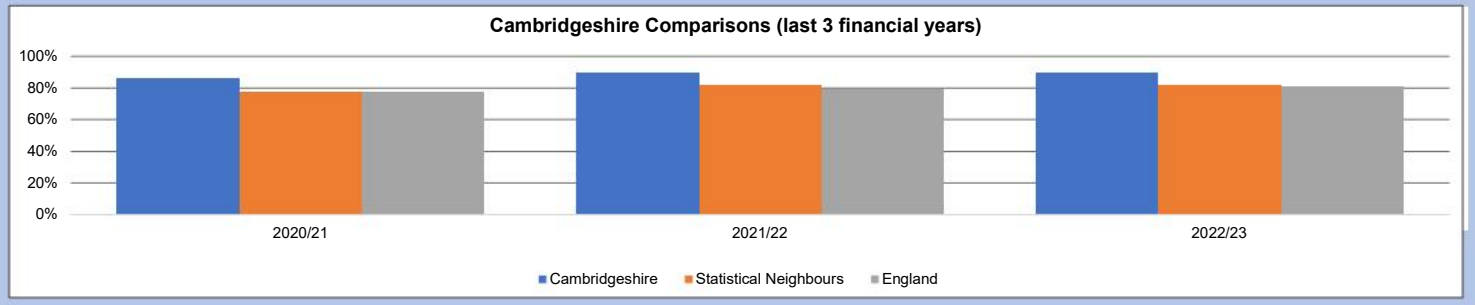
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, quarterly data reflects local reporting methods used to produce figures throughout the year. Year end data for Cambridgeshire and comparator groups is produced from the latest published statutory return data. Please note that the CIPFA nearest neighbour comparison group for Cambridgeshire changed from the 2022/23 financial year.

Performance has remained consistent, with outcomes being asked in just under 94% of enquiries in Q1 and Q2 2024/25. This is well above the national and statistical neighbour averages for 2022/23, but slightly lower than local performance in Q1 and Q2 2023/24. The high % of enquiries where outcomes were asked suggests the making safeguarding personal approach is fully embedded into working practise.

Actions

Indicator 234: % total people accessing long term support in the community aged 18-64

Return to Index November 2024

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	90.7%	91.0%	Declining

Statistical Neighbour Mean	England Mean	RAG Rating
83.2%	85.1%	In Development

Indicator Description

We want people to be supported in a community setting whenever that is best for them. Community settings include sheltered housing and extra care housing. Residential and nursing homes are the right choice for those with the most complex needs but good performance on this indicator should reflect partnership working with housing to provide alternatives for housing with support. Using an indicator that splits ages helps monitor equity between client groups.

Calculation:

(X/Y)*100

Where:

X = Total number of people accessing long-term support in the community aged 18-64

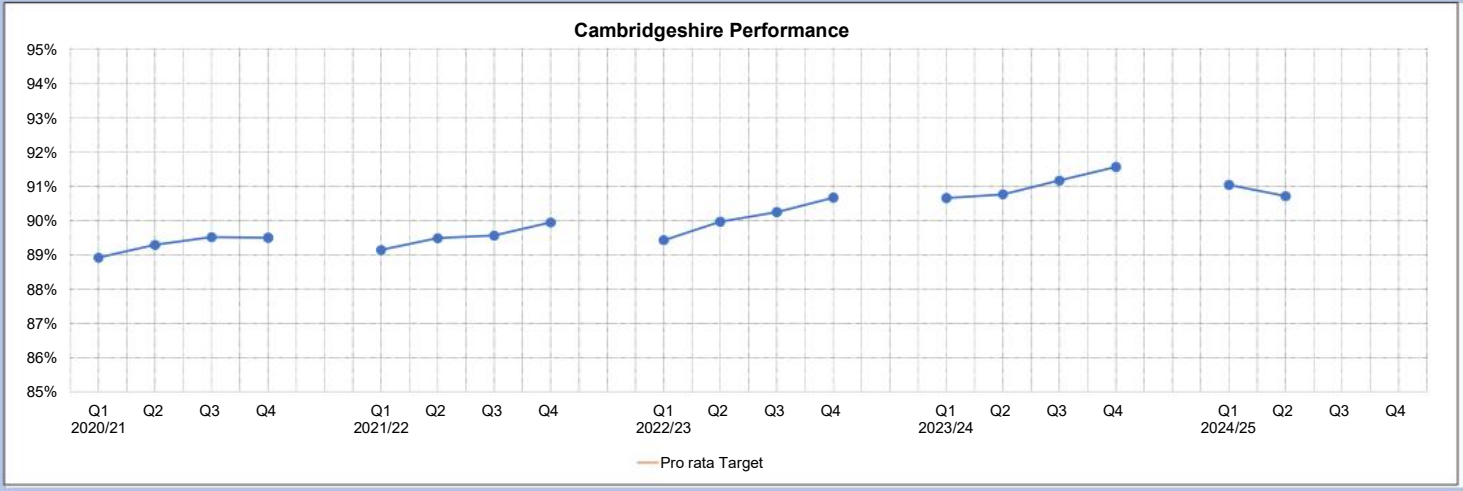
Y = Total number of people accessing long-term support aged 18-64

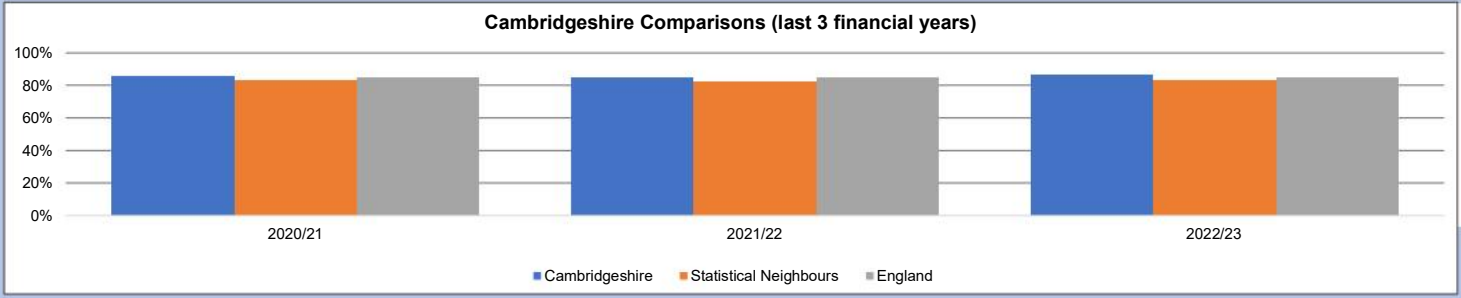
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, quarterly data reflects local reporting methods used to produce figures throughout the year. Year end data for Cambridgeshire and comparator groups is produced from the latest published statutory return data. Please note that the CIPFA nearest neighbour comparison group for Cambridgeshire changed from the 2022/23 financial year.

The percentage of clients aged 18-64 accessing long term support in the community was fairly static throughout 2023/24 and has remained close to 91% in Q1 and Q2 2024/25. This is slightly higher than the national average and statistical neighbours average for 2022/23.

Actions

Indicator 235: % total people accessing long term support in the community aged 65 and over

Return to Index November 2024

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	61.4%	62.4%	Declining

Statistical Neighbour Mean	England Mean	RAG rating
58.9%	61.8%	In Development

Indicator Description

We want people to be supported in a community setting whenever that is best for them. Community settings include sheltered housing and extra care housing. Residential and nursing homes are the right choice for those with the most complex needs but good performance on this indicator should reflect partnership working with housing to provide alternatives for housing with support. Using an indicator that splits ages helps monitor equity between client groups.

Calculation:

(X/Y)*100

Where:

X = Total number of people accessing long-term support in the community aged 65 and over

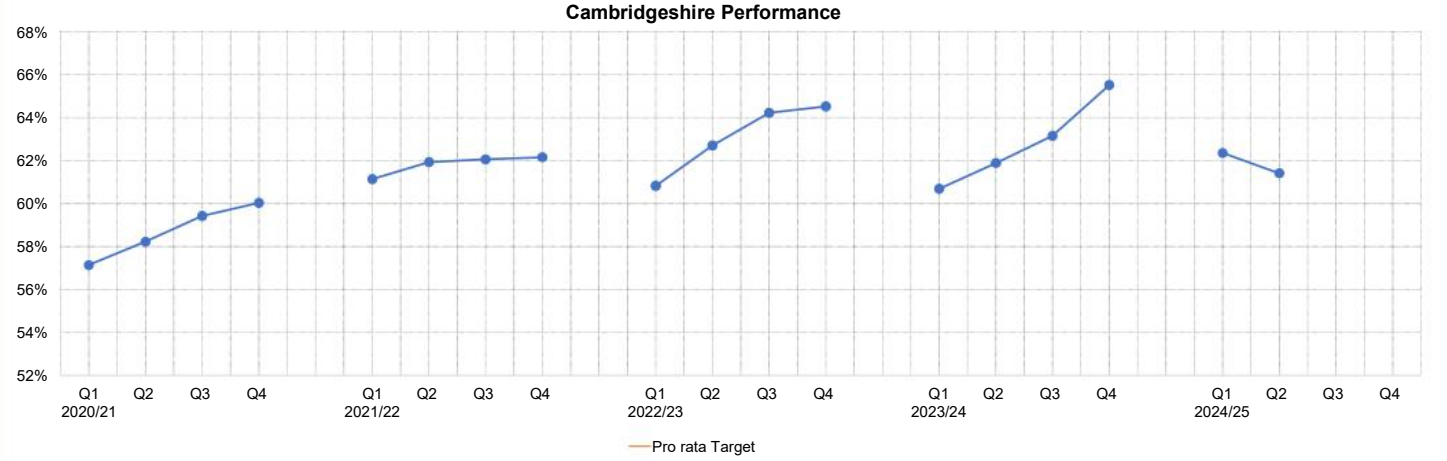
Y = Total number of people accessing long-term support aged 65 and over

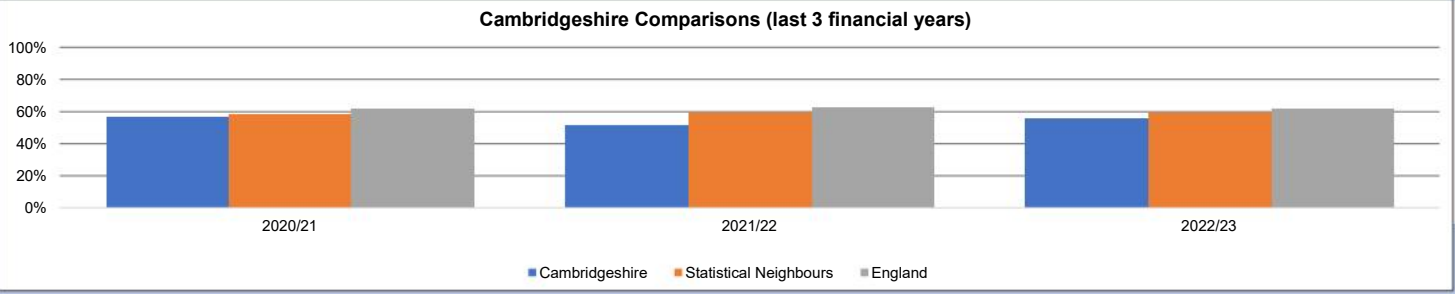
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, quarterly data reflects local reporting methods used to produce figures throughout the year. Year end data for Cambridgeshire and comparator groups is produced from the latest published statutory return data. Please note that the CIPFA nearest neighbour comparison group for Cambridgeshire changed from the 2022/23 financial year.

The percentage of clients aged 65+ accessing long term support in the community increased during the course of 2023/24, but fell slightly to 62.36% in Q1 2024/25. The percentage has fallen further to 61.42% in Q2 2024/25, which is marginally lower than during the same quarter last year.

Actions

Indicator 229: Percentages of safeguarding enquiries where risk has been reduced or removed

Return to Index November 2024

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
In Development	↑	91.6%	91.4%	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
90.4%	91.0%	In Development

Indicator Description

This indicator tracks the effectiveness of safeguarding enquiries in reducing or removing risk. It should be viewed alongside indicators 236 and 105, which reflect the desired outcomes of the person at risk. This is to ensure that there is not a perverse incentive to go against the person's wishes and eliminate risk when that person has capacity to decide on a level of risk that is acceptable to them.

Calculation:

(X/Y)*100

Where:

X = The number of enquiries where the risk had been reduced or removed when the enquiry concluded

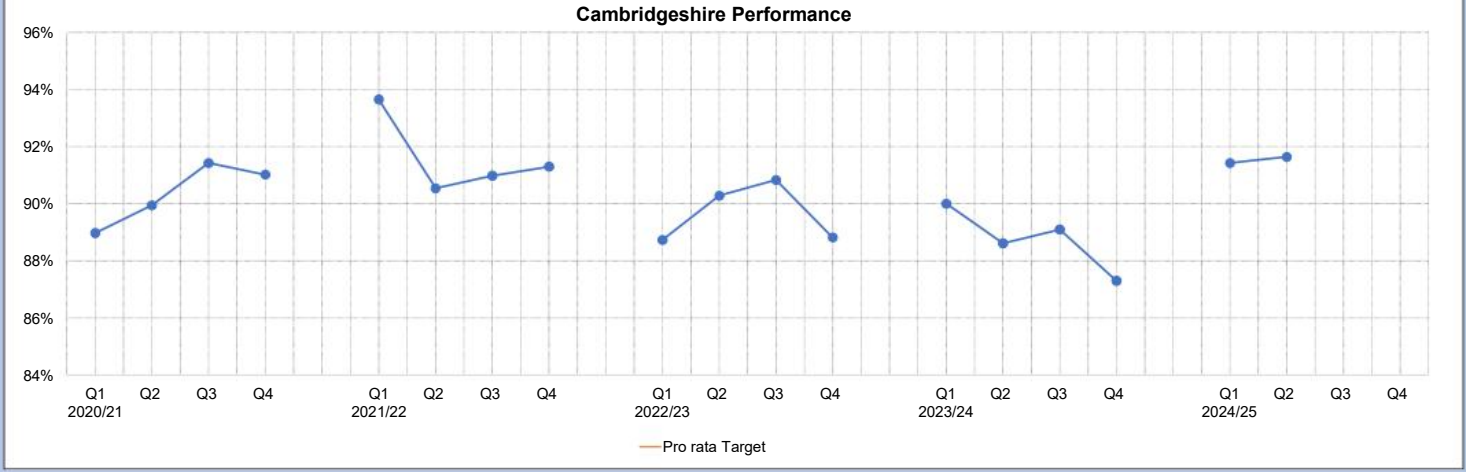
Y = The number of concluded enquiries where a risk was identified

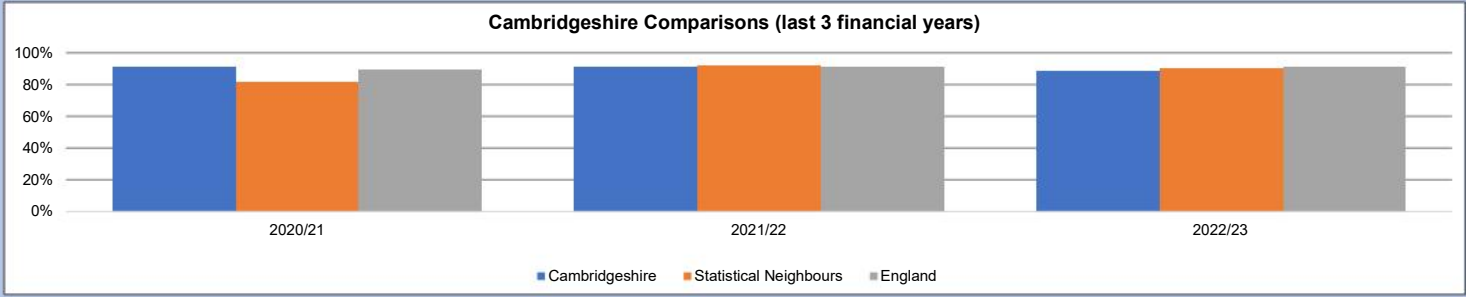
Useful Links

Measures from the Adult Social Care Outcomes Framework from NHS Digital

The local area benchmarking tool from the Local Government Association

The Adult Social Care Outcomes Framework 2018/19 Handbook of Definitions:





Commentary

Please note, quarterly data reflects local reporting methods used to produce figures throughout the year. Year end data for Cambridgeshire and comparator groups is produced from the latest published statutory return data. Please note that the CIPFA nearest neighbour comparison group for Cambridgeshire changed from the 2022/23 financial year.

The proportion of safeguarding enquiries where the risk was reduced or removed has increased slightly from 91.4% in Q1 to 91.6% in Q2 2024/25. The improved performance from the 2023/24 financial year is due to an amendment to the methodology to align more closely with the year-end statutory return.

Actions

Survey of Adult Carers Analysis

Introduction

Every two years NHS Digital, the analytics function in Department of Health and Social Care, directs Local Authorities to conduct a national survey of adult carers. The latest survey took place in Autumn 2023 and the results were published nationally in late June 2024.The previous survey took place in the Autumn of 2021, after being postponed a year due to Covid.

We sent out 1365 surveys in 2023 and received 500 responses, a response rate of **37%.** This was lower than the **40%** response rate we had for the survey undertaken in 2021.

A questionnaire template was provided by NHS Digital. The questionnaire is divided into six sections:

1. Section 1: About the person you care for
2. Section 2: About your needs and experiences of support
3. Section 3: The impact of caring and your quality of life
4. Section 4: Information and advice quality
5. Section 5: Arrangement of support and services in the last 12 months
6. Section 6: About yourself

Who were the carers?

Demographics

The demography of the carers known to the Council has always been predominantly female. In 2023, **67.9%** of carers in Cambridgeshire were female and **32.1%** were male, which is similar to national proportions (**68.6%** female and **30.7%** male). The biggest group of carers were aged 55-64 **(26.4%)**, followed by those aged 75-84 **(21.0%)**, and those aged 65-74 **(20.4%)**. These three age bands were also the largest nationally. **91.5%** of carers in the sample were white British. This has reduced from 2021 **(94.9%)** but remains much higher than the proportion of white British carers nationally.

Employment

59.9% of carers responding were retired, an increase from **54.3%** in 2021, and slightly higher than the **58.3%** of respondents nationally. **30.1%** are employed or self-employed full time or part time, a notable increase on the last three carer surveys (**21.9%** in 2021, **23.9%** in 2018, and **23.5%** in 2016). **6.7%** were doing voluntary work, a small increase on **6.3%** in 2021. **12.6%** were not in paid employment, a decrease from **21.7%** in 2021.

15.35% of carers indicated that they were not in paid employment because of their caring responsibilities. This was a big decrease on **26.3%** in 2021; however, the high

percentage in 2021 may be reflective of the impact of Covid (in 2018, **18.8%** indicated that they were not in paid employment due to their caring responsibilities).

Of those who were in employment **16.6%** felt supported by their employer (up from **11.1%** in the previous survey)

Health

The proportion of carers who stated they had a health condition or disability decreased in all categories (physical impairment or disability, sight or hearing loss, mental health problem or illness, learning disability or difficulty, long-standing illness, or "other") compared with 2021. The biggest decrease was in those who stated they had a mental health problem or illness, down to **10.7%** in 2023 compared with **19.2%** in 2021. The proportion of carers who declared themselves to have no health condition or disability rose to **44.6%**, from **33.8%** in 2021.

In contrast, national results showed an increase in the proportion of carers who stated they had a health condition or disability, in all categories except "long-standing illness" or "other" which decreased marginally. The proportion declaring no health condition or disability was **38.9%** nationally, lower than in Cambridgeshire **(44.6%)**.

The table below illustrates the carers responses to how they felt their caring role had impacted on their own health, with responses from 2021 shown for comparison.

