ADULTS AND HEALTH

Cambridgeshire
County Council

Thursday, 09 March 2023

Democratic and Members' Services
Linda Walker
Interim Monitoring Officer

10:00

New Shire Hall
Alconbury Weald
Huntingdon
PE28 4YE

Red Kite Room, New Shire Hall PE28 4YE
[Venue Address]

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1. **Apologies for absence and declarations of interest**
    Guidance on declaring interests is available at
    http://tinyurl.com/ccc-conduct-code

2. **Adults and Health Minutes - 15 December 2022**   **5 - 32**

3. **Petitions and Public Questions**

    STRATEGIC ISSUES

4. **Cambridgeshire Care Sector Strategy of Commissioned Services**   **33 - 58**

5. **A review of the Learning Disability Partnership Section 75 pooled** **59 - 68**
    budget financial risk share arrangements

KEY DECISIONS

DECISIONS

BREAK

HEALTH SCRUTINY

Date of Next Meeting

29 June 2023

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The Adults and Health comprises the following members:

Councillor Richard Howitt (Chair)   Councillor Susan van de Ven (Vice-Chair) Councillor Gerri Bird Councillor Chris Boden Councillor Steve Corney Councillor Adela Costello Councillor Claire Daunton Councillor Nick Gay Councillor Anne Hay Councillor Mark Howell Councillor Mac McGuire   Councillor Edna Murphy Councillor Kevin Reynolds Councillor Philippa Slatter and Councillor Graham Wilson   Councillor Sam Clark (Appointee) Councillor Lis Every (Appointee) Councillor Corinne Garvie (Appointee) Councillor Jenny Gawthorpe Wood (Appointee) Councillor Steve McAdam (Appointee)

Clerk Name:	Tamar Oviatt-Ham
Clerk Telephone:	01223 715668
Clerk Email:	Tamar.Oviatt-Ham@cambridgeshire.gov.uk

Adults and Health Committee Minutes

Date:	Thursday 15 December 2022
Time:	10.00 am - 16.00 pm
Venue:	New Shire Hall, Alconbury Weald, PE28 4XA
Present:	Councillors Chris Boden, Adela Costello, Claire Daunton, Corinne Garvie (Appointee, part 2 only) Nick Gay, Jenny Gawthorpe-Wood (Appointee, part 2 only) Bryony Goodliffe, Mark Howell, Richard Howitt (Chair), Steve McAdam (Appointee, part 2 only), Mac McGuire, Edna Murphy, Philippa Slatter, Susan van de Ven (Vice-Chair) and Graham Wilson.

135. Apologies for Absence and Declarations of Interest

Apologies received from Councillors David Ambrose-Smith, Steve Corney (substituted by Mac McGuire), Gerri Bird (substituted by Bryony Goodliffe), Anne Hay, Lis Every (Part 2 only), Sam Clark (part 2 only).

Councillor Daunton declared a non-statutory pecuniary interest as she was the County Council appointed Governor for Cambridgeshire and Peterborough NHS Foundation Trust.

Councillor Daunton declared a non-statutory pecuniary interest as she was the County appointed Governor on the Royal Papworth Trust.

Councillor Howell declared a non-statutory pecuniary interest in item 8 on the agenda 'Insourcing Supported Living' and did not take part in the debate and vote on this report. He also declared a non-statutory pecuniary interest in item 16 on the agenda 'Cambridgeshire South Care Partnership (ICP) Update', as he was a South Cambridgeshire District Councillor.

The Chair explained that Charlotte Black had announced plans to leave both her current interim role as Executive Director of People Services and substantive role of Director of Adults and Safeguarding across both Councils at the end of January. He stated that she was currently leading on work to develop options for both councils to consider for the future leadership arrangements for Adults, Children, Education and Commissioning, which would be ready for consultation by the end of January. He thanked Charlotte for her service over the past 20 years at the council.

The Chair also announced that there would be a change to the way that the scrutiny session in the afternoon would be structured with less items to give more time for questions.

136. Minutes – 5 October 2022 and Action Log

The minutes of the meeting held on 5 October 2022 were agreed as a correct record.

In relation to the action log, a member commented that there had not been a meeting with Cambridgeshire Children's Hospital for a while and asked that this be chased up. ACTION REQUIRED. The action log was noted.

137. Petitions and Public Questions

There were no petitions or public questions.

138. Review of Draft Revenue and Capital Business Planning Proposals for 2023-28

The committee considered a report that outlined the current business and budgetary planning position and estimates for 2023-2028; the principal risks, contingencies and implications facing the committee and the council's resources and the process and next steps for the council in agreeing a business plan and budget for future years.

In particular the presenting officers highlighted;

- Corporately there was a £12.8m gap, and this was being worked on.

- Full implementation of the Adult Social Care reforms delayed for a minimum of two years but that there was funding that would be made available in the next year and guidelines around the funding were awaited.

- Officers had budgeted 10p off the final announcement for the minimum wage which brought an additional cost of £1.5million to the Adult Social Care budget.

- An additional £7.3 million had been factored into the budget on demand for services in the next year and a further £14.7 million of inflation of which £12.1 million was supporting the national/real living wage.

- £3.6million of savings had already been identified, listed at table 66.2 and 66.3 of the report and since the last committee had identified a further £890,000 of savings listed in table 66.5 of the report.

- Further opportunities included a review of the Learning Disability pooled budget and the respective contributions between health and the local authority and opportunities to support the cost-of-living pressures.

- Public Health received an uplift to its grant for 2022-23 of £776,000 which had been used to cover inflationary pressures in the stop smoking service and

health checks and to pay for the agenda for change pay increase for NHS services and investment in child weight management.

- Public Health receive its grant allocation late in the financial year so did not yet know what they would receive for 2023-24 which limited ability for planning ahead.

- Identified a number of small cuts to Public Health services to the value of £61,000 and some historical savings that had not yet been released to the lifestyle contract. There had not yet been agreement on where the money saved would be directed, but there was an initial proposal for this to potentially be used for the infection control nurse who was currently paid for by a grant that would run out at the end of the financial year.

Individual members raised the following points in relation to the report;

- Requested some commentary on short term funding which seemed to be a common thread throughout budget discussions and the challenges of deploying the funding. Officers explained that any funding was welcome including short term funding and there had been examples over the last few years, of working collectively across the system, to find the best ways to use the funding for individuals. It was challenging in particular in relation to securing additional workforce on a short-term basis or additional capacity, which also came at a premium price. Preference would always be for long term funding which would allow for workforce planning with providers and money could be used more efficiently as a result.

- Queried whether there was a significant difference between national living wage and real living wage. Officers stated that there was a difference with the national living wage being £10.42 and the real living wage £10.90, the national living wage had gone up by 9.7% and the real living wage by 10% so they tended to move together but that there would always be a gap. The Chair explained that it was important that the authority monitored the pathway to full implementation of the real living wage and that this would be built into all new contracts.

- Questioned what figure was being assumed for client contributions inflation. Officers explained that this was calculated based on the triple lock pension increases. Officers clarified that they were waiting for an announcement on the minimum income guarantee and assumed that this would align with the pension benefits increases.

- Expressed concern that there seemed to be a significant increase in charges for adults' social care clients set out on page 91 of the document pack, which saw an increase from £130 for setting up an agreement to £219. Officers explained that there was an ongoing review of charges and cost of living increases would be factored into the review and that a report would be coming back to committee in due course. Officers stated that as part of the review of charges, the authority had benchmarked itself across other authorities and independent providers that support people. The Chair stated that any changes

in relation to charging policy needed to be raised in conjunction with the national review of charging policy. If charges were to increase self-funders would potentially be more able to absorb the increases than others and difficult choices would need to be made.

- Queried the Mental health section 75 vacancy factor and queried whether there were disadvantages resulting from these posts being vacant. Officers explained that effectively they were not reducing the service in any way, the proposal was about a one-off reduction as the service could not recruit these staff at the moment. Officers highlighted that the funding would go back into the budget, in the next year as the expectation was that the service would still want to recruit the staff. Officers clarified that they would go back to colleagues to review the scoring of the proposal. ACTION REQUIRED

- Sought further detail on the new model of delivery in relation to the decommissioning of discharge block cars. Officers explained that as part of the Care Together programme, there was a focus on attracting locally based carers working with partners to deliver care at a neighbourhood level in the community. Officers stated that the Council was making a significant investment into the programme over a period of four years, to develop local community capacity. A member highlighted that it was important to understand what deterred individuals from becoming carers such as issues related to allowances being paid. Sufficient provision would need to be made for the workforce and that the authority was not in conflict with its own policies.

- Queried why mental health costs had remained static in relation to the table on page 55 of the papers. Officers stated that there were increasing costs in relation to mental health and that it was a reflection on how they had allocated inflation at this stage. Officers explained that the line that related to 'mental health central' which had remained static was in relation to staffing and was held corporately currently.

- A member expressed concern in relation to the changes on adults and mental health employment support and highlighted that there was a failure to direct funding to areas where there was greatest need, in particular in relation to Fenland. Officers stated that the housing related support service was currently being retendered to provide more equitable support across the County and stated that they would come back to the member with a more detailed response. ACTION REQUIRED

- A member queried whether there was a potential to seek greater recurring savings in relation to post hospital discharge reviews as a result of better use of tech and reablement over a number of years. Officers explained that currently the numbers did look low but that on average, the authority was accepting 70 people a week and that officers would continue to the review the process in relation to capacity.

- The Chair highlighted that the Adult Social Care reforms had been postponed but the consequences of the reforms where being felt now in terms of budgets in particular Fair Cost of Care, which had raised expectations that needed managing.

In bringing the debate to a close the chair stated that there had been a few points not covered in the debate. In relation to public health spend the steer from the committee should be for public health spend ringfencing to be respected and that any funding should be redistributed to improve public health outcomes as the key priority. He also highlighted that officers continued a very constructive dialogue with health partners on the pooled budget for Learning Disabilities.

It was resolved to:

a) Note the progress made to date and next steps required to develop the business plan for 2023-2028.

b) Comment on and endorse the budget and savings proposals that are within the remit of the Committee as part of consideration of the Council's overall Business Plan.

c) Note the updates to fees and charges for 2023-24.

139. Director of Public Health Annual Report 2022/23

The committee considered a report from the Director of Public Health, which was a statutory requirement, to produce an annual independent report on the health of the population of Cambridgeshire and Peterborough. The report raised awareness and understanding of local health issues, highlighting areas of specific concern and made recommendations for change. The Director of Public Health gave a presentation to members that highlighted the key points in the report.

Individual members raised the following points in relation to the report and presentation;

- The Vice Chair highlighted that historically the council had always taken a targeted geographical approach to health inequalities. She highlighted the compelling points made by the Director of Public Health, in that the greatest proportion of those in need were being missed. She explained that she represented a division in an affluent district but that the division had the greatest health inequalities in South Cambridgeshire in relation to school age children. She stated that the report came at a pivotal moment when the ICS was in its early stages of development and that prevention was key. She welcomed the report and was excited about the proposed changes and benefits they would bring.

- A member highlighted that in the previous report, on the agenda, it had been stated that spend should be proportional to need and that everyone should

have access to services. He highlighted that this was fine in theory but that in his opinion, in practice, with the limits in the amounts of resource the authority had, this would not work and that hard choices needed to be made. He stated that he fundamentally disagreed with some of the comments made by the Director of Public Health in the report. He explained that there was a need to look at each intervention individually and in its own context and that it was not a case of having a blanket approach. He stated that he believed that there should be a focus on geographical areas with the poorest health outcomes, as this was more likely to reduce health inequality. He highlighted that one of the issues with universal services was that it was easier for those in less deprived areas to access the services, unless some degree of targeting takes place. He requested that clear measurements be put in place to show how the decisions that have been made and the measures that have been put in place, going forwards, had helped to reduce health inequalities. The Director of Public Health explained that the approach would be universal services first by default, supplemented by targeted interventions based on evidence, through the systematic identification of individuals rather than geographical targeting. She highlighted that data was currently presented by geography as this was how the data had been made available and that there were many other inequalities including gender and ethnicity that needed to be considered

- A member highlighted that times where changing. She gave an example of resistance to measures being put in place most recently in relation to vaccinations and the lessons that had been learnt in terms of engaging individuals. She explained that access to information was more universal than it had ever been, and the use of social media had grown substantially and the massive opportunities for promoting public health initiatives. She highlighted that transport was key in relation to universal services and in order for them to be successful and that best practice in services should be shared across the board. The Director of Public Health acknowledged that social media was pertinent and that some funding had been allocated through behavioural insights and this will be used to inform targeted social media campaigns, and this would help to understand and address the challenges of uptake of the services.

- A member commented that with a universal approach to services the results were not always known for 10-20 years. He asked whether, within the universal approach, there would be a focus on any particular groups, such as in relation to alcoholism. The Director of Public Health stated that all of the public health funding for alcohol was currently going into treating alcoholics and was missing the population drinking at home, and that this needed to be addressed.

- A member highlighted that there should be a focus on young people and childhood. He commented that in the past there was a universal health visiting system and a school nursing system that had been dramatically cut and that it was crucial this was reviewed. The Director of Public Health acknowledged that provision of school nursing needed further consideration. She explained that the health visiting service had not been cut since moving to the County Council but that there had been workforce issues.

- The Chair stated that targeting services in the past had not worked and that the council were looking to make better choices and decisions in the future. The aim was to lower health inequalities wherever they were.

It was resolved to:

> note the independent report 2022/23 from the Director of Public Health for Cambridgeshire and Peterborough.

140. Cardiovascular Disease Prevention Strategy

The committee received a report that sought comments on the draft Cambridgeshire and Peterborough Cardiovascular Disease Prevention Strategy.

In particular the presenting officer highlighted;

- 25% of deaths nationally and locally were attributed to cardiovascular disease and that it was a highly preventable condition.

- Adult and Health Committee had allocated investment to prevention in primary care and strengthen the smoking in pregnancy interventions and strengthening NHS health checks.

- The strategy focused on behavioural risks especially smoking and diet and early identification and treatment of clinical risks. It built on the interventions in place already and strengthened the clinical pathways, that had been affected by COVID. Key theme of how we use and pull our resources together across the system to improve interventions, services and outcomes.

Individual members raised the following points in relation to the report;

- Queried the target in relation to ambitions for reducing adults' overweight obesity levels to pre covid times by 2030, as it did not seem to be an ambitious target. Also queried the target to reduce inequalities in overweight/obesity as there were no figures currently. The officer stated that the targets were set nationally as part of the NHS five-year plan and very few targets at present were local, however currently work was underway to refine targets in the Health and Wellbeing Strategy.

- Questioned whether the service was working with the active travel group in relation to the target to achieve a 10% increase in the number of adults who undertake 150 minutes of physical activity. The officer clarified that they had good connections with the active travel group and the challenge was to get individuals to use the active travel options provided. This was being addressed by the forthcoming commission of behavioural insights research that would inform the ongoing development of this work.
- A member commented that in reducing the inequalities in relation to cardiovascular disease, it was his opinion that better results would be

achieved by targeting the geographical areas that were in the most need of intervention and that a universal approach would not necessarily be of greatest benefit over a longer period of time. The officer commented that it was very much about using the understanding provided by behavioural insights research into how interventions are responded to by different population groups. There would be a universal offer but that could be delivered in different ways for different population groups

- Sought further information on the success and progress of NHS health checks and the state of affairs of primary care regarding following up on the outcomes of the checks. The officer stated that numbers of health checks had been picking up and more had been more commissioning through the lifestyle/behaviour change service which had the adaptability and flexibility to offer the service in different locations. The officer stated that if a clinical problem was identified through a health check, they are then referred to primary care and good feedback was received on this.

- Queried whether there was a focus on workplaces and how they could support interventions and if there were good links with occupational health. The officer explained there had been a lot of learning through covid in relation to the workforce and workplace. She stated that the biggest concern in relation to occupational health was with small and medium size organisations who do not have access to these resources. She explained that they worked closely with organisations, the Combined Authority and District Council Economic Development Officers to support them in terms of providing information to businesses.

- The Chair highlighted that it was important to look at what had not worked in the past and experience from other parts of the country.

It was resolved to support the following recommendations:

a) The high-level outcome ambitions.

b) The focus upon behavioural and clinical risk factors identified in the Strategy.

c) The planned interventions to mitigate the behavioural and clinical risks.

141. Rapid Discharge and Transition Block Homecare Provision

The committee considered a report that sought approval for the recommissioning of the Rapid Discharge and Transition block homecare provision on a 12-month basis, extendable up to a further four years, six months at time, with a total contract value of £2,975,000 over five years, from June 2023 to June 2028.

In particular the presenting officer highlighted;

- Reduced level on flexible contract terms to meet levels of care whilst a new placed based model was implemented, part of the homecare transformation work in the care together programme, aimed to make it easier for people to deliver care in their local community.

- The current provision had been analysed to understand demand, in order to review the specification on how the service was delivered including more capacity with morning calls as well as more zones in which the cars operate to support care pools.

Individual members raised the following points in relation to the report;

- Queried why one year had been chosen in relation to the ultra-flexible contract period. The officer explained that extensive soft market testing was undertaken before this was implemented and the main reason behind the decision was the move towards a place-based model.

- The chair stated that he wanted to move further and faster towards place-based care and there had to be a safety net for those that needed it and that in this instance one year flexibility in contracts was justified.

- Sought further information on how the homecare place-based model was progressing as part of care together. The officer stated that the homecare model had place-based zones, and the zones would be analysed in relation to demand and how services could be tailored to meet demand in those areas including work on a sliding scale of rates.

It was resolved to:

a) Approve the recommissioning of the Rapid Discharge and Transition block homecare provision on a 12-month basis, extendable up to a further four years, six months at time, with a total contract value of £2,975,000 over five years, from June 2023 to June 2028.

b) Delegate approval of award and extension periods to the Executive Director of People and Communities.

142. Insourcing of a Supported Living Service

The committee received a report which sought agreement to the insourcing of a supported living support service in Wyton near Huntingdon as part of the service delivered under the Learning Disability Partnership Section 75 Agreement. The annual value was in the region of £633,214 per annum to include terms and conditions of staff transferring under TUPE.

In particular the presenting officer highlighted;

- The service was currently commissioned from an independent provider that acted as landlord and care provider of the service. They had taken the decision to sell the property to a new social landlord and had given notice on the care and support of the scheme.

- The proposal being put forward was that the Learning Disability Partnership in house services would undertake the management of staffing of the scheme, which was a six bedded unit, consisting of five bungalows with four current service users. Tenants would remain at the scheme and new tenancies would be put in place and it was envisaged that the other two vacancies at the scheme would be recruited to and filled.

- The current provider had been having difficulties in recruiting and the service had done some soft market testing which had also not been successful. There were strong in-house services locally and a good pool of staff. The staff would be TUPE'd across to join the service.

Individual members raised the following points in relation to the report;

- Commented that it was good to see that the local in-house provision was of a good level and standard and queried whether this was the case for other local in-house provisions. The officers explained that through the care suites study some pockets in locations had been identified where it was difficult to recruit staff and a number of factors affected this including demography and transport.

- Highlighted that it was a cost-effective proposal that would bring better care for individuals.

- A member explained that they had an issue in terms of the report as it did not state where the provision was. He requested that if it was about a particular location and this was not going to cause any confidentiality issues, that it was stated clearly in the report as members may potentially have an interest to declare.

- A member stated that he was surprised that the report was being taken in a public session as it referred specifically to allocating a contract to bring a service in house. He also asked whether this would set a dangerous precedent that providers could say that they would give up services as they could rely on the County Council to take services in house. The chair stated that the report had been through the relevant sign off process with legal colleagues and that this process had not raised any issues in terms of confidentiality. The chair explained that he would however reflect with officers on how similar reports would be brought to committee in the future outside of the meeting. ACTION REQUIRED. The chair also commented that the report sent a positive signal that the Council was interested in direct provision, and this provided a continuity of service for the service users involved. The officer stated that the continuity of the care was very important as the current provider had been there for many years but has had increased difficulty

recruiting staff to the area. The officer explained that by insourcing the provision it would provide better value as the two vacant places at the scheme could be filled.

- Queried what the staff and the families currently knew about the proposal. The officer stated that in the new year the current provider would be able to undertake a proper managed communication with the individuals, families and staff involved to explain the sale and the impact. The officer clarified that some pre-emptive communications had been carried out and highlighted the importance on ensuring that the staff, residents and families were given assurance and were supported through the transition. Officers explained that once agreement was given by committee, this would allow time for the mental capacity assessments and best interest assessments with the residents to commence and to start the statutory consultation with the staff in the new year.

It was resolved to:

agree the insourcing of a supported living support service as part of the service delivered under the Learning Disability Partnership Section 75 Agreement at an annual value in the region of £633,214 per annum to include of terms and conditions of staff transferring under TUPE.

143. Mental Health Supported Accommodation Service Re-Procurement

The committee considered a report that sought approval for the recommissioning of the Accommodation Based Supported Living Service for People with Moderate to Severe Mental Health Needs in Cambridgeshire on a 3-year basis from 1st July 2023 with an option for two 2 Year extension periods.

In particular the presenting officer highlighted;

- The contract would cost £1,210,000 annually, a total of £8,470,000 over the total term of the contract and extension periods.

- Engagement and coproduction that had taken place in the summer of 2022 with service users, providers, carers, social workers, mental health teams and landlords to develop a comprehensive report that had fed into the review.

Individual Members raised the following points in relation to the report;

- A member highlighted that out of the 117 places available only 3-4 were available for East Cambridgeshire and Fenland and they would be at the lower level of service, so there was an inequality of the provision geographically. He did state however that this was a better service than had been previously available and was grateful for the steps being made to start to address the imbalance. The officer acknowledged the inequality and stated that this re-procurement was a starting point to address this once there was a

greater understanding of needs by making use of data regarding East Cambridgeshire and Fenland.

- Questioned what the property and workforce prospects were in East Cambridgeshire and Fenland. The officer explained that workforce was always a challenge and that it would be clearly stated in the tender information about the expansion of the service. The officer stated that there had been challenges in relation to workforce with the current provider but that they had managed to recruit and retain staff.

- Queried what the provider market was looking like and what could be done to improve it.

- Highlighted the changing profile of use of the individuals needing the service as there were now higher levels of need. The officer acknowledged that there was an emerging profile of individuals with more complex needs.

- Sought assurances that the tender would deal with lessons learnt in the past. The officer explained that this information had been built into the quality questions and the specification as part of the tender process.

It was resolved to:

a) approve the recommissioning of the Accommodation Based Supported Living Service for People with Moderate to Severe Mental Health Needs in Cambridgeshire on a 3-year basis from 1st July 2023 with an option for two 2 Year extension periods. This will cost £1,210,000 annually, a total of £8,470,000 over the total term of the contract and extension periods.

b) delegate approval of award and extension periods to the Executive Director of People and Communities.

144. Adult Social Care Self-Assessment

The committee considered a report detailing the self-assessment and the key recommendations of the subsequent LGA Peer review for adult social care.

In particular the presenting officer highlighted;

- the report covered the top achievements as well as the biggest challenges

- Officers were currently completing a further self-assessment on the draft CQC assurance framework and external challenge for this was planned for February 2023.

- The authority had invited the LGA to undertake a peer review and received a lot of positive feedback. The report covered areas for development from this review and the actions that needed to be taken forward.

- Work had been undertaken with the Adults Social Care Forum and partnership boards to identify stakeholder priorities, 'you said, we did'.

Individual members raised the following points in relation to the report;

- Sought clarity on some of the terminology used including 'Adults Positive Challenge', 'co-production', 'think local and act personal' and 'changing the conversation'. Officers explained that the 'Adults Positive Challenge' was a three-year transformation programme and that there had been a number of update reports to the committee on the programme. It focused on early intervention and prevention and strengthening practice through better use of tech enabled care and maximising reablement. The officer clarified that 'changing the conversation', was about ensuring that practitioners were not just focusing on people's needs but also their strengths, understanding what individuals were able to do for themselves. The officer stated that co-production was well embedded with front line social workers and whenever they did an assessment or review this was co-produced with the individual. The officer also explained that 'think local act personal' was another way of saying local person-centred care.

- Queried whether there were sufficient resources available to all individuals that could benefit from the tech first approach. The officer stated that the use of tech enabled care was embedded in front line practice. The officer explained that the investment that had been discussed was around additional practitioners for when individuals were discharged from hospital, focusing on reablement and technology-based care. A Member queried whether the £110,000 investment was a one off or would it be a recurrent cost. The officer stated that if the extra resource was needed in future years, then this cost would need to be built into the budget.

- Highlighted that under the majority of the 'you said we did' statements it talked about producing another strategy or plan rather than improving local services.

- Stated that the framework results showed a lot of the KPI equivalents where the authority was worse than average across England and the East of England and the service seemed to have deteriorated over recent years. The officer explained that work in these areas was included in the improvement plan.

- The Chair shared concern in relation to the lack of management information in relation to safeguarding, not funding voluntary and community sector organisations enough in relation to prevention and the back log in relation to Deprivation of Liberty Safeguarding reviews. He also stated that in relation to equality, diversity and inclusion, the authority was good at evidencing in relation to staff but not in relation to services. The officer explained that over the last twelve months the business intelligence team had been building adult social care KPI dashboards and had been developing a dashboard for Safeguarding which could give the management information insight, and this information would be available for the next performance report to committee. The officer stated that they had taken on the comments and feedback on

funding for the voluntary sector, looking at how the winter pressures funding could be used with the voluntary sector. She explained that the service was working with the ICB on proposals to set up a voluntary sector alliance to address some of these issues. She acknowledged that the Deprivation of Liberty Safeguarding backlog was concerning and stated that they had been in discussions with an external agency on how they could support the work on the backlog, but this would come at quite a high cost.

It was resolved to:

a) note the findings of the self-assessment and adult social care national outcomes metrics for 2021/22.

b) note the key recommendations for the LGA peer review.

c) note the coproduced "You Said – We Did" work undertaken in 2021/22 and the further planned visioning and co-production development.

145. Cambridgeshire and Peterborough Safeguarding Adults Partnership Board Annual Report 2021-22

The committee received the Cambridgeshire and Peterborough Safeguarding Adults Partnership Board Annual Report for 2021-22 which included information on the work that has been undertaken by the board in the period April 2021- March 2022.

In particular the presenting officer highlighted;

- Partner agencies, including Cambridgeshire County Council, contributed to the information contained within the annual report.

- The annual report was approved by the Safeguarding Adult Board in November 2022 and was subsequently published on the Boards website (www.safeguardingpeterborough.org.uk) and shared on social media.

Individual members raised the following points in relation to the report;

- Questioned the way in which risk was managed in relation to safeguarding and how it was measured. The officer explained that there were a lot of strands in relation to the management of risk and that the governance arrangements in relation to the safeguarding board and reporting were crucial. The officer stated that there was a triage system through the MASH team that dealt with all safeguarding concerns.

- Questioned whether the percentages highlighted in the report were a fair assessment in relation to the rest of the country. The officer explained that the service looked at its performance against the regional and national average and were focused on conversion rates and whether they were getting this right. The officer explained that they were looking to get some external input to test the system.

- A member highlighted that in the report is stated that the majority of risks were identified in people's own homes followed by residential care homes which they found quite concerning and they sought further comment on this. The officer explained that there was a high turnover of staff in care homes and safeguarding concerns were more likely to be picked up. Concerns were monitored very carefully including a fortnightly check in order that any themes are picked up.

- The chair stated that he sat on the Adults Safeguarding Board, and he commended the quality of work that took place.

It was resolved to:

a) receive and note the contents of the 2021-22 annual report.

b) recommend that work is undertaken by Adult Social Care officers on how transparency and accountability can further be improved in safeguarding case reviews, not simply in promoting organisational learning and seeking to prevent recurrences in relation to failings identified; but also in seeking for the County Council to provide clear and timely acceptance of responsibilities to relatives for any failings including apologies where appropriate. Any recommendations would be further shared with partners in the Safeguarding Board for their consideration.

146. Adults & Health Risk Register

The Committee considered a report outlining the risks in relation to adults and public health.

Individual members raised the following points in relation to the report;

- Highlighted that the risk appetite was low. The Executive Director- People Services stated that there was a corporate risk scoring process that the organisation operated within.

- Acknowledged that high profile serious cases always remained at the forefront of people's minds. The Executive Director- People Services commented that there was a commitment to learn from these serious cases, to ensure that measures were put in place and to learn from mistakes.

It was resolved to note the Adults & Public Health risk registers.

147. Finance Monitoring Report October 2022-23

The committee considered a report on the financial position of services within its remit as at the end of October 2022.

In particular the presenting officer highlighted;

- Continuing to see pressures on mental health and physical disability budgets and these had been offset by underspends on the older people budget.

- Learning Disability budget savings were still being worked on with partners, but it was unlikely that this would be resolved for this financial year but were looking to back date the savings.

- Adult social care reform had now been delayed which had not been reflected in the report when it was published but would be updated for the November report.

- Expected the provisional government finance settlement imminently.

Individual members raised the following points in relation to the report;

- Queried what way different departments of the council were contributing to the making connections and sustainable transport survey and how this translated to the cost of transport and care giving. The Executive Director- People Services explained that as part of the consultation there were ongoing discussions in relation to care workers and how they could be treated differently in relation to road charging.

It was resolved to:

review and comment on the relevant sections of the People Services and Public Health Finance Monitoring Report as at the end of October 2022.

148. Adults and Health - Key Performance Indicators'

The committee received a report outlining the key performance indicators under the committee's remit.

Individual members raised the following points in relation to the report;

- A member asked if a comparison could be done at some point on how the authority compared regionally and nationally in relation to key performance indicators. ACTION REQUIRED

It was resolved to:

note and comment on the performance information outlined in this report and take remedial action, as necessary.

149. Adult and Health Committee Agenda Plan and training plan

It was resolved to note the agenda plan and training plan.

Part 2 – Health Scrutiny

150. Cambridgeshire South Care Partnership (ICP) Update

The committee received an update on the Cambridgeshire South Care Partnership (ICP) which aimed to enable citizens to enjoy healthy lives in strong, connected communities through partnership work and the development of six workstreams including community champions; the care together programme; and cross referrals, such as hospitals referring patients to the Household Support Fund. The officer expressed hope that the ICP would allow patients to meet their personal ambitions. but highlighted that the ICP was also facing high levels of disparity in Cambridge City, a stretched workforce, and insufficient financing.

In particular, the officer highlighted:

- That small integrated neighbourhood care teams existed, particularly in East Cambridgeshire, to connect services at a neighbourhood level. Employment was being sought for a personalised care lead who would mentor these roles.

- That the Cambridgeshire South Partnership team had grown from three to fifteen.

- That hosting arrangements with Cambridge University Hospitals (CUH) had been agreed, and it was hoped that the partnership agreement with CUH and a formal mandate for place partnerships from the Integrated Care Board would be available by the end of the financial year.

- That it was important the service listened and responded to the population they served, hence the focus on local solutions. To ensure these views were represented, the service was accountable to Cambridgeshire University Hospitals, which managed the budget. The partnership was also accountable to the public, as decisions were made in a public forum and the ICB was chaired by a patient representative. Cambridgeshire County Council's Adult and Health Scrutiny Committee also provided an importance mechanism for democratic accountability. Scrutiny of the Joint Strategic Board may be furthered in future.

- Primary determinants of health and wellbeing in an area were largely social such as labour type, green spaces and schools. These factors were under local authority control.

- The importance of the Health and Wellbeing Board in informing and assessing the actions of the ICP.

- The statement made by former Massachusetts General Chief of Medicine that all healthcare systems would get a population level benefit from doubling financing for primary and community care. This would improve health outcomes and save costs. However, investment was often directed towards more high profile, low impact interventions.

- That there had been an unreasonably short application window for the winter pressures grant which had caused stresses on the system. This form of funding also did not accommodate long-term employment contracts.

- That primary care was contracted to independent contractors, not the NHS. Variation in this provision was affected by the contractor as well as community demands. Fortunately, partnership through the ICP assisted in establishing where these variations were unwarranted.

- That the effectiveness of Integrated Neighbourhoods varied across areas but had improved overall since summer. Many Integrated Neighbourhood employees had previous work experience with partners, which contributed to networking.

- That both North and South Cambridgeshire had received £1m from the NHS winter grant to be directed towards primary care and community care. This money had been delegated down to neighbourhoods in order that financing could be directed to meet the needs of the hundred most vulnerable people in each area. The ICP had oversight of this through neighbourhood reporting, such as on the shift from unplanned to planned care.

- Significant differences between the CCG and ICB. Concerns were expressed about the level of representation from primary care on the Integrated Care Board.

- That a key challenge for the system was the Integrated Care Board's current limitation on financial delegations, which reduced the resource the ICP had for service delivery.

- It was anticipated by the end of 2023 there would be an update for the Adults and Health Committee from South ICP which would include a mix of changes delivered and a Joint Strategic Board performance dashboard, feedback from data gathering for patient/staff experiences, and anticipated improvements to partnership delivery.

- By 2024, the service hoped to have made tangible impacts to Cambridgeshire citizens using person centred support. In the short term, this impact would be an improvement to lived experiences; in the long term, this this impact would be a reduction in larger scale problems, such as life expectancy and obesity.

Individual members raised the following points in relation to the report:

- Suggested there should be a format through which NHS social prescribers and local councillors were made aware of one another and the community offer.

- Asked why GP services were not being developed in new build areas.

- Recognised that financial delegations from the ICB to the ICP were required for the ICP to meet targets.

- Highlighted the delivery of the Anti-Poverty Strategy and warmth hubs in Cambridge City Council with statutory and non-statutory partners.

- Recognised that Cambridgeshire County Council was decentralising their Care Together Programme to include directorates for which health was associated, such as Highways.

- Complimented the Local Neighbourhood Zero spreadsheet.

- Requested that future reports include a link to PCN catchments, a holistic overview of the system, reflections on Health and Wellbeing Board Committee meetings, and a performance dashboard.

- Thanked the partners for coming and reiterated the local authority's commitment to the ICP.

It was resolved to:

Note and comment on the report.

151. Learning Disability Paper

The committee received a report on the Learning Disability Summit. Compared nationally, Cambridgeshire had good outcomes for individuals with learning disabilities. However, following pandemic pressures, there remained concerns for people with learning disabilities, particularly those admitted to hospital. As a result, the CCG and ICB had organised a summit within which workstreams had been developed to improve hospitals' approaches to individuals with learning disabilities.

The Director for People's Services recommended scrutinising the outcomes from this work in future to ensure accountability but noted that CCC is the lead provider of community services for people with learning disability so has a joint responsibility.

Due to sector strikes, the Chief Nurse was unavailable and therefore questions were addressed to the Director for People's Services. In response to questions from members, the Director for People's Services highlighted:

- That the Learning Disability Summit had been triggered, in part, because the Integrated Care Board was not meeting the 67% target for NHS health checks.

- That there were currently challenges in working with the market to meet the care needs of people with Learning Disabilities

- That the 0-25 Disability Service had been placed in Adult Services to manage the transition between children and adults services. However, it was

acknowledged that parents and carers continue to challenge whether the Council could do more do improve the transition process.

- The success of the Learning Disability Partnership which had improved services' problem-solving capabilities through joint working. Throughout the pandemic, the integrated care model had mitigated carer breakdowns and illnesses. This practice was encouraged to continue.

- That changes in practice enabled adults to be diagnosed with ADHD and autism.

- The need to link healthcare services with mainstream schools and ensure that healthcare partners had input in Education, Health and Care Plans (EHCPs).

- Agreed to an internal briefing on learning disability display and diagnosis. ACTION REQUIRED.

- Encouraged people with learning disabilities wishing to advise how services could be improved to better accommodate their needs to contact their councillor and the local authority.

- Members raised additional questions for written response from the Chief Nurse: ACTION REQUIRED

- Noted the benefits of health passports for individuals with autism or in the social care system and asked for information on the use of health passports in the county.

- Requested a statistical breakdown of mortality rates and premature deaths amongst individuals with learning disabilities locally and nationally.

- Asked for information on support for carers.

- Enquired about how NHS health checks for individuals with learning disabilities could be improved. Feedback from individuals and their families had raised questions, especially regarding diagnosis pathways.

- Wondered how the challenges in the care market could be progressed.

- Asked for details on the performance of the Advocacy Service. This could alternatively be included in the development session.

- Queried whether individuals with learning disabilities were receiving respect and dignity in local hospitals.

It was resolved to:

- Approve a check and challenge meeting is held with the Chief Nurse and Chief Executive of the ICB with each of the workstreams to establish new dates and trajectories for workstreams to deliver (planned for 18 January 2023). In the interim the working groups continue to work on existing action plans

- Agree a co-production Risk Summit workshop is organised for February 2023 to further test the plans with people with a lived experience

- Agree a Partnership Learning Disability and Autism Workforce Strategy to address the capacity and demand challenges.

152. Scrutiny Forward Plan

The forward plan for scrutiny was reviewed and the following services were suggested for scrutiny in future:

- Primary care networks and access to the GP services including the scope for remote GP services.

- ICB Financial Plans

- International recruitment and housing problems.

- Health prevention in early years.

- Research funded healthcare and clinical trials. Examples of organisations to invite included the East of England Health Science Network or primary care within the Clinical School.

- The balance of primary and acute care within the ICB.

- NHS Workforce Development

- Integrated Care Neighbourhoods.

The following comments were made by members on existing items on the forward plan:

- All Age Autism Strategy: Sought to expand the review to look at all overlooked areas, not only diagnosis in girls.

- Dentistry Commissioning: Queried whether new information would be obtained by re-reviewing the service, despite continuing problems with NHS dentistry appointments. The officer highlighted that in March the ICB would take over NHS Dentistry Commissioning and the Chief Executive of the ICB could be consulted on their future approach.

The following item was requested as Adults and Health Committee item:

- Sexual and reproductive health services.

The following suggestions were made for improving future scrutiny:

- Using quarterly liaison meetings to set up questioning lines.

- Services visits.

- Formal development sessions.

- Use of lines of questioning by asking for similar questions when a particular subject was raised.

- SWOT analysis.

- More compact seating arrangements.

- Utilising the ability to make recommendations to the service for consideration.

The following ideas were proposed for improving future meetings:

- Spending more time on topics for which committee input could make a difference, such as KPIs. The Chair responded that little time was already spent on key decisions which the committee was unlikely not to approve.

- Allowing follow up questions.

153. Date of Next Meeting

It was noted that the next meeting would take place 9 March 2023.

Chair

ADULTS AND HEALTH COMMITTEE MINUTES - ACTION LOG

This is the updated action log as at 1 March 2023 and captures the actions arising from the most recent Adults and Health Committee meeting and updates Members on the progress on compliance in delivering the necessary actions

Meeting 5 October 2022						
Minute No.	Report Title	Action to be taken by	Action	Comments	Status	Review Date
123.	Winter Planning – Prevention and Control of Winter Infections	Jyoti Atri	Commented that community centres offering vaccines were querying what would be happening to funding after December. The Director of Public Health stated that she would need to seek an update from ICB colleagues on this and would report back	23.01.23 Update from Greg Lane C&P Mass Vaccination Programme Director NHS Cambridgeshire & Peterborough Programme funding until 31/03/23 has been confirmed and community centre sites continue to support us with hosting vaccination events. NHSE have confirmed programme funding for 23/24, with community vaccination provision still being a crucial part of delivery to make vaccination capacity as local for patients as possible and to support driving down health inequalities.	Closed	
125.	Commissioning Behavioural Insights Research & Interventions	Val Thomas	Requested that an early understanding of the findings including case studies be brought back to committee.	To be added to the forward plan in due course	Ongoing	
133.	Cambridge University Hospitals NHS Foundation Trust – Update	Kate Parker	Agreed to be provided with a paper submission of the Complaints and PALS review	Briefing Note circulated 25.01.23	Closed	

Meeting 15 December 2022						
Minute No.	Report Title	Action to be taken by	Action	Comments	Status	Review Date
136.	Minutes – 5 October 2022 and Action Log	Kate Parker	In relation to the action log, a member commented that there had not been a meeting with Cambridgeshire Children's Hospital for a while and asked that this be chased up.	A quarterly liaison meeting with Cambridge Children's Hospital has been set for 2nd Feb 2023.	Closed	
138.a	Review of Draft Revenue and Capital Business Planning Proposals for 2023-28	Debbie McQuade	Queried the Mental health section 75 vacancy factor and queried whether there were disadvantages resulting from these posts being vacant. Officers explained that effectively they were not reducing the service in any way, the proposal was about a one-off reduction as the service could not recruit these staff at the moment. Officers highlighted that the funding would go back into the budget, in the next year as the expectation was that the service would still want to recruit the staff. Officers clarified that they would go back to colleagues to review the scoring of the proposal	CPFT confirmed that ongoing recruitment to vacancies is continuing to be progressed, there is no further disadvantage as the vacancies exist and it is a one off proposal re vacancy saving	Closed	

| 138.b | Review of Draft Revenue and Capital Business Planning Proposals for 2023-28 | Will Patten | A member expressed concern in relation to the changes on adults and mental health employment support and highlighted that there was a failure to direct funding to areas where there was greatest need, in particular in relation to Fenland. Officers stated that the housing related support service was currently being retendered to provide more equitable support across the County and stated that they would come back to the member with a more detailed response | From Dec 2022, the MH Employment Support contract has been delivered by new organisations. The major part of it is now operated by CPDT Individual Placement Service, and the minor part is operated by LifeCraft.

The change widens the geographical coverage and increases the support capacity across the county including Fenland. We would be happy to provide a further update in six months' time after the contract has stabilised. | Closed | |

| 142. | Insourcing of a Supported Living Service | Will Patten | A member stated that he was surprised that the report was being taken in a public session as it referred specifically to allocating a contract to bring a service in house. He also asked whether this would set a dangerous precedent that providers could say that they would give up services as they could rely on the County Council to take services in house. The chair stated that the report had been through the relevant sign off process with legal colleagues and that this process had not raised any issues in terms of confidentiality. The chair explained that he would however reflect with officers on how similar reports would be brought to committee in the future outside of the meeting. | The decision to present the case to Members was consistent with the governance criteria. To ensure no confidential information was presented, the report removed the private organisations name. Officers would be content to have similar cases heard in private should Members decide that was appropriate.

Members should be assured that cases like this one is not frequent. Prior to this proposal being put to Members, extensive work was completed with the provider to establish if the service could remain in private ownership. This work was carried out over 2 years, and many ideas were tested before the change of sourcing recommendation was made. As a result we don't anticipate this sets a precedence. | Closed | |
| 148. | Adults and Health – Key Performance Indicators' | Debbie McQuade and Val Thomas | A member asked if a comparison could be done at some point on how the authority compared regionally and nationally in relation to key performance indicators. | The information requested is provided routinely as part of the report re Key Performance Indicators, however, a separate report has been requested to ensure members are aware of the data being provided routinely. | Closed | |

151.a	Learning Disability Paper	Kate Parker	Agreed to an internal briefing on learning disability display and diagnosis.	TBC		
151.b	Learning Disability Paper	Kate Parker	Members raised additional questions for written response from the Chief Nurse	TBC		

Cambridgeshire Care Sector Strategy of Commissioned Services

To:	Adults and Health Committee
Meeting Date:	9 March 2023
From:	Will Patten, Service Director, Commissioning
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	Not applicable
Outcome:	A more resilient care sector delivering an equitable range of services to provide our residents with the right services, in the right place, at the right time in sufficient levels to meet current and future needs.
Recommendation:	It is recommended that the Adults & Health Committee:

a) note the approach commissioners are developing to manage demand information at a local community level as set out in para 2.1.

b) note and comment on the pressures affecting market sufficiency and resilience levels, as set out in para 2.3.

c) endorse the proposed focus to improve market sufficiency and resilience levels as set out in para 2.4.

Officer contact:
Name: Gurdev Singh
Post: Head of Commissioning (Adult Social Care)
Email: Gurdev.singh@cambridgeshire.gov.uk
Tel: 07747 455016

Member contacts:
Names: Councillors Howitt and Councillor van de Ven
Post: Chair/Vice-Chair
Email: Richard.Howitt@cambridgeshire.gov.uk , susanvandeven5@gmail.com
Tel: 01223 706398

1. Background

1.1. The County Council's responsibilities in relation to promoting diversity and quality in provision of care and support services derives from Part 1 section 5 of the Care Act 2014. This includes facilitating a diverse, sustainable high-quality market for our local population, including those who pay for their own care, and to promote efficient and effective operation of the whole adult care and support market.

1.2. The performance of these responsibilities involves an understanding of people's needs and an understanding of existing and future care and support services. This means:

- using robust evidence found in joint strategic needs assessments (JSNA). The JSNAs are complimented by further analysis set out in the Public Health Outcomes Framework (PHOF) produced by Public Health England.

- using a best practice approach to commissioning services. We adopt, "The Commissioning for Better Outcomes: A Route Map methodology[1],"

1.3. The Covid-19 pandemic has reinforced the importance of the adult social care sector to the safety and well-being of the people of Cambridgeshire. The impact on the adult social care market capacity has been significant. We need to address new challenges especially in relation to service models, the resilience of smaller providers, care sector workforce, and relationships with providers more generally.

1.4. The implementation of the Health and Care Act 2022 remains embryonic. However, the changes it introduces will give more people access to social service. This will add to the challenges in the care market.

1.5. Cambridgeshire and Peterborough Integrated Care System has a strategy to help tackle health inequalities. More commissioning work is required to help reduce these inequalities by addressing service capacity shortfalls and drive innovation into the care market.

1.6. The next part of this report provides a self-assessment of the sufficiency of commissioned services to meet people's needs and address health inequalities. This is not only undertaken with a view to improving quality or achieving better outcomes for individuals through prevention, but also ensuring value for money. It highlights the strategic risk resulting from the market resilience levels, opportunities to improve them, and stimulate debate about the way forward from a County Council perspective.

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[1] [commissioning-for-better-outcomes-a-route-map-301014.pdf (adass.org.uk)](commissioning-for-better-outcomes-a-route-map-301014.pdf)

2. Main Issues

2.1. Forecasting demand for services

2.1.1. According to ONS data, Cambridgeshire's population in 2020 was 659,853 with this predicted to increase to 697,614 by 2040 (a 5.7% increase). Within this growth forecast for the county, we see two diverging population trends over the twenty-year period:

- Older People 65yrs+ shows a projected increase of 38%,
- Adults shows a projected decline of 1%.

From further work, we note alongside this an ageing population who have an increase in acuity of needs. With increased longevity in older people and those with learning disabilities, we are seeing increasing complexity of needs due to growing rates of co-morbidities and the associated daily care impacts.

2.1.2. The changing population and care and support needs in Cambridgeshire should be seen within the context of the growing number of options for care, and the different choices that people are making about their care and support. We prioritise the importance of supporting people to remain in their own homes. Where this is not possible, we strive to help people remain independent through housing-with-care solutions. Whilst recognising the part which traditional care homes will play, we continue to explore alternative housing options which may offer better outcomes for people.

2.1.3. During 2021 an older people's accommodation needs assessment work was completed. The resulting forecast was underpinned by Office of National Statistics population projections and then adjusted to take account of market intelligence, experience of the local care and support market, together with consultation of care and support providers. The aim of the documents is to explain what accommodation is needed, from a care perspective, including how much, when, and where.

2.1.4. The result was a set of Demand Profiles which were published in March 2022. For the first time, this information was shared with care providers, developers, and investors at district level instead of county level. They present a shared view of forecasted demand for Older People's specialist accommodation in the form of residential care homes, nursing care homes, independent living services, and extra care services, and domiciliary care in each of the five Cambridgeshire Districts.

2.1.5. The effect of Covid-19 pandemic has significantly shifted our placements numbers away from residential care for older people and that we expect this trend to continue for the near future. There is also the expectation that people will wish to stay at home with care for as long as possible, increasing demand in homecare. However, we recognise the need to develop our model of home care to deliver care closer to home, delivered by carers from the local community who can provide more localised and personalised care in the home. This in turn will

enable us to collaborate with providers to deliver social value to their local communities.

2.1.6. The demand profile for adults under the age of 65 requiring specialist accommodation for adults who have additional care needs, related to learning disability, autism, mental health, or physical disabilities is being completed. We expect to publish those profiles during 2023/24.

2.1.7. The growth forecasts are based on census data from 2011 and therefore these will need to be updated once the new census data is available during 2023/24. Preliminary information indicates that increases may exceed predictions in this needs assessment.

2.2. Self-assessment of commissioned services resilience

2.2.1. Notwithstanding unplanned demand pressures, such as extreme winter pressures and other seasonal pressures, a successfully commissioned service is sustainable and sufficiently available for meeting the needs for care and support of adults. Commissioners completed a self-assessment of commissioned services and highlighted which services are developing and do not necessarily sufficiently meet current and therefore future needs.

2.2.2. The process has enabled us to seek challenge, both internally and externally, to strengthen the service and encourage innovation to improve outcomes. This approach informs our work around co-production, ensuring we listen and respond to feedback from people at the heart of services.

2.2.3. The significance of each service is set out in the table below:

Service	Number of People	Annual Expenditure*
Older People & Physical Disabilities Services		
Accommodation based	1,390	£59m
Community based	2,262	£35m
Physical Disabilities under 65 age		
Accommodation based	45	£3m
Community based	428	£8m
Learning Disabilities		
Accommodation based	275	£30m
Community based	1,819	£64m
Mental Health Services (all), Autism Services		
Accommodation based	251	£9m
Community based	425	£9m
Totals	**6,895**	**£217m**

Table 1: Note annual expenditure has been rounded-up to no decimal places and is gross of contributions from health, clients, etc.

People should be supported to live as independently as possible in settled accommodation in the community, rather than living long term in institutional

settings. The paragraphs below separate out accommodation-based and community-based services into those that are sufficient and those where development is required. Further details of each service are listed in Appendix A.

2.2.4. Our accommodation-based commissioning approach is to develop a range of housing options including new models. Our work focuses on two types of services:
- long-term accommodation – here the person has security of tenure/residence in the medium to long term or is part of a family household including independent living services for older people; and
- short-term accommodation – here a person can be accommodated for a brief period, for example, to prevent an avoidable admission into a hospital setting.

The table below shows priority work should focus on mental health services and learning disability services, in additional to joint up work with the NHS.

Accommodation Based Provision

Areas of Good Practice	Areas of Development
Care Homes	Mental Health Supported Accommodation
Independent Living Service	Development of the Mental Health Brokerage Function
Focus on improving utilisation - Care Homes	Planned and Unplanned Respite – Learning Disabilities
Extra Care	Crisis Accommodation and general placements – Learning Disabilities
Specialist Accommodation – Learning Disabilities	Technology Enabled Care in Care Homes
Housing Related Support - Cambridgeshire	Integration and Joined Up working with the NHS
Hospital Discharge Support Pathway - Housing	

2.2.5. Our community-based commissioning work focuses on a range of services that allow people to live in their own home in their communities for as long as possible, with appropriate care and support. Private and voluntary sector bodies across Cambridgeshire support people to do this by offering services. We are focusing on:
- introducing a place-based approach to commissioning care and support in the community for older people;
- improving the homecare offer available to local people; and
- improving older people's early intervention and prevention services, helping to delay people's need for long term health and social care.

The table below shows priority work should focus on self-directed support, day opportunities, and support for carers, in additional to joint up work with the NHS.

Community Based Provision:

Areas of Good Practice	Areas of Development
Care Together	Homecare - Cambridgeshire
Homecare	Day Opportunities Older People and Learning Disabilities - including employment
Microenterprises - Cambridgeshire	Self-Directed Support
Voluntary and Third Sector	Occupational Therapy
Occupational Therapy	Learning Disability Section 75 Arrangements
	Carers
Carers Support	Advocacy
Mental Health	Integration and Joined Up working with the NHS
	Community Equipment

2.3. Pressures affecting market sufficiency and resilience levels

2.3.1. Despite our health and care system providing a strong joint response throughout the Covid-19 pandemic, there were inevitable impacts due to the challenges we faced during this period, including an impact on waiting lists due to the reprioritisation of resources. Some of those pressures continue to have an impact and challenge the sufficiency of commissioned services. We have seen the results of these pressures in the form of some care home closures, and workforce capacity issues leading to care package hand backs. Re-tendering these packages has resulted in changes in services for service users as well as higher prices for commissioned services.

2.3.2. The Cambridgeshire and Peterborough ICS Health Inequality Strategy summarises themes identified by people as barriers. These included:

- poor communication from health and care providers, with people often unaware of the help available to them;
- the rising cost of living which is impacting on people's ability to afford services;
- digital exclusion makes it harder for people to access online;
- the lack of public transport in rural locations makes it more challenging and expensive to attend appointments;
- lack of suitable housing causing additional problems; and
- people with physical disabilities living in accommodation that is unsuitable for their needs.

The above factors all have a layering effect increasing the difficulties people face in accessing services.

2.3.3.   Providers are telling us that they are having severe issues with recruitment and retention of staff and are having to use more agency staff which can often be a key cause of quality concerns and increased cost pressures. They cite:

- leaving the EU impacted the workforce. The introduction of visas meant many people went home to work, instead of applying for visas, or did not return after visiting family having been away so long.

- the recruitment of staff in an already challenging market, became increasingly difficult due to mandatory Covid-19 vaccination. This was felt across all sectors, including the retail, hospitality, and warehouse fulfilment (geographically important in North Cambridgeshire), resulting in a rise in wages. Competitive wages from industries where the costs can be transferred to the consumer are manageable, however not possible in statutory funded homecare.

2.3.4.   Further providers, particularly smaller and voluntary sector ones, are telling us that they are having issues remaining financially competitive due to:

- rising competition for labour from other sectors able to pay increased rates to attract staff. An inability to retain staff has led to a reliance on the use of agency which is both expensive and can impact on quality due to lack of consistency and turnover.

- the unprecedented inflationary costs during past two years, providers have been proactively flagging with CCC officers the exceptional pressure that they are facing. The main themes that have been reported by aside from staffing are rising fuel, utility, and salary costs.

- the legacy effect of some learning disability packages. Older care packages are often synonymous with lower weekly fees. These package fees levels are being scrutinised by providers and considered unsustainable. The consequence could be higher prices to align these packages to market norms.

2.3.5.   There is currently a shortfall of nursing care home capacity across the county but with most significant gaps within East Cambridgeshire. This shortfall has led to 11% of Council placements being made out of county with the highest proportion of these out of county placements being nursing and nursing dementia.

2.3.6.   It remains difficult to place people with complex needs and behaviours that challenge services. The next part of the report outlines the key pressures and associated mitigations.

2.4.   Opportunities to improve market sufficiency and resilience levels

2.4.1.   Commissioning plans for 2023/24 has been formulated to prioritise work on these challenges and improve the sufficiency of service to our service users. These include the development areas set out in para 2.2.4 and para 2.2.5.

2.4.2.   We plan to provide information and transparency to help the care market target their investments and services in the right place. This will include publishing:

- Cost of Care assessments;
- Market Sustainability Plans;
- Market Position Statement incorporating the 2021 Census; and
- District Demand Profiles for all accommodation-based service.

2.4.3.   We plan to increase collaborative working to make it easier for the care market to understand commissioning requirements, increase capacity, and engage with the public sector. This will include:

- co-produce our services with people with lived experiences. This will help us assure we avoid service features which add cost and no value;
- enhance collaboration with health commissioning colleagues to promote a more joined up approach to market shaping and management;
- creating capacity through voluntary, community or social enterprise organisations wanting to get into homecare. by partnering with the Health and Social Care Academy; and
- working with and supporting care homes to deliver the highest level of service possible by promoting the work the Council has established through the Care Home Support Team and the Living in a Care Home review team.

2.4.4.   We want to develop a social care workforce that is skilled, feels valued and experiences lower levels of turnover. We therefore propose to move forwards with the policy objectives, for our own workforce but also work to support the care workforce more widely across the county, to create:

- a well-trained and developed workforce;
- a healthy and supported workforce;
- a sustainable and recognised workforce; and
- a plan to incorporate the roll-out of the real living wage investment into how we manage price uplift negotiations with care providers.

2.4.5.   We want to develop a more collaborative care market which delivers value from collective problems solving and creating innovative solutions. This will include:

- increasing the identification and implementation of social value;
- exploring how with economic development assistance we can support resilience and growth within the local market.
- increasing partnership working with providers and care associations;
- improve resilience through our fee uplift process and use of the Market Sustainability Fund focusing funding to those packages and providers which are demonstrably at risk.
- reduce the number of empty beds which cannot be used because referrals are not compatible to the residents of a care home; and

- growing the community-based homecare, personal assistance, and care micro enterprise market.

3. Alignment with corporate priorities

3.1 Environment and Sustainability
There are no significant implications for this priority.

3.2 Health and Care
The report above sets out the implications for this priority in paragraphs 2.3.2

3.3 Places and Communities
The report above sets out the implication for this priority in Appendix A – Self Assessment of commissioned services.

3.4 Children and Young People
There are no significant implications for this priority.

3.5 Transport
There are no significant implications for this priority.

4. Significant Implications

4.1 Resource Implications
There are no significant implications for this priority.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications
All procurement activity will be compliant with the Council's Contract Procedure Rules

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 for this priority.

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 Environment and Climate Change Implications on Priority Areas
There are no significant implications within this category.

4.8.1 Implication 1: Energy efficient, low carbon buildings.
Positive/neutral/negative Status: Neutral

Explanation: There are no significant impact

4.8.2   Implication 2: Low carbon transport.
Status: Neutral
Explanation: There are no significant impact

4.8.3   Implication 3: Green spaces, peatland, afforestation, habitats and land management.
Status: Neutral
Explanation: There are no significant impact

4.8.4   Implication 4: Waste Management and Tackling Plastic Pollution.
Status: Neutral
Explanation: There are no significant impact

4.8.5   Implication 5: Water use, availability and management:
Status: Neutral
Explanation: There are no significant impact

4.8.6   Implication 6: Air Pollution.
Status: Neutral
Explanation: There are no significant impact

4.8.7   Implication 7: Resilience of our services and infrastructure and supporting vulnerable people to cope with climate change.
Status: Neutral
Explanation: There are no significant impact

Have the resource implications been cleared by Finance?   Yes
Name of Financial Officer: Justine Hartley

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement and Commercial?
      Yes
Name of Officer: Clare Ellis

Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or Pathfinder Legal?   Yes
Name of Legal Officer: Linda Walker

Have the equality and diversity implications been cleared by your EqIA Super User?
Yes
Name of Officer: Lisa Sparks

Have any engagement and communication implications been cleared by Communications? Yes

Name of Officer: Matthew Hall

Have any localism and Local Member involvement issues been cleared by your Service Contact?   Yes
Name of Officer: Will Patten

Have any Public Health implications been cleared by Public Health?
Yes
Name of Officer: Emily Smith

If a Key decision, have any Environment and Climate Change implications been cleared by the Climate Change Officer?
Yes
Name of Officer: Emily Bolton

5.   Source documents guidance

5.1   Source documents

None

Appendix A – Self Assessment of commissioned services

1. **Accommodation Based Commissioned Services**

Commissioning Portfolio	Description of Good Practice
Care Homes	In 2020, Cambridgeshire County Council made the decision to launch a large- scale block bed procurement. This not only responded to growing vacancy levels which created a risk of instability across the market but also enabled the service to address significant deficits in supply within some areas of the County whilst controlling escalating costs to the Council due to the rising costs associated with higher proportions of spot purchasing. However, ultimately by expanding both the number of beds and mix of care homes we block purchased beds with the tender enabled us to provide more choice and control to people who need a permanent placement. The block tender also introduced the use of flexibility clause enabling the Council to access vacant block bed capacity for short term usage on discharge from hospital or when somebody is in a crisis in the community to prevent admission where appropriate. This has enabled Cambridgeshire to decommission some interim block capacity which was not well utilised and did not achieve value for money whilst continuing to service this need. Detailed, system wide discharge and placement flow have been developed and agreed to enable both existing and new care home residents to be discharged from hospital to their care home of choice in a timely manner resulting in a better experience and individual outcome for the service user. This is promoted using Care Home Trusted Assessor service commissioned to prevent delays due to the need for a care home to allocate time and capacity to assess the service user in hospital. Rather a trusted assessor working with health and social care agencies as well as providers undertakes this function. Routine contract monitoring arrangements for care homes is in place and working in close partnership with the Council's in house Care Home Support Team and NHS Partners any concerns whether individual or organisational are proactively identified and managed to prevent an escalation of events wherever possible and ensure people continue to receive a good standard of care and support within these settings. Where individual concerns are identified during the process referrals can be made to other services such as the falls prevention service or technology enabled care to ensure they are addressed.

| Independent Living Service | Cambridgeshire County Council's Independent Living Service (ILS) model aims to provide prospective tenants with complex Health and Social Care needs an affordable home for life. The ILS will offer up to 64 individual tenancy based self-contained suites with a focus on enabling and maintaining independence. It is expected that the suites will be accessed primarily by older people, but any adult who has a need for self-contained housing with access to care and support with nursing can be considered.

LS aims to offer greater choice, control, and independence leading to positive personal outcomes and to address a gap in the current market at the point that a decision is made to move into a new home. ILS will be fully accessible, secure, attractive, and homely. The model focused on those with a need higher than extra care but who can still maintain some independence. The accommodation will be designed to be adaptable and will be available not just to single people but couples, siblings living together and elderly parents and their adult disabled children. Access is based on need, not on age.

The first ILS will be developed by the County Council in collaboration with the NHS. Within this ILS there will be a standalone inpatient rehabilitation ward which will be leased to the NHS. The ILS housing management services and care and support with nursing services providers can influence the design and layout of the building.

The project team undertook extensive market research and service user engagement to ensure that the project is developed with those who have lived experiences. Focus groups took place, facilitated by Healthwatch to obtain insight and feedback from a spectrum of service users, as well as their families, friends, and carers. It also engaged with a wide variety of professionals from the outset and their expertise helped to inform and refine the design. We also engaged with providers utilising a variety of methods to maximise opportunities to seek their input and expertise. |
|---|---|
| Focus on improving utilisation - Care Homes | The Brokerage Team effectively monitor the utilisation of bock bed capacity within Cambridgeshire. Where utilisation requires improvement, intelligence is shared with Contract Managers who then actively manage performance through routine monitoring and meetings. This approach has resulted in funding being clawed back where the Council are unable to access beds within the terms and conditions of the contract increasing value for money. |
| Extra Care | Across the Council 18 Extra Care Schemes are commissioned with plans to expand the use of provision in line with projections developed as part of the accommodation needs assessment. Extra care housing enables people to live independently in their own flat and yet benefit from the provision of 24/7 care team on site which can meet their personal care needs outlined in their individual support plans and respond to emergency calls should the need arise. |

	Extra Care provision commissioned within Cambridgeshire is commissioned as a core block service with additional care hours purchased based on an assessment of need. There is also Housing Related Support funding to support development of activities and other support within schemes. Extra Care is key to prevention and a key alternative to delaying entry to residential care. Whilst we commission extra care support within a scheme from a single provider, tenants do have the right to exercise choice and control through choosing to receive their support from an alternative provider via direct payment. However, this is not common due to the consistency and quality of support received from commissioned providers. Local extra care provision has also proven flexible to meeting the needs of people as they become increasingly more complex with extra support being funded in a temporary basis where necessary to enable individuals to stay in situ rather than go into nursing/end of life for a brief period of time.
Specialist Accommodation – Learning Disabilities	Accommodation and associated support for people with Learning Disabilities is commissioned through a number of different routes. Within Cambridgeshire, support is sourced through a standard and complex supported living framework, as well as a complex and standard residential framework. This approach is complemented by a range of in-house provision. This approach has enabled the needs of individuals across a broad spectrum to be met. The structure of the frameworks provides the flexibility to be re-opened on a regular basis enabling the Council to expand the market and increase capacity where required. Where the frameworks or local market cannot meet an individual's needs, Commissioners are able to undertake bespoke to commissioning which is tailored to everyone ensuring their needs and outcomes are met. More recently, Commissioners have also worked within in house services to insource a scheme where the provider had served notice. Quick and flexible action has resulted in the needs of people continuing to be met with greater value for money being achieved.
Housing Related Support - Cambridgeshire	In 2018 a Housing Related Support needs assessment was completed in partnership with District Council and City Council Housing partners. Findings from the needs assessment informed the development of an integrated and robust housing related support strategy which set out the vision for service provision in the future and plans to progress this. The vision was more person centred and focused on the delivery of increased flexibility to ensure positive outcomes are achieved across a range of diverse needs. Existing homelessness services across the County were then redesigned and recommissioned through use of co-production with a range of partners and stakeholders. Work was also undertaken with the

	Counting Every Adult Team using a human learning system approach to engage experts by experience in the process and this was carried right through the evaluation of the tender. In addition to this specific surveys and engagement sessions were also used. Use of the local Housing Board which has representation from District Councils, Peterborough City Councils, and other agencies throughout the commissioning cycle proved important to ensuring collaboration within these areas. Finally, the project also achieved good political member engagement throughout through the using a member reference groups and specific briefing sessions. Through this project, the Council took a lead role in driving forward an entire system approach to innovating and developing services within this area. The new service designs were informed by best practice for Children's and Adults including St Basils Pathway and Housing First and both a Trauma and Gender Informed support approach. It has also proven successful in receiving additional funding to establish Countywide Housing First offer, has enabled local providers to work in partnership to deliver services differently and has made significant financial savings.
Hospital Discharge Support Pathway - Housing	The Council was successful in bidding for funding to support the development of housing options for people who are experiencing or at risk of homelessness and need to be discharged from hospital to enable system partners to manage demand within this area in a more effective and outcome-based way through identifying people with accommodation challenges earlier.

Commissioning Portfolio	Area of Development
Mental Health Supported Accommodation	Current contracts for supported accommodation are very historical and there is a need to review and recommission this to ensure a pathway which is more person centred. Work on this already underway and has piloted alternative referral pathways, amended the structure and complexity of need managed by the service and has engaged in co-production in development of an alternative approach in the lead up to a procurement in 2023. The Council also commission supported accommodation for people with Mental Health and/or Autism. Whilst this represents positive progress in addressing the needs of people who present with a range of need and often a dual diagnosis, there are only a limited number of providers operating on the framework. Work is currently underway to plan for the re-opening and variation of the framework to explore the option of expanding it to learning disabilities further increasing flexibility in meeting individual outcomes and engaging with the market to create more choice and control.

Development of the Mental Health Brokerage Function	Additional resource has been recruited to support the mental health brokerage function. Alongside this a standard operating procedure has been developed which enables more consistent access to the market and control over governance for high-cost placements. This is currently being embedded.
Planned and Unplanned Respite – Learning Disabilities	A shortfall in capacity has been identified within this area and a review has been completed. Findings from the review have identified need for single service not just shared support. Younger people with higher needs and requirements for nursing care also coming through. Commissioners are currently progressing a procurement approach which will aim to source provision able to deliver better outcomes for individuals needed support, their families and wider respite usage. As part of this approach, extensive engagement has been conducted with experts by experience and people currently accessing services to ensure their views are heard in design and delivery of innovative approach. This was primarily completed through surveys and existing partnership boards. Soft market testing is being undertaken at present to harness the views and identify opportunities within the local market.
Crisis Accommodation – Learning Disabilities	The closure of inpatient facilities and secure units has resulted in a lack of capacity to meet the increasingly complex needs of people in a crisis. This is a national trend which we are seeing in Cambridgeshire. Work is underway in collaboration with NHS Colleagues to put in place an action plan to address the capacity gap through focusing on short-, medium- and long-term solutions allowing organisations to address immediate risks whilst longer term developments are considered and pursued. This will aim to ensure people appropriate preventative intervention is in place to manage crisis including support to providers, but accommodation is made available for use where necessary.
Technology Enabled Care in Care Homes	There is a need to develop a more robust approach to rolling out Technology Enabled Care within the Care Home Sector. Work with in-house Technology Enabled Care Teams across both Councils needs to be undertaken with more explicit linked made to the Integrated Care Board to ensure a joined-up approach to this area. This will be addressed through the development of the Accommodation Needs Assessment and Strategy.
Integration and Joined Up working with the NHS	There is more work to be undertaken to ensure NHS partners and the local Integrated Care System (ICS) are engaged in the delivery of a joined-up approach to managing the housing and accommodation needs of our local population as well as identifying opportunities to commission in a more joined up way at both a macro and micro level. Whilst early discussions have taken place as part of the accommodation needs assessment focus, the focus of local NHS partners has been on managing the transition to the new ICS structure. However, regular feedback on progress and

	opportunities for alignment in this area is fed in through relevant governance meetings. Given this is also a key requirement of adult social care reforms we will be moving to progress this further as the new structures and ways of working begin to embed.

2. Community-based commissioned services

Commissioning Portfolio	Description of Good Practice
Care Together	Care Together is a Cambridgeshire County Council led programme to help more older people remain living independently and happily in their own home for longer. Care Together will transform the way care and support for older people in the community is commissioned and delivered. Care Together has three objectives: 1. Introduce a place-based approach to commissioning care and support in the community for older people 2. Improve the homecare offer available to local people 3. Improve older people's early intervention and prevention services, helping to delay people's need for long term health and social care During 2021, a Care Together pilot began in East Cambridgeshire. Following 3 months of engagement with local people and partners, 12 projects were developed and are now underway to improve care and support for older people living at home. These range from accessible public transport to more holistic homecare and even trialling use of GP Frailty information to reach some of the most vulnerable older people. These projects are led by different Council departments and partners (including East Cambridgeshire District Council and South Integrated Care Partnership), demonstrating a new level of collaboration and joint working around a specific 'place.' Extensive co-production with local residents, communities and service users has also been completed. Funding is now in place to expand the programme across the remaining districts in the county. This will begin in 2022/23 and continue over a four-year period. If successful, Care Together will achieve the following outcomes: • Contribute to a reduction or delay in the need for health and social care support • Stimulate new employment opportunities and smaller enterprises contributing to localised economic growth and community wealth building • Older people live well at home for longer • Older people have more choice and control about the care and support they receive • Older people's satisfaction with council funded homecare improves

	• Changes to council funded homecare will reduce car travel and contribute towards the Council's climate change aspirations. Further detail can be found within the document pack provided.
Homecare	A Homecare Vision is in place for Cambridgeshire. In line with the approach taken in Care Together (above), the vision aims to move the commissioning of homecare provision towards a more holistic, placed based model which is focused on maximising independence for individuals. It also seeks to address gaps in service provision in areas such as mental health, learning disabilities and autism. The approach will also see to explore how introducing place-based commissioning and microenterprises can diversify the market, offering more choice and control to service users. Current provision is commissioned through a Dynamic Purchasing System in Cambridgeshire which covers all client groups and all ages and was originally commissioned to include continuing healthcare. Provision is of good quality and Contract Management is undertaken with providers on a monthly basis – this is determined by risk, in terms of quality concerns, hours delivered, which naturally informs us of spend information. This element forms just a part of the overall contract management of providers. A monitoring tracker exists and forms part of the contract management process which plots out the quality monitoring reviews of our providers and when they will be. This tracker allows the team to plan resource to ensure timely reviews are undertaken and where appropriate, reviews are moved forwards to a sooner date if concerns exist around those providers. The Home and Community Services Contracts for Cambridgeshire detail the quality monitoring process and how the contract will be quality monitored, which includes defaults. This quality monitoring allows us to understand and establish whether the provider delivers a service for the client that is personalised, and person-centred always, in line with the requirements of the contract and specification. Following a quality monitoring visit, whether in full or focused, it will determine the next steps where individual care needs are not be appropriately met and the Contract Management Team can take necessary action to remedy such concerns. Cambridgeshire also commission a range of block homecare provision which enables the Council to respond quickly where shortfalls in capacity is identified and support hospital discharge in a timely manner. More recent development of the hospital discharge service includes an incentivisation payment for enabling service users to increase their independence and achieve better outcomes whilst also ensuring swift movement into mainstream care on discharge from hospital. Through this work we have also introduced electric vehicles making the service more environmentally friendly to deliver.

	Commissioners have also led on development of a national informal homecare commissioning network established and utilised to inform commissioning intentions, benchmarking and share best practice/innovations. In addition to this, joint Forums are in place with Health and Social Care targeted to changes in guidance, legislation, key improvement themes and requested support from providers. The forums are planned and can be influenced by feedback and evidence from service users and forums.
Microenterprises - Cambridgeshire	Cambridgeshire County Council initially commissioned Community Catalysts in 2021 to develop a market of community based micro-enterprises to support the provision of adult social care services within East Cambridgeshire. This vision aims towards a placed based model, focusing on helping people to stay happy at home for longer. It explores how introducing place-based commissioning and microenterprise can diversify the market, offering more choice and control to service users. The Care Micro-Enterprise provider model will enable individuals to coproduce their own care and support through a more flexible and personalised approach. This aligns with the introduction of Individual Service Funds for Local Authority funded clients. There has been a 4-year investment (starting 22/23) with a commitment to expand Community Catalysts across the remaining districts through the Care Together programme. Care Together commits to diversifying the Adult Social Care market to offer more choice to individuals. This also aligns with the introduction of Individual Service Funds. To date, this has led to the establishment of 9 microenterprises, 6 of which are delivering homecare within local areas.
Voluntary and Third Sector	Cambridgeshire are working in partnership with NHS partners to commission voluntary and third sector provision through an Early Intervention and Prevention Pseudo Dynamic Purchasing System. The approach has enabled us to combine contracts under a single lot which can be commissioned under 3 different lots: 1. Lot 1- Avoidance and discharge support 2. Lot 2 - Information and Advice 3. Lot 3 - Community Support The approach taken is person centred and not solely based on one client group. It has been set up to call off based on provider skills and outcomes under a process which will ensure commissioners are adopting a person-centred approach. We currently have a wide mix of contracts and grants which have responded to local area of needs over time and are very much person centred in their delivery with returns from providers to assure of this. The approach also providers commissioners across the system to review and refine areas of duplication to ensure value for money and an integrated approach to commissioning

	provision within this area. A recent example of this is commissioning services to support discharge to assess pathways. The DPS can also be re-opened enabling new providers to join and diversify over time.
Occupational Therapy	The community Occupational Therapy Service which delivers support to adults over the age of 18 in Cambridgeshire has been provided as an integrated health and social care service since 2004. The delivery of the social care element of the service is governed by a Section 75 Agreement with the provider, Cambridgeshire & Peterborough NHS Foundation Trust (CPFT). Section 75 Agreements were legally provided by the NHS Act 2006 to enable budgets to be integrated and pooled between local health and social care organisations and authorities. The Occupational Therapists and Therapy Assistants provide a full service from assessment through to rehabilitation, provision of daily living equipment and recommendations for minor and major housing adaptations. This ensures that, in most cases, one practitioner can support them through their health and social care journey. The OT service is delivered as an integral part of the CPFT Neighbourhood Teams with the OT staff working alongside physiotherapists, community nurses and liaising closely with the County Council's Social Care teams.
Community Equipment	The Community Equipment Service has recently been recommissioned with the incumbent provider retaining the contract. The service is focused on maximising independence for longer through provision of a range of equipment which both prevents the need for long term support but also supports people with long term conditions to remain at home for longer and the specification was reviewed to ensure it remained person centred, and outcome focused. The service is commissioned in a fully integrated way across Cambridgeshire, Peterborough, and the ICB and is also an all-age provision sitting across adults and children. There is a robust understanding of how the Council benchmarks against other Local Authorities both for TEC and community equipment. There is also a robust understanding of key areas of pressure and demand. The Local Authority have led on regional work undertaken within this area which local authorities have adopted nationally. The contract is subject to robust, routine contract management and monitoring with any areas of concerns and issues being addressed proactively. The split in funding between partners was also recently reviewed using an evidenced based approach relating to activity. This resulted in a saving within Cambridgeshire County Council being achieved. Key Activity Trends (based on June 2022 data):

	- Waiting times are beginning to return to pre-pandemic levels (average wait of 9.5 weeks for an assessment compared to 5 weeks pre-pandemic) - Longest wait remains high at 46 weeks but is reducing month on month - The response to the most urgent referrals is being maintained at above target (see KPIs below) - OT interventions continue to deliver outcomes in terms of reduced care hours and demand management avoided costs. There is also a robust governance structure in place to ensure ongoing management and oversight is maintained to proactively address any risks and issues arising.
Carers Support	An All-Age Carers Strategy is in place and was developed in partnership with NHS Partners. Under this new strategy the carers support service was recommissioned in 2020. It was commissioned in a more joined up and person- centred way with the procurement taking place across three lots to ensure the development of an all-age service. The three lots include: 1. Adult Carers (including variation for additional support for carers) 2. Young Carers 3. Carers of Adults with MH needs The specification is centred on the 'I thrive' Model which is preventative in nature and focused on maximising outcomes. The Council has placed carers at the heart of programmes for improvement for the last three years with emphasis placed on increasing the identification of carers and ensuring person centred, outcome focused approaches are adopted to supporting them. The Council are now taking a leading role in exploring more creative and innovative ways to build upon this work through working with local communities and exploring how we identify populations of hidden carers. This is supported through additional investment allocated in 2022/23. In addition to this, Think Communities are currently seeking to engage with local communities to stimulate development of informal support networks. This has culminated in the development of a carers buddying pilot in East Cambridgeshire
Mental Health	The Council deliver a range of services designed to support people with mental health challenges. These services have been commissioned with evidence of need and are designed to deliver person centred outcome focused support. A summary has been included below:

Commissioning Portfolio	Area of Development
Homecare - Cambridgeshire	Through the Care Together programme, a placed based and more holistic approach to homecare will be tried, tested and adopted. This will commence with the following initiatives being initially undertaken within East Cambridgeshire: 1. Holistic Homecare – providers will be commissioned to delivery a more holistic homecare model which not only seeks to deliver personal care but also funds them to undertake a more holistic assessment of an individual's wider wellbeing and support them to access local preventative and inclusive provision. This could range from technology through to day opportunities or access to local community groups and assets. The pilot has been developed in partnership with local provider and service users and will run from October 2022 to April 2023 with an evaluation and lessons learning informing the ongoing expansion of the approach. 2. Placed Based Homecare – the Council are aiming to move away from county wide commissioning to a more localised approach with the development of a more outcome focused specification and Key Performance Indicators which balances this against the challenges of payment based on outcomes. This approach will look to generate localised, more efficient capacity. The tender for this approach is due to commence in April 2023 with the pilot going live from October 2023. 3. Skills Development - A partnership between PCC & CCC and the Social Care Academy has created opportunity for providers to access free training, specialist training and market roadmaps for VCSE organisations who would like to become CQC registered, as well as career pathways for those entering care to boost interest in those joining social care. 4.
Day Opportunities Older People and Learning Disabilities - including employment	The Day Opportunities Review Project covers external and in-house provision of Day Opportunities, for people with Learning Disabilities and/or Autism, as well as Older People, across Cambridgeshire. The vision and key objectives agreed for the project *to achieve a Person-centred, localised, and co-produced offer which connects people to their local communities according to their interests and aspirations, to maximise independence and reduce social isolation.* The project is aligned to the strategic direction of Adult Social Care, increasing outcome-based commissioning, and supporting the Care Together objective to introduce a place-based approach to commissioning care and support in the community for older people. It is also developed to consider environmental impacts and increased social value in line with corporate objectives.

