Public Document Pack

Adult Health and Social Care Policy Committee

Wednesday 8 February 2023 at 10.00 am

To be held in the Town Hall, Pinstone Street, Sheffield, S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillor Angela Argenzio
Councillor George Lindars-Hammond
Councillor Steve Ayris
Councillor Abtisam Mohamed
Councillor Ruth Milsom
Councillor Kevin Oxley
Councillor Martin Phipps
Councillor Safiya Saeed
Councillor Ann Woolhouse

Sheffield City Council

PUBLIC ACCESS TO THE MEETING

The Adult Health and Social Care Policy Committee discusses and takes decisions on Adult Health and Social Care:

- Adult social work, care and support including specialist social work
- Carers
- Occupational therapy, enablement and support for independent living
- Adult safeguarding

Meetings are chaired by the Committees Co-Chairs, Councillors Argenzio and Lindars-Hammond.

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk . You may not be allowed to see some reports because they contain confidential information. These items are usually marked * on the agenda. Members of the public have the right to ask questions or submit petitions to Policy Committee meetings and recording is allowed under the direction of the Chair. Please see the Council's democracy webpages or contact Democratic Services for further information regarding public questions and petitions and details of the Council's protocol on audio/visual recording and photography at council meetings.

Policy Committee meetings are normally open to the public but sometimes the Committee may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last on the agenda.

Meetings of the Policy Committee have to be held as physical meetings. If you would like to attend the meeting, please report to an Attendant in the Foyer at the Town Hall where you will be directed to the meeting room. However, it would be appreciated if you could register to attend, in advance of the meeting, by emailing committee@sheffield.gov.uk, as this will assist with the management of attendance at the meeting. The meeting rooms in the Town Hall have a limited capacity. We are unable to guarantee entrance to the meeting room for observers, as priority will be given to registered speakers and those that have registered to attend.

Alternatively, you can observe the meeting remotely by clicking on the 'view the webcast' link provided on the meeting page of the website.

If you wish to attend a meeting and ask a question or present a petition, you must submit the question/petition in writing by 9.00 a.m. at least 2 clear working days in advance of the date of the meeting, by email to the following address: committee@sheffield.gov.uk.

In order to ensure safe access and to protect all attendees, you will be recommended to wear a face covering (unless you have an exemption) at all times within the venue. Please do not attend the meeting if you have COVID-19 symptoms. It is also recommended that you undertake a Covid-19 Rapid Lateral Flow Test within two days of the meeting.

If you require any further information please email committee@sheffield.gov.uk.

FACILITIES

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall. Induction loop facilities are available in meeting rooms. Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

ADULT HEALTH AND SOCIAL CARE POLICY COMMITTEE AGENDA
8 FEBRUARY 2023

Order of Business

1.	**Welcome and Housekeeping** The Chair to welcome attendees to the meeting and outline basic housekeeping and fire safety arrangements.	
2.	**Apologies for Absence**	
3.	**Exclusion of Press and Public** To identify items where resolutions may be moved to exclude the press and public	
4.	**Declarations of Interest** Members to declare any interests they have in the business to be considered at the meeting	(Pages 7 - 10)
5.	**Minutes of Previous Meeting** To approve the minutes of the last meeting of the Committee held on 19th December 2022.	(Pages 11 - 20)
6.	**Public Questions and Petitions** To receive any questions or petitions from members of the public	
7.	**Work Programme** Report of the Director of Legal	(Pages 21 - 36)

Formal Decisions

8.	**Hospital Discharge and Urgent Care Delivery Plan**	(To Follow)
9.	**Adult Health & Social Care Digital Strategy**	(Pages 37 - 68)
10.	**Transforming Care Homes for Citizens of Sheffield**	(Pages 69 - 142)
11.	**Revenue Budget Monitoring Report - Month 8** Report of Executive Director, Resources	(Pages 143 - 152)

Items For Noting

12.	**Approve city Wide Autism Strategic Delivery Plan**	(To Follow)
13.	**Approve All Age Mental Health and Emotional Wellbeing Strategy (Commitments 1,6 ASC Strategy)**	(Pages 153 - 188)

14.	**Endorse Director of Adult Social Care (DASS) Report and delivery plan**	(Pages 189 - 248)
15.	**Endorse Adult Social Care Financial Update and Progress with Financial Recovery Plan**	(Pages 249 - 272)
16.	**Market Oversight and Sustainability - Adult Social Care**	(Pages 273 - 384)

NOTE: The next meeting of Adult Health and Social Care Policy Committee will be held on Thursday 16 March 2023 at 10.00 am

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ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

If you are present at a meeting of the Council, of its Policy Committees, or of any committee, sub-committee, joint committee, or joint sub-committee of the authority, and you have a **Disclosable Pecuniary Interest** (DPI) relating to any business that will be considered at the meeting, you must not:

- participate in any discussion of the business at the meeting, or if you become aware of your Disclosable Pecuniary Interest during the meeting, participate further in any discussion of the business, or
- participate in any vote or further vote taken on the matter at the meeting.

These prohibitions apply to any form of participation, including speaking as a member of the public.

You **must**:

- leave the room (in accordance with the Members' Code of Conduct)
- make a verbal declaration of the existence and nature of any DPI at any meeting at which you are present at which an item of business which affects or relates to the subject matter of that interest is under consideration, at or before the consideration of the item of business or as soon as the interest becomes apparent.
- declare it to the meeting and notify the Council's Monitoring Officer within 28 days, if the DPI is not already registered.

If you have any of the following pecuniary interests, they are your **disclosable pecuniary interests** under the new national rules. You have a pecuniary interest if you, or your spouse or civil partner, have a pecuniary interest.

- Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner undertakes.

- Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period* in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

  *The relevant period is the 12 months ending on the day when you tell the Monitoring Officer about your disclosable pecuniary interests.

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority –

  - under which goods or services are to be provided or works are to be executed; and
  - which has not been fully discharged.

- Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

- Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

- Any tenancy where (to your knowledge) –
  - the landlord is your council or authority; and
  - the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

- Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -

  (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and

  (b) either -
    - the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
    - if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

If you attend a meeting at which any item of business is to be considered and you are aware that you have a **personal interest** in the matter which does not amount to a DPI, you must make verbal declaration of the existence and nature of that interest at or before the consideration of the item of business or as soon as the interest becomes apparent. You should leave the room if your continued presence is incompatible with the 7 Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership).

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or

- it relates to or is likely to affect any of the interests that are defined as DPIs but are in respect of a member of your family (other than a partner) or a person with whom you have a close association.

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously.

You should identify any potential interest you may have relating to business to be considered at the meeting. This will help you and anyone that you ask for advice to fully consider all the circumstances before deciding what action you should take.

In certain circumstances the Council may grant a **dispensation** to permit a Member to take part in the business of the Authority even if the member has a Disclosable Pecuniary Interest relating to that business.

To obtain a dispensation, you must write to the Monitoring Officer at least 48 hours before the meeting in question, explaining why a dispensation is sought and desirable, and specifying the period of time for which it is sought. The Monitoring Officer may consult with the Independent Person or the Council's Standards Committee in relation to a request for dispensation.

Further advice can be obtained from David Hollis, Interim Director of Legal and Governance by emailing david.hollis@sheffield.gov.uk.

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SHEFFIELD CITY COUNCIL

Adult Health and Social Care Policy Committee

Meeting held 19 December 2022

PRESENT: Councillors George Lindars-Hammond (Co-Chair), Ann Woolhouse, Ruth Milsom, Kevin Oxley, Martin Phipps, Angela Argenzio (Co-Chair)

1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Councillor Steve Ayris.

2. EXCLUSION OF PRESS AND PUBLIC

2.1 There were no exclusions of the press or public.

3. DECLARATIONS OF INTEREST

3.1 There were no declarations of interest made.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on the 16th of November 2022 were approved as a correct record.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 No petitions or questions from members of the public had been received.

6. WORK PROGRAMME

6.1 Councillor Lindars-Hammond noted that there would be an additional urgent item of business, titled 'Improving Wellbeing Outcomes and Tackling Inequalities Through Early Intervention, Integration and Partnership Working'.

6.2 The Committee received a report containing the Committee's Work Programme for consideration and discussion. The aim of the Work Programme is to show all known, substantive agenda items for forthcoming meetings of the Committee, to enable this Committee, other committees, officers, partners and the public to plan their work with and for the Committee. Any changes since the Committee's last meeting, including any new items, had been made in consultation with the Co-Chairs and Deputy Chair via their regular pre-meetings. The Work Programme will remain a live document and will be brought to each meeting of the Committee.

6.3 It was reported that, in relation to recommendation 4 in the report, there had

been no referrals made to the Committee by any of the Local Area Committees.

6.4 **RESOLVED UNANIMOUSLY:** That the Committee's work programme, as set out in Appendix 1, be agreed, including the additions and amendments identified in Part 1 of the report.

7. DEVELOPMENT OF A NEW INFORMATION, ADVICE AND GUIDANCE PLATFORM

7.1 The Committee received a report which outlined and explained the work being undertaken by Adult Social Care and partners to develop a comprehensive city-wide approach to information and guidance for citizens of Sheffield regarding adult and young people's health and social care. Tim Gollins, Assistant Director Mental Health, Safeguarding and Access, presented the report.

7.2 **RESOLVED UNANIMOUSLY:** That the Adult Health and Social Care Policy Committee:-

Endorse the work being done to develop city-wide citizen facing information, advice and guidance for adults and young people in Sheffield.

7.3 **Reasons for Decision**

Endorsing the work being done and the future development of the city-wide platform for information, advice and guidance about social care, and health will enable further development to partnership working across health and social care, with the voluntary sector and people who use services and carers to provide a truly coproduced and relevant, cutting-edge information, advice and guidance service. It provides options to develop cost effective demand management functions over the next year in response to legislative changes.

7.4 **Alternatives Considered and Rejected**

7.4.1 The alternative was to remain with the old platform, but in discussion with all stakeholders, after due consideration it was agreed the platform was not fit for purpose, and a step change in our information and advice capability was needed.

7.4.2 Procurement options were considered and the national framework for information and advice organisations developed by ADASS was used to secure the leading provider. This was led by corporate procurement colleagues. All procurement rules were followed.

8. APPROVE CITY WIDE UNPAID CARERS STRATEGIC DELIVERY PLAN (COMMITMENT 5, 6 ASC STRATEGIC PLAN)

8.1 The Committee received a report asking for approval of the multi-agency Carers Delivery Plan (2022-25). Mary Gardner and Lee Teasdale-Smith were in attendance to present the paper.

8.2 **RESOLVED UNANIMOUSLY:** That the Adult Health and Social Care Policy Committee:-

Approve the Carers Delivery Plan (2022-2025) signaling our continued support for people who are unpaid carers across the City

8.3 **Reasons for Decision**

8.3.1 Carers are vital to our health and social care systems. They provide care to some of the most vulnerable in our communities and in doing so, save the economy billions of pounds per year, however, being a carer can lead to social, educational and health inequalities.

8.3.2 It is therefore essential, that we recognise, value and support those in a caring role and prevent inappropriate caring, especially with young carers; a delivery plan will help us do this and that is why it is the preferred option.

8.4 **Alternatives Considered and Rejected**

8.4.1 No Update to The Delivery Plan - Not updating the delivery plan was rejected as an option. Now is a good time to be reaffirming our commitment to Unpaid Carers due to the negative impact of the pandemic and cost of living crisis on Unpaid Carers. Not refreshing our Delivery Plan sends out the wrong message. If we want Unpaid Carers to feel recognised and supported, what we are doing to make that happen needs to be obvious. The Delivery Plan is a great tool to show what organisations are doing to improve carers lives and outcomes and enable carers to feel valued.

9. APPROVE ADULT SOCIAL CARE CO-PRODUCTION AND ENGAGEMENT STRATEGIC DELIVERY PLAN (COMMITMENT 4, ASC STRATEGY)

9.1 The Committee's endorsement was sought on the approach to co-production and the development of involvement. Catherine Bunten, Head of Commissioning, Adults and Kate Damiral, Practice Development Co-ordinator presented the report.

9.2 **RESOLVED UNANIMOUSLY:** That the Adult Health and Social Care Policy Committee:

- Endorse the approach to involvement and engagement set out in the delivery plan at Appendix 1.

- Agree that Adult Health and Social Care sign up to Making it Real as demonstration of our commitment to coproduction and personalisation.

- Request that the Director of Adult Health and Social Care bring back six□monthly updates on progress in relation to delivery upon the plan

9.3 **Reasons for Decision**

9.3.1 The report asks for an endorsement of our ambition to further develop our involvement offer for local people. We propose to create new ways to empower citizens to inform, have influence, and to hold Adult Social Care to account across its services; and to lead our approach to co-production and other forms of involvement.

9.3.2 It's aimed that this approach will promote continuous improvement, which can then provide assurance to Committee regards our impact on people in partnership with people.

9.4 **Alternatives Considered and Rejected**

9.4.1 Option 1 - Option 'to do nothing' and have no involvement framework. However, this would not enable citizens to be involved in shaping and continuous improvement of adult health and social care activity in an open and transparent way.

9.4.2 Option 2 – Delay request for approval and implementation of the framework to enable further learning, benchmarking, and engagement. It is planned that benchmarking, learning and engagement will take place on an ongoing and dynamic basis to ensure it delivers what matters to people of Sheffield and is responsive to changing circumstances.

10. APPROVE DIRECT PAYMENTS AND PERSONALISATION STRATEGIC DELIVERY PLAN (COMMITMENT 5, ASC STRATEGY)

10.1 The Committee received a report seeking approval for Sheffield's Personalisation and Direct Payment Strategy and Delivery Plan and to provide and update on progress made to date to improve the Direct Payments offer in Sheffield. Andy Buxton, Commissioning Officer for Direct Payments and Mary Gardner, Strategic Commissioning Manager for Direct Payments and Carers attended and presented the paper.

10.2 **RESOLVED UNANIMOUSLY:** That the Adult Health and Social Care Policy Committee:-

1. Approve Sheffield's Personalisation and Direct Payments Strategy and associated Delivery Plan.

2. Note the progress made to date to improve the Direct Payments offer in Sheffield.

3. Requests the Director of Adult Health and Social Care to bring back an update in relation to progress in delivering the strategy within six months.

10.3 **Reasons for Decision**

10.3.1 To ensure the Council is fully compliant in its duties and responsibilities around Direct Payments and personalisation.

10.3.2 To ensure the achievement of the outcome in the Council's delivery plan to deliver a Direct Payments and Personalisation Strategy and Strategic Delivery Plan.

10.3.3 To make a commitment to the fulfil the priorities co-produced with local people to develop, improve, and grow personalised approaches in Sheffield for people who use social care.

10.4 **Alternatives Considered and Rejected**

10.4.1 Do nothing

10.4.2 If the Council leaves Direct Payments and personalised approaches as they are this would result in the Council not being fully compliant with duties and responsibilities outlined in the Care Act (2014).

