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Adults and Health Committee

Agenda

Date: **Monday, 27th September, 2021**

Time: **10.30 am**

Venue: **The Ballroom, Sandbach Town Hall, High Street, Sandbach, CW11 1AX**

PLEASE NOTE – This meeting is open to the public and anyone attending this meeting will need to wear a face covering upon entering and leaving the venue. This may only be removed when seated.

The importance of undertaking a lateral flow test in advance of attending any committee meeting. Lateral Flow Testing: Towards the end of May, test kits were sent to all Members; the purpose being to ensure that Members had a ready supply of kits to facilitate self-testing prior to formal face to face meetings. Anyone attending is asked to undertake a lateral flow test on the day of any meeting before embarking upon the journey to the venue. Please note that it can take up to 30 minutes for the true result to show on a lateral flow test. If your test shows a positive result, then you must not attend the meeting, and must follow the advice which can be found here: https://www.cheshireeast.gov.uk/council_and_democracy/council_information/coronavirus/testing-for-covid-19.aspx

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and in the report.

It should be noted that Part 1 items of Cheshire East Council decision-making meetings are audio recorded and the recordings are uploaded to the Council's website.

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Apologies for Absence**

   To note any apologies for absence from Members.

2. **Declarations of Interest**

   To provide an opportunity for Members and Officers to declare any disclosable

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pecuniary and non-pecuniary interests in any item on the agenda.

3. **Minutes of Previous Meeting** (Pages 5 - 10)

To approve as a correct record the minutes of the previous meeting held on 13 July 2021.

4. **Public Speaking/Open Session**

In accordance with paragraph 2.24 of the Council's Committee Procedure Rules and Appendix on Public Speaking, set out in the Constitution, a total period of 15 minutes is allocated for members of the public to put questions to the committee on any matter relating to this agenda. Each member of the public will be allowed up to two minutes each to speak, and the Chair will have discretion to vary this where they consider it appropriate.

Members of the public wishing to speak are required to provide notice of this at least three clear working days' in advance of the meeting.

5. **Performance Scorecard - Quarter 1 (2021/22)** (Pages 11 - 18)

To consider the key performance indicators/measures from Quarter 1, 2021/22.

6. **Adult Social Care Improvement Plan - Learning from Covid-19** (Pages 19 - 48)

To receive a presentation in respect of the Adult Social Care Improvement Plan and learning from Covid-19.

7. **Advocacy Service Recommission** (Pages 49 - 66)

To approve the arrangements to recommission advocacy services, in response to changes in legislation (LPS).

8. **Assistive Technology Recommission** (Pages 67 - 84)

To approve the recommission of the Assistive Technology service and to delegate authority to the Director of Commissioning to award the contract(s).

9. **NHS Health Checks Recommission** (Pages 85 - 98)

To approve the recommission of NHS Health Checks service and to delegate authority to the Director of Commissioning to award the contracts.

10. **All Age Carers Hub and Strategy** (Pages 99 - 172)

To approve the draft carers strategy and the recommissioning of the All-Age Carers Hub contract.

11. **Assistive Technology Charging Policy** (Pages 173 - 212)

To consider the Assistive Technology Charging Policy.

12. **Referral of Notice of Motion: Right to Food** (Pages 213 - 254)

To consider a report in response to a Notice of Motion on Right to Food.

13. **Work Programme** (Pages 255 - 258)

To consider the Work Programme and determine any required amendments.

Membership: Councillors P Butterill, J Clowes, A Critchley, B Evans, S Gardiner, L Jeuda, A Kolker, A Moran (Vice Chair), D Murphy, J Rhodes (Chair), R Vernon, J Weatherill and N Wylie

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CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Adults and Health Committee**
held on Tuesday, 13th July, 2021 at Glasshouse, Alderley Park, Congleton Road, Nether Alderley, Macclesfield, SK10 4TF

PRESENT

Councillor J Rhodes (Chair)
Councillor A Moran (Vice-Chair)

Councillors P Butterill, J Clowes, M Houston (substitute), B Evans, S Gardiner, L Jeuda, D Murphy, R Vernon, J Weatherill and N Wylie

OFFICERS IN ATTENDANCE

Roisin Boressi, Senior Solicitor – Adults and Education
Jill Broomhall, Director of Adult Social Services
Paul Goodwin, Head of Financial Services
Brian Reed, Head of Democratic Services and Governance
Nichola Thompson, Director of Commissioning
Matt Tyrer, Director of Public Health

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillors A Critchley (substituted for by Councillor M Houston) and A Kolker.

2 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

3 **PUBLIC SPEAKING/OPEN SESSION**

There were no members of the public present who wished to speak.

4 **ADULTS AND HEALTH BUDGETS 2021/22**

Consideration was given to a report that outlined the capital and revenue budgets, schemes and reserves related to the council's services that fell within the responsibility of the Adults and Health Committee.

RESOLVED –

1 That the decision of the Finance Sub-Committee to allocate the approved capital and revenue budgets, related policy proposals and earmarked reserves to the Adults and Health Committee, as set out in Appendix A be noted.

2 That the Medium Term Financial Strategy timelines, as set out in paragraphs 5.9 to 5.12 of the report, be noted.

3 That the supplementary estimates, as set out in Appendix B to the report, be noted.

5 **MARKET POSITION STATEMENT**

The committee considered the draft Cheshire East Market Position Statement 2021-25, which summarised the supply, demand and commissioning intentions with regard to the care market in Cheshire East, as well as the proposed arrangements to consult on it with interested and partnering organisations within the borough.

It was noted that, following the period of consultation, the final Cheshire East Market Position Statement 2021-25 would be presented for approval to both the Adults and Health Committee and Children and Families Committee.

Members agreed it was a comprehensive report, summarising some good practices and new ways of working, however, also raised concern about the timeliness of the consultation period and whether engagement levels would be lower during the school summer holidays. The committee requested that the consultation period be extended to accommodate for this and to ensure engagement and response levels would be as high as possible.

RESOLVED –

1 That the draft Cheshire East Market Position Statement 2021-25, set out at Appendix 1 to the report, be approved for the basis of consultation, subject to the planned period of consultation being extended.

2 That it be noted that, following consultation, the final version of the Cheshire East Market Position Statement 2021-25 would be presented for approval to the Adults and Health Committee, and Children and Families Committee.

6 **HEALTH AND SOCIAL CARE INTEGRATION**

The committee received an update on the development of the Cheshire and Merseyside Integrated Care System, which was required to be in place by April 2022. Members were informed that the Government White Paper was due for its second reading in Parliament this week, and that regional representatives had placed a real emphasis on making sure that the views and needs of Cheshire East are represented and reflected in it.

The committee welcomed the shared vision of the Cheshire and Merseyside Integrated Care System and plan to reduce inequalities and

improve health and wellbeing outcomes for Cheshire East residents. Some concerns were raised that there was a lack of sufficient consultation on the development of this new health structure, as well as in respect of the increased size of the organisational footprint and the implications of shared budgetary responsibility.

The committee requested further clarification on what a recognised Local Community was.

RESOLVED –

1 That the update be noted, but that the committee's concerns in respect of the development of the Cheshire and Merseyside Integrated Care System and what it would look like in practice, be noted.

2 That a map of the Care Communities be circulated to Members.

7 **FLU REPORT**

Consideration was given to the annual Flu Report which summarised the cases and impact of seasonal flu over winter 2020/21. The report also highlighted the proposed and planned work to be undertaken by the council and partners during the upcoming flu season to ensure high vaccination uptake and preparedness for what was expected to be a challenging winter flu period.

Members raised concerns that the uptake of flu vaccinations was low amongst many population groups including those aged under 65, pregnant women and the BAME community. Officers agreed that they would review local communications and messaging in respect of these concerns, specifically around winter wellbeing advice and the vaccination programme.

It had been proven during the pandemic that people in the obese weight category were more likely to suffer serious health implications than those in other weight categories. It was agreed that there was a need to build on and adapt the council's winter wellbeing messaging to increase the uptake for vaccinations in respect of those in the obese category.

RESOLVED –

1 That the report be noted.

2 That the Director for Public Health conduct a review of the council's winter wellbeing advice with a view to increasing the uptake in the vaccination programme in winter 2021/22, particularly those in the obese weight category or those that have other health conditions.

8 **PERFORMANCE SCORECARD - QUARTER 4 (2020/21)**

Consideration was given to a report that outlined the performance data and measures related to services that fell within the responsibility of the Adults and Health Committee, from Quarter 4 of 2020/21. The committee asked questions and put comments in relation to a number of the performance measures and sought greater clarity on how Covid-19 had affected the data.

RESOLVED –

That the report be noted.

9 **APPOINTMENTS TO SUB-COMMITTEES, WORKING GROUPS, PANELS, BOARDS AND JOINT COMMITTEES**

The committee considered its appointments to the Cheshire East Health and Wellbeing Board and the Joint Extra Care Housing Management Board, with one member to be nominated by the committee and chair, respectively, to each.

RESOLVED –

1 That Councillor J Rhodes be appointed to the Cheshire East Health and Wellbeing Board as one its three voting councillors.

2 That Councillor A Moran be appointed to the Joint Extra Care Housing Management Board as one of the council's three members represented on the Board.

10 **WORK PROGRAMME**

The committee considered its work programme and noted that there were a considerable number of reports scheduled to be considered at its next meeting on 27 September 2021. Officers were asked to review the work programme with a view to holding an additional meeting to enable the committee to give appropriate consideration to all scheduled reports.

RESOLVED –

1 That the work programme be approved, subject to a review to be undertaken by lead officers following the committee's request for an additional meeting to be held.

2 That consideration be given to the establishment of a joint working group with the Children and Families Committee following the review of the 'Adult Social Care Improvement Plan – Learning from Covid 19' report which was to be considered at the September meeting.

The meeting commenced at 10.30 am and concluded at 11.58 am

Councillor J Rhodes (Chair)

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BRIEFING REPORT

Adults and Health Committee

Date of Meeting:	27 September 2021
Report Title:	Adult Social Care Performance Scorecard – Quarter 1 2021/22
Report of:	Jill Broomhall – Director Adult Social Care

1. Executive Summary

1.1. The performance scorecard includes 56 separate measures covering all areas of the service and notable performance against service areas are shown in the following sections. Each measure reported shows the Year End Outturn position at the end of 2020/21 and the updated figure for 2021/22 in quarter 1 (Q1) along with a red, amber, green (RAG) rating to highlight any concerns of note.

1.2. The main areas for highlighting are:

1.2.1. Rising numbers of Residential Admissions

1.2.2. Proportion of adults receiving direct payments

1.2.3. The Percentage of Clients who have received Long Term Support for 12 and 24 months that have been reviewed

1.2.4. Number of Contacts resulting in a New Referral

1.2.5. Number of mental health act assessments completed

1.2.6. Number of new Safeguarding Concerns received in a period (events not individuals).

1.3. This report and the performance scorecard (Appendix 1) provide an overview of performance across Adult Social Care for quarter 1 of 2021/22.

1.4. The Adults Social Care Scorecard reports measures across a number of key, strategic areas including the Statutory Adult Social Care (ASCOF) Measures, Core Service Activity, Care4CE and Reablement Activity, Active Service Users, Risk Enablement (including Mental Health, DOLS and Safeguarding). All of which feed into the strategic aims and objectives in the Council's Corporate Plan 2021-25.

2. Background

2.1. The Adults Social Care Scorecard enables appropriate scrutiny of key performance measures and helps to highlight areas of poor and good performance and to scrutinise the effectiveness of plans in place to improve services. This scorecard provides insight into the performance management systems of the Local Authority and provides essential data, along with qualitative information, to measure the effectiveness of services.

3. Briefing Information

3.1. Each measure included in the Scorecard shows the Year End Outturn position at the end of 2020/21 and the updated figure for 2021/22 Q1 along with a RAG rating to highlight any concerns of note.

3.1.1. Residential Admissions for 65+ age band – The 2020/21 figure was largely impacted by the restrictions linked to COVID-19 with a focus on supporting individuals in their own home wherever possible. 2021/22 (136 in Q1) suggests that we are now seeing an increase in individuals placed in permanent residential/nursing placements (though still below pre-pandemic levels). We are also aware that there may be significant issues in parts of the authority with community care delivery. This measure may see a further increase in Q2.

3.1.2. Residential Admissions for 18-64 age band - Whilst this is clearly being impacted by the COVID-19 pandemic in terms of supporting individuals wherever possible at home, we are not seeing a rise in individuals remaining in short term placements. This may also have been impacted by individuals with elderly carers delaying planned moves/ shielding.

3.1.3. Councils are currently (still) unable to report Delayed Transfers of Care as this data is still not being collected and published by the NHS due to COVID impacts.

3.1.4. Proportion of adults receiving direct payments – in Q1 we are reporting 17.3% of clients receiving a Direct Payment which represents a small decrease from the previous year. The reason for the decrease is because we have seen additional clients receive a community Package of Care. These are clients who would potentially have been placed in Long-term Residential/Nursing care, but because of the effects of COVID-19

have been supported by a traditional community care package and have not wanted to (or been able to) take a Direct Payment.

3.1.5. The percentage of Clients who have received Long Term Support for 12 months continuously that have been reviewed is lower than previous quarters. This will be due to COVID-19 pandemic restrictions and a balance of risk based on whether a review is a priority for a stable package of care. The higher review percentage figures for clients who have received Long Term Support for 24 months provides confidence that, overall, those requiring long term support have an up-to-date package of care that has been reviewed either within or prior to the pandemic. However, this should be monitored to ensure the 12-month picture doesn't start to have an adverse impact.

3.1.6. Number of Contacts resulting in a New Referral – the Q1 figure suggests a continued increase in the numbers of individuals requiring support (3369 new contacts of which 2333 resulted in a new referral). This possibly continues to reflect new ways of working as family members return to offices / move out of Furlough and are unable to support family members in the same way. This rising number and the focus on dealing with the increased number of new contacts has a knock-on effect against capacity and what this will do to performance on assessments and reviews. New safeguarding referrals particularly impact against this due to the time required to investigate.

3.1.7. Proportion of service users in receipt of a community-based service - This is a potentially positive impact of the pandemic as services have adapted to support individuals within the community (91% in Q1). This may also reflect the reluctance of many who do not wish to enter long term bed-based services.

3.1.8. Percentage of community support reablement completed with no ongoing package of care (75% in Q1) continues to demonstrate the success of early support in preventing the need for long term care and support.

3.1.9. Number of mental health act assessments completed (160 in Q1) - Overall, the picture presented is indicating a slightly higher picture than last year. It is possible we are now beginning to see an increase in requests - and complexity - as the impacts of the pandemic on the mental health of individuals are becoming more apparent.

3.1.10. Number of new Safeguarding Concerns received in a period (events not individuals) (1331 in Q1) - The rising numbers potentially indicate that individuals are at increased risk due to COVID-19 pressures.

4. Implications

4.1. Legal

4.1.1. No implications.

4.2. Finance

4.2.1. Although there are no financial implications related to this report, performance measures may be used as an indicator of where more or less funding is needed at a service level.

4.3. Human Resources

4.3.1. Although there are no Human Resource implications related to this report performance measures may be used as an indicator of where extra resourcing is needed at a service level (i.e. volume and timeliness measures).

Access to Information	
Contact Officer:	Jill Broomhall Jill.Broomhall@cheshireeast.gov.uk
Appendices:	Appendix 1: Adults Social Care Scorecard Quarter 1 2021/22
Background Papers:	None

Adult Social Care Scorecard - Quarter 1 2021/2022

PI Ref	Measure	Polarity	NW stat Av	National Av	20-21 Target	Year end 2020-2021	Quarter 1	Quarter 2	Quarter 3	Quarter 4	21-22 yr. to date	RAG	Comments
Benchmarking/ ASCOF Indicators													
1.01	Residential Admissions for 18-64 age band (Total Admissions YTD)	Low is good			<30	13	7				7		Whilst this is clearly being impacted by the COVID-19 pandemic in terms of supporting individuals wherever possible at home, we are not seeing a rise in individuals remaining in short term placements. This may also have been impacted by individuals with elderly carers delaying planned moves/ shielding
1.02	Residential Admissions for 18-64 age band per 100k population (ASCOF 2A1) ytd fig	Low is good	13.7	13.3		6.0	3.2				3.2		see above
1.03	Residential Admissions for 65+ age band (Total Admissions YTD)	Low is good			<530	443	136				136		The measure being returned in the SALT submission is 502 residential admissions per 100k of the population (443 people placed in Residential/Nursing Care). This is a significant decrease from last years' 775 per 100k of population (672 people placed in Residential/Nursing Care). The 2020/21 figure was largely impacted by the restrictions linked to COVID-19 with a focus on supporting individuals in their own home wherever possible. Q1 admissions suggest that we are now seeing an increase in individuals placed in residential/ nursing placements. We are also aware that we have significant issues in parts of the authority with community care delivery. This may see a further increase in Q2.
1.04	Residential Admissions for 65+ age band per 100k population (ASCOF 2A2) ytd fig	Low is good	715.0	628.2		502.0	156.3				156.3		see above
1.05	Total number of individuals currently in residential/ nursing care 18-64	Low is good				170	181				181		This is very small numbers which suggest negligible impact.
1.06	Total number of individuals currently in residential/ nursing care 65+	Low is good				868	1072				1072		See above
1.07	Delayed transfers of care from hospital - days per quarter total	Low is good			<2225 per quarter	N/A	NHS Digital has made the following statement: '**Due to the coronavirus illness (COVID-19) and the need to release capacity across the NHS to support the response, we are pausing the collection and publication of these and some of our official statistics'** which has meant a pause in the publication of DToC data.				N/A		See NHS Digital statement
1.08	Delayed transfers of care from hospital - days per quarter attributable to Social Care	Low is good			<725 per quarter	N/A					N/A		See NHS Digital statement
1.09	Delayed transfers of care from total days delayed per 100,000 population (ASCOF 2C1) (average monthly fig)	Low is good		N/A	243.9	N/A					N/A		See NHS Digital statement
1.10	Delayed transfers of care from hospital days delayed which are attributable to adult social care per 100,000 population (ASCOF 2C2) (average monthly fig)	Low is good		N/A	78.0	N/A					N/A		See NHS Digital statement
1.11	Proportion of adults with a learning disability in paid employment (ASCOF 1E)	High is good	3.7%	5.8%		12.0%	5.1%				5.1%		The outturn also includes those supported by the supported employment service which we can't report on throughout the year.
1.12	Proportion of adults with a learning disability living in their own home or with their family (ASCOF 1F) - YTD	High is good	85.7%	75.4%	87%	86.6%	85.5%				85.5%		Little change - where possible we support individuals to remain independent.
1.13	Proportion of adults receiving self-directed support - YTD	High is good	83.4%	86.90%		100.0%	100.0%				100.0%		No change
1.14	Proportion of adults receiving direct payments - YTD	High is good		28.1%	25%	17.4%	17.3%				17.4%		This year we are reporting 17.4% of clients receiving a Direct Payment, this is a decrease of 3.7% from the previous year. In previous years this measure has been reporting between 21% and 24%. The reason for the decrease is because we have seen an additional 200+ clients receive a community Package of Care this year (2,936) to the previous year (2,705). These are clients who would potentially have been place in Long-term Residential/Nursing care, but because of the effects of COVID-19 have been supported by a traditional community care package and have not wanted to (or been in a position to) take a Direct Payment
Core Service Activity													
2.01	Number of New case Contacts in period	Low is good			13000	11,662	3,369				3,369		These figures will only take into account those individuals contacting the front door service and will exclude the range of queries directed to the People Helping People Service. The downward trend from last year may also reflect the longer term impact of the Live Well Site and the range of other online support currently being offered
2.02	Percentage of all new contacts (other than safeguarding) where the Client had any other Contact in the previous 12 months	Low is Good				36%	36%				36%		No change
2.03	Number of Contacts resulting in a New Referral	Low is good				8,050	2,333				2,333		Q1 figure suggests a continued increase in the numbers of individuals requiring support. This possibly continues to reflect new ways of working as individuals return to offices/ move out of Furlough and are unable to support family members in the same way.
2.04	Number of Assessments completed in period	n/a				2,684	586				586		Despite new referrals being up, the number of assessments being completed is much reduced. We are confident that individuals are not being put at risk as a result of the delay in being assessed. Many individuals have refused face to face assessments. Revised discharge arrangements have seen individuals discharged into step down beds without assessment, it has not been possible to undertake follow up assessment due to restrictions in Care homes, however these are monitored and undertaken when safe to do so.
2.05	% of assessments that result in any commissioned service (including long-term, short-term and telecare)	n/a				82.8%	84.1%				84.1%		This suggests that the right cases are progressing to referral and assessment. There will always be some cases that don't result in packages due to changing circumstances during assessment/ self funders
2.06	Number of Support Plan Reviews completed in quarter	High is good				4,802	1,156				1,156		Based on the figures to date this would suggest that a similar level of cases continue to be reviewed.
2.07	Percentage of Clients who have received Long Term Support for 12 months continuously that have been reviewed in the last 12 months - snapshot position at end of quarter	High is good			75%	74.8%	62.1%				62.1%		The reduction will be impacted due to COVID-19 pandemic restrictions and a balance of risk based on whether a review is a priority for a stable package of care.

PI Ref	Measure	Polarity	NW stat Av	National Av	20-21 Target	Year end 2020-2021	Quarter 1	Quarter 2	Quarter 3	Quarter 4	21-22 yr. to date	RAG	Comments
2.08	Percentage of Clients who have received Long Term Support for 24 months continuously that have been reviewed in the last 24 months - snapshot position at end of quarter	High is good				93.3%	92.7%				92.7%		This provides confidence that overall those requiring long term support have an up to date package of care that has been reviewed either within or prior to the pandemic - we need to keep a watchful eye on the 12 month picture to ensure it doesn't start to have an adverse impact.
2.09	Proportion of service users in receipt of a community based service.	High is good			80%	88.4%	91.0%				91.0%		This is a potentially positive impact of the pandemic as services have adapted to support individuals within the community. It reflects the reluctance of many who do not wish to enter long term bed based services. We have also seen an increase in carers to our Carers Hub reflecting family desires to support individuals at home.
2.09a	Number of service users in receipt of a community based service.	High is good				5,301	5,513				N/A		see above
2.10	External Care Costs	Low is good				£111,161,275	£26,857,698				£26,857,698		This is an indicative Q1 figure but suggest that costs are being contained despite increases in individuals in permanent care/ receiving community based services
Care4Ce													
3.01	Number of mental health reablement referrals received in quarter	n/a				2,462	757				757		Q1 figure suggests a rise in referrals and should this continue at the same rate we will see a 23% increase on the referrals last year
3.02	% of referrals where individual engaged	High is good				77.0%	75%				75%		There has been a small decrease in engagement this quarter. Hopefully as more individuals receive both vaccinations and people become more confident that the relaxation of guidance is not having an adverse impact then this will increase.
3.03	% of completed interventions which resulted in no ongoing package (ongoing package defined as a Long Term Support Service)	High is good				100.0%	100.0%				100.0%		see above comments
3.04	Number of dementia reablement referrals received in quarter	n/a				935	290				290		Q1 is showing an increase which possibly suggests that individuals are feeling slightly safer as increased number of 65+ have received at least one vaccination.
3.05	Number of community support reablement referrals received in quarter	n/a				947	279				279		Rising numbers of referrals are increasing the pressure on the service which is magnified due to issues around COVID-19 and additional requirements for PPE.
3.06	% community support reablement completed with no ongoing package of care (ongoing package of care defined as Long Term Support in SALT)	High is good				67%	71%				71%		This continues to demonstrate the success of re-ablement and early support in preventing the need for long term support.
Active Service Users													
4.01	Total number of individuals on the visual impairment register	n/a				2,231	2,268				2,268		It is important to understand the numbers in order to be able to develop sufficiency of services and inform equality impact assessments when changing services to ensure no individuals are adversely affected.
4.02	Learning Disability Support (18-25) - Clients with an active service (other than Telecare)	n/a				151	147				147		see overall comments above re individuals supported in the community
4.03	Learning Disability Support (26-64) - Clients with an active service (other than Telecare)	n/a				672	672				672		see overall comments above re individuals supported in the community
4.04	Learning Disability Support (65+) - Clients with an active service (other than Telecare)	n/a				116	122				122		see overall comments above re individuals supported in the community
4.05	Mental Health Support (18-64) - Clients with an active service (other than Telecare)	n/a				270	274				274		see overall comments above re individuals supported in the community
4.06	Total number of Clients with an active service other than Telecare (18-25)	n/a				222	221				221		see overall comments above re individuals supported in the community
4.07	Total number of Clients with an active service other than Telecare (26-64)	n/a				1,359	1,368				1,368		see overall comments above re individuals supported in the community
4.08	Total number of Clients with an active service other than Telecare (65-84)	n/a				1,527	1,536				1,536		see overall comments above re individuals supported in the community
4.09	Total number of Clients with an active service other than Telecare (85+)	n/a				1,223	1,240				1,240		see overall comments above re individuals supported in the community
4.10	Total number of Clients only receiving a Telecare service	n/a				1,762	1,706				1,706		Given that we are seeing increased numbers of individuals being supported in the community we are monitoring the take up of telecare products. We are however aware that some families are utilising other forms of digital products and platforms in a range of innovative ways to support family members in ways that traditionally may have required telecare products. These advancements in technology will form part of our understanding and planning process moving forward.
4.11	Total number of Clients receiving any service - including Telecare (65+)	n/a				4,408	4,387				4,387		see overall comments above re individuals supported in the community
4.12	Numbers of individuals supported through the carer hub	n/a				1,749	417				417		The total Carers supported in 2020/21 is 1,749, of which 979 are new carers supported in the year. We have a dedicated Carer Liaison manager overseeing the increases and impact.
4.13	Number of Carers receiving a Carer Service (per 10k population)					58	17				17		Numerator for this measure includes all carers from indicator 4.12 plus carers assessed (with no service) plus carers with a service recorded on LiquidLogic.
Risk Enablement													
5.01	Number of mental health act assessments completed	n/a				605	160				160		Overall the picture presented is indicating a slightly higher picture than last year. It is possible we are now beginning to see an increase in requests as the impacts of the pandemic on the mental health of individuals are becoming more apparent.
5.02	Number of S117 clients (includes Z65 MH Aftercare from Q4)	n/a				929	950				950		
5.03	New DOLS Requests (Cumulative)	n/a				2836	836				836		Q1 21/22 is showing a continued rising picture. There is ongoing preparatory work to assess the potential impact of the LPS guidance which is currently being finalised.
5.04	New DOLS Requests per 100,000 (Cumulative)	n/a	433	454		932.1	270.9				270.9		see above
5.05	Timeliness of DOLS Application processing *Average days lapsed from Date Application Received to Date Application Signed Off (for completed applications)*	Low is good				40 (Average over year)	47				N/A		This figure shows the processing timescale in average days for completed applications. This is calculated based on the Date Application Received and the Date Application Signed Off (i.e. after all assessments, etc are carried out and a decision made regarding the application).

PI Ref	Measure	Polarity	NW stat Av	National Av	20-21 Target	Year end 2020-2021	Quarter 1	Quarter 2	Quarter 3	Quarter 4	21-22 yr. to date	RAG	Comments
5.06	Number of Substantiated (including Partially Substantiated) S42 Enquiries concluding with a 'Type' of Domestic Abuse	Low is good				15	10				10		The increase in those where Domestic Abuse features reflects a national picture around rising issues during the COVID-19 pandemic. The service works closely alongside the domestic abuse service to ensure services are there to support individuals.
5.07	Number of new Safeguarding Concerns received in a period (events not individuals)	n/a				4238	1331				1331		The rising numbers potentially indicate that individuals are at increased risk due to COVID-19 pressures.
5.08	Number of new S42 Safeguarding Enquiries starting in period	n/a				1189	394				394		Changes in the process for recording Safeguarding enquiries will impact on the figures.
5.09	Number of new Other (Non-S42) Safeguarding Enquiries starting in period	n/a				167	40				40		Changes in the process for recording Safeguarding enquiries will impact on the figures.
5.10	Number of S42 Enquiries Concluded in the period	n/a				1161	371				371		Changes in the process for recording Safeguarding enquiries will impact on the figures.
5.11	Percentage of S42 Enquiries Concluded for which the client expressed their desired outcomes	High is good				62%	62.0%				62.0%		Changes in the process for recording Safeguarding enquiries will impact on the figures.
5.12	Of S42 Enquiries Completed that the client expressed their desired outcomes, the percentage that were fully achieved (not partially achieved)	High is good				68%	70.0%				70.0%		Changes in the process for recording Safeguarding enquiries will impact on the figures.
5.13	% of concluded S42 enquiries where outcome of enquiry was substantiated/ partially substantiated	High is good				53.1%	56.3%				56.3%		Changes in the process for recording Safeguarding enquiries will impact on the figures.

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Lessons Learned and Recovery Planning Adult Social Care

Jill Broomhall & Nichola Thompson
Director Adult Social Care
Director of Commissioning
Sept 2021

CONTENTS

1. INTRODUCTION AND PURPOSE

On 23rd March 2020 the government announced that the UK would be sent into `lockdown' in an unprecedented step to attempt to limit the spread of Covid-19. The pandemic has impacted on over 190 countries; and in the UK it has presented us with the biggest challenge our health and care system has ever faced.

Across Cheshire East the majority of services were already overstretched with workforce challenges and increasing demand within significant financial constraints; and yet our health and care services and how we work collectively to deliver them, has been completely transformed in an extremely short space of time. We have attempted to capture the learning from this crisis and it feels right that we reflect on our response to the Covid-19 pandemic.

Adult Social Care has taken time to reflect on the changes in practice and service delivery in social care to understand the effect of those changes on the care sector and to assess the impact on service delivery post the current crisis. Reflections are informing the development of social care recovery plans and will contribute to wider whole system recovery to support the health and wellbeing of our local populations. The recovery plan will be used to inform longer term plans for the 'new normal' ensuring that the key principles of our Corporate Plan is taken into account.

Consideration will also need to be given to direction of travel pre Covid-19, in particular the focus on personalisation, prevention, an increased focus on the use of digital and technology and our Mid Term Financial Strategy; and the potential for further market change/disruption that may arise out of a 3rd wave. To inform our thinking moving forward it is therefore important that we understand:

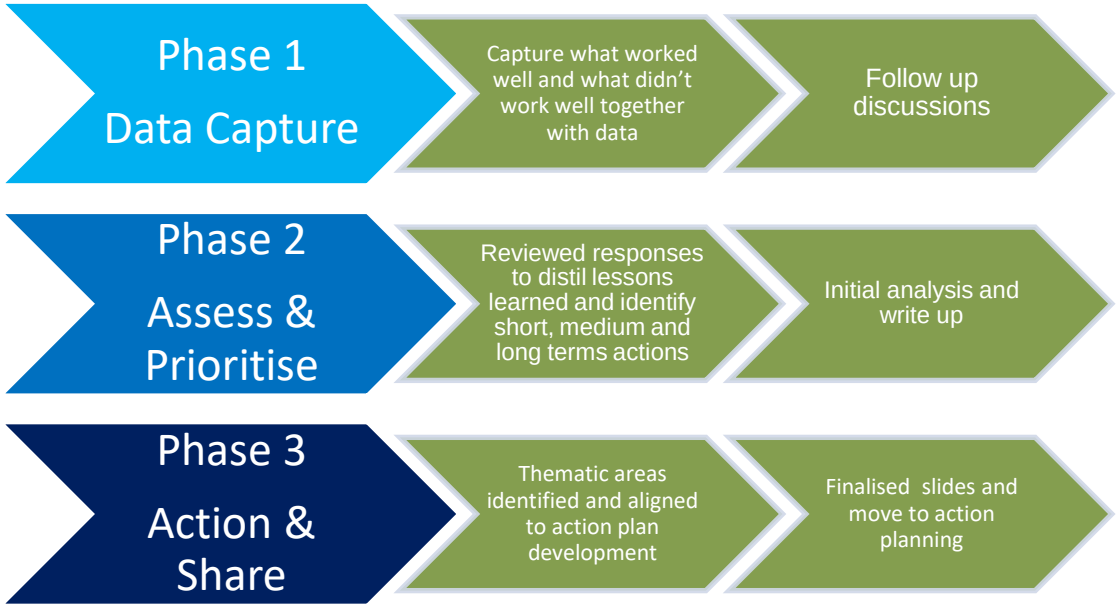
- The significant changes that have been made, the impact of these, and any unintended consequences
- We can retain the positive transformational changes that have come from this crisis
- We understand what the 'new normal' should look like and help shape the next phase of our strategic vision
- We need an evidence base to inform Recovery and Restoration planning
- The conditions that enabled our rapid response and use these to accelerate future service transformation.

2. DEVELOPING OUR APPROACH TO RECOVERY

- We have followed a phased-approach to recovery planning that will evolve as we move from phases of responding and managing the crisis through to service transformation

- The data capture included information from:
  - Operation and Commissioning Directors
  - Heads of Operational Services
  - Heads of Commissioning
  - Principal Social Worker
  - Performance and Data reports
  - Finance reports

- Further refinement of the report and action plan will be required as we move to further implementation.



3. CONSIDERATIONS

Initially few of the lessons learned and the resulting changes in practice are able to be evidenced. However, we will capture information as we continue this process on what has supported or enabled the change.

The Social Care aim is to work collectively to influence the reform and reset of social care within the wider context of population health and wellbeing .

The feedback in this report relates to the learning from the council and does not provide insight into the views of our populations in response to Covid-19. Understanding how the public's behaviours and attitudes have changed in response to this crisis will be collected over time and will be critical to 'lock-in' changes appropriately.

The impact of Covid-19 on our local communities and the changes in patterns of demand for health and social care services, will need to be understood and inform recovery planning.

Changes in legislation, decision making, governance, the financial context and leadership roles while the incident is ongoing have raised important questions about the future structure of the Health and Care system. This context provides a timely opportunity for partners to shape what a whole system approach to supporting population health and wellbeing needs to look like to best serve the population.

4. Lessons learned: ‘Top Ten’ lessons from feedback

1. Strong collaborative working and improved relationships with care providers has been positive and must be maintained and built upon moving forward.
2. There has been a strong focus on personalisation, with many imaginative service delivery methods identified. This should continue to be explored as an alternative to more traditional models of care.
3. The use of technology for both staff and individuals in receipt of services has been essential in supporting problem solving, delivering personalised care solutions and enabling effective service planning and delivery.
4. Decision making has been timely, through streamlined governance, changes to legislation and a different financial regime. Our governance processes have been agile and flexible and have enabled us to respond swiftly and safely, driven by the necessity to protect our communities and staff.
5. Many aspects of our future strategies have been accelerated and enabled; Integrated Discharge, work with Primary Care Networks and community health providers to deliver integrated health and social care in local communities and collaborative work with the community and voluntary sector and wider partners in the police, ambulance service and housing to ‘shield’ vulnerable groups within our population. This is an approach that we can build on as a foundation for a Population Health management.
6. This crisis has disproportionately impacted vulnerable groups within our population, most notably older people and people with a learning disability, which is worsening health and care inequalities, this needs attention.
7. Strong relationships with the Voluntary and Community Sector have been forged, they have become a real partners in the response to the pandemic and we need to ensure that they continue to be valued as equal partners as we move forward.
8. The pandemic has inevitably had a significant effect on the health and wellbeing of all of our staff. We must continue to support our staff through providing targeted health and wellbeing and mental health support.
9. We have seen positive changes in the behavior of our population during the crisis, for example, people working with their family and community to self care and not looking to more formal statutory support systems to keep themselves healthy and well; we should continue to work with our local populations and community services to retain this positive change.
10. There has been a real willingness to share information and learn from good practice which needs to continue, as we cant go back to silo working and silo thinking.

4. THEMES & OUR PRIORITIES

1	**System Leadership, Culture & Partnership Working** • Collaborative working and operating as a system • Quicker decision making and greater appetite for risk • Integrated services discharge planning • System level capacity management and working	• Strategic Recovery Planning • Integrated Commissioning • Hospital Discharge • Sustained and regular management meeting and leadership responsibilities • ICP development and implementation
2	**Market Shaping and Provider Sustainability** • Demand • Models of service provision • Safeguarding • Working with our local communities • VCS • Care homes • Testing and PPE	• Nursing Care • Residential Care • Hospital Discharge, Intermediate Care and Reablement • Home Care • Extra Care • Supported Living • Day Care • PAs (Direct Payments) • Preventative Low Level Support, Voluntary Sector and Universal Services
3	**Workforce** • Assessment & Review • Working virtually where possible • Flexible use of workforce	• Social Work • Carers • Provider Workforce • Volunteers • Generic Workforce and other LA Back Office Support Staff • Psychological Impact and Support
4	**Digital, AT & ICT**	• Understand changes driven through Covid response • Develop a short, medium and long term ICT / Digital Strategy
5	**Finance and Procurement**	• Identify and account for the financial impact of Covid • New cost landscape – projection/MTFS • Financial planning • PPE stocks & supply • Central Procurement Hub to support providers • Care market procurement and strategic planning
6	**Intelligence**	• Have live information on impact of virus • Flexible data flows to allow change reporting as circumstances and demand changes • Support the development of long term recover new landscape
7	**Premises and Estate**	• One public estate review • Care Provision Estate Strategy • Office requirements

5. What have we STARTED DOING that we want to CONTINUE WITH?

THEME	WHAT HAS CHANGED?	WHAT HAS ENABLED THE CHANGE? And HOW CAN WE DO THIS MOVING FORWARD?
1. System Leadership, Culture & Partnership Working	Built **great relationships** with partners during Covid which enabled us to "make things happen" at a greater speed and collectively.	All working together towards the same goal and common purpose Legislation Building on good relationships and systems working in existing local partnerships Streamlined decision making via CEMART/Operational Group
	Discharge guidance and discharge to assess model has worked well and removed barriers, want those barriers to stay removed.	Money has been available due to Covid and some of the relevant legislation has been suspended (e.g. Continuing Health Care and the Care Act). These changes have been beneficial so work on how we can keep the processes when the legislation is reinstated and use the learning to build on pre existing processes and arrangements e.g. Trusted Assessment, community follow up; and to redesign Hospital Discharge Services and pathways to ensure increased flow is maintained through winter.
	Speedy decision making - we have demonstrated that we have the ability to address and resolve issues as a system on same day	Clarity of purpose (i.e. now Covid but could be other agreed joint objectives) Collective decision making Legislation
	Enhanced neighbourhood working, linking Health and Social Care teams to Care Communities with better understanding of each organisation and their roles and responsibilities	IT infrastructure to enable remote consultation and assessment Doing the right thing has transcended organisations Previous focus on building base to host MDT teams was a block, this can now move forward at a much quicker pace through virtual teams. Barriers to information sharing removed.
	Public perception and expectation on our roles has improved, public appreciate our service.	Positive stories and national recognition of key workers Care workers in particular being valued alongside healthcare workers i.e. parity of esteem
	People **working collaboratively** to offer support for example, Council wide, mutual aid through partners, councils and agencies sharing good practice	Legally mandated command and control structures introduced to manage crisis System wide willingness to work across geographical and organisational boundaries in support of same goal and common purpose

5.What have we STARTED DOING that we want to CONTINUE WITH?

THEME	WHAT HAS CHANGED?	WHAT HAS ENABLED THE CHANGE? And HOW CAN WE DO THIS MOVING FORWARD?
2. Market Shaping and Provider Sustainability	**Improved relationships** with community and voluntary sector,	3rd sector having a place at the table and parity with other sectors. VCS taking lead on and coordinating across sector Review the role of Communities Teams and their links to wider ASC
	We should continue to build upon the **excellent working relationships** and improved communications and engagement with the care sector which has been hugely important	Recognition of the importance of each others role National recognition of the valuable role care workers play in supporting vulnerable members of our community National recognition that the health service could not function without the support of social care
	Mutual Aid (across boundaries and across agencies) has been fantastic, particularly domiciliary care cross working arrangement	Legislation supporting temporary changes that haven't had to go through protracted HR or governance processes Barriers to information sharing removed (within bounds of GDPR)
	Further **integration / joint working with Health** – around operational issues / pathways / financial / commissioning / market engagement and doing joint messages to the market joint strategies and pathways and redesign projects	Giving people permission to just get on and work together IT supporting virtual working i.e. don't need to be sat together to work together.
	We have had the opportunity to **provide support in alternative ways** i.e. alternative options to traditional day care, for example linked groups for peer support and virtual day services pilot and greater use of voluntary sector and volunteers to support vulnerable adults, including the introduction of digital offer instead building based service, using technology to keep in touch, socialise and exercise, receiving support from community volunteers.	Legislation and in the absence of other services, peoples willingness to try alternative ways to be supported Need to take the opportunity to consider different more personalised services and models of care; and take an asset based approach to assessment We could remodel some services to ensure they are better able to 'flex' support as and when Service Users need it or in the event of a 3rd wave

5. What have we STARTED DOING that we want to CONTINUE WITH?

THEME	WHAT HAS CHANGED	WHAT HAS ENABLED THE CHANGE? And HOW CAN WE DO THIS MOVING FORWARD?
2. Market Shaping and Provider Sustainability	Co-ordinating **training / education support** for providers	Necessity - needed to offer virtual training alternatives at scale and in pace with frequent changes to practice guidance Proved to be a good way to ensure that there is consistent good quality training across the market
	The importance of **infection control** now and as we move forward and our role in prioritising the rollout of Test, Trace and Vaccinations	Regular information from providers Evidence of the impact good IPC can have on managing and controlling spread of the virus. Good uptake of Vaccination within the borough. Test and Trace working well.
	Block purchase of care home beds at scale as a contingency to meet a surge in demand	Legislation and temporary government funding Consider potential annual commissioning of additional market capacity for winter use
	Recognition of the value in working with providers to develop robust **business continuity plans**	Learning from apparent lack of preparedness e.g. PPE, Testing, IPC. Take international, national and sub regional learning to inform joint work with provider to ensure that we are prepared for any further waves and have plans in place for other disruptive events

5. What have we STARTED DOING that we want to CONTINUE WITH?

THEME	WHAT HAS CHANGED?	WHAT HAS ENABLED THE CHANGE? And HOW CAN WE DO THIS MOVING FORWARD?
3. Workforce	We need to understand the positive change to people's lives from the **revised care offer** - assessment leads supported to understand the opportunity for alternative support and that the previous offer may no longer be a preferred option e.g. reduced demand for residential care and for home care. Changes to the trends in demand and service provision. Many want personalisation	Legislation and in the absence of other services, peoples willingness to try alternative ways to be supported Need to take the opportunity to consider different more personalised services and models of care; and take an asset based approach to assessment. Review SALT and ASOF data to inform trend analysis
	Make use of this opportunity of **heightened and changed public perceptions of the sector** to attract more people to work in care. We need to continue to celebrate and wave the flag for the care sector workforce and the importance of the role and give it the recognition it deserves and build upon the momentum	National, regional and local promotion of the work of key workers Public recognition of the valuable role care workers play in supporting vulnerable members of our community Public and government recognition that the health service could not function without the support of social care- parity of esteem.
	Changing the balance between utilisation of long-term and short-term / enabling services – i.e. changing the balance between the majority of people going straight into long-term services as opposed to firstly going through short-term enabling / rehab services	Individual and family choice not to go into care homes Limited choice of placement due to current restricted access to long term bed based provision Increased informal support networks from families/extended networks being furloughed and increased voluntary/community support Move away from care homes being the default offer
	7 day working arrangements in designated areas and undertake further review of requirements to expand to a full 8am to 8pm offer Staff have the trust of management to manage their working week	Flexible HR policies have been extremely useful and timely Legislation - reduced governance Increased flexibility / capacity over extended operating hours and weekend working has proved beneficial and should be reviewed to identify what should be retained as we move forward Staff more willing to work flexibly over 7 day period Mobile and agile policies to be based on Trust

5. What have we STARTED DOING that we want to CONTINUE WITH?

THEME	WHAT HAS CHANGED?	WHAT HAS ENABLED THE CHANGE? And HOW CAN WE DO THIS MOVING FORWARD?
3. Workforce	Greater use of **technology / virtual meetings** to support flexible working arrangements We should continue with the positive aspect of Agile working and working from home e.g. no time lost due to travel, no travel costs, no meeting room/conference hire costs, easier to work across larger footprints	Use of Microsoft teams / zoom to hold meetings. Virtual assessments and reviews (where appropriate) across both health and social care specialism including the use of digital platforms has been positive Changes to HR policies in support of this. Greater attendance at meetings virtually. We want to keep this as there are efficiencies in time and travel expenses.
	Corporate teams have responded in the crisis to provide a programme of **workforce learning**	Reduction in silo working, willingness to work together to meet the same goal, IT development support Good practice needs to be retained to support consistency of practice across Care Sector; welfare assistance; robustness of services during crises and greater professionalisation of the Care Sector
	Staffs have been willing to **work outside of their usual role** and do what was needed. Managers have place greater trust on staff to manage their working week.	Legislation/ mutual aid/flexible response from staffs, HR and unions. Flexible HR policies have been extremely useful and timely and we should work to see what can be retained Should consider having more generic job descriptions as this has allowed flexibility to respond in the crisis
	Previously some **practitioners over relied on managers to problem solve** for them, without actively seeking solutions themselves. This period has witnessed practitioners make decisions for themselves which have been appropriate, therefore, increased their confidence in their own practice.	Increased autonomy through remote working. Permission to 'get on and do'. This needs to continue to drive up autonomy in practice, producing a greater skilled workforce.
	Waiting lists for assessments (Social Worker and OTs) – doing today's work today model would be good moving forward. Processes have developed that do not promote lean working	The use of technology and acceptance of virtual assessment / reviews from both practitioners and service users Undertake peer Challenge/review of demand and lean processes

5. What have we STARTED DOING that we want to CONTINUE WITH?

THEME	WHAT HAS CHANGED	WHAT HAS ENABLED THE CHANGE? And HOW CAN WE DO THIS MOVING FORWARD?
4. Digital, AT & ICT	Individuals, care homes staff and professions e.g. GPs, community nurses and social workers are willing to **carry out consultations and assess on a virtual basis**.	Change in public and professionals attitude borne out of necessity. A range of technology to support remote interaction between members of the public and health & care professionals e.g. skype, Microsoft teams, zoom etc. In addition, some areas have telecare/telemedicine systems in place. We have a fantastic opportunity to evaluate the most effective remote assessment and monitoring systems to support more personalised less intrusive interaction between the public and professionals; and the opportunity to establish virtual wards. Legal requirement for some assessments to be done face to face
	Staff having **greater autonomy to make decisions** has been good and has worked well.	Legislation, lean governance. Remote working. We need to look at processes and system permissions to build in this flexibility and Authority to make changes as we move forward
	We have seen an increase in the number of people opting to **use assistive technology** as an **alternative** to **or as part of their care package**	Legislation and in the absence of other services, peoples willingness to try alternative ways to be supported, We need to build and roll out AT pilots (proof of concepts) via AT consultation; and up the pace of deployment of technology for the care sector including to support remote staff working.
	The majority of the councils' workforce is **working remotely from home.**	National directive from government. Greater use of technology / virtual meetings to support flexible working arrangements e.g. Microsoft teams, zoom etc. Why does this need to change, what are the functions that require office based work

5. What have we STARTED DOING that we want to CONTINUE WITH?

THEME	WHAT HAS CHANGED	WHAT HAS ENABLED THE CHANGE? And HOW CAN WE DO THIS MOVING FORWARD?
5. Finance and Procurement	LAs (and health) have received **temporary funding to support the care sector** and in particular care homes,	Government grants We need to understand the financial sustainability of the sector in the context of temporary funding being removed and changes in public demand for services. Public and government recognition that the health service could not function without the support of social care (parity of esteem) We need to review our HLBC and MTFS in the light of this funding
	Local authorities worked together and as individual LAs to use their buying power to secure PPE for the care sector, in particular for care homes.	All partners working together towards the same goal. Temp government funding to meet cost. We should use the learning to look at using our LA/Sub regional buying power to support external market with supplies e.g. consider potential for LAs to purchase goods to reduce cost of care, e.g. PPE, uniforms, food or to support the market to work together to increase buying power
6. Intelligence	There has been a recognition that we **need to share information across the system and originations to reduce risk**	Collaborative working arrangements, timely data sharing agreements We need to take the opportunity to fully embed shared care records e.g. care homes, work collectively to agree same data sets to provide system wide asks from a single data set; and maximise the use of **BI** to ensure wider focus on community requirements and impact e.g. third sector, statutory community services across health and social care
7. Premises and Estate	The majority of **council buildings** are now empty or are open for essential key workers only	National directive from government to work from home. Greater use of technology / virtual meetings to support flexible working arrangements e.g. Microsoft teams, zoom etc. Effective IT infrastructure and support We need to risk assess and plan for a safe return to work and understand the impact on LA, other Public Sector and provider owned estate.

5. What have we STOPPED DOING that we DON'T WANT TO RESTART?

THEME	WHAT HAS CHANGED?	WHAT HAS ENABLED THE CHANGE?
1. System Leadership, Culture & Partnership Working	**Can't go back to teams not sharing resources** / intelligence across boundaries.	Proved the extent to which information can be shared across geographies and organisations (in line with GDPR) Realising the benefits of systems wide views (intelligence) to support decision making and focus actions
	National bureaucracy is not always helpful - central directives regarding operational issues are better managed at a local level	Local Resilience Cells/forums have worked well. Arrangements have built on existing relationships and strategic forums and will therefore have potential to be sustained post Covid
	Strategic Planning - work on strategic/transformation plans has been on hold. Need to re set thinking/realign the vision.	Strategic Plans will need to be reviewed in light of Covid and to inform recovery planning. All plans/strategies will need to be reviewed to understand the impact and any potential change/redirection e.g. MTFS
2. Market Shaping and Provider Sustainability	A **lot of buildings based services** e.g. day services, respite have **been closed** in line with government directives around social distancing and IPC	Individuals, families and carers have worked with Social workers and commissioners to take up offers of alternative support . We need to continue to look at more **personalised alternatives** to traditional day care i.e. social care v personal care
	There has been a **reduction in the number of people accessing long term care**, in particular, we have seen a reduction in the number of people going into care homes	We have an opportunity to work with individuals, families, carers and system wide assessment leads to re imbed independence at home as the preferred model of care Redress balance between service users being committed to long term care against the use of reablement services and other bed based provision such as Extra Care Housing
3.Workforce	**There has been a change in commissioning of care, use of voluntary sector and PHP**	We need to ensure that when we **review any packages of care** we look for personalised care solutions and don't just automatically re-start what was in place before

5. What have we STARTED DOING that we will need to STOP DOING?

THEME	WHAT HAS CHANGED?	WHAT HAS ENABLED THE CHANGE?
1. System Leadership, Culture & Partnership Working	The **daily calls with partner agencies** and NHS will reduce as BAU starts to slowly be implemented. Internal regular calls across services has proved very successful	Regular contact with partners has been positive but contact needs to reduce to provide the capacity needed to move forward. Internal regular calls will continue on a reduced basis
2. Market Shaping & Provider Sustainability	Block purchase of care beds as a contingency measure in the event of a surge in demand	Requirement to have 'capacity' in all parts of the H&SC system Temporary government funding Capacity in the market is in excess of that predicted and public demand has reduced, discussions are required to determine the risk and sustainability of current arrangements
	We are have **provided support and supplies to services** that would ordinarily form part of their contract to deliver e.g. PPE, training, business continuity planning	We need to work with providers to agree what support is required and what both parties would like to see retained as we move forward- acknowledging the impact on the contractual relationship between commissioners and providers
	Commissioners have been holding **daily mutual aid calls with providers** which have been positive but these are reduced and now by exception	Positive working relationships with providers have been supported through daily mutual aid calls i.e. calls to discuss contingency plans, PPE usage and where daily concerns are addressed in partnership with providers and the LA. However, these are now reduced or ceased to create capacity for providers and commissioners to move forward.

