Appendix 2b
Adults and Health

Pressures / Investments

Business Planning: Business Case - Pressure

Project Title: Increased staffing within the Young Adults Team

Committee: Adults and Health Committee

2022-23 Pressure amount: £148,834k

Brief Description of proposal:
To increase the existing staffing structure within the Young Adult's Team, to better manage demand verses capacity, and deliver a safe, cost-effective service.

Date of version: September 2021 BP reference: A/R.4.040

Business Leads / Sponsors: Sasha Long, Head of Service, Disability Social Care 0 – 25 Service

1. Please describe what the proposed outcomes are:

To deliver a safe and cost-effective service, be better placed to manage demand by increasing the existing capacity within the team and to improve outcomes for young people.

The current structure of the Young Adult's Team is as follows:

- 1 WTE Team Manager
- 2 WTE Senior Social Workers
- 6 WTE Social Workers
- 3 WTE Adult Support Coordinators.
- 1 WTE Business Support Assistant.

The proposed structure of the service moving forward:

- 1 WTE Team Manager
- 4 WTE Senior Social Workers
- 6 WTE Social Workers
- 4 WTE Adult Support Coordinators.
- 1 WTE Business Support Assistant.

Implementing the proposed staffing structure as above would enable cases to be allocated to workers at an appropriate level, and to eradicate the need for a 'waiting list.' This would result in the safer management and prompt allocation of new cases being referred through to the team.

The addition of two new Senior Social Workers would enable each to be 'linked' with an LDP (Learning Disabilities Partnership) Team, thus improving working together across the two service areas, streamlining transfer processes and enabling a richer multi-agency consideration of each case under discussion.

The additional Adult Support Coordinator post would provide some much-needed capacity to cover the lower-level cases, thus enabling the Social Workers and Senior Social Workers to dedicate their time and resources to the higher-level cases requiring urgent attention. High level tasks, such as CoP DoLS (Deprivation of Liberty Standards) applications, could be undertaken without delay and the Council would be at reduced risk of drawn-out, costly legal proceedings.

The additional team capacity would enable all team Key Performance Indicators to be consistently adhered to and would support the team in delivering results in line with the PFA (Preparing for Adult) model. It would also free-up the time of the senior members of the team to enable them to focus on staff development, training opportunities, and improving outcomes for the young people the team supports.

Current budget:

Description:	Budget:
Current YAT staffing budget:	£538,508
Required vacancy savings:	£30K
Current forecast for 2021/22 year end position:	Balanced budget.

Conclusion:	No surplus within the current budget and no identified vacancy savings to draw down on.

Additional Resource Required:

To expand the current team, the service would require funding for: *2 x additional SSW's:* £109,926 *1 x additional ASCO:* £38,908	Total: £148,834

2. What evidence has been used to support this work, how does this link to any existing strategies / policies?

Context and Rationale for the expansion of the Young Adult's Team.

The Young Adult's Team is part of the Disability Social Care 0-25 Service. This service is responsible for the statutory safeguarding of vulnerable children and young adults with disabilities across Cambridgeshire, as well as the transition of eligible young adults to adult social care, and it is therefore essential that the team have the capacity to do robust assessments, support planning, financial forecasting, and safeguarding investigations.

When the Young Adult's Team was first created, the intention was for the team to have the capacity to undertake early Preparation for Adulthood work with families open to the Children's Disability Teams. The YAT should be getting involved when the young person reaches the age of 16 years, to guide them through the adult assessment including completion of MCA assessments, CoP DoLs as appropriate and the support planning process before the young person was 17.5 years old. The intention was therefore that the family would have an agreed budget and support plan in place well in advance of the young person's 18th birthday, and know exactly what services would be provided, to ease the transition to adulthood, this includes ensuring CHC (Continuing Healthcare Care) and any joint funding has been explored and agreed.

However, due to the current staffing / capacity / demand issues across the Young Adult's Team, the reality is that the team are constantly managing crises for the highest level of cases, whilst the day-to-day tasks are being overlooked. As such, they are unable to get involved with families much before each young adult's 18th birthday. This results in the team being unable to undertake the Preparation for Adulthood work required and there is little opportunity for thoroughly reviewing care packages, 'changing the conversation' with families, or maximising the young adults' strengths / independence. These cases are then being presented to the LDP QA (Quality Assurance) Panel close to the young adult's 18th birthday, with the likelihood being that the care package in place throughout their time with children's services will have to continue for a period, which is costed higher than the adult provisions.

Current caseload pressures:

There are currently 257 cases allocated to the Young Adult's Team, with an additional 85 cases being held on a 'waiting list.' (In ideal circumstances the team would not have a waiting list and all incoming referrals would be allocated immediately, however the team do not currently have the

capacity to do this.) This equates to a total of 342 cases who require support from the service. In addition to this, there are 92 carers who are also open to the team and who receive an assessment and service, with an additional 3 carers on the ‘waiting list’. This equates to a total of 95 carers who require support from the service.

Business Intelligence have confirmed that on average there are 9 new referrals to YAT per month, with an average of 7 cases being closed to the team each month. Therefore, the number of cases coming in, are steadily exceeding the number going out.

In addition to this, we have noticed a trend in EHCP’s remaining in place for the maximum amount of time (until the young person reaches 25 years of age) due to the increasing number of SEND (Special Educational Needs and Disabilities) Tribunals. As such, cases which would previously have transitioned out of the Young Adult’s Team when the young person was around 20 years old, are now remaining open for several additional years.

The Young Adult’s Team are allocated a high number of DoLS cases by nature of the fact that many of the 18yr olds who transfer to their team have complex needs. Due to the staffing / capacity pressures within the team, there is currently a backlog of overdue DoLS reviews, and essential DoLS applications are being delayed. These cases cannot transfer to the LDP Locality Teams until this work has been completed, this is impacting on the throughput of cases within the Young Adult’s Team, further reducing team capacity.

There are currently several high-risk cases within the team taking a disproportionate amount of time to actively manage and support, including those at those at risk of admission, carer breakdown, placement breakdown and complex legal action.

The Young Adult’s Team regularly receive new referrals from the Children’s Disability Teams, mainstream Children’s Social Care Teams, and external agencies, where the young adult has not been known to Social Care in the past and therefore requires extensive assessment / support planning. With very few cases transferring out of the team, the team’s capacity to turn these assessments around in quick timescales has been steadily reduced and these cases often stay on the ‘waiting list’ for several months as other, more urgent cases must be prioritised.

Most of the annual reviews for young adults being supported by the Young Adult’s Team result in changes to care packages (due to their education packages reducing year by year) and re-assessments are therefore required, along with renewed applications to the LDP QA funding panel. The Young Adult’s Team consistently present the highest number of cases to the funding panel, evidencing the throughput of the work and the frequently changing nature of their care packages. Therefore, even cases which have been with the team several years still generate a great deal of work on a regular basis. The intent moving forward once JASP (Joint Access and Support Panel) is embedded in CCC (Cambridgeshire County Council) (Cambridgeshire County Council) is that the YAT will only present cases at JASP where there will be robust oversight of all transition cases, however it is a higher number of cases will be deferred if PFA work has not been completed.

Current staffing pressures:

The team is currently comprised of a Team Manager (who should not hold any cases), two Senior Social Workers (who should have a reduced caseload in recognition of their supervisory roles), six Social Workers (including ASYE’s who should hold a reduced caseload throughout their

assessment year) and three Adult Support Coordinators (who should have a caseload of less complex cases in recognition of the fact that they are alternatively qualified members of staff.)

However, considering the disproportionately high number of cases open to the team and sitting on the waiting list, the reality is that the TM must actively work several cases, both Senior Social Workers are holding excessively high caseloads, and the Social Worker (including the ASYE's) and ASCO's are all holding more cases than they should, including cases with increasing complexity.

This has resulted in a high turn-over of staff within the team and significant challenges around retainment, with several members of staff citing workload pressures and a lack of capacity as their reason for leaving the service. It has also resulted in the need to employ costly agency staff on a regular basis, to manage vacancies and to respond to gaps when staff leave and there is a delay in new staff joining the service.

As the Young Adult's Team is a frontline safeguarding social work team managing a high level of complexity and risk, it is reasonable to expect the average caseload per role within this team to be as follows:

- Senior Social Workers, up to 15 cases each, to enable them to have enough free time to support less experienced staff, carry out supervisions, provide case oversight.
- Social Workers, up to 20 cases each (so they have the time and capacity to manage complex case issues.)
- ASYE's, up to 18 cases each (so they have the capacity and space to continue their learning and developing their confidence / experience throughout their assessed year.)
- ASCOs, up to 30 less complex cases each (so they can provide a high-quality service to those cases with less complexity but still requiring active support, and oversight / actions as required on those cases which only need to be 'open to review'.)

Based on the current staffing structure, if we were to divide the number of cases allocated to the team (including those on the waiting list) between the current staff, the average caseload would by far exceed that which is considered optimal, manageable, or safe.

3. Has an options and feasibility study been undertaken? Please explain what options have been considered.

Disability Social Care 0-25 funding considerations:

The staffing budget for the Young Adult's Team sits within the LDP pooled budget. The Disability Social Care 0-25 Service currently contributes £45,678 towards the staffing budget for the Young Adult's Team, which funds 1 x SW post and 'tops up' the cost of a Senior Practitioner post to make this a full-time position. In exploring the potential expansion of the Young Adult's Team, we have reviewed our staffing budget across the Children's Disability Teams to identify if there are surplus funds / posts which could be transferred to the Young Adult's Team. However, we have concluded that further reductions to the staffing budget are not possible due to the workload held within the children's teams, as follows:

Within our Disability Social Care 0-18 teams, our average caseloads are currently as follows:
Senior Practitioners: 16 cases.

Social Workers: 18 cases.
ASYE Social Workers: 16 cases.
Child Practitioners: 14 cases.

In mainstream Children's Social Care teams, the recommended average caseloads are as follows:
Senior Practitioners: Up to 10 cases.
Social Workers: Between 16-18 cases.
ASYE Social Workers: Up to 10 cases.
Child Practitioners: Up to 15 cases.

This indicates that the average caseloads held by the staff in our 0-18 Children's Disability Teams are in line with our mainstream colleagues. We already work flexibly across our service and we are currently using any spare capacity within our Children's Disability Teams to support the Young Adult's Team but the demand on our children's teams is and will continue to increase as restrictions begin to lift post the pandemic and the current support (albeit minimal) cannot be sustained.

4. What are the next steps/ actions the Council should take to pursue it? Please include timescales.

Task	Start Date	End Date	Overall Responsibility
Business Case to be reviewed and authorised.	9 December 2021		

5. Could this have any effects on people with Protected Characteristics including poverty and rural isolation? If so, please provide as much detail as possible.

If team capacity remains stretched, the prioritisation of resource relies on intelligence received. Statistically those from difficult to reach / historically excluded groups may not reach out or be advocated for as widely and this could result in inaccurate prioritisation.

An Equality Impact Assessment (EqIA) will be developed to ensure this proposal is equitable in its aims and delivery. This is to ensure CCC's decision-making is inclusive for staff and communities with protected characteristics in line with the Equality Act (2010) and Public Sector Equality Duty (section 149).

6. What financial and non-financial benefits are there and how will you measure the performance of these? Are there any dis-benefits? These MUST include how this will benefit the wider internal and external system.

Financial Benefits

Whilst we recognise the need for financial investment to make this proposal a reality, we believe this is justified considering the savings this will generate for the council, alongside the improvement to the current service delivery, and staff well-being.

Non-financial benefits

This business case sets out the proposal to request funding to enable the expansion of the Young Adults Team within the Disability Social Care 0-25 Service. This additional resource is required so that there is sufficient capacity across the service to manage the demand caused by the steadily increasing number of referrals / open cases, the extended period these cases remain open to the team, and the increased complex case activity (including essential DoLS work) across the team. The current level of demand cannot be safely managed with the current staffing structure in place, or within the current staffing budget. By expanding the Young Adult's Team:

- caseloads would be lower and therefore more manageable
- there would no longer be a need for a waiting list
- the team could undertake thorough Preparation for Adulthood work, achieving savings across the service whilst improving outcomes for the young people we support.

7. Are there any identified risks which may impact on the potential delivery of this? What is the risk if we do not act?

Risk	**Mitigation**	**RAG** (should the risk occur)	**Overall Responsibility**
Ability to Recruit to the additional positions.	Team to promote a Team specific recruitment campaign.	Red	Team Manager

8. Scope: What is within scope? What is outside of scope?

In scope is an increase of staff for the Young Adults Team.

Business Planning: Business Case proposal

Project Title: Additional Resource – Quality and Practice Team

Committee**:** Adults and Health

2022-23 Investment: £68k

Brief Description of proposal:

The request is for permanent investment of £113,042 per annum.

(Approx £68,000 of this from Cambridgeshire County Council and £45,000 being requested from Peterborough City Council) This would be to fund three auditors for the Quality and Practice team to ensure we are meeting our statutory responsibilities in the new assurance framework which will be overseen by the Care Quality Commission inspection.