10.4.3 This option would mean the Council is unable to achieve the outcome in the Council's delivery plan to deliver a Direct Payments and Personalisation Strategy and Strategic Delivery Plan.

10.4.4 Proceed with Direct Payment Improvement Programme only

10.4.5 This option would result in a programme of improvement focussing on improving Direct Payments operating in isolation and without a clear strategy to co-ordinate and connect to other and alternative opportunities to improve personalisation in Sheffield.

10.4.6 Although this option would ensure the Council is compliant with some aspects of the Care Act (2014) around Direct Payments, there would still need to be further commitments made to be fully compliant with responsibilities around personalisation of care and support services.

10.4.7 This option would mean the Council is unable to achieve the outcome in the Council's delivery plan to deliver a Direct Payments and Personalisation Strategy and Strategic Delivery Plan.

11. FAIR COST OF CARE EXERCISE

11.1 The Committee received a report which provided an update on the position from Central Government in relation to the Social Care Reform and the Fair Cost of Care exercise. It included implications on the Grant and future reporting. Liam Duggan, Assistant Director, Governance and Inclusion and Catherine Bunten, Head of Commissioning – Adults presented the report.

11.2 **RESOLVED UNANIMOUSLY:** That the Adult Health and Social Care Policy Committee:-

1. Note the latest position from UK Government

2. Approve the proposals for use of the 2022/23 Market Sustainability and Fair Cost of Care Fund.

3. Approve that contributions for backdated fee increases are waived, with people being informed about the fee rate increase and impact on contributions on 10th January 2023, and the increase in contributions taking effect from 23rd January 2023

4. Approve the proposed process for fee setting in 2023/24

11.3 **Reasons for Decision**

11.3.1 The recommendations for the use of the Fair Cost of Care Grant are made to ensure compliance with the Grant conditions.

11.3.2 The Council will continue to monitor the costs and pressures facing each type of care provision to support a stable, quality and diverse market during a very challenging time for providers, for pope who use services and for the Council and wider health and social care system.

11.4 **Alternatives Considered and Rejected**

11.4.1 The conditions of the Market Sustainability and Fair Cost of Care Fund dictate local authorities should use this additional funding to increase fee rates paid to providers beyond the level required to cover increases in core costs such as inflation, workforce pressures, National Living Wage, and National Insurance.

11.4.2 Funding must be spent within the designated financial year.

11.4.3 Therefore, the only other option would be to not allocate the Fund to providers. Given the risks and issues faced by providers, including those relating to financial stability, this is not recommended.

12. EQUIPMENT AND ADAPTATIONS ELIGIBILITY CRITERIA UPDATE

12.1 The Committee received a report seeking approval for the refreshed eligibility criteria for access to equipment and adaptations. It also set out refreshed guidance on access to the Disabilities Facilities Grant. Jo Pass, Assistant Director – Aging Well and Ian Menzies, Equipment and Adaptations Manager were in attendance to present the report.

12.2 **RESOLVED UNANIMOUSLY:** That the Adult Health and Social Care Policy Committee:-

Approve the Adult Health and Social Care Equipment and Adaptations

Criteria at Appendix 1 and approve publication on the Sheffield Directory – the information and advice hub

Agree that updates in relation to expenditure on the Disability Facilities Grant will be provided through the budget update reports to Committee on a six-monthly basis

Requests that the Director of Adult Health and Social Care brings an update in relation to implementation of the Criteria in one year.

12.3 **Reasons for Decision**

Reviewing and relaunching the Equipment and Adaptations Criteria gives a structured approach to the promotion of independent living through equipment and adaptations as well as how people can access the funding for their prescribed equipment and adaptations. It will also provide greater accountability and transparency of how will do this.

Asking for regular updates and refreshes of the Equipment and Adaptations delivery plan will keep the Committee, wider stakeholders, and the public the ability to hold the Council to account for progress and provide an additional mechanism to input to future development.

12.4 **Alternatives Considered and Rejected**

12.4.1 Not reviewing the Equipment and Adaptations Criteria and not reviewing the Disabilities Facilities Grant were considered. However, this would not provide the assurances required to ensure that we are striving towards a high performing and financially sustainable service.

13. MONTH 7 – BUDGET MONITORING REPORT

13.1 Liz Gough, Head of Service – Finance, presented a report to the Committee which provided an update on the Council's financial position as at Month 7 2022/3

13.2 **RESOLVED UNANIMOUSLY** That the Adult Health and Social Care Policy Committee:

1. Note the Council's financial position as at the end of October 2022 (month 7)

13.3 **Reasons for Decision**

13.3.1 This paper is to bring the committee up to date with the Council's current financial position as at Month 7 2022/23.

13.4 **Alternatives Considered and Rejected**

13.4.1 The Council is required to both set a balance budget and to ensure that in-year income and expenditure are balanced. No other alternatives were considered.

14. COMMISSIONING OF CITY WIDE CARE AT NIGHT SERVICES

14.1 A report was presented to the Adult Health and Social Care committee which asked that an extension be granted for a further six months of the jointly commissioned Sheffield City Council and the South Yorkshire Integrated Care Board for the Sheffield Place arrangements of provision of the Night Care Visiting Service.

14.2 **RESOLVED UNANIMOUSLY** That the Adult Health and Social Care Policy Committee:

1. Note the extension of the current Care at Night Service until the 30th of September 2023.

2. Endorse the proposal for an options appraisal and agree that the outcomes of the options appraisal and proposals for recommissioning of Care at Night Services are progressed.

14.3 **Reasons for Decision**

14.3.1 The extension of the contract will enable organisations to undertake activities and actions and give full consideration through an options appraisal to determine the best, viable commissioning, and procurement Page 235 Page 8 of 8 model approach and, ensure minimal disruption to individuals and whilst other key commissioning activity of the new Care and Wellbeing service takes place.

14.4 **Alternatives Considered and Rejected**

14.4.1 The option of “do nothing” was considered. However, given that the current contract will end in March 2023 and a recommissioning of care and wellbeing services is underway there is no longer an option to do nothing.

14.4.2 The extension of the contract will provide the opportunity to review the current delivery model and build upon the learning and partnerships built over this last 5 years. It provides an opportunity to take account of the joint ambitions and priorities of the Council and ICB Sheffield as well as learning from the new city-wide Care and Well Being Service which will be implemented in summer of 2023.

15. ENDORSE DIRECTOR OF ADULT SOCIAL CARE (DASS) REPORT AND DELIVERY PLAN

15.1 Alexis Chappell, Director of Adult Social Services, provided the committee with an update on the performance and governance of Adult Health and Social Care Services, including progress in DASS accountabilities and delivery of statutory requirements.

15.2 This report was for information and was noted by the Committee.

16. ENDORSE ADULT SOCIAL CARE FINANCIAL UPDATE AND PROGRESS WITH FINANCIAL RECOVERY PLAN

16.1 Liam Duggan and Jonathan McKenna Moore provided a financial update to the Adult Health and Social Care Policy Committee including milestones for December for Expenditure, COVID grants, Establishment Controls and Contract Management Controls.

16.2 This report was for information and was noted by the Committee.

17. IMPROVING WELLBEING OUTCOMES AND TACKLING INEQUALITIES THROUGH EARLY INTERVENTION, INTEGRATION AND PARTNERSHIP WORKING

17.1 Sandie Buchan of the Integrated Care Board (ICB) presented a collaborative report carried out by Sheffield City Council and the ICB which outlined joint working between health and social care in Sheffield and the ways in which this could improve outcomes and help to reduce health inequalities.

17.2 **RESOLVED UNANIMOUSLY:** That the Adult Health and Social Care Policy Committee:-

1. Note progress in relation to the Adult Health and Social Care Integrated Working Delivery Plan – Improving Outcomes through Tackling Inequalities through Integrated Working attached at Appendix 1.

2. Approve the Sheffield Wellbeing Outcomes Framework described at section 1.9.

3. Agree that Director of Adult Social Care brings back 6 monthly reports on progress in implementation of the Delivery Plan and Outcomes Framework.

17.3 **Reasons for Decision**

17.3.1 The report provides an update in relation to Improving Wellbeing Outcomes and Tackling Inequalities Through Early Intervention, Integration and Partnership Working theme in the Council's Delivery Plan. It also seeks approval for city wide health and wellbeing outcomes framework.

17.3.2 It's aimed that this approach will promote continuous improvement, which can then provide assurance to Committee regards our impact on people as a collaboration across health and care.

17.4 **Alternatives Considered and Rejected**

17.4.1 Option 1 - Option ‘to do nothing’ and have no outcomes framework. However, this would not enable citizens to see the impact of health and social care activity in an open and transparent way.

17.4.2 Option 2 – Delay request for approval and implementation of the framework to enable further learning, benchmarking, and engagement. It is planned that benchmarking, learning and engagement will take place on an ongoing and dynamic basis to ensure it delivers what matters to people of Sheffield and is responsive to changing circumstances.

Report to Adult Health and Social Care Policy Committee

26th January 2023

Report of: Director of Legal and Governance

Subject: Committee Work Programme

Author of Report: Fiona Martinez, Principal Democratic Services Officer

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Summary:

The Committee's Work Programme is attached at Appendix 1 for the Committee's consideration and discussion. This aims to show all known, substantive agenda items for forthcoming meetings of the Committee, to enable this committee, other committees, officers, partners and the public to plan their work with and for the Committee.

Any changes since the Committee's last meeting, including any new items, have been made in consultation with the Chair, and the document is always considered at the regular pre-meetings to which all Group Spokespersons are invited.

The following potential sources of new items are included in this report, where applicable:

- Questions and petitions from the public, including those referred from Council
- References from Council or other committees (statements formally sent for this committee's attention)
- A list of issues, each with a short summary, which have been identified by the Committee or officers as potential items but which have not yet been scheduled (See Appendix 1)

The Work Programme will remain a live document and will be brought to each Committee meeting.

Recommendations:

1. That the Committee's work programme, as set out in Appendix 1 be agreed, including any additions and amendments identified in Part 1;
2. That consideration be given to the further additions or adjustments to the work programme presented at Part 2 of Appendix 1;
3. That Members give consideration to any further issues to be explored by officers for inclusion in Part 2 of Appendix 1 of the next work programme report, for potential addition to the work programme; and
4. If items are referred from LACs, these should be highlighted to the Principal Democratic Services Officer to ensure they are dealt with appropriately

Background Papers: None

Category of Report: Open

COMMITTEE WORK PROGRAMME

1.0 Prioritisation

1.1 For practical reasons this committee has a limited amount of time each year in which to conduct its formal business. The Committee will need to prioritise firmly in order that formal meetings are used primarily for business requiring formal decisions, or which for other reasons it is felt must be conducted in a formal setting.

1.2 In order to ensure that prioritisation is effectively done, on the basis of evidence and informed advice, Members should usually avoid adding items to the work programme which do not already appear:

- In the draft work programme in Appendix 1 due to the discretion of the chair; or
- within the body of this report accompanied by a suitable amount of information.

2.0 References from Council or other Committees

2.1 Any references sent to this Committee by Council, including any public questions, petitions and motions, or other committees since the last meeting are listed here, with commentary and a proposed course of action, as appropriate:

2.2 None received

3.0 Member engagement, learning and policy development outside of Committee

3.1 Subject to the capacity and availability of councillors and officers, there are a range of ways in which Members can explore subjects, monitor information and develop their ideas about forthcoming decisions outside of formal meetings. Appendix 2 is an example 'menu' of some of the ways this could be done. It is entirely appropriate that member development, exploration and policy development should in many cases take place in a private setting, to allow members to learn and formulate a

position in a neutral space before bringing the issue into the public domain at a formal meeting.

2.2 Training & Skills Development - Induction programme for this committee.

Title	Description & Format	Date

Appendix 1 – Work Programme

Part 1: Proposed additions and amendments to the work programme since the last meeting:

New Items	**Proposed Date**	**Note**
Market Oversight and Market Sustainability (aligned to DASS and Care Act duties)	February	Awaiting Form 1
Adult Health and Social Care Digital Strategy	February	To provide a framework for decisions on use of digital technology going forward, and a plan to best optimise it as part of our new operating model.
Rescheduled Items	**Proposed Date**	**Note**
Approve New Mental Health Social Work Model and Delivery Plan	February	Item removed as this will be covered as part of a briefing
Approve Liberty Protection Standards Preparation Delivery Plan	February	Item removed as this will be covered as part of a briefing
Approve Adult Social care - Complaints and Compliments report 2021 -2022 - Annual	February	Item removed as covered within DASS report
Sheffield's Mental Health and Emotional Wellbeing Strategy	February	Item removed as this will be covered under the Citywide Mental Health Strategic Health Plan
Endorse Adult Social Care Performance and Quality Report and Progress Report	February	Item removed as covered within DASS report
Approve Sheffield Health and Social Care Integrated Outcomes Framework (Commitment 6 ASC Strategy)	February	Item removed as covered in December's committee
Approve Citywide learning disability strategic delivery plan (commitment 1,6 ASC Strategy)	March	Item moved from February to March
Approve Adult Social Care Climate Response Delivery Plan (Commitment 1 ASC Strategy)	TBC	Item deferred
Learning Disability Service Delivery Update	March	Item moved from February to March
Approve Adult Social Care Workforce Strategic and Delivery Plan (Commitment 5 ASC Strategy)	March	Item moved from February to March

Part 2: List of other potential items not yet included in the work programme

Issues that have recently been identified by the Committee, its Chair or officers as potential items but have not yet been added to the proposed work programme. If a Councillor raises an idea in a meeting and the committee agrees under recommendation 3 that this should be explored, it will appear either in the work programme or in this section of the report at the committee's next meeting, at the discretion of the Chair.