	At present, OP services are delivered through a range of grant agreements and in house services. LD services are delivered through a framework approach for both standard and complex needs in Cambridgeshire, as well as in house provision. Performance in relation to LD Employment is also not optimal. To date, the project has undertaken an extensive co-production and engagement exercise across all areas of these services to understand what is working well and what is not working so well to shape the next steps.
	
	Using this intelligence, improvement will be delivered across 4 different workstreams in a phased approach:
	1. Phase 1 will take place between August 2022 and March 2024 and will see delivery of
	   a. Develop a Day Opportunities Framework targeted at Older People to ensure people with statutory support needs have access to the right level of provision across the County and this complements rather than duplicates in house capacity.
	   b. Re-design the grants model so it is focused on developing preventative provision within place and covers both LD and OP. This will see funding combined within a wider grant funding budget to enable more strategic decisions to be made on allocations in accordance with need.
	   c. Review of in-house service provision from an OP perspective to ensure it aligns and complements commissioned provision as part of a wider offer
	   d. Review and improvement to current referral routes and access points to make this more consistent and user friendly
	   e. Improving routes to Employment for adults with Learning Disabilities and/or Autism focused on an all-age approach to mapping existing provision, pathways, and capacity with a view to improving current performance.
	2. Phase 2 will take place between April 2024 and April 2025 and will look to review LD In House Services across both Councils to identify whether any further market shaping activities are required.

Self-Directed Support	Recognising the need to improve performance in the use of direct payments across both Councils, a strategy was developed prior to the pandemic which addressed all areas of improvement required across operational processes and commissioning. The strategy places personalisation, choice and control at the heart of care and support as individuals are free to use their personal budget in any way, and with any provider, that meets agreed eligible care needs. It also seeks to increase uptake of DPs as an alternative to commissioned care packages, thus supporting demand management in sectors with capacity issues such as Home Care.

	Post pandemic the governance for this has been re-established and a review of the strategy is taking place to determine next steps and timescales.

In addition to this, under the Care Together Programme Individual Service Funds are being developed. Individual Service Funds increase personalisation and choice by allowing a third party, chosen by the service user, to pay for care and support from a variety of different providers on behalf of the service user, relieving them of the burden of responsibility of being an employer of a PA or the passivity of depending on a single form of commissioned care such as Home Care. Instead, the personal budget can be used to pay for a plethora of services that complement one another and meet a wider range of care and support needs than currently possible. At the start of 2022, a group of providers to deliver ISF's were commissioned, and this approach is being rolled out currently with significant system developments being agreed and progressed. |
| Occupational Therapy | Over the years, the model has proven successful in improving waiting times and reducing hand-offs between health and social care, with most service users only requiring contact with one OT practitioner for all their health and social care needs. However, the pandemic has had a significant impact on the service following the large-scale redeployment of staff to support discharge to assess pathways to ensure people were able to be discharged from hospital in a timely manner with appropriate support in place. Whilst the service continued to meet any urgent needs for OT intervention, those individuals requiring planned or preventative intervention were placed on a waiting list which has grown significantly throughout this period. This will undoubtedly have an impact on both the outcomes for these individuals and the ability of the Council to prevent and delay the need for formal support –a key priority for adult social care.

This has led to the Council commissioning an independent review being recommissioned to ensure this model continues to meet adult social care priorities, achieve value for money and funded to meet current and future demand. This work will be managed in collaboration with CPFT through the section 75 governance structure |
| Learning Disability Section 75 Arrangements | The Learning Disability Partnership (LDP) was established in 2002 to deliver countywide, integrated specialist health and social care services to adults with a learning disability across Cambridgeshire. The service aims to ensure that people with Learning Disabilities, their families and carers can live safe and happy lives as part of their local community and feel supported and empowered to pursue their individual aspirations, interests, and choice. The support provided is joined up, high quality and places |

	the individual at the centre of their care ensuring the right level of support is delivered at the right time, in the right place and by the right people to meet their needs. The service is delivered through a Section 75 Agreement between Cambridgeshire County Council (CCC) and Cambridgeshire and Peterborough Integrated Care Board with CCC being both the lead commissioner and provider of the service. The Agreement covers both the delegated responsibilities for operating as a fully integrated service delivering both health and social care statutory functions and the pooled budget arrangement. The funding in the pooled budget includes staffing and provision of both health and social care packages of care. Work across the ICB and Council has been undertaken to review and refresh existing documents to ensure they reflect the current services being delivered and the strategic priorities and outcomes for all partner organisations involved. The aim across the agreements was to form an accurate baseline from which we could develop a future countywide offer which more effectively addressed local health inequalities and gaps in provision. It also introduced a more robust governance structure and monitoring arrangements. In addition to this work is being undertaken to review the pooled budget within Cambridgeshire following sample evidence suggesting that the split is not reflective of current need due to the rising complexity of cases being managed by the service.
Carers	The current carers support strategy is under review and process of co-production will take place with people with lived experience to inform development of a refreshed version. This work is also taking place in collaboration with NHS Colleagues to ensure that current approach and strategy aligns to Nice Guidance on best practice. The recommissioning of this service beyond 2023 will be informed by the development of the strategy.
Advocacy	The current contract for advocacy services is under review and the contract is to due end and be recommissioned in October 2023. At present, the advocacy service is an integrated arrangement able to meet the needs of all ages across health and social care, it is compliant with statutory responsibilities and person centred in delivery and there is a robust contract management structure and monitoring arrangements in place. The service is currently under review and consideration needs to be given to how organisations integrate advocacy into existing strategies as should become a feature across the entirety of adult

	social care, as well as reducing risk and reliance on a single provider operating within a relatively small market. The review will also consider development of transformation and improvement within this area.
Integration and Joined Up working with the NHS	There is more work to be undertaken to ensure NHS partners and the local Integrated Care System (ICS) are engaged in the delivery of a joined-up approach to managing the housing and accommodation needs of our local population as well as identifying opportunities to commission in a more joined up way at both a macro and micro level. Whilst early discussions have taken place as part of the accommodation needs assessment focus, the focus of local NHS partners has been on managing the transition to the new ICS structure. However, regular feedback on progress and opportunities for alignment in this area is fed in through relevant governance meetings. Given this is also a key requirement of adult social care reforms we will be moving to progress this further as the new structures and ways of working begin to embed.

A review of the Learning Disability Partnership Section 75 pooled budget financial risk share arrangements

To:	Adults and Health Committee
Meeting Date:	9 March 2023
From:	Will Patten, Service Director, Commissioning
Electoral division(s):	Countywide.
Key decision:	Yes
Forward Plan ref:	2023/027
Outcome:	A reduction in the share of funding the County Council contributes to the Learning Disability Partnership Section 75 pooled budget.
Recommendation:	The Adults and Health Committee are being asked to:

a) endorse the recommended approach as set out in para 2.5 of Option 3 to seek to adjust the risk share to a level between 70:30 and 60:40, depending on the outcome of reassessment activity;

b) agree to the associated financial impact outlined within this report; and;

c) delegate the responsibility to reach a negotiated settlement to the section 151 Officer and the Director of Commissioning.

Officer contact:
Name: Gurdev Singh
Post: Head of Commissioning (Adult Social Care)
Email: Gurdev.singh@cambridgeshire.gov.uk
Tel: 07747 455016

Member contacts:
Names: Councillors Howitt and Councillor van de Ven
Post: Chair/Vice-Chair
Email: Richard.Howitt@cambridgeshire.gov.uk , susanvandeven5@gmail.com
Tel: 01223 706398

1. Background

1.1 The Cambridgeshire Learning Disability Partnership (LDP) has been in existence since 2002 and provides an integrated health and social care service to adults over 18 with a learning disability and their families, thus avoiding hand-offs and aiming to provide a more streamlined and seamless service.

1.2 Since inception, Cambridgeshire County Council and Cambridgeshire and Peterborough CCG (now ICB) have had a Section 75 Agreement in place to support development and delivery of this integrated service. There are two aspects to the Section 75 agreement, firstly the delegated authority to run an integrated service and secondly a pooled health and social budget.

1.3 A significant component of the LDP is the pooled budget, which brings together into a single budget the health and social care spending, including that for placement and care package costs, day services, inpatient (Assessment & Treatment Unit) beds, operational teams (social workers, nurses and allied health professionals) together with commissioning and management of the service. This service is delivered through a pooled budget which operates on the following split:

2022/2023	Annual Budget (£)	% Split
Total Budget	**105,675,047**	
Cambridgeshire County Council's Contribution	81,139,170	76.78%
Cambridgeshire and Peterborough ICB's Contribution	24,535,877	23.22%

1.4 In 2018/19, a desk top analysis was carried out on learning disabilities care packages which identified the risk share contribution between the Council and the CCG (now ICB) needed to be realigned. The partner organisations agreed that a dedicated team was to be established to carry out a review of the approximately 700 cases.

1.5 The project commenced in January 2020, but due to the resource implications associated with the COVID pandemic, the project was subsequently put on hold. However, a pilot review of 30 LDP cases was undertaken jointly with the CCG (now ICB) to provide an indicative position and test the concept. A more recent desktop review has indicated that this figure has increased substantially since the original work was carried out. However, this is indicative and requires verification through the review process and application of the NHS Continuing Health Care Framework.

1.6 Whilst the ICB agreed to recommence the review as a priority when the UK started to progress into COVID-19 Recovery phase, this has been delayed several times due to subsequent surges, redeployment to vaccination roll out and more recently focus on developing new structures under the integrated care system and their own savings plan. This has had a significant impact on the achievement of savings through the MTFS.

1.7   At present, the following savings have been built into the MTFS:

LDP Pooled Budget Review Savings Targets				
2022/23	2023/24	2024/25	2025/26	2026/27
£1.25m	£1.7m	£1.0m	£1.65m	£1.65m

1.8   Due to the delays outlined, in June 2022 we commissioned an independent consultant, RedQuadrant, to complete a review of the LDP Section 75 pooled budget arrangement. This report presents their findings and our recommendations for the Councils next steps.

2.   Main Issues

2.1   In order to gain their perspective on the LDP Section 75 pooled budget financial arrangements, RedQuadrant carried out one-to-one interviews with all key stakeholders at the Council. The general view was the benefits of an integrated health and social care service outweighed the challenges.

Positives
- A single health and social care service delivers significant service user benefits
- Integrated working is accepted as important by all parties
- There are very few service users in hospital indicating the model works well
- The pooled budget reduces potential disputes in determining split of health and care and consequent delays in making placements
- Operational and commissioning efficiencies are achieved through avoidance of duplication

Challenges
- Unfair risk share and no mechanism to change the funding split
- Increasing health needs not being reflected in health contribution to pool
- Team may be under-resourced or underperforming as reviews are significantly behind
- Efficiency savings have been difficult to identify because of the funding split issue
- Risk of reduction in trust between CCC and ICB on needs assessment

2.2   For some years, the County Council has observed that health needs have been increasing and the general acuity levels of those being supported has been increasing, leading to a view that the Council is contributing a greater share of the pooled budget than is reflective of current health and social care needs.

As illustrated in the graph below, work carried out by RedQuadrant confirmed the number of 100% social care funded service users have increased over time. At the same time the number of joint funded and 100% health funded service users has remained stable.

Figure 1: This graph shows the average number of service users over the last 3 years broken down by those who are 100% health funded, 100% social care funded and those who are joint funded.

Further analysis indicates the average annual cost per service user has increased for all areas. In particular, it has increased most sharply for those that are 100% health funded, moving from an average of £100,000 to £140,000 over a 3-year period.
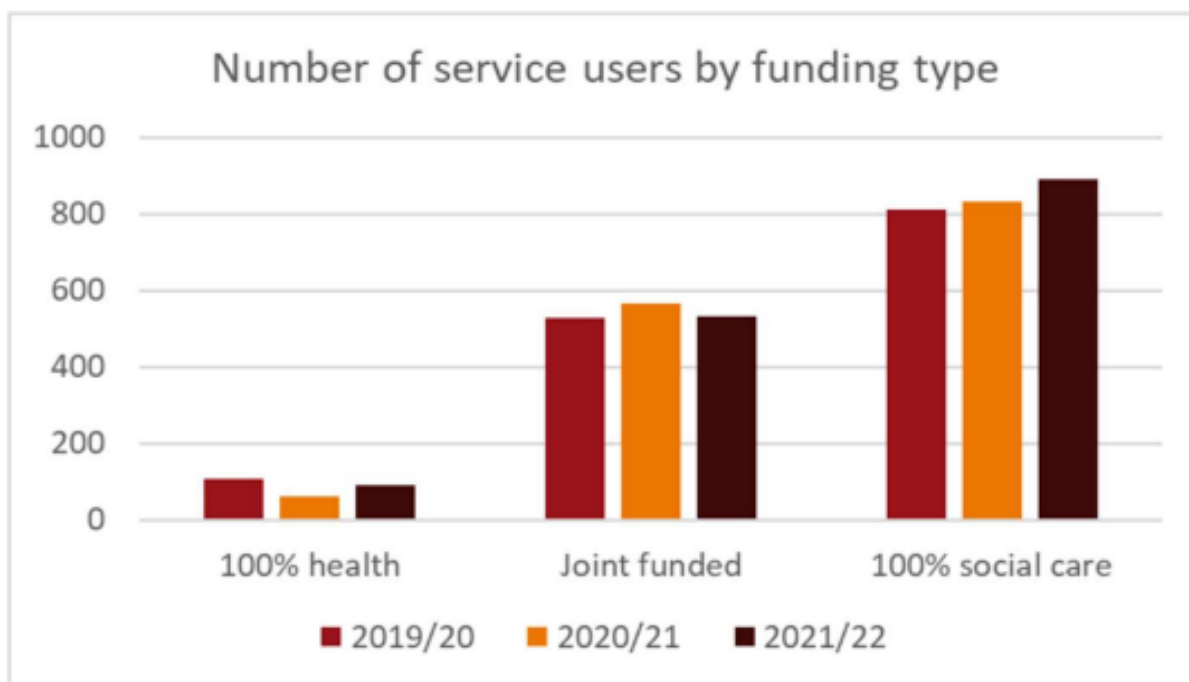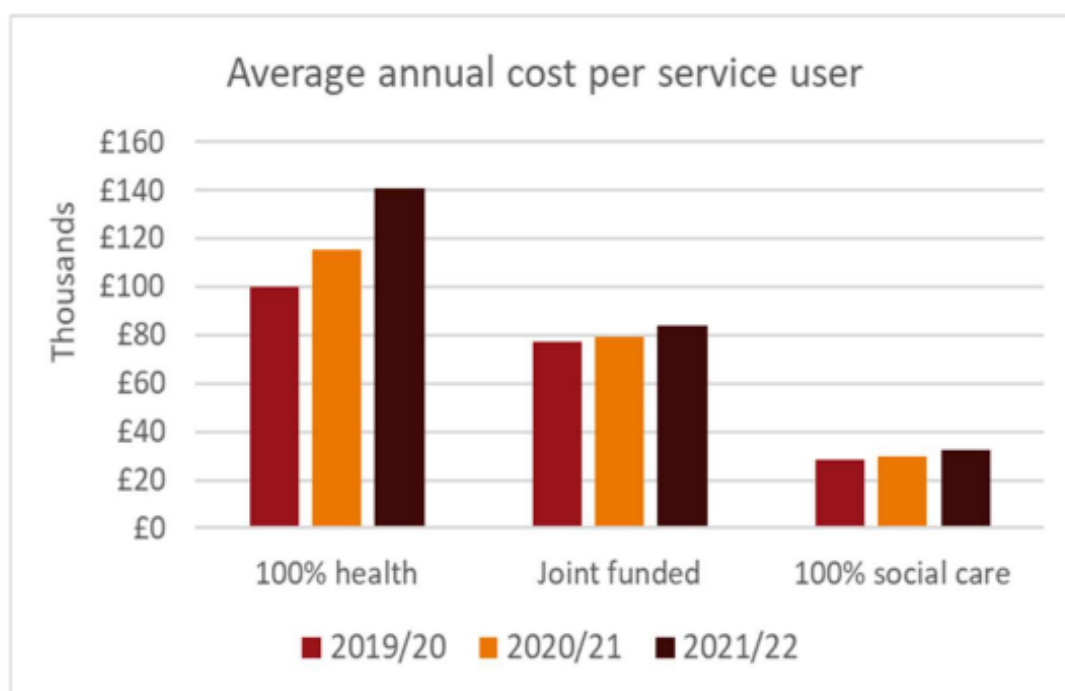

Figure 2: This graph shows the average annual cost per service users over the last 3 years broken down by those who are 100% health funded, 100% social care funded and those who are joint funded.

Consequently, the number of service user and average annual cost per service user analysis confirmed that there is a risk that the inclusion of 100% health needs cases within the pool with a fixed risk share, results in the Council funding an increasing proportion of health care needs year on year, and a corresponding increasing risk of charging service users for healthcare in error.

2.3   To establish if this was seen by other local authorities, Red Quadrant also completed a benchmarking exercise reviewing 19 other local authority arrangements and identified 9 LD pooled budgets as potential comparators. Further analysis of the contents of these pooled budgets allowed an assessment of how similar their arrangements were. The remaining 10 local authorities did not have a pooled budget arrangement but had some examples of aligned budgets.

A summary table from report outlining this has been included below:

Local authority	% risk share Council(s)	% risk share ICBs
Hertfordshire County Council*	48.78	51.22
Oxfordshire County Council*	49.71	47.21
Leicestershire County Council	55.62	44.38
Lincolnshire County Council	69.62	30.38
Cambridgeshire County Council	76.78	23.22
West Sussex*	81.45	18.55
LB of Islington	81.99	18.01
Milton Keynes Council	94.3	5.7

* Indicates the local authority is a statistical neighbour

Whilst it is difficult to precisely determine the components of each pooled budget and therefore an exact like for like comparison, the evidence supports a view that Cambridgeshire contributes a higher proportion into the pooled budget than many comparators. It was noted in two cases, Lincolnshire and Leicestershire, that their pooled budgets recently had been revised to exclude funding of 100% health and 100% social care cases. On balance the analysis indicated CCC to be an outlier against other integrated services.

2.4   After analysing the pooled budget make-up, case analyses and speaking with Cambridgeshire County Council internal stakeholders, RedQuadrant identified a number of options which could lead to a more equitable relationship. The appraisal framework contains four headline criteria (value for money, system benefit, service user benefit, and environmental, strategic, political) which were used to appraise each option. Within each headline criteria key questions that have been applied to each option, to identify benefits, detractors, and risks.

The assessment was applied to the following six options:

1. Retain current pooled budget risk share arrangement.
2. Retain current pooled budget risk share arrangement with a strengthened governance structure, annual/bi-annual reviews, and a phased approach to changing the risk share over time.

3. Retain pooled budget in its current form but with a revised risk share (ranging from 60-40 to 70-30), with an annual/bi-annual review with an adjustment based on actual activity and a strengthened governance structure.
4. Revise current pooled budget to remove 100% health needs cases and 100% social care cases and agree a provisional risk share (65-35) based on an analysis of current health and social care need cases.
5. Maintain integrated working and joint commissioning but remove all placement costs from pooled budget and retain only for staffing, day care and other services.
6. End pooled budget entirely, including separating commissioning, staffing, day care and other services budgets.

2.5   Red Quadrant have advised the Council to progress one of the following two options of which Option 3 is the recommended option:

Option Descriptions	Projected Gross Financial Impact (£,000)	
	2023/24 Interim Risk Share	**24/25 Onwards**
Option 3 - would be to adjust the risk share to a level between 70:30 and 60:40, depending on the outcome of reassessment activity. An interim risk share is proposed of 65:35 to be implemented in the forthcoming financial year and for adjustments to be made dependent on the results of the reassessment work.	-11,252	-11,252 dependent on the outcome of the reviews
Option 4 - is that the pooled budget is restructured so as to exclude cases which are 100% health care (e.g., CHC) and 100% social care needs. The pooled budget would be retained for all other aspects and for cases identified as having both health and social care needs. As in option 3, an interim risk share of 65:35 is proposed, pending the outcome of reassessment work.	-11,252	-7,102m based on current desktop analysis and dependent on the outcome of reviews

2.6   Should negotiations with the ICB fail, then Red Quadrant have advised we pursue Option 5 or even Option 6 and service notice on the Section 75 Arrangement in its current form. Should we reach this position, the Council will want to prioritise Option 5 where we maintain integrated working and joint commissioning but remove all placement costs from pooled budget and retain only for staffing, day care and other services. This would reduce the scope of the Section 75 Agreement and require an amendment to the contract.

Ongoing Investment Required and Net Financial Impact

2.7   Given the increasingly complex needs of users, which is reflected in the increasing cost of care packages, particularly for 100% health funded packages, a regular, annual or bi-annual review of the pooled budget service is important in order to reflect these changes and to maintain an appropriate risk share arrangement. To progress as part of business-as-usual activity in the future, additional and ongoing investment in operational resource is required. This will include dedicated staff at an annual cost of £0.42m.

2.8 From a contractual perspective, pursuing both options would involve a straightforward contract variation being implemented within the current Section 75 Agreement.

2.9 The report findings have been shared with the Corporate Leadership Team. Consequently, Red Quadrant have recommended the following next steps are taken within timescales outlined. Support from Directors from across Operations, Commissioning and Finance will be required to facilitate progression and a positive outcome.

Action	Timescale
Open formal negotiations with the ICB through issuing correspondence confirming request and setting up a meeting with senior officers aimed at producing a resolution	February 2023
Decision Point: Confirm negotiated approach or pursue action to service notice on the Section 75 Agreement	March 2023
Adults and Health Committee Update and/or Key Decision	March 2023
Commence procurement of additional resource to undertake reviews either jointly with the ICB or as part of the BAU CHC process	April – June 2023
Adults and Health Committee Update and/or Key Decision	June 2023
Commence Reviews	June -November 2023
Determine outcome of the review of the risk share arrangement	December 2023
Confirm new risk share arrangement with the ICB ready to implement for 2024/25	December 2023

3. Alignment with corporate priorities

3.1 Environment and Sustainability
There are no significant implications for this priority.

3.2 Health and Care
There are no significant implications for this priority as even if para 2.6 comes into effect work to support people still takes place but under a changed governance arrangement.

3.3 Places and Communities
There are no significant implications for this priority.

3.4 Children and Young People
There are no significant implications for this priority.

3.5 Transport
There are no significant implications for this priority.

4. Significant Implications

4.1 Resource Implications
The report above sets out details of significant implications in para 2.5 and para 2.7

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications for this priority at this time.

4.3   Statutory, Legal and Risk Implications
        The report above sets out details of significant implications in para 2.6 with option details in
        para 2.4. Should para 2.6 comes into effect work to support people still takes place but
        under a different governance arrangement

4.4   Equality and Diversity Implications
        There are no significant implications for this priority.

4.5   Engagement and Communications Implications
        There are no significant implications for this priority.

4.6   Localism and Local Member Involvement
        There are no significant implications for this priority.

4.7   Public Health Implications
        There are no significant implications for this priority.

4.8   Environment and Climate Change Implications on Priority Areas

4.8.1   Implication 1: Energy efficient, low carbon buildings.
        Positive/neutral/negative Status: Neutral
        Explanation:

4.8.2   Implication 2: Low carbon transport.
        Positive/neutral/negative Status: Neutral
        Explanation:

4.8.3   Implication 3: Green spaces, peatland, afforestation, habitats and land management.
        Positive/neutral/negative Status: Neutral
        Explanation:

4.8.4   Implication 4: Waste Management and Tackling Plastic Pollution.
        Positive/neutral/negative Status: Neutral
        Explanation:

4.8.5   Implication 5: Water use, availability and management:
        Positive/neutral/negative Status: Neutral
        Explanation:

4.8.6   Implication 6: Air Pollution.
        Positive/neutral/negative Status: Neutral
        Explanation:

4.8.7   Implication 7: Resilience of our services and infrastructure, and supporting vulnerable
        people to cope with climate change.
        Positive/neutral/negative Status: Neutral
        Explanation:

Have the resource implications been cleared by Finance?   Yes
Name of Financial Officer: Justine Hartley

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement and Commercial?   Yes
Name of Officer: Clare Ellis

Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or Pathfinder Legal?   Yes
Name of Legal Officer: Linda Walker

Have the equality and diversity implications been cleared by your EqIA Super User?
Yes
Name of Officer: Lisa Sparks

Have any engagement and communication implications been cleared by Communications?
Yes
Name of Officer: Matthew Hall

Have any localism and Local Member involvement issues been cleared by your Service Contact?   Yes
Name of Officer: Will Patten

Have any Public Health implications been cleared by Public Health?
Yes
Name of Officer: Emily Smith

If a Key decision, have any Environment and Climate Change implications been cleared by the Climate Change Officer?
Yes
Name of Officer: Emily Bolton

5.   Source documents guidance

5.1   None

An update on Cost of Care and Market Sustainability Planning in Adult Social Care

To: Adults and Health Committee

Meeting Date: 9 March 2023

From: Will Patten, Service Director, Commissioning.

Electoral division(s):   All

Key decision: No

Forward Plan ref: 2023/009

Outcome:

1. A robust Market Sustainability Plan is produced, informed by a deeper understanding of local market pressures and the costs of delivering care.

2. The sustainability of Cambridgeshire's care market is improved, and local people continue to have access to a choice of quality care services.

3. The Council complies with Government requirements and grant funding terms in respect of the publication of Cost of Care (CoC) exercise and Market Sustainability Plans

Recommendation: Adults and Health Committee is recommended to:

    a) Note the published Cost of Care (CoC) exercises.
    b) Note ongoing work to produce a Market Sustainability Plan in line with Government requirements.
    c) Delegate responsibility for approval of the Market Sustainability Plan to the Director of Adults & Safeguarding (ADASS).

Officer contact:
Name: Jo Melvin
Post: Strategic Lead, Adult Social Care Commissioning
Email: joanne.melvin@peterborough.gov.uk
Tel:

Member contacts:
Names: Councillor Richard Howitt
Post: Chair
Email: Richard.howitt@cambridgeshire.gov.uk
Tel: 01223 706398

1.   Background

1.1   Under section 5 of the Care Act 2014, local authorities have a 'market shaping' duty to promote the efficient and effective operation of their local social care market to ensure services are diverse, sustainable and high quality for the local population, including those who pay for their own care. Government's definition of a sustainable market is one which "has a sufficient supply of services but with provider entry and exit, investment, innovation, choice for people who draw on care, and sufficient workforce supply".

1.2   In 2021, the Department for Health and Social Care (DHSC) published Build Back Better- our plan for health and social care and People at the heart of care - adult social care reform white paper which outlined significant legislative changes to Adult Social Care, planned to come into effect from October 2023. In preparation for these changes, councils across England with social care responsibilities were required to provide information on the sustainability of their local care provider market, and to conduct an exercise with the market to establish the costs of providing care.

1.3   In December 2021, DHSC announced the Market Sustainability and Fair Cost of Care Fund to support local authorities to prepare their markets for reform and move towards paying providers a fair cost of care. Cambridgeshire's allocation for 2022-23 was £1,568,738.

1.4   As a condition of receiving funding, local authorities were required to submit the following to DHSC by 14ᵗʰ October 2022:

- cost of care exercises for older peoples' care homes and homecare (for adults aged 18+)

- a draft market sustainability plan, using the cost of care exercise as a key input to identify risks in the local market

- a spend report detailing how funding allocated for 2022-23 is being spent in line with the fund's purpose

1.5   The scope and methodology of the Cost of Care (CoC) exercise was set by DHSC to help local authorities identify the lower quartile, median and upper quartile costs in the local area for a series of care categories. The term 'cost of care' describes the actual costs a care provider incurs in delivering care at the point in time that the exercise is undertaken. It is typically presented as a unit cost for an hour of homecare or a bed per week in a care home.

1.6   In summer 2022, the Council commissioned Laing-Buisson to undertake the Cost of Care data gathering exercise on its behalf, the results of which were used to produce the Council's two Cost of Care reports and Market Sustainability Plan. The three documents were submitted in draft form to DHSC in October 2022.

1.7   In November 2022, the Chancellor announced the planned Adult Social Care Charging Reforms would be delayed for 2 years (to 2025). In late December, DHSC announced all local authorities must publish their Cost of Care reports on their GOV.UK websites by 1ˢᵗ February 2023 and Market Sustainability Reports by 27ᵗʰ March 2023.

1.8   This report updates Committee on the published Cost of Care exercises and ongoing work to produce a Market Sustainability Plan (MSP).

2.   Main Issues

2.1   Cost of Care reports

2.1.1   Both Cost of Care reports are provided as appendices to this report and are available to view on the Council's website Cost of Care exercise - Cambridgeshire County Council

2.1.2   Around half of local providers responded and the Council would like to thank all those who took part in the exercise.

2.2   Cost of Care (CoC) Exercise key points - Care Homes for people aged 65+

2.2.1   The output of the cost of care exercise is a median cost for the 4 types of care within care homes for people aged over 65 (see Table 1).

2.2.2   Table 1 shows the CoC output is significantly higher than the average rates the Council currently pay for all care types. This is not unexpected as we know care homes charge those who pay for their own care more than they charge the Council for those in Local Authority care. The Adult Social Care Reform agenda set out to address this differential by allowing those who pay for their own care to ask the Council to commission that care on their behalf giving access to the rates to Council pays. As noted in 1.7, these charging reforms have subsequently been delayed until at least 2025 by Government.

Table 1: Cost of Care output rates for 65+ care home per week compared to spot purchasing over the last year

	CoC Output	In-County Spot Beds	Out of County Spot Beds
Residential	£911.17	£719.93	£786.09
Residential Enhanced	£915.57	£726.96	£712.59
Nursing	£1,170.69	£1,058.56	£1,023.82
Nursing Enhanced	£1,223.65	£1,158.42	£1,153.96

2.2.3   The CoC median cost is based on information supplied to the Council by 53.8% of the local market. Smaller providers were under-represented amongst respondents as many struggled to find the resources to engage with the exercise. Therefore, the CoC output is not fully representative of Cambridgeshire's care market. The 'middle' average also masks the natural variation and fluctuations in care costs as fee rates are determined by several factors such as:

- a person's individual needs
- current occupancy levels in the care home
- workforce availability
- operating costs and inflation

- quality
- location and land values
- each provider's business model.

2.2.4 The estimated cost to the Council of paying the CoC in Cambridgeshire is illustrated in Table 2 below. This shows additional estimated costs of £13.3m if all care home placements <u>under</u> the assessed CoC were to be raised to that CoC, rising to £14.9m if out of County placements were included.

Table 2: Estimated additional costs if 65+ care home placements moved to assessed Cost of Care

	Uplift all placements under CoC £'000
In County Spot Placements	7,993
Block placements	5,345
In County Placements Only	**13,338**
Out of County Spot Placements	1,571
All Placements	**14,909**

2.2.5 The cost increases set out in Table 2 are in line with estimates provided by Newton Europe in work done with the County Councils Network earlier in the year. This estimated that Cambridgeshire would need an extra £14.7m to meet increased care cap for residential placements for over 65s.

2.2.6 The full cost of care report for Age 65+ Care Homes is attached at Appendix 1.

2.3 **CoC Exercise key points – Homecare for people aged 18+**

2.3.1 The CoC output is the median rate per hour of homecare. The table below shows the CoC output is above the cost the Council pays for homecare. Again, this is not unexpected as we know that care agencies can charge those who pay for their own care more than they charge the Council for those in Local Authority care.

Table 3: Cost of Care output rates per hour for homecare compared to current packages

	CoC Output	Current average framework rate	Current average off framework rate
Homecare	£24.73	£19.24	£20.19

2.3.2 The CoC median cost is based on information supplied to the Council by 48% of the local market. Some of our biggest providers did not take part which means we are unable to include their costs. For this reason, the homecare CoC exercise is considered less robust than the care homes exercise due to the level of returns received. As noted with the CoC

Care Homes exercise, the simplicity of a 'median' value masks the natural variance and fluctuations in care costs as fee rates are determined by several factors such as:

- a person's individual needs
- workforce availability and competition
- operating costs and inflation
- quality
- each provider's business model

2.3.3 The UK Home Care Association has set a minimum hourly rate for providers who pay the Real Living Wage of £24.08 so the output of the CoC exercise is in line with this rate.

2.3.4 The additional cost of paying this rate to the Council would be in the region of £8m.

2.3.5 The full cost of care report for Homecare is attached at Appendix 2.

2.4. **Implications of the Cost of Care (CoC) exercises**

2.4.1 Both CoC exercises have helped the Council to better understand the costs of care delivery in Cambridgeshire and the Council wishes to thank all providers who took part in the exercise. The information from the reports will inform the development of a Market Sustainability Plan.

2.4.2 The CoC exercises suggest a funding gap of £23m in the care home and home care sectors of the market. The true gap in care costs across the entire adult social care market is unknown.

2.4.3 The £1.57m funding received from Government in 22-23 to support Adult Social Care market sustainability is not sufficient to close the funding gap identified by the CoC exercises. Without significant additional funding from Government, the Council is unable to close the gap and remains in a position of 'moving towards' paying a higher cost of care. The impact upon the sustainability of the local market remains to be seen though it will be somewhat mitigated by the Government's delay of charging reforms.

2.4.4 As DHSC guidance makes clear, the outcome of the CoC exercise is not intended to set fee levels paid by the Council or replace its commissioning processes and individual contract negotiation. The Council will continue to negotiate and use competition to establish fee rates as it strives to balance its best value duties with the costs of providing care. Fee rates paid by the Council will continue to vary across providers, localities and care types.

2.5 **Market Sustainability Plan**

2.5.1 Throughout February and March, officers will produce a Market Sustainability Plan using the template published by DHSC on 1st February 2023 and the outputs of the CoC exercises.

2.5.2 The Market Sustainability Plan (MSP) will be made up of 3 sections:

1. Assessment of the current sustainability of local older people's care home and homecare markets;
2. Assessment of the impact of future market changes between now and October 2025 on local older people's care home and homecare markets
3. Plans to address these sustainability issues in both markets, including how the £1.57m funding has been spent and the impact on the market and other actions to improve market sustainability such as waiting times, workforce, technology expansion or innovative care models

2.5.3 The £1.57m market sustainability funding for 22-23 has been targeted at the lowest cost care home and home care packages. Grant conditions require that a minimum of 75% of the grant is passed to the provider market to increase rates of pay so the Council will be well within this limit (see table below). A more detailed view of how the funding was spent and the impact on the local market will be included in the Market Sustainability Plan currently being produced.

Table 5: Use of the Market Sustainability and Fair Cost of Care Fund 2022-23

	£
LaingBuisson Costs	32,900
Additional internal resource to support cost of care work	25,000
Passed to providers in the care home and homecare market	1,510,838
TOTAL	**1,568,738**

2.5.4 Adults & Health Committee is requested to delegate approval of the Market Sustainability Plan to the Director of Adult Social Services in order the MSP is published by the deadline of 27th March 2023 set by the Government as part of grant funding conditions. An update report is tabled for Adults and Health Committee in June 2023.

2.5.5 A key limitation of the Government's CoC and MSP requirements is its focus on only two parts of the local market (care homes for older people and homecare). In Cambridgeshire, as probably across the rest of the country, sustainability is an issue for the entire market including services for adults with learning disabilities, housing-related support providers, Extra Care providers and the voluntary and community sector.

2.5.6 The provider engagement sessions to inform the MSP will share the Council's understanding of wider market sustainability issues and involve providers in shaping our approach to market sustainability. It is an opportunity to be transparent with providers about the funding gap within adult social care and develop an approach to target funding to the most acutely pressured parts of the entire local care market, should Government funding conditions allow in 23/24. This is with the intention to explore how tangible improvements in Cambridgeshire's adult social care market can be delivered within a financially challenging landscape so local people continue to have choice and easy access to high quality care and support when they need it.

3. Alignment with corporate priorities

3.1 Environment and Sustainability

There are no significant implications for this priority. The ability of the market to deliver improved carbon and environmental outcomes did not form part of the market engagement at this stage. This will be integrated during the implementation stage of the process once the Market Sustainability Plan is agreed and Terms and Conditions received.

3.2 Health and Care

The report above sets out the implications for this priority in 2.1-2.5

3.3 Places and Communities

The report above sets out the implications for this priority in 2.1-2.5

3.4 Children and Young People

There are no significant implications for this priority.

3.5 Transport

There are no significant implications for this priority.

4. Significant Implications

4.1 Resource Implications

The following bullet points set out details of significant implications identified by officers:
- Both CoC exercises identified a median care cost above the average paid by the Council but are not fully representative of the market (as only c.50% of providers responded)
- The CoC exercises do not 'set' the funding level to be paid by the Council. CCC will continue to use its commissioning processes to negotiate fee levels with the market and obtain best value for the public purse. Fee levels will continue to vary across provider, care types and localities
- CoC median care costs indicates a c.£23m funding gap in two parts of the care market. The true funding gap across the entire adult social care is market is not known
- Government funding of £1.57m is insufficient to close the gap suggested by the CoC exercise. Without significant additional funding from Government, the Council is limited in how far it can 'move towards' paying a higher cost of care
- The impact of the funding gap on the market is mitigated by the Government's delayed introduction of Charging Reforms
- The Council will develop a Market Sustainability Plan to target the limited Government funding towards the most pressured parts of the market, informed by the CoC exercises and provider engagement.

4.2   Procurement/Contractual/Council Contract Procedure Rules Implications
- The CoC exercises do not 'set' the funding level to be paid by the Council. CCC will continue to use its commissioning processes to negotiate fee levels with the market and obtain best value for the public purse. Fee levels will continue to vary across provider, care types and localities

4.3   Statutory, Legal and Risk Implications

The report above sets out details of significant implications in 1.1

4.4   Equality and Diversity Implications
There are no significant implications within this category

4.5   Engagement and Communications Implications
- The Council will develop a Market Sustainability Plan to target the limited Government funding towards the most pressured parts of the market, informed by the CoC exercises and provider engagement.
- The Council must publish its CoC reports and Market Sustainability Plans by 1st February and 27th March 2023 respectively to comply with Government funding conditions

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   Environment and Climate Change Implications on Priority Areas (See further guidance in Appendix 2):
There are no significant implications within this category

4.8.1   Implication 1: Energy efficient, low carbon buildings.
Positive/neutral/negative Status: Neutral
Explanation: Beyond scope of report

4.8.2   Implication 2: Low carbon transport.
Positive/neutral/negative Status: Neutral
Explanation: Beyond scope of report

4.8.3   Implication 3: Green spaces, peatland, afforestation, habitats and land management.
Positive/neutral/negative Status: Neutral
Explanation: Beyond scope of report

4.8.4   Implication 4: Waste Management and Tackling Plastic Pollution.
Positive/neutral/negative Status: Neutral
Explanation: Beyond scope of report

4.8.5   Implication 5: Water use, availability and management:
Positive/neutral/negative Status: Neutral
Explanation: Beyond scope of report

4.8.6   Implication 6: Air Pollution.
Positive/neutral/negative Status: Neutral
Explanation: Beyond scope of report

4.8.7   Implication 7: Resilience of our services and infrastructure and supporting vulnerable people to cope with climate change.
Positive/neutral/negative Status: Neutral
Explanation: Beyond scope of report

Have the resource implications been cleared by Finance?   Yes
Name of Financial Officer: Justine Hartley

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement and Commercial?   Yes
Name of Officer: Clare Ellis

Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or Pathfinder Legal?   Yes
Name of Legal Officer: Linda Walker

Have the equality and diversity implications been cleared by your EqIA Super User?
Yes
Name of Officer: Gurdev Singh

Have any engagement and communication implications been cleared by Communications?
Yes
Name of Officer: Simon Cobby

Have any localism and Local Member involvement issues been cleared by your Service Contact?   Yes
Name of Officer: Will Patten

Have any Public Health implications been cleared by Public Health?
Yes
Name of Officer: Emily Smith

If a Key decision, have any Environment and Climate Change implications been cleared by the Climate Change Officer? Yes
Name of Officer: Emily Bolton

5.   Appendices

- Appendix 1 - Annex B Care Homes Cost of Care Report v2
- Appendix 2 - Annex B Homecare Cost of Care Report v2
- Appendix 3 - Equality Impact Assessment

6.   Source documents

Cost of Care exercise - Cambridgeshire County Council

Cambridgeshire County Council

Cost of Care exercise – Autumn 2022

Homecare

1   Introduction

1.1   **Headline Results**

1.1.1   In 2021, the Department for Health and Social Care (DHSC) published [Build Back Better-our plan for health and social care](#)[1] and [People at the heart of care - adult social care reform white paper](#)[2] which outlined significant legislative changes to Adult Social Care which would come into effect from October 2023. As part of these changes, councils across England with social care responsibilities were required to conduct an exercise with the local provider market to establish the costs of providing care based on guidance and a standardised methodology issued by DHSC. This report sets out the results of that exercise for homecare provision in Cambridgeshire for people over the age of 18.

1.1.2   Submissions for the CoC exercise were received from 37 providers, 5 of whom were deemed to be out of scope for the exercise – one was an extra care provider and four were providers in Peterborough who are not on the Council's homecare framework contract. Of the remaining 32 providers, all of them on the Council's homecare framework contract, and 28 of them are currently providing homecare to the Council's service users. The 32 returns represent 48% of providers in scope for this exercise.

1.1.3   Table 1 below shows the Cost of Care (CoC) median output from the exercise, together with Cambridgeshire County Council's (the council average hourly homecare framework rate and average hourly off-framework rate for homecare. The full breakdown of the figures from the CoC exercise can be found in Appendix 1, Table 3.

Table 1: CoC output and Cambridgeshire County Council's homecare hourly rates, as at September 2022

	CoC median output	CCC average hourly framework rate	CCC average hourly off-framework rate
Hourly rate	£24.73	£19.24	£20.19

1.1.4   The median CoC returned by providers is higher than the Council is currently able to procure through its homecare framework, and off-framework. This is a key concern as the Council strives to balance its duties to obtain best value for money for the public purse with the market position on costs that are being incurred in the provision of care. And the impact is wider than the CoC exercises undertaken so far, as these only cover homecare and care homes for those aged over 65. The financial impact of increasing rates of pay in these areas will be felt across the wider care market with rates for other care provision also increasing and creating significant financial pressure.

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[1] https://www.gov.uk/government/publications/build-back-better-our-plan-for-health-and-social-care
[2] https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper

1.1.5　As with many local authorities, the Council is in an extremely difficult financial situation with significant savings to find to deliver a balanced budget in 2023/24 and beyond. The Council has many statutory services to deliver, which are all subject to increasing costs, of which adult social care is but one. Inflation is running at unusually high levels and putting further pressure on organisations and individuals which in turn puts pressure on the Council's limited budget. Therefore, whatever our aspirations for improving funding levels in the adult social care market, unless funding from central government meets the increased costs of this, the Council will be unable to meet the increased funding expectations generated by this exercise.

1.1.6　The Council recognises that the challenges of low fee rates, high inflation and workforce pressures affect the whole care market. It will target additional funding received from Government for 2023/24 and 2024/25 to address low fee rates to providers in the Cambridgeshire care market to help manage these challenges.

1.2　Contents of the Report

1.2.1　This report sets out:

- Section 2 – the approach Cambridgeshire County Council took to complete this exercise

- Section 3 – the level of provider engagement undertaken in completing the exercise and how the Council and LaingBuisson sought to promote provider engagement.

- Section 4 – the approach taken with the data received from providers including:
  - data validation,
  - identification of outlier values,
  - the approach taken with incomplete provider toolkit submissions,
  - how data has been uplifted to April 2022 values (where relevant),
  - the approach adopted for return on operations.

- Section 5 – analysis of the value and representativeness of the data collected.

- Section 6 – the relationship between the median CoC output and fee rates, including comparison to fee rates currently paid by the Council.

- Section 7 – the Council's approach to uplifting fee rates.

1.2.2　The Council would like to thank the providers who submitted data for this exercise for their time and effort in engaging with the process and we look forward to having the opportunity to engage with you and the wider market further over the coming months.

2   Approach

2.1.1   In June 2022, the Council commissioned LaingBuisson to undertake a Cost of Care (CoC) exercise covering registered homecare providers, as described and specified in Department of Health and Social Care (DHSC) guidance. LaingBuisson undertook provider engagement, data collection, validation and analysis for the Council and provided the Council with a CoC report and their analysis Excel spreadsheet.

2.1.2   The Council's Finance Team then undertook their own analysis and quality checking of the data. Four providers in the LaingBuisson dataset were excluded as these providers were based in Peterborough and they are not on the Council's homecare framework, therefore the Council does not consider them to be part of its market. Where other out of county providers are on the Council's homecare framework they were left in the dataset.

2.1.3   Data was collected between June and September 2022 using the cost of care toolkit developed by ARCC-HR Ltd in partnership with the Local Government Association. The toolkit is an Excel spreadsheet where providers input data, with the spreadsheet calculating outputs, including the data outputs required for the DHSC CoC exercise. Care providers submitted their toolkits to LaingBuisson.

2.1.4   All data providers gave was either given as 2022/23 values, or adjusted to 2022/23 values, as explained in section 4.

3   Provider Engagement

3.1   **Approach**

3.1.1   LaingBuisson worked with the Council throughout July and August to engage with providers through a variety of communication channels. The Council sent out multiple communications about the exercise to its providers via formal letters, email, newsletters and promoted the exercise through relevant provider forums and contract management meetings and negotiations. LaingBuisson contacted providers by telephone, explaining the exercise and encouraging them to participate.

3.1.2   The Council and LaingBuisson held 2-weekly project meetings to discuss progress with provider engagement and submission of toolkits. Council officers identified key strategic providers (those who provide a large number of hours of Council-commissioned homecare) who had not responded. LaingBuisson engaged in more targeted and intensive communication for those providers, with Council officers from contracts and commissioning teams contacting providers where they still did not want to engage with the process.

3.1.3   Whilst clear deadlines were set and communicated to the market, a flexible approach was taken to receiving submissions which aimed to maximise the

response rate. The Council and LaingBuisson agreed to extend the deadline for providers to submit returns three times, with the original date of 24ᵗʰ June 2022 being extended to the final submission date of 1ˢᵗ September 2022. This increased the initial length of time for submissions from 2 weeks to just under 12 weeks. Providers have also been able to alter their submissions after that date, with any updated submissions incorporated into data analysis.

3.1.4   LaingBuisson re-contacted all providers submitting toolkits by telephone after receiving their returns. The re-contact was necessary to clarify ambiguities in the toolkit submissions and provided the opportunity to ask further questions to gather supplementary information that could be used to inform the Council's future commissioning strategy. Toolkit ambiguities are further addressed in section 4.

3.2   **Level of Engagement**

3.2.1   In total 32 care providers submitted toolkits for the exercise. There were 67 providers in scope for the exercise – either homecare providers based in Cambridgeshire or close to the border who operate in Cambridgeshire and are on the Council's homecare framework. This represents a 48% response rate from providers in scope for the exercise. Those that didn't complete a submission were contacted by LaingBuisson to encourage positive engagement with the process and/or to ascertain why a submission would not be made.

3.2.2   The Council currently has service users placed with 28 of the homecare agencies who submitted a return in this exercise, although all 32 providers are on the Council's homecare framework.

3.2.3   Further exploration of the representativeness of submissions can be found in section 5.4. Table 6 in Appendix 1 shows segmented response rates as calculated by LaingBuisson.

3.2.4   Three of the providers LaingBuisson succeeded in contacting gave outright refusals to participate, with many more expressing hesitation and ultimately choosing not to submit returns. Where providers chose not to submit CoC returns, reasons given included concerns around confidentiality of information sharing, company policy preventing participation in surveys, that the provider did not believe the exercise would lead to any change in funding rates, and that the CoC exercise was too time consuming.

3.2.5   The latter was a particular problem for smaller providers, who do not necessarily have the in-house expertise to complete the return and would, for instance, outsource the preparation of their annual accounts. Large corporate groups who provide homecare were able to allocate staff to the task of completing multiple submissions. This is reflected in the over-representation of large corporate groups in Cambridgeshire's submissions and the under-representation of small group or independent providers.

4   Data

4.1   **Data Quality**

4.1.1   The quality of the data submitted by providers was variable, with some providers able to complete all sections of the toolkit, while others only filled out part of the template. Where possible, information from all submissions has been used.

4.1.2   LaingBuisson have said that in their experience from similar cost of care exercises, large corporate groups typically have the resources to submit consistent and reliable numbers, but SMEs and micro-businesses can find it challenging to deal with the volume and complexity of data requested in toolkits and may leave some questions unanswered and incorrectly answer others. Therefore, robust statistical validation of the data is necessary.

4.2   **Data Validation**

4.2.1   LaingBuisson checked toolkit submissions for sense and consistency and re-contacted all providers who submitted toolkits. This allowed the resolution of ambiguities around three specific datapoints reported in the toolkits, each of which could potentially have a significant impact on reported total costs:

- The financial year the costs submitted in the toolkit related to. It is not made clear in the ARCC toolkit what date providers should submit costs as at. It transpired that while some Cambridgeshire providers had submitted 2022/23 data, others had submitted data relating to 2021/22. Where this was the case LaingBuisson adjusted the data to 2022/23 values, as explained in 4.4.

- Whether the provider's direct staffing cost in the toolkit included travel hours. The ARCC toolkit assumes that providers' direct staffing costs will be the gross hourly pay rate, multiplied by the contracted and travel hours. However, LaingBuisson understands practice in much of the homecare sector is to include an element of mileage in their gross hourly pay rate and only pay contract hours. The direct staff costs in the dataset have been adjusted to reflect individual providers' treatment of this datapoint.

- What elements providers had included in their back-office costs. Back-office costs stated in toolkits were highly variable, with some accounting for a large proportion of total costs. Some anomalies LaingBuisson came across in their conversations with providers were staff doubling up as care workers and back-office staff, and back-office staff being used to support other business lines. Both of these instances would lead to double counting and overstatement of costs. Where anomalies were found, LaingBuisson amended toolkit submissions with the provider's agreement.

4.2.2 LaingBuisson have fully validated submissions from 26 providers in scope for this exercise. They have partially validated data from all 6 remaining providers.

4.3 **Missing and Incomplete Toolkit Submissions**

4.3.1 Missing and apparent outlier values remain in Cambridgeshire's data where providers have been unable or have not wanted to engage in the validation process. However, where possible data from all toolkits has been included in the CoC output.

4.3.2 LaingBuisson used an outlier exclusion approach to identify and exclude outliers from the dataset. Outliers are defined as null or zero values for any cost line where a null or zero value is inappropriate, and non-zero values which are outside specified boundaries.

4.3.3 They adopted Double Median Absolute Deviation (Double MAD) as their preferred approach to setting outlier boundaries for each individual cost line.[3] This method was chosen because statistical testing for skewedness in the dataset confirms that it suffers from a highly asymmetric distribution across almost all categories. Using a singular Median Absolute Deviation (MAD) value would disregard this asymmetry and produce unreliable results.

4.3.4 An outlier was determined to be any data point that was more than 2 X MAD above or below the median of the validated dataset, with any such outlier excluded from the calculation of median costs in Table 3 (Appendix 1). This means that where LaingBuisson have not validated a provider's full submission, the provider's data is still included in the calculation of median costs if it is within 2 X MAD of the median of the validated submissions.

4.4 **Base Price Year and Uplifts**

4.4.1 All the CoC results cited in this report are expressed at April 2022 prices. Where a provider only submitted 2021/22 data, LaingBuisson have uplifted these figures to 2022/23 prices. They have uplifted the data based on the National Living Wage for low-paid staff (care and domestic), the monthly earnings index for other staff, and CPI (Consumer Price Index) and CPIH

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[3] $MAD = median(|X_i - \bar{X}|)$

Median Absolute Deviation (MAD) is calculated by finding the absolute difference between each validated data point and the validated sample median and then calculating the median of these absolute differences. For normally distributed data, MAD is multiplied by a constant b = 1.4826, however, the distribution is unknown and not symmetric in our data sample.

The premises of the Double MAD method are similar to the classic version, with the only difference being the calculation of two Median Absolute Deviations: 1) the median absolute deviation from the median of all points less than or equal to the median and (2) the median absolute deviation from the median of all points greater than or equal to the median. This allows us to set pertinent outlier thresholds taking into account skewness in the data sample.

(Consumer Price Index with Housing) percentage change figures for non-staffing costs for the 12 months up to April 2022[4]. These figures have been chosen on a point-by-point basis, where appropriate figures have been identified to account for relative price effects[5], with overall CPI inflation figures used where no appropriate, goods/services-specific CPI figure has been identified. Uplift figures with CPI codes for each cost heading can be found in Table 7 in Appendix 1.

4.5 **Choice of Subtotals or Individual Lines**

4.5.1 The output of the DHSC CoC exercise (shown in Table 3, Appendix 1) must be submitted to DHSC as Annex A of councils' Market Sustainability and Fair Cost of Care returns. DHSC allows an Annex A return that assumes the CoC to be the sum of individual lines, the sum of the subtotals for each section of costs, the median total cost stated in returns, or any other median-based approach. Authorities are encouraged to choose the most appropriate median-based approach for their dataset.[6]

4.5.2 Given the varied approach of providers to paying care workers for their travel time separate to their contracted hours or including an allowance for travel in the gross pay rate, to use the sum of individual data lines would skew the direct care costs. Taking the median of the direct care cost when some of the data includes an allowance for travel time and some does not would return a value that is artificially high for a rate that does not include travel time and artificially low for a rate that does. Taking the median of the travel time datapoint would return a value that is artificially low for travel time, but is non-zero, so is also not appropriate for providers who include an allowance for travel time in the rates they pay.

4.5.3 Therefore, it is considered that taking the total of the two subtotals "total careworker costs" and "business costs" is the most appropriate treatment of the data. The business costs subtotal is also more aligned with the Homecare Association's (HCA) costs of running the business (£5.95) than the sum of the lines in the business costs section.

4.5.4 However, it should be noted that taking the sum of individual lines returns a CoC output of £23.88 per hour. This is £0.85 lower than the CoC output taking the total of the two subtotals "total careworker costs" and "business costs". The sum of individual care worker costs lines is £0.30 lower than the median "total careworker costs" subtotal, and the sum of individual business costs lines is £0.51 lower than the median "business costs" subtotal. Therefore,

[4] Table 22, https://www.ons.gov.uk/economy/inflationandpriceindices/datasets/consumerpriceinflation

[5] Our approach to uplifting is broadly in line with guidance on inflationary adjustment set out in The Green Book 2022, Section 5.13,
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1063330/Green_Book_2022.pdf

[6]
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1100304/annex-a-example-grant-template-august-2022.xlsx (accessed 03/10/2022)

there is a risk that the CoC output of £24.73 may be overstating the cost of care. On balance though, it is believed this is the most appropriate treatment of the data for the reasons previously stated.

4.6 **Return on Operations**

4.6.1 The Council has chosen to use a return on operations (RoO) figure of 5%. The return on operations represents the provider's profit before interest, tax, depreciation, amortisation and rent payments. Although there are some not-for-profit providers in the homecare market, these providers specialise in supported living for younger adults and are therefore not representative of the wider homecare market.

4.6.2 Amongst the toolkit submissions stating a return on operations percentage, the mean RoO was 5.6%, with the median and modal value both being 5%. The Homecare Association's minimum price for homecare allows a profit/ surplus figure of 3%.

4.6.3 The Council has considered the return on operation submissions of providers, together with the Homecare Association's 3% profit margin. The Council recognises that it has both a duty to stewardship of public funds and a duty to support the care provider market, which are often in conflict with one another. However, the Council's adult social care commissioning strategy is to move towards supporting more people in their own homes and reducing reliance on accommodation-based care. Therefore, it wishes to recognise the need to support the homecare market to invest in the development of services in its CoC output.

5 Validity and Representativeness of Data

5.1 **Sensitivity of Data**

5.1.1 The median total costs set out in Table 3 (Appendix 1) are sensitive to the following factors:
- The efficacy of the validation process in eliminating implausible and incorrect toolkit submissions for individual cost lines.
- The validity of the rules adopted for elimination of outliers before calculating the medians for each cost line.
- The return on operations benchmark adopted.

5.1.2 This section examines some of these sensitivities.

5.1.3 The Double MAD method of data validation is a reasonable method of removing outliers, although the number of outliers removed varies greatly across individual lines, with the lowest percentage of submissions used for an individual line being 25.0% and the highest being 87.5%. The mean percentage used was 67.0%. On average, this means that around a third of datapoints were excluded as outliers, giving some idea of the variability of the data.

5.1.4 A larger sample size would probably have allowed better identification of outliers, as it would be expected that the majority of the sample would trend towards a norm. However, identification of outliers is harder in a smaller sample of data.

5.1.5 The return on operations benchmark has been set at 5%. Were this to be reduced to the Homecare Association's minimum rate of 3%, it would reduce the CoC output by 47 pence. Each 1% change in return on operations represents a 24 pence change in the hourly rate.

5.2 **Testing against the Homecare Association's Minimum Price for Homecare**

5.2.1 The Homecare Association is the trade body for the independent homecare sector in the UK. It has published pro-forma costing models, the latest of which is for the year 2022/23.[7] To date it has been the only benchmark in the public domain for the hourly costs of homecare.

5.2.2 The HCA defines different minimum prices for homecare by wage rate. The two most appropriate to the Cambridgeshire market are the minimum homecare rate for providers paying the national living wage and the minimum homecare rate for providers paying the real living wage, which are reproduced below in Table 2.

	HCA minimum hourly rate		
	Paying National Living Wage (£ per hour)	Paying Real Living Wage (£ per hour)	CoC median output
Careworkers' contact time (gross pay before on-costs)	9.50	9.90	10.80
Careworkers' travel time (gross pay before on-costs)	1.93	2.02	0.70
NI and pension contributions	1.34	1.39	1.60
Other wage-related on-costs	2.28	2.38	3.66
Mileage	1.52	1.52	1.21
Running the business	5.95	6.18	5.58
Profit or surplus (3%)	0.68	0.70	1.18
Total	**23.20**	**24.08**	**24.73**

Table 2: Homecare Association's minimum price for Homecare by wage rate 2022-23, compared to the median output of Cambridgeshire's CoC exercise.

5.2.3 The median hourly rate (excluding travel time) paid to care workers in the toolkit submissions we have received from providers is £9.95. Therefore, the real living wage rate seems the most appropriate comparator. Although £9.95 is the median rate for carers, and the value for care workers' contact time will be weighted for a mix of carers and senior carers and include enhancements for weekend and bank holiday working.

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[7] https://www.homecareassociation.org.uk/resource/homecare-association-minimum-price-for-homecare-2022-2023.html (accessed 06/10/22)

5.2.4 Care worker's contact time is £0.90 higher in Cambridgeshire's CoC output than the HCA rate. This is likely because Cambridgeshire's toolkit returns include a number of providers whose pay rates include an allowance for travel time. This is borne out by the median travel time in the CoC output, which is £1.32 lower than the HCA rate.

5.2.5 Overall, the HCA rate for direct care costs (everything excluding running the business and profit) is £17.21. This is £0.76 lower than the CoC output value of £17.97.

5.2.6 The cost of running the business is set at £6.18 by the HCA, whereas the equivalent figure in the output of the CoC exercise is £5.58. Possibly the HCA includes PPE in its business costs rather than in its direct care costs, but this would still leave a discrepancy of £0.17, with the CoC output being lower than the HCA rate. It is possible that although providers' returns show they are on average paying the real living wage or above, they do not pay their back-office staff the real living wage. This may mean the business costs in the CoC output are better compared to the HCA's national living wage rate of £5.95.

5.2.7 The different treatment of return on operations to the HCA figure has been explored in 4.6.

5.2.8 Overall, Cambridgeshire's CoC output of £24.73 is 2.7% higher than the HCA's minimum hourly rate for a provider paying the real living wage.

5.3 **Data Sample Size**

5.3.1 The dataset covered 32 homecare providers, which represents 48% of providers in scope for the exercise. The Council currently has service users placed with 28 of the providers, although all 32 providers are on the Council's homecare framework. A return rate of 48% is reasonable but means 52% of providers in scope for the exercise did not submit a return and over half the market is missing. Additionally, the sample size for some data points was far smaller than for others, as not all providers filled in the full return.

5.3.2 There is a substantial variation in the figures returned by providers, even once their toolkits have been validated, which makes statistical exclusion of outliers in the data difficult. In a larger sample of data, values would be expected to trend towards a median point, making it easier to identify outliers. The variability of the data limits the confidence we can have in its accuracy, hence comparison to benchmarks such as the Homecare Association's minimum costs becomes more important. The variation in the data is demonstrated by the lower and upper quartiles shown in Table 3, Appendix1.

5.4 **Representativeness of the Data Sample**

5.4.1 The dataset represents 48% of homecare providers in scope that are on the Council's homecare framework, meaning over half of the data needed to

make a fully informed judgement on the cost of care for in-county framework providers is not available.

5.4.2   If we consider the number of hours of homecare delivered by providers over the past month, the toolkit returns come from providers delivering 58% of the Council's homecare hours. This is a slightly improved representation level in comparison to the percentage of providers represented and reflects the fact that ten providers deliver around half of our homecare hours. However, 42% is still a large proportion of commissioned hours that are not represented through this exercise.

5.4.3   No toolkit submission was received from two of the Council's top three providers in terms of numbers of hours of care delivered. These providers represent 16.4% of the Council's spot commissioned hours of homecare in the last month, with one provider providing 9.5% of these hours. Therefore, there is a significant portion of the Council's commissioned homecare that is not represented in the returns. Had these providers submitted returns, whatever rates they submitted could have had a significant impact on CoC median output and would certainly have had an impact on the CoC rate weighted for the number of hours of homecare provided to the Council's service users.

5.4.4   It is unknown whether these providers would have submitted a higher or lower hourly rate than the CoC exercise, but they are currently delivering around 4,700 hours of homecare per week for the Council at or below the homecare framework maximum rate of £20.16.

5.4.5   The Council has calculated a weighted average hourly rate for the data return, based on the number of hours of care delivered over the last month by each provider in the data sample. This returns an hourly rate of £24.57. While it is understood that a median cost of care for a whole market is perhaps a better demonstration of the cost of providing care in that market, this demonstrates the variability of the data. It could also be inferred that providers delivering more hours of care are able to deliver care at a lower cost. Although it is recognised that the hours of care commissioned by the Council will rarely make up a provider's whole business.

5.4.6   LaingBuisson have provided a segmented analysis of responses (Appendix 1, Table 6). This shows that representation does vary by provider group size, with large corporate groups and medium groups better represented than small groups and independent providers. If providers have differing cost bases according to their size then this underrepresentation of small and independent providers could be skewing the output of the exercise. Certainly, CIPFA believes that micro-enterprises could deliver lower cost homecare for councils than large providers.[8]

5.4.7   The DHSC CoC exercise is aiming to find a median rate for a council's whole market. However, in a large county such as Cambridgeshire, it can be the

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[8] CIPFA webinar: Making the most of the cost of Care Exercise – 20th July 2022

case that there are different, more localised care markets. Staffing costs make up the largest proportion of a provider's homecare rate, meaning the fee rate is highly sensitive to the hourly rate paid to carers. In Cambridgeshire there could be said to be distinct, localised markets for care staff; in Cambridge city there are numerous employment options paying above National Living Wage, making working in the care sector a less attractive option. South Cambridgeshire has good transport links to Cambridge city and other employment centres south of the county, whereas residents in Fenland have poorer transport options to employment centres.

5.5 **Out of County Placements**

5.5.1 Cambridgeshire is bordered by eight other local authorities with responsibility for adult social care, who have all completed their own median cost of care exercises. Homecare agencies do operate across county boundaries and are often on different local authorities' homecare frameworks at different rates. This makes it important for local authorities to work with their neighbouring authorities to understand the implications of the outcome of this CoC exercise on each other's markets. As stated above, it may be that in a large county such as Cambridgeshire, different rates for different district areas are appropriate – the Council's homecare framework currently has a different lot for each district.

5.5.2 The Council has 103 providers on its homecare framework contract, although it only currently has 80 framework providers delivering homecare placements. This means 36 framework providers (35%) are outside the scope of this exercise as they are based in another local authority area and their main market is outside Cambridgeshire. This number drops to 13 providers (16%) outside scope if we only consider providers currently delivering homecare hours on-framework.

5.5.3 If we consider the 80 providers delivering homecare placements for the Council, the 28 submissions to the CoC exercise from providers currently delivering homecare hours represent 35%.

5.5.4 Cambridgeshire will need to work with its neighbouring authorities to understand the output of their CoC exercises and determine whether there are more localised homecare markets, that may or may not overlap local authority borders.

5.6 **Further Testing**

5.6.1 LaingBuisson note that in previous cost of care exercises they have undertaken, they have sought external confirmation of the figures returned, by asking providers to submit payroll data to confirm staffing costs or staffing rotas to confirm hours of care provided, for example. They have not sought this evidence from providers for this exercise.

5.6.2 The Council has not undertaken any verification of the data through external evidence either. The Council notes that this is something that may need to be

undertaken to ensure that none of the returns are misrepresenting costs in any way and would require cooperation from the provider market in making the information available to verify costs in their submissions. The Council has a duty of stewardship of public funds and must achieve best value. Under adult social care reform, if local authorities and individuals funding their care privately are to move towards paying the same rate for a care placement, local authorities also have a duty to these individuals to set fee rates that represent value for money.

6 Relationship between the cost of care and fee rates

6.1.1 The Department for Health and Social Care (DHSC) has recognised in its guidance that the median actual operating costs from which local authorities arrive at a cost of care in their area will not reflect the costs of each individual provider in their local area. The guidance states that "the outcome of this cost of care exercise is not therefore intended to be a replacement for the fee setting element of local authority commissioning processes or individual contract negotiation."[9]

6.1.2 The DHSC expectation is that actual fees will be informed by the cost of care exercise, but fee rates will continue to be based on sound judgement, evidence, and through a negotiation process, as is the case currently. The guidance goes on to say "paying a fair cost of care does not mean that all providers are paid the same rate, but rather the fair cost of care is the median value which fee rates will be "moving towards"…. As many local authorities move towards paying the fair cost of care, it is expected that actual fee rates may differ due to such factors as rurality, personalisation of care, quality of provision and wider market circumstances."

6.1.3 Table 1 in Section 1 shows Cambridgeshire County Council's average hourly homecare framework rate and average hourly off-framework rate for homecare, compared to the CoC median output. It is reproduced here for ease.

Table 1: CoC output and Cambridgeshire County Council's homecare hourly rates, as at September 2022

	CoC median output	CCC average hourly framework rate	CCC average hourly off-framework rate
Hourly rate	£24.73	£19.24	£20.19

6.1.4 The Council procures most of its homecare through a framework contract, which has a maximum hourly rate of £20.16 in 2022/23. There are 103 providers registered on the framework, some of whom are based outside Cambridgeshire. Currently 80 providers on framework are providing homecare to Cambridgeshire service users. Around 28,500 hours of homecare per week

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[9] https://www.gov.uk/government/publications/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023-guidance/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023-guidance (accessed 30/09/22)

are provided to adults over the age of 18 through the homecare framework contract.

6.1.5 Hourly rates for homecare on the framework range from £17.78 to £20.16, with a mean hourly rate of £19.24. The homecare framework started in 2017, with providers' hourly rates uplifted each year by a contractual mechanism. Therefore, providers' current hourly rates are the rates they tendered with in 2017, with five years of uplifts applied. In the past two years the Council has awarded additional uplifts to bring fee rates up to more sustainable levels. Further details of uplifts awarded are in section 7.

6.1.6 Around 1,100 hours of homecare per week are provided off-contract, so are commissioned on an exemption rate because no provider on the framework can be found to take on the care package. These are largely placements for service users with learning disabilities who require specialist provision. These homecare hours are delivered by 20 providers. The mean hourly rate for off-contract homecare placements is £20.19.

6.1.7 As demonstrated by the data in Table 1, the Council currently pays substantially less than the CoC output for its framework and most of its off-framework homecare. However, these rates do reflect what the Cambridgeshire and surrounding market is willing to accept placements at.

6.1.8 This is likely to be because there is still cross-subsidy in the market between individuals privately funding their care and local authorities/ the NHS. Although data collected by LaingBuisson shows that among the providers who submitted toolkits, 84% of their business is council-funded. This would suggest that unless private individuals are charged substantially more than council rates there is not a high level of cross-subsidy occurring in the homecare market.

6.1.9 This does raise the question of how homecare providers can run their businesses as going concerns when most of their business is at hourly rates at least 22.7% below the median output of the CoC exercise.

6.1.10 Therefore, although the Council intends to move towards uplifting its lowest fee rates, it does not expect the output of the CoC exercise to represent the fee rates it should currently be paying the market. Particular concerns with this exercise include:

➢ the low number of toolkit submissions collected, particularly in light of the significant variation in their data, making statistical exclusion of outliers difficult;
➢ the lower level of engagement of smaller providers in the cost of care exercise;
➢ differences in the labour markets across the county in which providers are operating, meaning a single CoC value may not be appropriate if there are more localised markets in operation; and
➢ inflationary issues with inflation running at such unusually high levels at the current time.

6.1.11 Further work will be needed in collaboration with the market as part of future fee setting.

7   Approach to Uplifting Fee Rates

7.1.1   The Council has not yet set its uplift strategy for 2023/24. However, the general approach to setting an inflation budget to uplift fee rates applies. The Council applies the percentage uplift in the National Living Wage to the care commitment assumed to relate to staffing costs for the lowest paid workers, and an estimate for CPI increase to other parts of the commitment it intends to award uplifts on.

7.1.2   For 2023/24, the Council is likely to take an approach of awarding some uplifts as recurrent funding and offer further, one-off support to providers to help them to deal with inflationary pressures in the current economic climate. Some prices (energy, fuel) are volatile and are currently affected by an international situation that will eventually change, with prices expected to return to more normal levels as a result.

7.1.3   The Council's elected Members have made a commitment to support care providers in moving towards paying the Real Living Wage where they do not currently do so, and the uplift strategy will align with this commitment.

7.1.4   The Council's homecare framework has an inbuilt contractual mechanism for uplifts that links these to national living wage and CPI increases. In addition to contractual uplifts, over the past two years the Council has given extra support to homecare providers in bringing their fee rates up to more sustainable levels. In December 2020 providers were given a 1% increase to their fee rates, with a further 4% applied in April 2021. In February 2022 65 pence per hour was added to all provider homecare fee rates, backdated to the start of April 2021. And in April 2022 homecare providers were awarded an additional 10 pence per hour to help them meet the employer cost of the health and social care levy. This has had the impact of increasing the maximum fee rate on the homecare framework from £17.62 per hour in April 2020 to £20.16 per hour in April 2022.

7.1.5   The data collected through the CoC exercise is welcomed, as it enables the Council to further understand the split of costs in homecare placements and should help us to develop our uplift strategy for homecare in a more targeted manner. Where the data shows consistency, we may be able to apply more targeted CPI indices to elements of our placement costs.

7.1.6   It should be noted that, as with all local authorities, Cambridgeshire County Council is in an extremely difficult financial situation with significant savings to find to deliver a balanced budget in 2023/24. The Council has many statutory services to deliver, which are all subject to increasing costs, of which adult social care is but one. Therefore, whatever our aspirations for improving funding levels in the adult social care market, unless funding from central

government meets the increased costs of this the Council will be unable to meet the increased funding demands of the care provider market.

Appendix 1

Table 3: Median cost of care exercise results presented to DHSC in Cambridgeshire County Council's Annex A submission. Also showing the lower and upper quartiles of the data.