Date of version: 8 September 21 BP Reference: A/R.4.041

Business Leads / Sponsors: Charlotte Black, Director of Adults and Safeguarding

1. Please describe what the proposed outcomes are:

With the 'Integration and innovation: working together to improve health and social care for all' White Paper, comes the proposal of a new assurance framework for adult social care to be overseen by the Care Quality Commission (CQC) inspection. This will result in increased regulation for adult social care (ASC), and we will need to ensure compliance. Our experience of Ofsted and Children's social care, tells us that non-compliance can lead to costly remedial action being required. The current capacity in the quality and practice team achieves two thematic audits a year. A thematic audit is an in-depth study on a particular area; used to assess the quality of practice and identify themes, risks and areas for learning. The current capacity does not cover auditing of all our statutory responsibilities, nor is it able to give full assurance of our statutory responsibilities.

CQC inspection of ASC will be from April 2022. In addition to this, COVID-19 has had increased demand on resources and pressures to Adult Social Care. Currently, it is even more important that we pay attention to quality and practice. We have a growing vacancy rate, which is compounded by increased demand with staff and managers trying to tackle back logs and deal with more complex cases. We need assurance that our quality is maintained in line with our statutory responsibilities.

As a result, there is a request to fund the cost of three auditors within the team, to assure ourselves we are fulfilling our statutory responsibilities, help prepare reports for CQC inspections and ensure we are proactive in addressing any practice issues/needs. This investment will mitigate the risk of future costs we may incur if remedial actions are needed to ensure CQC compliance following inspections.

This would be split across Peterborough City Council and Cambridgeshire County Council – the team currently is a shared services role and works across the whole service. Cost based on 40% PCC (Peterborough City Council), 60% CCC (Cambridgeshire County Council)

PCC Total cost £45,216.80 per annum

CCC total cost £67,825.20 per annum

To ensure that we can audit our statutory responsibilities and comply with the new assurance framework and CQC inspection requirement, there is a need to increase the number of thematic audits carried out across the service. For a thematic audit on our statutory assessments, to get a viable outcome we would need to complete three times the number of audits the teams are currently able to complete.

Benefits

- Carry out six thematic audits per year
- Increase of four audits to assure we audit our statutory responsibilities
- Free up the senior social workers to improve the timeliness of actions to the findings, implement systemic changes, and supporting operational teams.

The implications from the white paper on health and social care reform, Adult Social Care will come under greater scrutiny and include a new inspection regime from CQC. With increased capacity to carry out audits across all adult services in PCC and CCC we will be more prepared and assured for the inspections.

There is a significant risk if we do not invest and fail on an inspection, that this will incur a high cost to rectify this situation. In addition to this there is likely to be an increase in workload because of the new regulations. If there is increased workload that is related to social care practice, this will be able to be supported by the Quality and Practice Team with additional staffing in post. This will present a challenge to Adults services if there is no additional capacity, with the risk that staff will be diverted from delivering their statutory functions, to support auditing and CQC inspection preparations. We know from Children's inspections that a substantial amount of resource and work is required in relation to an inspection. If there are improvements to be made, such as planning and delivering improvements, setting up an improvement framework and then being reinspected to assure that the improvements have been made, this could result in significant costs to the local authority.

To take this approach an additional 3 x FTE (Full Time Equivalent) equivalent staff members at SO1/SO2 are required to carry out the additional audits.

There are reoccurring themes from thematic audit re: practice standards and legal compliance. This evidences that whilst we are collecting data, we are not able to do enough to change practice and ensure legal compliance year on year.

The new resource would increase the number of themes being audited, giving a more robust thematic audit programme throughout the year helping us to prepare for the new inspection regime.

Additional benefits are that it will increase the capacity of existing staff to work with those teams on development and improving the service. The existing practitioners are skilled social workers and if we release them from completing the audit, they could better use their time to analyse the data and implement the action plans.

2. What evidence has been used to support this work, how does this link to any existing strategies/policies?

Measure of benefits

We have in place a system for monitoring our development and improvement in practice. Through the Practice Governance Board smart actions for learning and improvement are agreed and monitored. The Practice Governance Board action plan holds all the learning from various sources and monitors the completion of actions. The managerial audit programme triangulates the evidence of improvement in practice. These established processes will monitor the impact of having the three adult support coordinators allowing the senior social workers to improve our service.

Further evidence of the need of these roles can be found in section one of this report.

3. Has an options and feasibility study been undertaken? Please explain what options have been considered.

As mentioned in section One, this is currently the only viable option to meet this need, and doing nothing would result in high levels of risk. There is not the capacity in other service areas to support this function and the team does not currently have the capacity to undertake this work.

This role and function sit within the current team. It is best placed, as it builds on current workload, skills, and capabilities of the service. The team are skilled in data collection, thematic audits, audit reports and supporting action plans because of audits. However, the additional regulations will create additional workload which we do not have the staff capacity to complete within the service as it is currently.

This needs to be an internal audit and support function, due to the nature of the work that will be required and any sensitivities around this. If we do not begin to plan, assure our work, and improve where required, it would be unlikely that PCC/CCC would meet the regulation standards, though we do not yet know what these are. Where we have completed thematic audits on our statutory functions, there are always areas for improvement, some of these are very simple to support to rectify with an action plan. However, there are some areas for improvement where we have significantly failed in fulfilling our statutory responsibilities and there has been a requirement for a large amount of work to support practice improvement. There is therefore a risk to the department's reputation and financial risk if we must undertake remedial action. There is no choice regarding the inspections and regulations as these are nationally mandated.

4. What are the next steps/ actions the Council should take to pursue it? Please include timescales.

The next steps would be to advertise the posts and recruit into them within 12 weeks. This would then enable us to draw up a more robust thematic audit programme which would cover all our statutory responsibilities and enable the department to have an action plan in place, where we fall below expected standards. This will be beneficial when we get to the CQC auditing processes.

5. Could this have any effects on people with Protected Characteristics including poverty and rural isolation? If so, please provide as much detail as possible.

No negative impacts have been identified, however doing nothing could result in some residents with protected characteristics being affected negatively.

An Equality Impact Assessment (EqIA) will be developed to ensure this proposal is equitable in its aims and delivery and any potential adverse impacts on people with protected characteristics are mitigated against. This is to ensure CCC's decision-making is inclusive for staff and communities with protected characteristics in line with the Equality Act (2010) and Public Sector Equality Duty (section 149).

6. What financial and non-financial benefits are there and how will you measure the performance of these? Are there any dis-benefits? These MUST include how this will benefit the wider internal and external system.

Financial Benefits

Without the increase in audit capacity, there are several financial risks facing the authority. By recruiting additional officers to the Quality and Practice Team, we are taking preventative measures to ensure that the authority does not have to incur unnecessary spending.

Risks

- Delay in understanding risk across the department
- Gathering the evidence without the capacity to action the learning and service improvement
- Organisational risk, - Human rights, poor practice, Safeguarding, Local Government Ombudsman. The cost from an LGO findings can be £100 to £1,000 unless it is an exceptional case. The highest payment made in the last year has been £1800. This does not include the cost of any loss of service which can be any amount. The highest to CCC has been £85k. Time wise on average 3 senior managers input per LGO complaint at 20 hours each.
- Financial – LGO, Legal challenge, over commissioning of services, increased crisis management – not picking up areas of concern early enough, resource from Q&P team being used in the wrong areas.
- There is a risk of damages being awarded where we have been in breach of our statutory responsibilities, however this is difficult to quantify. A case was brought to court in 2021 whereby Haringey had unlawfully deprived an individual of their liberty. They were required to pay £143,000 in damages. This covered an eight-year period which equates to £17,825 per year. They did not dispute the services provided or the placement the individual was in. This would usually be covered by insurance, however, is a significant claim.
- There is also a financial risk of remedial action. For instance, if we are found to be lacking in a specific area and this requires additional resources. It is again hard to quantify this as it could be that we would need five additional workers for a six-month period or less work force for a greater period etc.

However, the on-costs of one social worker for 12 months are £44,659 which rises significantly if we needed to recruit locum practitioners.

The implications from the white paper on health and social care reform mean that Adult Social Care will come under greater scrutiny and include a new inspection regime from CQC. With increased capacity to carry out audits across all adult services in PCC and CCC we will be more prepared and assured for the inspections.

There are reoccurring themes from thematic audit re: practice standards and legal compliance. This evidences that whilst we are collecting data, we are not able to do enough to change practice and ensure legal compliance year on year. There is a risk that we could face financial penalties from CQC if we are not fulfilling/able to evidence we are fulfilling our statutory responsibilities.

Non-Financial Benefits

Benefits

- Audit is a useful tool providing the evidence of areas of practice improvement
- Increased audit activity – we can review more areas across the service
- Increase re-audit capacity to measure the impact of actions taken to improve practice.
- Increased capacity for SSW to implement the learning
- Review previous audits to see patterns of change/improvement etc.

The increase in capacity x3 auditors will give

- Assured statistical viability to the evidence from the audits
- Capacity to increase the amounts of thematic audits completed in the year
- Increase the capacity to collate the data.

7. Are there any identified risks which may impact on the potential delivery of this? What is the risk if we do not act?

- Risks that the department does not fully understand the regulations and what will be audited.
- Risks of delayed recruitment if we cannot fulfil the posts
- Financial risk of remedial action if we do not act (as detailed above in financial benefits section)
- Risk of reputational damage if we do not act.

8. Scope: What is within scope? What is outside of scope?

The Policy and Practice Team – to increase the number of auditors by three.

With the ‘Integration and innovation: working together to improve health and social care for all’ White Paper comes the proposal for CQC inspection of adult social care which will give greater visibility of our statutory work. The current capacity in the quality and practice team achieves two thematic audits a year. The current capacity does not achieve statistical viability nor cover auditing all our statutory responsibilities. The current resource does not give full assurance of our statutory responsibilities.

As a result, there is a request to fund the cost of 3 auditors within the team, to assure ourselves we are fulfilling our statutory responsibilities, help prepare reports for CQC inspections and ensure we are proactive in addressing any practice issues/needs. This role and function sit within the current team. So, this is where best placed, as builds on current workload, skills, and capabilities in that service. They are well versed in data collection, thematic audits, audit reports and supporting action plans a result of audits.

Business Planning: Business Case – Investment proposal

Project Title: Care Home Support Team

Committee**:** Adults and Health

2022-23 Investment amount: N/A (already budgeted)

2023-24 Investment amount: £220k

Brief Description of proposal:

This proposal is to agree permanent funding for the Care Home Support Team which is currently funded for two years. Current end date April 2023.

The annual cost of the Care Home Support Team is £220k (74%) for CCC (Cambridgeshire County Council) and £77k (26%) for PCC (Peterborough City Council)

The cost is already budgeted into the MTFS (Medium Term Financial Strategy) for 2021/22 and 2022/23 as a temporary investment.

This business case is asking for permanent investment from 2023/24 onwards of

CCC: 220k per annum

PCC: 77k per annum

Whilst this service will not deliver a saving, it is mitigating a financial risk of up to £542k per annum to the Council.

Date of version: October 2021 BP Reference: A/R.5.006

Business Leads / Sponsors: Charlotte Black, Director of Adults and Safeguarding

1. Please describe what the proposed outcomes are:

This proposal links to the CCC outcomes “A good quality of life for everyone” and “Protecting and caring for those who need us.”

The Care Home Support Team (CHST) is currently funded for two years. This business case sets out the need for this team to be made permanent. The cost of this team is already budgeted for in financial years 2021/22 and 2022/2023, so annual investment needs to be factored in from 2023/24 onwards.

The team stemmed from experiences during the COVID-19 pandemic in which there were a small, but significant number of care homes, which required focussed input from both contract management and operational staff to address quality and practice issues. This presented several risks to both councils in terms of quality of care for care home residents, provider failure and potential reputational damage. The CHST is aimed at enhancing the support already provided by the contract monitoring team. It is an additional, flexible, and intensive support service where there are practice concerns. CHST have the in depth and practical knowledge required to build a partnership with care homes to improve standards in residential and nursing homes as well as learning disability supported living providers.

It is clear from the support already provided by CHST that there is a widespread need for providers to be supported to improve practice quality. Care providers tend to either be unaware of what improvement is required or lack the knowledge to drive that improvement forward.

The role of CHST

- Completing a period of observational visits in the care setting to best understand how it operates daily.
- Talking to residents, their family, and staff to gather their concerns and provide advice and reassurance
- Ensuring care and support documentation is up to date and meets the needs of all, including the self-funding residents and is proportionate to ensure agency staff and others can understand how to meet resident’s needs.
- Supporting adherence to Mental Capacity Act and Deprivation of Liberty Safeguards statutory duties across the home
- Liaising with the safeguarding teams as appropriate and supporting the care home to understand their safeguarding duties and what documentation they should have.
- Identifying opportunities for use of technology to support practice throughout the home as opposed to a resident-by-resident basis (particularly applicable for larger homes)
- Work alongside home management to ensure they understand what is required and can take the changes forward positively, utilising systems theory, strengths-

based practice, social learning theory, crisis intervention theories and others as appropriate.
- Support homes to ensure meaningful activities are taking place for all residents
- Ensuring good risk assessments and that the home is taking a preventative approach
- Facilitating meaningful interactions with other professionals to aid in building a support network around the provider to improve quality of care
- Where required, working with key CCC/PCC internal teams and senior managers, to identify where improvements in our support and interaction with providers can be beneficial in contributing to improved outcomes for the residents.