Topic	Approve Adult Social Care Climate Response Delivery Plan (Commitment 1 ASC Strategy)
Description	
Lead Officer/s	Catherine Bunten
Item suggested by	*Officer, Member, Committee, partners, public question, petition etc*
Type of item	*Referral to decision-maker/Pre-decision (policy development/Post-decision (service performance/ monitoring)*
Prior member engagement/ development required *(with reference to options in Appendix 2)*	
Public Participation/ Engagement approach*(with reference to toolkit in Appendix 3)*	
Lead Officer Commentary/Proposed Action(s)	

Part 3: Agenda Items for Forthcoming Meetings

Meeting 5	**8th February 2023**	Time				
Topic	**Description**	**Lead Officer/s**	**Type of item** *Decision/Referral to decision-maker/Pre-decision (policy*	**Prior member engagement/ development required**	**Public Participation/ Engagement approach**	**Final decision-maker (& date)**

			development)/Post-decision (service performance/ monitoring)	*(with reference to options in Appendix 1)*	*(with reference to toolkit in Appendix 2)*	This Cttee/Another Cttee (eg S&R)/Full Council/Officer
Endorse Director of Adult Social Care (DASS) Report and delivery plan		Alexis Chappell	Post-Decision	Yes	No	Adult Health and Social Care
Endorse Adult Social Care Financial Update and Progress with Financial Recovery Plan		Liam Duggan/Liz Gough	Post-Decision	Yes	No	Adult Health and Social Care
Endorse Progress with Discharge from Hospital Improvement Plan		Rebecca Dixon	Decision	Yes	No	Adult Health and Social Care
Approve city Wide Autism Strategic Delivery Plan		Alexis Chappell/Kate Damiral	Strategic Delivery			Adult Health and Social Care
Approval to recommission Residential care services for older adults (Commitment 3 ASC Strategy)		Andy Hare/Catherine Bunten/Jo Pass	Decision		Engagement will be undertaken with stakeholders, including people who are supported in residential care services, providers, and health and social care partners to shape and inform the	Adult Health and Social Care

					service specification and procurement	
Approve Conversion Practice Policy	The Sheffield Adult Safeguarding Partnership Board is seeking endorsement on its proposal to produce a position statement on Conversion Practice and to note its direction of travel. We are asking our Council members and wider organisations to endorse the position statement which condemns this harmful and unethical practice.	Jeanette Munday, Janet Kerr	Decision/Position Statement	Members briefed 23.11.22 and 30.11.22	The Council has engaged and consulted on this proposal with: The Safeguarding Adults Partnership Equalities and Human Rights UK Limited Children's Services The Diocese of Sheffield LGBTQ+ members of the community and a survivor of Conversion Therapy.	Adult Health and Social Care
Approve All Age Mental Health and Emotional Wellbeing Strategy (Commitments 1,6 ASC Strategy)	This strategy seeks to provide strategic direction and focus for all city partners seeking to improve and support Sheffield people's mental health and emotional wellbeing.	Louisa King and Steve Thomas	Strategy/Policy Committee	Members have been engaged with this strategy up to this point already, but it has been agreed to hold a joint briefing session with members from both the Adults' and Children's committees prior to this item going to the Adults' committee for final sign off.	A range of public engagement events and consultation were carried out prior to the development of this strategy	Adult Health and Social Care
Adult Health & Social Care Digital Strategy	Agree a digital strategy for adult health & social care, to inform and contribute to the whole organisation's digital strategy.	Jon Brenner, Tabi Green	Decision	Initial member briefing – 9.1.23 Final briefing with members – 18.1.23	Approach used previous wider involvement work, including that informed the operating model.	Adult Health and Social Care

					Specific solutions to include involvement and co-production in their production – for instance content for the new information	
Market Sustainability and Oversight	This Market Sustainability Plan and Market Oversight report summarises how SCC maintains a sufficient market, and meets our duties as set out in the Care Act 2014. It supports our Market Position Statement and covers our oversight of the market (the capacity and quality of services) together with any risks and how we plan to address these.	Catherine Buten	Strategy/Policy Development	Members have approved a Market Shaping Statement and received briefings on related activity, such as the Fair Cost of Care exercise. A further briefing session will be held with members from the Adult Health and Social Care Policy Committee prior to this item going for final sign off.	A range of public engagement events and consultation were carried out prior to the development of this strategy.	Adult Health and Social Care
Revenue Budget Monitoring Report – Month 8		Jane Wilby	Decision			
Standing items	• *Public Questions/ Petitions* • *Work Programme*					

Meeting 6	**16th March 2023**	Time				
Topic	**Description**	**Lead Officer/s**	**Type of item** *Decision/Referral to decision-maker/Pre-decision (policy development)/Post-*	**Prior member engagement/**	**Public Participation/**	**Final decision-maker (& date)**

			decision (service performance/ monitoring)	**development required** *(with reference to options in Appendix 1)*	**Engagement approach** *(with reference to toolkit in Appendix 2)*	This Cttee/Another Cttee (eg S&R)/Full Council/Officer
Endorse Director of Adult Social Care (DASS) Report and delivery plan		Alexis Chappell	Post-Decision	Yes	No	
Endorse Adult Social Care Financial Update and Progress with Financial Recovery Plan		Liam Duggan/Liz Gough	Post-Decision	Yes	No	Adult Health and Social Care
Approve Adult Social Care Annual Domestic Abuse Report 2021 - 2022		Janet Kerr/Sam Martin	Performance & Quality			Adult Health and Social Care
Approve Better Care Fund Submission		Joe Horobin/ Sandie Buchan/ Catherine Bunten				Adult Health and Social Care
Approve Better Care Fund Annual Report		Joe Horobin/ Sandie Buchan/ Catherine Bunten	Decision			Adult Health and Social Care

Approve Adult Social Care Strategy and Quality Improvement Delivery Plan Progress Update		Jon Brenner/Catherine Bunten	Post-decision	Decision at June Committee, following Cabinet decision on Strategy in March 2022.	Consultation through various existing groups	N/A
Endorse Progress with Changing Futures Delivery Plan		Michael Corbishley/Sam Martin	Post-Decision	Yes	Yes	Health Scrutiny
Endorse Progress with Transitions Improvement Plan		Andrew Wheawall/Nicola Shearstone				Adult Health and Social Care
Endorse Progress with Safeguarding Improvement Delivery Plan		Janet Kerr/Tim Gollins				Adult Health and Social Care
Approve City wide Older Adults / Ageing Well Strategic Delivery Plan (Commitment3 1,6 ASC Strategy)		Jo Pass				Adult Health and Social Care

Approve Adult Social Care Prevention, Independent Living and Wellbeing Strategic Delivery Plan (Commitment 2 ASC Strategy)		AD Enablement/ Catherine Bunten/ Joe Horobin	Decision		Consultation through various existing groups	Adult Health and Social Care
Approve Adult Social Care Voids Policy		Andrew Wheawall/Catherine Bunten/Joe Horobin	Decision		Consultation, including through AH&SC Change Programme Board, providers and various existing groups.	Adult Health and Social Care
Revenue Budget Monitoring Report – Month 9		Jane Wilby	Decision			
Learning Disability Service Delivery Update		Andrew Wheawall/Andy Hare				Adult Health and Social Care
Approve Adult Social Care Workforce Strategic and Delivery Plan (Commitment 5 ASC Strategy)		John Chamberlain/Janet Kerr	Decision	Yes	Yes	Adult Health and Social Care

Standing items	• *Public Questions/ Petitions* • *Work Programme*					

Meeting 1	**2023-4**	Time				
Topic	**Description**	**Lead Officer/s**	**Type of item** *Decision/Referral to decision-maker/Pre-decision (policy development)/Post-decision (service performance/ monitoring)*	**Prior member engagement/ development required** *(with reference to options in Appendix 1)*	**Public Participation/ Engagement approach** *(with reference to toolkit in Appendix 2)*	**Final decision-maker (& date)** This Cttee/Another Cttee (eg S&R)/Full Council/Officer
CQC assurance readiness and framework (June '23, September '23 and December '23)	Provide a report to committee setting out ASC readiness for CQC assurance from 2023	Janet Kerr and Liam Duggan	Decision	Member briefings	N/A	Adult Health and Social Care
Standing items	• *Public Questions/ Petitions* • *Budget Monitoring* • *Work Programme*					

Appendix 2 – Menu of options for member engagement, learning and development prior to formal Committee consideration

Members should give early consideration to the degree of pre-work needed before an item appears on a formal agenda.

All agenda items will anyway be supported by the following:

- Discussion well in advance as part of the work programme item at Pre-agenda meetings. These take place in advance of each formal meeting, before the agenda is published and they consider the full work programme, not just the immediate forthcoming meeting. They include the Chair, Vice Chair and all Group Spokespersons from the committee, with officers
- Discussion and, where required, briefing by officers at pre-committee meetings in advance of each formal meeting, after the agenda is published. These include the Chair, Vice Chair and all Group Spokespersons from the committee, with officers.
- Work Programming items on each formal agenda, as part of an annual and ongoing work programming exercise
- Full officer report on a public agenda, with time for a public discussion in committee
- Officer meetings with Chair & VC as representatives of the committee, to consider addition to the draft work programme, and later to inform the overall development of the issue and report, for the committee's consideration.

The following are examples of some of the optional ways in which the committee may wish to ensure that they are sufficiently engaged and informed prior to taking a public decision on a matter. In all cases the presumption is that these will take place in private, however some meetings could happen in public or eg be reported to the public committee at a later date.

These options are presented in approximately ascending order of the amount of resources needed to deliver them. Members must prioritise carefully, in consultation with officers, which items require what degree of involvement and information in advance of committee meetings, in order that this can be delivered within the officer capacity available.

The majority of items cannot be subject to the more involved options on this list, for reasons of officer capacity.

- Written briefing for the committee or all members (email)
- All-member newsletter (email)
- Requests for information from specific outside bodies etc.
- All-committee briefings (private or, in exceptional cases, in-committee)
- All-member briefing (virtual meeting)
- Facilitated policy development workshop (potential to invite external experts / public, see appendix 2)
- Site visits (including to services of the council)
- Task and Finish group (one at a time, one per cttee)

Furthermore, a range of public participation and engagement options are available to inform Councillors, see appendix 3.

Appendix 3 – Public engagement and participation toolkit

Public Engagement Toolkit

On 23 March 2022 Full Council agreed the following:

A toolkit to be developed for each committee to use when considering its 'menu of options' for ensuring the voice of the public has been central to their policy development work. Building on the developing advice from communities and Involve, committees should make sure they have a clear purpose for engagement; actively support diverse communities to engage; match methods to the audience and use a range of methods; build on what's worked and existing intelligence (SCC and elsewhere); and be very clear to participants on the impact that engagement will have.

The list below builds on the experiences of Scrutiny Committees and latterly the Transitional Committees and will continue to develop. The toolkit includes (but is not be limited to):

a. Public calls for evidence
b. Issue-focused workshops with attendees from multiple backgrounds (sometimes known as 'hackathons') led by committees
c. Creative use of online engagement channels
d. Working with VCF networks (eg including the Sheffield Equality Partnership) to seek views of communities
e. Co-design events on specific challenges or to support policy development
f. Citizens assembly style activities
g. Stakeholder reference groups (standing or one-off)
h. Committee / small group visits to services
i. Formal and informal discussion groups
j. Facilitated communities of interest around each committee (eg a mailing list of self-identified stakeholders and interested parties with regular information about forthcoming decisions and requests for contributions or volunteers for temporary co-option)
k. Facility for medium-term or issue-by-issue co-option from outside the Council onto Committees or Task and Finish Groups. Co-optees of this sort at Policy Committees would be non-voting.

This public engagement toolkit is intended to be a quick 'how-to' guide for Members and officers to use when undertaking participatory activity through committees.

It will provide an overview of the options available, including the above list, and cover:

- How to focus on purpose and who we are trying to reach
- When to use and when not to use different methods
- How to plan well and be clear to citizens what impact their voice will have
- How to manage costs, timescales, scale.

There is an expectation that Members and Officers will be giving strong consideration to the public participation and engagement options for each item on a committee's work programme, with reference to the above list a-k.

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Report to Policy Committee

Author/Lead Officer of Report: Jon Brenner, Principal Programme Manager

Tel: 07805 804911

Report of:	*Director of Adult Health & Social Care*
Report to:	*Adult Health & Social Care Policy Committee*
Date of Decision:	*8th February 2023*
Subject:	*Adult Health & Social Care Digital Strategy*

Has an Equality Impact Assessment (EIA) been undertaken?	Yes	x	No	
If YES, what EIA reference number has it been given? This strategy supports the delivery of the Future Design of Adult Social Care which is covered by EIAs 1148 and 1281 Additionally, where individual projects and activities have specific equality impacts these will be subject to separate assessments and mitigating action (for example the Development of a New Information, Advice and Guidance Platform which is covered by EIA ref 1344)				
Has appropriate consultation taken place?	Yes	x	No	
Has a Climate Impact Assessment (CIA) been undertaken? Climate Impact Assessments are being completed for individual projects and activities which contribute towards delivering the strategy, allowing for more detailed assessment of the impacts.	Yes	x	No	
Does the report contain confidential or exempt information?	Yes		No	x
If YES, give details as to whether the exemption applies to the full report / part of the report and/or appendices and complete below:-				

Purpose of Report:

Agree a digital strategy for adult health & social care, to inform and contribute to the whole organisation's digital strategy.

This will provide a framework for decisions on use of digital technology in adult health and social care going forward, and a plan to best optimise it as part of our new operating model.

Recommendations:

It is recommended that the Adult Social Care Policy Committee:

1. Approve the digital strategy for adult health & social care, and confirm it aligns with the Committee's strategic direction.

2. Request that the Director of Adult Health and Social Care bring a six-monthly report noting update and progress made with implementation of the strategy to Committee.

Background Papers:

Adult Health & Social Care Strategy 2022-30, Living the life you want to live
Adult Health & Social Care Strategy Delivery Plan
Future Design of Adult Social Care
Development of a new Information, Advice and Guidance Platform
Technology Enabled Care Contract Extension and Strategy

Appendices:
Appendix 1 – Adult Health & Social Care Digital Strategy
Appendix 2 - Adult Health & Social Care Digital Strategy Delivery Plan

<table>
<tr><th colspan="3">Lead Officer to complete:-</th></tr>
<tr><td rowspan="4">1</td><td rowspan="4">I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.</td><td>Finance: Ann Hardy</td></tr>
<tr><td>Legal: Patrick Chisholm</td></tr>
<tr><td>Equalities & Consultation: Ed Sexton</td></tr>
<tr><td>Climate: Jessica Rick</td></tr>
<tr><td></td><td colspan="2">Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.</td></tr>
<tr><td>2</td><td>SLB member who approved submission:</td><td>Alexis Chappell, Director of Adult Health & Social Care</td></tr>
<tr><td>3</td><td>Committee Chair consulted:</td><td>Cllr Angela Argenzio, Cllr Steve Ayris, Cllr George Lindars-Hammond</td></tr>
<tr><td rowspan="3">4</td><td colspan="2">I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Committee by the SLB member indicated at 2. In addition, any additional forms have been completed and signed off as required at 1.</td></tr>
<tr><td>Lead Officer Name:
Jon Brenner</td><td>Job Title:
Principal Programme Manager</td></tr>
<tr><td colspan="2">Date: 17th January 2023</td></tr>
</table>

1. PROPOSAL

1.1 Strategic Direction

1.1.1 In March 2022 Sheffield City Council approved a new Adult Health & Social Care Strategy 'Living the life you want to live'. It sets out the ambitions for adult social care this decade, supporting the city's Health & Wellbeing Strategy.

1.1.2 It was followed by the Adult Health & Social Care Strategy Delivery Plan, which was approved by this Policy Committee at its inaugural meeting in June 2022. The strategy and delivery plan set out the direction to improve how we deliver our statutory duties, set out the Care Act 2014 and associated legislation.

1.1.3 In November 2022, the Adult Health & Social Care Policy Committee approved a new operating model and design for adult social care in Sheffield. The Operating Model describes the way Adult Health and Social Care operates to deliver upon its vision, strategy, and strategic outcomes.

1.1.4 The use of technology was identified as a key enabler underpinning the design of the new operating model – "*Use of digital systems, automation and technology enabled care to optimise our processes and systems which support greater efficiency and joined up working as well as support to individuals through technology enabled care*."