5. What have we STARTED DOING that we will need to STOP DOING?

THEME	WHAT HAS CHANGED	WHAT HAS ENABLED THE CHANGE?
3. Workforce	To support the discharge to assess model we have implemented 7 day working, this has been on a voluntary basis. Further work is needed to understand the effectiveness and safety of the approach which will need to be evaluated.	Temporary HR policy changes / working arrangements have been established. If 7 day working is to continue formal HR policies / working arrangements will need to consulted upon prior to implementation.
	It was felt that when working from home was first introduced, the working day became longer as the distinction between travelling to/from work was removed. This has resulted in some **colleagues working very long days** with little time away from their screens. Whilst this practice is not supported corporately, practitioners need to recognise this is not an expectation and this needs to stop for their own wellbeing.	The changes to day to day working practice has blurred the lines for work life balance. HR have circulated policy to address provide clarity and concerns. If WFH continues at the current level this will need monitoring to support staff wellbeing.
	There is a project to review demand into ASC, together with review of processes, Going forward we will be looking at remodelling some of the process and staff deployment. Re-assessments will be taking place utilising strength based approach, and other options such as community solutions, telecare and personal budgets will be reconsidered.	The ability to identify and develop innovative solutions to provide care and support to our most vulnerable residents in response to Covid-19.
5. Finance & Procurement	**Additional temporary beds have been commissioned** to support and manage the impact of Covid-19 on the health and care system.	Flexibility of financial resources and the ability to commission additional beds at pace. We need to understand the new cost of care beds post Covid-19. (pathways 2,3)

5. What have we STOPPED DOING that we will need to RESTART?

THEME	WHAT HAS CHANGED	WHAT HAS/WILL ENABLED THE CHANGE?
2. Market Shaping & Provider Sustainability	The ongoing **quality assurance and monitoring of providers** ceased whilst responding to immediate needs in support of the Covid-19 response. We need to consider how will move forward with quality assurance and develop new ways of monitoring providers.	Recognition that access to services was limited to prevent infection (IPC). Consider alternative ways to gather QA information from providers e.g. self assessment and system wide intelligence to inform targeted interventions, with spot checks as an assurance mechanism.
	Business Continuity Planning, we need to look at how BCP's encompass both dealing with the emerging issues, whilst at the same time assessing/mapping what work needs to continue.	In action, response and delivery phase need to ensure lessons are built into plans for potential 3rd wave. Staff responded well to BCP together with 4 phase approach to managing pandemic.
	Carers support has been adversely impacted whilst informal care from carers has increased. - beginning to see increase in demand - need to understand pressure to carers and respond accordingly. Greater reliance on Carers Hub with fewer formal assessment and service offers. Reduction in direct payments.	Carers support has been impacted by both formal and informal carers becoming unwell, limiting capacity within a system that was already overstretched. Consideration should be given to the future commissioning of services to both formal and informal carers. Review DP strategy.
	Commissioning activity to support the development of **Future model of care (Emerging themes from the Newton Report and ADASS member engagement)** has been delayed.	Commissioners time was refocussed to responding to the crisis e.g. PPE, IPC, staffing, funding etc. and commissioning additional bed based provision. Previous developments and proposals for future models of care should be reviewed to ensure they will support the changed needs and expectations as we move forward.
	Scale and pace of **savings through the ASC demand management programme** has been impacted and includes: Payment on actuals / ECM for ASC, reassessment programme, AT in supported living project, Direct payments review, charging policy review, AT / Digital Strategy, Reablement, Single handed care. Review of demand into FPOC and processes has not taken place	Many services had significant savings to make and the financial impact of Covid-19 has exasperated this. All savings proposals should be reviewed in light of learning from crisis and in anticipation of a potential 3rd wave, prior to consultation / implementation. Demand management work to be reinstated

5. What have we STOPPED DOING that we will need to RESTART?

THEME	WHAT HAS CHANGED	WHAT HAS/WILL ENABLE THE CHANGE?
	Reduced demand at the **Front Door and for Early Intervention and Prevention** work during the initial months of the pandemic This has now increased beyond pre pandemic numbers.	In response to Covid-19 the demand initially on the front door reduced partly due to individuals supporting people at home for longer but also due to the significant role the voluntary and community sector have played within communities. This is now changing and there is an increase in referrals and demand. Consideration should be given to the role of the VCS and how they can enable people to remain within community services therefore reducing demand on statutory services.
	Reduction in the availability of **informal care evidenced by the large increase in referrals to Carers Hub, together with the employment of Carers Liaison Officer**	Analysis is needed to understand the how much informal care is provided and also level of support on offer to ensure that informal care provides to ensure this can be factored in to future business continuity planning.
	There has been a **loss in public confidence** in care homes and home care services which may impact on the demand for such services moving forward. **Review impact on publics loss of confidence in care homes and home** care.	Media briefings highlight the issues faced by care homes and home care services when dealing with Covid-19 in accommodation based services and entering into homes where residents / staff may be infected. Rebuild confidence in Care homes.
	Some provision of respite, day services, shared lives and alternative day services reduced	Government direction to stay at home, social distancing and IPC. Need to understand and assess the risk to vulnerable people and their carers and re introduce service provision based on risk via Day Care consultation.
3. Workforce	**Supervision** formal and informal has been impacted by limited staff / management capacity.	Supervision has been conducted remotely. Need to understand impact on staffs and managers and introduce/update supervision policies. Results of Pulse survey will feed this work
	It is felt that as soon as it is safe to do so, **some face to face individual** and team contact needs to commence. Not on an everyday occurrence, but for the purpose of moving forward into a new way of working.	Face to Face **assessments** (where appropriate) and full DST and CHC **assessments** recommenced alongside team contact. This will ensure residents and staff are supported appropriately. Recovery plans will include greater use of telehealth and assistive technologies. Reviewing attendance in the office on rota basis of 40/60% at home/in office

5.What have we STOPPED DOING that we will need to RESTART?

THEME	WHAT HAS CHANGED	WHAT HAS ENABLED THE CHANGE?
	Student social worker placements, AYSE, Student AMHP placements, recruitment and induction has all been limited during the pandemic	Capacity to support placements / recruitment and induction has been limited. Work needs to be taken forward to ensure placements are supported and appropriate recruitment and induction can take place. This will be particularly important if there is a 3rd wave.
	We continue to manage **DoLS** and advise as we have done pre pandemic. There has been an increase in DoLS applications from the managing authorities and this is being followed up by the DoLS/MCA lead. Also the transfer to LPS.	DoLS application and analysis is needed to understand if there are other factors that have contributed to the increase in applications to ensure residents are safe and processes and policies can be developed in the event of a 3rd wave.
	Staff have not been taking holidays during the past year as capacity has been limited	Agreement have been reached to enable people to carry over leave. Plans need to be developed to support staff to take leave in a timely manner ensuring appropriate service capacity whilst supporting staff to have a rest.
4. Digital, AT & ICT	B4B implementation was delayed System changes – such as Payment by Actuals (for all services) Restart work to merge Adult and Children's LiquidLogic systems	System implementations now proceeding and looking for other opportunities where systems can support practice

5. What have we STOPPED DOING that we will need to RESTART?

THEME	WHAT HAS CHANGED	WHAT HAS/WILL ENABLE THE CHANGE?
5. Finance & Procurement	A range of prevention contracts were temporarily ceased – these will be gradually commenced i.e. shared lives day care, Voluntary sector services changed to support pandemic effort.	Requirement to undertake essential duties relating to Covid. Refocus of priorities and a need to deliver statutory services has limited the delivery of preventative services. Work should be undertaken to understand the impact this has had plans developed to ensure service delivery can commence in a timely fashion.
	Full Financial Assessments were not undertaken/joint funding panels ceased temporarily. Some Families unable to make 3rd party top ups	Emergency guidance did not require financial assessments to be undertaken on discharge or where packages were jointly/wholly funded by health. Work should be prioritised so that capacity is available to undertake financial assessments moving forward. Joint funding panels should be re-established Review of 3rd party top ups required ASAP.
7. Premises & Estate	Majority of staff no longer working out of an office base.	Identify which staffs need to return in part/ or in full to an office base. Based on function not form Ensure office and environments are considered for return to work for some. Consideration to be given to social distancing and the need to be 'on-site'. Identify the functions requiring Office base

7. Principles, Recovery Priorities

Principles

As we look to the next phase of our response, the re-establishment of full service, it is recognised that recovery will take place at different levels across local systems and the core purpose of this work is to ensure that, as we work towards a new normal, we are committed to working collectively towards the following principles:

- **Work with our communities to enable them to continue to support their own wellbeing; and where additional support is needed, offer personalised care that improves outcomes for individuals, families and carers.**
- **Minimise the inequalities exacerbated by the Covid-19 situation, particularly the impact on our older population and on people with a learning disability.**
- **Support the move towards a place based approach to population health and wellbeing and understand social cares role within this to deliver services which better meet the needs of individuals and local communities.**
- **Where appropriate, reduce variation in the delivery and quality of our services; and work with our provider partners to aspire to excellence.**
- **Make best use of our resources and understand financial sustainability within the new normal**

7. Recovery Priorities in PHASE 1: OVERLAP WITH RESPONSE

Maintaining the care market to deliver safe, effective care:

- **Work with PH and partners to ensure sufficiency of IPC support in care homes; and other community settings**
- Access to testing in all settings, particularly care homes and supported living
- Ensure adequate sources and supply of PPE/key supplies, to meet current demand and in the event of future outbreaks
- Work with health and other partners to enhance clinical in reach, medicines management and end of life support into care homes; and other community settings supporting people with high acuity
- **Continue temporary financial support and undertake modelling to understand the impact when funding ceases**
- **Reduce risk posed by Care Home sustainability: *over provision, lack of demand and resident isolation***

Safe re introduction of suspended services:

- **Work with community sector to re introduce suspended preventative support services**
- **Re opening of some building based day services and respite, supported by updated protocols and pathways for access to day services and respite**
- **Re opening of some building based intermediate care, supported by updated discharge protocols and pathways for access**

7. Recovery Priorities in PHASE 1: OVERLAP WITH RESPONSE

Workforce:

- **Ensure support is in place for carers as they return to work when furlough comes to an end**
- **Provide support to our shielded staffs to help them return to work**
- ***Ensure we have sufficient capacity in SW teams to complete strength based assessments/reviews as temporary Covid guidance is lifted***
- **Ensure mental health support is available for our workforce, in particular front line care workers and carers**

Supporting vulnerable people in our communities:

- Working with partners to meet the health, care and wellbeing needs of homeless people
- Working with partners to support people at home and in the community as shielding is lifted; and for those who are still shielded

Business Continuity and Winter Planning:

- Working with provider market to ensure plans are in place to meet winter pressures and that contingency plans are updated in anticipation of a further wave
- Work with health to imbed discharge to assess as the default discharge process
- **Development home closure protocol**

7. Recovery Priorities: Planning for the New/Normal

Understanding the impact and imbedding lessons learned:

- **Working with PH and other colleagues to understand and address the impact of Covid, particularly the impact on older people, people with a learning disability and BAME;**
- **Working together to understand current and future impact on demand for care; and the subsequent impact on the care market**
- **Developing a leadership/governance framework to replace the statutory Resilience Forums, that continues to support timely, effective system wide and sub regional decision making *(DASSs)***
- **Changing systems and processes to build the learning into practice going forward**

Building capacity to support people with high acuity in the community:

- Work with PCNs, community health and voluntary sector to develop *population health* approach to providing information, support, care services that are tailored to provide support to local communities
- **Work together to develop a model for Independence at Home that compliments a wider shift to a population health approach and imbeds recent good practice including D2A, use of technology, increased support from community and voluntary sector, mutual aid etc.**
- **Plan for expected increase in demand for care at home, including potential increased demand for assistive technology, adaptations and community equipment.**

7. Recovery Priorities: Planning for the New/Normal

Growing alternatives to traditional models of care:

- **Growth of Extra Care Housing**
- **Expanding the use of personalised budgets/Direct Payments**
- **Use learning from LeDeR reviews and MRF impact assessments to progress a new model of care for people with a learning disability: Shared Lives, a move away from shared to individual supported living, equal access to affordable housing and extra care housing, meaningful activity and employment**

Supporting our Residential and Nursing Care Sector to aspire to excellence:

- **Professional support for Care Home Managers**
- **publication of a quality assurance framework**
- **Continue and expand Audit of quality, local value and risk to care home stock, to support Market Diversification**
- **Capital programme required to consolidate position of future stock that is fit for purpose**
- **Programme of digital support in Care Homes- initially focussed on Electronic Care Records**

Supporting individuals, families and local communities to stay healthy and well:

- **Engage with customers over the support and services they would like to have moving forward**
- Work with voluntary and community sector to scale preventative support/social prescribing
- **Use learning from increased application of technology to support assessment for personalised, less intrusive care**

7. Recovery Priorities: Planning for the New/Normal

Workforce:

- **Work with providers to understand vacancy rates and skills gaps**
- ***Work with providers to address financial sustainability***
- **Work with providers and wider partners to develop our workforce through the introduction of blended roles and trusted assessment and growth in the number of Personal Assistants**
- **Increase the number of staff working in home care settings– 'Grow your own' approach, apprenticeships**
- **Work in primary and secondary schools highlighting career pathways in social care**

Guiding Principles

Our focus will be on improving life opportunities for individuals, their family and the community and place in which they live.
Our work will be guided by the following principles:

- *We will make use of our collective strengths to reduce inequality and improve health and wellbeing by working closer with public health and partners*
- *We will share good practice, learn from each other , reduce unnecessary variation and make best use of our resources*
- *We will look to provide the support and mutual aid our partners may need in times of crisis*
- *We will jointly support our shared provider market and workforce*

Next Steps

- Integrate Workplace recovery plans into this report
- Develop Formal Action Plan
- Share across partners and LA
- Engage with Stakeholders
- Co produce future Social Care priorities
- Identify opportunities to integrate with partners.
- Identify review of the plans

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Cheshire East Council

Working for a brighter future together

Adult and Health Committee

Date of Meeting:	27th September 2021
Report Title:	Recommissioning of the Statutory Advocacy Service
Report of:	Nichola Thompson, Director of Commissioning
Report Reference No:	AH/08/21-22
Ward(s) Affected:	All wards

1. Executive Summary

1.1. Local Authorities have a statutory requirement to provide advocacy services, to enable an individual (usually a person who is vulnerable, isolated, or disempowered) to be supported to understand and participate in decision making which affects them.

1.2. These advocacy services currently include:

- Independent Mental Capacity Advocacy (IMCA) including Deprivation of Liberty Safeguards (DoLS);
- Paid Relevant Persons Representative (RPR) role under DoLS;
- Independent Mental Health Advocacy (IMHA); and
- Care Act Advocacy and Continuing Health Care Advocacy (CHC).

1.3. This paper recommends that the current Statutory Advocacy Contract and Partnership Agreement with Cheshire West and Chester Council is extended and that a new service is recommissioned jointly with Cheshire West and Chester Council that will align with the new Liberty Protection Safeguard legislation when it is introduced. This will have a wider scope than current Deprivation of Liberty Safeguards (DoLS) and will apply to the following settings: care homes, NHS Hospitals, Education Facilities, Independent Hospitals, and a person's own home, noting that the revised legislation will also include younger people aged 16 to 17 years of age.

1.4. The current advocacy service has been in place since 1st June 2016 as a jointly commissioned service between Cheshire West and Chester Council (as lead commissioner) and Cheshire East Council. The current

contract is due to cease on the 31st May 2022, however a further three month extension has been agreed by Cheshire West and Chester Council, and permission is being sought to extend until 31st August 2022.

1.5. The Statutory Advocacy Service contributes to the following priorities in the Council's Corporate Plan:

- An open and enabling organisation
- A council which empowers and cares about people.

2. Recommendations

That the Adults and Health Committee:

2.1. Delegate authority to the Director of Commissioning in consultation with the Director of Governance and Compliance to:

2.1.1. Extend and, if necessary, update the current Statutory Advocacy Contract (by way of modification) and overarching Partnership Agreement with Cheshire West and Chester Council by a maximum of 15 months.

2.1.2. Recommission the Statutory Advocacy Service jointly with Cheshire West and Chester Council and, if beneficial to all partners, other Cheshire Clinical Commissioning Groups to align with the new Liberty Protection Safeguard legislation when it is introduced; and

2.1.3. Take all actions necessary to implement the above including but not limited to agreeing, procuring, awarding and executing any necessary Partnership Agreements, Memorandum of Understanding, procurement documents and Contracts together with any ancillary documents

3. Reasons for Recommendations

3.1. Recommissioning the service will ensure that Cheshire East Council continues to meet its statutory requirements to provide appropriate advocacy locally. Moreover, the new service will take account of new Liberty Protection Safeguards legislation. The Department of Health and Social Care indicative Liberty Protection Timeline is attached as Appendix A.

3.2. This commission will align to the priorities outlined in the Council's Corporate Plan 2021-2025 of delivering; 'an open and enabling organisation' and a 'council which empowers and cares about people'.

3.3. Commissioning the service jointly with Cheshire West and Chester will ensure advocacy provision is equitable across a Cheshire-wide footprint and will offer a simpler model for stakeholders, as well as economies of scale.

3.4. The new specification for the service will be informed by extensive engagement work to ensure that it takes account of the needs of users and other relevant organisations such as Cheshire Clinical Commissioning Group and the Acute Trusts.

3.5. An extension period to the current advocacy contract is required due to the delay to the publication of the national Liberty Protection Safeguards Code of Practice.

3.6. Due to national legislative delays for the implementation of Liberty Protection Safeguards, for which the local authority has no control.

4. Other Options Considered

4.1. There are no alternatives to having the service in place because local authorities have a statutory requirement to provide an independent advocacy service.

4.2. Consideration was given to Cheshire East Council commissioning the service separately, but it would mean existing benefits would be lost such as reduced costs and simpler referral pathways for partners.

5. Background

5.1. The role of an advocate in health and social care is to support a vulnerable or disadvantaged person to have their rights upheld in a health or social care context. There are a number of different types of advocacy including:

- Independent Mental Capacity Advocacy (IMCA) including Deprivation of Liberty Safeguards (DoLS) [to be replaced];
- Paid Relevant Persons Representative (RPR) role under DoLS;
- Independent Mental Health Advocacy (IMHA);
- Care Act Advocacy
- Continuing Healthcare (CHC)

5.2. The contract for the current advocacy service has been in place since June 2016 with Age UK Cheshire. This is a jointly commissioned service between Cheshire West and Chester Council as lead commissioner) and Cheshire East Council. This is due to expire on 31st May 2022. However, Cheshire West and Chester Council have requested a further extension period to this contract due to the delays in the publication of the Liberty Protection Safeguards Code of Practice and the need for the recommissioning to be informed by this.

5.3. Cheshire West and Chester Council are following their governance decision making processes to sign off the joint re-procurement of the Statutory Advocacy services by January 2022.

5.4. The current service delivery model is based on an agreed number of core delivery hours and an hourly rate and has been renegotiated during the course of the contract term owing to a need for additional hours. Service activity is summarised in Appendix B.

5.5. Due to the statutory nature of the service, steps will be undertaken to prepare for procuring a new statutory advocacy service. An agreement in principle has been reached with Cheshire West and Cheshire Council that Cheshire East Council would act as lead commissioner for this recommission. This agreement in principle with be formalised by way of a legally binding document between the parties.

5.6. A comprehensive review is being undertaken to explore major aspects of service delivery. These include: the effectiveness of the current service model, options for the new service including payment method, approach in other areas and achievement of value for money. However, most importantly, it is also considering how the new statutory Liberty Protection Safeguards legislation and code of practice should be taken account of in the new commission.

5.7. Liberty Protection Safeguards will replace the Deprivation of Liberty Safeguards for cases involving care homes, hospitals and will provide legal authorisation where the person lacks capacity to consent to their confinement. The code of practice was expected to be published for public consultation during Spring 2021 (this follows a delay due to the pandemic), however as at 14th September 2021 this has not happened. A summary of the eight key changes resulting from Liberty Protection Safeguards is attached as Appendix C.

5.8. It is expected that implementation of Liberty Protection Safeguards will result in an overall increase in demand for statutory advocacy support across all elements of advocacy activity. This will be due to the impact of a number factors, including for example, extending the age range to include those individuals aged 16 to 17 years, expansion of locations and settings to which Liberty Protection Safeguards will apply and the inclusion of two new Responsible Bodies (specifically the Clinical Commissioning Group and the Hospital Trust), in addition to the Local Authority.

5.9. It will also mean that advocacy needs will be identified sooner. As such they will start from the beginning of the process where it is first identified that someone may be deprived of their liberty and will continue until the authorisation comes to an end. Additionally, the individual will be entitled to an ‘Appropriate Person’ to support them through the process to help them understand why and what is happening, and to help them be involved as much as possible.

5.10. There may be a significant number of individuals who are unfriended (have no relatives), are estranged (relationship has broken down) and/or

there maybe safeguarding concerns regarding family members, in all these cases the Appropriate Person would be an advocate. As per Deprivation of Liberty Safeguards, if the person is objecting to their care and accommodation, they may require an advocate to help support them appeal using the court process.

5.11. Adult Social Care have undertaken analysis to provide a best estimate of referral rates for Liberty Protection Safeguards. This found that 446 advocacy referrals would have been required if the new model had been used over the September 2020-August 2021 period, in comparison to 396 under the existing arrangements. This is a projected 13% increase in activity.

5.12. Additionally, we know that there is a high percentage of people receiving care in Cheshire East who are funding the care themselves (approximately 60%) and as such are not known to the local authority. It is not yet clear as to how many of these may require an authorisation under Liberty Protection Safeguards and who may also require an advocate.

5.13. Liberty Protection Safeguards and Deprivation of Liberty Safeguards will run parallel (for the local authority) for the first 12 months of implementation.

5.14. To support this work, a core project board has been set up involving key stakeholders from Adult and Children social care, health, SEND, finance, legal and procurement (links will also be made with Strategic Housing and Shared Lives). Additionally, two sub-groups have been formed with a focus on mental health/learning disability and Care Act advocacy to ensure that key stakeholders are able to share their views, experiences to inform the recommission

5.15. This is complemented by the Liberty Protection Safeguards Implementation Steering Group, chaired by the Head of Adult Safeguarding. This group focuses on operational practice and meets on a monthly basis, with representation from Adult Safeguarding, Adult and Children's Social Care, NHS Cheshire Clinical Commissioning Group, East Cheshire NHS Trust, Mid-Cheshire Hospital Trust, Cheshire and Wirral Partnership Trust, and Adult Commissioning and Contracting Officers. This will be a key critical friend in the development of the new service.

5.16. Procurement of the service would take place using an open competitive tender exercise. This would also include questions which will be assessed relating to social value.

6. Consultation and Engagement

6.1. Engagement and co-production will be vital in the recommissioning process. Consequently, a draft engagement plan has been developed

informed by the statutory advocacy project board and working groups. This details: stakeholders, method of engagement and the timeline for this work. For example, market engagement will be undertaken with service providers, and consultation/engagement with service users (as lived experts) and residents. This will help to inform and shape the design of the new service. A copy of the statutory advocacy engagement overview is attached as Appendix D.

7. Implications

7.1. Legal

7.1.1. Under Section 67 of the Care Act 2014, the local authority has a statutory duty to provide independent (statutory) advocacy for individuals who have substantial difficulty in participating in their assessment and/or in the preparation of their care and support plan or where there is an absence of "appropriate individual" to support them. This applies to individuals who are 16 years old, where applicable for Independent Mental Health Advocacy (IMHA), Independent Mental Capacity Advocacy (IMCA), Care Act Advocacy, whilst Deprivation of Liberty (DoLS) advocacy is for adults aged 18 years and over.

7.1.2. The Liberty Protection Safeguards will replace Deprivation of Liberty under the Mental Capacity (Amendment) Act 2019 with the expectation that full implementation will take place in April 2022. The government has announced that some provisions covering new roles and training will come into force ahead of this date, and that a twelve week consultation on the draft regulations and Code of Practice for Liberty Protection Safeguards will be undertaken. However, it should be noted that the Code of Practice was due in the Spring of 2021, as of 14th September 2021 this has not been published.

7.1.3. The use of existing Deprivation of Liberty Safeguards (Deprivation of Liberty Safeguards)/Court of Protection processes will commence from the implementation date of Liberty Protections Safeguards. Any deprivation of liberty arrangements already in place from this date will continue to apply until they are reviewed. A deprivation of liberty under Deprivation of Liberty Safeguards arrangements must be reviewed within twelve months, all existing Deprivation of Liberty Safeguards authorisations should cease or transition to Liberty Protection Safeguards within the first 12 month period. Therefore, to note that during the first year of implementation, these will run parallel.

7.1.4. The recommissioning of this service will need to be compliant with the Public Contracts Regulations 2015 and the Council's

Contract Procedure Rules. Ongoing support from Procurement and Legal will be required throughout the recommissioning process.

7.2. Finance

7.2.1. The Cheshire East Council base budget for the statutory advocacy service in Adults has been increased via a growth bid approved by the Medium Term Financial Strategy (MTFS) for the financial year 2021 – 2022 onwards, to address ongoing financial cost pressures as a result on increasing demand for the service. The annual budget from 2021/22 will be £300k p.a. and sits within the Peoples Commissioning Team Plan.

7.2.2. The extension period for this statutory service will be funded by this budget.

7.2.3. As part of the recommissioning process, cost modelling in terms of service delivery model, affordability, efficiency, and value for money will be an essential core component and will need to ensure that the future cost of the service for Cheshire East Council is within the Mid Term Financial Strategy budgeted value. There will be a robust audit trail to support the recommended delivery model with agreement with financial representatives. The recommissioned service will ensure that the current Deprivation of Liberty Safeguards, future Liberty Protection Safeguards, and dual running period advocacy needs will be able to be met by the new contract.

7.2.4. Ongoing conversations are taking place with NHS Cheshire Clinical Commissioning Group seeking support for those patients who require advocacy provision from a health perspective, such as for example, Continuing Health Care, or mental health provision. There is further opportunity to explore how the statutory advocacy provision can support health to allow them to meet their new statutory responsibilities with the implementation of the Liberty Protection Safeguards.

7.2.5. Work will be ongoing to quantify the financial implication of Liberty Protection Safeguards for the council including the impacts for advocacy. It is currently anticipated that additional costs linked to the implementation of the new Liberty Protection Safeguards legislation will be met from additional funding provided by central government, as this is a new burden for Local Authorities.

7.3. Policy

7.3.1. The provision of a statutory advocacy service in Cheshire East will ensure that Cheshire East Council is meeting its statutory

obligation. Therefore, local residents will have a voice and be supported independently to enable them to access appropriate statutory advocacy provision to meet their needs.

7.4. Equality

7.4.1. An initial Equality Impact Assessment has been completed.

7.5. Human Resources

7.5.1. It is not anticipated that additional staff resources will be needed for the re-commissioning of advocacy services.

7.6. Risk Management

7.6.1. A risk log be maintained by the project board throughout the recommissioning of the service. Escalation will take place to Commissioning, Adult Social Care and Children's Management Teams where appropriate.

7.6.2. There have been national delays to the implementation of the Liberty Protection Safeguards. This has resulted in the implementation date moving from October 2020 to April 2022, although noting that the Liberty Protection Safeguards Code of Practice has not yet been published, and therefore may result in further delay. Any further slippage would be managed, for instance, by appropriate communication to stakeholders.

7.7. Rural Communities

7.7.1. All areas across Cheshire East will benefit from the statutory advocacy service delivered in the Borough.

7.8. Children and Young People/Cared for Children

7.8.1. It is noted that young people aged 16 to 17 years of age will feature within the revised Liberty Protection Safeguard legislation. Once the statutory code of practice is published further consideration and work will be undertaken to meet these requirements.

7.9. Public Health

7.9.1. Advocacy can support the mental health and wellbeing of an individual by ensuring that decisions are made in their best interest.

7.10. Climate Change

7.10.1. The Council has committed to becoming carbon neutral by 2025 and to encourage all businesses, residents, and organisations in Cheshire East to reduce their carbon footprint. Reflective learning from how services have been delivered during the

current pandemic and features which have reduced the carbon footprint will be incorporated into the recommissioned service.

7.10.2. The procurement process is aligned to social value. This will include considering environmental impact.

Access to Information	
Contact Officer:	Nichola Thompson, Director of Commissioning Nichola.Thompson@cheshireeast.gov.uk
Appendices:	Appendix A – Liberty Protection Safeguards indicative timeline (Department of Health and Social Care) Appendix B – Summary of hours and referral type Appendix C – Liberty Protection Safeguards eight key changes Appendix D – Engagement Plan
Background Papers:	Cheshire East Corporate Plan 2021-2025 www.cheshireeast.gov.uk/pdf/council-and-democracy/corporate-plans/cec-corporate-plan-2021-to-2025.pdf

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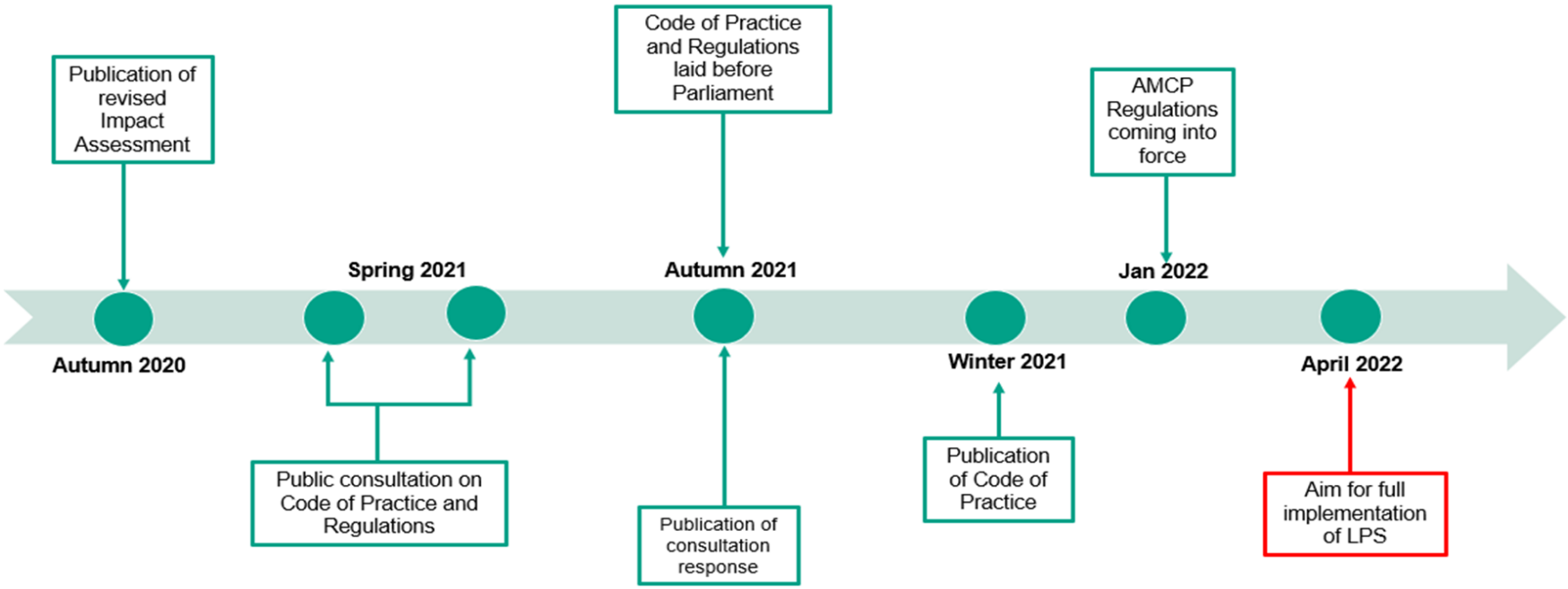
Planned milestones for Liberty Protection Safeguards



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Appendix B

Statutory Advocacy Service – summary of activity

Performance data capturing number of referrals, advocacy type, and total number of hours advocacy provision for the financial years from 2016 to 2021 is detailed below:

Number of Referrals

2016/17	2017/18	2018/19	2019/20	2020/21
1,015	950	942	906	855

Referrals by advocacy type

Advocacy type	2016/17	2017/18	2018/19	2019/20	2020/21
Independent Mental Capacity Advocacy (IMCA)	263	311	272	271	288
Relevant Person's Representative (RPR)	330	275	267	281	260
Independent Mental Health Advocacy (IMHA)	249	214	260	224	191
Care Act	170	147	139	128	116
Non-Stat	3	3	4	2	0
Continuing Health Care (CHC)	0	0	0	0	0
Total	**1015**	**950**	**942**	**906**	**855**

Total number of hours delivered

Advocacy type	2016/17	2017/18	2018/19	2019/20	2020/21
Independent Mental Capacity Advocacy (IMCA)	3,358	3,048	2,781	2,782	2,906
Relevant Person's Representative (RPR)	4,589	4,937	4,647	3,957	4,025
Independent Mental Health Advocacy (IMHA)	1,203	882	1,085	914	973
Care Act	2,160	1,687	1,760	1,870	1,694
Non-Stat / Continuing Health Care (CHC)	4	8	58	1	0
Total	**11,314**	**10,562**	**10,331**	**9,524**	**9,598**

Out of area provision – total number of hours

2019/2020	2020/21
553	**711**

Deprivation of Liberty Protection Safeguards and Liberty Protection Safeguards key changes

Deprivation of Liberty Safeguards	Liberty Protection Safeguards
Local Authority authorises all arrangements	NHS Acute Trusts and CCG's authorise arrangements. Local authorities and NHS bodies will be 'Responsible Bodies' under the LPS. Responsible bodies will organise the assessments needed under the scheme and ensure that there is sufficient evidence to justify a case for deprivation of liberty. Ultimately, the responsible body is responsible for authorising any deprivation of liberty in certain settings
6 assessments	3 assessments: • A capacity assessment • Medical assessment to determine whether the person has a mental disorder and; • A 'necessary and proportionate' assessment to determine if the arrangements are necessary to prevent harm to the person and proportionate to the likelihood and seriousness of harm The assessment process wll be embedded into existing care planning e.g. Care Act
Current maximum length of authorisation is 12 months	Extension period renewal from 12 months to 3 years (for individuals with long term stable conditions)
Role of Responsible Persons Representative (paid or unpaid advocate)	Ensure person is supported by an 'Appropriate Person' and if no one is available Independent Mental Capacity Professional (IMCA) to be appointed
Families / carers may be consulted	Explicit duty to consult with carers and families
Disputed cases go to the Court of Protection	An Independent Approved Mental Capacity Professional (AMCP), previously known as a

	BIA (Best Interest Assessor) will review arrangements. To note AMCP will undertake a of the information on which the responsible body relies and determine whether the authorisation conditions are met but it will still be possible for an appeal to be made to the Court of Appeal

Two separate processes for DoLS and DiDS (Deprivation of Liberty in domestic setting)	LPS will cover a wider range of settings, such as :
	• Individuals residing in domestic settings who need to be deprived of their liberty. Domestic settings include for example:
	  • The persons own home and family home
	  • Shared lives and
	  • Supported living
	
	This change esnures that all individuals who need to be deprived of their liberty will be protected under LPS, regardless of where they reside, without the need to go to court.

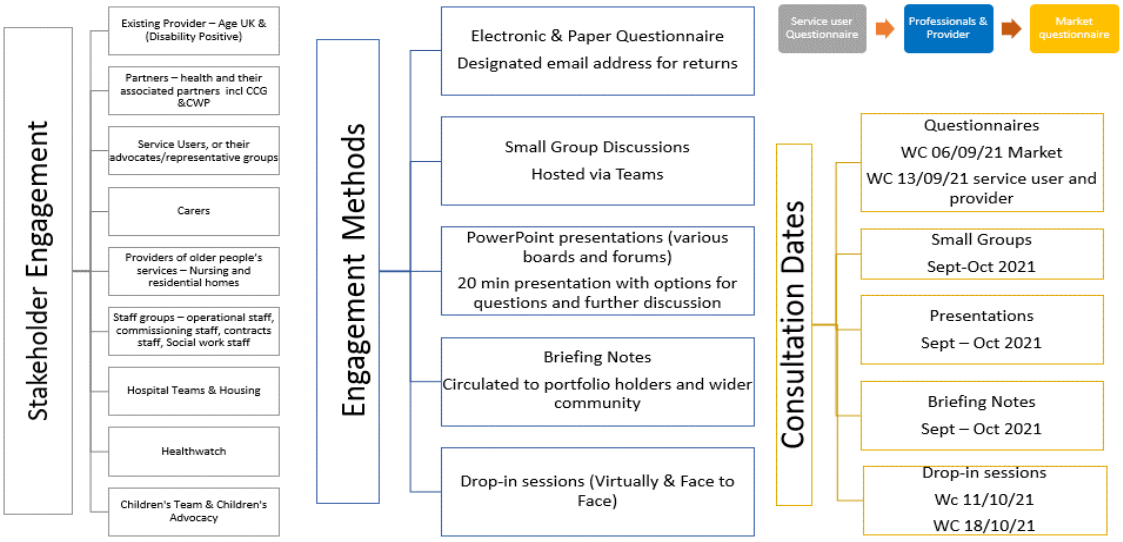
DoLS is applicable to people aged 18+	LPS is applicable to people aged 16+

(The current role of the signatory disappears under the Liberty Protection Safeguards).

Appendix D

Statutory Advocacy Service

Engagement – overview



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Working for a brighter future together

Adults and Health Committee

Date of Meeting:	27 September 2021
Report Title:	Recommissioning of the Assistive Technology Service
Report of:	Nichola Thompson, Director of Commissioning
Report Reference No:	AH/07/21-22
Ward(s) Affected:	All

1. Executive Summary

1.1. Assistive Technology (also known as Telecare) is an umbrella term to describe a range of electronic devices which can support someone in their home and in their local community. This enables the Council to meet duties under the Care Act.

1.2. This report recommends the recommissioning of this service with a revised model built on learning from the last three years including feedback from users and changes in the Assistive Technology market. This approach aligns with the priority within the Corporate Plan of; “A Council which empowers and care about people”.

2. Recommendations

2.1. That the Adults and Health Committee:

2.2. Approve the recommission of the Assistive Technology service.

2.3. Delegate authority to the Director of Commissioning to award the contract(s).

3. Reasons for Recommendations

3.1. Assistive Technology plays an important role in ensuring that the Council meets its statutory duties under the Care Act and also supports the choice and control of service users thereby increasing their independence.

3.2. A survey of Assistive Technology users carried out from May-July 2021 disclosed that a large majority value the service. For instance, 93% (634 responses) strongly agreed or agreed with the statement that it, “provides reassurance for your family knowing that access to help is available quickly”.

4. Other Options Considered

4.1. Decommissioning the service - this would divert incidents (such as non-serious falls) to formal and informal support routes (such as the North West Ambulance Service) most likely leading to individuals receiving delayed help (in comparison to the current service). This would increase the risk of problems escalating into crisis.

4.2. Varying the Community Equipment Service contract to include Assistive Technology – this option is still actively being explored due to the potential economies of scale that it would offer. The potential drawback of this approach is whether the provider could offer the same level of innovation as a specialist technology provider. Additionally, it could make the service more complex to run.

5. Background

5.1. Assistive Technology describes a range of electronic devices which can support an individual to be independent at home and in the community. This includes devices such as pendant alarms (involving a button an individual can press when they need help), falls detectors (which automatically send an alert when a fall is sensed) to bed and chair sensors which identify when an individual has decided to stand. These function in conjunction with a call centre and mobile response team to monitor and protect individuals.

5.2. A survey of Assistive Technology users conducted between May-July 2021 underscores how valued the service is. For instance, 93% of respondents said it, “Provides reassurance for your family knowing that access to help is available quickly” (634 responses). This approbation was also confirmed in one-to-one interviews undertaken with service users.

5.3. A number of priorities detailed in the Corporate Plan 2020-2025 relate to Assistive Technology. These include:

- Reducing health inequalities across the borough
- Reducing the reliance on long term care by improving services closer to home and providing more extra care facilities, including dementia services
- A commitment to protect the most vulnerable people in our communities
- Increasing the life opportunities for young adults and adults with additional needs.

5.4. Work is currently underway on developing the Council's Digital Strategy. This commission will also be aligned with this approach.

5.5. New products emerge onto the Assistive Technology market regularly, some of which offer appreciable improvements such as new functionality or greater battery capacity. Moreover, this includes a shift for more standard consumer products to include aspects of Assistive Technology functions. For instance, the Apple Watch contains a falls detector which can alert the Emergency Services. Mobile phones can also serve an alert function. This will create opportunities for service development in the future. However, there will still be a need for devices which are specifically designed for people with social care needs allied with the support from a specialist team.

5.6. Another shift within the industry is growing recognition that use of Assistive Technology needs to facilitate proactive care. This means putting temporary support in place where an individual's behaviour appears to have altered to prevent or delay escalation in the intensity of their long-term needs. Developing this further locally will require strengthening of referral processes to relevant services (such as the Local Area Coordinators and People Helping People).

5.7. The Council recommissioned the service in 2018, with Welbeing (part of the Doro Group) delivering the service from December of that year. In May 2021, around 2,254 users accessed this service. The model is relatively traditional in scope and is thus similar to services commissioned by other Local Authorities. It provides the following service components: a mobile response service (including falls pick-up), a monitoring centre, assessment of users for specific devices, supply/ installation/ maintenance and collection of equipment.

5.8. A recommissioned service would aim to build on learning from the current contract and also aim to widen the scope of support offered. This would involve moving from a position where we are purely providing traditional telecare devices, to exploring widening the service scope by promoting the use of apps, tablets and mobile phones for a proportion of service users who could derive real benefit from these options. This would have the object of meeting assessed care needs more effectively and will also include increased support for people who are socially isolated.

5.9. A key challenge for the new service will be to take account of is the national Digital Switchover which will take place by 2025. This will see the Public Switched Telephone Network (PSTN) replaced by a digital all-IP network, meaning that current analogue devices (such as most telephones and telecare kit) will no longer work as they do now. This will bring both opportunities and challenges.

5.10. A short-term solution is the use of an adapter to plug a device into the Wi-Fi router which will utilise the new IP network. However, at the moment there is a lack of consensus in the industry over how devices will function practically. In recent market engagement sessions held with providers, the majority view was that it is likely that there would be failures in communication with the telecare monitoring centre (note: a device would repeatedly send a signal until contact is made). However, the full extent of the problem is unclear.

5.11. As a result of this, it is likely that there will be cost implications for the service given that the Council owns the current stock of analogue Assistive Technology devices. Currently, the cost of digital telecare equipment is estimated to be around 25% higher. As a result of this, the Council plans to work with the new provider to transition to digital only equipment where this is necessary. This would also seek to use devices connected to the mobile phone network to allow greater portability. There is also the opportunity to explore utilising devices that service users already own into the offer (where it is safe and effective to do so). For instance, the recent survey established that 19.3% of users had a smartphone and a further 33.4% said they had a simple mobile phone.

5.12. The recommission will take place via a competitive procurement process and will continue to be shaped by engagement with providers (through a second market engagement event) as well as other stakeholders such as GPs and operational social care managers. It is projected that the core components of the service (such as assessment for specific devices by the Provider, a call centre and a mobile response team) will remain the same as for the current model of provision.

5.13. An ongoing priority for the Council in the delivery of an Assistive Technology Service is the issue of information governance given the range of data that can be collected. As such, ensuring transparency of data use and consent will remain central to how the service is delivered in the future. It is of note that research considering barriers to adoption highlighted that privacy was a central concern for older people[1].

5.14. Referrals to Assistive Technology are predominantly from Adult Social Care. However, there is the ambition to increase the range of professionals who can refer into the service in the future. For instance, GPs and other health professionals. A key change that we would like to introduce is a free trial of the service, followed by which a customer can choose to continue provision or opt out.

[1] Yusif S, Soar J, Hafeez-Baig A. Older people, assistive technologies, and the barriers to adoption: A systematic review. Int J Med Inform. 2016 Oct;94:112-6. doi: 10.1016/j.ijmedinf.2016.07.004. Epub 2016 Jul 7. PMID: 27573318

5.15. Partnership working is continuing to take place given the interrelationship between this service and others e.g. the North West Ambulance Service, Acute Trusts and hospital discharges. It is of note that Cheshire Clinical Commissioning Group is currently exploring increasing the capacity of two hour response services from April 2022 as a result of increased Department of Health funding. However, this will predominantly target people with complex medical conditions.

6. Consultation and Engagement

6.1. Engagement has taken place with all current Assistive Technology users via a survey which was sent to them by post. 932 responses were received out of a total user base of 2,254. This asked key questions related to the recommission and will help shape it.

6.2. In addition to this, interviews have been held with service users to understand their views about technology in more depth. The intention is to continue to involve social care users with the development of the service in the coming years. This includes involving them in the piloting of devices.

7. Implications

7.1. Legal

7.1.1. If the total value of this contract (net of VAT) over its entire term (including any options to extend) exceeds the financial threshold of £189,330.00 it will need to be procured in accordance with the Public Contracts Regulations 2015. The proposed contract is for the provision of equipment as well as installation and maintenance services and is likely to be classified as a mixed contract in accordance with Regulation 4 of the Public Contract Regulations 2015.

7.1.2. When procuring mixed contracts it is important to identify which category they fall into (i.e. supplies, services or works) because the correct categorisation determines whether or not or the extent to which the PCR 2015 will apply. For mixed contracts that have two or more categories as their subject matter, the correct categorisation is made by reference to the main subject matter of the contract which will be the part which has the greater value.

7.2. Finance

7.2.1. The Assistive Technology service should be funded in full via the Better Care Fund and by client contributions. However, the service has been significantly overspent for the last few years. The overspend on the contract in 2020/21 was £471k.

7.2.2. The budget for the Assistive Technology contract is £757k per annum and is within the Peoples Commissioning Team Plan.

7.2.3. As well as planning to address the cost of the digital switch over mentioned in 5.9, the recommission also needs to address the budget pressure.

7.2.4. If it is anticipated that the contract can't be brought in line with the current budget through the recommission then this needs to be addressed through one or more of the following actions:

- Increasing the agreed contribution from the Better Care Fund for Assistive Technology. This would need to be agreed by the Better Care Fund Governance Group which includes Cheshire Clinical Commissioning Group.
- Increasing client charging above the current budgeted level.
- A growth bid in the Council's Medium Term Financial Strategy.

7.2.5. There is a current proposal around Assistive Technology charging which would result in an increase in client contributions, but this has not yet been approved. Due to the unknown impacts of this proposal, on both uptake and financial assessments, we are not able to estimate what the likely additional income could be at this time.

7.3. Policy

7.3.1. None.

7.4. Equality

7.4.1. An Equality Impact Assessment is available in Appendix 1.

7.5. Human Resources

7.5.1. It is likely that TUPE would apply for staff from the existing provider.

7.6. Risk Management

7.6.1. Recommissioning of the service follows a project management approach which includes the identification of risks. Any significant risk will be controlled for and escalated for action where appropriate.

7.7. Rural Communities

7.7.1. Assistive Technology is particularly useful for individuals in a rural communities who may find it harder to access informal and formal support networks.

7.8. Children and Young People/Cared for Children

7.8.1. None.

7.9. Public Health

7.9.1. Assistive Technology can be an important element of a solution to address the health and wellbeing needs of people in receipt of social

care. In addition to this, it offers the opportunity for carers and the public to obtain greater reassurance through knowing that they would be alerted through technology if there was an issue with the individual.

7.10. Climate Change

7.10.1. The recommission of the service will include social value questions including one specific to the environment. This will seek to minimise the environmental impact of the service. The service specification will also contain specific requirements relating to this.

Access to Information	
Contact Officer:	Nik Darwin, Senior Commissioning Manager Nik.Darwin@cheshireeast.gov.uk 01606 275897
Appendices:	Appendix 1 – Equality Impact Assessment
Background Papers:	Cheshire East Corporate Plan 2021-2025 Cheshire East Digital Strategy

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CHESHIRE EAST COUNCIL – EQUALITY IMPACT ASSESSMENT FORM

EQUALITY IMPACT ASSESSMENT

TITLE: Recommissioning of Assistive Technology

VERSION CONTROL

Date	Version	Author	Description of Changes
12/8/21	1	ND	

CHESHIRE EAST COUNCIL –EQUALITY IMPACT ASSESSMENT

Stage 1 Description: Fact finding (about your policy / service /

Department	Adult Social Care		**Lead officer responsible for assessment**		Nik Darwin	
Service	Commissioning		**Other members of team undertaking assessment**		NA	
Date	12/8/21		**Version**		1	
Type of document (mark as appropriate)	**Strategy**	**Project**	**Function**	**Policy**	**Procedure**	**Service** x
Is this a new/ existing/ revision of an existing document (please mark as appropriate)	**New** x		**Existing**		**Revision**	
Title and subject of the impact assessment (include a brief description of the aims, outcomes, operational issues as appropriate and how it fits in with the wider aims of the organisation) **Please attach a copy of the strategy/ plan/ function/ policy/ procedure/ service**	**Re-commissioning of Assistive Technology** Assistive Technology is an umbrella term which describes a range of electronic devices designed to keep an individual safe and independent at home and to participate in their local community. Cheshire East Council has a responsibility to ensure that the assessed needs to service users are met using a range of services and resources. Assistive Technology is an important strand of this given the advantages its offers for individuals in keeping them safe and independent at home in a way which can maximise their independence and control. The recommission of the service is taking place in order to put a new contract in place so that service user need can continue to be met. In addition to this, it also aims to take account of recent market innovation e.g. to make use of a new devices which can support assessed needs in new ways. The service will continue to consist of a number of core components including supply of equipment, delivery and collection of equipment, contact centre and a mobile response service. As such, the service provided will not otherwise be significantly changed under the new contract.					

Who are the main stakeholders and have they been engaged with? (e.g. general public, employees, Councillors, partners, specific audiences, residents)	Service users, employees, Councillors, residents	
Consultation/ involvement carried out.	Yes	91.2% of respondents strongly agreed or agreed in this consultation that the service “makes you feel safer at home”. A similar majority in agreement was also shown for “Provides reassurance for your family knowing that access to help is available quickly“, which was supported by 634 responses (93.1%).
What consultation method(s) did you use?	Survey to all current users of Assistive Technology. Other residents were also able to complete this.	