Please see the attached report of CHST work to evidence the scale of input for homes so far.

The care settings supported by CHST so far have needed on average eight separate visits to support improvements. Team members tend to be in a home for most of the day either observing or supporting care homes in implementing changes. This input takes time as the manager and carers require the dedicated time of a social worker to support with changes to practice. Additionally, observations of the home require seeing the home at all times of the day so the home manager can be provided with an effective assessment and understand the practice areas which require development. Once practical support has been provided, CHST will review those settings at 3, 6, and 9 month intervals to ensure these changes have been maintained. Furthermore, additional input will be needed at the review periods to reinforce learning and to also notice any further areas requiring improvement. Again, the same method will be applied of providing the dedicated time to support change. To illustrate the time commitment through one example, the maximum visits for one care home so far have been 19 separate visits.

It is vital to have social workers providing the practice support to homes as an enhancement of the contract monitoring support they already receive. Social workers have the practical experience of completing the tasks that care providers are required to do and as such can role model the tasks to aid in supporting practical application of the knowledge that formal training provides them. Many providers only complete e-learning and this does not provide them enough knowledge to apply to practice. At a time when providers have limited resources, the practice knowledge, and skills that social workers can share is invaluable in driving improvement in quality. Social Workers are experienced in application of legislation to practice and supporting individuals who have complex needs. Social workers are used to working within theory, models and approaches of practice and can share that knowledge with providers. The different perspective that social workers will have allows for us to work alongside our contract monitoring colleagues to provide a complimentary and enriched support service for providers.

2. What evidence has been used to support this work, how does this link to any existing strategies/policies?

Out of the 28 Care Homes CHST have been working with in the first three months, CHST highlighted practice concerns in 17 of these where they had not been found by the contract monitoring team or CCG (Clinical Commissioning Group) quality support team. This is not a negative but evidences the importance of different teams to support care providers to ensure holistic support. We have provided practice support (in partnership with contracts who provided support for contractual concerns) to two providers in the first three months who were providers of concern. These providers would not have been able to improve practice standards without the team's support. The concern relating to these providers was not new and no progress or change had been seen previously. It is reasonable to assume therefore that, based on the level of poor practice prior to our support, these homes could have been considered unsafe to continue to place individuals and we would have needed to move current funded residents to new placements and led to provider failure. These two homes were part of small individual owned companies which did not have access to the same resources as the bigger national and regional companies. Therefore, to solely inform them of what is requiring development does not result in them being able to resource the support to drive change. The consequences of this could mean that the provider fails, and the local authority incurs the financial and non-financial impact of this (as described below). Therefore, the local authority having the CHST to provide the practice support reduces the risks and means increased likelihood of improved outcomes.

Provider failure:

An example of the financial and reputational risk to the councils is reflected in provider failure. If a care home fails due to quality or financial sustainability, placements must be suspended, and home closure is a risk. This did occur in 2019 when a care home had to be closed and residents supported to move to alternative placements. This specific care home had already had placements suspended and intensive input provided. A social worker from the operational team was re-deployed for 6 weeks to work with the home and there was intensive support from contract management as well as several senior management individuals. It provides a real example of the cost of this failure.

Cost to the council:

At the time of closure there were only 8 residents left who the council funded.

Key cost implications of this were:

£785.19 – weekly increase in funding in total for the 8 residents due to moving placement.

£10,000 – for a consultant, the local authority funded to support the home for 2 months for 2.5 days a week

£40, 942.05 – total annual cost to the council for this provider failure.

£122,826.15 – utilising the above figures this would be the approximate increase in spending over 3 years (average time a person spends in a care home)

There were only a small number of residents left in this home by the time it closed. If we consider the two homes who were provider of concern already this year, that CHST has been involved with to improve practice, we can consider the potential cost mitigated based on the above example.

The two homes we supported had an average of 40 residents. Both had a large proportion of local authority funded residents; an average of 25 local authority funded residents in each of these homes.

Therefore, the potential annual cost mitigated following the joint support from CHST and contract monitoring for these homes was: £255,887.81 per year.

We have bigger homes within Cambridgeshire and Peterborough, the most beds in one home are 158 and the average occupancy is 50. Therefore, cost avoidance can potentially be significant.

We are now approaching 6 months of the team being in place and we are currently working with 3 further providers that are on the cusp of becoming providers of concern. 2 are nursing homes and 1 is a supported living provider with multiple provisions. All have concerns relating to practice, so we are taking an intensive, preventative approach in collaboration with contracts, aiming to improve practice standards. All homes are ones considered as having historical ongoing issues.

If we take these figures, we can mitigate further potential cost. Collectively the three homes have a bed occupancy of 150. If we considered there could be a 62.5% occupancy rate (same percentage applied to the 2 other providers of concern) that results in a potential impact of moving 93 individuals. When applying the same weekly cost increase of finding new placements, as above, that is a potential cost of:

£9127.83 per week

£475,951.14 per annum

£1,427,853.41 over 3 years (it should be noted that learning disability providers cost far higher than residential or nursing homes for older people and those individuals tend to remain in those placements for a significant period of their life. We have used the figures based on older people providers so the proportion relevant to the supported living provider has the potential for far higher cost implication).

This, therefore, equates to 5 homes so far that realistically could result in provider failure in one year without intensive practice support.

This is a total potential cost mitigated of £731,838.95 annually across both Councils.

It is important to note that following COVID, costs of managing a home have increased so the likelihood of failure is much higher. With the costs going up it is reasonable to suggest that this will mean care providers, especially the smaller independent ones, will not be able to access as effective training. This is another reason the CHST will be

imperative in supporting homes to continue to operate and ensure quality of care at the same time.

The provider failure case study also evidences an additional non-financial impact.

- A social worker from the operational teams was supporting the home for 6 weeks which impacted capacity in those teams and meant less statutory tasks were being completed for individuals. Social workers have 20-25 individuals to support at any one time so to take a social worker from the team for a significant period has a detrimental impact on the operational team.
- There were key individuals from senior management involved in this provider failure so to have a dedicated team involved to support the homes relevant to practice also lessens the impact on their capacity
- Distress to residents was a significant impact.
- Reputational damage
- Loss of bed capacity in an already stretched market

Complaints

11% of formal complaints responded to by the local authority in 2020-2021 were primarily about the provision of care delivered by care homes. This is an increase compared to the 2019-2020 period. 65% of these were about expected standards of care not being met. This was a significant increase of 28% compared to the previous reporting year. While some of these complaints were relating specifically to COVID, this does not mean they were not indicative of practice as concerns around restrictions is relevant to practice. The service needs to ensure guidance is upheld but that individuals' human rights are still central to decision making as well as the individual's wellbeing is held as priority. In particular, this requires a robust understanding of the Mental Capacity Act 2005, which we know is a development need across providers.

Over the last 2 years, for Cambridgeshire, there have been 10 adult social care complaints investigated by the local government ombudsmen and 6 of these related to the standard of care provided by the care homes commissioned by the local authority. The recommendation was for the local authority to work with the providers to improve their practice in areas such as record keeping, safeguarding and staff practice knowledge.

The CHST is addressing the recommendations by the ombudsmen which is vital as to not address this recommendation leads to reputational damage and has financial implications for the local authority.

Current example of CHST input

Case study:

CHST got involved with a care home during their COVID outbreak and upon visiting it was clear that practice standards were poor. CHST and the contract monitoring team took a collaborative approach in supporting the home to improve standards of care.

CHST have supported this home for several months to improve their practice and have done this through a process of role modelling good practice and improving documentation. Had CHST not been in place this home would have been expected to make changes independently but without the knowledge and skill to do so. The probability is that this would have led to prolonged and increasing concern and consequently continued suspensions of much needed placements. This is additionally evidenced by the fact that the contract monitoring team had repeatedly had concerns about this home and sustained improvements had not been seen. Had this home failed we would have been looking at a significant financial impact for the council due to moving residents, lack of bed capacity and reputational damage as well as resident distress due to moving to new homes.

Feedback from providers so far

'I am glad that I asked for the care home support team to get involved with parts of our home, as I was at one point very insecure about what are we doing right, are we doing enough, are our support plans sufficient, are our MCA what they should be? The feedback I am getting is not only constructive but also accompanied by support of finding a solution if something does not work as well as we would like. Working with Lucy has also given me the encouragement to go through our support plans with a different point of view and applying the approaches we discussed. ‘

D also said she would like to pass her thanks on to whoever created the care home support team.

When asked if the manager would have seen improvement without CHST, response have been:

‘Not around MCA’s no Steffi was very helpful and knowledgeable and gave us the knowledge and confidence to do MCA’s and record them right now’

K ‘does not feel that the improved practice would have been achieved without the intervention’

‘I believe Leigh’s involvement has made us take a more person-centred approach. The work would have been done but not to such high standard.’

‘100% useful - It’s easy to get complacent and even though we always strive to be better, there is nothing like having fresh eyes with different experience to get new ideas and discuss different options and outcomes.

‘I had no idea of some of the areas we needed to improve on, I didn’t think about TEC to be less restrictive, we didn’t think about amending our admission checklist and our care plans, MCAs and risk assessments have 100% improved, we wouldn’t have done this without the support’

CHST can evidence the widespread need across Cambridgeshire and Peterborough for this team, as evidenced above.

The lack of retention of staff and managers in care homes, the regular changes to practice guidance, the pressures on care homes with less resources and the increasing population of people who require care settings, as well as the ever-present reality of COVID all indicate that support will continuously be needed. 2 years does not result in the local authority being able to sustain and have assurance of quality and practice across the provider market.

3. Has an options and feasibility study been undertaken? Please explain what options have been considered.

Previous options have been:

Operational teams

Social workers from operational teams have been asked to provide intensive support to care homes to improve practice. This has been in the context of crisis when there are critical concerns about the safety and wellbeing of residents. However, it is clear operational teams cannot provide the level of support that care homes and supported living require for practice improvement. The support to care homes needs to be available without compromising other statutory work. Historically, social workers have been utilised from operational teams to assist care homes who require intensive practice support, which then has an impact on capacity in operational teams where there is already demand and pressure. It also means that homes cannot get longer term support to promote sustained improvement as the social workers are only able to be re-deployed for short amounts of time.

All social care input to care homes from operational teams is on an individual resident basis. PCC and CCC have a statutory duty to review the needs and care arrangements of all residents on at least an annual basis, and this takes place more frequently where a resident has significantly changing needs. Meeting the statutory duty to undertake Care Act reviews is a challenge in Cambridgeshire and Peterborough as these scheduled planned reviews are deprioritised to respond to urgent unplanned changes in service user circumstances or in response to provider failure. As with all Councils we struggle to complete regular reviews within 12 months, with the average number of days a review is overdue being 90 (3 months). Reviews of care home residents although important are balanced against the need to ensure that people in their own homes can live safe and independent lives.

Given the pressures experienced in covering the requirements of the reviews in a timely way it is not possible for the current workforce to also provide additional support for care homes as set out in this business case.

Contract monitoring team:

The contract monitoring team previously have been monitoring aspects of practice and including practice issues within an action plan if they have noticed something missing or incomplete. However, they do not have the knowledge and experience, as social workers do, that would enable them to proactively support change and development in

a home. This has linked with the historic approach of calling upon the support of the operational teams in a crisis however this lacks a preventative approach and as outlined above is not sustainable for the operational teams. Additionally, the contract monitoring team do not have the resource within the team to provide the intensive support providers require. Therefore, this is not seen as a viable option.

4. What are the next steps/ actions the Council should take to pursue it? Please include timescales.

CHST have continued to develop the framework in which the support is delivered to care homes and continue to gain feedback as to its effectiveness. There will be ongoing reporting of what has been achieved by this team.

Demand is high for this level of support as the team now have a waiting list of homes that require support. As stated above, this team is funded until April 2023, but the business case is requesting permanent funding from that point onwards.

5. Could this have any effects on people with Protected Characteristics including poverty and rural isolation? If so, please provide as much detail as possible.

The CHST supports care providers in enhancing their practice during a time where the COVID-19 pandemic has had a significant impact on older people and people with a diagnosis of a learning disability. We work with care homes to ensure that individuals who live in these settings have their human rights protected and promote that their wellbeing needs to be considered alongside the infection control protocols that need to be in place. As a team we promote equality and diversity within care settings and ensure the settings consider how best to support individuals' intersectionality.