1.1.5 Digital technology is a key component of our future design of adult social care and will contribute towards enabling individuals to live the life they want to live, reducing avoidable demand and through establishing greater efficiencies in how we work, enabling our workforce to release time to care.

1.1.6 Its our ambition to be a leader in the use of technology across social care and the strategy provides a foundation for us to make this a reality.

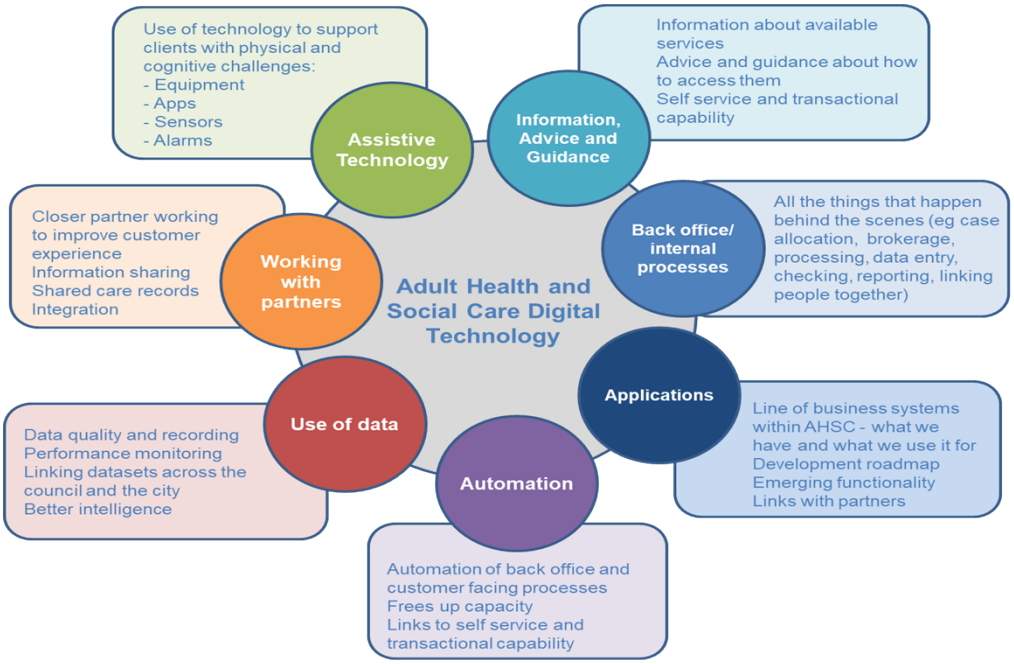
1.2 Adult Social Care Digital Strategy – Background to Development

1.2.1 The use of digital technology in adult social care is wide ranging across the use of:

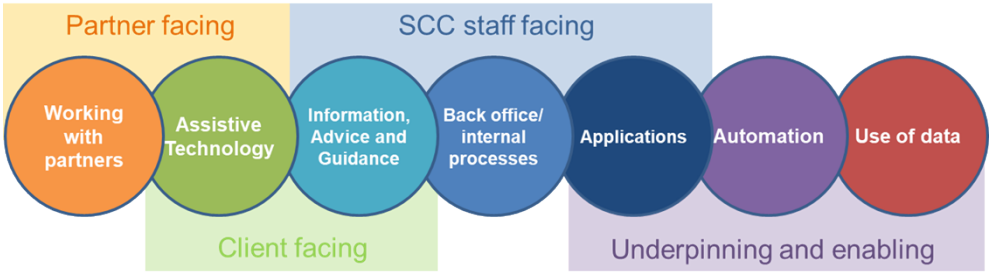
- Assistive technology
- Use of Data
- How we Work with Partners
- Automation
- Applications
- Information and advice

1.2.2 Essential to all of these are the ability to connect these together to enable

people to live the life they want to live and enable our workforce to release time to car through reducing inefficiencies in processes.



1.2.3 It is used directly by adult social care clients, our partners, and our internal staff, as well as "behind the scenes" to enable our processes and ways of working.



1.2.4 There is already a range of activity underway to develop and improve our use of digital technology to support a better operating model. This includes development of:

- A Technology Enabled Care Strategy and associated tests of change, which were approved at Committee on 16th November 2022
- A new Information And Advice Platform which was endorsed at Committee on 16th December 2022
- Automation tests of change as a partnership with Sheffield Council IT Services to improve efficiency of delivery.
- A new provider portal and tests of change to improve customer experience. This is noted in budget report to Committee today.
- Tests of change to improve hospital admission avoidance and discharge experience and capacity.

1.2.5 There is work underway across the Sheffield City Council to develop a

Digital Strategy. Adult Health and Social Care will contribute to this to ensure it reflects the needs and requirements of the people we support, our partners and workforce.

1.2.6 In addition, there is significant work underway across NHS, ADASS and Providers of care to support better use of technology to improve outcomes for people. There are also opportunities for integrated and joint working with colleagues to work collectively in our use of technologies.

1.2.7 There is also potential to develop further pilots and initiatives with existing and new partners and to embed digital working across all adult social care and as part of our commissioning activity.

1.2.8 However, unless we can clearly articulate a vision for how we want to use digital technology and understand how our current activity is contributing to achieve the vision, we risk a disjointed approach which could lead to duplication of effort and/or missed opportunity.

1.3 What are we doing about this? – the Adult Health & Social Care Digital Strategy

1.3.1 The Adult Health & Social Care Digital Strategy considers each area of digital technology use to present a focussed view of:

- Where do we want to get to?
- What are the current challenges?
- What do we need to do in the short and longer term?

1.3.2 This view has been developed from:

- Feedback from the people we support, their carer's, our partners, and our workforce as part of the Future Design of Adult Social Care (operating model).
- Specific input from officers leading on current activity to develop the digital offer.
- Specific input from the Adult Health and Social Care leadership team.

1.3.3 Several common themes were identified across all areas, which will be key enablers to successful delivery. These include: - Ownership of digital technology, Governance of application and implementation, ensuring links to practice improvement, workforce development, design of services and principles, embedding change and use of technology across all aspects of social care.

1.3.4 It's planned to use these enablers to embed champions and leadership to deliver upon the strategy.

1.3.5 The Strategy is enclosed at Appendix 1 for approval. To enable delivery

upon the strategy an accompanying delivery plan is enclosed at appendix 2 for approval. This includes:

- High level timeline and milestones of current project activity which contributes towards the delivery of the strategy.
- Identification of further activity which will be needed.

2. HOW DOES THIS DECISION CONTRIBUTE?

2.1 A new operating model for adult social care is a fundamental part of the delivery plan for the Adult Social Care Strategy 2022- 2030, 'Living the life you want to live'.

2.2 This proposal directly supports the future design of Adult Social Care (operating model) and, as such, enables removal of avoidable demand and helps to ensure an efficient, effective system. The design of the new system is rooted in improving the experience of people through the care system and maximising their independence wherever possible.

3. HAS THERE BEEN ANY CONSULTATION?

3.1 This proposal supports the proposals in the operating model which have been built on significant co-production and consultation activity with people receiving care, carers, providers, partners, staff and trade unions over the last 18 months.

3.2 Formal consultation took place on the adult health and social care strategy, which has heavily informed the operating model.

3.3 Where specific digital solutions are designed and implemented as part of the delivery of the Adult Health & Social Care Digital Strategy – for example content for the new customer information offer – involvement and co-production with people receiving care, carers, providers, partners and staff will be actively sought and responded to.

4. RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

4.1 <u>Equality Implications</u>

4.1.1 As an overall process, the changes in operating model will be benefit all people in the adult social care system through a more effective system. This is equally true of the Adult Health & Social Care Digital Strategy which supports the new operating model.

4.1.2 Some individual projects and activities which contribute to the digital

strategy will have different equality impacts and these will be subject to separate assessments and mitigating action (for example the Development of a New Information, Advice and Guidance Platform which is covered by EIA ref 1344).

4.2 Financial and Commercial Implications

4.2.1 The new operating model is an important building block of a financially sustainable social care system. Specific financial implications are covered as part of the Committees budget setting process.

4.2.2 The Adult Health and Social Care Digital Strategy will be delivered by a range of project and "business as usual" activities. Where these have specific Financial and Commercial implications, they will be subject to individual risk analysis, impact assessment and financial approval as appropriate.

4.3 Legal Implications

4.3.1 The Care Act Statutory Guidance requires at para 4.52 that "… Local authorities should have in place published strategies that include plans that show how their legislative duties, corporate plans, analysis of local needs and requirements (integrated with the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy), thorough engagement with people, carers and families, market and supply analysis, market structuring and interventions, resource allocations and procurement and contract management activities translate (now and in future) into appropriate high quality services that deliver identified outcomes for the people in their area and address any identified gaps.

4.3.2 The Living the life you want to live – Adult Social Care Strategy which was approved in March 2022 set out the high-level strategy to ensure these obligations are met.

4.3.3 The Future Design of Adult Social Care which was approved in November 2022 built upon that by setting out how the aims of the strategy will be delivered through the operating model. This report builds further by providing more detail about how the use of digital technology will underpin the new operating model.

4.4 Climate Implications

4.4.1 The climate implications of the overall changes to the operating model are multi-faceted. The basic premise is that supporting people to maximise independence with timely, good quality social care will reduce the need for care provision in the system as a whole – which carries a significant carbon footprint.

4.4.2 Improving our use of digital technology is expected to reduce our carbon

footprint by minimising the use of paper and reducing avoidable demand in the system (unnecessary paperwork, travel, etc). Carbon emissions related to travel and resource use can therefore be reduced using digital technology.

4.4.3 There are impacts in the energy demand for running digital tools, however these can be minimised through effective procurement of hosting and digital service providers.

4.4.4 Sharing data more effectively with partners should also prevent data capture being done more than once and may even reduce demand on hosting systems which use energy 'behind the scenes'.

4.4.5 Improving back-office systems with digital technology has the potential to help us be more consistent in our approach to identifying and managing climate impacts. A Climate Impact Assessment App is currently in development for example.

4.4.6 Improving data collection will mean we are potentially able to track more performance indicators than previously. For example, new KPI's covering climate impacts involved in service delivery by us and our partners such as travel, energy use and resource use could be tracked to monitor the effects of any requirements around carbon reduction/management.

4.4.7 The contributions from individual projects and activities will vary. Detailed climate impact assessments will continue to be completed for all significant components of the change programme, including those that contribute to the delivery of the digital strategy.

5. ALTERNATIVE OPTIONS CONSIDERED

5.1 **No Adult Health & Social Care Digital Strategy** – we could choose not to have a digital strategy for Adult Health & Social Care. However this would result in a less coherent approach to our use of digital technology, particularly in the absence of a corporate Digital Strategy.

5.2 **A different delivery plan** – the attached delivery plan is intended as an "umbrella" for the individual elements which contribute to it. The constituent pieces of work will be progressed in different ways, with some of them resulting in their own future reports to the Committee. Some of these will also appear as constituents of the operating model delivery plan. However, it was felt that there is value in providing a specific digital technology focussed view of delivery.

6. REASONS FOR RECOMMENDATIONS

6.1 An approved Adult Health & Social Care Digital Strategy will enable us to articulate a vision and direction of travel in terms of our use of digital technology to support the new operating model. In turn, this will help us to:

- Provide greater accountability and transparency about how we intend to use digital technology.
- Align with partners to deliver a system wide approach.
- Maximise opportunities to develop further activity to improve the use of digital technology in alignment with our aspirations and goals.
- Ensure the needs and requirements of Adult Social Care (clients, carers, partners and staff) are reflected in any future corporate Digital Strategy.

6.2 An approved Adult Health & Social Care Digital Strategy Delivery plan will allow us to track progress towards delivering the strategy – even when the delivery of specific elements may be part of other projects or carried out as “business as usual”.