	Median £		1st Quartile £		3rd Quartile £	
Total Careworker Costs:	**17.97**	**(22)**	**16.52**	**(22)**	**20.67**	**(22)**
Direct Care - direct pay	10.80	(25)	10.36	(25)	12.06	(25)
Travel Time	0.70	(24)	0.00	(24)	1.87	(24)
Mileage	1.21	(21)	0.87	(21)	1.63	(21)
PPE	0.50	(24)	0.35	(24)	0.88	(24)
Training (staff time)	0.22	(23)	0.09	(23)	0.34	(23)
Holiday	1.67	(22)	1.60	(22)	1.85	(22)
Additional Non-Contact Pay Costs	0.36	(10)	0.16	(10)	0.44	(10)
Sickness/Maternity & Paternity Pay	0.46	(25)	0.19	(25)	0.64	(25)
Notice/Suspension Pay	0.15	(9)	0.11	(9)	0.31	(9)
NI (direct care hours)	1.16	(23)	0.82	(23)	1.37	(23)
Pension (direct care hours)	0.44	(22)	0.39	(22)	0.49	(22)
Business Costs:	**5.58**	**(25)**	**4.10**	**(25)**	**7.39**	**(25)**
Total Back Office Staff	3.30	(24)	2.63	(24)	4.42	(24)
Travel Costs (parking/vehicle lease etc.)	0.13	(9)	0.08	(9)	0.22	(9)
Rent / Rates / Utilities	0.35	(23)	0.23	(23)	0.46	(23)
Recruitment / DBS	0.13	(28)	0.06	(28)	0.27	(28)
Training (3rd party)	0.06	(23)	0.03	(23)	0.17	(23)
IT (Hardware, Software CRM, ECM)	0.15	(23)	0.10	(23)	0.24	(23)
Telephony	0.08	(27)	0.03	(27)	0.15	(27)
Stationery / Postage	0.04	(25)	0.02	(25)	0.05	(25)
Insurance	0.14	(24)	0.04	(24)	0.18	(24)
Legal / Finance / Professional Fees	0.09	(21)	0.06	(21)	0.16	(21)
Marketing	0.05	(17)	0.01	(17)	0.08	(17)
Audit & Compliance	0.06	(21)	0.03	(21)	0.14	(21)
Uniforms & Other Consumables	0.05	(22)	0.02	(22)	0.10	(22)
Assistive Technology	0.05	(9)	0.03	(9)	0.13	(9)
Central / Head Office Recharges	0.24	(12)	0.04	(12)	0.52	(12)
Additional Costs (Totals)	0.04	(8)	0.02	(8)	0.27	(8)
CQC Fees	0.11	(23)	0.09	(23)	0.13	(23)
Sub-total Operational Costs	**23.56**		**20.62**		**28.06**	
Return on Operation	**1.18**		**1.03**		**1.40**	
Total Cost per hour	**24.73**		**21.65**		**29.47**	

Supporting Information on important cost drivers used in calculations:	
Number of location level survey responses received	32
Number of locations eligible to fill in the survey (excluding those found to be ineligible)	67
Carer basic pay per hour	£10.12
Minutes of travel per contact hour	11.1
Mileage payment per mile	£0.36
Total direct care hours per annum	669,164.0

The values in brackets are the number of submissions contributing towards that figure. Section subtotals are the median subtotals, rather than the subtotal of the costs they relate to.

Table 4: Cost per visit length

Visit Length	Average Cost (£)	Median Cost (£)
15 minutes	8.45	7.92
30 minutes	14.05	13.39
45 minutes	19.66	18.86
60 minutes	25.27	24.33

The "average cost" is the mean. Hourly rates include travel costs.

The figures are not directly comparable with the CoC output in Table 3, as they have necessarily had to exclude providers who include travel time in the hourly rate paid to carers, rather than paying travel time separately.

Table 5: Number of appointments per week by visit length

Visit Length	Median	1st Quartile	3rd Quartile
15 minutes	71	44	141
30 minutes	477	153	772
45 minutes	152	68	230
60 minutes	63	22	133

Table 6: Segmented response rates (validated plus partially validated) by key characteristics

Responses	Respondents	Respondents as % of services in scope
Total	32	48%
Validated	26	39%
Strategic providers	8	67%
For-profit	31	51%
Not-for-profit	1	20%
Large corporate group	4	67%
Medium group	5	56%
Small group or independent	23	44%
Large service scale (100,000+ hours annually)	5	N/A
Medium service scale (15,000 - 99,999 hours annually)	22	N/A
Small service scale (< 15,000 hours annually)	4	N/A
Good or Outstanding	23	43%
Requires Improvement or Inadequate	4	50%
Urban	6	N/A
Mainly Urban	11	N/A
Rural	2	N/A
Mainly Rural	9	N/A
Mainly (60%+) private pay	0	N/A
Mainly (60%+) public pay	26	N/A

Table 7: Uplifts from 2021/22 to 2022/23

	CPI Code	CPI Item	12 Month % change to April 2022
Direct Care	-	National Living Wage % increase[10]	6.6
Travel Time	-	National Living Wage % increase	6.6
Mileage	D7H3	07.2 Operation of personal transport equipment	16.5
PPE	D7NO	06.1 Medical products, appliances and equipment	1.3
Training (staff time)	-	National Living Wage % increase	6.6
Holiday	-	National Living Wage % increase	6.6
Additional Non-Contact Pay Costs	-	National Living Wage % increase	6.6
Sickness/Maternity & Paternity Pay	-	National Living Wage % increase	6.6
Notice/Suspension Pay	-	National Living Wage % increase	6.6
NI (direct care hours)	-	-	-
Pension (direct care hours)	-	National Living Wage % increase	6.6
Back Office Staff	-	Average earnings index, April – April	4.1
Travel Costs (parking/vehicle lease etc.)	D7GE	07 Transport	13.5
Rent / Rates / Utilities	D7GB	04 Housing, water, electricity, gas and other fuels	19.2
Recruitment / DBS	D7OB	12.7 Other services (nec)	-3.1
Training (3rd party)	L7TA	10.4 Tertiary education	5.1
IT (Hardware, Software CRM, ECM)	D7IY	08.2/3 Telephone and telefax equipment and services	2.6
Telephony	D7IY	08.2/3 Telephone and telefax equipment and services	2.6
Stationery / Postage	D7GF	08 Communication	2.8
Insurance	D7HF	12.5 Insurance	11.7
Legal / Finance / Professional Fees	D7GJ	12 Miscellaneous goods and services	2.9
Marketing	D7GJ	12 Miscellaneous goods and services	2.9
Audit & Compliance	D7GJ	12 Miscellaneous goods and services	2.9
Uniforms & Other Consumables	D7GA	03 Clothing and footwear	8.3
Assistive Technology	D7GJ	12 Miscellaneous goods and services	2.9
Central / Head Office Recharges	D7G7	CPI (overall index)	9.0
Other Costs	D7G7	CPI (overall index)	9.0
CQC Registration Fees (4)	-	-	-

Source: Office for National Statistics for different CPI series

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[10] https://www.gov.uk/government/news/national-living-wage-increase-boosts-pay-of-low-paid-workers#:~:text=The%20improvement%20in%20the%20economic,2.2%20per%20cent)%20in%202021.

Cambridgeshire County Council

Cost of Care exercise – Autumn 2022

Care Homes for over 65s

1 Introduction

1.1 **Headline Results**

1.1.1 In 2021, the Department for Health and Social Care (DHSC) published [Build Back Better-our plan for health and social care](#)[1] and [People at the heart of care - adult social care reform white paper](#)[2] which outlined significant legislative changes to Adult Social Care which would come into effect from October 2023. As part of these changes, councils across England with social care responsibilities were required to conduct an exercise with the local provider market to establish the costs of providing care based on guidance and a standardised methodology issued by DHSC. This report sets out the results of that exercise for care home provision in Cambridgeshire for people over the age of 65.

1.1.2 Submissions for the CoC exercise were received from 49 care homes; the Council currently has service users placed in 48 of these care homes. The returns represent 53.8% of providers in scope for this exercise.

1.1.3 The median cost of care returned through the exercise for each bed type is shown in the table below, together with the average cost of current Cambridgeshire County Council (CCC) placements for over 65s. The average rate values for Nursing and Nursing Dementia beds have been adjusted for Funded Nursing Care (FNC)[3] to make them comparable to the Cost of Care (CoC) output. The full breakdown of the figures in the cost of care exercise can be found in Appendix 1, Tables 2-3.

Table 1: CoC output and mean Cambridgeshire County Council over-65s bed rates, as at September 2022

	CoC Output	All Beds	In-County Spot Beds	Block Beds	Out of County Spot Beds
Residential	£911.17	£707.61	£719.93	£642.96	£786.09
Residential Enhanced	£915.57	£712.95	£726.96	£682.31	£712.59
Nursing	£1,170.69	£1,024.43	£1,058.56	£993.40	£1,023.82
Nursing Enhanced	£1,223.65	£1,121.33	£1,158.42	£1,012.83	£1,153.96

1.1.4 The data collected shows a higher cost for all care types from the CoC exercise when compared to the average rates the Council is currently able to procure through both spot and block bed commissioning. The CoC rates are between 9% and 28% higher than the rates currently paid for care home placements. This is a key concern as the Council strives to balance its duties to obtain best value for money for the public purse with the market position on costs that are being incurred in the provision of care. And the impact is wider than the CoC exercises undertaken so far, as these only cover homecare and

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[1] https://www.gov.uk/government/publications/build-back-better-our-plan-for-health-and-social-care

[2] https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper

[3] The NHS pays £209 per week towards care home placements where the service user has nursing needs, thus the rates the Council pays to providers for nursing placements are net of FNC contribution.

care homes for those aged over 65. The financial impact of increasing rates of pay in these areas will be felt across the wider care market with rates for other care provision also increasing and creating significant financial pressure

1.1.5 As with many local authorities, the Council is in an extremely difficult financial situation with significant savings to find to deliver a balanced budget in 2023/24 and beyond. The Council has many statutory services to deliver, which are all subject to increasing costs, of which adult social care is but one. Inflation is running at unusually high levels and putting further pressure on organisations and individuals which in turn puts pressure on the Council's limited budget. Therefore, whatever our aspirations for improving funding levels in the adult social care market, unless funding from Central Government meets the increased costs of this, the Council will be unable to meet the increased funding expectations generated by this exercise.

1.1.6 The Council recognises that the challenges of low fee rates, high inflation and workforce pressures affect the whole care market. It will target additional funding received from government for 2023/24 and 2024/25 to address low fee rates to providers in the Cambridgeshire care market to help manage these challenges.

1.2 Contents of the Report

1.2.1 This report sets out:

- Section 2 – the approach CCC took to complete this exercise

- Section 3 – the level of provider engagement undertaken in completing the exercise and how the Council and LaingBuisson sought to promote provider engagement.

- Section 4 – the approach taken with the data received from providers including:
  - o data validation,
  - o identification of outlier values,
  - o the approach taken with incomplete provider toolkit submissions,
  - o how data has been uplifted to April 2022 values (where relevant),
  - o how nursing staff and care staff costs have been calculated
  - o the approach adopted for return on capital and return on operations.

- Section 5 – analysis of the value and representativeness of the data collected.

- Section 6 – the relationship between the median CoC output and fee rates, including comparison to fee rates currently paid by the Council.

- Section 7 – the Council's approach to uplifting fee rates.

1.2.2 The Council would like to thank the providers who submitted data for this exercise for their time and effort in engaging with the process and we look forward to having the opportunity to engage with you and the wider market further over the coming months.

2 Approach

2.1.1 In June 2022, the Council commissioned LaingBuisson to undertake a Cost of Care (CoC) exercise covering registered care homes for older people (65+), as described and specified in Department of Health and Social Care (DHSC) guidance. LaingBuisson undertook provider engagement, data collection, validation and analysis for the Council and provided the Council with a CoC report and their analysis Excel spreadsheet.

2.1.2 The Council's Finance Team then undertook their own analysis of the data, making some small changes to arrive at the figures presented by the Council in this report. These were specifically relating to the nursing and care staff lines and the treatment of PPE costs. Further details on the treatment of the data are provided in Section 4.

2.1.3 Data was collected between June and September 2022 using the Fair Cost of Care portal, commissioned by DHSC from iESE for this exercise. Care providers gave data as at April 2022, and/ or for the year 2021/22.

2.1.4 Both LaingBuisson and the Council registered on the iESE portal for Cambridgeshire, with LaingBuisson analysing the data collected through the portal and using the portal to raise queries with providers around outlier data.

3 Provider Engagement

3.1 **Approach**

LaingBuisson worked with the Council throughout July and August to engage with providers through a variety of communication channels. The Council sent out multiple communications about the exercise to its providers via formal letters, email, newsletters and promoted the exercise through relevant provider forums and contract management meetings and negotiations. LaingBuisson contacted providers in the market by telephone, explaining the exercise and encouraging them to participate. Over the course of the project, LaingBuisson made a total of 384 calls to care home providers in Cambridgeshire.

3.1.1 The Council and LaingBuisson held 2-weekly project meetings to discuss progress with provider engagement and submission of toolkits. Council officers identified key strategic providers (those who provide a large number of Council-commissioned beds) who had not responded. LaingBuisson engaged in more targeted and intensive communication for those providers, with Council officers from contracts and commissioning teams contacting providers where they still did not want to engage with the process

3.1.2   LaingBuisson also provided support to providers in completing their toolkit submissions through provision of remote advice and guidance.

3.1.3   Whilst clear deadlines were set and communicated to the market, a flexible approach was taken to receiving submissions, which aimed to maximise the response rate. The Council and LaingBuisson agreed to extend the deadline for providers to submit returns three times, with the original date of 24th June 2022 being extended to the final submission date of 1st September 2022. This increased the initial length of time for submissions from 2 weeks to just under 12 weeks. Providers have also been able to alter their submissions after that date, with any updated submissions incorporated into data analysis.

3.1.4   Where the data given by providers appeared incomplete or inaccurate, LaingBuisson contacted providers via the iESE portal and by phone to attempt to validate the data and arrive at accurate figures.

3.2   **Level of Engagement**

3.2.1   In total, 77 care providers out of the 91 Cambridgeshire providers in scope for this exercise registered on the iESE portal. Of those 77 providers, 49 made CoC submissions via the portal. This represents 53.8% of the Cambridgeshire providers in scope. Those that didn't complete a submission were contacted by LaingBuisson to encourage positive engagement with the process and/or to ascertain why a submission would not be made.

3.2.2   The Council has service users placed in 48 of the 49 care homes who submitted a return. At the time of writing this report, the Council has service users placed in 85 of the care homes in scope for the exercise. Therefore, in relation to homes the Council has service users placed in, this represents a 56.4% response rate.

3.2.3   Further exploration of the representativeness of submissions across different bed types and types of providers can be found in section 5.5. Table 4 in Appendix 1 shows segmented response rates as calculated by LaingBuisson.

3.2.4   Where providers chose not to submit CoC returns, reasons given included that the provider did not believe the exercise would lead to any change in funding rates, and that the CoC exercise was too time consuming. The latter was a particular problem for smaller providers, who do not necessarily have the in-house expertise to complete the return and would, for instance, outsource the preparation of their annual accounts. Large corporate groups of care homes were able to allocate staff to the task of completing multiple submissions. This is reflected in the over-representation of large corporate groups in Cambridgeshire's submissions and the under-representation of small group or independent homes.

4   Data

4.1   Data Quality

4.1.1   The quality of the data submitted by providers was variable, with some providers able to complete all sections of the template with April 2022 and 2021/22 figures, while others only filled out part of the template or only provided 2021/22 data. Where possible, information from all submissions has been used.

4.1.2   LaingBuisson have said that in their experience from similar cost of care exercises, large corporate groups typically have the resources to submit consistent and reliable numbers, but SMEs and micro-businesses can find it challenging to deal with the volume and complexity of data requested in toolkits and may leave some questions unanswered and incorrectly answer others. This appears to be the case in the Cambridgeshire data, which may leave smaller providers further under-represented in Cambridgeshire's CoC numbers with a resulting impact on the accuracy of the cost outputs from the exercise.

4.2   Data Validation

4.2.1   LaingBuisson checked toolkit submissions for sense and consistency, contacting providers where there appeared to be anomalies. These were amended with the agreement of providers.

4.2.2   LaingBuisson checked each toolkit individually and compared it to submissions from similar care homes and to LaingBuisson's historic Care Cost Benchmarks dataset[4]. Toolkit submissions for individual cost lines were queried when they were found to be significantly outside of expected ranges, with particular attention paid to the plausibility of figures which contribute most notably towards total costs - most of which being costs related to staffing.

4.2.3   The iESE platform included a facility to query provider submissions, which was used by LaingBuisson to contact providers. The facility marks the submission as "in query" and it can only be brought out of "in query" by changes to submissions on the provider side. Where providers have not attempted to resolve queries on the platform their submission remains "in query". Cambridgeshire has 9 such submissions.

4.2.4   LaingBuisson have fully validated submissions from 23 providers (14 nursing homes and 19 residential homes). They have partially validated data from all 26 remaining providers (11 nursing homes and 5 residential homes).

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[4] LaingBuisson has collected cost data from UK wide care home surveys and local Fair Price exercises commissioned by councils, the NHS and independent care associations over more than a decade. They provided a useful source of benchmarking data against which 2022 CoC toolkit submissions could be compared, in particular with regard to staff hours per resident per week, which is the single most important driver of care home costs.

4.3   **Missing and Incomplete Toolkit Submissions**

4.3.1 Missing and apparent outlier values remain in Cambridgeshire's data where providers have been unable or have not wanted to engage in the validation process. However, where possible data from all toolkits has been included in the CoC output.

4.3.2 LaingBuisson used an outlier exclusion approach to identify and exclude outliers from the dataset. Outliers are defined as null or zero values for any cost line where a null or zero value is inappropriate, and non-zero values that are outside specified boundaries.

4.3.3 They adopted Double Median Absolute Deviation (Double MAD) as their preferred approach to setting outlier boundaries for each individual cost line.[5] This method was chosen because statistical testing for skewedness in the dataset confirms that it suffers from a highly asymmetric distribution across almost all categories. Using a singular Median Absolute Deviation (MAD) value would disregard this asymmetry and produce unreliable results.

4.3.4 An outlier was determined to be any data point that was more than 2 X MAD above or below the median of the validated dataset, with any such outlier excluded from the calculation of median costs in Table 2 (Appendix 1). This means that where LaingBuisson have not validated a provider's full submission, the provider's data is still included in the calculation of median costs if it is within 2 X MAD of the median of the validated submissions.

4.4   **Base Price Year and Uplifts**

4.4.1 All the CoC results cited in this report are expressed at April 2022 prices. Where a provider only submitted 2021/22 data, LaingBuisson have uplifted these figures to April 2022 prices. They have uplifted the data based on the National Living Wage for low-paid staff (care and domestic), the monthly earnings index for other staff, and CPI (Consumer Price Index) and CPIH (Consumer Price Index with Housing) percentage change figures for non-staffing costs for the 12 months up to April 2022[6]. These figures have been

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[5] $MAD = median(|X_i - \bar{X}|)$

Median Absolute Deviation (MAD) is calculated by finding the absolute difference between each validated data point and the validated sample median and then calculating the median of these absolute differences. For normally distributed data, MAD is multiplied by a constant b = 1.4826, however, the distribution is unknown and not symmetric in our data sample.

The premises of the Double MAD method are similar to the classic version, with the only difference being the calculation of two Median Absolute Deviations: 1) the median absolute deviation from the median of all points less than or equal to the median and (2) the median absolute deviation from the median of all points greater than or equal to the median. This allows us to set pertinent outlier thresholds taking into account skewness in the data sample.

[6] Table 22, https://www.ons.gov.uk/economy/inflationandpriceindices/datasets/consumerpriceinflation

chosen on a point-by-point basis, where appropriate figures have been identified to account for relative price effects[7], with overall CPI inflation figures used where no appropriate, goods/services-specific CPI figure has been identified. Uplift figures with CPI codes for each cost heading can be found in Table 5 in Appendix 1.

4.4.2 This was seen as the most appropriate way to uplift 2021/22 data by LaingBuisson. However, it does apply a full year's inflation to 2021/22 costs, where had the provider stated April 2022 values, they may not have reflected a full year's inflation as April is the start of the financial year, not the mid-point.

4.5 **Approach to Nursing and Care Staff Lines**

4.5.1 Taking the median of care staff lines for each bed type returned a higher care staff cost for residential homes than for residential enhanced homes. This was despite the median (and mean) carer hours delivered in an enhanced residential placement being higher than in a residential placement.

4.5.2 The dataset for enhanced residential placements was smaller than for residential placements, with 21 submissions contributing to the median cost of care staff in enhanced residential placements, versus 33 for residential placements. Closer analysis of the dataset shows that there are four homes whose cost of care staff in a residential placement is greater than the highest validated cost of care staff in an enhanced residential placement. Three out of these four homes are nursing homes that also have residential placements (but no residential enhanced placements), with the fourth being a home with only residential placements.

4.5.3 Rather than making specific judgements about which homes should or should not be included in the calculation of medians and deviating from a statistical approach towards the data, the Council decided to calculate the median number of care staff hours for each bed category and a median blended hourly rate for care staff across all returns. Multiplying these together gives an adjusted median cost of care staff for each bed category.

4.5.4 This approach has also been adopted for care staff costs in the other bed categories, and for nursing staff costs, as we feel that it gives a truer median value in the market, rather than compounding factors that may lead to care or nursing staff costs being unusually high or low. The data points that affect the care and nursing staff costs figures are: the number of hours for each type of staff; the hourly rate paid to each type of staff; the on-costs rate used; the number of days staff are paid for, but do not work, e.g., paid training, annual leave, sick leave; the number of hours covered by agency staff; and the agency staff rates paid.

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[7] Our approach to uplifting is broadly in line with guidance on inflationary adjustment set out in The Green Book 2022, Section 5.13,
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1063330/Green_Book_2022.pdf

4.5.5 A CIPFA qualified accountant at the Council studied how the iESE Fair Cost of Care tool calculates the care staff and nursing staff lines for each bed type in its output and used this knowledge to identify the relevant data points in the dataset for calculating median hourly rates for each type of staff and number of hours of care for each bed type.

4.5.6 New datapoints were calculated for each provider submission ("care staff hours" and "nursing staff hours" for each bed type, and "care staff rate" and "nursing staff rate"). Double MAD data validation was applied to the new datapoints to exclude outliers before the median was calculated on the remaining datapoints.

4.5.7 "Care staff hours" was calculated by summing the number of hours of care provided by carers, senior carers and nursing assistants for each bed type in each home in the dataset. (Nursing assistants are treated as care staff in the iESE tool).

4.5.8 "Care staff rate" and "nursing staff rate" incorporate the hourly rates paid to staff; the on-costs rate used; the number of days staff are paid but do not work, e.g., paid training, annual leave, sick leave; the rate paid to agency staff; and the proportion of hours covered by agency staff rather than employed staff.

4.5.9 "Care staff rate" is a blended rate for carers, senior carers and nursing assistants, taking into account the proportion of "care staff hours" delivered by each role and the hourly rate for that role, accounting for all the factors set out in 4.5.8. above.

4.5.10 It was felt that calculating blended "care staff hours" and "care staff rate" was necessary to account for different mixes in care home staffing – for example, very few homes have nursing assistants, but those who do have reduced carer or senior carer hours.

4.6 **Choice of Subtotals or Individual Lines**

4.6.1 The output of the DHSC CoC exercise (shown in Table 2, Appendix 1) must be submitted to DHSC as Annex A of councils' Market Sustainability and Fair Cost of Care returns. DHSC allows an Annex A return that assumes the CoC to be the sum of individual lines, the sum of the subtotals for each section of costs, the median total cost stated in returns, or any other median-based approach. Authorities are encouraged to choose the most appropriate median-based approach for their dataset.[8]

4.6.2 The Council considers that (excluding nursing and care staff costs) the most appropriate representation of costs is to use the subtotals for each section.

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https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1100304/annex-a-example-grant-template-august-2022.xlsx (accessed 03/10/2022)

This is because providers have variously included costs within different lines within a section. Some providers have provided commentary on the iESE portal to that effect, telling us that they have included a datapoint in a different line. Therefore, to use the sum of individual lines would risk over or under-stating the value of some lines where some providers have inappropriately included or excluded costs. As long as providers have included costs in the right section, using the median subtotal for each section removes this risk.

4.6.3   As the Council has chosen a different method to calculate nursing and care staff lines, a non-nursing and care staff costs subtotal has been calculated excluding these lines.

4.6.4   Given the Council has chosen to use subtotals from individual sections, and individual lines feed into those subtotals, the Council has chosen to interpolate PPE costs. 73% of our provider returns had left this line blank. Providers will have no costs associated with PPE while this is provided for free by DHSC. However, without this support providers will have a PPE cost associated with each bed. Therefore, the median non-null value for PPE from validated submissions has been substituted for the null values in provider returns. Discussions with colleagues from other councils confirms this approach has also been taken in other submissions.

4.7   **Return on Capital and Return on Operations**

4.7.1   The Council has chosen to use the following rates for Return on Capital (RoC) and Return on Operations (RoO).
- Return on capital – 6% per annum
- Return on operations – 5% per annum.

4.7.2   DHSC guidance[9] cites the Competition and Markets Authority's advice in its 2017 report on the care home market[10], that the cost of capital for care homes should be calculated as the product of a) the value of the assets invested in the care home and (b) the required percentage annual return on capital.

4.7.3   To determine the value of assets invested in the home, care homes could provide a 'Red Book' valuation in the iESE toolkit and the date of the valuation in question. 23 of the Cambridgeshire submissions provided this information. LaingBuisson adjusted the valuations to express them as a 2022/23 £ value per resident in the home. Among the Cambridgeshire toolkits which reported valuations, the median figure was £73,234 per resident per annum.

4.7.4   The required percentage annual return on capital is determined by LaingBuisson to be 6%, based on the price that a care home operator typically must pay for a long-tern lease on a turnkey care home asset. This

9 Annex E: further detail on return on capital and return on operations - GOV.UK (www.gov.uk)
10 https://www.gov.uk/government/publications/care-homes-market-study-summary-of-final-report

aligns with advice given by CIPFA at a CIPFA Adult Social Care Network webinar.[11]

4.7.5 To determine a value per bed per week for return on capital, it is necessary to apply the rate of return to a capital value per resident. This is the median freehold value per bed, divided by the occupancy per registered bed, expressed as a weekly value.

4.7.6 Cambridgeshire's return on capital (£99.47 per bed per week) is therefore calculated as:

$$\frac{6\% \times £73,234}{87\% \times 7/365}$$

4.7.7 The Council has chosen to use a return on operations (RoO) figure of 5%. The return on operations represents the provider's profit before interest, tax, depreciation, amortisation and rent payments.

4.7.8 73.5% of providers gave a return on operations percentage in their submissions. Validated return on operations percentages ranged from 5% to 15%, with all submissions being from for-profit providers. We recognise that we have a lack of representation in our returns from smaller providers.

4.7.9 The Council recognises that it has both a duty to stewardship of public funds and a duty to support the care provider market, which are often in conflict with one another. It has considered the submissions from providers in this exercise, and in the homecare cost of care exercise in which the mean RoO submitted was 5%. It has also benchmarked its treatment of return on operations against that of regional local authorities.

4.7.10 The Council considers that once property costs have been stripped out of care homes, the operating business (employing and managing staff to deliver care and support) has many similarities and similar risks to the operating business of a homecare provider. In the interests of consistency across the care provider market as a whole, and within the regional care market, we have therefore adopted a standard RoO of 5% for care homes as well.

5 Validity and Representativeness of Data

5.1 **Sensitivity of Data**

5.1.1 The median total costs set out in Table 2 (Appendix 1) are sensitive to the following factors:
- The efficacy of the validation process in eliminating implausible and incorrect toolkit submissions for individual cost lines.
- The validity of the rules adopted for elimination of outliers before calculating the medians for each cost line.

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[11] CIPFA webinar: Making the most of the cost of Care Exercise – 20th July 2022

- The return on capital and return on operations benchmarks.
- Calculation of capital cost per occupied bed, to which the return on capital benchmark is applied.
- Occupancy levels.

5.1.2 The nursing staff and care staff lines specifically are sensitive to the following factors:
- The hourly rates paid to nurses – nursing staff line.
- The hourly rates paid to carers, senior carers and nursing assistants – care staff line.
- The mix of care staff in a home.
- The cost and usage of agency staff.

5.1.3 This section examines some of these sensitivities.

5.1.4 The Double MAD method of data validation is a good method of removing outliers, although the number of outliers removed varies greatly across individual lines, with the lowest percentage of submissions used for an individual line being 35.4% and the highest being 83.3%. The use of subtotals instead of individual lines in arriving at CoC figures removes some of this variability. The lowest percentage of submissions contributing to a subtotal line is 59.2% and the highest is 81.6%. This still means that data from just over 40% of submissions has been excluded from one of the subtotal lines, as this data was outside the boundaries set by Double MAD validation.

5.1.5 The return on capital benchmark seems appropriate as a methodology, as it can be linked to the capital invested in the business. The return on operations benchmark seems less appropriate given providers generally seek a return on the capital invested in the business, and RoO is linked to operating costs and head office costs instead. Residential homes are under-compensated for their investment in the business, while homes that only have nursing and nursing dementia beds are over-compensated by this methodology.

5.1.6 The cost of capital per occupied bed was highly variable across the submissions we received. None were excluded through Double MAD validation but adopting a median value could significantly over-compensate some homes for their investment in their business and under-compensate others. The cost of land varies significantly across the county, such that a care home being built in the south of the county or in Cambridge city would require higher capital investment than one in the north of the county.

5.1.7 There was variation in the rates paid by homes to different care staff roles, but it was not significant. Very few submissions were excluded by Double MAD validation, with 90.0% of nurse rate figures and 86.4% of carer rate figures being used in determining the median.

5.1.8 It is worth noting that 35 homes (71%) are paying the real living wage or higher to their lowest paid care staff. Most of the remainder have made steps towards paying the real living wage, with only two (4%) paying their carers £9.50 per hour (the 2022/23 national living wage).

5.1.9 There was significant variation in the rates paid for agency staff and the usage of agency staff. The homes paying most for agency staff appear to be paying a premium of 50% on the lowest rates paid.

5.1.10 There are a variety of staffing models in the dataset, with providers submitting data for individual units in their care homes where they were able to. There is also variation across the units in some individual homes. There are several nursing homes that also provide residential and enhanced residential care. Many of their submissions show that they have nurses working on a unit with residential and enhanced residential beds and some may have fewer senior carers on that unit as a result. However, the iESE model only counts nursing staff costs against nursing and enhanced nursing beds, which we agree with in principle. However, in practice this may not reflect the setup of some nursing providers and may under-state the staff hours allocated to residential care types.

5.2 Occupancy Levels

5.2.1 Occupancy levels affect the CoC median outputs as all non-nursing staff and care staff lines are calculated by taking the cost for that item and dividing it by the number of occupied beds. Therefore, if a care home was at 50% occupancy, its non-nursing and care staff cost lines would be double the cost they would be if it were at 100% occupancy. The data will contain a mixture of fixed, semi-fixed and variable costs, so in some cases (variable costs) this treatment will be appropriate, but in most cases it will not. For example, care home management costs and head office costs charged to the home are likely to be the same regardless of its occupancy level.

5.2.2 Even nursing staff and care staff costs are likely to be semi-fixed costs, as a unit will have a number of residents it can support with a core staffing level before it needs to take on more care or nursing staff. A carer will not be assigned to care for one service user, but several. Therefore, some homes may be running at full capacity with the staffing hours they have stated, while others may be able to support more residents without needing to take on extra staff.

5.2.3 Occupancy levels in the Cambridgeshire dataset varied from 44% to 100% of active beds. The mean occupancy level was 87% of active beds, although this equates to 82% of CQC registered beds. Four homes had occupancy levels of under 70%, with a further seven homes having occupancy levels of between 70% and 80% of active beds.

5.2.4 Sector knowledge suggests that an efficient level of occupancy for a care home would be at or above 90%, with CIPFA guidance being that any care home running at an occupancy level of below 80% is unsustainable as a business.[12] The Council considers that this should be 80% of CQC registered

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[12] CIPFA webinar: Making the most of the cost of Care Exercise – 20th July 2022

beds, although guidance for this exercise suggests we consider occupancy to be the percentage of active beds filled.

5.2.5   Considering this, the Council tested the data against three different occupancy scenarios, with occupancy defined as the percentage of active beds filled. The first scenario removed the returns from the four homes with occupancy of under 70%; the second scenario adjusted all occupancy levels to 90%; and the third scenario adjusted any occupancy levels under 80% to 80%.

5.2.6   The results of this sensitivity testing affected the median output of the CoC by up to £20 per week but did not have the same magnitude of impact across all scenarios or bed types. Therefore, the Council has not adjusted the values in its return to reflect a higher level of occupancy. However, it recognises that improving occupancy levels across those care homes in Cambridgeshire with low occupancy would improve their sustainability and reduce their cost per bed.

5.3   **Testing against LaingBuisson's *Care Cost Benchmarks***

5.3.1   LaingBuisson's *Care Cost Benchmarks* have been established for two decades and provide an objective, market-related norm to test the results of the CoC exercise against.

5.3.2   *Care Cost Benchmarks* would expect nursing care costs to be about £250 higher per week than residential care costs – made up from registered nursing staff input, plus some additional non-nurse care staff input. Cambridgeshire's CoC rates show a higher differential between residential and nursing rates than this, with the CoC value of a nursing bed being £260 more than that of a residential bed. The CoC value of an enhanced nursing bed is £308 more than that of an enhanced residential bed. In part this is due to the return on operations for nursing beds being £13-£15 higher than for residential beds.

5.3.3   It is also worth noting that the median number of carer hours in Cambridgeshire's dataset is slightly lower for a nursing bed than for the residential bed types. This does not reflect the expectations of LaingBuisson's *Care Cost Benchmarks*.

5.3.4   *Care Cost Benchmarks* would expect a differential between enhanced and non-enhanced residential care, with enhanced care at a higher cost. They would not expect any differential between enhanced and non-enhanced nursing care. This is not reflected in the output of Cambridgeshire's CoC data, with minimal differential (£4.40 per week) between residential and enhanced residential care, the latter being the more expensive. There is also a substantial differential between nursing and enhanced nursing CoC output (£52.96 per week).

5.3.5   LaingBuisson's *Care Cost Benchmarks* also provides data relevant to return on capital. LaingBuisson state that assuming an even spread of stock between the floor and ceiling, in line with the national balance between

converted and new build stock, the average capital value is about £70,000 per registered bed (£78,000 per occupied bed) nationally. This is similar to the median of £75,234 per bed in the Cambridgeshire CoC dataset.

5.4   **Data Sample Size**

5.4.1   The dataset covered 49 homes, which represents 53.8% of the Cambridgeshire providers in scope for the exercise. The Council currently has service users placed in 48 of the homes, which represent 56.5% of the homes in scope that the Council has service users placed in. A return of over 50% is not completely unrepresentative of the market, but equally 46.2% of the providers in scope did not submit a return for the exercise, which is a substantial segment of the market missing.

5.4.2   The data sample for residential and enhanced residential placements was higher than for nursing and enhanced nursing placements as some nursing homes also have residential or enhanced residential placements.

5.4.3   The sample size for some data points was far smaller than for others, as not all providers filled in the full return. Additionally, how the return treats the data means that some provider data had to be excluded. For example, most providers chose to give a return on capital figure as a weekly value, representing the rent they pay per bed. Only 23 providers submitted a freehold valuation per bed. That means that Cambridgeshire's return on capital figure is based on data from 25.3% of providers in scope for the exercise.

5.5   **Representativeness of the Data Sample**

5.5.1   The dataset represents 56.5% of the care homes in scope that the Council has service users placed in. If instead of providers we consider placements, the dataset covers 70.4% of the Council's in-county placements of over 65s in care homes. At the time of writing this report, the Council has 1,326 service users placed in care homes within the scope of this exercise; 934 of those service users are placed in care homes that have submitted a return for the CoC exercise. This is largely because although the Council buys beds in homes from across the market, it has a large concentration of placements in a smaller number of homes. This is partly due commissioning of block contracts for care home beds.

5.5.2   Representation of care homes the Council has block contracts with is 78.4%, whereas representation of care homes with spot purchased beds is lower at 65.5%. The Council's spot purchased beds represent its greatest price volatility in the market, so it would have been helpful to have greater representation and a better understanding of their costs.

5.5.3   The representation across the different bed types is variable, with the lowest representation for nursing dementia beds – 65.8% in scope were covered by CoC returns, falling to 53.7% of spot purchased nursing dementia beds. The highest representation is for nursing beds – 73.9% in scope were covered by

CoC returns. (The Council's commissioned bed types are residential, residential dementia, nursing and nursing dementia, with dementia beds being equivalent to the "enhanced" beds in the exercise).

5.5.4   This level of representation is welcomed. However, a quarter to a third of the Council's in-county placements remain un-represented, depending on the bed type considered.

5.5.5   Representation of providers varies across the county, with higher representation in the south of the county and lower representation in the north, see Appendix 1, Figure 1 and Table 4. Land values in South Cambridgeshire and Cambridge city are far higher than in Fenland; South Cambridgeshire is over-represented in the sample with Fenland being under-represented. This could skew return on capital values to be higher than if there was even distribution of returns across the county.

5.5.6   Additionally, staff pay rates may be affected by the location of a care home; in Cambridge city there are numerous employment options paying above National Living Wage, making working in the care sector a less attractive option. South Cambridgeshire has good transport links to Cambridge city and other employment centres south of the county, whereas residents in Fenland have poorer transport options to employment centres.

5.5.7   The Council's block bed rates reflect these factors, with the rate paid for beds in Fenland being the lowest and for beds in Cambridge city and South Cambridgeshire being the highest. Providers were happy to tender for contracts on these terms, which suggests that the market could also believe there is variability in the cost of care across the county. Therefore, a single median rate based on data from across the whole county may not be the most representative measure for the cost of care in Cambridgeshire.

5.5.8   There is also varying representation across different types of providers, with large corporate groups over-represented in the dataset for both residential and nursing homes (88% and 92% represented respectively), and small group or independent residential homes significantly under-represented (21% represented). Small homes may be expected to have lower overheads than a home that is part of a large corporate group, so this could skew some parts of the median CoC data.

5.5.9   It should also be noted that DHSC's CoC exercise is attempting to set a median cost of care across the market that assumes the same rate will be charged for every bed within a care type. The market does not work in that way and will not work in that way after adult social care reform. Some rooms in a care home will be nicer than other rooms, particularly in a care home that is converted rather than purpose built. Some rooms will be larger than others, have better views than others or better facilities. It is expected that there will continue to be variation in how much the market charges for individual rooms in these situations. Given councils' duty of stewardship of public funds, it is expected that the differential between a standard room and a better room may

be made up by first- or third-party top ups. The way the data is treated in the CoC exercise does not allow for this nuance.

5.6   **Out of County Placements**

5.6.1   Cambridgeshire is bordered by eight other local authorities with responsibility for adult social care, who have all completed their own median cost of care exercises. It is the expectation of local authorities that when they place a service user in an out of county placement, under adult social care reform the rate they pay for that placement will be determined by the host authority. To do otherwise would skew other local care markets.

5.6.2   The Council currently has 163 over 65s placed in out of county placements, which represents 10.7% of care home placements for over 65s. Some of these will be in homes just over the border from Cambridgeshire.

5.6.3   There is substantial variation in the use of out of county placements across bed types, with residential beds at the lowest rate (8.4%) and nursing dementia beds being at the highest rate (18.8%), reflecting the lack of supply of nursing dementia placements in Cambridgeshire.

5.6.4   Given the high level of out of county placements, particularly for nursing dementia beds, the CoC exercise would never be able to return figures that are representative of the cost of the Council's placements, even if the figures could be taken as representative as the cost of Cambridgeshire placements. This makes it impossible for the Council (and any council with out of county placements, which is assumed to be all councils) to determine the financial impact of uplifting placement costs.

5.7   **Further Testing**

5.7.1   LaingBuisson note that in previous cost of care exercises they have undertaken, they have sought external confirmation of the figures returned, by asking providers to submit payroll data to confirm staffing costs or staffing rotas to confirm hours of care provided, for example. They have not sought this evidence from providers for this exercise.

5.7.2   The Council has not undertaken any verification of the data through external evidence either. The Council notes that this is something that may need to be undertaken to ensure that none of the returns are misrepresenting costs in any way and would require cooperation from the provider market in making the information available to verify costs in their submissions. The Council has a duty of stewardship of public funds and must achieve best value. Under adult social care reform, if local authorities and individuals funding their care privately are to move towards paying the same rate for a care placement, local authorities also have a duty to these individuals to set fee rates that represent value for money.

6   Relationship between the cost of care and fee rates

6.1.1 The Department for Health and Social Care (DHSC) has recognised in its guidance that the median actual operating costs from which local authorities arrive at a cost of care in their area will not reflect the costs of each individual provider in their local area. The guidance states that "the outcome of this cost of care exercise is not therefore intended to be a replacement for the fee setting element of local authority commissioning processes or individual contract negotiation."[13]

6.1.2 The DHSC expectation is that actual fees will be informed by the cost of care exercise, but fee rates will continue to be based on sound judgement, evidence, and through a negotiation process, as is the case currently. The guidance goes on to say "paying a fair cost of care does not mean that all providers are paid the same rate, but rather the fair cost of care is the median value which fee rates will be "moving towards".… As many local authorities move towards paying the fair cost of care, it is expected that actual fee rates may differ due to such factors as rurality, personalisation of care, quality of provision and wider market circumstances."

6.1.3 Table 1 in Section 1 shows the average rates currently paid by the Council for its in-county and out of county spot placements, and block placements (all in-county), compared to the CoC median output. It is reproduced here for ease.

Table 1: mean Cambridgeshire County Council over-65s bed rates, as at September 2022

	CoC Output	All Beds	In-County Spot Beds	Block Beds	Out of County Spot Beds
Residential	£911.17	£707.61	£719.93	£642.96	£786.09
Residential Enhanced	£915.57	£712.95	£726.96	£682.31	£712.59
Nursing	£1,170.69	£1,024.43	£1,058.56	£993.40	£1,023.82
Nursing Enhanced	£1,223.65	£1,121.33	£1,158.42	£1,012.83	£1,153.96

6.1.4 One third of the Council's care home placements for over 65s are on a block contract, although this varies by bed type, with greater block coverage for nursing placements (47%), and lower coverage for other bed types (25%-28%). These beds were commissioned in 2019 and 2020 on 10–15-year contracts and have preferential rates due to the guaranteed income to the provider, even when beds are empty. Separate lots were tendered for each bed type in each district in Cambridgeshire, with lower rates offered in some district areas than others to reflect the local market.

6.1.5 The remainder of the Council's beds are purchased on spot contracts, the majority off a spot framework, as and when placements are needed. The Council does not have set spot bed rates, but its brokerage team purchase beds from the market at a negotiated rate for each placement. Therefore, there is wider variation in the rates paid for spot beds and their rates are more unpredictable.

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[13] https://www.gov.uk/government/publications/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023-guidance/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023-guidance (accessed 30/09/22)

6.1.6   10.7% of the Council's care home placements of over 65s are in out of county homes. The rates paid here are even more variable as they depend on the local market the placement is made in.

6.1.7   As demonstrated by the data in Table 2, the Council currently pays substantially less than the CoC output across all its bed types. However, these rates do reflect what the Cambridgeshire and surrounding market is willing to sell placements to the Council at. Table 6 in Appendix 1 shows the average rates the Council has paid for beds on its spot framework since September 2021. This further demonstrates that the market is not currently demanding the median rates that are returned by the CoC exercise.

6.1.8   This is likely to be because there is still cross-subsidy in the market between individuals privately funding their care and local authorities/ the NHS. However, this cross-subsidy is not set to start ending until October 2023, with private individuals who entered care homes prior to that date expected to continue paying the fee rates they agreed with the care home. Furthermore, there is expected to remain some differentiation in rates after October 2023 as some private individuals will choose to pay first- or third-party top ups for a higher standard of accommodation, or bypass local authorities in purchasing their care direct from care providers.

6.1.9   Therefore, although the Council intends to move towards uplifting its fee rates, it does not expect the output of the CoC exercise to represent the fee rates it should currently be paying the market. A range of issues will impact the costs of individual care homes and no model can address all the nuances in the care home market. Particular factors include:

➢   the lower level of engagement of smaller providers in the cost of care exercise;
➢   differences in the participation of care providers across different areas of the county, and the labour markets and capital values within which those homes are operating;
➢   inflationary issues with inflation running at such unusually high levels at the current time. Costs as at April 2022 would normally be expected to prevail over the full financial year. However, the high levels of inflation seen so far throughout 2022/23 mean that where providers have submitted cost information as at April 2022, care home costs per resident may change significantly over the course of the year.

6.1.10 Further work will be needed in collaboration with the market as part of future fee setting.

7   Approach to Uplifting Fee Rates

7.1.1   The Council has not yet set its uplift strategy for 2023/24. However, the general approach to setting an inflation budget to uplift fee rates applies. The Council applies the percentage uplift in the National Living Wage to the care

commitment assumed to relate to staffing costs for the lowest paid workers, and an estimate for CPI increase to other parts of the commitment it intends to award uplifts on.

7.1.2 For 2023/24, the Council is likely to take an approach of awarding some uplifts as recurrent funding and offer further, one-off support to providers to help them to deal with inflationary pressures in the current economic climate. Some prices (energy, fuel, food) are volatile and are currently affected by an international situation that will eventually change, with prices expected to return to more normal levels as a result.

7.1.3 The Council's elected Members have made a commitment to support care providers in moving towards paying the Real Living Wage where they do not currently do so, and the uplift strategy is expected to align with this commitment.

7.1.4 The 2021/22 uplift strategy targeted care home placements where the Council was paying its lowest fee rates, uplifting all those placements under a floor to that floor to improve market sustainability. The 2022/23 uplift strategy has given a blanket percentage uplift to care homes, as is written into the block contracts and spot framework contract. Where providers feel this is insufficient to meet their costs, they have the option to submit a Budget Analysis Form to the Council, detailing their cost pressures and their financial situation – profit/ loss, reserves.

7.1.5 The data collected through the CoC exercise is welcomed, as it enables the Council to further understand the split of costs in care home placements and should help us to develop our uplift strategy for care homes in a more targeted manner. Where the data shows consistency, we may be able to apply more targeted CPI indices to elements of our placement costs.

7.1.6 It should be noted that, as with all local authorities, the Council is in an extremely difficult financial situation with significant savings to find to deliver a balanced budget in 2023/24. The Council has many statutory services to deliver, which are all subject to increasing costs, of which adult social care is but one. Therefore, whatever our aspirations for improving funding levels in the adult social care market, unless funding from central government meets the increased costs of this the Council will be unable to meet the increased funding demands of the care provider market.

Appendix 1

Table 2: Median cost of care exercise results presented to DHSC in Cambridgeshire County Council's Annex A submission.

Cost of Care exercise results - all cells should be £ per resident per week	Non-Nursing		Non-Nursing with enhancement		Nursing		Nursing with enhancement	
Staffing	**499.56**		**503.75**		**746.72**		**797.16**	
Nursing Staff	-		-		255.77	(18)	255.77	(18)
Care Staff	352.29	(34)	356.48	(23)	343.68	(15)	379.35	(13)
Non-Nursing and Care Staff	**147.27**	**(29)**	**147.27**	**(29)**	**147.27**	**(29)**	**147.27**	**(29)**
Therapy Staff	-	(0)	-	(0)	-	(0)	-	(0)
Activity Coordinators	9.58	(32)	9.58	(32)	9.58	(32)	9.58	(32)
Service Management	43.72	(34)	43.72	(34)	43.72	(34)	43.72	(34)
Reception & Admin	12.65	(29)	12.65	(29)	12.65	(29)	12.65	(29)
Chefs / Cooks	29.09	(34)	29.09	(34)	29.09	(34)	29.09	(34)
Domestic Staff	42.99	(38)	42.99	(38)	42.99	(38)	42.99	(38)
Maintenance & Gardening	9.54	(21)	9.54	(21)	9.54	(21)	9.54	(21)
Other Care Home Staff	19.96	(17)	19.96	(17)	19.96	(17)	19.96	(17)
Care Home Premises	**53.45**	**(44)**	**53.45**	**(44)**	**53.45**	**(44)**	**53.45**	**(44)**
Fixtures & Fittings	20.52	(20)	20.52	(20)	20.52	(20)	20.52	(20)
Repairs and Maintenance	23.69	(37)	23.69	(37)	23.69	(37)	23.69	(37)
Furniture, Furnishings and Equipment	3.72	(33)	3.72	(33)	3.72	(33)	3.72	(33)
Other Care Home Premise Costs	3.46	(32)	3.46	(32)	3.46	(32)	3.46	(32)
Care Home Supplies and Services	**128.69**	**(33)**	**128.69**	**(33)**	**128.69**	**(33)**	**128.69**	**(33)**
Food	40.36	(31)	40.36	(31)	40.36	(31)	40.36	(31)
Domestic & Cleaning	6.66	(31)	6.66	(31)	6.66	(31)	6.66	(31)
Medical Supplies	2.42	(41)	2.42	(41)	2.42	(41)	2.42	(41)
PPE	2.61	(43)	2.61	(43)	2.61	(43)	2.61	(43)
Office Supplies	2.28	(31)	2.28	(31)	2.28	(31)	2.28	(31)
Insurance	6.69	(34)	6.69	(34)	6.69	(34)	6.69	(34)
Registration Fees	3.74	(37)	3.74	(37)	3.74	(37)	3.74	(37)
Telephone & Internet	1.76	(45)	1.76	(45)	1.76	(45)	1.76	(45)
Council Tax / rates	1.23	(40)	1.23	(40)	1.23	(40)	1.23	(40)
Electricity, Gas & Water	38.93	(38)	38.93	(38)	38.93	(38)	38.93	(38)
Trade and Clinical Waste	4.73	(24)	4.73	(24)	4.73	(24)	4.73	(24)
Transport & Activities	2.55	(24)	2.55	(24)	2.55	(24)	2.55	(24)
Other Care Home	3.62	(42)	3.62	(42)	3.62	(42)	3.62	(42)
Head Office	**91.35**	**(30)**	**91.35**	**(30)**	**91.35**	**(30)**	**91.35**	**(30)**
Central / Regional Management	47.82	(34)	47.82	(34)	47.82	(34)	47.82	(34)
Support Services	25.34	(39)	25.34	(39)	25.34	(39)	25.34	(39)
Recruitment, training & vetting	9.26	(30)	9.26	(30)	9.26	(30)	9.26	(30)
Other head office costs	13.23	(18)	13.23	(18)	13.23	(18)	13.23	(18)
Sub-total Operating Costs	**773.05**		**777.24**		**1,020.21**		**1,070.65**	
Return on Operations	38.65		38.86		51.01		53.53	
Return on Capital	99.47		99.47		99.47		99.47	
Total	**911.17**		**915.57**		**1,170.69**		**1,223.65**	

Supporting information	Non-Nursing	Non-Nursing with enhancement	Nursing	Nursing with enhancement
Number of Location level survey responses received (fully verified)	18	13	13	13
Number of locations eligible to fill in the survey (excluding those found to be ineligible)		50		41
Number of residents covered by the responses	744	577	742	745
Number of carer hours per resident per week	24.4	24.6	23.8	26.2
Number of nursing hours per resident per week	-	-	9.3	9.9
Average carer basic pay per hour	£10.77	£10.77	£10.77	£10.77
Average nurse basic pay per hour	-	-	£18.50	£18.50
Average occupancy as a percentage of active beds	87.0%			
Freehold valuation per bed	£75,234			

The values in brackets are the number of submissions contributing towards that figure. Section subtotals are the median subtotals, rather than the subtotal of the costs they relate to. The Non-Nursing and Care Staff row has been added to better illustrate Cambridgeshire's approach to the staffing data.

Table 3: Lower and Upper Quartiles from the DHSC cost of care exercise

Cost of Care exercise results - all cells should be £ per resident per week	LOWER QUARTILE				UPPER QUARTILE			
	Non-Nursing	Non-Nursing with enhancement	Nursing	Nursing with enhancement	Non-Nursing	Non-Nursing with enhancement	Nursing	Nursing with enhancement
Staffing	**467.31**	**461.48**	**728.68**	**806.68**	**560.96**	**537.50**	**928.54**	**908.05**
Nursing Staff	-	-	234.79	221.74	-	-	312.31	349.66
Care Staff	295.19	309.73	295.47	320.07	389.36	370.70	353.13	366.99
Non-Nursing and Care Staff	**134.79**	**134.79**	**134.79**	**134.79**	**171.50**	**171.50**	**171.50**	**171.50**
Therapy Staff	-	-	-	-	-	-	-	-
Activity Coordinators	8.28	8.28	8.28	8.28	11.72	11.72	11.72	11.72
Service Management	35.95	35.95	35.95	35.95	48.55	48.55	48.55	48.55
Reception & Admin	10.42	10.42	10.42	10.42	15.68	15.68	15.68	15.68
Chefs / Cooks	24.70	24.70	24.70	24.70	37.64	37.64	37.64	37.64
Domestic Staff	33.66	33.66	33.66	33.66	52.29	52.29	52.29	52.29
Maintenance & Gardening	7.62	7.62	7.62	7.62	11.44	11.44	11.44	11.44
Other Care Home Staff	14.55	14.55	14.55	14.55	40.32	40.32	40.32	40.32
Care Home Premises	**34.80**	**34.80**	**34.80**	**34.80**	**86.72**	**86.72**	**86.72**	**86.72**
Fixtures & Fittings	4.98	4.98	4.98	4.98	29.13	29.13	29.13	29.13
Repairs and Maintenance	20.29	20.29	20.29	20.29	31.75	31.75	31.75	31.75
Furniture, Furnishings and Equipment	0.66	0.66	0.66	0.66	6.56	6.56	6.56	6.56
Other Care Home Premise Costs	0.82	0.82	0.82	0.82	38.61	38.61	38.61	38.61
Care Home Supplies and Services	**114.74**	**114.74**	**114.74**	**114.74**	**134.54**	**134.54**	**134.54**	**134.54**
Food	38.42	38.42	38.42	38.42	43.21	43.21	43.21	43.21
Domestic & Cleaning	5.49	5.49	5.49	5.49	8.46	8.46	8.46	8.46
Medical Supplies	0.72	0.72	0.72	0.72	4.26	4.26	4.26	4.26
PPE	2.61	2.61	2.61	2.61	2.61	2.61	2.61	2.61
Office Supplies	0.89	0.89	0.89	0.89	3.51	3.51	3.51	3.51
Insurance	5.74	5.74	5.74	5.74	7.95	7.95	7.95	7.95
Registration Fees	3.38	3.38	3.38	3.38	4.25	4.25	4.25	4.25
Telephone & Internet	1.00	1.00	1.00	1.00	2.96	2.96	2.96	2.96
Council Tax / rates	0.64	0.64	0.64	0.64	1.52	1.52	1.52	1.52
Electricity, Gas & Water	32.88	32.88	32.88	32.88	52.96	52.96	52.96	52.96
Trade and Clinical Waste	4.27	4.27	4.27	4.27	5.90	5.90	5.90	5.90
Transport & Activities	2.21	2.21	2.21	2.21	2.89	2.89	2.89	2.89
Other Care Home	2.06	2.06	2.06	2.06	14.41	14.41	14.41	14.41
Head Office	**80.33**	**80.33**	**80.33**	**80.33**	**99.42**	**99.42**	**99.42**	**99.42**
Central / Regional Management	27.13	27.13	27.13	27.13	62.85	62.85	62.85	62.85
Support Services	11.04	11.04	11.04	11.04	46.08	46.08	46.08	46.08
Recruitment, training & vetting	5.91	5.91	5.91	5.91	10.84	10.84	10.84	10.84
Other head office costs	3.90	3.90	3.90	3.90	14.63	14.63	14.63	14.63
Sub-total Operating Costs	**752.25**	**724.32**	**985.20**	**1,047.70**	**857.00**	**796.86**	**1,197.90**	**1,156.18**
Return on Operations	37.61	36.22	49.26	52.38	42.85	39.84	59.89	57.81
Return on Capital	82.27	82.27	82.27	82.27	156.31	156.31	156.31	156.31
Total	**872.13**	**842.81**	**1,116.73**	**1,182.36**	**1,056.16**	**993.02**	**1,414.11**	**1,370.31**

Supporting information	Non-Nursing	Non-Nursing with enhancement	Nursing	Nursing with enhancement	Non-Nursing	Non-Nursing with enhancement	Nursing	Nursing with enhancement
Number of carer hours per resident per week	20.6	22.0	20.9	20.7	26.6	26.7	25.6	27.0
Number of nursing hours per resident per week			7.9	7.7			11.1	12.2
Average carer basic pay per hour	£10.26	£10.26	£10.26	£10.26	£10.94	£10.94	£10.94	£10.94
Nurse basic pay per hour			£17.61	£17.61			£20.00	£20.00
Occupancy as a percentage of active beds	78.5%				99.0%			
Freehold valuation per bed	£60,007				£135,843			

Subtotals are the quartile subtotals, rather than the sum of the lines they relate to.

Table 4: Segmented response rates (validated plus partially validated) by key characteristics

	Nursing Homes			Residential Homes		
	Respondents	Homes in scope with the relevant characteristic	Response rate (%)	Respondents	Homes in scope with the relevant characteristic	Response rate (%)
Total	25	38	66%	24	48	50%
Strategic providers	16	23	70%	11	22	50%
Provider sector						
For-profit	24	37	65%	19	39	49%
Not-for-profit	1	1	100%	5	9	56%
Build status						
Purpose built	15	26	58%	10	16	63%
Not purpose built	6	12	50%	7	32	22%
Operator scale						
Large corporate group [1]	12	13	92%	7	8	88%
Medium group [2]	8	15	53%	13	21	62%
Small group or independent [3]	5	10	50%	4	19	21%
Service scale						
Large service scale (50+ beds)	18	28	64%	8	11	73%
Medium service scale (20-49 beds)	6	8	75%	14	33	42%
Small service scale (<20 beds)	1	2	50%	2	4	50%
CQC ratings						
Good or Outstanding	21	31	68%	23	44	52%
Not Good or Outstanding	4	5	80%	1	4	25%
District Council						
Cambridge City Council	4	8	50%	2	5	40%
East Cambridgeshire District Council	3	3	100%	3	6	50%
Fenland District Council	8	11	73%	4	9	44%
Huntingdonshire District Council	6	7	86%	6	14	43%
South Cambridgeshire District Council	4	6	67%	7	10	70%

[1] 40 or more care homes for older people across the UK
[2] 3 - 39 care homes for older people across the UK
[3] Fewer than 3 care homes for older people across the UK
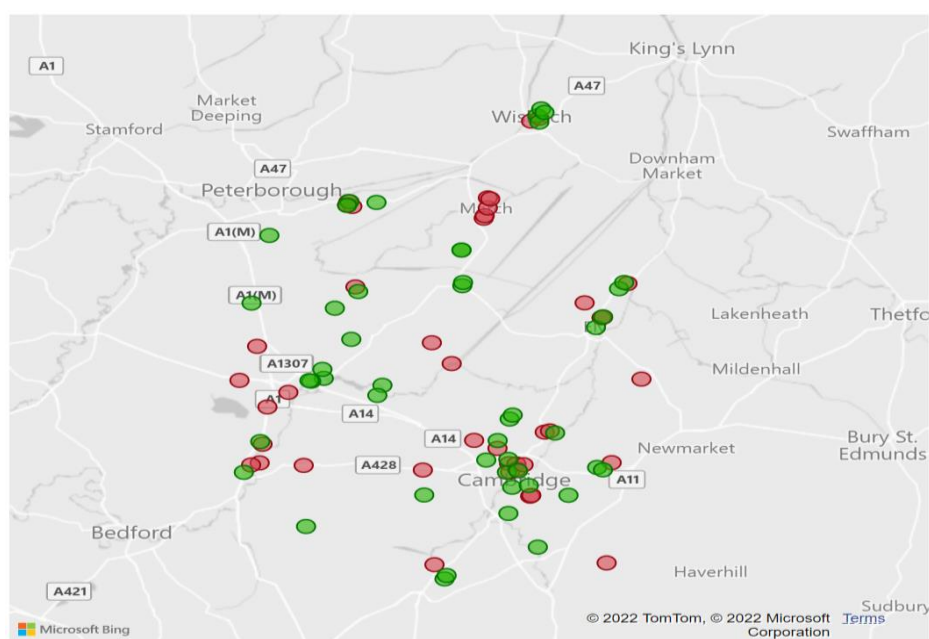
Table 5: Uplifts from 2021/22 to 2022/23

	CPI Code	CPI Item	12 Month % change to April 2022
Low paid staff (carers and domestic staff)	-	National Living Wage % increase, April - April[14]	6.6
Other staff (nurses and back office)	-	Average earnings index, April – April	4.1
Fixtures & fittings	D7GW	05.3 Household appliances, fitting, and repairs	9.9
Repairs and maintenance	D7GR	04.3 Regular maintenance and repair of the dwelling	7.6
Furniture, furnishings, and equipment	D7GU	05.1 Furniture, furnishings, and carpets	15.0
Other care home premises costs	D7G7	CPI (overall index)	*9.0*
Food supplies	D7G8	01 Food and non-alcoholic beverages	6.7
Domestic and cleaning supplies	D7GZ	05.6 Goods and services for routine maintenance	6.8
Medical supplies (excluding PPE)	D7NO	06.1 Medical products, appliances, and equipment	1.3
PPE	D7NO	06.1 Medical products, appliances, and equipment	1.3
Office Supplies	D7IH	05.6.1 Non-durable household goods	10.3
Insurance (all risks)	D7HF	12.5 Insurance	11.7
Registration fees	D7G7	CPI (overall index)	9.0
Telephone & internet	D7GF	08 Communication	2.8
Council tax / rates	CRQT	Council tax and rates (CPIH)[15]	7.9
Electricity, Gas & Water	D7GB	04 Housing, water, electricity, gas and other fuels	19.2
Trade and clinical waste	D7G7	CPI (overall index)	9.0
Transport & Activities	D7GG	09 Recreation and Culture	5.9
Other care home supplies and services costs	D7G7	CPI (overall index)	9.0
Central / Regional Management	D7NN	All services	4.7
Support Services (finance / HR / legal / marketing etc.)	D7NN	All services	4.7
Recruitment, Training & Vetting (incl. DBS checks)	D7NN	All services	4.7
Other head office costs (please specify)	*D7OB*	*12.7 Other services (NEC)*	*-3.1*

Source: Office for National Statistics for different CPI series

[14] https://www.gov.uk/government/news/national-living-wage-increase-boosts-pay-of-low-paid-workers#:~:text=The%20improvement%20in%20the%20economic,2.2%20per%20cent)%20in%202021.

[15] Tables 8 and 22, https://www.ons.gov.uk/economy/inflationandpriceindices/datasets/consumerpriceinflation

Figure 1 Map of care homes in Cambridgeshire

● Submitted ● Not Submitted

Table 6: Average rates paid for spot bed framework beds, September 2021 – September 2022

Cambridgeshire spot placements made since 1st September 2021 65+ to 13th September 2022	All Cambridgeshire in county spot placements 65+	Cambridge City	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire	Out of county 65+ placements	CCC total spend on spot placements Including out of county
No. Res	94	18	36	12	7	20	9	102
Average £	£ 697.58	£ 715.11	£ 688.13	£ 690.42	£ 649.77	£ 722.23	£ 665.56	695.22
No. Res DE	89	9	20	18	21	21	3	94
Average £	£ 713.70	£ 768.56	£ 701.55	£ 685.28	£ 697.14	£ 742.12	£ 755.00	£ 714.22
No. Nursing	30	2	3	8	6	10	12	41
Average £	£ 844.94	£ 668.21	£ 1,054.21	£ 910.93	£ 730.70	£ 845.20	£ 797.73	£ 829.58
No. Nurs DE	24	8	5	5	5	1	9	33
Average £	£1,000.00	£ 1,245.77	£ 1,102.40	£ 752.00	£ 712.36	£ 912.40	£ 844.71	£ 956.32
Total No. Spot Placements	237	37	64	43	39	52	33	270
Average placement £	£ 751.45	£ 841.29	£ 736.89	£ 736.45	£ 696.74	£ 757.57	£ 769.16	£ 753.26

EQUALITY IMPACT ASSESSMENT - CCC485500116

Which service and directorate are you submitting this for (this may not be your service and directorate):

Directorate	Service	Team
Commissioning	Commissioning Services	Commissioning Services

Your name: Charlotte Knight

Your job title: Commissioner

Your directorate, service and team:

Directorate	Service	Team
Commissioning	Commissioning Services	Commissioning Services

Your phone: 07773015731

Your email: Charlotte.Knight@peterborough.gov.uk

Proposal being assessed: Update on Cost of Care and Market Sustainability Planning in Adult Social Care

Business plan proposal number: N/A

Key service delivery objectives and outcomes: Under section 5 of the Care Act 2014, local authorities have a 'market shaping' duty to promote the efficient and effective operation of their local social care market to ensure services are diverse, sustainable and high quality for the local population, including those who pay for their own care. Government's definition of a sustainable market is one which "has a sufficient supply of services but with provider entry and exit, investment, innovation, choice for people who draw on care, and sufficient workforce supply".   In 2021, the Department for Health and Social Care (DHSC) published Build Back Better-our plan for health and social care and People at the heart of care - adult social care reform white paper which outlined significant legislative changes to Adult Social Care, planned to come into effect from October 2023. In preparation for these changes, councils across England with social care responsibilities were required to provide information on the sustainability of their local care provider market, and to conduct an exercise with the market to establish the costs of providing care.   In December 2021, DHSC announced the Market Sustainability and Fair Cost of Care Fund to support local authorities to prepare their markets for reform and move towards paying providers a fair cost of care. Cambridgeshire's allocation for 2022-23 was £1,568,738. As a condition of receiving funding, local authorities were required to submit the following to DHSC by 14th October 2022: ·   cost of care exercises for older peoples' care homes and homecare (for adults aged 18+) ·   a draft market sustainability plan, using the cost of care exercise as a key input to identify risks in the local market ·   a spend report detailing how funding allocated for 2022-23 is being spent in line with the fund's purpose The scope and methodology of the Cost of Care (CoC) exercise was set by DHSC to help local authorities identify the lower quartile, median and upper

quartile costs in the local area for a series of care categories. The term 'cost of care' describes the actual costs a care provider incurs in delivering care at the point in time that the exercise is undertaken. It is typically presented as a unit cost for an hour of homecare or a bed per week in a care home. In summer 2022, the Council commissioned Laing-Buisson to undertake the Cost of Care data gathering exercise on its behalf, the results of which were used to produce the Council's two Cost of Care reports and Market Sustainability Plan. The three documents were submitted in draft form to DHSC in October 2022. In November 2022, the Chancellor announced the planned Adult Social Care Charging Reforms would be delayed for 2 years (to 2025). In late December, DHSC announced all local authorities must publish their Cost of Care reports on their .GOV.UK websites by 1st February 2023 and Market Sustainability Reports by 27th March 2023. The report being taken to A+H is to update committee members on the published Cost of Care Exercises and the ongoing work to produce a Market Sustainability Plan.

What is the proposal: There is no proposal at this stage, however A+H are being asking to note the publishing of the cost of care exercises and the on-going work to produce a Market Sustainability Plan in line with Government requirements. Delegated approval is also being sought so that the Director of Adult Social Care Services can approve the MSP. A further paper will be taken to A+H to approve the spend of the Market sustainability fund monies. It is within this piece of work where a full EQIA is needed to establish the impacts of the allocation of funds. At this stage, we are just asking for noting and delegated approval

What information did you use to assess who would be affected by this proposal?: 1. Department of Health and Social Care - "Build Back Better; our plan for health and social care" Build Back Better-our plan for health and social care 2. Department of Health and Social Care White Paper - "People at the Heart of Care - Adult Social Care Reform" People at the heart of care - adult social care reform white paper 3. Cost of Care exercise completed in 2022 - Cost of Care exercise - Cambridgeshire County Council

Are there any gaps in the information you used to assess who would be affected by this proposal?: No

Does the proposal cover: Specific teams

Which particular employee groups/service user groups will be affected by this proposal?: Colleagues in Commissioning and Contracts will be impacted as the work to tight deadlines to achieve this piece of work. The second report (outlined above) will outline the spending allocations and this is where we will see impacts to Service users/customers etc.

Does the proposal relate to the equality objectives set by the Council's Single Equality Strategy?: No

Will people with particular protected characteristics or people experiencing socio-economic inequalities be over/under represented in affected groups: About in line with the population

Does the proposal relate to services that have been identified as being important to people with particular protected characteristics/who are experiencing socio-economic inequalities?: No

Does the proposal relate to an area with known inequalities?: No

What is the significance of the impact on affected persons?: As stated, at this stage we are simply asking A+H to note work done and work being done to produce a Market Sustainability

Plan. The Market Sustainability Plan and accompanying EQIA will highlight the impact on affected persons as it will state where monies are being spent and where they are not.

Category of the work being planned: Project

Is it foreseeable that people from any protected characteristic group(s) or people experiencing socio-economic inequalities will be impacted by the implementation of this proposal (including during the change management process)?: No

Age: The proposal is seeking Adults and Health Committee to note work done and work being done to produce a Market Sustainability Plan (MSP). The Market Sustainability Plan and accompanying EQIA will highlight the impact on affected persons as it will state where monies are being spent and where they are not. It is in this piece of work whereby commissioners will be able to outline the impact on those with Protected Characteristics. Without having the MSP produced, we are not aware of the potential impacts.

Disability: The proposal is seeking Adults and Health Committee to note work done and work being done to produce a Market Sustainability Plan (MSP). The Market Sustainability Plan and accompanying EQIA will highlight the impact on affected persons as it will state where monies are being spent and where they are not. It is in this piece of work whereby commissioners will be able to outline the impact on those with Protected Characteristics. Without having the MSP produced, we are not aware of the potential impacts.

Gender reassignment:

The proposal is seeking Adults and Health Committee to note work done and work being done to produce a Market Sustainability Plan (MSP). The Market Sustainability Plan and accompanying EQIA will highlight the impact on affected persons as it will state where monies are being spent and where they are not. It is in this piece of work whereby commissioners will be able to outline the impact on those with Protected Characteristics. Without having the MSP produced, we are not aware of the potential impacts.

Marriage and civil partnership: The proposal is seeking Adults and Health Committee to note work done and work being done to produce a Market Sustainability Plan (MSP). The Market Sustainability Plan and accompanying EQIA will highlight the impact on affected persons as it will state where monies are being spent and where they are not. It is in this piece of work whereby commissioners will be able to outline the impact on those with Protected Characteristics. Without having the MSP produced, we are not aware of the potential impacts.

Pregnancy and maternity: The proposal is seeking Adults and Health Committee to note work done and work being done to produce a Market Sustainability Plan (MSP). The Market Sustainability Plan and accompanying EQIA will highlight the impact on affected persons as it will state where monies are being spent and where they are not. It is in this piece of work whereby commissioners will be able to outline the impact on those with Protected Characteristics. Without having the MSP produced, we are not aware of the potential impacts.

Race: The proposal is seeking Adults and Health Committee to note work done and work being done to produce a Market Sustainability Plan (MSP). The Market Sustainability Plan and accompanying EQIA will highlight the impact on affected persons as it will state where monies are being spent and where they are not. It is in this piece of work whereby commissioners will be able to outline the impact on those with Protected Characteristics. Without having the MSP produced, we are not aware of the potential impacts

Religion or belief (including no belief): The proposal is seeking Adults and Health Committee to note work done and work being done to produce a Market Sustainability Plan (MSP). The Market Sustainability Plan and accompanying EQIA will highlight the impact on affected persons as it will state where monies are being spent and where they are not. It is in this piece of work whereby commissioners will be able to outline the impact on those with Protected Characteristics. Without having the MSP produced, we are not aware of the potential impacts.

Sex: The proposal is seeking Adults and Health Committee to note work done and work being done to produce a Market Sustainability Plan (MSP). The Market Sustainability Plan and accompanying EQIA will highlight the impact on affected persons as it will state where monies are being spent and where they are not. It is in this piece of work whereby commissioners will be able to outline the impact on those with Protected Characteristics. Without having the MSP produced, we are not aware of the potential impacts.

Sexual orientation: The proposal is seeking Adults and Health Committee to note work done and work being done to produce a Market Sustainability Plan (MSP). The Market Sustainability Plan and accompanying EQIA will highlight the impact on affected persons as it will state where monies are being spent and where they are not. It is in this piece of work whereby commissioners will be able to outline the impact on those with Protected Characteristics. Without having the MSP produced, we are not aware of the potential impacts.

Socio-economic inequalities: The proposal is seeking Adults and Health Committee to note work done and work being done to produce a Market Sustainability Plan (MSP). The Market Sustainability Plan and accompanying EQIA will highlight the impact on affected persons as it will state where monies are being spent and where they are not. It is in this piece of work whereby commissioners will be able to outline the impact on those with Protected Characteristics. Without having the MSP produced, we are not aware of the potential impacts.

Head of service: Gurdev Singh

Head of service email: gurdev.singh@cambridgeshire.gov.uk

Confirmation: I confirm that this HoS is correct

Procurement of Additional Respite Service Capacity for Adults Respite for Adults with Learning Disabilities and Autism

To: Adults and Health Committee

Meeting Date: 9 March 2022

From: Service Director: Commissioning

Electoral division(s):   Countywide

Key decision: Yes

Forward Plan ref: 2023/025

Outcome: Effective and efficient Respite Service provision that supports people with Learning Disabilities and/or Autism to access short-term support thereby providing temporary relief for their usual unpaid carer.

Recommendation: The Adults and Health Committee is recommended to:

a) approve the commissioning of respite services for people with Learning Disabilities and/or Autism on a five-year basis from 1st November 2023 with an option for a three-year extension and a further option for a final two-year extension. This will cost £767,500 annually, a total of £7,675,000 over the total term of the contract and extension periods, split as below into shared and single beds:

- Commissioning of four shared beds at £290k pa (outsourced)
- Development of two inhouse single service beds at £477.5k pa (insourced)

b) delegate approval of award and extension periods and execution of agreement and extension periods to the Director of Adults and Safeguarding (DASS).

c) delegate the decision to outsource two single service beds if required (if we do not insource) to the Director Adults and Safeguarding (DASS).

d) delegate the decision on additional future shared or single service beds within the contract period to the Director of Adults and Safeguarding (DASS) provided the costs can be covered within the current funding envelope.

Officer contact:
Name: Toni Bawden
Post: Commissioner LD/Autism
Email: toni.bawden@cambridgeshire.gov.uk
Tel: 07442 942096

Member contacts:
Names: Councillor Howitt
Post: Chair
Email: Richard.howitt@cambridgeshire.gov.uk
Tel: 01223 706398

1. Background

1.1 Under the Care Act 2014, Cambridgeshire County Council has a statutory responsibility to meet the needs of people eligible for care and support including carers and to ensure sufficiency of services to meet those needs locally. The council meets these duties through its provision of residential respite through existing contracts with external providers and inhouse services in Cambridgeshire.

1.2 Respite Care for people with Learning Disabilities (LD) and/or Autism is defined as short-term support for an individual in order to provide temporary relief for their usual unpaid carer. Services are provided to the person but provide the dual benefit of not only a break for the informal carer from their caring duties but also a positive experience for the person receiving respite through activities, social opportunities and skills development. The carers and individual's well-being is improved, enabling disabled people to live at home longer and delaying or even preventing admission to long-term care.

1.3 Two case studies for respite (shared and single service) are included at Appendix A.

1.4 Cambridgeshire currently has a total of 19 respite beds for adults with LD/Autism. 15 are provided by three Learning Disability Partnership (LDP) inhouse services - Alder Close (5 beds in March), St Luke's (6 beds in Huntingdon), Russell Street (4 beds in Cambridge). The annual budget for these services is £1,450,000. In addition, there are four beds outsourced in Histon Cambridge at an annual expenditure of £290,000.

1.5 Commissioners have undertaken a review of respite services in Cambridgeshire, working with stakeholders and analysing data to understand trends in residential respite usage, evolving needs and built this into a future model of service delivery which requires a mix of shared and single service respite. For Cambridgeshire there is a requirement for two additional single service beds, bringing the total to 21 beds: a net increase of two beds.

1.6 This report is requesting approval from Committee for an additional two beds in Cambridgeshire on a single service model of support and the re-tendering of the four outsourced beds. This will mean creating an increase in the number of beds which will be available to help with providing temporary relief for more unpaid carers.