Stage 2 Initial Screening

Who is affected and what evidence have you considered to arrive at this analysis? (This may or may not include the stakeholders listed above)	Service users and staff members
Who is intended to benefit and how	Service users from a revised service which takes account of recent market innovation

Could there be a different impact or outcome for some groups?	The Assistive Technology offer that a service user receives is shaped around their needs
Does it include making decisions based on individual characteristics, needs or circumstances?	Yes
Are relations between different groups or communities likely to be affected? (eg will it favour one particular group or deny opportunities for others?)	No
Is there any specific targeted action to promote equality? Is there a history of unequal outcomes (do you have enough evidence to prove otherwise)?	Yes, the service aims to address different levels of need therefore reducing health inequality.

Is there an actual or potential negative impact on these specific characteristics? (Please tick)

Age		**N**	**Marriage & civil partnership**		**N**	**Religion & belief**		**N**
Disability		**N**	**Pregnancy & maternity**		**N**	**Sex**		**N**
Gender reassignment		**N**	**Race**		**N**	**Sexual orientation**		**N**

Stage 3 Evidence

What evidence do you have to support your findings? (quantitative and qualitative) Please provide additional information that you wish to include as appendices to this document, i.e., graphs, tables, charts		Level of Risk (High, Medium or Low)
Age	Currently; 4% of users are aged 19-54, 4% are aged 55-64, 9% are aged 65-84, 24% are aged 75-84 and 59% are 85. There is a slightly higher proportion of older people accessing the service in comparison to the overall make-up of service users, due to how Assistive Technology (AT) supports their needs. A recent consultation was conducted with service users on a change in charging plus the recommission. However, no specific impacts were identified relating to age for the new service. Older people are more likely to suffer falls which is a need directly supported by the service e.g. the mobile response team. They are also more likely to live alone and thus require the additional support mechanism that AT provides. The new service design aims to enable people from all age groups to access technology which better supports their care needs. For instance, the Council will use devices offering greater portability. Service provision will need to be sensitive to an individuals' needs including that deriving from their age. Staff will require appropriate training and procedures and communication materials will need to take account of the differing needs of service users.	***Low***
Marriage and Civil Partnership	The impact of this policy is neutral on this protected characteristic.	***Low***
Religion	The impact of this policy is neutral on this protected characteristic.	***Low***
Disability	42% of users have a primary support reason of person care support; 40% access and mobility; 8% support with memory and cognition. A recent consultation was conducted with service users on a change in charging plus the recommission. However, no specific impacts were identified relating to disability for the new service. The new service design aims to enable people with a range of disabilities to access technology which better supports their care needs. This will include use of devices such as Alexa and connected devices which can support people with a severe physical disability. Service provision will need to be sensitive to an individuals' needs including that deriving from their disability such as a cognitive impairment. Staff will require appropriate training and procedures and communication materials will need to take account of the differing needs of service users.	***Low***

Pregnancy and Maternity	The impact of this policy is neutral on this protected characteristic.	***Low***
Sex	31% of users are male and 69% of users are female. This reflects the general the make up of service users as a whole. A recent consultation was conducted with service users on a change in charging plus the recommission. However, no specific impacts were identified relating to gender for the new service. The new service design aims to enable people (including those from both genders) to access technology which better supports their care needs.	***Low***
Gender Reassignment	The impact of this policy is neutral on this protected characteristic.	***Low***
Race	95.8% of users are White British with the remainder being White Other (1%); White Irish (.7%); Black Caribbean (2%). A recent consultation was conducted with service users on a change in charging plus the recommission. However, no specific impacts were identified relating to race for the new service. As such, the impact of this policy is deemed neutral on this protected characteristic.	***Low***
Sexual Orientation	The impact of this policy is neutral on this protected characteristic.	***Low***

Stage 4 Mitigation

Protected characteristics	**Mitigating action** *Once you have assessed the impact of a policy/service, it is important to identify options and alternatives to reduce or eliminate any negative impact. Options considered could be adapting the policy or service, changing the way in which it is implemented or introducing balancing measures to reduce any negative impact. When considering each option you should think about how it will reduce any negative impact, how it might impact on other groups and how it might impact on relationships between groups and overall issues around community cohesion. You should clearly demonstrate how you have considered various options and the impact of these. You must have a detailed rationale behind decisions and a justification for those alternatives that have not been accepted.*	**How will this be monitored?**	**Officer responsible**	**Target date**

Age	-Staff to have appropriate training relating to the needs of this protected characteristic -For procedures to be designed around the needs of individuals -For assessment and device allocation to be sensitive to the needs of this age group -For communication materials to be available in large-print	Via the Contract Management Process	Nik Darwin/ Steve Clews	April 2022
Marriage and Civil Partnership	N/A			
Religion	N/A			
Disability	-Staff to have appropriate training relating to the needs of this protected characteristic -For procedures to be designed around the needs of individuals -For assessment and device allocation to be sensitive to the needs of this group (including a cognitive impairment) -For communication materials to be available in suitable formats including easy-read	Via the Contract Management Process	Nik Darwin/ Steve Clews	April 2022
Pregnancy and Maternity	N/A			

Sex	N/A			
Gender Reassignment	N/A			
Race	N/A			
Sexual Orientation	N/A			

5. Review and Conclusion

Summary: provide a brief overview including impact, changes, improvement, any gaps in evidence and additional data that is needed			
Specific actions to be taken to reduce, justify or remove any adverse impacts	**How will this be monitored?**	**Officer responsible**	**Target date**
Tailored approach to support for individuals which in particular takes account of their disability. This relates	Contract Management Meetings	Steve Clews	April 2022

to assessment and customer service processes.			
Please provide details and link to full action plan for actions			
When will this assessment be reviewed?	April 2022		
Are there any additional assessments that need to be undertaken in relation to this assessment?	N/A		
Lead officer sign off	Nik Darwin	**Date**	12/8/21
Head of service sign off	Shelley Brough	**Date**	10/9/21

Please publish this completed EIA form on the relevant section of the Cheshire East website

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Working for a brighter future together

Adults and Health Committee

Date of Meeting:	27 September 2021
Report Title:	Recommissioning of NHS Health Checks
Report of:	Nichola Thompson, Director of Commissioning
Report Reference No:	AH/11/21-22
Ward(s) Affected:	All

1. Executive Summary

1.1. NHS Health Checks are a mid-life screening for individuals aged 40-74 (not on relevant disease registers) aiming to reduce the risk of ill-health linked to cardiovascular disease such as stroke, heart disease and kidney disease plus dementia. A Health Check incorporates blood pressure, BMI and cholesterol tests into an appointment which typically lasts 20-30 minutes, as well as a set of lifestyle questions covering smoking, exercise and alcohol. Content is set by Public Health England.

1.2. The report recommends that delivery of NHS Health Checks continues to take place via General Practices. This is because they are best placed to support needs identified via the Health Check programme. Moreover, they have sole access to the data required to establish patient eligibility.

1.3. Commissioning of the programme aligns with the priority within the Corporate Plan to “Reduce Health Inequality across the Borough”. There is also a statutory requirement for Councils to deliver this programme under Local Authorities Regulations from 2013.

2. Recommendations

2.1. To recommission the NHS Health Checks service.

2.2. To delegate authority to the Director of Commissioning to award the contracts.

3. Reasons for Recommendations

3.1. Commissioning of NHS Health Checks is a statutory requirement of Councils resulting from The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013.

3.2. Health Checks are an important means by which the health of the population can be improved, by identifying individuals who would benefit both from clinical support and lifestyle interventions.

4. Other Options Considered

4.1. Not applicable.

5. Background

5.1. The NHS Health Check programme is a Public Health risk assessment and management programme which aims to prevent or delay the onset of Cardiovascular disease including diabetes, heart disease, kidney disease and stroke. Cardiovascular disease is responsible for around one in four premature deaths in the UK and also accounts for the largest gap in healthy life expectancy[1].

5.2. The programme can help individuals reduce their risk by offering help and advice across a range of risk factors and lifestyle behaviours such as smoking, alcohol use, weight management, diet and physical activity. It also aims to reduce levels of alcohol related harm and to raise awareness of the signs of dementia. The programme is eligible to those aged 40-74 who are not on a relevant disease register.

5.3. Assessment of risk is aided by three measurements: for blood pressure, cholesterol and BMI. These are fed into an accredited clinical assessment tool which calculates the individual's risk of developing Cardiovascular disease within the next 10 years.

5.4. NHS Health Checks are an important instrument to address health inequalities within the Borough. This is by systematically identifying and supporting patients who are likely to experience worse health outcomes. Notably, those in the most deprived 10% of the UK population are almost twice as likely to die as a result of Cardiovascular disease than those in the least deprived 10% of the population[1].

5.5. As such, the programme links to the Council's commissioned integrated lifestyle service 'One You Cheshire East' which provides a referral pathway for patients who would benefit from sustained lifestyle change. This relates to physical activity, weight management and smoking cessation programmes.

[1] NHS England, Cardiovascular Disease, https://www.england.nhs.uk/ourwork/clinical-policy/cvd/

5.6. Commissioning of the programme aligns with the priority within the Corporate Plan to “Reduce Health Inequality across the Borough”. An action to “Promote regular screening and take up of preventative health opportunities supporting residents to make healthier choices” is identified in the plan as one means to deliver this.

5.7. Following an open tender process in 2016, contracts were awarded to local GP Practices for a 5 year period (including 2 x 1 year extensions). These contracts were then extended for a further year during the pandemic until 31 March 2022 (using an exemption for COVID-19). Following Procurement advice, the intention is to carry out a direct award to practices for Health Check delivery for a further 3 years (with the option of two further one year extensions). This will mean new contracts commence from 1 April 2022.

5.8. Key reasons for continuing the present model are that practices have sole access to patient data which is required to establish if an individual is eligible for an NHS Health Check. Moreover, analysis from Public Health England has concluded that this model is the most effective approach to achieve positive outcomes for patients[2].

5.9. Practices are paid on an activity basis. This includes for the invitations they make to patients (either by letter or text) as well as for the Health Check itself. Each practice is also given a target to deliver against. Targets are higher for practices in areas of deprivation.

5.10. The overall budget for Health Checks for 2022/23 is £280K. However, this is likely to vary each year dependent on financial pressures on the Local Authority and Public Health priorities for that year.

5.11. There are two practices who have currently opted to send invites to patients but not to deliver NHS Health Checks themselves. In order to ensure their patients receive support, One You Cheshire East (delivered by Reed Wellbeing) has previously agreed to deliver this for them. Data is then fed back to practices to enable clinical support to be provided where necessary. This arrangement will be extended unless these practices revise their position.

5.12. Performance on NHS Health Checks in 2020/21 was severely inhibited by the pandemic. This was firstly due to the difficulty in holding physical meetings with patients and secondly due to the need for practices to prioritise treatment of patients with COVID-19. However, the next few years provide an opportunity to catch-up on delivery.

[2] Findings from the 2019/20 NHS Health Check Delivery Survey, Public Health England

5.13. Performance over time is shown below:

- 2020/21 919 Health Checks delivered
- 2019/20 9,298 Health Checks delivered
- 2018/19 10,384 Health Checks delivered

6. Consultation and Engagement

6.1. Engagement with Practices is planned in September via a special workshop which is being run in partnership with the Local Medical Council. This will include discussion around: price for delivery, targeting of patients in areas of deprivation and training needs.

7. Implications

7.1. Legal

7.1.1. Contracts for the provision of health services (such as these) which are listed under Schedule 3 of the Public Contracts Regulations 2015 (PCR 2015) and valued at or above £663,540.00 throughout their entire term, (excluding VAT) are subject to the Light Touch Regime which is a less rigorous application of the PCRs.

7.1.2. Despite its less rigid approach, mandatory procedural rules still apply. As a result, the Council must advertise above threshold services using either a contract notice or a Prior Information Notice (PIN) which must be published on the Find a Tender Service (FTS) website.

7.1.3. In addition, the Council should make procurement documents available on the internet at the same time that the contract notice is published and if the Council is using a contract notice (as opposed to a PIN) it must also publish the details of the proposed contract on the Contracts Finder website.

7.1.4. The Light Touch Regime does not prescribe any specific procurement procedure and the Council may design award procedures that are tailored to their specific service, provided that the procedure is transparent and treats suppliers equally.

7.1.5. The Council should also ensure that the procurement is conducted in accordance with the information set out in the contract notice or PIN and submit a contract award notice to FTS if the contract value is at or above £663,540.

7.2. Finance

7.2.1. This service is affordable and budgeted for within the Public Health ringfenced budget and Team Plan.

7.2.2. The budget allocated is £280k per year, however as noted in the body of the report this is an activity based contract and the actual spend my vary. If activity increased, taking the cost above the £280k budget, any

possible additional cost could still be met within the Public Health budget.

7.3. Policy

7.3.1. None.

7.4. Equality

7.4.1. An Equality Impact Assessment is available in Appendix 1.

7.5. Human Resources

7.5.1. None.

7.6. Risk Management

7.6.1. Recommissioning of the service follows a project management approach which includes the capture of risks. Any significant risk identified will be controlled for and escalated for action where appropriate.

7.7. Rural Communities

7.7.1. NHS Health Checks are available to local residents in all parts of the Borough including in rural locations.

7.8. Children and Young People/Cared for Children

7.8.1. None.

7.9. Public Health

7.9.1. Delivery of NHS Health Checks is a statutory Public Health function for Local Authorities.

7.10. Climate Change

7.10.1. The new service specification will include a specific section on managing the environmental impact of service provision.

Access to Information	
Contact Officer:	Nik Darwin, Senior Commissioning Manager Nik.Darwin@cheshireeast.gov.uk 01606 275897
Appendices:	Appendix 1 – Equality Impact Assessment
Background Papers:	Cheshire East Corporate Plan 2021-2025

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CHESHIRE EAST COUNCIL – EQUALITY IMPACT ASSESSMENT FORM

EQUALITY IMPACT ASSESSMENT

TITLE: NHS Health Checks Recommission

VERSION CONTROL

Date	Version	Author	Description of Changes
29/08/21	1	ND	First draft

CHESHIRE EAST COUNCIL –EQUALITY IMPACT ASSESSMENT

Stage 1 Description: Fact finding (about your policy / service /

Department	Adult Social Care		**Lead officer responsible for assessment**		Nik Darwin	
Service	Commissioning		**Other members of team undertaking assessment**		N/A	
Date	29.08.21		**Version**		1	
Type of document (mark as appropriate)	**Strategy**	**Project**	**Function**	**Policy**	**Procedure**	**Service** x
Is this a new/ existing/ revision of an existing document (please mark as appropriate)	**New** x		**Existing**		**Revision**	
Title and subject of the impact assessment (include a brief description of the aims, outcomes, operational issues as appropriate and how it fits in with the wider aims of the organisation) **Please attach a copy of the strategy/ plan/ function/ policy/ procedure/ service**	Recommissioning of NHS Health Checks The NHS Health Check is a sophisticated check of your heart health. Aimed at adults in England aged 40 to 74, it checks vascular or circulatory health and works out the risk of developing some of the most disabling – but preventable – illnesses. The check includes blood pressure, cholesterol, and BMI measurements. It also provides personalised advice on how to reduce it. The check is free of charge, including any follow-up tests or appointments. An individual is eligible for a Health Check once every five years. Content and eligibility for the Health Check are mandated by Public Health England. The recommissioning of the service will maintain the current service configuration. This will see GP Practices continue to deliver the intervention to patients. As such, the wider community will continue to be able to access health checks in venues convenient to them. The service budget will also remain the same.					
Who are the main stakeholders and have they been engaged with?	Patients, GP Practices, Councillors (engagement via Adult and Health Committee), One You Cheshire East (due to referrals from Health Checks).					

(e.g. general public, employees, Councillors, partners, specific audiences, residents)		
Consultation/ involvement carried out.	Yes	
What consultation method(s) did you use?	Consultation is due to be conducted with GP Practices predominantly to refine the payment mechanism for the service. This is likely to further support areas of deprivation in order to help reduce health inequality within the Borough. Service elements (which directly affect the public) will remain static due to the mandatory nature of the service.	

Stage 2 Initial Screening

Who is affected and what evidence have you considered to arrive at this analysis? (This may or may not include the stakeholders listed above)	Patients aged 40-74 receive the service, GP Practices
Who is intended to benefit and how	Patients aged 40-74 receive the service through the ability to access a Health Check
Could there be a different impact or outcome for some groups?	Not outside of the required cohort of patients
Does it include making decisions based on individual characteristics, needs or circumstances?	Yes, tailored advice and treatment will be provided dependent on an individual's health.
Are relations between different groups or	No

communities likely to be affected? (eg will it favour one particular group or deny opportunities for others?)	
Is there any specific targeted action to promote equality? Is there a history of unequal outcomes (do you have enough evidence to prove otherwise)?	The NHS Health Check supports individuals with health need predominantly relating to cardiovascular disease. This will assist individuals from areas of deprivation within the Borough.

Is there an actual or potential negative impact on these specific characteristics? (Please tick)

Age		**N**	**Marriage & civil partnership**		**N**	**Religion & belief**		**N**
Disability		**N**	**Pregnancy & maternity**		**N**	**Sex**		**N**
Gender reassignment		**N**	**Race**		**N**	**Sexual orientation**		**N**

Stage 3 Evidence

What evidence do you have to support your findings? (quantitative and qualitative) Please provide additional information that you wish to include as appendices to this document, i.e., graphs, tables, charts		**Level of Risk (High, Medium or Low)**
Age	The recommission will duplicate the existing model of provision. Health Check content and eligibility will also remain as mandated nationally. This includes providing a Health Check to people aged 40-74. People who are older than this will receive an annual health check instead via their GP (rather than this commissioned service). As such, the impact of this approach is deemed neutral on this protected characteristic.	***Low***
Marriage and Civil Partnership	The impact of this approach is deemed neutral on this protected characteristic.	***Low***

Religion	The impact of this approach is deemed neutral on this protected characteristic	***Low***
Disability	The recommission will duplicate the existing model of provision. Health Check content and eligibility will also remain as mandated nationally. The effect of this service will be to help reduce incidence of disability related to cardiovascular disease within the Borough. As such, the impact of this approach is deemed neutral on this protected characteristic	***Low***
Pregnancy and Maternity	The impact of this approach is deemed neutral on this protected characteristic	***Low***
Sex	The impact of this approach is deemed neutral on this protected characteristic	***Low***
Gender Reassignment	The impact of this approach is deemed neutral on this protected characteristic	***Low***
Race	The impact of this approach is deemed neutral on this protected characteristic	***Low***
Sexual Orientation	The impact of this approach is deemed neutral on this protected characteristic	***Low***

Stage 4 Mitigation

Protected characteristics	**Mitigating action** *Once you have assessed the impact of a policy/service, it is important to identify options and alternatives to reduce or eliminate any negative impact. Options considered could be adapting the policy or service, changing the way in which it is implemented or introducing balancing measures to reduce any negative impact. When considering each option you should think about how it will reduce any negative impact, how it might impact on other groups and how it might impact on relationships between groups and overall issues around community cohesion. You should clearly demonstrate how you*	**How will this be monitored?**	**Officer responsible**	**Target date**

	have considered various options and the impact of these. You must have a detailed rationale behind decisions and a justification for those alternatives that have not been accepted.			
Age				
Marriage and Civil Partnership				
Religion				
Disability				
Pregnancy and Maternity				
Sex				
Gender Reassignment				

Race				
Sexual Orientation				

5. Review and Conclusion

Summary: provide a brief overview including impact, changes, improvement, any gaps in evidence and additional data that is needed			
Specific actions to be taken to reduce, justify or remove any adverse impacts	**How will this be monitored?**	**Officer responsible**	**Target date**
Please provide details and link to full action plan for actions			
When will this assessment be reviewed?			

Are there any additional assessments that need to be undertaken in relation to this assessment?			
Lead officer sign off	Nik Darwin	**Date**	29/08/21
Head of service sign off	Shelley Brough	**Date**	03/09/21

Please publish this completed EIA form on the relevant section of the Cheshire East website

Working for a brighter future together

Adults and Health Committee

Date of Meeting:	27 September 2021
Report Title:	All Age Carers Hub and Strategy
Report of:	Nichola Thompson, Director of Commissioning
Report Reference No:	AH/09/21-22 and AH/10/21-22
Ward(s) Affected:	All

1. Executive Summary

1.1. The Care Act 2014 and Children's and Families Act 2014 sets out the duty for the Council and partners to provide services for carers regardless of their age. In response, the Council published it's the All Age Carers Strategy 2016-18. Leading from the actions within the strategy the Council commissioned the All Age Integrated Carers Hub in April 2018.

1.2. The report provides details on the journey so far for carers services in Cheshire East, the initial results of consultation and engagement that has already taken place, as well as plans for further engagement and consultation for the Carers Strategy.

1.3. The contract for the All Age Integrated Carers Hub will end on 31 December 2022. This report recommends the joint re-commissioning of the All Age Carers Hub with Cheshire Clinical Commissioning Group and seeks permission to procure the service.

1.4. The Council's current All Age Carers Strategy 2016-18 needs to be reviewed to reflect up-to-date local information, analysis, demand, customer experiences and service gaps. This report outlines the review and refresh of the Council's All Age Carers Strategy 2021-25 and seeks approval to go out to wider public consultation and engagement.

1.5. The key milestones for the successful delivery of the project are aligned to the 6 stages of the commissioning cycle (see Appendix 1).

2. Recommendations

2.1. That the Adults and Health Committee and Children and Families Committee:

2.2. Approve the draft carers strategy as outlined in Appendix 2 for the basis of consultation.

2.3. Following consultation of the strategy, note that the final version of the All Age Carers Strategy will be presented for approval to the Adults and Health Committee, and Children and Families Committee.

2.4. Approve the recommission of the All Age Carers Hub contract which ends in December 2022, with Cheshire West and Chester Local Authority, and Cheshire Clinical Commissioning Group.

2.5. Delegates authority to the Director of Commissioning to award the jointly commissioned All Age Carers Hub contract.

3. Reasons for Recommendations

3.1. To meet our obligations to the Care Act 2014 and Children's and Families Act 2014, and the Council Corporate Plan 2021-25 we need continue to review, consult and progress with the All Age Carers Strategy and the re-commissioning of the All Age Carers Hub.

3.2. The All Age Carers Hub model has been working well in Cheshire East, however from our survey with carers in February 2021 there is still a need to continue with this journey, to improve the single point of contact for all carers in Cheshire East and this would be well served by the re-commissioning of the All Age Carers Hub.

3.3. That the All Age Carers Hub is approved for recommissioning prior to the final version of the All Age Carers Strategy being submitted to committee for approval to publish.

4. Other Options Considered

4.1. Decommissioning - although the Council has a statutory obligation to provide services for carers, we also recognise the valuable contribution carers make to the local community and the support to the social care and health system. Providing access to information, advice and guidance at an early stage prevents carer breakdown and longer-term impacts on carers. Although there would be an immediate financial saving, the subsequent demand on the social and health care would outstrip any initial savings.

5. Background

5.1. The Care Act 2014, Children and Families Act 2014 sets out the Council's responsibility for carers and the need to improve health and wellbeing outcomes for carers.

5.2. The above legislation provides a coherent framework for young carers and requires the Council to offer children and young people the right to 'young carer's assessment' and introduces the 'whole family' approach to assessment and support. It requires the Council to consider the needs of young carers who are providing or intending to provide care. Additionally, the act requires Adults and Children's Departments to work together to avoid and reduce multi-assessment and allow departments to combine assessments and the right to transition assessment.

5.3. We are required to provide statutory information for the Children's Commissioner including Young Carers Data, in 2015-16 the Young Carers Data Collection Document only recorded a figure of 13 young people that had received a young carer's assessment by the Council.

5.4. The Council carried out a whole system redesign of services to carers in 2017, this involved engagement and consultation with all carers. Carers told the Council that they needed a single point of access, 24/7 helpline and help much earlier support to prevent carers breakdown. Children and Families Services identified the need to provide an individual young carer's assessment and provide better tailored support for young carers. These comments and concerns were fed into the Cheshire East Carers Strategy 2018. In response to the feedback, the Council in partnership with the Clinical Commissioning Groups (CCG), tendered for an organisation that would provide the Cheshire East All Age Carers Hub.

5.5. The current All Age Carers Hub contract is jointly commissioned across the Council and NHS Cheshire CCG via the Better Care Fund (NHS 2006 Act, s75). The service was commissioned in 2018, a service descriptor which includes the aim, description and outputs forms part of the legal agreement. The service supports the delivery of the four Better Care Fund metrics with a primary focus on reducing non-elective admissions and reducing the number of people admitted to residential care. There is annual monitoring of the performance of the All Age Carers Hub through the Better Care Fund End of Year report which is presented to the Health and Wellbeing Board.

5.6. The integration of carers service through an 'Hub and Spoke' model would coordinate early help support for adult, parent, and young carers, and has provided a single point of access at any stage of a carers journey. It also provided other many benefits, below is a snapshot of some of the All Age Carers Hub key activities:

- Single point of access
- 24/7 Carers Helpline

- Peer Support, networking
- Access to early help services e.g. Living Well Fund and Take a Break, Crisis support
- Community based support
- Online assessments via Live Well
- Reduce hospital admissions.

5.7. The contract was awarded to nCompass in partnership with the Alzheimer's Society and was available for all carers in Cheshire East from 1 April 2018 to 31 December 2022.

5.8. Since this date the service has continued to develop its service to respond to carers needs and feedback. A key achievement was changing the adult's statutory carers assessment in February 2020, moving to an online assessment accessible via the Council Live Well website. In March 2020 the online assessment system also included young carers. This process change means that carers in Cheshire East receive a single point of access/assessment from the first point of contact. Equally it also reduces double counting and for the Council provides a better reflection of the number of young carers the Council was supporting, which previously was not reflected on the LiquidLogic case management system.

5.9. There has been a significant change to the whole approach of carers assessments, which now focus on the personalised outcomes for the individual rather than just a means of accessing services. The Hub have incorporated the Council's statutory assessment with their own assessment which includes wellbeing outcomes. Therefore, as well as being assessed for carers support, it looks at different ways that caring affects a carers life and the services that can support the carer. The assessment includes the physical, mental and emotional wellbeing and this is at the heart of this assessment. A review of the outcomes is carried out at 3 months and the carer's wellbeing is reassessed; this is followed with an annual review.

5.10. The pandemic has amplified the importance of the caring role, and its significant function on the health and social care system. The report '*Caring behind closed doors: 6 months on'* (2020) produced by Carers UK, promotes the crucial part carers play on the system and the health and wellbeing inequalities many carers face. During the pandemic there was a need to shift services to vertical platforms, providing a big challenge to the All Age Carers Hub. The All Age Carers Hub combined its effort by increasing the digital platform access, wellbeing telephone calls and home visits where appropriate.

5.11. The All Age Carers Hub worked with the People Helping People service to ensure no carer was left struggling at this difficult time. Initially in March 2020 we saw a decrease to the number of referrals to the service, but this

has now increased by 110% in the number of referrals for support comparing Quarter 1 to Quarter 4 (2020/21).

5.12. The All Age Carers Hub played a key part in acting as the single point of access for vaccines to carers. It ensured all carers gained registration and assessment. It ensured all carers were listed on the GP Carers Register.

5.13. To date Cheshire East has 5061 carers registered with the service. The key highlights of the performance in 2020/21 are:

- 1644 adult carers referred to the Carers Hub for information, advice and/or support services – 71% of these were new referrals that had not previously registered with the Hub.
- 538 adult carers awarded a Living Well fund to enable them to take a break from their caring role.
- 589 statutory adult carers assessments completed.
- 310 carers have taken up the offer of an Emergency Card to let others know they are a carer if they are in an accident / taken ill.
- 186 wellbeing calls by volunteers to carers, not able to engage with the online groups, through the CHAT line (not previously offered before the pandemic).
- 78% increase in referrals from Council teams following early identification through People Helping People and online briefing sessions run by the Hub.
- Carers' outcomes remained positive in 2020-21, carers outcomes are assessed at the start of their journey and then reviewed 3 months on. From these assessments we can see that on average 97% of adult carers felt their ability to manage their caring role had improved following support from the Carers Hub. 96% of carers reported increased choice, control and independence; 95% felt engaged, involved and that they have a voice; and 98% reported improved emotional wellbeing.
- 147 young carers were referred to the Young Carers service and 84% were new referrals not previously known to the Hub.
- 111 young carers accessed the Living Well Fund grant to enable them to take a break from their caring role.
- 99 statutory young carers assessments were completed.
- 45 young carers group support sessions held (majority over Zoom) with an average of 30 young carers attending each session by Quarter 4.

- In 2020-21, the Carers Hub changed the method they use to assess young carers outcomes and now use the Positive and Negative Outcomes of Caring (PANOC-YC20) tool. This tool highlights that young carers can experience both positive and negative impacts of caring. 100% of young carers felt their positive outlook had improved and 100% had improved relationships, self-esteem, and resilience. 58% felt that the emotional impact of their caring role had been reduced.

5.14. The refreshed All Age Carers Strategy for 2021-25 aims to support the shift in social care and health transformation, providing key messages for specific markets and carers. It will start with asking the following questions:

- Who are our carers – demographics?
- What support and services are in place at the moment, and what is not available and should be?
- What carers tell us, including the accessibility and quality of services for carers and what they tell us is needed?
- What support and services the Council think people will need in the future?

5.15. The draft All Age Carers Strategy has been developed jointly by the local authority with NHS Cheshire CCG to ensure that it developed in line with the recently published White Paper 'Integration and Innovation: Working Together to Improve Health and Social Care for All' and is therefore acknowledges Health and Social Care integration developments. Its development is part of the recommissioning activity that is undertaken by the Council, with the results of the coproduction, engagement and consultation influencing the service specification for the All Age Carers Hub.

5.16. With the delivery of health and social care services focusing on how they achieve integrated ways of delivering services, it is more important than ever to have a clear offer and vision for carers' services, which builds on the aspirations and statutory frameworks of The Care Act (2014) and Children and Families Act 2014; and prepare for the implementation of the White Paper 'Working together to improve health and social care for all' in 2022.

5.17. The initial formal consultation and engagement process will shape the development of the draft All Age Carers Strategy.

6. Consultation and Engagement

6.1. Consultation, engagement is a continual process for commissioning as it provides the intelligence that inform the strategy, policy, quality assurance and performance of all our services. Equally, carers are affected by the

decision the council makes on services to the cared for individual. Therefore, carers have been consulted and engaged with on several services, strategies and polices. These include the following:

- Carers Survey (February 2021) – included within Appendix 4
- Survey for carers - Living Well Fund (2020)
- Day Opportunities
- Assistive technology charging policy
- Dementia Strategy
- Autism consultation
- Cheshire East Carers Forum

6.2. The next steps are to gain further feedback from carers, partner agencies, and professionals that will shape the strategy and future of the All Age Carers Hub service. However, with the current restrictions and uncertainty of the Covid-19 pandemic, the proposed consultation and engagement will include:

- Publication of the draft Cheshire Strategy on the Council website along with an online survey and questionnaire to receive comments.

- Communication will include social media campaigns with a press release to make residents aware of the Council's consultation and engagement process.

- Communication to all contracted providers on the Commissioning Intentions.

- Virtual online Market Place events for providers, advertised by the Chest Procurement Portal for wider markets to attend.

- Virtual service development events with carers, advertised by social media, the Council website and with current existing routes for example, Carers Forum, Parent Carers Forum, Older People Engagement Network.

- All relevant stakeholders will be notified including partners, members, and town/parish councils.

- Briefings to networks such as Health and Wellbeing Boards, and Children and Young People's Trusts of the development and results.

6.3. The Cheshire East Carers Forum aims to be a voice to inform service providers of the needs of carers and their families.

6.4. The Cheshire East Carers Forum will facilitate two–way communication between carers and services used by all carers and their families in Cheshire East. The forum will work to provide feedback on services, offer constructive challenge to current services and input into decision making and planning for future service provision.

7. Implications

7.1. Legal

7.1.1. The Council has a responsibility to provide suitable services for all carers as set out within The Care Act 2014 and Children's and Families Act 2014.

7.1.2. There is an expectation enshrined in case law that any local authority making decisions affecting the public will do so fairly and in a way that cannot be said to be an abuse of power.

7.1.3. It is therefore important to test the fairness of the Council's proposed strategy in relation to All Age Carers by way of consultation on any changes which potentially have the effect of withdrawing existing benefits or advantages available to carers. Such consultation will involve those directly affected by such changes as well as any relevant representative groups. The responses to the consultation will need to be conscientiously taken into account when Council decision makers make any future decision in adopting the strategy.

7.1.4. Consultation approach is outlined in 6.2 of this report and will be conducted with adherence to the following:

(a) the consultation must take place at a time when the proposals are still at a formative stage.
(b) the proposer must give sufficient reasons for any proposal to permit of intelligent consideration and response.
(c) adequate time must be given for consideration and response.
(d) the product of the consultation must be conscientiously taken into account in finalising the proposals

7.1.5. It should be noted that failure to meet the Public Sector Equality Duty (PSED) or breach of a duty to consult would risk the Council being subjected to legal challenge by way of judicial review.

7.1.6. A legal collaboration agreement will be developed with all partners prior to the commencement of the commissioning and procurement activity, to clearly define the roles and responsibilities of each of the partners in relation to the procurement process and subsequent contract management.

7.1.7. Any procurement would need to be carried out in accordance with the Council's Contract Procedure Rules and the Public Contract Regulations 2015.

7.1.8. Any service contract will contain suitable provisions to allow the Council to terminate the contract in event of funding from the Better Care Fund ceasing.

7.2. Finance

7.2.1. The commissioning of an All Age Carers Hub service would offer an opportunity to ensure value for money, improved outcomes for carers by aligning services and creating consistency across Cheshire for residents.

7.2.2. Cheshire East Council spends £751,000 per annum on the All Age Carers Hub. This includes £661,631 from the Better Care Fund (BCF) and £89,369 from Children's and Families Services (CEC base budget). The BCF is a Pooled Budget operated in partnership with colleagues from Cheshire CCG. Funding is confirmed through the Comprehensive Spending Review and the NHS 5-year Plan. The current direction of travel is for increased integration and further extension of these shared financial arrangements.

7.2.3. The new contract would be for a 3-year period (1 January 2023 to 31 December 2026) with a possible 2 x 12 months extension period.

7.2.4. The budget for the full five years (including the 2 x 12 months extensions) would be £3,755,000.

7.3. Policy

7.3.1. The All Age Carers Strategy will contribute towards the vision of the Corporate Plan 2021-2025 to be an open, fair, and green Council and help to deliver the priority to be a Council which empowers and cares about people. The All Age Carers Strategy enables the Council to be open and transparent about our commissioning intentions based on capacity, demand, engagement and coproduction in partnership with key stakeholders, and importantly with local residents and people who use carers services and those who may use them in the future.

7.3.2. The All Age Carers Hub and Strategy will comply with any of the new legislation requirements of the Build Back, Better: Our Plan for Health and Social Care, September 2021, HM Government.

7.4. Equality

7.4.1. An Equality Impact Assessment has been started and a copy is attached in this report in Appendix 3.

7.4.2. The EIA will develop further during consultation and engagement with carers.

7.4.3. Inequalities identified will be actioned and addressed through the recommissioning activity and included as performance measures for the service to adhere to via the service specification and contract.

7.5. Human Resources

7.5.1. There is no direct impact on any employees within Cheshire East Council.

7.5.2. All employees of the current provider/s will be eligible for TUPE, and during the tender all applicants will be provided with a full list of eligible employees.

7.6. Risk Management

7.6.1. There is a potential risk that the governance timeline will not meet key deadlines and will slow the commissioning process down. Early progression and decision making will mitigate this as outlined in the project key milestones in Appendix 1.

7.6.2. With Cheshire Clinical Commissioning Group ceasing to exist from 31 March 2022, work is in progress to finalise/formalise a new structure for commissioning services in 2022. Although this may present some risks it will be mitigated by working in close partnership with representatives from the NHS Cheshire Clinical Commissioning Group, who will provide regular updates.

7.6.3. The Carers Hub is funded via the Better Care Fund, which contributes to most of the budget.

7.6.4. The Department of Health and Social Care published the White Paper 'Integration and innovation: working together to improve health and social care for all' (2021). The White paper set out the legislative proposals for a health and care Bill. The White Paper refers to the Better Care Fund it sets out a technical change to separate the fund from the process for setting the NHS Mandate.

7.6.5. The Better Care Fund planning and policy guidance for 2021/22 hasn't been released, the funding envelope for the Better Care Fund has been identified nationally and the local allocations have been set for 2021/22. In recent years the funding has only been guaranteed from year to year, the local allocations for Cheshire East haven't been released for 2022/23.

7.6.6. We have commissioned services to be delivered over multiple years with only an upfront guarantee that the current year's funding can be met from the Better Care Fund/Improved Better Care Fund. There is a risk that the Better Care Fund won't continue into 2022/23 and future years, typically the risk is highlighted and recorded through the corporate risk register. The All Age Carers Hub in Cheshire East was commissioned in 2018 over multiple years until 2022, at the time of the service being commissioned it wasn't known whether the funding would be guaranteed for the life of the contract from the Better Care Fund. Part of the ongoing mitigation of the risk is for the Better Care Fund Governance Group to receive ongoing updates about the All Age Carers Hub commission.

7.6.7. The service contract will include suitable termination provisions so that in the unlikely event that the Better Care Fund ceases, the Council can seek to terminate the contract for the All Age Carers Hub.

7.7. Rural Communities

7.7.1. There are no direct implications for rural communities and the service would be developed to improve access.

7.7.2. There is a review with Cheshire West and Chester Council that could align some services within the All Age Carers Hub would improve access to carers living in rural communities across Cheshire. It would remove the postcode lottery, especially for those individual living on the boundaries of the two Councils.

7.8. Children and Young People/Cared for Children

7.8.1. The service will be developed with young carers with a focus on those on Child Protection and Child in Need Plans.

7.8.2. Developing the multi-agency support and safeguarding approach will be part of the service development and shape the future offer.

7.8.3. A key development is to align the service with education settings. This will improve the identification of young carers to support at the earliest opportunity.

7.9. Public Health

7.9.1. Supporting carers early with appropriate services reduces health and wellbeing inequalities. The future service will continue to focus on prevention and wider determinates on their health, this could be by signposting individuals to Public Health lifestyle and support programmes.

7.10. Climate Change

7.10.1. The recommissioning of the service will include expectations around Social Value, this includes social, economic and environmental impacts. The service provider will need to demonstrate their impact on the environment throughout the life of the contract. This will be included as part of the service specification and monitored by quarterly performance measures. Targets around recycling, carbon reduction with the use of electric vehicles, employing people within the community it serves and offering services virtually or on a Place based locality will be measured continually.

Access to Information	
Contact Officer/s:	Elizabeth Smith (All Age Carers Hub recommissioning) Senior Commissioning Manager Liz.Smith@cheshireeast.gov.uk Jill Stenton (All Age Carers Strategy) Senior Commissioning Manager Jill.Stenton@cheshireeast.gov.uk
Appendices:	1. Key Milestones and Commissioning Cycle 2. All Age Carers Strategy 3. Equality Impact Assessment 4. Carers Survey
Background Papers:	1. Cheshire East Council Corporate Plan 2. Care Act 2014 3. Children and Families Act 2014 4. Caring behind closed doors: 6 months on: Carers UK 2020. 5. Working together to improve health and social care for all – White Paper, Febraury 2021 6. Build Back, Better: Our Plan for Health and Social Care, HM Government, September 2021

Appendix 1.

Key Milestone and Commissioning Cycle
All Age Carers Hub and Strategy Development

1. **What is the question:**
- The development of the Project Initiation Document (PID) and Initial Business Case – June to August 2021
- Committee's Papers to approve recommissioning and consultation for the strategy – September/October 2021
- BCF Briefing – August 2021
- Service Review – June to December 2021
- Initiate EIA – June 2021
- Initiate DPIA – June 2021

2. **Know your customers:**
- Comprehensive Engagement and Co-production Plan – January to August 2021
- Needs Assessment – June 2021 to January 2022
- Review Business Case – January 2022

3. **Outcomes and Priorities:**
- Engagement and Coproduction programme– February 2021 to January 2022
- Outcomes Framework Developed – February 2022

4. **What will it look like:**
- Draft Service Specification, Contract and Performance Management
- Draft All Age Carers Strategy
- Framework – June 2021 to January 2022
- Draft Terms and Conditions – June to January 2022
- Commissioning Intentions Document– June to August 2021
- Procurement Strategy – June to December 2021

5. **How will we get there:**
- Finalise Service Specification, Contract and Performance Management Framework – February 2022
- Procurement – March to June 2022
- Award Contract – June 2022
- Formal Consultation on All Age Carers Strategy October 2021 – January 2022
- Publication of All Age Carers Strategy – March 2022

6. **Measure the impact:**
- Service Mobilisation – June to December 2022
- New service goes live – 1st January 2023
- Cheshire East Carers Forum to review the progress of the Strategy's Action Plan

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Cheshire East All Age Carers Strategy

Version 1

Helping shape Cheshire East All Age Carers Strategy 2021-2025

Caring for a family member or friend, unpaid, is a vital, valuable and important contribution to the delivery of adult social care and health services. You are the expert in care for those you look after, and we are asking you to help plan the new All Age Carers Strategy (2021-2025) which aims to:

- adapt local services to support carers in their caring role
- to help adult carers live a life outside of caring
- support young carers not to spend so much time caring that they can't live a child's life.

It is important that decisions about how to improve support for unpaid carers across Cheshire East are shaped by and for carers. So, whatever your age, background, experience, or caring role your help is valuable.

Please read this draft document to see the different ways you can take part. It has been jointly written by Carers in Cheshire East, Cheshire East Borough Council and Cheshire Clinical Commissioning Group.

Executive Summary/Foreword

INSERT

1. Introduction

Unpaid carers are our unsung heroes, and the Covid-19 pandemic amplified the importance this role has on society and public services. Most of us will become an unpaid carer at some point in our lives it is essential that advice, information, guidance and support that is available is accessible, appropriate and timely for carers.

The Care Act 2014 defines a carer as:

'A carer is someone who helps another person, usually a relative or friend, in their day-to-day life. This is not the same as someone who provides care professionally or through a voluntary organisation'.

Carers are a valuable asset to our society but providing care can have an impact in terms of their own health; education; ability to remain employed; relationships and social life. Legislation such as the Care Act 2014 and Children's and Families Act 2014 provides an opportunity to enhance our support to Carers as, for the first time, it places them on an equal footing with those they care for and recognises the importance of their own 'wellbeing'.

Research tells us that the number of family and unpaid carers who provide care and regular support to another individual will increase substantially over the next ten to fifteen years because people are living longer. This means that there will be an increase in the number of people who are carers and that on average they will be undertaking caring roles for longer periods of time. The physical and mental health conditions associated with the ageing process means that family and unpaid Carers will need a range of support to enable them to feel valued and manage their caring responsibilities alongside enjoying their own lives.

It is estimated that there are over 40,000 hidden carers residing in Cheshire East (this number is approximate for the size of Cheshire East's population. The stats are difficult to estimate as we know but this is ranged between 1 in 8 adults and 1 in 6 adults) we are currently working collaboratively with local, regional networks and carers to co-produce an all age carers strategy, to improve the service provision that supports all carers.

Cheshire East Council recognise the diversity of the caring role and aim to offer the right support at the right time through a whole system approach through all its policies and strategies.

The All Age Carers Strategy will be co-produced by carers, statutory partners and voluntary and community sector partners who provide services or have an interest in carers. It demonstrates our commitment to carers and seeks to respond to local

issues, outlining how everyone across the system is working together to improve the lives of our carers and those that they care for.

This Strategy aims to give an overview of national and local policy, using these to inform and shape Cheshire East priorities. We want to demonstrate how our priorities in Cheshire East have been created through the review of the data produced from the Carers Joint Strategic Needs Assessment (JSNA) and the review of our current provision. We also aim to draw on and reflect the lived experience of Carers across Cheshire East and use these to help shape our priorities.

2. The Purpose of the Strategy?

The All Age Carers Strategy for 2021-25 will support the shift in social care and health transformation, providing key messages for specific markets and carers. It will start with asking the following questions:

- Who are our carers – demographics?
- What support and services are in place at the moment, and what is not available and should be?
- What carers tell us, including the accessibility and quality of services for carers and what they tell us is needed?
- What support and services the Council think people will need in the future?

3. Our Vision

Health and social care work effectively in partnership with other providers of services to support carers of all ages in Cheshire East ensuring that the voice of carers is centre stage and that their wellbeing and identified priorities are at the heart of all decisions. To make this real for carers, all the partners work as a team to support carers and their families, involving them in service and product design, delivery and evaluation.

4. Our Mission

We will ensure that carers within our community are recognised, valued and provided with timely and appropriate support. We will listen, understand, and engage with carers and together design robust support for all carers.

5. Our Priorities

In order the meet the ambitions set out within this Strategy, we have agreed a number of key priorities, which will be co-produced through extensive engagement and working with carers, families, professionals and our partners.

The key priorities for this strategy are:

- Health Inequalities (Health & Wellbeing)
- Early Help
- Prevention - Carer Breakdown/Respite
- Information & Access
- Employment, Education and Training
- The Carers Voice

6. Our Aims

Will be to ensure that all carers:

- Are valued and respected
- Are identified and recognised by health, social care, employers, education settings and wider partners.
- Are supported to have a life outside the caring role, including employment, training, volunteering, relaxation and leisure activities
- Are confident that they know who they can contact when they need information and advice.
- Have the time to take care of their own health and wellbeing needs
- Have a voice
- Have the right to be supported if they decide to stop caring or the caring role ends

- Have access to training to support them in their caring role

7. How the Strategy will be developed?

The co-production and consultation will follow the principles of the Council's **Together** guidance.

We intend to consult with carers, organisations, stakeholders on the development of an All Age Carers Strategy adhereing to the proposed timeline of key dates:

- Consultation and Engagement Process
- Development of Draft All Age Carers Strategy and Framework
- Consultation on Draft Strategy
- Launch of All Age Carers Strategy and Framework

The consultation and engagement events that will be planned in as many different formats and will tease out the positives learnt from the pandemic and work with our carers, stakeholders and organisations on how we can build on this.

We will consult with carers, providers (including staff) and service users around what support can be offered to carers and how can they be identified and supported to relevant services to continue their caring responsibilities in a positive way.

A Consultation document will be shared with our providers onto the Chest to seek further information and ideas around what is the local offer to support our carers and what ways can they as a provider support this.

A key part of consultation around the all age carers strategy will be operational staff undertaking reviews and reassessment of individuals needs, aspirations and outcomes, at the request of other strategies taking place including Cheshire East Connected Communites Strategy (what will be the offer for our carers from the VCFS).

We will consult with the above stakeholders to develop and review services that support our carers.

To avoid engagement overload, we intend to piggy back on the engagement activities of other services so we can ensure that carers are at the forefront of everything we do. We need to ensure that carers are fully engaged and assist in the co-production of services that support the carer and the cared for.

We will also consult with our colleagues and other stakeholders in other areas of the Council to ensure that the All Age Carers Stategy works in conjunction and aligns with their strategy and ensure carers play an active role in the development of those services which in turn aligns to the All Age Carers service.

Work is progressing regionally and nationally, CEC commissioners are engaged in all national and regional developments some of which will inform the All Age Strategy for example:

- Carers Passport
- G.P. registration for carers
- Employment for carers
- NICE Guildines.

8. Our Journey So Far - 2014 to 2021

In 2014, Cheshire East Health and Social Care came together as a partnership through the local Health and Well Being Board. The Board looks at the joint needs of the population and agree strategic plans. This was delivered through two transformation programmes; in South Cheshire this was called ‘Connecting Care’ and in Eastern Cheshire it was ‘Caring Together’, all of which prioritises the need to identify carers and provide support.

This was the start of the consultation and engagement with carers, partners, and professionals in Cheshire East. During these consultation and engagement events carers told the Council that they needed a single point of access, 24/7 helpline and help much earlier to prevent carers breakdown. The Children and Families Department identified the need to provide an individual young carers assessment. These comments and concerns were fed into the Cheshire East Carers Strategy 2016/18. Subsequently, the Council in partnership with the Clinical Commissioning Groups tendered for an organisation that would provide the Cheshire East Integrated All Age Carers Hub.

The All Age Carers Hub Model

The integration of carers service through an 'Hub and Spoke' model would coordinate early help support for adult, parent, and young carers, and has provided a single point of access at any stage of a carers journey. It also provided other many benefits, below is a snapshot of some of the All Age Carers Hub key activities:

- Single point of access
- 24/7 Carers Helpline
- Peer Support, networking
- Access to early help services e.g. Living Well Fund and Take a Break, Crisis support
- Community based support
- Online assessments via Live Well
- Reduce hospital admissions

The Integrated All Age Carers Hub to date (June 2021) has 5061 carers registered with the service and has been key in developing a single point of access and assessment for carers.

Re-design of Carers Respite services

Bed based Carer Respite and Community Respite

Carer Respite support was recommissioned in December 2018. At the time, it was recognised that despite people being allocated a number of "nights" in a residential care home environment in order to provide a much needed break for carers, some service users and their carers were not making use of the support they were allocated. Consultation with service users and their carers resulted in the service being re-designed. Market engagement with service providers took place and in response to feedback from service users, carers and key stakeholders, the model of support was extended to include Community Respite support.

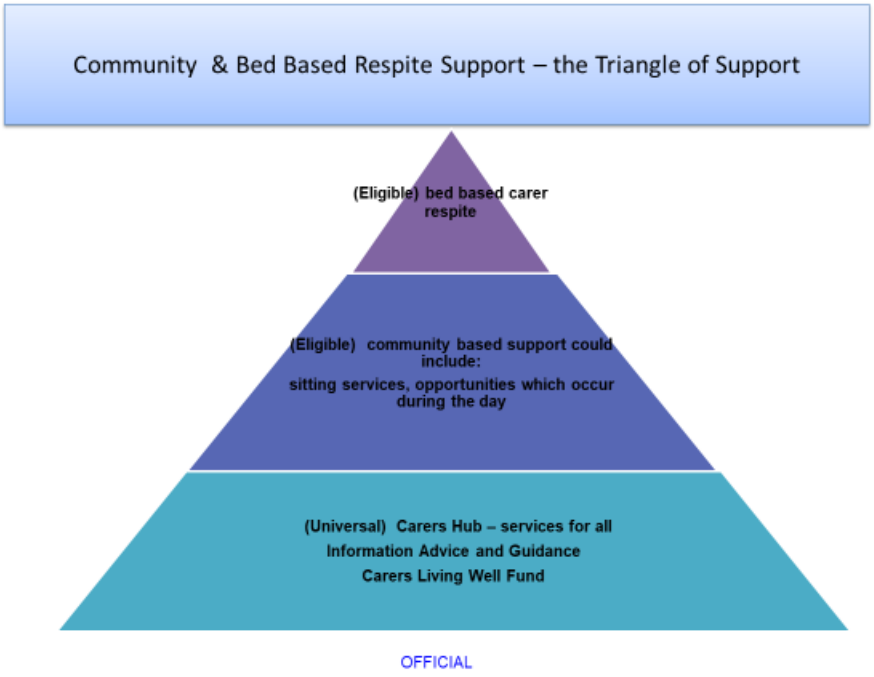
It was apparent that the bed based support offered a lifeline for many, however, some service users and carers were telling us that they didn't want to go into a residential care home, even if only for a few days. However, carers still needed a

break. Community Respite was designed to enable the cared for person, to access support in their own home.