However, an Equality Impact Assessment (EqIA) will be developed to ensure this proposal is equitable in its aims and delivery and any potential adverse impacts on people with protected characteristics are mitigated against. This is to ensure CCC's decision-making is inclusive for staff and communities with protected characteristics in line with the Equality Act (2010) and Public Sector Equality Duty (section 149).

6. What financial and non-financial benefits are there and how will you measure the performance of these? Are there any dis-benefits? These MUST include how this will benefit the wider internal and external system.

Financial benefits are evidenced above.

Non-financial benefits to providers having support to improve practice:

- Increased wellbeing and quality of life for residents
- Increased application of Technology Enabled Care (TEC) to support delivery of care in care homes which can also aid in a reduction of 1:1 funding.
- Reduction in delayed transfers of care because care homes are more confident in managing risk and seeking support from specialist staff in the CCG, community health services and the Councils. This also provides assurances that care homes are more confident in supporting residents with more complex needs.
- Increase in care homes taking a preventative approach which can reduce incidents which can lead to increased needs e.g. falls.
- Better documentation which can support the CHC (Continuing Healthcare Care) process which can have a positive impact for the councils.
- Reduced risk of LGO finding fault and judicial review and reputational damage to the sector and the LAs (Local authorities) as commissioners
- Enhanced support that contract monitoring team already provides for providers at risk of failure due to their practice

A significant benefit of having a team of social workers supporting providers is the added knowledge to a multi-disciplinary, collaborative approach. Not only is this about the CHST and contract monitoring team working together but also for the service to work with public health colleagues. Working closely with the CCG quality support team as well as colleagues in the medication optimisation team has been invaluable in creating a robust and supportive system around the providers across Cambridgeshire and Peterborough. We additionally work to link providers with the relevant professionals across CPFT (Cambridgeshire and Peterborough NHS Foundation Trust) (Cambridgeshire and Peterborough NHS Foundation Trust) and primary health. We have linked with the CPFT Safeguarding nurse to look at effective ways to share intelligence about homes to ensure we are aware of concerns across the various organisations to aid in focusing our resources on the right homes and enabling us to effectively risk assess.

7. Are there any identified risks which may impact on the potential delivery of this? What is the risk if we do not act?

This approach relies on the cooperation of care homes and the ability to recruit the right staff. We are currently in a staffing crisis in social care and this will have an impact in terms of sustainability of the intervention. However, this also means an increased risk of practice standards declining and therefore increases the need for support to be available. A number of risks have been identified above detailing the risks associated with not acting.

8. Scope: What is within scope? What is outside of scope?

With the five social workers in this team, support can be provided to nursing, residential and supported living providers. A waiting list is currently in operation, so this team does need to prioritise intervention based on risk. The team needs to ensure the intensive support to providers is possible and not impact this detrimentally by taking on too much work at one time. With the current number of social workers in the team there is no scope to provide this support to domiciliary care, day centres or any other setting the council commissions to provide support to individuals across Cambridgeshire and Peterborough. If this were required, the team would require a larger resource.

Business Planning: Business Case – Investment / Savings

Project Title: Expansion of the Enhanced Response Service

Committee**:** Adults and Health

2022-23 Investment amount: £181k

Permanent annual investment of £180,509 and net saving of £29.3k (Cambridgeshire County Council))

Cost avoidance saving - £209,798 per annum

Brief Description of proposal:
Extension of the Enhanced Response Service to deliver earlier intervention, preventing escalation of need and associated cost avoidance

Date of version: 23 November 2021 BP Reference: A/R.5.009

Business Leads / Sponsors: Charlotte Black, Director of Adults and Safeguarding

1. Please describe what the proposed outcomes are:

To extend the remit of the Enhanced Response Service (ERS) for Cambridgeshire to respond to additional Carelines and to provide a short term urgent social care package across 24/7 at the request of GPs and 111.

This proposal has been developed to assist the Council in meeting the requirement to provide urgent social care within a two-hour target time.

Strategic fit

- Supports health and social care recovery to a new business as usual after the pandemic
- Supports 'Think TEC (Technology Enabled Care) first' approach
- Investment in prevention and early intervention
- Think Community
- Linked to the Lifeline and telecare service provisions and business cases for the increasing referrals to Technology Enabled Care Services

2. What evidence has been used to support this work, how does this link to any existing strategies/policies?

The recent growth and investment of the Technology Enabled Care Services (TECS) needs to be matched with a growth in the Enhanced Response Service to ensure a comprehensive preventative offering. The provision of technology needs to be matched with a person response to meet the wide range of unpredictable needs that helps people to continue living at home safely and give informal carers peace of mind.

GPs have voiced the need for accessible urgent social care support available 24/7 particularly where GPs are involved in front of house admission avoidance and Herts Urgent Care who provide 111 services.

Cambridgeshire County Council currently funds £734K for the existing ERS since 2017 and intends to maintain this commitment. Additional investment of £180,509 per annum is required to expand the service provision.

Current Enhanced Response Service Provision in Cambridgeshire

The Enhanced Response Service (ERS) was established in Cambridgeshire during 2017 to provide a mobile person response for telecare activations where no informal carer was available. The service operates 24/7 with two vehicles within the boundaries of Cambridgeshire and is entirely funded by Cambridgeshire County Council. Prior to this service all calls from Alarm Receiving Centres were sent to Ambulance Service

when family are not able to respond. The existing service is already contributing to avoiding ambulance calls.

The typical types of calls that ERS responds to includes:

- Non injured falls: for assistance with moving and handling to get up from the floor
- One off personal care: diarrhoea, vomiting, anxiety, incontinence.
- Silent calls: activations where the Alarm Receiving Centre cannot speak with the alarm holder. A number of these are people who have fallen but are out of voice/hearing range of the Lifeline.

ERS is responding to on average 508 calls a month (range 383-625) and current provision is at capacity.

- 32% of calls are for falls
- 31% for silent calls
- 23% for personal care
- 6% for anxiety
- 8% other

ERS responds to calls from seven Alarm Receiving Centres that have the greatest number of alarm holders in Cambridgeshire

- Astraline (new) 8%
- Tunstall 14%
- North Herts Careline 14%
- Cross Keys Homes 40%
- Sanctuary 365 4%
- Centra Pulse/Doro13%
- Appello 1%

ERS also takes calls from the Ambulance service if someone has dialled 999 but is not a medical emergency, and from the Council's Emergency Duty Team. Ambulance calls 4% average 19 calls a month.

ERS receives approximately 1-2 calls from the 111 helpline a month. ERS has a few individual arrangements to respond to the call centres for Housing Associations with small numbers of sheltered units in Cambridgeshire (8 Housing Associations with 820 units). ERS will attend for people in their own homes, sheltered accommodation and in the event of a fall will attend Extra Care Schemes.

ERS is regulated by CQC (Care Quality Commission) and is currently rated as good. ERS can escalate their calls to other services if they identify any concerns during their visit. ERS data shows that ERS called the following services:

- 5.5% Ambulance
- 0.6% Police – access to property, aggression
- 0.7% GP – medical review and medication review
- 0.8% to JET and Out of hours District Nursing – skin tears, wounds, urine test, catheter issues, pressure areas

The roles of ERS and Joint Emergency Team (JET) are distinct and different. ERS response is staff with social care skills and is relevant for people who continue to have recurrent falls despite all intrinsic and extrinsic risk factors being optimised. ERS will make onward referrals to other preventative and early intervention services relevant to that individual's circumstances. ERS does refer to JET and Out of Hours district nurses skin tears, wounds, urine test and pressure area concerns.

3. Has an options and feasibility study been undertaken? Please explain what options have been considered.

Extension of ERS provision

This proposal is to extend the remit of ERS to respond to urgent requests for adult social care from 111, Ambulance Service, GPs, District Nurses, EDT, acute hospital's turnaround services. Urgent social care would be for very short periods such as overnight, weekend or bank holiday provision and until a Reablement or Care Provider can pick up the care or the person can manage independently. There would need to be an exit arrangement in place prior to ERS accepting a referral for short term social care.

Referrals would be made by telephone only so that ERS can immediately inform the referrer whether they have the capacity to assist or not. The expectation is that the extended service could respond within an average of three hours of a referral. Referrals would be prioritised according to the presenting situation, so less urgent situations may wait longer than three hours.

This urgent social care service would be fully integrated with the existing ERS provisions of responding to telecare activations and assistance following a fall.

There are benefits for integrating the urgent social care and responding to alarm activations is that it gives maximum flexibility of responding in a timely manner, coverage of the whole geography and minimising down time for staff.

The extension of service provision included in this proposal is:

- To respond to additional Alarm Receiving Centres such as Lifeline 24 that has 1,300 customers and Age UK/PPP Taking Care that has around 900 customers
- Urgent short-term social care provision needed at request of GPs, District Nurses, Ambulance and 111 to prevent hospital admission where appropriate
- Urgent short-term social care provision to support rapid hospital discharges, prevent hospital admissions and prevent carer breakdown

The proposal is to increase current ERS provision by having one additional vehicle with two staff covering three shifts to operate across 24 hours a day.

Proposed Activity Levels

Estimation of call out rate based on population over 75 years (population stats for 2019)

	Cambridgeshire
Population over 75yrs	57,528
Calls per annum	6,079 (actual)
Calls per month	508 (actual)

Proposed increase in activity levels per month

Monthly activity split

	Cambridgeshire
Lifeline calls	85
Urgent social care	80
	165

4. What are the next steps/ actions the Council should take to pursue it? Please include timescales.

The proposal is to increase provision of having one additional vehicle with two staff covering three shifts to operate across 24 hours a day. The next steps would be to recruit the staff required for the additional vehicle operating 24/7. This service is operational now although not yet at full capacity. It has temporary funding for the extension agreed with CCG in September 2021. However, the temporary funding will end March 2022. The request is for continuation of the extended service from April onwards.

5. Could this have any effects on people with Protected Characteristics including poverty and rural isolation? If so, please provide as much detail as possible.

This will have a positive impact on all people with protected characteristics, with a greater level of service provision to respond to urgent social care needs.

However, an Equality Impact Assessment (EqIA) will be developed to ensure this proposal is equitable in its aims and delivery and any potential adverse impacts on people with protected characteristics are mitigated against. This is to ensure CCC's decision-making is inclusive for staff and communities with protected characteristics in line with the Equality Act (2010) and Public Sector Equality Duty (section 149).

6. What financial and non-financial benefits are there and how will you measure the performance of these? Are there any dis-benefits? These MUST include how this will benefit the wider internal and external system.

The Adults Positive Challenge Programme demonstrated cost savings for social care over the past two years in TECS and ERS. Although savings have been attributed to TECS a significant proportion is due to ERS in Cambridgeshire too. TECS received an investment of £327,414 for staffing and equipment over the two years. There was no corresponding investment in ERS although there has been an increase in ERS activity over these two years.

Cambridgeshire APC (Adults Positive Challenge) demonstrated £9.6 million savings over the last two years

	2019-20	2020-21
Cambridgeshire cost saving	£5,980,582	£3,663,863

Cost saving postponement of care

The modelling used in Cambridgeshire demonstrates that TECS and ERS can postpone the start of domiciliary care by 14.41 weeks and the start of a care home placement by 11.58 weeks. This is based on actual data accumulated over the past three years.

Cambridgeshire could cover their proportion of the costs by postponing 51 out of 1263 new individuals with domiciliary care packages and 23 out of 419 new care home placements. For Cambridgeshire to avoid double counting savings from the 2020-21 baseline ERS would have to take on responding to Lifeline 24 and PPP as new Alarm Receiving Centres. If stretch targets were agreed of 60 domiciliary care and 25 care home placements postponed this would deliver a net saving of £29.3K.

The rationale for the figures above considers:

- The increased activity in ERS year on year (except for the Covid year) shows that there is demand for the service. This is reinforced by the fact that there can be times when ERS cannot accept all the calls that come in at the same time.
- The robust calculator used for tracking savings in TECS and ERS established in the Adult's Positive Challenge (APC) programme
- The positive feedback on the difference that informal carers and alarm holders give on having ERS responding means that it has significantly reduced their anxiety and demand for domiciliary care. Similarly, where ERS makes multiple responses for some customers this is postponing the decision to move to a care home.
- Having ERS means that more people are agreeable to having a Lifeline – evidenced by the higher-than-expected recruitment rate for the Lifeline Service. More people with Lifelines and ERS increases the numbers of people postponing domiciliary care.
- Increased access to ERS urgent social care for up to 72 hours for GPs and primary care, 111, Transfers of Care, Reablement, Ambulance, Emergency Duty Team prevents a crisis in the community and escalation to a hospital admission. Most domiciliary care packages and care home placements commence after a hospital admission.

Benefits in quality-of-service provision

Although TECS and ERS cannot prevent people having falls, these services do prevent the complications of having a long lie. The complications of having a long lie after a fall are pressure sores, rhabdomyolysis, pneumonia, hypothermia, dehydration, shock and even death. Generally, ERS has a quicker response time than a low category Ambulance call for non-injury falls, minimising the complications of a long lie. A long lie can often lead to a hospital admission and discharge to a care home placement or large care package. This is supported by evidence from research[1].