2. Main Issues

Specification

2.1 During the respite review a wide range of engagement activities were undertaken including soft market test, surveys and workshops with participation and family carer groups. Key findings around overnight respite were that:

- It is essential to the wellbeing of both the carer and individual
- It requires continuity of service for location and carer
- It requires robust staff training and ability to support with complex needs and behaviours that challenge
- A number of people are being placed in respite services as a 'crisis' placement and they may end up staying for a long time and preventing people with planned respite needs from accessing this service

- People with complex health needs at a younger age including healthcare tasks often require support in shared services with an increased level of delegated nursing tasks
- Increase in younger people with 1:1 needs who require a shared environment
- There is a reported negative impact on both individuals and their families of not being able to access respite due to the wrong model (e.g. only offering a shared service when single service is required) or when care is cancelled due to people with long stays and / or incompatible needs
- In some cases, people have had to enter permanent placements such as supported living or residential care much earlier than anticipated due to lack of access to appropriate respite.

2.2 After detailed studying of the issues raised, the following innovations will be incorporated into the service to maximise choice and flexibility for those receiving care, reduce impact on the environment and ensure best value for the public purse:

- A more robust brokerage and operational prioritisation of these people's needs, and a future housing accommodation needs strategy which seeks to increase supply of specialist accommodation properties will support these people to be more appropriately placed long term and will free up shared beds for planned and short-term placements.
- There will be further exploration by commissioning around how clinical nursing needs in respite can be supported. There are low numbers of people requiring clinical care and insufficient demand to justify any of the services registering for nursing. These will be reviewed on a case-by-case basis to ensure clinical oversight, delegation of tasks, providing own nursing care under Personal Health Budget, spot purchasing beds or block purchasing a bed and feasibility discussions with CPFT.
- Requirement for single service environment with high level of support for people with behaviours that challenge who are incompatible with a shared environment or group setting.
- Additionally, there is ICB investment in a new single service community crisis space, which may lessen future referrals to respite in an emergency situation.

Volumes

2.3 During Covid lockdown periods, the capacity of CCC inhouse respite services was reduced due to social distancing and staffing levels. A snapshot analysis was undertaken to identify the impact on reduced respite availability during the Covid lockdowns on people entering alternative support in Cambridgeshire. This showed a rise in placements made into long term 24/7 care from 16 cases in 2019/20 to 23 cases in 2022/23 with two months to run in the financial year.

2.4 The two single service beds in Cambridgeshire will accommodate people who might otherwise have to access alternative permanent provision such as supported living when shared services do not meet their needs. They are well suited for people who may be injurious to self, others, or environment and for those who need a pared back environment with minimum stimulation. Ideally single service beds would be co-located with shared services to provide value for money and share staffing and resources.

2.5 It is expected that a sufficiency of long-term accommodation will negate the use of further additional shared beds, however this will be overseen by robust monitoring on

usage, referrals, and refusals. Should additional beds be required during the period of the contract then they can be commissioned additionally.

Procurement

2.6 The contract for outsourced provision will be a total of ten years from 1 November 2023 to 31 October 2028 with the option to extend for three years to 31 October 2031 and a further two years to 31 October 2033. The recommended contract length of ten years is advisable for a service of this nature, providing regular long-term respite for a vulnerable group of people and their carers. It is well known that for people with LD and/or Autism a change in routine and/or environment (that can arise from reprocuring a service) can be a huge source of anxiety and disruption and therefore implementing a longer-term service will mitigate risks around this. It reflects the soft market testing feedback, whilst balancing with the option of continued review for service utilisation and changing needs after year five following further assessment, or continuity of the service if all extensions are exercised.

2.7 It is proposed that the Council buys this service on a 'block' basis. This gives the Council guaranteed capacity and a proactive approach adjusting around individual support needs (e.g., to avoid a crisis). The downside of purchasing via a block is that the Council must pay for the hours, whether they are used to deliver care or not. However, it is thought that the Block Contract model will still deliver best value for money due to the consistency of support that can be offered to service users through the guaranteed capacity, thus avoiding their earlier transition to 24/7 care options. The contract form will also drive stability in the market with providers appreciating that investment in shared and single service beds will deliver support over several years. The outsourcing of single service beds may take longer to onboard, however those beds will co-terminate in line with the ten-year timelines identified.

2.8 A member of the procurement team is supporting with the procurement and evaluation will be a combination of quality and value at proportion of 60:40% including an assessment of social value delivered by the service.

2.9 The successful Cambridgeshire County Council (CCC) provider will be required to demonstrate how they intend to meet the service requirements and will be judged on their ability to provide outcome-based and person-centred care for the cohort supported. The provider will be required to pay staff at the Real Living Wage rate as a minimum.

2.10 An indicative timeline for the procurement of respite services is presented below:

Respite Procurement Timeline		
Event	**Deadline**	**Governance/ Responsible**
Complete specification, quality criteria & financial submission template	January/February	Commissioning
Joint Commissioning Board report for approval to procure	January 2023	JCB
Formal agreement between CCC and PCC	February 2023	Legal, Commissioning

Respite Procurement Timeline		
Event	**Deadline**	**Governance/ Responsible**
Adults Health Committee approval		AHC
Bid writing session	End of March 2023	Commissioning, Procurement
Complete ITT & Contracts		Procurement, Contracts
Publish ITT	April 2023	Procurement
ITT Submission Deadline	End May 2023	Procurement
Evaluation & Moderation	June 2023	Procurement, Commissioning, Operations
JCB Approval		JCB
PCC Cabinet Report Approval		Cabinet
Award Contracts	August 2023	
Mobilisation	Aug, Sept, Oct 2023	
Contract Start	November 2023	

Expenditure, Sourcing options, and benefits

2.11 The costs of providing a shared service provision (average £72,750 pa for the current outsourced beds and £96,667 pa for the LDP inhouse service beds) are significantly lower than the estimated costs of providing a single service. This is because of lower staffing establishment which allows for shared costings across beds and lower staffing ratios, shared management costs, perhaps lower training requirements around complexity and challenging behaviour and separate accommodation costs. Co-located services may bring efficiencies through shared management and care staff and well as indirect costs related to overheads.

2.12 The estimated costs of outsourced provision of two single service beds (at a cost of £207,115 per bed) have been calculated using Care Cubed: a nationally recognised calculator tool to estimate the fair costs of care services. It is therefore possible following a tender that the market costs may come in higher or lower than these figures. The estimated costs of the inhouse provision of two single service beds (at a cost of £238,750 per bed) are modelled on the proposed staffing structure needed for this provision but could be lower if the services were able to co-locate with another in house unit and share some staff. Across the two beds this represents £63,282 per annum more on an insourcing basis than outsourcing.

2.13 The main reasons for the higher inhouse costings are largely due to favourable employment terms of CCC attributed to improved pay and benefits which make CCC an employer of choice for care sector roles compared to private organisations:
- Better employer pension scheme for in house services; most care providers will offer 2% employer contribution, while CCC's employer contribution cost is 21%;
- Enhancements such as more favourable antisocial hours rates and holidays; and
- Enhanced hourly rates with CCC estimated to pay at least £1 per hour additional than outsourced provider.

2.14 Insourcing, because of the improved pay and conditions of staff, provides us with considerable benefits:

- Staff stability, better recruitment and retention, reduced turnover, reflective of a happy and sustainable workforce
- Ability to use inhouse staffing pool and flexibility in contracts in delivering a range of services
- Less resource intensive back-office management (compared with outsourcing) around commissioning, procurement, contracts and recommissioning without risk of managing the market with issues around sustainability and capacity and annual uplift negotiations
- Good staff support, training, supervision, and robust workforce able to support people with complex needs
- Improved support to individuals and families and increased satisfaction with services
- High quality of provision. Inhouse respite provision in Huntingdon area (a nearby site has been ear-marked for co-location of services) has been graded as 'outstanding' by CQC and the same management and staffing would be delivering other services in the area.

2.15 Insourcing this service aligns to the priorities and ambition of the joint administration to expand in house provision where it makes sense to do so, but it also ensures the needs of some of our most vulnerable people are met and they receive high quality care and support.

2.16 The aggregated long term care costs of placements made when respite services were not available is an estimated expenditure of £1m per year. After reviewing care and support packages with social workers, we estimate approximately 50% of the annual expenditure could have been avoided if sufficient, suitable respite provision were available. Consequently, there is a cost avoidance opportunity of £500,000 pa which will cover the cost of the provision.

2.17 Committee are asked to agree the in-house provision option. Officers would then begin work on commissioning suitable sites for the service, close to existing inhouse services. If this becomes unviable, then officers would revert to the outsourcing option for the two single service beds.

2.18 The ICB will need to agree their share of the funding for the respite beds within the pooled budget at the proportion of 76.78%:23.22% for CCC and Integrated Care Board (ICB) respectively.

Service	Cost per annum	CCC 76.78%	ICB 23.22%
4 shared beds (outsourced)	£290,000	£222,622	£67,388
2 single service beds (insourced)	£477,000	£366,240	£110,760
15 shared beds (In House)	£1,450,000	£1,113,310	£336,690
2 single service beds (outsourced)	£414,200	£318,022	£96,177

3. Alignment with corporate priorities

3.1 Environment and Sustainability
There are no significant implications for this priority
Environment and climate considerations are being incorporated into the processes for invitation to tender (ITT) and insourcing

3.2 Health and Care
The following bullet points set out details of implications identified by officers:
- Improve outcomes and combat health inequalities based on population health management across the county including leading the 'health in all policies' approach across the authority

3.3 Places and Communities
There are no significant implications for this priority

3.4 Children and Young People
There are no significant implications for this priority

3.5 Transport
There are no significant implications for this priority

4. Significant Implications

4.1 Resource Implications
The report above sets out details of significant implications in paragraphs 2.3.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications
The procurement will comply with the Council's Contract Procedure Rules

4.3 Statutory, Legal and Risk Implications
Statutory – the service relates to the operational delivery of delegated health functions to ensure a holistic approach to meeting the needs of people with a Learning Disability

4.4 Equality and Diversity Implications
Service the support delivered would be appropriate to a range of needs and accessible to anyone with protected characteristics with primary need of Learning Disability and/or Autism

4.5 Engagement and Communications Implications
Robust comms around timing of informing service users and staff of change

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 Environment and Climate Change Implications on Priority Areas
There are no significant implications within this category

4.8.1 Implication 1: Energy efficient, low carbon buildings.
Positive/neutral/negative Status: Positive
Explanation: If insourcing is the preferred option then we will have control over the environmental standards in buildings that are put in place

4.8.2 Implication 2: Low carbon transport.
Positive/neutral/negative Status:
Explanation: Neutral

4.8.3 Implication 3: Green spaces, peatland, afforestation, habitats and land management.
Positive/neutral/negative Status:
Explanation: Neutral

4.8.4 Implication 4: Waste Management and Tackling Plastic Pollution.
Positive/neutral/negative Status:
Explanation: Neutral

4.8.5 Implication 5: Water use, availability and management:
Positive/neutral/negative Status:
Explanation: Neutral

4.8.6 Implication 6: Air Pollution.
Positive/neutral/negative Status:
Explanation: Neutral

4.8.7 Implication 7: Resilience of our services and infrastructure and supporting vulnerable people to cope with climate change.
Positive/neutral/negative Status:
Explanation: Positive

Have the resource implications been cleared by Finance?   Yes 01/02/23
Name of Financial Officer: Justine Hartley

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement?   Yes date 27/01/23
Name of Officer: Clare Ellis

Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or Pathfinder Legal?   Yes 30/01/23
Name of Legal Officer: Linda Walker

Have the equality and diversity implications been cleared by your EqIA Super User?
Yes 10/02/23
Name of Officer: Lisa Sparks

Have any engagement and communication implications been cleared by Communications?
Yes 10/02/2023
Name of Officer: Simon Cobby

Have any localism and Local Member involvement issues been cleared by your Service Contact?   Yes 01/02/23
Name of Officer: Will Patten

Have any Public Health implications been cleared by Public Health? Yes 27/01/23

Name of Officer: Emily R Smith

If a Key decision, have any Environment and Climate Change implications been cleared by the Climate Change Officer? Yes 06/02/23
Name of Officer: Emily Bolton

5.   Source documents guidance

5.1   None

<u>Appendix A</u>

Case Study 1 – Respite Shared Service

<u>Situation requiring respite</u>
Service user A came into respite as an emergency from his own flat approximately 7 months ago. He initially came in as there was concerns relating to him not allowing staff from his care company to go into his flat to support him and there were concerns noted from district nurses due to a decline in his general well-being which was impacting on his health.

<u>Support at respite and identifying needs</u>
Since A has been at St Luke's respite unit staff have been able to gain his trust and observe and support him in order to ascertain what areas he required a little more support with. The information which has been gathered during his stay at respite has enabled the staff to compile a comprehensive support plan which gives clear guidance on the levels of support that he needs as well as how he likes staff to engage with and support him. If someone works with him in a way that he believes is not respecting his wishes he can find himself getting angry and shouting at others; due to the proactive work staff have done with A he is now able to express his wishes and explain how he would like things done to support him. Although A went through a stage where he was raising his voice regularly, the occasions of this happening are now very rare due to the work which has been completed with him to ensure his support plan reflects his wishes, feelings and aspirations. Information which has been gathered using these methods have been shared with his social worker and appropriate colleagues in health with A's consent to assist them in updating assessments and help them to gather a better understanding of his current levels of need.

<u>Transitional support</u>
A found the transition from living on his own in his own flat to coming into the respite unit as an emergency quite difficult initially as although he consented to and wanted to come into respite, he had a lot of mixed feelings that he struggled to process.

<u>Promoting independence</u>
Staff have encouraged A to remain as independent as possible whilst supporting him in areas where he needed some additional support such as personal care (bathing and shaving), cooking and support and encouragement to make some healthy choices as he likes food which is high in sugar and needs to be supported with ideas of what healthy snacks are as well as with portion management. Staff ensure that they give A encouragement in all areas of his life and that the offer regular praise as this helps A to feel more positive.

Prior to Christmas A became very excited as was looking forward to spending Christmas with other people as well as having a Christmas dinner. He indicated that he had not had the opportunity for either in many years. Staff supported him to think about how he would like Christmas at St Luke's to be and ensured that food that he wanted was ordered; as well as a list being written by him of what he would like to get for Christmas. Staff then supported him to purchase items on the list. When the Registered Manager returned to work after the Christmas break A told her "I've had the best Christmas ever"; whilst saying this A had a massive smile on his face.

<u>Developing family contacts</u>
After A's brother made telephone contact with him; which came out of the blue as they had not spoken for years staff supported A to maintain this contact via a video call and to meet his brother face to face. A's brother and his wife came to Huntingdon from Scotland to see him a few weeks ago. This has been an emotional experience for A; whilst also being a very positive

one as he is now able to maintain regular contact with his family.

Move on and accommodation

Since A has been at St Luke's staff have supported him to liaise with all professionals who are in his circle of support; this has involved some challenging conversations for A as it became apparent that he would not be able to go back to his own flat due to needing a higher level of support than he previously had. In addition to this A really wanted to stay in Huntingdon. Unfortunately, there wasn't any supported living placements available in Huntingdon so his social worker had to look further afield. As A has developed positive relationships with staff at St Luke's staff have supported him to look at an alternative placement in Ely. He was initially very anxious and reluctant; but staff have worked with him and as well as ensuring an IMCA was involved to support A; staff have discussed the positives of living in another area such as Ely on a daily basis to assist him to get used to the idea of living in another area. Although A had experienced a lot of anxiety prior to the visits he agreed to go and look around and is now really looking forward to moving into a shared supported living.

Summary of outcomes

This has been a complex case as there has been a lot of different elements which needed to be considered and met in order to support the individual using a person-centred approach. Staff have encouraged A to work with other professionals who are involved in supporting him around his care and support needs as there have been times where he has found this challenging and not wanted to engage with others. We have received positive feedback from his social worker about how well the staff team have worked with and supported him in order to support A to move on to what we hope will not be his forever home!

Case Study 2 – Respite Single Service

Individual

Service user B is a young person with Learning Disability and Autism, epilepsy and sleep difficulties. His behaviour has been escalating causing concerns at home and school.

Requirement for single service respite

B has been supported by the Young Adults Team. Whilst under children's services B received support of one night per week across the year at a children's short breaks service but this was not sufficient to give his parents a break and as he transitioned into adult services at 19 there was a reduction in education.

B is now assessed as requiring three nights per week respite across 52 weeks per year. He requires a single service due to incompatibility with other individuals. He does not tolerate over stimulation or noise and can act impulsively towards others and put them and himself at risk of harm. His challenging behaviours can be difficult and due to vocalisation, being self-injurious and aggressive towards others.

B was taken in by St Luke's respite unit for assessment but this had to take place when there was no one else in service. Due to their capacity and demand for the service St Luke's were unable to offer the frequent assessed service support to this individual.

Due to the lack of single service respite, alternative options were explored including supported living arrangements and permanent care and support.

Procurement of Care and Support Service in Extra Care

To:	Adults and Health Committee
Meeting Date:	9 March 2023
From:	Service Director: Commissioning
Electoral division(s):	All
Key decision:	Yes
Forward Plan ref:	2023/032
Outcome:	To enable older people to continue to be supported to live independently in extra care.
Recommendation:	Adults and Health Committee is recommended to:

a)   Approve the general procurement approach and the overall budgeted value of £5,431,190 (at 2022/23 prices) over 10 years;

b)   Tender the care and support in the following extra care schemes:
(i)   Mill View, Hauxton
(ii)   Willow Court, Whittlesey.

c)   Delegate responsibility for awarding and executing a contract for the provision of care and support in:
(i)   Mill View starting 3 February 2024 and extension periods to the Director for Adults and Safeguarding (DASS)
(ii)   Willow Court starting 10 February 2024 and extension periods to the Director for Adults and Safeguarding (DASS)

Officer contact:
Name: Lynne O'Brien
Post: Commissioning Manager
Email: lynne.o'brien@cambridgeshire.gov.uk
Tel: 0777 667 9591

Member contacts:
Names: Councillor R Howitt / Cllr S van de Ven
Post: Chair/Vice-Chair
Email: Richard.howitt@cambridgeshire.gov.uk
              Susanvandeven5@gmail.com
Tel: 01223 706398

1. Background

1.1 Extra care housing schemes are an important part of the overall provision for older people. The schemes are specialist housing schemes for older people that have been specifically designed to maximise people's independence. There are 18 extra care schemes in Cambridgeshire.

Table One: Extra Care schemes in Cambridgeshire

District	No. of schemes	Overall number of flats	
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

++ Dunstan Court and Willowbank in Cambridge City also have 17 and 13 sheltered flats respectively.

Each person will also have their own respective landlord.

1.2 All tenants have their own apartment with a front door and yet also benefit from the availability of the 24/7 on-site care and support service. The care and support service is flexible and tailored to individual's needs.

1.3 The supportive environment in extra care enables older people to live independently for longer, without having to worry about repairs or other on-going maintenance issues. It is an important aspect of the prevention agenda as people's health and wellbeing is maintained thereby delaying and/or reducing the use of residential care. A case study is attached in Appendix A.

1.4 The care and support services are delivered via contracts which are tendered by the county council. People living in extra care schemes can choose to make arrangements for their own care and would still be able to access the contracted care provider for emergency calls.

1.5 Applications for the extra care flats would have been considered by allocations panel, which would have included an up-to-date assessment of their care and support needs. The allocations into extra care housing are managed with the aim of developing a balanced and stimulating community that supports and promotes independence. Schemes are generally well located with good access to local facilities. Applications are usually considered by a multi-agency panel which consists of a representative from the respective adult social care

community scheme, the housing provider, the district council (but this varies from district to district), and the care provider (who will usually attend in an advisory capacity).

1.6 The contracts for these schemes are due to end in February 2024. Contracts in the other schemes have been re-tendered more recently and are not due to expire.

2. Main Issues

2.1 The Council tenders for a flexible core and add-on contract, so each scheme has core hours (i.e. the guaranteed element of the contract) which ensures that care staff are on-site 24/7. Any additional hours above the core daytime, are dependent upon the assessed care needs of the tenants and are invoiced separately. The additional hours i.e. flexible element of the contract, can vary from month to month.

2.2 In addition, there may be private self-funders (or people on direct payments) as well as people who purchase additional staff time for activities which are not covered by their assessment such as cleaning and laundry.

The breakdown of the hours for December 2022 for each of the schemes are set out below:

Scheme	Weekly daytime core hours	Weekly hours above daytime core – Dec 22	Private hours	Total
Mill View	105	0	57.25	162.25
Willow Court	140	156	75	371

Table Two: Breakdown of care hours December 2022

2.3 It is proposed that contracts for care and support for both schemes are tendered at the same time thereby reducing overall procurement costs. It is also proposed that the services should be re-tendered for 5 + 5 years with a standard 6 months' break clause.

2.4 Recruitment and retention of staff in the care sector is challenging and longer term contracts would provide more certainty for care providers, enable more investment in training and provide the opportunity to build long term relationship with the housing provider. The new contract will also include an obligation on the provider to pay the Real Living Wage. These elements should enable providers to plan for the longer term and invest in upskilling staff regarding technology enabled care innovations, supporting people living with dementia and linking with the wider community. The development of staff skills would also support the Council's direction of travel to enable people to continue to live in extra care for longer.

3. Mill View

3.1 Mill View extra care scheme in Hauxton, south Cambridgeshire was developed by bpha (Bedfordshire Pilgrims Housing Association) and opened in August 2019. The scheme consists of 70 flats, of which 45 are 2 bedroomed leasehold properties and 25 are 1 bedroomed rental flats as well as a range of communal facilities. Mill View is the only scheme in Cambridgeshire where the number of leasehold flats far outweighs the rental flats.

4.   Willow Court

4.1   Willow Court in Whittlesey was developed by Longhurst Group and was specifically designed for people living with dementia. The scheme opened in February 2020 and has 60 flats, of which 47 have one bedroom and the remaining 13 flats have two bedrooms. The scheme has a range of communal facilities including a micro-shop which is operated by the tenants.

5.   The Procurement

5.1   In-house provision for the care service in the schemes has been considered and would cost considerably more, mainly due to organisational overheads and would not represent value for money. It is therefore proposed that the schemes should be re-tendered as two separate lots. Service users will be involved in formulating and evaluating a method statement which will form part of the quality criteria. Bidders' social value offer will be evaluated and use of the Social Value Portal will be used to implement the Themes, Outcomes and Measures (TOMs) approach to do this.

5.2   A high level project plan has been produced and the key timelines are below:

- Specifications and consultation End of May 2023
- Tender Go Live June 2023
- Evaluation and Moderation End of August 2023
- Approval of award 27 September 2023
- Decision to Award / standstill period mid-October 2023
- Implementation and Mobilisation mid-October 2023 – Feb 2024

5.3   It is proposed that the contract will include a capped formula for future increases to the contract price to enable providers to meet increases in salary costs and other direct costs which they cannot control. This uplift will be incorporated into the annual business planning process through the annual uplift strategy, thereby ensuring the services are financially sustainable for the Council and appropriate governance is in place. In addition, the Council intends to raise the awareness of extra care and its benefits in enabling people to live independently. Information on the council's website will be reviewed and a leaflet will be developed which social care staff can give people who may want to consider extra care at the time of their assessment or in the future. This will generate more interest in the schemes and ensure that that the care contracts are used more effectively and potentially reduce the need for residential care.

6.   Future development of services

6.1   The Council continues to encourage schemes to become more active in the local community and incorporating Social Value into the procurement will provide an opportunity for bidders to include wider aspects beyond the delivery of the care and support service. Many schemes have facilities which can be used by people living locally, such as a large communal lounge and encouraging their use will help to ensure they become vibrant communities. This will not only increase people's awareness of extra care but should increase their popularity as well. From previous consultations with older people and their families, many are aware of sheltered housing and residential care but not aware of extra

care schemes. Appendix B provides an explanation of the different types of provision.

7. Alignment with corporate priorities

7.1 Environment and Sustainability
There are no significant implications for this priority.

7.2 Health and Care
The report above sets out the implications for this priority in paragraphs 1.1 and 1.2.

7.3 Places and Communities
The report above sets out the implication for this priority in paragraph 6.1.

7.4 Children and Young People
There are no significant implications for this priority.

7.5 Transport
There are no significant implications for this priority.

8. Significant Implications

8.1 Resource Implications
There are likely to be resource implications as there have been significant increases in staffing and associated on-costs in the care market since these services were last tendered. However, usually there are a healthy number of responses to extra care tenders which ensures they are secured at a competitive rate. Work is underway to incorporate learning from recent procurements. A formula or mechanism for price reviews over the course of the contract will be incorporated into the contract.

8.2 Procurement/Contractual/Council Contract Procedure Rules Implications
Work is underway with Procurement to apply Contract and Procurement Rules and Public Contract regulations.

8.3 Statutory, Legal and Risk Implications
There are no significant implications within this category.

8.4 Equality and Diversity Implications
There are no significant implications within this category.

8.5 Engagement and Communications Implications
Meetings will be arranged with people living in each of the schemes, as well as family members. The aim will be to explain the procurement process, ascertain their views of the current service to incorporate changes to the service specification.

8.6 Localism and Local Member Involvement
There are no significant implications within this category.

8.7 Public Health Implications
There are no significant implications within this category.

8.8   Environment and Climate Change Implications on Priority Areas
       There are no significant implications within this category.

8.8.1 Implication 1: Energy efficient, low carbon buildings.
       Neutral:
       Explanation: The buildings where this service will be delivered are out of scope for this contract, therefore the status is neutral.

8.8.2 Implication 2: Low carbon transport.
       Status: Neutral
       Explanation:

8.8.3 Implication 3: Green spaces, peatland, afforestation, habitats and land management.
       Status: Neutral
       Explanation:

8.8.4 Implication 4: Waste Management and Tackling Plastic Pollution.
       Status: Neutral
       Explanation:

8.8.5 Implication 5: Water use, availability and management:
       Status: Neutral
        Explanation:

8.8.6 Implication 6: Air Pollution.
       Status: Neutral
       Explanation:

8.8.7 Implication 7: Resilience of our services and infrastructure and supporting vulnerable people to cope with climate change.
       Status: Neutral
       Explanation:

       Have the resource implications been cleared by Finance?   Yes
       Name of Financial Officer: Justine Hartley

       Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement and Commercial?   Yes
       Name of Officer: Clare Ellis

       Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or Pathfinder Legal?   Yes
       Name of Legal Officer: Linda Walker

       Have the equality and diversity implications been cleared by your EqIA Super User?
       Yes
       Name of Officer: Lisa Sparks

Have any engagement and communication implications been cleared by Communications?
Yes
Name of Officer: Simon Cobby

Have any localism and Local Member involvement issues been cleared by your Service Contact?   Yes
Name of Officer: Will Patten

Have any Public Health implications been cleared by Public Health?
Yes
Name of Officer: Emily R Smith

If a Key decision, have any Environment and Climate Change implications been cleared by the Climate Change Officer?
Yes
Name of Officer: Emily Bolton

9.   Source documents guidance

9.1   None

A detailed case study was provided for a 68 year old man who suffered with severe depression who had moved into one of the schemes. His care and support package comprised 15 minutes in the morning, lunchtime and evening (total 5.25 hours per week). This was mainly for prompts with medication, personal care, daily living tasks, food and fluid preparation and monitoring of mental health concerns. He had no family or friends, had been diagnosed with prostate cancer, a high falls risk, mental health concerns and anxiety that made him feel physically unwell. He had not left his previous flat in two years due to depression and anxiety and was visited by a mental health nurse and a volunteer from Age UK. He found moving and changes difficult and his anxiety was exacerbated very easily. Communication was particularly difficult in that he could not even articulate what he wanted to eat.

The care provider began to support him and devised a step-by-step plan to improve his independence, confidence, self-esteem and to help him to manage health concerns both physical and mental. Over the course of five months care staff supported him to start making friends, firstly in controlled quiet environments with minimal individuals in the vicinity. The staff then arranged for him to sit with compatible individuals in the dining room for lunch and then over time he started to engage and participate in conversation and jokes. In terms of his health, staff supported him to read his visual prompts (devised by the care team) to ensure that he understood the importance of food and had sufficient fluid intake. He has greatly improved in terms of his mental health and does not experience many low and anxious days. He now uses his strategies to redirect himself away from the negative thoughts and feelings.

He has made such good progress that he has been signed off by the mental health team. He is now able to speak with confidence about how he is feeling, what he needs and how to find his own solutions to problems.

He received radiotherapy treatment for 12 weeks and was moved to tears when he received a hospital letter to tell him that his treatment had been successful, and he was in remission from the cancer.

Shortly afterwards, he decided with his new lease of life feeling that he wanted to do something that he had been wanting to do for years, he bought himself a car. He now goes out nearly every day running errands, visiting community groups and has subsequently made a circle of friends outside the extra care scheme and has even found himself a partner, and they are planning a holiday for next year together.

Accommodation provision for older people

Own Home	Sheltered Housing	Extra Care Housing	Independent living service	Residential Care	Nursing Care
People remain independent within their own property with limited or no support.	Typically, several self contained, independent homes –flats and sometimes bungalows– each with their own front door. A lower age limit of 55 or 60 is common. The individual units are typically linked to an emergency alarm service and include design features to make life easier for elderly people. There is usually an en site warden, and communal facilities such as a lounge and laundry. Rental and privately owned sheltered housing is available, although not always on the same site	These units offer an older person self-contained accommodation with their own front door, but also provide a significantly higher level of support than sheltered accommodation. The service element is often integral to the extra care product. There are additional facilities (for example, in terms of bathroom design) for the less mobile. Communal facilities tend to include social and practical facilities, such as lounges and laundries. A meals service is usually on offer. It aims to provide greater independent living.	ILS is a 24hr care & support service focus on enabling and maintaining independence for older people. The level of support can increase as the person's level of care need increases. Round the clock care is available including nursing care. Tenants need never to move homes again.	Typically, residential homes offers personal care and ensures tenants basic personal needs such as meals, bathing, going to the toilet and medication are met. Residential homes essentially provide a home for people who struggle to live independently and need additional support but aren't (yet) in need of nursing care.	Nursing Care is like residential care, but with trained nurses on duty. A nursing home is considered for one's condition that needs regular medical care and attention. Often this would be a clinical decision made by the multidisciplinary team. People may have lived in residential care or even in the community for a period before going to a nursing home due to a deterioration in their condition and the district nurse support do not have the capacity or ability to take care of the person's health needs.

Awarding of a 12 Month Contract for the Care Home Trusted Assessor Service

To:	Adults and Health Committee
Meeting Date:	9 March 2023
From:	Service Director: Commissioning
Electoral division(s):	All
Key decision:	Yes
Forward Plan ref:	2023/026
Outcome:	The Committee is asked to consider the situation regarding the Care Home Trusted Assessor (CHTA) Service and make a decision as outlined below
Recommendation:	Adults and Health Committee is recommended to:

a) Approve a Direct Award of 12 months (01/04/2023 – 31/03/2024) for the CHTA service in Cambridgeshire at a cost of £118,980

b) Agree to a review period of 3 months, during which time the viability of the service to be moved in-house can be explored. A further paper will be brought to the June Committee with a recommendation as to whether the service should be moved in-house or if an alternative procurement strategy should be pursued.

Officer contact:
Name: Alison Bourne
Post: Commissioning Manager, Adult Social Care
Email: alison.bourne@cambridgeshire.gov.uk
Tel: 07840494629

Member contacts:
Names: Richard Howitt
Post: Chair
Email: Richard.howitt@cambridgeshire.gov.uk

Name: Susan Van de Ven
Post: Vice-Chair
Email: susan.vandeven@cambridgeshire.gov.uk

1.   Background

1.1   Care Home Trusted Assessors (CHTA) provide a service by which older people in hospital settings who need to be discharged to a Care Home are assessed so that they can be placed in the setting which best meets their needs.   Prior to the start of the CHTA service, Care Home managers had to travel to acute hospitals in order to assess people, leading to delayed discharges, and also to people often having to undergo multiple assessments from different Care Home managers. The CHTA conducts one assessment which can then be used by various care homes, saving time and money and leading to better outcomes for the people being assessed as their transfer to a suitable Home is smoother and quicker.

1.2   In 2017 the service was trialled in Addenbrookes and Hinchingbrooke hospitals. Due to its success, a 3-year contract to deliver the service was awarded to a voluntary sector organisation, the Lincolnshire Care Association (LinCA) in 2018. The model was envisaged as part of the Better Care Fund programme to promote greater integration between Health and Social Care, and particularly with a view to reducing Bed Day Delays (Delayed Transfers of Care – DTOCs) between acute hospitals and care homes.

1.3   LinCA was commissioned to employ a full-time equivalent Trusted Assessor in the two acute hospitals in Cambridgeshire. This resulted in significant reductions in bed day delays by speeding-up the process by which care homes felt confident to receive discharged patients (almost exclusively Older Adults) based on the recommendations and referral forms completed by the Trusted Assessors. Care home managers were no longer required to travel to hospitals and assess patients on the wards after they had been declared medically fit for discharge. On average, 3-4 days per discharge are saved per assessment.

1.4   The total costs of this service per annum in Cambridgeshire are £118,980. These costs are covered by the Improved Better Care Fund (iBCF), for which spending plans are jointly agreed by the Local Authority and the Integrated Care Board

1.5   In September 2020, the Discharge to Assess (D2A) process was introduced and the Joint Commissioning Board approved an extension of the service up to end September 2021 to allow time for an evaluation of the system changes under D2A. A Procurement exercise was carried out with the service requirement advertised through Lot 1 (Admission Avoidance and Discharge Support) of the Early Intervention and Prevention (EIP) Pseudo Dynamic Purchasing System (PDPS). This did not result in any bidders, and so the contract with LinCA was extended whilst another procurement was carried out.

1.6   The current service delivery was reviewed, discussions held with the operational teams, and feedback sought from the Care Home Providers via a questionnaire. The feedback was very positive about the service, and Care Home Managers were clear they believe the service saves time and money, resulting in swifter and better discharges for Service Users. Further market engagement was undertaken Providers on Lot 4 of the EIP DPS to make them aware of the opportunity, with three Providers indicating they might be interested in bidding. At the point of the tender going live, further communication was issued to inform all the Providers to ensure they were aware and had links to the tender. The second tender went live in December 2022. Again, no bids were received. The current Provider, LinCA, was and remains ineligible to bid as they are not on the EIP DPS Framework.

2. Main Issues

2.1   The current CHTA service is delivered primarily remotely and covers the two acute hospitals in Cambridgeshire, namely Addenbrookes and Hinchingbrooke.

2.2   The budget for the CHTA service is jointly agreed by the Council and the ICB and funded through the Improved Better Care Fund (iBCF). The current cost is £118,980 per annum.

2.3   The CHTA service supports timely assessments and enables people to move from a hospital setting to a permanent care home placement. Without this service, care home managers have to carry out assessments themselves, leading to delays in discharge and the possibility of a service user being assessed multiple times. All parties involved agree that a central service is necessary to support better outcomes, both for the individual and for the system as a whole.

2.4   There have now been two failed procurement exercises regarding this tender. Should the contract end on 28/02/2023 it is likely that there will be considerable pressure added into the system, with people not being discharged in a timely manner. LinCA have confirmed that they are happy to continue to provide this service.

2.5   Given that there appears to be no appetite amongst providers on the EIP DPS framework to bid for this service, a further procurement exercise would serve little purpose. Given the tight timescales between the Tender closing and the contract ending, it has not been possible to explore the implications of bringing the service in-house. A Direct Award of a 12-month contract to the current providers, at a cost of £118,980, would allow the possibility of bringing the service in-house to be explored. A paper will then be brought to the June Committee with a recommendation as to whether the service should be moved in house or if an alternative procurement strategy should be pursued.

2.6   The Public Contract Regulations (2015) allow for a Direct Award, known as a negotiated procedure without prior publication, where 'no tenders, or no suitable tenders have been submitted' (Regulation 32 (2) (a)). The Council's Contract Procedure Rules require approval from the Procurement Team for a Direct Award, and this has been granted.

2.7   The cost of the Contract to date is £498,725. A waiver for 31 days has been put in place (01/03/2023 – 31/03/2023) to allow this paper to be brought before Committee, at a cost of £10,105, and a further 12-month Direct Award of £118,980 will bring the cumulative cost to £627,810 and is therefore above the threshold for a Key Decision.

3.   Alignment with corporate priorities

3.1   **Environment and Sustainability**
There are no significant implications for this priority.

3.2   **Health and Care**
The report above sets out the implications for this priority in paragraph 1.1 and paragraph 2.3

3.3   **Places and Communities**
       There are no significant implications for this priority.

3.4   **Children and Young People**
       There are no significant implications for this priority.

3.5   **Transport**
       There are no significant implications for this priority.

4.   Significant Implications

4.1   Resource Implications
       The report above sets out details of significant implications in 2.7 above.

4.2   Procurement/Contractual/Council Contract Procedure Rules Implications
       The report above sets out details of significant implications in 2.6 above.

4.3   Statutory, Legal and Risk Implications
       There are no significant implications for this priority.

4.4   Equality and Diversity Implications
       There are no significant implications for this priority.

4.5   Engagement and Communications Implications
       There are no significant implications for this priority.

4.6   Localism and Local Member Involvement
       There are no significant implications for this priority.

4.7   Public Health Implications
       There are no significant implications for this priority.

4.8   Environment and Climate Change Implications on Priority Areas
       There are no significant implications for this priority.

4.8.1 Implication 1: Energy efficient, low carbon buildings.
       Neutral Status:

4.8.2   Implication 2: Low carbon transport.
       Neutral Status:

4.8.3 Implication 3: Green spaces, peatland, afforestation, habitats and land management.
       Neutral Status:

4.8.4   Implication 4: Waste Management and Tackling Plastic Pollution.
       Neutral Status:

4.8.5   Implication 5: Water use, availability and management:
       Neutral Status:

Explanation:

4.8.6　Implication 6: Air Pollution.
Neutral Status:

4.8.7　Implication 7: Resilience of our services and infrastructure and supporting vulnerable people to cope with climate change.
Neutral Status:

Have the resource implications been cleared by Finance?　　Yes
Name of Financial Officer: Justine Hartley

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement?　　Yes
Name of Officer: Clare Ellis

Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or Pathfinder Legal?   Yes
Name of Legal Officer: Linda Walker

Have the equality and diversity implications been cleared by your EqIA Super User?
Yes
Name of Officer: Gurdev Singh

Have any engagement and communication implications been cleared by Communications?
Yes
Name of Officer: Sarah Silk

Have any localism and Local Member involvement issues been cleared by your Service Contact?　　Yes
Name of Officer: Will Patten

Have any Public Health implications been cleared by Public Health?
Yes
Name of Officer: Emily Smith

If a Key decision, have any Environment and Climate Change implications been cleared by the Climate Change Officer?
Yes
Name of Officer: Emily Bolton

5.　Source documents guidance

5.1　Source documents:
None

All Age Advocacy Service

To:	Adults and Health Committee
Meeting Date:	9 March 2023
From:	Debbie McQuade, Service Director of Adults & Safeguarding (DASS).
Electoral division(s):	All
Key decision:	Yes
Forward Plan ref:	2023/005
Outcome:	The Advocacy service enables people to take action to help them say what they want, secure their rights, represent their interests and obtain services they need, promoting social inclusion, equality and social justice.
Recommendation:	Adults and Health Committee are recommended to:

a) Approve the re-commissioning and procurement of Cambridgeshire Adult Advocacy Lot within the Cambridgeshire and Peterborough All-Advocacy Service on a three-year initial contract extendable up to a further 12 months. The Cambridgeshire Adult Advocacy Lot will have a total contract value of £2,055,808 over 4 years. The ICB will contribute £98,162 annually towards this or £392, 648 over 4 years.

b) Delegate responsibility for awarding a contract for the provision of Advocacy services starting 3rd October 2023 and extension periods to the Service Director of Adults and Safeguarding (DASS).

c) Delegate responsibility for executing a contract for the provision of Advocacy services to the Service Director of Adults and Safeguarding (DASS).

Officer contact:
Name: Lisa Sparks
Post: Senior Commissioning Manager
Email: lisa.sparks@cambridgeshire.gov.uk
Tel: 07900163590

Member contacts:
Names: Cllr Richard Howitt / Cllr Susan Van de Ven
Post: Chair/Vice-Chair
Email: Richard.Howitt@cambridgeshire.gov.uk
Susanvandeven5@gmail.com
Tel: 01223 706398

1. Background

1.1 Advocacy Services are part of the Local Authorities statutory duties, covered by several legislative acts (outlined in section 4.3 below). This service meets these obligations through the provision of advocates to support our residents. This contract is a joint contract with Peterborough City Council (PCC), with the Integrated Care Board (ICB) also contributing funding.

1.2 Voiceability provide Cambridgeshire County Council (CCC) with an All-Age Advocacy service. The contract with Voiceability expires 2nd October 2023. Voiceability's All-Age Advocacy service includes:

- Care Act Advocacy, including specialism in physical disability; specialism in learning difficulties; specialism in mental health and individuals under a Community Treatment Order (CTO)

- Independent Mental Health Advocacy (IMHA)

- Independent Mental Capacity Advocacy (IMCA)

- Independent Health Complaints Advocacy (IHCA)

- Advocacy Support for Children and Young People

Current Service delivery

1.3 The table below shows the number of adults supported, by type of advocacy, over the last year.
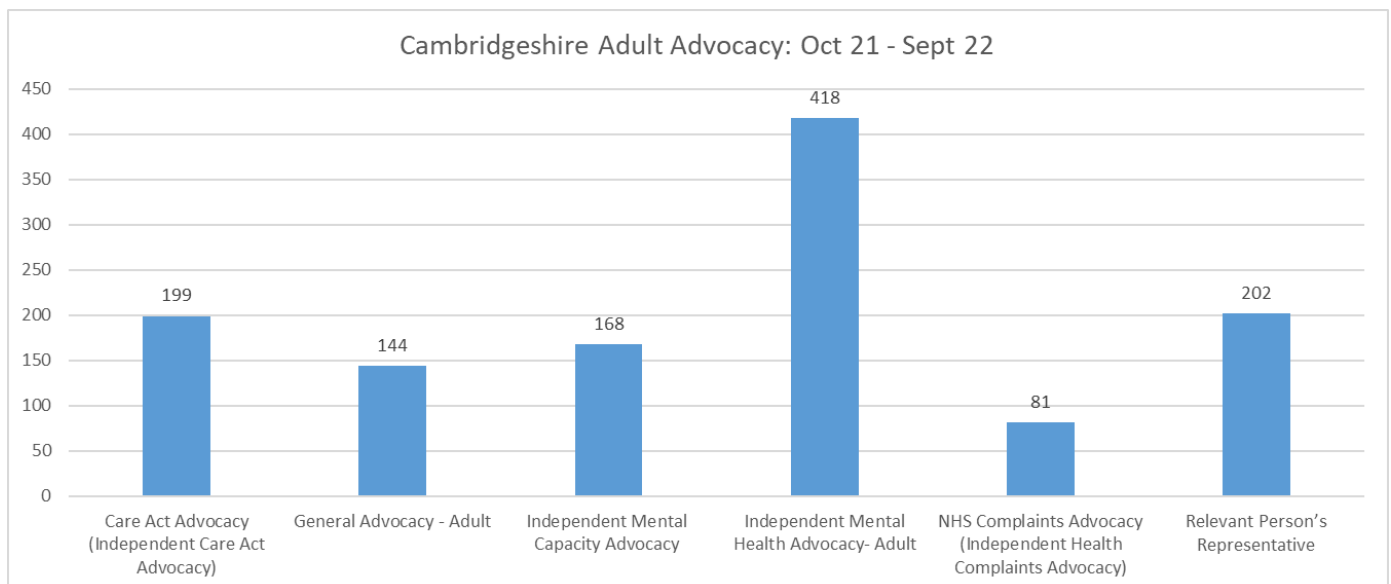
1.4 The case studies in appendix (a) illustrate the impact of the service for individuals. The recommissioned service will have a greater focus on outcomes reporting.

1.5 Feedback from customers demonstrates there is clarity on the service offer and how to access the service. Customers highlighted at a face-to-face session with commissioners,

some of the direct benefits of the service, for example, if they did not have an advocate supporting them through benefit renewals, they would not have been able to successfully secure their welfare benefits.

1.6   The advocates provide a mobile service by way of home and community visits making them accessible. They also provide varied ways of communication such as telephone and video calling, electronic means such as email and social media and thus there is no anticipation for any geographical constraints in accessing the service.

1.7   Approval is being sought to recommission the Adults element of the advocacy service.

2.   Main Issues

2.1   The current contract with Voiceability covers both Cambridgeshire and Peterborough and supports both Adults and Children. Voiceability sub-contract out the Children's element and support for the deaf community. The council have not seen the anticipated benefits of this structure materialise throughout the life of the contract.

2.2   The increasing population of Cambridgeshire (an increase of 9.2% in the 2021 Census compared to 2011) results in the number of residents requiring advocacy support increasing.

2.3   Adult Advocacy is a specialised service with a limited provider market, as we found out during our soft market testing. The soft market testing resulted in 6 provider responses, 2 of whom would be unlikely to choose to deliver the complete range of adult advocacy support we require and would be more suited to offering specialist support through a sub-contract arrangement.

2.4   The service also needs to ensure it can support people to develop the skills required to enable effective and confident 'self-advocacy'. The importance and benefits of this will be clearly highlighted within the specification.

2.5   During the life of this contract we have identified a need to ensure there is a clear process to support spot-purchase arrangements out of area. The new specification will reflect this to ensure clarity of the new contract. The specification also has been reviewed to ensure it meets all statutory requirements, for example, Liberty Protection Safeguards.

Procurement Approach

2.6   Members should note the Care Act (2014) states that advocacy services must be independent of the Local Authority.

2.7   The Council considered a larger block contract, either combining the Adult Advocacy lot with either Peterborough Adult Advocacy, or with the Children's Advocacy. These were rejected in favour of a separate lot for Cambridgeshire's Adult Advocacy on the grounds that this allows the service to be more focused on one specific set of needs, allowing the creation of a more bespoke service which remains large enough to deliver an efficient and effective advocacy service.

2.8   The total proposed contract value for the Cambridgeshire Adult Advocacy Lot is over 4 years. £2,055,808 of this will be paid by Cambridgeshire, with the ICB contributing a further £392,584 over the span of the 4-year contract. The table below shows the amounts per annum

Team	Amount per Annum
Cambridgeshire Adults	**£513, 952**
ICB	**£98,146**

2.9   There will be 3 Lots within the tender, as per below, but only 2 of these relate to Adult Advocacy services:

Lot 1: Adult Advocacy for Cambridgeshire

Lot 2: Adult Advocacy for Peterborough

Lot 3: Children's Advocacy for Cambridgeshire and Peterborough

The procurement process will be joint with Peterborough however, the Lot 2 contract will be held by Peterborough directly.

The Procurement will be led by Cambridgeshire County Council.

Please note, that procurement approval for Lot 3 will be sought from Childrens and Young Peoples Committee.

2.10   The table below outlines the proposed indicative timeline for recommissioning the contract:

Procurement Timetable	
Event	**Date**
Approval of ITT documents	22/03/23 at JCB
Issue ITT	Week beginning 17/04/23
Deadline for tender returns	19/05/23
Tender Evaluation	22/05/2023 – 09/06/2023
Moderation Meeting	13/06/2023
Approval of Award	28/06/2023 at JCB
Contract award	12/07/2023
Contract Start Date	03/10/2023

2.11   Social Value
All bidders will be required to demonstrate how their proposed service solution will deliver social value. Responses will be evaluated and delivery of commitments monitored

3.   Alignment with corporate priorities

3.1   Environment and Sustainability
As part of the Procurement process, bidders will be expected to set out how they will contribute to environmental sustainability and what they will do to support carbon reduction targets. Responses will be evaluated as part of tender evaluation.

3.2   Health and Care
There are no significant implications for this priority.

3.3   Places and Communities
There are no significant implications for this priority.

3.4   Children and Young People
There are no significant implications for this priority.

3.5   Transport
There are no significant implications for this priority.

4.   Significant Implications

4.1   Resource Implications
The following bullet points set out details of significant implications identified by officers:
This provision will consider and support:
- The voice of service users, enabling them to represent their interests and wishes and engage in other Health and Social Care services more to enable better outcomes from those services
- The contract will be funded through the planned base budget and has already been incorporated into the MFTS. The annual budget of £513,952 is a continuation of the existing contract spend. This offers value for money as it is supporting an increasing number of residents for the same money due to efficient running of provision.

4.2   Procurement/Contractual/Council Contract Procedure Rules Implications
- The report sets out above details of significant implications in 2.4 - 2.7
- The procurement will be fully compliant with the Council's Contract Procedure Rules

4.3   Statutory, Legal and Risk Implications
The service forms part of the statutory responsibilities of the Local Authority under the following ACTS:
- The Equality Act 2010 outlines the requirements of advocates to not discriminate against people and applies to all instances where an advocate supports an individual(s). This outlines the requirements of advocates to not discriminate against people and applies to all instances where an advocate supports an individual(s).

- The Care Act 2014 says Local Authorities must: include people in the decisions that are made about them and their care and support. Local Authorities must help people to express their wishes and feelings and support people to make choices and help them to make their own decisions. The Care act also says: independent advocacy is about

giving the person as much control as possible over their life. It helps them understand information, say what they want and what they need.

- Advocacy should be considered from the first point of contact, request or referral and at any subsequent stage of the care and support process. The right to an advocate applies in all settings regardless of whether the person lives in the community or a care home and includes prisons.

- Mental Health Act 1983: Independent Mental Health Advocate. People detained in hospital under the Mental Health Act 1983, or who are subject to a Community Treatment Order, can ask for an IMHA. An IMHA is trained to support people in understanding their rights under the mental health act and participate in decisions about their care and treatment.

- Mental Capacity Act 2005: Independent Mental Capacity Advocacy and Deprivation of Liberty Safeguard (DoLS). The Mental Capacity Act 2005 introduced the role of the IMCA as a legal safeguard for people who lack capacity to make specific important decisions, including about where they live and medical treatment options.

- A DoLS IMCA is a specialist advocate working with people from all vulnerable backgrounds with all nature of impairments that can leave someone lacking capacity. They only deal with issues relating to DoLS applications. They are independent of the Safeguarding Board and safeguard the rights of people who lack capacity.

- Health and Social Care Act 2012: Independent Health Complaints Advocacy IHCA is a free and independent advocacy service that helps people make a complaint about any aspect of their NHS care or treatment. This includes treatment in a private hospital or care home that is funded by the NHS.

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   Environment and Climate Change Implications on Priority Areas

4.8.1   Implication 1: Energy efficient, low carbon buildings.
        neutral
        Explanation: not applicable

4.8.2   Implication 2: Low carbon transport.
        neutral
        Explanation: not applicable

4.8.3   Implication 3: Green spaces, peatland, afforestation, habitats and land management.
neutral
Explanation: not applicable

4.8.4   Implication 4: Waste Management and Tackling Plastic Pollution.
neutral
Explanation: not applicable

4.8.5   Implication 5: Water use, availability and management:
neutral
Explanation: not applicable

4.8.6   Implication 6: Air Pollution.
neutral
Explanation: not applicable

4.8.7   Implication 7: Resilience of our services and infrastructure, and supporting vulnerable people to cope with climate change.
neutral
Explanation: not applicable

Have the resource implications been cleared by Finance?   Yes
Name of Financial Officer: Justine Hartley

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement and Commercial?   Yes
Name of Officer: Clare Ellis

Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or Pathfinder Legal?   Yes
Name of Legal Officer: Linda Walker

Have the equality and diversity implications been cleared by your EqIA Super User?
Yes
Name of Officer: Gurdev Singh

Have any engagement and communication implications been cleared by Communications?
Yes
Name of Officer: Simon Cobby

Have any localism and Local Member involvement issues been cleared by your Service Contact?   Yes
Name of Officer: Will Patten

Have any Public Health implications been cleared by Public Health?
Yes
Name of Officer: Emily R Smith

If a Key decision, have any Environment and Climate Change implications been cleared by the Climate Change Officer? Yes
Name of Officer: Emily Bolton

5.   Appendix

5.1   Appendix A – Case Study

6.   Source Documents

5.1   None

Legal/police: A couple were arrested due to safeguarding concerns about their baby that were identified on a hospital visit. Couple were arrested at 6pm on Thursday evening. On Friday morning around 11am, the police made contact with CDA because they were unable to find interpreters to read the couple their rights, to interview them or to support them emotionally and mentally. Our Advocate was able to attend the police station at 4.30pm on Friday as an urgent visit. The Advocate made sure the police were aware of their responsibilities of booking interpreters and explained very clearly how to make sure interpreters were booked for interviews with Deaf people. The Advocate checked in on both parents to see if there was any urgent, well-being needs that needed to be attended to. Mother needed her anxiety tablets from home and her asthma inhaler as she had been struggling in the cell overnight. Father was ok but both were very emotional as they didn't fully understand about why they were taken into custody or what was happening with their son. Advocate sat in on both interviews once a remote interpreter was finally booked through "The Big Word." Advocate was able to support communication between the client and the interpreter when colloquialisms or idiosyncratic signs were used. Advocate also supported the couple to understand the process and the bail conditions. The couple were extremely grateful as they hadn't had anyone communicate with them in 22hours and finally understood what was going on. The custody time had to be extended (Via special sergeant approval) a further 8 hours to ensure the police had time to interview them. The couple finally left the station at 2am in the morning (Saturday).

Housing: Deaf lady who has learning difficulties. She has basic level of understanding English so reading letters can be really difficult for her. She was victim of coercion and control and financial abuse by her boyfriend. Boyfriend began claiming housing benefits on his hostel in her name. This meant that housing benefit stopped paying for her house. She built up arrears of £3700.

Housing sent her a number of letters, warnings and a notice of seeking possession. Her boyfriend told her not to worry about these.

Finally, housing contacted CDA to ask someone to support her to understand the risk of losing her home.

CDA Advocate visited the house and supported her to understand all the letters and why this had happened. She said that her boyfriend told her the arrears had built up from her 17year old son not paying the rent.

Advocate attended the court date with her and was able to postpone the court due to lack of interpreter in the court. Advocates have then been working hard with her to understand how to apply for Universal Credit to ensure housing benefit and council tax reduction and discretionary housing benefit was still able to be re-instated. Advocates have worked hard on creating a visual time table of when the payments need to be made to pay off the arrears, supported for the Direct debit to be set up. Universal credit has now been approved and the rent has agreed to be paid directly to the landlord to reduce the chance of getting into debt again.

Adult Service User Experience Survey 2022 Analysis

To:	Adult and Health Committee
Meeting Date:	9 March 2023
From:	Debbie McQuade, Service Director: Adult Social Care
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	N/A
Outcome:	To provide an overview of the findings of the 2022 Adult Social Care Statutory Service User Survey the results for which were published in November 2022.
Recommendation:	Adults and Health Committee is being asked to note and consider the results for the 2022 Adult Social Services Users Experience Survey.

Officer contact:
Name: Tina Hornsby
Post: Head of Adult Performance and Strategic Development
Email: tina.hornsby@cambridgeshire.gov.uk
Tel: 01480 376338

Member contacts:
Names: Councillors Cllr Richard Howitt / Cllr Susan van de Ven
Post: Chair/Vice-Chair
Email: Richard.howitt@cambridgeshire.gov.uk and susanvandeven5@gmail.com
Tel: 01223 706398

1. Background

1.1 Every winter NHS Digital, the analytics function in Department of Health and Social Care, directs Local Authorities to conduct a national survey of people receiving long term council funded adult social care. The survey was paused during the pandemic meaning that the survey undertaken in 2022 was the first since the winter of 2020. The 2022 survey took place in between January and March 2022, and results were published nationally in the Autumn of 2022.

1.2 The council sent out **1454** Surveys and received back **440** responses, a response rate of **30.3%.** This was a slightly lower response rate than for the survey undertaken in 2020, which had a response rate of 33.7%.

1.3 The questionnaire template is provided by NHS Digital with tightly prescribed questions and response options, although local questions can be added. In 2022 we added one question as part of our work with the partnership boards around access to information and advice and digital inclusion, which was a question around how people usually found out about support services or welfare benefits. We also included free text boxes for people to tell us what we do well and what we could do better.

1.4 The make up of the sample for the survey is also prescribed by NHS Digital to be representative of people receiving council funded care and support. In 2022 we surveyed 108 people receiving nursing care (7.4% of the sample), 274 people receiving residential care (18.8% of the sample) and 1072 people receiving care in their own home or community (73.7% of the sample). 41% of the sample were male and 59% were female, whilst 61% were aged 65 or over and 39% were aged 18-64. The sample were predominantly of white ethnicity (95%) with the next largest group being Asian/Asian British (1.8%). 425 (29%) of those sampled had learning disability as primary reason for needing support with a further 131 (9%) having the primary support reason of mental health support. The largest group was those requiring personal care support which was 716 people (49%).

1.5 Of the 440 people who completed and returned the survey, 50% had personal care support as primary support need, 31% had learning disability support, and 6% had mental health support. Of the others in the sample 6% had support for social isolation, 3% had support with access and mobility only, 2.5% had support with memory and cognition only.

2. Main Issues

2.1 **Adult Social Care Outcomes Framework (ASCOF) metrics fed by the survey**
Several the council's national performance indicators for adult social care are fed by the survey. These are summarised in the table below. Most indicators had got worse since the 2020 survey, excepting the proportion of people who felt safe where the percentage had increased from 71.5% to **72.7%.** However, when compared to comparator councils and the region and England overall the council ranked comparatively well on 5 of the 7 indicators:
- Social care related Quality of life, where the council scored **19/24** and ranked 57th of 150 councils, a low rank is good.
- The proportion of people who use services who have control over their daily life, where the **80.3%** answered positively and the council ranked 33rd of 150 councils.

- The proportion of people who used council services who reported that they had as much social contact as they would like, where **41.7%** answered positively and the council ranked 55th of 150 councils.
- Overall satisfaction of people who use services with their care and support, where **65.8%** answered positively and the council ranked 51st of 150 councils.
- The proportion of people who use services who feel safe, where **72.7%** answered positively and the council ranked 28th out of 150 councils.

2.2 The council performed less well in two areas
- The proportion of people who use services who found it easy to access information about support, where only **60.3%** responded positively and the council ranked 125th out of 150 councils.
- The proportion of people who use services who say that those services have made them feel safe and secure, where only **74.3%** responded positively and the council ranked 145th out of 150 councils. Although this indicator should be looked at alongside the comparatively high percentage who stated they felt safe overall

ref	Indicator	Data Type	Polarity	Cambridgeshire 2022	Cambridgeshire 2020	Eastern Region 2021/22	CIPFA Comparator group 2021/22	England 2021/22	21/22 CCC rank
1A	**Social care-related quality of life score (Score out of 24)**	%	Good to be high	**19.0**	19.4	18.9	19	18.9	**57**
The quality-of-life score is an amalgamation of responses from a across a range of questions and as such links to the outcomes in the rest of the table below.									
1B	**The proportion of people who use services who have control over their daily life**	%	Good to be high	**80.3**	80.6	77.3	77.8	76.9	**33**
Breakdown of responses: 139 people stated that they had as much control as they would like, whilst the largest number 206 stated that they had adequate control. 62 people had some control but not enough, whilst 22 people felt they had no control. **Ongoing actions** Maximising the ability of people to take control of their own lives is one of the key focuses of our Care Together approach and our wider strengths based practice. We are doing further work to ensure wishes of the person are clearly fed into care and support plans and safeguarding enquiries, with practice audits focussing on this.									
1I(1)	**The proportion of people who use services who reported that they had as much social contact as they would like**	%	Good to be high	**41.7**	46.9	39.6	41.2	40.6	**55**

ref	Indicator	Data Type	Polarity	Cambridgeshire 2022	Cambridgeshire 2020	Eastern Region 2021/22	CIPFA Comparator group 2021/22	England 2021/22	21/22 CCC rank

Breakdown of responses:

The largest number of people, 181, stated that they had as much social contact as they wanted with people that they like. 129 people stated that they had adequate social contact. 88 people stated that they had some social contact, but not enough, whilst 35 people said that they had little social contact and felt socially isolated.

Ongoing actions

Linking people into their communities and supporting with options for befriending an localised support are all key ways to enhance social contact, this is a key focus of the Care Together programme. There is also a focus on making sure that supporting people to maintain social networks is part of our care and support planning and a focus of our reviews.

ref	Indicator	Data Type	Polarity	Cambridgeshire 2022	Cambridgeshire 2020	Eastern Region 2021/22	CIPFA Comparator group 2021/22	England 2021/22	21/22 CCC rank
3A	**Overall satisfaction of people who use services with their care and support**	%	Good to be high	**65.8**	66.1	65.4	65.1	63.9	51

Breakdown of responses:

The largest number of respondents, 285, stated that they were extremely or very satisfied with the support services they received. 104 stated they were quite satisfied. 25 stated that they were neither satisfied or dissatisfied. 12 people were quite dissatisfied and 9 people were very or extremely dissatisfied.

Ongoing actions

The council continues to look to learn from complaints to address issues that commonly cause dissatisfaction. We also share case studies and compliments we receive when we have got things right so that we can learn from practice that delivers good outcomes too. For this survey there was a local question added around what we do well and what we could do better and the response to this will be fed into our service improvement workstreams. We have also been working with our co-production forums to develop customer feedback questionnaires which we can embed into our day-to-day work in order to have a better real time view of the experience of those accessing adult social care.

ref	Indicator	Data Type	Polarity	Cambridgeshire 2022	Cambridgeshire 2020	Eastern Region 2021/22	CIPFA Comparator group 2021/22	England 2021/22	21/22 CCC rank
3D(1)	**The proportion of people who use services who find it easy to find information about support**	%	Good to be high	**60.3**	66.8	63.2	63.6	64.6	125

Breakdown of responses:

The largest number of respondents, 182, stated that they had never tried to find information and advice in the last 12 months. The next largest group were those who had found it fairly easy to find information or advice, 79. 64 people stated they found it fairly difficult whilst 32 people found it very difficult. 56 people stated they found it very easy.

Ongoing actions

ref	Indicator	Data Type	Polarity	Cambridgeshire 2022	Cambridgeshire 2020	Eastern Region 2021/22	CIPFA Comparator group 2021/22	England 2021/22	21/22 CCC rank
	Access to information and advice is one of the key priorities identified by our partnership boards and we continue to work with them to find ways to improve accessibility. As part of this work we have reviewed our standard letters to ensure they are more informative, and we are also working with The Speak Out Council to ensure accessibility of information targeted to people with a learning disability. Work is currently underway to align health and social care information with the Integrated Neighbourhoods by using the new social prescribing websites and referral system across health and social care.								
4A	The proportion of people who use services who feel safe	%	Good to be high	72.7	71.5	69.9	70.7	69.2	28
4B	The proportion of people who use services who say that those services have made them feel safe and secure	%	Good to be high	74.3	85.8	84.3	86.6	85.6	145
	Breakdown of responses: The two questions on safety should be read together as often people will state that service do not help to feel safe simply because they do not feel unsafe. In response to the question of how safe people felt the largest number, 314, stated that they feel as safe as they want. 97 felt adequately safe but not as safe as they would like. 14 people felt less than adequately safe and 6 people did not feel safe at all. In response to the question of whether care and support services helped people to feel safe 300 people responded "Yes" and 115 people responded "No" **Ongoing actions** There has been work undertaken in the past to understand what might lead to people feeling unsafe and that was most commonly for older people the fear of falling whilst outside the house. For younger adults with learning disability it was fear of crime in their local neighbourhood. We will be doing some further work with our coproduction groups to explore if the reasons for feeling unsafe have changed since the pandemic and to consider how support services might help people to feel safe if they do not.								

The table above shows the councils position on the ASCOF measures fed by the survey with a comparison to the 2020 survey (where dark blue is better) and comparison with regional, national and councils most similar to Cambridgeshire (where red indicates that Cambridgeshire does less well).

2.3 Levels and types of care needs among respondents

2.3.1 The survey asks several questions around the respondent's support needs and what they could do for themselves. Respondents' ability to do things for themselves worsened compared to 2020 in three areas:

- Getting around indoors (excepting steps) by yourself where **52.1%** answered positively. This was slightly lower than 2020 (52.3%) and lower than England overall (53%)

- Managing to use the toilet by yourself, where **55.6**% answered positively. This was lower than in 2020 (57.5%) and lower than England overall (59.2%)
- How well your house is designed to meet your needs, where **86.4%** answered positively, lower than 2020 (87.2%) but higher than England overall (84.5%).

2.3.2   In all other areas relating to respondent's level and type of care needs there was an increase in positive responses since 2020, these were:
- Managing to get in and out of bed (or chair) by yourself, where **53.3%** answered positively. This was slightly higher than 2020 (53.0%) but lower than England overall (55.9%)
- Managing to wash your face and hands by yourself, where **68.7%** answered positively. This was higher than 2020 (66.9%) but lower than England overall (70.2%).
- Managing to get dressed or undressed by yourself, where **41.9%** answered positively. This was higher than 2020 (37.4%) but lower than England overall (42.9%).
- Managing to wash all over by yourself, using either a bath or shower, where **29.6%** answered positively. This was higher than 2020 (28.4%) but lower than England overall (32.4%)
- Dealing with finances and paperwork (for example paying bills, writing letters) by yourself, where **22.2%** answered positively. This was higher than 2020 (17.3%) and higher than England overall (19.6%)
- Usually managing to feed yourself, where **77.8%** answered positively. This was higher than 2020 (75.3%) and higher than England overall (76.6%).

2.3.3   Respondents in Cambridgeshire expressed being less able to do tasks for themselves than respondents across England overall in 6 of the 9 areas.

2.4   **Overall health and factors that affect health**

2.4.1   The survey contains 8 questions which provide a picture of the respondent's overall health and factors which may impact that.   Responses to these questions were more positive than 2020 in the five areas below:
- How is your health in general where **45.7%** of respondents felt their health was good or very good. This was better than 43.2% in 2020 and better than England overall (43.5%).
- Anxiety or depression, where **53.6%** stated that they were not anxious or depressed better than the 50.8% in 2020 and 48.4% in England overall.
- In respect of being able to get out and about, **30.1%** stated they were able to get to all the places in the local area that they wanted. This was better than 29.4% in 2020 and better than the 29.6% in England overall.
- A clean and comfortable home, where **64.2%** responded that their home was as clean and comfortable as they want. This was better than 62.6% in 2020 but not as good as England overall (65.5%).
- Keeping clean and presentable, where **57%** of respondents felt clean and able to present themselves in the way that they like. This was better than 55.4% in 2020 and better than England overall (56.6%)

2.4.2   The responses around health and health related factors worsened in the following two areas:
- Pain or discomfort, where only **38.5**% stated that they felt no pain or discomfort

compared to 39.4% in 2020. However, this is better than the 37% responding this way in England overall.
- Food and drink, where **65.5%** stated that they get all the food and drink they like when they want, compared to 66.8% in 2020. However, this is better than the 63.5% responding this way in England overall.

2.4.3   Overall, for the questions relating to health Cambridgeshire respondents answered more positively than the national picture on 6 out of 7 of the questions.

2.5   **What care and support were people receiving?**

2.5.1   The survey asked a range of questions around what social care services supported respondents with. The percentage of respondents reporting receiving support had increased in five of the seven areas. Areas with increased percentages were:
- Support to have a better quality of life, where **93.7%** of respondents said services supported them with this. This was higher than 2020 (93.1%) and higher than England overall (90.4%).
- Support with the way you spend your time, where **63.1%** of respondents who felt they needed support with this said that services supported them with this. This was higher than 2020 (60.3%) and but lower than England overall (68.2%)
- Help with social contact, where **62.2%** of respondents who felt that they needed support with this said that services helped them with this. This was higher than 2020 (60.3%) but lower than England overall (68.2%).
- Help keeping your home clean and comfortable, where **64.9%** of respondents who felt they needed support with this said that services helped them with this. This was slightly higher than 2020 (58.2%) but significantly lower than England overall (72.2%).
- Help getting food and drink, where **82.4%** of respondents who felt they needed help with this said that services did help them with this. This was higher than 2020 (73.5%) and higher than England overall (80.4%)

2.5.2   There were two areas in which a smaller percentage reported receiving support from services, this was:
- Keeping clean and presentable in appearance, where **85.2%** of respondents who felt they needed help said that services did help them with this. This was lower than 2020 (85.4%) and lower than England overall (85.4%).
- Help feeling safe, where **72.3%** felt support services helped them to feel safe. This was lower than 2020 (82.8%) and lower than England overall (85.6%).

2.6   **Experience and outcomes**

2.6.1   There are a range of questions in the survey which explore the respondents' quality of life and experience of care and support services.   The reported experience of respondents improved when compared to the 2020 survey in the following three areas:
- Thinking about the good and bad things that make up your quality of life, how would you describe your quality of life, where **63%** responded that it was either good or better. This was better than 2020 (61.3%) and better than England overall (60.8%).
- Do care and support services help you have control over your daily life, where **90.2%** said either "yes" (83.1%) or that they did not need care and support to have control over their daily life (7.8%). This was an improvement on 89.9% in 2020 and better than

England overall (87.6%).
- Feeling safe, where **72.9%** of respondents stated that they felt as safe as they wanted. This was higher than 2020 (68.5%) and higher than England overall (69.2%).

2.6.2 The reported experience had worsened in the following seven areas
- Overall, how satisfied are you with the care and support services you receive, where **89.4%** were either quite (23.9%), very or extremely satisfied (65.5%). This was lower than 2020 (90.7%) but better than England overall (87.9%)
- **83.9%** said that either having care and support made them feel better about themselves or did not negatively affect how they felt about themselves. This was worse than the 88.9% in the previous year and England overall (84.1%)
- How the way I am helped and treated makes me feel about myself, where **87.1%** stated it made them feel better (65.1%) or did not affect the way they felt (24.5%). This was worse than 2020 (89.6%) but better than England overall (85.5%).
- In the past year have you found it easy or difficult to find information and advice about support, services or benefits, where **58.4%** had found it fairly or very easy to find. This was lower than 63.6% in 2020 and lower than England overall (64.5%)
- How you spend your time, where **69.7%** stated that they were at least able to do enough of things they valued and enjoyed with their time. This was lower than 2020 (71.9%) and lower than England overall (67.1%).
- How much control you have over your life, where only **32.4%** felt they had as much control as they wanted. This was lower than 2020 (37%) and lower than the England average (34.1%)
- Choice over care and support, where **71.9%** either said they had enough choice (67.7%) or did not need choice (5.8%). This was lower than 2020 (74.4%) but higher than England overall (68.1%).

2.6.3 When comparing to England overall Cambridgeshire respondents were more positive on 6 of the 10 indicators relating to overall experience and outcomes.

2.7 **Local questions**

2.7.1 Alongside the national questions Cambridgeshire asked two local questions. A question around how people access information and advice was selected by the engagement forums to inform the co-production work being undertaken around access to information and advice and digital inclusion. As this was a local question there is no benchmarking information available. The question and responses are show in the table below, respondents could select multiple answers:

What do you use to find information and advice about services or benefits?

Family and friends	219	49.8%
Internet	109	24.8%
Advice from a professional	84	19.1%
Leaflet / Newsletter	62	14.1%
Telephone helpline	56	12.7%
Advice from a voluntary or community group	55	12.5%
Other	35	8.0%
Not applicable	65	14.8%

2.7.2 Family and friends were the most common source of information and advice, which further supports the need to get access to information and advice for carers right. Almost a quarter of respondents used the internet, but professionals, voluntary and community groups and telephone helplines were also sources used, each by over 10% of respondents.

2.7.3 Free text questions were also included to ask what respondents thought adult social care did well and what we could do better. Below are some of the key themes identified from responses to these questions:

2.7.4 Key themes - What do you think we do well?
- Lots of positive comments about care provision, in particular day opportunities and home care.
- Support and advice and help to develop new skills from support workers
- Reablement, equipment, technology enabled care and occupational therapy.
- Co-ordination of care and finding care at short notice
- Training and positive attitude of staff

2.7.5 Example quotes:
"I am very satisfied with the care agency that I have. They have done their best to schedule visits to suit me. I have four visits per day and I have one main carer & a few other carers that all know my needs. They make me feel safe and respected. The care and support services give me a better quality of life and allow me to remain in my own home"

"The standard of care I have received has been excellent and all the little useful tips I've picked up from them have made tasks so much easier for me. They always arrive smiling and cheerful and immediately their presence makes me feel in 'safe hands'. I have found them all extremely polite, adaptable, flexible, understanding and a joy to be with"

"The county council tech service is brilliant as the occupational therapists & physios. Professional, supportive, efficient, and able to think outside the box to adapt things to suit my needs. The Reablement Service was excellent- highly trained and very caring"

"Social Services have responded to our request to renew the care package. We found the staff members involved (by telephone) extremely helpful and supportive. Good communication skills and empathy were evident"

2.7.6 Key themes – What could we do better?
- Care call time too short or rushed and not always on time or cancelled
- More staff, more day care
- Better communication, including in accessible formats – e.g., Makaton, signing
- Better training for staff in working with people with learning disabilities
- Better / more visible monitoring of care providers and vetting of care staff
- Returning telephone calls
- Shortage of support for people with more complex needs (health)
- More information on services and activities available in the local area, closer links to voluntary sector and befriending services.
- Work opportunities with support
- Speed and accessibility of letters and invoicing

- Better seamless working between health and social care services

Example quotes
"Improved communication between care provider organisation and social services. Improved communication between departments within social services including finance"

"List of activities or groups to join would be extremely helpful. I personally struggle to have social contact and confidence so would love to join other groups and get to know other people like me"

"Better training for support workers. More and better vetting for the kinds of people employed as support workers information to be widely available and most importantly include the parent carers"

"I would like to have more access to do things for 'adults with disabilities'. However, I also find that 'disability' gets lumped together. I would like to find things to do for people with learning disabilities"

"Send a regular carer at regular times. Not knowing who is coming or what time they will come is in itself very stressful"

2.8   Responses by district geography

2.8.1   The responses to the survey can be broken down to district geographies, however it should be noted that because numbers sampled are small it can make comparison difficult as a single negative / positive answer can impact the overall percentage more in districts with smaller overall sample numbers.   The table below shows the % of respondents from each district responding positively on a selection of key survey questions. The table excludes respondents who were supported outside of Cambridgeshire

Question	Cambridge	East Cambs	Fenland	Hunts	South Cambs
Overall satisfaction	88.7%	90.6%	87.7%	89.7%	89.0%
Quality of Life	62.7%	62.7%	66.7%	57.6%	59.1%
Choice over care and support	71.3%	65.2%	70.5%	70.4%	64.9%
Control over daily life	84.5%	79.6%	80.9%	77.6%	70.6%
Feeling safe	68.3%	73%	67.3%	67%	71.3%
Social contact	43.4%	50.8%	48.8%	37.2%	41%
Finding information and advice	37.4%	31.1%	40.7%	36.7%	33.5%

2.9   Next steps

2.9.1   The results of the survey analysis will be fed into the work underway to redesign services, and might be a useful benchmark against which to measure impact of Care Together, although noting that the timing of the 2022 survey just following the pandemic might have impacted the outcomes.   The 2023 survey is currently underway and will provide a more current picture of experience when it is submitted and analysed during 2023/24

2.9.2   We have also identified 2 areas from the Adult Social Care Outcomes Framework where we have historically done less well. For these areas we will be approaching our engagement

forums and partnership boards to do some further co-production work with us on how we could improve experience and outcomes. These areas are:

- The proportion of people who use services who find it easy to find information about support. Which can be looked at alongside the local question on how people access information and advice, see paragraph 2.7.
- The proportion of people who use services who say that those services have made them feel safe and secure

2.9.3 Appendix 1 provides a full breakdown of answers to each question within the survey for reference.

3. Alignment with corporate priorities

3.1 Environment and Sustainability
There are no significant implications for this priority.

3.2 Health and Care
The report sets out the implications for this priority in paragraph 2.9, however the full content of the report outlines the experience of people receiving long term and care and support services from the council in respect of their overall health and impact services have on their lives.