Scenario - Mrs Jones (the carer), has become socially isolated as she is the sole carer for her husband Mr Jones (the cared for person). Mrs Jones emotional and physical wellbeing is deteriorating, Mr Jones is aware of this and it is exacerbating his condition as a result of the stress he is feeling. Both Mr & Mrs Jones are adamant that Mr Jones will not access bed-based respite support in a care home.

The Community Respite service could provide 6 hours of support every 4 weeks, to enable Mrs Jones to take a break and see her friends who she used to go walking with (improving both her emotional and physical wellbeing). Mrs Jones knows that Mr Jones is cared for in his own home and Mr Jones can receive the support he needs in an environment where he is comfortable.

The new model of Carer Respite support, incorporating both a Community and Bed-based offer of support was implemented between December 2018 and April 2019. The Community Respite provision is a less intrusive model of support, however, the take up of the Community Respite offer was fairly limited, possibly because it was a new way of facilitating support for carers. The diagram below illustrates the model of support:



By 2020, the impact of the Coronavirus pandemic meant that the offer of both bed-based Respite and Community Respite support were severely impacted. Since residential care homes have been able to re-open, we are now seeing a steady increase, month by month on the number of bed-based Respite Support stays taking place. However, due to the significant challenges being faced throughout the Care at Home sector (which is the sector commissioned to deliver Community Respite), the ability to offer this service isn't practicable at present, as the sector are focusing on delivering essential care calls.

Care at Home is due to be recommissioned in 2021 with new contracts being mobilised in readiness for September 2021. Community Respite support is being considered as a service that will sit under the overarching Care at Home contract.

Bed based Respite support will form part of the overarching Accommodation with Care contract when the service is re-commissioned in 2024.

Development of the Carer's Forum 2021

The Cheshire East Carers Forum will facilitate two–way communication between carers and services used by all carers and their families in Cheshire East. The forum will work to provide feedback on services, offer constructive challenge to current services and input into decision making and planning for future service provision.

By working co-operatively and collaboratively with local service providers carers can contribute to improvements in the services delivered for carers

- Through regular communication with carers ensuring they can decide whether to be involved in a piece of work/consultation.
- Ensuring a diverse forum membership and representation of diverse views from carers from all backgrounds and sectors of the community.
- Promoting a reputation and image of the Cheshire East Carers Forum which reflects its aims and values.
- By establishing the Cheshire East Carers Forum, it will help facilitate health and social care commissioners to work in partnership with Carers to develop and evaluate innovative new ways in supporting Carers and their cared for.
- Coproduction is key, the carers forum will work together as equal partners to improve, develop, and deliver services towards a common goal for all our children, young people, families, and adults.
- Using the Together guide that has been coproduced together with children, young people, families and adults living in Cheshire East

Engagement and Co-production

The People Commissioner continually engage and consult residents on our services and strategies. Some recent consultation and engagement activities:

- Carers and their response to Day Opportunities Strategy
- Carers and their response to Assistive Technology charging policy
- Carer and their response to Dementia strategy
- Making Carers Visible CEC, NHS CCG and My CWA webinar – Carers supporting people living with dementia and Domestic Abuse

- Carers response to the autism strategy
- Transition Strategy
- Mental Health Strategy
- The End of Life Strategy

We are working with our Procurement and ConsultationConulstation teams to share all relevant consultation and engagement materials related to carers to ensure we reach out to our providers that offer support to carers and the cared for.

Carers are the continuous link in all that we do they are part of all the delivery plans with the above strategies and will continue to do so

Everything we commission, recommission or decommission for the future there is a section within all our service specifications requesting information on *'what is their offer for carers, how do you identify a carer'?*

9. Where are we now?

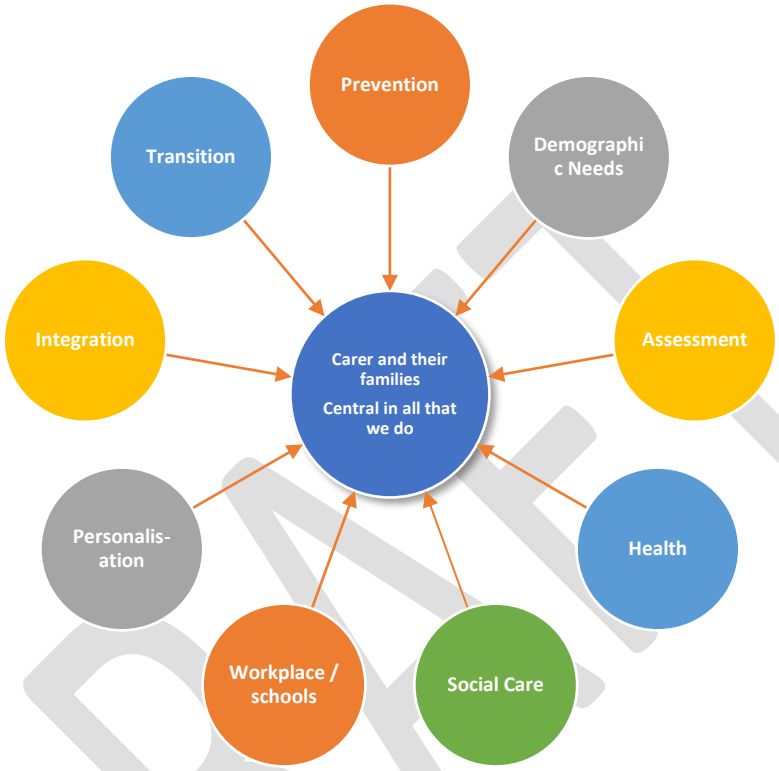
Cheshire East are in a position where services need to continue to be aligned, not only to address the current financial climate and population growth but also to ensure that services are streamlined to work closely together to provide the most effective service in a timely manner. This will benefit the carer and their families as the most appropriate service(s) will be offered.

The Strategy will address the following elements, and these will be incorporated into the strategic intentions:

- Health and Social Care needs
- Value of carers
- Population growth
- Financial challenges
- Whole system approach (including recent strategies).
- Employment and carers

The carer remains at the focal point of this strategy and future commissioned services that will support this.

Figure 1: Elements of caring that need to be addressed



Carers play such an important role in all that we do. The diagram above (Figure 1) shows that with every health and social intervention there is a carer involved. If we ensure that there are clear pathways for carers in all of the highlighted circles it will allow us to deliver the right support at the right time. For example, Young carers need to be identified as early as possible, so they receive the right support; a carer identified within their G.P practice to ensure they receive the right support at the right time.

Carers are not a homogenous group; their circumstances are wide ranging in terms of the type of care they provide and the amount of their time they spend caring. Some may care for a few hours a week, yet others may care for over fifty hours per week.

Covid has impacted on carers dramatically and we can see this by the high increase on carer referrals to the Cheshire East Carers Hub (over 500 new referrals in the last 9 months). COVID-19 pandemic continues to have a monumental impact on unpaid carers lives – not only because of the increased amount of care that many are having to provide, but because of the far-reaching effect that providing this care is having on many aspects of life:

- Relationships
- Mental and physical health
- Work
- Emotional well being

There have been positive innovations in technology-based support for carers a vast majority of carers have found life significantly more difficult. A decrease in support and sometimes complete closure of local services alongside the increase in are needs has led to most carers having to provide much more care.

https://www.carersuk.org/for-professionals/policy/policy-library/caring-behind-closed-doors-six-months-on

National Context & Demographics

- 1 in 8 adults (around 6.5 million people) are carers
- Every day another 6,000 people take on a caring responsibility – that equals over 2 million people each year.
- 58% of carers are women and 42% are men.
- 1.3 million people provide over 50 hours of care per week.
- Over 1 million people care for more than one person
- As of 2020, Carers UK estimates there are around 13.6 million people caring through the pandemic.
- Carers save the economy £132 billion per year, an average of £19,336 per carer.

- 5 million people in the UK are juggling caring responsibilities with work - that's 1 in 7 of the workforce.
- However, the significant demands of caring mean that 600 people give up work every day to care for an older or disabled relative.
- Carer's Allowance is the main carer's benefit and is £67.25 for a minimum of 35 hours, the lowest benefit of its kind.
- People providing high levels of care are twice as likely to be permanently sick or disabled.
- 72% of carers responding to Carers UK's State of Caring 2018 Survey said they had suffered mental ill health as a result of caring.
- 61% said they had suffered physical ill health as a result of caring.
- 8 in 10 people caring for loved ones say they have felt lonely or socially isolated.

Key statistics

- 4 in 5 unpaid carers (81%) are currently providing ***more*** care than before lockdown.
- More than three quarters (78%) of carers reported that the needs of the person they care for have ***increased*** recently.
- Most carers (64%) have ***not been able to take any breaks at all*** in the last six months.
- **More than half** (58%) of carers have seen their physical health impacted by caring through the pandemic, while 64% said their mental health has worsened

Young Carers

Young Carers aged 5-17 years care for an adult or family member in the UK

A 1/3 of Young Carers reported having a mental health problem

https://www.carersuk.org/for-professionals/policy/policy-library/caring-behind-closed-doors-six-months-on

National Legislation

The Care Act 2014

The Care Act replaces previous legislation regarding Carers and people being cared for and has the following provisions:

- All Carers' have the right to an assessment when they appear to have needs
- All Carers have the right to support if they meet the eligibility criteria
- Local Authorities are required to provide information to Carers
- Local Authorities may arrange for other organisations such as charities or private companies to carry out assessments of need
- Local Authorities have a duty to promote an 'individual's wellbeing'
- Local Authorities must support Carers to achieve the outcomes they want in day-to-day life
- Local Authorities must have regard to whether the Carer works or wishes to do so
- Local Authorities must have regard to Carer participation in education, training, and recreation

The Care Act ensures that Carers have as many rights for support as those they care for. For those assessed as having eligible needs, authorities are required to provide advocacy and personal budgets.

http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

The Children and Families Act 2014

The Children and Families Act 2014 gives Young Carers the entitlement to the same help and support as Adult Carers. The legislation means that all Young Carers under the age of 18 are entitled to an assessment of their support needs. The Local Authority has to consider what services it can provide to meet these needs. Specific duties for Local Authorities under this legislation are:

- Taking reasonable steps to identify the extent to which there are Young Carers in their area with needs for support and, if so, what those support needs are
- Carry out an assessment for Young Carers upon request

http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

The Children Act 1989

A Local authority in England must assess whether a parent carer within their area has needs for support and, if so, what those needs are. A local authority in England must take reasonable steps to identify the extent to which there are Parent Carers within their area who have needs for support.
http://www.legislation.gov.uk/ukpga/1989/41/contents

Young Carers

The Care Act 2014, and Children's and Families Act 2014, make specific provision for Young Carers in the transition from children to adult's services. A young carer is someone aged under 18 who helps look after a relative with a disability, illness, mental health condition, or drug or alcohol problem. Young Adult Carers are young people aged between 16 and 25 who are caring for another child or young person, or an adult.

In relation to Young Carers, the Care Act requires that:

- Where it appears to a local authority that a Young Carer is likely to have needs for support after becoming 18, the authority must assess:
    - Whether the Young Carer has needs for support and if so, what those needs are;
    - Whether the Young Carer has needs for support after becoming 18, and if so, what those needs are likely to be;

http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Assessments for Young Carers

The Care Act 2014 requires local authorities to consider the needs of Young Carers if, during the assessment of an adult with care needs, or of an adult carer, it appears that a child is providing, or intends to provide care. In these circumstances the local authority must consider whether the care being provided by the child is excessive or inappropriate; and how the child's caring responsibilities affects their wellbeing, education, and development.

Local authorities should ensure that adults' and children's services work together to offer Young Carers and their families an effective service, are able to respond to the needs of a young carer, the person cared for, and others in the family. This avoids the need for multiple assessments where children and adults find they are expected to give the same answers to professionals from different services, coming into their home at different times.

http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

National Policy

The Government's Carers Action Plan 2018 – 2020 'Supporting Carers Today'.

This remains the current national policy for supporting Carers. The plan sets out the cross-government programme of work to support Carers until 2020. It is structured around the following themes:

- Services and systems that work for Carers
- Employment and financial wellbeing
- Supporting Young Carers
- Recognising and supporting Carers in the wider community and society
- Building research and evidence to improve outcomes for Carers

https://www.gov.uk/government/publications/carers-action-plan-2018-to-2020

The Prime Minister's Challenge on Dementia 2020

The Prime Minister's challenge on dementia 2020 sets out a vision to create a society where those with dementia, their Carers and families, receive high quality compassionate care from diagnosis to end of life across all settings; at home, hospital or care home. Carers of people with dementia provide a vital role and we know that the availability of appropriate care and support and the quality of services has a significant bearing on whether Carers feel able to take a break from their caring responsibilities and providing Carers with better information, training and coping strategies, including emotional and psychological support, improves their quality of life.

https://www.gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020

NHS England's Commitment to Carers 2014

This identifies eight priority areas for the development of increased support to Carers in Primary Care. These are:

1. Raising the profile of Carers
2. Education, training, and information
3. Service development
4. Person-centred, well-coordinated care
5. Primary care
6. Commissioning support
7. Partnership links
8. NHS England as an employer

NHS Strategic Aims for Carers

- To secure better outcomes of care for patients, and for the millions of people who care, unpaid.
- To build a carer-friendly NHS to a greater extent than ever before.
- To start to build an NHS where no carer feels left alone and that the NHS is there to support them in their caring journey

- To change things so that carers are better able to look after their own health and wellbeing, manage the care of the person being cared for and are less likely to go into crisis.
- To increase recognition of carers as a vulnerable community and caring as a social determinant of health

https://www.england.nhs.uk/wp-content/uploads/2014/05/commitment-to-carers-may14.pdf

NHS Long Term Plan Commitment to Carers - Deliverables 2020-2024

- Identifying and supporting carers, particularly those from vulnerable communities
- Introducing best practice quality markers for primary care
- Adoption of best practice carer passport schemes and development/ introduction of quality markers in hospital settings
- Ability to share caring status with healthcare professionals wherever they present via electronic health record
- Carers understand the out-of-hours options that are available to them and have appropriate back-up support in place for when they need it
- Young Carer “top tips” for general practice to include preventative health approaches, social prescribing, and timely referral to local support service.

This plan outlines a revised health model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting. Supporting Carers is recognised as an important strand to this model, and in particular the following priorities are identified:

- Greater recognition and support for Carers in both primary and secondary care (including the implementation of Quality Markers for GP practices developed by CQC)
- Focus on supporting Carers in vulnerable communities
- A more proactive approach to identifying and supporting Young Carers
- Develop digitally enabled support
- Include Carers themselves in the development of Carer services

https://www.longtermplan.nhs.uk/

NHS Care Quality Markers 2019

The NHS has introduced Care Quality markers that have been created through working in partnership with Carers Trust, Carers UK, and The Children's Society, and have been endorsed by the Care Quality Commission (CQC).

The markers consist of six questions that can be used by care services to demonstrate how effective they are in recognising and supporting Carers.

The questions have been based on what Carers, and their representatives, have told us matter most to them, and require the care service to show how they go about supporting Carers for each of the six themes identified. Each question is supported by a number of practical ideas that care services can put into place to help them develop the support they give to Carers. The care service completes an annual declaration as evidence of how it is supporting Carers and this evidence can be used for CQC inspections.

https://www.england.nhs.uk/publication/supporting-carers-in-general-practice-a-framework-of-quality-markers/

Social Care Institute for Excellence (SCIE) and Carers UK

Guidance was issued in June 2019 on providing and commissioning Carers' breaks, plus advice and information for Carers on how to get a break. Research by Carers UK shows 46 per cent of unpaid Carers were unable to get a break in the last five years, even though they wanted one. Evidence indicates that there needs to be a wider choice of breaks available, and to ensure they are accessible, personalised, and enjoyable for both the carer – and the person they care for.

https://www.scie.org.uk/carers/breaks/adults/commissioning

https://www.scie.org.uk/news/mediareleases/carers-respite-press-release

Integration of Health and Social Care

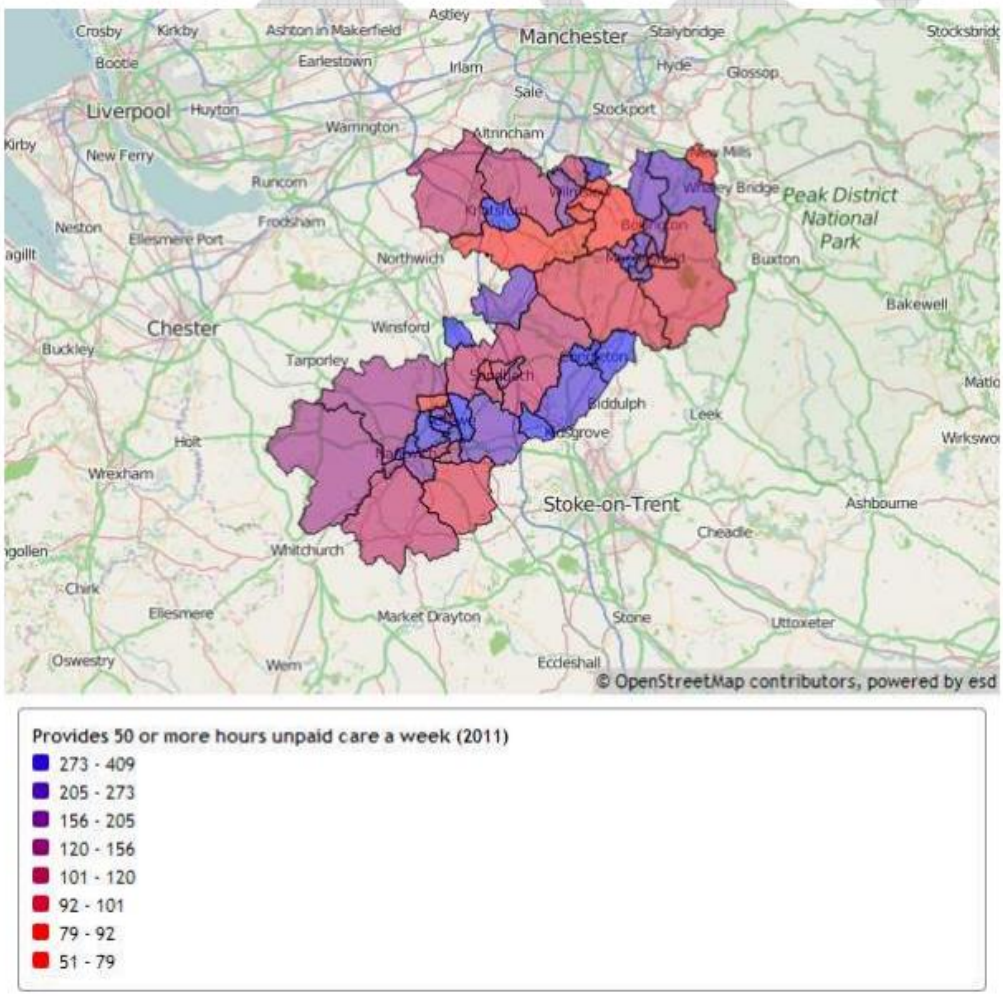
There is a drive throughout England for healthcare, social care, district and borough councils and the voluntary, community and faith sectors to develop integrated approaches to designing and delivering services. Cheshire East is driving hard the agenda along with other

partners to have an Integrated Care System (ICS) driving forwards a focus on the delivery of services in a local footprint. Promoting closer partnership working, these arrangements harness the potential of organisations that can link together to support carers and undertake their own action plans to align with the priorities in the strategy. There is a robust track record of health and social care working in partnership to envelop the support available to carers. However, we recognise that there is more to do, particularly to strengthen the governance that supports partnership work

Local Context & Demographics

From the 2011 Census, we know that 12,453 people in Cheshire East identified themselves as caring for 20 hours per week or more, with a further 27,481 caring between 1 and 19 hours per week. Altogether that is almost 11% of the population of Cheshire East. caring for 50 hours or over has increased by nearly a third since 2001 to 8,014, with over 42% of them aged 65 or over Carers caring for 50 hours or more per week

Carers caring for 50 hours or more per week by Cheshire East ward



The 2021 Census is currently being evaluated; we would hope that the data gathered from the census will support the All Age Carers Strategy.

In Cheshire East there is a single point of access for carers to receive information, advice, and support through the Cheshire East Carers Hub. This is an all age service and supports young, adult and parent carers. To end of March 2021 there were 5,061 carers registered with the Hub. 1,160 new adult carers and 124 new young carers accessed the service in 2020/21.

The Cheshire East Carers Hub also carries out statutory carer's assessments on behalf of the Council. Between April 2020 and March 2021, the Hub completed 589 adult carers assessments and 99 young carers assessments.

Health and Wellbeing

Cheshire and Merseyside Health and Care Partnership Plan

The Cheshire and Merseyside Health and Care Partnership Plan has committed to actions that need to be taken across Health and Social Care and considers a more joined up approach to supporting all age Carers.

Cheshire Clinical Commissioning Group Commissioning and Contracting Intentions 2020/21

The Cheshire Clinical Commissioning Group recognises the importance of Carers within their Cheshire Commissioning & Contracting Intentions 2020/21. Priority one is the development of a new service model to deliver person centred care for individuals and their Carer's.

The CCG wants to see:

- Increased number of people accessing support via social prescribers
- Increased focus on personalised care and people feeling empowered to self-care using digital options to make informed choices
- Reduced demand for appointments – GP, Hospital and Community Services
- Improved staff awareness of personal health budgets (PHB)
- Support Carers to maintain their caring role
- More people to access support to maintain their caring role
- Increase support to Young Carers
- Consistent offer for Carers across Cheshire
-

They plan to implement this by

- Supporting the implementation of social prescribing link workers
- Continue to expand on current PHB offer and expand to children and young people and section 117 aftercare
- Community Contracts to support staff development and training around person patient centred care.
- Continue to build on programmes such as One You, Healthy You, and the NHS Long-term Plan

- To develop digital options for people to manage their own wellbeing
- Further developing an all age model to support Carers across Cheshire

https://www.cheshireccg.nhs.uk/media/1782/cheshire-commissioning-and-contracting-intentions-2020-21.pdf

The All Age Carers Strategy will align with the above priorities.

Local Need and Strengths (Assets)

https://www.cheshireeast.gov.uk/pdf/jsna/carers-jsna-june-2018-final-v2.pdf

Healthwatch data

https://healthwatchcheshireeast.org.uk/wp-content/uploads/2019/10/Experiences-of-Unpaid-Carers-Registering-with-their-GP-Practice-in-Cheshire-Report-1.pdf

Co-production together guide

https://www.cheshireeast.gov.uk/pdf/livewell/together/together-our-coproduction-guide-and-definition.pdf

Corporate Plan

https://www.cheshireeast.gov.uk/council_and_democracy/council_information/consultations/corporate-plan-consultation.aspx

Social Value

https://www.cheshireeast.gov.uk/pdf/business/procurement/cheshire-east-social-value-policy-nov-20.pdf

How will we achieve this?

Key Delivery Actions

To enable us to successfully deliver the All Age Carers Strategy for Cheshire East several key delivery actions have been identified.

We will develop an outcomes-based approach to carers and their cared for and where services are provided for a carer that will achieve a set of results for the cared for.

We will deliver outcomes through working with the joint commission of the Carers Hub Service and by the development and Co-production of the All Age carers Strategy:

- Identifying the outcomes that are expected to be achieved prior to making any referrals to services
- Contracting for services based on outcomes and then monitoring based on those outcomes e.g. Joint commissioned carers service
- Work collaboratively with our health partners to ensure seamless pathways

Key Delivery Action	How we will achieve this?	Lead Organisation(s)
1. Develop a high quality and diverse range of services to support carers	• Develop a take a break service that will support carers • Emergency respite • Community respite • Flexible respite • Support Providers including the Voluntary Community and Faith Sector (VCFS) to support carers • Right information at the right time	• Commissioning Team including health • Communities Team • Commissioned carers service • Children's participation team • Schools / pastoral service
2. Ensure that carers are supported and included in the support around the cared for	• Development of take a break service for carers • Commission of a joint hub and spoke carers service • Regular contract monitoring of commissioned carers service • Training and collaboration with all G.P practices • Collaboration with two hospitals for clearer carer pathways • Work collaboratively with children services and schools / education • Co-production of the All Age carers Strategy	• Commissioning Team including health & children's services • Safeguarding team • Contracts and Quality Monitoring Team • Commissioned carers service • Carers Forum

3. Encourage and increase the numbers of people using Direct Payments to carer support	• Provide improved signposting and information about using direct payments • Promote alternative options in terms of carer support • Improve the Live Well site to support carers	• Commissioning Team • Live Well Team • Commissioned carers service
4. Ensure Co-production in the future development of The All Age Carers Service across the whole of Cheshire East working closely and collaboratively with CWAC on the Joint Commission of the Carers Service	• Work closely with carers, providers, operations teams to ensure we hear their voice	• Commissioned carers service • Carers Forum • Cheshire East Parent carer forum & other forums • Schools and pastoral service • Children's Participation team
5. Respond to the impact of COVID 19 and ensure carers are at the for front in all that we do	• Build on the learning and feedback from the lockdowns • Encourage the use and access to technology for carers	• Commissioning Team • Operational Social Work Teams • Carers Forum • Other forums
6. Ensure there is local support for carers	• Respond to need linking in with SW, G.P practices, hospitals • Revisit the Living Well fund and Carers Choice awards so we ensure that we support a carer where there is a real need e.g. care breakdown or to prevent care breakdown • Employment offer to support carers • Improve information and advice	• Commissioning Team, • Communities Team and health • Commissioned carers service • Carers Assessments • Carers Choice Awards • Living Well Fund • Local organisations
7. Promote employment, volunteering, and skills development opportunities as an alternative to traditional day opportunities services	• Develop stronger links between local employers, educational settings and community groups • Training and support on how to identify and support an employee who has caring responsibilities	• Supported Employment Team • Operational Social Work Teams • Commissioned carers service

Staff with Caring Responsibilities The need to provide care is likely to affect most of us at some point in our working lives. With an ageing population and people living longer, many employees are finding themselves caring for older, disabled or seriously ill friends or family. Several people also fall into the 'sandwich generation' (those who care for ageing parents while supporting their own children) and have to juggle parental and • How can I provide care in a period of lockdown? • How can I juggle my childcare and caring responsibilities now that schools are closed? With support from CEC Human Resource Department, several support sessions have been held for CEC managers to raise the awareness of staff who have caring responsibilities. To encourage conversations	Develop the induction toolkit to support managers around support for carers Anything we commission will request what support they offer staff who have caring responsibilities Support sessions for staff who have caring responsibilities Have a clear definition of what it means to be a carer. Hold more support sessions for staff who have caring responsibilities Possible carer champions within the organisation Recognise carers within policies and procedures and regularly publicise your carers' policy/framework or guidance to all employees. Including induction documentation Do our commissioned services offer support for their staff who have caring responsibilities? 'What is their Offer' Promote other resources, such as occupational health and employee assistance programmes, and point to external sources of support	Commissioners CEC HR Children's team Administration and education Children's participation team Commissioned services Cheshire east Social Action partnership (CESAP)

with staff about any vulnerable household that are dependent on employees for care 8. Social Value	Need to raise awareness of the organisation's support for carers (through posters, leaflets, social events)	
9. ICP		

References

Appendix

Abbreviations / Glossary

Acknowledgements

Key Documents

Budgets / Spend – Joint across Health and LA

Strategy Action/Implementation Plan

For further information of this draft document please contact

Jill Stenton – Senior Commissioning Manager

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EQUALITY IMPACT ASSESSMENT FORM

Equality impact assessment is a requirement for all strategies, plans, functions, policies, procedures and services under the Equalities Act 2010. We are also required to publish assessments so that we can demonstrate how we have considered the impact of proposals.

Date 25.6.21	**Version Number: V 1.1**

Section 1: Description

Department	People		**Lead officer responsible for assessment**		Jill Stenton	
Service	Commissioning		**Other members of team undertaking assessment**		Colin Jacklin	
Date	25.6.21		**Version**		1.1	
Type of document (mark as appropriate)	**Strategy X**	**Plan**	**Function**	**Policy**	**Procedure**	**Service**
Is this a new/existing/revision of an existing document (mark as appropriate)	**New**		**Existing**		**Revision X**	
Title and subject of the impact assessment (include a brief description of the aims, outcomes , operational issues as appropriate and how it fits in with the wider aims of the organisation) **Please attach a copy of the strategy/plan/function/policy/procedure/service**	**Carers Support Re-Commission and Draft Carers Strategy Development** Existing support to carers is currently commissioned out to the Carers Hub service that covers the Cheshire East area. This contract is due to come to an end soon and a recommissioning process will commence in due course. It has been identified that many care issues cross Local Authority boundaries and some areas across the sub region have a greater level of accessibility than others. It has therefore been decided to run this a joint commissioning exercise between Cheshire East Council and Cheshire West & Chester Councils. At the same time there is a need to refresh the existing Carers Strategy.					

	The purpose of this EIA is therefore: 1). To assess any potential negative disproportionate effects on people with protected characteristics due to the recommission with particular reference to the change to its joint nature with Cheshire West and changed footprint 2). To assess any potential negative disproportionate effects on people with protected characteristics due to the development of a new Carers Strategy 3). To pay particular regard when assessing potential negative impacts, to the effects of the pandemic and forecast changes in demand and other determinants as the area enters into a recovery phase The outgoing strategies for reference are here:  cec-carers-hub-eia-2018-signed-off-14.09.  joint-carers-strategy-2016-2018.pdf The rationale for a single commission approach to carer support will remain unchanged and as described in the Carers Hub EIA above. The mission to recognise the vital support that carers provide and the need to promote available support, celebrate their importance and provide a support that will carefully and sensitively assess need provide practical support is also unchanged and as laid out in the previous strategy as above. A report is to be taken to the Council's Adult & Health Committee to seek approval for the recommission of the carers hub. Research, reviews and consultation with residents and stakeholders will take place on the Pan Cheshire service offer. The Council has recently formed a Carers Partnership Board. This Board has met once and will be an excellent sounding board for this EIA.
Who are the main stakeholders? (eg general public, employees, Councillors, partners, specific audiences)	People who use services Carers

	Independent Sector Providers Commissioners Operational Staff NHS

Section 2: Initial screening

Who is affected? **(This may or may not include the stakeholders listed above)**	All the stakeholders identified.
Who is intended to benefit and how?	Carers, their families and the people they are caring for
Could there be a different impact or outcome for some groups?	Potentially
Does it include making decisions based on individual characteristics, needs or circumstances?	All social care services are offered on the basis of assessed eligible need.
Are relations between different groups or communities likely to be affected? **(eg will it favour one particular group or deny opportunities for others?)**	This will be identified through the on-going development of the strategy and this EIA which can be monitored by the Carers Partnership Board and any consultation processes. However, we don't anticipate that relations between different groups or communities will be affected, if anything they will be enhanced by greater links between the service provision and local stakeholders.
Is there any specific targeted action to promote equality? Is there a history of unequal outcomes (do you have enough evidence to prove otherwise)?	No – all decision and solutions will be based on a fully personalised approach. Alternative providers and future providers will be expected to evidence an equality and inclusion policy and plan.
Is there an actual or potential negative impact on these specific characteristics? (Please tick)	

Age		**Y**	**Marriage & civil partnership**		**Y**	**Religion & belief**		**N**	**Carers**	**Y**	
Disability		**Y**	**Pregnancy & maternity**		**N**	**Sex**		**N**	**Socio-economic status**	**Y**	
Gender reassignment		**N**	**Race**		**N**	**Sexual orientation**		**N**			

What evidence do you have to support your findings? (quantitative and qualitative) Please provide additional information that you wish to include as appendices to this document, i.e., graphs, tables, charts		**Consultation/involvement carried out**	
		Yes	**No**
Age	There is strong evidence to confirm that caring responsibilities can have an especially negative impact on the lives of young people, and older adults. As the Strategy evolves so will this EIA in order to assess any disproportionate effects. These can then be fed back to the team developing the strategy to determine what mitigating actions can be out on place. As a starting point, existing data from the Carers Hub will be analysed to look at age profiles and any feedback that has been recorded about the negative impact of being young or elderly.		**No**
Disability	We know that many carers are themselves elderly and may have disabilities/health conditions themselves. Existing data from the Carers Hub will be analysed to assess how many carers currently being supported fall into this category and any particular negative impacts that are surfacing.		**No**
Gender reassignment	No recording of gender reassignment takes place on the Council's social care record system as such data on this will be unavailable. However, there is no known element in these proposals which is likely to lead to discrimination of the basis of this protected characteristic.		**No**
Marriage & civil partnership	It is possible that caring duties could place additional strain in marriages for instance when one of the couple is carrying out caring duties. There is no known data on this and so could be a subject for discussion at the newly formed Carers Partnership Board and to see if further consultation is required.		**No**
Pregnancy & maternity	It is possible that some couples who had been planning a family may have had to delay these plans if they have needed to take on some caring duties of a family member. There is no direct evidence of this as yet. However, this could		**No**

	be a subject for discussion at the newly formed Carers Partnership Board and to see if further consultation is required.		
Race	Analysis needs to take place to establish if there is a disproportionately low take up of carer support from ethnic minority people. Anecdotal evidence suggests that many families especially from Asian, Afro-Caribbean and Chinese ethnicities tend to provide "in-family" care and not always seek needed support. This this could be a subject for discussion at the newly formed Carers Partnership Board to see if further consultation is required.		**No**
Religion & belief	It is possible that families who take part in and our part of a religious community may benefit from emotional, spiritual and practical support e.g. through church support. It is not known what overall beneficial effect that this brings but could be a subject for discussion at the newly formed Carers Partnership Board and to see if further consultation is required.		**No**
Sex	The patterns of caring are different in men and women. The majority of adults caring are women although the percentage of carers who are men increases with age. As a starting point, existing data from the Carers Hub will be analysed to look at this.		**No**
Sexual orientation	Data is not routinely recorded related to this protected characteristic for customers. However, there is no known evidence to suggest an impact is likely for this group.		**No**
Carers	This protected characteristic group is the subject of this EIA.		**No**
Socio-economic status	Carers who have high levels of savings may not need to continue to work and choose to take up a caring duty (e.g. of a family member) and then give up work. This choice may not be possible for someone who has to maintain work in order to have sufficient income to live/keep their house/pay rent, bills etc. Additional strain may feature for people who have to maintain full-time work and commit to caring duties. As a starting point, existing data from the Carers Hub will be analysed to look at this and then discussed at the Carers Partnership Board to see if further consultation is required.		**No**
Proceed to full impact assessment? (Please tick)	**Yes**		**Date** 25/6/21

If yes, please proceed to Section 3. If no, please publish the initial screening as part of the suite of documents relating to this issue

Section 3: Identifying impacts and evidence

This section identifies if there are impacts on equality, diversity and cohesion, what evidence there is to support the conclusion and what further action is needed

Protected characteristics	Is the policy (function etc….) likely to have an adverse impact on any of the groups? Please include evidence (qualitative & quantitative) and consultations	Are there any positive impacts of the policy (function etc….) on any of the groups? Please include evidence (qualitative & quantitative) and consultations	Please rate the impact taking into account any measures already in place to reduce the impacts identified **High:** Significant potential impact; history of complaints; no mitigating measures in place; need for consultation **Medium:** Some potential impact; some mitigating measures in place, lack of evidence to show effectiveness of measures **Low:** Little/no identified impacts; heavily legislation-led; limited public facing aspect	Further action (only an outline needs to be included here. A full action plan can be included at Section 4)
Age	There is strong evidence to confirm that caring responsibilities can have an especially negative impact on the lives of young people, and older adults. As the Strategy evolves so will this EIA in order to assess any disproportionate effects. These can then be fed back to the team developing the strategy to determine what mitigating actions can be out on place.		Medium	As a starting point, existing data from the Carers Hub will be analysed to look at age profiles and any feedback that has been recorded about the negative impact of being young or elderly people. This will help to shape the development of the new Carers Strategy and the

	There would appear to be no disproportionate effect on this group regarding the service being expanded to the larger area. The effects of the pandemic may have increased the demand on existing informal caring duties. If the carer is themselves elderly of with a health condition then they may not have been able to directly carry out some of the previous support roles (e.g. going to the pharmacy or taking some respite and going out to the theatre/pub etc.). This will ease as all restrictions are eased but there may be some legacy effects that need to be analysed.			recommissioning process for the Carers Support Service
Disability	We know that many carers are themselves elderly and may have disabilities/ health conditions themselves. There would appear to be no disproportionate effect on this group regarding the service being expanded to the larger area. The effects of the pandemic may have increased the demand on existing informal caring duties. If the carer is disabled (and in a vulnerable group) then they may not have been able to directly carry	.	Medium	Existing data from the Carers Hub will be analysed to assess how many carers currently being supported fall into this category and any particular negative impacts that are surfacing. This will help to shape the development of the new Carers Strategy and the recommissioning process for the Carers Support Service.

	out some of the previous support roles (eg going to the pharmacy or taking some respire and going out to the theatre/pub etc.) This will ease as all restrictions are eased but there may be some legacy effects that need to be analysed.			
Gender reassignment	No recording of gender reassignment takes place on the Council's social care record system as such data on this will be unavailable. However, there is no known element in these proposals which is likely to lead to discrimination of the basis of this protected characteristic.		Low	
Marriage & civil partnership	It is possible that caring duties could place additional strain in marriages for instance when one of the couple is carrying out caring duties. There would appear to be no disproportionate effect on this group regarding the service being expanded to the larger area.		Medium	There is no known data on this and so could be a subject for discussion at the newly formed Carers Partnership Board and to see if further consultation is required.

	The effects of the pandemic may have also put additional strain on couples with caring duties who have also had to contend with home education of their children during lockdown. There may be a legacy effect of this post-pandemic.			This will help to shape the development of the new Carers Strategy and the recommissioning process for the Carers Support Service
Pregnancy and maternity	It is possible that some couples who had been planning a family may have had to delay these plans if they have needed to take on some caring duties of a family member. There would appear to be no disproportionate effect on this group re the service being expanded to the larger area. No obvious COVID issues relate to this group.		Medium	There is no direct evidence of this as yet. However, this could be a subject for discussion at the newly formed Carers Partnership Board and to see if further consultation is required. This will help to shape the development of the new Carers Strategy and the recommissioning process for the Carers Support Service
Race	Analysis needs to take place to establish if there is a disproportionately low take up of carer support from ethnic minority people. Anecdotal evidence suggests that many families especially from Asian, Afro-Caribbean and Chinese ethnicities tend to provide "in-family" care and not always seek needed support.	.	Medium	This this could be a subject for discussion at the newly formed Carers Partnership Board to see if further consultation is required. This will help to shape the development of the new Carers Strategy and the

	There would appear to be no disproportionate effect on this group regarding the service being expanded to the larger area. The effects of the pandemic may have increased the demand on existing informal caring duties. If the carer is from an ethnic minority group it is more likely that they will not have historically sought support. If this non take up of support continued during lockdown then the increase demands and strain may have been felt even more acutely. This will ease as all restrictions are eased but there may be some legacy effects that need to be analysed.			recommissioning process for the Carers Support Service.
Religion & belief	It is possible that families who take part in and our part of a religious community may benefit from emotional, spiritual and practical support e.g. through church support. There would appear to be no disproportionate effect on this group regarding the service being expanded to the larger area.		Medium	It is not known what overall beneficial effect that this brings but could be a subject for discussion at the newly formed Carers Partnership Board and to see if further consultation is required. This will help to shape the development of the new Carers Strategy and the recommissioning process for the Carers Support Service

Sex	The patterns of caring are different in men and women. The majority of adults caring are women although the percentage of carers who are men increases with age. There would appear to be no disproportionate effect on this group regarding the service being expanded to the larger area. The effects of the pandemic may have increased the demand on existing informal caring duties. Females are the predominant carers. Often their jobs are within sectors that have been hit harder by the pandemic. This could have a doubling effect if reduced income at the same time as maintaining significant caring duties.		Medium	As a starting point, existing data from the Carers Hub will be analysed to look at this. This will help to shape the development of the new Carers Strategy and the recommissioning process for the Carers Support Service
Sexual orientation	Data is not routinely recorded related to this protected characteristic for customers. However, there is no known evidence to suggest an impact is likely for this group.		Low	
Carers	This protected characteristic group is the subject of this EIA.		High	
Socio-economics	Carers who have high levels of savings may not need to continue		Medium	As a starting point, existing data from the Carers Hub will

	to work and choose to take up a caring duty (e.g. of a family member) and then give up work. This choice may not be possible for someone who has to maintain work in order to have sufficient income to live/keep their house/pay rent, bills etc. Additional strain may feature for people who have to maintain full-time work and commit to caring duties. There would appear to be no disproportionate effect on this group regarding the service being expanded to the larger area. The effects of the pandemic may have increased the demand on existing informal caring duties. If the carer is from a low income group then it is more likely that their job will have been furloughed (eg hospitality, travel, non-essential retail, beauty/ hairdressing etc). This will ease as all restrictions are eased but there may be some legacy effects that need to be analysed.			be analysed to look at this and then discussed at the Carers Partnership Board to see if further consultation is required. This will help to shape the development of the new Carers Strategy and the recommissioning process for the Carers Support Service

Is this project due to be carried out wholly or partly by contractors? If yes, please indicate how you have ensured that the partner organisation complies with equality legislation (e.g. tendering, awards process, contract, monitoring and performance measures)

The same principles in this process will be applied to any potential provider, spec development and commissioning. The tendering and awarding process will consider this as part of the assessment process. Additionally, ongoing effective monitoring of contracts will take place. The provider will be organised, and Services provided, in a way which does not discriminate against the Service User or Employee in respect of any of the protected characteristics under the Equality Act 2010.

Section 4: Review and conclusion

Summary: provide a brief overview including impact, changes, improvement, any gaps in evidence and additional data that is needed The initial action that will be planned around all the above will focus on analysis of existing data from the Carers Hub. This will then be presented and discussed at the Carers Partnership Board to see if further consultation is required. This will help to shape the development of the new Carers Strategy and the recommissioning process for the Carers Support Service.			
Specific actions to be taken to reduce, justify or remove any adverse impacts	**How will this be monitored?**	**Officer responsible**	**Target date**
Identification of individuals currently accessing services and good communications of the service change.	Carers Partnership Board Carers is a cross cutting theme in most other groups and partnerships as well and so feedback will be sought from this wider network as well	Jill Stenton	25.6.21
Please provide details and link to full action plan for actions	A full action plan will be developed and a dedicate sub-group of the Carers Partnership Board will be formed to oversee this		
When will this assessment be reviewed?	23.8.21		

Are there any additional assessments that need to be undertaken in relation to this assessment?	N/A		
Lead officer signoff			
Head of service signoff			

Please publish this completed EIA form on your website

Draft Copy

Issue date – xx/xx/2021

Carers Provider Market Engagement Questionnaire

Cheshire East Council is seeking to engage on the development and delivery of a comprehensive All Age Carers Strategy.

Anyone can become a carer, and carers come from all walks of life, all cultures and can be any age. Many feel that they're doing what anyone would do in the same situation, caring for a mother, father, wife, husband, son, daughter or best friend, for example. Around 3 in 5 people will be carers at some point in their lives.

There are nearly six million unpaid carers in the UK. You are a carer if you provide unpaid support with day to day living tasks or personal care to a family member or friend such as helping them to wash, get dressed, eat, taking them to appointments, or keeping them company when they feel lonely or anxious. Those you care for could be ill, frail, disabled, suffer from poor mental health or have a substance or alcohol misuse problem.

Often carers care for more than one person and there may be family situations where, for example, a couple mutually care for each other and there is no main carer.

In Cheshire East, around 42,000 people identify themselves as carers. This does not include the carers of all ages that we're unaware of, 'hidden' from mainstream services and support, either not recognising or choosing not to declare their caring role.

A young carer is someone under 18 who helps look after someone in their family, or a friend, who is ill, disabled, has a mental health condition or misuses drugs or alcohol. It could be a brother or sister or a parent or grandparent.

We are seeking to develop a co-produced All Age Carers strategy involving people who use services, their families/carers, and providers, that explains what the Council offers around the support for carers. The aim is to provide carers with choices, information and advice, support, and guidance to fulfil their role as a carer but also to assist them in whilst maintaining good health and wellbeing.

When services are provided, we want them to be of a high quality. We want to design a strategy to ensure that future carer services are relevant, flexible, affordable, and developed in line with the learning and good practice developed during the current pandemic so that we can ensure people's needs are met.

Why are we looking to engage?

We need to ensure carers are better prepared for caring and can get support early to look after their own health and wellbeing with easily available advice and information as well as learning and training for carers to help them plan, prepare and provide care

How will we engage?

Due to the ongoing COVID-19 Pandemic we are unable to hold face-to-face meetings at this present time. Therefore, we will be using a variety of ways to reach out to as many people, organisations, and forums as possible through questionnaires, virtual focus groups and online market engagement events.

Completing this Questionnaire

We want to hear from providers who currently deliver services or those who may look to deliver them in the future and give you the opportunity to make comments and suggestions about the way that services are provided in the future in relation to supporting carers.

We are seeking to obtain the views from a wide range of providers of day opportunities, including voluntary sector organisations, community groups and organisations who can provide information and advice and how they identify and support carers within their environment.

Your responses will be used by commissioners, in commercial confidence, to help in the development of a co-produced All Age Carers Strategy for Cheshire East.

If possible, please try to limit the size of your response to each question to ensure that it is brief and to the point. Simple bullet point responses would be acceptable for certain questions. Please ensure that you clearly state any assumptions made when responding.

Please note, you are not obliged to answer all or any of the questions asked within the questionnaire. Your responses will not be scored in anyway. This is an information gathering exercise to inform our strategy and is not a pre-qualification process. Completion of this questionnaire does not create any formal relationship between the responder and the Council.

You must carefully consider the use of phrases such as “in confidence” or “commercially sensitive” when responding since they will not necessarily protect your organisation’s information from disclosure under the Freedom of Information Act 2000. If any of the information submitted by your organisation is considered commercially sensitive, you should clearly identify such information as “commercially sensitive”.

At this point this is an opportunity for you to have your say and provide the Council with feedback to us to enable your organisation to have the opportunity to contribute and influence the future redesign, to ensure that services are fit for purpose, meet the assessed outcomes of carers and in turn help support the needs of the cared for.

Name of Provider/Organisation:
Email Address: **This will be used for contacting you regarding future developments around carer opportunities**
1. Please provide a short summary (no more than 500 words) of the service you deliver that supports carers. This should include details on: • **The type of support provided (building based, community based, workplace based etc)** • **client group(s) you support,** • **location, of services** • **current cost of attending the services (day/weekly rate if applicable)** **If you don’t currently deliver any services, please leave blank, add n/a and move on to Q2.**

2.	**In terms of providing future services, please state how you could potentially help Cheshire East widen its current offer by supporting carers in developing innovative ways that can be cost effective providing positive outcomes for a carer and the cared for**

3.	**What potential barriers or issues do you feel that would need to be taken into account and may prevent you (as a provider) from considering developing a wider offer for a carer (this could include cost implications, staffing capacity and capability, implications of COVID-19, locations etc)**

4.	**Cheshire East Council are considering developing a Take a Break service for carers for the future commissioning** *Offering a take a break service for carers will give them an opportunity to take some time out from their caring duties knowing that their loved one is in safe hands either for a few hours of the day or to gain a good night's sleep to recharge their batteries* **Would your organisation be willing to tender to deliver commissioned services in the future? Please list any potential positive and negative aspects of this proposed approach.**

5.	**Are there any other points of consideration that you feel that the Council would need to consider when commissioning breaks for carers**

Many thanks for taking the time to complete this questionnaire, your participation and responses are appreciated.

Deadline for questionnaire responses is **TBC**

Please either email or upload completed forms via The Chest or if you have queries, these should be addressed to **TBC**

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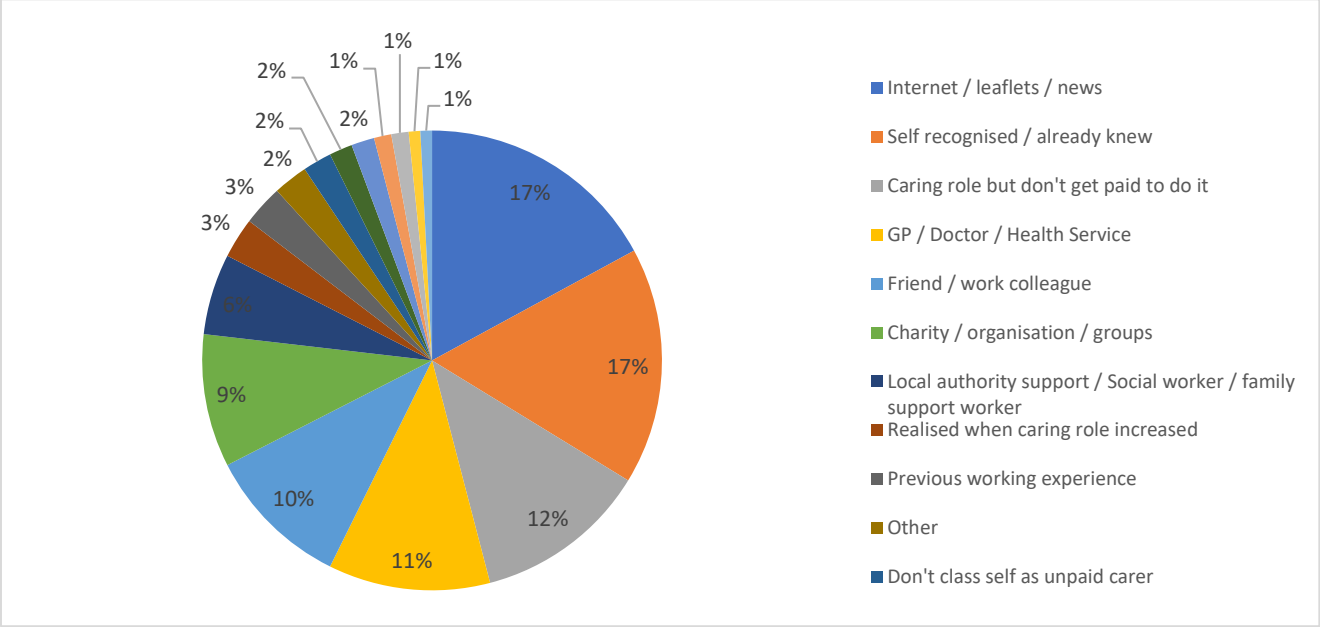
Cheshire East All Age Carers Survey Results

1. How did you know that you were an unpaid carer?

Mixture of reasons given for how carers recognised they had an unpaid caring role. Largest number of comments reflected that they used the internet, leaflets and/or news articles; or were able to recognise themselves easily that they were a carer. A number of people commented how it was the fact they didn't get paid to provide care that emphasises how they are an 'unpaid' carer.