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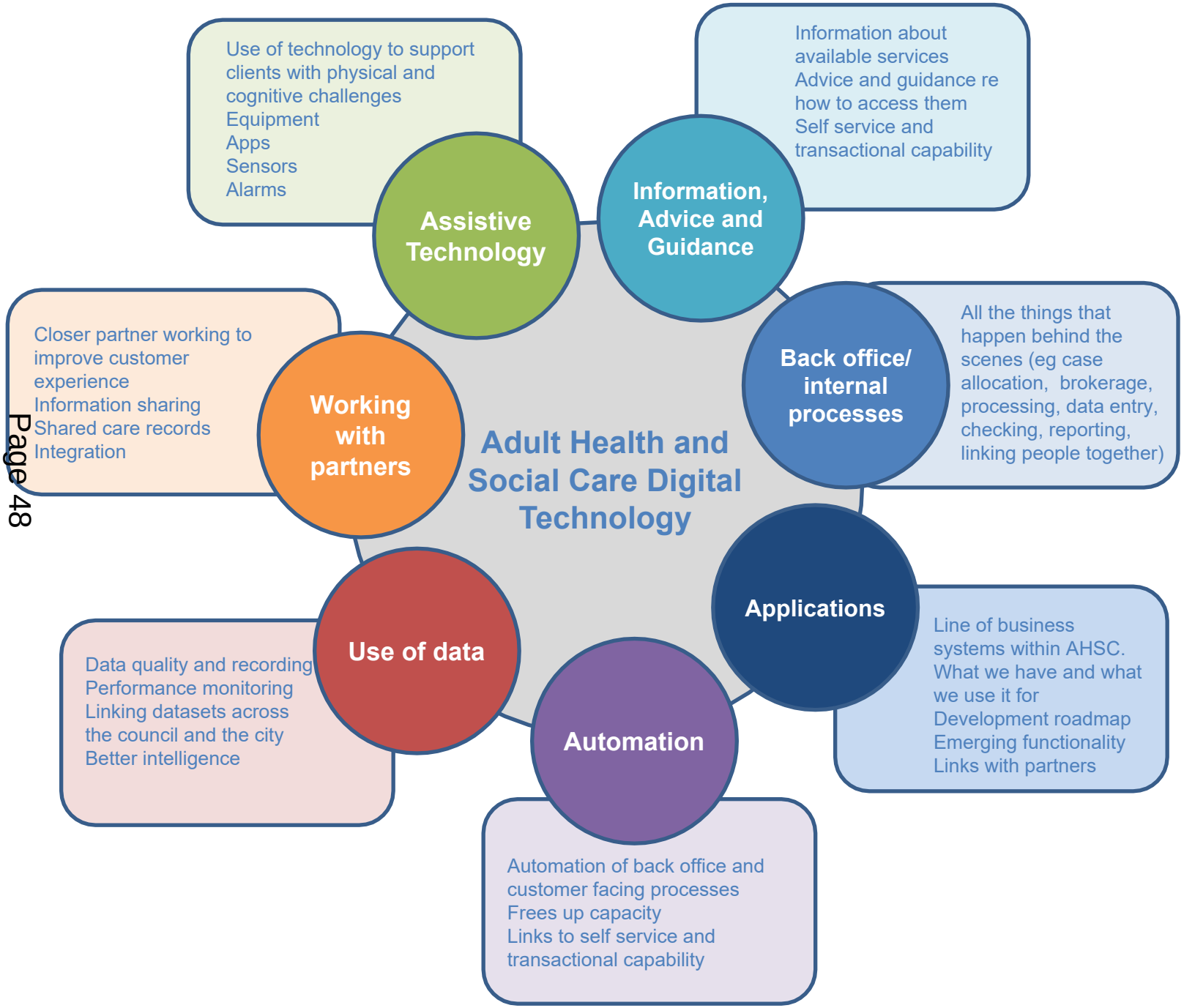
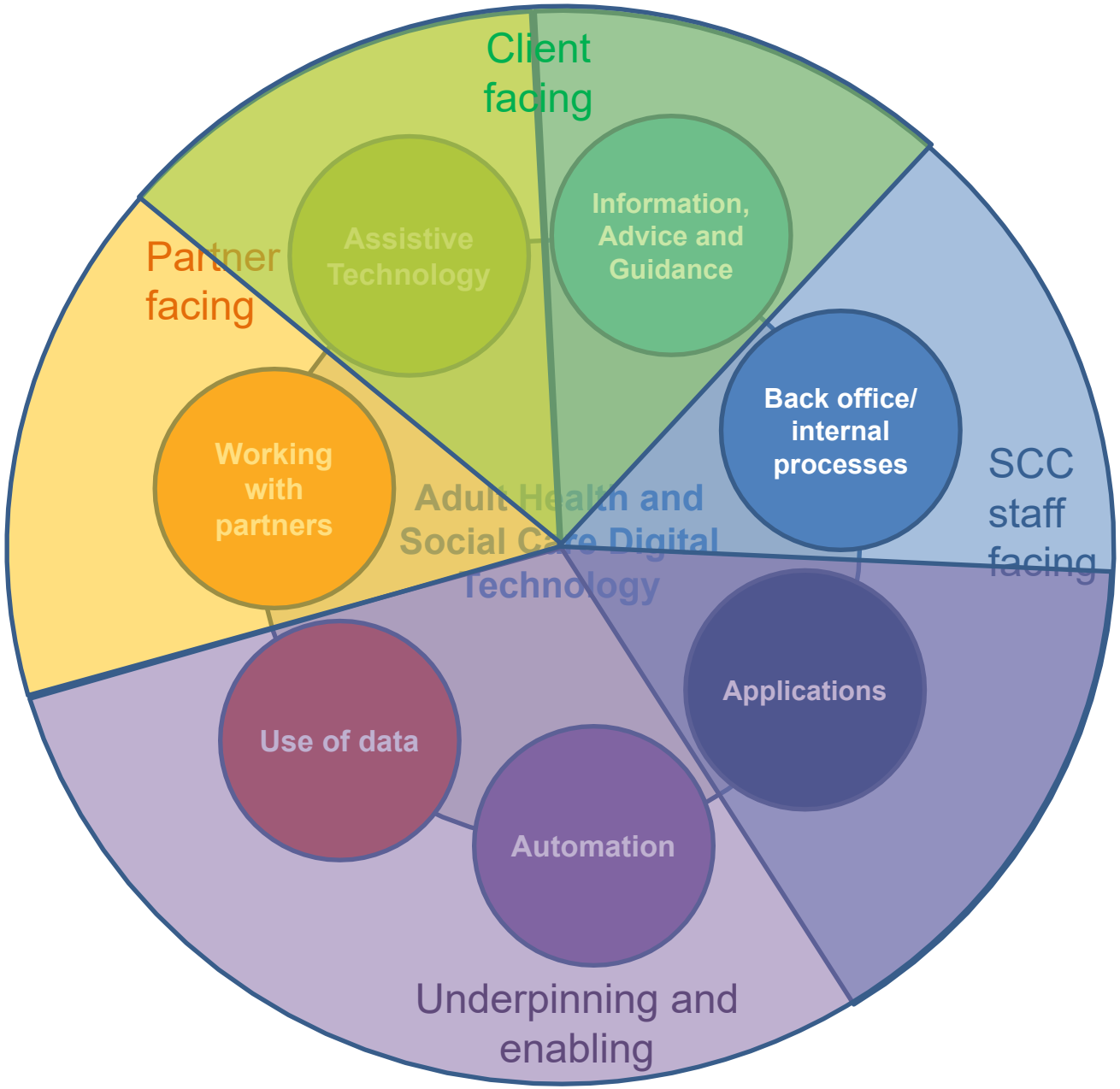
Adult Health
and Social
Care Digital
Strategy


Adult Health and Social Care Digital Technology
Assistive Technology
Use of technology to support clients with physical and cognitive challenges
Equipment
Apps
Sensors
Alarms
Information, Advice and Guidance
Information about available services
Advice and guidance re how to access them
Self service and transactional capability
Back office/ internal processes
All the things that happen behind the scenes (eg case allocation, brokerage, processing, data entry, checking, reporting, linking people together)
Applications
Line of business systems within AHSC.
What we have and what we use it for
Development roadmap
Emerging functionality
Links with partners
Automation
Automation of back office and customer facing processes
Frees up capacity
Links to self service and transactional capability
Use of data
Data quality and recording
Performance monitoring
Linking datasets across the council and the city
Better intelligence
Working with partners
Closer partner working to improve customer experience
Information sharing
Shared care records
Integration


Client facing
Assistive Technology
Information, Advice and Guidance
Partner facing
Working with partners
Adult Health and Social Care Digital Technology
Back office/ internal processes
SCC staff facing
Applications
Use of data
Automation
Underpinning and enabling

Assistive Technology

Where do we want to get to?

- We support improved experiences and independent living through the use of technology enabled care and digital solutions
- Our staff (internal and partners) understand what's available and how to support people to get it

What are the current challenges?

- What's available is changing all the time and there is a lot of choice which can be bewildering.
- Current procurement arrangements are not sufficiently flexible.
- Current offer is limited and staff are not always made aware of how to access it.
- Knowledge and confidence about the use of digital solutions is inconsistent.

What do we need to do?

In the short term

- Consider procurement challenges as part of the upcoming citywide alarm service development (enabler for pilots)
- Build in expectations around use of technology enabled care with providers in our contracts and frameworks
- Workforce development to ensure existing support is fully understood and utilised
- Identification of immediate priority assistive technologies and workforce development to pilot and promote them

In the longer term

- Develop a joint long term strategy for technology enabled care with partners (health and providers) including ownership and governance
- Deliver workforce development in line with the strategy

Information, Advice and Guidance

Where do we want to get to?

- The information we provide meets the needs of everyone in Sheffield, with plain language and simplified access steps.
- We enable self service options and allow people to transact with us digitally.
- People can access their own information.

What are the current challenges?

- Our current web offer is not clear and accessible.
- We don't currently offer any interactive guidance to help people find the information they need.
- We don't enable self service.
- Improvements are implemented piecemeal.
- Our internal workforce have told us they need more information and guidance too.

What do we need to do?

In the short term

- New platform for Sheffield Directory (now live)
- Overhaul all current online content (in progress)
- Learn from best practice in other organisations
- Customer portal implementation? (we have already bought it)
- Deliver online financial assessment capability
- Deliver online self assessment capability
- Design refreshed customer journeys utilising new capabilities and including which platform(s) they are on
- Develop internal IAG offer to support our workforce
- Put mechanism in place to prioritise IAG development activity
- Develop authoring model for future customer journeys

In the longer term

- Forward plan for continuous improvement of our IAG and self service offer

Back Office / Internal Processes

Where do we want to get to?

- Our processes support our practice
- Behind the scenes, our processes are digital by default
- Our processes look, feel and flow like they are all part of the same system
- Our processes are effective and efficient

What are the current challenges?

- Processes vary between teams and sometimes there is a lack of guidance about an agreed way to do things.
- This makes it hard for teams to understand how each other do things.
- We have too much avoidable demand. Our processes are not as effective and efficient as they could be.

What do we need to do?

In the short term

- Review processes impacted by Target Operating Model phase 1 implementation (in progress)
- Agree prioritisation criteria, design principles, governance and ownership for ongoing process review / continuous improvement (link to performance, practice development, identified avoidable demand)

In the longer term

- Catalogue processes
- Prioritise process review based on agreed criteria
- Systematic process review in line with best practice, design principles and developing design patterns
- Workforce development to support continuous improvement

Applications

Where do we want to get to?

- Applications exist to support our practice and our processes
- Applications are simple to use
- Our use of applications is confident and consistent
- We are making the most of the tools we have

What are the current challenges?

- Although we have a skilled internal development team for Liquid Logic / Controcc, development is driven by operational process requirements and is not always consistently prioritised or linked to best practice.
- Use of the system is inconsistent and there are gaps in staff knowledge.
- Development and ownership of other systems is unclear.

What do we need to do?

In the short term

- Short term application changes to support implementation of Target Operating Model phase 1 (in progress).
- Identify what applications we have, their product owners and capabilities. What can they do that we aren't making full use of?
- Identify decision making body (design authority?) and governance process to prioritise requirements and maintain integrity in line with practice priorities across all applications.
- Prioritise current development backlog for Liquid Logic
- Identify most urgent areas of inconsistency / underuse and develop training to resolve (blend of practice and systems).

In the longer term

- Standardise processes and design patterns to deliver them by
- Review process to elicit future requirements

Automation

Where do we want to get to?

- We automate wherever it makes sense to
- We use automation to minimise waste and speed up our processes
- We use our people to do the things that only a person can do
- We free up time to care

What are the current challenges?

- We don't yet fully understand what automation can do for us (as a council as well as a service).
- We haven't really thought about our business processes in terms of automation potential.
- Our processes and data capture are often not sufficiently standardised.
- We are not fully utilising our existing applications (eg workflow).

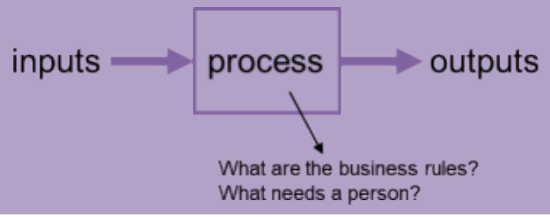
What do we need to do?

In the short term

- Identify pilot opportunities to start to prove the value and learn from
- Identify best practice / learning opportunities from other organisations who might be ahead of us

In the longer term

- Standardise data and processes – it's very hard to automate systematically until that's been done
- Identify and prioritise opportunities for automation across all business processes
- This will require ownership and governance



Use of data

Where do we want to get to?

- We use data to make sound decisions
- We use outcomes of customer insight and audits arising from all frameworks to drive continuous improvement
- We are able to link datasets across the council and the city when we need to

What are the current challenges?

- Our data recording is inconsistent so it's not always easy to find the data that we need (on a case by case look-up basis or for reporting).
- We don't always record the data that is needed to generate insights and business intelligence.
- Lack of consistent data standards across the organisation.

What do we need to do?

In the short term

- Develop standards for the recording of data in our applications in line with practice and processes.
- Workforce development (internal) around data recording.
- Develop a repository of customer insight to inform continuous improvement (in progress).
- Ensure performance reporting requirements are considered for all new frameworks and change initiatives.

In the longer term

- Joint development of appropriate information sharing organisation wide to ensure we are aware when we need to work with other services around an individual's circumstances and to generate broader intelligence.

Working with partners

Where do we want to get to?

- We share information with our partners as standard so that customers can meet their outcomes quicker and don't have to tell the same story over and over again
- We share digital processes with our partners to enable multi disciplinary approaches and reduce duplication
- We know who is working on a case

What are the current challenges?

- We are culturally very apprehensive about sharing information we hold about someone, even when it's in their best interest.
- Our processes and systems are not always designed to facilitate information sharing with partners.

What do we need to do?

In the short term

- Provider portal implementation (Controcc).
- Provider review design and implementation.
- Workforce practice development and guidance that empowers staff to make decisions to share information appropriately based on the best interest of the person.
- Lead by example in giving partners access to our systems and information where appropriate.
- Ensure information sharing requirements (both ways) are considered as part of any framework or change initiative.

In the longer term

- Identify requirements and digital solutions to enable multi disciplinary team (MDT) working across organisations.
- Consider partner accessibility in all future developments.


Technology enables independence
Information is available, accessible, accurate and interactive
Our processes are simple
We share information as standard
We free up time to care
Our applications support effective working practises
We use data to make sound decisions
We automate wherever sensible

Fundamental building blocks

(Common themes across all areas)

Ownership	There is currently a lot of digital related activity happening in disconnected pockets across the service. By bringing a view of it together and assigning ownership, we increase the clarity of vision and chance of successful delivery.
Governance	We need to consider a long term governance model so that we maintain visibility of our digital landscape and to ensure that decisions about new digital technology are made in line with AHSC practice requirements and design principles, as well as linking in with corporate governance channels as appropriate.
Links to practice	Our use of digital technology must support our practice model. Digital processes, systems and technology are only tools to help us deliver good practice and must be driven by practice requirements.
Workforce development	Supporting the workforce (internal and wider) will be key across all aspects of our use of digital technology. Staff need to know what's available, how to access it and how it works in order to carry out their roles in line with the practice model and support people effectively.
Design principles and standards	We already have design principles for the Target Operating Model which still apply, but we need to take this to the next level of detail when designing digital services so that the look, feel and flow of our systems is consistent and gets familiar to the user (whether that's our customers, our partners or our staff).
Embedding digital change	We will need to understand the impact of digital change and develop the skills to embed it effectively. The embedding phase is vital and often overlooked / under resourced. We will need to consider the design of ongoing support to embed the change with our staff, the wider workforce and customers.

Next steps

- Start to develop a roadmap
  - Existing programme activity
  - Gap analysis
  - Definition of further activity
  - Links and dependencies
  - Delivery Plan

- Identify an owner and other responsibilities

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Adult Health and Social Care

Digital Strategy

Delivery Plan 2022 to 2024

Adult Health and Social Care: Digital Strategy Delivery Plan 2022 - 2024

Our Vision and Ambitions for people of Sheffield

Our vision is that ‘everyone in Sheffield lives in a place they can call home, in communities that care, doing things that matter to them, celebrated for who they are - and when they need it, they receive care and support that prioritises independence, choice, and recovery.

The vision is centred around delivery of five outcomes and six commitments. The commitments and outcomes are the guiding principles we will follow and how we deliver the strategy. They show how we’ll achieve our outcomes and highlight what we want to do better. These commitments are:

1. Support people to live a fulfilling life at home, connected to the community and resources around them, and provide care and support where needed.
2. Provide temporary assistance to help people regain some stability and control in their life following ill health or crisis
3. Provide care and support with accommodation where this is needed in a safe and supportive environment that can be called home.
4. Make sure support is led by ‘what matters to you’, with helpful information and easier to understand steps.
5. Recognise and value unpaid carers and the social care workforce, and the contribution they make to our city.
6. Make sure there is a good choice of affordable care and support available, with a focus on people’s experiences and improving quality.