3.3 Places and Communities
There are no significant implications for this priority.

3.4 Children and Young People
There are no significant implications for this priority.

3.5 Transport
There are no significant implications for this priority.

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
The following bullet point set out details of significant implications identified by officers:
- The adults service user survey is a statutory survey which must be completed annually, the results feed into the national Adult Social Care Outcomes Framework.

4.4 Equality and Diversity Implications
There are no significant implications within this category.

4.5   Engagement and Communications Implications
The following bullet point set out details of significant implications identified by officers:
- Following presentation to committee the results will be shared with our adult engagement forums and there will be some co-production work to explore areas of poorer experience as described in paragraph 2.9.2

4.6   Localism and Local Member Involvement
There are no significant implications for this priority.

4.7   Public Health Implications
There are no significant implications for this priority

4.8   Environment and Climate Change Implications on Priority Areas

4.8.1 Implication 1: Energy efficient, low carbon buildings.
Neutral
Explanation: This report is for information only

4.8.2 Implication 2: Low carbon transport.
Neutral
Explanation: This report is for information only

4.8.3 Implication 3: Green spaces, peatland, afforestation, habitats, and land management.
Neutral
Explanation: This report is for information only

4.8.4 Implication 4: Waste Management and Tackling Plastic Pollution.
Neutral
Explanation: This report is for information only

4.8.5 Implication 5: Water use, availability, and management:
Neutral
Explanation: This report is for information only

4.8.6 Implication 6: Air Pollution.
Neutral
Explanation: This report is for information only

4.8.7 Implication 7: Resilience of our services and infrastructure and supporting vulnerable people to cope with climate change.
Positive
Explanation: This report is for information only.

Have the resource implications been cleared by Finance?   Yes
Name of Financial Officer: Justine Hartley

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement and Commercial?   Yes
Name of Officer: Clare Ellis

Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or Pathfinder Legal?   Yes
Name of Legal Officer: Linda Walker

Have the equality and diversity implications been cleared by your EqIA Super User?
Yes
Name of Officer: Faye McCarthy

Have any engagement and communication implications been cleared by Communications?
No (20th February 2023)
Name of Officer:

Have any localism and Local Member involvement issues been cleared by your Service Contact?   Yes
Name of Officer: Debbie McQuade

Have any Public Health implications been cleared by Public Health?
No (20th February 2023)
Name of Officer:

If a Key decision, have any Environment and Climate Change implications been cleared by the Climate Change Officer?
No (20th February 2023)
Name of Officer:

5.   Source documents guidance

5.1   Source documents
- Personal Social Services Adult Social Care Survey, England 2021/22 methodology and results
- Cambridgeshire responses to the Personal Social Services Adult Social Care Survey, England 2021/22

5.2   Location
Personal Social Services Adult Social Care Survey, England 2021/22 methodology and results - Personal Social Services Adult Social Care Survey, England, 2021-22 - NDRS (digital.nhs.uk)

Cambridgeshire responses to the Personal Social Services Adult Social Care Survey, England 2021/22 – these are held by the Business Intelligence Team digitally but can be view nationally by using the NHS Digital analytical hub and filtering for Cambridgeshire Microsoft Power BI.

Appendix 1 – Adult Social Care Survey Results 2021/22 – national questions

If a different format is required, please contact tina.horsby@cambridgeshire.gov.uk

Question 1

Overall, how satisfied are you with the care and support services you receive?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I am extremely or very satisfied	63.9	65.8	66.1	⬇
I am quite satisfied	24	22.7	25.2	⬇
I am neither satisfied or dissatisfied	6.8	6.2	5	⬆
I am dissatisfied	2.8	3	1.7	⬆
I am extremely or very dissatisfied	2.6	2.2	2	⬆

Question 2

Thinking about the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
So good it could not be better	30.6	35.7	31	⬆
Good	30.2	27.5	31.3	⬇
Alright	28.6	27.8	30.4	⬇
Bad	6.6	7	4.3	⬆
Very bad or so bad it could not be worse	4.0	2	3	⬇

Queston 2 b

Do care and support services help you have a better quality of life	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
Yes	90.4	93.7	93.1	⬆
No	9.6	6.3	6.9	⬇

Question 2c

Which of the following statements best describes how much choice you have over the care and support services you receive?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I do have enough choice over care and support services	64	68.3	70.1	⬇
I don't have enough choice over care and support services	30	26.6	24.9	⬆
I don't want or need choice about care and support services	6	5	5	-

Question 3a

Which of the following statements best describes how much control you have over your daily life?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I have as much control over my daily life as I want	34.1	33.5	36.5	⬇
I have adequate control over my daily life	42.7	46.8	44.1	⬆

	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I have some control over my daily life but not enough	17.9	15	14.9	⬆
I have no control over my daily life	5.3	4.8	4.4	⬆

Question 3b

Do care and support services help you in having control over your daily life?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I do not need care and support services to help me have control over my daily life	13.3	7.9	N/A	NEW
Yes	76.1	83.2	90.8	⬇
No	10.7	8.9	9.2	⬇

Question 4a

Thinking about keeping clean and presentable in appearance, which of the following statements best describes your situation?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I feel clean and able to present myself the way I like	56.6	57.9	56.3	⬆
I feel adequately clean and presentable	36.5	35	39	⬇
I feel less than adequately clean or presentable	5.8	6.5	4.5	⬆
I don't feel at all clean or presentable	1.2	0.6	0.3	⬆

Question 4b

Do care and support services help you in keeping clean and presentable in appearance?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I do not need care and support services to help me keep clean and presentable	16.3	9	N/A	NEW
Yes	71.5	77.9	86.7	⬇
No	12.2	13.2	13.3	⬇

Question 5a

Thinking about the food and drink you get, which of the following statements best describes your situation?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I get all the food and drink I like when I want	63.5	64.1	67.2	⬇
I get adequate food and drink at OK times	29.5	29.6	26.9	⬆
I don't always get adequate or timely food and drink	5.5	3.5	5.3	⬇
I don't always get adequate or timely food and drink, and I think there is a risk to my health	1.5	2.8	0.6	⬆

Question 5b

Do care and support services help you to get food and drink?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I do not need care and support services to help me get food and drink	16.2	9.5	N/A	NEW
Yes	67.4	75	77.3	⬇
No	16.4	15.5	22.7	⬇

Question 6a

Which of the following statements best describes how clean and comfortable your home is?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
My home is as clean and comfortable as I want	65.5	63.5	63.1	⬆
My home is adequately clean and comfortable	28.9	31.1	33.4	⬇
My home is not quite clean or comfortable enough	4.8	4.5	2.9	⬆
My home is not at all clean or comfortable	0.9	0.9	0.6	⬆

Question 6b

Do care and support services help you in keeping your home clean and comfortable?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I do not need care and support services to help me keep my home clean and comfortable	15.2	8.9	N/A	NEW
Yes	61.2	63.6	63.1	⬆
No	23.6	27.4	36.9	⬇

Question 7a

Which of the following statements best describes how safe you feel?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I feel as safe as I want	69.2	72.7	71.5	⬆
Generally I feel adequately safe, but not as safe as I would like	24.8	22.4	23.4	⬇
I feel less than adequately safe	4	3.2	4	⬇
I don't feel safe at all	2	1.7	1.1	⬆

Question 7b

Do care and support services help you in feeling safe?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
Yes	85.6	74.3	85.8	⬇
No	14.4	25.7	14.2	⬆

Question 8a

Thinking about how much contact you've had with people you like, which of the following statements best describes your social situation?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I have as much social contact as I want with people I like	40.6	41.7	46.9	⬇
I have adequate social contact with people	31.8	32.3	29.5	⬆
I have some social contact with people, but not enough	19.4	20.9	15.1	⬆
I have little social contact with people and feel socially isolated	8.3	7.9	5.7	⬆

Question 8b

Do care and support services help you in having social contact with people?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I do not need care and support services to help me have social contact with people	17.6	14.2	N/A	NEW
Yes	55	57	64.7	⬇
No	27.4	28.8	35.3	⬇

Question 9a

Which of the following statements best describes how you spend your time?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I am able to spend my time as I want, doing things I value or enjoy	37.4	40.6	38.6	⬆
I am able to do enough of the thing I value or enjoy with my time	29.7	29.9	35.2	⬇
I do some of the things I value or enjoy with my time but not enough	24.8	24.9	23.1	⬆
I don't do anything I value or enjoy with my free time	8.2	4.6	3.1	⬆

Question 9b

Do care and support services help you in the way you spend your time?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I do not need care and support services to help me in the way I spend my time	17.5	12.8	N/A	NEW
Yes	56.3	59.4	65.2	⬇
No	26.2	27.8	34.8	⬇

Question 10

Which of these statements best describes how having help to do things makes you think and feel about yourself?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
Having help makes me think and feel better about myself	61.5	61	62.6	⬇
Having help does not affect the way I think or feel about myself	26.8	26.6	26.6	-
Having help sometimes undermines the way I think and feel about myself	9.9	11.3	8	⬆
Having help completely undermines the way I think and feel about myself	1.7	1	2.8	⬇

Question 11

Which of these statements best describes how the way you are helped and treated makes you think and feel about yourself?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
The way I'm helped and treated makes me think and feel better about myself	61.9	67.9	65.5	⬆
The way I'm helped and treated does not affect the way I think or feel about myself	27.6	21.9	24.4	⬇
The way I'm helped and treated sometimes undermines the way I think and feel about myself	9	8.9	8.7	⬆
The way I'm helped and treated completely undermines the way I think and feel about myself	1.5	1.2	1.3	⬇

Question 12

In the past year, have you generally found it easy or difficult to find information and advice about support, services or benefits?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I've never tried to find information or advice	43.5	44	49.9	⬇
Very easy to find	15.9	13.6	13.5	⬆
Fairly easy to find	20	19.9	19.3	⬆
Fairly difficult to find	12.4	14.5	13.9	⬆
Very difficult to find	8.3	3.8	3.4	⬆

Question 13

How is your health in general?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
Very good	15.8	20.4	15.8	⬆
Good	27.7	26.2	28.7	⬇
Fair	37.8	38.7	43.1	⬇
Bad	13.8	11.8	10	⬆
Very bad	4.9	2.9	2.4	⬆

Question 14a

Which statement best describes your own health state today?- Pain or discomfort	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I have no pain or discomfort	37	39.5	40.1	🔻
I have moderate pain or discomfort	49.3	49.4	50.2	🔻
I have extreme pain or discomfort	13.7	11.1	9.7	🔼

Question 14b

Which statement best describes your own health state today?- Anxiety and depression	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I am not anxious or depressed	48.4	54.1	50.8	🔼
I am moderately anxious or depressed	42.3	38.8	42.4	🔽
I am extremely anxious or depressed	9.2	7.1	6.8	🔼

Question 15a

Do you usually manage to get around indoors (except steps) by yourself?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I can do this easily by myself	53	51.2	51.2	-
I have difficulty doing this myself	25	25.1	21.3	🔼
I can't do this by myself	22	23.8	27.4	🔽

Question 15b

Do you usually manage to get in and our of a bed (or chair) by yourself?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I can do this easily by myself	55.9	53.4	52.6	🔼
I have difficulty doing this myself	20.6	17.8	19.6	🔽
I can't do this by myself	23.5	28.8	27.8	🔼

Question 15c

Do you usually manage to feed yourself?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I can do this easily by myself	76.6	77.9	75.7	🔼
I have difficulty doing this myself	15.2	12.6	15.9	🔽
I can't do this by myself	8.2	9.4	8.4	🔼

Question 15d

Do you usually deal with finances and paperwork- for example, paying bills, writing letters- by yourself?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I can do this easily by myself	19.8	22.5	14.5	⬆
I have difficulty doing this myself	17	16.7	14.7	⬆
I can't do this by myself	63.2	60.8	70.8	⬇

Question 16a

Do you usually manage to wash all over by yourself, using either a bath or a shower?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I can do this easily by myself	32.4	29.8	27.3	⬆
I have difficulty doing this myself	26	25.3	23.6	⬆
I can't do this by myself	41.6	44.9	49	⬇

Question 16b

Do you usually manage to get dressed and undressed by yourself?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I can do this easily by myself	42.9	42.4	36.6	⬆⬇
I have difficulty doing this myself	25	22.8	24.3	⬇
I can't do this by myself	32.1	34.7	39.1	⬇

Question 16c

Do you usually manage to use the WC/ toilet by yourself?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I can do this easily by myself	59.2	55.5	55.6	⬇
I have difficulty doing this myself	17.5	17.1	17.2	⬇
I can't do this by myself	23.3	27.4	27.2	⬆

Question 16d

Do you usually manage to wash your hands and face by yourself?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I can do this easily by myself	70.2	68.8	65	⬆⬇
I have difficulty doing this myself	15.2	14.1	16.8	⬇
I can't do this by myself	14.6	17.1	18.2	⬇

Question 17

How well do you think your home is designed to meet your needs?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
My home meets my needs very well	54.5	56.8	58.7	⬇
My home meets most of my needs	30	29.3	29.7	⬇
My home meets some of my needs	11.9	10.8	9.8	⬆
My home is totally inappropriate for my needs	3.6	3	1.9	⬆

Question 18

Thinking about getting around outside of your home, which of the following statements best describes your present situation?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I can get to all the places in my local area that I want	29.6	29.8	28	⬆
At times I find it difficult to get to all the places in my local area that I want	22.4	25.2	25.3	⬇
I am unable to get to all the places I want in my local area	18.9	18.4	19.6	⬇
I do not leave my home	29.1	26.5	27.2	⬇

Question 19

Do you receive any practical help on a regular basis from your husband/ wife, partner, friends, neighbours, or family members?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
Yes, from someone living in my household	39.6	40.5	40.4	⬆
Yes, from someone living in another household	45	47.8	51.7	⬇
No	23.9	21.8	17.6	⬆

Question 20

Do you buy any additional care or support privately or pay more to 'top up' your care and support?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
Yes, I buy some more care and support with my own money	28.2	27.9	29.8	⬇
Yes, my family pays for some more care and support for me	10.1	8.6	6.3	⬆
No	64	66.5	65.7	⬆

Question 21

Did you have any help from someone else to complete this questionnaire?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
No, I did not have help	23.6	23	22.1	⬆
I had help from a care worker	28.8	29.6	22.8	⬆
I had help from someone living in my household	20.9	21.7	20.5	⬆
I had help from someone living outside my household	26.6	25.7	34.6	⬇

Question 22

What type of help did you have to complete this questionnaire?	National (%)	Cambridgeshire 2021/22 (%)	Cambridgeshire 2019/20 (%)	Change since 2019/20
I didn't have any help	22.6	22.4	21.8	⬆
Someone else read the questions to me	47.4	48.5	45.3	⬆
Someone else translated the questions for me	20	21.9	21.8	
Someone else wrote down the answers for me	35.4	43.2	38.2	⬆
I talked through the questions with someone else	29	32.7	28.8	⬆
Someone answered for me, without asking me the questions	8.5	9.4	9.4	

Finance Monitoring Report – March 2022/23

To:	Adults and Health Committee
Meeting Date:	9 March 2023
From:	Executive Director of People Services Director of Public Health Chief Finance Officer
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	N/A
Outcome:	The committee should have considered the financial position of services within its remit as at the end of January 2023.
Recommendation:	Adults and Health Committee is recommended to review and comment on the relevant sections of the People Services and Public Health Finance Monitoring Report as at the end of January 2023.

Officer contact:
Name: Justine Hartley
Post: Strategic Finance Manager
Email: justine.hartley@cambridgeshire.gov.uk
Tel: 07944 509197

Member contacts:
Names: Cllr Richard Howitt / Cllr Susan van de Ven
Post: Chair/Vice-Chair
Email:
Tel: 01223 706398

1. Background

1.1 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.

1.2 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.

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

1.4 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.

1.5 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 5 – this sets out the savings for Adults and Public Health in the 2022/23 business plan, and savings not achieved in 2021/22 that are still thought to be deliverable.
- Appendix 6 – this sets out the position on reserve balances for Adults and Public Health as at the end of October 2022 and the forecast position at year end.

1.6 The FMR presented to this Committee and included at Appendix 1 covers People Services and Public Health. The budget headings in the FMR that are within the remit of this committee are set out in Appendix 2, but broadly are those within Adults & Safeguarding, Adults Commissioning, and Public Health.

2. Main Issues

2.1 The FMR provides summaries and detailed explanations of the financial position of Adults and Public Health services. At the end of January, Adults and Safeguarding (including Adults Commissioning) are forecasting an underspend of £664k, and Public Health is forecasting an underspend of £353k:

Table 1: Budget and forecast position summary at end of January 2023

Directorate	Budget 2021/22 £000	Actual January 23 £000	Forecast Outturn Variance £000
Adults & Safeguarding	189,170	160,671	88
Adults Commissioning (including Local Assistance Scheme)	19,013	15,279	-752
Public Health (excl. Children's Health)	30,860	5,523	-353
Total Expenditure	**239,043**	**181,473**	**-1,016**
Grant Funding (including Improved Better Care Fund, Public Health Grant etc.)	-48,149	-40,239	-1
Total	**190,894**	**141,235**	**-1,017**

2.2   For ease, the main summary sections of the FMR are replicated below in section 2.3.

2.3   Taken from sections 1.4 and 1.5 of the January FMR:

Adults

2.3.1 The overall position for Adults and Safeguarding and Adults Commissioning is a forecast underspend of £664k at the end of January. However, this masks considerable variances across the different service user groups. We are seeing financial pressures across Learning Disability, Physical Disability and Mental Health, but these are being offset by forecast underspends elsewhere, and particularly in the costs of services for Older People. Following on from the pandemic we are continuing to see demand for residential care for Older People at below pre pandemic levels and it is anticipated that this trend will continue for some time to come.

2.3.2 Care providers are continuing to report cost pressures related to both workforce issues and the current cost of living rises. These are putting pressure on uplift budgets across all care types. The position of the care market, particularly related to workforce issues, is making some placements more difficult to source, particularly at the more complex end of provision.

2.3.3 In line with the social care reform agenda the Council has undertaken "cost of care" exercises with both homecare and care home providers. Whilst the implementation of the reforms has now been delayed until October 2025, the outcomes of the cost of care exercises are a gap for many providers between what is currently paid, and the "cost of care" derived from provider data. Whilst we have some funding from government for 2022/23 and beyond to start to close this gap, this will be far from enough to fund the cost increases indicated by the "cost of care" exercises which are estimated at £23.4m per annum for homecare for all Adults and care homes for Older People. Increased rates in these areas would also likely increase the costs of other care packages not currently included in the remit of the "cost of care" work such as care homes for people aged under 65 and supported living placements.

2.3.4 As part of its 2022/23 Business Plan, the Council committed to providing additional funding to care providers towards all paying the real living wage within three years. Dedicated capacity was resourced to initiate a review of providers in Cambridgeshire to consider if they were paying the real living wage or above to their caring staff. This review has been undertaken alongside the "cost of care" work required under the government's Adult Social Care reform agenda. Of 220 providers surveyed, 38 providers (17.3%) evidenced payment of below the 2021/22 real living wage rate of £9.50 per hour. Work is now underway to plan implementation of the real living wage with these providers.

2.3.5 Hospital Discharge systems continue to be pressured. The medium-term recovery of clients assessed as having primary health needs upon hospital discharge can return individuals to social care funding streams. In addition, the impact of delayed health care treatments such as operations, will also affect individual needs and health inequalities negatively.

2.3.6 Work is ongoing to assess future demand, cost pressures and the financial implications of the government's social care reforms which have now been postponed to October 2025. This work will feed into business planning for 2024/25 and beyond. If demand increases above current expectations within the current financial year, we have provision to offset the costs of this in the Adult's risk reserve which currently stands at £4.7m.

Public Health

2.3.7 The Public Health Directorate is funded wholly by ringfenced grants, mainly the Public Health Grant. The work of the Directorate was severely impacted by the pandemic, as capacity was re-directed to outbreak management, testing, and infection control work. The Directorate is now focussed on returning business as usual public health activity to full capacity as soon as possible and addressing issues arising from the pandemic which have impacted on the health of the County's population.

2.5.8 At the end of January, the Public Health Directorate is forecasting a small underspend of £353k (0.9%). However, there are continuing risks to this position:

i)   much of the Directorate's spend is contracts with, or payments to, the NHS for specific work. The NHS re-focus on the pandemic response and vaccination reduced activity-driven costs to the PH budget throughout 2020/21 and 2021/22. The NHS continues to be under pressure, and it may take some time for activity levels to return to pre pandemic levels;

ii)   the unprecedented demand for Public Health staff across the country has meant recruitment has been very difficult through the pandemic resulting in underspends on staffing budgets. This position may continue through 2022/23, although appointments are now starting to be made; and

iii)   recruitment challenges are reflected in our provider services which has affected their ability to deliver consistently.

3.   Alignment with corporate priorities

3.1   Communities at the heart of everything we do

The overall financial position of the People Services and Public Health directorates underpins this objective.

3.2   A good quality of life for everyone
The overall financial position of the People Services and Public Health directorates underpins this objective.

3.3   Helping our children learn, develop and live life to the full
The overall financial position of the People Services and Public Health directorates underpins this objective.

3.4   Cambridgeshire: a well-connected, safe, clean, green environment
There are no implications for this priority.

3.5 Protecting and caring for those who need us
The overall financial position of the People Services and Public Health directorates underpins this objective.

4. Significant Implications

4.1 Resource Implications
The attached Finance Monitoring Report sets out the details of the overall financial position for People Services and Public Health.

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
The report sets out the financial position of the Public Health Directorate

4.8 Environment and Climate Change Implications on Priority Areas

4.8.1 Implication 1: Energy efficient, low carbon buildings.
Neutral

4.8.2 Implication 2: Low carbon transport.
Neutral

4.8.3 Implication 3: Green spaces, peatland, afforestation, habitats and land management.
Neutral

4.8.4 Implication 4: Waste Management and Tackling Plastic Pollution.
Neutral

4.8.5 Implication 5: Water use, availability and management:
Neutral

4.8.6 Implication 6: Air Pollution.
Neutral

4.8.7 Implication 7: Resilience of our services and infrastructure, and supporting vulnerable people to cope with climate change.
Neutral

5. Source documents guidance

5.1 Source documents

Finance Monitoring Reports are produced monthly, except for April, for all of the Council's services. These are uploaded regularly to the website below.

5.2 Location

[Finance and performance reports - Cambridgeshire County Council](#)

Appendix 1: People Services and Public Health Finance Monitoring Report January 2023

See separate document

Appendix 2 : Budget Headings within the remit of the Adults and Health Committee

1   The budget headings that are the responsibility of this committee are set out below along with a brief description of the services these headings contain. The financial information set out in appendices 1 and 2 of the main FMR use these budget headings.

2   Adults & Safeguarding Directorate (FMR appendix 1):

Budget Heading	Description
Strategic Management - Adults	Cross-cutting services including transport and senior management. This line also includes expenditure relating to the Better Care Fund and social care grants.
Transfers of Care	Hospital based social work teams
Prevention & Early Intervention	Preventative services, particularly Reablement, Adult Early Help and Technology Enabled Care teams
Principal Social Worker, Practice and Safeguarding	Social work practice functions, mental capacity act, deprivation of liberty safeguards, and the Multi-Agency Safeguarding Hub
Autism and Adult Support	Services for people with Autism
Adults Finance Operations	Central support service managing social care payments and client contributions assessments
Learning Disabilities	Services for people with learning disabilities (LD). This is a pooled budget with the NHS – the NHS contribution appears on the last budget line, so spend on other lines is for both health and social care.
Head of Service	
LD - City, South and East Localities	
LD - Hunts and Fenland Localities	
LD - Young Adults Team	
In House Provider Services	
NHS Contribution to Pooled Budget	
Older People and Physical Disability Services	Services for people requiring physical support, both working age adults and older people (OP).
Management and Staffing	
Older People's Services - North	
Older People's Services - South	
Physical Disabilities - North	
Physical Disabilities - South	
Mental Health	Services relating to people with mental health needs. Most of this service is delivered by Cambridgeshire and Peterborough NHS Foundation Trust.
Mental Health Central	
Adult Mental Health Localities	
Older People Mental Health	

3   Commissioning Directorate (FMR appendix 1):

Budget Heading	Description
Strategic Management - Commissioning	Costs relating to the Commissioning Director, shared with CYP Committee.
Local Assistance Scheme	Scheme providing information, advice and one-off practical support and assistance
Central Commissioning - Adults	Discrete contracts and grants that support adult social care, such as carer advice, advocacy, housing related support and grants to day centres, as well as block domiciliary care contracts.
Integrated Community Equipment Service	Community equipment contract expenditure. Most of this budget is pooled with the NHS.
Mental Health Commissioning	Contracts relating to housing and community support for people with mental health needs.

4   The Executive Director budget heading in FMR appendix 1 contains costs relating to the executive director of People Services and is shared with other People Services committees.

5   Public Health Directorate (FMR appendix 2):

Budget Heading	Description
Drug & Alcohol Misuse	A large contract to provide drug/alcohol treatment and support, along with smaller contracts.
SH STI testing & treatment - Prescribed	Sexual health and HIV services, including prescription costs, advice services and screening.
SH Contraception - Prescribed	
SH Services Advice Prevention/Promotion - Non-Prescribed	
Integrated Lifestyle Services	Preventative and behavioural change services. Much of the spend on these lines is either part of the large Integrated Lifestyles contract or is made to GP surgeries.
Other Health Improvement	
Smoking Cessation GP & Pharmacy	
NHS Health Checks Programme - Prescribed	
Falls Prevention	Services working alongside adult social care to reduce the number of falls suffered.
General Prevention, Traveller Health	Health and preventative services relating to the Traveller community, including internal income from Cambs Skills for adult learning work.
Adult Mental Health & Community Safety	A mix of preventative and training services relating to mental health.
Public Health Strategic Management	Mostly a holding account for increases in the ringfenced Public Health Grant pending its allocation to specific budget lines.
Public Health Directorate Staffing and Running Costs	Staffing and office costs to run Public Health services
Health in All Policies	Staffing costs for embedding health considerations in the Council's policies
Enduring Transmission Grant	Expenditure under a pilot scheme to tackle Covid-19 transmission where rates are persistently higher than average. The pilot covers Fenland, Peterborough and South Holland but is administered by Cambridgeshire County Council.
Contain Outbreak Management Fund	Expenditure relating to the COMF grant, a large grant given over 2020/21-22 to deliver outbreak management work under the Health Protection Board.

Service: People Services and Public Health
Subject: Finance Monitoring Report – January 2023
Date: 15th February 2023

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		The following appendices are not included each month as the information does not change as regularly:	
Appx 5	Savings Tracker	Each quarter, the Council's savings tracker is produced to give an update of the position of savings agreed in the Business Plan.	35-38
Appx 6	Technical Appendix	Twice yearly, this will contain technical financial information showing: Grant income received Budget virements and movements in Service reserves	

1. Revenue Executive Summary

1.1 Overall Position

People Services are forecasting an overspend of £3,204k at the end of January 2023.

Public Health are forecasting an underspend of £353k at the end of January 2023.

1.2 Summary of Revenue position by Directorate
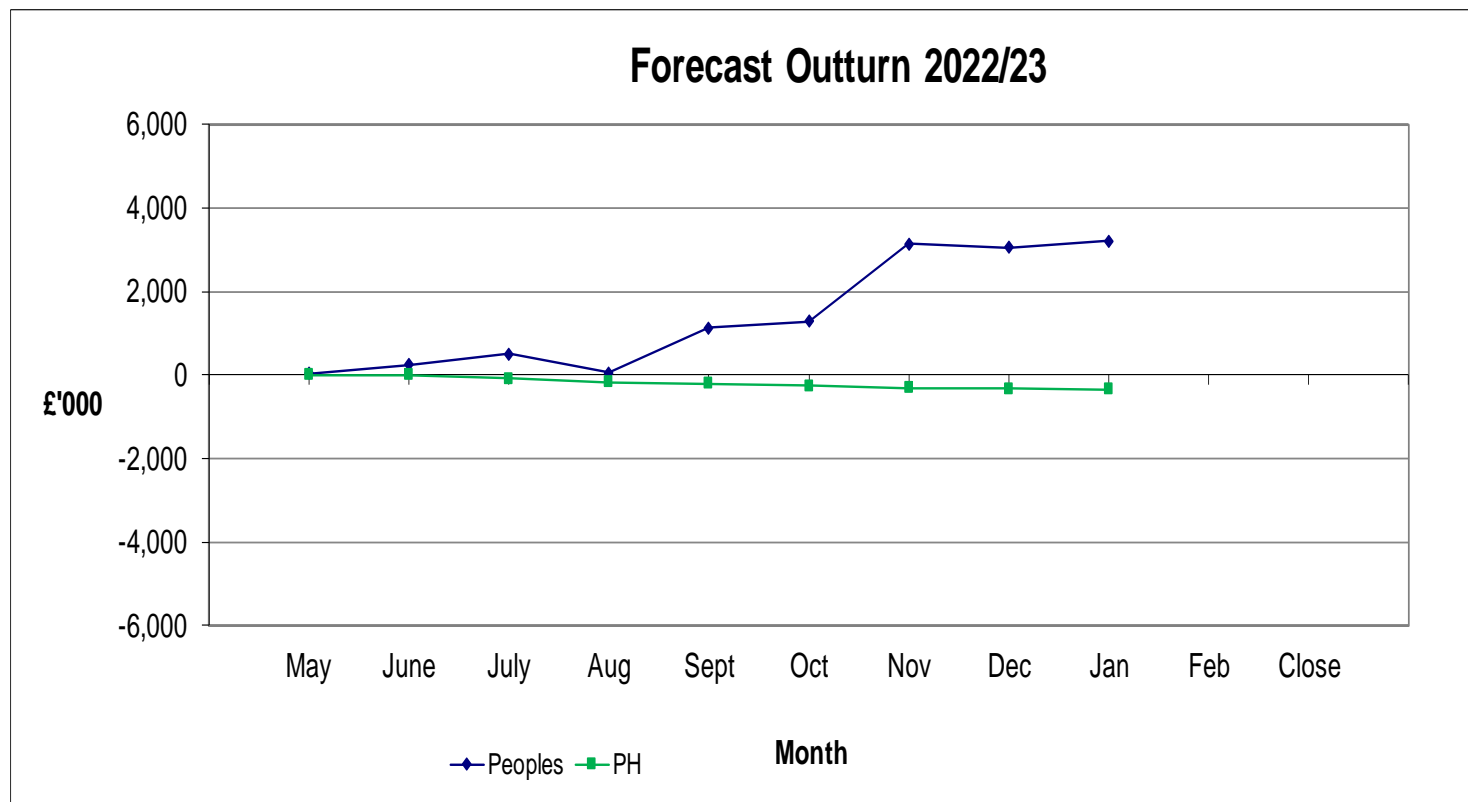
1.2.1 People Services

Forecast Outturn Variance (Previous) £000	Directorate	Budget 2022/23 £000	Actual £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
78	Adults & Safeguarding	189,170	160,671	88	0.1%
-72	Commissioning	44,793	34,712	372	0.8%
-335	Children & Safeguarding	61,796	47,737	-390	-0.6%
3,375	Education - non DSG	47,585	16,151	3,133	6.6%
11,800	Education - DSG	101,680	96,995	11,800	11.6%
-0	Executive Director	1,026	810	0	0.0%
14,846	**Total Expenditure**	**446,050**	**357,076**	**15,004**	**3.4%**
-11,800	Grant Funding (including DSG)	-134,041	-127,627	-11,800	8.8%
3,046	**Total**	**312,009**	**229,449**	**3,204**	**1.0%**

1.2.2 Public Health

Forecast Outturn Variance (Previous) £000	Directorate	Budget 2022/23 £000	Actual £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
-0	Children Health	9,393	8,043	-1	0.0%
-10	Drugs & Alcohol	6,692	3,274	3	0.0%
-7	Sexual Health & Contraception	5,293	3,085	87	1.6%
-28	Behaviour Change / Preventing Long Term Conditions	5,615	2,337	-54	-1.0%
-4	Falls Prevention	433	51	-7	-1.6%
4	General Prevention Activities	11	-17	4	32.9%
-2	Adult Mental Health & Community Safety	250	-149	-2	-0.8%
-279	Public Health Directorate	12,566	-3,058	-384	-3.2%
-326	**Total Expenditure**	**40,253**	**13,566**	**-353**	**-0.9%**

1.3 Summary by Committee

People Services and Public Health Services are overseen by different Committees – these tables provide Committee-level summaries of services' revenue financial positions.

1.3.1 Adults & Health Committee

Forecast Outturn Variance (Previous) £000	Directorate	Budget 2022/23 £000	Actual 2022 £000	Forecast Outturn Variance £000
78	Adults & Safeguarding	189,170	160,671	88
-722	Adults Commissioning (including Local Assistance Scheme)	19,013	15,279	-752
-326	Public Health (excl. Children's Health)	30,860	5,523	-353
-970	**Total Expenditure**	**239,043**	**181,473**	**-1,016**
-0	Grant Funding (including Improved Better Care Fund, Public Health Grant etc.)	-48,149	-40,239	-1
-970	**Total**	**190,894**	**141,235**	**-1,017**

1.3.2 Children and Young People Committee

Forecast Outturn Variance (Previous) £000	Directorate	Budget 2022/23 £000	Actual 2022 £000	Forecast Outturn Variance £000
650	Children's Commissioning	25,008	18,587	1,200
0	Communities & Safety - Central Integrated Youth Support Services	0	0	0
-335	Children & Safeguarding	61,796	47,737	-390
3,375	Education – non DSG	46,585	15,151	3,133
-0	Public Health - Children's Health	9,393	8,043	-1
3,690	**Total Expenditure**	**142,781**	**89,518**	**3,943**
0	Grant Funding (excluding Dedicated Schools Grant etc.)	-23,008	-18,853	1
3,690	**Total Non-DSG**	**119,773**	**70,665**	**3,944**
0	Commissioning – DSG	245	0	0
11,800	Education – DSG (incl. contribution to combined budgets)	102,680	97,995	11,800
11,800	**Total DSG (Ringfenced Grant)**	**102,925**	**97,995**	**11,800**

1.3.3 Cross Cutting People Services Policy Lines

Forecast Variance Outturn (Previous) £000	Directorate	Budget 2022/23 £000	Actual 2022 £000	Forecast Outturn Variance £000
0	Strategic Management – Commissioning	528	846	-76
0	Executive Director	1,026	810	0
0	**Total Expenditure**	**1,553**	**1,656**	**-76**
0	Grant Funding	0	0	0
0	**Total**	**1,553**	**1,656**	**-76**

1.4 Significant Issues – People Services

At the end of January, People Services is forecasting an overspend of £3,204k (1.0%). Significant issues within the Directorate are set out in the paragraphs below. Appendix 1 provides the detailed financial information by service, with Appendix 1a providing a more detailed breakdown of areas funded directly from the Dedicated Schools Grant (DSG) and Appendix 3 providing a narrative from those services with a significant variance against budget.

1.4.1 Adults

The overall position for Adults and Safeguarding and Adults Commissioning is a forecast underspend of £664k at the end of January. However, this masks considerable variances across the different service user groups. We are seeing financial pressures across Learning Disability, Physical Disability and Mental Health, but these are being offset by forecast underspends elsewhere, and particularly in the costs of services for Older People. Following on from the pandemic we are continuing to see demand for residential care for Older People at below pre pandemic levels and it is anticipated that this trend will continue for some time to come.

Care providers are continuing to report cost pressures related to both workforce issues and the current cost of living rises. These are putting pressure on uplift budgets across all care types. The position of the care market, particularly related to workforce issues, is making some placements more difficult to source, particularly at the more complex end of provision.

In line with the social care reform agenda the Council has undertaken "cost of care" exercises with both homecare and care home providers. Whilst the implementation of the reforms has now been delayed until October 2025, the outcomes of the cost of care exercises are a gap for many providers between what is currently paid, and the "cost of care" derived from provider data. Whilst we have some funding from government for 2022/23 and beyond to start to close this gap, this will be far from enough to fund the cost increases indicated by the "cost of care" exercises which are estimated at £23.4m per annum for homecare for all Adults and care homes for Older People. Increased rates in these areas would also likely increase the costs of other care packages not currently included in the remit of the "cost of care" work such as care homes for people aged under 65 and supported living placements.

As part of its 2022/23 Business Plan, the Council committed to providing additional funding to care providers towards all paying the real living wage within three years. Dedicated capacity was resourced to initiate a review of providers in Cambridgeshire to consider if they were paying the real living wage or above to their caring staff. This review has been undertaken alongside the "cost of care" work required under the government's Adult Social Care reform agenda. Of 220 providers surveyed, 38 providers (17.3%) evidenced payment of below the 2021/22 real living wage rate of £9.50 per hour. Work is now underway to plan implementation of the real living wage with these providers.

Hospital Discharge systems continue to be pressured. The medium-term recovery of clients assessed as having primary health needs upon hospital discharge can return individuals to social care funding streams. In addition, the impact of delayed health care treatments such as operations, will also affect individual needs and health inequalities negatively.

Work is ongoing to assess future demand, cost pressures and the financial implications of the government's social care reforms which have now been postponed to October 2025. This work will feed into business planning for 2024/25 and beyond. If demand increases above current expectations within the current financial year, we have provision to offset the costs of this in the Adult's risk reserve which currently stands at £4.7m.

1.4.2 Children's

To address continuing difficulty in recruiting to Social Worker posts, a programme board has been established to focus on recruitment, retention, and development of the workforce offer. The next phase of implementation of the work of the programme board will see the launch of our international recruitment campaign as of February 2023.

Fostering and Supervised Contact continues to forecast an underspend of £200k against Professional and Link Foster Carers primarily as a result of the reduction of the Children in Care (CiC) population accessing this provision. Whilst better utilisation of vacant beds has resulted in a more positive placement mix (54% of Cambridgeshire children with in-house carers versus 46% external), it is considered unlikely that the full 190 placements budgeted for will be utilised within the year.

Integrated Front Door continues to forecast an overspend of £200k within the staffing budget is mainly due to the use of agency staff, allowances given to Emergency Duty Team (EDT) adult workers, as well as additional hours worked by EDT to cover sickness and support with increased demand.

Adoption Allowances - continues to forecast an underspend of £300k, primarily against Special Guardianship Orders, which is a result of savings realised from changes made to allowances following the introduction of a new means testing tool, in line with DfE recommendations.

Safeguarding East continues to forecast an underspend of £185k. This is due to no current no recourse to public funds (NRPF) families within the service area and therefore no expenditure. There is also reduced Section 17 expenditure due to the service utilising charitable support and/or other avenues of support to assist children and families where needed.

Children in Care Placements – The Children in Care placements budget is now forecasting a revised overspend of £1.2m. The biggest impact on the Placement Budget has been three high- cost placements for children with exceptional behaviours and complex needs. These costs have been incurred since August. These children have been subject of multiple placement searches, two of whom moved to reduce cost provisions in November. Costs for one child remain excessive whilst endeavours are being made to find suitable alternative reduced cost provision capable of meeting need.

The placement market is highly competitive with demand outstripping supply, this results in providers cherry picking when matching placements within their residential provision, this coupled with excessive demand means that placement costs are in some cases 30% + higher than pre-pandemic levels.

A number of providers have justified fee uplift requests in response to the high inflation levels currently being experienced, this is in particular in regard to IFA placements where the cost-of-living increases are affecting fostering families. The last few months have seen a decrease in our ability to access in-house provision with a greater number of placements being made in the independent sector.

1.4.3 Education

Outdoor Education - The Outdoor centres are continuing to forecast a pressure of £98k. This is primarily as a result of an underlying staffing pressure at Stibbington exacerbated by bookings remaining low and not recovering as expected following easing of Covid restrictions.

Cambridgeshire Music – The forecast overspend relates to a pressure within the service staffing budgets. Demand for services has lessened through the Autumn Term affected in part by the national economic picture, as a result it has taken longer to build newly appointed staff up to their correct level of work mid-year. In addition, the impact of the agreed pay award added costs beyond the budgeted level.

Redundancy and Teachers Pensions – The redundancy and Teachers pensions budget is forecasting an underspend due to a significant reduction in the number of individuals receiving pension payments. There has also been lower than anticipated activity in redundancies.

SEND Specialist Services – The Education Psychology service continue to report a forecast pressure of £250k. It was hoped that some of this could be offset by under spends in other areas, but this is now not the case. The service is experiencing increasing demand which cannot be met from within the substantive team and is therefore being met through use of locum Education Psychologists. This pressure is due to the significant increase in requests for EHCNA that continued over the summer. The locum spend has helped to get the numbers of advice unallocated or late down significantly (19% submitted on time to around 60%, above national average, on time by October). Without the use of locums this would not have been possible. This feeds into the DfE expectations of Cambridgeshire in terms of meeting deadlines.

0-19 Organisation and Planning – 0–19 Organisation and Planning are now reporting a forecast underspend of £131k. £65k of this is within the Safeguarding team following a review of their offer which resulted in delivering a wider range of courses and increasing their marketing. The remaining £48k being generated by Welfare Benefits.

Transport – All transport budgets have been significantly impacted by the underlying national issue of driver availability which has led to less competition for tendered routes. This has also resulted in numerous contracts being handed back by operators as they are no longer able to fulfil their obligations and alternative, often higher cost, solutions are required. The increase in fuel costs is placing further pressure on providers.

Home to School Transport Special continues to forecast an overspend of £2.13m. Following the retender of 330 routes for Sept 2022, average contract costs have gone up by 18.5% from 2021 reflecting the strong impact of inflation. In addition, there has been an increase in the number of pupils being transported to special schools. The lack of special school places available locally has necessitated longer and less efficient transport routes and has added to the pressure on this budget.

Uncertain market conditions have led to an unprecedented number of contract hand backs across the service. The expected position at the end of the autumn term will be a total of 200 hand backs. There is a lack of providers bidding on contracts for post 16 provision, many courses only require transport for 3 days a week which has made these routes less attractive to the market and has led to an increase in cost. Operators are not able to find the drivers and passenger assistants for these routes, preferring to bid on whole week contracts. There is also a lack of providers in the Cambridge South area, which means that contractors are coming in from Peterborough and Huntingdon to cover these routes at a high cost. The Stagecoach retendering exercise has also contributed to the additional pressure. Whilst all routes were covered this has led to an increased spend of around £543 per day.

Children in Care (CIC) transport continues to forecast a £300k pressure. There has been an increase in transport demand arising from an increasing shortage in local placements, requiring children to be transported further. In addition, transport requests for CIC pupils as part of their care package have increased due to carers feeling unable to meet the increased fuel costs.

Home to School mainstream continues to forecast a £715k pressure. As with all the transport budgets, driver shortages and inflation have increased contract costs. In addition, several areas in the county have a lack of local places meaning that pupils must be transported further at higher cost.

There are the same issues with transport provision as stated for SEN budget. In addition, the lack of bus operator and drivers has resulted in one school needing to be covered with 5 taxis, as a 53-seater bus could not be procured, despite multiple tenders and market testing.

The lack of places continues to generate extra taxis provision. This has been higher in the Cambridge South area, where refugee guests are taking up places that had already been forecasted for, resulting in pupils being transported further afield.

Dedicated Schools Grant (DSG) –Appendix 1a provides a detailed breakdown of all DSG spend within People Services. The budget figures are net of recoupment for academies and High Needs place funding.

Due to the continuing increase in the number of children and young people with an EHCP, and the complexity of need of these young people, the overall spend on the High Needs Block element of the DSG funded budgets has continued to rise. At the end of 2021/22 there was a net DSG overspend of £12.43m to the end of the year. When added to the existing DSG deficit of £26.83m and following prior-year adjustments in relation to early years a revised cumulative deficit of £39.32m was brought forward into 2022/23.

In 2020-21 the DfE introduced the safety valve intervention programme in recognition of the increasing pressures on high needs. A total of 14 local authorities have now signed up to agreements, and the programme is being expanded to a further 20 local authorities, including Cambridgeshire in 2022-23.

The programme requires local authorities to develop substantial plans for reform to their high needs systems, with support and challenge from the DfE, to rapidly place them on a sustainable footing. If the authorities can demonstrate sufficiently that their DSG management plans create lasting sustainability and are effective for children and young people, including reaching an in-year balance as quickly as possible, then the DfE will enter into an agreement with the authority, subject to Ministerial approval.

If an agreement is reached, local authorities are held to account for the delivery of their plans and hitting the milestones in the plans via quarterly reporting to the DfE. If adequate progress is being made, authorities will receive incremental funding to eliminate their historic deficits, generally spread over five financial years. If the conditions of the agreement are not being met, payments will be withheld.

1.5 Significant Issues – Public Health

The Public Health Directorate is funded wholly by ringfenced grants, mainly the Public Health Grant. The work of the Directorate was severely impacted by the pandemic, as capacity was re-directed to outbreak management, testing, and infection control work. The Directorate is now focussed on returning business as usual public health activity to full capacity as soon as possible and addressing issues arising from the pandemic which have impacted on the health of the County's population.

At the end of January, the Public Health Directorate is forecasting an underspend of £353k (0.9%). There are continuing risks to this position:

i) much of the Directorate's spend is contracts with, or payments to, the NHS for specific work. The NHS re-focus on the pandemic response and vaccination reduced activity-driven costs to the PH budget throughout 2020/21 and 2021/22. The NHS continues to be under pressure, and it may take some time for activity levels to return to pre pandemic levels.

ii) the unprecedented demand for Public Health staff across the country has meant recruitment has been very difficult through the pandemic resulting in underspends on staffing budgets. This position continued into the early part of 2022/23, although a number of appointments have now been successfully made; and

iii) recruitment challenges are reflected in our provider services which has affected their ability to deliver consistently.

Detailed financial information for Public Health is contained in Appendix 2, with Appendix 3 providing a narrative from those services with a significant variance against budget.

2.   Capital Executive Summary

2022/23 In Year Pressures/Slippage

At the end of January 2023, the capital programme forecast underspend is £13,015k. The level of slippage and underspend in 2022/23 has exceeded the revised Capital Variation Budget of £9,114k. The Capital Variation Budget has been recalculated following the CLT restructure, reflecting the movement of schemes to Strategy & Partnerships as outlined below.

Details of the currently forecasted capital variances can be found in Appendix 4.

3.   Savings Tracker Summary

The savings trackers are produced quarterly to monitor delivery of savings against agreed plans. The third savings trackers of 2022/23 for People Services and Public Health are shown in Appendix 5.

4.   Technical note

On a biannual basis, a technical financial appendix is included as Appendix 6. This appendix covers:

- Grants that have been received by the service, and where these have been more or less than expected

- Budget movements (virements) into or out of People Services from other services (but not within People Services), to show why the budget might be different from that agreed by Full Council

- Service reserves – funds held for specific purposes that may be drawn down in-year or carried-forward – including use of funds and forecast draw-down.

5. Key Activity Data

The Actual Weekly Costs for all clients shown in section 5.1.1 - 5.2.6 are calculated based on all clients who have received a service, are receiving a service, or we plan will receive a service. Some clients will have ceased receiving a service in previous months, or during this month, or we will have assumed an end date in the future.

5.1 Children and Young People

5.1.1 Key activity data at the end of January 2023 for Children in Care Placements is shown below:

Service Type	BUDGET				ACTUAL (January 2023)				FORECAST		
	No of placements Budgeted	Annual Budget	No. of weeks funded	Average weekly cost per head	Snapshot of No. of placements January 2023	Yearly Average	Forecast Outturn	Average weekly cost per head	Yearly Average budgeted no. of placements	Net Variance to Budget	Average weekly cost diff +/-
Residential - disability	11	£1,669k	52	2,918.30	4	4.00	£751k	3,276.58	-7.00	-£918k	358.28
Residential - secure accommodation	1	£548k	52	10,528.85	2	1.49	£659k	8,537.50	0.49	£112k	-1,991.35
Residential schools	7	£538k	52	1,477.65	6	6.01	£488k	1,632.20	-0.99	-£50k	154.55
Residential homes	40	£8,738k	52	4,200.81	51	46.38	£10,396k	5,360.25	6.38	£1,658k	1,159.44
Independent Fostering	198	£9,153k	52	888.96	174	177.24	£8,095k	901.11	-20.76	-£1,058k	12.15
Tier 4 Step down	2	£465k	52	4,472.26	2	1.02	£142k	4,318.34	-0.98	-£323k	-153.92
Supported Accommodation	13	£1,549k	52	2,291.91	19	17.73	£2,979k	6,301.54	4.73	£1,430k	4,009.63
16+	3	£50k	52	321.01	5	3.49	£70k	309.63	0.49	£20k	-11.38
Supported Living	3	£412k	52	2,640.93	2	2.74	£597k	3,587.80	-0.26	£185k	946.87
Growth/Replacement	0	£k	0	0.00	0	0.00	£143k	0.00	-	£143k	0.00
Additional one off budget/actuals	0	£k	0	0.00	0	0.00	£k	0.00	-	£k	0.00
Mitigations required	0	£k	0	0.00	0	0.00	£k	0.00	-	£k	0.00
TOTAL	278	£23,122k			265	260.10	£24,322k		-17.90	£1,200k	
In-house Fostering	190	£4,046k	56	393.41	166	160.31	£3,765k	450.45	-29.69	-£280k	57.04
In-house fostering - Reg 24	27	£268k	56	177.13	20	33.65	£333k	189.68	6.65	£64k	12.55
Family & Friends Foster Carers	20	£311k	52	283.05	18	17.88	£340k	364.24	-2.12	£29k	81.19
Supported Lodgings	5	£38k	52	145.42	1	1.74	£11k	124.38	-3.26	-£27k	-21.04
TOTAL	242	£4,663k			205	213.58	£4,449k		-28.42	-£214k	
Adoption Allowances	95	£1,091k	52	220.22	76	78.86	£1,013k	246.37	-16.14	-£78k	26.15
Special Guardianship Orders	313	£2,421k	52	148.35	278	279.54	£2,180k	149.60	-33.46	-£241k	1.25
Child Arrangement Orders	51	£414k	52	155.52	48	47.85	£389k	155.72	-3.15	-£25k	0.20
Concurrent Adoption	2	£22k	52	210.00	0	0.00	£k	0.00	-2.00	-£22k	-210.00
TOTAL	461	£3,947k			402	406.25	£3,582k		-54.75	-£365k	
OVERALL TOTAL	981	£31,732k			872	879.93	£32,352k		-101.07	£621k	

NOTES:

In house Fostering payments fund 56 weeks as carers receive two additional weeks payment during the summer holidays and one additional

week each for Christmas and birthday.

5.1.2 Key activity data at the end of January 2023 for SEN Placements is shown below:

The following key activity data for SEND covers 5 of the main provision types for pupils with EHCPs.

Budgeted data is based on actual data at the close of 2021/22 and an increase in pupil numbers over the course of the year.

Actual data are based on a snapshot of provision taken at the end of the month and reflect current numbers of pupils and average cost.

Provision Type	BUDGET				ACTUAL (January 2023)					FORECAST	
	No. pupils	Expected in-year growth	Average annual cost per pupil (£)	Budget (£000) (excluding academy recoupment)	No. Pupils as at January 2023 Actual	Variance	% growth used	Average annual cost per 1 FTE pupils as at January 2023 Actual (£)	Variance (£)	Forecast spend (£)	Variance (£)
Mainstream top up *	2,800	280	7,100	19,859	3,245	445	259%	7,944	844	19,859	0
Special School **	1,610	161	12,000	21,465	1,682	72	145%	11,054	-946	21,465	0
HN Unit **	250	n/a	13,765	4,152	290	40	n/a	14,502	737	4,152	0
SEN Placement (all) ***	281	n/a	53,464	15,012	278	-3	n/a	49,585	-3,879	15,012	0
Out of School Tuition	168	n/a	38,649	5,034	177	9	n/a	32,168	-6,481	5,034	0
Total	5,109	441	-	65,522	5,672	563	228%	-	-	65,522	0

* LA cost only

** Excluding place funding

*** Education contribution only

Provision Type	BUDGET				ACTUAL (January 2023)					FORECAST	
	No. pupils	Expected in-year growth	Average weekly cost per pupil (£)	Budget (£000) (excluding academy recoupment)	No. Pupils as at January 2023 Actual	Variance	% growth used	Average weekly cost per 1 FTE pupils as at January 2023 Actual (£)	Variance (£)	Forecast spend (£)	Variance (£)
Out of School Tuition	168	n/a	991	5,034	177	9	n/a	821	-170	5,034	0
Total	168	0	-	5,034	177	9	n/a	-	-	5,034	0

5.2   Adults

In the following key activity data for Adults & Safeguarding, the information given in each column is as follows:

- Budgeted number of care services: this is the number of full-time equivalent (52 weeks) service users anticipated at budget setting
- Budgeted average unit cost: this is the planned unit cost per service user per week, given the budget available
- Actual care services and cost: these reflect current numbers of service users and average cost; they represent a real time snapshot of service-user information.

A consistent format is used to aid understanding, and where care types are not currently used in a particular service those lines are greyed out.

The direction of travel (DoT) compares the current month's figure with the previous month.

The activity data for a given service will not directly tie back to its outturn reported in Appendix 1. This is because the detailed variance includes other areas of spend, such as care services which have ended and staffing costs, as well as the activity data including some care costs that sit within Commissioning budgets.

5.2.1 Key activity data at the end of January 2023 for Learning Disability Partnership is shown below:

Learning Disability Partnership	BUDGET			ACTUAL (January 2023)				Forecast		
Service Type	Expected No. of Care Packages 2022/23	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	255	£2,128	£28,344k	237	↓	£2,068	↓	£27,067k	↓	-£1,277k
~Nursing	5	£2,698	£716k	9	↑	£4,280	↑	£1,315k	↑	£599k
~Respite	15	£1,029	£718k	17	↑	£661	↓	£792k	↑	£74k
Accommodation based subtotal	**275**	**£2,022**	**£29,779k**	**263**		**£2,010**		**£29,175k**		**-£604k**
Community based										
~Supported Living	517	£1,439	£38,809k	561	↓	£1,424	↑	£39,313k	↓	£505k
~Homecare	348	£403	£7,306k	352	↓	£448	↑	£9,743k	↑	£2,437k
~Direct payments	423	£493	£10,866k	414	↑	£495	↓	£10,968k	↓	£102k
~Live In Care	15	£2,132	£1,692k	2	↔	£898	↔	£781k	↓	-£911k
~Day Care	463	£196	£4,733k	474	↓	£202	↑	£4,855k	↓	£122k
~Other Care	53	£85	£869k	44	↓	£81	↑	£1,524k	↓	£655k
Community based subtotal	**1,819**	**£671**	**£64,273k**	**1,847**		**£684**		**£67,183k**		**£2,910k**
Total for expenditure	**2,094**	**£848**	**£94,052k**	**2,110**		**£849**		**£96,358k**	↓	**£2,306k**
Care Contributions			-£4,311k					-£4,422k	↓	-£111k

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

LDP Activity and Weekly Cost from April 2021
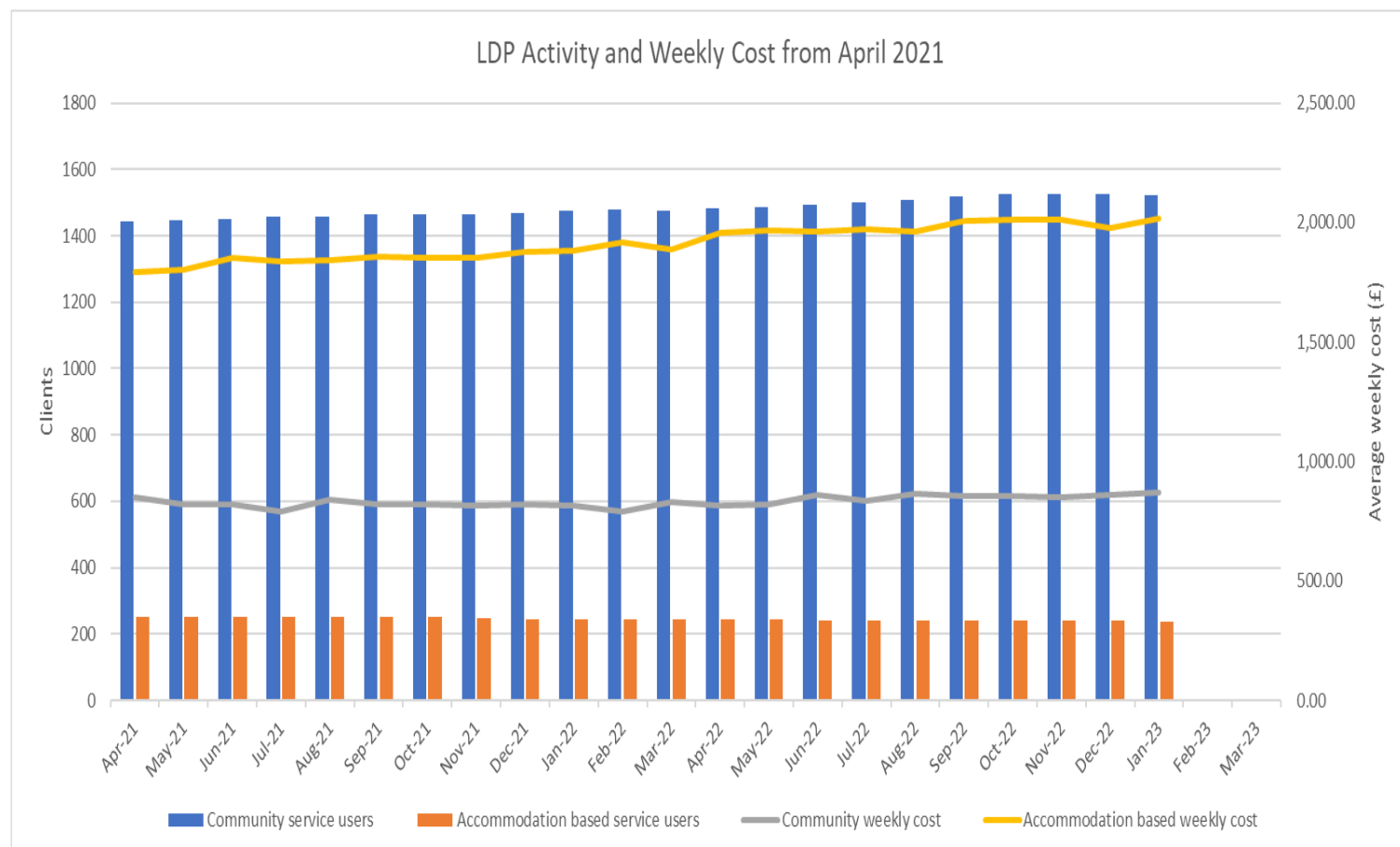
5.2.2 Key activity data at the end of January 2023 for Older People and Physical Disabilities Services for Over 65s is shown below:

Older People and Physical Disability Over 65	BUDGET			ACTUAL (January 2023)				Forecast		
Service Type	Expected No. of Care Packages 2022/23	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	422	£690	£15,190k	364 ↓		£710 ↓		£14,695k ↓		-£495k
~Residential Dementia	451	£783	£18,416k	417 ↑		£713 ↑		£16,901k ↑		-£1,515k
~Nursing	336	£869	£14,783k	260 ↓		£826 ↑		£13,788k ↑		-£995k
~Nursing Dementia	181	£1,033	£9,941k	163 ↓		£904 ↑		£9,459k ↓		-£482k
~Respite			£750k	48		£182		£739k ↓		-£12k
Accommodation based subtotal	**1,390**	**£808**	**£59,080k**	**1,252**		**£733**		**£55,581k**		**-£3,499k**
Community based										
~Supported Living	434	£271	£6,128k	423 ↓		£156 ↑		£6,326k ↑		£198k
~Homecare	1,506	£292	£22,488k	1,432 ↓		£280 ↓		£23,363k ↓		£876k
~Direct payments	202	£328	£3,455k	156 ↓		£413 ↑		£3,396k ↓		-£58k
~Live In Care	42	£876	£1,919k	35 ↓		£964 ↑		£2,101k ↑		£182k
~Day Care	78	£166	£673k	57 ↓		£71 ↓		£572k ↓		-£101k
~Other Care			£558k	6 ↔		£30		£261k ↑		-£297k
Community based subtotal	**2,262**	**£298**	**£35,221k**	**2,109**		**£270**		**£36,021k**		**£800k**
Total for expenditure	**3,652**	**£492**	**£94,301k**	**3,361**		**£442**		**£91,602k ↓**		**-£2,699k**
Care Contributions			-£26,349k					-£26,892k		-£542k

OP Activity and Weekly Cost for Care Homes
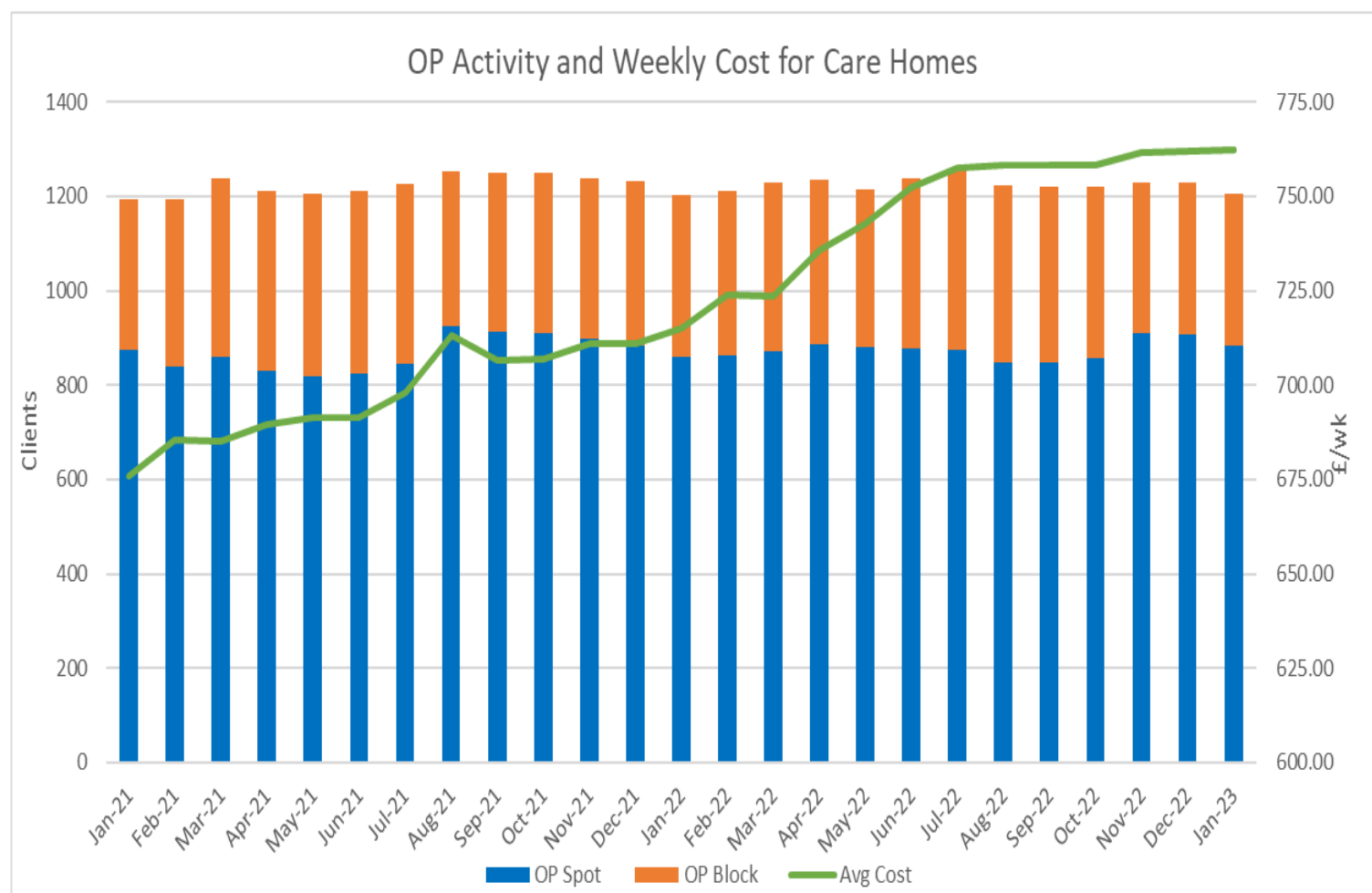
5.2.3 Key activity data at the end of January 2023 for Physical Disabilities Services for Under 65s is shown below:

Physical Disabilities Under 65s	BUDGET			ACTUAL (January 2023)				Forecast		
Service Type	Expected No. of Care Packages 2022/23	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	20	£1,161	£1,211k	26	↑	£1,139	↓	£1,307k	↓	£96k
~Residential Dementia	3	£723	£113k	5	↑	£768	↑	£170k	↑	£56k
~Nursing	22	£1,073	£1,231k	21	↓	£1,219	↑	£1,385k	↑	£155k
~Nursing Dementia	0	£0	£k	1	↔	£840	↔	£45k	↑	£45k
~Respite	0	£0	£k	9		£123		£38k	↓	£38k
Accommodation based subtotal	**45**	**£1,089**	**£2,555k**	**62**		**£966**		**£2,946k**		**£391k**
Community based										
~Supported Living	8	£822	£343k	25	↓	£402	↓	£327k	↑	-£16k
~Homecare	206	£265	£2,846k	311	↓	£271	↑	£3,472k	↑	£626k
~Direct payments	169	£341	£3,483k	196	↓	£426	↑	£3,610k	↑	£128k
~Live In Care	27	£853	£1,201k	28	↓	£940	↑	£1,301k	↓	£100k
~Day Care	18	£95	£89k	20	↔	£106	↓	£90k	↓	£1k
~Other Care			£247k	6	↔	£61	↔	£10k	↓	-£237k
Community based subtotal	**428**	**£335**	**£8,209k**	**586**		**£353**		**£8,810k**		**£601k**
Total for expenditure	**473**	**£407**	**£10,763k**	**648**		**£411**		**£11,756k**	↑	**£993k**
Care Contributions			-£1,434k					-£1,155k		£279k

5.2.4 Key activity data at the end of January 2023 for Older People Mental Health (OPMH) Services:

Older People Mental Health	BUDGET			ACTUAL (January 2023)				Forecast		
Service Type	Expected No. of Care Packages 2022/23	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	37	£746	£1,212k	34	↓	£712	↓	£1,056k	↓	-£156k
~Residential Dementia	37	£718	£1,109k	38	↔	£786	↑	£1,303k	↑	£194k
~Nursing	29	£799	£1,013k	28	↓	£793	↓	£1,041k	↓	£28k
~Nursing Dementia	71	£960	£3,088k	77	↑	£888	↑	£3,206k	↑	£119k
~Respite	3	£66	£k	2	↓	£703	↑	£148k	↑	£148k
Accommodation based subtotal	**177**	**£822**	**£6,422k**	**179**		**£808**		**£6,755k**		**£333k**
Community based										
~Supported Living	12	£190	£110k	9	↓	£225	↑	£43k	↓	-£67k
~Homecare	95	£267	£1,160k	62	↓	£338	↑	£1,094k	↑	-£66k
~Direct payments	7	£500	£193k	6	↔	£559	↔	£171k	↑	-£21k
~Live In Care	11	£1,140	£660k	13	↔	£1,130	↑	£772k	↑	£112k
~Day Care	5	£316	£1k	4	↔	£40	↔	£24k	↑	£22k
~Other Care	7	£189	£17k	4	↔	£51	↔	-£3k	↓	-£19k
Community based subtotal	**137**	**£340**	**£2,140k**	**98**		**£423**		**£2,101k**		**-£39k**
Total for expenditure	**314**	**£612**	**£8,562k**	**277**		**£672**		**£8,856k**	↑	**£294k**
Care Contributions			-£1,270k					-£1,221k	↓	£50k

5.2.5 Key activity data at the end of January 2023 for Adult Mental Health Services is shown below:

Adult Mental Health	BUDGET			ACTUAL (January 2023)				Forecast		
Service Type	Expected No. of Care Packages 2022/23	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	60	£812	£2,388k	62	↔	£812	↓	£2,708k	↑	£320k
~Residential Dementia	3	£787	£118k	2	↔	£786	↔	£84k	↑	-£33k
~Nursing	9	£791	£388k	8	↑	£760	↓	£247k	↓	-£141k
~Nursing Dementia	1	£929	£51k	1	↔	£882	↔	£36k	↓	-£15k
~Respite	1	£20	£k	1	↔	£20	↔	£43k	↑	£43k
Accommodation based subtotal	**74**	**£799**	**£2,944k**	**74**		**£796**		**£3,119k**		**£175k**
Community based										
~Supported Living	123	£300	£2,869k	120	↓	£397	↓	£3,400k	↓	£531k
~Homecare	149	£89	£1,257k	142	↔	£111	↑	£1,257k	↓	£k
~Direct payments	14	£271	£206k	14	↔	£312	↔	£210k	↑	£4k
~Live In Care	2	£1,171	£123k	2	↔	£1,210	↔	£129k	↓	£7k
~Day Care	4	£69	£18k	5	↑	£70	↓	£20k	↑	£2k
~Other Care	5	£975	£3k	4	↑	£14	↓	£27k	↑	£25k
Community based subtotal	**297**	**£207**	**£4,476k**	**287**		**£246**		**£5,044k**		**£568k**
Total for expenditure	**371**	**£325**	**£7,420k**	**361**		**£359**		**£8,163k** ↓		**£743k**
Care Contributions			-£367k					-£300k		£67k

5.2.6 Key activity data at the end of January 2023 for Autism is shown below:

Autism	BUDGET			ACTUAL (January 2023)				Forecast		
Service Type	Expected No. of Care Packages 2022/23	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		£808	£46k	2	↔	£2,159	↔	£272k	↔	£226k
~Residential Dementia										
Accommodation based subtotal		**£808**	**£46k**	**2**		**2,159**		**£272k**		**£226k**
Community based										
~Supported Living	21	£1,092	£1,181k	22	↔	£726	↑	£928k	↑	-£253k
~Homecare	17	£161	£142k	18	↔	£232	↓	£190k	↓	£48k
~Direct payments	22	£377	£424k	25	↓	£353	↑	£452k	↑	£29k
~Live In Care		£405	£21k	0	↔	£0	↔	£18k	↔	-£3k
~Day Care	18	£77	£72k	17	↓	£91	↑	£77k	↓	£5k
~Other Care		£79	£12k	6	↑	£126	↑	£19k	↑	£7k
Community based subtotal	**82**	**£439**	**£1,852k**	**88**		**£355**		**£1,685k**		**-£168k**
Total for expenditure	**83**	**£443**	**£1,898k**	**90**		**£395**		**£1,956k** ↑		**£58k**
Care Contributions			-£71k					**-£89k**		**-£18k**

Due to small numbers of service users some lines in the above have been redacted.