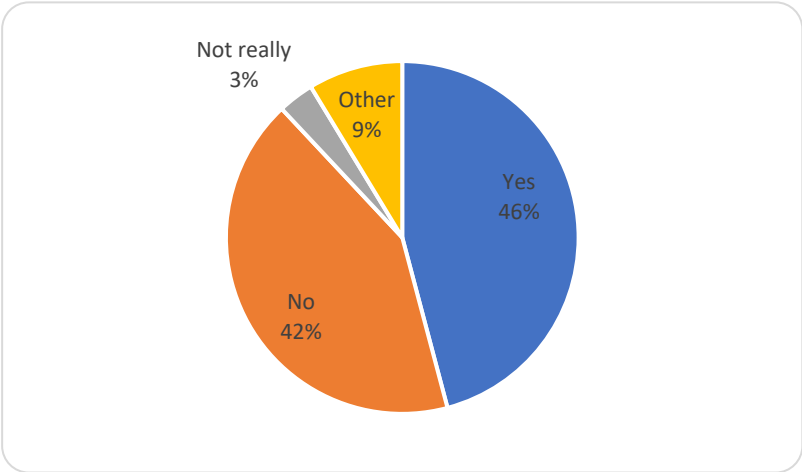
2. Did it take you a while to realise that you were an unpaid carer?

Fairly even split between people noting that Yes it did take time to realise and No it didn't. Other comments included:

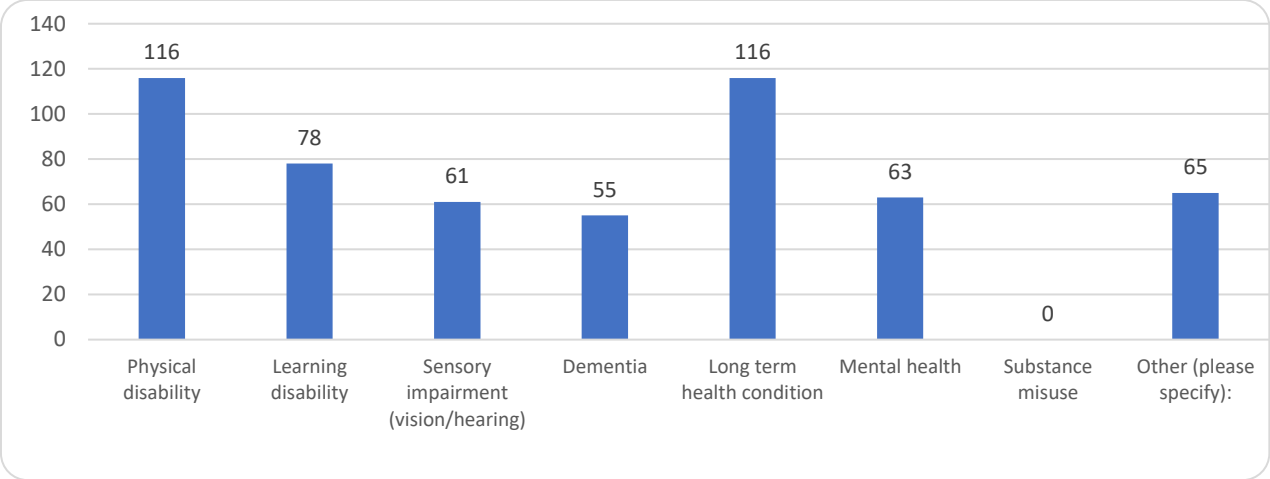
"You care because they are family and you do what you do because you love them"

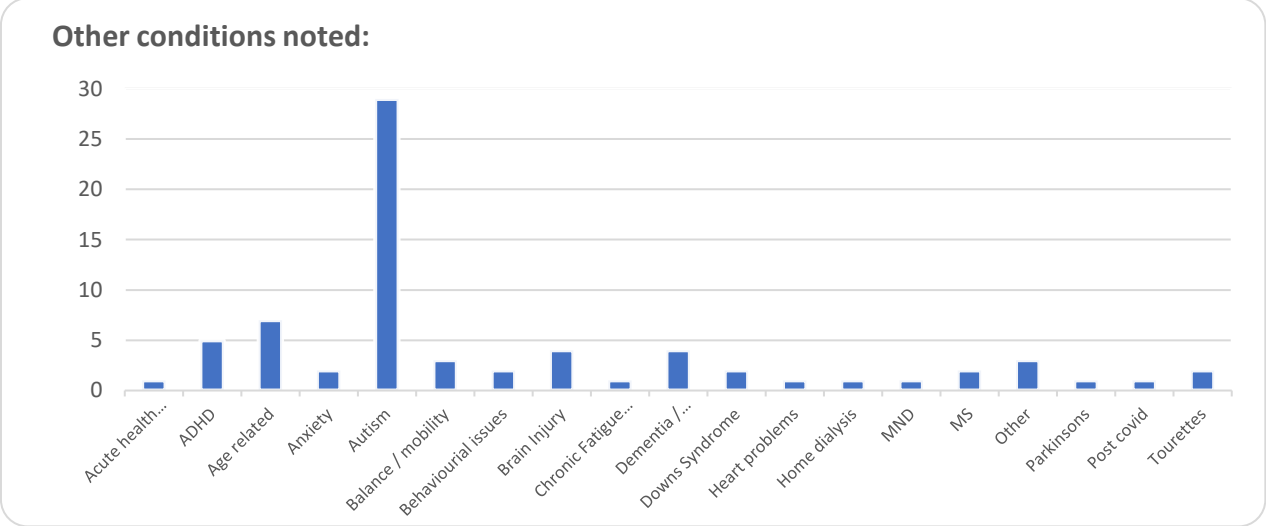
"I'm not. I'm a mum, wife, daughter... I also don't recognise paid support staff as 'carers'. Why are they referred to as 'carers', not 'paid carers'?"

"Covid-19 has bought home to me that I am an unpaid carer when I realised my parents wouldn't cope if I was ill. This has caused me a lot of worry."



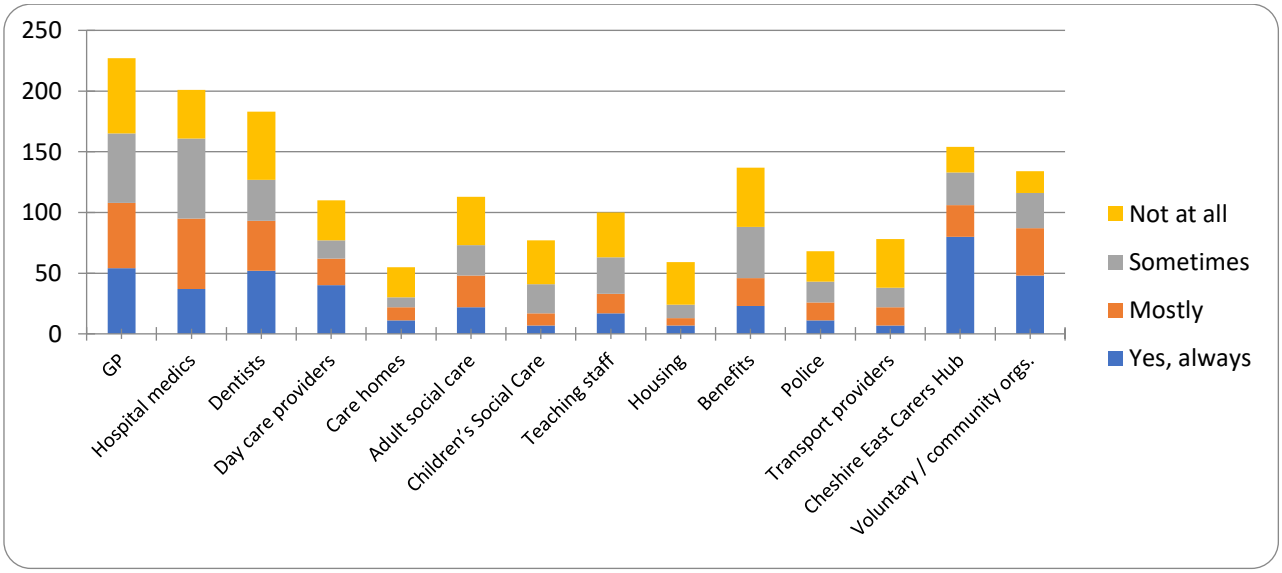
3. Thinking about the person you care for, which below best describes their situation?

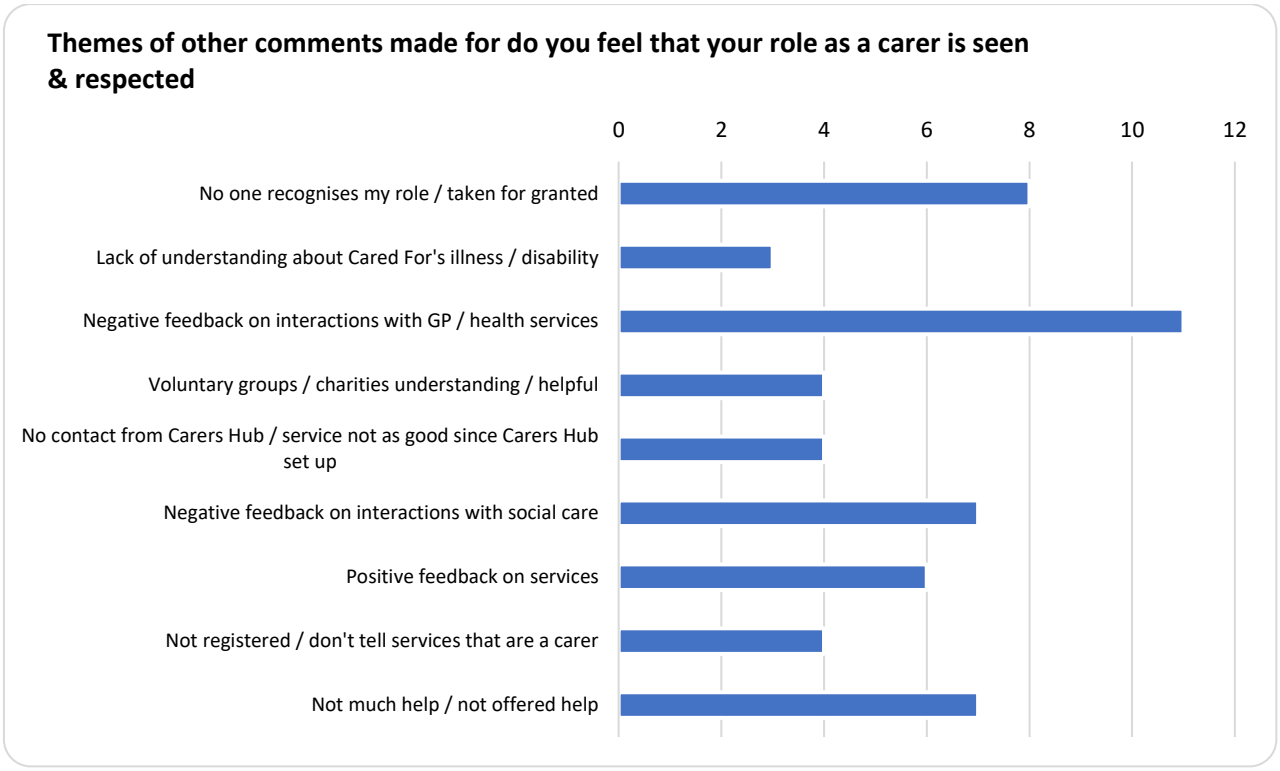




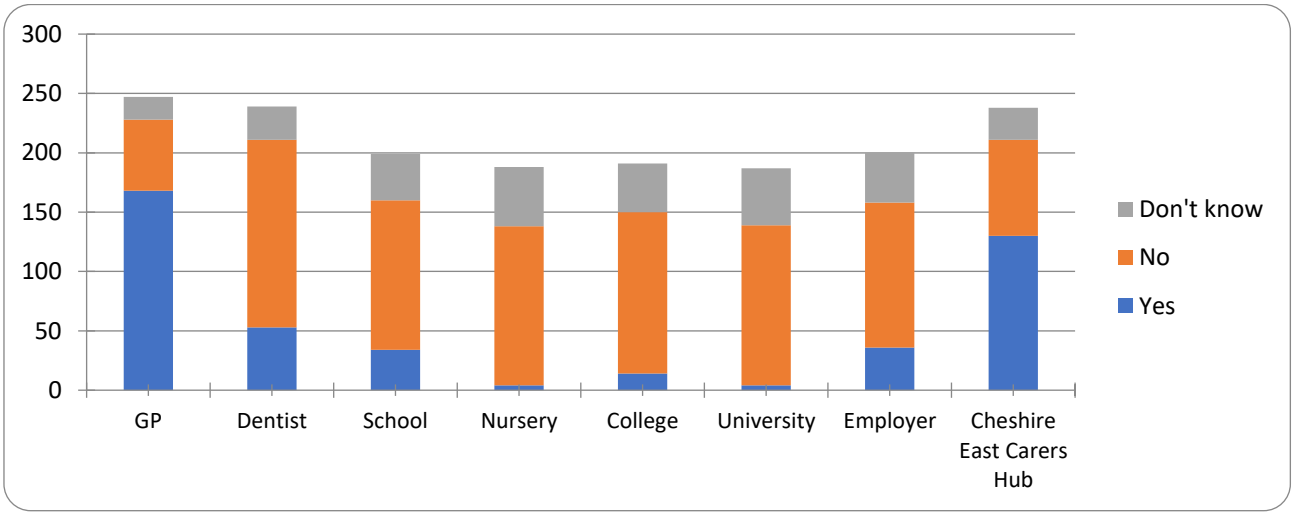
The main ‘other’ condition noted was Autism.

4. Do you feel that your role as a carer is seen and respected by the services listed below?



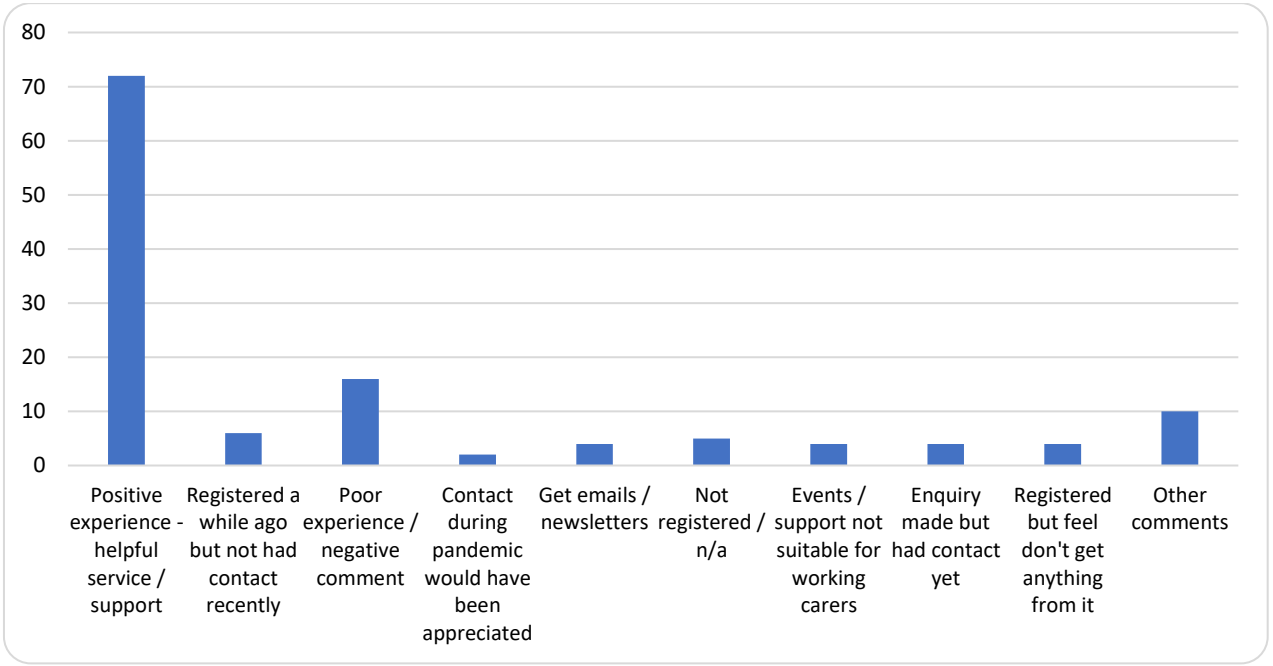


5. Have you registered / recorded your role as an unpaid carer with any of the services below?

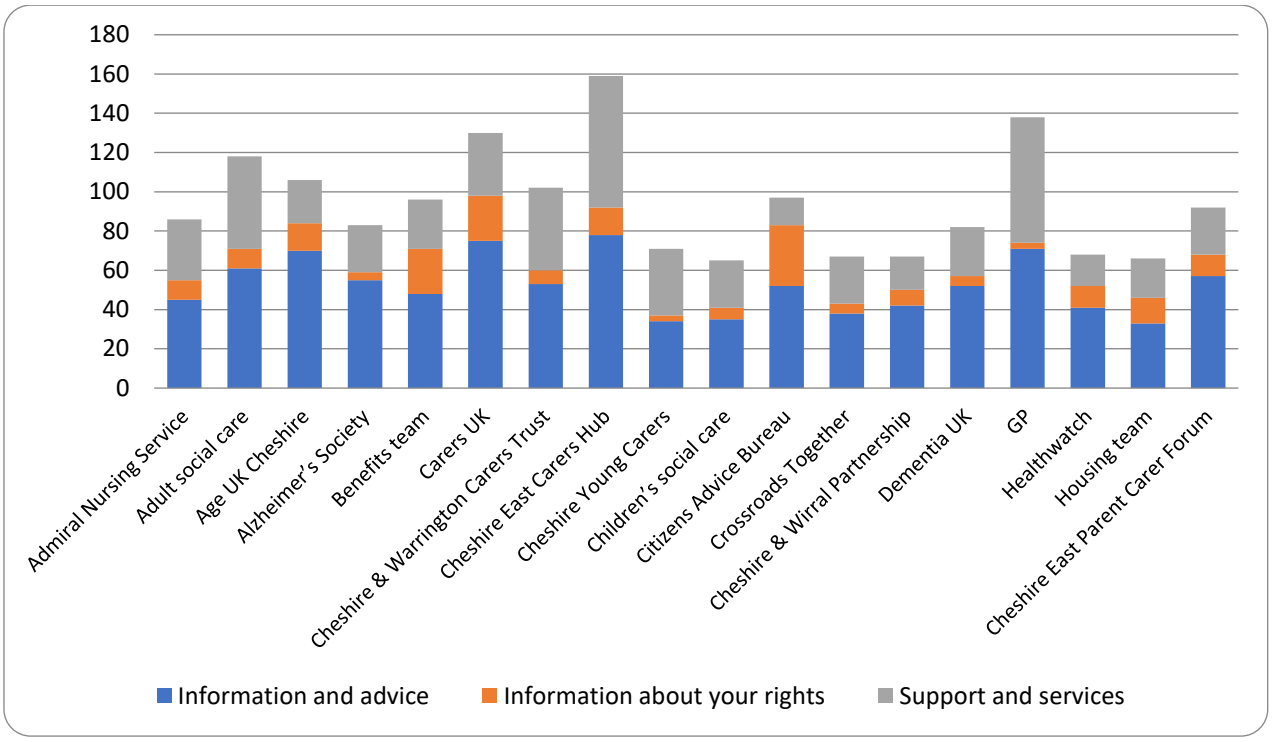


6. We asked carers to share their experiences of registering with the Cheshire East Carers Hub.

127 carers gave an answer to this question and the below chart summarises the themes of their answers. There were 72 comments (57%) noting a positive experience of registering with the Carers Hub

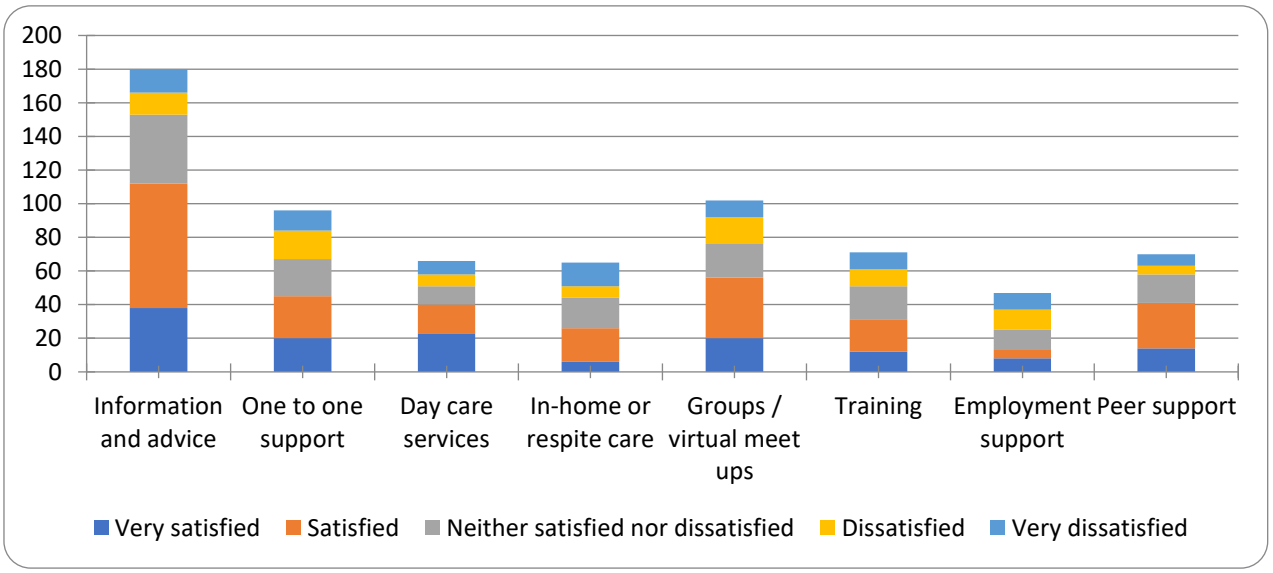


7. Where would you go to seek information, advice and support about your rights and your role as a carer?



Other organisations noted include Space4Autism, SENDIASS, Cheshire Buddies, Ruby's fund, MND Association, Dementia Reablement, In Control, Kidney Care UK, peer support and ADCA. There were also a number of comments from carers that they would have liked to select more than one option for some services as they use them for more than one element (e.g. information, advice and support).

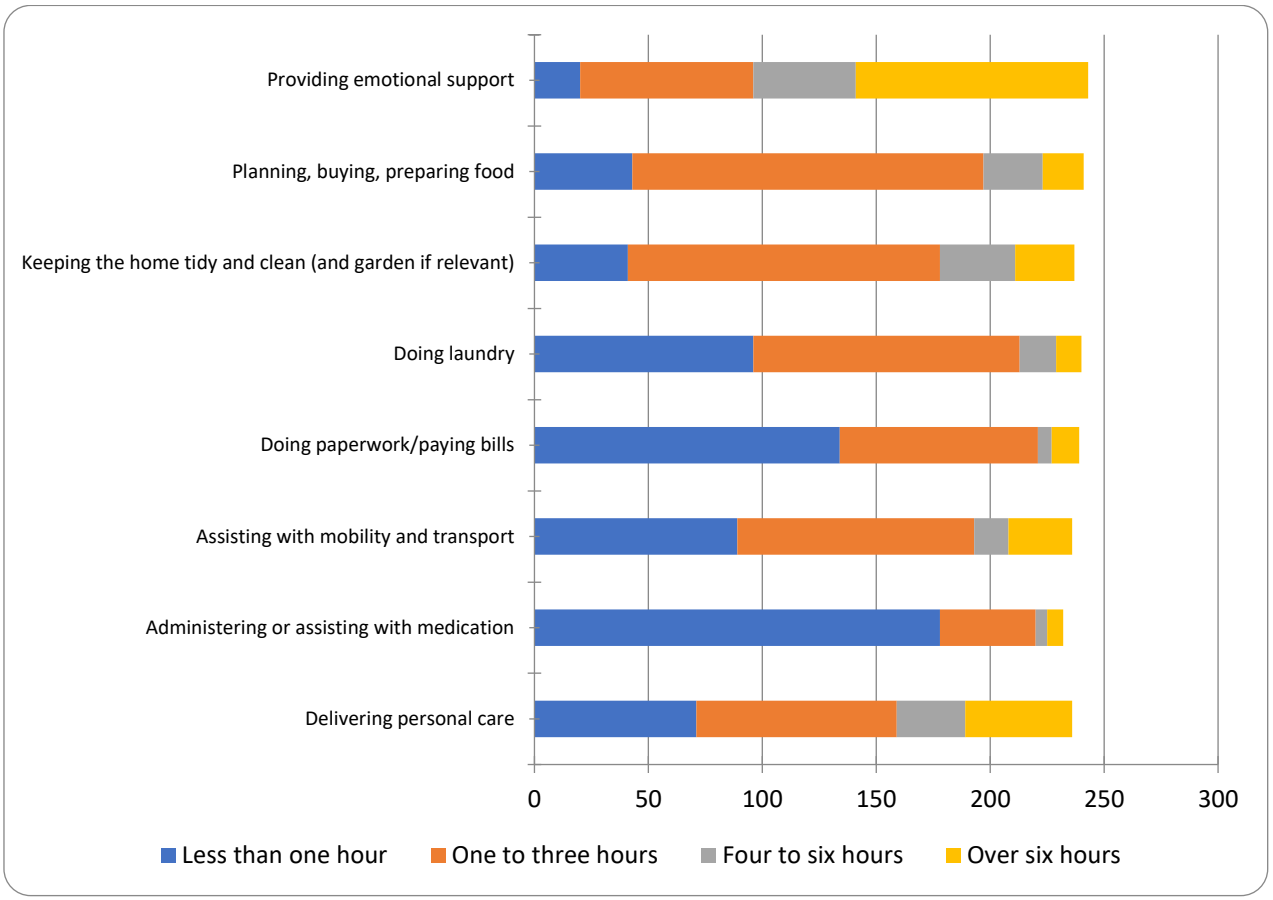
8. If you have received support in your caring role, what types of support have you had and how satisfied or dissatisfied were you with this?



Comments received in relation to this question were mixed. A number of other services were mentioned including positive feedback for Space4Autism, Admiral nurses at ECH and Cheshire & Warrington Carers

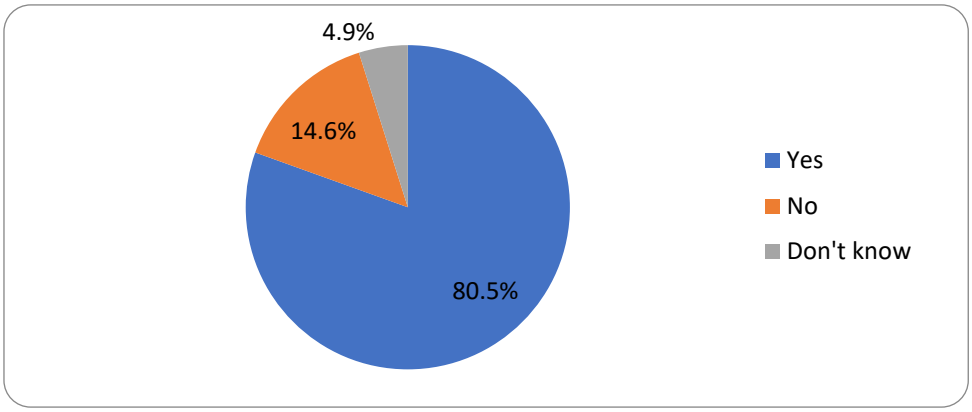
Trust. Some carers noted that they had not received any support, a couple noted that support groups are not always local and have trouble with transport and that can't attend some groups as can't leave the person they care for alone.

9. Thinking about your role as a carer, select the average number of hours you think you spend each day on the support tasks below?

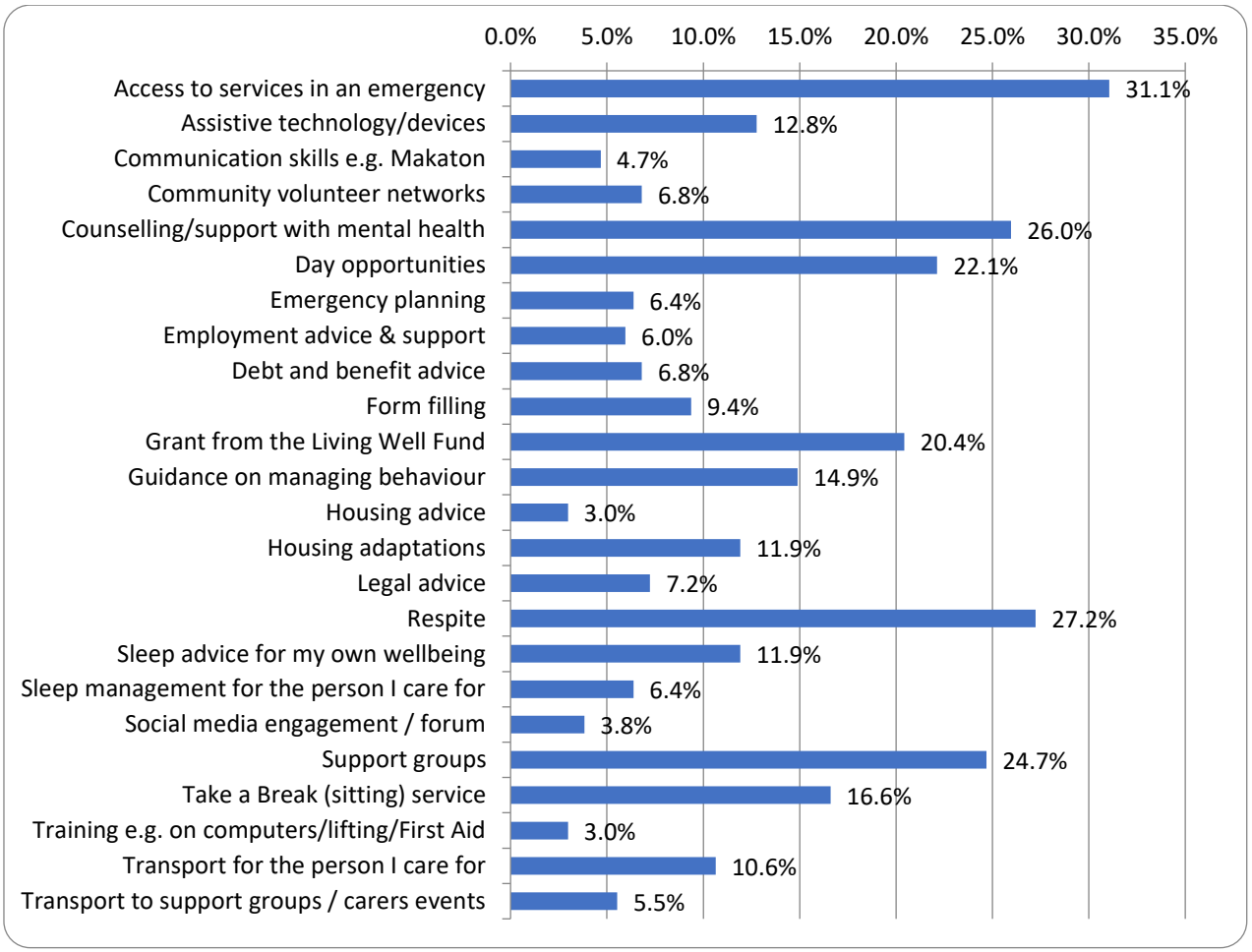


Carers spend the most amount of time each day providing emotional support and delivering person care. Tasks taking a medium length of time include food tasks, cleaning and laundry. Administering medications and doing paperwork are tasks that take the shortest amount of time.

10. Do you feel if this has increased in the last year due to the impact of Covid?



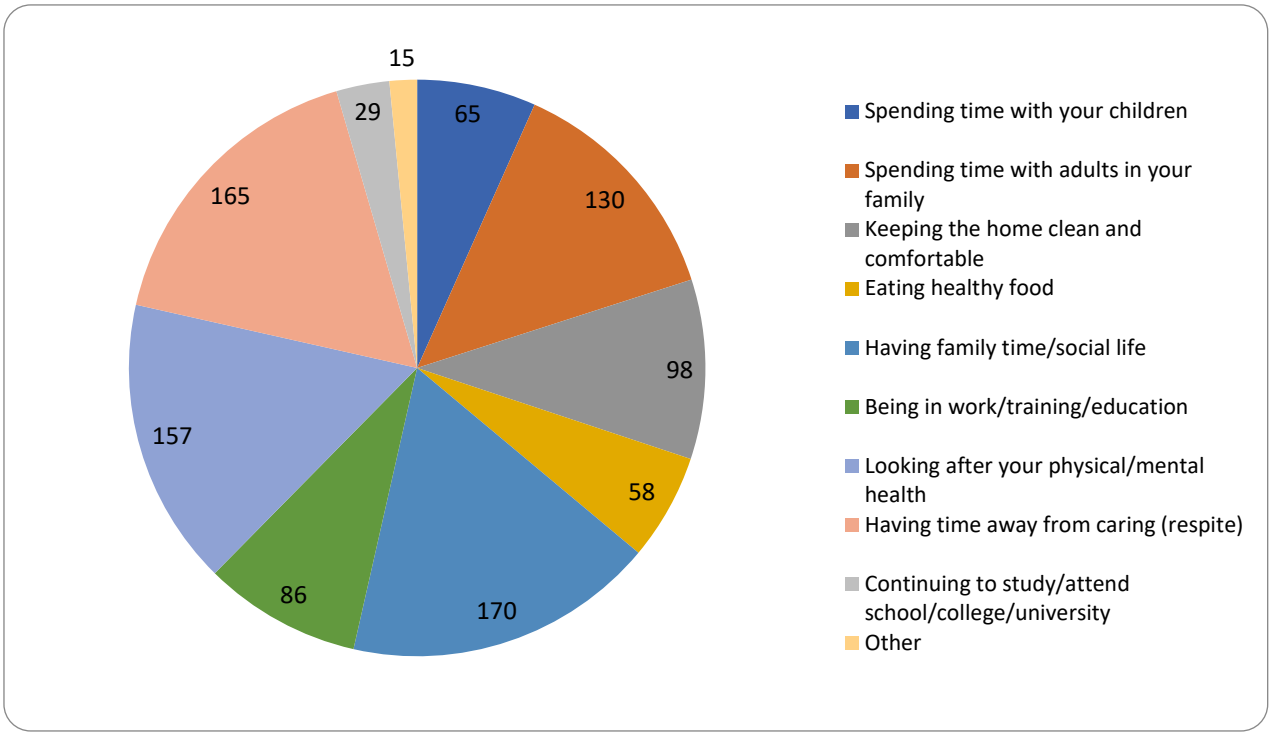
11. Which of the following types of information and support would help you the most in your caring role?



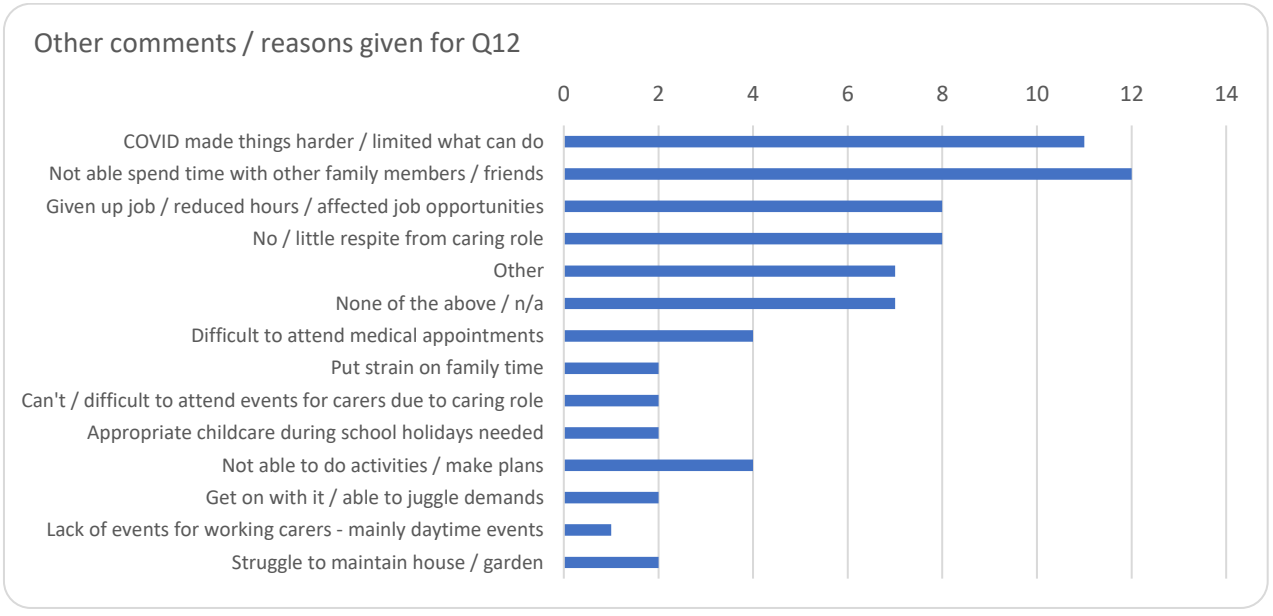
Top 5 types of information & support identified by carers that would help them most:

Access to services in an emergency	31.1%
Respite	27.2%
Counselling / support with mental health	26.0%
Support groups	24.7%
Day opportunities	22.1%

12. Does your caring role make it difficult for you to do any of the activities below?

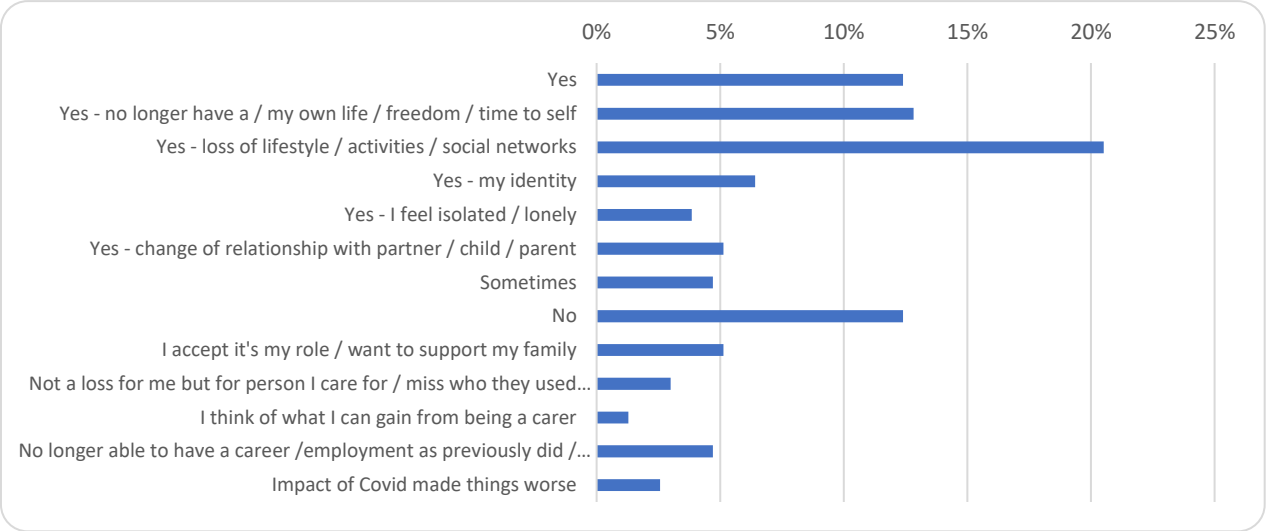


The highest number of responses for having family time / social life, looking after their own physical / mental health and having time away from their caring role. This was also reflected in the other comments made, as well as the impact of COVID and lockdowns on being able undertake activities outside of caring role.



13. Do you feel any sense of loss because of your caring role?

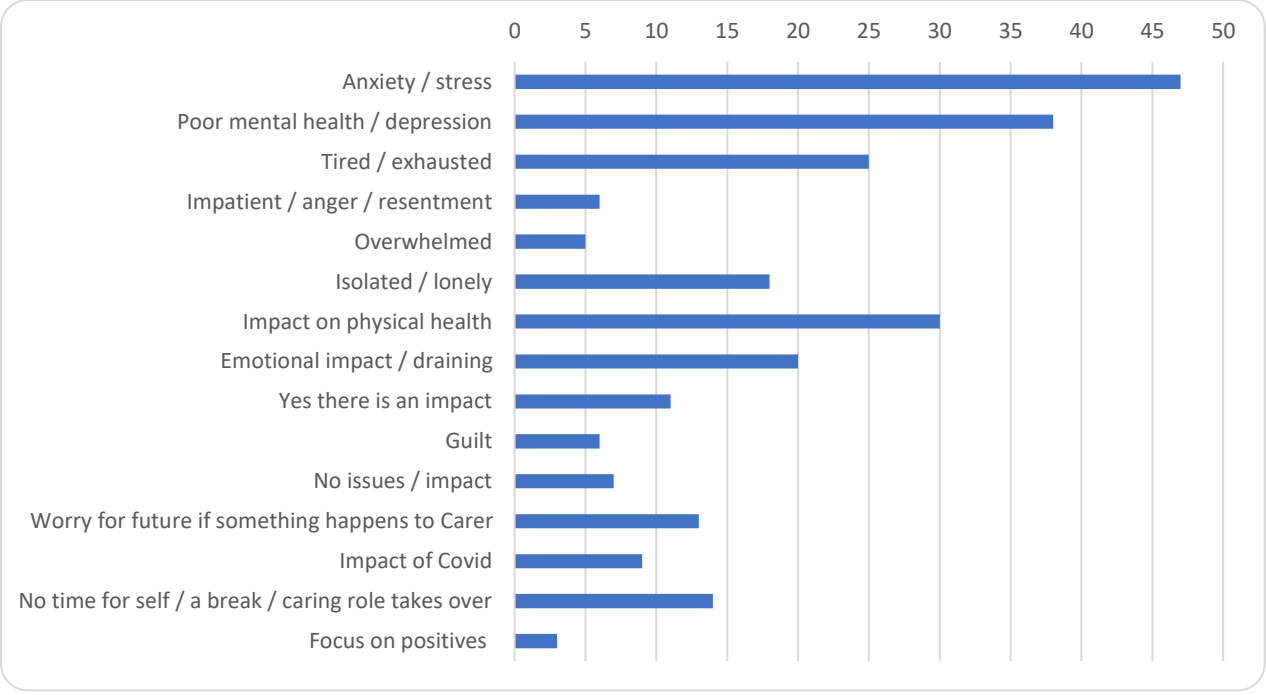
Themes of the answers given to this open question.



69% of carers noted that they have experienced some sense of loss because of their caring role. 21% noted in particular that they have experienced a loss of their own lifestyle with no longer being able to partake in hobbies, activities and social networks due to caring for someone else. 13% noted that their caring role hadn't caused a sense of loss. The impact of Covid & lockdowns has also made situations worse for a few carers.

14. Please tell us if your caring role has affected your emotional, mental or physical wellbeing

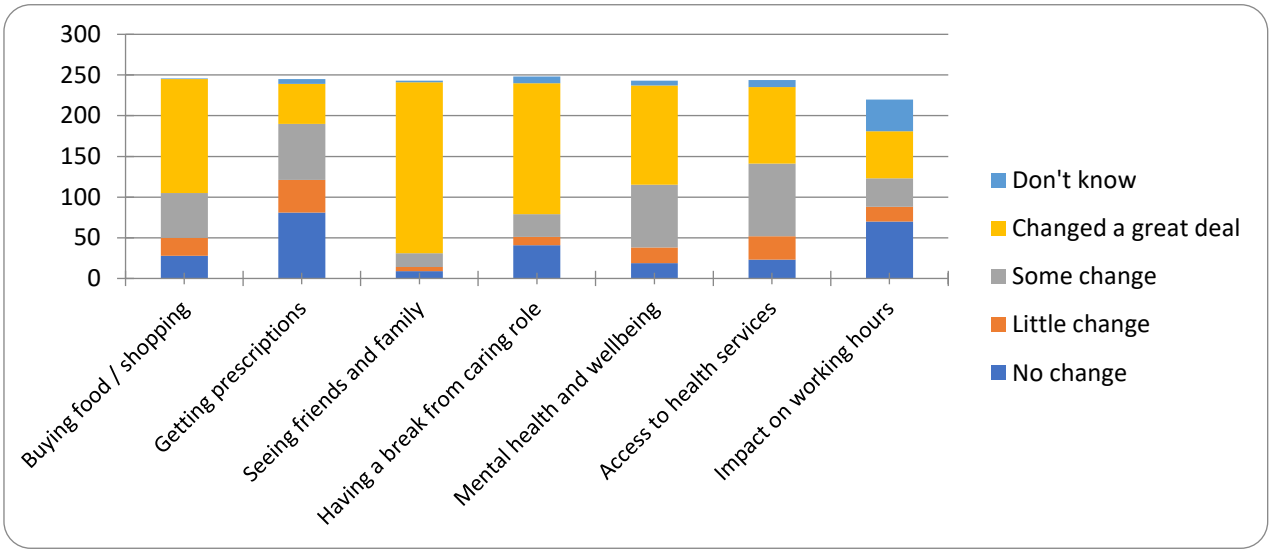
This was an open question, so the answers have been collated into themes.



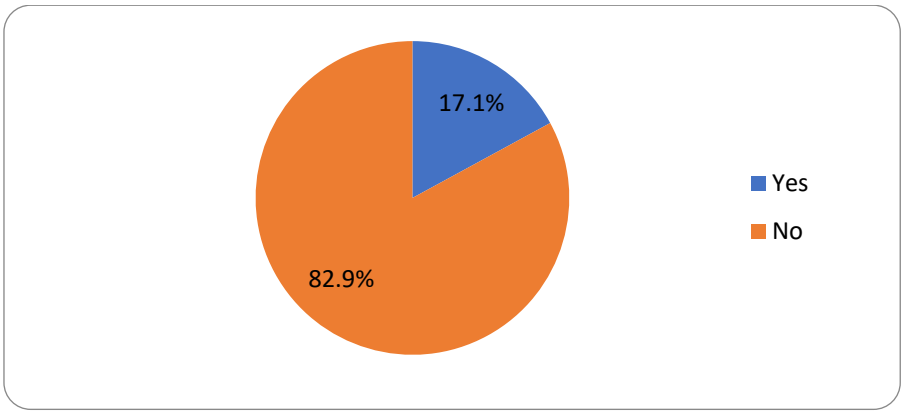
The most comments were about the impact their caring role has had on their mental health with 47 comments relating to anxiety and / or stress and 38 noting depression and increase in poor mental health.

There were 30 comment noting a negative impact on the carer's physical health. There were some comments noting there hasn't been an impact and 3 comments saying they try to look at the positives and what they can gain as a carer.

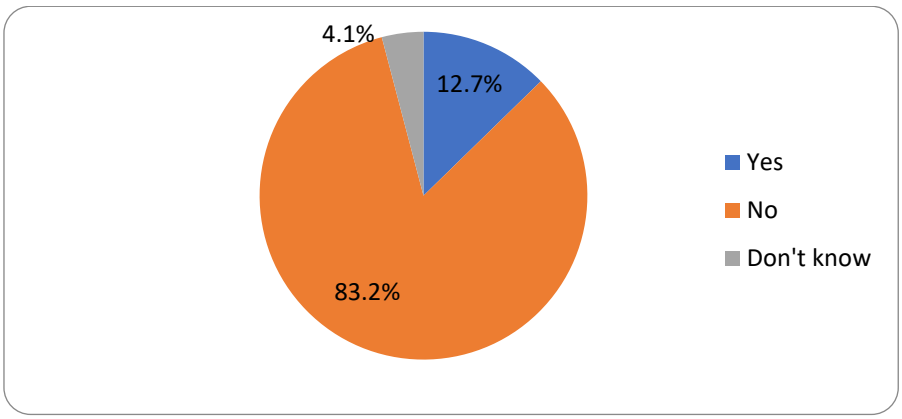
15. How much has Covid-19 impacted you in your role as a carer?