Impact on health	**2021**	**2023**	**Change**
Feeling tired	75.6%	76.6%	↑
Feeling depressed	49.6%	47.5%	↓
Loss of appetite	8.3%	11.4%	↑
Disturbed sleep	68.1%	65.8%	↓
General feeling of stress	65.7%	62.9%	↓
Physical strain (e.g. back)	34.3%	35.3%	↑
Short tempered / irritable	47.6%	44.0%	↓
Had to see own GP	21.7%	25.7%	↑
Developed my own health condition	22.4%	20.3%	↓
Made an existing condition worse	24.4%	19.9%	↓
Other	2.8%	3.9%	↑
No, none of these	9.4%	8.1%	↓

Caring arrangements

63.6% of carers lived with the person they were caring for, a significant drop from **77.1%** in 2021**.**

Only **17.5%** of respondents had been looking after the person they cared for 20 years or more, a significant decrease from **47.7%** in 2021. The largest group was those who had been caring for between 5 and 10 years **(25.6%).** Nationally, those

caring for over 20 years made up the largest group in 2018 and 2021 and remained the largest group in 2023 at **24.8%.**

The majority of respondents, **26.4%**, care for someone for 100 or more hours a week, although this percentage had reduced since 2021 **(34.8%).** This was also the most frequent response nationally at **36.2%.** There was a comparatively even split between other caring hour ranges, with the next most common being 0-9 hours per week at **11.2%.**

In relation to the type of care provided, the highest results were for 'other practical help' **(92.6%)** similar to 2021 **(94.9%)**, and 'keeping an eye on them to see if they are all right' **(91.8),** also similar to 2021 **(91.7%)**. Helping with paperwork or financial matters at **90.3%** was also common and slightly higher than in 2021 (**89.0%**).

Who were they caring for?

As in 2016 and 2018, the largest age groups cared for were 75-84 **(26.0%)** and 85+ **(36.6%).** This was a significant increase from 2021, when **19.7%** were aged 75-84 and **18.1%** were aged 85+. The percentage aged 25-34 dropped sharply to **4.7%** from **17.7%** in 2021 and the 35-44 age group decreased to **4.7%** from **10.2%**. The most notable change was the high proportion of cared-for people in the 85+ age group, as the proportions in other age groups, while differing from the 2021 survey, are broadly similar to 2016 and 2018.

The most common reason for the cared for person requiring support was due to a physical disability. This was the same in 2021, however the proportion has decreased from **53.1%** to **49.3%.** The percentage with dementia rose significantly from **26.6%** in 2021 to **40.3%** in 2023, as did the percentage with problems connected to ageing (**35.4%** in 2023 compared with **25.4%** in 2021). The percentage with a learning disability or difficulty fell steeply to **20.0%** from **45.7%** in 2021; however, it was similar in 2018 **(19.4%)** and 2016 **(20.5%).**

The change in support reasons is likely to be related to the larger proportion of cared-for people in older age groups compared with the 2021 survey. This differing make up of the cared-for cohort in comparison to last year is likely to be reflected in responses to certain survey questions.

56.7% of the people cared for received funding from the Council, up from **24.2%** in 2021. The proportion of cared-for people with home care / home help rose steeply from **35.2%** in 2021 to **46.3%** in 2023.

Carers support

The proportion of carers who did not have a formal carer assessment or review in the year fell slightly, from **86.5%** in 2021 to **85.5%** in 2023.

15.2% of those cared for had received a breaks service to allow the carer to take a break at short notice or in an emergency, down from **19.5%** in 2021. **18.5%** had used a breaks service for longer than 24 hours, a significant decrease from **34.9%** in 2021, but broadly in line with 2018 **(20.5%)** and 2016 **(16.9%)**. **26.8%** reported having had support from a carers group in the last 12 months, up from **22.6%** in 2021.

Carers experience – Headline results.

Key Improvements from the Previous Survey were as follows:

Overall satisfaction with services received by the cared for person - Of those who received support from Social Services in the last 12 months, the percentage who were “extremely satisfied” increased slightly to **13.6%,** from **13.4%** in 2021**.** The percentage who were “very satisfied” also increased, from **21.0%** to **25.7%.** The percentages of people who were “quite dissatisfied”, “very dissatisfied” or “extremely dissatisfied” with support services all decreased from 2021. **15.9%** of respondents said they did not receive report from Social Services, up from **10.8%** in 2021.

How we compare

Overall, how satisfied or dissatisfied are you with the support or services you and the person you care for have received from Social Services in the last 12 months? *Excluding those who answered "We have not received any support or services from Social Services in the last 12 months"*	**National**	**Cambridgeshire compared to England**	**Change since 2021**
I am extremely satisfied	13.1%	13.6% Better	⇧
I am very satisfied	23.7%	25.7% Better	⇧
I am quite satisfied	30.3%	28.9% Worse	⇩
I am neither satisfied or dissatisfied	17.4%	18.2%	⇧
I am quite dissatisfied	7.5%	7.5% Same	⇩
I am very dissatisfied	3.6%	2.4% Better	⇩
I am extremely dissatisfied	4.4%	3.6% Better	⇩

Having control over daily life – The percentage of carers who reported having as much control over their daily life as they wanted increased from **19.4%** in 2021 to **24.9%.** Those who stated they did not have enough control over daily life fell from

63.6% to **59.4%.** This improvement may be in part due in part to Covid; however, the figures are also an improvement on the 2018 survey results. The percentage who reported having no control over their daily life fell from **17.0%** to **15.7%**, although it is still marginally above the national percentage**.**

How we compare

Which of the following statements best describes how much control you have over your daily life?	**National**	**Cambridgeshire compared to England**	**Change since 2021**
I have as much control over my daily life as I want	21.5%	24.9% Better	
I have some control over my daily life but not enough	63.3%	59.4% Better	
I have no control over my daily life	15.1%	15.7% Worse	

Looking after myself – In respect of getting enough sleep or eating, the proportion of carers who felt they looked after themselves rose from **46.8%** in 2021 to **50.3%** in 2023. Those who felt they only sometimes looked after themselves well enough fell from **33.2%** to **28.8%.** However, there was a slight increase in the proportion of carers who felt they were neglecting themselves, from **20.0%** to **20.8%.**

How we compare

Thinking about how much time you have to look after yourself – in terms of getting enough sleep or eating well – which statement best describes your present situation?	**National**	**Cambridgeshire compared to England**	**Change since 2021**
I look after myself	46.7%	50.3% Better	
Sometimes I look after myself well enough	33.1%	28.8% Better	
I feel I am neglecting myself	20.2%	20.8% Worse	

Personal safety – The percentage of carers with no worries about their personal safety increased from **79.4%** to **84.7%**, and the percentage with some worries fell from **18.2%** to **12.2%**. However, there is a small but increasing proportion of carers who are extremely worried about their personal safety (**3.1%** in 2023 compared with **2.4%** in 2021).

How we compare

Thinking about your personal safety, which statement best describes your present situation?	**National**	**Cambridgeshire compared to England**	**Change since 2021**

I have no worries about my personal safety	81.0%	84.7% Better	
I have some worries about my personal safety	17.2%	12.2% Better	
I am extremely worried about my personal safety	1.9%	3.1% Worse	

Helpfulness of information and advice – the results in respect of the helpfulness of information and advice have improved from 2021. A similar proportion of carers **(69%)** sought out information and advice. Of those who sought advice, **25.9%** found it "very helpful" compared to **24.6%** in 2021. The percentage who found it "quite helpful" rose from **55.0%** to **57.6%.** The percentage who found the advice "quite unhelpful" or "very unhelpful" has fallen.

In the last 12 months, how helpful has the information and advice you received been? *Excluding those who did not try to find information or advice*	**National**	**Cambridgeshire compared to England**	**Change since 2021**
Very helpful	28.2%	25.9% Worse	
Quite helpful	57.0%	57.6% Better	
Quite unhelpful	10.8%	12.9% Worse	
Very unhelpful	4.0%	3.5% Better	

Social contact – A greater percentage of carers felt they had as much social contact as they wanted with people they liked, **34.0%,** up from **27.6%** in 2021. The percentage who had some social contact but not enough has decreased to **48.4%** from **53.9%** in 2021. There was also a reduction in the percentage of carers who stated that they had little social contact and felt socially isolated, **(17.6%)**. This was lower than in 2021 **(18.5%)**, 2018 **(19.4%)** and 2016 **(17.7%)**.

How we compare

Thinking about how much social contact you've had with people you like, which statement best describes your social situation?	**National**	**Cambridgeshire compared to England**	**Change since 2021**
I have as much contact as I want with people I like	30.0%	34.0% Better	
I have some social contact with people but not enough	51.2%	48.4% Better	
I have little social contact with people and feel socially isolated.	18.7%	17.6% Better	

Loneliness – This year a new question was asked: "How often do you feel lonely?". Responses indicate that carers in Cambridgeshire felt less lonely that carers nationally: **11.4%** felt lonely "Often or always" (**13.3%** nationally), and **28.2%** felt lonely "Some of the time" (**30.8%** nationally). **16.6%** of carers reported never feeling lonely, compared with **14.5%** nationally.

How often do you feel lonely?	**National**	**Cambridgeshire compared to England**	**Change since 2021**
Often or always	13.3%	11.4% Better	-
Some of the time	30.8%	28.2% Better	-
Occasionally	26.1%	29.0%	-
Hardly ever	15.4%	14.8% Worse	-
Never	14.5%	16.6% Better	-

Key areas where results have worsened from the previous survey were as follows:

Access to information and advice – A similar proportion of carers sought advice in 2023 compared to 2021, about **69%.** Of those who sought advice, the percentage who found it "very easy to find" fell from **13.5%** in 2021 to **12.6%** in 2023, while the percentage who found it "fairly easy to find" increased from **39.8%** in 2021 to **44.9%** in 2023. **13.5%** found it "Very difficult to find", an increase from **11.7%** in 2021. Responses to this question were more positive nationally than in Cambridgeshire.

How we compare

In the last 12 months, have you found it easy or difficult to find information and advice about support, services or benefits. *Excluding those who did not try to find information or advice*	**National**	**Cambridgeshire compared to England**	**Change since 2021**
Very easy to find	13.5%	12.6% Worse	
Fairly easy to find	45.5%	44.9% Worse	
Fairly difficult to find	28.2%	29.0% Worse	
Very difficult to find	12.7%	13.5% Worse	

Carers feeling consulted with – Questions in relation to carers engagement with care and support planning for the person they supported were not as positive as in 2021. The proportion who had not been aware of any discussions in the last 12 months has decreased slightly, from **21.7%** in 2021 to **20.7%** in 2023. Of those who were aware of discussions taking place, the proportion of carers who said they "always felt involved or consulted" fell from **42.4%** to **40.4%** and those who "usually felt involved or consulted" fell from **33.2%** to **32.0%.** The percentage who only

"sometimes felt involved or consulted" increased from **19.7%** in 2021 to **26.8%** in 2023. However, a smaller percentage of carers reported that they "never felt involved or consulted", down to **5.2%** from **7.6%** in 2021.

In the last 12 months, do you feel you have been involved or consulted as much as you want to be, in discussions about the support provided to the person you care for? *Excluding those who were not aware of any discussions*	**National**	**Cambridgeshire compared to England**	**Change since 2021**
I always felt involved or consulted	36.9%	40.4% Better	
I usually felt involved or consulted	29.5%	27.6% Worse	
I sometimes felt involved or consulted	25.1%	26.8% Worse	
I never felt involved or consulted	8.4%	5.2% Better	

Financial difficulties – The percentage of carers reporting no financial difficulties caused by their caring role in the last 12 months fell from **58.3%** in 2021 to **56.6%** in 2023. Those responding that they had faced a financial impact to some extent has increased from **33.7%** in 2021 to **35.8%** in 2023. However, those reporting a lot of financial difficulties fell slightly, from **7.9%** to **7.5%.** National responses show an increase in the proportion of carers experiencing financial difficulties.

How we compare

In the last 12 months, has caring caused you financial difficulties?	**National**	**Cambridgeshire compared to England**	**Change since 2021**
No financial difficulties	53.4%	56.6% Better	
Yes, to some extent	36.6%	35.8% Better	
Yes, a lot	10.0%	7.5% Better	

Comments from carers

Below is a small sample of the some of the many additional comments included by carers

Theme: Access to Support

I have received great help and signposting to all sorts of services to support my elderly mother- much appreciated. This has happened as a result of case review via

social care for elderly. Brilliant service. A brief/easy to understand definition sheet would be helpful, it is hard to navigate benefit claims etc when not aware of what is around/who provides funds etc

As a first time carer it was difficult to know where to go first and what should be the priority order of needs..

Being a carer its extremely difficult to have time to make calls to services and end up spending more time waiting for an answer after going through the options. When you need help and advice you need to call just one number and one person, not be pushed from pillar to post.

Becoming a carer when you are elderly especially if you live in a more rural community is especially hard. You very quickly become isolated and there are little or no local services to help**.**

Theme: Systems

From the moment the services were involved I felt supported and involved in any decisions and choice was provided. The adult support coordinator was really proactive and supportive, she made the whole experience of reaching out for support much better and easy to navigate.

The application for social care funding was dealt with efficiently although a slight delay. Main difficulty is finding organisations that can help and for them to have sufficient staff and time to provide the pa service. Difficult to find suitable activities and social events for the young person

I would be grateful for the periodic phone calls to ask how I am and how my elderly mother whom I'm looking after is progressing etc. I feel something like this would be supportive.

I worry that the care and financial support mum received is in direct relation to my ability to fill in, often quite complex forms.

Theme: Caring Role

I look after both of my parents who are both in their late 90's. Without the help of social services, carers, OT and the rest of my family they would not be able to be in their house of 69 years. So thank you!

My mums current care package allows a good balance for me to offer support and…..meet her current needs. I do not feel overwhelmed as I feel sharing her care needs works for her and me…. The support of the social worker at her care reviews has been excellent. I am so happy with all the services in place for my mum, and feel this shared care ensures my mum is at the centre of her care.

I do not think that my care alone is sufficient to meet the young person's needs and because of this, over the past year the young person's needs have become more intense and had a greater impact on my health and wellbeing.

Public Health Performance Monitoring Report: Quarter 2 2024/25

To:	Adults and Health Committee
Meeting Date:	12 December 2024
From	Executive Director of Adults, Health and Commissioning
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	Not applicable

Executive Summary: The report describes the performance of the main Public Health commissioned services for Quarter 2 2024/25.

Recommendation: The Committee is asked to:

a) acknowledge the performance and achievements.

b) support the actions undertaken where improvements are necessary.

Officer contact:
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1. Creating a greener, fairer, and more caring Cambridgeshire

1.1 Public Health commissioned services reflect the seven strategic ambitions to varying degrees. There is strong alignment with ambitions addressing health inequalities, supporting people to have healthy, safe, and independent lives, and supporting children to thrive.

1.2 This Report reflects the Council's seven ambitions.

Net zero carbon emissions for Cambridgeshire by 2045, and our communities and natural environment are supported to adapt and thrive as the climate changes.

- There are implications with the introduction of virtual and digital services into commissioned services, but these are not covered in this performance report.

Travel across the county is safer and more environmentally sustainable.

- There are implications with the introduction of virtual and digital services, but these are not covered in this performance report.

Health inequalities are reduced.

- The Service does address health inequalities and included interventions to address groups that experience poorer sexual and reproductive health outcomes.

People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs.

- The services do support people to enjoy healthy, safe, and independent lives through timely support most suited to their needs, but this is not detailed in the report.

Helping people out of poverty and income inequality.

- The services do impact upon poverty and income inequality, but this is not detailed in the report.

Places and communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised.

- There are implications for places and communities, but these are not covered in this performance report.

Children and Young People have opportunities to thrive.

- The services do support children to thrive, but this not detailed in this report.

2. Background

2.1 The Performance Management Framework sets out that Policy and Service Committees should:
- Set outcomes and strategy in the areas they oversee
- Select and approve addition and removal of Key Performance Indicators (KPIs) for the committee performance report
- Track progress quarterly
- Consider whether performance is at an acceptable level
- Seek to understand the reasons behind the level of performance
- Identify remedial action

2.2 This report presents performance against the selected KPIs for Public Health commissioned services at the end of Quarter 2, 31st September 2024.

Indicators are 'RAG' rated where targets have been set.
- **Red** – current performance is off target by more than 10%.
- **Amber** – current performance is off target by 10% or less.
- **Green** – current performance is on target by up to 5% over target.
- **Blue** – current performance exceeds target by more than 5%.
- **Baseline** – indicates performance is currently being tracked against the target.

2.3 These performance indicators are for the Public Health high value contracts that are preventative or provide treatment e.g., Drugs and Alcohol Treatment Service. They include both locally set targets and national where applicable. There are key performance indicators for the Healthy Child Programme that is funded from the Public Health Grant. As these are not currently monitored by the Children and Young People's (CYP) Committee they are included here as priority indicators. There are nine indicators described in this report.

3. Main Issues

3.1 In summary the distribution of rag ratings for the performance of services described in the Report were as follows.

- Blue: 2
- Green: 3
- Amber: 2
- Red: 2

3.2 The key areas which have seen substantial improvement are NHS Health Checks and the Healthy Child Programme, with NHS Health Checks exceeding its target for the first time. Tier 2 Weight Management Services continue to achieve above target, driven by a very high demand for services. Currently measures are being taken to manage this high level of demand which exceeds current resources.

3.3 The main area of concern is Stop Smoking Services. Smoking rates have fallen considerably in recent years. In Cambridgeshire currently 11.1% of the population are

estimated to smoke. The model for stop smoking services has traditionally been driven by referrals from health services primarily GP practices. However, there are population groups with much higher rates who do not always present in GP practices. For example, the homeless rate is 75%, manual and routine 27%.

3.4 New national additional funding has been allocated to local authorities for expanding and developing stop smoking and the wider tobacco control services. These are currently being developed and there will be a focus on population groups that have high rates of smoking and regulatory services to address illegal tobacco sales and vaping.

3.3 Drug and Alcohol Services

Indicator	FY 2022/ 23	National average (latest Q)	Quarter 1 23/24	Quarter 2 23/24	Quarter 3 23/24	Quarter 4 23/24	Status
201: % Achievement against target for drug and alcohol service users - Treatment Progress Measure **(benchmarked against national average)**	**48.9%**	**48.0%**	**49.4%**	**48.3%**	**48.1%**	**48.4%**	**Green**
Please note that performance data is extracted from the National Drug Treatment Monitoring System (NDTMS). The 2024/25 drug/alcohol treatment data are restricted statistics and as such must not be released into the public domain until the national report is published (Dec 2025). Recent performance data is available to commissioners and is used for local performance monitoring and service planning. The national 'treatment progress' measure includes both successful completions (excluding those that have acute housing problems), those that are drug free in treatment or have a sustained reduction in drug/alcohol use. The Q2 24/25 data available to commissioners for this indicator remains strong, it has dropped slightly but still performing in line with national average and is closely monitored.							

Health Behaviour Change Services

Indicator	Full Year 2023/24	Quarter 1 24/25	Quarter 2 24/25	Quarter 3 24/25	Quarter 4 24/25	Status
82: Tier 2 Weight Management Services: % achievement of the target for users who complete the course and achieve a 5% weight loss. **Target: 30% of those in the service. Consistently well above target.**	**48%**	**50%**	**48%**			**Blue**
237: Health Trainer: (Structured support for health behaviour change): % achievement against target referrals to the service received from deprived areas. **Target: 30% Above target for Q2.**	**34%**	**28%**	**31%**			**Green**
56: Stop Smoking Services: % achievement against target for smoking quitters who have been supported through a 4-week structured course. **Annual Target: 1906 quitters. Below target**	**796 quits. (42% of annual target)**	**259 quits. (54% of quarterly target)**	**264 quits (55% of quarterly target)**			**Red**
53: NHS Health Checks (cardiovascular disease risk assessment) Achievement against local target set for completed health checks. The ambition is to work over the next three years to meet the national target of 37,000 p.a. **Target: 23,500 Above target**	**20,216 (101% of annual target)**	**5,633 (96% of quarterly target)**	**6,411 (109% of quarterly target)**			**Blue**

Commentary on performance:

Indicator 82: Tier 2 Adult Weight Management.
Throughout 2023/24 and into Quarter 1 of 2024/25, referral numbers to Tier 2 services have remained exceptionally high, with 1,368 referrals received against a target of 586—representing 233% of the target and an 11% increase compared to Quarter 1 of the current year. This sustained and significant rise in referrals is largely attributable to the NHS enhanced service specification, which incentivises GP practices to refer patients to weight management services through financial rewards. Additionally, the introduction of weight loss medications, such as Semaglutide (Wegovy), has further driven demand for both Tier 2 and Tier 3 services.