Appendix 1 – People Services Level Financial Information

Forecast Outturn Variance (Previous) £'000	Ref	Service	Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
		Adults & Safeguarding Directorate				
-455	1	Strategic Management - Adults	-7,113	-10,667	-134	-2%
0		Transfers of Care	2,197	2,167	0	0%
0		Prevention & Early Intervention	10,582	9,880	-35	0%
-0		Principal Social Worker, Practice and Safeguarding	1,694	1,654	-0	0%
31		Autism and Adult Support	2,325	2,033	33	1%
-0		Adults Finance Operations	1,932	1,552	-6	0%
		Learning Disabilities				
-436	2	Head of Service	6,677	4,338	-436	-7%
360	2	LD - City, South and East Localities	41,698	35,979	360	1%
747	2	LD - Hunts & Fenland Localities	38,289	32,736	747	2%
1,257	2	LD - Young Adults Team	11,956	11,196	1,257	11%
-12	2	In House Provider Services	7,996	6,817	122	2%
-445	2	NHS Contribution to Pooled Budget	-24,756	-18,622	-476	-2%
1,471		**Learning Disabilities Total**	**81,860**	**72,444**	**1,573**	**2%**
		Older People and Physical Disability Services				
0		Management and Staffing	5,212	4,529	0	0%
-1,290	3	Older Peoples Services - North	29,427	24,337	-1,241	-4%
-2,227	3	Older Peoples Services - South	35,708	28,904	-2,374	-7%
542	3	Physical Disabilities - North	4,206	4,183	610	14%
975	3	Physical Disabilities - South	4,692	4,770	705	15%
-2,000		**Older People and Physical Disability Total**	**79,246**	**66,723**	**-2,300**	**-3%**
		Mental Health				
-154	4	Mental Health Central	3,647	3,091	-148	-4%
825	4	Adult Mental Health Localities	5,527	5,230	799	14%
360	4	Older People Mental Health	7,273	6,564	305	4%
1,031		**Mental Health Total**	**16,447**	**14,885**	**956**	**6%**
78		**Adults & Safeguarding Directorate Total**	**189,170**	**160,671**	**88**	**0%**
		Commissioning Directorate				
0		Strategic Management –Commissioning	528	846	-76	-14%
0		Local Assistance Scheme	300	295	0	0%
		Adults Commissioning				
-670	5	Central Commissioning - Adults	14,724	14,009	-681	-5%
-125	6	Integrated Community Equipment Service	1,779	-966	-150	-8%
73		Mental Health Commissioning	2,210	1,940	79	4%
-722		**Adults Commissioning Total**	**18,713**	**14,984**	**-752**	**-4%**
		Children's Commissioning				
650	7	Children in Care Placements	23,122	17,360	1,200	5%
-0		Commissioning Services	2,131	1,228	0	0%
650		**Children's Commissioning Total**	**25,253**	**18,587**	**1,200**	**5%**
-72		**Commissioning Directorate Total**	**44,793**	**34,712**	**372**	**1%**

Forecast Outturn Variance (Previous) £'000	Ref	Service	Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
		Children & Safeguarding Directorate				
0		Strategic Management - Children & Safeguarding	2,705	2,568	0	0%
0		Safeguarding and Quality Assurance	3,466	2,460	0	0%
-200	8	Fostering and Supervised Contact Services	9,751	8,099	-200	-2%
0		Corporate Parenting	7,486	7,016	0	0%
200	9	Integrated Front Door	4,464	4,120	200	4%
150		Children´s Disability Service	7,675	6,358	95	1%
0		Support to Parents	1,758	797	0	0%
-300	10	Adoption	5,646	4,252	-300	-5%
0		Legal Proceedings	2,050	1,571	0	0%
0		Youth Offending Service	2,249	1,735	0	0%
		District Delivery Service				
-0		Children´s Centres Strategy	-238	-327	0	0%
0		Safeguarding West	1,131	884	0	0%
-185	11	Safeguarding East	4,509	1,474	-185	-4%
-0		Early Help District Delivery Service –North	4,122	2,948	0	0%
0		Early Help District Delivery Service – South	5,023	3,783	0	0%
-185		**District Delivery Service Total**	**14,546**	**8,762**	**-185**	**-1%**
-335		**Children & Safeguarding Directorate Total**	**61,796**	**47,737**	**-390**	**-1%**
		Education Directorate				
-16		Strategic Management - Education	4,280	5,724	-16	0%
-15		Early Years' Service	5,135	4,523	-15	0%
-25		School Improvement Service	1,084	728	-29	-3%
-15		Virtual School	1,859	1,245	-15	-1%
98		Outdoor Education (includes Grafham Water)	19	-230	98	523%
0	12	Cambridgeshire Music	0	427	94	-%
-1		ICT Service (Education)	-200	-722	-1	0%
0	13	Redundancy & Teachers Pensions	3,717	3,437	-254	-7%
		SEND Specialist Services (0-25 years)				
250	14	SEND Specialist Services	12,083	9,488	251	2%
0		Funding for Special Schools and Units	38,152	33,317	0	0%
-0		High Needs Top Up Funding	32,367	29,944	0	0%
0		Special Educational Needs Placements	15,846	15,099	0	0%
-0		Out of School Tuition	5,034	3,254	0	0%
0		Alternative Provision and Inclusion	7,343	6,846	0	0%
11,800	15	SEND Financing – DSG	-9,752	682	11,800	121%
12,050		**SEND Specialist Services (0-25 years) Total**	**101,072**	**98,629**	**12,051**	**12%**
		0-19 Place Planning & Organisation Service				
-38	16	0-19 Organisation & Planning	2,992	2,564	-131	-4%
-4		Education Capital	185	-23,786	9	5%
2,130	17	Home to School Transport – Special	17,745	12,517	2,130	12%
300	18	Children in Care Transport	1,630	1,348	300	18%
711	19	Home to School Transport – Mainstream	9,749	6,741	711	7%
3,099		**0-19 Place Planning & Organisation Service Total**	**32,300**	**-615**	**3,020**	**9%**
15,175		**Education Directorate Total**	**149,265**	**113,146**	**14,933**	**10%**

Forecast Outturn Variance (Previous) £'000	Ref	Service	Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
		Executive Director				
-0		Executive Director	1,025	810	0	0%
-0		Lost Sales, Fees & Charges Compensation	0	0	0	0%
0		Central Financing	1	0	0	0%
-0		**Executive Director Total**	**1,026**	**810**	**0**	**0%**
14,846		**Total**	**446,050**	**357,076**	**15,004**	**3%**
		Grant Funding				
-11,800	20	Financing DSG	-103,136	-97,995	-11,800	-11%
0		Non Baselined Grants	-30,905	-29,632	0	0%
-11,800		**Grant Funding Total**	**-134,041**	**-127,627**	**-11,800**	**9%**
3,046		**Net Total**	**312,009**	**229,449**	**3,204**	**1%**

Appendix 1a – Dedicated Schools Grant (DSG) Summary FMR

Forecast Outturn Variance (Previous) £'000	Ref	Service	Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
		Commissioning Directorate				
		Children's Commissioning				
0		Commissioning Services	245	0	0	0%
0		**Children's Commissioning Total**	**245**	**0**	**0**	**0%**
0		**Commissioning Directorate Total**	**245**	**0**	**0**	**0%**
		Children & Safeguarding Directorate				
		District Delivery Service				
0		Early Help District Delivery Service –North	0	0	0	0%
0		Early Help District Delivery Service – South	0	0	0	0%
0		**District Delivery Service Total**	**0**	**0**	**0**	**0%**
0		**Children & Safeguarding Directorate Total**	**0**	**0**	**0**	**0%**
		Education Directorate				
0	-	Early Years' Service	2,287	1,817	0	0%
0		Virtual School	150	73	0	0%
0		Redundancy & Teachers Pensions	0	0	0	0%
		SEND Specialist Services (0-25 years)				
0		SEND Specialist Services	7,703	5,332	0	0%
0		Funding for Special Schools and Units	38,152	33,317	0	0%
0		High Needs Top Up Funding	32,367	29,087	0	0%
0		Special Educational Needs Placements	15,846	15,099	0	0%
0		Out of School Tuition	5,034	3,254	0	0%
0		Alternative Provision and Inclusion	7,262	6,232	0	0%
11,800	15	SEND Financing – DSG	-9,752	650	11,800	121%
11,800		**SEND Specialist Services (0 - 25 years) Total**	**96,611**	**92,970**	**11,800**	**12%**
		0-19 Place Planning & Organisation Service				
0		0-19 Organisation & Planning	2,232	2,135	0	0%
0		Home to School Transport – Special	400	0	0	0%
0		**0-19 Place Planning & Organisation Service Total**	**2,632**	**2,135**	**0**	**0%**
11,800		**Education Directorate Total**	**101,680**	**96,995**	**11,800**	**12%**
11,800		**Total**	**101,925**	**96,995**	**11,800**	**12%**
0		**Contribution to Combined Budgets**	**1,000**	**1,000**	**0**	**0%**
		Schools				
0		Primary and Secondary Schools	126,513	105,393	0	0%
0		Nursery Schools and PVI	36,502	30,407	0	0%
0		Schools Financing	-265,940	-221,896	0	0%
0		Pools and Contingencies	0	-42	0	0%
0		**Schools Total**	**-102,925**	**-86,138**	**0**	**0%**
11,800		**Overall Net Total**	**0**	**11,857**	**11,800**	**-%**

Appendix 2 – Public Health Service Level Financial Information

Forecast Outturn Variance (Previous) £'000	Ref	Service	Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
		Children Health				
-0		Children 0-5 PH Programme	7,271	7,104	-0	0%
-0		Children 5-19 PH Programme - Non Prescribed	1,781	599	-0	0%
0		Children Mental Health	341	340	-1	0%
-0		**Children Health Total**	**9,393**	**8,043**	**-1**	**0%**
		Drugs & Alcohol				
-10		Drug & Alcohol Misuse	6,692	3,274	3	0%
-10		**Drug & Alcohol Misuse Total**	**6,692**	**3,274**	**3**	**0%**
		Sexual Health & Contraception				
-0		SH STI testing & treatment - Prescribed	3,713	2,117	-0	0%
-5		SH Contraception - Prescribed	1,096	754	89	8%
-2		SH Services Advice Prevention/Promotion - Non-Prescribed	484	214	-2	0%
-7		**Sexual Health & Contraception Total**	**5,293**	**3,085**	**87**	**2%**
		Behaviour Change / Preventing Long Term Conditions				
-5		Integrated Lifestyle Services	2,858	1,440	-60	-2%
-23		Other Health Improvement	909	534	81	9%
0		Smoking Cessation GP & Pharmacy	736	113	0	0%
-0		NHS Health Checks Programme - Prescribed	1,112	249	-75	-7%
-28		**Behaviour Change / Preventing Long Term Conditions Total**	**5,615**	**2,337**	**-54**	**-1.0%**
		Falls Prevention				
-4		Falls Prevention	433	51	-7	-2%
-4		**Falls Prevention Total**	**433**	**51**	**-7**	**-2%**
		General Prevention Activities				
4		General Prevention, Traveller Health	11	-17	4	33%
4		**General Prevention Activities Total**	**11**	**-17**	**4**	**33%**
		Adult Mental Health & Community Safety				
-2		Adult Mental Health & Community Safety	250	-149	-2	-1%
-2		**Adult Mental Health & Community Safety Total**	**250**	**-149**	**-2**	**-1%**
		Public Health Directorate				
0		Public Health Strategic Management	1,932	0	0	0%
-279	21	Public Health Directorate Staffing & Running Costs	2,782	-4,678	-259	-9%
0	22	Health in All Policies	125	0	-125	-100%
-0		Enduring Transmission Grant	1,815	238	-0	0%
0		Contain Outbreak Management Fund	5,911	1,383	0	0%
0		Lateral Flow Testing Grant	0	-0	0	0%
-279		**Public Health Directorate Total**	**12,566**	**-3,058**	**-384**	**-3%**
-326		**Total Expenditure before Carry-forward**	**40,253**	**13,566**	**-353**	**-1%**

Forecast Outturn Variance (Previous) £'000	Ref	Service	Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
		Funding				
0		Public Health Grant	-27,301	-20,746	0	0%
0		Enduring Transmission Grant	-1,815	-1,815	0	0%
0		Contain Outbreak Management Fund	-5,911	-5,911	0	0%
0		Other Grants	-1,382	-987	0	0%
0		Drawdown from reserves	-3,843	0	0	0%
0		**Grant Funding Total**	**-40,253**	**-29,460**	**0**	**0%**
-326		**Overall Net Total**	**0**	**-15,894**	**-353**	**0%**

Appendix 3 – Service Commentaries on Outturn Position

Narrative is given below where there is an adverse/positive variance greater than 2% of annual budget or £100,000 whichever is greater for a service area.

1) Strategic Management – Adults

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
-7,113	-10,667	-134	-2%

Strategic Management – Adults is forecasting an underspend of £134k. The key forecast variances contributing to this balance are:

i)   The 2022-23 Business Plan assumed an increased contribution of £1.1m from the NHS to the Learning Disability Pooled budget as a result of joint work being undertaken to reassess the cost sharing agreement between the Council and Health. The review of packages required to agree a revised split of costs for the pool has not yet commenced, and there is a risk that the revised contribution will not be agreed in the current financial year creating a budgetary pressure.

ii)   Adult's transport is expected to be overspent by £140k in the current financial year as a result of inflationary pressures on transport costs;

iii)   Offsetting these pressures, income is expected to exceed target by £413k. This is principally due to the Better Care Fund contribution from Health increasing from 2021/22 to 2022/23 at a higher % rate than anticipated in the Business Plan. This funding increase is held centrally to contribute to demand pressures across Adult Social Care;

iv)   There is a forecast underspend of £490k on the Council's Learning Disability budget held outside of the Learning Disability Partnership which is partially offsetting the forecast overspend reported in note 2 below;

v)   Underspends arising from vacant posts are exceeding budgeted levels by £200k due to difficulties in recruiting in some areas; and

vi)   An element of the Social Care grant is held centrally within Strategic Management – Adults to fund services delivered within the Directorate. The levels of vacant posts within services mean that not all of this grant money will be applied as originally intended. The grant monies will instead be used to offset pressures across the Adults and Safeguarding Directorate.

2) Learning Disability Services

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
81,860	72,444	1,573	2%

The Learning Disability Partnership (LDP) budget is forecasting an overspend of £2,050k at the end of December, of which the Council's share per the pooled budget arrangement with the NHS is £1,573k. This is the same position as was forecast in November.

The overspend is largely due to demand on the budget for externally commissioned care placements. At the beginning of the year, it was proving incredibly challenging to find placements in the external provider market for service users transitioning from children's services, and for existing service users who needed placement moves. Over the last couple of months, we have seen more placements being made and the number of service users supported by the Young Adults team has exceeded the number of transitions anticipated from children's services. There are also new service users entering the locality teams directly. It remains incredibly challenging to source care placements and prices charged by the market have increased and continue to increase. This is in part due to providers struggling with staffing shortages, high agency costs and a high level of general inflation. Young people are also transitioning to adult services with more complex needs, so there are fewer suitable placements available and those that are available are higher cost in order to meet service user needs. The locality area budgets are seeing similar challenges when service users' needs increase, and they need new placements.

There is also a substantial risk around provider uplifts as the Council is still in negotiations with some providers over the level of inflationary uplift, they will be awarded in 2022-23. The budget for uplifts was set before the current inflationary pressures were known, so most providers are making uplift requests over and above the budgeted amount as they are facing cost pressures themselves, particularly around staffing.

The budget for service user transport is facing particular pressures with a forecast overspend of ~£600k. Driver shortages and fuel price inflation have increased transport costs, with fewer suppliers willing to cover routes. The transport retender has stabilised costs for the set routes, although the cost for these routes is in excess of the budget set for them, but there remains uncertainty around the cost of individual and ad hoc transport commissioned for service users.

The in-house provider services have an overspend due to absence levels requiring relief worker cover. Absence levels are higher than expected and require cover to enable the service to remain operational.

The LDP are working on strategies to control escalating demand and placement costs in the medium to long term, but there are limited short term solutions. A Transitions Panel has been set up to better plan young people's transitions from children's to adults' services with the aim that transitions planning will happen from a younger age and adults' services will have more time to plan care and source placements. However, currently most of the panel's work is focussed on young people approaching their 18th birthday.

Adults Commissioning are developing an LD Accommodation Strategy that will enable them to work with the provider market to develop the provision needed for our service users, both now and looking to future needs. This should lead to more choice when placing service users with complex needs and consequently reduce costs in this area, but this is a long-term programme. The LDP social work teams and Adults Commissioning are also working on strategies to increase the uptake of direct payments, to deliver more choice for service users and decrease reliance on the existing care market.

3) Older People and Physical Disability Services

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
74,033	62,194	-2,300	-3%

Older People's and Physical Disabilities Services have undergone a service redesign for the start of 2022-23 to realign the Long-Term care teams into single locality-based community care teams and a specialist care home team. As part of this redesign, a cohort of over-65 clients previously allocated to the Physical Disabilities care budget have been realigned to the Older People's care budget, which means that the Physical Disabilities care budgets relate to working-age adults only.

The service as a whole is forecasting a net underspend of -£2.3m. Demand patterns that emerged during 2021/22 are continuing into 2022/23, and these are reflected in the individual forecasts for the service.

Ongoing analysis will be carried out to review in detail activity information and other cost drivers to validate this forecast position. This remains subject to variation as circumstances change and more data comes through the system.

Older People's North & South

It was reported throughout 2021/22 that despite high levels of activity coming into service, driven largely by Hospital Discharge systems, net demand for bed-based care remained significantly below budgeted expectations, and there was no overall growth in the number of care home placements over the course of the year. This trend is continuing into 2022/23 and a high proportion of new placements are being made within the Council's existing block bed capacity, which is resulting in a significant underspend. This is being partially offset by a significant increase in demand for domiciliary care with the month-on-month increase in service users exceeding budgeted expectations. We are reporting a net underspend of -£3.615m.

Physical Disabilities North & South

There has been a significant increase in demand for community-based care above budgeted expectations. The increase in demand largely relates to home care, both in terms of numbers of clients in receipt of care and increasing need (i.e. average hours of care) across all clients. During 2021/22, this impact was offset by a reduction in demand in the over-65 cohort that have been realigned to the Older Peoples budget. This, in conjunction with a reduction in income due from clients contributing towards the cost of their care, is resulting in the reported forecast overspend of £1.315m.

4) Mental Health

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
16,447	14,885	956	6%

Mental Health Services are forecasting an overspend of £956k, reflecting significant additional demand pressures, primarily within the Adult Mental Health service. This is partially offset by an expected underspend against the Section 75 Contract.

Adult Mental Health services are continuing to see significant additional demand within community-based care, particularly there has been a notable increase in the volume of new complex supported living placements made since the start of the year.

Older People's Mental Health services had previously seen a reduction in demand for community-based support. This is now returning to match budgeted expectations. Activity in bed-based care remains high, as reported last year. This, and a reduction in income expected from clients contributing towards the cost of their care, is contributing to the reported budget pressures this year.

5) Central Commissioning - Adults

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
14,724	14,009	-681	-5%

Central Commissioning – Adults is forecasting an underspend of -£681k at the end of January. This is a decrease of £11k on the position reported in December.

Savings of -£575k have been made through the decommissioning of six local authority funded rapid discharge and transition cars as part of the wider homecare commissioning model. This offsets the pressure and delivers a net underspend on the budget. The long-term strategy is to decommission all the local authority funded cars, meeting the need for domiciliary care through other, more cost-effective means, such as:

- A sliding scale of rates with enhanced rates to support rural and hard to reach areas.
- Providers covering specific areas or zones of the county, including rural areas.
- Supporting the market in building capacity through recruitment and retention, as well as better rates of pay for care staff.

There are some additional small underspends on recommissioned contracts, with the additional £80k underspend forecast in November being due to additional underspends on contracts being identified, including on a budget for consultancy where it was possible to deliver some of the contract review work internally.

6) Integrated Community Equipment Service

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
1,779	-966	-150	-8%

The Integrated Community Equipment Service is a pooled budget with the NHS. It is forecasting an underspend of -£312k at the end of January, of which the Council's share according to the agreed percentage split for the pool is -£150k.

The service is being delivered under a new contract that commenced on 1st April 2022. The underspend is due, in part, to the lower prices delivered under the new contract, but also associated with the current backlogs with the service and the financial penalties associated with these backlogs. The backlog of equipment deliveries is now starting to be cleared.

7) Children in Care Placements

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
23,122	17,360	1,200	5%

The Children in Care placements budget is now forecasting a revised overspend of £1.2m. The biggest impact on the Placement Budget has been three high- cost placements for children with exceptional behaviours and complex needs. These costs have been incurred since August. These children have been

subject of multiple placement searches, two of whom moved to reduce cost provisions in November. Costs for one child remain excessive whilst endeavours are being made to find suitable alternative reduced cost provision capable of meeting need.

The placement market is highly competitive with demand outstripping supply, this results in providers cherry picking when matching placements within their residential provision, this coupled with excessive demand means that placement costs are in some cases 30% + higher than pre-pandemic levels.

A number of providers have justified fee uplift requests in response to the high inflation levels currently being experienced, this is in particular in regard to IFA placements where the cost-of-living increases are affecting fostering families. The last few months have seen a decrease in our ability to access in-house provision with a greater number of placements being made in the independent sector.

8) Fostering and Supervised Contact Services

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
9,751	8,099	-200	-2%

We continue to forecast an underspend of £200k against Professional and Link Foster Carers primarily as a result of the reduction of the Children in Care (CiC) population accessing this provision. Whilst better utilisation of vacant beds has resulted in a more positive placement mix (54% of Cambridgeshire children with in-house carers versus 46% external), it is considered unlikely that the full 190 placements budgeted for will be utilised within the year.

9) Integrated Front Door

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
4,464	4,120	200	4%

The forecasted overspend of £200k within the staffing budget has been caused by the use of agency staff within the service, AMPH allowance given to Emergency Duty Team (EDT) adult workers, as well as additional hours worked by EDT to cover sickness and support with increased volume of work on occasions.

10) Adoption

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
5,646	4,452	-300	-5%

Adoption services continue to forecast an underspend of £300k, primarily against Special Guardianship Orders, which is a result of savings realised from changes made to allowances following the introduction of a new means testing tool, in line with DfE recommendations.

11) Safeguarding East

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
4,509	1,474	-185	-4%

Safeguarding East continues to forecast an underspend of £185k. This is due to no current no recourse to public funds (NRPF) families within the service area and therefore no expenditure. There is also reduced Section 17 expenditure due to the service utilising charitable support and/or other avenues of support to assist children and families where needed.

12) Cambridgeshire Music

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
0	427	94	-%

Cambridgeshire Music are forecasting a year end overspend of £94k, The forecast overspend relates to a pressure within the service staffing budgets. Demand for services has lessened through the Autumn Term affected in part by the national economic picture, as a result it has taken longer to build newly appointed staff up to their correct level of work mid-year. In addition, the impact of the agreed pay award added costs beyond the budgeted level.

13) Redundancy & Teachers Pensions

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
3,717	3,437	-254	-7%

The redundancy and Teachers pension budget is forecasting a £254k underspend due to a significant reduction in the number of individuals receiving pension payments. There has also been lower than anticipated activity in redundancies.

14) SEND Specialist Services

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
12,083	9,488	251	2%

The Education Psychology service continues to report a forecast pressure of £251k. It was hoped that some of this could be offset by under spends in other areas, but this is now not the case. The service is experiencing increasing demand which cannot be met from within the substantive team and is therefore being met through use of locum Education Psychologists. This pressure is due to the significant increase in requests for EHCNA that continued over the summer. The locum spend has helped to get the numbers of advice unallocated or late down significantly (19% submitted on time to around 60%, above national average, on time by October). Without the use of locums this would not have been possible. This feeds into the DfE expectations of Cambridgeshire in terms of meeting deadlines.

15) SEND Financing DSG

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
-9,752	682	11,800	121%

Due to the continuing increase in the number of children and young people with Education, Health, and Care Plans (EHCPs), and the complexity of need of these young people, the overall spend on the High Needs Block element of the DSG funded budgets has continued to rise. The current in-year forecast reflects the initial latest identified shortfall between available funding and current budget requirements.

16) 0-19 Organisation & Planning

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
2,992	2,564	-131	-4%

0–19 Organisation and Planning are now reporting a forecast underspend of £131k. £65k of this is within the Safeguarding team following a review of their offer which resulted in delivering a wider range of courses and increasing their marketing. The remaining £48k being generated by Welfare Benefits.

17) Home to School Transport - Special

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
17,745	12,517	2,130	12%

A £2.13m pressure is forecast. Following the retender of 330 routes for Sept 2022, average contract costs have gone up by 18.5% from 2021 reflecting the strong impact of inflation. In addition, there has been an increase in the number of pupils being transported to special schools. The lack of special school places available locally has necessitated longer and less efficient transport routes and has added to the pressure on this budget.

Uncertain market conditions have led to an unprecedented number of contract hand backs across the service. The expected position at the end of the autumn term will be a total of 200 hand backs. There is a lack of providers bidding on contracts for post 16 provision, many courses only require transport for 3 days a week which has made these routes less attractive to the market and has led to an increase in cost. Operators are not able to find the drivers and passenger assistants for these routes, preferring to bid on whole week contracts. There is also a lack of providers in the Cambridge South area, which means that contractors are coming in from Peterborough and Huntingdon to cover these routes at a high cost. The Stagecoach retendering exercise has also contributed to the additional pressure. Whilst all routes were covered this has led to an increased spend of around £543 per day.

18) Children in Care Transport

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
1,630	1,348	300	18%

Children in Care (CIC) transport is forecasting a £300k pressure. There has been an increase in transport demand arising from an increasing shortage in local placements, requiring children to be transported further. In addition, transport requests for CIC pupils as part of their care package have increased due to carers feeling unable to meet the increased fuel costs.

19) Home to School Transport - Mainstream

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
9,749	6,741	711	7%

A £0.711m pressure is forecast. As with all the transport budgets, driver shortages and inflation have increased contract costs. In addition, several areas in the county have a lack of local places meaning that pupils must be transported further at higher cost.

There are the same issues with transport provision as stated for SEN budget. In addition, the lack of bus operator and drivers has resulted in one school needing to be covered with 5 taxis, as a 53-seater bus could not be procured, despite multiple tenders and market testing.
The lack of places continues to generate extra taxis provision. This has been higher in the Cambridge South area, where refugee guests are taking up places that had already been forecasted for, resulting in pupils being transported further afield.

20) Financing DSG

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
-103,136	-97,995	-11,800	-11%

Above the line within People Services, £103.1m is funded from the ring-fenced DSG. Net pressures will be carried forward as part of the overall deficit on the DSG.

21) Public Health Directorate Staffing & Running Costs

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
2,782	-4,678	-259	-9%

There is a forecast underspend on staffing and running costs due to vacant posts. In addition, an element of grant funding needed to fund inflationary increases for providers in future years is not required in 2022/23 due to vacant posts in those provider services, creating a further in year underspend.

22) Health In All Policies

Budget 2022/23 £'000	Actual £'000	Forecast Outturn Variance £'000	Forecast Outturn Variance %
125	0	-125	-100%

This was a new investment in 2022/23 Business Planning but has now been superseded by the move to an integrated self-assessment tool of which this will form a part. No spend is therefore anticipated in this financial year.

Appendix 4 – Capital Position

4.1 Capital Expenditure

Original 2022/23 Budget as per BP £'000	Scheme	Revised Budget for 2022/23 £'000	Actual Spend (Jan 23) £'000	Forecast Outturn Variance (Jan 23) £'000	Total Scheme Revised Budget £'000	Total Scheme Variance £'000
24,224	Basic Need - Primary	5,574	3,275	**-62**	184,036	552
40,926	Basic Need - Secondary	32,817	5,885	**-16,860**	225,674	200
1,566	Basic Need - Early Years	2,119	81	**-1,694**	7,419	0
6,197	Adaptations	5,002	2,390	**-200**	10,075	0
3,250	Conditions Maintenance	5,377	4,057	**0**	31,563	0
780	Devolved Formula Capital	1,979	0	**0**	9,053	0
16,950	Specialist Provision	14,976	7,968	**-2,450**	38,018	0
1,050	Site Acquisition and Development	150	246	**0**	1,200	0
750	Temporary Accommodation	750	168	**-299**	8,000	-299
650	Children Support Services	650	0	**0**	6,500	0
15,223	Adult Social Care	6,554	5,071	**-523**	110,283	0
1,400	Cultural and Community Services	0	-7	**-41**	0	0
-13,572	Capital Variation	-9,114	0	**9,114**	-58,878	0
733	Capitalised Interest	660	0	**0**	5,316	0
-1,770	Environment Fund Transfer	-1,770	0	**0**	-3,499	0
98,357	**Total People Services Capital Spending**	65,724	29,132	-13,015	574,760	453

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

Northstowe 2nd Primary

Revised Budget for 2022/23 £'000	Forecast Spend- Outturn (Jan 23) £'000	Forecast Spend- Outturn Variance (Jan 23) £'000	Variance Last Month (Dec 22) £'000	Movement £'000	Breakdown of Variance: Underspend/ Overspend £'000	Breakdown of Variance: Reprogramming / Slippage £'000
200	700	500	500	0	500	0

Expected £500k overspend in 2022/23 due to increased scheme costs identified at MS2. The scheme delivery schedule has now also been confirmed. Revised costs being presented at August capital programme board.

Littleport Primary School

Revised Budget for 2022/23 £'000	Forecast Spend- Outturn (Jan 23) £'000	Forecast Spend- Outturn Variance (Jan 23) £'000	Variance Last Month (Dec 22) £'000	Movement £'000	Breakdown of Variance: Underspend/ Overspend £'000	Breakdown of Variance: Reprogramming / Slippage £'000
649	100	-549	-549	0	0	-549

Plans to expand Littleport Community Primary School from 420/2FE to 630/3FE have been delayed as pupil numbers have not increased as expected because of slower than expected progress in local housing developments and lower annual births in the village. Project team will keep under review with school place planning. Additional Millfield Early Years Scheme delayed due planning validation issues.

Soham Primary Expansion

Revised Budget for 2022/23 £'000	Forecast Spend-Outturn (Jan 23) £'000	Forecast Spend-Outturn Variance (Jan 23) £'000	Variance Last Month (Dec 22) £'000	Movement £'000	Breakdown of Variance: Underspend/ Overspend £'000	Breakdown of Variance: Reprogramming / Slippage £'000
49	690	641	641	0	0	641

Plans to expand the Shade Primary School from 420/2FE to 630/3FE have been delayed as pupil numbers have not increased as fast as expected because of slower than expected progress in local housing developments. Project team will keep under review with school place planning.

Waterbeach New Town Primary

Revised Budget for 2022/23 £'000	Forecast Spend-Outturn (Jan 23) £'000	Forecast Spend-Outturn Variance (Jan 23) £'000	Variance Last Month (Dec 22) £'000	Movement £'000	Breakdown of Variance: Underspend/ Overspend £'000	Breakdown of Variance: Reprogramming / Slippage £'000
350	650	300	300	0	0	300

Expected accelerated spend of £300k to cover redesign fees which will be incurred this financial year.

Alconbury Weald secondary and Special

Revised Budget for 2022/23 £'000	Forecast Spend-Outturn (Jan 23) £'000	Forecast Spend-Outturn Variance (Jan 23) £'000	Variance Last Month (Dec 22) £'000	Movement £'000	Breakdown of Variance: Underspend/ Overspend £'000	Breakdown of Variance: Reprogramming / Slippage £'000
14,500	2,000	-12,500	-12,500	0	0	-12,500

New tendering approach taken for procurement of this project following increases in estimated cost for SEN works. SEN School will now be delivered one year later in 2024. The secondary to be retendered and completion date to be confirmed.

Sir Harry Smith Community College

Revised Budget for 2022/23 £'000	Forecast Spend-Outturn (Jan 23) £'000	Forecast Spend-Outturn Variance (Jan 23) £'000	Variance Last Month (Dec 22) £'000	Movement £'000	Breakdown of Variance: Underspend/ Overspend £'000	Breakdown of Variance: Reprogramming / Slippage £'000
3,200	1,600	-1,600	-1,600	0	0	-1,600

Start on site has been delayed to early 16th January 2023 due to delays with planning and highways decisions, with a revised completion date of 8th March 2024.

Cambourne Village College Phase 3b

Revised Budget for 2022/23 £'000	Forecast Spend-Outturn (Jan 23) £'000	Forecast Spend-Outturn Variance (Jan 23) £'000	Variance Last Month (Dec 22) £'000	Movement £'000	Breakdown of Variance: Underspend/ Overspend £'000	Breakdown of Variance: Reprogramming / Slippage £'000
14,000	11,200	-2,800	-2,800	0	0	-2,800

Expected slippage of £2,800k as it has taken time to ensure the project can be delivered on budget. Slightly longer programme schedule with project completion now expected April 2024.

LA Early Years Provision

Revised Budget for 2022/23 £'000	Forecast Spend-Outturn (Jan 23) £'000	Forecast Spend-Outturn Variance (Jan 23) £'000	Variance Last Month (Dec 22) £'000	Movement £'000	Breakdown of Variance: Underspend/ Overspend £'000	Breakdown of Variance: Reprogramming / Slippage £'000
1,803	200	-1,603	-1,603	0	0	-1,603

Includes two schemes, one is the Teversham permanent build which was approved by the capital programme board in November 2022, for delivery during 2023/24. The second scheme is Meldreth, which is also to be delivered during 2023/24.

Samuel Pepys Special School

Revised Budget for 2022/23 £'000	Forecast Spend-Outturn (Jan 23) £'000	Forecast Spend-Outturn Variance (Jan 23) £'000	Variance Last Month (Dec 22) £'000	Movement £'000	Breakdown of Variance: Underspend/ Overspend £'000	Breakdown of Variance: Reprogramming / Slippage £'000
1,200	200	-1.000	0	-1,000	0	-1,000

Slippage of £1,000k forecast due to delay in purchasing land, now expected to complete in April 2023, with work programmed to commence in May 2023.

Additional Countywide SEN places

Revised Budget for 2022/23 £'000	Forecast Spend-Outturn (Jan 23) £'000	Forecast Spend-Outturn Variance (Jan 23) £'000	Variance Last Month (Dec 22) £'000	Movement £'000	Breakdown of Variance: Underspend/ Overspend £'000	Breakdown of Variance: Reprogramming / Slippage £'000
1,350	150	-1,200	-1,200	0	0	-1,200

Pending the outcome of the Safety Valve capital application, 7 low capital cost schemes have been presented to Capital Programme Board with a view to release 66 special school places and 40 Enhance Resource Base places for Sept 23. Slippage of £1,200k forecast.

Temporary Accommodation

Revised Budget for 2022/23 £'000	Forecast Spend-Outturn (Jan 23) £'000	Forecast Spend-Outturn Variance (Jan 23) £'000	Variance Last Month (Dec 22) £'000	Movement £'000	Breakdown of Variance: Underspend/ Overspend £'000	Breakdown of Variance: Reprogramming / Slippage £'000
750	451	-299	-299	0	-299	0

There has been a significant reduction in the number of new temporary solutions required across the county, realising a £299k underspend in 2022/23.

Independent Living Service: East Cambridgeshire

Revised Budget for 2022/23 £'000	Forecast Spend-Outturn (Jan 23) £'000	Forecast Spend-Outturn Variance (Jan 23) £'000	Variance Last Month (Dec 22) £'000	Movement £'000	Breakdown of Variance: Underspend/ Overspend £'000	Breakdown of Variance: Reprogramming / Slippage £'000
1,084	561	-523	-523	0	0	-523

In year underspend due to slippage in the project, caused by a delay in the purchase of land. The NHS is not able to release the site until they have received approval for their own capital project, which has been delayed.

Other changes across all schemes (<250k)

Revised Budget for 2022/23 £'000	Forecast Spend-Outturn (Jan 23) £'000	Forecast Spend-Outturn Variance (Jan 23) £'000	Variance Last Month (Dec 22) £'000	Movement £'000	Breakdown of Variance: Underspend/ Overspend £'000	Breakdown of Variance: Reprogramming / Slippage £'000
		-916	-866	-50	-175	-1,091

Other changes below £250k make up the remainder of the scheme variance.

People Services Capital Variation

The Capital Programme Board recommended that services include a variations budget to account for likely slippage in the capital programme, as it is sometimes difficult to allocate this to individual schemes in advance. The allocation for People Services negative budget has been revised and calculated using the revised budget for 2022/23 as below. As of December 2022, the Capital Variation budget has been fully utilised.

Service	Capital Programme Variations Budget £000	Forecast – Outturn (Jan 23) £000	Capital Programme Variations Budget Used £000	Capital Programme Variations Budget Used %	Revised Forecast Variance - Outturn (Jan 23) £000
People Services	-9,114	-22,129	-9,114	100	-13,015
Total Spending	-9,114	-22,129	-9,114	100	-13,015

4.2 Capital Funding

Original 2022/23 Funding Allocation as per BP £'000	Source of Funding	Revised Funding for 2022/23 £'000	Spend - Outturn (Jan 23) £'000	Funding Outturn Variance (Jan 23) £'000
14,679	Basic Need	15,671	15,671	0
3,000	Capital maintenance	5,877	5,877	0
780	Devolved Formula Capital	1,978	1,978	0
0	Schools Capital	0	0	0
5,070	Adult specific Grants	5,070	5,070	0
21,703	S106 contributions	11,343	11,343	0
2,781	Other Specific Grants	9,487	2,709	-6,778
1,200	Other Revenue Contributions	0	0	0
0	Capital Receipts	0	0	0
39,147	Prudential Borrowing	16,297	11,110	-5,187
9,997	Prudential Borrowing (Repayable)	0	0	0
98,357	Total Funding	65,724	53,759	-11,965

Slippage on Alconbury SEN school now means £7.7m of High Needs capital grant will be used in 2023/24.

Appendix 5 – Savings Trackers

People Services

RAG	BP Ref	Title	Service	Committee	Original Saving £000	Forecast Saving £000	Variance from Plan £000	% Variance	Direction of travel	Commentary
Green	A/R.6.176	Adults Positive Challenge Programme - demand management	People	A&H	-154	-154	0	0%	↔	On track
Black	A/R.6.177	Cambridgeshire Lifeline Project	People	A&H	-10	0	10	100%	↓	Service expansion target not expected to be delivered and future income assumptions removed from Business Planning.
Green	A/R.6.179	Mental Health Commissioning	People	A&H	-24	-24	0	0%	↔	Delivered
Green	A/R.6.185	Additional block beds - inflation saving	People	A&H	-390	-390	0	0%	↔	On track
Amber	C/F 21-22 Saving	Adult Social Care Transport	People	A&H	-220	-72	148	67%	↓	All routes now retendered. Saving achieved is lower than expected due to the inflationary pressures on transport.
Amber	A/R.6.188	Micro-enterprises Support	People	A&H	-133	-30	103	77%	↔	At risk due to capacity in the market. Establishment of micro-enterprises has progressed well in East Cambridgeshire. Embedding this in the wider roll out of Care Together is needed to deliver on the scale of savings.
Green	A/R.6.190	iBCF	People	A&H	-240	-240	0	0%	↔	Delivered
Green	A/R.6.191	Extra care retendering	People	A&H	-87	-87	0	0%	↔	Delivered
Green	A/R.6.192	Shared lives	People	A&H	-50	-50	0	0%	↔	On track
Green	A/R.6.193	Expansion of Emergency Response Service	People	A&H	-210	-210	0	0%	↔	On track

RAG	BP Ref	Title	Service	Committee	Original Saving £000	Forecast Saving £000	Variance from Plan £000	% Variance	Direction of travel	Commentary
Green	A/R.6.194	Interim Bed recommissioning	People	A&H	-412	-412	0	0%	↔	Delivered
Black	A/R.6.195	Increased support for carers	People	A&H	-219	0	219	100%	↓	Investment and related savings have been delayed taking account of the refreshed carers strategy.
Green	A/R.6.197	Community Equipment Service contract retender	People	A&H	-121	-121	0	0%	↔	Delivered
Green	A/R.6.198	Decommissioning of domiciliary care block provision	People	A&H	-236	-236	0	0%	↔	Delivered
Amber	A/R.6.200	Expansion of Direct Payments	People	A&H	-234	-965 -100	134	57%	↓	Delivery of savings has been delayed, as has the level of investment. Direct Payment programme is reviewing the recommendations from the peer review to refine its focus, this has led to some delays in the expansion programme.
Red	A/R.7.111	Client Contributions Policy Change	People	A&H	-562	-264	298	53%	↓	Changes were introduced to the Adult Social Care charging policy in April 2020. The new policy was applied as part of a review of individual circumstances, often when changes had occurred, as opposed to a targeted focus. Post covid and with the cost-of-living crisis, work on the remaining reassessments has not been a priority. Overall client contributions over-recovery is mitigating the shortfall.
Green	A/R.7.112	Community Equipment Pool	People	A&H	-155	-155	0	0%	↔	Delivered

RAG	BP Ref	Title	Service	Committee	Original Saving £000	Forecast Saving £000	Variance from Plan £000	% Variance	Direction of travel	Commentary
Amber	A/R.7.113	Learning Disability Partnership Pooled Budget Rebaselining	People	A&H	-1,125	-965	160	14%	↑	Agreement has been reached in principle to an increased contribution for 22/23 and a focus on commencing detailed work with ICB to review the pool position. However, savings built into the Business Plan for future years remain at risk until the review work is completed.
Green	A/R.6.255	Children in Care - Placement composition and reduction in numbers	People	C&YP	-600	-600	0	0%	↔	This saving is on track, however, other pressures within the service mean that an overspend is being reported
Green	A/R.6.257	Special Guardianship Orders	People	C&YP	-250	-250	0	0%	↔	On track
Green	A/R.6.268	Transport - Children in Care	People	C&YP	-380	-380	0	0%	↔	This saving has been delivered, however, other pressures within the service mean that an overspend is being reported
Green	A/R.6.269	Virtual School	People	C&YP	-50	-50	0	0%	↔	On track
Green	A/R.6.271	Maximising use of existing grants	People	C&YP	-350	-350	0	0%	↔	On track
					-6,212	-5,140	1,072			

Public Health

RAG	BP Ref	Title	Service	Committee	Original Saving £000	Forecast Saving £000	Variance from Plan £000	% Variance	Direction of travel	Commentary
Green	E/R.6.034	Reduction in demand led Public Health budgets	PH	A&H	-328	-328	0	0%	↔	Delivered
					-328	-328	0			

Key to RAG Ratings:

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

Adults and Health Key Performance Indicators

To:	Adults and Health Committee
Meeting Date:	9 March 2023
From:	Jyoti Atri, Director of Public Health, Debbie McQuade, Director of Adult Social Care
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	N/A
Outcome:	The Committee receives performance reports at future meetings containing information on agreed indicators
Recommendation:	Adults and Health Committee are recommended to note and comment on the performance information outlined in this report, and take remedial action as necessary

Officer contact:
Name:	Val Thomas / Tina Hornsby
Post:	Deputy Director of Public Health / Head of Adults Performance and Strategic Development
Email: val.thomas@cambridgeshire.gov.uk / tina.hornsby@peterborough.gov.uk
Tel: 07884 183374 / 01733 452428

Member contacts: Names: Cllr R Howitt / Cllr S van de Ven
Post: Chair / Vice-Chair
Email: Richard.howitt@cambridgeshire.gov.gov
        Susanvandeven5@gmail.com
Tel: 01223 706398

1. Background

1.1 The Council adopted a new Strategic Framework and Performance Management Framework in February 2022, for the financial year 2022/23. The new 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 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

1.2 This report presents the position of performance against the selected KPIs for Public Health and Adult Social Care as at the end of December 2022, Quarter 3.

2. Adult Social Care Performance Update

2.1 It was agreed that KPIs would be grouped into small bundles linked to a theme to provide a more rounded picture of performance whilst still reflecting headline performance.

2.2 The four agreed themes are;
- Early intervention and prevention – supporting people early with targeted information and advice and low-level and community support and reablement services, to prevent or delay the need for long term care and support.
- Long term care and support when needed is personalised and keeps people connected to their communities
- Adults at risk are safeguarded from harm in ways that meet their desired outcomes.
- Transitions between health and social care services work well

There are 11 indicators in total.

2.3 **Early intervention and prevention – supporting people early with targeted information and advice and low-level and community support and reablement services, to prevent or delay the need for long term care and support.**

Number of new client contacts for Adult Social Care per 100,000 of the population 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 who do need it					
Quarter 3 21/22	Full Year 2021/22	Full Year England	Full Year Stat neighbours	Quarter 3 2022/23	Direction of travel - since Q2
1845	3579	4451	4478	**3553**	**Increasing** Higher is better
Percentage of new client contacts not resulting in long term care and support This indicator is important to look at in line with the above 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 on contacts.

Quarter 3 21/22	Full Year 2021/22	Full Year England	Full Year Stat neighbours	Quarter 3 2022/23	Direction of travel – since Q2
89.7%	93%	91.8%	91.7%	**88%**	**Decreasing** Higher is better

The proportion of people receiving reablement who did not require long term support after reablement was completed.
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 the level of independence. Setting a target too high on this indicator can be a perverse incentive to decline the service for those with more complex needs. A target should be set that reflects a balance of use. It can be viewed alongside the trends on new clients with long term service outcomes (the indicator above) to ensure that more complex cases are not being diverted straight into long term care.

Quarter 3 21/22	Full Year 2021/22	Full Year England	Full Year Stat neighbours	Quarter 3 2022/23	Direction of travel – since Q2
84.8%	87.7%	77.6%	79.3%	**84.7%**	**Decreasing** Higher is better

Comments on Performance for Early Intervention and Prevention

The growth in new contacts in the year has been in relation to hospital discharges returning to levels more similar to pre pandemic and also in the community referrals to the customer call centre and Adult Early Help which did not see a reduction during the pandemic and has been on an increasing trend throughout. We are currently implementing a new referral to Adult Early Help directly from GP systems which is hoped to further increase referrals where early intervention and prevention can be targeted. This should increase overall numbers of contacts but also it is expected to increase the percentage not requiring long term care. This will be tracked for a 3-month period initially to measure impact and will start in the fourth quarter of this financial year.

There has also been an increase in the number of referrals to reablement, again recovering from a reduction during the pandemic. The percentage with the outcome of no long-term care has been decreasing slightly within the year but remains similar to quarter 3 in the previous year and continues to be comparatively good when looked at alongside England average and statistical neighbours.

2.4   **Long term care and support when needed is personalised and keeps people connected to their communities**

Proportion of people using social care who receive direct payments (%)
Direct payments provide people with more choice and control over how they meet they care and support needs. 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.

Quarter 3	Full Year	Full Year	Full Year Stat	Quarter 3	Direction of travel

21/22	2021/22	England	neighbours	2022/23	– since Q2
22%	21.1%	26.7%	27.6%	**19.2%**	**Increasing** Higher is better

Proportion of people receiving long term support with who had not received a review in the last 12 months

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.

Quarter 3 21/22	Full Year 2021/22	Full Year England	Full Year Stat neighbours	Quarter 3 2022/23	Direction of travel – since Q2
Not available	50.2%	45%	41.3%	**21%**	**Decreasing** Lower is better

Number of carers assessed or reviewed in the year per 100,000 of the population.

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 to the cared for person. It is an opportunity to support carers to continue their caring role but also to plan ahead for the future.

Quarter 3 21/22	Full Year 2021/22	Full Year England	Full Year Stat neighbours	Quarter 3 2022/23	Direction of travel – since Q2
54.1	74.1	1398	440.8	**68.5**	**Increasing** Higher is better

Percentage of total people accessing long term support in the community

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

Age 18-64

Quarter 3 21/22	Full Year 2021/22	Full Year England	Full Year Stat neighbours	Quarter 3 2022/23	Direction of travel – since Q2
89.6%	84.9%	84.7%	82.4%	**90.2%**	**Increasing** Higher is better

Age 65 and over

Quarter 3 21/22	Full Year 2021/22	Full Year England	Full Year Stat neighbours	Quarter 3 2022/23	Direction of travel – since Q2
62.1%	51.7%	62.4%	59.3%	**64.2%**	**Increasing** Higher is better

Comments on Performance for long term care and support

The percentage of people receiving direct payments continues to be low, reflecting the challenge in making direct payments an attractive solution. Plans to offer individual service funds as alternative to direct payments continue to progress. This alongside the work to developed place based micro-enterprises within the Care Together programme should help to build on the range of options available.

Good progress has been made on statutory reviews with completion for older people and

disability teams being at 90%. However there are still some challenges for learning disability and mental health reviews.

We have seen increases in the proportion of both younger and older adults supported in the community in the year, and this is positive reflection on work which has taken place to increase capacity of commissioned community support.

A move away from carers assessments - by default to a more constructive and timely conversation – accounts for the comparatively low volume of carers assessments. Although having set a new baseline we are now beginning to see expected growth in the number of assessments.

This should be seen alongside our carers conversation and carers triage activity. In the period April- December 2022 we have completed.
- 2162 carers conversations
- 387 carers assessments or reviews

However we recognise that we do need to do more to maintain contact with and support carers in their role and this is a focus of the new carers' strategy and review of practice which is currently in progress.

2.5 Adults at risk are safeguarded from harm in ways that meet their desired outcomes

Percentage of cases where Making Safeguarding Personal (MSP) questions have been asked

It is important when undertaking a safeguarding 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 that we are involving people in this way.

Quarter 3 21/22	Full Year 2021/22	Full Year England	Full Year Stat neighbours	Quarter 3 2022/23	Direction of travel – since Q2
73.2%	89.7%	79.8%	81.6%	**85.7%**	**Increasing** Higher is better

Percentage of those able to express desired outcomes who Fully or Partially Achieved their desired outcomes.

This indicator links to the indictor above and monitors how well we have been able to support the person to achieve the outcomes they wanted from the safeguarding enquiry

Quarter 3 21/22	Full Year 2021/22	Full Year England	Full Year Stat neighbours	Quarter 3 2022/23	Direction of travel – Since Q2
93.6%	92.4%	95.4%	97.1%	**94.7%**	**Decreasing** Higher is better

Percentage of safeguarding enquiries where risk has been reduced or removed

This indicator tracks the effective of safeguarding enquiries in reducing or removing risk. It should be seen alongside the indicators above reflecting the desired outcomes of the person involved, so that there is not a perverse incentive to counter the wishes of the person themselves to eliminate risk when that person has capacity to decide on the level of risk that is acceptable to them.

	Quarter 3 21/22	Full Year 2021/22	Full Year England	Full Year Stat neighbours	Quarter 3 2022/23	Direction of travel – Since Q2
	91%	91.1%	91.2%	92%	**91.8%**	**Increasing** Higher is better
Comments on Performance for Safeguarding						
We continue to have reporting gaps for safeguarding. New dashboards are currently in their final testing phase meaning not all the data needed to inform these indicators is available for routine use by staff, however, with the information available performance against this indicator suggest that the Making Safeguarding Personal agenda is fully imbedded in the safeguarding process and that safeguarding enquiries are effective in reducing the level of risk, although we could do better at meeting desired outcomes. We are currently undertaking a practice audit for safeguarding where recording of mental capacity and identifying outcomes are two of the areas we are focussing on.						

2.6   Transitions between health and social care services work well
The Department of Health and Social Care are still to realise their metrics around health and care integration, and therefore as yet Key Performance Indicators for this area have not yet been set.

3.   Public Health performance update

3.1   These indicators reflect our high value contracts that are primarily preventative or provide treatment e.g., Drugs and Alcohol Treatment Service. They include both locally set targets and national where applicable. There are some key performance indicators for the Healthy Child Programme that is funded from the Public Health Grant. As these are not currently monitored by the CYP Committee they are included here as priority indicators. There are 9 priority indicators in this set.

3.2   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

3.3   **Drug and Alcohol Treatment Services**

Indicator	FY 21/22	National average (latest Q)	Q1 22/23	Q2 22/23	Status
201: % Achievement against target for drug and alcohol service users who successfully complete treatment. (Benchmarked against national average) **Above target but decreasing**	21.84%	20.43%	21.76%	**21.25%**	**Green**
Comments of Performance					
Q3 data is not yet available. The Cambridgeshire commissioned Drug and Alcohol Treatment Service provided by Change Grow Live, continues to perform strongly against national indicators despite seeing an increase in the complexity of patients presenting during the covid pandemic. The challenge is to ensure that services are continuously promoted, and individuals present to treatment at the earliest opportunity. New National investment in the treatment sector will see an increase in capacity and quality of provision.					

3.4   **Health Behaviour Change Services (lifestyles)**

Indicator	FY 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Status
82: Tier 2 Weight Management Services: % achievement of the target for Tier 2 Weight Management adult service users who complete the course and achieve a 5% weight loss. **Target: 30% of those in treatment Above target and improving**	38%	42%	56%	**48%**	**Blue**
237: Health Trainer: (Structured support for health behaviour change): % achievement against target for adult referrals to the service from received from deprived areas. **Target: 30% Unchanged and exceeding target**	31%	34%	34%	**34%**	**Blue**

56: Stop Smoking Services: % achievement against target for smoking quitters who have been supported through a 4-week structured course. **Target: 2234 quitters** **Below target and declining**	36.2%	144 (26% of Q1 target)	142 (25% of Q2 target)	**TBC**	**Red**
53: NHS Health Checks (cardiovascular disease risk assessment) Achievement against target set for completed health checks **Target: 20,000** **Below target but improving**	6,408 (32% of annual target)	2450 (49% of Q 1 target)	2777 (56% of Q 2 target)	**3564 71% of Q 3 target)**	**Red**

Comments on performance

Tier 2 Adult Weight Management – referrals into the Tier 2 services continue to be high with 1380 referrals received in Q3 against a target of 420. The providers are managing this increase well. Additional funding has been allocated to ensure the provider continues to manage the increased demand for this service. Despite demand, the service is performing well with 48% of completers in Q3 achieving a 5% weight loss against a target of 30%.

Health Trainer Services – referrals into the Health Trainer service are slightly above target with 774 referrals received in Q3 against a target of 689. 34% of these referrals are from the 20% most deprived areas which is above the 30% target. The target is being consistently achieved this year.

Stop Smoking Services – Stop Smoking performance data is always two months behind the reporting period. This is due to the intervention taking two months in total to complete. This means the complete quarter 3 data is not available at this time.

Stop smoking services were significantly impacted by the COVID-19 pandemic with only 36% of the local target achieved in 21/22. During quarter 2 22/23 the Behaviour Change Service/Stop Smoking had reduced staff capacity whilst its newly recruited colleagues were completing their induction and mandatory training. However, it achieved 98% of its trajectory target in quarter 2, compared to only 64% in quarter 1. GP practices also provide stop smoking services but are still experiencing demand pressures and are finding it challenging to provide stop smoking services along with two of the main smoking cessation pharmacotherapies (Champix and Zyban) have been withdrawn due to safety issues both factors are impacting the overall numbers.

NHS Health Checks – NHS Health Checks are primarily delivered in GP practices. Delivery wase significantly impacted by the pandemic with only 46% of the local target achieved in 21/22. In 22/23 delivery has improved despite many practices still struggling with backlogs, capacity issues and other pressures. Year to date 8791 NHS Health Checks have been completed (44% of annual target and above the numbers completed in 2021/22). In Q3 there were 3564 NHS Health Checks completed which is 71% of the Q3 target showing a continued improvement. The commissioning of NHS Health Checks has been diversified with GP Federations delivering on behalf of some practices and the Behaviour Change Services increasing its opportunistic NHS Health Checks along with supporting practice delivery. Other models are being explored to encourage increased activity. (A GP federation is a group of

general practices or surgeries forming an organisational entity and working together within the local health economy)

3.5   **Healthy Child Programme**

The Healthy Child Programme is universal in reach and personalised in response. There are no national targets and we have set ourselves some challenging local targets as it is an important preventative service which offers every child a schedule of health and development reviews, screening tests, immunisations and health promotion guidance and support for parents tailored to their needs at key times. In Cambridgeshire and Peterborough the service is provided by the two NHS community trusts through a single Section 75 agreement. Here we report only on some of the health visitor contacts but a large part of the work (e.g safeguarding, targeted support) happens outside these mandated contacts. Since this data is taken just after the Q3 reporting period, percentages may be higher in the final submissions.

Indicator	FY 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Status
59: Percentage of births that receive a face-to-face New Birth Visit (NBV) within 14 days, by a health visitor. **Local target: 90% Below target and declining**	55%	42%	40%	**38%**	**Red**
60: Percentage of children who received a 6–8-week review by 8 weeks. **Local target: 95% Below target but improving**	28%	32%	37%	**42%**	**Red**
62: Percentage -of children who received a 2-2.5-year review by 2.5 years. **Local target: 90% Below target but improving**	42%	48%	42%	**57%**	**Red**
57: Percentage of infants breast feeding at 6-8 weeks (need to achieve 95% coverage to pass validation). **Local target: 57% Achieving target and fluctuates**	50%	52%	58%	**54%**	**Amber**
Comments on Performance					

59 & 60: New birth and 6–8-week checks. Commissioners work closely with the provider to ensure a high coverage level across all mandated contacts and if contacts completed outside of timescale were also included in this data, coverage would be significantly higher (e.g. if those completed between 14 and 21 days are included, the average for New Birth visits increases to **97**% and if those completed after 8 weeks are included, the average for 6-8 week checks increases to **89%** demonstrating that most families are receiving this contact. It is important to note there is no national target and this is a challenging target set locally and a priority to move to more face-to-face delivery (which was reduced during the pandemic).

Commissioners are intending to prioritise returning all mandated contacts into timescale in the 2023/24 service Annual Development Plan.

62: 2-2.5-year checks: As with the previous indicators the reported data does not include the number of reviews completed after 2.5 years. If these were included in the data, the Q3 average would increase to **87%**. Commissioners agreed with providers to prioritise this contact as part of the 2022/23 Annual Development Plan as it is recognised that this year's cohort will be the first children born in lockdown to have this development assessment.

57: The overall **breastfeeding** prevalence of 54% is higher than the national average of 47%. Breastfeeding rates, which include both exclusive breastfeeding and mixed feeding, do however continue to vary greatly across the county. Broken down by districts, breastfeeding rates for 2022/23 quarter 3 stand at 68% in Cambridge City, 60% in South Cambridgeshire, 55% in East Cambridgeshire, 52% in Huntingdonshire, and 30% in Fenland. The Health Visiting service remains Stage 3 UNICEF Baby Friendly accredited. This shows quality of care in terms of support, advice and guidance offered to parents/carers.

In October 2022, we also launched the new 5-year Infant Feeding strategy which sets out our ambitions to improve the quality of support provided to parents across the continuum of their infant feeding journey. Work is now underway to develop an action plan against this strategy which aligns to the Family Hubs transformation programme delivery plan across Peterborough and Cambridgeshire.

4.   Alignment with corporate priorities

4.1   Environment and Sustainability
There are no significant implications for this priority.

4.2   Health and Care
The following bullet points set out details of implications identified by officers:
- The performance indicators describe any impacts upon health and care.

4.3   Places and Communities
The following bullet points set out details of implications identified by officers:
- The performance indicators describe any impacts upon places and community

4.4   Children and Young People
The report above sets out the implications for this priority in paragraph 3.5.

4.5   Transport

The following bullet points set out details of implications identified by officers:
- The performance indicators describe any impacts upon transport

5.   Significant Implications

5.1   Resource Implications
There are no significant implications within this category.

5.2   Procurement/Contractual/Council Contract Procedure Rules Implications
        There are no significant implications within this category.

5.3   Statutory, Legal and Risk Implications
        The following bullet point set out details of significant implications identified by officers:
        - Any implications for procurement/contractual/Council contract procedure rules will be considered with the appropriate officers from these Departments and where necessary presented to the Adult and Health Committee before proceeding.

5.4   Equality and Diversity Implications
        The following bullet point set out details of significant implications identified by officers:
        - Any equality and diversity implications will be identified before any service developments are implemented

5.5   Engagement and Communications Implications
        The following bullet point set out details of significant implications identified by officers:
        - Any equality and diversity implications will be identified before any service developments are implemented

5.6   Localism and Local Member Involvement
        The following bullet point set out details of significant implications identified by officers:
        - Services will require the ongoing support of local communities and members to support and ensure services delivery supports health and wellbeing

5.7   Public Health Implications
        The report above sets out details of significant implications in paragraphs 3.4, 3.5, 3.6

5.8   Environment and Climate Change Implications on Priority Areas

5.8.1   Implication 1: Energy efficient, low carbon buildings.
        Neutral
        Explanation: Not factored into this performance report

5.8.2   Implication 2: Low carbon transport.
        Neutral
        Explanation: Not factored into this performance report

5.8.3   Implication 3: Green spaces, peatland, afforestation, habitats, and land management.
        Neutral
        Explanation: Not factored into this performance report

5.8.4   Implication 4: Waste Management and Tackling Plastic Pollution.
        Neutral
        Explanation: Not factored into this performance report

5.8.5   Implication 5: Water use, availability, and management:
        Neutral
        Explanation: Not factored into this performance report

5.8.6   Implication 6: Air Pollution.
Neutral
Explanation: Not factored into this performance report

5.8.7   Implication 7: Resilience of our services and infrastructure and supporting vulnerable people to cope with climate change.
Positive
Explanation: Services are expected to provide information and signposting to any vulnerable people affected by climate change.

Have the resource implications been cleared by Finance?   Yes
Name of Financial Officer: Justine Hartley

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement and Commercial?   Yes
Name of Officer: Clare Ellis

Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or Pathfinder Legal?   Yes
Name of Legal Officer: Linda Walker

Have the equality and diversity implications been cleared by your EqIA Super User?
Yes
Name of Officer: Faye McCarthy

Have any engagement and communication implications been cleared by Communications?
No (20th February 2023)
Name of Officer:

Have any localism and Local Member involvement issues been cleared by your Service Contact?   Yes
Name of Officer: Debbie McQuade

Have any Public Health implications been cleared by Public Health?
Yes
Name of Officer: Jyoti Atri

If a Key decision, have any Environment and Climate Change implications been cleared by the Climate Change Officer?
No (20th February 2023)
Name of Officer:

6.   Source documents guidance

6.1   Source documents

None

Produced on: 07 February 2023

Performance Report

Quarter 3

2022/23 financial year

Adults and Health Committee

Business Intelligence
Cambridgeshire County Council
business.intelligence@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 — March 2023

Pro Rata Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
TBC	↑	3552.5	2422.5	Increasing

Statistical Neighbour Mean	England Mean	RAG Rating
4477.9	4450.5	TBC

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.
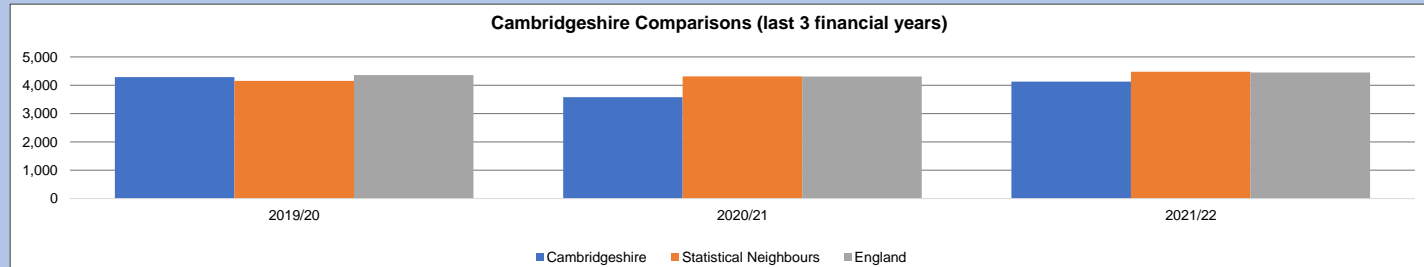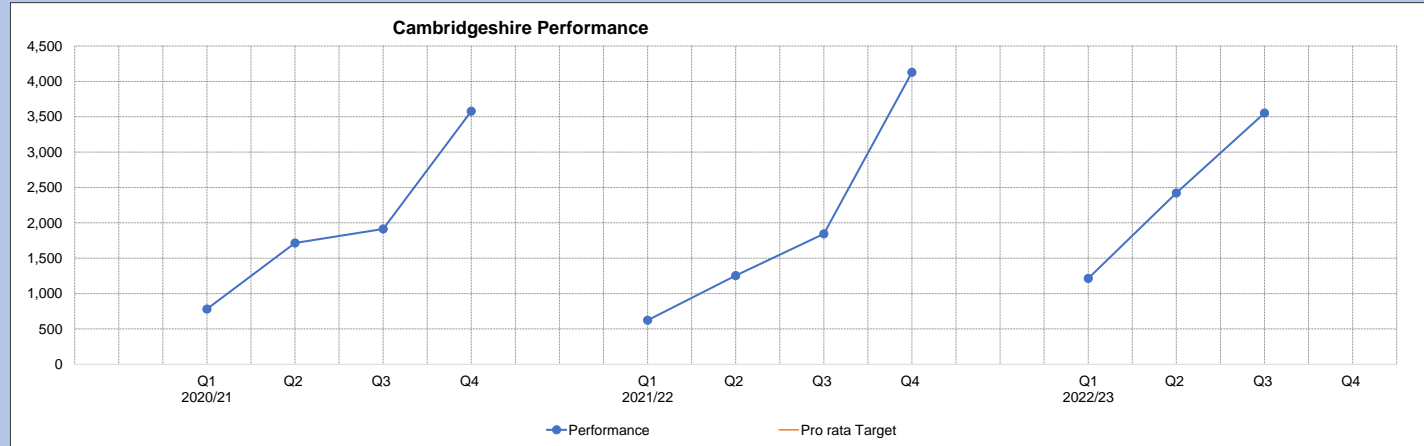
Calculation:

(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

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:

Cambridgeshire Performance

Cambridgeshire Comparisons (last 3 financial years)

Commentary

In the last two financial years Cambridgeshire has had a slightly lower number of new client contacts per 100,000 of population compared to statistical neighbours and the England average, although this is not statistically significant.

Cambridgeshire has a higher number of new client contacts recorded in Q1-Q3 in the current financial year compared to the previous two financial years. In part this is attributable to the new reporting processes implemented in the latter part of the 2021/22 financial year, as well as normal statistical variation. However, there has been a level of increase in new client contacts that is felt to be linked to need in the community (see indicator 231), reflected in the increased numbers of new client assessments for care and support being undertaken (2021/22 monthly average of completed assessments: 330, 2022/23 so far monthly average = 380). Part of the increase in contact numbers may also be due to proactive work with primary care social prescribers to increase awareness of prevention and early intervention services such as lifeline alarms.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards. We are working with the Intergated Care System to enable electronic referrals from GP and social prescribing systems, to make the referral route easier and to increase the quality of referral information received. This will also allow for better reporting of the number of referrals being recieved from primary care.

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

March 2023

	Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
	TBC	↑	88.0%	88.1%	Declining

Statistical Neighbour Mean	England Mean		RAG Rating
91.7%	91.8%		TBC

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)
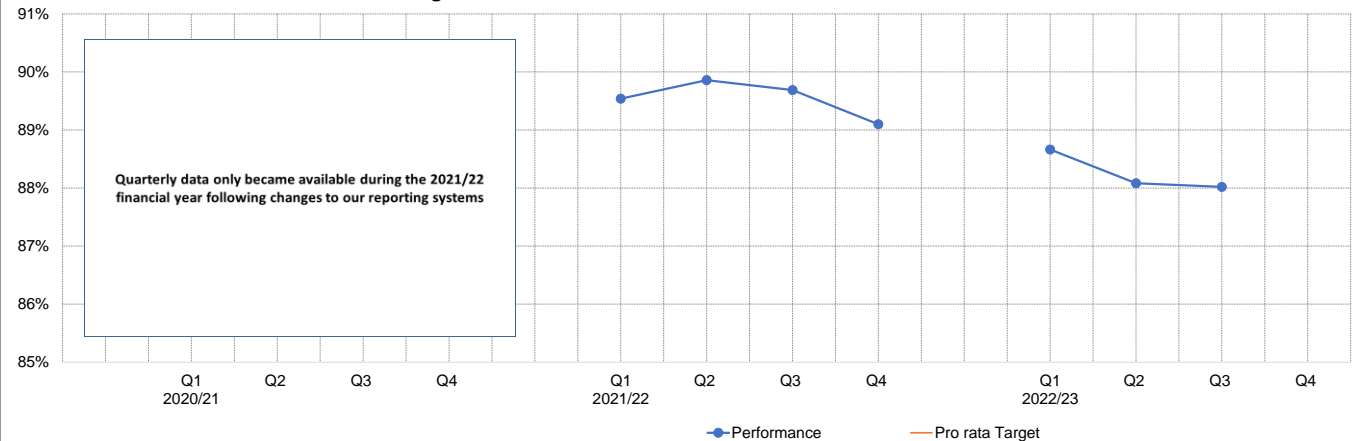
Useful Links

Cambridgeshire Performance

Quarterly data only became available during the 2021/22 financial year following changes to our reporting systems

Cambridgeshire Comparisons (last 3 financial years)
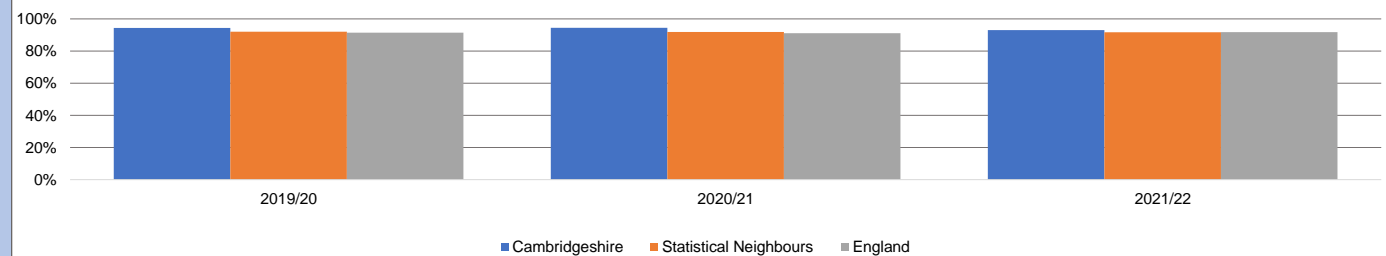
Commentary

The percentage of new client contacts not resulting in long-term care and support has shown a decreasing trend over the last year and is now below national and statistical neighbour averages. When interpreted in conjunction with indicator 230, which is showing an increase in the number of new client contacts as compared to the same period last year, this suggests the increase in the number of new contacts is being predominantly driven by an increase in need for long-term care and support.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

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

March 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
TBC	↑	84.7%	86.8%	Declining

Statistical Neighbour Mean	England Mean	RAG Rating
79.3%	77.6%	TBC

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.

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:

Cambridgeshire Performance
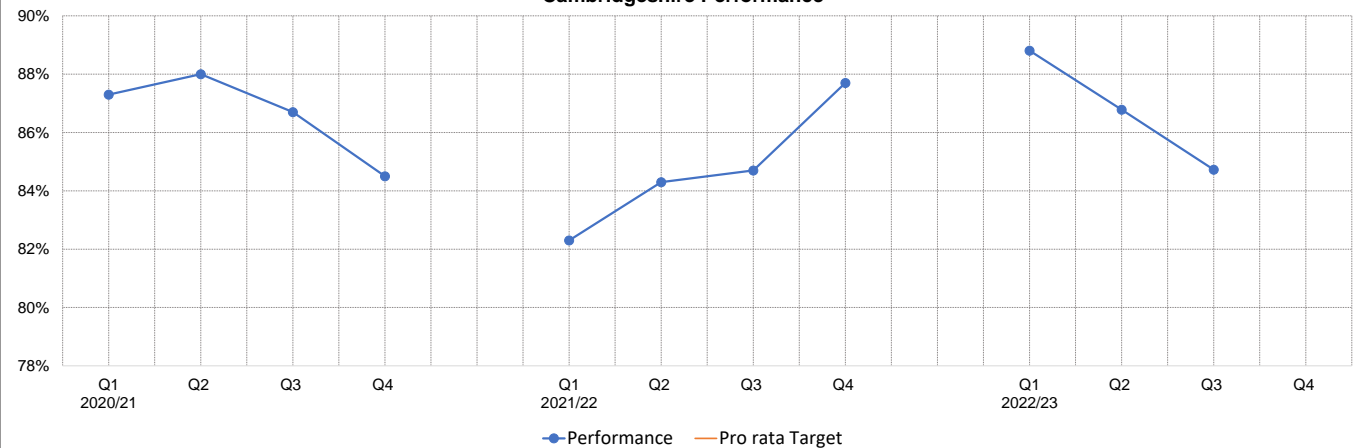
Cambridgeshire Comparisons (last 3 financial years)
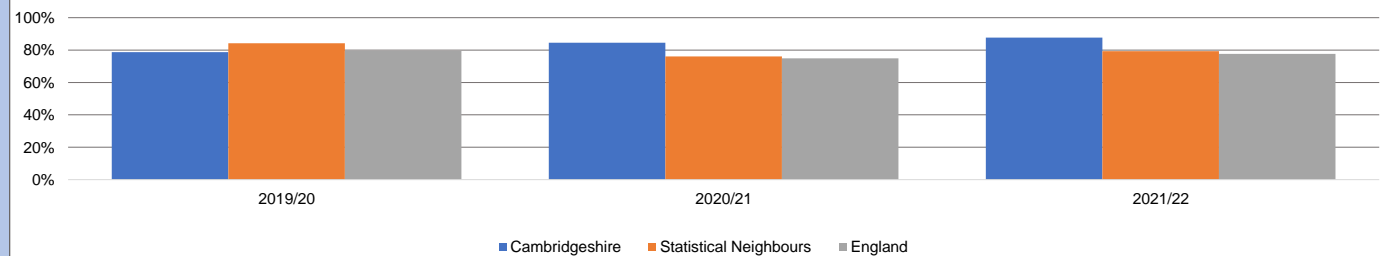
Commentary

The proportion of people not requiring long-term support after a period of reablement remains high, and well above the national and statistical neighbour average.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

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

March   2023

	Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
	TBC	↑	19.2%	18.4%	Improving

Statistical Neighbour Mean	England Mean	RAG rating
27.6%	26.7%	TBC

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.
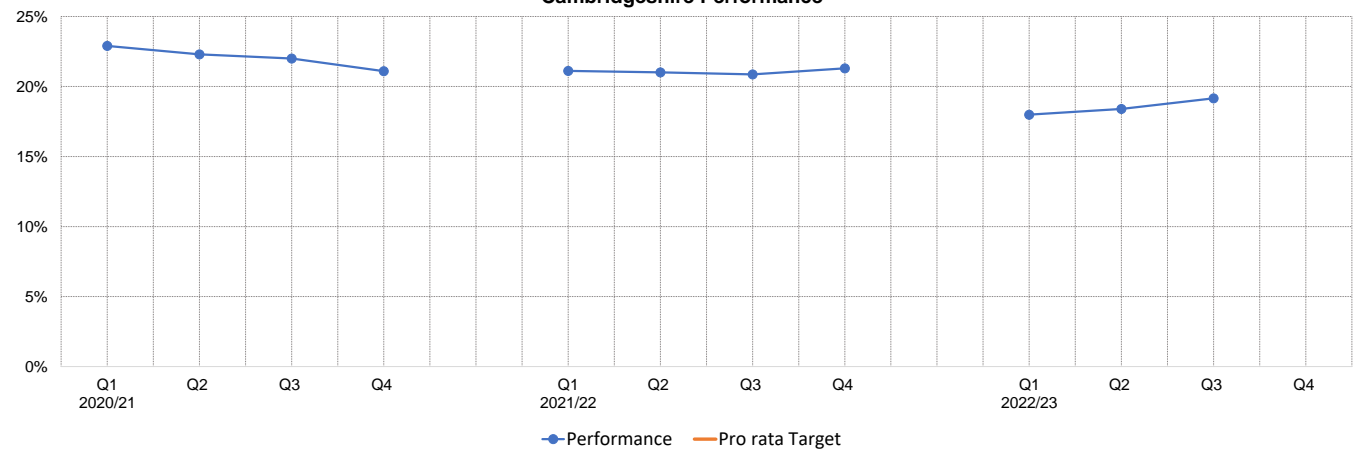
Y = Clients aged 18 or over accessing long term support at the end of the period.

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:

Cambridgeshire Performance

Cambridgeshire Comparisons (last 3 financial years)
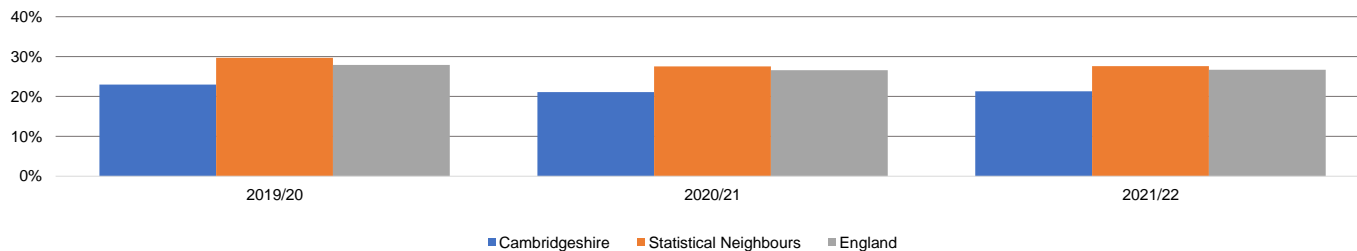
Commentary

The percentage of people receiving direct payments continues to be low in comparison to national and statistical averages, reflecting the challenge in making direct payments an attractive solution. It should be noted though, that the drop in performance compared to previous financial years is mostly driven by an increase in the number of people using social care rather than the number of people receiving direct payments which 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.

During this year the Council will be introducing 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

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards. We now have a programme manager in place to oversee the work to increase direct payments and hopefully this will support progress to begin to deliver a noticeable impact.

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**   **March 2023**

	Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
	TBC	↓	21.0%	25.2%	Improving

	Statistical Neighbour Mean	England Mean		RAG Rating	
	41.3%	45.0%		**TBC**	

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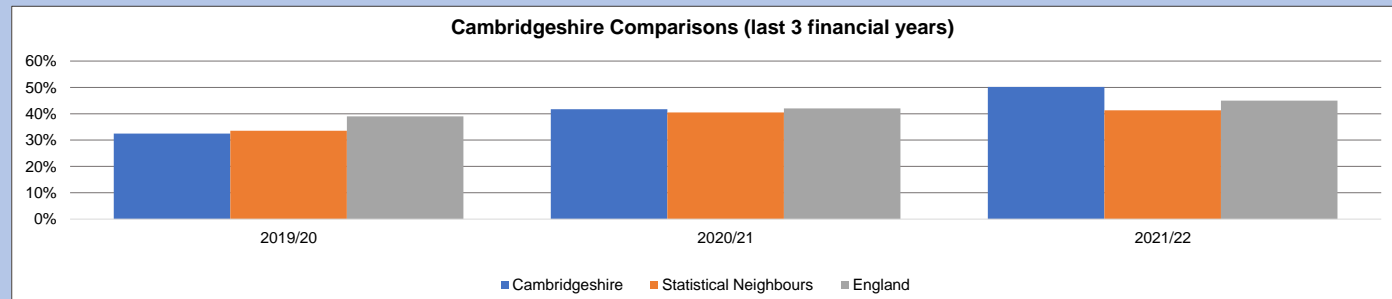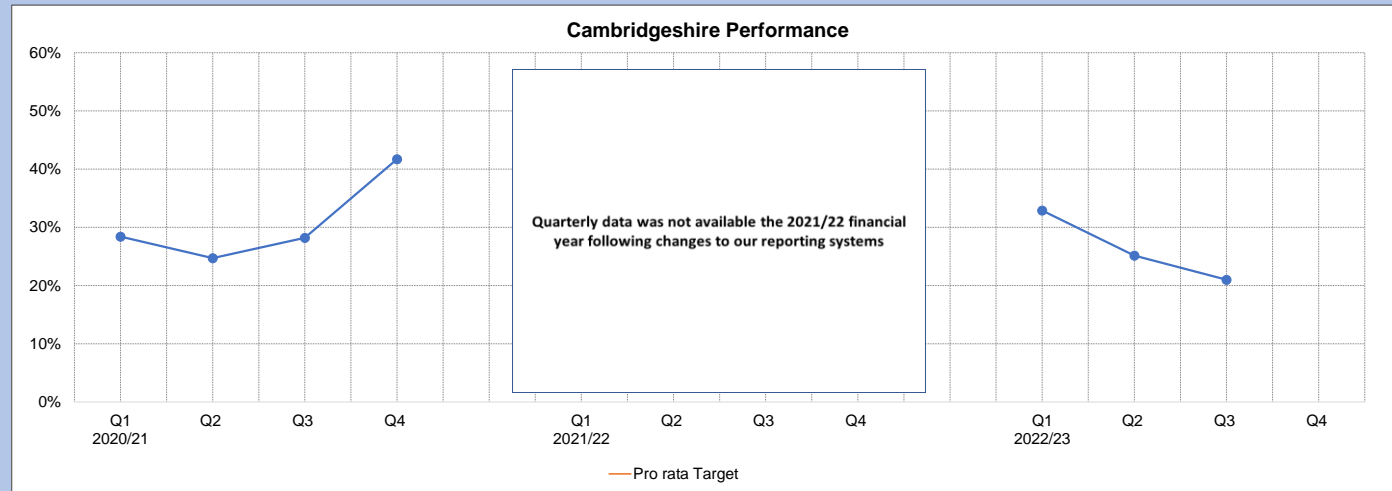
Y = Total number of people receiving long-term support for over 12 months at the end of the period

Useful Links

Cambridgeshire Performance

Quarterly data was not available the 2021/22 financial year following changes to our reporting systems

— Pro rata Target

Cambridgeshire Comparisons (last 3 financial years)

■ Cambridgeshire ■ Statistical Neighbours ■ England

Commentary

During this quarter, new reporting, in the form of a new interactive dashboard, has been published and is avaliable for routine use by staff. This will enable greater monitoring in this area.