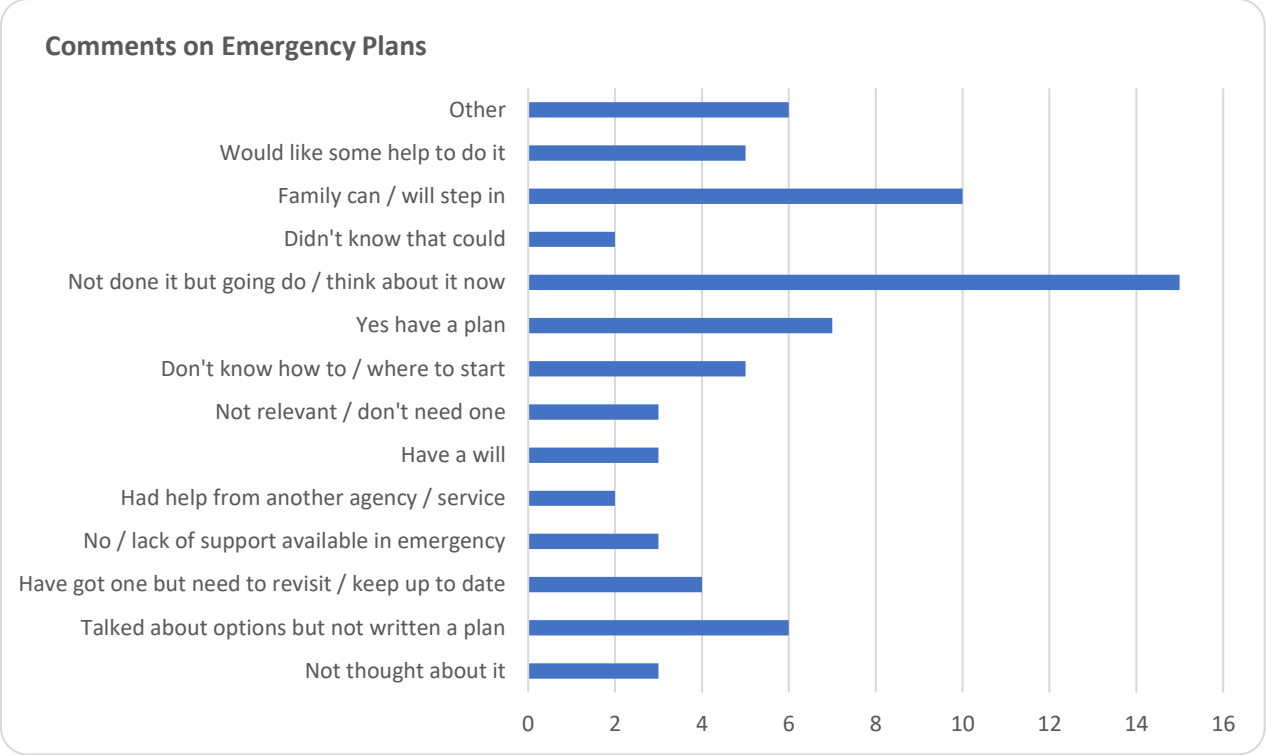


16. Have you contacted the Cheshire East Carers Hub to request support during Covid-19 pandemic?



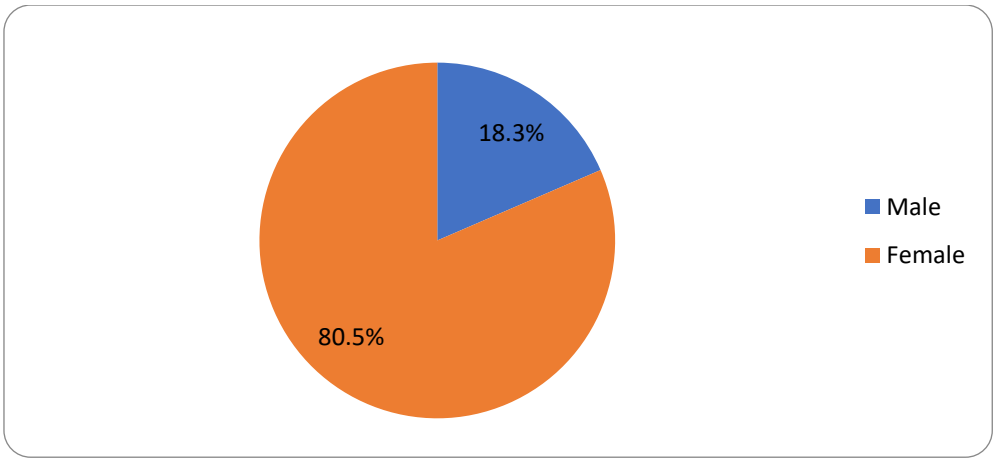
17. Have you written an emergency plan in case you are unable to continue to provide care at any time?





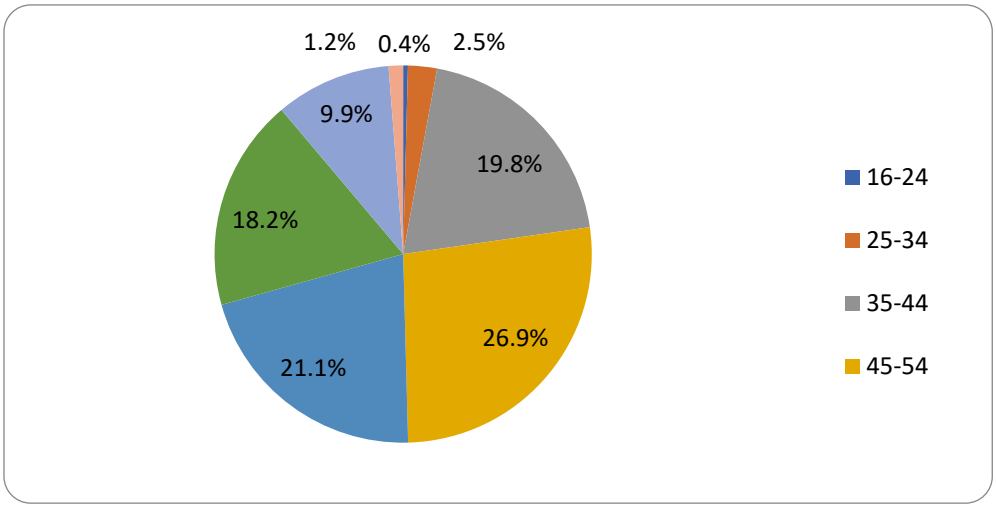
Demographics of respondents

18. What is your gender identity?

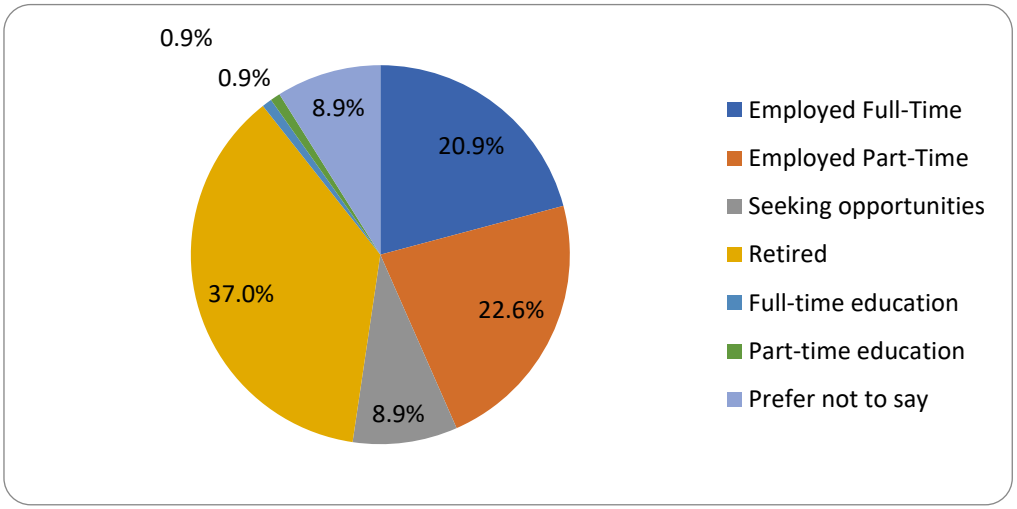


There were 3 comments noted under ‘Prefer to self describe’ but contents of these didn’t relate to gender identity.

19. What age group do you belong to?

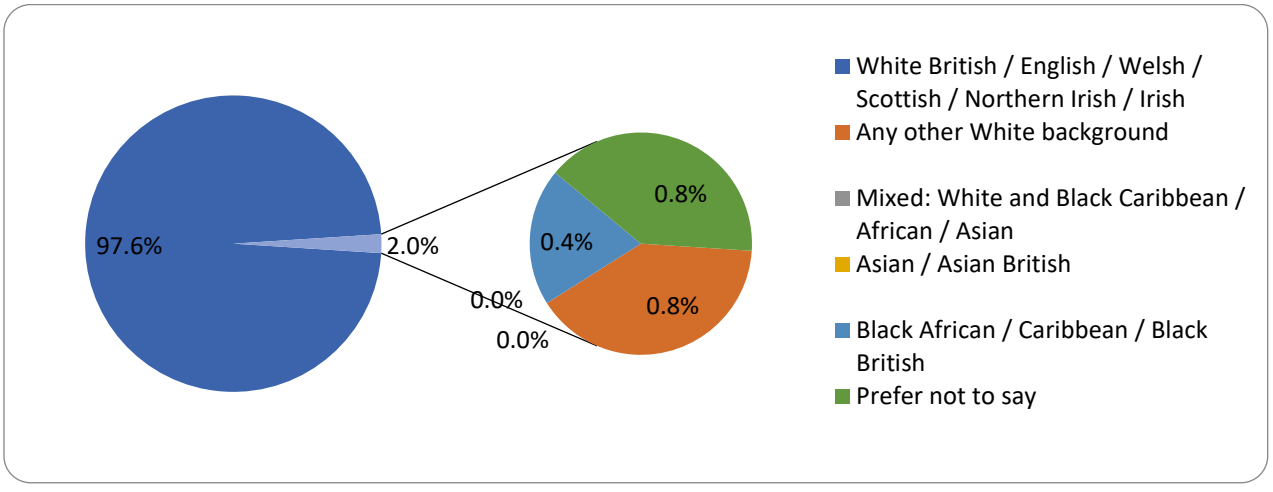


20. What of the following best describes your current status?

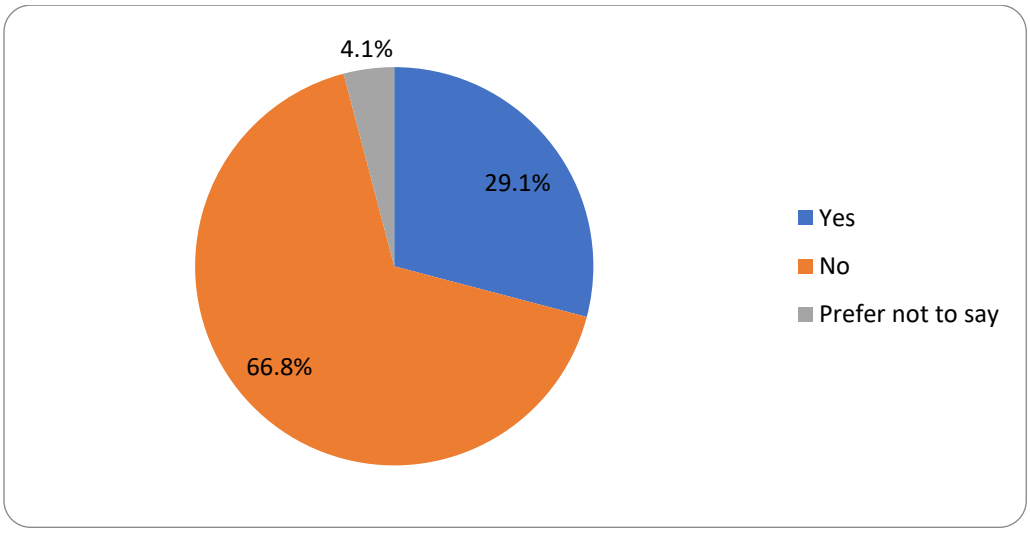


There were some comments that noted how ‘carer’ wasn’t an option to select in this list.

21. What is your ethnic origin?



22. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? This includes problems related to old age.



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Working for a brighter future together

Adults and Health Committee

Date of Meeting:	27 September 2021
Report Title:	Consultation on the Assistive Technology Charging Policy
Report of:	Nichola Thompson, Director of Commissioning
Report Reference No:	AH/30/21-22
Ward(s) Affected:	All

1. Executive Summary

1.1. Assistive Technology is an important means by which people can be supported to live independently in their own homes in lieu of traditional care support (such as care at home).

1.2. The Council wishes to develop this service, by increasing the number of people who can access it, and the range of devices they can obtain to address their care needs more effectively. However, a necessary step in implementing this change is to review the charging structure for the service. As such, a consultation has been carried out on a proposal for the same charge to be levied on those aged 85 plus and living alone as all other users (individuals aged 85 plus and living alone currently pay no charge). Those affected could request a financial assessment. This would ensure those unable to pay, would not need to do so.

1.3. This report carefully considers the consultation feedback received from a variety of methods including a consultation survey, telephone surveys and other discussions with stakeholders. However, the case for the proposal remains compelling, given the need to make the service sustainable over the long-term.

1.4. A number of priorities detailed in the Corporate Plan 2020-2025 relate to Assistive Technology. These include reducing health inequalities; reducing reliance on long term care and protecting the most vulnerable.

2. Recommendations

2.1. To implement the consultation proposal that people aged 85 and over who are living alone are charged £5 per week for the Assistive Technology service. This will be the same levy as for all other users of Assistive Technology. This is subject to users being able to ask for a financial assessment, which would check their ability to pay. People with a cognitive impairment will be appropriately supported in this process.

3. Reasons for Recommendations

3.1. Levying the same charge on all users, would allow the service to be sustainable in the longer term. This would enable the service to grow and to be accessed by additional vulnerable people. Without this, financial pressure will build, given the welcome projected 15% increase in those people aged 85+ by 2025 (in comparison to 2020) and 36% by 2030[1].

3.2. Currently, half of users are paying for the service and half are not, thus meaning one set of users are effectively subsidising others (including 212 people aged 85+ living with others). This is unfair. In implementing the change, the financial assessment process will ensure that no one who cannot afford to pay, would have to pay.

3.3. Consultation responses have been carefully considered including the clear message over how valued Assistive Technology is. Nonetheless, it is deemed not unusual that some people would object to paying for a service in the future that they have had for free, even if this concession is not offered by other Councils.

3.4. Care Act guidance specifically references the need for charging to be "sustainable…in the long-term". It also emphasises a need to, "apply the charging rules equally so those with similar needs or services are treated the same and minimise anomalies between different care settings"[2].

4. Other Options Considered

4.1. *Raising the charge to £8 for users* currently *paying* – this could raise a similarly large amount of income but might be deemed unfair by those having to pay this

4.2. *Removing the physical response service* – however, users expressed strong support for this facility in consultation feedback**.**

5. Background

5.1. Assistive Technology is an important means to address the assessed care needs of service users by supporting people to stay independent in their own home for longer, whilst providing improved choice and control. For

[1] Projecting Older People Population Information System, www.poppi.org.uk
[2] Care and Support Statutory Guidance, www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#charging-and-financial-assessment

instance, devices such as pendant alarms can help safeguard individuals more likely to fall due to frailty by alerting a call centre who can in turn trigger the service's mobile response team. Other examples include falls detectors, bed sensors and GPS devices.

5.2. A number of priorities detailed in the Corporate Plan 2020-2024 relate to Assistive Technology. These include:

- Reducing health inequalities across the borough
- Reducing the reliance on long term care by improving services closer to home and providing more extra care facilities, including dementia services
- A commitment to protect the most vulnerable people in our communities
- Increasing the life opportunities for young adults and adults with additional needs.

5.3. Currently, a charge of £5 a week is levied on users of the Council's Assistive Technology service unless the user is aged 85+ and living alone. The level of the charge has not changed since 2015.

5.4. A consultation was launched on a proposal to implement a single charge for all users. The consultation took place from 27 May-22 July 2021 (8 weeks). This followed Cabinet approval to undertake this exercise at a meeting on 13 April 2021.

5.5. A total of 932 responses were received to the consultation. 51% of these were from people who received the service for free.

5.6. The number of service users utilising the service fluctuates over time, as does the portion of clients who are aged 85+ and living alone. At the start of the consultation period; there were 2,253 in receipt of Assistive Technology, with 1,128 receiving this at no charge (50%). Out of these; there are 212 people aged 85 and over who are subject to the charge because they do not live alone. Similarly, there are also 534 users aged 75-84; 197 users aged 65-74 and 182 users aged less than 65 who also pay the weekly charge.

5.7. The consultation questionnaire served two purposes: to provide information from the public about the consultation proposal but also to provide valuable feedback which would inform the recommissioning of the Assistive Technology service (and also the digital switchover). A separate Committee Report has been submitted on this.

5.8. The full consultation report is available in Appendix 1. However, the following paragraphs give headlines. It is to be remembered that, "…effective consultation allows…informed decisions on matters of policy, to

improve the delivery of public services, and to improve the accountability of public bodies" (Government Consultation Code of Practice)[3]. As such it is not a referendum, but an opportunity to review the business case for a proposal based on any new information provided by respondents.

5.9. A majority of respondents disagreed or strongly disagreed that people aged over 85 and over who live alone should pay a charge for telecare (56%). A further 28% of respondents agreed or strongly agreed with the statement and 16% neither agreed or disagreed. The percentage of those disagreeing or strongly disagreeing with the proposal amongst those aged 85+ and living alone (those directly affected) was marginally higher at 60%.

5.10. The most selected reason for disagreeing was, 'the charge is unfair to those affected' at 56%; followed by at 36%; 'savings should be made elsewhere'. No 'reasons in favour' options were included for those who agreed with the proposal. However, feedback received highlighted both that the service was valued and that some people felt able to pay the proposed charge.

5.11. As part of work alongside the consultation, comparison has been made of charges in other areas. This is available in Appendix 2. No other Local Authority applies an aged 85+ and living alone exemption.

5.12. Analysis has also found that there are 516% more people accessing the service in areas at an Index of Multiple Deprivation level of 9 and 10 (least deprived) in comparison to those at level of 1 and 2 (most deprived). This pattern can be viewed as the direct consequence of areas of deprivation having lower levels of life expectancy. For instance, average life expectancy in the most deprived ward in the Borough: 'Crewe Central' is only 72.6 in comparison to the least deprived area 'Wilmslow East' where it is 84.3.

5.13. It has also disclosed that the free telecare policy for those 85+ and living alone has contributed to a 273% increase in take up by this cohort since January 2016. This has created a position where around half of users are receiving the service for free.

5.14. Of further note, is that Assistive Technology predominantly offers secondary prevention for falls. This means its impact on prevalence of falls is highly limited. Therefore, the more vital focus needs to be on stopping them to begin with.

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3 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/100807/file47158.pdf, p3

5.15. Examples of preventative work conducted by the Council, include an increase in One You Cheshire East falls prevention capacity to 900 places following a recommissioning process (the original figure was 380). This has been further enhanced to around 1,200 places this year as part of a COVID-19 recovery plan. It has also involved (driven by the Cheshire East Falls Prevention Strategy) increasing the number of falls hazard checks conducted in people's homes and raising public awareness of this health issue e.g. via dissemination of a falls prevention booklet.

5.16. There was estimated to be 12,300 people aged 85+ in Cheshire East in 2020 (note: 43% of people aged 85 are estimated to fall each year). As such, the percentage of people receiving the service at no charge is currently around 9.2%. Residents can also obtain a less comprehensive Assistive Technology service privately by using an alternative provider. However, it is not possible to estimate how many are currently choosing to do this.

5.17. Partnership working is continuing to take place on the issue of falls (including with the Integrated Care Partnership) given the knock-on effect it can have on other services such as the Acute Trusts and North West Ambulance Service.

6. Consultation and Engagement

6.1. The following measures were taken to encourage service users and the general public to participate in the consultation:

- A letter was sent to all Assistive Technology users directly affected by the consultation proposal. This included a consultation information pack, questionnaire and freepost envelope.
- A letter was sent to all other Assistive Technology users with the same supporting materials.
- Reminder letters were sent a few weeks after these to encourage further response.
- A briefing meeting was held which was open to all Councillors on 21 June.
- Copies of the consultation information pack, questionnaire and freepost envelopes were distributed to local libraries.
- Social media was used to build awareness of the consultation. This included four separate pushes.
- Face to face, online and telephone meetings were offered to users. Note: the offer of the six face to face meetings had to be amended during the consultation due to the rise in COVID-19 cases.

- The consultation was accessible from the home page of the Council's website.
- Additionally, articles about the consultation have been featured in the press.

7. Implications

7.1. Legal

7.1.1. There are no immediate legal implications arising from this proposal.

7.2. Finance

7.2.1. The Assistive Technology service should be funded in full via the Better Care Fund and by client contributions. However, the service has been significantly overspent for the last few years. The overspend in 2020/21 was £471k.

7.2.2. The current value of client income received for Telecare services is around £280k per year, which means that for the under 85 cohort we charge around 80% of clients. The reason for this is that although Telecare services are not formally financially assessed if a person can truly not afford to contribute to the costs then the charge is waived.

7.2.3. Assuming that 80% of the 1,128 over 85 service users were to be charged the additional income could be up to £235k per year.

7.2.4. However, many clients who are 85+ may also have care packages that they already make client contributions towards. This could mean that Telecare income could increase, but contributions to their other care costs could decrease, as their financial assessment of affordability would be impacted.

7.2.5. This means the overall increase in income will be lower, but we are not able to estimate accurately what the likely additional income will be at this time as each person's circumstances will be different.

7.3. Policy

7.3.1. The paper concerns a change to the Council's Assistive Technology charging policy.

7.4. Equality

7.4.1. An Equality Impact Assessment has been completed on the consultation proposal and was updated to take account of comments made by respondents in the consultation. This is available in Appendix 3.

7.5. Human Resources

7.5.1. There are no human resource related implications.

7.6. Risk Management

7.6.1. A risk management process will be followed when implementing this work to ensure that risks are properly managed and mitigated where possible.

7.7. Rural Communities

7.7.1. Assistive Technology is helpful in supporting vulnerable people in rural locations to live independently. This includes providing reassurance to carers.

7.8. Children and Young People/Cared for Children

7.8.1. This report only relates to changes to charges for older people aged 85+ and living alone.

7.9. Public Health

7.9.1. Reducing health inequalities is a key principle of a Public Health approach. This is referenced within paragraphs 5.12-5.13.

7.10. Climate Change

7.10.1. None.

Access to Information	
Contact Officer:	Nichola Thompson Nichola.thompson@cheshireeast.gov.uk 01270 371404
Appendices:	Appendix 1: Consultation Report Appendix 2: Charges Levied by Other Local Authorities Appendix 3: Equality Impact Assessment
Background Papers:	Cheshire East Corporate Plan 2021-2025

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Cheshire East Council

Telecare Charging Consultation Survey

Summary of results

Production date: July 2021

Introduction

Background and Methodology

Between the 27th May and 22nd July 2021 Cheshire East Council conducted a survey as part of a review of telecare services. Its aim was to capture views on a proposal to introduce a charge for Telecare (also known as Assistive Technology) for those aged 85 and over who live alone. It also gave general feedback about the Telecare Service to help improve it in the future. As such, the findings of this survey will help inform and shape the new Telecare Service Specification for the new service (expected to be launched in April 2022). Telecare devices include items such as falls detectors, lifelines/pendant alarms and beds sensors.

This survey was distributed to all current users of telecare (2,253) by post. The survey and background information were also available on the Cheshire East Council website. Hard copies were also made available in the libraries.

In total, we received and analysed a total of 932 responses. Of these for 701 responses it was indicated that they were from or behalf of someone with telecare. Please note that for the purposes of this report open comments received have been coded and grouped into themes.

The survey was split into three sections as follows:

- Part A – Your views about the Charging Proposal
- Part B – About Telecare Services in General
- Part C – About you

Note: categorising written comments is a complex task, so numbers have been provided as an approximate guide only, in order to give an indication of quantity of comments received on that subject.

Part A: Your views about the Charging Proposal

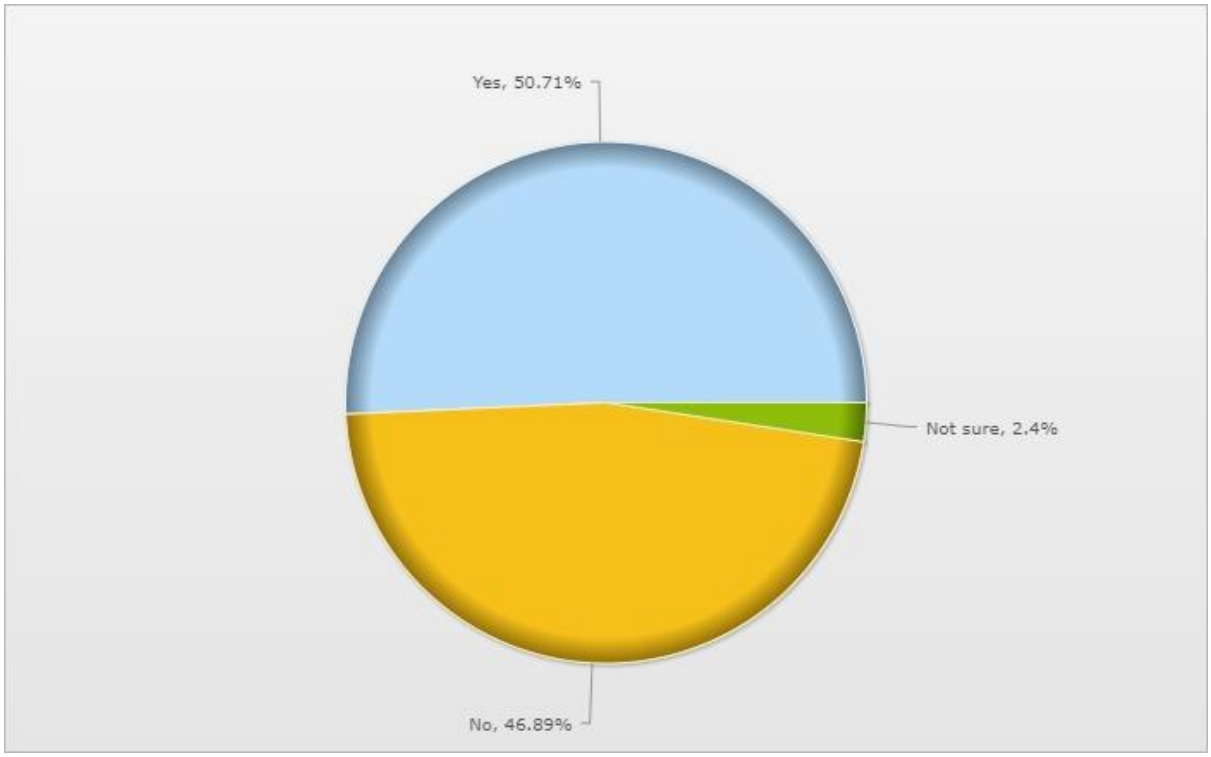
Key Findings

The first question asked if the respondent was currently receiving telecare for free because they were aged 85 or over and living alone.

This was an important question as it would be these individuals who would be directly affected by the consultation proposal.

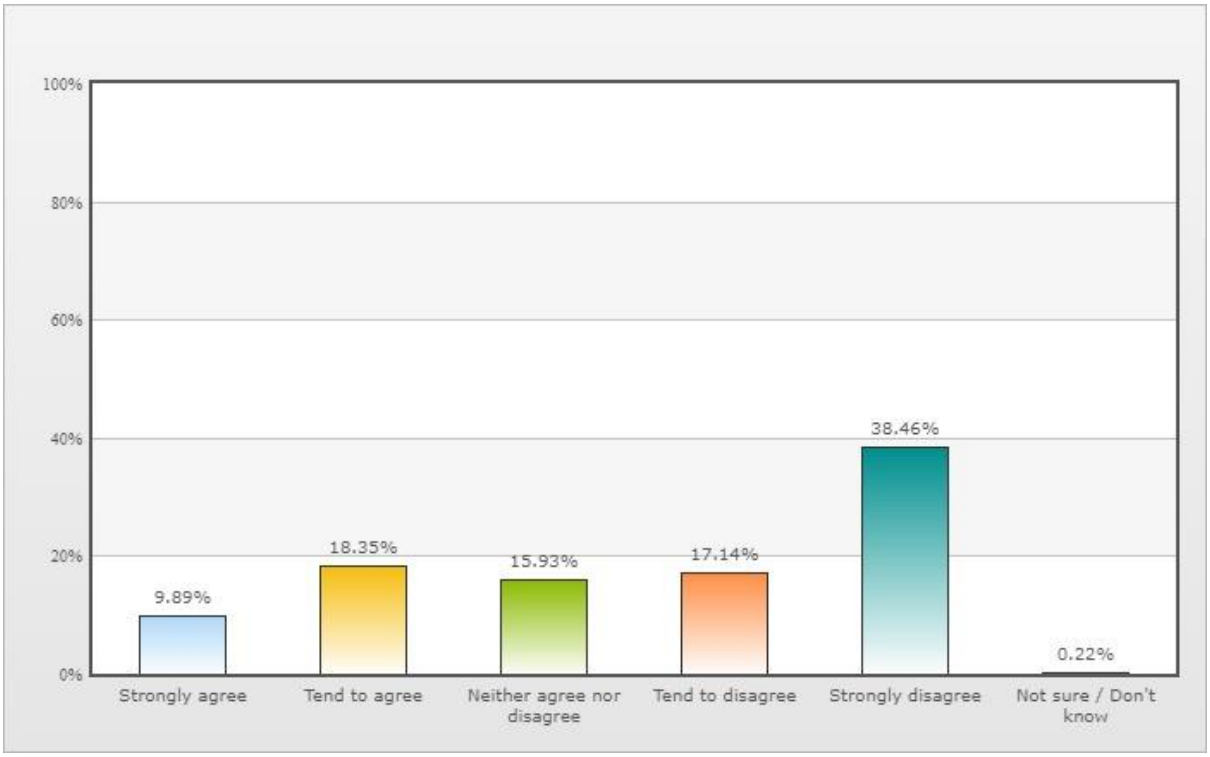
Out of the responses received, the groups were relatively evenly split with 50.7% (465 responses) saying they received telecare for free because they are aged 85 and over and living alone, and 46.9% (430 responses) saying they did not. There was also a very small tranche who were unsure if they fell into this bracket (2.4%, 22 responses).

Figure 1: Do you currently receive telecare for free, because you are aged 85 or over and live alone?



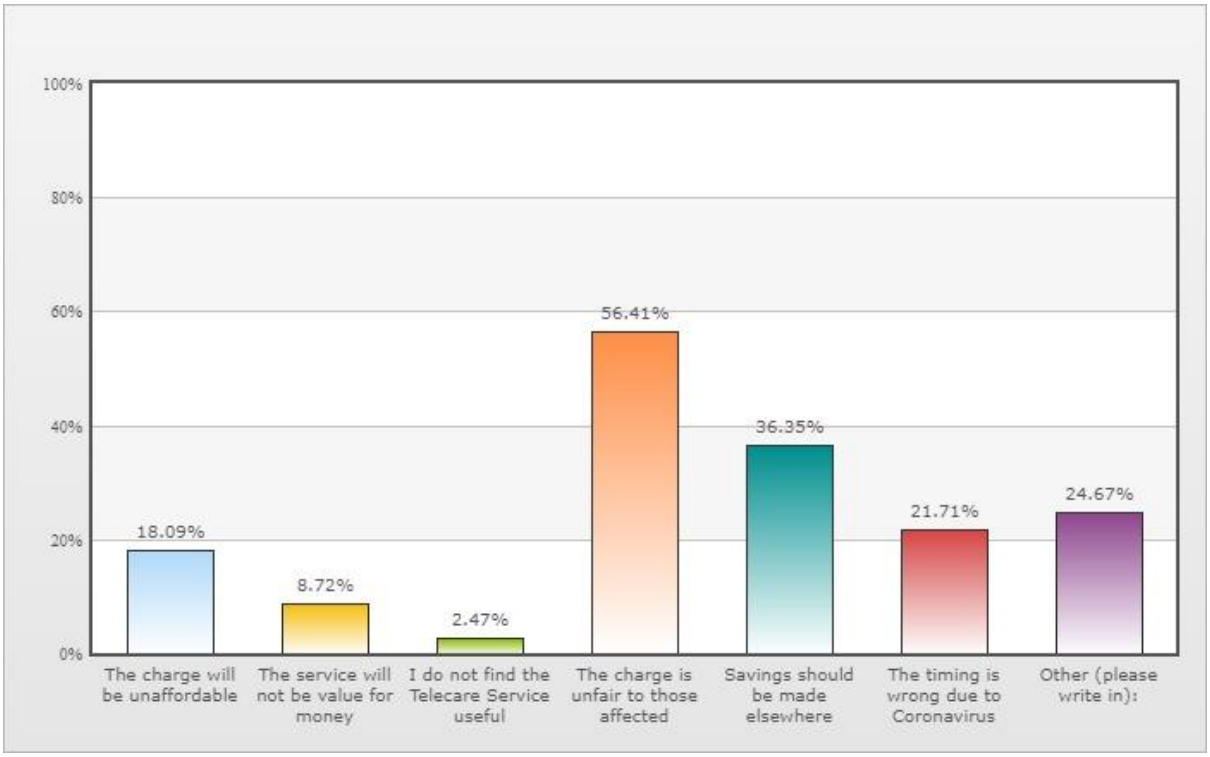
The next question directly asked how strongly respondents agreed or disagreed with the consultation proposal. Overall, a majority was against this, with 55.6% (506 respondents) either strongly disagreeing or disagreeing. A further 28.2% or 257 respondents agreed or strongly agreed with the statement and 15.9% (145 respondents) neither agreed nor disagreed. Figure 2 provides a full breakdown.

Figure 2: How strongly to you agree or disagree that people aged 85 and over who live alone should pay a charge for telecare, like other telecare users? No one who cannot afford to, would be made to pay the charge (subject to a financial assessment process).



Those respondents who disagreed with the proposal to introduce a telecare charge for those aged 85 and over who live alone, were asked to select their reasons from a list of statements. Most people selected (343 respondents, 56.4%) “the charge is unfair to those affected”, which was followed in popularity by 36.4% saying “savings should be made elsewhere”. A little under a quarter (21.7% or 132 respondents) said the “timing is wrong due to the coronavirus” and a further 18.1% (110 respondents) said “the charge would be unaffordable”. See Figure 3 for a full breakdown. Note: respondents could tick more than one statement.

Figure 3: If you disagree that a telecare charge should be introduced for those aged 85 and other who live alone, can you tell us why?



An 'Other' box was included alongside the main options so that respondents could give arguments which hadn't been included in the main options. However, many of these individuals used it to underline their previous point relating to the unfairness of the proposal being put forward or that the charge would be unaffordable.

In terms of new arguments: a proportion of respondents (25 responses) stated that the measure would be counter-productive because it would ultimately cost the Council and the NHS more over the long term. An example comment is shown below:

> *"The service actually saves money by identifying a fall immediately. Any delay would mean a more severe situation causing additional cost."*

Additionally, the point was made that the cost of administering the financial assessment process might be higher than the revenue raised from the charge itself (5 responses plus a comment at a telephone meeting). The reassurance that the service gave was also emphasised (6 responses).

In addition to this, individual points were made over the financial assessment process potentially delaying access to the service; that individuals might be reluctant to undertake the financial assessment process and whether the charge could reflect the number of call-outs by an individual.

Seven respondents wrote comments relating to either agreeing with the proposal or agreeing to pay. For instance:

"I live alone, family live in Surrey. I pay a support worker for cleaning and shopping. I need telecare for reassurance and therefore will pay."

Equality Impacts

In the next question individuals were also asked a question regarding the impacts it would have on them due to age, gender, religion, ethnicity or because of a disability. This question was specifically designed to help inform the Equality Impact Assessment for the proposal. However, the majority of respondents interpreted the question differently. A proportion of them either merely stated the disability they had or made a general comment about the proposal. The most relevant remarks to the equality impacts are shown below:

"Due to physical disability, I might not be able to reach my landline telephone in the event of a fall."

"I don't think it should be subject to a financial assessment of people especially having to supply financial details at that age."

"People with dementia are continuously worried about money and this will adversely impact on mental health."

"My father would not want a financial assessment as he would see it as invasive."

"This would impact on the current benefits I receive such as pension credits etc. £5 a week is a lot of money to me at my age of 96 years."

Any Other Comments About the Proposal

The last question in this section asked people to state if they had any other comments about the proposal. A large number of people chose to write something in this section. Again, many individuals elucidated further on why they disagree with the proposal. This included that it was unfair (92 responses) with an argument often repeated that people aged 85 and over had paid taxes throughout their working lives. The problem of the affordability of the charge was also cited by many respondents (38 responses). Illustrative comments to both these points were:

"When Telecare provision was first offered free for over-85's living alone that must have been considered to be reasonable and fair. I believe that is still the case and withdrawal should not be justified on cost-saving grounds alone…"

"Utterly shocking and negligent. How short sighted can you be? All this for a couple of quid a week. Older people will stop using it which could result in unnecessary hospital admission respite etc, peace of mind is so important. Isn't that something you should be trying to prevent?"

"They give us a pension, then take it all back."

"Totally disagree with withdrawing and or charging for this service. No financial assessment should be done, some people have paid through council tax, national insurance, and tax all their working lives and yet again penalised for working hard and saving and the ones who have lazed around on benefits etc for most of their working lives get the benefit free."

"It's the cost. I receive guaranteed income support and would struggle paying for the service. I have appreciated the service for 3 years and find it a huge support to my wellbeing."

"It's hard living on a pension, no other income and prices rising as they do. I feel you should think hard about this decision…"

Furthermore, a few comments were received suggesting that the approach was in some way discriminatory. For example:

"You know over 85's are vulnerable and wish to make a profit of their immobility and lack of computer literacy. Shameful over £20 a month."

Another commonly made point was that money should be saved elsewhere. For instance, by cutting Council staff pay, not spending money on cycle lanes or processing equality information (23 responses). Comments were also made about prevention and that there would be no long-term saving to the Council and NHS from the change due to an individual needing more expensive services in the longer-term (21 responses).

"Savings will be minuscule. Get your money from capping town hall staff wages."

"Poorly designed policy that ignores the evidence on the benefits of low-cost interventions in reducing risk of loss of independence in older people."

The reassurance it provides to family and/or to the service user was also stressed by around 10 responses. For example:

"My mother has had falls previously she lives alone and the service offers a degree of security to her."

Whilst the majority of comments were against the consultation proposal. Around 30 comments were received in favour. These included reference to the policy being fairer (including to deprived areas) and that there was no reason to single people over 85 in particular for a free service. The fact that people who could not afford to pay would still receive the service for free was also seen as an important. In addition to this, a few respondents also stated that they felt the service was good and worth paying for.

For instance:

> *“People who have over the capital threshold should pay for all services. Charging would also mean that people return equipment in a timely manner when it is no longer required.”*
>
> *“The policy of giving free telecare only to those over 85 is highly discriminatory against deprived areas where the life expectancy is lower. Putting it bluntly few people from deprived areas live to 85. This policy gives free services to the affluent while making those less well-off pay for the service.”*
>
> *“Not aware that the service was free for over 85's, seems reasonable to apply charge to support the service as population increases.”*

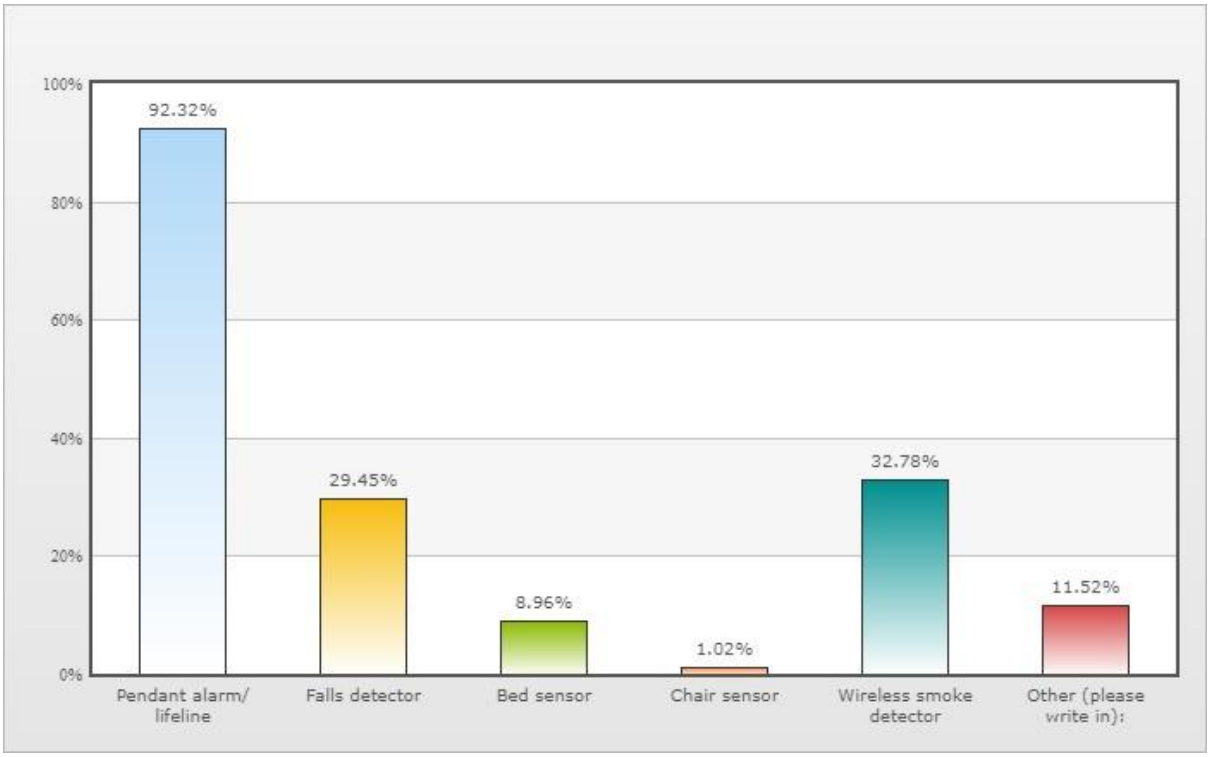
In terms of alternatives to the proposal; a small number of comments suggested that either a reduced charge should be used instead; or that only new users should be charged for the service. It was also suggested that the age on the policy could be raised so that some individuals would still benefit from a free service; and one respondent suggested removing the response facility as this was seldom used.

Part B: About Telecare in General

This section was for anyone who has telecare from the Council and was to help inform a review of the service and the move to digital telecare (including potential use of mobile phone networks).

The vast majority of respondents, 721 or 92.3% said they have a pendant alarm or lifeline. A third, 32.8% or 256 are in receipt of a wireless smoke detector and a similar number, or 29.5% have a falls detector. Note: people can have more than one device. Figure 4 provides a breakdown.

Figure 4: Which of the following telecare devices do you have?



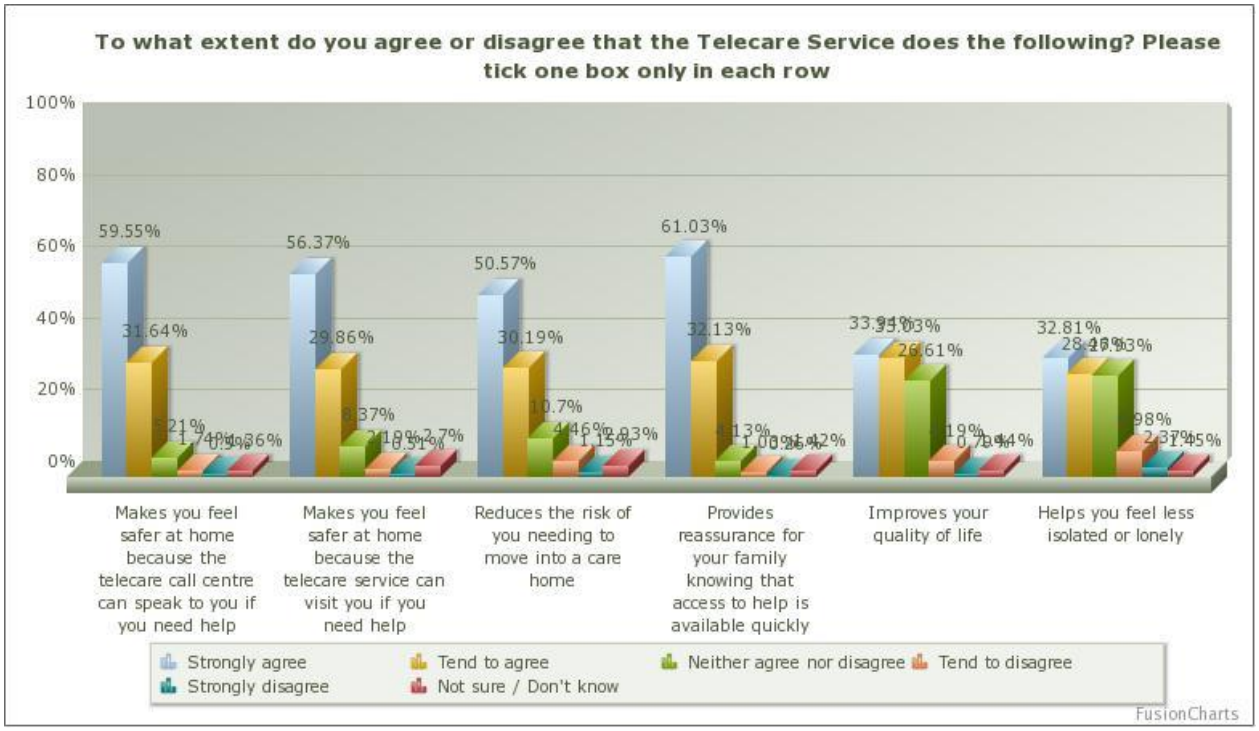
Respondents were asked how much they agreed or disagreed with a series of statements about what the telecare service offers. The overwhelming majority of respondents, 735 (or 91.2%) strongly agreed or agreed that it “makes you feel safer at home”. A similar majority in agreement was also shown for “Provides reassurance for your family knowing that access to help is available quickly“, which was supported by 634 responses (93.1%).

The percentage dropped slightly for the statements, “Reduces of risk of you needing to move into a care home” to 80.8% (634 responses in agreement) and “makes you feel safer at home because the telecare service can visit…” 670 responses agreeing (83.6%). However, both proportions were still high.

The last two options were still supported by a majority of respondents but far less overwhelmingly. These were: “Improves your quality of life” (455 responses in

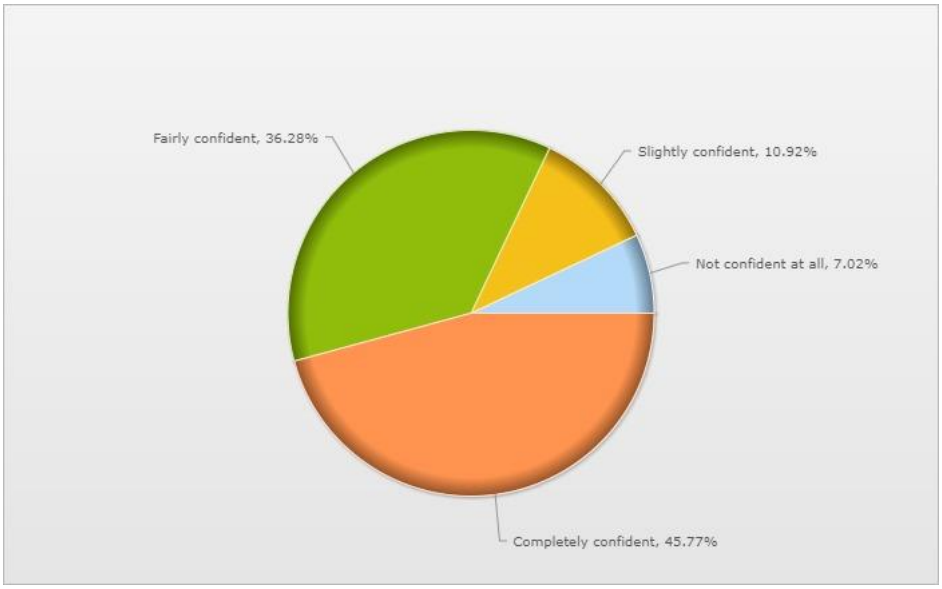
agreement, 66.90%) and “Helps you feel less isolated or lonely” (428 responses in agreement, 61.30%). For a full breakdown, please see Figure 5.

Figure 5: To what extent do you agree or disagree that the Telecare Service does the following?



When people were asked how confident they felt in being able to use their telecare equipment, the majority 82.1% (631 respondents) said they were completely or fairly confident. However, a notable minority of 17.9% (138 respondents) said they were slightly confident or not confident at all.

Figure 6: How confident do you feel in using your telecare equipment?



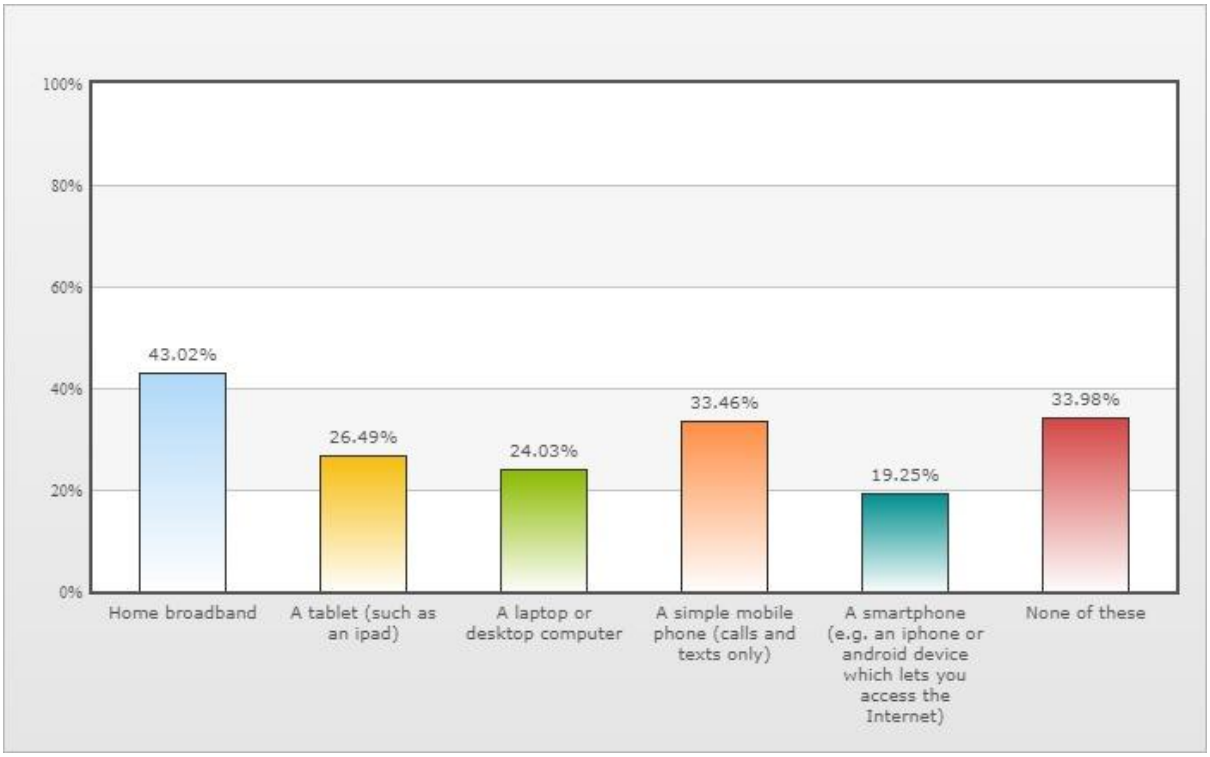
Access to Devices

Respondents were asked if they had any of the following devices in their home that are not currently provided through the Council's telecare service. Note: respondents could select more than device.

Under half, 43% (333 respondents) said they have home broadband. A third (33.4% or 259 respondents) said they had a simple mobile phone (for phone calls or texts) and 19.3% said they had a smartphone (149 respondents). In total, 391 respondents said they had one of these options [note: some respondents ticked both].