The percentage of completers achieving 5% weight loss continues to far exceed the target of 30%, with 48% achieving a 5% weight loss in Quarter 2.

Indicator 237: Health Trainer.
The number of referrals into the Health Trainer service for people from deprived areas was just above target for Quarter 2 (103% of target). This is positive in response to missing this indicator in Quarter1, practitioners have attended events in Fenland to raise awareness of the service and the support it can provide. The task for Quarter 3 is to maintain this level of engagement from deprived communities.

Indicator 56: Stop Smoking Services
The Stop Smoking service intervention takes two months in total for a service user to complete from initiation date.

During Quarter 1 24/25 the Behaviour Change Service/Stop Smoking Service achieved 54% of its quarterly 4-week quitter target, following some improvement over the previous year. During Quarter 2 24/25 this has increased to 55%.

GP practices continue to face demand pressures and find it challenging to provide stop smoking services. Additionally, the withdrawal of two main smoking cessation pharmacotherapies (Champix and Zyban) due to safety concerns has impacted overall 4-week quit numbers.

During Quarter 1 24/25 the Allen Carr Easyway to Stop Smoking method has been introduced offering NICE approved smoking cessation seminars in person and online to smokers in Cambridgeshire, which has been promoted through GP's, Integrated Neighbours, and partner organisations in addition to paid social media marketing undertaken by Allen Carr Easyway. There is a high demand for this method of support, since launch at the end of July, 328 smokers have attended and another 64 are booked onto a seminar.

The pilot Fenland Stop Smoking Service specifically targeting the local homeless population which has high smoking rates. This initiative, delivered within the Closer to Communities programme, involves NHS Neighbourhood Managers promoting and developing new face-to-face clinics in collaboration with GP practices to send bulk text messages to smokers.

Locally, several national campaigns are to be actively promoted:

- New Year Quit in January
- National No Smoking Day in March

The “Swap to Stop” initiative provides quitters with a free starter vape kit under the national programme and is popular with smokers making a quit attempt. New funding associated with the Smokefree Generation legislation will be at targeted smokers who are homeless, have poor mental health and those misusing drugs and alcohol, groups that have rates of smoking and poor health outcomes.

Indicator 53: NHS Health Checks

NHS Health Checks are mainly delivered in GP practices, alongside a supplementary, targeted provision provided through our behaviour change service - Healthy You and Cambs GP Network. In 2023/24, 101% of the target was met. In 2024/25, the target has been increased from 20,000 NHS Health Check completed to 23,500, an increase of 17.5%.

The service has demonstrated a strong response to this significant increase in target. During Quarter 1 of 2024/25, achieving 96% of the quarterly target. Performance has further improved in Quarter 2, with 108% of the target achieved. At the mid-year point, the service is exceeding the cumulative half-year target by 2.5%. Furthermore, historical projections indicate that 60% of the annual target will be met during the second half of the programme year, providing confidence that the overall annual targets will be successfully achieved.

The allocation of additional funding from the Department of Health and Social Care for 13,500 workplace cardiovascular disease checks, delivered using innovative, digital technology and supported by the Healthy You Behaviour Change Service, will be a significant boost to achieving the increased annual target. Since its inception in late September and through the end of Quarter 2, over 1,000 self-service health kiosk checks have been successfully completed in local workplaces, it is expected that around 5% of these will go on to complete a full face-to-face NHS Health Check.

Healthy Child Programme

Indicator	Full Year 23/24	Quarter 1 24/25	Quarter 2 24/25	Quarter 3 24/25	Quarter 4 24/25	Status
59: Health visiting mandated check - Percentage of births that receive a face-to-face New Birth Visit (NBV) within 14 days, by a health visitor. **Local target: 95% (National Benchmark 83.0% in 23/24)** **Below target but improved and better than National**	84%	86% (96% including those completed after 14 days)	89% (96% including those completed after 14 days)			**Amber**
60: Health visiting mandated check – percentage of children who received a 6–8-week review by 8 weeks. **Local target: 95%. (National Benchmark 81.8% in 23/24)** **Below target but in line with national**	69%	82% (95% including those completed after 8 weeks)	81% (95% including those completed after 8 weeks)			**Red**
62: Health visiting mandated check - Percentage -of children who received a 2-2.5-year review. **Local target: 90%. (National Benchmark 78.4% in 23/24)** **Below target but in line with national**	73%	72% (80% including those after 2.5 years old)	78% (82% including those after 2.5 years old)			**Amber**
57: % of infants breastfeeding at 6 weeks **Local Target: 56%** Need to achieve 95% coverage to pass validation **Local target achieved**	60%	62%	63%			**Green**

Commentary on performance:
Indicators 59 & 60: Health visiting mandated checks (New Birth Visit & 6-8 check). Health visiting mandated checks (New Birth Visit & 6-8 check). Performance of the Health Visiting service is traditionally challenging in Quarter 2 with summer holidays impacting staffing capacity and increased cancellations of appointments from families. However, performance this quarter has been maintained or improved across the mandated checks. In Quarter 2, 89% of new birth assessments were completed in 14 days (3% increase in comparison to Q1) as well as 81% of 6–8-week reviews (very slight reduction compared to Quarter 1). When including checks completed outside of timeframes, performance data shows that 96% of families received a New Birth Visit and 95% a 6–8-week check. Vacancy rates continue to be low across Cambridgeshire and current cohort of students all on track to qualify in January. **Indicator 62: Health visiting mandated check (2.2.5-year review).** The improvements on the delivery of this contact that were seen throughout 23/24, and Quarter 1 have been built on in Quarter 2 of 24/25 with a 6% increase to 78% within timescales. Work is planned to understand more about those families not accessing this check through a Health inequalities lens. **Indicator 57: % of infants breastfeeding at 6-8 weeks.** The overall breastfeeding prevalence of 63% is higher than the national average of 52.7% and is meeting the locally agreed stretch target. Breastfeeding rates, which include both exclusive breastfeeding and mixed feeding, do however continue to vary greatly across the county and we have worked to partners to continue to expand the support offered in the North of the county over this quarter. We continue to move forward on the actions identified in the Infant Feeding strategy which we report on as part of the Family Hubs transformation programme and are support UNICEF Baby Friendly accreditation preparation with infant feeding colleagues within our maternity providers.

4. Alternative Options Considered

Not applicable

5. Conclusion and reasons for recommendations

5.1 The performance of the Public Health commissioned services described in this paper is generally positive. The key areas of improvement are NHS Health Checks exceeding its target for two consecutive quarters and the Healthy Child Programme. Tier 2 Weight Management Services continue to overachieve against their target driven by a very high demand. Currently measures are being taken to manage this high level of demand which exceeds current resources.

The main area of concern is Stop Smoking Services Recent national additional funding has been allocated for expanding and developing stop smoking and the wider tobacco control

services. These are currently being developed and there will be focus on population groups that have high rates of smoking and regulatory services to address illegal tobacco sales and vaping.

6. Significant Implications

6.1 Finance Implications

This performance report does not include a financial analysis of the services commissioned.

6.2 Legal Implications

There are no current legal implications in this report.

6.3 Risk Implications

The key risk is the poor performance of the Stop Smoking Services. The measures that are being taken to address these risks are indicated in the report.

6.4 Equality and Diversity Implications

Any equality and diversity implications will be identified before any service developments are implemented.

6.5 Climate Change and Environment Implications (Key decisions only)

All commissioned services are required to ensure that their services minimise any negative impacts and support positive climate and environmental improvements.

7. Source Documents

7.1 None

Adults, Health and Commissioning Risk Register Update (including Public Health)

To:	Adults and Health Committee
Meeting Date:	12 December 2024
From:	Executive Director, Adults, Health & Commissioning
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	N/A
Outcome:	Adults and Health Committee is briefed on the risks in relation to Adults, Health and Commissioning, including Public Health.
Recommendation:	Adults and Health Committee are recommended to note the updated Adults, Health and Commissioning, including Public Health Risk Register.

Officer contact:
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1. Background

1.1 It is a requirement to present Risk to Committee on a recommended quarterly basis and this report focuses on the Adults, Health and Commissioning, including Public Health, risks.

2. Main Issues

2.1 Cambridgeshire County Council has a clear and approved Risk Management framework, policy and procedures which set out the key aspects of identifying, assessing and mitigating risks for the Council which includes:

- Rating of risks are based upon their probability and their impact from a scale of 1-5 (5 being the highest level of concern) and multiplied to gain a risk score.

- Impact of risks are scored against five categories:
    - Legal and Regulatory
    - Financial
    - Service Provision
    - People and Safeguarding
    - Reputation

- The Council tolerable level of risk is set at 16, where all risks of 16 or above will be escalated for further action / decision as required. This could mean; accepting the risk rating at that time; applying additional mitigating actions and/or other actions to lower the risk level as appropriate.

2.2 The Adults, Health and Commissioning, risk register, including Public Health, contains the main strategic risks across the whole Directorate, which includes all adults' operational services, commissioning and public health. The risk register is regularly reviewed and updated by the Adults Leadership Team.

3. Alignment with ambitions

3.1 Net zero carbon emissions for Cambridgeshire by 2045, and our communities and natural environment are supported to adapt and thrive as the climate changes.

There are no significant implications for this ambition.

3.2 Travel across the county is safer and more environmentally sustainable.

There are no significant implications for this ambition.

3.3 Health inequalities are reduced.

There are no significant implications for this ambition.

3.4 People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs.

There are no significant implications for this ambition.

3.5 Helping people out of poverty and income inequality.

There are no significant implications for this ambition.

3.6 Places and communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised.

There are no significant implications for this ambition.

3.7 Children and young people have opportunities to thrive.

There are no significant implications for this ambition.

4. Significant Implications

4.1 Resource Implications
There are no significant implications within this category.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications
There are no significant implications within this category.

4.3 Statutory, Legal and Risk Implications
There are no significant implications within this category.

4.4 Equality and Diversity Implications
There are no significant implications within this category.

4.5 Engagement and Communications Implications
There are no significant implications within this category.

4.6 Localism and Local Member Involvement
There are no significant implications within this category.

4.7 Public Health Implications
There are no significant implications within this category.

4.8 Climate Change and Environment Implications on Priority Areas
There are no significant implications within this category.

5. Source documents guidance

5.1 None

ADULTS, HEALTH & COMMISSIONING, INCLUDING PUBLIC HEALTH RISK LOG

The below table is taken from the Corporate Risk Management Policy and outlines how risks are scored on the likelihood and impact of each risk. Scores of 16 or above are in excess of the Council's tolerated risk level and will be highlighted as a red risk; any red risks must be escalated to CLT.

VERY HIGH	5	10	15	20	25
HIGH	4	8	12	16	20
MEDIUM	3	6	9	12	15
LOW	2	4	6	8	10
NEGLIGIBLE	1	2	3	4	5
IMPACT / LIKELIHOOD	VERY RARE	UNLIKELY	POSSIBLE	LIKELY	VERY LIKELY

ADULTS, HEALTH & COMMISSIONING, INCLUDING PUBLIC HEALTH MATRIX OF RISKS

The below matrix provides an overview of the current risk scores for all risks relating to Adults Services. The letters indicate which risk it relates too.

VERY HIGH		4	12		
HIGH	8	1, 2, 7,	9, 11	3	
MEDIUM			5, 6,	10	
LOW					
NEGLIABLE					
IMPACT					

LIKELIHOOD	VERY RARE	UNLIKELY	POSSIBLE	LIKELY	VERY LIKELY

The Risk	**1: Joint Commissioning arrangements and services are adversely impacted as a result of partner organisation/s financial failure.**
Risk owner/s	Patrick Warren-Higgs, Executive Director for Adults, Health and Commissioning and Richard Hills, Service Director for Commissioning
Residual Risk level:	**Likelihood = 2** **Impact = 4** **Score = 8** **Direction of risk =** Remains the same
Triggers:	• Financial instability of partner organisation resulting in unilateral and rapid cuts in services and spend • Problems with the section 75 arrangements • Political instability of partner organisation
Consequences:	• Arrangements and services are negatively impacted
Controls:	**1. Close Monitoring and Oversight** • Maintain close monitoring and oversight of joint contracts to ensure any risks and issues arising are identified and managed at the earliest possible point **2. Review current commissioning arrangements and risks** • Review all jointly commissioned arrangements and identify potential financial and service risks. • Work in a prioritised way to either contractually mitigate risks and/or develop alternative commissioning arrangements
Review date:	22nd November 2024: Risk reviewed by Patrick Warren-Higgs and Sarah Bye.
Next review date:	February 2025

The Risk	**2: A serious incident occurs, preventing services from operating and/or requiring a major/ critical incident response**
Risk owner/s:	Patrick Warren-Higgs, Executive Director for Adults, Health and Commissioning
Residual Risk level:	**Likelihood = 2** **Impact = 4** **Score = 8** **Direction of risk =** Remains the same
Triggers:	• Loss of large quantity of staff or key staff • Loss of premises (including in-house Provider services) • Loss of IT equipment, data or access

	• Cyber attack • Back up digital recovery solution fail • Loss of a key Provider or Partner • Loss of utilities or fuel • Major incident e.g. flood, fire, public health pandemic • Partnership responsibilities within major incidents aren't fully understood leaving gaps in responses
Consequences:	• Loss of system access
Controls:	**1. <u>Business Continuity Plans</u>** • All services and teams have up to date BCP's in place which provide a clear plan for how services will respond in the event of a critical incident • BCP's are reviewed and updated annually - to comply with new corporate templates and process • BCP templates for Mosaic are available in the event of system downtime • Adults on-call rota is in place with updated contact details available – under review • All managers to attend appropriate BCP training including regular refreshers **<u>2. IT Systems</u>** • ASC Lead working with corporate System Lead at times of stability and challenge to mitigate system issues and impacts to workforce • ASC Systems and digital board in place where corporate partners collaborate and are held to account for IT systems delivery • BCPs are enacted including manual recording processes **<u>3. Response to Provider Failure</u>** • Tried and tested response to provider failure is in place and has mitigated risks to individuals and the council • Cross system response available to support clinical need of individuals displaced by provider failure • Contract Monitoring and proactive support to providers with oversight of an operational leadership team comprising of Health and Social care staff is in place **<u>4. Adults with care and support needs list</u>** • BI report for people with care and support needs who may be at risk is available in the event of a critical incident • On-call managers are able to locate and download the people who draw on services who may be at risk list • Plan to test use of people at risk list in simulation exercise
Review date:	22nd November 2024: Risk reviewed by Patrick Warren-Higgs and Sarah Bye
Next review date:	February 2025

The Risk:	**3: Arrangements to support people with Learning Disabilities result in poor outcomes due to uncertainty of decoupling of funding arrangements via section 75 agreement**
Risk owner/s:	Patrick Warren Higgs, Executive Director for Adults, Health and Commissioning, Richard Hills, Service Director for Commissioning and Sally Shaw, Service Director of Adult Social Care
Residual Risk level:	**Likelihood = 4** **Impact = 4** **Score = 16** **Direction of risk:** Increased likelihood score from 3 to 4.
Triggers:	• Due to care packages support not being reviewed systematically over a number of years has resulted in neither partner understanding what they are responsible to fund. • We are not achieving best outcomes for people with learning disabilities and autism as governance arrangements between the council and health do not support the right conversations and decision making. • Notice has been served on the section 75 arrangement and also to the management arrangement to CPFT • Not yet established with the ICB the future state of the service, nor milestones and timescales to do so. • We may not be able to put a new set of financial arrangement in place to ensure we can make the correct contribution to care cost and pay providers. • Final decisions regarding delivery and funding models cannot be reached in a timely way which results in uncertain funding and relationships between commissioning authorities. • Financial instability of partner organisation resulting in unilateral and rapid cuts in services and spend. • Political instability of partner organisation
Consequences:	• People who use LDP services not having seamless service provision through an integrated arrangement, their experience and poorer outcomes.
Controls:	**1) <u>Action via the s75 agreement</u>** • Notice period end date agreed with ICB. • Legal advice in place to support ending agreement. • Cross system governance arrangement agreed to establish oversight of the exit process. • Internal programme board established with senior representation from several Council departments 2) **<u>External review</u>** • Review by Red Quadrant complete indicating that the current split needs to be substantially changed in order to accurately reflect our respective responsibilities. • The Council and ICB have separately commissioned organisation to independently carry out 600 partly or fully funded Health packages 3) **<u>Internal preparation and readiness</u>** • Dedicated programme and project resources in place • Internal programme Board established and associated workstreams well established • Further defining of financial implications is ongoing as reviews of health/social care funded package are completed

	• Mechanism for monitoring actions, risks and outcomes in place • Ongoing engagement with people with lived experience **4) <u>Ongoing relationship building with health colleagues</u>** • Strategic group chaired by Exec DASS and Chief Nurse (ICB) is established to support joined up decision making about the future model • Working hard with partners including the ICB, acute and place based accountable bodies in the North and South, as well as CPFT to build stronger relationships. • Seeking appropriate advice and agreed approach to the Council's position in relation to LDP decoupling to avoid/manage escalation wherever possible • Escalation through the Council's Chief Execute to ICB Chief Executive, alongside NHSE on specific issues as appropriate. • Working closely with providers to give clarity on future models, and demand for services. Maintaining regular communications with people who use services and their families/carers, to provide assurance on continuity of care **5) <u>Close monitoring and oversight</u>** • Maintain close monitoring and oversight of joint contracts to ensure any risks and issues arising are identified and managed at the earliest possible point. **6) <u>Review current commissioning arrangements and risks</u>** • Review all jointly commissioned arrangements and identify potential financial and service risks. • Work in a prioritised way to either contractually mitigate risks and / or develop alternative commissioning arrangements.
Review date:	22nd November 2024: Risk reviewed with Patrick Warren-Higgs and Sarah Bye
Next review date:	February 2025

The Risk:	**4: Potential reputational damage and legal challenge when the Council cannot provide assurance and is not always able to intervene to prevent / mitigate harm, due to legal and ethical limitations of working with adults.**
Risk owner/s:	Patrick Warren-Higgs, Executive Director for Adults, Health and Commissioning, Sally Shaw, Service Director for Adult Social Care and Kirstin Clarke, Service Director for Adult Social Care.
Residual Risk level:	**Likelihood = 2** **Impact = 5** **Score = 10** **Direction of risk:** Remains the same
Triggers:	• Capacity to meet incoming demand of safeguarding activity is lacking creating delays in responsiveness within the ASC system to safeguarding concerns and at times the volume require response prioritisation. • Individual choice and control to continue to live with risks. • Assessment and legislative routes, processes and forms create delays in implementing potential risk mitigations. • Legal routes and process create delay in implementing potential mitigations.