During this year, there has been a significant level of activity undertaken to clear review backlogs that built up during the pandemic. Since March 2022 an external agency has been commissioned to work through the backlog of reviews for clients receiving long-term services. This additional capacity has significantly increased the number of reviews being completed; in 2021-22 there was an average of 294 reviews completed per month, which has increased to an average of 480 reviews for the first 6 months of the current financial year (2022-23). The increase of reviews being completed has resulted in a higher percentage of those receiving long-term services having had a review in the last 12 months. The external agency has been comissioned to conitnue providing some support for Q4 to continue to help work through backlogs in this area.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards. The work of the external review agency is coming to an end and action plans are being developed to plan in scheduling reviews in order to mitigate against backlogs building up once more, once the additonal capacity is removed.

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

March   2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
TBC	↑	68.5	38.5	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
440.8	1398.3	**TBC**

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

Cambridgeshire Performance

— Pro rata Target

Cambridgeshire Comparisons (last 3 financial years)

■ Cambridgeshire ■ Statistical Neighbours ■ England
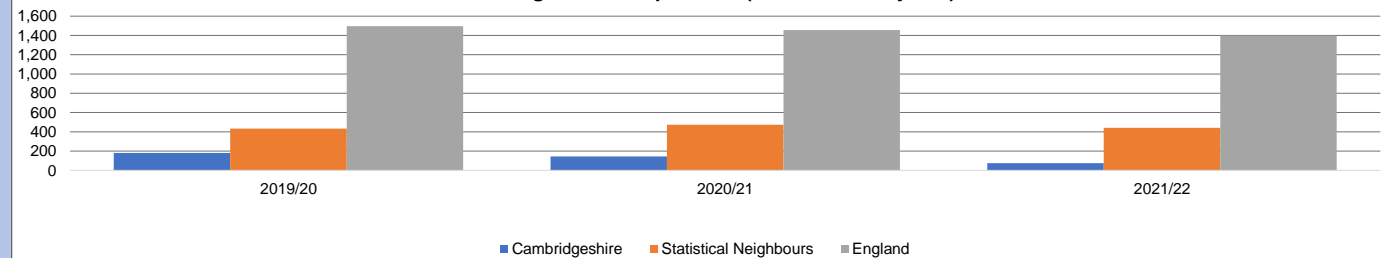
Commentary

A move away from carers assessments by default to a more constructive and timely conversation accounts for the lower volume of carers assessments. This should be seen alongside our carers conversation and carers triage activity. In quarter three we have completed:
•105 carers assessments
•23 carers reviews
•790 carers conversation steps
•1782 carers conversations considering the carers needs whilst supporting the person being cared for

The number of carers assessed or reviewed in the period is significantly below the national average, and the average of our statistical neighbours. This is due to how carer activity is recorded in Cambridgeshire and a reflection of our process. Activity by teams supporting carers can be recorded as carers conversations (on average 826 conversations were completed per month so far in 2022-23), which would not be counted in the above measure. The number of carers assessed or reviewed is comparable with previous years and reflects a similar rate.
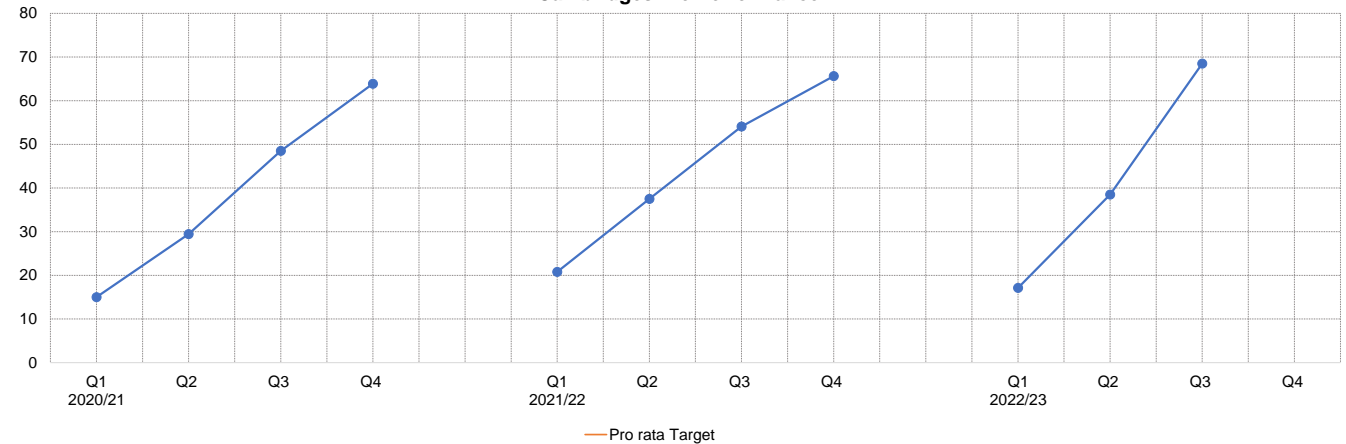
Useful Links

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

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

Indicator 234: % total people accessing long term support in the community aged 18-64   Return to Index   March 2023

Target	Direction for Improvement	Current Month	Previous Month	Change in Performance
TBC	↑	90.2%	90.0%	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
82.4%	84.7%	TBC

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.
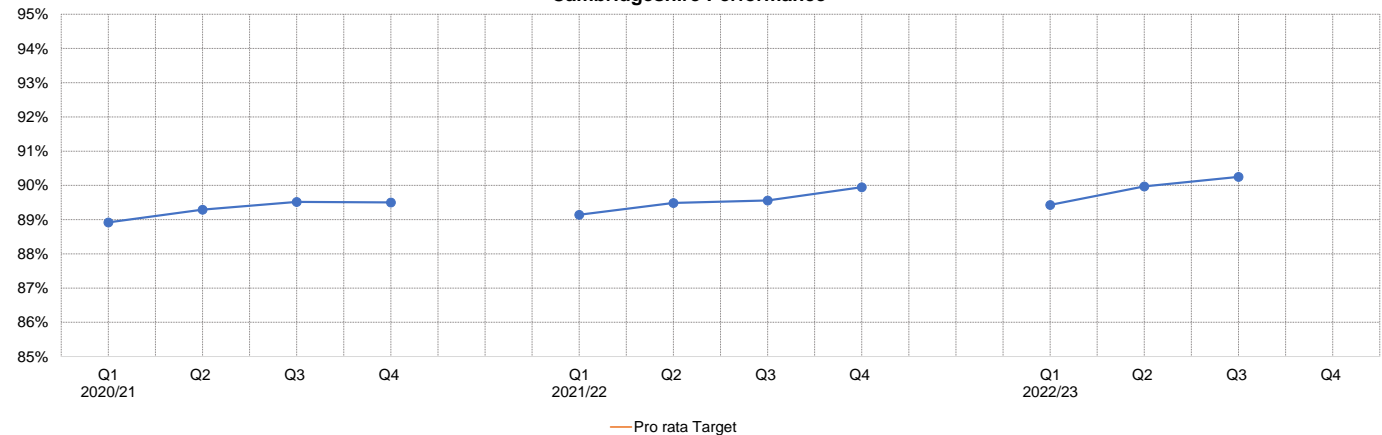
Calculation:

(X/Y)*100

Where:

X = Total number of people accessing long-term support in the community aged 18-64

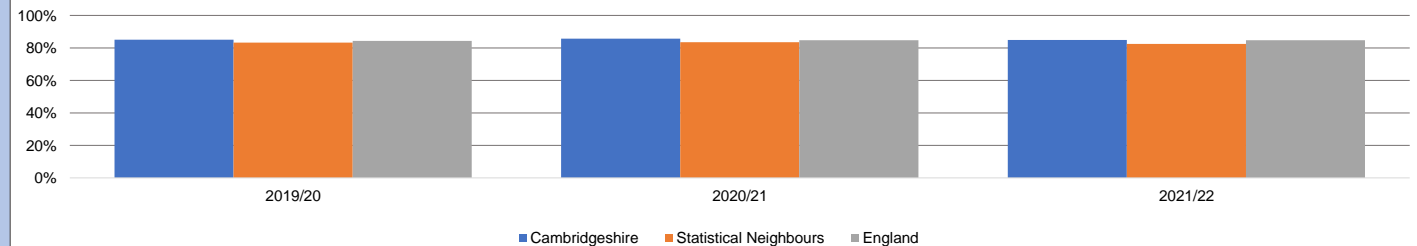Y = Total number of people accessing long-term support aged 18-64

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:

Cambridgeshire Performance

Cambridgeshire Comparisons (last 3 financial years)

Commentary

The number of people aged 18-64 receiving long-term support has increased slightly over the last 12 months (rising from 2,443 at the end of December 2021 to 2,492 at the end of December 2022 - an increase of 49). The proportion supported in a community setting has increased very slightly this quarter to remain above 90%.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

Indicator 235: % total people accessing long term support in the community aged 65 and over   **Return to Index**   **March   2023**

	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
Target				
TBC	↑	64.2%	62.7%	Improving

Statistical Neighbour Mean	England Mean	RAG rating
59.3%	62.4%	**TBC**

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:

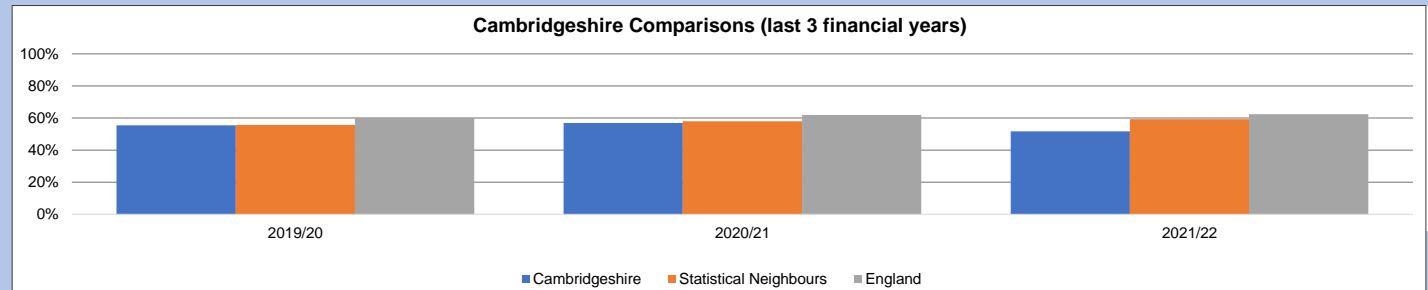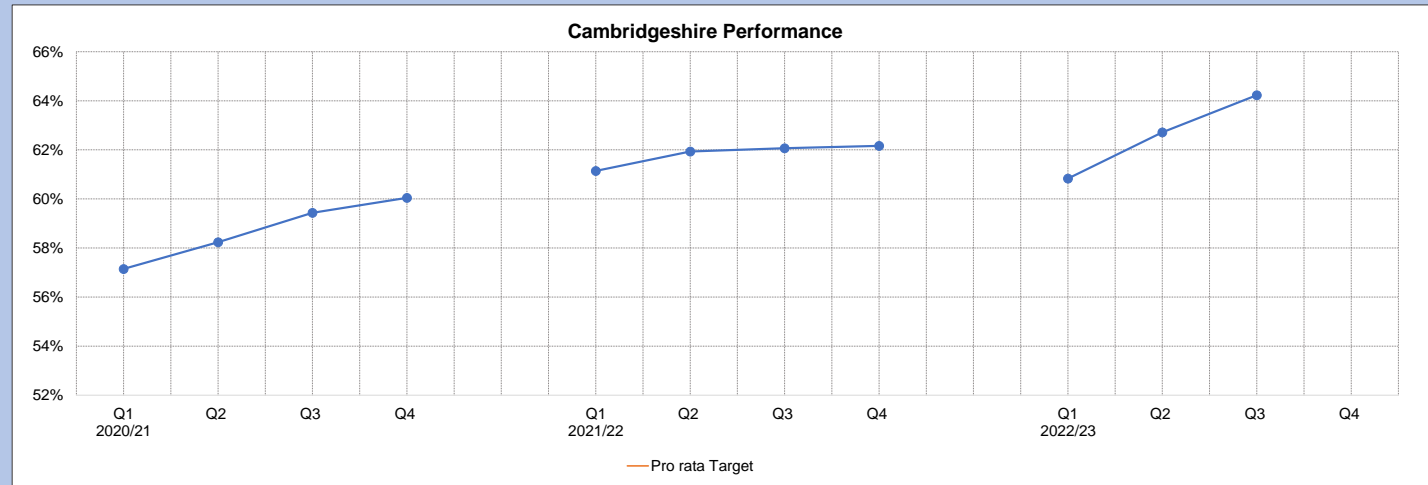X = Total number of people accessing long-term support in the community aged 65 and over

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:

Cambridgeshire Performance

— Pro rata Target

Cambridgeshire Comparisons (last 3 financial years)

■ Cambridgeshire   ■ Statistical Neighbours   ■ England

Commentary

The number of people aged 65+ receiving long-term support has increased slightly over the last 12 months (rising from 5,069 at the end of September 2021 to 5,113 at the end of September 2022 – an increase of 44). The proportion supported in a community setting has been increasing this financial year and is now above 64%, the highest it has been in the last 3 years.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

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

March   2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
TBC	↑	85.7%	83.5%	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
81.6%	79.7%	**TBC**

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
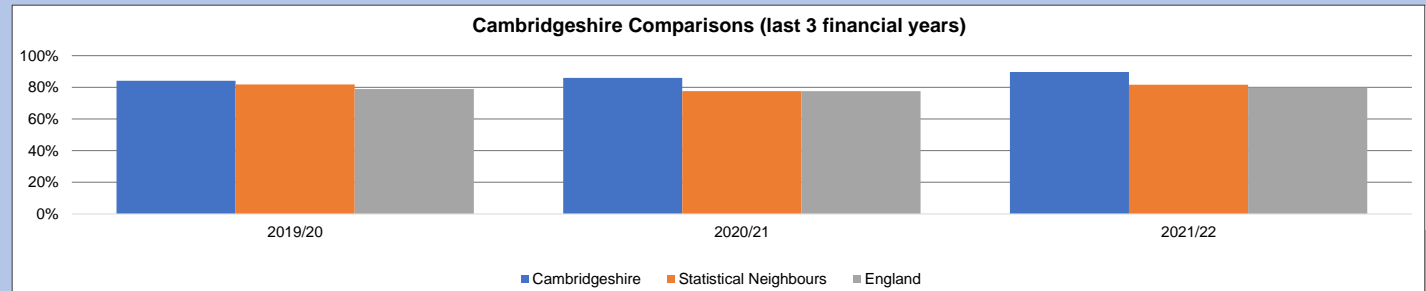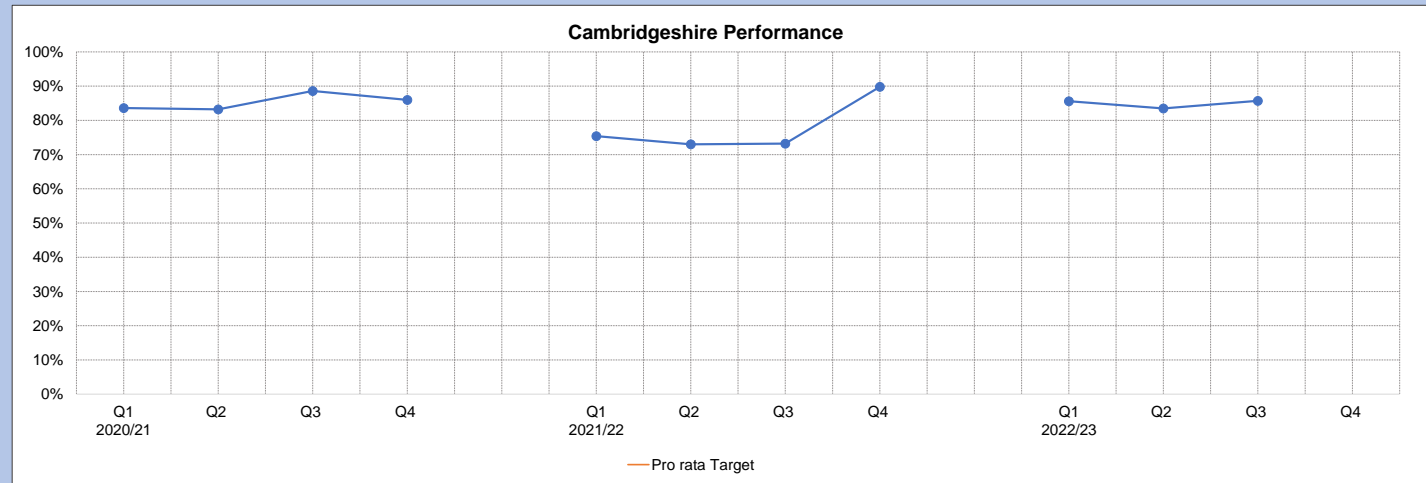
Y = The number of concluded enquiries

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:

Cambridgeshire Performance

Cambridgeshire Comparisons (last 3 financial years)

Commentary

Performance in this area continues to be high and comparable with national and statistical neighbour averages.

We continue to have reporting gaps for safeguarding. New dashboards are currently in development meaning not all the data needed to inform these indicators is available for routine use by staff. However, current performance suggests that the Making Safeguarding Personal agenda is fully imbedded in the safeguarding process.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

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

March   2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
TBC	↑	94.7%	96.9%	Declining

Statistical Neighbour Mean	England Mean	RAG Rating
97.1%	95.4%	TBC

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.

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:

Cambridgeshire Performance

Cambridgeshire Comparisons (last 3 financial years)
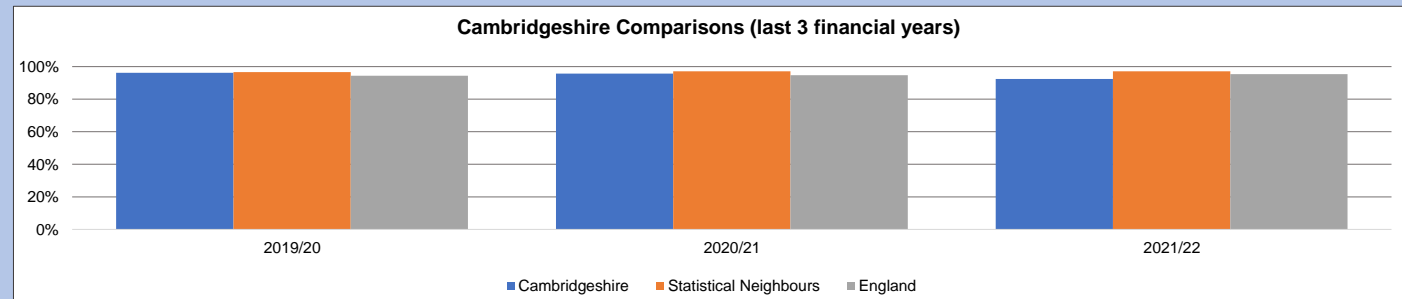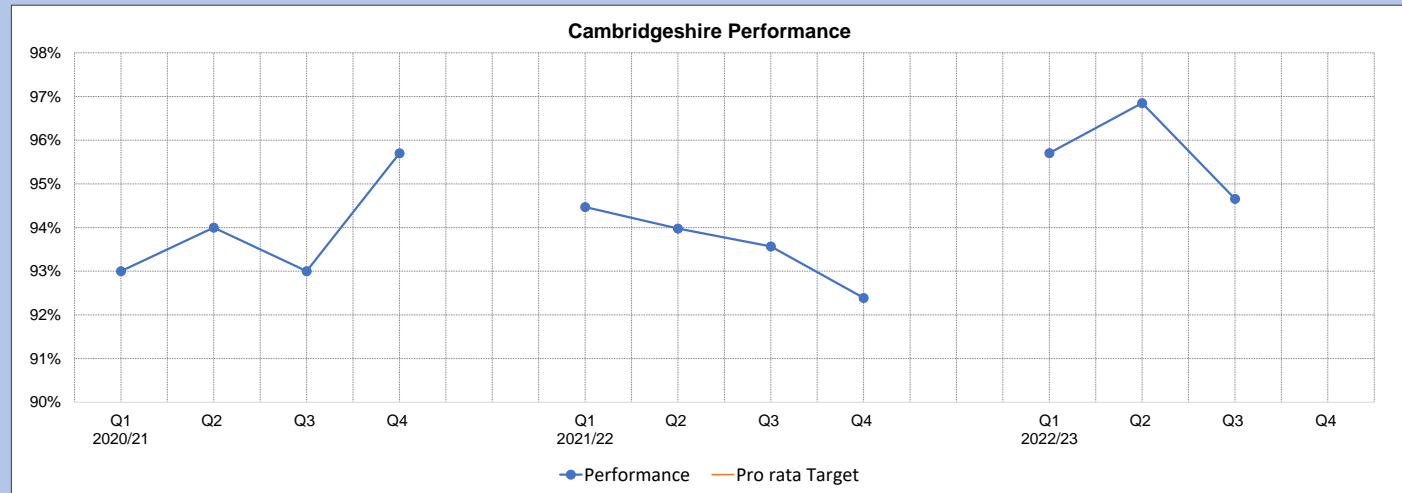
Commentary

Performance in this area continues to be high and comparable with national and statistical neighbour averages. Despite small fluctations between quaters, this financial year has shown a slight improvement in performance compared to previous years.

We continue to have reporting gaps for safeguarding. New dashboards are currently in development meaning not all the data needed to inform these indicators is available for routine use by staff. However, current performance suggests that the Making Safeguarding Personal agenda is fully imbedded in the safeguarding process.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

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

March 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
TBC	↑	91.8%	90.0%	Improving

Statistical Neighbour Mean	England Mean	RAG Rating
92.0%	91.2%	TBC

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:

Cambridgeshire Performance

—— Pro rata Target

Cambridgeshire Comparisons (last 3 financial years)

■ Cambridgeshire ■ Statistical Neighbours ■ England
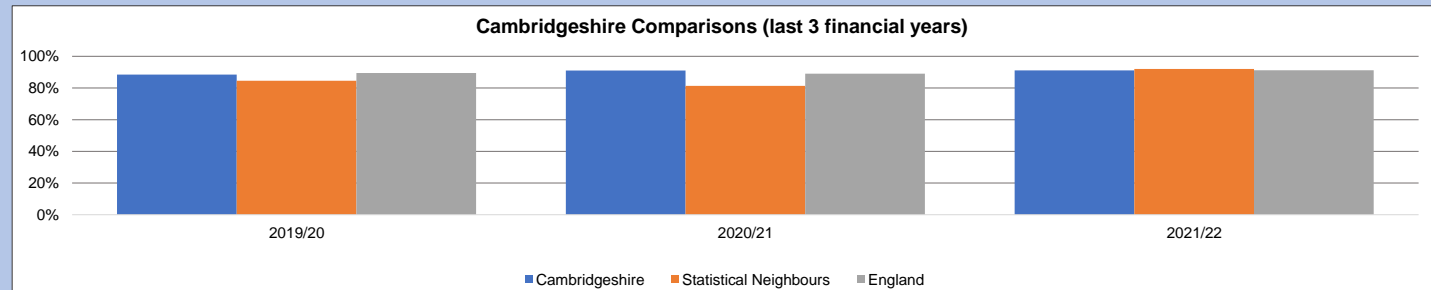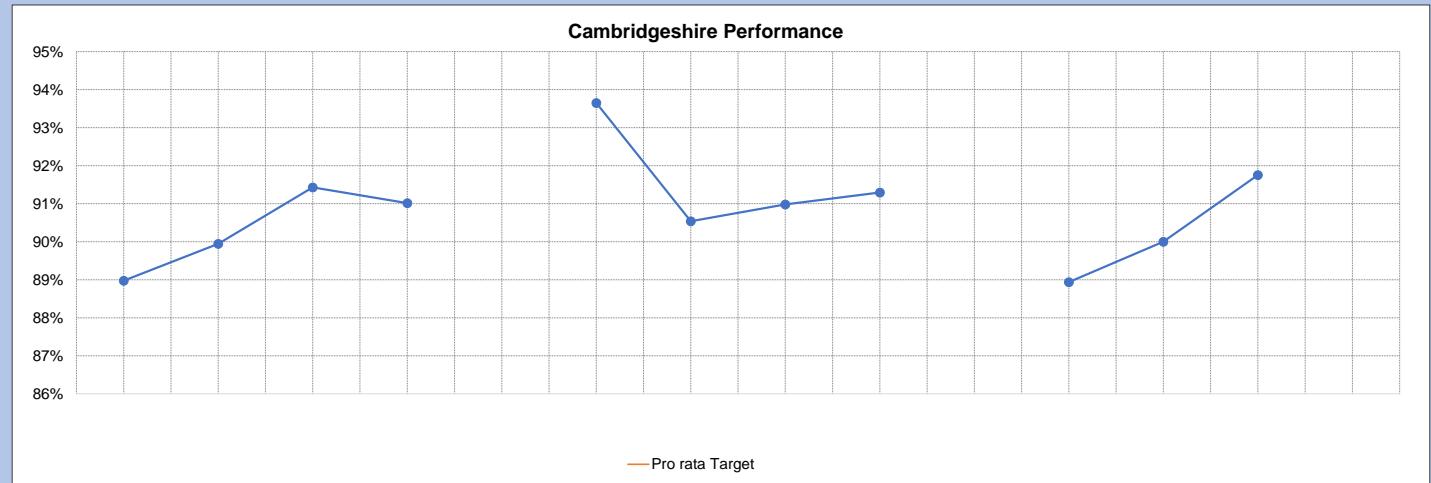
Commentary

Performance in this area continues to be high and is now above national and statistical neighbour averages.

In this quarter, new reporting in the form of new interactive dashboards, has been published and is avaliable for staff.

Actions

Data contained in this report will be used to inform a target setting process and targets will be reported from Q4 onwards

Indicator 201: Achievement against target for drug and alcohol service users who successfully complete treatment | Return to Index | March 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
20.4%	↑	21.25%	21.76%	Declining

Statistical Neighbour Mean	England Mean	RAG rating
N/A	N/A	Green

Indicator Description

Baseline period: Completion period: 01/04/2017 to 31/03/2018
Latest Period: Completion period: 01/04/2018 to 31/03/2019
Benchmarking comparison: (all substance groups): Opiates, Non-opiates, Alcohol & Non-opiates and Alcohol.

Direction of travel: Current data measured against the baseline (B). Due to rounding small differences, it may not be visible in displayed percentages, but are taken into account in direction of travel calculation.

Calculation:

(X/Y)*100

Where:

X = Successful completions.

Y = Total individuals in treatment.

Cambridgeshire Performance

Commentary

The Cambridgeshire commissioned Drug and Alcohol Treatment Service provided by Change Grow Live, continues to perform strongly against national indicators despite seeing an increase in the complexity of patients presenting during the covid pandemic. The challenge is to ensure that services are continuously promoted and individuals present to treatment at the earliest opportunity when they start struggling with drug/alcohol misuse.

Useful Links

National Drug Treatment Monitoring System statistics webpage

Actions

Indicator 237: % achievement against target for adult referrals to Health Trainers/Behaviour Change Service (Lifestyle) from the 20% most deprived areas.   **Return to Index**   **March 2023**

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
0	↑	34.0%	34.0%	Unchanged

Statistical Neighbour Mean	England Mean	RAG Rating
#N/A	#N/A	Blue

Indicator Description

This indicator is the proportion of referrals to the Health Trainer Service that live in the 20% most deprived areas of Cambrdiegshire

The target proportion (%) is 30% of the total number of referrals

.

If an individual is referred who lives in the 20% most deprived areas (Quintile 1 postcode) then they are considered a referral from an area of high deprivation.

Health Trainers support people to make healthy behaviour changes. They are one of the services that make up the Behaviour Change Services (Lifestyle).

Useful Links

Cambridgeshire Performance
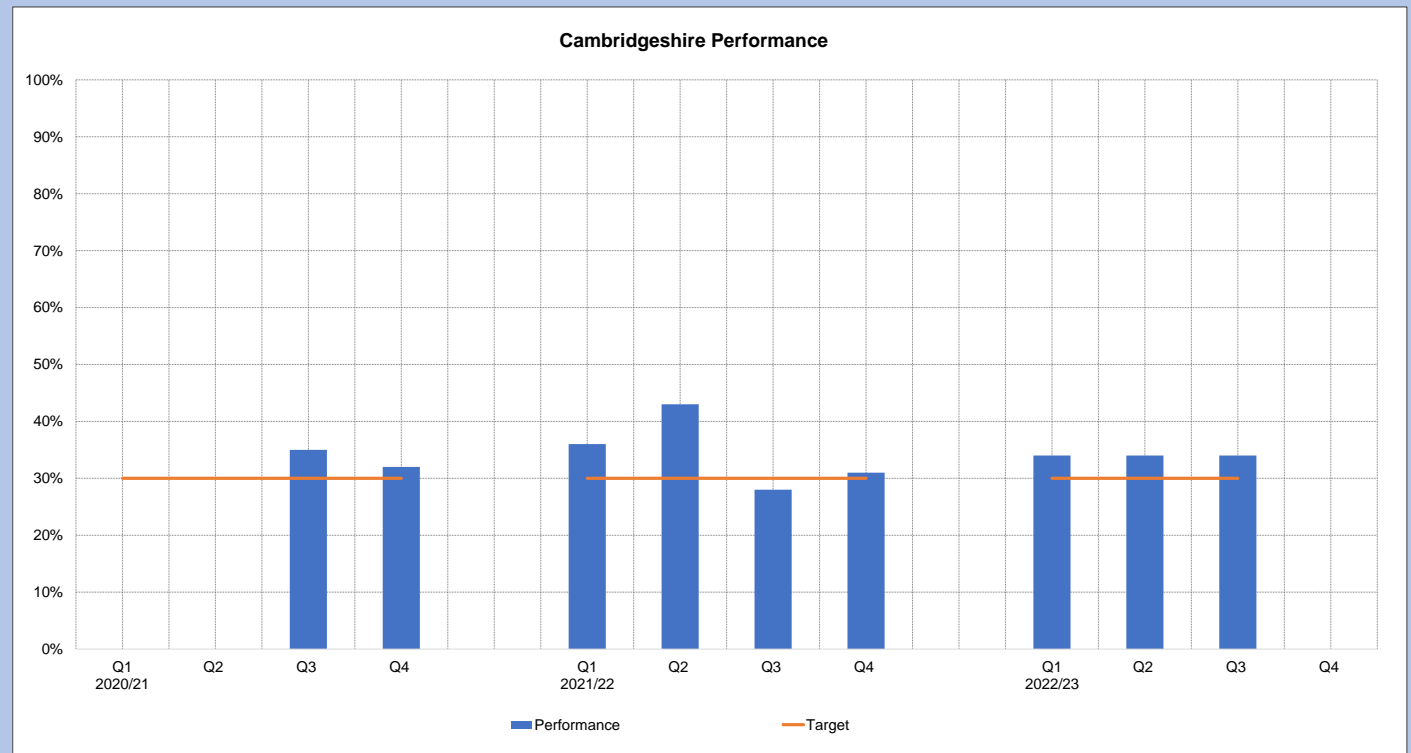
Commentary

Referral into the Health Trainer service have been above target for Q3 at 774 referrals against a target of 689. Of those referrals, 267 (34%) are from the 20% most deprived areas which is above the 30% target. The target is consistently being achieved this year.

The data for this indicate is not available for the first two quarters of 2020/21 due to a change in contract.

Actions

The Behaviour Change Service is establishing new working relationships with Primary Care Networks (PCN) in the areas of high deprivation to increase referrals.

In addition the Service is locating more face-to-face clinics in areas of high deprivation to increase accessibility for the people who live in those areas.

Indicator 56: % achievement against target for smoking quitters who have been supported through a 4-week structured course

Return to Index **March 2023**

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
100%	↑	25.4%	25.8%	Declining

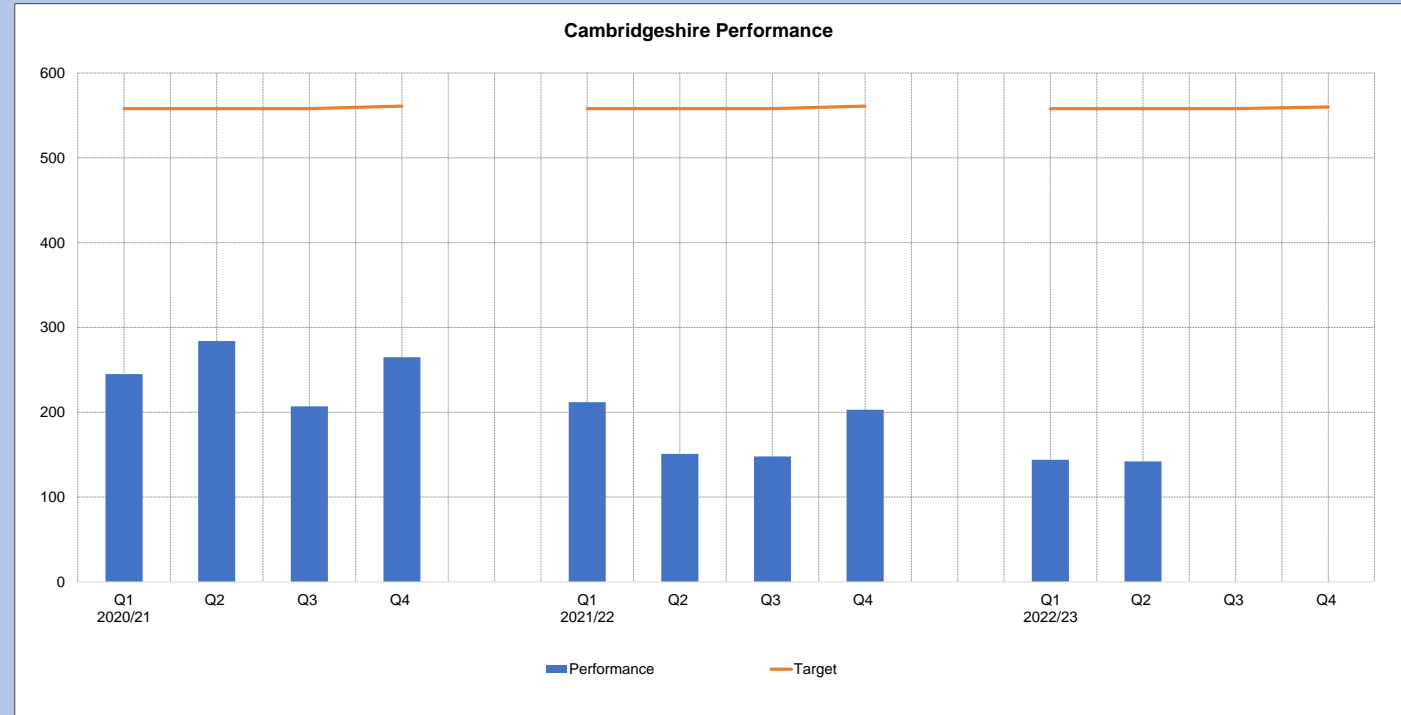| Statistical Neighbour Mean	England Mean	RAG rating
N/A	N/A	**Red**

Indicator Description

Smoking remains a Public Health priority area. It remains the main cause of preventable illness in England.

This indicator is calculated as the number of individuals accessing a stop smoking programme (through a GP, pharmacy or behaviour chnage service (lifestyle), who set a quit date which is followed by 4 weeks of an evidence based, structured, programme of support. The indicator refers to those who are confirmed as quitting after 4 weeks.

Targets are made by the Public Health Intelligence team. This is based on the national guidance and based on the estimated number of smokers.

Calculation: Number of 4 week quitters.

Source: National Centre for Smoking Cessation and Training (NSCST) Stop Smoking Guidance

Useful Links

The local area benchmarking tool from the Local Government Association

The National Institute for Health Care Excellence (NICE) stop smoking interventions guidelines

Cambridgeshire Performance

Commentary

Stop Smoking performance data is always two months behind the reporting period. This is due to the intervention taking two months in total to complete. This means the complete quarter 3 data is not available at this time.

In Cambridgeshire stop smoking services that is the provision of a structured 4 week quit attempt are provided by GP practices, community pharmacies and the Behaviour Change Service (lifestyle). The target includes quits from all the providers.

During the COVID-19 pandemic stop smoking services stopped in GP practices and community pharmacies. It fell in the behaviour change service but did not stop in the period. None of the services have fully recovered and the target is not being met by any of them.

During quarter 2 22/23 the Behaviour Change Service/Stop Smoking had reduced staff capacity whilst it's newly recruited colleagues were completing their induction and mandatory training. However, it achieved 98% of it's trajectory target in quarter 2, compared to only 64% in quarter 1. GP practices are still experiencing demand pressures and are find it challenging to provide stop smoking services plus two of the main smoking cessation pharmacotherapies (Champix and Zyban) have been withdrawn due to safety issues both these issues are impacting the overall numbers.

Actions

The Behaviour Change Service now had a full team of trained Stop Smoking Advisors. They are establishing new working relationships with the Primary Care Networks (PCNs) to support stop smoking clinics and 'road show' events to increase awareness of the stop smoking services for Cambridgeshire residents.

Additional funding is being provided to increase staff capacity within the Stop Smoking Behaviour Change Service, this will allow for more targeted interventions in areas where smoking prevalence is higher e.g. Fenland and Cambridge City. Funding is also being provided to fund stop smoking app licenses to engage those people who don't wish to attend traditional stop smoking services and would prefer digital support.

The Behaviour Change team has increased engagement with GP Practices to support the providers to increase activity to pre-Covid levels. The Service staff will continue to support GP practices and deliver on-site services. This has been achieved by ensuring their patients can have easy access to services, both in "safe" face to face contact and also virtually.

Indicator 53: NHS Health Checks (cardiovascular disease risk assessment) Achievement against target set for completed health checks

Return to Index   **March   2023**

YTD Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
15000	↑	3564	2777	Improving

Statistical Neighbour Mean	England Mean	RAG rating
N/A	N/A	**Red**

Indicator Description

The NHS Health Check is a national Programme. It provides a way of engaging people in early conversations about their health, risks and lifestyle changes. It is risk assessment for the early detection of risk factors relating to Diabetes, Hypertension and Cardiovascular Disease. It also provides an opportunity to discuss dementia awareness.

This is measured as the number of people aged between 40 and 74 years of age, without any diagnosed ongoing condition, who receive an NHS Health Check through their GP Practice or through the outreach NHS Health Checks. The latter are undertaken by the Lifestyle Services with hard to reach groups or populations with high rates of cardiovascular disease.

Targets are set based on the eligible population for an NHS Health Check. This is outlined in the NHS Health Check programme guidance. The local authority's Public Health Intelligence Team support with target setting across all GP practices.
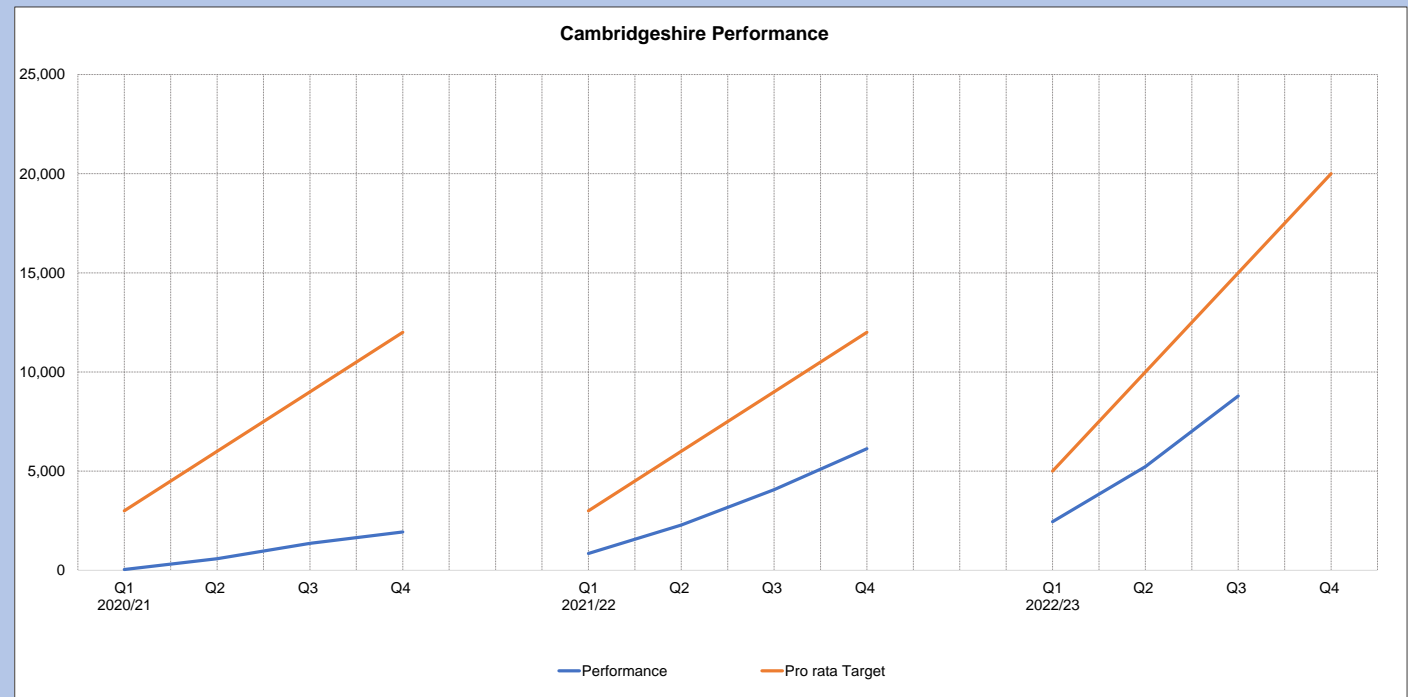
Calculation: Number of health checks completed within a financial quarter.

Source: NHS Health Check National Guidance

Useful Links

The local area benchmarking tool from the Local Government Association

Health Check National Guidance from the National Health Service

Cambridgeshire Performance

Commentary

NHS Health Checks are mandatory for the Local Authority to commission/provide. However it is collaborative delivery with GP practices, as eligible GP practice patients are invited from their patient lists. In Cambridgeshire most of the NHS Health Checks are provided by GP practices but the Behaviour Change Service also provides opportunistic NHS Health Checks.

During the COVID-19 pandemic GP practices were told by Department of Health and Social Care/NHS England/Public Health England that NHS Health Checks were not a priority and there were periods when GPs stopped all NHS Health Check activity. Also the Behaviour Change Services did not undertake any NHS Health Checks during the pandemic.
Consequently no local targets were set for primary care for 2020/21. Recovery started in 2021/22 but due to GP practice pressures including vaccination demands numbers were slow to recover.

In 2022/23, delivery continued to improve in GP practices. However, many practices are still struggling with backlogs, capacity issues and other pressures, and so we are seeing a very mixed response in performance across GP practices and areas of the county. In Q3 (Oct to Dec '22), activty has improved from approx 50% to 70% of the targets set.

Actions

Public Health has commissioned local GP Federations, to deliver on behalf of GP practices (from Quarter 3). (GP Federations are groups of practices that come together to deliver services and provide additional capacity)
We have commissioned GP Federations to deliver catch up NHS Health Checks and help practices to meet their targets. Incentive payments will also be paid for meeting targets.

We are also commissioning the Behaviour Change Service to undertake NHS Health Checks on behalf of GP practices and to increase the number of opportunistic NHS Health Checks. Starting in 2022 / 2023, practices will also be receiving personalised performance reports across all Public Health commissioned services.

Indicator 57: % Of infants breastfeeding at 6-8 weeks (need to achieve 95% coverage to pass validation)

March   2023

	Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
	56.0%	↑	54.0%	58.0%	Declining

	Statistical Neighbour Mean	England Mean (2021/22)		RAG Rating
	57.0%	49.0%		Amber

Indicator Description

There has been a lot of research published demonstrating the positives outcomes breastfeeding can have on mother and infant. It is recommended that mothers exclusively breastfeed. Breastmilk is associated with several benefits. These include a reduction in the risk of infections, obesity and diabetes in the infant, and a reduced risk of ovarian/breast cancer in the mother.

Breastfeeding is also known to have a positive impact on mother and infant attachment that can enhance the quality of relationships between parents and their babies. This will positively influence a child's future life chances.

Calculation:

(X/Y)*100

Where:

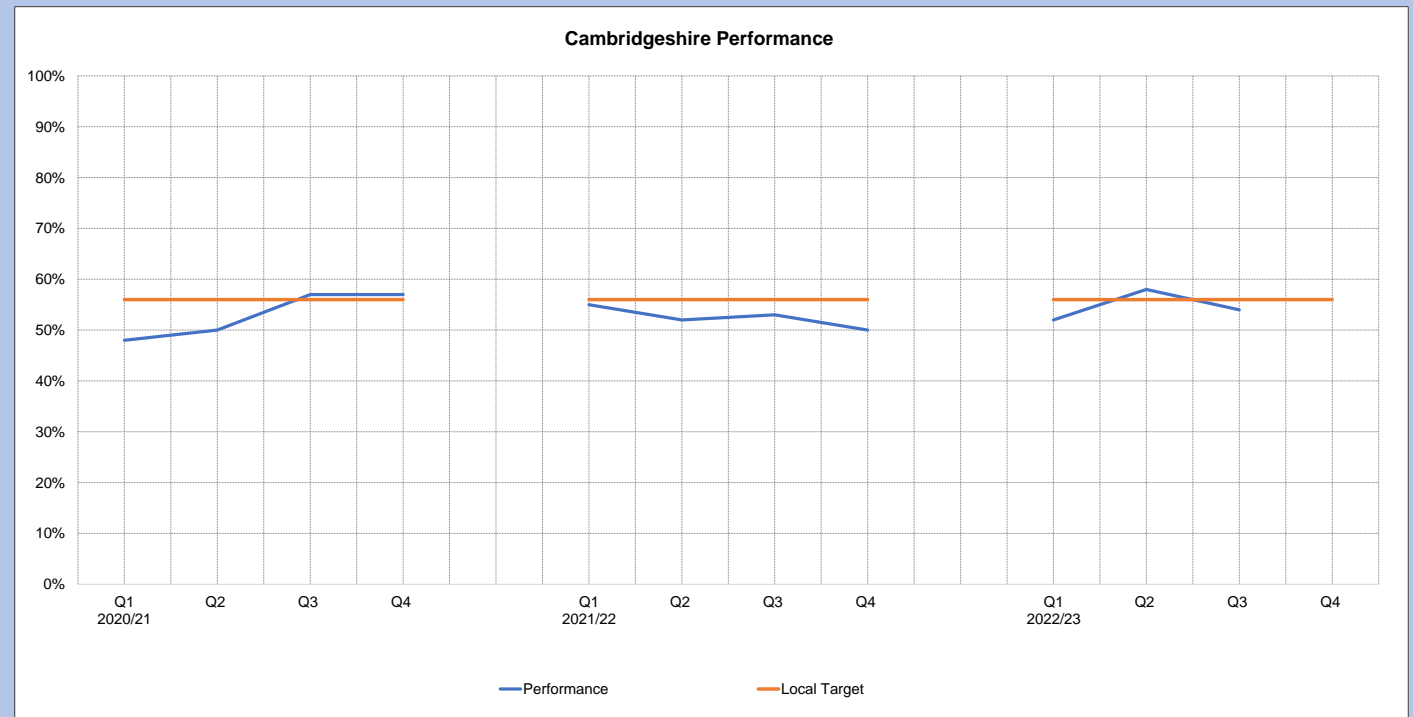X = Number of infants recorded as being totally and partially breastfed at 6 to 8 weeks

Y = Total number of infants due 6 to 8 week check.

Cambridgeshire Performance

Commentary

This is a challenging, locally set target. It considers the national average currently stands at 47%. County-wide performance breastfeeding statistics tends to fluctuate but continues to exceed the England Average and in spite of an increase in breastfeeding rates in Q2, this has dropped marginally again in Q3. It is likely that this is due to a lower recording of breastfeeding status at the 6-8 week check in December which is linked to disruption to contacts due to the festive period causing a time lapse in contact completions. It is envisaged that a data refresh of the January 2023 data will improve this figure. Breastfeeding rates, which include both exclusive breastfeeding and mixed feeding, do however continue to vary greatly across the county. Broken down by districts, breastfeeding for 2022/23 quarter 3 stand at 68% in Cambridge City, 60% in South Cambridgeshire, 55% in East Cambridgeshire, 52% in Huntingdonshire, and 30% in Fenland.

The Health Visiting service remains Stage 3 UNICEF Baby Friendly accredited. This shows quality of care in terms of support, advice and guidance offered to parents/carers. It also shows the excellent knowledge staff have in respect of responsive feeding. The Health Visiting specialist infant feeding team continues to face a high level of demand and have subsequently appointed three additional Infant Feeding Advisors to manage this.

Useful Links

The local area benchmarking tool from the Local Government Association

Public Health England breastfeeding statistics webpage

Actions

To address low breastfeeding rates in Fenland, a weekly infant feeding clinic had been set up to help better support families experiencing difficulties, as well as home visits and a virtual offer to maximise access. Along with support offered through Health Visitors, there is also a community breastfeeding peer support service commissioned in the district and is provided through the NCT. In October 2022, we also launched the new 5-year Infant Feeding strategy (https://cambridgeshireinsight.org.uk/wp-content/uploads/2022/11/Cambridgeshire-and-Peterborough-Infant-feeding-Strategy-2022-27.pdf) which sets out our ambitions to improve the quality of support provided to parents across the continum of their infant feeding journey. Work is now underway to develop an action plan against this strategy which aligns to the Family Hubs transformation programme delivery plan across Peterborough and Cambridgeshire, where support for infant feeding is a core priority area. Specific actions around this workstream are firmed up, including a decision on future commissioning intentions for the community peer support service which ends 1st October 2023.

Indicator 59: Health visiting mandated check - Percentage of births that receive a face to face New Birth Visit within 14 days, by a health visitor

　　March 2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
90.0%	↑	38.0%	40.0%	Declining

Statistical Neighbour Mean	England Mean (2021/22)	RAG Rating
87.0%	83.0%	**Red**

Indicator Description

The new birth visit is a face to face review. This includes providing information on a range of topics including infant feeding, Sudden Infant Death Syndrome prevention and safe sleep, the immunisation schedule and outcomes of all screening and Newborn and Infant Physical Examinations. The Health Visitor will also assess maternal mental health and the baby's growth and development.
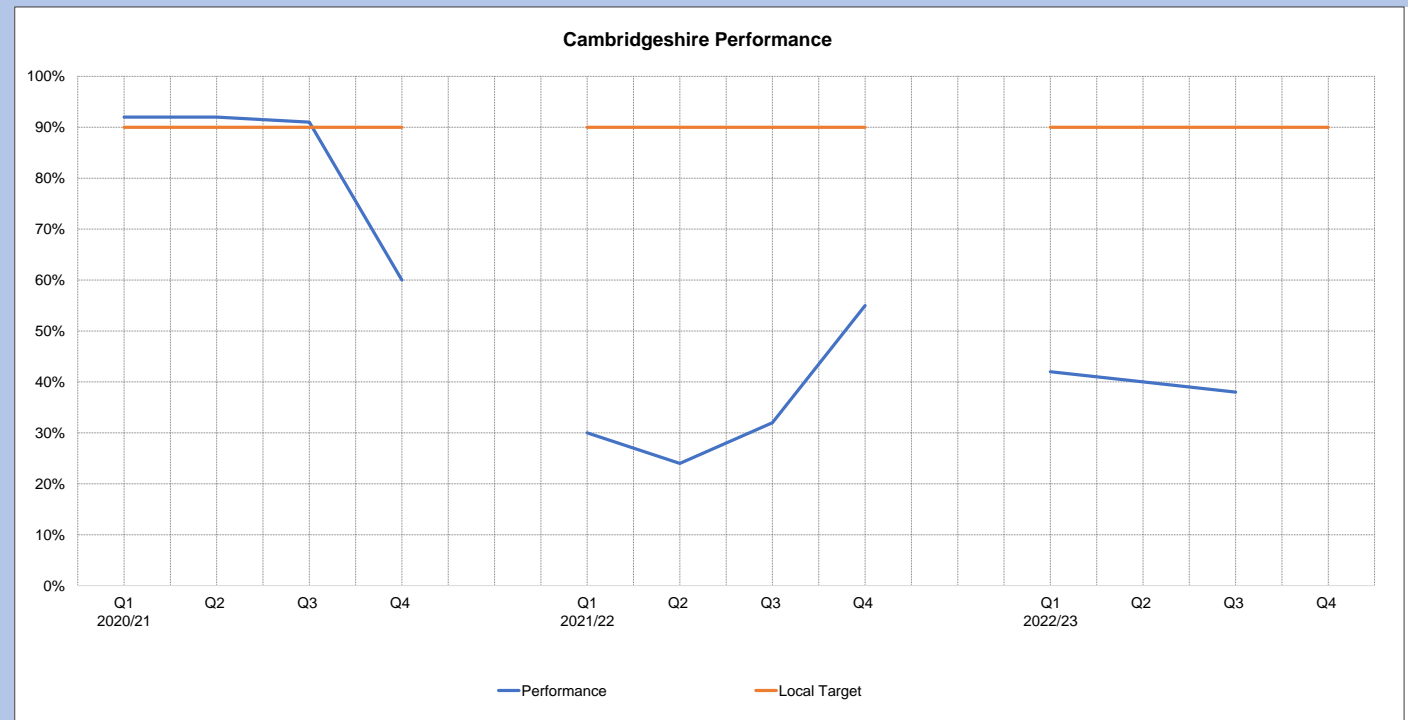
Calculation:

(X/Y)*100

Where:

X = Total number of infants who turned 30 days in the quarter who received a face to face New Birth Visits undertaken within 14 days from birth. Visits must be undertaken by a Health Visitor with mother (and ideally father).

Y = Total number of infants who turned 30 days in the quarter.

Useful Links

The local area benchmarking tool from the Local Government Association

Public Health England health visitor service delivery statistics 2018 to 2019

Cambridgeshire Performance

Commentary

Initially instigated as part of Covid-19 response measures and as a mitigation measure to address capacity pressures within the service, Commissioners agreed jointly with the provider to allow a delay in the timeframe within which the new birth visit (stretched to 21 days) and 6-8 check (stretched to 12 weeks) contact could be completed. The provider is working hard to bring these back into timescale however continues staffing pressures have impacted the ability to achieve this as quickly as anticipated. Therefore a lot more families are being seen than reported in these figures. Commissioners work closely with the provider to ensure a high coverage level across all mandated contacts and if contacts completed outside of timescale were also included in this data, coverage would be significantly higher. For this indicator, if those completed after 14 days are included, the quarterly average increases to 97% for the Q3 period. This is 1% below the overall 98% target for completed visits, but indicates that most families are receiving this contact, albeit after the 14th day. All new birth visits are now taking place face to face as part of a home assessment.

Actions

The provider will continue to progress efforts to bring all mandated contacts back within timescale, this includes an excerise with professional leads to review the appointment booking process to improve diary management. Commissioners are intending to prioitise returning all mandated contacts into timescale in the 2023/23 service Annual Development Plan.

Indicator 60: Health visiting mandated check - Percentage of children who received a 6 to 8 week review by 8 weeks

　　March　2023

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
95.0%	↑	42.0%	37.0%	Improving

Statistical Neighbour Mean	England Mean (2021/22)	RAG Rating
77.0%	82.0%	**Red**

Indicator Description

This visit is crucial for assessing the baby's growth and wellbeing. It also helps provide core health messages. These include breastfeeding, immunisations, sensitive parenting and for supporting on specific issues such as sleep.

The Health Visitor will review the baby's general health and provide contact details for local health clinics and children's centres where the parents can access a range of support. The visit, in addition to the 6 to 8 week medical review (which is often completed by the GP) and forms part of the Child Surveillance Programme.
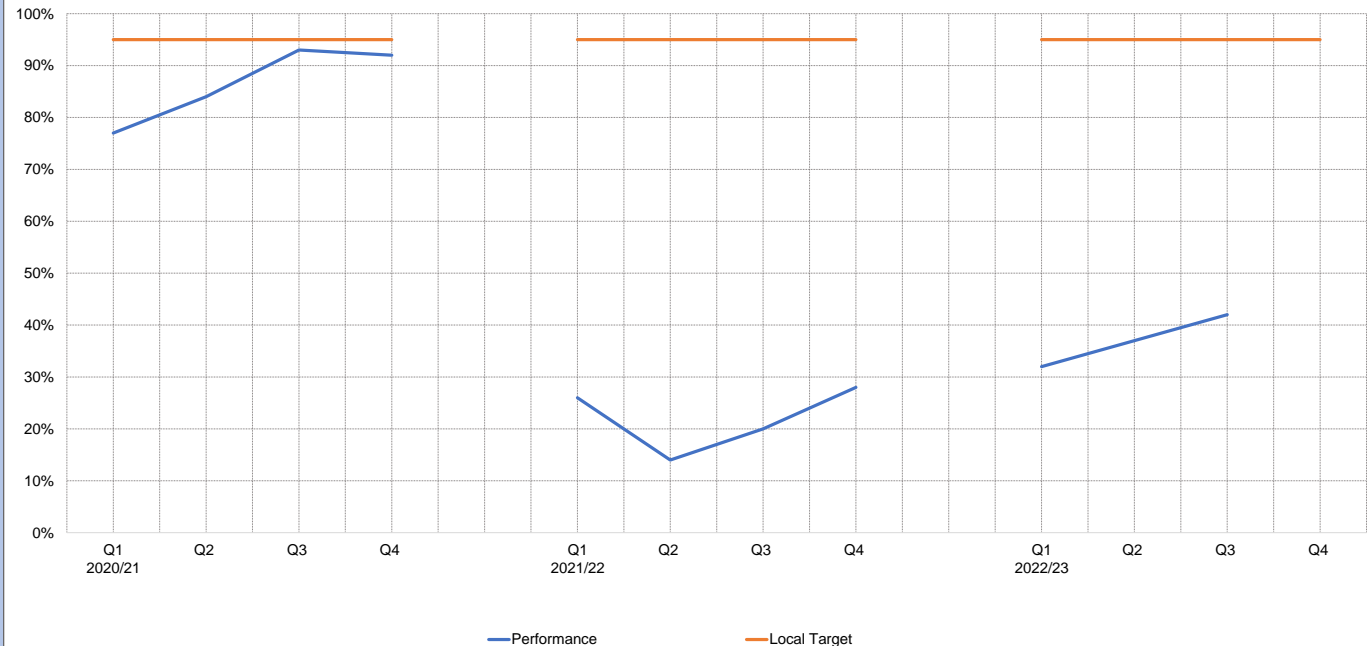
Calculation:

(X/Y)*100

Where:

X = The number of children due a 6 to 8 weeks review by the end of the quarter who received a 6 to 8 weeks review by the time they turned 8 weeks.

Y = Total number of infants turning 8 weeks old during reporting period.

Cambridgeshire Performance

Useful Links

The local area benchmarking tool from the Local Government Association

Public Health England health visitor service delivery statistics 2018 to 2019

Commentary

Initially instigated as part of Covid-19 response measures and as a mitigation measure to address capacity pressures within the service, Commissioners agreed jointly with the provider to allow a delay in the timeframe within which the new birth visit (stretched to 21 days) and 6-8 check (stretched to 12 weeks) contact could be completed. The provider is working hard to bring these back into timescale however continues staffing pressures have impacted the ability to achieve this as quickly as anticipated, although progress has been made during Q3. Therefore a lot more families are being seen than reported in these figures. Commissioners work closely with the provider to ensure a high coverage level across all mandated contacts and if contacts completed outside of timescale were also included in this data, coverage would be significantly higher. For this indicator, if those completed after 8 weeks are included, the quarterly average for 83 increases to 89% demonstrating that most families are receiving this contact, albeit after the 8th week, with a high proportion being completed within 10 weeks. All 6-8 week visits are now taking place face to face as part of a home visit.

There is an understanding that this is a challenging target to meet. Therefore, it has been agreed that if the provider can show the ability to sustain 95% 6 to 8 week Breastfeeding Coverage target, this could potentially be scaled back to 90% as there is no natioanlly set target. This quarter has been the first time this 95% breastfeeding coverage target has been achieved since pre-pandemic and needs to be monitored further until any decision is made.

Actions

The provider will continue to progress efforts to bring all mandated contacts back within timescale, this includes an excerise with professional leads to review the appointment booking process to improve diary management. There is also a piece of work required to better understand how this contact aligns to the GP 6-8 week contact for all new-borns. Commissioners are intending to prioitise returning all mandated contacts into timescale in the 2023/23 service Annual Development Plan.

Indicator 62: Health visiting mandated check. Percentage of children who received a 2 to 2.5 year review by the age of 2.5 years
Return to Index   **March   2023**

Target	Direction for Improvement	Current Quarter	Previous Quarter	Change in Performance
90.0%	↑	57.0%	42.0%	Improving

Statistical Neighbour Mean	England Mean (2017/18)	RAG Rating
N/A	68.0%	**Red**

Indicator Description

The 2 year check includes the review with parents of the child's, emotional, social, behavioural and language development using the The Ages & Stages Questionnaires (ASQ). The visit will respond to any concerns, offer guidance on behaviour management, promote language development, encourage the take up of early education and the two year old funded offer, as well as general health promotion (dental health, healthy eating, injury and accident prevention, toilet training).

Calculation:

(X/Y)*100

Where:

X = Total number of children who turned 2.5 years in the quarter who received a 2-2.5 year review, by the age of 2.5 years of age.

Y = Total number of children who turned 2.5 years, in the appropriate quarter.

Useful Links

The local area benchmarking tool from the Local Government Association

Public Health England health visitor service delivery statistics 2018 to 2019

Cambridgeshire Performance
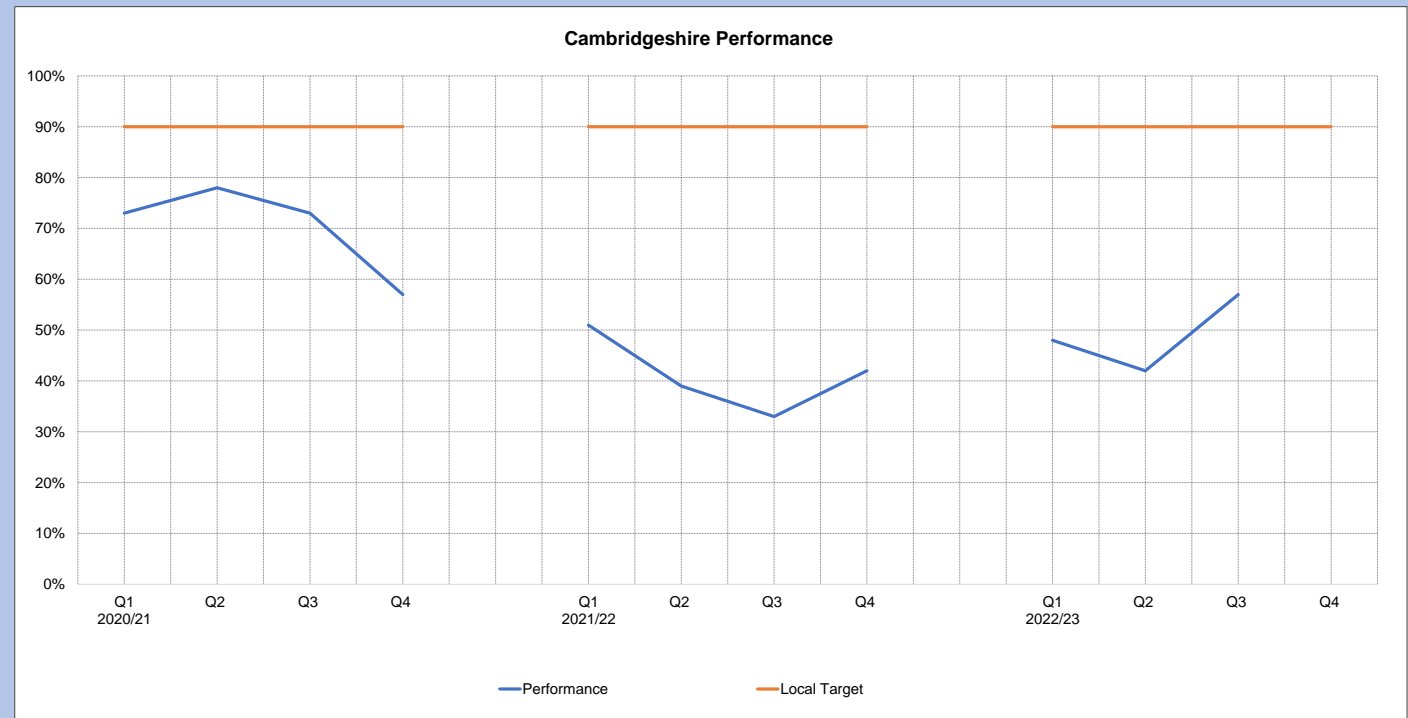
Commentary

Performance against this contact has been challenging over recent years and commissioners have agreed with providers to prioritise this contact as part of the Annual Development Plan as it is recognised that this years cohort will be the first children born in lockdown to have this development assessment. Part of the measures to improve coverage have also included the launch of an innovative pilot of a multi-agency approach to this deliver this with Child and Family Centres and Early Years to enable a broader number of practitioners undertake this review with supervision and oversight of the Healthy Child Programme - this is completed in a group based setting within a child & family centre and offers a more holistic review of the child and wider support availbale to the family. It is important to note that this is only for universal families and a traditional home-based or virtual review is completed for more vulnerable families or based on parental choice. An early evaluation of the pilot has been conducted and improvements are starting to show and the incentives set against this has been achieved at all milestones set this year, however it is not clear in this data as it does not include the number of reviews have been completed after 2.5 years. If these were included in the data, the Q3 average would increase to 87%, which is substantially higher that the figure reported.

Actions

Further improvements are expected as part of the Annual Development Plan and there are key actions arising from the pilot early evaluation to apply learning and also expand this to other parts of the county. Presently this pilot is operating in Cambridge City and Peterborough, with plans to roll this out in the Sawtry and St Neots area of Huntingdonshire from February 2023.

Adults and Health Policy and Service Committee Agenda Plan

Published 1st March 2023

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	Timings	Deadline for reports	Agenda despatch date
09/03/23	Procurement of additional respite service capacity for Adults with Learning Disability and Autism	T Bawden	2023/025		24/02/21	01/03/23
	Procurement of care and support in Extra Care	L O'Brien	2023/032			
	A review of the Learning Disability Partnership Section 75 pooled budget financial risk share arrangements	G Singh	2023/027			
	An update on the cost of care and market sustainability	J Melvin	2023/009			
	Care Home Trusted Assessor Tender – Contract Exemption Request	A Bourne	2023/026			
	All Age Advocacy Procurement	L Sparks	2023/005			

Committee date	Agenda item	Lead officer	Reference if key decision	Timings	Deadline for reports	Agenda despatch date
	Adults Social Care Service User Survey Feedback	D McQuade	Not applicable			
	Finance Monitoring Report	J Hartley	Not applicable			
	Performance Monitoring Report	V Thomas T Hornsby	Not applicable			
	Cambridgeshire Care Sector Strategy	G Singh	Not applicable			
	Scrutiny Items					
	Major Trauma Unit	TBC	Not applicable			
	Virtual wards	TBC	Not applicable			
	Quality Accounts Governance	Kate Parker	Not applicable			
27/04/23 Reserve Date	Integrated Neighbourhoods (Development Session)	D McQuade W Patten			14/04/23	19/04/23
29/06/23	Finance Monitoring Report	J Hartley	2023/047		16/06/23	21/06/23
	Cost of Care: Market Sustainability Report - Outcome	W Patten/G Singh	Not applicable			
	Performance Monitoring Report	V Thomas T Hornsby	Not applicable			
	CQC Assurance (Progress report on LGA Peer Review recommendations)	T Hornsby C Townsend	Not applicable			
	Carers Strategy	L Sparks	Not applicable			
	Smoking Cessation Service Update	V Thomas	Not applicable			
	Scrutiny Items					
Tentative	Access to GP Primary care Services	TBC	Not applicable			

Committee date	Agenda item	Lead officer	Reference if key decision	Timings	Deadline for reports	Agenda despatch date
Tentative	ICB Financial Plans	TBC	Not applicable			
Tentative	Share care records	TBC	Not applicable			
21/09/23 Reserve Date					08/09/23	13/08/23
05/10/23	Behaviour Change Services re-commission	Val Thomas	2023/003		22/09/23	27/09/23
	Workforce Update	TBC	Not applicable			
	Business Planning	D McQuade/W Patten	Not applicable			
	Finance Monitoring Report	J Hartley	Not applicable			
	Performance Monitoring Report	V Thomas T Hornsby	Not applicable			
	Scrutiny Items					
Tentative	NHS Workforce Development	TBC	Not applicable			
14/12/23	Business Planning	D McQuade/W Patten	Not applicable		01/12/23	06/12/23
	Finance Monitoring Report	J Hartley	Not applicable			
	Performance Monitoring Report	V Thomas T Hornsby	Not applicable			
	Scrutiny Items					
25/01/24					12/01/24	17/01/24

Committee date	Agenda item	Lead officer	Reference if key decision	Timings	Deadline for reports	Agenda despatch date
Reserve Date						
07/03/24	Finance Monitoring Report	J Hartley	Not applicable		23/02/24	28/02/24
	Performance Monitoring Report	V Thomas T Hornsby	Not applicable			
	Scrutiny Items					
25/04/24 Reserve Date					12/04/24	17/04/24

Please contact Democratic Services democraticservices@cambridgeshire.gov.uk if you require this information in a more accessible format

To be added at a future date:

- Demographics – linked to recruitment, mental health, housing etc – January or March 2024

Adults and Health Committee Training Plan 2021/22

Below is an outline of topics for potential training committee sessions and visits for discussion with the new Adults and Health Committee.