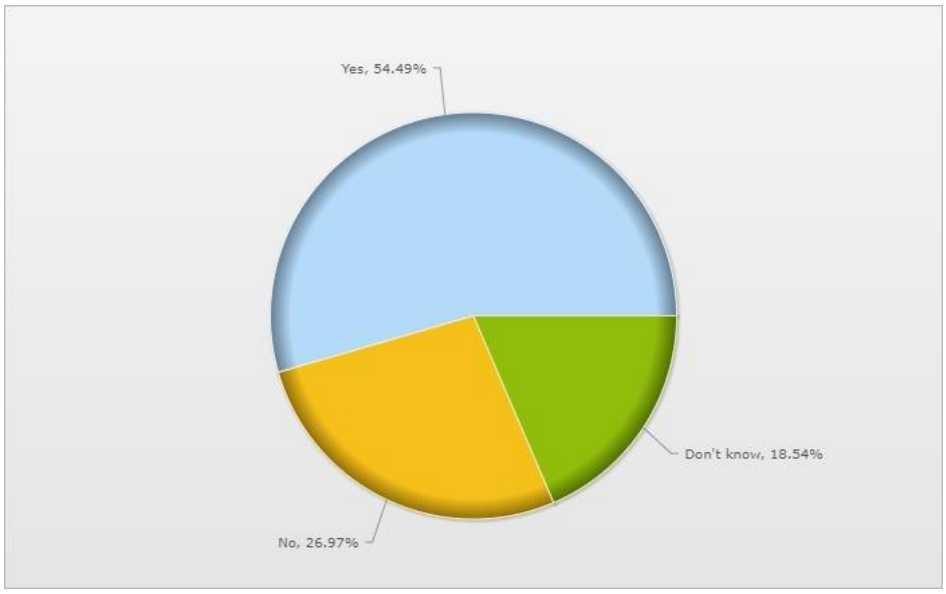
In addition to this, just over a quarter (26.5% or 205) of respondents had a tablet device (such as an ipad) and 24% (186 respondents) said they had a laptop or desktop computer. Around a third of the respondents (263 or 34%) said they had none of these devices.

Figure 7: Do you have any of the following devices? Please tick all that apply



For those who had a mobile phone, we asked if they had good mobile phone reception in all parts of their home. Over half, 54.5% said they did, but a quarter (27%) disagreed and 18.5% didn't know. Note: the Council may explore using more devices making use of the mobile phone network, which would enable them to be more portable. Therefore, having this information is really valuable.

Figure 8: If you have a mobile phone, do you have good mobile phone reception in all parts of your home?



Technology which might be incorporated

Respondents were also requested to state any devices which they felt might be included into the Assistive Technology service offer. The number of responses received was less than the written comments in the first part of the survey. But there was still a great deal of information provided.

Around 39 respondents stated that they had limited skills with technology so would not be able to utilise new equipment. 10 respondents stated that they would need more information on what was available in order to comment.

9 respondents stated that they had sensory needs. As such, it was stated both that use of devices was difficult and secondly that devices which were suitable for these needs would be helpful.

Around 8 respondents made comments relating to the need for devices to be more portable. This would allow them to be used both in different locations in the house and in the community.

In terms of specific devices which it was felt might be useful, the following were mentioned: voice controlled devices, broadband, tablets and simple mobile phones, video security (including for the front door) and movement sensors. A wellbeing call was also mentioned by one individual.

Comments on how the telecare service could be improved

A number of general positive comments were received about the telecare service (41 responses). Representative quotes are shown below:

> *"I don't think it could be improved. It gives a wonderful lifeline to my mum and myself knowing that they are there if she needs them."*

> *"I think the service is excellent and I have been very well looked after - how lucky we are!!"*

However, there was criticism of the service as well, including in relation to how long it took for some calls to be answered, and the time the mobile response service took to come out (26 responses).

> *"The response time was too long to answer the call."*

> *"Response time to alarm calls is often too long. I only used it for testing but the call centre didn't know and once took nearly 10 mins."*

> *"It takes 20mins to get through and then you wait an hour and a half for someone to attend, causing my carer to hurt her back."*

A small number of respondents also felt that the staff manner could be improved together with their knowledge about the service (3 responses).

Responses were also received relating to the ability to use the equipment in other parts of the house (11 responses). There was also some criticism of some of the equipment (16 responses). This particularly centred on the falls detector/wristband being too sensitive. One respondent also mentioned that the wriststrap for this device was also uncomfortable.

Comments were also made that equipment needed to be checked more often. This could be either via the phone or via a visit in person.

Finally, approximately 23 respondents used this response box as a further means to explain why they were against the proposal.

Part C: About You

The overwhelming majority of people completing the survey said they have telecare to support them (42.3%, 356 responses) or a family member/friend or paid carer had completed it on their behalf (38.5%, 324 responses). A further 107 members of the public or 12.7% of respondents said they were not in receipt of telecare services.

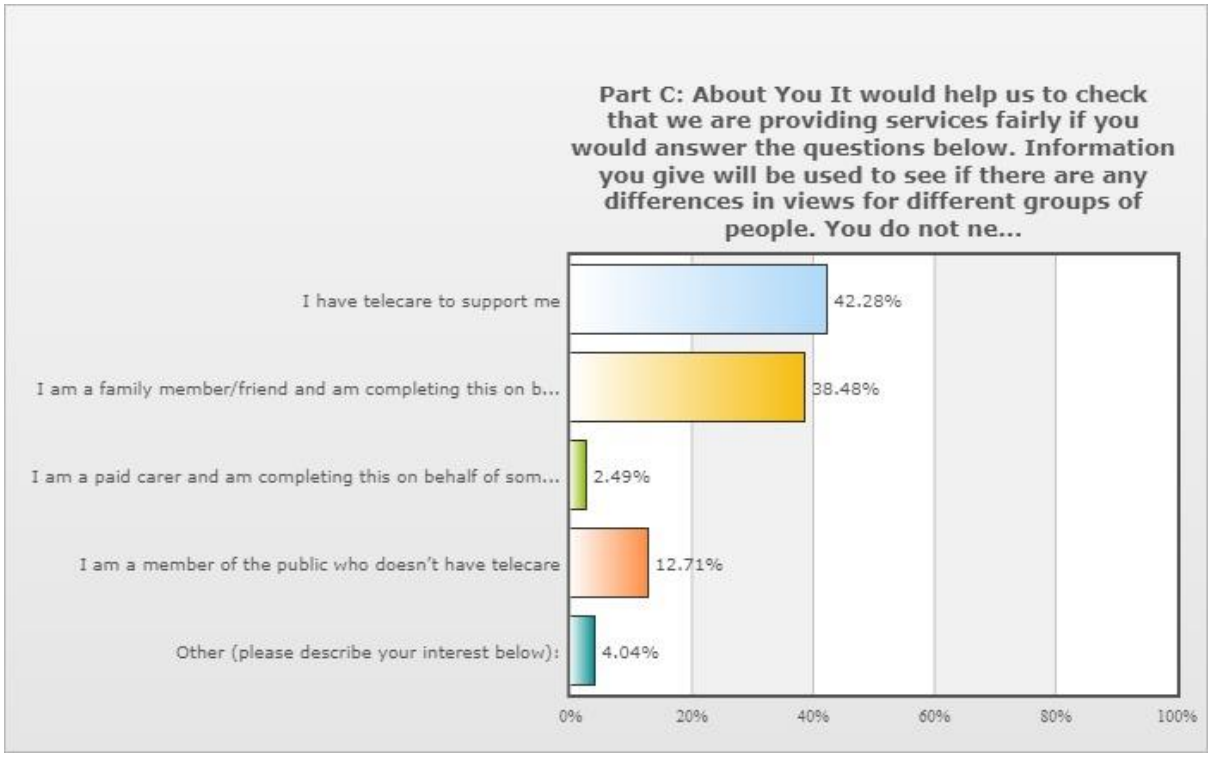
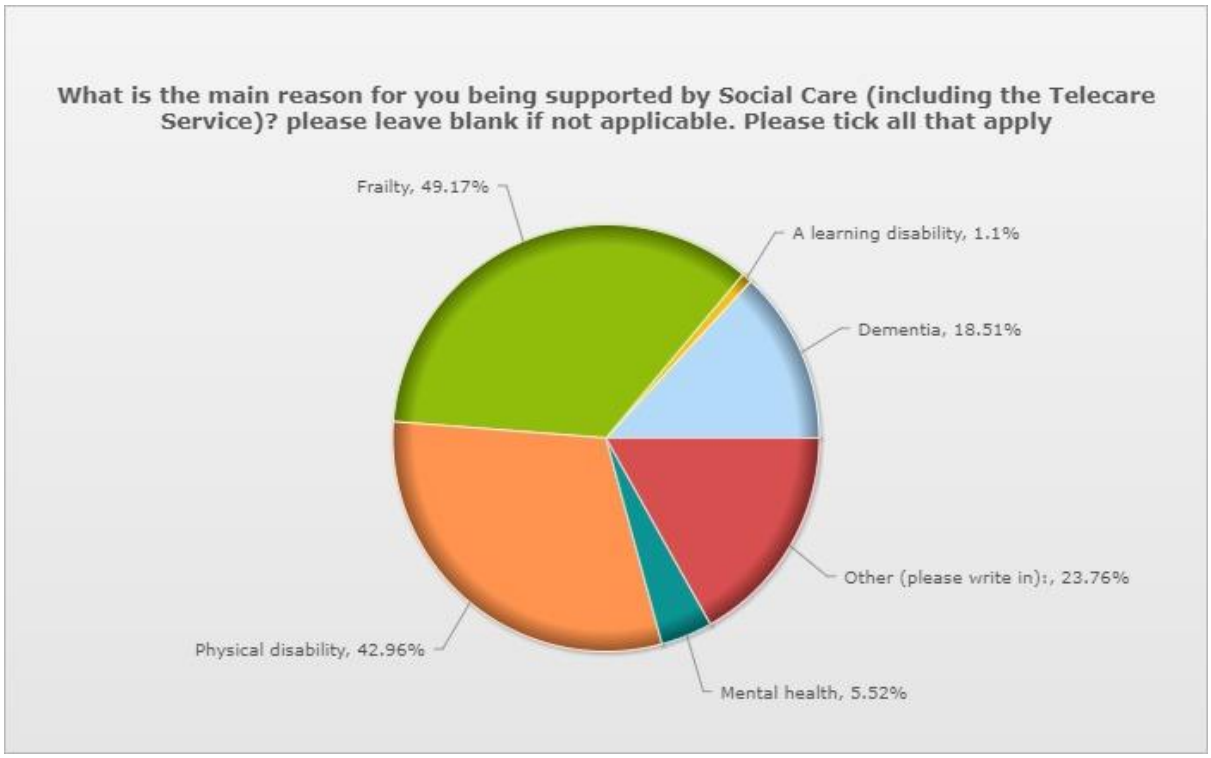


Figure 9: Person completing the form

The main reason given for receiving support from Social Care (including the Telecare Service) was frailty (49.2% or 356 respondents). This was followed by 311 respondents (43%) stating a physical disability. Note: there is likely to be some overlap between how respondents defined these these conditions. A further 18.5% (134 respondents) selected dementia. Note: people could state more than one condition. A full breakdown is given in Figure 10.

Appendix 1 gives a summary of the demographics of respondents. A comparison of all telecare users against those responding shows that an identical proportion of those aged 85 or over submitted a questionnaire (59%). The proportion of male (33.4%) and females (64.4%) responding was also very similar to the overall user base (males 31.3%; females 68.9%) with 1.6% prefering not to say and 0.6% stating 'Other'. Direct comparison by condition is more difficult as 'Primary Support Reason' is captured by the social care record system in comparison to indicating a number of conditions.

Figure 10: What is the main reason for you being supported by Social Care (including the Telecare Service)?



Next Steps

Feedback from this survey will help inform the decision about the charging proposal and the service specification which will describe the new Assistive Technology service that the Council is planning to put in place.

It is currently planned a decision will be made on the consultation charging proposal in September 2021.

Appendix One: Demographic Tables

Gender Identity:

No.	Category	%	No. of Responses
1	Male	33.37%	290
2	Female	64.44%	560
3	Prefer not to say	1.61%	14
4	Other (please write in):	0.58%	5

Age Group:

No.	Category	%	No. of Responses
1	16 - 24	0.11%	1
2	25 - 34	1.03%	9
3	35 - 44	1.37%	12
4	45 - 54	4.00%	35
5	55 - 64	5.15%	45
6	65 - 74	9.73%	85
7	75 - 84	17.62%	154
8	85 and over	59.50%	520
9	Prefer not to say	1.49%	13

Ethnic Origin:

No.	Category	%	No. of Responses
1	White English/Welsh/Scottish/Northern Irish/ Irish	95.66%	815
2	Any other white background	0.82%	7
3	Mixed: White and Black Caribbean / African / Asian	0.23%	2
4	Asian/Asian British	0.35%	3
5	Black/African/Caribbean/Black British	0.59%	5
6	Prefer not to say	2.00%	17

7	Any other ethnic group (please write in below):	0.35%	3

Appendix Two: Telecare Equipment Provided

▪ Lifeline unit ▪ Bed sensor* ▪ Smoke detector ▪ PIR (passive infrared sensor) movement detector - detects changes in infra red heat when an intruder walks into the protected area, ▪ Personal alarm wrist ▪ Chair sensor ▪ Temperature extremes ▪ Universal sensor ▪ Personal alarm neck (pendant) ▪ X10 for table lamp ▪ CO detector (property with gas only) ▪ T/care meds disp - linked to lifeline ▪ Exit sensor inc PIR ▪ Auto ceiling light ▪ Gas detector mains/ hard-wired	▪ Stand alone meds ▪ Care Assist Pager - a portable device that provides carers with a means to receive instant alerts from a range of telecare sensors. With a typical range of up to 200m. Means individuals and their informal carers do not have to be connected to a 24 hour monitoring centre service. ▪ Gas detector plug-in ▪ Bogus Caller alert ▪ Falls detector WRIST ▪ Enuresis detector (bedwetting detector) ▪ Flood detector ▪ Key Safe ▪ Falls detector multi -clip/pendant ▪ Radio pull cord ▪ Epilepsy mon ▪ Timed voice prompts

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Charges Levied by Other Local Authorities

Local Authority Area	*Device Range*	*Physical Response Service **	*Pricing*
Stoke on Trent	Lifeline plus additional sensors including epilepsy sensor, medication dispenser.	Y	£16 per month plus installation fee
Stockport	A range of sensors in addition to a lifeline including bed sensors, flood detectors, heat sensors.	Y (optional)	£6 per week. Free for the first 6 weeks.
Warrington	Range of devices offered	N	£4 per week for telephone unit. £5 for GSM (mobile phone unit)
Tameside	Lifeline plus range of devices including temperature sensors, room sensors, chair sensors	Y	£6.65 per week
Staffordshire	Does not directly provide telecare.	N/A	
Stafford and Rural Homes (Housing Association)	Lifeline	N	£4.33 per week

* This means a visit can be made to someone's home by a response team to provide rapid support. This includes safely picking someone up after they have sustained a non-injurious fall using specialist devices. This is a relatively expensive service to operate and will form a significant portion of the service cost and thus charge.

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EQUALITY IMPACT ASSESSMENT

Assistive Technology - Revised Charging Policy

VERSION CONTROL

Date	Version	Author	Description of Changes
08/01/2021	1	Nik Darwin	
07/04/2021	2	Nik Darwin	General amendments to text in introduction and further reference to consultation being conducted under evidence
08/04/2021	3	Nik Darwin	Reasons for proposal added

			from Cabinet Paper. Plus other small amendments in response to comments.
20/08/2021	**4**	**Nik Darwin**	**Updated following the consultation to include user feedback. Reasons section updated to reflect report**

CHESHIRE EAST COUNCIL –EQUALITY IMPACT ASSESSMENT

Stage 1 Description: Fact finding (about your policy / service /

Department	People Directorate		**Lead officer responsible for assessment**		Nik Darwin	
Service	Commissioning		**Other members of team undertaking assessment**		Shelley Brough, Helen Clark	
Date	07/01/21		**Version**		0.4	
Type of document (mark as appropriate)	**Strategy**	**Plan**	**Function**	**Policy**	**Procedure**	**Service x**
Is this a new/ existing/ revision of an existing document (please mark as appropriate)	**New x**		**Existing**		**Revision**	
Title and subject of the impact assessment (include a brief description of the aims, outcomes, operational issues as appropriate and how it fits in with the wider aims of the organisation) **Please attach a copy of the strategy/ plan/ function/ policy/ procedure/ service**	**Assistive Technology Charging Policy** Assistive Technology (also sometimes referred to as Telecare) is a range of electronic gadgets that can help you to live independently in your own home. This includes things such as: i) sensors/detectors that link to a monitoring centre. For example; a falls detector, pendant alarm, smoke, low temperature and property exit sensors ii) devices which use GPS to raise alerts to a carer or a monitoring centre iii) sensors that can support a person or their carer in and around the home. For example; pendant buttons, door contacts or motion sensors linked to a pager iv) The service includes support from a monitoring centre and a falls pick up service. A proposal is being put forward on revising the current Assistive Technology (AT) Charging Policy. This would mean that people who currently do not pay for the service because they are aged 85 and living alone, would pay the same fees as all other Assistive Technology users. This would be a flat rate charge of £5 per week (regardless of level of support required including number of devices). No one who could not afford to this charge would be asked to pay it (subject to a financial assessment process).					

	A consultation has been held to understand the views of users on this issue before the proposal is considered by the Council's Adults and Health Committee. The proposal has been forward for the following reasons: • Levying the same charge on all users, would allow the service to be sustainable in the longer term. This would enable the service to grow and to be accessed by additional vulnerable people. Without this, financial pressure will build, given the welcome projected 15% increase in those people aged 85+ by 2025 (in comparison to 2020) and 36% by 2030[1]. • Currently, half of users are paying for the service and half are not, thus meaning one set of users are effectively subsidising others (including 212 people aged 85+ living with others). This is unfair. In implementing the change, the financial assessment process will ensure that no one who cannot afford to pay, would have to pay.	
The Who are the main stakeholders, and have they been engaged with? (e.g. general public, employees, Councillors, partners, specific audiences, residents)	Consultation/engagement has been undertaken with the following groups: • Assistive Technology Users • The Commissioned Service Provider - Welbeing • Cheshire East Council Members (via Cabinet and a briefing session) • Staff who refer individuals for Assistive Technology	
Consultation/ involvement carried out	Yes	
What consultation method(s) did you use?	A survey has been sent to all AT service users. An online form was also available for completion by residents in general.	

[1] Projecting Older People Population Information System, www.poppi.org.uk

Stage 2 Initial Screening

Who is affected and what evidence have you considered to arrive at this analysis? (This may or may not include the stakeholders listed above)	1,128 users are affected by this change out of a total of 2,253 users who receive the service in total (note: data from May 2021). This data is derived from software called CONTROCC which the Council uses to monitor who receives the service.
Who is intended to benefit and how	Social care service users in general as the additional funds would be used to supplement the existing Assistive Technology budget. This would mean that the service could be expanded to either existing service users or new service users as part of the social care assessment/review process, meaning that they would also benefit from the advantages of the AT service.
Could there be a different impact or outcome for some groups?	The charge would apply equally to all Assistive Technology users. However, these have different levels of disability which is in part reflected in the type and number of devices that they have.
Does it include making decisions based on individual characteristics, needs or circumstances?	A financial assessment process would be used to establish the ability for an individual to pay the charge. If it was established that they could not afford this, then the charge would be waived.
Are relations between different groups or communities likely to be affected? (eg will it favour one particular group or deny opportunities for others?)	The perception might be that people aged 85 plus and living alone were being singled out. However, the policy aims to treat each individual in receipt equally (with the exception of the financial means test).
Is there any specific targeted action to promote equality? Is there a history of unequal outcomes (do you have enough evidence to prove otherwise)?	The revised charging policy aims to ensure that all people are charged the same fee for receiving the service. Targeted action takes place to ensure that those who cannot afford to pay for the service do not need to. This will particularly benefit those living in areas of deprivation.

Is there an actual or potential negative impact on these specific characteristics? (Please tick)								
Age	**Y**		**Marriage & civil partnership**		**N**	**Religion & belief**		**N**
Disability	**Y**		**Pregnancy & maternity**		**N**	**Sex**	**Y**	
Gender reassignment		**N**	**Race**		**N**	**Sexual orientation**		**N**

Stage 3 Evidence

What evidence do you have to support your findings? (quantitative and qualitative) Please provide additional information that you wish to include as appendices to this document, i.e., graphs, tables, charts		Level of Risk (High, Medium or Low)
Age	Frailty is known to increase with age[2]. This also means that an increasing proportion of people in higher age bands who would benefit from Assistive Technology. This policy change specifically targets those aged 85+ and living alone. However, it aims to do this in a fair way so that only those with the ability to pay are asked to pay the new charge. This includes ensuring that there is fair notice and opportunity for people within this category to ask for a financial assessment (for those who would find the charge unaffordable). Introducing the charge would mean that the service could be expanded to other users who would also benefit from this service due to the advantages it brings in terms of safeguarding individuals and supporting independence (where the individual has relevant needs). Assistive Technology is known to maintain or improve an individual's functioning and independence, thereby promoting their well-being[3]. A small amount of relevant comments were received in the recent consultation relating to the equality impact on age. This included that i) it was felt inappropriate for older people to have to disclose personal details as part of the financial assessment process. Note: the approach followed by Cheshire East Council is set by legislation and having a different approach for older people in itself could be viewed as	***Medium***

[2] Prevalence of frailty and disability: findings from the English Longitudinal Study of Ageing, Age and Ageing, Volume 44, Issue 1, January 2015, https://pubmed.ncbi.nlm.nih.gov/25313241/

[3] World Health Organization, Assistive Technology Factsheet., www.who.int/en/news-room/fact-sheets/detail/assistive-technology

	discriminatory; ii) that older people have limited finances and that the policy could place financial stress on them. Note: anyone who did not have ability to pay would not have to pay subject to a financial assessment. This works within the framework of national policy on social care charging which has been separately impact assessed.	
Marriage & civil partnership	The impact of this policy is deemed neutral on this protected characteristic.	***Low***
Religion	The impact of this policy is deemed neutral on this protected characteristic.	***Low***
Disability	Users of Assistive Technology are largely those who have a disability such as physical disability or cognitive impairment such as dementia. Implementing this policy means that the cost would not weigh disproportionately on these users. More generally, Assistive Technology is known to maintain or improve an individual's functioning and independence, thereby promoting their well-being. It was commented during the consultation process that there might be additional impact on people with dementia due to financial worries.	***Medium***
Pregnancy & maternity	The impact of this policy is deemed neutral on this protected characteristic.	***Low***
Sex	Due to the fact that the life expectancies of men and women are different, there are a higher number of women than men who use the service and who would be liable for the new charge. However, the argument remains the same to that detailed under the 'age' section.	***Low***
Gender Reassignment	The impact of this policy is deemed neutral on this protected characteristic.	***Low***
Race	The impact of this policy is deemed neutral on this protected characteristic.	***Low***
Sexual Orientation	The impact of this policy is deemed neutral on this protected characteristic.	***Low***

Stage 4 Mitigation

Protected characteristics	**Mitigating action** *Once you have assessed the impact of a policy/service, it is important to identify options and alternatives to reduce or eliminate any negative impact. Options considered could be adapting the policy or service, changing the way in which it is implemented or introducing balancing measures to reduce any negative impact. When considering each option you should think about how it will reduce any negative impact, how it might impact on other groups and how it might impact on relationships between groups and overall issues around community cohesion. You should clearly demonstrate how you have considered various options and the impact of these. You must have a detailed rationale behind decisions and a justification for those alternatives that have not been accepted.*	**How will this be monitored?**	**Officer responsible**	**Target date**
Age	-To ensure that the consultation plus any implementation process such as financial assessment takes account of the particular needs of this group e.g. large print text, someone to speak to via the telephone, face to face meetings where useful. -To ensure that users who are recommended for Assistive Technology by a Social Care Assessor (plus other staff) understand that a fee will be required if they wish to take up this service. -To ensure that (if the policy is implemented) those affected are given fair opportunity to ask for a financial assessment due to their ability to pay. This would involve ensuring that letters are in large print and messages are clear and that additional steps are taken for those recorded as having reduced capacity.	Implementation plan if proposal is adopted	Nik Darwin/ Lee Hudson	TBC
Marriage & civil partnership	N/A			
Religion	N/A			
Disability	-To ensure that the financial assessment process takes account of the particular needs of this group e.g.			

	Learning Disability friendly material, a range of methods for contact, support to work through the financial assessment process. -To ensure that users who are recommended for Assistive Technology by a Social Care Assessor (plus other staff) understand that a fee will be required if they wish to take up this service. -For support provided to be sensitive to the needs of the user for instance, because they have a cognitive impairment.			
Pregnancy & maternity	N/A			
Sex	N/A			
Gender Reassignment	N/A			
Race	N/A			
Sexual Orientation	N/A			

5. Review and Conclusion

Summary: provide a brief overview including impact, changes, improvement, any gaps in evidence and additional data that is needed			
Specific actions to be taken to reduce, justify or remove any adverse impacts	**How will this be monitored?**	**Officer responsible**	**Target date**

If the policy is implemented, then users would be financial assessed to understand their ability to pay	Via the Cheshire East Council client records system LiquidLogic	Lee Hudson	TBC
Revising the referral process to ensure there is clear information on the charge	Updated procedure documents/ briefing note for staff	Nik Darwin	TBC
Please provide details and link to full action plan for actions	N/A		
When will this assessment be reviewed?	N/A		
Are there any additional assessments that need to be undertaken in relation to this assessment?	This assessment will be revised following the decision at Committee.		
Lead officer sign off	Nik Darwin	**Date**	02/09/21
Head of service sign off	Shelley Brough	**Date**	02/09/21

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Cheshire East Council

Working for a brighter future together

Adults and Health Committee

Date of Meeting:	27 September 2021
Report Title:	Notice of Motion 'Right to Food'
Report of:	Nichola Thompson, Director of Commissioning
Report Reference No:	AH/28/21-22
Ward(s) Affected:	All wards

1. Executive Summary

1.1. On 22 June 2021 a notice of motion was submitted to Council calling the 'Right To Food' to be incorporated into the 'National Food Strategy'. This notice of motion included asking the Chief Executive, Lorraine O'Donnell to write to Henry Dimbleby to further this request to support the notion that the 'Right to Food' should be incorporated into the National Food Strategy. This report aims to provide further information on that request and includes a current position regarding food poverty and inequalities in Cheshire East.

1.2. The content of this report contributes to the following strategic aims of the Council's Corporate Plan 2021-25:

- 'Reduce health inequalities across the borough' by working with partners to address issues associated with poverty.
- 'A Collaborative way of working with partners to support communities to achieve their full potential'. Working in partnership with community-based providers to inspire confidence and develop resilience.
- 'Reduce impact on the environment' by addressing food waste and sustainability.

2. Recommendations

2.1. To consider if Chief Executive, Lorraine O'Donnell, should write to Henry Dimbleby to incorporate the 'Right to Food' movement into the 'National Food Strategy' by emailing foodstrategy@defra.gov.uk.

2.2. Acknowledge the services and provision in Cheshire East which address and prevent food poverty and food insecurity.

2.3. To agree that the Council should develop its own Right to Food Strategy that meets local anticipated need over the next 4 years which aligns to the Corporate plan.

3. Reasons for Recommendations

3.1. To update the Adults and Health Committee on how the Council has responded to the rising needs around food poverty during the pandemic and to respond to the notice of motion made on the 22 June to full Council.

3.2. To demonstrate by working together with residents and partners to support people and communities to reduce health inequalities across the borough we can collectively ensure food poverty does not become prevalent across the borough.

3.3. To recognise that although the Council has supported communities to prevent food poverty with various schemes during the last 12 months it is important that we develop a strategic approach that is local.

4. Other Options Considered

4.1. Not to write to Henry Dimbleby to incorporate the 'Right to Food' movement into the 'National Food Strategy'

5. Background

National Food Strategy

5.1. The National Food Strategy is an independent review of England's entire food system and seeks to achieve a food system that enables people to access 'safe, healthy, affordable food; regardless of where they live or how much they earn' and provides a series of recommendations to achieve this vision (source: National Food Strategy). The review was conducted in two phases by Henry Dimbleby, lead non-executive board member of the Department for Environment, Food and Rural Affairs. In July 2020 Part One of the report was published, which became an urgent response to the issues of hunger and ill health raised by the Covid-19 pandemic, as well as the trade and food standards issues created by the end of the EU Exit transition period. Part Two takes a close look at how the food system really works, the damage it is doing to our bodies and ecosystem and makes suggestions on interventions to prevent these harms.

The Right to Food Campaign

5.2. The 'Right to Food' campaign was launched in November 2020 by Ian Byrne, MP for Liverpool West Derby. Ian partnered with Merseyside organisation 'Fans Supporting Foodbanks' (a joint initiative between rival

Liverpool F.C. and Everton F.C. supporters) and submitted an Early Day Motion to parliament which was supported by 59 cross-party MPs. The campaign aims to make access to food a legal right for all and seeks for "Right to Food" to be enshrined into legislation in Parliament. The Right to Food Campaign states that food banks are a sticking plaster over a gaping wound and that systemic intervention is required to tackle it. The campaign calls for the following:

- Accountability: There should be legislation enshrined in law to place new responsibilities on authorities to ensure everyone has access to food.
- Accessibility: Food needs to be practically in reach for everyone by way of wage and benefits levels, pricing, direct provision, or a combination of all three.
- Adequacy: food must be sufficient in quantity, safety and nutritional content.
- Availability: there must be sufficient production, supply and distribution of food.

The Right to Food Campaign makes a number of initial recommendations for the government to implement, including universal free school meals, expanding the use of school kitchens to become 'community kitchens', becoming more transparent in benefit and wage calculations, ensuring food security and providing independent enforcement.

Wider National picture on food poverty

5.3. A briefing published by the Government's Environment, Food and Rural Affairs Committee in April 2021 defines food poverty, or 'food insecurity' as a household who cannot acquire 'an adequate quality or sufficient quantity of food in a socially acceptable way' (source: Food Poverty: Households, food banks and free school meals (30.04.21). The briefing describes the national picture, reporting that in 2019/20 5 million people were in food insecure households, which rose to 7 million during April to September 2020, demonstrating the impact of the Covid-19 pandemic. The effect of Covid-19 is evident in the demands on emergency food provision, with UK Independent Food Aid Network (IFAN) reporting a 126% increase in the number of parcels distributed by food banks between February 2020 and May 2020. In addition, around 302,000 pupils became "newly eligible" for free school meals during the pandemic.

Cheshire East picture on food poverty

5.4. A Joint Strategic Needs Assessment (JSNA) (Appendix 1) conducted by Cheshire East Social Action Partnership (CESAP) engaged with a range of providers across the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector to understand the level of food inequality in Cheshire East, specifically addressing the sustainability and connectivity of food banks. Local food banks reported a 110% increase in demand for

emergency food parcels in financial year 2020/21 compared to 2019/20 (which is akin to national findings). The JSNA found that reasons for using food banks include low income, delays in benefit claims and mental health issues, with many of the food banks reporting that their clients are presenting with increasingly multiple and complex needs.

5.5. Cheshire East Council, in partnership with groups and organisations across all three sectors, have invested heavily to respond to the increase in food inequality caused by the pandemic. This is explored below:

Cheshire East Emergency Assistance Scheme (EAS)

An in-house core service which provides a safety net for people in crisis, providing access to emergency food, fuel and other essentials. In the financial year 2019/20, 150 food-related referrals were processed. In the same period during 2020/19, 148 referrals were made. EAS was not impacted by the pandemic due to the rapid mobilisation of People Helping People. EAS provides an annual grant to 8 food banks in Cheshire East to enable sustainability and maintain their ability to respond quickly to requests. The funding offered is dependent on demand and a number of food banks chose not to accept the monies offered to them.

People Helping People (PHP) / Shielding

A service established in response to the pandemic, aimed at channelling volunteer resource and community-based activity to meet the needs of vulnerable and isolated people. PHP provides access to a range of basic requirements, particularly food, with volunteers undertaking supermarket shopping and facilitating access to community-based food provision. PHP was available to anyone who classed themselves as vulnerable, with over 4000 residents of Cheshire East benefitting from the service between April 2020 and March 2021. 88% of referrals required a food-related intervention, all of whom were matched with a volunteer or community-based activity to meet their needs, with many relationships becoming sustainable so support was ongoing. Due to the success of the PHP model, the management of shielding (Clinically Extremely Vulnerable) people did not require high financial investment into direct food parcels.

Community Covid Response and Recovery Fund

A scheme set up in July 2020 to channel central and local government funding into the VCFSE sector to build on existing community-based services and kickstart new services where needed. A total of £278,334 has been allocated to 58 food-based providers between July 2020 and today. This funding was provided by Department for Environment, Food and Rural Affairs (DEFRA), a total of £326,000 was awarded to the Council. All beneficiaries are subject to a monitoring procedure and provided with support to ensure their service is sustainable and demonstrates impact.

Covid Winter Grants Scheme (CWGS) – Appendix 2

A programme funded by DWP to provide support to vulnerable households and families with children, particularly those affected by the pandemic. The scheme ran from 1 December 2020 until 16 April 2021 and provided 41,627 food vouchers to young people and families. The CWGS was superseded by the Covid Support Grant Scheme (CSG) which has the same eligibility requirements and has provided 10,760 vouchers since 17 April 2021.

Holiday Activity Fund (HAF) – Appendix 3

A government scheme aimed at providing support for vulnerable children in receipt of benefits-related free school meals. Enables access to provision over school holidays, giving children the opportunity to eat a healthy meal, engage in physical activity and learn about health and nutrition. Cheshire East received a total of £881,340 to commission activities over Easter, summer and Christmas holiday in 2021. During the Easter holidays, 463 children attended HAF funded holiday club sessions. Throughout the summer holiday, there are a further 1900 spaces available.

5.6. In addressing food poverty / insecurity, there is a vast amount of locally delivered community based provision and social value commitments from private sector partners which are not accounted for in the analysis above. Examples include a community café who modified their service to provide meals on wheels for a nominal fee, a community supermarket who channel surplus food to those in need and a private catering business who used their own resources and expertise to deliver healthy meals to those known to be isolating in their local community.

Next steps

5.7. We recognise we are only now starting to understand the indirect impact of Covid-19 in relation to food poverty. As a Council is it is important that we develop a strategic direction to how we can combat a potential increasing need and sustain some of the short-term provision we have put in place over the last 12 months. By developing a Right to Food Strategy we will greater understand the voice of local people, we will have a greater knowledge of how initial and future anticipated need can be met and we work over a greater period aligned to the Council's Corporate plan on how we can prevent the root causes that bring about food poverty.

6. Consultation and Engagement

6.1. This report has been compiled with information provided from internal and external stakeholders to accurately assess the current position regarding food poverty and inequalities in Cheshire East. A Joint Strategic Needs Assessment (JSNA) analysed food bank provision by engaging with partners in the Voluntary, Community, Faith and Social Enterprise sector.

6.2. Cheshire East benefits from a multitude of services, organisations and groups who aim to address food poverty. The impact of the Covid-19 pandemic has encouraged these stakeholders to become more connected and collaborative, resulting in better engagement and partnership working.

7. Implications

7.1. Legal

7.1.1. There do not appear to be any substantive legal implications arising from the notice of motion referred to above. In principle, what is proposed is a gesture of support, involving no financial or other commitment on behalf of the Council aside from asking the Chief Executive to write to Henry Dimbleby supporting the initiative.

7.2. Finance

7.2.1. As this is not a decision at this stage (only a recommendation to consider) there are no financial implications or changes required to the MTFS as a result of the recommendations in this report.

7.2.2. If the decision is to be taken to support the incorporation of the 'Right to Food' movement into the 'National Food Strategy' then the implications would need to be considered across the Council and brought back through the appropriate governance processes for approval.

7.2.3. It is worth noting that many of the schemes in section 5 are temporary schemes linked to Covid grants and funding, so will only be in place for the specific time periods that the grants are linked to.

7.2.4. The development of the Council's own Right to Food Strategy would not have any financial implications, as the strategy would be developed through existing teams and resources.

7.3. Policy

7.3.1. The National Food Strategy is an independent review of England's entire food system, which has been developed over a number of years and contains a suite of recommendations to prevent inequalities and reduce harm to our eco system. Cheshire East Council intend to understand the context upon which these recommendations can be implemented locally, with a view to developing local policy to address food poverty.

7.4. Equality

7.4.1. The Right to Food campaign, the National Food Strategy and the work done by Cheshire East all aim to reduce inequalities.

7.5. Human Resources

7.5.1. Staffing resource implications could be a factor if Cheshire East Council embeds locally the aims the right to food campaign intends to achieve.

7.6. Risk Management

7.6.1. The initial risk is the political connotations the Right to Food campaign may imply.

7.7. Rural Communities

7.7.1. Rural and Urban food poverty is addressed by the Right to Food campaign, the National Food Strategy and the work done by Cheshire East Council locally.

7.8. Children and Young People/Cared for Children

7.8.1. Children and young people's needs are addressed by the Right to Food campaign, the National Food Strategy and the work done by Cheshire East Council locally.

7.9. Public Health

7.9.1. This report seeks to analyse and understand interventions related to food poverty in Cheshire East, with a view to highlighting health inequalities within our borough. The intelligence gathered will be used to develop a local multi-agency approach to addressing these inequalities.

7.10. Climate Change

7.10.1. Recommendation 3 of the National Food Strategy states 'make the best use of our land'. This describes the need for reform in the use of farmland, investment in sustainable food production and development of ethical trade policy. These recommendations may influence local policy to achieve aims around carbon emissions and nature restoration.

Access to Information	
Contact Officer:	Katy Ellison - Senior Community Development Officer 07976 767757 Katy.Ellison@cheshireeast.gov.uk
Appendices:	Appendix 1 – Food JSNA Appendix 2 – Covid Winter Grants Scheme impact report Appendix 3 – Holiday Activity Fund impact report
Background Papers:	• Notice of Motion request • National Food Strategy – Independent Review for Government • Right to food campaign

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Food Bank Questionnaire and Deep Dive Interviews
22 July 2021

Background
Food availability and quality is a wider determinant of health. Food banks provide a mechanism to feed people in poverty who would otherwise not have enough to eat. In the absence of detailed information on food banks in Cheshire East (CE), this piece of work was initiated to provide data which could inform a Joint Strategic Needs Assessment (JSNA) on the topic.

Aim
To provide quantitative and qualitative data on the sustainability and connectivity of food banks providing targeted support to residents of CE of all ages.

Objectives
- To survey food banks in CE to understand their number, distribution and characteristics
- To interview food bank representatives in CE to understand their operation, changes in provision and sustainability of provision.

Definition of a food bank
There is no universally accepted definition of what a food bank is in England. In this project, the Independent Food Aid Network (IFAN) definition is used: "a venue which regularly gives out emergency food parcels at least once a week."

Methods
An initial mapping exercise conducted by CESAP contacted a range of community food providers in CE and gathered contact details and information on the services provided. This mapping exercise took place in January 2021 and was used to generate a sampling frame of food banks in CE.

Quantitative data was collected using a desktop questionnaire. The questionnaire was online and was constructed using SurveyMonkey. This was distributed to food bank providers using snowball sampling. Questions asked about the characteristics of the foodbank, the services offered, funding, COVID-19 impacts, number of people supported, reasons for referral and demographics of users. The survey was distributed on the 29th April 2021 and open for responses until the 24th May 2021.

Qualitative data was collected using semi-structured interviews with food bank operators. Representatives from four foodbanks were interviewed, these were chosen as a purposive sample, based on geography and size of the food bank. Interviews were transcribed and text analysed using thematic analysis.

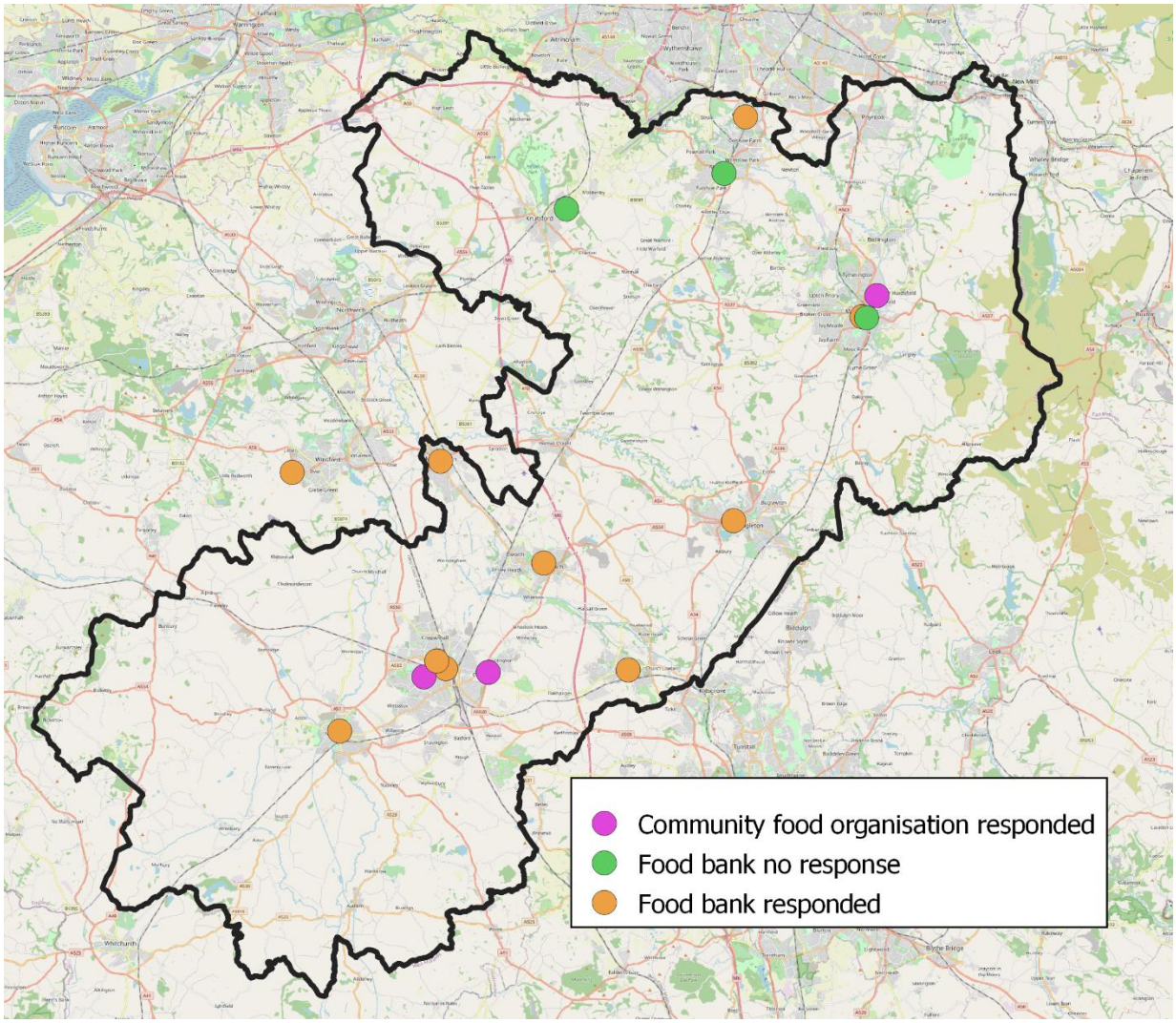
Cheshire East Social Action Partnership (CESAP) undertook data collection with service providers, with the work being co-ordinated with Cheshire East Council public health team.

Results

The mapping exercise identified 12 food banks (using the IFAN definition). It also identified a range of community food organisations which provided services such as: free hot food at a café, delivered prepared meals, cookery teaching, and subsidised food shopping.

Quantitative

The questionnaire was completed by 13 organisations; 9 of which met the IFAN food bank definition. The geographical distribution of these organisations, and the three food banks who didn't respond to the questionnaire, is shown in the map below.



The average duration of operation for these organisations was 7.5 years, with a range between 1 year and 15 years. Some of these organisations operated from multiple sites, with a central hub. While all food banks gave out food parcels (with some delivering during COVID-19), four

organisations ran drop-in cafés and one delivered ready meals. Many organisations had associations with churches.

Most food banks relied on local community donations of food and money, with some donations from businesses such as supermarkets. Four of the 13 food banks reported that their primary funding source was grants from CE Council, these grants were reported as secondary fundraising sources by three further food banks.

In the previous month, the 13 food banks reported distributing food to 3,228 people in CE. The average number of people was 269, with a range from 10 to 600. It was not possible to accurately calculate the quantity of food provided, as parcels were of different sizes and there was no way of consistently measuring. All food banks reported an increase in demand and the numbers requiring support during the COVID-19 pandemic, and also noted the challenges of staffing their services with older volunteers who needed to isolate.

In addition to the questionnaire results, the Trussell Trust publish data on a local authority basis and currently have 4 distribution centres serving CE. They reported distributing 4,396 parcels in financial year 2019/20, increasing 110% to 9,232 in financial year 2020/21.

There were a wide range of referring agencies and bodies, including Jobcentre Plus, Citizens Advice, CE Council service, housing associations, schools and general practitioners. Primary reasons for using the food bank were low income, delays in benefit claims (usually Universal Credit) and mental health issues. Several food banks did not collect data on the sex of service users, but of those that did, most found that 50% were female, with one site reporting 90% of users were male. Only eight of the 13 reported age data, and this related to the percentage of service users aged over 65. This varied from 0.75% to 70%, with the median percentage being 6%

Qualitative

A qualitative analysis of the “deep dive” interviews focused on the following key themes: reasons for people using food banks, the impact of COVID-19, collaboration between food banks, referrals to food banks and sustainability of food banks.

Why people use food banks

A common understanding among participants was that food poverty is not a stand-alone factor in people’s lives – it is ‘poverty’ of many levels. Their experience was that people who approach the food bank have multiple complex needs which can cascade and lead to destitution. They reported that while some have lost jobs, face delays in accessing Universal Credit; others come from a growing number of people in work with very low incomes, with an unexpected bill or financial commitment leaving them without enough money to buy sufficient food, or making a choice between eating and heating their homes.

Within this setting, all food bank interviewed reported increasing demands to feed children. Although schools are a major referrer to these food banks, they reported confusion caused by Free School Meals (which is only open to children classified as Pupil Premium) and the Foodbank Voucher which is open to anyone facing food poverty. There did not appear to be a corresponding increase in demand from older people, something reflected in the quantitative questionnaire results.

A common feeling among participants was that there is still significant stigma and shame attached to people asking for help, particularly when it comes to food and people being able to feed their families. This stigma can be a barrier to people approaching a food bank for help, particularly for the first time. Participants from the food banks described the substantial efforts they make to help people retain their dignity and reduce the stigma associated with accessing their support.

Impact of COVID-19 on food bank usage

All participants reported that their food banks had a "huge" increase in demand due to COVID-19, with challenges in meeting this demand due to older volunteers self-isolating. Their experience was that this demand was linked with the economic consequences of lockdowns, with people losing jobs and earnings in furlough. They conveyed the way that this increase in demand has not been constant during the pandemic, but has fluctuated in tandem with the lockdown, compounded with the winter increase in fuel bills.

Collaboration between foodbanks

Of the four foodbanks which participated in this deep dive interview process, two were independent and two were associated with the Trussell Trust. Those which were associated with the Trussell Trust were able to access a range of resources and organisational support. However, both these and the independent food banks appeared to be networking well together and sharing resources. They reported ad hoc negotiation and balancing of supplies with food banks in other areas, helping to eliminate waste and even out excess supply or remedy shortages of particular food types.

Referrals to food banks

From discussions with participants, it was clear that while none of the food banks accept self-referrals, if someone turns up to the food bank in need, they will be given a food parcel to get them through that immediate crisis. The individual is then encouraged to have dialogue with a referring agency who can understand their personal circumstances and build support for them, give wider advice and guidance on housing, eligibility for benefits etc. The referring organisation will then issue a food voucher which can then be picked up from a food bank of choice. All food banks operate a booking system for appointments, so that food parcels can be collected safely.

The experience of some participants was that some people have learnt to navigate the system and have received referrals from multiple organisations so that they can have several food vouchers at once. This can be difficult to identify by each individual food bank and requires collaboration and cross-dialogue between food banks, particularly in making decisions locally about who the lead 'referring' organisation should be.

Participants related how greater understanding of geography and logistics is needed for some referring organisations as rural poverty and access to affordable transport can be an issue. For some people the next nearest food bank can be in another county e.g. Alsager Foodbank and Market Drayton in Shropshire, or for Bollington and Poynton, the nearest is Stockport.

There were described concentrations of demand in particular area, which did not necessarily align with the food banks nearest those requesting help. For example, requests for food bank support in Macclesfield appear on the radar of several food banks, including Hope Central (Handforth and North East Cheshire) and Mid Cheshire Foodbank. The reason why referrers are not referring local people in need directly to food organisations in Macclesfield is unknown, and leads to challenges in the delivery of support to these people.

Sustainability of current food bank operations

The experience of participants was that the majority of food banks in CE are funded by community fundraising events, but also through individual, personal, business donations e.g. supermarkets, which includes money and food. A smaller number of food banks have secured grant funding, for example from CE Council during the COVID-19 pandemic, but these organisations were not believed to be dependent on grants, but rather had tapped into these resources to meet increased COVID-19 demand in their area.

Conclusion

Previously, there was little available information on the number, distribution and usage of food banks in CE. This analysis provides crucial quantitative and qualitative data on food banks, which would be required for a future JSNA section on this topic. This information can then be combined with wider socio-economic data as part of the SOP and quality assurance steps that go into producing a JSNA section.

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Cheshire East

TOGETHER for Children and Young People

Together we will make Cheshire East a great place to be young

Cheshire East COVID Winter Grant Scheme Impact Report

May 2021

Contents

1. Introduction and Summary

The COVID Winter Grant Scheme (CWGS) was a DWP funded programme with the aim of providing support to vulnerable households and families with children, particularly those affected by the pandemic. The CWGS ran from 01/12/20 until 31/03/2021, at which point the scheme was then extended until 16/04/21. The national value of the CWGS was £229m, of which Cheshire East Borough Council received £1.18m. The funding guidelines required a minimum of 80% of the funding to target both food and utilities, with a 20% discretion for essentials such as white goods. Reflecting these parameters, the funding guidelines also ring-fenced a minimum of 80% of the funding for children and families, with a further 20% allocation to vulnerable households.

To implement this programme, Cheshire East Council targeted approx. 9,500 known vulnerable/at risk children and families who would automatically receive their vouchers, these were:

- are in receipt of income related free school meals
- are in receipt of early years pupil premium and two-year funding
- are care leavers up to age 25
- are not in education, employment or training aged 16-18
- are young carers for their parents/carers
- are known to domestic abuse services

In addition to these groups, if professional agencies were able to identify a need, they could refer. Upon referral, they could also apply for utilities and white goods support. In summary:

- 43k vouchers given out
- Approx. 9.5k children and families received the grant
- 37.5k food vouchers provided to pre-existing groups with a further 3.8k provided via inquiry forms
- 1.6k utilities vouchers and support provided to children and families
- 104 households support with white goods requests

2. Cheshire East Council's Implementation

2.1 Planning and Mobilisation

Cheshire East's CWGS implementation began on the 01/12/20 and ran until the final day of the grant period, 16th April 2021. The project had 3 significant roll-out periods; the 2020 Christmas Holidays; February Half Term; and the Easter Holidays. External to these rollout periods, inquiry forms were available for families to access support.