	• Other professionals and organisations may be the lead for aspects of risk mitigation and not Adult Social Care and their responsiveness is outside of ASC's control.
Consequences:	• An adult with mental capacity who has care and support needs experiences or continues to experience harm, abuse, or neglect as they refuse to engage in or accept potential mitigation options. • An adult with care and support needs experiences abuse and or neglect which results in fatality or severe injury that the Council is unaware of until after the serious incident occurs. • Negative impacts to Council reputation. • Negative CQC assessment rating and ongoing impacts of this.
Controls:	**1. <u>Comprehensive and robust safeguarding training.</u>** • The ASC workforce has access to safeguarding training (appropriate to individual roles) which includes training around inherent jurisdiction and capacitated adults, which is reviewed annually as a minimum to ensure the ASC workforce can recognise and respond to safeguarding concerns. • ASC has robust processes and assurance in place that are regularly reviewed. • Safeguarding training opportunities and mandatory requirements are clear and monitored across ASC. • There are informal and formal opportunities for staff, through regular supervisions, CPD (Continuing Professional Development) sessions, practice workshops, facts sheets, to build knowledge and confidence around safeguarding procedures and practice. • Continued learning from Safeguarding Adult Reviews and internal/external Serious Incidents Effectiveness: Good **2. <u>Front Door and Immediate Responsiveness</u>** • Robust and responsive front door • Responsive Prevention and Early Intervention offer • Community Duty Teams in place for urgent, same day responses. • MASH able to triage new safeguarding concerns daily and implement immediate safety planning. High risk cases that meet the three-stage statutory test are allocated an enquiry lead, to complete safeguarding enquiry and implement ongoing safety plan where required. • Ability of ASC system to move assessment and care management capacity to meet demand. • Adult Social Care will enact the Multi-Agency Risk Management (MARM) meetings to engage wider professionals and organisations. Effectiveness: Good **3. <u>Quality Assurance</u>** • Robust process of internal quality assurance (QA framework) including safeguarding case auditing and monitoring of practice and processes. • Safeguarding Adult Board (SAB) monitors effectiveness of partnership safeguarding practice and process via the Quality Effectiveness Group.

	Effectiveness: Good 4. **Multi Agency Safeguarding Hub (MASH)** • The MASH provides a robust single point of access (except for Hospital activity) for incoming safeguarding activity across ASC and system partners, providing a consistent response to SA (Safeguarding Adult) concerns and enquiries. Effectiveness: Good **5. People in Position of Trust policy** • Clear 'People in Position of Trust' policy and guidance in relation to adults Effectiveness: Good **6. Practice processes and procedures.** • Robust safeguarding procedures and practice guidance in place which clearly depict the customer journey for those adults with care and support needs that are at risk of abuse and or neglect. • For those adults with care and support needs that do not meet the three-stage statutory safeguarding test system partners are able to use the Multi-Agency Risk Management (MARM) process to discuss and engage individuals at risk and agree risk mitigation plans and safety plans. • ASC have fortnightly provider Temperate Check meetings where concerns relating to care providers are shared, actions are discussed and agreed to mitigate the identified risks. • ASC has a continuous process of updating practice and procedures, linking to local and national trends, including learning from local and national reviews such as Safeguarding Adult Reviews. Effectiveness: Good 7. **Provider Monitoring.** • Regular monitoring of social care providers and information sharing meetings with other local organisations, including the Care Quality Commission and ICB are in place. • ASC have a structure in place to raise, discuss and address provider quality concerns across the health and social care system. If improvements are not made, escalation routes are in place and progress and risks are continually shared with the CQC regulator. Effectiveness: Good
Review date:	22nd November 2024: Risk reviewed by Patrick Warren-Higgs and Sarah Bye
Next review date:	February 2025

The Risk:	**5. Relationships and governance across Integrated Care System (ICS) do not support the best outcomes for our population**

Risk owner/s:	Patrick-Warren Higgs, Executive Director for Adults, Health and Commissioning
Residual Risk level:	**Likelihood = 3** **Impact = 3** **Score = 9** **Direction of travel:** Remains the same.
Triggers:	• The reorganisation of the health system in ICS may impact on the way our services work with NHS services and current integrated arrangements. • Governance arrangements do not support effective decision making. • Challenging finances across the system lead to a reduction of preventative investments. • Inability to achieve joined up data sharing agreements across the local health system and lack of resource (analytical and leadership time) to implement shared work using shared data. • Separation of CCC and PCC Public Health Teams has destabilised some of the system wide work. • Failure to agree and deliver on system priorities
Consequences:	• Impact of this implementation changes the way LA services work currently. • Impact on capacity and workload for senior managers. • Worse population health outcomes. • Opportunities for prevention are missed leading to escalating need for health and social care. • Ineffective use of funds (duplication of what we are commissioning) across Cambridgeshire.
Controls:	**1. <u>Attendance at Boards</u>** • CEO and Director of Public Health representation at ICS Board. • Ensure LA priorities are fed into ICS governance/boards at all levels • Work to ensure the correct representation on other Boards on going. • Participation in system-wide boards and groups to promote public health as a system priority and support the wider work of the healthcare system. **2. <u>Working Relationships</u>** • Building positive working relationships across all levels continues • Some progress is being made to clarify governance and decision making • Local Authority considerations have been discussed with Members. • ICS implemented from 1st July 2022 - LA engaging with key ICS implementation and strategic meetings. • Proactive working being undertaken beneath Board level to drive progress in key work streams i.e. Hospital Discharge and CHC • CCC continues to invest in relationship building in the ICS/ICB **3. <u>Ensuring that the two local authority Public Health teams in Cambridgeshire and Peterborough continue to adopt a system wide approach where appropriate to improving health outcomes.</u>** • Identifying how Public Health teams across both Cambridgeshire and Peterborough collaborate, where relevant, to support the system most effectively.

	4. <u>Produce MOUs</u> • Ongoing work to produce MOUs to clarify roles and responsibilities between the local authority and partner organisations. **5. <u>Ensure effective engagement across system wide partnerships</u>** • Review partnership assessments. • Working with partners to establish joint objectives. • Establish key measures to demonstrate effectiveness of partnership.
Review date:	22nd November 2024: Risk reviewed and updated with Patrick Warren-Higgs and Sarah Bye
Next review date:	February 2025

The Risk:	**6. Providers leave the market and are unable to continue services leading to insufficient availability and capacity**
Risk owner/s:	**Patrick Warren-Higgs, Executive Director for Adults, Health and Commissioning and Richard Hills, Service Director for Commissioning**
Residual Risk level:	**Likelihood = 3** **Impact = 3** **Score = 9** **Direction of risk:** Decreased following review.
Triggers:	• Continued increase in financial pressures for providers (i.e. Significant inflation (CPI, NLW) and costs of fuel/energy, workforce and managing preventative controls) - Providers unable to continue to operate, due to the increased costs • Reduction in the number of providers able to provide care; Care costs increase as demand exceeds providers available; Financial warnings from providers • There is a risk that inflationary rises, and the changes to pay rates alongside the fees the Local Authority are able to afford will result in providers withdrawing from the market. • Increased complexity and population growth. • Provider failure due to inability to recruit an appropriately trained workforce. • Competition amongst different partners for workforce with similar skills.
Consequences:	• Shortage of operators at reasonable rates • Inflationary pressures leading to increased costs for providers and therefore becoming unaffordable to either operate or commission • Additional pressure on the wider health and social care system.
Controls:	**1. <u>Appropriate monitoring and plans</u>** • Data regularly updated and monitored to inform service priorities and planning • Working with Providers to develop action plans • Maintain an effective range of preventative services across all age groups and service user groups including adults and older people • Directorate Performance Board monitors performance of service provision

	• Capacity Overview Dashboard in place to capture market position • Regular engage with commissioners and providers to put action plans in place to resolve workforce issues • Robust monitoring procedures • Active involvement by commissioners in articulating strategic needs to the market • Increased engagement with CQC for market oversight • Market sustainability plan • CQC monthly meetings • Wicked issues communications • CQC alerts • Fee uplift discussions • Inspection steps including contract monitoring and Provider of Concern processes • Failure management standard operating procedure in place **2. Development of Provider action plans** • Continued work with Voluntary & Community Sector (VCS) for preventative actions • Market shaping activity - including maintaining good relationships with providers, so support can be provided where needed • Strong contract management • Uplift strategy **3. Funding** Use additional national funding to mitigate cost pressures, we do this by: • Take flexible approach to managing costs of care • Risk-based approach to in-contract financial monitoring • Coordinate procurement with the ICS to better control costs and ensure sufficient capacity in market **4. Market Shaping** • Residential and Nursing Care Project has been established as part of the wider Older People's Accommodation work • Programme to increase the number of affordable care homes beds at scale and pace. • Development of a Home Care Strategy **5. Joint commissioning models that utilise scarce workforce resources most effectively.** • Recommissioning opportunities and place-based working will facilitate more effective use of scarce workforce resources.
Review date:	22nd November 2024: Risk reviewed by Patrick Warren-Higgs and Sarah Bye.
Next review date:	February 2025

The Risk:	**7: Increasing demand for Adult Social Care decreases responsiveness of services and places pressure on the financial envelope of the Council.**
Risk owner/s:	Patrick-Warren Higgs, Executive Director for Adults, Health and Commissioning and Kirstin Clarke, Service Director for Adult Social Care.

Residual Risk level:	**Likelihood = 2** **Impact = 4** **Score = 8** **Direction of risk:** Remain the same.
Triggers:	• Demand into ASC overtakes growth assumptions within allocated financial envelopes. • New customers in without prior ASC support continues to grow and preventative options do not meet individual need. • Complexity of needs places pressure on costs per package and areas such as bed-based care. • Partnership Agency changes can adversely impact ASC budgets for example ICB and D2A processes into bed-based care or FNC (Funded Nursing Care) application or Police and Right Care, Right Person.
Consequences:	• Poor experience of ASC experienced by individuals with care and support needs or unpaid carers. • Increasing waiting lists and wait time within Adult Social Care. • Increase in complaints. • Poor CQC rating because of poor responsiveness and wait lists • Provider Failure/Closure diverts ASC resources away from core ASC activity.
Controls:	**1. Data Analysis, Reporting, Prediction and System Assurance.** The organisation engages in the on-going process of data analysis and review to understand current and predict future trends to support good assurance such as: • Oversight via Finance and Performance Board which meets monthly to review waiting list performance and agree any actions required • Data Delivery Board meets monthly, to ensure data reporting meets requirements and sets priorities. • Forecasting ASC spend monthly monitors trends and growth in service provision and projects future in year financial spend providing early warning to changing trends and growth. Regular reporting and monitoring provide leaders with the data to amend in year and future year plans to ensure responsive services and decrease potential pressure on the financial envelope. Effectiveness: Good **2. Systems and Process in Place.** • Robust arrangements in place to respond to provider failure which has mitigated risks to individuals and the council • Cross system response available to support clinical need of individuals displaced by provider failure • Contract Monitoring and proactive support to providers with oversight of an operational leadership team comprising of Health and Social care staff is in place • System wide Provider Monitoring processes in Place (Operational Leadership Team) to share intelligence and ensure wider system quality and safety. Effectiveness: Good 3. **Utilising funding streams available to maximise capacity to meet demand.** • Utilising available one-off grants to support wait times and waiting list numbers, ASC and Commissioning have drawn up plans to use one off grant monies such as the MSIF to support the reduction of waiting lists and waiting numbers across the ASC system. • Teams and Services utilise their capacity to ensure responsiveness is equitable across the County.

	• There is a specific improvement plan and funding secured and in place for the DOLs (deprivation of liberty) backlogs that has had oversight from CLT. Effectiveness: Good **4. <u>Data reporting, management and Improvement Plans</u>** • Waiting list data on all areas of operation is monitored monthly via Operational Meetings. • AAT team additional resourcing and oversight of prioritisation by Service Director is in place 2024/25. • DoLs (deprivation of liberty) additional resource signed off by Committee for 24/25 and 25/26. • Tracking data improved for LDP Health waiting list via Power BI dashboards • Reviews waiting list project and use of an agency has been undertaken to improve overdue review position. • Use of Market Sustainability and Improvement plan to secure resource to address wait lists • Improvement plan also includes threshold assessments for people in care, OT waiting list, LD Health waiting lists linked to section 75 agreements, care and support plan delays, including brokerage of increases or changes to care packages, financial assessment, and financial data entry delays • Strengthening of Early Intervention and Prevention offer via initiatives to secure the right staffing resource and review of customer journey to increase our ability to prevent or delay the need for long term services • Continue demand Management at the front door using VS and universal preventive services e.g. Community Navigators to reduce the pressure. Effectiveness: Good
Review date:	22nd November 2024: Risk reviewed and updated by Patrick Warren-Higgs and Sarah Bye
Next review date:	February 2025

The Risk:	**8: The Workforce across Adults, Health and Commissioning is under capacity and may not have the level of maturity of experience to deliver business needs.**
Risk owner/s:	Patrick Warren-Higgs, Executive Director for Adults, Health and Commissioning
Residual Risk level:	**Likelihood = 1** **Impact = 4** **Score = 4** **Direction of risk:** Remains the same.
Triggers:	• We do not have and/or are unable to recruit enough staff to fulfil our statutory responsibilities • A lack of qualified workers in the job market • Decrease in employee retention • Low levels of employee engagement • Ineffective workforce planning • Receive a poor rating in CQC enhanced assurance. • Insufficient strategic management control and planning • No capacity or correct skills to manage organisational change

	• Long standing vacancies in Health roles where LA holds responsibility under Section 75 agreement • Insufficient number of AMHPs to provide a safe services and cover rota • The separation of the public health directorate leading to 50% reduction in workforce and skills gaps.
Consequences:	• Insufficient workforce to adequately meet quality and demand • Unable to respond to public health emergency • Unable to support delivery of the HWB Strategy • Unable to support partnership working • Loss of Public Health training site accreditation for Public Health registrars

Controls:	**1. Employee Engagement** • Exit interviews to capture information about why people leave • Establishment of a staff engagement group in response to staff feedback as part of external assurance activity • Welcome induction sessions with the Executive Director for all new starters • Communication channels in place – Practice newsletter, Fortnightly update from ED, Regular Teams Live events for all adults' employees • Staff Survey results to be analysed and action plan produced to increase staff satisfaction and therefore retention • Care Professionals Academy has been launched for adult social care providers and professionals to access training, benefits and information from the council which supports staff with training and qualifications. 2. **Health/LA agreement** • Review of Section 75 arrangements 3. **Induction, Training and Development** • Increased number of Apprenticeship supported for OT and SWs • Commitment to 6 protected CPD days for professionally registered staff • Insufficient consultant capacity to supervise public health registrars **4. Retention** • Retention payment scheme in place for hard to recruit teams • ASYE Scheme in place to support newly qualified social workers • Apprenticeship Schemes supported and expanded. • 20 apprentice Social Worker opportunities have been launched. • Establishment of a staff engagement group in response to staff feedback as part of external assurance activity • Comprehensive wellbeing offer • Use of ringfenced grants to secure the workforce, such as supporting enhancements for 7 day working through the hospital discharge fund • Twice yearly Pay Progression Panel for social workers. • Use of secondments, interims, agency workers etc, to fill any remaining vacancies. **5. Vacancy tracker** • Oversight of vacancies via a recruitment tracker and HR data completed monthly with oversight from Adults Leadership Team and FAP. **6. Workforce Strategy** • Funding secured to develop an ASC specific workforce strategy, forecasting future need, setting out recommendations and actions to retain, succession plan and ensure pipelines of future workers – due to deliver summer 2024 • Horizon scanning and review of other LA offers as part of recruitment campaigns • Keeping up to date on national/ local trends & through ADASS network for hard to recruit professions **7. Recruitment** • In the process of recruiting to an AMHP Manager secondment. • Re-evaluation of consultant salary scales to ensure competitive benchmarking with other local authorities and health organisations

Review date:	22nd November 2024: Risk reviewed by Patrick Warren-Higgs and Sarah Bye
Next review date:	February 2025

The Risk:	**9. Adults, Health and Commissioning unable to deliver commissioned services within budget**
Risk owner/s:	Patrick Warren-Higgs, Executive Director for Adults, Health and Commissioning and Richard Hills, Service Director for Commissioning
Residual Risk level:	**Likelihood = 3** **Impact = 4** **Score = 12** **Direction of risk:** Remains the same
Triggers:	There is a continued risk across the whole of ASC to manage budgets and deliver savings, because of: • reliance on government funding grants such as MSIF to deliver BAU • growing demand on services • significant inflationary and workforce pressures on the provider market, impacting on the cost of care • Some capacity constraints, resulting in higher costs to place care, particularly in relation to specialist care • key partners are also under significant strain, which may impact on AHC directorate if demand management is not managed or increases • Fair cost of care funding cut during the MTFS cycle. • We cannot provide appropriate accommodation, or the right level of care and support be identified in a crisis for the most challenging individuals, this includes a lack of LD hospital beds. • Individuals are placed in settings that are not able to fully meet their needs, including extended use of section 136 suite or other place of safety, including extended use of section 136 suite or other place of safety. • The business planning for the next 3 years has savings targets for ASC. These targets will increase the risk to commissioning of staying within budget. • Our commitment to real living wage as opposed to the national living wage puts additional pressure on our ability to commission within budget.
Consequences:	• Poorer outcomes for adults
Controls:	**1. <u>Additional Funding</u>** • Continue to raise with Central Government regarding additional funding required in Adults Services • Work is ongoing on resolving issues with ICP over jointly funded packages of support (Continuing health care (CHC), section 41 and section 117). Further action will be taken if back payments cannot be secured. • Work is ongoing with the ICP to review the arrangements associated with the Learning Disabilities (Pool) and associated risk share agreements. 2. **<u>Finance, Activity & Performance Board</u>**

	• Performance & Activity is under regular review alongside financial data and savings delivery • CCC Commissioning Board in place to review commissioned services and services planned to be re-commissioned. • Uplift Board in place to manage uplift requests from providers **3. Managing Demand** • Transformation projects will contribute to making investment to save, this will include programmes such as the Adults Positive Challenge Programme / Demand Management / Front Door / Health and Social Care Integration • Early Help Services are operating more effectively to meet demand **4. Robust Business Planning Process** • ALT development of Adults Business and Service Plans • ALT dedicated Business Planning Sessions planned
Review date:	22nd November 2024: Risk reviewed and updated by Patrick Warren-Higgs and Sarah Bye
Next review date:	February 2025

The Risk:	**10. Insufficient resource to maintain service levels**
Risk owner/s:	Patrick Warren-Higgs, Executive Director for Adults, Health and Commissioning and Val Thomas, Acting Director of Public Health
Residual Risk level:	**Likelihood = 4** **Impact = 3** **Score = 12** **Direction of risk:** Remains the same
Triggers:	• Future Public Health grant allocations are insufficient to cover inflationary pressures. • Insufficient internal staffing capacity to meet current service levels, ambitions of the health and wellbeing strategy, and sufficiently monitor contract performance. • Inability to sustain current staffing due to ending of short-term grant funding or cessation of externally funded posts. • Increase in reserves due to de-coupling process could lead to reduction in future grant allocations.
Consequences:	• Worse health outcomes for service users if there is a reduction in services offered due to insufficient funding. • Population health outcomes do not improve and potentially worsen • Additional pressures on the wider health and social care system. • Health inequalities are not reduced and could widen further.
Controls:	**1. Management of reserve spend** Description: Active management of reserve spends to reduce the risk of significant underspend. Effectiveness: Good Critical success factors: Reserves fell across 23/24 2**. Ongoing Work with service providers**

	Description: Working with service providers to identify more efficient service delivery, e.g., hybrid/digital delivery models, revised skill mix. Effectiveness: Good Critical success factors: Efficiencies found in some areas, for example the healthy child programme. **3. Public Health prioritisation tool** Description: PH Prioritisation tool will be used to assess internal commissions both current and future to ensure value for money as requested by OHID & CLT. Effectiveness: Good Critical success factors: Prioritisation tool in place. **4. Appointment Description: Following appointment of substantive DPH, the service will be reviewed to support delivery of public health objectives.** Effectiveness: Reasonable Critical success factors: of substantive Director for Public Health **5. Working with partners** Description: Working with partner organisations to maximise the added value of service provision. Effectiveness: Good Critical success factors: Additional funding secured from the ICB, for services across public health including Weight management the MASH, shared analyst posts, Probation service etc.
Review date:	22nd November 2024: Risk reviewed by Patrick Warren-Higgs and Sarah Bye
Next review date:	February 2025

The Risk:	**11. There is a risk that the council and partnership response to future outbreaks/pandemics (including new variants of Covid-19) of infectious disease will be insufficient.**
Risk owner/s:	Patrick Warren-Higgs, Executive Director for Adults, Health and Commissioning and Val Thomas, Acting Director of Public Health
Residual Risk level:	**Likelihood = 3** **Impact = 4** **Score = 12** **Direction of risk:** Remains the same
Triggers:	• Insufficient comprehensive CPLRF lessons learnt process is conducted. • Insufficient national steer as to the expectations of local authorities regarding health protection moving forward. • Insufficient system resilience and system resource to respond to a future outbreak. • Insufficient resource within the local authority to mobilise quickly in the event of a future outbreak. • Reduction in resource in UKHSA has resulted in reduced leadership for outbreak management.
Consequences:	• Worse health outcomes for the population of Cambridgeshire if another outbreak of a pandemic pathogen occurs. • Avoidable morbidity and mortality occur. • Increased pressure on the wider health and social care system and other partner organisations who would be affected.