[1] *Fleming J, Inability to get up after falling, subsequent time on floor and summoning help: prospective study in people over 90. BMJ 208, 337, a2227

Benefits for social care:

- Support for 111 option 3 to access an immediate adult social care response that operates 24/7
- Support for the Emergency Duty Team who can allocate calls to ERS especially out of hours
- Long term support for those who have a Lifeline with sensors and ERS. This is particularly relevant for those who live alone and have unstable conditions and need practical assistance on an unpredictable and irregular basis.
- Helping to maintain peoples' independence, wellbeing, and confidence to remain living at home, thus postponing the need for a move to sheltered, extra care or care placement.
- Helping to postpone the need for a regular care package by successfully meetings peoples' unpredictable needs.

Benefits for informal carers:

- Rapid access to personal care for the cared for person in an urgent short term or one-off situation giving the informal carer peace of mind if they are unable to continue their caring role. ERS can be part of the carer's 'What If' plan.
- Informal carers who may not be available to respond because they are at work or on holiday or unable to leave their home overnight to respond to a telecare activation, for example, if they are a single parent
- Informal carers who may be too frail themselves to assist with moving and handling for getting up from the floor.
- Provides peace of mind for family that live at a distance that their relative can easily summon help 24/7 and they will receive a skilled person response when it is needed.
- Some customers do not have any informal contacts they can nominate ERS to respond, and they would benefit from having a Lifeline and being able to summon help whenever it is needed. Having ERS enables more people to benefit from having a Lifeline and increases the uptake of this preventative offering.

There are also operational benefits for the extension to ERS:

- ERS already operates over 24 hours while most other care providers operate over extended daytime hours
- ERS has continued to operate throughout the Covid pandemic

*Tinetti ME, Lui W, Claus EB, Predictors, and prognosis of inability to get up after falls among elderly persons. JAMA, 1993,269(1), 65,70

- ERS has a culture of enablement and making onward referrals to other prevention and early intervention services.
- ERS has a single telephone number for taking calls that is accessible 24 hours a day
- ERS has access to any relevant social care history on Mosaic. This is especially useful when responding to silent calls or for access difficulties establishing that the person is at home and not on respite or admitted to hospital
- ERS has good processes in place to access Reablement and if needed an assessment for social care. Any history from the urgent ERS visits would be available on Mosaic to inform any statutory assessment, review, or period of Reablement.
- Greater flexibility, capacity, geographical coverage, and robustness for business continuity with the existing ERS provision rather than a stand-alone commissioned service.

The combination of having a Lifeline and the Enhanced Response Service can meet unpredictable and ad hoc needs for care and support is one of the main services that postpones the need for health and social care services. It enables people to continue living in their own home longer with confidence that help is available as and when they need it. These services provide reassurance and peace of mind to the person and their informal carers.

People with Lifelines reduce demand on both health and social care. Informal carers respond to around 85% of activations when alarm holders are needing assistance thus avoiding calls to both health and social care.

7. Are there any identified risks which may impact on the potential delivery of this? What is the risk if we do not act?

Risk	Mitigation	RAG	Overall responsibility
1. Difficulty recruiting staff with suitable experience in care, especially to cover night shifts	Plan an effective social media campaign to attract applicants. Plan a thorough induction and shadowing with experienced staff. Consider secondments from current teams to new team.	Green	ERS
2. Time needed to recruit the Alarm Receiving Centres into using ERS is likely to be 3-6 months to meet all the GDPR requirements	Support ARCs with prepared template Information Sharing Agreements and template letters to send to their existing Customers informing	Green	ERS

	them of the new mobile responding service. Prepared presentations to Call Operators of ARC to implement use of new service.		
3. Level of activity does not reach the numbers in the business case. No demand modelling data available to estimate the numbers of requests for urgent social care.	Demand modelling for Lifelines has been based on activity levels shown in the existing ERS and applied it proportionately by population size. Communication strategy for launch of service with internal staff groups and targeted external agencies. Manage expectations of managers that numbers will be slow to build up at start of service.	Green	ERS
4. Urgent social care is a new and distinct service offering that is different from responding to Lifeline activations. No systems currently in place to capture data	Implementation plan is inclusive of setting up recording systems in Mosaic for urgent social care and that Business Intelligence include these in the Inform reports. Lifeline activations captured in Mosaic	Green	ERS

8. Scope: What is within scope? What is outside of scope?

In scope is extending the remit of the Enhanced Response Service to extend the availability of the service and capacity.

Business Planning: Business Case proposal

Project Title: Expanding Support for Informal Carers

Committee**:** Adults and Health Committee

2022-23 Investment amount: £253k

(£273,420 would be recurrent costs required after the first year). There is the potential to re-invest £70k of savings already made against the Carers Direct Payment budget into this proposal. This would reduce the overall investment requirement to £253,420 in Year 1 and £203,420 thereafter.

Brief Description of proposal:
This proposal seeks investment into a range of areas which will provide a range of additional support to carers, over and above the current commissioned and operational support services. Some of these services are jointly funded alongside NHS Partners and enable carers to identify their support needs, better manage their own wellbeing and maintain their caring role for longer delaying the need for individuals requiring higher cost and longer-term adult social care.

Date of version: 23 November 2021 BP Reference: A/R.5.010

Business Leads / Sponsors: Will Patten, Director of Commissioning

1. Please describe what the proposed outcomes are:

The Care Act 2014 defines a carer as someone who helps another person, usually a relative or friend, in their day-to-day life. This is different from someone who provides care professionally or through a voluntary organisation.

Carers are valuable to our society but providing care can have an impact on carers in terms of their own health, education, ability to remain employed, relationships and social life. The Care Act 2014 requires local authorities to take a preventative approach in providing support to a wider group of carers. It also introduced the right of carers to have a statutory assessment to identify their need for support and where those needs meet the national eligibility criteria, to receive support to meet those needs from the local authority.

Estimates from the 2011 census data indicate there were over 60,000 carers in Cambridgeshire. Although most are adults, there are 4,208 carers in Cambridgeshire who are under the age of 25. Research tells us that the number of family and unpaid carers who provide care and regular support to another individual will increase over the next ten to fifteen years. This is largely because people are living longer, so we expect to see this number to have grown when the 2021 Census Data is released in March 2022.

This proposal seeks investment into a range of areas which will provide a range of additional support to carers, over and above the current commissioned and operational support services. Some of these services are jointly funded alongside NHS Partners and enable carers to identify their support needs, better manage their own wellbeing and maintain their caring role for longer delaying the need for individuals requiring higher cost and longer-term adult social care.

The areas of investment outlined below will deliver the following outcomes to support informal carers in the caring role:

- Short-term formal care can be provided in an emergency preventing the need for more costly interventions
- Carers are more resilient and can maintain their caring role
- Carers can take a break from their caring role to support their own wellbeing
- More Carers are identified and able to access sources of support

These outcomes will be achieved through investment in the following areas:

a. Our commissioned carer support provider has reported an increase in activations of emergency support over and above their capacity to respond. This led to an increase in support provided by the council's Emergency Response Service. By increasing the capacity of the carers support provider, they will be able to provide urgent support to service users in an emergency as part of a preventative, contingency planning approach to meet rising demand.

b. The Listening Ear Service provides counselling, wellbeing, and emotional resilience support to enable carers to maintain their caring role and prevent breakdown. There is currently a significant waiting list for this service indicating that demand is exceeding capacity. By increasing capacity of the Listening Ear Service, the waiting list will be reduced, and carers will receive the support they need which could avoid carer breakdown and a potential care and support package.
c. To maintain their wellbeing, it is recognised that carers can take a break from their caring role and do something that they enjoy. This can help to prevent carer breakdown. A successful pilot saw volunteers providing company for the person being cared for to allow the carer to take a short break. To enable countywide roll-out of Short Breaks for Carers, support for the recruitment of volunteers is requested.
d. Building on recommendations from a successful social media campaign earlier this year, a further, specific media campaign that targets hidden carers, promotes the support and resources available for carers is proposed. Analytics will identify the impact as well as the number of people reached. Data from our commissioned providers can be measured to monitor if hidden carers are seeking support.

All the above aligns to Council priorities; protecting and care for those who need us, ensuring a good quality of life for everyone and placing communities at the heart of everything we do. Through volunteer programmes and community-based offers such as the Short Breaks for Carers there will be increased social value through this proposal which will increase community cohesion through volunteer led services, links to community assets and support local economies.

The proposals which require on-going investment build on work that is currently being carried out through the Council's commissioned provider affording an opportunity to expand either capacity or geographical coverage. The structures are in place for these proposed activities to be quickly rolled out and link to the preventative support that is already offered through the providers contracted service and provide a better route to successful delivery of the proposed outcomes then delivery through the Council's own operational structures.

2. What evidence has been used to support this work, how does this link to any existing strategies/policies?

Strategy

The proposal directly links to the All-Age Carers Strategy 2018-2022, developed by Cambridgeshire and Peterborough Local Authorities and the Clinical Commissioning Group, and will meet the following key strategic intentions outlined in the strategy:

Strategic Intention 2: Early identification of ***all*** carers

Strategic Intention 3: Access to information, advice, and support

Strategic Intention 4: Carers work/training/education – life balance

Strategic Intention 6: Reduced breakdown of care at home

Consideration of In-House Provision

The Council also strengthened their approach to support for Carers and their statutory duties under the Care Act by establishing the Carers Support Team in 2008 . In 2019 the responsibility to carry out Statutory Carer Assessments for Carers not known to Adult Social Care as well as providing support and signposting for this cohort of carers was brought back in-house. This had previously been carried out by commissioned providers but bringing this service in-house, linked with Adult Early Help and compliant delivery to the Care Act duties.

The preventative element of the service continues to be delivered as a commissioned services as this approach brings with it a level of flexibility and well-established links into a wide range of services and approaches within local communities. It also offers best value for money.

Performance and Impact

The work undertaken to improve support for carers has had a positive impact on both local and regional performance. Regionally, the approach Cambridgeshire has taken within this area has attracted positive attention and we regularly engage with other local authorities to share our experience and approach. This is evidenced from regional comparison information which indicates the number of carers assessed and/or reviewed within Cambridgeshire has increased from 180 to 556 between 2019/20 and 2020/21. We currently rank second highest in the region behind Essex.

Work was undertaken through the Adults Positive Challenge programme to focus on support for carers. The workstream looked at both operational and commissioned services and the programme of work supported progress towards achieving the following outcomes:

1. Carers can balance their caring roles and maintain their desired quality of life
2. Staff have the knowledge and ability to have the right conversations with carers, and direct carers towards the right level of support to meet their needs
3. Carers have access to the right tools and information to enable them to manage their health and wellbeing and support them to maintain their caring role
4. The right community-based support is available to carers across all client groups
5. All carer reviews are in date

In addition to this, we have reduced the level of spending on one-off Direct Payments through re-directing carers to alternative support to achieve better outcomes than a limited monetary sum. The carers' direct payment budget delivered an £80k saving on a £150k budget in 2020/21. Prior to 20/21 this budget had already made savings of £516k, with £466k of this being made permanent through budget reductions.

Feedback from carers themselves has also been positive and some key examples have been included below:

“I felt that I was the one that mattered as all other contact with other groups/agencies were focused solely on my husband whom I care for.”

“The advice and help I received… helped me to see that it wasn't wrong of me to want time for myself. Discussed ways of helping me cope with being full time carer to my wife and still manage to enjoy life whilst not having to feel depressed and alone but also be refreshed - ready for the challenges ahead’’

Whilst Cambridgeshire have achieved significant outcomes through the work undertaken to improve support for carers, recent findings from national reports following the COVID-19 pandemic highlight there is still more work to do.

Firstly, work is needed to ensure carers are considered effectively as part of developing hospital discharge processes. A national survey undertaken by Carers UK in relation to Discharge to Assess Hospital processes indicated that over half of carers providing significant care were not involved in decisions about discharge, most carers were not assessed, and two thirds did not feel listened to about their willingness and ability to care.[1]

In addition, COVID-19 has had a disproportionate impact with carers with surveys revealing that 81% of carers are providing more care than they had before lockdown, with 78% reporting the needs of the person they are caring for have increased. 58% of carers have also seen their physical health impacted by caring through the pandemic, while 64% said their mental health has worsened.[2]

This highlights the importance of continuing to improve and expand upon our Carers Support offer.

3. Has an options and feasibility study been undertaken? Please explain what options have been considered.

The following papers by various support agencies provides evidence on what works for supporting carers:

- Spotlight on a Carers Journey - National Development Team for Inclusion
- Assesssing Carers Needs: A Guide – Skills for Care and The Carers Trust
- Supporting Young Carers and Their Families – The Children’s Society

Cambridgeshire recognises that a preventative approach is key to supporting carers and this forms a central part of our approach to adult social care. We recognise the important role carers play and have proactively established approaches which enable early identification of the needs of carers and how the council and commissioned services can maximise the physical and mental wellbeing of carers.