The CWGS steering group first met on the 13/11/20. The group had representatives from Early Help, Children's Social Care, Commissioning, Education, Finance, Internal Audit, Legal, Public Sector Transformation, Benefits and Communities. The SRO for the project was the Director of Early Help & Prevention, Ali Stathers-Tracey.

The decision was taken early to manage the project in-house to facilitate a targeted approach, to allow the council to develop its knowledge of our vulnerable young people and families, provide an opportunity for the council to develop a relationship with our most vulnerable, highlight the highest risk families and individuals for further support and to provide the opportunity to compose comprehensive data on the project's recipients.
The inhouse method followed a process of identifying a range of eligibility criteria to include all at risk cohorts, and those whose risk was particularly affected by the pandemic during the winter months.

2.2 Cheshire East's CWGS Eligibility Criteria:

Cheshire East adopted the following eligibility criteria, ie those who are:

- in receipt of income related free school meals
- in receipt of early years pupil premium and two-year funding
- care leavers up to age 25
- not in education, employment or training aged 16-18
- young carers for their parents/carers
- known to domestic abuse services

The above groups amounted to over 9,000 young people and were identified as pre-existing groups who would receive food support automatically via their school or setting. In addition to these groups, referrals were accepted via trusted professionals for the following categories, ie those who are:

- known to children's social care and early help services
- parents/carers who are experiencing financial hardship due to being unable to work as their children are self-isolating
- vulnerable due to financial hardship and can be referred by a partner agency (e.g. GP, Teacher, Support Worker)

2.3 Implementation

The above cohorts were eligible for the scheme and so were able to access support in 3 targeted categories: food, utilities, and white goods.

- **Food** was provided via food vouchers. These were available from 01/12/20 until 16/04/21. The vouchers were purchased from Blackhawk Network which were initially valid for Tesco's, Morrison's, Aldi, Sainsburys, Asda, Waitrose, and M&S. Additionally, Aldi became available from 12/01/21. During the December roll out the vouchers were worth £15, per week, per child, which was increased to £20 on 18/01/21 when the need was identified.

- **Utilities** were available for electric, gas and water to the value of £49 per household. Both credit and prepaid meter households were supported. Utilities vouchers were purchased from Green Doctor Energy Consultants who provided additional energy advise to households referred. The first utilities vouchers were provided on 18/12/20 and were supplied until 16/04/2021.

- **White goods** were supplied via Cheshire East's Emergency Assistance team, based within the Benefits department. The benefits team had existing commissioned services called Click and St Paul's which were able to extend their support to the CWGS. The white goods were accessible once per household on a need's basis, with households able to access electric cooker, fridge, washing machine or microwave. Most goods supplied were recycled or refurbished but in some rare cases a new item would be provided. The first white goods referrals were accepted on 27/01/21 and were accepted until 16/04/21.

3. Impacts of the COVID Winter Grant Scheme

3.1 Summary of Impacts

The impacts of the CWGS can be viewed in appendix A. In summary, the impacts of the project were considerable, working with approx. 9,500 young people and families across Cheshire East, with a small percentage of young people from out of area (< 1%). In total, 41,627 food vouchers were provided to young people and families; 9,197 in December 2020; 9,403 in February 2021; 19,084 (9,542 young people) in April 2021 and 3,893 via inquiry forms. The main geographical areas of need (in descending order) were Crewe, Macclesfield, Nantwich, Congleton, Sandbach, Wilmslow, Knutsford, Alsager and Poynton.

In addition to food, the project also supported utilities and white good referrals from trusted professionals. In summary, 1689 utility vouchers provided over the course of the project, which equates to 975 pre-payment meter vouchers, 545 credit meter vouchers and 64 formal energy consultations (169 referrals yet to be completed).

In terms of white goods, the project supported a total of 122 households. The main goods requested were cookers (50), washing machines (37), fridge (21) and microwaves (14). The main geographical areas of need (in descending order) were Crewe, Macclesfield, Nantwich, Congleton, Sandbach, Wilmslow, Knutsford, Alsager and Poynton.

3.2 Pre-existing Cohort breakdown

Appendix B illustrates the postcodes of the settings which assisted the council in the CWGS. The report shows the most common areas that required support were Crewe, Macclesfield and Nantwich. However, Congleton, Sandbach, Wilmslow, Knutsford, Alsager and Poynton also had notable areas of need. In total, 369 schools/setting/colleges participated in the CWGS and assisted Cheshire East Council's voucher rollout.

The top 5 schools/settings/colleges which required the most pre-existing vouchers were Sir William Stanier Community School (715 vouchers), Underwood West Academy (647 vouchers), Wilmslow High School (625 vouchers), Ruskin Community High School (600 vouchers) and Macclesfield College (558 vouchers). The average number of vouchers sent to schools/settings/colleges was 75. Schools received the vast majority with approx. 82% of pre-existing food vouchers going via schools. Our second largest partner were early year settings who received approx. 8% of all vouchers.

Across the 3 implementation periods a trend was identified of increasing needs. The Christmas implementation went to a total of 9,197 individuals across all settings. The February half term release went to a total of 9,403 individuals and the Easter implementation required a total of 9,542 vouchers. This equates to an average of 9,380 vouchers per release, with a 3.8% increase from Christmas to Easter, a 2.2% increase from Christmas to February, and a 1.5% increase from February to Easter. Awareness may attribute to the increase, which we will continue to monitor when moving into the COVID Support Grant phase.

3.3 Food Inquiry Form Breakdown

Appendix C illustrates the postcodes of the recipients of the CWGS inquiry form who had requested for food. The total inquiry form food requests came to 3,893, with 28% referrals from primary schools (1089) and 18% from secondary schools (704). The team witnessed a steady increase in referrals across the grant period as awareness grew. The report shows the most common areas that required support were Crewe, Macclesfield and Nantwich. However, Congleton, Sandbach, Wilmslow, Knutsford, Alsager and Poynton also had notable areas of need.

The most common supermarkets requested was Aldi, Asda and Tesco, with Aldi being the most popular supermarket. A range of other settings participated in the inquiry form section of the scheme, with referrals being accepted from settings ranging from the NHS to libraries to 3rd sector charities. A full breakdown of referral agencies can be viewed in appendix D.

3.4 Utilities Inquiry Form Breakdown

Appendix E illustrates the postcodes of the recipients of the CWGS inquiry form who had requested utilities support. The total inquiry form food requests came to 1,689. The vast majority of referrals came from primary schools, with 18% from secondary schools. The most common support request was for 975 pre-payment meter vouchers. In addition, 545 credit meter vouchers were received, alongside 64 formal energy consultations. At the time of writing this report 169 vouchers were yet to be supplied.

There was a steady increase in referrals across the grant period as awareness grew. The report shows the most common areas that required support were Crewe, Macclesfield and Nantwich. However, Congleton, Sandbach, Wilmslow, Knutsford, Alsager and Poynton also had notable areas of need.

4. White Goods Inquiry Form Breakdown

Appendix D illustrates the postcodes of the recipients of the CWGS inquiry form who had requested white goods support. The total inquiry for white goods requests came to a total of 122 households. The main goods requested were cookers (50), washing machines (37), fridge (21) and microwaves (14). The main geographical areas of need (descending order) were Crewe, Macclesfield and Congleton.

5. Benefits of the COVID Winter Grant Scheme

The benefits of the scheme are most notably the scale and scope of the project, with the project sending out over 40,000 vouchers and working with approx. 9,500 children and families. Outside of the numerical data, the inhouse method implemented by the project also brought about notable realised outcomes. Firstly, the project was able to develop and grow its relationship with the community. This includes the recipients of the grant, schools, settings, and colleges. In the process of doing this, we have also developed a wealth of data

which can now be used to develop our understanding of our most vulnerable and map out where the need is in Cheshire East.

Alongside the established relationships, a working group positioned to swiftly deal with future grants with direct lines of communications has also been created and tested. Project engagement with our at-risk cohort has also allowed the signposting for further services to be completed, including Free School Meal sign up and Emergency Assistance. Further data benefits include being able to update our Free School Meal eligible list from our data.

Capturing feedback from those who used the scheme operationally and from recipients has been vital to evaluating the effect of the scheme. As the project had a wide scope of stakeholders and recipients, a variety of comments from these groups have been captured and represented below. Comments from families, schools, settings and front-line professionals produce a positive respond to the CWGS. The most commons themes were:

- ease of access
- timeliness of support
- the reliability of the vouchers
- the available spending categories.

These resulted in reductions in anxiety for families, improvements in food quality/nutrition, warm homes and increased assurance/security.

An example of some of the comments from families/professionals are set out below:

The vouchers have been really useful and a big help. The instructions on how to use them were also easy to follow

All of my families have been extremely grateful for this support so thank you very much!

Accessing the winter grant scheme has definitely eased some anxieties for parents around finances, especially the support towards utility bills!

The Winter Grant Scheme, supported my most in need families. Without it they would have been struggling to feed their children - the vouchers were easily accessible to them. My families were very grateful for this help and I felt it provided them with the ethos that they were supported during these difficult times.

6. Challenges and Future Learning

The main learning outcomes from the programme were around its operational implementation. This includes targeting communications and releasing the inquiry form after the main voucher release to avoid unnecessary referrals. The project team have amalgamated the learning and experience from the previous 4 months and are now in a strong position to deliver future work of this kind. Project feedback also made clear the vouchers made immediate short-term improvements to young people and families outcomes. However, we need to consider the long term needs of this cohort and how best to address them.

7. Conclusion and Next Steps

In conclusion, the CWGS had a major impact on the recipients of the grant. The grant has been far reaching and had a significant impact on those families in need during the pandemic.

The grant closed on the 16/04/21, however, a follow up grant called the COVID Support Grant (CSG) began implementation on 17/04/21, which will utilise the data and learning from the CWGS to benefit those families in need in Cheshire East.

The Holiday Activity Fund (HAF) was also implemented from Easter 2021, and will be running in Summer and Christmas 2021. HAF will provide meals and holiday activities for FSM eligible young people and will continue from the work the CWGS completed. In addition to the CSG and HAF the Department for Health and Social Care also increased healthy start vouchers from £3.10 to £4.25, alongside allocating £16m to 3rd sector charities.

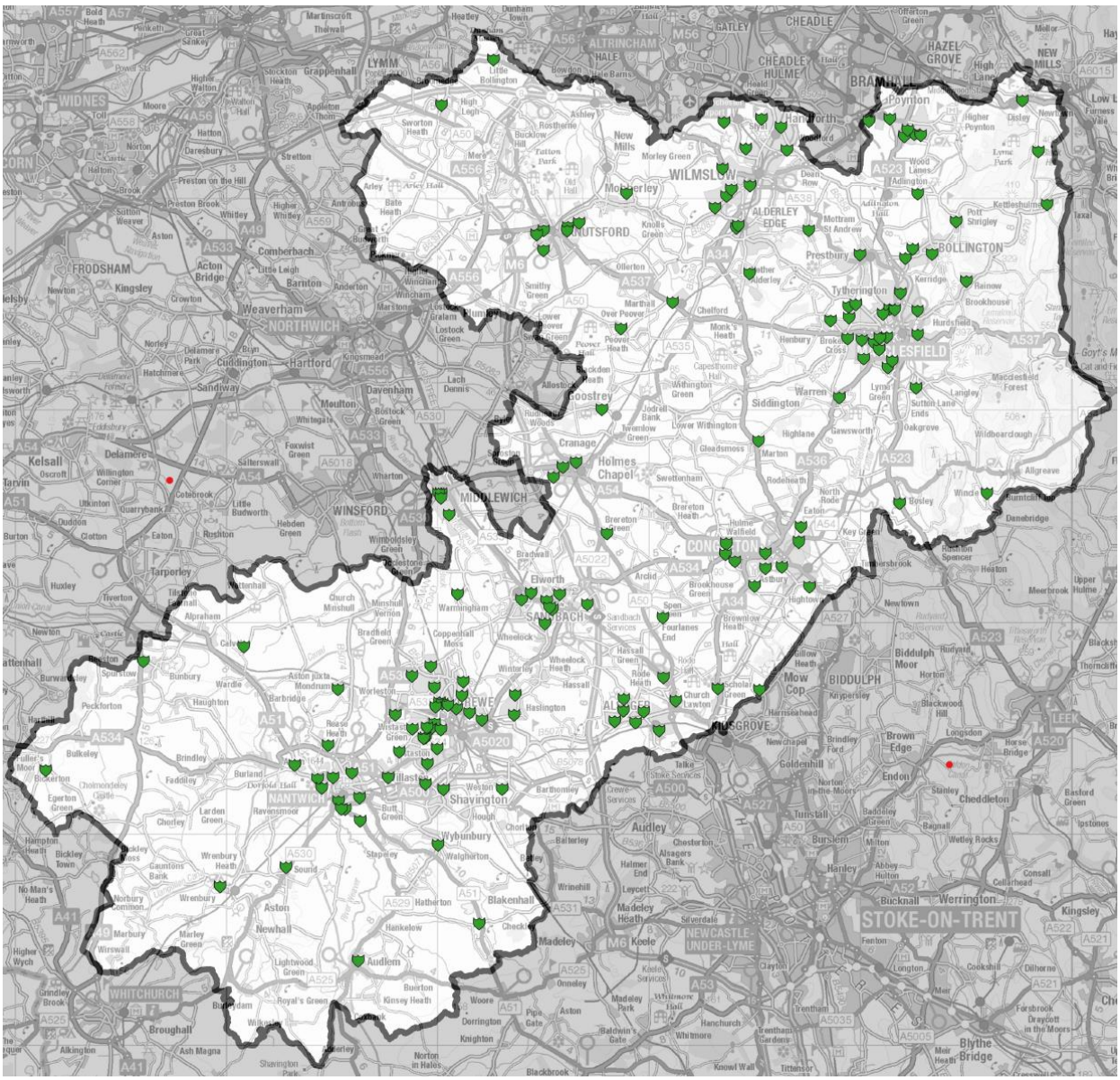
8. Appendices

Appendix A Voucher Delivery Tracker

	16/04/2021
Inquiry Forms Received (per child)	
Food	4222
Utilities	3699
White Goods	281
Total No on inquiry forms	4753
Vouchers Issued	
Food	3893
Utilities (households)	1689
Christmas Break	9197
February Half Term	9403
Easter Break	19084 (2 x £20)
Benefits - food vouchers	50
Total	43316
Inquiry Forms Completed	
Food	3893
Ground Work (households) (sent to GroundWork)	1453
White Goods (households)	104
Total	5450

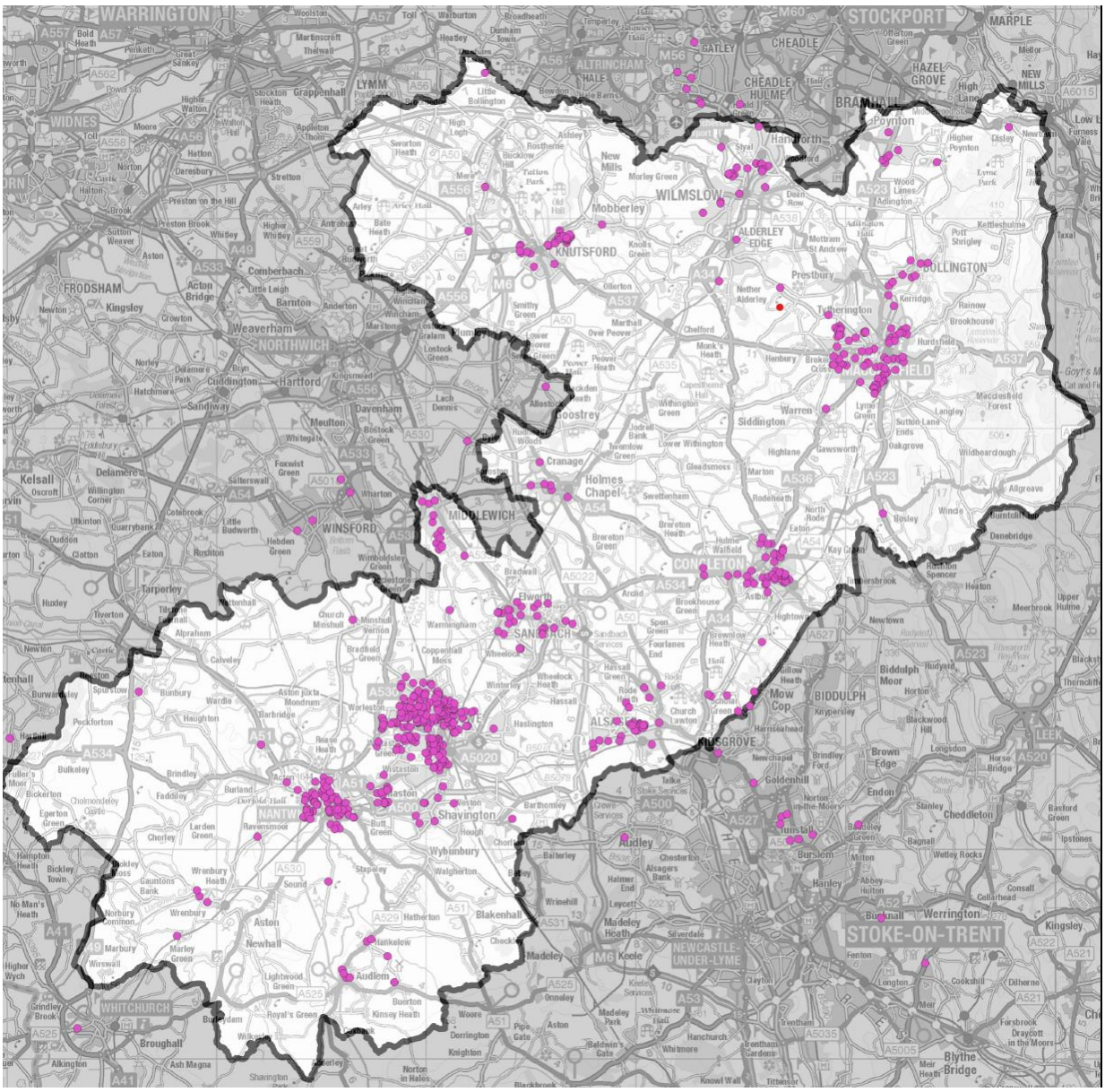
Cheshire East TOGETHER for Children and Young People

Appendix B - COVID Winter Grant Scheme School/Setting/College Map (16/04/2021)

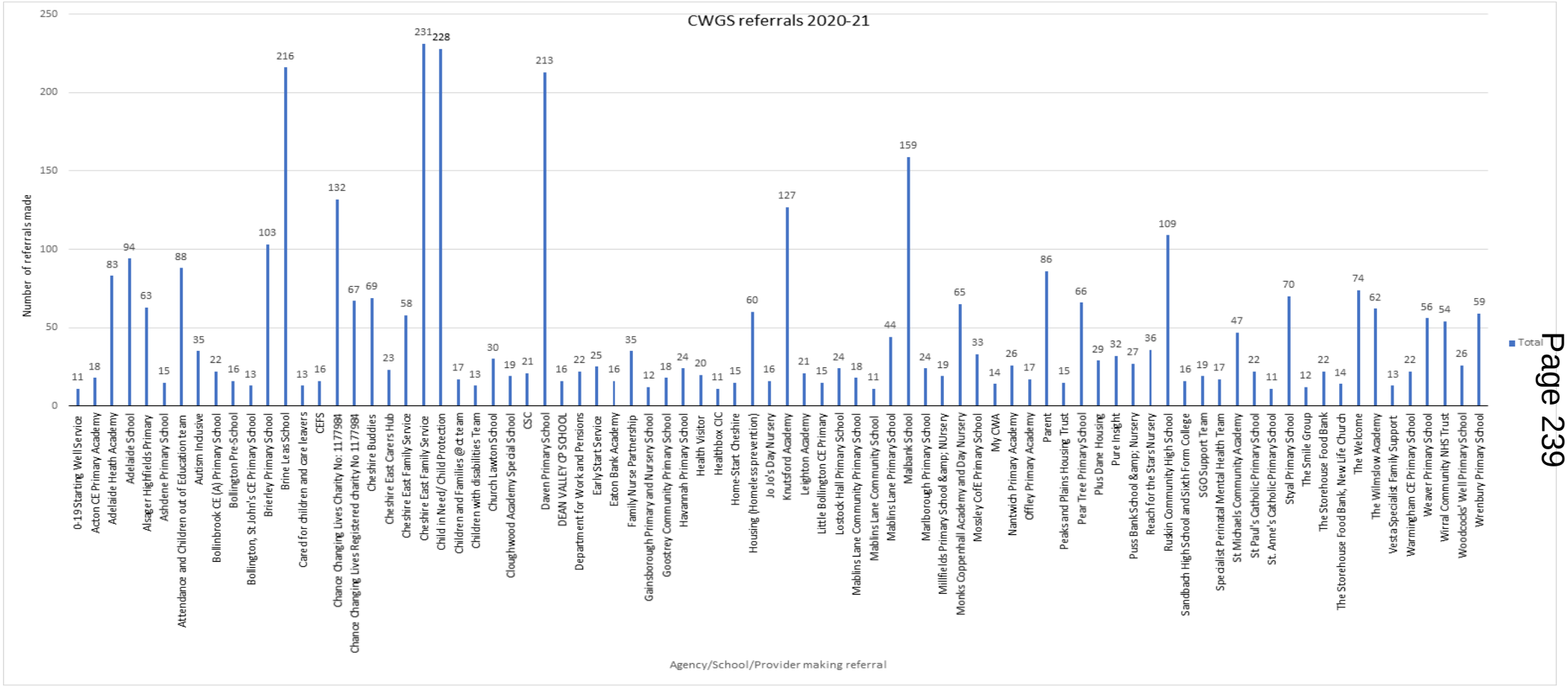


Cheshire East TOGETHER for Children and Young People

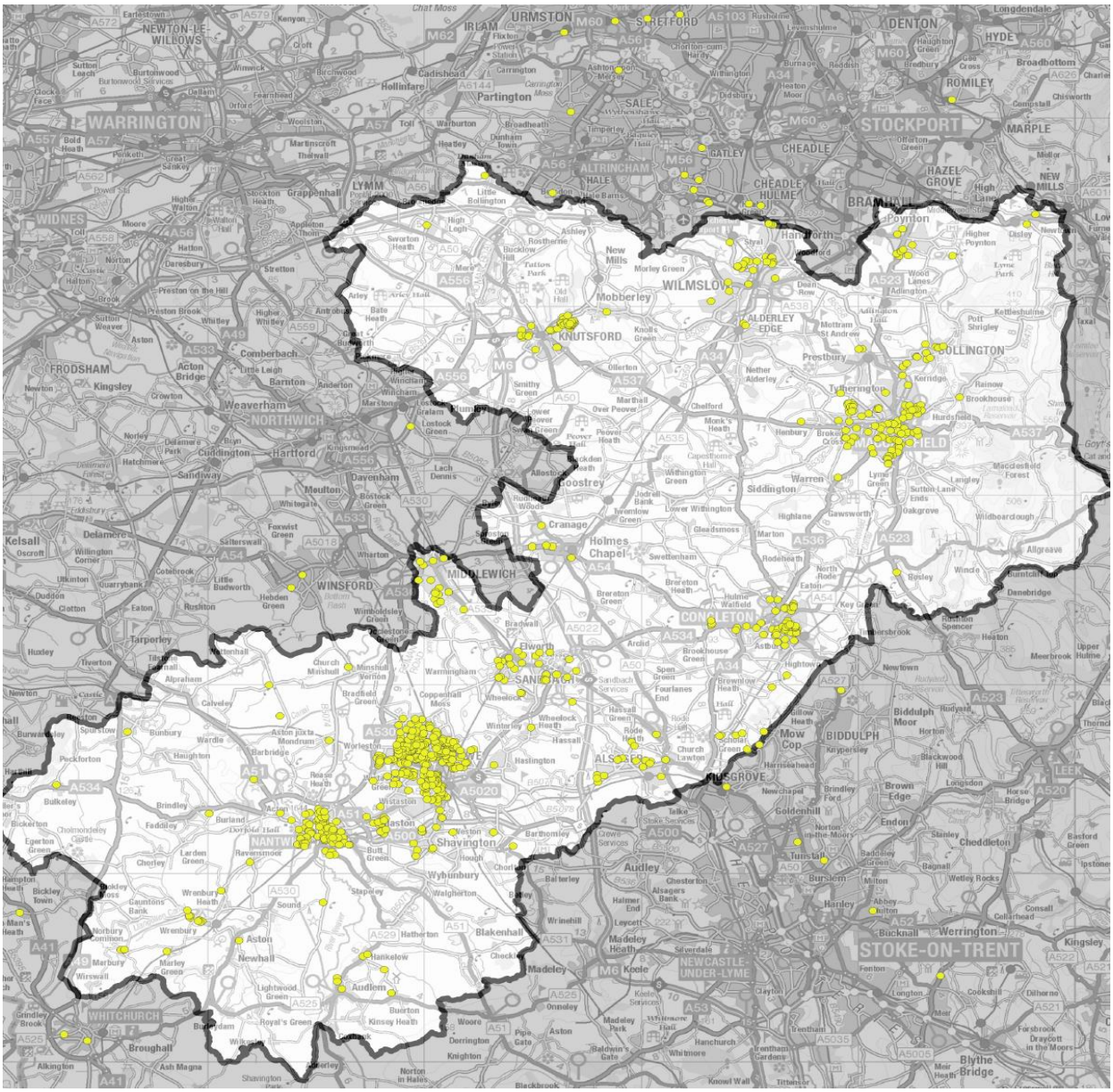
Appendix C, COVID Winter Grant Scheme Food Inquiry Map (16/04/2021)



Appendix D, CWGS Inquiry Form Referral Bar Chart



Appendix E, CWGS White Goods referral map



Cheshire East

TOGETHER for Children and Young People

Together we will make Cheshire East a great place to be young

Cheshire East COVID Holiday Activity Fund

Easter 2021

Title of Report:	Cheshire East Holiday Activity Fund Impact Report
Date of Report Completion	21/05/2021
Written by:	Douglas Hubbert, Business Development Manager at Cheshire East Council
Contact details:	Douglas.Hubbert@cheshireeast.gov.uk

Executive Summary

The Holiday Activity Fund programme will run in the Easter, Summer and Christmas holidays 2021. The programme is a government scheme with the aim of providing support to vulnerable children in receipt of benefits-related free school meals. Cheshire East Borough Council received £881,340 funding in total.

To implement, Cheshire East Council approached primary and secondary schools, Council led groups and charity organisations in the Cheshire East area, to offer a holiday club service free of charge, to vulnerable/at risk children who receive Free School Meals (FSM). In order to qualify for the grant funding offered by the Council to cover the cost of the provision being offered, the providers have to provide detailed information on how they can offer provision that will give the children the opportunity to eat more healthily over the school holidays be more active during the school holidays and develop a greater knowledge of health and nutrition.

Easter Holiday Results:

- 92 providers completed an Expression of Interest (EOI)
- 22 providers applied for HAF funding
- 18 were successful
- 4 were unsuccessful
- 1 dropped out at a later date due to lack of take up by FSM children
- £64,708.89 was awarded to providers
- 463 FSM children attended HAF funded holiday club sessions over Easter.

Introduction

On 8 November 2020, the government announced that the holiday activities and food programme will be expanded across the whole of England in 2021. The programme has provided healthy food and enriching activities to disadvantaged children since 2018.

The programme will cover the Easter, Summer and Christmas holidays in 2021. This holiday provision is for children who receive benefits-related free school meals.

Local authorities were asked to ensure that the offer of free holiday club provision was made available for all children eligible for and in receipt of Free School Meals (FSM) in their area, for the equivalent of at least 4 hours a day, 4 days a week, 6 weeks a year. This would cover 4 weeks in the summer and a week's worth of provision in each of the Easter and Christmas holidays in 2021.

The funding local authorities receive is to cover the:

- provision of free holiday places
- coordination of the programme locally.

As a result of this programme, the government wanted children who attend this provision to:

- eat more healthily over the school holidays
- be more active during the school holidays
- take part in engaging and enriching activities which support the development of resilience, character and wellbeing along with their wider educational attainment
- be safe and not to be socially isolated
- have a greater knowledge of health and nutrition
- be more engaged with school and other local services.

They also wanted to ensure that the families who participated in this programme:

- developed their understanding of nutrition and food budgeting
- are signposted towards other information and support, for example, health, employment and education.

Cheshire East Council's Implementation

Planning and Mobilisation

Cheshire East's implementation began on 1st March 2021 and the last holiday period covered will be Christmas 2021, with expected final government reporting required before 31st March 2022.

The programme has 3 significant roll-out phases:

- Easter holidays 2 April 2021 to 16 April 2021
- Summer holidays 22 July 2021 to 31 August 2021
- Christmas holidays 20 December 2021 to 3 January 2022

Mapping of the areas of need took place first to establish the target groups. After this an expression of interest cycle commenced inviting providers to put themselves forward for the programme and application process. The application process took place between 11 March 2021 to 24 March 2021.

Mobilisation Period

11/03/2021 – Grant Applications Go Live
18/03/2021 – 26/03/2021 Rolling Assessment of Applications
24/03/2021 – Funding Round Closes
22/03/2021 – 29/03/2021 Grant Offer Letters will be provided to successful applicants
29/03/2021 – Grant Brochures will be provided to HAF Stakeholders
29/03/2021 – Grant Reporting Templates will be provided to successful Grant Applicants
01/04/2021 – Providers begin Easter Delivery
09/04/2021 – First 50% Easter Payment made upon successful Grant Application.
03/05/2021 – Easter Evaluation Return Date
14/05/2021 – Second 50% Easter Payment made upon return of Evaluation

Determining a successful application

Providers were asked to complete an application form to include:

- Details on how they identified a need in their area/setting
- How they would meet the key principles of the programme
- What the service would provide
- How many children they intended to target/accommodate
- Detailed breakdown of projected costs
- Sustainability of project post HAF funding

All completed applications were assessed using the above criteria to determine level of need and the providers ability to deliver a suitable programme in the key principle areas set out by the Government.

Implementation

After the decision process was completed, outcome letters were sent to all providers detailing if they had been successful in securing funding for their clubs and how much funding they would receive. The providers were then able to begin preparations for roll out of their holiday activities.

A brochure was developed by the HAF team and this was publicised around the council service areas and distributed to schools and settings in the Cheshire East area. A publication was entered into the Schools Bulletin which is a weekly update on events that is distributed around all education settings in CE. A webpage was established with links to the online brochure and further information regarding the HAF and what it has to offer.

A 50% grant payment was made to all successful providers around 9 April 2021 and a further 50% payment would be made once completed evaluations were received after the clubs had ran over the Easter holidays.

Check ins were made by the HAF team at the end of the first week to gauge the uptake of FSM children and if the clubs were running successfully. The overall feedback received at the end of the first week was positive.

Impacts of the Cheshire East Holiday Activity Fund

Summary of Impacts

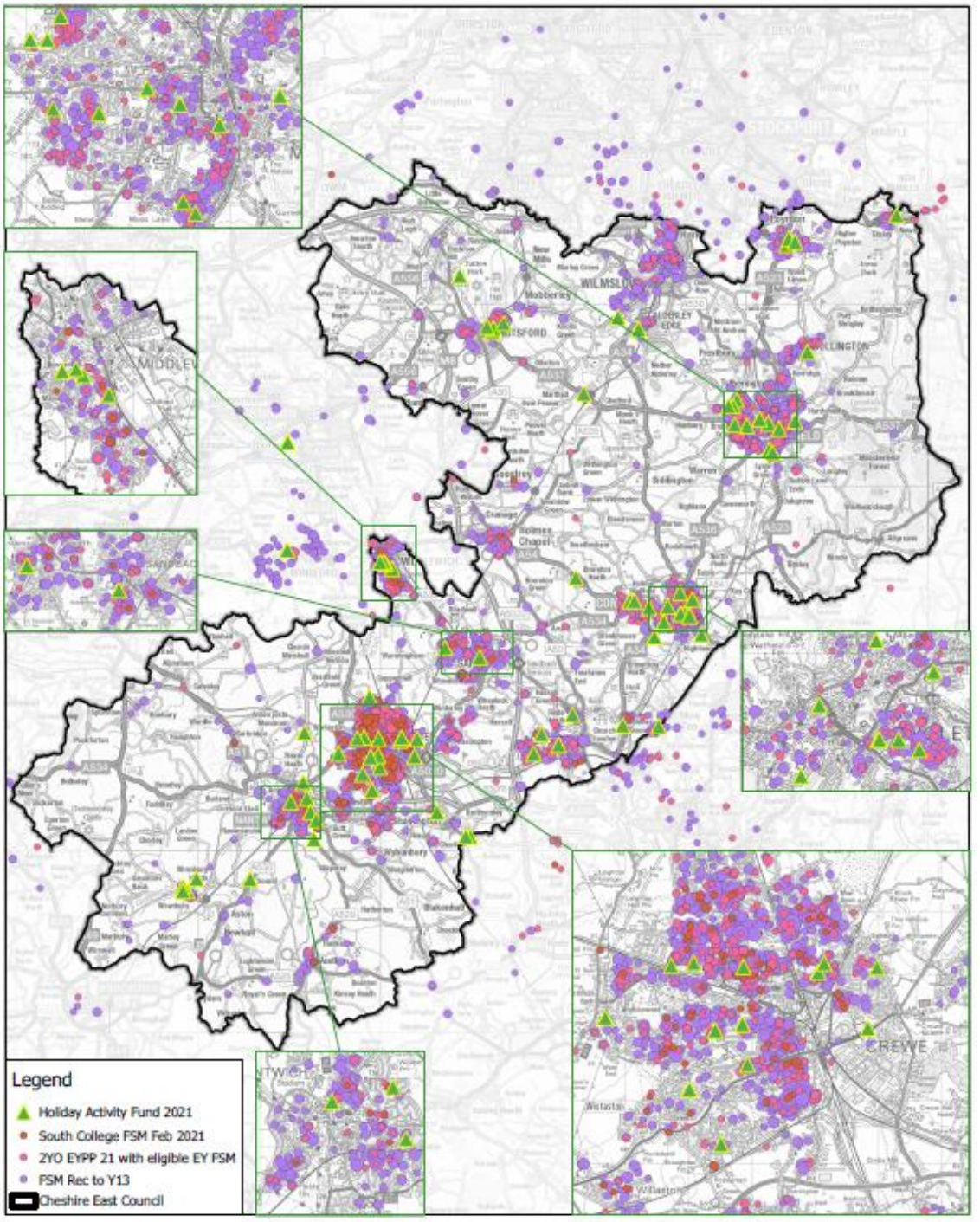
The impacts of the Cheshire East HAF can be viewed in appendix A. 463 children eligible for FSM attended the clubs, providing them with an opportunity to access a healthy daily meal and snacks, take part in enriching and engaging activities with peers and improve mental

health and wellbeing. Educational materials were provided to parents to develop their understanding of nutrition and food budgeting.

Delivery of HAF programme by area

Setting	Expected no. of Attendees	Actual no. of Attendees	Overall attendance	Sessions Clubs ran
St Marys RC Crewe	30	30	54	85
Cheshire Buddies	34	17	63	11
Sports Coaching Group	60	42	42	20
Havannah	30	24	24	5
RCSAT	26	2 – 26 booked on	69 +67 on report	2
Rodeheath	10	7	7	4
Nantwich Primary	20	16	150	5
Scholar Green	31	Between 15-21 daily	21	9
AMAT	60	40	52	36
Premier Education	20	24	25	6
Leighton Academy	20	34	112	152
CeCP	280	131	344	85
Outdoor Fun Forest	15	16	16	4
CE Youth Service	20	20	20	10 - 2 virtual
CE Children’s Centres	40	39	118	8 virtual

Mapping of areas of need and HAF programme



Feedback from providers/attendees

Setting Name	Activities delivered	Feedback received
St Mary's RC Crewe	Making smoothies Rock painting Easter egg hunt Decorating cupcakes Making rainbow blowers Parachute games Archery Giant outdoor games	100% of parents said that their child felt happy and safe at SMART Club 100% of parents rated the behaviour at SMART Club as "very good" Quotes from parent voice questionnaires: "Very organised and my kids feel very happy to attend" "Staff do a fab job entertaining the children and looking after them" "He enjoys interacting with friends as he's not been able to due to lockdowns" Pupil Voice questionnaires completed: 100% of pupils rated holiday club as "very good" 100% of pupils said that they feel happy and safe at SMART Club Quotes from pupil voice questionnaires: "I enjoy the activities because you get to do fun stuff" Favourite activity = Archery. Year 6 "I love football, painting and playing pool" Year 4 "I love everything, staff, meals and toys" Year 6 "I like making friends because I feel lonely" Favourite activity = Parachute. Year 4 Favourite activity - rock painting. Year 2 "I had a good time. I like cooking". Year 1
Cheshire Buddies	During the park sessions (held on sat, Tue, Thurs and sat) the children played football and basketball at Sandbach park for 2hrs. They were also involved in an egg hunt and games at the park (tag) and on the play equipment.	"I love coming to Cheshire buddies and I have made friends with the other children, if I hadn't heard about buddies I would be sitting at home just watching the TV with no friends to talk to it means a lot to me." "The kids have absolutely loved coming to the sessions in the park over easter, they've made plenty of friends." "M has loved being at the park. He has made friends. He would just be sat in the house on his tab." "L really enjoys coming to Easter club, it's amazing to see him outside and willing to go to the club. We struggle to get L outside due to his disabilities. He has friends, which he has never had before. What you have done for L is wonderful, I have seen my son smile and giggle, something he has not done for a very long time." "A wouldn't go anywhere if he didn't go out with Buddies apart from spending time with his 6 yr. old nephew, he has no friends locally that he can spend time with, and he's not socially where other 15 Yr. olds are at so Buddies is his life." "M really enjoyed the sessions. He particularly liked yesterday as he saw his school friends which hasn't been

		possible for some time. M liked doing the forest school activities at lower moss Woods, they made a fire." "I love Cheshire buddies and the range of activities on offer, M just loves attending and it makes a massive impact on his self-confidence and social skills. He would come full time if he could!" Sibling – "N has loved coming to the club. It has helped her to come out of her shell that bit more and to build her social skills. It has also given her the respite that she needs away from the demanding home environment, it has given her the chance to be a 'normal' child for a couple of hours a week rather than having to see and deal with things that are unique for our family." "S says she loves coming to club and meeting new people. She has made lots of new friends, she says she enjoys all the different activities which she would not be able to do if we were just out as a family. It gets her out and about and she has fun and looks forward to each session and the extra art and crafts and competitions, she can do, such as pottery bowls." "F&J greatly benefit from attending buddies. It gives them time away from caring responsibilities to just be children, make friends and participate in activities that would not normally be possible." "E is so grateful to be added to the group. She enjoys the time away from her siblings and has made some new friends, she is so happy to have found Cheshire buddies, we are very grateful as a family for all that you offer."
Sports Coaching Group	Netball Football Tennis Rugby Easter Egg Hunts Easter arts and crafts Fencing and Archery Mini Olympics and Boccia competitions	Children have given us lots of positive feedback to all the activities we have put on for them. Some children have requested to come back for additional days from having a positive experience the first time around. Social interaction with other kids has been another major positive point from both staff running the course but also from the children that have made new friends over the duration of the course.
Havannah week 1 (CeCP)	Activity club Easter Egg hunt Spring walk Garden games Forest school club	Feedback from the children included: "It's been fun being outside with friends and learning new games." "I liked it, but wish we could do this more regularly." "I wasn't very good at making a fire at first, but I did it in the end!" "I've missed having fun and being with friends." "I enjoyed learning new things and building dens in the woods." "Cooking in the wood and the woodland hunt was the best bit."
RCSAT	Multi Sports	No feedback provided

	Football Dodgeball bench ball archery nerf wars mini games etc	
Rode Heath All Stars Club	Woodwork Easter Baking wooden bird feeders colouring junk modelling team games football and cricket.	No feedback provided
Nantwich Primary	Football Basketball Cricket Hockey Tennis Fencing Drama Music	We have received positive verbal feedback from children and parents. Positive comments related to the range of activities, staff and enjoyment of the days.
Scholar Green	T-shirt dying Junk Modelling Planting/growing veg Campfire Baking Gymnastics Arts and Crafts	The children have really enjoyed coming to the Den (Easter Holiday Club) and have asked to come more often. They have enjoyed junk modelling, tie dying and the baking day they have done. All children have eaten the meals we have provided and had access to drinks and fruit during the day.
AMAT	making bird boxes cooking classes various sporting activities art and design activities drama 1st aid healthy eating wellbeing circus skills & team building.	The feedback from all the children and their parents / carers was very positive. As it was from the staff who ran or supervised the sessions.
Premier Education	Sporting activities such as: archery, football, dodgeball, cricket, multi-skill games, nerf battles, hockey, athletics etc. Wellbeing sessions where children were educated on healthy diets and how to look after their bodies.	Feedback from two parents – “Thanks to all the staff, I know my boys have loved their days with you, I hope it runs through other half terms” and “My two have loved it and it's been great having it on the school grounds. I hope you offer more in the future as we always need support in the holidays”.
Leighton Academy	Baking science experiments gardening drama vintage games den building football/ball games rounders	Feedback had not been provided at the time of writing this report. This has been requested and will affect their summer application.
CeCP	Trampolining coaching	“It was good to try something new.”

	football coaching dance workshop sports day baking Easter egg hunt arts & crafts day Forest School days nutrition & effects on the body, healthy eating circus skills archery scoot skills multi-sports garden games spring walk hockey woodwork PE/RE/Maths games colour runs.	"It was so nice being with my friends again." "The colour run was amazing - I've never had so much fun in the holidays." "Can we do this in every school holiday?". A parent commented that their child has autism and it was good that they were given time and support to be involved. Another parent commented that their child has never got involved with holiday clubs but after the first day couldn't wait to go back for day 2.
Cheshire East – Youth Support Centres	online sessions – scavenger hunt & Task Master session bingo pool competitions quiz willow weaving playing instruments making seed bombs arts and crafts games bird box making kite making Bush Craft Making a fire	"We have had so much fun." "I haven't been anywhere since the start of lockdown." "Please slow the time down." "Lighting the fire, making Jenga out of wood, it was amazing, lots of fun."
Cheshire East – Children's Centres	Cooking Parks Easter Sports Day Egg hunt Jack and the Beanstalk activities Teddy Bear picnic Messy play/seed planting	"Had a good day. Everything was prepared perfectly for kids and parents. Staff and their engagement with kids was awesome!!!!!" "My two sons had a great time, the two women from the children's centre were great and we had lots of fun." "The activity session was well organised it was a shame that there were only 2 children that turned up." "We had a really great time thank you for having us and we loved the goodie bags we had and the packed lunch." 1 family with a 4 & 9-year-old really enjoyed it. Mum commented that she doesn't usually attend these activities but felt it would be good as the children haven't accessed anything through lockdown. She felt it was good for her 4-year old's confidence taking part. The 9-year-old told us "it was the best day ever! He really enjoyed the session" A family text to say "I really enjoyed it today and so did the kids. P is so tired now thank god!"

		Other families all commented that they really enjoyed the activities and the children were all pleased with their goodie bags and sandwich box.
Outdoor Fun Forest	Plant in vegetables Den building Campfire cooking Bug Hotel making	The Outdoor-Fun team received very good feedback from both parents and children. One child saying he felt refreshed to be outdoors playing with his new friends. All the children were happy to return for more sessions and parents were happy with fact that the children were "Outside being active".

Conclusion

In conclusion, the HAF funding has had a great impact to FSM children in the CE area so far. The grant enabled 463 children to access a free holiday provision over the Easter period, enabling them to engage with peers and access enriching activities in a stimulating environment. Where children had become socially isolated due to Covid restrictions, these children were able to access this provision, which has helped with social interaction, mental health and wellbeing as well as offering both parents/carers respite.

The main geographical areas where the need was identified were, Macclesfield, Crewe, Nantwich and Congleton, although clubs were offered in other areas such as Sandbach, Alsager and Middlewich.

The Summer stage of the HAF programme has been started. Initial mapping of areas of need has been undertaken and a EOI round was undertaken between 15th April 7th May. So far 93 providers have registered their interest and this includes the 22 who participated in the Easter round. Overall the feedback received from, providers, parents and children who participated and benefitted from the HAF Easter roll out has been positive and all are keen to take part again in the Summer.

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Work Programme – Adults and Health Committee – 2021/22

Reference	Committee Date	Report title	Purpose of Report	Report Author /Senior Officer	Consultation and Engagement Process and Timeline	Equality Impact Assessment Required and Published (Y/N)	Part of Budget and Policy Framework (Y/N)	Corporate Plan Priority	Exempt Item and Paragraph Number
AH/01/21-22	27 Sep 2021	Adult Social Care Improvement Plan - Learning from Covid-19	To consider the Adult Social Care Improvement Plan and learning from Covid-19.	Director of Commissioning		Yes	Yes	A council which empowers and cares about people	
AH/08/21-22	27 Sep 2021	Advocacy Service Recommission	To approve the arrangements to recommission advocacy services, in response to changes in legislation (LPS).	Director of Commissioning		Yes	Yes	A council which empowers and cares about people	
AH/30/21-22	27 Sep 2021	Assistive Technology (AT) Charging Policy	To receive the consultation feedback and decision on charging	Director of Commissioning		Yes	Yes	A council which empowers and cares about people	N
AH/07/21-22	27 Sep 2021	Assistive Technology Recommission	To approve the arrangements on the recommission of Assistive Technology including the results of the consultation or the charging policy.	Director of Commissioning		Yes	Yes	A council which empowers and cares about people	
AH/10/21-22	27 Sep 2021	Carers Services Recommission	To approve the recommission of Carers' Services (funded through the Better Care Fund).	Director of Commissioning		Yes	Yes	A council which empowers and cares about people	
AH/09/21-22	27 Sep 2021	Carers Strategy	To approve the refreshed Carers Strategy.	Director of Commissioning		Yes	Yes	A council which empowers and cares about people	
AH/11/21-22	27 Sep 2021	NHS Health Checks Recommission	To approve the recommission of NHS Health Checks.	Director of Commissioning		Yes	No	A council which empowers and cares about people	
AH/16/21-22	27 Sep 2021	Performance Scorecard - Quarter 1 (2021/22)	To consider the key performance indicators/measures from Quarter 1, 2021/22.	Director of Adult Social Services		No	No	A council which empowers and cares about people	

Reference	Committee Date	Report title	Purpose of Report	Report Author /Senior Officer	Consultation and Engagement Process and Timeline	Equality Impact Assessment Required and Published (Y/N)	Part of Budget and Policy Framework (Y/N)	Corporate Plan Priority	Exempt Item and Paragraph Number
AH/28/21-22	27 Sep 2021	Referral of Notice of Motion: Right to Food	Full Council (22 June 2021) resolved to refer Councillor A Critchley's Notice of Motion 'Right to Food' to the Adults and Health Committee to determine whether or not the Motion be adopted.	Director of Commissioning	None	N/A	N/A	A council which empowers and cares about people	
AH/18/21-22	16 Nov 2021	Accommodation with Care Recommission	To approve the recommission of Accommodation with Care services (Care Homes).	Director of Commissioning		Yes	Yes	A council which empowers and cares about people	
AH/20/21-22	16 Nov 2021	Adult Social Care Winter Plan	To approve the Adult Social Care Winter Plan.	Director of Commissioning		Yes	Yes	A council which empowers and cares about people	
AH/12/21-22	16 Nov 2021	All-Age Sensory Strategy	To approve the new All-Age Sensory Strategy.	Director of Commissioning		Yes	No	A council which empowers and cares about people	
AH/17/21-22	16 Nov 2021	Care at Home Recommission	To approve the arrangements to recommission Care at Home services.	Director of Commissioning		Yes	Yes	A council which empowers and cares about people	
AH/19/21-22	16 Nov 2021	Day Opportunities Strategy	To approve the co-designed Day Opportunities Strategy.	Director of Commissioning		Yes	Yes	A council which empowers and cares about people	
AH/06/21-22	16 Nov 2021	Dementia Strategy	To approve a new updated Dementia Strategy.	Director of Commissioning		Yes	No	A council which empowers and cares about people	

Reference	Committee Date	Report title	Purpose of Report	Report Author /Senior Officer	Consultation and Engagement Process and Timeline	Equality Impact Assessment Required and Published (Y/N)	Part of Budget and Policy Framework (Y/N)	Corporate Plan Priority	Exempt Item and Paragraph Number
AH/29/21-22	16 Nov 2021	Live Well for Longer Strategy	To approve the Live Well for Longer Strategy.	Director of Commissioning	TBC	No	Yes	A council which empowers and cares about people	
AH/21/21-22	16 Nov 2021	Local Account	To consider the annually required Local Account of Adult Social Care Services, outlining how the council has supported people over the previous year.	Director of Adult Social Services		No	No	A council which empowers and cares about people	
AH/24/21-22	16 Nov 2021	Mid-Year Finance and Performance Review	To receive an update on the financial position for 2021/22, and to note or approve virements and supplementary estimates as required.	Director of Commissioning		No	Yes	A council which empowers and cares about people	
AH/22/21-22	16 Nov 2021	Performance Scorecard - Quarter 2 (2021/22)	To consider the key performance indicators/measures from Quarter 2, 2021/22.	Director of Adult Social Services		No	No	A council which empowers and cares about people	
AH/31/21-22	16 Nov 2021	Market Position Statement	To approve the Market Position Statement.	Director of Commissioning		Yes	Yes	A council which empowers and cares about people	
AH/14/21-22	18 Jan 2022	Channel Panel Annual Report & Self Assessment	To receive the Chanel Panel Annual Report & Self Assessment for 2020/21.	Director of Adult Social Services		No	No	A council which empowers and cares about people	
AH/13/21-22	18 Jan 2022	Director of Public Health Annual Report 2020/21	To receive and approve the Director of Public Health Annual Report 2020/21.	Director of Public Health		No	No	A council which empowers and cares about people	

Reference	Committee Date	Report title	Purpose of Report	Report Author /Senior Officer	Consultation and Engagement Process and Timeline	Equality Impact Assessment Required and Published (Y/N)	Part of Budget and Policy Framework (Y/N)	Corporate Plan Priority	Exempt Item and Paragraph Number
AH/15/21-22	18 Jan 2022	Local Safeguarding Adults Board Annual Report 2020/21	To receive the 2020/21 Annual Report of the Local Safeguarding Adults Board.	Director of Adult Social Services		No	No	A council which empowers and cares about people	
AH/25/21-22	18 Jan 2022	Medium Term Financial Strategy	To respond to the Budget consultation for Adults and Public Health Services.	Director of Finance and Customer Services (s151 Officer)	Yes	Yes	Yes	An open and enabling organisation	
AH/26/21-22	28 Mar 2022	Third Quarter Finance & Performance Review	To receive an update on the financial position for 2021/22, and to note or approve virements and supplementary estimates as required.	Director of Commissioning		No	Yes	A council which empowers and cares about people	