The Adult Health & Social Care Digital Strategy

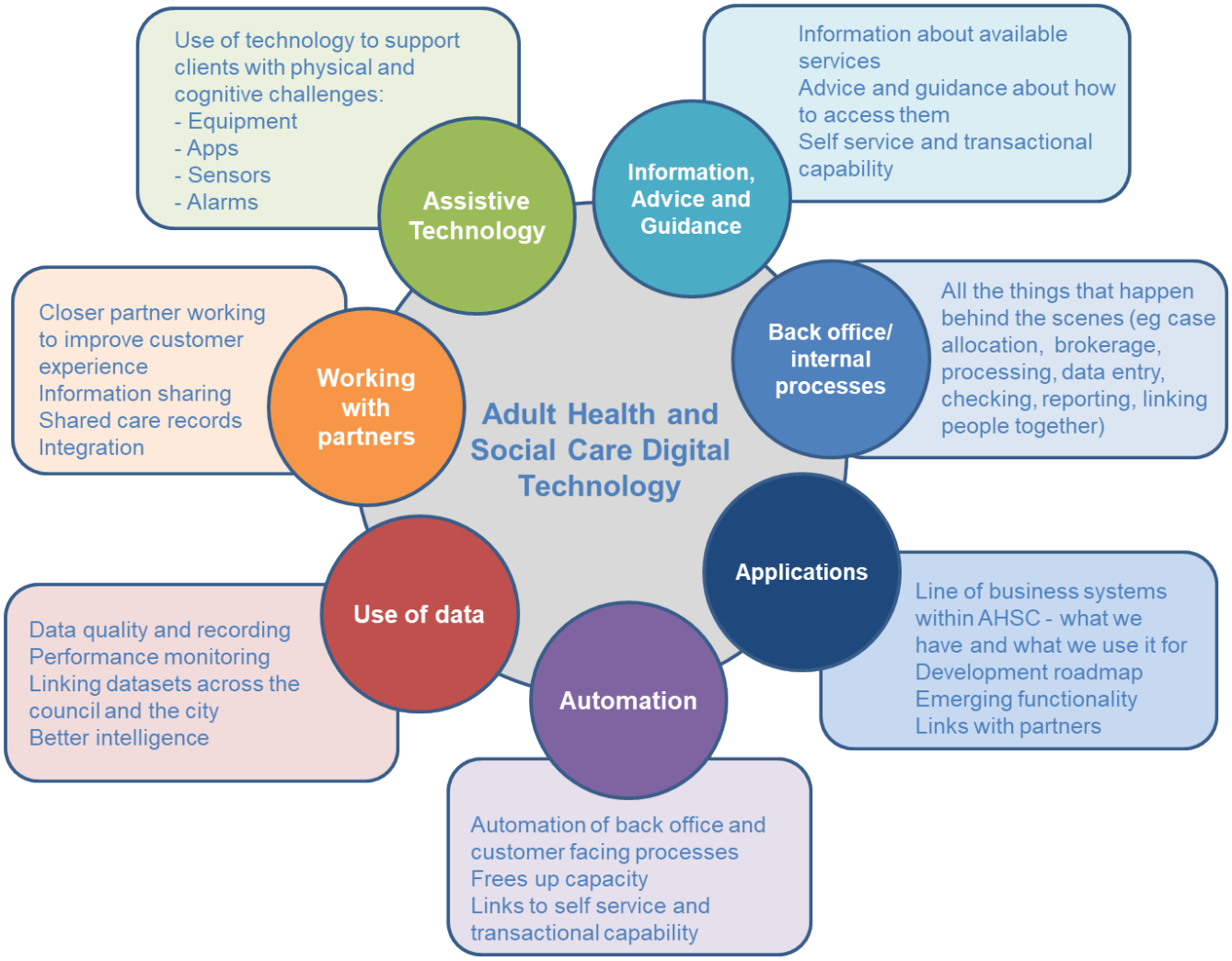
The Adult Health & Social Care Digital Strategy is a key enabler which supports the future design of Adult Health and Social Care.

It articulates how we aim to make use of digital technology across Adult Health and Social Care to deliver the vision and ambitions for the people of Sheffield.

This Delivery Plan aims to support the ambitions and governance roles of the Committee by setting out clear delivery milestones which allow us to track progress towards these aims across a variety of project and service led activity.

How is Digital Technology used in Adult Health & Social Care?

The use of digital technology in adult social care is wide ranging. It is used directly by adult social care clients, our partners and our internal staff, as well as “behind the scenes” to enable our processes and ways of working.



What Does Good Look Like?

Assistive Technology

Where do we want to get to?

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Automation

Where do we want to get to?

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Back Office / Internal Processes

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Applications

Where do we want to get to?

- Applications exist to support our practice and our processes
- Applications are simple to use
- Our use of applications is confident and consistent
- We are making the most of the tools we have

Key Enablers

Where do we want to get to?

- Ownership and governance support the strategy
- Our use of digital technology supports our practice model
- Our workforce is supported to use the technology
- We follow consistent design principles
- We embed digital change effectively

Adult Health and Social Care Digital Strategy Delivery Plan

Accountable Officer: Director Adult Health and Social Care	**Accountable Committee/ Board:** Adult Health and Social Care Policy Committee

Warning note: **Please be aware that this delivery plan shows a useful view of milestones and actions which contribute towards the Adult Health & Social Care Digital Strategy but which are, in many cases, being delivered as part of projects and programmes with a broader remit (for example the future design of adult social care operating model). This means that many of these milestones / actions also appear in other delivery plans. The dates and RAG statuses shown here are correct at the time of compilation but in the event of any discrepancy, please defer to the dates/statuses shown in the originating delivery plan.**

Completed/ On Track	Close Monitoring in Place	Identifying a Risk	Not Started

Theme	Milestone/action	By when	Lead	RAG
Assistive Technology	Technology Enabled Care (TEC) Market Position Statement	November 2022	Strategic Commissioning Manager (TEC Lead)	
	Extension to TEC Monitoring Service Contract	November 2022	Strategic Commissioning Manager (TEC Lead)	
	Design, development and implementation of new TEC service offer	September 2024	Strategic Commissioning Manager (TEC Lead)	
	Identify key available technology and provide workforce development to support its use	Tbc	Strategic Commissioning Manager (TEC Lead)	
Information, Advice and Guidance	Complete design and configuration of an improved information, advice, and self-help offer (platform).	March 2023	Assistant Director, Mental Health, Safeguarding and Access	
	Produce web content plan for Adult Social Care	March 2023	Assistant Director, Mental Health, Safeguarding and Access	
	Review and refresh web content across the service	December 2023	Assistant Director, Mental Health, Safeguarding and Access	
	Customer portal	April 2024	Assistant Director, Mental Health, Safeguarding and Access	
	Customer needs self-assessment	April 2024	Assistant Director, Mental Health, Safeguarding and Access	

	Customer financial self-assessment	Tbc	Assistant Director, Mental Health, Safeguarding and Access	
	Enhanced internal information, advice and guidance for staff	December 2023	Chief Social Work Officer	
Back Office / Internal Processes	Short term process improvement as part of future design of adult social care operating model phase 1 implementation	March 2023	Principal Programme Manager	
	Cataloguing and review of processes as part of the future design of adult social care operating model	December 2023	Principal Programme Manager	
Applications	Agree governance and prioritisation process for applications development to ensure alignment with strategy	February 2023	Principal Programme Manager	
	Prioritise current backlog for Liquid Logic development	February 2023	Principal Programme Manager	
	Short term systems improvement as part of future design of adult social care operating model phase 1 implementation	March 2023	Principal Programme Manager	
	System developments arising from review of processes as part of the future design of adult social care operating model	December 2023	Principal Programme Manager	
Automation	Identification and sizing of opportunities to put forward for prioritisation within corporate automation project (pilot areas)	March 2023	Service Manager, Operations	
	Identification of further automation opportunities arising from review of processes as part of the future design of adult social care operating model	December 2023	Service Manager, Operations	
	Automated customer experience survey go live (iterative development)	February 2023	Service Manager, Business Support, Operations	
	Social Care Accounts Service Automation (to be delivered as part of corporate Income and Payments Programme)	tbc	Assistant Director Governance and Inclusion	
Use of Data	Customer insight repository	December 2023	Principal Programme Manager	
	Workforce development (data recording)	December 2023	Chief Social Work Officer	

	Workforce development (data sharing)	April 2024	Chief Social Work Officer	
	Identify and plan further actions to deliver this aspect of the strategy	June 2023	Principal Programme Manager	
Working with partners	Provider portal (Controcc) - Care home providers using portal to receive and review organisation/financial information and raise queries / request updates	June 2023	Assistant Director, Commissioning and Partnerships	
	Provider portal – review additional portal functionality and implement where appropriate (for example to allow providers more direct contact with social workers)	December 2023	Assistant Director, Commissioning and Partnerships	
	Delegation Portal – allows a social worker to delegate tasks to a provider (for example reviews) and to give providers access to information stored in Liquid Logic (eg assessments)	December 2023	Assistant Director, Commissioning and Partnerships	
	Roll out provider portal to all new providers (eg homecare providers as part of new health and wellbeing contract)	December 2023	Assistant Director, Commissioning and Partnerships	
	Identify digital multidisciplinary team (MDT) working requirements, including community and hospital interfaces as part of the future design of adult social care operating model	December 2023	Principal Programme Manager	
Key Enablers	Agree ownership and governance of Adult Health & Social Care Digital Strategy	February 2023	Principal Programme Manager	
	Workforce offer is being developed as part of the future design of adult social care operating model	June 2023	Chief Social Work Officer	
	Develop approach to embedding digital change	tbc	Principal Programme Manager	
	Workforce development – digital skills	tbc	Chief Social Work Officer	
	Digital design principles	tbc	Principal Programme Manager	

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Report to Policy Committee

Author/Lead Officer of Report: Catherine Bunten/Joanne Knight

Tel: 01142057142

Report of:	Director of Adult Health and Social Care
Report to:	Adult Health and Social Care Policy Committee
Date of Decision:	8th February 2023
Subject:	Transforming Care Homes for Citizens of Sheffield

Has an Equality Impact Assessment (EIA) been undertaken?	Yes	x	No	
If YES, what EIA reference number has it been given?	*1401*			
Has appropriate consultation taken place?	Yes	x	No	
Has a Climate Impact Assessment (CIA) been undertaken?	Yes		No	x
Does the report contain confidential or exempt information?	Yes		No	x

If YES, give details as to whether the exemption applies to the full report / part of the report and/or appendices and complete below:-

*"The (**report/appendix**) is not for publication because it contains exempt information under Paragraph (**insert relevant paragraph number**) of Schedule 12A of the Local Government Act 1972 (as amended)."*

Purpose of Report:

This report provides an update on the proposals to develop/transform the care home market in Sheffield.

It includes a commissioning plan setting the strategic direction and an associated four stage delivery plan. The plan includes a re-procurement exercise and a market sustainability exercise.

Recommendations:
It is recommended that the Adult Health and Social Care Policy Committee: -

1. Approve the care homes commissioning plan which sets out the strategic direction for the development of care homes in Sheffield (in line with the Care Act 2014)

2. Approves the associated high-level delivery plan for the next 2 years (22-24) including the intention to re-procure, support, and sustain the market.

3. Agrees that an update on progress is provided to the Adult Health and Social Care Policy Committee on a six-monthly basis.

Background Papers:

Appendix 1 *- Commissioning Plan Care Homes*
Appendix 2 – *High Level Delivery Plan*
Appendix 3 *- Equalities Impact Assessment*

Lead Officer to complete:-		
1	I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.	Finance: *Ann Hardy*
		Legal: *Patrick Chisolm*
		Equalities & Consultation: *Ed Sexton*
		Climate: *Jessica Rick*
	Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.	
2	**SLB member who approved submission:**	*Alexis Chappell*
3	**Committee Chair consulted:**	*Cllrs Argenzio and Lindars-Hammond*
4	I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Committee by the SLB member indicated at 2. In addition, any additional forms have been completed and signed off as required at 1.	

Lead Officer Name: *Catherin Bunten/Joanne Knight*	**Job Title:** *Assistant Director Commissioning and Partnerships/Strategic Commissioning Manager*
Date: 16th January 2023	

1. PROPOSAL

1.1 This report describes the activities which will be undertaken over the next 2 years which work towards transforming the care home market in Sheffield and contribute towards delivery upon our Care Act duties. The report sets out:

- The strategic direction proposed to develop the care home market in Sheffield (the Care Homes Commissioning Plan)
- A high-level delivery plan for the next 2 years demonstrating the activities and support that will be undertaken to achieve this.
- An intention in the delivery plan to procure and move to more robust qualitative contracting arrangements with all care home providers

The Background - The Rationale for Change

1.2

1.2.1 The Adult Health and Social Care Strategy and accompanying Delivery Plan set out our vision for 2022 to 2030. Called 'Living the life you want to live', it's about how we work together to help the people of Sheffield to live long, healthy and fulfilled lives.

1.2.2 To enable operational implementation of the Strategy a Market Position Statement was approved at Committee on 21st September 2022, a Future Design Of Adult Social Care and Technology Enabled Care Market Position Statement on 16th November 2022. These set our ambitions to establish community connected care homes which deliver excellent quality care to citizens of Sheffield and in do so enable us to deliver upon Commitments 2 and 3 of the Strategy.

1.2.3 Over the past two years there has been a range of engagement and analysis to understand our current position, future demand and crucially the views of individuals, families, providers, and stakeholders about what good care home provision looks like in Sheffield.

1.2.4 There has also been review of learning from the recent cost of care exercise reported to Committee in September and December, the strategic market analysis completed by Cordis Bright in 2020, the Healthwatch report on experience of care homes published in November 2022, Social Care Institute of Excellence (SCIE) and NICE guidelines as well as benchmarking and consideration of digital and technological solutions.

1.2.5 We also know from discussions with the public, that all too often care homes are perceived as places of illness not wellness where privacy and independence are not possible due to communal living and where people lose identity and control.

1.2.6 However, despite the difficulties that communal living can present care homes are there to recognise and support individuality, culture, and difference, to allow people choice and control over their life, support people to have a purpose and be able to contribute and support the person to continue with their network of contacts and embrace their position as part of a local geographical or community of interest.

1.2.7 The care homes quality and commissioning plan is about making this a reality and about our care homes in the city being a good place to live, thrive and work.

1.3 The Quality and Commissioning Plan

1.3.1 The quality and commissioning plan for care homes is the start of a journey of transformation, it sets out the strategic direction that adult social care wishes to take in developing the care home offer for citizens of Sheffield and the activities we intend to undertake over the next 2 years to 2024. The full commissioning plan can be seen as Appendix 1 but this report highlights some of the main points

1.3.2 The 4-stage, 2-year delivery plan (See Appendix 2) aims to: -

- Set out our strategic direction and commissioning intentions for care homes
- Support the market, specify our plans, and develop our relationship with providers (through financial and non-financial activities)
- Strengthen our contracts, integrate more with partners, and support differing needs aligned to our recent developments regards homecare and day activities
- Build and develop the care homes model and begin to transform

1.3.3 As part of the development of the 2-year plan, a review will also be undertaken to consider additional opportunities such as direct provision by the Council and innovative new models of delivery. We want to encourage new ways of working and partnerships which support and enable excellent quality provision across the City through our new approach.