To date, we have focused on the following areas:

[1] 21 09 10 Carers Trust carers-experiences-of-hospital-discharge-report-2021.pdf
[2] Caring Behind Closed Doors - Carers UK

- Ensuring carers are identified early, and that meaningful conversations are carried out, thereby preventing carers from reaching crisis point and breakdown.
- Ensuring carers have access to information, tools, and support to enable them to manage their health and wellbeing and support them to maintain their caring role
- Ensuring support is available in the wider community, from commissioned services and, where required, from the Council to enable carers to balance their caring roles and maintain their desired quality of life
- Identification of and engagement with 'hidden carers' who are people who undertake a caring role and do not necessarily relate to the label of 'carer' but nevertheless may require or benefit from some support.

A range of activities have been undertaken to make improvements in support for carer across these areas. These have been highlighted below:

- Strengthening conversation with carers - We have delivered a new approach where carers are supported flexibly with a variety of support opportunities. The use of strengths-based conversations has been key to this approach.
- Commissioning an All-Age Carers Support Service – The new service commenced in August 2020 and provides support to a range of carers of all ages across three providers. The new service improved consistency, with emphasis on local needs and ease of access for local carers. It provides a range of support activities which aim to increase the early identification of carers, provide support to help carers, including Young Carers, to maintain their caring role and to prevent carer breakdown. The service also provides support to carers, who are unable to carry out their caring role due to an emergency for up to 72 hours.
- Young Carers – The council, working with its commissioned provider, Centre 33, is focusing on several initiatives to support Young Carers. Centre 33 is working with mental health services around support for Young Carers who are supporting family members with eating disorders, a caring role which has significantly increased during the pandemic. Carer Champions are being rolled out within schools to improve recognition and support of Young Carers within the school environment. 16+ Transitions Assessment and Support has been developed to ensure a smooth transition from young to adult caring responsibilities and is being viewed as an example of best practice in other local authorities who are keen to implement similar systems
- Sharing Best Practice and Awareness Raising - A range of activities are undertaken within this area. Key examples include development of a Carers Brochure to highlight good practice to adult social care practitioners; active participation in Carers Week annually including radio announcements and other published materials. We recently ran a hidden carers campaign to seek to direct people towards available support, information, and advice.
- Think Communities - Carers are a key priority under the Think Communities programme. A short break for carers pilot is currently being delivered by Caring Together. Work is underway to achieve the Carers Employer tick for Cambridgeshire County Council indicating we are an employer of people with a caring responsibility. The Community Engagement Vehicle is in regular use

across all the districts and the team are refining their approach to feedback key themes and community support ideas in relation to carers.

4. What are the next steps/ actions the Council should take to pursue it? Please include timescales.

To achieve the elements contained within the proposal there are several actions which will need to be taken. There have already been discussions with the relevant internal teams and commissioned providers who would be responsible for the delivery of the outcomes. The stakeholders involved include:

- Caring Together – commissioned provider of Carer Services
- Think Communities
- Communications Team
- Adults Positive Challenge Carers Workstream – Operations, Contracts, Commissioning, Finance and Business Intelligence

There will also be opportunities to link with the work being carried out under the Happy at Home programme as well as health partners through Primary Care Networks within each of the localities seeking opportunities to pool funding and resources wherever possible. The current pilot for Short Breaks for Carers is jointly funded with the Primary Care Network (PCN) in East Cambridgeshire and further opportunities would be explored with PCNs in other localities to determine their priority areas and the potential for investment into this area of support thus reducing the Council's overall contribution.

To deliver against the proposal, the following activities will be undertaken:

Activity/Task	**Responsible**	**Timescale**
Recruitment and training of 3 FTE additional workers to support response to contingency plans	Caring Together	Within 4 months
Recruitment of 1FTE counsellor to increase capacity of Listening Ear Service	Caring Together	Within 4 months
Recruitment and training of Volunteer Co-ordinator for each Locality to support delivery of Short Breaks for Carers	Caring Together	Within 4 months
Campaign to recruit volunteers in each locality to deliver short breaks for carers	Caring Together/Think Communities	Within 6 months
Training and support of volunteers to deliver short breaks for carers	Caring Together	Within 8 months

Hidden Carers Media Campaign (potential to link to winter campaigns)	Comms Team	To start within 6-8 weeks
Awareness raising of support available	Comms Team/Caring Together/Think Communities/Operational Teams	Throughout
Analytics of media campaign success	Comms Team/Caring Together	Following Media Campaign

Commissioners will commission the services outlined directly from the current provider under a variation to existing arrangements. The Carers Workstream will oversee the delivery of the additional support/areas of investment. The actions required will be incorporated into the Carers Action Plan and will be monitored against indicators of success to ensure the activity meets the required outcomes.

5. Could this have any effects on people with Protected Characteristics including poverty and rural isolation? If so please provide as much detail as possible.

A carer is anyone, including both children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. Therefore, the expansion of the Carers Support could actively be supporting any of the following protected characteristics.

- Age
- Disability
- Pregnancy and maternity
- Poverty
- Rural Isolation
- Race
- Sexual orientation
- Gender-reassignment (including intersex, transgender and non-binary people)
- Religion
- Marriage and civil partnership

To ensure this proposal is equitable in its aims and delivery and that any potential adverse impacts on people with protected characteristics are mitigated against, an Equality Impact Assessment (EqIA) will be developed. This is to ensure CCC's decision-making is inclusive for staff and communities with protected characteristics.

6. What financial and non-financial benefits are there and how will you measure the performance of these? Are there any dis-

benefits? These MUST include how this will benefit the wider internal and external system.

The total investment required to carry out all the activities outlined in the proposal is £323,420 in year 1 and then £273,420 recurrently. The investment required for each of the individual elements is shown below:

Investment Opportunity	Year 1 Investment	Recurrent Investment
Additional 24/7 provider capacity (3 FTE rapid responders) to support contingency planning	£185,000	£150,000
Additional capacity (x1 FTE qualified counsellor) to support Listening Ear Service	£50,000	£50,000
Roll-out of Short Breaks for Carers	£73,420	£73,420
Media Campaign to target hidden carers	£15,000	-
Total Investment	£323,420	£273,420
Offset Amount	(£70,000)	(£70,000)
Investment Required	£253,420	£203,420

Of the investment identified above £273,420 would be recurrent costs required after the first year.

There is the potential to re-invest £70k of savings already made against the Carers Direct Payment budget into this proposal. This would reduce the overall investment requirement to £253,420 in Year 1 and £203,420 thereafter.

Financial Benefits

Financial benefits can be summarised under the following areas:

Economic Contribution of Informal Carers

Using Census datarelating to the provision of unpaid care Carers UK and Leeds University estimated that, nationally, Carers make an economic contribution of £134 billion per year. They also estimated the value of Carers' contribution by local authority; looking at the number of Carers and estimating the cost of replacement care for the hours they provide. In Cambridgeshire and Peterborough, the value of Carers contribution in 2011 was estimated at £955 million.

Cost Avoidance

Analysis of care and support plans indicates that, with better support, carers can maintain their caring role. A snapshot capturing the impact of current practice in operational teams indicated cost avoidance of ~£2.4k per week for the interventions implemented during the snapshot period (1 month). Were we to assume that the snapshot month were typical of all months and that an intervention can prevent the need for escalation of someone's care needs for 3 months, we could say that current practice delivers preventative savings of ~£375k per year. In addition to this, our internal Carers Support Team supports carers caring for individuals not known to

adult social care and helps to prevent the requirement for statutory services. Our externally commissioned carer support providers also contribute to maintaining people within a caring role and avoided cost to the local authority.

Projected Cost Avoidance Savings	Cost Avoidance
Benefits of supporting carers to maintain their caring role through a preventative and are therefore not known to the Council	£210,000*
Benefits of increasing capacity to support carers in an emergency as part of an established contingency plan	£9143**
Total Projected Cost Avoidance:	~£219,143 per annum

*Caveat: Initial Estimate: Further work is required to verify this assumption using an agreed methodology and drawing on information from commissioned providers, Carers Support Team and Adult Social Care data to determine care packages resulting from carer breakdown.
**Caveat: Currently only 1 quarter of data available so cost avoidance analysis is based on limited information over a short period of time

Costs to ASC – Emergency Support

Increasing the capacity of the commissioned provider to deal with emergency situations and provide support for up to 72 hours as part of a carers contingency plan can also provide avoided cost to the Local Authority. Currently only two activations of contingency plans can be dealt with simultaneously. There are 3692 What If (contingency) plans registered with the provider, 120 new plans were registered in the first quarter of 21/22 and this provision continues to be seen as an important part of planning for emergencies with carers.

In Q1 of 21/22 44 emergency plans were activated and 50% of these plans did not have any nominated contacts (family/friends) who could support the cared for person as part of the response to the emergency. Eight (15%) plans could not be responded to within the quarter due to the lack of provider capacity.

Using verified proxies[3] for the cost of formal interventions (e.grespite or care packages required to support and safeguardshould the informal carer not be available), there could be a potential £2285.82 in Q1 of avoided cost; annually this would amount to £9143.28. However, we currently have only had Quarter 1 of 21/22 data available which provides information across the summer months, and we can make a reasonable assumption that there is likely to be a higher incidence of emergency support required for carers over the coming winter period.

A further cost avoidance rationale can be applied through ensuring that better support for carers of individuals not yet known to Adult Social Care will delay the requirement for commissioned formal care. Using an average cost of care of £350 per week and an assumption that at least 60 carers will be able to maintain their

[3] (source: Innovate and Cultivate Adult Social Care Costings)

caring role by 10 weeks, delaying the need for adult social care a cost avoidance figure of £210,000 can be applied. This is a small number of carers based on over 700 active carers seeking support from Caring Together, the commissioned provider, in Q1 of 21/22. Further work is required to verify this assumption using an agreed methodology and drawing on information from commissioned providers, Carers Support Team and Adult Social Care data to determine care packages resulting from carer breakdown.

Non-Financial Benefits

Further non-financial benefits can also be attributed to the proposal through the delivery of additional support to carers.

Opportunity	Benefits
Additional provider capacity to support contingency planning	• Meet increased demand • Maximise the use of contingency plans • Prevent carer breakdown • Reduce need for temporary care packages, hospital admission or reablement
Additional capacity to support Listening Ear Service	• Reduce waiting list for support • Prevent carer breakdown through earlier intervention • Prevent carer/cared for from requiring statutory intervention
Roll-out of Short Breaks for Carers	• Flexible option for carers to take a break from their caring role on a regular basis • Initial positive feedback from Carers accessing the pilot service in East Cambs
Media Campaign to target hidden carers	• Previous campaign successful in reaching a wide audience and increasing awareness • Can be targeted to increase awareness and support offered over acute period of winter pressures

7. Are there any identified risks which may impact on the potential delivery of this? What is the risk if we do not act?

Risk	**Mitigation**	**RAG** (should the risk occur)	**Overall Responsibility**
Additional provider capacity to support contingency planning - Demand does not increase and resource is not used	Flexible approach to recruitment and use of resources. Continue to promote the use of What If plans	Amber	Commissioning/Provider

Additional capacity to support Listening Ear Service - Only anecdotal evidence of impact available at this stage	Provider to gather further evidence of impact Continue to monitor the outcomes delivered as programme progresses	Amber	Commissioning/Provider
Roll-out of Short Breaks for Carers - Reliance on volunteers to meet demand	Engagement with local college/HE/communities to recruit volunteers Targeted campaigns in each Locality	Red	Think Communities/Provider
Roll-out of Short Breaks for Carers - Evidence of impact of pilot in East Cambs not yet available	Provider to gather further evidence of impact Continue to monitor the outcomes delivered as programme progresses	Amber	Commissioning/Provider
Media Campaign to target hidden carers - Final report from previous campaign not yet available	Midpoint Analytics from previous campaign available Ensure final report is circulated	Green	Communications Team
Media Campaign to target hidden carers - Clear analytics required to measure impact	Clear analytics and impact measurements to be defined at the outset of the campaign	Amber	Communications Team/Think Communities/Provider

8. Scope: What is within scope? What is outside of scope?

The following interventions are in scope for the proposed investment:

- Additional provider capacity to support ability to respond to contingency plans
- Additional capacity to support Listening Ear Service
- Roll out of short breaks for carers
- Media campaign to target hidden carers

Outside of scope are the following areas:

- Activities of the commissioned provider as defined by their service specification
- Actions identified under the Carers Action Plan as part of the Adults Positive Challenge Programme or Think Communities delivery
- Support for Carers through Carers Assessments and Carer Conversations

Business Planning: Business Case – Investment proposal

Project Title: Implementation of the Real Living Wage

Committee: Adults and Health Committee

2022-23 Investment amount: £1,187,000

Brief Description of proposal:

Implementation of the Real Living Wage to Adult Social Care staff which will include both internal council staff and third-party providers. This will commence in 2022/23 and will be phased in over a 2–3-year period. To ensure that we do this in an equitable way across the market, we are proposing to roll out incremental increases every six months to close the gap from the current rates to the Real Living Wage over a two-year period.