Controls:	**1. <u>Lessons learned exercise</u>** Description: Support for and participation in CPLRF lessons learned exercise. Effectiveness: Good Critical success factors: **<u>2. Resource allocation</u>** Description: Allocation of resource for resilience measures, such as FFP3 fit testing capacity. Effectiveness: Good Critical success factors: **<u>3. Portal registration</u>** Description: CCC registered with UKHSA's data sharing 'All Hazards Portal' Effectiveness: Good Critical success factors: **<u>4. Planning exercises</u>** Description: Participation in system-wide planning exercises. Effectiveness: Good Critical success factors: **<u>5. Production of a local Pandemic Plan</u>** Description: Pandemic Plan approved and adopted by CPLRF Effectiveness: Good
Review date:	22nd November 2024: Risk reviewed by Patrick Warren-Higgs and Sarah Bye
Next review date:	February 2025

The Risk:	**12. There are reputational and legal impacts when the Council's arrangements for Safeguarding Adults with Care and Support needs fail.**
Risk owner/s:	Patrick Warren-Higgs, Executive Director for Adults, Health and Commissioning and Kirstin Clarke, Service Director for Adult Social Care
Residual Risk level:	**Likelihood = 3** **Impact = 5** **Score = 15** **Direction of risk:** Remains the same
Triggers:	1. Inability to recruit, train and retain the level of skills required across the workforce to support safeguarding activity. 2. Governance arrangements for safeguarding are not robust or fail. 3. There is non-compliance within safeguarding practice guidance or processes. 4. Assurance measures fail or are not robust. 6. Internal organisational change impacts system safety. 7. External system/regulatory changes impact system safety. 8. Major incident results in spike in demand for services and/or inability to access Council systems, records, or buildings.

	9. Commissioned Services fail placing increased demand on the system and safety is compromised
Consequences:	1. Negative consequences are experienced by those with care and support needs and unpaid carers. 2. People lose trust in Council services and/or commissioned services. 3. Council is deemed to have failed in statutory duties. 4. CQC rating is impacted. 5. Decrease in government funding. 6. Legal challenges against the Council 7. Increase in complaints against the council, including LGSCO.
Likelihood factors:	**1) Vacancy Rates** Vacancy rates in Safeguarding and Operational teams impacting on capacity to undertake safeguarding activity. **2) Volume of safeguarding referrals** Increasing volume of safeguarding referrals, some of which are inappropriate, requiring triage and management. **3) Wider System Changes that impact Adult Social Care** Provider changes, with Registered Manager and Leadership changes, without oversight on implications from Adult Social Care. Police response to those living risky lives. **4) Provider changes** Partnership agencies may change systems or process which impacts adversely on ASC such as Right Care Right Person, impacting on increased activity within ASC and lack of available. **5) Regulator** Regulator not maintaining regular oversight on providers and engaging with Adult Social Care in a timely way.
Controls:	**1) <u>Adult Social Care Assurance.</u>** The organisation engages in the ongoing process of revising its practices and procedures to align with emerging local and national trends. This includes learning from local and national reviews such as Serious Case Reviews to continuously improve safeguarding measures. Critical Success Factors: Regular reporting and providing practitioners with tools and support for following best practices are critical success factors. Regular reporting includes monthly highlight reports that are shared with the Head of Service, MASH governance reports that are submitted to the MASH Governance Board. Annual self-assessments are submitted to the SAB Board which cover all safeguarding. We have the thematic audit cycle completed by Quality Standards and Practice Team and reported to Practice Governance Board, each team has service level improvement plans, and we have monthly managerial audits with a quarterly report and action plan - all held by Quality Standards and Practice Team and team managers are accountable for these. These are reported to Practice Governance Board. Adult Social Care Practice Update newsletter is circulated fortnightly and is sent out to all staff within the Adults, Health and Commissioning directorate, keeping staff up to date with relevant information to support them and those they work with.

	Assurance: Good assurance of effectiveness comes from the Eastern Region Sector Led Improvement Programme, Adults practice governance board, LGA (Local Government Association) Peer Review with associated improvement plans, and preparations for CQC readiness over the next 12 months. Effectiveness: Good **2) Skilled ASC Workforce** To ensure high quality safeguarding, staff receive comprehensive training, ongoing professional development opportunities, and regular supervisions that reinforce safeguarding procedures and best practices, enabling them to maintain professional registration. Critical Success Factors: A dedicated safeguarding training resource, with robust training programmes, annually reviewed, available multi-agency policies, themed audits are undertaken, robust training programs available, and an adult practice governance board provide assurance and oversight. The CCC Safeguarding training strategy outlines the training offered along with safeguarding training that is essential to each role across adult social care. Work is being completed on monitoring training compliance rates, and teams are asked to complete a manual check of all MCA / Safeguarding training. Assurance: There is a dedicated resource for safeguarding training within Learning and Development, Safeguarding has a focused training strategy document which is refreshed annually linking in operational / practice needs with Learning and Development colleagues. The Principle Social Worker has close oversight of this. Effectiveness: Good **3) Multi Agency Safeguarding** Multi-agency Safeguarding Boards and Executive Boards provides multi agency focus on safeguarding priorities and provides systematic review of safeguarding activity. Coordinated work between multi-agency partners. Police, County Council, Health and other agencies who are key members of the Board and subgroups. Critical Success Factors: Regular reports are submitted to the SAB Board including MASH Governance reports, and annual self-assessments and shared working outcomes Assurance: SAB annual report highlighting progress against priority areas shared with Adults & Health Committee. Effectiveness: Good **4) Internal Quality Assurance** Robust process of internal Quality Assurance (QA framework) including case auditing and monitoring of performance. Critical Success Factors: Regular auditing and reporting. Ability to highlight good practice and areas for improvement, robust service level improvement plans developed as needed. Annual safeguarding thematic audit, monthly managerial audits and quarterly reports to Practice Governance Board. Team level action plans held by managers and meet with Principal Social Worker to discuss on a quarterly basis. Assurance: Monthly Management Audits. Annual programme of Themed Audits. Adults practice governance board. Agreed Improvement Plan with Senior Responsible Leads. Effectiveness: Good **5) Commissioned Services**

	Regular monitoring of social care providers and information sharing meetings with other local organisations, including the Care Quality Commission and ICB are in place. ASC have a structure in place to raise, discuss and address provider quality concerns across the health and social care system. If improvements are not made, escalation routes are in place and progress and risks are continually shared with the CQC regulator. Critical Success Factors: Regular auditing and reporting. Ability to support providers at risk. Assurance: Contracts monitoring team, care home support team & provider of concern process. Effectiveness: Good **6) Coordinated work with system partners and agencies** Coordinated work between multi-agency partners for both Adults and Children's. Police, County Council, and other agencies to identify child sexual exploitation, including supporting children and young people transitions to adulthood, with the oversight of the Safeguarding Boards. Critical Success Factors: Effective and safe implementation. We have a number of task and finish groups - for example transitional safeguarding, MCA we have regular system wide groups - QEG. Assurance: SAB and key statutory partners. Effectiveness: Good **7) Information Sharing with regulatory bodies.** Continue to work with the CQC to share information. Critical Success Factors: Regular reporting. Assurance: Contracts monitoring team. Effectiveness: Good **8) Manage demand** Managing increasing demand and acuity to ensure adults receive right support at the right time. Regular DMT's to discuss and escalate issues. Critical Success Factors: Daily monitoring of referrals and waiting time is in place to reduce waiting times and review priority levels to provide proportionate and time critical responses to those at risk. Assurance: Escalation to CLT as required. Effectiveness: Good.
Review date:	14th November 2024: Risk reviewed and updated by members of ALT and Patrick Warren-Higgs.
Next review date:	February 2025

Adults and Health Policy and Service Committee Agenda Plan

Published 3 December 2024

Notes

The definition of a key decision is set out in the Council's Constitution in Part 2, Article 12.
* indicates items expected to be recommended for determination by full Council.
+ indicates items expected to be confidential, which would exclude the press and public.

The following are standing agenda items which are considered at every Committee meeting:

- Minutes of previous meeting and Action Log
- Agenda Plan, Training Plan and Appointments to Outside Bodies and Internal Advisory Groups and Panels

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for reports	Agenda despatch date
12/12/24	Application of Adult Social Care Charges Review	K Clarke	Not applicable	29/11/24	04/12/24
	Internal Audit report on the Adults Directorate Business Planning Review and Challenge Audit	S Bye	Not applicable		
	Homelessness and Housing Related Support	S Torrance / L Sparks	2024/035		
	Extra Care Contract Extensions	S Torrance and L Sparks	2024/006		
	Adult Social Care – Accommodation for Working Age Adults: Strategic Thinking	S Torrance	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for reports	Agenda despatch date
	Finance Monitoring Report	J Hartley	Not applicable		
	Adults Corporate Performance Monitoring Report – Quarter 2	S Bye	Not applicable		
	Public Health Corporate Performance Monitoring Report – Quarter 2	V Thomas	Not applicable		
	Risk Register	S Bye	Not applicable		
	Health Scrutiny items				
	Urgent and Emergency Care	R Greenhill	Not applicable		
	Health scrutiny work plan	R Greenhill	Not applicable		
	Health scrutiny recommendations tracker	R Greenhill	Not applicable		
23/01/25	Re-Commissioning Drug and Alcohol Treatment Services for Adults and Children and Young People	V Thomas	2025/005	10/01/25	15/01/25
	Scrutiny of Draft Business Plan and Budget	P Warren-Higgs	Not applicable		
	Re-commissioning Behaviour Change Services	V Thomas	2025/006		
	Health Scrutiny items				
	Health Inequalities	R Greenhill	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for reports	Agenda despatch date
	Access to Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) Mental Health Services (Re-scheduled from December)	R Greenhill	Not applicable		
	Health scrutiny work plan	R Greenhill	Not applicable		
	Health scrutiny recommendations tracker	R Greenhill	Not applicable		
06/03/25	Finance Monitoring Report	J Hartley	Not applicable	21/02/25	26/02/25
	Adults, Health and Commissioning Corporate Performance Monitoring Report – Quarter 3	S Bye	Not applicable		
	Risk Register	S Bye	Not applicable		
	Health Scrutiny items				
	Dental Provision in Cambridgeshire	R Greenhill	Not applicable		
	Annual Health Checks for people with Learning Disabilities	R Greenhill	Not applicable		
	Approval Process for Responses to NHS Quality Accounts 2024/25	R Greenhill	Not applicable		
	Draft Health Scrutiny Annual Report 2024/25	R Greenhill	Not applicable		
	Health scrutiny work plan	R Greenhill	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for reports	Agenda despatch date
	Health scrutiny recommendations tracker	R Greenhill	Not applicable		
19/06/25	Notification of the Chair and Vice Chair of the Adults and Health Committee 2025/26	R Greenhill	Not applicable	06/06/25	11/06/25
	Appointment of Co-opted Members for Health Scrutiny Business	R Greenhill	Not applicable		
	Finance Monitoring Report	J Hartley	Not applicable		
	Finance Monitoring Report: Outturn 2024/25	J Hartley	Not applicable		
	Adults, Health and Commissioning - Performance Monitoring Report – Quarter 4	S Bye	Not applicable		
	Health Scrutiny items				
	Health scrutiny work plan	R Greenhill	Not applicable		
	Health scrutiny recommendations tracker	R Greenhill	Not applicable		
[18/09/25] *Reserve date*				*[05/09/25]*	*[10/09/25]*
09/10/25	Finance Monitoring Report	J Hartley	Not applicable	26/09/25	01/10/25
	Health Scrutiny items				
	Health scrutiny work plan	R Greenhill	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for reports	Agenda despatch date
	Health scrutiny recommendations tracker	R Greenhill	Not applicable		
09/12/25 (Tuesday)	Finance Monitoring Report	J Hartley	Not applicable	26/11/25	01/12/25
	Health Scrutiny items				
	Health scrutiny work plan	R Greenhill	Not applicable		
	Health scrutiny recommendations tracker	R Greenhill	Not applicable		
22/01/26	Finance Monitoring Report	J Hartley	Not applicable	09/01/26	14/01/26
	Health Scrutiny items				
	Health scrutiny work plan	R Greenhill	Not applicable		
	Health scrutiny recommendations tracker	R Greenhill	Not applicable		
05/03/26	Finance Monitoring Report	J Hartley	Not applicable	20/02/26	25/02/26
	Health Scrutiny items				
	Health scrutiny work plan	R Greenhill	Not applicable		
	Health scrutiny recommendations tracker	R Greenhill	Not applicable		
18/06/26	Notification of the Chair and Vice Chair of the Adults and Health Committee 2026/27	R Greenhill	Not applicable	05/06/26	10/06/26

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for reports	Agenda despatch date
	Finance Monitoring Report	J Hartley	Not applicable		
	Finance Monitoring Report: Outturn 2025/26	J Hartley	Not applicable		
	Health Scrutiny items				
	Health scrutiny work plan	R Greenhill	Not applicable		
	Health scrutiny recommendations tracker	R Greenhill	Not applicable		

Please contact Democratic Services democraticservices365@cambridgeshire.gov.uk if you require this information in a more accessible format.

Health Scrutiny

Urgent and Emergency Care: Cambridgeshire and Peterborough Integrated Care System

To:	Adults and Health Committee
Meeting Date:	12 December 2024
From:	Chief Operating Officer Cambridgeshire and Peterborough Integrated Care System
Electoral division(s):	All

Officer contact:
Name: Stacie Coburn
Post: Chief Operating Officer, Cambridgeshire and Peterborough Integrated Care System

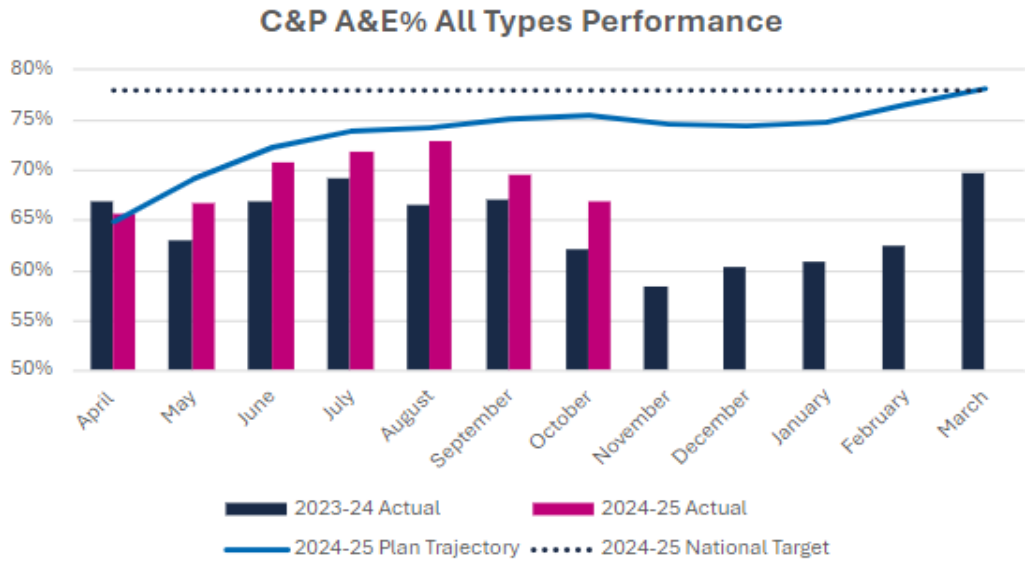
1. Background

1.1 The purpose of this report is to outline the current position in relation to Urgent and Emergency Care (UEC) across Cambridgeshire and Peterborough Integrated Care System (C&P ICS). It addresses key lines of enquiry regarding progress against actions taken to improve UEC performance at provider level, plans to manage both winter pressures and actions taken by the wider system contributing to improvements in patient flow, UEC performance and patient experience and safety.

2. Performance Summary

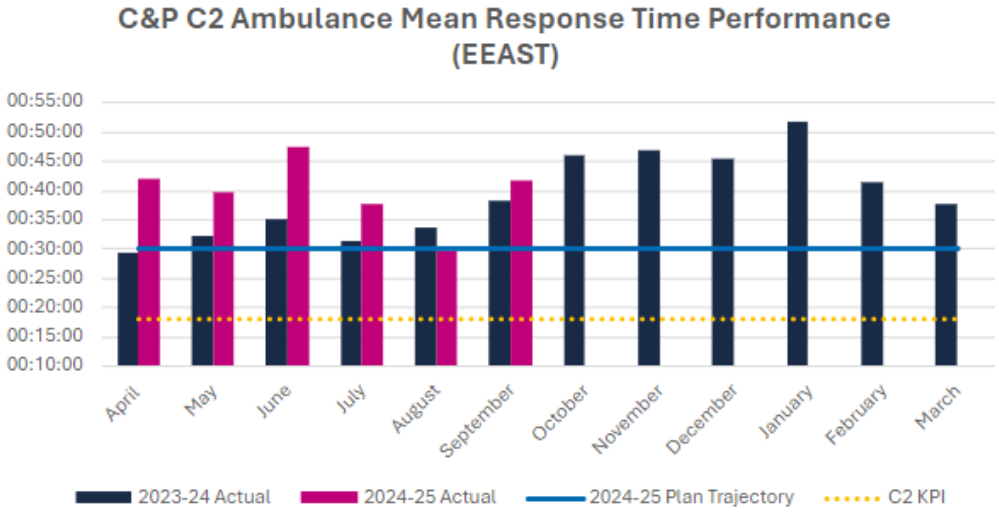
2.1 During 2024/25, Urgent and Emergency care (UEC) performance across C&P ICS has been below the planned trajectories submitted as part of the Integrated Care Board (ICB) operational plan and below the national standards. Two key national metrics for UEC are that Emergency departments should see and treat a minimum of 78% of patients within 4 hours of arriving in the department by the end of March 2025 (4-hour target) and people in the community categorised by the ambulance trust as C2 patients, should have an ambulance response time within 30 mins (C2 response time), both targets remain behind plan.

2.2 Improvements in 4-hour performance have been seen compared to performance for the same period in 2023 and between April and August 2024 there was a continued improvement in the delivery of the 4-hour target. This improvement was not to the planned level and performance has significantly declined through September and October, which was reported at 66.8%.



	April	May	June	July	August	September	October	November	December	January	February	March
2023-24 Actual	67%	63%	67%	69%	66%	67%	62%	58%	60%	61%	62%	70%
2024-25 Actual	66%	67%	71%	72%	73%	69%	67%					
2024-25 Plan	65%	69%	72%	74%	74%	75%	76%	75%	74%	75%	77%	78%
2024-25 National Target	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%

2.3 Category 2 (C2) ambulance mean response time performance is failing to meet the 30 - minute target. In the first six months of 2024/25, response times in C&P remained higher than reported for the same period in 2023/24, with only August performance falling below the 30 minute target at 29 minutes 33 seconds.