The Adults & Health Committee induction recording can be sent to Members by contacting democraticservices@cambridgeshire.gov.uk

Suggested dates	Timing	Topic	Presenter	Location	Notes	Attendees
Thursday 28 October 10:00 - 11:00 Virtual Teams meeting	1 hour	Public Health and the COVID-19 pandemic – roles and responsibilities Local Outbreak Management Plan	Deputy Director of Public Health (CCC) and consultant leads Cell leads / Surveillance	This will be an interactive session in relation to Outbreak Management In addition, in this session you have the opportunity to talk to staff involved in outbreak control including the contact centre staff who provide support to those self-isolating	**PH session: Hold in PH & Members' Diary** Minimum attendance of 4 members	**Cancelled due to lack of bookings**
Friday 29 October 15:00 - 16:00 Virtual Teams meeting	1 hour	Introduction to Children and Young People's Public Health Commissioning	Public Health Consultant lead – Children and Young People – Raj Lakshman	Virtual	**PH session: Hold in PH & Members' Diary** Children's Committee to be invited	Cllr Bryony Goodliffe Cllr Philippa Slatter Cllr Edna Murphy Cllr Hay
Thursday 11 November 10:00 - 12:00	2 hours	Introduction to Health Improvement and Public Health Commissioning	Deputy Director of Public Health (CCC) Public Health Joint Commissioning Unit (JCU) PH	Virtual introduction into public health commissioning	**PH session: Hold in PH & Members' Diary**	Cancelled, lack of bookings

Suggested dates	Timing	Topic	Presenter	Location	Notes	Attendees
Virtual Teams meeting			Commissioning Team Leads		Maximum attendance of 3 Members, can be arranged on request	
Thursday 11 November 9.00 – 10.00	1 hour	Overview of Transfers of Care, the role of the Transfers of Care Team and an overview of Brokerage: - What is 'discharge to assess'? - How the service works - how many people we support and some case examples?	Head of Transfers of Care, Head of Brokerage, Contracts & Quality Improvement	Virtual Teams meeting	**ASC Session:** Minimum attendance of 4 Members	Cancelled, lack of bookings
Wednesday 17 November 13:00 to 14:00	1 hour	Overview of Public Mental Health and Mental Health Services and the role of Social Care including an overview of commissioning related to Mental Health. Some examples of the current people we support	Trust Professional Lead for Social Work, CPFT Senior Commissioner: Prevention, Early Intervention and Mental Health Public Health Consultant lead for Mental Health	Virtual	**PH Session:** Minimum attendance of 4 members	**Cllr Edna Murphy**

Suggested dates	Timing	Topic	Presenter	Location	Notes	Attendees
Thursday 18 November **10:00 to 11:00**	1 hour	Introduction of Public Health Intelligence (PHI) – information for Public Health and Public Heath Inequalities	Deputy Director of Public Health (PCC) PHI lead and Team	Virtual Interactive	**Holds in the PH and Members' Diary**	Cancelled – only one member booked on
Thursday 18 November 11.00 – 12.00	1 hour	An overview of Adult Social Care Finance to include Charging policy and Direct Payments	Strategic Finance Manager, Head of Adults Operational Finance, Public Health	Virtual	**Finance Session** Minimum attendance of 4 Members	Cancelled, lack of bookings

Monday 22 November	1 day or 2 half days	Overview of the Adult Social Care Customer Journey including Prevention & Early Intervention Services and Long-Term Complex Services. At this session you will start the day at Amundsen House and be introduced to our Prevention & Early Intervention services, where many of our customers start their journey. You will have the opportunity to listen into live calls and get to know more about Adult Early Help, Reablement and Technology. In the afternoon, you will visit our Social Work Teams for Older People and the Learning Disability partnership in Scott House and have the opportunity to experience case work.	Head of Prevention & Early intervention, Head of Assessment & Care Management, Social Work Teams	Amundsen House & Scott House	**ASC Session:** Maximum attendance of 4 Members & can be arranged on request	Attended by Cllr Susan Van De Ven Cllr Adela Costello Cllr Philippa Slatter
Amundsen House 9.30 – 12.00 Scott House 13.00 – 16.00						

Suggested dates	Timing	Topic	Presenter	Location	Notes	Attendees
Thursday 25 November Amundsen House 9.30 – 12.00 Scott House 1pm – 4.30pm		As above				Cancelled, lack of bookings
Thursday 10 March 9.30am – 12.00pm & 1pm – 4.00pm		As above		Virtual		Cllr Graham Wilson Cllr Anne Hay
Monday 20th June 10am – 12pm & 1pm – 3pm		As above		Amundsen House & Scott House		Cllr Richard Howitt Cllr Susan van de Ven Cllr Claire Daunton (am only) Cllr Graham Wilson
Friday 11th November 10am - 4pm		PCC Overview of the Adult Social Care Customer Journey including Prevention & Early Intervention Services and Long-Term Complex Services.	Operations Manager and Head of Housing & Health Improvement	Sand Martin House		Cllr John Howard

Suggested dates	Timing	Topic	Presenter	Location	Notes	Attendees
Thursday 25 November 10:00 - 11:00	1 hour	Introduction Public Health and Prevention Primary Prevention Healthy Aging and Falls Prevention Mental Health	Deputy Director of Public Health (CCC) Public Health Consultant leads Adults & Social Care, Mental Health. Team Manager (Health in All Policies) Senior Public Health Manager Partnerships	Virtual	**PH Session:** Hold in PH & Members' Diary	**Cancelled due to lack of bookings**
Thursday 25 November 14.30 – 16.00	1 ½ hours	Introduction to Health Protection and Emergency Planning	Deputy Director of Public Health (PCC) Public Health Consultant lead TBC Senior Public Health Manager (Emergency Planning and Health Protection)	Virtual Interactive	**PH session:** Emmeline Watkins With Tiya Balaji Minimum attendance of 4 members	**Cancelled due to lack of bookings**

Tuesday 30 November	1 hour	Introduction to Integrated Care Systems	Jan Thomas (CCG appointed to CEO ICS)	Virtual	PH session:	Cllr Michael Atkins T
						Cllr Lynne Ayres A
						Cllr Gerri Bird T
						Cllr Ray Bisby A
						Cllr Sandra Bond A
						Cllr Shazia Bashir A
						Cllr Alex Bulat T
						Cllr Simon Bywater T
						Cllr Sam Clark T
						Cllr Adela Costello A
						Cllr Piers Coutts T
						Cllr Steve Criswell T
						Cllr Douglas Dew T
						Cllr Corinne Garvie A
						Cllr Jenny Gawthorpe Wood T
						Cllr Bryony Goodliffe T
						Anne Hay Cllr T
						Cllr Peter Hillier A
						Mark Howell Cllr A
						Cllr Richard Howitt T
						Cllr Elisa Meschini T
						Cllr Edna Murphy T
						Cllr Lucy Nethsingha T
						Cllr Lucinda Robinson A
						Cllr Brian Rush A
						Cllr Oliver Sainsbury A
						Cllr Tom Sanderson T
						Cllr Philippa Slatter A
						Cllr Ambrose Smith A
						Cllr Simone Taylor A
						Cllr Bryan Tyler A
						Cllr Susan van de Ven T
						Cllr Graham Wilson A

Suggested dates	Timing	Topic	Presenter	Location	Notes	Attendees
On request **November**	2 hours	Introduction to Health Improvement and Public Health Commissioning	Deputy Director of Public Health (CCC) Public Health Joint Commissioning Unit (JCU) PH Commissioning Team Leads	In this session, you will start at Scott House prior to visiting the Drug and Alcohol Service or Lifestyle services	**PH Session:** Maximum of 4 members to be arranged on request	
November Date to be confirmed External session	**TBC**	Introduction to Scrutiny	Director of Public Health Head of Public Health Business Programmes	Virtual	**Dem services** Minimum attendance of 4 members	
November Date to be confirmed External Session	**TBC**	Introduction to the Integrated Care System	Partners from the ICS /NHS will be leading this session for members of scrutiny committees across Cambridgeshire & Peterborough	Virtual	**Externally Lead** Minimum attendance of 4 members	

Suggested dates	Timing	Topic	Presenter	Location	Notes	Attendees
On request	1 hour + visit	Adult Safeguarding and Making Safeguarding Personal. An overview of how Safeguarding works and the role of the Multi Agency Safeguarding Hub (MASH)	Assistant Director of Safeguarding, Quality & Practice	Virtual or Stanton House and could include a visit to the MASH in God-Manchester	**ASC Session:** Maximum attendance of 4 Members, to be arranged on request	
On request **Monday 1 November** 11.00 – 13.00 **Thursday 3 March** 2pm – 4pm	90 mins	Overview of the Learning Disability Partnership (LDP) including an overview of commissioning related to Learning Disability including: - Adults & Autism - 0-25 Young Adults Team - Preparation for Adulthood - Housing and Accommodation - Day Opportunities- in house provision and external - Carers Direct Payments and Personal Health Budgets	Head of Learning Disability Partnership, Head of Commissioning Adults Social Care, Mental Health and Learning Disabilities, Senior Commissioner LDP	Scott House or Virtual, this could also include a visit to one of our In-House Provider settings	**ASC Session:** Maximum attendance of 4 Members, to be arranged on request	**Cllr Graham Wilson Cllr Bryony Goodliffe Cllr Anne Hay**

GLOSSARY OF TERMS / TEAMS ACROSS ADULTS & COMMISSIONING

More information on these services can be found on the Cambridgeshire County Council Website:
https://www.cambridgeshire.gov.uk/residents/adults/

ABBREVIATION/TERM	NAME	DESCRIPTION
COMMON TERMS USED IN ADULTS SERVICES		
Care Plan	Care and Support Plan	A Care and Support plans are agreements that are made between service users, their family, carers and the health professionals that are responsible for the service user's care.
Care Package	Care Package	A care package is a combination of services put together to meet a service user's assessed needs as part of a care plan arising from a single assessment or a review.
DTOC	Delayed Transfer of Care	These are when service users have a delay with transferring them into their most appropriate care (ie; this could be from hospital back home with a care plan or to a care home perhaps)
KEY TEAMS		
AEH	Adults Early Help Services	This service triages requests for help for vulnerable adults to determine the most appropriate support which may be required
TEC	Technology Enabled Care	TEC team help service users to use technology to assist them with living as independently as possible
OT	Occupational Therapy	
ASC	Adults Social Care	This service assesses the needs for the most vulnerable adults and provides the necessary services required
Commissioning	Commissioning Services	This service provides a framework to procure, contract and monitor services the Council contract with to provide services such as care homes etc.
TOCT	Transfer of Care Team (sometimes Discharge Planning)	This team works with hospital staff to help determine the best care package / care plan for individuals being discharged from hospital back home or an appropriate placement elsewhere
LDP	Learning Disability Partnership	The LDP supports adults with learning disabilities to live as independently as possible
MASH	Multi-agency Safeguarding Hub	This is a team of multi-agency professionals (i.e. health, Social Care, Police etc) who work together to assess the safeguarding concerns which have been reported

ABBREVIATION/TERM	NAME	DESCRIPTION
MCA DOLs Team	Mental Capacity Act Deprivation of Liberty Safeguards (DOLS)	When people are unable to make decisions for themselves, due to their mental capacity, they may be seen as being 'deprived of their liberty'. In these situations, the person deprived of their liberty must have their human rights safeguarded like anyone else in society. This is when the DOLS team gets involved to run some independent checks to provide protection for vulnerable people who are accommodated in hospitals or care homes who are unable to no longer consent to their care or treatment.
PD	Physical Disabilities	PD team helps to support adults with physical disabilities to live as independently as possible
OP	Older People	OP team helps to support older adults to live as independently as possible
Provider Services	Provider Services	Provider Services are key providers of care which might include residential homes, care homes, day services etc
Reablement	Reablement	The reablement team works together with service-users, usually after a health set-back and over a short-period of time (6 weeks) to help with everyday activities and encourages service users to develop the confidence and skills to carry out these activities themselves and to continue to live at home
Sensory Services	Sensory Services	Sensory Services provides services to service users who are visually impaired, deaf, hard of hearing and those who have combined hearing and sight loss
FAT	Financial Assessment Team	The Financial Assessment Team undertakes assessments to determine a person's personal contribution towards a personal budget/care
AFT	Adult Finance Team	The Adult Finance Team are responsible for loading services and managing invoices and payments
D2A	Discharge to Assess	This is the current COVID guidance to support the transfer of people out of hospital.
Carers Triage	Carers Triage	A carers discussion to capture views and determine outcomes and interventions such as progress to a carers assessment, what if plan, information, and/or changes to cared for support
DP	Direct Payment	An alternative way of providing a person's personal budget
DPMO	Direct Payment Monitoring Officer	An Officer who audits and monitors Direct Payments
Community Navigators	Community Navigators	Volunteers who provide community-based advice and solutions

GLOSSARY OF TERMS / TEAMS ACROSS PUBLIC HEALTH

ABBERVIATION/TERM	DESCRIPTION
Common Terms Used in Public Health	
Accreditation	The development of a set of standards, a process to measure health department performance against those standards, and some form of reward or recognition for those agencies meeting the standards.
Assessment	One of public health's three core functions. The regular collection, analysis and sharing of information about health conditions, risks, and resources in a community. Assessment is needed to identify health problems and priorities and the resources available to address the priorities.
Assurance	One of the three core functions in public health. Making sure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services. The services are assured by encouraging actions by others, by collaboration with other organisations, by requiring action through regulation, or by direct provision of services.
Bioterrorism	The intentional use of any microorganism, virus, infectious substance, or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bio-engineered component of any such microorganism, virus, infectious substance, or biological product, to cause death disease, or other biological malfunction in a human, an animal, a plant, or another living organism in order to influence the conduct of government or to intimidate or coerce a civilian population
Capacity	The ability to perform the core public health functions of assessment, policy development and assurance on a continuous, consistent basis, made possible by maintenance of the basic infrastructure of the public health system, including human, capital and technology resources.
Chronic Disease	A disease that has one or more of the following characteristics: it is permanent, leaves residual disability, is caused by a non-reversible pathological alteration, requires special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation or care.
Clinical Services/Medical Services/Personal Medical Services	Care administered to an individual to treat an illness or injury.

ABBERVIATION/TERM	DESCRIPTION
Determinants of health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations
Disease	A state of dysfunction of organs or organ systems that can result in diminished quality of life. Disease is largely socially defined and may be attributed to a multitude of factors. Thus, drug dependence is presently seen by some as a disease, when it previous was considered to be a moral or legal problem.
Disease management	To assist an individual to reach his or her optimum level of wellness and functional capability as a way to improve quality of health care and lower health care costs.
Endemic	Prevalent in or peculiar to a particular locality or people.
Entomologist	An expert on insects
Epidemic	A group of cases of a specific disease or illness clearly in excess of what one would normally expect in a particular geographic area. There is no absolute criterion for using the term epidemic; as standards and expectations change, so might the definition of an epidemic, such as an epidemic of violence.
Epidemiology	The study of the distribution and determinants of diseases and injuries in human populations. Epidemiology is concerned with the frequencies and types of illnesses and injuries in groups of people and with the factors that influence their distribution.
Foodborne Illness	Illness caused by the transfer of disease organisms or toxins from food to humans.
Health	The state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity. Health has many dimensions-anatomical, physiological and mental-and is largely culturally defined. Most attempts at measurement have been assessed in terms of morbidity and mortality
Health disparities	Differences in morbidity and mortality due to various causes experience by specific sub-populations.
Health education	Any combination of learning opportunities designed to facilitate voluntary adaptations of behaviour (in individuals, groups, or communities) conducive to health.
Health promotion	Any combination of health education and related organizational, political and economic interventions designed to facilitate behavioural and environmental adaptations that will improve or protect health.
Health status indicators	Measurements of the state of health of a specific individual, group or population.
Incidence	The number of cases of disease that have their onset during a prescribed period of time. It is often expressed as a rate. Incidence is a measure of morbidity or other events that occur within a specified period of time. See related prevalence
Infant Mortality Rate	The number of live-born infants who die before their first birthday per 1,000 live births.

ABBERVIATION/TERM	DESCRIPTION
Infectious	Capable of causing infection or disease by entrance of organisms (e.g., bacteria, viruses, protozoan, fungi) into the body, which then grow and multiply. Often used synonymously with "communicable
Intervention	A term used in public health to describe a program or policy designed to have an effect on a health problem. Health interventions include health promotion, specific protection, early case finding and prompt treatment, disability limitation and rehabilitation.
Infrastructure	The human, organizational, information and fiscal resources of the public health system that provide the capacity for the system to carry out its functions.
Isolation	The separation, or the period of communicability, of known infected people in such places and under such condition as to prevent or limit the transmission of the infectious agent.
Morbidity	A measure of disease incidence or prevalence in a given population, location or other grouping of interest
Mortality	A measure of deaths in a given population, location or other grouping of interest
Non-infectious	Not spread by infectious agents. Often used synonymously with "non-communicable".
Outcomes	Sometimes referred to as results of the health system. These are indicators of health status, risk reduction and quality of life enhancement.
Outcome standards	Long-term objectives that define optimal, measurable future levels of health status; maximum acceptable levels of disease, injury or dysfunction; or prevalence of risk factors.
Pathogen	Any agent that causes disease, especially a microorganism such as bacterium or fungus.
Police Power	A basic power of government that allows restriction of individual rights in order to protect the safety and interests of the entire population
Population-based	Pertaining to the entire population in a particular area. Population-based public health services extend beyond medical treatment by targeting underlying risks, such as tobacco, drug and alcohol use; diet and sedentary lifestyles; and environmental factors.
Prevalence	The number of cases of a disease, infected people or people with some other attribute present during a particular interval of time. It often is expressed as a rate.
Prevention	Actions taken to reduce susceptibility or exposure to health problems (primary prevention), detect and treat disease in early stages (secondary prevention), or alleviate the effects of disease and injury (tertiary prevention).

ABBERVIATION/TERM	DESCRIPTION
Primary Medical Care	Clinical preventive services, first contact treatment services and ongoing care for commonly encountered medical conditions.
Protection	Elimination or reduction of exposure to injuries and occupational or environmental hazards.
Protective factor	An aspect of life that reduces the likelihood of negative outcomes, either directly or by reducing the effects of risk factors.
Public Health	Activities that society does collectively to assure the conditions in which people can be healthy. This includes organized community efforts to prevent, identify, pre-empt and counter threats to the public's health.
Public Health Department	Local (county, combined city-county or multi- county) healthy agency, operated by local government, with oversight and direction from a local board of health, which provides public health services throughout a defined geographic area.
Public Health Practice	Organisational practices or processes that are necessary and sufficient to assure that the core functions of public health are being carried out effectively.
Quality assurance	Monitoring and maintaining the quality of public health services through licensing and discipline of health professionals, licensing of health facilities and the enforcement of standards and regulations.
Quarantine	The restriction of the activities of healthy people who have been exposed to a communicable disease, during its period of communicability, to prevent disease transmission during the incubation period should infection occur.
Rate	A measure of the intensity of the occurrence of an event. For example, the mortality rate equals the number who die in one year divided by the number at risk of dying. Rates usually are expressed using a standard denominator such 1,000 or 100,000 people.
Risk Assessment	Identifying and measuring the presence of direct causes and risk factors that, based on scientific evidence or theory, are thought to directly influence the level of a specific health problem.
Risk Factor	Personal qualities or societal conditions that lead to the increased probability of a problem or problems developing.
Screening	The use of technology and procedures to differentiate those individuals with signs or symptoms of disease from those less likely to have the disease.
Social Marketing	A process for influencing human behaviour on a large scale, using marketing principles for the purpose of societal benefit rather than for commercial profit.
Social Norm	Expectations about behaviour, thoughts or feelings that are appropriate and sanctioned within a particular society. Social norms can play a powerful role in the health status of individuals.

ABBERVIATION/TERM	DESCRIPTION
Standards	Accepted measure of comparison that have quantitative or qualitative value.
State Health Agency	The unit of state government that has leading responsibility for identifying and meeting the health needs of the state's citizens. State health agencies can be free standing or units of multipurpose health and human service agencies.
Surveillance	Systematic monitoring of the health status of a population.
Threshold Standards	Rate or level of illness or injury in a community or population that, if exceeded, call for closer attention and may signal the need for renewed or redoubled action.
Years of Potential Life lost	A measure of the effects of disease or injury in a population that calculates years of life lost before a specific age (often ages 64 or 75). This approach places additional value on deaths that occur at earlier ages.
Health and Care Organisations in Cambridgeshire & Peterborough	
CAMHS	Community Child and Adolescent Mental Health Services https://www.mind.org.uk/information-support/for-children-and-young-people/understanding-camhs/?gclid=EAIaIQobChMIr_P53PKW8QIV_4FQBh1GmgBYEAAYASAAEgl2Q_D_BwE
CAPCCG	Cambridgeshire and Peterborough Clinical Commissioning Group https://www.cambridgeshireandpeterboroughccg.nhs.uk
CCC	Cambridgeshire County Council https://www.cambridgeshire.gov.uk
CCS	Cambridgeshire Community Services NHS Trust http://www.cambscommunityservices.nhs.uk/
CHUMS	Mental Health & Emotional Wellbeing Service for Children and Young People http://chums.uk.com/
CPFT	Cambridgeshire and Peterborough NHS Foundation Trust (Mental health, learning disability, adult community services and older people's services) http://www.cpft.nhs.uk/
CQC	Care Quality Commission (The independent regulator of health and social care in England) http://www.cqc.org.uk/
CUH	Cambridge University Hospitals NHS Foundation Trust (Addenbrooke's and the Rosie) https://www.cuh.nhs.uk
EEAST	East of England Ambulance Service NHS Trust http://www.eastamb.nhs.uk

ABBERVIATION/TERM	DESCRIPTION
HH	Hinchingbrooke Hospital (Provided by North West Anglia NHS Foundation Trust – NWAFT) https://www.nwangliaft.nhs.uk
HUC	Herts Urgent Care (provide NHS 111 and Out of Hours) https://hucweb.co.uk/
ICS	Integrated Care Systems
Helpful NHS Terminology Links	
https://www.nhsconfed.org/acronym-buster	The NHS uses a number of acronyms when describing services this acronym buster may be of some help.
https://www.kingsfund.org.uk/audio-video/how-does-nhs-in-england-work	The Kings Fund have produced a good video explaining how the NHS in England works. The Kings Fund website in general contains many resources which you may find helpful.
https://www.england.nhs.uk/learning-disabilities/	NHS terms used in the field of disabilities
https://www.thinklocalactpersonal.org.uk/ Browse/Informationandadvice/CareandSupportJargonBuster/	Think Local Act Personal jargon buster search engine for health and social care.

Health Scrutiny Support

To:	Adults and Health Committee
Meeting Date:	9 March 2023
From:	Democratic Services Manager
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	Not applicable
Outcome:	The committee is being asked to consider arrangements to support the health scrutiny process, which will enhance the effectiveness of health scrutiny.
Recommendation:	The committee is asked to consider and comment on the arrangements set out in the report to support the health scrutiny process.

Officer contact:
Name: Michelle Rowe
Post: Democratic Services Manager
Email: michelle.rowe@cambridgeshire.gov.uk
Tel: 01223 699180

Member contacts:
Names: Cllr Richard Howitt / Cllr Susan van de Ven
Post: Chair/Vice-Chair
Email: Richard.howitt@cambridgeshire.gov.uk Susanvandeven5@gmail.com
Tel: 01223 706398

1. Background

1.1 The Health and Social Care Act 2001 gave specific powers to a local authority's overview and scrutiny committee (OSC) to examine health services. This was laid out in the Local Authority (Overview and Scrutiny Committees Health Scrutiny functions) Regulations 2002.

1.2 The local authority's powers of Health scrutiny allow it to scrutinise health service changes and performance, and to consult with stakeholders on their local health services. The purpose of health scrutiny is to:

- improve the health and well-being of residents.
- provide a critical friend to the NHS.
- facilitate greater involvement of stakeholders in local health issues.
- tackle the 'democratic deficit' in health and ultimately improve the health of local people.

1.3 The primary aims of health scrutiny are to identify whether:

- health services reflect the views and aspirations of the community.
- all sections of the community have equal access to services.
- all sections of the community have an equal chance of a successful outcome from service.
- proposals for substantial service changes are reasonable.

1.4 The committee with responsibility for health scrutiny can review any matter relating to the planning, provision and operation of health services within the area.

1.5 The role of the OSC is to look at strategic issues affecting the health of the area, rather than individual complaints. Its remit stretches further than looking at the NHS services and organisations but it should not be involved in performance management. There will be times when a scrutiny process needs to consider health care provided by the private and independent sector on behalf of the NHS. In these circumstances, the committee will need to consider the issue through the commissioning body. Committees do not have the power to require individual GPs, dentists, pharmacists or those providing ophthalmic services to attend a committee meeting to answer questions.

1.6 Topics for scrutiny should be chosen on the basis of whether they are:

- in the public interest.
- not being addressed by another body (e.g., the Care Quality Commission) or another scrutiny committee.
- being requested by the NHS directly.
- proposed substantial developments.
- offering the potential for outcomes affecting local people.

1.7 The OSC has the power to:

- review and scrutinise any matter relating to the planning, provision and operation of health services in the local authority's area (including the Council's

contribution to the health of local people and the provision of health services, as well as other agencies involved in healthcare).

- make reports and recommendations to the local NHS on any matter reviewed or scrutinised.

- require the attendance of an officer of the local NHS to answer questions and provide explanations about the planning, provision and operation of health services.

- require the local NHS to provide information about the planning, provision and operation of health services.

- establish joint committees with other local authorities to undertake overview and scrutiny of health services.

- delegate functions of overview and scrutiny of health to another local authority committee.

2.   Main Issues

Scrutiny Training

2.1   Following the election in May 2021, newly elected members took part in an extensive Member Induction Programme approved by the Member Development Panel. Whilst there was a session on Adults and Health Committee held on 10 June 2021, it did not include specific scrutiny training. To make the most of scrutiny, councillors need high quality, independently led training. It is therefore proposed to identify an organisation to provide training for members, co-opted members and substitutes on the committee.

Democratic Services Scrutiny Support

2.2   The committee currently has some scrutiny support provided by the Public Health directorate. It is suggested that there should be a degree of separation given, for example, the Executive Director of Public Health's role on the Integrated Care Board (ICB). The complexity of commissioning, joint commissioning and the ICB means that both social care and Public Health are often co-commissioners of health services. Public Health also directly commissions health services, which can lead to conflicts of interest, including for the chair of Adults and Health Committee.

2.3   The scrutiny function is usually provided by democratic services in other councils, which does not fit the Public Health ringfence grant. It is therefore proposed that the committee should receive dedicated scrutiny support from a Democratic Services Officer who will liaise with the Head of Public Health Programmes in co-ordinating the scrutiny programme for the committee. Close working with the Head of Public Health Programmes, who has supported health scrutiny for many years, is essential if democratic services' scrutiny support is going to be effective, particularly in relation to liaison meetings and co-ordination with the NHS.

2.4   The role of the Democratic Services Officer will involve the following:

-    attending quarterly health liaison group meetings and providing a briefing note of issues for the committee and possible scrutiny items for consideration.

-    writing briefings on NHS organisations and documents for the committee, and identifying sources of background information such as Healthwatch reports or needs assessments to aid scrutiny.

-    arranging briefings and/or seminars for the committee via Teams to enhance knowledge and improve scrutiny.

-    identifying lines of enquiry to enable the committee to scrutinise effectively.

-    maintaining the committee's work programme to ensure scrutiny is focused on subject areas and issues that matter the most to make best use of time and resources.

-    drawing up and agreeing results following scrutiny sessions, and taking responsibility for acting on the findings (e.g. coordinating with Communications in terms of external messaging, feeding results back to the relevant local health partners directly and forwarding as necessary to the Department of Health).

-    arranging visits to NHS organisations.

-    arranging all-member seminars to explain the work and role of health scrutiny to the rest of the Council beyond those on the committee.

Adults and Health Committee Scrutiny Pre-Meeting and Wash Up Sessions

2.5   It is proposed to hold a pre-meeting with the committee once the agenda has been published, to go through the lines of enquiry. This will enable members to agree (or at least to discuss) some lines of questioning that are to be put to a witness or group of witnesses. It can allow for members to agree who will be asking the questions and the extent that supplementary questions will be put. It is important to identify what kind of questions and questioning the committee will be asking:

-    Will questioning be organised by theme, with all councillors being allowed to come in where appropriate, and with the use of supplementary questions being quite tightly defined?

-    Alternatively, will the questioning be in a fairly free flowing format with the Chair calling people to raise questions when they indicate they wish to do so? If this approach is adopted, it is still important that questions reflect certain key lines of questioning, to prevent the session becoming a series of unconnected and possibly irrelevant questions. There should also be clear conclusions and recommended actions at the end of questioning.

2.6   It also proposed to hold an informal wash-up session once the meeting has concluded and the stream has been stopped, to review the success of the questioning. A good evaluation

can help to improve the quality of future meetings and contribute to future successes.

Scrutiny Agenda Plan

2.7 It is important that the scrutiny agenda plan is considered at every meeting of the Adults and Health Committee, as it is the role of the committee to identify future items for scrutiny. However, there is a key role for the Chair and Vice-Chair to manage this plan if, for example, timetabling proves an issue.

3. Alignment with corporate priorities

3.1 Environment and Sustainability

There are no significant implications for this priority.

3.2 Health and Care

Scrutiny provides a critical friend challenge to the NHS and offers the opportunity to bring issues that matter to local people and the local community into decision making. It is therefore important that it has the necessary dedicated support to do this effectively.

3.3 Places and Communities

There are no significant implications for this priority.

3.4 Children and Young People

There are no significant implications for this priority.

3.5 Transport

There are no significant implications for this priority.

4. Source documents

4.1 Health and Social Care Act 2001 (legislation.gov.uk)

The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (legislation.gov.uk)

Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

Major Trauma in the East of England and the Potential Establishment of a 2nd Major Trauma Centre in Norwich

To:	Adults and Health Committee
Meeting Date:	9 March 2023
From:	Simon Griffith, Head of Acute Services, NHS England – East of England
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	N/A
Outcome:	To consider the programme of work set out in this paper to undertake a network review to establish a second Major Trauma Centre at the Norfolk and Norwich University Hospital. Improved access to major trauma now and in the future and alleviate pressure on the Cambridge service.
Recommendation:	The committee is recommended to support the programme of work to determine the establishment of a second Major Trauma Centre in the region.

Officer contact:

Name: Simon Griffith
Post: Head of Acute Services, NHS England – East of England
Email: simongriffith@nhs.net
Tel:

Member contacts:
Names: Cllr Richard Howitt / Cllr Susan van de Ven
Post: Chair/Vice-Chair
Email: Richard.howitt@cambridgeshire.gov.uk Susanvandeven5@gmail.com
Tel: 01223 706398

1. Background

Every year across England and Wales, 16,000 (approximately) people die after injury. It is the leading cause of death among children and young adults of 44 years and under, and as such is a serious public health problem. In the East of England there were approximately 900 Major Trauma related deaths between July 2020 & June 2022.

Seriously injured adults and children are described as having suffered from major trauma. This is measured on a scale known as the Injury Severity Score (ISS) which scores injuries from 1 to 75, the latter being the most serious. Patients who have an ISS>15 are defined as having suffered from major trauma. In addition, patients with an ISS of 9-15 have moderately severe trauma.

It is not possible to determine the ISS at the time of injury as it requires a full diagnostic assessment and often surgical intervention in hospital. For these reasons a system of triage is used which identifies those patients who are most likely to have had major trauma, these patients are referred to as "candidate major trauma" patients. Pre-hospital emergency services have developed major trauma decision protocols for use by crews to determine the most appropriate destination of injured patients. Those with potential major trauma injuries ("candidate" major trauma patients) are taken directly to a Major Trauma Centre (MTC) where travel times allow, otherwise to the nearest Trauma Unit (TU) for rapid stabilisation and transfer to the MTC where those injuries exceed the capability of a Trauma Unit and in line with local protocols.

Major Trauma care is delivered through an inclusive Trauma Network delivery model. A Trauma Network includes all providers of trauma care, particularly: pre-hospital services, other hospitals receiving acute trauma admissions (Trauma Units), and rehabilitation services. The network has appropriate links to the social care and the voluntary/community sector. Major Trauma Centres (MTCs) sit at the heart of Trauma Networks as the centres of excellence providing multi-specialty hospital care to seriously injured patients, optimised for the provision of trauma care. They manage all types of trauma but specifically have the lead for managing candidate major trauma patients, providing consultant-level care and access to tertiary and specialised level services. Within the Trauma Network the MTC:

- Is optimised for the definitive care of injured patients. In particular it has an active, effective trauma Quality Improvement programme. It also provides specialist early/hyper acute rehabilitation as well as a managed transition to rehabilitation and the community.
- Takes responsibility for the care of all patients with Major Trauma in the area covered by the Network. It also supports the Quality Improvement programmes of other hospitals in its Network.

An MTC provides all the major specialist services relevant to the care of major trauma, i.e. general, emergency medicine, vascular, orthopaedic, plastic, spinal, maxillofacial, cardiothoracic and neurological surgery, specialist early/hyper acute rehabilitation and interventional radiology, along with appropriate supporting services, such as critical care.

The NHSE Service Specification D15/S/a Major Trauma states *"It is widely accepted that access and travel times by ambulance to a major trauma centre should be within 45 minutes, unless the patient is too unstable and requires a more immediate optimisation at a TU prior to a secondary transfer to an MTC"* . Secondary transfers from a TU to a MTC will occur within an hour of the request for transfer; this is to minimise the patient's time from injury to accessing definitive treatment. This is a particular challenge in East of England where significant populations reside more than 45 minutes away from the MTC at Cambridge.

A TU could be the primary receiver of seriously injured patients and are responsible for resuscitating and caring for such patients who require optimisation if they were too unstable and therefore are unable to cope with a 45 min land ambulance transfer to MTC. A TU may also receive local trauma patients with less serious injuries, which will include simple fractures of one limb, lacerations, and minor head injuries. In addition, trauma units need to have the expertise to recognise patients who are beyond their capability to treat, and to be able to transfer them rapidly to the MTC.

2. The East of England Trauma Network

The East of England Trauma Network was created in April 2012 to provide comprehensive major trauma services for residents of the East of England region (Bedfordshire, Cambridgeshire, Norfolk and Suffolk and parts of Essex and Hertfordshire).

Major Trauma care is delivered through an inclusive Trauma Network delivery model. A Trauma Network includes all providers of trauma care, particularly: pre-hospital services, other hospitals receiving acute trauma admissions (Trauma Units), and rehabilitation services. The network has appropriate links to the social care and the voluntary/community sector.

The configuration of the East of England Trauma Network was based on detailed modelling of major trauma activity undertaken in 2010. This indicated that the regional trauma system should be prepared to manage an age standardised rate of 33.7 severely injured patients (defined as an injury severity score > 8) per 100,000 residents per year.

It was considered that most of these patients could be managed within the Acute Hospital setting but that a proportion of them, particularly the more seriously injured patients (defined as ISS > 15) would benefit from access to a specialised Major Trauma Centre.

The directly age standardised rate for ISS > 15 patients was 12.1 per 100,000 population (95% CI 11.0 to 13.2). Based on a population of 5,717,400 at a time and taking geographical factors and neighbouring Trauma Network facilities into account, these rates equated to between:

- 1,818 and 2,035 ISS > 8 patients a year and
- 629 and 755 ISS > 15 patients a year.

These activity levels, together with the configuration of existing hospital services, led to the development of a Trauma Network hub and spoke model with a single regional Major Trauma Centre at Cambridge surrounded by 12 Acute Hospital Trauma Units.

Patients from the south of Essex and south Hertfordshire have a pathway into London Trauma Networks.

3. Major Trauma patients in the region

The mid-2019 population estimate for the East of England is 6,236,072. An increase of 518,672 or 9% since 2010. The population is spread over an area of 19,120 km2 and 39.3 % of residents are aged 65 years or older.

Trauma Audit and Research Network (TARN) data in the 10 years from 2010 to 2020 shows a gradual increase in the number of ISS>15 patients being recorded. In the 2018-19 and 2019-20 years, there were 1757 and 1745 ISS>15 patients across the Network, representing 28.3 per 100,000 population. With an incomplete TARN dataset, this will be an under-estimate of actual numbers. The initial Network modelling was taken from several sources, many with incomplete datasets. Along with the rise in population, improved data collection can largely explain the current higher rate rather than a notable change in the incidence of major trauma events.

An increasing number of major trauma patients are not being transferred to the MTC. The November 2022 TARN report shows that (excluding CUHs numbers) 83.4% of ISS>15 remained in TUs, whereas it was 77.9% in the Nov 2021 report. The level of Consultant delivered trauma team care, and the prolonged delays in transferring patients from a Trauma Unit into the Cambridge MTC remain areas of concern. The proportion of major trauma patients remaining in Trauma Units across the Network reflects inequitable access. Given the geography of the East of England and applying the specified 45mins journey time by road to a Major Trauma Centre, much of the region, particularly in the coastal regions of Norfolk and Suffolk, sit outside of this zone. Therefore, in cases of major trauma in these areas, unless transferred by air, patients will not be transferred directly to the MTC at CUH, but will be transported to the closest Trauma Unit with a second onward transfer to the MTC following stabilisation if required. The nearest MTC outside of London and EoE is the Queens Medical Centre in Nottingham (circa 90 minute travel time from Peterborough).

4. The Challenge

The combination of population expansion (9% increase on planned population), demographic change together with existing hospital and service pressures and a significant population cohort outside of the 45-minute travel time (see Annex A) has resulted in a network operating under significant pressure.

The recent Covid19 pandemic has further highlighted capacity and network resilience issues within the MTC and Trauma Network with an increasing number of diverts being implemented due to capacity constraints at CUHFT.

A request was issued through the EoE Trauma Network to local Trauma Unit providers to note their interest in being part of the solution to the regional resilience issues and the Norfolk and Norwich University Hospitals NHS Foundation Trust (N&NUH) provided the only positive response.

The East of England Trauma Network, CUHFT, N&NUH and NHSE Specialised Commissioning had collaborative discussions about strengthening the resilience of trauma services in the region. N&NUH is by far the busiest Trauma Unit in the

Network (seeing approximately 825 cases a year which compared to 1745 at CUHFT) with a comprehensive range of additional clinical services to support major trauma patients, consequently it was identified as ideally suited to being able to provide care safely and effectively to a defined group of major trauma patients who would otherwise be transferred to the MTC in Cambridge. On 25th November 2020 it was agreed Norfolk and Norwich Hospital's would provide specialised trauma support (non cranial only) for the region from 1st December 2020. This support was considered, at this stage, in the context of a mutual aid arrangement in the face of COVID related pressures facing the established provider. The December target date slipped, however on 19th January 2021, Norfolk & Norwich University Hospital commenced provision of enhanced specialised trauma support, establishing a service to receive selected (non-cranial & non-pelvic) secondary transfers from neighbouring Trauma Units (TUs).

The modelling expectations based on TARN returns suggested that the impact of diverts from West Suffolk Hospital, Queen Elizabeth Hospital and Ipswich Hospital are in the order of 3 patients each month.

The establishment of the Norwich service was successful and placed the network on a more resilient footing. Following further discussions a broad consensus was arrived at following collaborative engagement with clinicians, Trust Executives, and managers from across the system that to meet rising demand, improve mortality outcomes, address delays in transferring patients and embed greater resilience in the system the establishment of a second Major Trauma Centre for the region, based at N&NUH should be carefully considered. Subsequently on 29th April 2021 a paper was presented to the Regional Executive Team (RET) requesting support for:

i)   the continuation of Norfolk and Norwich University Hospital NHSFT (N&NUH) specialised trauma support (non-cranial & non-pelvic only) to the network; and

ii)   a network review to consider the establishment of 2nd regional Major Trauma Centre (MTC) within the network located at N&NUH.

5. The Current Programme

The N&NUH has executive level support to become an MTC and is supported by CUHFT Trauma Team and CUHFT executive team. Norwich is geographically well placed to address equity of access issues and outside of CUHFT has the most comprehensive range of clinical expertise available to support the establishment of an MTC. Plans for Neurosurgery support from CUHFT have been agreed. In addition, the Colman Unit at Norfolk Community Health and Care Trust is the only level 1 neuro-rehabilitation unit in the East of England and is therefore well placed to facilitate enhanced trauma rehabilitation as part of an ICS solution.
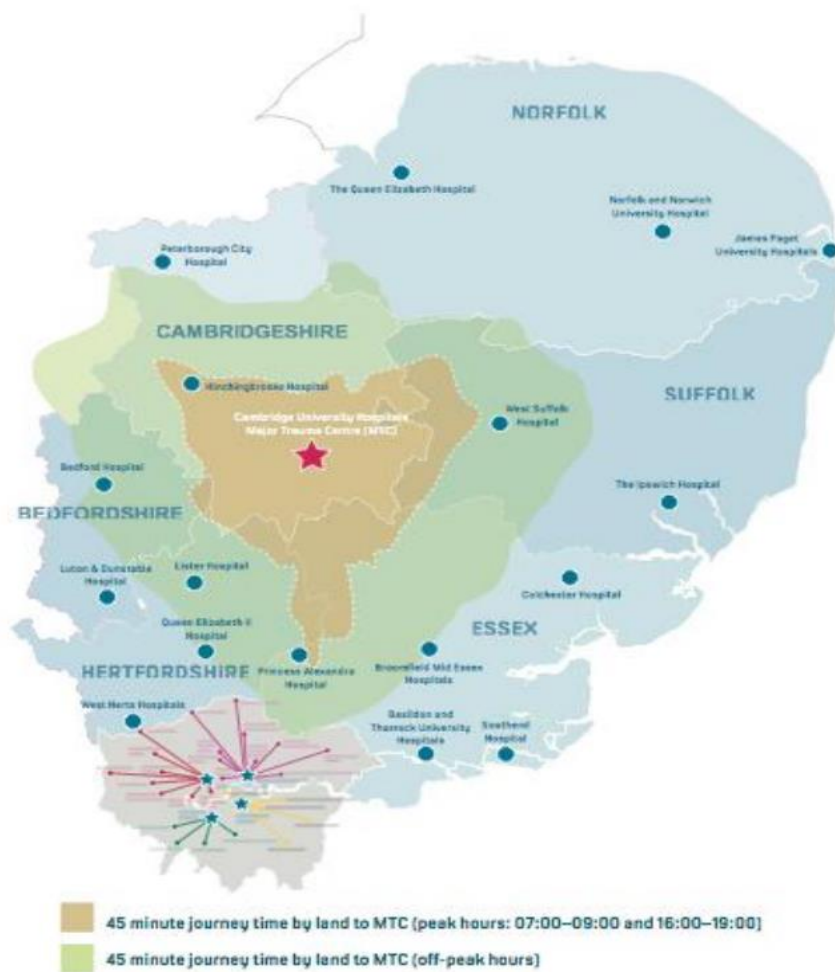
A Project Planning Group has been established. The programme is working through a first phase, the purpose of which is to review current and future demand for major trauma alongside the current Major Trauma Network in the region and make an evidence-based recommendation as to how a sustainable, clinically effective MTC located at N&NUH could meet service demands now and in the future. These are not 'new' patients within the region, they are already here but the pathway for some patients may change for better care provision.

This first phase involves five projects which will be delivered up to March 2023 when a recommendation will be made based on the projects' outcomes:

1. A public health needs assessment of the population

2. A gap analysis and service requirements for N&NUH

3. A clinical case for change

4. A financial impact assessment

5. Effective and comprehensive stakeholder involvement

Engagement planning is underway with regional stakeholders (NHSE Specialist Commissioning, NHSE CRG Major Trauma, Regional ICSs, Regional Healthwatch, East of England Ambulance Service and Acute Hospitals within the Trauma Network) and HOSCs to collaborate in undertaking an impact analysis for the introduction of a second adult MTC in the Network based at N&NUH.

Annex A: Major Trauma Blue Light Travel Times

45 minute journey time by land to MTC (peak hours: 07:00–09:00 and 16:00–19:00)

45 minute journey time by land to MTC (off-peak hours)

Annex B - EoE Trauma Network providers

Major Trauma Centre
Cambridge University Hospital NHS Foundation Trust
Trauma Units
Bedford Hospital NHS Trust
Colchester Hospital University NHS Foundation Trust
East and North Hertfordshire NHS Trust (Lister Hospital)
Ipswich Hospital NHS Trust
James Paget University Hospital NHS Foundation Trust
Luton and Dunstable Hospital NHS Foundation Trust
Mid Essex Hospital Services NHS Trust
Norfolk and Norwich University Hospital NHS Foundation Trust
Peterborough and Stamford Hospitals NHS Foundation Trust
Princess Alexandra Hospital NHS Trust
Queen Elizabeth Hospital King's Lynn NHS Trust
West Suffolk NHS Foundation Trust
Local Emergency Hospital
Hinchingbrooke Hospital Healthcare NHS Trust
Ambulance Service
East of England Ambulance Service NHS Trust

Annex C - East of England Trauma Network Distribution of patients by ISS

East of England Trauma Network

Distribution of patients by ISS

Hospital	1 - 8	9 - 15	16 - 24	25 - 45	>45	Total	>15
Addenbrooke's Hospital	252 (14.4%)	606 (34.6%)	329 (18.8%)	527 (30.1%)	39 (2.2%)	1753	895 (51.1%)
Bedford Hospital	85 (26.5%)	125 (38.9%)	62 (19.3%)	49 (15.3%)	0 (0.0%)	321	111 (34.6%)
Broomfield Hospital	134 (26.6%)	229 (45.4%)	105 (20.8%)	36 (7.1%)	0 (0.0%)	504	141 (28.0%)
Colchester General Hospital	56 (27.1%)	100 (48.3%)	25 (12.1%)	26 (12.6%)	0 (0.0%)	207	51 (24.6%)
Hinchingbrooke Hospital	34 (28.8%)	45 (38.1%)	23 (19.5%)	16 (13.6%)	0 (0.0%)	118	39 (33.1%)
Ipswich Hospital	76 (24.5%)	133 (42.9%)	53 (17.1%)	48 (15.5%)	0 (0.0%)	310	101 (32.6%)
James Paget Hospital	62 (23.5%)	140 (53.0%)	35 (13.3%)	27 (10.2%)	0 (0.0%)	264	62 (23.5%)
Lister Hospital	122 (24.4%)	197 (39.5%)	114 (22.8%)	64 (12.8%)	2 (0.4%)	499	180 (36.1%)
Luton & Dunstable Hospital	103 (27.1%)	169 (44.5%)	62 (16.3%)	44 (11.6%)	2 (0.5%)	380	108 (28.4%)
Norfolk & Norwich University Hospital	168 (20.4%)	386 (47.0%)	160 (19.5%)	107 (13.0%)	1 (0.1%)	822	268 (32.6%)
Peterborough City Hospital	112 (24.6%)	212 (46.6%)	76 (16.7%)	55 (12.1%)	0 (0.0%)	455	131 (28.8%)
Princess Alexandra Hospital	51 (16.9%)	163 (54.0%)	48 (15.9%)	40 (13.2%)	0 (0.0%)	302	88 (29.1%)
Queen Elizabeth Hospital Kings Lynn	51 (22.0%)	117 (50.4%)	41 (17.7%)	23 (9.9%)	0 (0.0%)	232	64 (27.6%)
West Suffolk Hospital	93 (27.0%)	145 (42.2%)	73 (21.2%)	33 (9.6%)	0 (0.0%)	344	106 (30.8%)
Total	**1399 (21.5%)**	**2767 (42.5%)**	**1206 (18.5%)**	**1095 (16.8%)**	**44 (0.7%)**	**6511**	**2345 (36.0%)**

Distribution of patients by ISS

Annex D - List of Major Trauma services provided at Addenbrookes

A MTC has all the facilities and specialties required to be able to treat patients with any type of injury in any combination. Examples of such patients are patients who have suffered traumatic amputation of one or more limbs, patients with a serious head injury and patients who have suffered a number of injures (known as polytrauma) such as a combination of abdominal and chest injuries.

MTC Requirements (not exhaustive)

• 24/7 consultant available on site to lead the trauma team

• Trauma team present 24 hours a day for immediate reception of the patient.

• Ability to undertake resuscitative thoracotomy in the emergency department (ED);

• A massive haemorrhage protocol in place for patients with severe blood loss which includes the administration of tranexamic acid within 3 hours of injury, and transfusion specialist advice should be available 24 hours a day;

• 24/7 immediate availability of fully staffed operating theatres;

• Consultants available on site within 30 minutes when required; Neurosurgery; Spinal and spinal cord surgery; Vascular surgery; General surgery (adult or child); Trauma and Orthopaedic surgery; Cardiothoracic surgery; Plastic surgery; Maxillofacial surgery; Ear nose and throat surgery; Anaesthetics; Interventional radiology; Intensive care.

• Immediate (defined as within a maximum of 60 minutes, ideally within 30 minutes) access to computerised tomography (CT) scanning and appropriate reporting within 60 minutes of scan

• Availability of interventional radiology within 60 minutes of referral.

• Immediate access to critical care or high dependency care

• A defined team to manage on-going patient care, to support patients through the pathway and into rehabilitation. Model for the key worker may vary in centres.

• Specialist nursing and allied health professional trauma roles.

• Access to cross speciality supporting services which will include pain management, rehabilitation medicine and neuropsychology and neuropsychiatry.

• A defined ward for major trauma patients

• A defined service for early/hyper acute trauma rehabilitation which meets the needs of patients with ISS >8.

• Review within 3 calendar days by a Rehabilitation Medicine consultant or alternative consultant with skills and competencies in rehabilitation

The prescription for rehabilitation reflects the assessment of the physical, functional, vocational, educational, cognitive, psychological and social rehabilitation needs of a patient.

Clinical Specialties

• Emergency Medicine

- Radiology • Interventional Radiology

- Neurosurgery

- Spinal Cord Injury Services (acute)

- Vascular Surgery • General Surgery

- Cardiothoracic Surgery

- Trauma and Orthopaedic Surgery

- Plastic Surgery

- Maxillo-Facial Surgery

- Ear nose and throat surgery

- Transfusion Services

- Pathology services

- Anaesthetics

- Theatres

- Intensive Care

- Early/Hyper Acute Phase Rehabilitation Services

- Clinical Psychology

- Organ Donation

Major Trauma Centres — NHS

April 2012

Adult and Children's Major Trauma Centres
1. Addenbrooke's Hospital Cambridge
2. Frenchay Hospital Bristol
3. James Cook University Hospital Middlesborough
4. John Radcliffe Hospital Oxford
5. King's College Hospital London
6. Leeds General infirmary
7. Queen's Medical Centre Nottingham
8. Royal London Hospital
9. Royal Victoria infirmary Newcastle
10. St Mary's Hospital London
11. St George's Hospital London
12. Southampton General Hospital

Adult Major Trauma Centres
13. Derriford Hospital Plymouth
14. Hull Royal infirmary
15. Northern General Hospital Sheffield
16. Queen Elizabeth Hospital Birmingham
17. Royal Preston Hospital
18. Royal Sussex County Hospital Brighton
19. University Hospital Coventry
20. University Hospital of North Staffordshire Stoke on Trent

Children's MTCs
21. Alder Hey Children's Hospital Liverpool
22. Birmingham Children's Hospital
23. Royal Manchester Children's Hospital
24. Sheffield Children's Hospital

Collaborative
25. Manchester Collaborative MTC
a) Salford Royal NHS Trust
b) Manchester Royal infirmary
c) University Hospital South Manchester
26. Liverpool Collaborative MTC
a) Aintree University Hospital
b) Walton Centre
c) Royal Liverpool University Hospital
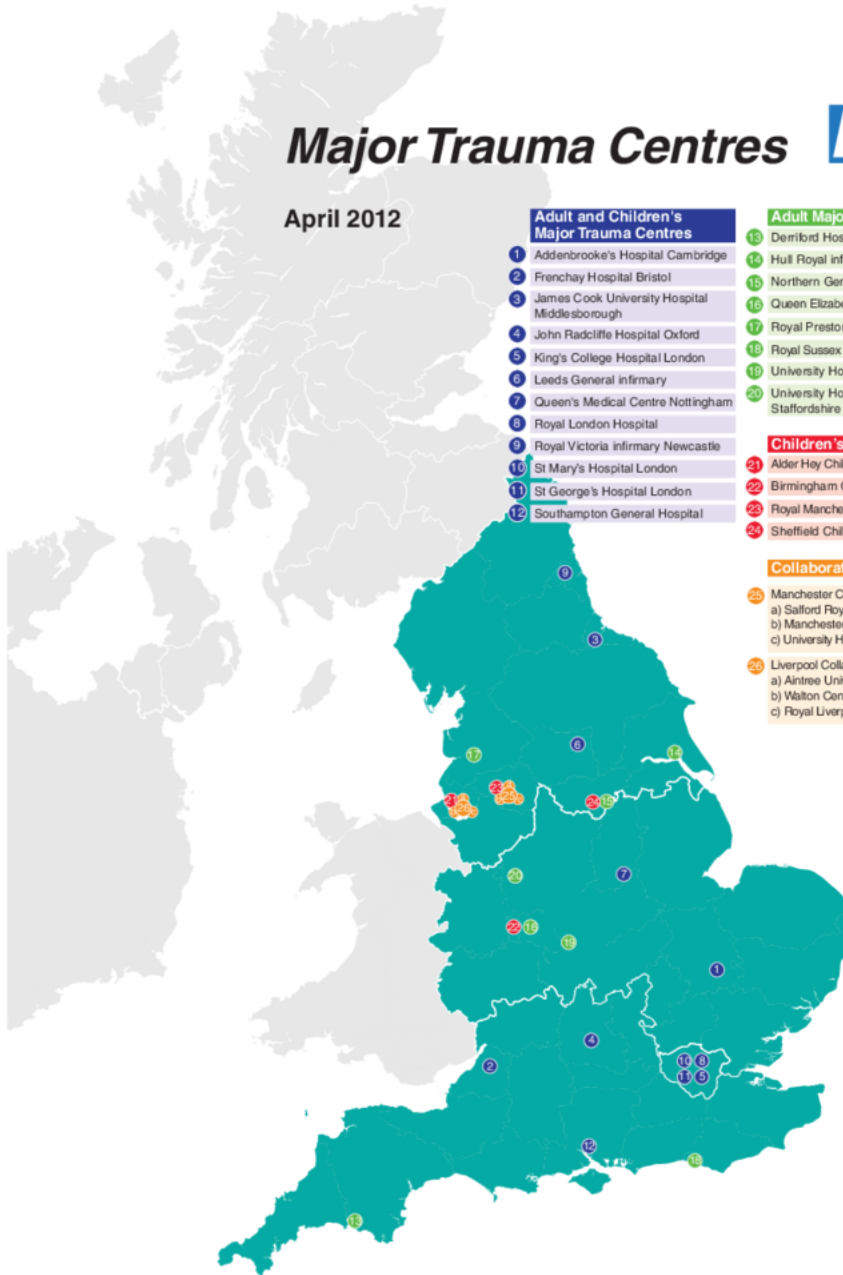
Virtual Wards

To:	Adults and Health Committee
Meeting Date:	9 March 2023
From:	John Rooke, SRO for virtual wards, Cambridgeshire and Peterborough ICS and Managing Director, North Cambridgeshire and Peterborough Care Partnership
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	N/A
Outcome:	For Information & General Discussion
Recommendation:	To note the progress of the Virtual Ward Programme

Officer contact:
Name: John Rooke
Post: Managing Director
Email: john.rooke@nhs.net
Tel: 07720167975

Member contacts:
Names: Councillors Cllr Richard Howitt / Cllr Susan van de Ven
Post: Chair/Vice-Chair
Email: Richard.howitt@cambridgeshire.gov.uk and susanvandeven5@gmail.com
Tel: 01223 706398

1.   Background

1.1   Our aim is to implement virtual wards which allow patients to get the care they need at home safely and conveniently, rather than being in hospital. This will:
- support people with frailty or acute respiratory infections;
- support people at the place they call home, including care homes;
- provide remote monitoring using apps, technology platforms and medical devices such as pulse oximeters;
- involve face-to-face care from multi-disciplinary teams based in the community; and
- provide alternatives to hospital admission.

1.2   Acute Virtual Wards are being commissioned across the entirety of NHS England as part of a national strategy to increase capacity and align capability and resources to manage prioritised groups of patients at home.

1.3   Since April 2022, Cambridgeshire and Peterborough Integrated Care System (C&P ICS) has been developing and implementing its Virtual Ward model of care. The model of care was formed from a formal options appraisal April through May '22 and described in a delivery plan submitted to NHS England (NHSE) in June '22. One of the key determinants from the options appraisal was the range of patient management systems in place across providers with each acute provider having uniquely different systems. It was therefore more practical in the short to medium term to plan and develop the model on a provider level (Acute Trust) basis.

1.4   The Integrated Care System (ICS) has implemented a hub and spoke model in year one (2022/23) with three acute hospital Trusts having developed acute virtual wards from autumn 2022. There is an ICS level programme board overseeing the development of the new structures, resource requirements and the interface with NHS England East of England Virtual Ward programme team.

1.5   Set-up funding of £2.8m was allocated by NHSE to the ICS to establish the delivery plan and open the Virtual Wards. There was also an additional £112k of non-recurrent funding allocated to fund remote technology systems to support acute care at home.

1.6   The patient group priorities as defined by NHSE, in year one, included Frailty, Respiratory and Heart Failure patients. Crucially the defining criteria is that these patients would otherwise still not be medically fit and occupying a hospital acute bed. As such, Virtual Wards are not an alternative for patients living with long terms conditions or those medically fit and currently in hospital.

1.7   Virtual Ward care is not entirely new and therefore an initial exercise was to establish the existing level of activity that meets the national definition and what new activity would be required above that to reach the trajectory points. Predominantly this was found to be intravenous infusion services delivered in patients own homes for particular type of short lasting acute infections and COVID care across respiratory services.

1.8 Virtual Ward care is only one facet of a range of unscheduled care initiatives and commissioned services across the Integrated Care System. As such in the planning process it has been essential to be definitive in the role and function of virtual care and the interface and synergies alongside other services in the community.

2. Key achievements

2.1 As of February 2023, we have created capacity of approximately 190 virtual ward bed 'equivalents'. This has been achieved through the commitment of our care staff to develop new models of care in the community. Presently we are reporting between 50% and 65% occupancy and our focus is on ensuring that occupancy of current capacity is optimised.

2.2 In line with national direction, the ICS programme board has also focused on safely avoiding the need to admit patients to hospital beds developing alternatives to hospital care to support admission avoidance. Across the ICS the Greater Peterborough Network (GP Federation) is working collaboratively with North West Anglia Foundation Trust (NWAFT) and Granta (GP Primary care Network provider) with Cambridgeshire University Hospitals Foundation Trust (CUHFT) to deliver step up virtual ward capacity to support admission avoidance. Patients can be cared for in their home, with up to 5 days wrap around support provided from health and care professionals. This model of care is also supporting proactive identification of patients currently in hospital who would benefit from care at home, specifically for frailty.

2.3 Virtual ward services are being managed operationally at Acute Trust level and the clinical governance and operational accountability being managed through Virtual Ward triumvirate teams (Clinical Lead, Head of Nursing and the Operational Manager). These teams are also developing local plans, pathways and links into services who may benefit from virtual ward care.

2.4 The local triumvirate teams are developing systems and processes for capturing and measuring patient experience and outcomes from the virtual wards. Oversight of progress is managed through the ICS Virtual Ward Programme Board, ICS Unplanned Care Board and ICB Quality, Performance and Finance Committee on a monthly basis.

3. Next steps in 2023/24

3.1 By September '23 the NHS expects virtual wards to operate at 80% occupancy. Therefore, we will continue to focus on scaling up capacity to over 200 beds (exact number is currently in planning) but also ensuring occupancy is optimised.

3.2 Whilst Frailty, Heart Failure and Respiratory have been the year one (2022/23) priorities, the plan for 2023/24 is to develop new pathways for musculoskeletal care elements of palliative care, paediatric, acute surgery and admission avoidance through in-reach into our emergency departments.

4. Source documents guidance

4.1 Source documents

https://www.england.nhs.uk/wp-content/uploads/2021/12/B1207-ii-guidance-note-frailty-virtual-ward.pdf
https://www.england.nhs.uk/publication/enablers-for-success-virtual-wards/

Appendix 1: Health Inequalities Impact Assessment template
This templated has been designed to be completed sequentially during each stage of the HIIA process and should be completed by the team responsible for the decision.

Name of people completing this analysis:
Peter Gent, Virtual Ward Programme Manager

Name of Sponsor Director:
John Rooke

Date last completed:
28th February 2023

Stage 1 questions – Description of the change and the health impacts **Date completed:**
Please provide a brief description of the change that is being assessed. Our aim is to implement virtual wards which allow patients to get the care they need at home safely and conveniently, rather than being in hospital. This will: • support people with frailty or acute respiratory infections; • support people at the place they call home, including care homes; • provide remote monitoring using apps, technology platforms and medical devices such as pulse oximeters; • involve face-to-face care from multi-disciplinary teams based in the community; and • provide alternatives to hospital admission.   What are the impacts on health likely to be? Please refer to Health Impact Assessment conclusions. 1. Virtual Wards will allow a wide range of patients to be cared for outside of the hospital environment as well as avoiding the need for inpatient admission for some others. 2. Appropriate patients are managed remotely in their usual place of residence and not in an acute hospital environment. 3. From a patient experience perspective, shifting the balance of care from acute beds to care in own homes has the potential to improve overall experience. 4. Reduction in length of stay in acute hospital beds 5. Release hospital bed capacity for patients who require inpatient stays 6. There will be improvements in patient health, mental health and well-being outcomes through home based care.

Stage 2 and 3 questions – Brainstorming, and assessing the inequalities impact and finding evidence
Date Stage 2 completed: 28 February 2023
Date Stage 3 completed: 28 February 2023

Stage 2 questions
Please list all the possible positive and negative impacts on *access* or *health outcome* that your team can think of for the following groups. N.B. At this stage it is better to include as many as possible.

Stage 3 questions
Please describe the evidence used to assess the likelihood of these impacts and the evidence used to make that judgement (this may include local data, national research, surveys, reports, discussions with patient representatives or third sector organisation, focus groups, pilot activity evaluations or other Equality Analyses.

Ensure those listed in EIA (1) are captured here

Group	Stage 2			Stage 3
	Impacts on access and likelihood (rare, unlikely, possible, likely, almost certain)	**Impacts on outcome and likelihood** (rare, unlikely, possible, likely, almost certain)		**Evidence**
Lower socio-economic groups (e.g. those on low incomes, unemployed, receiving means-tested benefits)	Almost certain Positive	Almost certain Positive		All patients will be considered within scope for virtual ward, so there should be benefits for all patient groups including those with protected characteristics with very little adverse impact or risk. For example: a) patients of lower socio-economic groups with lower incomes will be more able to maintain their usual support network in their own home, due to transport costs making patient visits by family etc to hospital more difficult.

			b) Any patient with issues with financial security and the move to a virtual ward will enable these issues to be identified and addressed more effectively through support sought from partner organisations (e.g. local government housing and benefits teams)
Disadvantaged groups			
People who are minority ethnic	Almost certain	Almost certain	All patients will be considered within scope for virtual ward, so there should be benefits for all patient groups including those with protected characteristics with no adverse impact or risk. For example, patients will be in their own home and therefore able to access their usual support network. This will hopefully facilitate more culturally competent care planning and improve the management of their condition.
People who are Lesbian, Gay, Bisexual and Transgender plus	Almost certain	Almost certain	All patients will be considered within scope for the virtual ward, so there should be benefits for all patient groups including those with protected characteristics with no adverse impact or risk
Older adults, particularly those living in rural areas who rely on public transport	Almost certain	Almost certain	All patients will be considered within scope for the virtual ward, so there should be benefits for all patient groups especially those who will be at

				their usual place of residence rather than an acute hospital.
Those with current or prior justice system involvement	Almost certain	Almost certain		All patients will be considered within scope for the virtual ward, so there should be benefits for all patient groups including those with protected characteristics with no adverse impact or risk
Those who spent time in care as a child or experienced multiple Adverse Childhood experiences**	Almost certain	Almost certain		Children are not currently served by the virtual ward. However, all adults will be considered within scope for the virtual ward, so there should be benefits for all patient groups including those with protected characteristics with no adverse impact or risk
Inclusion health groups				
Those sleeping rough or housing insecure	Almost certain	Almost certain		All patients will be considered within scope for virtual ward, so there should be benefits for all patient groups including those with protected characteristics with no adverse impact or risk. For example, the move to a virtual ward will enable housing insecurity issues to be identified earlier and addressed more effectively (with and through partner organisations) for the patients for whom the virtual ward is being considered.

Those belonging to the Gypsy Roma and Traveller community	Almost certain	Almost certain		All patients will be considered within scope for the virtual ward, so there should be benefits for all patient groups including those with protected characteristics with no adverse impact or risk
Asylum seekers, refugees and undocumented migrants	Almost certain	Almost certain		All patients will be considered within scope for virtual ward, so there should be benefits for all patient groups including those with protected characteristics with no adverse impact or risk. For example, the move to a virtual ward will enable housing insecurity/no recourse to public funds issues to be identified earlier and addressed more effectively (with and through partner organisations) for the patients for whom the virtual ward is being considered.
Those who do not speak English	Almost certain	Almost certain		All patients will be considered within scope for the virtual ward, so there should be benefits for all patient groups including those who don't speak English through the use of translation services.
Street-based sex workers	Almost certain	Almost certain		All patients will be considered within scope for the virtual ward, so there should be benefits for all patient groups including those with protected characteristics with no adverse impact or risk

Those with a severe mental illness	Almost certain	Almost certain		All patients will be considered within scope for the virtual ward, so there should be benefits for all patient groups including those with mental health conditions and support services and/or key workers will be involved in the care provided.
Those with a learning difficulty	Almost certain	Almost certain		All patients will be considered within scope for the virtual ward, so there should be benefits for all patient groups including those with learning disabilities and carers, support services and/or key workers will be involved in the care provided.

Stage 4 questions
Risks to increase in inequalities, opportunities to decrease inequalities and mitigation plans
Date completed: 28 February 2023

Please describe what mitigating steps have been taken to reduce the negative impacts or enhance the positive impacts. Please state the risks that have been included in the project risk register.

There are no risks identified concerning an increase in inequalities, however, the holistic care planning for individuals will be monitored to ensure that we support the individual needs of the patient transferring to the virtual ward and to any care services beyond.

Stage 5 questions
Monitoring and Evaluation
Date completed: 28 February 2023

Please describe how you will monitor and evaluate the impact that your decision has on inequalities.

To date, the virtual ward has been established for only a few months. Detailed analysis of inequalities has not yet been undertaken by the programme. However, the following monitoring is underway.

1. Clinical audit will take place on a monthly basis where a sample set of 10% will be monitored and reviewed via current clinical governance structures. These audits will make use of agreed data sets that match those already being utilised within hospitals. They will include number of patients in the virtual wards, discharges, length of stay, adverse incidents and patient satisfaction.

2. Virtual ward Standard Operating Procedures (SOP) have been written in conjunction with the NHSE guidance which include the hospital at home framework. Compliance with NICE Guidance and current clinical best practice will be delivered in the virtual ward.

3. All NICE guidance will be applied to any SOP. Patient will always comply with the clinical pathways including NICE Guidance recommendations for all conditions.

4. Patient Reported Outcome Measures will be utilised to report quarterly and this feedback will be monitored to make changes/improvements where deemed necessary.

As the programme develops into 2023/24 (beyond the initial set-up phase) these measures will include how the virtual ward impacts on inequalities using formal patient feedback and the impact on protected characteristics groups identified.

Stage 6: Assessment of benefits of integration
Date completed: 28th February 2023

Would providing this service in an integrated way, either integrated within health service or integrated with social care, reduce inequalities in access to those services or reduce inequalities in the outcomes achieved?

Answer: Yes

If yes, please briefly state the plan for this integration:

1. All stakeholders within the ICS will be involved in delivery of the virtual ward as inter-partnership working. The holistic assessment of needs of an individual will draw on support of multiple agencies.

2. This programme is led by the ICS Unplanned Care Board and the Virtual Ward Programme Boards. All partners contribute to the two Programme Boards, which oversee the delivery of the virtual ward Programme and encourages partners to work together to deliver an effective service. The Programme Boards oversee the monitoring and resultant changes to the pathways. They also encourage partners to share learning across the system.

3. All patients (except children) will be considered within scope for the virtual ward and the aim is to ensure that no one is disadvantaged by the proposal.

4. Any impacts on inequalities will be identified and addressed as part of the next monitoring and evaluation of the virtual ward.

Date of finalisation of Health Inequalities Impact Assessment: 28 February 2023

APPENDIX 2 – GUIDANCE AND CHECKLIST FOR IMPLICATIONS

Report authors should decide whether in each category there are no, some or significant implications, considering each of the prompt questions. A commentary need only be included within the report where there are <u>significant</u> implications. Report authors will need to clear each implication category with the relevant Team. They may wish to this before the drafting a report particularly if the issue is contentious.

<u>**A working definition of "significant"**</u> is where the broader implications of a proposal are so evident /substantial that they need to be taken into consideration when Members are making a decision on the proposal.

All headings (in bold below) should be included. However, if the implications have been referenced earlier in the report, the detail does not need to be repeated – just a reference made to the relevant text.

Resource Implications	- What are the capital and revenue costs? - What is the availability of current and future budget provision? - Is the organisation delivering value for money? - Is the best placed organisation delivering this service? - What are the implications for our property assets? - What are the implications for Information and Communications Technologies (ICT) and data ownership? - What are the impacts on human resources – employees' Terms & Conditions, work location, staffing levels, industrial relations, Human Resources (HR) policies and if so has advice on the report been sought? - Are resources being used in a sustainable way, with regard to carbon dioxide (CO_2) emissions, climate change adaptation/mitigation, and long-term impact on environment? - Have we considered and are we in line with best practice? - Is our performance as an authority or partnership impacted?
Procurement/ Contractual/ Council Contract Procedure Rules Implications	- Have you evidenced compliance with the Council's Contract Procedures Rules? - Have you identified where you are seeking Committee to approve an exemption from the Contract Procedure Rules and detailed the risks and mitigations? - Have you identified any EU or UK legislative risks associated with the exemption process such as non-compliance with the Public Contract Regulations Act 2015, transparency and open competition? - Have you identified the procurement or contractual risks associated with a contract? - Has the contract/procurement been subjected to the Council's Commercial Board? - This includes re-procurement
Statutory, Legal and Risk Implications	- Did the proposal originate as a result of statute? - What is the relevant statutory guidance? - Are there any legal implications? - Are there any reputational implications? - What are the key risks and how might they be managed? - Are there any community safety implications? - Are there any health and safety implications? - Are there any human rights implications? Please consult with the Legal Team for advice on completing this section?

Equality and Diversity Implications	The completion of this paragraph demonstrates that you have had due regard to the Council's equalities duties under • The Public Sector Equality Duty within the Equality Act 2010 • Other relevant legislation such as The Public Sector Bodies (Websites and Mobile Applications) (No. 2) Accessibility Regulations 2018, • The Council's commitment to meet the Public Sector Equality Duty for Socio-economic Inequalities. Depending on the situation, it may also demonstrate that you have had due regard to the Council's duties under the Equality Act as it relates to our work as: • An employer • A service provider • An education authority and/or • A property owner. The Council has decided to use the Equality Impact Assessment (EqIA) process to help us demonstrate that we have met the above requirements. For more information on our duties and responsibilities, and guidance how to use the EqIA e-form etc, please see the CCC Equality Impact Assessment Hub A completed EqIA form (downloaded from the EqIA e-form) must be attached as an appendix to this report. The key findings – including mitigating actions or opportunities to improve equality, diversity, and inclusion – should be included in the report as appropriate.
Engagement and Consultation	• Has there been community engagement / public consultation and if so, what were the results? • Has discussion on the proposals taken place across directorates and with other relevant councils / agencies? • What are the implications for engagement with voluntary/community sector? • Have affected employees been consulted? • Have local Members been consulted and their views taken into consideration? • Where you are recommending changes that impact on a community, has an Equality Impact Assessment been carried out incorporating feedback from community engagement where appropriate? (see section on Equality and Diversity Implications, above)
Localism and Local Member Involvement	• Does the proposal empower communities to do more for themselves? • How will the proposal harness the energy of local communities to work with the County Council? • Does the proposal involve devolving decision-making and delivery to a more local level? • Have you fully informed Local Members about matters affecting their divisions during the formative stages of policy development and discussion at informal meetings, as required by Part 5.3 – Member/Officer Relations of the Council's Constitution?

Public Health	• Will the proposal have an impact on the health of Cambridgeshire residents? • Will the proposal support improving the health of the worst off fastest? • Will the proposal impact on a key health and wellbeing need identified in the Cambridgeshire Joint Strategic Needs Assessment (JSNA) • How does the proposal ensure that public health preventative measures for COVID-19 are being adhered to. • What national guidance on COVID-19 is relevant to this proposal. All national guidance can be reviewed at the following link: https://www.gov.uk/coronavirus The suite of Cambridgeshire JSNA documents are available on the Council website at the following link: http://www.cambridgeshireinsight.org.uk/jsna Please consult with the Public Health Team for advice on completing this section. Contact number: 01223 699689.

Environment and Climate Change	Answering the below questions will help indicate the positive/neutral/negative status of the Environment and Climate Change implications. Where the answer is "yes" the section response is "positive".
	Energy efficient, low carbon buildings:
	• Will the proposal decrease energy use for the council and/or communities?
	• Will the proposal lead to a switch to low-carbon energy supply, including renewables?
	Low Carbon Transport:
	• Will the proposal decrease use/reliance on the private car?
	• Will the proposal encourage use of cleaner modes of transport? Eg. EV, cycling, walking.
	• Will the proposal increase use of public transport?
	Green spaces, peatland, afforestation, habitats and land management:
	• Will the proposal encourage, incorporate or implement tree planting?
	• Will the proposal prevent or minimise tree removal?
	• Will the proposal create, enhance or reduce damage to green space or natural habitats?
	• Will the proposal improve the accessibility of green space or nature?
	• Will the proposal lead to the improvement of peatland condition or extent? E.g. sustainable agriculture, restoration
	Waste Management and Tackling Plastic Pollution:
	• Will the proposal reduce waste generated by the council and/or residents, increase recycling, or encourage use of sustainable materials?
	• Will the proposal reduce rubbish and waste, especially plastics, or reduce emissions from landfill?
	Water use, availability and management:
	• Will the proposal lead to reduced risk of flooding?
	• Will the proposal promote and/or implement nature-based solutions to climate change (e.g balancing ponds, Sustainable Drainage solutions, tree planting etc) to manage the effects of climate change? E.g. Flood risk or heatwaves.
	• Will the proposal help minimise use and wastage of water at the council and/or for communities, or help secure water supplies for the future?
	Air Pollution:
	• Will the proposal lead to a reduction in air pollution or an improvement in air quality?
	Resilience of our services and infrastructure, and supporting vulnerable people to cope with climate change:
	• Will the proposal lead to our services having greater ability to cope with the effects of climate change? E.g. flooding or heatwaves
	• Will vulnerable people better cope with climate change?
	See the Climate Change and Environment strategy here for further information on the Council's climate priorities.
	Contact the Climate Change Officer if you encounter any issues in completing these implications: mlei@cambridgeshire.gov.uk.

NHS Quality Accounts – Establishing a process for responding to 2022-23

To:	Adults and Health Committee
Meeting Date:	9 March 2023
From:	The Monitoring Officer
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	
Outcome:	For the Committee as part of its statutory function of scrutiny of the NHS to provide a response to NHS Provider Trusts Quality Accounts.
Recommendation:	The Adults and Health Committee is asked to note the requirement for NHS Provider Trusts to request comment form Health Scrutiny committees and

a) to delegate approval of the responses to the Quality Accounts to the Head of Public Health Business Programmes acting under instruction the members of the Committee appointed to the Task and Finish Group.

b) to appoint those members of the committee that participate in the quarterly liaison groups to become members of the associated Task and Finish group on NHS Quality accounts.

Officer contact:
Name: Kate Parker
Post: Head of Public Health Business Programmes
Email: Kate.Parker@cambridgeshire.gov.uk
Tel: 07535 694729

Member contacts:
Names: Cllr Richard Howitt / Cllr Susan van de Ven
Post: Chair/Vice-Chair
Email: Richard.howitt@cambridgeshire.gov.uk Susanvandeven5@gmail.com
Tel: 01223 706398

1. Background

1.1 NHS Healthcare providers are required under the Health Act 2009 to produce an annual Quality Account report. A Quality Account is a report about the quality of services by an NHS healthcare provider.

1.2 Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive, and patient feedback about the care provided.

1.3 This paper outlines the proposed response to the Quality Accounts received by the Health Committee and the internal deadlines to respond to the NHS Trusts.

2. Main Issues

2.1 It is a requirement for NHS Healthcare providers to send to the Health Committee in its Overview and Scrutiny function a copy of their Quality Account for information and comment. Statements received from Healthwatch and Health Overview and Scrutiny Committees must be included in the published version.

2.2 NHS Healthcare providers are required to submit their final Quality Account to the Secretary of State by 30th June each year. For foundation trusts the Quality Accounts are required to be submitted to NHS Improvement by 31st May for audit purposes. However, each provider will have internal deadlines for receipt of any comments from relevant statutory consultees.

2.3 As discussed at the Health Committee meeting in previous years, the timing of the Quality Account deadlines puts the Committee in a difficult position to provide an adequate response. Often NHS Trusts are unable to send copies of their draft Quality Accounts until mid to end of April, resulting in a short timescale for the committee members to formally agree a response. There is no statutory requirement for the Adults and Health Committee to respond to the Quality Accounts.

2.4 Due to the pressures NHS Trusts were under in dealing with the pandemic the requirement to produce Quality Accounts 2019/20 was paused in 2020. Quality Accounts were produced by some Trusts for the 2020/21 year but a process was not established for the Adults and Health Committee to respond to these adhoc requests.

2.5 A new process was introduced in 2018 whereby the Health Committee appointed members of the committee to a task and finish group. This group reviewed the content of the Quality Accounts that they were in receipt of and feedback was provided to the Trust. The Head of Public Health Business Programmes was responsible for submitting final statements to each Trust. It is a legal requirement for the Trusts to publish these statements as part of their complete quality account.

2.6 Selected members in the committee currently participates in the following quarterly liaison meetings

3.   Responding to NHS Quality Accounts

3.1   Under the committee system of governance, it is not possible to delegate decisions to individual elected members or groups of members, but scrutiny regulations require that scrutiny be carried out by elected members and not delegated to officers.

3.2   Due to time constraints identified in section 2.2, responses before 2018 were limited to details of where the Trust has attended the Health Committee for the purposes of health scrutiny. Any recommendations made by the committee were submitted within the statement. Feedback received from the Trusts noted that they had expected more of a reflection and comment on the content of the Quality Account rather than an overview of scrutiny actions.

In 2022 this process was replicated to review the Quality Accounts received for 2021/22 and membership to task and finish group was agreed at committee. However, it was difficult for committee members who were not familiar with particular trusts to comment on their Quality Accounts. Therefore it is proposed that for 2022/23 Quality Accounts members of the existing quarterly liaison meetings that meet with senior representatives from these trusts form the associated task and finish group.

3.3   The following NHS Trusts have established quarterly liaison meetings:

- Cambridgeshire Community Services (CCS)
- Cambridgeshire & Peterborough Foundation Trust (CPFT)
- Cambridge University Hospital NHS Trust (CUH)
- North West Anglia Foundation Trust (NWAFT)
- Royal Papworth Hospital Trust (RPH)

3.4   As in previous years the scheduling of the committee meeting does not allow for members to discuss the responses at the next Committee meeting scheduled for June 2023 prior to the deadline the Trusts will require a response.

3.5   If the Adults and Health Committee want to submit a response to the Quality Accounts received by NHS Trusts then agreement is needed to establish a task and finish group (as proposed in section 3.2) that has delegated authority to respond to the Quality Accounts on behalf of the Adults and Health Committee

4.   Source Documents

Source Documents	Location
NHS Choices information on Quality Accounts	http://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Pages/about-quality-accounts.aspx
Reports to and minutes of Health Committee	https://cmis.cambridgeshire.gov.uk/ccc_live/Committees/tabid/62/ctl/ViewCMIS_CommitteeDetails/mid/381/id/6/Default.aspx