The total permanent investment required on a Business Planning basis is forecast as below:

2022/23	2023/24	2024/25	2025/26	2026/27
1,187k	4,408k	3,619k	409k	543k

Date of version: 23 November 21 BP Reference: A/R.5.011

Business Leads / Sponsors: Will Patten, Director of Commissioning

1. Please describe what the proposed outcomes are:

The Real Living Wage is a minimum income standard which is based on what people need to earn to maintain an acceptable standard of living within the UK. It is calculated on an annual basis by an independent body called the Living Wage Foundation which is made up of leading living wage employers, trade unions and academic partners amongst others. The current Real Living Wage Rate is £9.50 per hour.

Delivery of the Real Living Wage is expected to achieve the following outcomes against the Councils key priorities:

- Protecting and caring for those who need us
  For some time now the adult social care workforce has struggled to increase capacity in line with the growth in demand for services. This impacts on the quality of services received the level of choice and control people can exercise in identifying services to meet their support needs and the cost of services to the Council. Recruitment and retention challenges are a major contributing factor to this due to comparatively low wages, high levels of competition from other sectors and lack of an established and formalised career pathway. Investing in the sector through ensuring the workforce is paid the Real Living Wage will help to tackle these issues and facilitate growth within the sector.

- Ensuring a good quality of life for everyone through addressing a key cause of local social mobility challenges
  As a major local employer and purchaser of services, the Council can choose to play a significant role in addressing social mobility challenges experienced amongst the lowest paid workforce in helping to safeguard this workforce from in-work poverty and ensure they are able to live a healthy life, particularly important given the high cost of living within Cambridgeshire.

- Communities at the heart of everything we do
  An increase in wages will inevitably lead to an increase in spending activity boosting the local economy and community. This will not only have economic advantages but will also have a positive impact on community cohesion and engagement with adult social care, linking to the placed based and think communities' approach.

2. What evidence has been used to support this work, how does this link to any existing strategies/policies?

Strategies and Policy

Introduction of the Real Living Wage forms a key priority of the new joint administration within Cambridgeshire who are seeking to drive up the quality and dignity of care work and services, integrating the Council’s social value approach as well as improve training, career development, pay and conditions for frontline care workers. This includes a phased implementation of the Real Living Wage.

As an organisation, the Council are also actively exploring new and more sustainable approaches to meeting growing demand for adult social care services. This includes development of more localised, placed based approaches evident through Adult Social Care and Think Communities priorities. The aim is to improve the quality, efficiency and sustainability of adult social care provision whilst also giving people receiving support maximum choice and control over who and how it is delivered. This will ensure they are enabled to remain as independent as possible for longer. However, the impact of these approaches will be limited if workforce capacity to implement and deliver them is restricted. The Real Living Wage could help to address this challenge.

Alignment with Existing Projects

The Real Living Wage could also positively align and impact on several specific projects currently being progressed including development of a placed based homecare model, roll out of the 'happy at home' pilot which is looking at different approaches to delivering support in local communities, as well as increasing direct payments and individual service funds which require an active personal assistant workforce to be available.

Evidence and Feedback

Skills for Care – Scope and Workforce

The latest Skills for Care workforce statistics indicate that there were an estimated 15,000 jobs in adult social care in Cambridgeshire, split between local authorities (7%), independent sector providers (87%) and jobs working for direct payment recipients (6%). Skills for Care estimate that 8,600 of these jobs are direct care workers, often in receipt of the lowest salaries. As of March 2020, this data indicated that Care Workers within the Eastern Region were paid an average rate of £8.73 per hour. This is 77p per hour lower than that Real Living Wage.

Skills for Care estimate that the staff turnover rate in Cambridgeshire was 36.6%, which was higher than the regional average of 32.9% and higher than England, at 31.9%. Pay differentials was identified as one of the main reasons for high turnover. Implementing the Real Living Wage could therefore have a positive impact on capacity as well as recruitment and retention.

The Real Living – Research on Impact

The Real Living Wage Foundation have undertaken a survey of all organisations currently accredited for roll out of the Real Living Wage:

- 93% of those surveyed reported they had gained as a business after becoming a Real Living Wage employer.
- 86% of respondents reported that Living Wage accreditation had enhanced their organisation's general reputation as an employer.
- 8% of large employers also reported that following accreditation staff motivation was increased.

Further evidence and statistics can be found here: The Living Wage is Good for Business | Living Wage Foundation

Feedback

Locally, the Council are aware from our interactions and engagement with providers that recruitment and retention challenges are increasing across the market. This often

results in increased use of agency staff and lack of continuity and consistency for those receiving services. The EU Exit and salaries offered within other sectors has a major impact on this.

Feedback from other Local Authorities who have implemented the Real Living Wage has been positive, advising it has:

- Helped to support the market during the COVID-19 pandemic to attract and retain staff within the sector, and to recognise the valuable work undertaken by the social care workforce during the pandemic.
- Improvement in the quality of services and motivation of the workforce
- Improvement in recruitment and retention within and across sectors, including better quality applicants being received by providers
- Improved supplier relations

3. Has an options and feasibility study been undertaken? Please explain what options have been considered.

Several options for implementing the Real Living Wage have been considered and outlined within the table below:

Option Description	Advantages	Disadvantages	Investment
1. Real Living Wage Accreditation	• Positive reputational impact associated with accreditation and support from the Living Wage Foundation to roll out approach • Full realisation of benefits outlined above • The Council can undertake a light touch review of third-party contracts within the first 12 months to determine level of investment required and implement the changes with a voluntary scheme with providers.	• Significant investment in both services and capacity to implement required within 2-3 years. • Neighbouring Councils and local health partners may not engage in the approach limiting impact. • This could impact on the cost of care from self- funders. • Providers will need to fund differential pay increases to retain staff who are on higher grades.	Estimated Initial Total: £8,501,000 Estimated upfront investment of £8m spread over a 2–3-year period for adult social care. Further investment will be required to service future annual inflation against the real living wage* In addition to this a £501k investment in capacity over the 3- year period would be required to implement the approach. This includes on cost and inflation.
2. Internal roll out of the Real Living Wage to Council employed staff and third-party providers over a 4–5-year period with Real Living Wage Accreditation being explored later	• Benefits associated with the Real Living Wage will be immediately applied to direct employees of the Council • Spreading the cost of implementing the Real Living Wage would have a positive impact on cashflow and the management of pressure. • The Council can undertake a detailed review of third-party contracts within the first 12 months to determine level of investment required and link the investments to when contracts are naturally renewed. • Work can be undertaken with neighbouring Councils and local health partner to seek engagement prior to accreditation	• No accreditation or support from the Living Wage Foundation to roll out approach within the first 2-3 years. • Benefits will take longer to realise. • Investment in additional capacity to implement will be required over a longer period. • Providers will need to fund differential pay increases to retain staff who are on higher grades.	Estimated Initial Total: £8,568,000 Estimated upfront investment of £8m spread over a 4-5year period for adult social care. Further investment will be required to service future annual inflation against the real living wage* In addition to this a £568k investment in capacity over the 5- year period would be required to implement the approach. This includes on cost and inflation.

	• Marketing of the approach being undertaken will still have a positive reputational impact even without immediate accreditation		
3. Maintenance of the Real Living Wage to Council employed staff only - no Real Living Wage Accreditation	• Benefits associated with the Real Living Wage will be immediately applied to direct employees of the Council by implementing supplement payments • No additional investment required from Adult Social Care. • Can be implemented within short timescales.	• Benefits outlined will not be fully realised • Limited reputation impact as will only be applied internally • No accreditation or support from the Living Wage Foundation • This will not challenge or address the nationally agreed pay scale	£25k investment has been ringfenced by the Council. Nil impact within Adult Social Care Budgets.
4. Maintenance of the Real Living Wage to Council employed staff and third-party contracts for Adult Social Care only - no Real Living Wage Accreditation	• Benefits associated with the Real Living Wage will be immediately applied to direct employees of the Council • Limit investment required from the Council as a whole • Partial achievement of benefits outlined above, particularly in relation to recruitment and retention	• No accreditation or support from the Living Wage Foundation • Significant investment from adult social care in both services and capacity to implement required within 2-3 years • Neighbouring Councils and local health partners may not engage in the approach limiting impact. • This could impact on the cost of care from self- funders. • Providers will need to fund differential pay increases to retain staff who are on higher grades. • Implementing the Real Living Wage within adult social care alone could create inequity across the range of sectors supported by the Council • Benefits outlined will not be fully realised • Limited reputational impact	Same as Option 1 with no additional investment required from the outstanding areas of spend within the Council

*****Over the past 10 years the gap between National Living Wage and Real Living Wage has narrowed, with NLW (National Living Wage) increasing by 4.1% per year on average and RLW increasing by 3.1% per year on average. If this move towards convergence continues then after the initial investment to implement the Real Living Wage, the subsequent additional investment each year to maintain RLW will be less than the annual increase in budget to maintain NLW rates.

It has been recommended that Option 4 is progressed, but with a phased implementation to manage the level of investment required commencing in 2022/23 and phasing this over a two-to-three-year period. To ensure that we do this in an equitable way across the market, we are proposing to roll out incremental increases every six months to close the gap from the current rates to the Real Living Wage. The level of investment proposed includes the additional commissioning/contract management resource to do this as highlighted within the table above.

Whilst this option will not provide the Council with immediate accreditation from the Real Living Wage Foundation, adult social care services make up 33% of total spend including schools and will still therefore have a significant impact on outcomes. This will also enable the Council to evaluate the impact of delivering the Real Living Wage, including consideration of social value to inform approaches taken across the remainder of the Council.

4. What are the next steps/ actions the Council should take to pursue it? Please include timescales.

To implement this approach a targeted Project Group will need to be established and attended by Contract Management, Commissioning, Finance, commissioners of health services and a Project Manager from the BID (Business Improvement & Development) Team. The project scope, plan and market engagement activities will need to be developed. This will ensure that there is a clear and costed action plan in place with associated governance, market engagement and risks/issues accounted for.

To enable this to take place, recruitment to additional capacity will need to be progressed as a priority.

High Level Timetable

Task	**Start Date**	**End Date**	**Overall Responsibility**
Recruit to additional posts	December 2021	April 2022	Commissioning/ Contract Management
Identify BID Project Management Capacity	December 2021	April 2022	Commissioning/ Contract Management
Establish Project Group and Confirm Membership	January 2022	April 2022	Project Manager
Complete Project Plan and Management Documentation	April 2022	May 2022	Project Group and Project Manager
Agree Social Value Portal Measures to be adopted	April 2022	May 2022	Project Group and Project Manager

Develop Market Engagement Plan	April 2022	June 2022	Project Group and Project Manager

A costed schedule for roll out of the Real Living Wage to all adult social care providers will need to be developed as part of the project plan by September 2022 for implementation.

5. Could this have any effects on people with Protected Characteristics including poverty and rural isolation? If so, please provide as much detail as possible.

This proposal will apply to all adult social care services which cover all protected characteristics. Implementation of the Real Living Wage will have a positive impact on the adult social care workforce currently earning below the current Real Living Wage standard of £9.50 per hour and in doing so could increase their social mobility, quality of living and ability to continue undertaking their role.

Improved retention rates of the adult social care workforce could in turn lead to a positive impact on those in receipt of care, with experienced staff and better continuity of care.

An Equality Impact Assessment (EqIA) will be developed to ensure this proposal is equitable in its aims and delivery and any potential adverse impacts on people with protected characteristics are mitigated against. This is to ensure CCC's decision-making is inclusive for staff and communities with protected characteristics in line with the Equality Act (2010) and Public Sector Equality Duty (section 149).

6. What financial and non-financial benefits are there and how will you measure the performance of these? Are there any dis-benefits? These MUST include how this will benefit the wider internal and external system.

Financial Benefits

The Council currently spend just over £193m on adult social care provision. A substantial proportion of this spend funds services which operate using a lower-than-average paid workforce who often receive the National Living Wage rather than Real Living Wage. Increasing the income for this cohort will increase their economic activity generally but this cannot be quantified at this stage and will not result in a direct return to the Council.

The project group will aim to work with procurement and the market to identify measures of social value that could potentially produce a social value return on investment as part of the process.

Non-Financial Benefits

However, there are significant non-financial benefits to both the Council and individuals who receive adult social care services:

- Improved recruitment and retention
  Allowing providers to expand capacity to meet growing demand. It will enable the Council to work with health partners and adult social care providers to create a 'career in care' which is more attractive and creates longevity – less people waiting for domiciliary care, increase in the number of people supported by Personal Assistants through Direct Payments, reduction in the use of agency staff and staff turnover across care settings as well as the creation of employment opportunities.