	April	May	June	July	August	September	October	November	December	January	February	March
2023-24 Actual	00:29:12	00:32:12	00:35:06	00:31:23	00:33:29	00:38:04	00:45:56	00:46:45	00:45:22	00:51:31	00:41:20	00:37:38
2024-25 Actual	00:41:51	00:39:40	00:47:12	00:37:34	00:29:36	00:41:33						
2024-25 Plan Trajectory	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00
C2 KPI	00:18:00	00:18:00	00:18:00	00:18:00	00:18:00	00:18:00	00:18:00	00:18:00	00:18:00	00:18:00	00:18:00	00:18:00

2.4 A system wide UEC improvement plan is in place in addition to provider recovery action plans, to support performance improvement. The Integrated Care Board (ICB) Quality, Performance and Finance Committee review the plan monthly, with the ICB Board also receiving regular updates on progress. Detailed operational conversations also take place with all providers through contract assurance meetings, UEC tiering/assurance meetings and system Unplanned Care Board.

3. Provider plans to address UEC performance

3.1 In August 2024, C&P ICS was moved into NHS England (NHSE) national UEC tiering oversight programme. As part of this, the system was offered national support from the NHS Rapid Improvement Team, a team of multi-disciplinary professionals with a focus for C&P on Internal professional standards (IPS), Same Day Emergency Care (SDEC) and length of stay (LoS).

3.2 Both Trusts have recovery plans in place to build operational resilience, improve performance against the 4-hour A&E wait target and respond dynamically to winter pressures. Below is an overview of key areas of focus:

3.3 North West Anglia Foundation Trust's (NWAFT) Back on Track winter plan for 2024/25 focusses on:

- Maximising patient flow: re-establishing mechanisms to identify discharges earlier, maximising use of virtual ward provision, extending the Discharge Lounge hours and capacity, increased capacity in assessment areas, development of a Frailty Same Day Emergency Care (SDEC), extension of SDEC opening hours.
- Increasing physical capacity: Opening an additional ward with plans for further wards through the reconfiguration of the Peterborough City Hospital site 4th floor into additional bed capacity
- Workforce planning: Workforce and medical rota reviews and escalation plans for additional staffing to ensure correct levels of staffing and skill mix availability
- Visible Leadership adding value: increased visibility of senior leadership teams in clinical and non-clinical areas, cancellation of non-urgent meetings to join huddles, support ward rounds, manager-on-call presence on site out of hours

3.4 Cambridge University Hospitals NHS Foundation Trust's (CUHFT) Recovery Plan focusses on four main workstreams:

- Acute Front door: review of ambulance handover space, model reviews for Urgent Treatment Centre (UTC) and SDEC, rota alignment to demand, review of frailty model
- Acute Inpatient Flow: a 33% target for early discharge (pre-12pm), further development of virtual ward pathways, a focussed weekend delivery team to begin discharge planning on a Thursday, improving board rounds and mechanisms to plan and allocate discharge tasks.
- Site Management – introduction of seasonal escalation processes and triggers
- Capacity and Configuration: detailed, comprehensive review of the bed base.

3.5 Progress against Trust recovery plans and the work underway with the Rapid Improvement teams is reviewed with the ICB and NHS England at fortnightly tiering meetings to gain assurance and oversight on delivery and to have focused discussions on headline indicators, key areas of risk, mitigations and deviation from recovery trajectories outlined in their plans.

3.6 Tiering has proved a useful forum for sharing best practice and learning between the Trusts and the Ambulance service as well as an understanding of individual organisational challenges and nuances.

4. Winter Planning and System Engagement

4.1 In September 2024, NHSE sent a letter to all ICBs outlining the national winter and H2 priorities and following review, C&P aligned the winter schemes within the UEC Improvement Plan to the areas of focus outlined within it. The key areas of focus are:

- National Flu immunisation programme and Covid 19 vaccination rollout
- Optimisation of Same Day Emergency Care (SDEC), Single Point of Access (SPoA) and virtual ward provision
- Hospital avoidance and provision of alternatives to ED (AtED), providing high quality, safe care to patients in their own homes/place of residence
- Provision of a community Frailty service
- Pro-active management of Long-Term Conditions (LTC)
- Collaborative working with community partners, local government and social care

4.2 Using a data driven approach and in collaboration with system partners, the ICS has revised its UEC improvement plan to accelerate some interventions ahead of winter. The ICS plan is focused only on those areas where a collaborative multi agency approach is required and in areas where it was determined there could be the biggest impact this year. A copy of the plan shared with ICB Board in September 2024 is attached as appendix A.

4.3 The system winter schemes are categorised under four key areas: Health Optimisation; Acute illness and UEC Hub, Home First and Demand and capacity. A summary of some of the key interventions and their progress are outlined below:

- UEC Hub development - All ICBs are developing UEC Hubs in line with NHSE guidance. The C&P ICS hub will be a single point of access for referrals and advice and guidance for alternative UEC pathways to hospital emergency departments. The hub will build on the current successes of the advice and guidance service for ambulances (Call before Convey) and will maximise utilisation and efficiency of current Urgent Community Response (UCR) services and integrate our system wide alternatives to ED pathways. This will include community based UCR services, Virtual Wards, voluntary sector services, Local Authority services, as well acute based services such as SDEC. The hub will operate 7 days a week from 8am – 8pm and has a planned go live date of 9th December 2024.

- Additional Same Day Emergency Care Capacity Hubs - Three services will be established across C&P ICS with bases at Sawston, Peterborough City Care Centre and a site yet to be agreed at Hinchingbrooke. These services will offer a total of 240 additional primary care appointments per day for patients needing urgent same day treatment. Referrals into the hubs will be made via 111 ED Streaming, 111 and directly from emergency departments. These services are due to go live in January 2025.

- 111 ED Streaming - All patient's self-presenting at the emergency Department (with clinical exception) on any of the three hospital sites will be triaged by a 111 Health Advisor using technology and care navigation on arrival. All patients not suitable for ED will be redirected to an alternative service and where possible will leave with an appointment in hand. 111 ED streaming in planned for go live January 2025.

- Acute Frailty (North and South) - Work is being progressed by both NWAFT and CUHFT to implement an Integrated Frailty Service with a view to reducing the number of ambulance conveyances, admissions, and readmissions for frail patients as well as reducing the amount of time those who need to be admitted spend in hospital by:
  - Offering rapid access frailty clinics for patients identified as moderately or severely frail, available in both acute and community settings, offering a comprehensive multidisciplinary team (MDT) Geriatric assessment and the development of ongoing care plans.
  - In reach to Care Homes supported by a Geriatrician to identify and support frail patients earlier to avoid ambulance dispatch and/or hospital admission and remain in the home.
  - Increased utilisation of Virtual Ward capacity, to both step-down patients i.e. support earlier discharge from the Acute Trusts and develop step up pathways from UCR and other services to enable patients to remain safely at home.

  It is expected that the Frailty offer will go live from January 2025.

- Discharge capacity and pathway one (PW1) - Pathway one health discharge delays make up 40% of all discharge delays across C&P ICS. To increase capacity, Cambridge and Peterborough Foundation Trust (CPFT) will be mobilising additional cars to facilitate Pathway 1 (PW1) discharges with wrap around care (management, therapies, and other support) also provided. This increase in capacity will begin to roll out in November and will ramp up to full capacity by January 2025.

4.4 Performance and delivery against the winter improvement schemes will be monitored via the ICB's PMO, with fortnightly Executive oversight. Monthly reporting on deliverable, KPIs, risks and mitigations will be presented to ICS unplanned care board, with formal evaluation and assessment of schemes taking place in February-April 2025.

5. Summary

5.1 Maintaining and continually improving urgent and emergency care is of critical focus for all C&P system partners over the coming 6 months. The UEC Improvement Plan and its key areas of focus were developed in collaboration with system partners and progress against UEC performance and the winter schemes is regularly reviewed and monitored through ICB governance.

6. Source documents

6.1 NHS England - Delivery plan for recovering urgent and emergency care services - Jan 2023

C&P UEC IMPROVEMENT PLAN

UPDATED SEPTEMBER 2024

PURPOSE

This document sets out the Cambridgeshire and Peterborough ICB Urgent and emergency care improvement approach and priorities in 24/25.

It builds on the existing UEC strategy, reflects progress and learning year to date, and outlines the priorities to ensure momentum on performance improvement is maintained through winter. It highlights current risks, mitigations and how the governance structure will ensure oversight and assurance of delivery of the plan.

CONTEXT

Urgent and Emergency Care (UEC) delivery remains a high priority nationally and locally. The national standard for four- hour performance has been set for 2024/25 at 78% and C2 ambulance response times are expected to be below the interim target of 30 minutes.

In March 2024 C&P ICS reviewed the UEC strategy which underpins the delivery of system wide improvements across primary, community and secondary care UEC pathways. The delivery of the strategy was through two streams – delivery of system-wide improvement programmes and provider internal improvement programmes. It was developed and agreed with all system partners building on national best practice, the national UEC recovery plan and utilising local data, and benchmarking. National funding received for urgent and emergency care improvement was aligned to the priority areas identified in the strategy. Governance of the strategy is through the System Unplanned Care Board.

The programmes outlined in the strategy have been progressed during the first half of 2024/25 (H1) and C&P ICS has seen improvements in key metrics including 4-hour emergency department target, flow and discharge metrics. During H1, the New Care Models vision has been developed in response to the long-term challenges that the New Hospitals Programme identified where if there was no change in delivery of care there would be an expected deficit of 379 acute care beds by 2030. The local healthcare system is also facing other significant challenges such as ensuring the sustainability of Primary Care, increasing demand for mental health support services, and increasing staffing challenges with health care professionals reporting high levels of job dissatisfaction and burnout. As part of the New Care Models, the acute illness clinical model has started to emerge over the past few months.

Building on the acute illness clinical model, the current performance and anticipated risks ahead of winter, system wide discussions have been underway, including a workshop in July, to determine areas for accelerated delivery of the strategy ahead of winter to manage expected demand and ensure people access services in the right setting.

- **Feb 24**: C&P commences tiering meetings for enhanced oversight on UEC performance
- **Mar 24**: C&P UEC strategy agreed and supporting investment areas
- **Apr 24**: 24/25 plans go live, underpinned by continuous improvement approach
- **Jun 24**: Local C&P effectiveness review, learn and adapt for ongoing improvement plans
- **Aug 24**: Change in national tiering ranking, UEC plan updated to include learning and winter preparedness

UEC STRATEGY

VISION

System partners working collaboratively to provide Cambridgeshire & Peterborough's population with high quality, safe urgent and emergency care by delivering preventative initiatives close to home, enhanced urgent community response and admission avoidance schemes to reduce ambulance conveyances and minimise time spent in hospital, whilst supporting continuous improvements in hospital pathways for those who require access to secondary care.

AIMS

- To deliver high quality, safe urgent and emergency care
- To develop and deliver preventative services closer to home
- To continue to develop and improve services to avoid unnecessary hospital admission or/and ambulance conveyances
- To develop effective post hospital and discharge services to minimise time spent in hospital, optimize patient flow, and ensure patients are discharged to the most appropriate setting
- To continue to improve urgent and emergency pathways in primary, community and secondary care

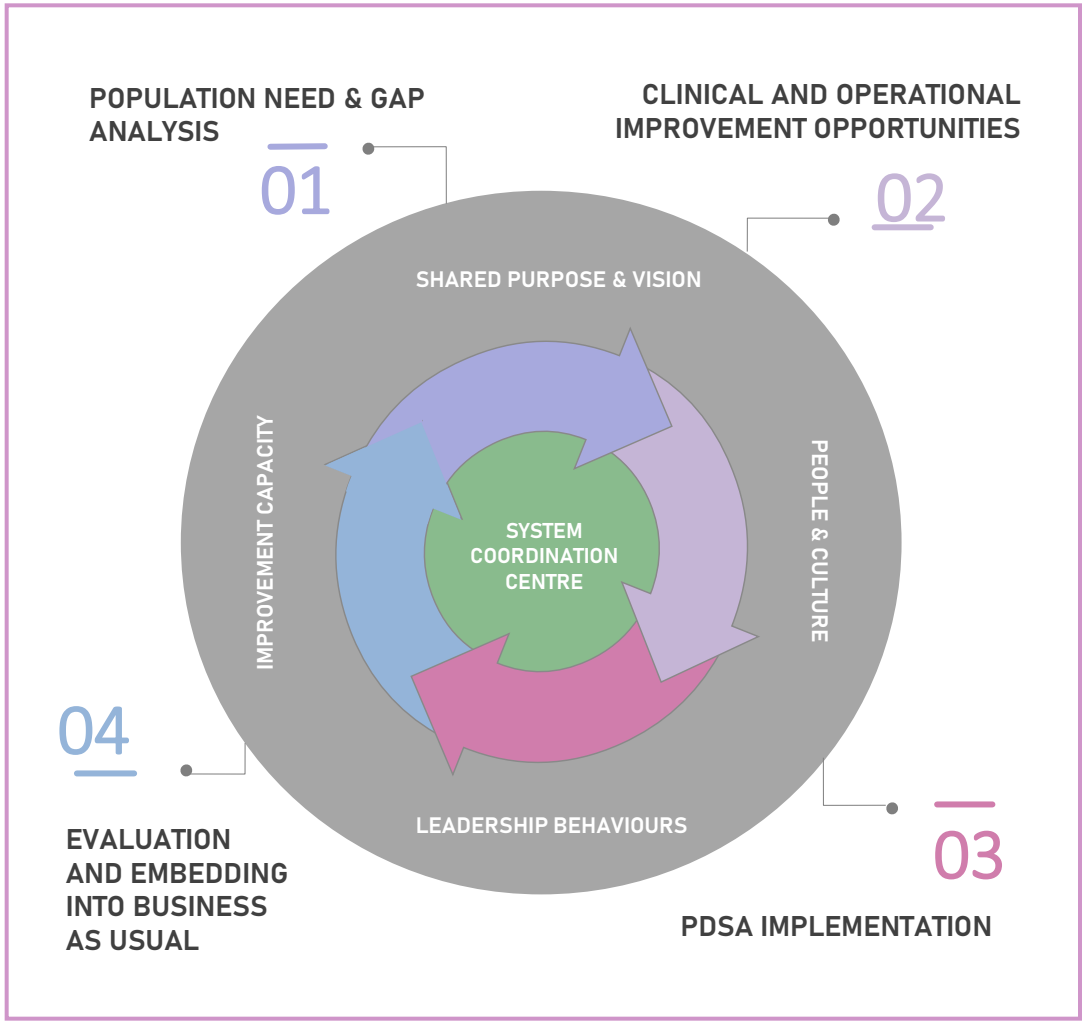
OBJECTIVES

1. Establishing a well-co-ordinated integrated community urgent care response service enabling patients to be supported at home where clinically appropriate
2. Ensuring ambulances reach patients in line with national target response times and can handover patients to hospital services quickly
3. Supporting Acute Trusts to deliver and sustain the 4-hour ED performance target
4. Minimising delays experienced by patients at any stage of their hospital stay thereby reducing average LOS and improving bed occupancy
5. Ensuring timely discharge and access to appropriate community-based services and intermediate support to complete rehabilitation
6. Embedding and refining our System Control Centre (SCC) model to ensure tight day to day grip on flow and effective escalation processes are in place
7. To improve patient experience, waiting times, and outcomes.

KPIS

1. C2 response times
2. Avg. handover time
3. Urgent community response
4. A&E attendances
5. A&E 4hr performance
6. G&A Bed occupancy
7. Zero-day Length of Stay
8. Non-elective admissions
9. Admissions from care homes
10. Length of stay 14+ days
11. Not meeting Criteria to Reside (daily avg.)
12. Virtual Wards occupancy

OUR APPROACH



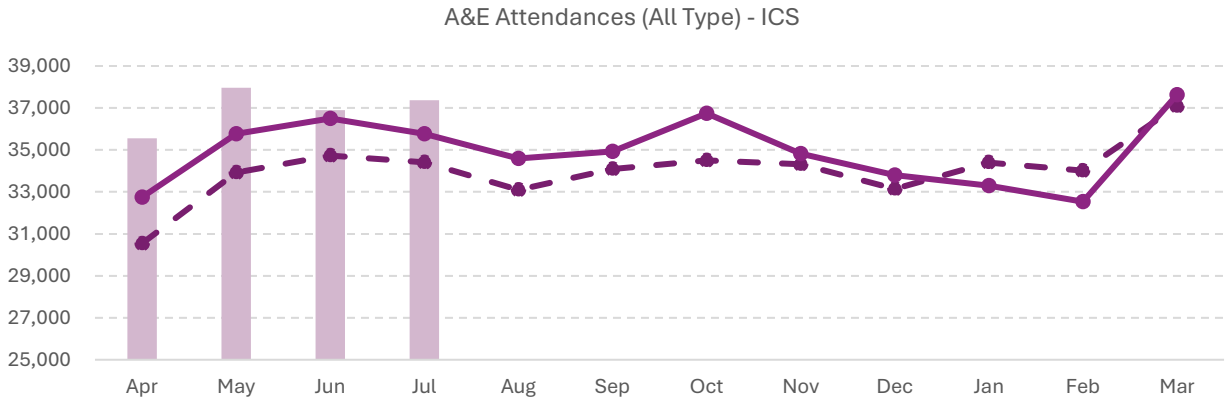
C&P ICS has a live UEC improvement plan in place, a version of which has been in place since winter 22/23. While taking the opportunity to do a full reset annually, aligned to operational planning guidance, the UEC plan is centred on the principles of continuous quality improvement. It brings together the key interventions required to support UEC improvement, developed by and agreed with all system partners through the Unplanned Care Board.

The UEC improvement plan supports a small number of collective interventions where a collaborative system approach is required. The ICS plan does not replace provider plans but is supplementary to the actions being taken by individual providers to manage their own performance.

The interventions in this plan are the result of discussions at system level and analysis of quantitative and qualitative evidence to identify schemes that are most likely to have a high impact in the next six months.

BASELINE – KEY PRIORITIES

Extensive data analysis has been completed by the ICB Strategic Commissioning Unit to support winter preparedness and ongoing UEC improvement. This data points to two key issues for C&P in the coming 6 months – managing overall demand and enhancing alternatives for those patients who should be able to be supported through proactive and better reactive care pathways.



A&E attendances continue to be above plan. All type attendances are 11% higher than in 23/24 and 2.7% above plan year to date. The demand is increasing for walk in patients, with ambulance conveyances flat compared to 23/24. This is contra to the national position which shows 4% ambulance conveyance growth. 39% of all patients attending A&E, UTC or MIU settings in C&P are being discharged with no diagnostics and no intervention, above the national average of 28%.

Avoidable Admissions: Top 10 Complaints (NHS Cambridgeshire and Peterborough ICS)

	May-2023	Dec-2023	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024[†]	% of All Avoidable Admissions	Diff to Last Month	Diff to May 2023
NHS CAMBRIDGESHIRE AND PETERBOROUGH ICS										
Falls 74yrs+	355	425	425	345	380	415	380	20.5%	-35	25
Non-specific chest pain	155	190	200	200	235	230	190	10.3%	-40	35
COPD	135	215	190	165	210	150	175	9.5%	25	40
Heart failure	155	135	160	200	145	140	165	8.9%	25	10
UTI	150	145	160	155	160	145	160	8.6%	15	10
Acute mental health crisis	135	115	120	130	130	100	130	7.0%	30	-5
Cellulitis	130	110	90	120	125	140	95	5.1%	-45	-35
Atrial Fibrillation	60	100	75	85	90	85	95	5.1%	10	35
Diabetes	95	95	120	105	100	90	75	4.1%	-15	-20
Asthma	50	75	65	80	70	60	70	3.8%	10	20

[†] Data is presented with a two month lag.

N.B. Numbers are suppressed, refer to metadata for methodology.

Avoidable admissions are above regional average in C&P, with c23% of all admissions potentially meeting the criteria over the last 6 months. The most common 10 complaints are shown in the table opposite with opportunities for improvement in this position through maximising proactive intervention (COPD & Heart Failure) and through expanding Urgent Community Response services as an alternative to the Emergency Department through the UEC hub (UTI, Non-specific chest pain and falls).