1.4 *Phase 1 – Set out the strategic direction and commissioning intentions – June 22 – Feb 23*

1.4.1 The commissioning plan suggests the vision for care homes should be aligned with the Sheffield Adult Social Care Vision as this was co-created with local people and is an adaptation of the Social Care Futures[1] vision which has been widely accepted nationally as a good vision for adult social care to aspire and achieve.

[1] https://socialcarefuture.org.uk

1.4.2 '*Everyone in Sheffield lives in a place they can call home, in communities that care, doing things that matter to them, celebrated for who they are - and when they need it, they receive care and support that prioritises independence, choice, and recovery*.'

1.4.3 There is an opportunity to create a new vision exclusively for the care home sector, however evidence from the Social Care Institute for Excellence (SCIE) suggests this isn't necessary and a growing body of evidence indicates the vision above should be the guiding 'north star' as we consider where we want to be in the future.

1.4.4 There is evidence to suggest, however, that a good care home should have a set of core principles which are of the heart of what is provided.

1.4.5 Consolidating the evidence base and feedback we can identify a set of 8 overarching/ guiding principles that suggest what elements/activities constitute a good care home.

- *Information sharing*
- *Community connectedness and meaningful relationships*
- *Choice and control and shared decision making*
- *Promoting independence and maintaining identity*
- *Person centred and outcome focused*
- *Strong leadership culture and workforce*
- *Promoting Equality and inclusiveness*
- *Adopting Innovation*

1.4.6 These will be used to both specify our requirements of providers through any formal contracting agreements and used to develop our monitoring and quality toolkit

1.4.7 Care homes will be expected to demonstrate and evidence that they can meet these core principles through our commissioning and funding arrangements.

1.5 Phase 2 - Support to the Market/ Specifying our plans and relationship building – March 23 – Aug 23

1.5.1 To deliver excellent quality care homes which are experienced positively by individuals, families, and our workforce, it is important to build the foundations which mean individuals, families, care home providers, partner agencies, commissioners and social work teams are working towards the same aim and understand each other's drivers for change.

1.5.2 To do this we aim to develop a partnership working group who will explore support options to both sustain the market and build the relationships.

1.5.3 These will be non-financial support options which could include supporting providers to understand tenders and how they work, using Business and Opportunity Sheffield and their expertise in business development and funding opportunities, exploring the potential for using our purchasing power to lower purchasing costs for providers and developing a quality framework together.

1.5.4 During this phase we will also develop more understanding about the views, experiences and needs of people who currently live in care homes and who may live in care homes in the future and what the likely demand will be. This will help ensure the care home market is able to deliver upon what good looks like from perspective of individuals and families as well as respond to the needs identified and is right sized for the future.

1.5.5 At the same period, we will also introduce the following as part of our implementation of the future design of social care to support collaborative working set out in the plan.

- Dedicated care home social work teams led by the Assistant Director Living and Ageing Well North who will lead the assessment, safeguarding and care management function and support quality assurance.
- Dedicated leadership roles in commissioning service focused on supporting quality of care, business development of care providers.
- Citizen's involvement and coproduction in line with the approval provided at Committee on 16th December 2022.
- Health and Care Quality Board as a way of having collective oversight and governance of quality of care across the city.

1.6 Phase 3 - Strengthen Our Contracts, Integrate More with Partners, and Support Differing Needs – Sept 23- March 24

1.6.1 An important part of this phase is to respecify what our expectations are for the provision of care in a residential and nursing home.

1.6.2 Using the feedback sourced from individuals, carers and family members, stakeholders, and the evidence about the 8 core principles of a good care home, we will develop an outcome-based specification and contract monitoring arrangements to replace the current placement agreement and monitoring arrangements we currently use.

1.6.3 We will also take this opportunity to introduce and embed our Adult Health and Social Care Digital Strategy (presented at the Adult Health and Social Care Policy Committee 8th February 2023) within the specification so care homes have the opportunity to develop the latest approaches for improving quality, effectiveness and efficiency through technology.

1.6.4 Our expectations are that new specifications will be in place in late 2023/early 2024 and that all providers will sign up to deliver this for the next 5 years if they wish to continue taking referrals from the council.

1.6.5 Once our contracting mechanisms are more robust, and the newly designed specification is in place, the development of our monitoring and quality assurance systems will give absolute assurance that peoples voices are being heard and quality is being maintained and improved.

1.6.6 This phase will be undertaken in partnership with individuals, families and colleagues across health, housing, communities, economic development, voluntary sector, social care providers and academia so that our approach are integrated and co-ordinated.

1.6.7 In addition, to enable our care homes to be connected to communities this phase will also focus on working with local area committees and local areas so that our care homes are and feel very much part of their communities.

1.7 Phase 4 – Build the Care Homes Model and Transform - March 24 and beyond

1.7.1 The final phase of the 2-year plan is to begin to transform and innovate for the future. This really means exploring very different ways of working and options for providing care in accommodation.

1.7.2 By this time the foundations for a stable and well supported market will already be established, the expectations about what good looks like will be in place and the contracting and quality assurance framework will be working to drive up quality.

1.7.3 Therefore, this is the time to innovate and develop care in accommodation for the future looking at other models of delivery used both nationally and internationally and ensuring there is more specialised support for people with more enhanced needs

2. HOW DOES THIS DECISION CONTRIBUTE?

2.1 The development of the care homes commissioning and delivery plan assists in meeting our duties under the following: -

- *The **Care Act 2014 Section 8(1)(2)(3)*** – Meeting Needs – which describes the need to provide accommodation with care in a care home or premise. It should provide this itself or arrange for another to do this

- *The **Care Act 2014 (5)*** – Which describes the need to promote an effective, efficient, and sustainable market which meets needs and offers choice.

2.2 The ***Adult Social Care Strategy, "Living the Life you Want to Live" 2021*** in particular

- Commitment 2 - Provide temporary assistance to help people regain some stability and control in their life following ill health or crisis by ensuring that when individuals are assessed they are given an opportunity to maximise their potential before doing so.

- Commitment 3 - Provide care and support with accommodation where this is needed in a safe and supportive environment that can be called home by offering a safe and enabling environment which supports their recovery**.**

- The 'Efficient and effective' outcome set out in the Adult Social Care Strategy. Effective Market Shaping should ensure that people have a choice of good services that meet their needs and give them a positive experience regardless of their background, ethnicity, disability, sex, sexual orientation, religion, or belief.

2.3 This proposal has a strong link to the ***Local Area Committees*** and their ***Empowering Communities*** work. In particular:

- Empowering communities – building community-based resources

- Improving health and wellbeing – supporting the local population to recover and regain skills they may have lost through ill health or crisis and supporting carers to maintain their health and wellbeing

2.4 This proposal also supports and contributes to: -

- ***Our Sheffield Council Delivery Plan*** - Healthy lives and wellbeing for all: Sheffielder's all have the opportunity to lead long, healthy, active and happy lives and can connect to the right health and wellbeing support at the right time
- ***People at the Heart of Care 2021*** – The Government white paper which suggests several reforms including a cap on personal care costs, support towards care costs, a fair cost of care for providers and changes to arranging care for self-funders. We know that these changes have been delayed but the fair cost of care has not.
- ***Adult Social Care The Future Design*** – This describes an operating model for adult social care and in particular the development of community connected care homes across Sheffield.
- ***The Sheffield Dementia Strategy 2018 - 2024*** – A multi-agency strategy aimed to help people live well, stay well, and die well. Given that a significant proportion of people living with dementia reside in care homes then the 13 commitments described in the report are of particular importance
- ***The Sheffield Carers Delivery Plan 2022-2025*** – Supporting

carers and family members is an integral part of a care homes remit, as family members and carers remain an integral part of the person's life. The 6 principles of the carers' strategy are important and the need for good information and advice about Care Homes and what they provide and that carers needs wants and opinions are considered as part of any support package that the cared for person receives.

3. HAS THERE BEEN ANY CONSULTATION?

3.1 Discussion has taken place with several individuals living in care homes both on a planned and routine basis (as part of the quality monitoring process). This has assisted in understanding what people feel about care homes and what aspirations they have for the future. See Appendix 1 for full report. The most recent feedback has been: -

- During July and August 2022 Healthwatch Sheffield spoke to 5 relatives and 16 older people living in residential and nursing care homes in Sheffield, they wanted to understand about people's experiences, what works and what doesn't work, as well as what they would like to change or improve.
- In September and October 2022, care home providers were invited to engagement sessions focussing on what a new service specification for care homes might look like. Attendees were asked about new ideas in their practice and about what worked and what didn't.
- During May, July, August, and September 2022, 25 Adult care employees were asked for their views on what a care home specification might look like.
- During 2021, as part of the development of the Adult Care Strategy, discussion took place with individual employers, voluntary and community sector workers and managers, social workers, carers, and family members of people who receive services or who receive direct payments. This was to explore what social care and support for older people might look in the future.
- There have also been several discussions with health colleagues about their feedback on what a good care homes should look like.

3.2 The key messages from these consultations have helped to shape the 8 key principles of a good care home which are described in section 1.4.4

4. RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

4.1 <u>Equality Implications</u>

4.1.1 As a Public Authority, we have legal requirements under sections 149 and 158 of the Equality Act 2010. These are often collectively referred to as the 'general duties to promote equality.' Section 149(1) contains the Public Sector Equality Duty, under which public authorities must, in the

exercise of their functions, have due regard to the need to:

- Eliminate discrimination, harassment, victimisation, and any other conduct that is connected to protected characteristics and prohibited by or under this Act.
- Advance equality of opportunity between those who share a relevant protected characteristic and those who do not.
- Foster good relations between those who share a relevant protected characteristic and those who do not

4.1.2 An Equality Impact Assessment has been completed. There is expected to be an overall positive impact through strengthening market sustainability and developing the provider market to meet a wider range of needs.

4.1.3 It is also expected to impact positively as the requirement to recognise and respond to diversity is a key element of the care principles

4.1.4 The Equality Impact Assessment can be found at Appendix 3

4.2 Financial and Commercial Implications

4.2.1 The Council currently commissions in the region of 1,900 residential and nursing beds across the city, including short-term beds, at any one time, this includes all beds for older people and younger adults. The cost of this is circa £80m which does *not* include a price increase for 2023/24.

4.2.2 The 2023/24 budget will be £78.7m and includes pressures for the fee uplifts for 2023/24. As the costs at £80m do not include the cost of uplifts the efficiency required will be somewhat greater than the £1m these numbers suggest.

4.2.3 The commissioning plan does refer to a re-procurement of existing care homes for older people however this will be undertaken within the current financial envelope on a like for like financial basis and is not linked to any fee increases

4.3 Legal Implications

4.3.1 The core purpose of adult health and social care support is to help people to achieve the outcomes that matter to them in their life. The Care Act 2014 sets out the Council's statutory power to direct the provision that:

- promotes wellbeing
- prevents the need for care and support
- protects adults from abuse and neglect (safeguarding)
- promotes health and care integration
- provides information and advice

- promotes diversity and quality.

4.3.2 Further, to shape how Local Authorities may meet these objectives, the Care Act 2014 also sets out the law around market development in adult social care. It enshrines in legislation duties and responsibilities for market related issues for various bodies, including local authorities. Section 5 of the Care Act sets out duties on local authorities to facilitate a diverse, sustainable high-quality market for their whole local population, including those who pay for their own care and to promote efficient and effective operation of the adult care and support market. The statutory guidance to the Act suggests that a local authority can best commence its market shaping duties under Section 5 of the Care Act by developing published Market Position Statements with providers and stakeholders. The proposals are therefore in line with the Council's legal obligations.

4.3.3 Legal Services will provide advice as required during the further implementation of the plans.

4.4 Climate Implications

4.4.1 We acknowledge that the provision of care in care homes has an impact and that there are things we can do to help providers mitigate these and support Sheffield's ambition to becoming a net zero city by 2030.

4.4.2 For any re-procurement opportunities we can test out the providers willingness and ability to support the Councils objectives to be net zero by 2030. This would include potentially including some requirements in the tender documentation to address impacts of care provision.

4.4.3 We can, as part of the support package to providers look at how support organisations can help care homes deal with fuel wastage and adapting to climate change in terms of how they operate and their policies. A webinar is planned for January 2023 to provide advice and information for care home providers on energy efficiency and any potential actions that could be taken to reduce energy costs. Specifically, relevant impacts would be building condition and operation, energy usage and efficiency, water use, food and drink provision, use of products and waste management.

4.4.4 There may also be the potential to access available external funding sources for sustainability improvements if there is the appetite for this from providers.

4.4.5 The development of the quality assurance system for care homes offers an opportunity to look at climate impacts and how these can be assessed when monitoring the performance of providers.

5. ALTERNATIVE OPTIONS CONSIDERED

5.1 In developing the commissioning plan another alternative was considered, this being: -

5.1.1 *Do nothing - Continue with the existing services as is*

This alternative was rejected because:

- It does not respond to feedback gathered
- It does not allow us to update the current service agreements
- It does not allow us to develop an improved relationship with providers
- It would not necessarily provide a well sustained market
- The provision would not be fit for the future

6. REASONS FOR RECOMMENDATIONS

6.1 This commissioning plan is recommended because it: -

- Starts a journey of transformation so care homes are a positive choice as a place to live and work
- Builds in time for there to be some stabilisation of the market and development of relationships and partnerships all of which should benefit the individuals living there
- Builds trust with partners and providers leading to better outcomes for people
- Delivers the outcomes that people said were most important to them and has quality assurance systems which test this
- Ensures care homes are part of a wider community and accepted as an invaluable resource in that community

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Care Homes Commissioning and Delivery Plan

June 2022 – April 2024

Contents

1 Background and Scope

This is an outline commissioning plan relating to care homes across Sheffield. It brings together several activities/information into one place and includes a high-level delivery plan for taking the next steps in the commissioning of care homes in Sheffield.

Purpose of the Care Homes Commissioning and Delivery Plan

This Plan will:

- Introduce the background to and scope of the commissioning plan, including how this aligns with the principles and outcomes of the relevant strategies.

- Set out our strategic aim for care homes including: -
    - The vision
    - What good looks like

- What we know about care homes for older people including: -

    - A needs/demand analysis
    - A market analysis
    - Investment in the market

- Describe feedback from customers and other stakeholders about their aspirations for older people's care homes

- Set out how we benchmark against what good looks like, including a self-assessment of where we believe we are in meeting those principles giving some examples to suggest where we need to shift our thinking.

- Set out a high-level plan and timeline for delivery

This plan will not:

- Describe the proposals for fee uplifts over the next 2 years but it will refer to the financial envelope available to support the commissioning plan. The fees proposals will be subject to a committee report in 2023.

Further work will be undertaken to develop this commissioning plan over the next 2 years.