- Social Value
  As a major employer and commissioner of services, the Council can positively impact on in-work poverty and social mobility challenges often arising amongst the lowest paid segments of the adult social care workforce. This will not only improve the quality of their lives but will increase their spending levels in turn boosting local communities and economy. This is particularly important given the inflated cost of living within Cambridgeshire. The commitment to use the Real Living Wage will also stimulate the development of smaller, more local enterprises which will have a similar impact – local increase in microenterprises and small businesses, identified TOMS from the Social Value Portal.

  Examples of this include:
  - Improved health and wellbeing: Low income has been found to have a direct impact on the conditions into which we are born, grow, live, work and age – which result in unfair and unjust inequalities in length and quality of life. Addressing income levels so they reflect the cost of living rather than surviving has a positive impact on this. It enables people to become more active, to undertake and become more productive in employment, it enables parents to access more opportunities for their children thereby improving the quality of their life.
  - Wider economic value: At a basic level, the Real Living Wage enables people to engage to wider communities and leisure activities like going out for dinner, joining community groups, classes and or support. It enables them the space to consider alternative training or business opportunities. Coupled with the right support, this could not only result in increased development of small business contributing to wider community outcomes and priorities but has economic benefits too. Research undertaken by an Independent Think Tank called the Smith Institute has identified that if 25% of low paid workers were moved to National Living Wage this would produce a return of £1.5bn to the local economy.[1]

[1] The Living Wage Dividend: maximising the local economic benefits of paying a living wage

- Quality Improvement
  Research has shown improved motivation and morale amongst employees [2]. This is critical when delivery adult social care services to people who are often at the most vulnerable stages of their lives – Reduction in quality concerns across various categories, improvement in local CQC (Care Quality Commission) Ratings.

- Positive Reputational Impact
  Positive reputational impact through enabling the Council to promote our status as a Real Living Wage employer for adult social care services and encouraging wider changes through procurement of services. This is also likely to improve relations between the Council and the local employers.

7. Are there any identified risks which may impact on the potential delivery of this? What is the risk if we do not act?

Risk	**Mitigation**	**RAG** (should the risk occur)	**Overall Responsibility**
Recruitment to additional capacity required to implement the Real Living Wage delaying implementation	Commence recruitment process prior to the start of the financial year	Amber	Commissioning and Contract Management
Implementing the Real Living Wage could erode the pay differentials between staffing grades if the higher grades do not receive a proportionate increase. This could impact on financial projections and assumptions used	Early audit of ASC independent sector provider salaries and robust engagement with the market	Amber	Project Group
At present, more specialist services within areas such as Children's Social Care and Learning Disabilities attract staff through offering wages over and above the national living wage. Implementing the Real Living Wage across the sector could lead to staff leaving to work in other, less challenging areas	Close contract monitoring and communication with these services to monitor risk throughout the phased roll out	Amber	Project Group

[2] Henry E, Nash D and Hann D, The Living Wage Employer Experience, Cardiff: University of Cardiff (2017), https://www.cardiff.ac.uk/news/view/722069-employer-experienceof-the-living-wage

unless their wages increase accordingly			
May generate a counter response from other competing employers locally	Monitor closely to assess the risk	Amber	Project Group
Feedback from other Councils has indicated reluctance from some providers to engage due to the work they undertake with other Councils and NHS Partners not engaged in rolling out the Real Living Wage. This means we cannot mandate this in contracts.	Engage with health partners and the market to understand whether this is a risk from the outset,	Amber	Project Group

8. Scope: What is within scope? What is outside of scope?

This proposal covers the application of the Real Living Wage to all Adult Social Care Services delivered both through the Council and by third party contractors. Any other service delivered or commissioned by the Council falls outside the scope of this project.

Business Planning: Business Case – Investment proposal

Project Title: Health Impact Assessment Fund Proposal

Committee**:** Adults and Health Committee

2022-23 Investment request: £125,000
(Plus £45,000 non recurrent)

Brief Description of proposal:

The use of Health impact assessment (HIA) is a systematic approach to identifying differential health impacts of proposed and implemented policies, programmes, and projects within a democratic, equitable, sustainable and ethical framework. It identifies both positive and negative health impacts so that the positive health effects can be maximised, and the negative impacts minimised within an affected community.

It is proposed to set up a £125k annual fund for department directors to use to carry out Health Impact Assessments on specific policies or programmes, through external resource or training of existing staff to carry out the HIA.

It is anticipated that approximately five HIAs will be completed per year, depending on the type of HIA undertaken (rapid, intermediate or comprehensive).

A further £45k will be used to support training across the system on the determinants of health, the role that all can play in improving health outcomes and on health impact assessments.

Date of version: 21/09/2021 BP Reference: E/R.5.007

Business Leads / Sponsors: Jyoti Atri / Emmeline Watkins

1. Please describe what the proposed outcomes are:

Health impact assessment (HIA) is a systematic approach to identifying differential health impacts of proposed and implemented policies, programmes, and projects within a democratic, equitable, sustainable and ethical framework.

This allows the identification of both positive and negative health impacts of policies and programmes enabling that the positive health effects can be maximised, and the negative impacts minimised within an affected community.

The proposed fund will ensure that key policies and programmes address the corporate priorities of:

- A good quality of life for everyone
- Helping our children learn, develop and live life to the full
- Communities at the heart of everything we do
- Cambridgeshire: A well-connected, safe, clean, green environment

It uses a range of structured and evaluated sources of evidence that includes public and other stakeholders' perceptions and experiences as well as public health, epidemiological, toxicological, and medical knowledge (dependant on the level of Health Impact Assessment undertaken).

HIA’s follow a standard approach using eight core steps:

- Screening (screening which projects, policies etc. would benefit from an HIA
- Scoping (scoping out the areas to be addressed within the HIA)
- Baseline (setting a baseline of the current health profile of the population affected by the programme / policy)
- Community Involvement (key community and other stakeholders are engaged to feed in their experience of the project or policy)
- Evidence an analysis (a systematic review of the potential impacts including the significance of the impacts, the magnitude of the impacts and any differential impacts between groups and individuals)
- Mitigation (suggested measures for reducing negative impacts and enhancing positive impacts)
- Final report (a final report summarising the steps taken, the findings, and any mitigation measures, and future monitoring)
- Monitoring (monitoring the impacts post implementation)

HIAs help to deliver better and improved policy, programme, and project outcomes that enhances community and societal health and wellbeing.

They can either be used:

- as an analysis tool to forecast the potential negative and positive health impacts
- as a participation tool that can help residents, local community groups and other stakeholders be involved in the design of a programme / policy

- as a project management tool that can help to structure the development and implementation of policies, programmes, projects and services
- as an evaluation tool to monitor the achievement of stated objectives, outputs and outcomes or those policies, programmes, projects and services

Usually, a HIA will involve a combination of all four.

HIAs can be done on policies, programmes, and projects at the:

- beginning (i.e. during the development or pre-development stage of a programme / policy formation etc.), known as a prospective HIA;
- middle (i.e. during the implementation stage of a programme / policy), known as a concurrent HIA,
- end (i.e. at the operation or closure stage to look back and evaluate) known as a retrospective HIA.

HIAs vary in complexity and speed and are classed as rapid, intermediate or comprehensive HIAs.

Health impact assessments assess the potential impact of programmes on outcomes for those with protected characteristics as well as any environmental issues that may impact on health such as air quality.

2. What evidence has been used to support this work, how does this link to any existing strategies/policies?

The action plan for the Joint Administration Agreement section highlights a need to develop and implement “a clear action plan to deliver “health in all policies” including criteria for evaluating policies”.

This paper outlines the background to Health Impact Assessments (HIA) as a way of evaluating policies and proposals to deliver a range of HIA’s and an approximation of the costs.

Health impact assessment is a globally recognised approach used to judge the potential health effects of a policy, programme or project on a population, particularly on vulnerable or disadvantaged groups.

Therefore, this approach will support both the Health and Wellbeing Strategy as well as the Integrated Care System Strategic framework in improving health and reducing inequalities.

3. Has an options and feasibility study been undertaken? Please explain what options have been considered.

It is proposed to set up “fund” for department directors to use to carry out Health Impact Assessments on specific policies or programmes. This fund could be used to either “buy in” an external resource to carry out HIAs or to train existing staff to carry out HIAs,

this is dependent on the capacity of the department to release staff both for training and subsequent HIA assessments. On average, HIAs take about two to three months to complete so the option to buy in external consultants to undertake HIAs may be preferrable, but it may not be sustainable in the longer term if HIAs are to be used for all significant projects and / or policies, it may be more cost effective to “grow our own” resource inhouse.

Each department director will need to screen which policies / programmes would benefit from a HIA, and then decide the level of HIA needed (Rapid, Intermediate, or Comprehensive). Public Health could produce a framework and guidance for this.

It is anticipated that five HIAs will be completed per year, this will flex depending on the type of HIA undertaken i.e. if more comprehensive HIAs are undertaken fewer than five will be possible, if more rapid HIAs are undertaken more than five may be possible.

Costs to undertake Health Impact Assessments is hard to ascertain due to the varied nature and scope of HIAs, so approximate costs for consultants to produce Environmental Impact Assessments has been used as a proxy.

Generally costs vary from a day rate of £1,400.00 for high grade technical input, to a total project cost of £25,000.00 for an assessment which takes three months. Therefore, it is proposed that a budget of £125,000.00 is allocated for the fund which would enable a mix of a small number of comprehensive HIAs and several rapid HIAs.

As HIAs are underpinned by a comprehensive set of public health data there may be additional demands on the Public Health Intelligence and Business Intelligence teams to supply or signpost any consultants appointed to sources of data.

The recurrent budget of £125,000.00 is based on a number of assumptions:

- The costs of HIAs are comparable with Environmental Impact Assessment reviews.
- The Council will need to prioritise which programmes / polices need an HIA Undertaken and in which order (to manage the budget if HIA costs exceed the average cost of £25K).
- There is capacity within Public Health, Public Health Intelligence, Business intelligence to support the fund and any appointed consultants.

4. What are the next steps/ actions the Council should take to pursue it? Please include timescales.

The fund will be flexible as to approach and therefore resource could be to buy in external capacity or train existing staff. The process of a health impact assessment specifically includes community and stakeholder involvement through the process.

High Level Timetable

Task	Start Date	End Date	Overall Responsibility
HIA fund agreed	9 December 2021	8 February 2022	Jyoti Atri
PH to provide framework/guidance on selecting policies / programmes that would benefit from HIA and level	Q3 2021/22	Q4 2021/22	Emmeline Watkins
Work with Corporate directors to screen which policies / programmes	Q4 2021/22	Q4 2021/22	Emmeline Watkins
Prioritisation of programmes and decision as to internal / external resource	Q4 2021/22	Q1 2022/23	Jyoti Atri
Training to be commissioned	Q4 2021/22	Q4 2021/22	Iain Green
Training to be delivered	Q1 2022/23	Q4 2022/23	Iain Green

5. Could this have any effects on people with Protected Characteristics including poverty and rural isolation? If so please provide as much detail as possible.

Health impact assessment is a globally recognised approach used to judge the potential health effects of a policy, programme or project on a population, particularly on vulnerable or disadvantaged groups and therefore should improve health impacts and outcomes for individuals with protected characteristics, those living in poverty and in rural isolation.

6. What financial and non-financial benefits are there and how will you measure the performance of these? Are there any dis-benefits? These MUST include how this will benefit the wider internal and external system.

Financial Benefits

This HIA fund ensures that key policies / programmes maximise short and long-term health benefits for our population and don’t unintentionally worsen health inequalities. Those benefits may not be seen specifically by the council or achieve any direct savings

Non-Financial Benefits

The project will contribute to identification of social value in programmes / projects where they can indirectly benefit health. Health impact assessments also assess the potential impact of programmes on environmental issues that may impact on health such as air quality and co-benefits to the environment can be significant enabling the potential to deliver on both health and environmental ambitions and improving value for money.

Success measures will need to be dependent on the projects / programmes identified.

7. Are there any identified risks which may impact on the potential delivery of this? What is the risk if we do not act?

Risk	**Mitigation**	**RAG** (should the risk occur)	**Overall Responsibility**
PH leadership capacity challenges due to COVID-19	Use of COMF funded staff to support COVID-19 response where possible with increased return to BAU planned for substantive staff	Amber	JA
System capacity challenges due to COVID-19 and lack of ability to carry out HIA internally	Option to use external resource to carry out HAI	Green	IG/Director for policy/programme

Non delivery of the project means that large policies / programmes could unintentionally worsen health outcomes and increase health inequalities and internal skill set around Health Impact Assessments is not developed

Assumptions: costs of HIA are comparable to environmental impact assessment reviews. If incorrect, fewer HIAs will be carried out

8. Scope: What is within scope? What is outside of scope?

Any policy programmes or projects can identified by the relevant director. However, it is anticipated that through this fund, approximately five HIAs will be completed per year, depending on the type of HIA undertaken (rapid, intermediate or comprehensive).

Public Health will provide framework/guidance on selecting policies / programmes that would benefit from HIA and level of HIA.