PERFORMANCE

Data: Jun 2024	ACTUAL	PLAN	MOM MOVEMENT	ON TRAJECTORY
C2 RESPONSE TIME (MINS:SECS)	41:27 YTD	30:00	-09:30	✗
AVERAGE HANDOVER TIME (MINS:SECS)	41:06 YTD	30:00	-18:06	✗
URGENT COMMUNITY RESPONSE <2 HOURS	85%*	70%	+4%	✓
A&E ATTENDANCES	147,775 YTD	140,789 YTD	+466	✗
A&E FOUR HOUR PERFORMANCE	69% YTD	70%	+1%	✗
G&A BED OCCUPANCY	93.7%	92%	-0.8%	✗
ZERO DAY LENGTH OF STAY	27.5%	40%	+1%	✗
NON-ELECTIVE ADMISSIONS	38,459 YTD	35,833 YTD	+657	✗
NON-ELECTIVE LENGTH OF STAY	5.8* Days	6.60 Days	-0.16	✓
NOT MEETING RESIDE CRITERIA (DAILY AVG)	298	127	-7	✗
VIRTUAL WARDS OCCUPANCY	83%	80.0%	+4%	✓

UEC performance across C&P in Q1, as shown opposite, was below plan in several areas. There were several specific drivers for poor performance including extensive infection prevention and control issues resulting in closed beds and ambulance handover delays, issues with workforce availability and demand significantly exceeding planned activity in May.

Since Q1, there has been a return to continuous improvement across UEC performance indicators. We have rapidly taken learning from Q1 and adapted our approach for Q2 and beyond. A&E performance has improved across providers and is now closing the gap to trajectory to achieve the 78% standard by the end of the year. Ambulance handover performance has improved dramatically, with C&P achieving average handovers and C2 response below the 30-minute targets in August. Reducing length of stay is supporting better bed occupancy along with greater utilisation of alternatives to ED and hospital, including UCR and Virtual ward services.

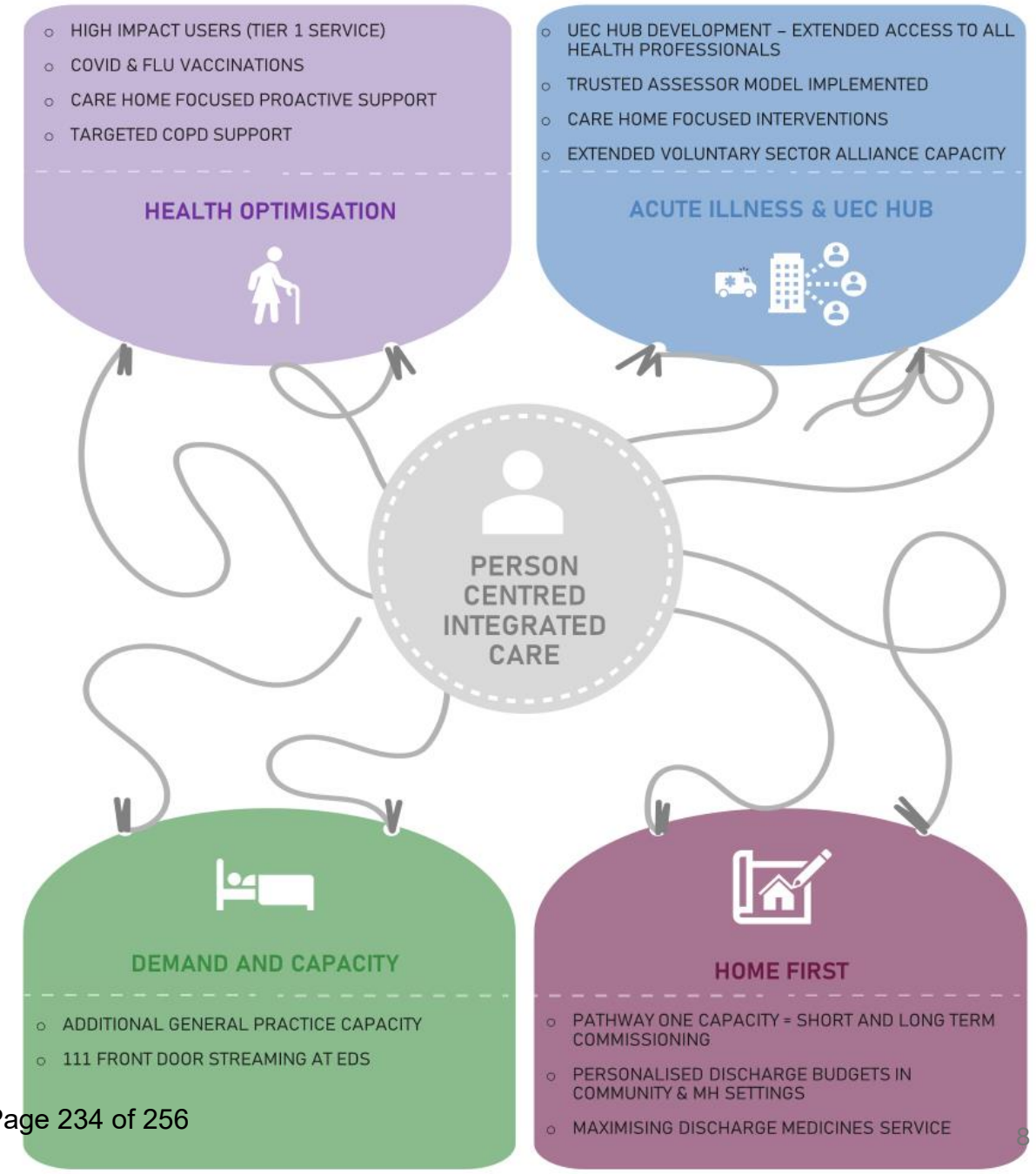
The NHS England national team is developing a winter dashboard that is likely to include a range of different metrics. Once available, these metrics will be used to monitor performance in UEC tiering and as part of our overarching UEC improvement plan.

KEY FOCUS AREAS NEXT 6 MONTHS

The updated UEC improvement plan has four key themes, reflecting the data and known opportunities aligned to healthcare utilisation model (optimisation and acute illness). The plan builds on the minimum national expectations as outlined in the NHS UEC improvement plan and the specific winter requirements expected to be published by NHS England in late September.

Each thematic area has a defined set of interventions and actions, contained within detailed delivery plans, which will be monitored through existing governance arrangements.

Further narrative on each area is shown on slide 9 and a summary delivery plan shown on slide 10.



KEY FOCUS AREAS NEXT 6 MONTHS

Health Optimisation:

- **Proactive intervention with high-risk cohorts** will support reversible risk, reducing the number of people experience acute exacerbations of illness and minimising the need for patients to require a hospital admission. **Focus on respiratory, care homes and seasonal illnesses.**

Acute illness & UEC hub:

- We know that when people are unwell, coordination of care is desired. Through the **expansion of the C&P hub** and alignment of all onward services through a **single trusted assessor model**, we can ensure that more people end up in the right service first time, both in and outside of hospital. By introducing a **single point of access for all healthcare professionals** in C&P, we can support all clinical professionals, including general practice, by enabling patients to receive the right service.

Demand and capacity:

- While winter demand peaks are not what they once were, with growth in demand all through the year, we know that access continues to be a challenge for our population. By targeting two specific interventions to manage and stream demand effectively, through **additional GP capacity linked** to our other urgent and emergency care services and through introducing robust **streaming at our EDs**, we can direct patients to the right service, ensuring those that are acutely unwell receive timely high-quality care.

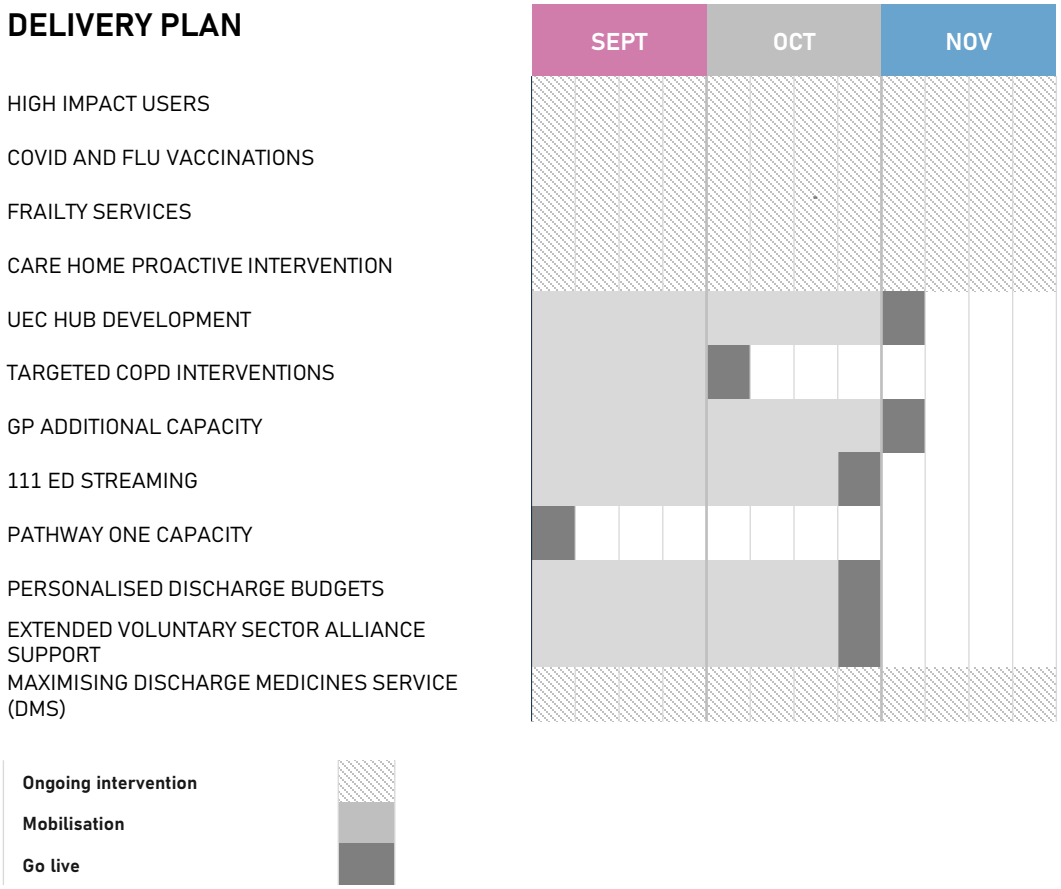
Home First:

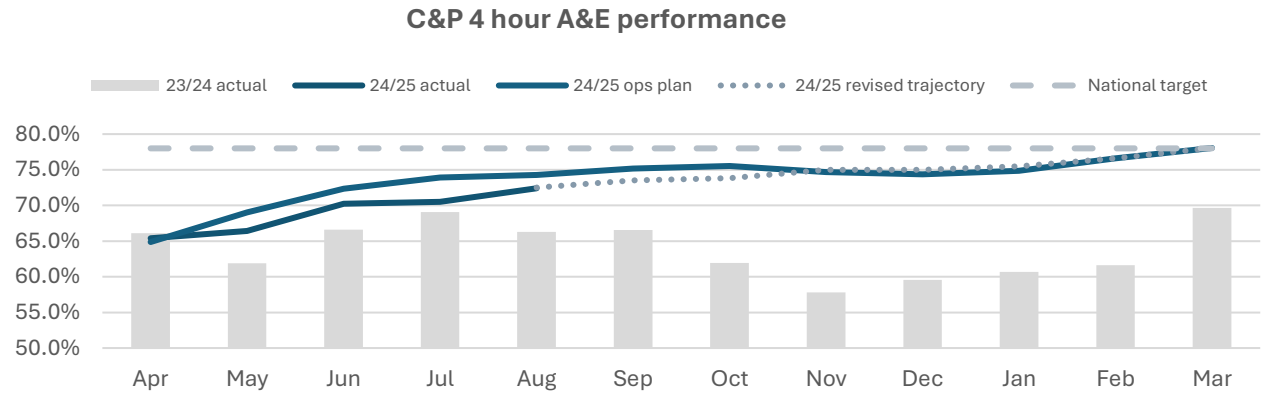
- Supporting patients to return home as soon as they are able is critical for their outcomes. The focus for this coming period is on maximising the work already done to improve discharge flows in acutes with **enhanced voluntary sector support** and expanding these to support those in **community and mental health** settings.

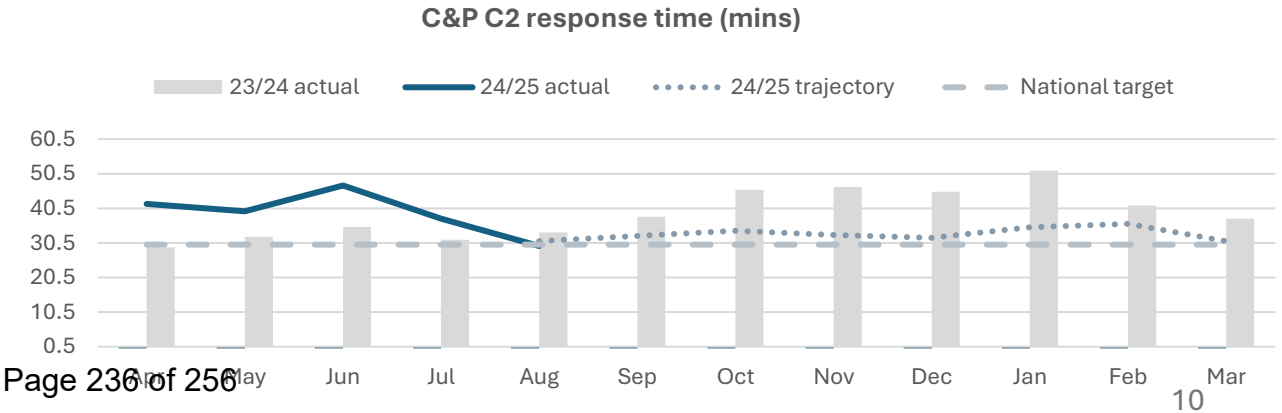
SUMMARY PLAN

All delivery plans are aligned to the core UEC indicators for improvement – A&E four-hour performance and improved C2 ambulance response times, with trajectories for performance shown below. The ICS expect to achieve the 78% four-hour A&E target by March as per our operational plan submission, however the trajectory to get there has changed slightly reflecting slower than anticipated improvement year to date. C2 ambulance response time is an annualised target of 30 minutes and at this stage, it is unlikely C&P can achieve this for the full year. C2 performance is not entirely within the control of the C&P system, as while ambulance handovers contribute, other factors such as EEAST resource availability have a material impact. Performance over the coming months is expected to remain above 30 minutes due to a combination of factors but demonstrate improvement when compared with the previous year.

DELIVERY PLAN







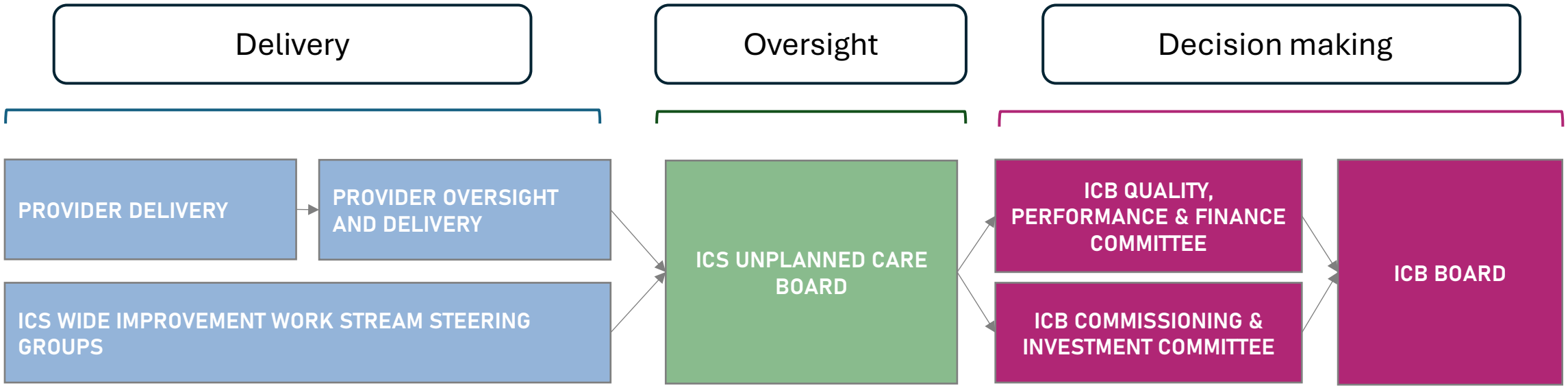
INVESTMENT OVERVIEW

The updated UEC improvement plan has four key themes, reflecting the data and known opportunities aligned to healthcare utilisation model (optimisation and acute illness) and removing duplication between individual provider owned plans and those which are system owned.

Many of the priority areas remain those identified at the beginning of the year, with schemes and services implemented to support more effective integrated UEC across C&P. There are several areas of additional investment expected in H2 as outlined in the table below, these will be supported by specific national funding for capacity and demand / UEC performance, with detailed schemes subject to Commissioning and Investment Committee review and expected to be finalised through September 2024.

Priority Area	April 2024	September 2024	Total
NWAFT & CUHFT (bed capacity & winter preparedness)	£21,424,000	£0	£21,424,000
Care of the elderly (North & South)	£0	£2,100,000	£2,100,000
UEC Hub**	£1,800,000	£1,800,000	£3,600,000
Urgent Wrap Around Care (UWAC /North & South)	£2,200,000	£0	£2,200,000
Virtual Wards	£3,552,470	£0	£3,552,470
GP Hubs and 111 ED streaming	£0	£4,100,000	£4,100,000
Discharge Support	£3,920,000	£0	£3,920,000
Voluntary sector (including EoL care)	£754,229	£233,076	£987,305
Integrated Respiratory Care Teams	£0	£75,000	£75,000

GOVERNANCE



The governance arrangements around UEC improvement, including winter preparedness and delivery, are well embedded across the ICS. These are kept under constant review to ensure that they are adaptable to changing needs, particularly relating to delivery work streams and in line with performance risks.

RISKS AND MITIGATION

Risk	Mitigation
GP Collective Action Dependent on actions taken we could see substantially different patient flows and access across the C&P locality	Ongoing system response structure in place, continuation of engagement with primary care, planning for UEC improvement alternatives to mitigate additional demand
Workforce Recruitment delays into vacancies, increased staff challenges over winter due to sickness, high levels of job dissatisfaction and burnout	Individual recruitment plans in place for winter accelerated actions. Ongoing health and wellbeing initiatives across system and providers.
Infection, prevention and control (IPC) or spike in specific illness or condition High levels of COVID, Flu or Norovirus within care settings resulting in closure of beds. Limitations with COVID vaccination programme due to national pricing structure.	Vaccination programmes in place with mitigations sought through alternative providers i.e. community pharmacy. IPC controls undertaken within provider settings with greater alignment paan C&P to ensure adherence to national protocols.
Incident declaration Local declaration or NHS level 4 national incident impacting local provision, capacity and response	Established Incident Response Plan and local and regional governance routes in place
Elective delivery Maintaining electives through winter is always challenging with UEC pressures taking priority on OP capacity and increased staff absence resulting in short notice cancellations	System commitment to keep focus on cancer, diagnostics and routine elective activity, robust governance across planned care to focus on evolving risks. Strong performance in elective year to date (H1 24/25) building up mitigation for any slow down in performance in H2.

Health Scrutiny

Urgent and Emergency Care: East of England Ambulance Service

To:	Adults and Health Committee
Meeting date:	12 December 2024
From:	Marika Stephenson Executive Lead, Cambridgeshire and Peterborough East of England Ambulance Service NHS Trust
Electoral division/s	All

Officer contact:
Name: Marika Stephenson
Post: Executive Lead, Cambridgeshire and Peterborough, East of England Ambulance Service NHS Trust

1. Background

1.1 The purpose of this report is to provide the Committee with information regarding the performance of the East of England Ambulance Service NHS Trust (EEAST) in Cambridgeshire and Peterborough.

1.2 The data covers April to October 2024.

2. Summary

2.1 Response times in the Cambridgeshire and Peterborough ICB sector for our most serious incidents (Category 1) have increased slightly compared to 2023, with an average response time of 9 minutes 19 seconds.

2.2 Response times for Category 2 incidents, which include serious medical emergencies such as chest pains and strokes, have also increased compared to 2023, with an average response time of 40 minutes 56 seconds.

2.3 15,435 hours of patient-facing time has been lost due to delays in handing over patients at hospital, equivalent to 1,286 ambulances being off the road. This compares to 8,448 hours over the same period in 2023.

2.4 NHS England has removed EEAST from the National Recovery Support Programme in recognition of the significant improvements we have made. The programme was formerly known as Special Measures.

3. Response times

3.1 The number of incidents we have responded to between April and October has increased by 1908 compared to 2023. Our response times for C1 incidents have increased slightly, and our C2 response times have also increased.

3.2 **Table 1 – 2024**

Month	C1 Response Time	C2 Response Time	C3 Response Time	C4 Response Time
Apr-24	00:09:00	00:41:51	02:20:35	03:36:16
May-24	00:09:16	00:39:44	02:19:39	03:09:44
Jun-24	00:09:41	00:47:12	02:31:50	03:54:51
Jul-24	00:08:58	00:37:34	01:59:33	02:23:06
Aug-24	00:08:46	00:29:36	01:30:47	02:35:46
Sep-24	00:09:48	00:41:32	02:23:07	02:55:27
Oct-24	00:09:42	00:48:31	02:53:19	03:48:41
Mean	**00:09:19**	**00:40:56**	**02:16:01**	**03:12:14**

3.3 **Table 2 – 2023**

Month	C1 Response Time	C2 Response Time	C3 Response Time	C4 Response Time
Apr-23	00:08:41	00:29:12	01:16:59	01:38:00
May-23	00:08:52	00:32:12	01:29:04	02:26:36
Jun-23	00:09:09	00:35:06	01:44:28	02:49:29
Jul-23	00:08:44	00:31:23	01:27:12	03:05:16
Aug-23	00:08:45	00:33:29	01:37:02	02:33:54
Sep-23	00:09:16	00:38:04	02:06:20	03:00:05
Oct-23	00:09:29	00:45:57	02:26:10	02:04:21
Mean	**00:09:00**	**00:35:08**	**01:43:15**	**02:34:37**

3.4 In Cambridgeshire and Peterborough in August 2024, EEAST met the national target for average C2 response times set by NHS England, which is 30 minutes. The average C2 response time in Cambridgeshire and Peterborough in August was 29 minutes 36 seconds.

3.5 Since then, response times have increased and this can be correlated with an increase in lost hours due to hospital handover delays. In August, 891 patient-facing staff hours were lost. This increased to 1,943 hours in September and 2,696 in October.

3.6 We are looking at several ways in which we can improve our response times and increase our resources, including:

- Increasing clinical cover within our control rooms, so we can triage all appropriate calls to improve patient safety and maximise the use of alternative services which are available within communities.
- Working with our system partners to implement agreed handover targets at A&E departments across the region. The primary aim is to reduce avoidable harm, including deaths, in communities because of delayed ambulance response times, which are consequential to delayed handovers of emergency patients at acute trusts.
- Completing our roll out of advanced practice cars in both urgent and critical care in each county, who will be able to provide more specialist clinical care and support in patients' homes.
- Increasing Hear and Treat rates to 13% through Clinical Assessment Service (CAS) expansion. CAS allows more patients to be treated over the phone rather than needing an ambulance response.
- Segmenting Category 2 calls by clinical need. This new system allows a conversation between the patient and the clinician in the control room where together they can decide whether an ambulance is the best response or if they would be better cared for in the community.
- Increasing the use of Community First Responders (CFRs) to assist with patients that have fallen. They can be dispatched to falls where the patient is uninjured or where a clinician has deemed the incident appropriate for a CFR, they can also be used as a resource for trust staff to use as a backup option to support them on scene with lifting patients.
- Using a web based portal we are transferring electronically (Access to the Stack) appropriate lower acuity calls (C3 – C5) to our Urgent Community Response partners who respond to those calls within two hours, allowing ambulances to respond to more serious emergencies in the area.

4. Hospital handovers

4.1 We continue to collaborate with partners across the system to try to minimise handover times at hospitals. This includes having dedicated Hospital Admissions Liaison Officers (HALOs) at A&Es to facilitate smoother and faster handovers. These roles are now a permanent position within EEAST.

4.2 However, hospital handovers remain a significant issue which affects EEAST's performance. Handover times are split into two main categories: Arrival to handover, and handover to clear. Arrival to handover is primarily hospital controlled, and handover to clear is primarily ambulance controlled.

4.3 The national mandate from NHS England is for all patients to be handed over to the hospital within 15 minutes of arrival, however this is rarely being achieved. These delays are reducing the number of ambulances in operation and are significantly affecting our ability to respond to 999 calls.

4.4 Following discussions with hospitals and Integrated Care Boards across the east of England we have agreed to reduce the time taken to handover patients into the care of emergency departments – this is known as 'Release to Respond'. We have agreed target handover timescales with hospitals within all Integrated Care Systems in the east of England, with the exception of Cambridgeshire and Peterborough.

4.5 We are in continuing discussions with Cambridgeshire and Peterborough ICS about the introduction of the 'Release to Respond' scheme.

4.6 Between April and October this year, 65% of handovers at hospitals in Cambridgeshire and Peterborough have exceeded 15 minutes. 15,435 hours have been lost to handover delays, which is equivalent to 1,286 ambulances. Handover delays have worsened compared to the same period in 2023, where 55% of handovers exceeded 15 minutes.

4.7 **Handover times at Cambridgeshire and Peterborough hospitals**

Addenbrooke's Hospital

- Average arrival to handover is 34 minutes 22 seconds
- 49% of handovers are achieved within 15 minutes
- 6,356 hours lost due to handover delays – equivalent to 529 ambulances off the road

Peterborough City Hospital

- Average arrival to handover is 52 minutes 3 seconds
- 11% of handovers are achieved within 15 minutes
- 7,923 hours lost due to handover delays – equivalent to 660 ambulances off the road

Hinchingbrooke Hospital

- Average arrival to handover is 23 minutes 6 seconds
- 41% of handovers are achieved within 15 minutes
- 1,515 hours lost due to handover delays – equivalent to 126 ambulances off the road

4.8 To support the national Urgent and Emergency Care recovery plan of C2 performance to 30 minutes in 2024/25, the maximum weekly ambulance hours lost to handover delays has been independently modelled by NHS England and agreed at 2,000 Trust wide (this is approximately 166 ambulances). These levels have never been reached.

4.9 As we head into winter, we know that handover delays will increase as the health and care system comes under increased pressure. We know that unwell patients in the community who are undiagnosed are at the highest risk if we cannot respond to them quickly. We have agreed handover timescales with hospitals across the region, with the exception of Cambridgeshire and Peterborough, to allow ambulances to quickly return to responding to medical emergencies. Discussions are continuing with Cambridgeshire and Peterborough ICS about agreeing handover timescales at their hospitals.

4.10 We are also committed to understanding the impact we play in handover delays and are identifying patients with a non-critical emergency and patients that are transported to A&E departments due to a failed referral so that we can work with system partners to find alternative services to reduce demand on our hospitals.

4.11 A Trust wide initiative has been implemented to support the improvement of handover to clear times with the aims of:

- Improving the handover to clear (H2C) times which will increase patient facing staff hours (PFSH) providing more time for focussed patient care.
- Improving response times in line with national standards.
- Reducing mental load on staff allowing them to focus on other tasks following a clinical handover of care of a patient.
- Reducing time spent at hospital can improve emergency department (ED) flow by reducing queues and demonstrates that EEAST are committed to reducing delays within the wider system.

Staff will receive reminder messages on their radio handsets and Mobile Data Terminal (MDT) screens to alert them if they are about to breach the times in line with national standards.

5. Winter pressures

5.1 We recognise this winter is likely to see UEC services and EEAST come under significant strain, and many patients will face longer waits at certain points in the pathway than acceptable. It is vital in this context to ensure basic standards are in place in all care settings and patients are treated with kindness, dignity and respect. This means focusing on ensuring patients are cared for in the safest possible place for them, as quickly as possible, which requires a whole-system approach to managing winter demand and a shared understanding of risk across different health and care settings.

5.2 EEAST's operational performance improvement plan (OPIP) is based on four priority areas. The Trust's C2 performance remains the Trust's largest area of operational risk and is a key priority across the region and nationally. The additional measures being put into place over

the winter period aim to support the operational performance and reduce any negative impact to the Trust. The four key priorities are outlined below.

5.3 **Job Cycle Time**

The shorter the job cycle time – the total time taken to assist a single patient - the more patients can potentially be assisted. The longest part is typically the on-scene times, and these can be within our control. To help our clinicians address this, the Trust is planning and delivering bespoke training on 'quality efficiencies on-scene' to all operational areas, providing training on clinical best practice on-scene decision-making, and looking at IT solutions to help – including an operational information portal for clinicians to easily see a range of data about how they are performing to help with learning and improvement.

5.4 **Vehicles**

To tackle the number of vehicles off road, the Trust is bringing in 228 new operational ambulances, increasing workshop infrastructure, and recruiting vehicle technician posts within budget.

5.5 **Improving Hear and Treat**

The Trust plans to increase capacity for Hear and Treat (H&T), accelerating recruitment and expanding the use of agency clinicians, and undertake GP triage outsource. The goal is to increase the calls handled per hour, focusing resource on specific call types (C2), where appropriate.

5.5 **Increasing Patient Facing Staff Hours**

We want to increase the number of hours our staff have to directly help patients, through reducing the time taken to acquire C1 driving licences and implementing a centralised scheduling system to anticipate demand on the service and roster staff accordingly.

5.6 The main impact for the Trust alongside high demand has been identified as significant and prolonged delays in handing patients over to hospital. This is why, alongside other ambulance services, we are implementing a 45-minute limit on patient handovers.

Source documents

6.1 None.

Health Scrutiny Work Programme 2024/25

Healthwatch has a standing invitation to participate in all health scrutiny sessions and/ or provide written evidence.

Committee date	Agenda item	Expected attendees
12/12/2024	Urgent and Emergency Care	Stacie Coburn, Chief Operating Officer, Integrated Care Board (ICB) Dr Andrew Anderson, GP and ICB Clinical Lead for Urgent and Emergency Care. Marika Stephenson, Executive Lead for Cambridgeshire & Peterborough, East of England Ambulance Service NHS Trust (EEAST) Terry Hicks, Chief Clinical Operating Officer, EEAST
	Health scrutiny work plan	R Greenhill
	Health scrutiny recommendations tracker	R Greenhill

Committee date	Agenda item	Expected attendees
23/01/25	Tackling Health Inequalities	Louis Kamfer, Deputy Chief Executive, ICB Jonathan Bartram, ICB Programme Director for Health Inequalities Dr Ashley Shaw, Medical Director at Cambridge University Hospitals NHS Foundation Trust and Executive Lead for Health Inequalities and Clinical Steering group lead
	Access to Cambridgeshire and Peterborough NHS Foundation Trust Mental Health Services (Deferred from December)	Steve Grange, CEO and/ or Scott Haldane, Executive Director
06/03/25	Dental Provision in Cambridgeshire	TBC
	Annual Health Checks for People with Learning Disabilities	TBC
	Approval Process for Responses to NHS Quality Accounts 2024/25	R Greenhill
	Draft Health Scrutiny Annual Report 2024/25	R Greenhill
	Health scrutiny work plan	R Greenhill
	Health scrutiny recommendations tracker	R Greenhill

Committee date	Agenda item	Expected attendees
19/06/25	Adults and Health Committee Statements on Local Provider NHS Quality Accounts 2024/25	R Greenhill
	Health scrutiny work plan	R Greenhill
	Health scrutiny recommendations tracker	R Greenhill

Adults and Health Committee

Health Scrutiny Recommendations Tracker

Purpose:
To record the recommendations made by the Adults and Health Committee in the discharge of its health scrutiny function, and their outcomes.

Meeting 14th December 2023

Report title	Officer/s responsible	Recommendation/s	Outcomes	Status
Improving Health Outcomes for People with Learning Disabilities	C Anderson, Chief Nursing Officer, ICS	The Committee requests a short written update in 12 months' time (January 2025) on the outcome of the pilot project to align annual health care checks for people with learning disabilities with their birthdays. This should state whether this initiative will be rolled out across the county; and, if so, the timescale for doing so.	This information will be provided for the scrutiny session on annual health checks for people with learning disabilities which has been scheduled for March 2025.	On-going
Improving Health Outcomes for People with Learning Disabilities	P Warren-Higgs, Executive Director Adults, Health and Commissioning/ C Anderson, Chief Nursing Officer, ICS	Recommends that County Council officers work with Health Service partners to offer basic healthcare training to carers so that they can carry out basic health checks and support such as mouth care and inspections; foot care inspections; and supporting good eating techniques to reduce the risk of aspiration for people with learning disabilities.	On-going work with health partners to establish appropriate available training options for those carers supporting those with LD in these specific areas and access routes into these specific training programmes. Reminders sent 24.05.24,16.08.24 & 06.11.24	On-going
Improving Health Outcomes for People with	C Anderson, Chief Nursing Officer, ICS	Requests a short written evaluation in 12 months' time (January 2025) of the learning from the keyworker pilot project.	Reminder sent 06.11.24	Follow up requested

Report title	Officer/s responsible	Recommendation/s	Outcomes	Status
Learning Disabilities		This should include the number of people with learning disabilities receiving the support of a keyworker against the known population of people with learning disabilities in Cambridgeshire in December 2023 and December 2024 (separate figures for adults and children); and an assessment of the impact in practical terms of the keyworker programme in improving access to and the experience of health care services by people with learning disabilities, including supporting the transition from children's to adult services.		January 2025
Improving Health Outcomes for People with Learning Disabilities	R Greenhill, Democratic Services Officer	The Committee will seek feedback from people with learning disabilities about their experience of having a keyworker in 12 months' time via the Learning Disability Partnership, Voiceability and Healthwatch Cambridgeshire.	11.11.24: Requests for feedback sent to the Learning Disability Partnership, Voiceability and Healthwatch Cambridgeshire.	On-going
Improving Health Outcomes for People with Learning Disabilities	C Anderson, Chief Nursing Officer, ICS	Requests a short written evaluation in 12 months' time (January 2025) of the pilot project being run in two special schools to deliver health services in an education setting. This should include whether the programme will be extended, maintained or discontinued.	Reminder sent 06.11.24	Follow up requested January 2025
Improving Health Outcomes for People with	C Anderson, Chief Nursing Officer ICS	Notes that all organisations that provide NHS care have been legally required to follow the Accessible Information Standard since 2016. The Committee requests an	Reminder sent 06.11.25 This can be followed up as part of the scrutiny session on annual health checks	Follow up requested January 2025

Report title	Officer/s responsible	Recommendation/s	Outcomes	Status
Learning Disabilities		update in 12 months' time (January 2025) on the progress made in rolling out health care information in easy read format across Cambridgeshire's health services.	for people with learning disabilities in March 2025.	
Improving Health Outcomes for People with Learning Disabilities	R Greenhill, Democratic Services Officer	The Committee will consult the Learning Disability Partnership, Voiceability and Healthwatch in 12 months' time to request their perspectives on the progress made in rolling out health care information in easy read format across Cambridgeshire's health services.	11.11.24: Requests for feedback sent to the Learning Disability Partnership, Voiceability and Healthwatch Cambridgeshire.	On-going
Improving Health Outcomes for People with Learning Disabilities	C Anderson, Chief Nursing Officer	Requests an update in 12 months' time (January 2025) on the number of NHS healthcare professionals in Cambridgeshire who have completed the Oliver McGowan training course at each level, the percentage figures for staff trained out of the total staff number identified as needing to undertake this training; and a comparison of Cambridgeshire's performance against national training completion rates.	Reminder sent 06.11.24 This can be followed up as part of the scrutiny session on annual health checks for people with learning disabilities in March 2025.	Follow up requested January 2025
NHS Workforce Development – Primary Care and Nursing Workforce	P Warren-Higgs, Executive Director for Adults, Health and Commissioning	Requests that County Council officers liaise with the Chief People Officer at the ICS to explore the potential for joint working in relation to the County Council's new social care academy, the Cambridgeshire Academy for Reaching Excellence (CARE). A short written update is requested in three months' time.	Reminders sent 24.05.24, 16.08.24 & 06.11.24	Follow up requested April 2024

Meeting 7th March 2024

Report title	Officer/s responsible	Recommendation/s	Outcomes	Status
The Provisions of NHS Dental Services in Cambridgeshire	P Warren-Higgs/ N Briggs, CFO ICB/ C Iton, Chief People Officer, ICB	The Committee requests that County Council officers and the ICB discuss wider collaboration in relation to the ICB's workforce strategy, including dentistry, and the opportunities offered by the new Care Academy.	Reminders sent 24.05.24,16.08.24 & 06.11.24	On-going

Meeting 10th October 2024

Report title	Officer/s responsible	Recommendation/s	Outcomes	Status
Maternity Services at Cambridge University Hospitals NHS Foundation Trust	Roland Sinker CBE, Chief Executive CUH	The Committee recommends the Trust adopt a target figure of 100% on safeguarding training.	26.11.24 CUH response: We set a Trust target for all mandatory training including safeguarding to 90%. This allows for movement of staff due to our 12-13% turnover rate per year. We do however monitor long term non-compliance with mandatory training and this is reviewed for all staff during their appraisals.	Completed
Maternity Services at Cambridge University Hospitals NHS Foundation Trust	Jan Thomas, Chief Executive ICB	The Committee recommends that the issue of women's health hubs is re-visited locally in terms of providing an equitable approach to the treatment of women's and men's health.	19.11.24: The Chair of the ICB has advised that the Cambridgeshire and Peterborough ICB has recently approved funding for the establishment of women's health hubs as per the Government's guidelines for implementation. Funding is being distributed	Completed

Report title	Officer/s responsible	Recommendation/s	Outcomes	Status
			to both North and South Place Partnerships and directed into areas of higher deprivation. At least one hub will be operational by 31st December 2024.	
Maternity Services at Cambridge University Hospitals NHS Foundation Trust	Roland Sinker CBE, Chief Executive CUH	The Committee welcomes the work to date in relation to triage, but notes that 20% of patients due to be seen within 15 minutes are being seen after an hour. The Trust is encouraged to continue with efforts to address this, and the Committee requests a short briefing note in February 2025 to provide an update on progress.		Due February 2025
Maternity Services at Cambridge University Hospitals NHS Foundation Trust	Roland Sinker CBE, Chief Executive CUH	The Committee accepts the offer of a revised Appendix 2 containing a complete set of figures for the Friends and Family Test score and further detail around what might lay behind the deterioration in scores during 2024.	26.11.24: Revised figures and narrative circulated electronically to committee members, co-opted members and CYP Spokes.	Completed
The Redevelopment of Hinchingbrooke Hospital	Deborah Lee, Senior Responsible Officer	The Committee recommends that the redevelopment team intensify its efforts to engage with hard to reach groups as part of its service user engagement programme.		On-going
The Redevelopment of Hinchingbrooke Hospital	Deborah Lee, Senior Responsible Officer	The Committee recommends the promotion of greater public awareness of how the redevelopment of Hinchingbrooke Hospital is being		On-going

Report title	Officer/s responsible	Recommendation/s	Outcomes	Status
		developed within the new model of care approach.		
The Redevelopment of Hinchingbrooke Hospital	Deborah Lee, Senior Responsible Officer	The Committee welcomes and encourages the wider vision around the development of the Hinchingbrooke Hospital campus and requests further information about this over time.		On-going