2 What Is a Care Home?

A care home is a communal setting where nursing, and or personal care, and accommodation are provided together. The accommodation is sometimes purpose built and residents have their own bedroom, some offer an en-suite bathroom or other private facilities. All meals and refreshments are provided, as are housekeeping services such as laundry and cleaning.

Generally, there are also communal areas such as lounges and dining rooms and often a garden or other outdoor space. Some offer hair salons and cafes or a bar. Family and friends are welcome to visit (subject to COVID restrictions), and residents can expect to have regular social activities organised for them. These homes provide 24-hour on site care teams and visits from GPs, dentists, physiotherapists, and other providers can be arranged.

There are two main categories of care homes:

- Care homes that provide nursing care in-house are generally known as nursing homes
- Care homes that provide personal care, but not nursing care are generally known as residential care homes.

The council purchase from both residential and nursing homes although we do not fund the nursing element in nursing homes. This is funded through Free Nursing Care which is paid via the Integrated Commissioning Board (ICB – formally CCG, currently £209.19 per week for 22/23)

The ICB also place people in nursing homes under Continuing Healthcare Care (CHC) funding, this is entirely free to the individual as it constitutes an NHS service however it must be proven that the person has a 'primary health need'

For many people a care home is their sole place of residence and although they do not legally own or rent their accommodation, it becomes their home.

Care homes offer accommodation rather than ‘housing’ because it is neither self-contained nor offers security of tenure through tenancy or ownership rights. Care home residents are licensees and are only entitled to minimal notice to leave. They pay an inclusive charge for accommodation, care, food, and other services. [1]

[1] Social Care Institute for Excellence (SCIE)

3 Why is change needed?

Context

Despite the difficulties that communal living can present Care Homes are there to recognise and support individuality, culture, and difference, to allow people choice and control over their life, support people to have a purpose and be able to contribute and support the person to continue with their network of contacts and embrace their position as part of a local geographical or community of interest.

All too often however Care Homes are not seen in this way, they are perceived as places of illness not wellness where privacy and independence are not possible due to communal living and where people lose identity and control.

We know most people would prefer to stay in their own home, but we also know there are ways to improve how people perceive and experience care in a Care Home by working with providers and individuals/families/friends. This commissioning plan starts a journey of improvement to enable Care Homes in Sheffield to be the best that they can be for the people who live there.

To deliver such improvements, however, change cannot be only on the part of Care Homes, there must be a sustainable market of provision and this commissioning plan will also acknowledge the need to support the Care Home sector and workforce if we are to reach our goal to make positive change.

Local and National Drivers

This plan is underpinned by a number of national and local drivers (as referenced in the Adult Social Care Market Sustainability Plan which can be found here market-shaping-statement-2022.pdf (sheffield.gov.uk) (and which was discussed at the Adult Social Care Committee meeting in September 2022) but also driven by the aspirations of people who live and work in the sector

In summary the main links and dependencies are with:-

- *The Care Act 2014 (5)* – Which describes the need to promote an effective, efficient and sustainable market which meets needs and offers choice.
- *People at the Heart of Care 2021* – The Government white paper which suggests a number of reforms including a cap on personal care costs, support towards care costs, a fair cost of care for providers and changes to arranging care for self-funders. We know that these changes have been delayed but the fair cost of care has not
- *The Adult Social Care Strategy 2022 - 2030* – Living the Life you Want to Live, its vision, outcomes and commitments. People living in care homes have the right to expect the same chances and opportunities to meet their goals and aspirations to live a good life

- *The Sheffield Dementia Strategy 2018 - 2024* – A multi-agency strategy aimed to help people live well, stay well and die well. Given that a significant proportion of people living with dementia reside in care homes then the 13 commitments described in the report are of particular importance
- *The Sheffield Carers Strategy 2016-2020* – Supporting carers is an integral part of a care homes remit, this maybe because the person has been cared for at home prior to their admission or maybe as the carer remains an integral part of the person's life and needs to continue to be part of the support on an ongoing basis, they may also be using the Care Home to provide some short-term respite for the unpaid carer. The 6 principles of the carers' strategy are important in particular the need for good information and advice about Care Homes and what they provide and that carers needs wants and opinions are considered as part of any support package that the cared for person receives
- *The Adult Health and Social Care Digital Strategy 2023* – Ensuring care homes are part of the digital and technological development approach will be important moving forward. This will ensure they are supported with the latest approaches for improving quality, effectiveness and efficiency. In particular we will expect providers to work with us to develop our approaches to use of technology generally but also to utilise new digital processes which are currently being introduced and will support information sharing and payment

4 Strategic Aim - Commissioning Principles and Objectives

The Vision for Care Homes

Creating and agreeing a vision for care homes is an important step in ensuring everyone is signed up to working towards the same goals/outcomes but a vision should be co-created to make sure it is real and meaningful.

The Adult Social Care Strategy for Sheffield was approved at Sheffield City Council's Co-Operative Executive on 16th March 2022 and covers the period of 2022- 2030. The document, and background information, can be found here on the Council's website.

The Sheffield vision (stated below) was co-created with local people but is an adaptation of the Social Care Futures[2] vision which has been widely accepted nationally as a good vision for adult social care to aspire and achieve.

'*Everyone in Sheffield lives in a place they can call home, in communities that care, doing things that matter to them, celebrated for who they are - and when they need it, they receive care and support that prioritises independence, choice, and recovery*.'

The same vision is appropriate to care homes as well as any other social care service however this is an opportunity to create a new vision specifically for the care homes sector. Evidence from the Social Care Institute for Excellence (SCIE) suggests this isn't necessary and a growing body of evidence indicates the vision above should be the guiding 'north star' as we consider where we want to be in the future.

The need for a separate care homes vision will be discussed further in the coming months as part of the commissioning delivery plan however the need for this is unlikely if we want all care home residents to be afforded the same opportunities as others.

What does a good care home look like?

Over the past few years, we have amassed a body of evidence and feedback about what a good care home should look like, not least more recently a Healthwatch report specifically on this subject What matters to us: Older people's experiences of living in a care home | Healthwatch Sheffield.

Rather than search for more feedback it is important to now collate, recognise and reflect on this and start to plan how we will respond.

The Social Care Institute for Excellence[3] in their report "A place we can call home - 2021" looked at all types of care with accommodation including care homes to

[2] https://socialcarefuture.org.uk
[3] https://www.scie.org.uk/housing/role-of-housing/place-we-can-call-home

determine what factors need to be taken account of in making a good home. They also considered the specific needs of diverse communities who often find it more difficult than others to access high-quality housing that facilitates their care and support

Their research paper indicates that excellence in housing with care and support has 7 basic principles

- Person centred and outcome focused
- Community connectedness
- Strong leadership culture and workforce
- Adopting innovation
- Enabling choice and control
- Promoting equality
- Co-production and shared decision-making

Feedback from Healthwatch and other consultation events has also given good insight into what people want from a care home which is similar to the national evidence base with some exceptions: -

- Communication and sharing of information
- The importance of meaningful relationships
- The importance of choice and control
- Promoting independence and maintaining identity
- Person centred assessment and reviews
- Inclusiveness
- Well paid and skilled workforce

My Home Life England was originally founded in 2006 by the National Care Forum in partnership with Help the Aged (now Age UK) and the city University of London. They continually develop best practice resources and suggest a good care home should:-

- Developing best practice together,
- Focusing on relationships,
- Be appreciative, and
- Have caring conversations.

5 What we currently know about care homes (Older Peoples Care Homes Only)

The following sections on needs analysis, market analysis, customer/stakeholder insight and investment are focussed on older peoples care homes, as the largest group of care homes in the city and demonstrate the type of information that can be obtained in support of future commissioning and delivery plans. A more detailed analysis of other more specialist homes for adults with disability and mental health will be undertaken separately when the Office for National Statistic (ONS) data is available in the next couple of months. (Linked to the 2021 census).

Needs analysis (recent admissions)

A needs analysis of the people currently living in older peoples care homes was undertaken in December 2022. (See Appendix 1 for full report). The analysis focussed on SCC funded admissions of older people living in care homes, although there was some data on self-funders. The report did not include a prediction of future needs.

The impact of Covid may have changed the makeup of the population in older ages but the analysis suggested it was important to wait for Office for National Statistics (ONS) to undertake their population projections based on the 2021 Census data before making any firm conclusions about likely future demand.

The data covered admissions over a 5-year period from 2017/18- 2021/2022. (The data for 2022/23 covered 8 months April- 22 November 22)

The main findings indicated a typical care home profile to be as follows

Characteristics	**Typical Profile**
Gender	Female
Age	84.3
Admission route	S2A/Hospital
Service required	Residential Care
Primary support reason	Physical Support (and falls and dementia feature)
Ethnicity	Most likely to be White - English/Welsh/Scottish/British/Northern Irish

The conclusions from this report were: -

From the data we do have, we can profile a typical care home admission

- Most admissions are female
- Average age for admission is 84.3
- The main service required is residential care
- Hospital is the main route for admissions
- The primary support reason is physical support and falls and dementia also feature

- Most people are white- English/Welsh/Scottish/British/Northern Irish. The only other reported category is Black or Black British – Caribbean. Further work is needed to understand why there are fewer people from an ethnic background in care homes
- Most people don't report their sexual orientation, this might be because some people don't want to share this information. Those who have reported it are straight/heterosexual.
- Self-funders have increased over time, although the health data this is based on isn't entirely robust. Self-funders will include council supported admissions with capital over the threshold who then became self-funders, as well as people who are solely privately paying residents. Sheffield is an outlier with the national trend.
- The Cordis Bright population projections carry health warnings as they were done pre covid and the impact of Covid may have changed the makeup of the population in older ages. We need to wait for Office for National Statistics (ONS) to undertake their population projections based on the 2021 Census data before making any firm conclusions about likely future demand.

Market Analysis

A recent analysis of the older people care home market was completed in January 2023, the full report can be found at Appendix 2.

The findings from this report will be considered as part of a Market Sustainability Plan which has previously been submitted to the Adult Health and Social Care Policy Committee and mitigating and supporting actions will be undertaken as part of this work

The analysis suggests that 22/23 has been another challenging year for the care home sector. Whilst many of the additional regulations related to Covid-19 have been withdrawn and deaths associated with Covid-19 have substantially reduced, their remains lasting impact from the previous years of the pandemic. Some homes still have high vacancy rates and there are still outbreaks occurring which result in temporary staff shortages or closure to admissions.

Recruitment and retention of staff which has been an issue for several years has become even more challenging due to burnout of staff from the pandemic years and staff shortages nationwide meaning that other sectors are offering improved wages and benefits to fill their vacancies encouraging some staff to leave the sector.

The cost-of-living crisis has hit both staff and providers working in the sector. Providers have seen their costs increases at rates of inflation far exceeding recent years and some providers may have experienced even greater cost increases, for example if their fixed price fuel contracts have ended this year. Care staff who are often on low wages have been especially hit by the crisis with many struggling to feed their families, heat their homes and pay other essential expenses.

Sheffield currently pays for Standard Residential and Nursing Care at a flat rate of £565 per week, in addition Nursing placements receive a standard Funded Nursing Care (FNC) payment of £209.19 per week from the NHS. This method differs from many other local authorities who have different fee rates for different types of care such as High Dependency or Elderly Mentally Infirm (EMI). This is after a recent £18 per week increase following the fair cost of care exercise.

Care home providers in Sheffield range from small, long-established operators with a single care home in a converted property, to large national organisations that run many purpose-built care homes – typically focused on areas of the city where land costs are lower.

There are 69 care homes in Sheffield that have older people as their main specialism and not run by the NHS. 54 of these homes are operated by groups with more than one home either at a local, regional or national level, these homes are split between 27 different providers, the remaining 15 homes are one-offs with the company owning just a single home.

Compared to the national average Sheffield's Older Peoples care homes are likely to be larger and nursing and residential care is more likely to be co-located in the same dual registered home. Whilst homes are more likely to be purpose built, they are also more likely to be older with older purpose-built homes dominating the market. A larger proportion of the Sheffield Market is run by not-for-profit companies with more than half of the not-for-profit market being run by Sheffcare who took over the running of some council run homes in 2002.

An analysis of care home financial performance was undertaken by the Council's finance teams using information from published financial accounts as of January 2021. The overall market picture showed 21% of care home companies in the city were ranked at moderate to high risk of business failure. Despite the significant challenges in the care home market only one home (residential) has closed in the past year, no care homes have opened in this time. In addition, 3 nursing homes have been taken over by a new provider to Sheffield with the previous provider entering liquidation soon after.

When using a CQC rating of Good or Outstanding of care being of an acceptable standard Sheffield Care Homes are currently outperforming the national average. The is particularly the case in Residential homes where the difference is most notable and has been consistent every year.

Whilst there has been some improvement in occupancy levels in care homes since the height of the pandemic most types of provision still have below the 90% occupancy rate that is often anecdotally cited as an optimum to promote financial viability whilst maintaining choice of provision. Nursing Care has higher occupancy rates than Residential Care and Dementia beds has higher occupancy rates as general for both Nursing and Residential Care. It is possible that these types of care have shown the greatest recovery as these types of provision are harder to replicate in other settings.

Admissions into care homes fell significantly during 2020/2021 due the pandemic. Since then, admissions into Nursing Care have recovered to similar levels to years prior to the pandemic, however admissions into residential care remain lower.

Investment into older people's care homes

Approximately £46m per annum is spent annually by SCC on care homes for older people

The Government announced the Market Sustainability and Fair Cost of Care Fund on 16th December 2021 with the primary to support local authorities to prepare their markets for reform and to support local authorities to move towards paying providers a fair cost of care. Given the Autumn Statement, it's unclear at this time the implication until guidance is given on 21st December 2022. Due to this, and without the detailed funding letter noted above, the Fund for 2022/ 2023 must now be considered as a one-off fund at this stage.
Where average fee rates are below the fair cost of care, local authorities should use this additional funding to increase fee rates paid to providers beyond the level required to cover increases in core costs such as inflation, workforce pressures, National Living Wage, and National Insurance.

Options are being considered and presented to the Adult Health and Social Care Committee (in Dec 22 and March 23) about how the grant funding should be allocated and how these impact on the fee rates for 23/24.

6 Customer/stakeholder Insight

Discussion has taken place with a number of individuals living in care homes both on a planned and routine basis (as part of the quality monitoring process). This assisted our understanding what people feel about care homes and what aspirations they have for the future. Discussions have also taken place with social care workers, internal staff, and providers. (See Appendix 3 for further information).
The feedback has been pulled together into themes to illustrate what people said was important to them

Communication and sharing of information

- Having the right information at the right time before moving into a care home
- Helping people plan for contingencies, provide more support with direct payments, and provide support to self-funders
- Developing relationships build trust and improve partnership working with providers

The importance of meaningful relationships

- Positive relationships with other residents and members of staff for a sense of connection and self-worth, particularly for those with no family or friends also,
- For those who had family and friends it was about keeping those connections

The importance of choice and control

- Having the ability to influence changes and having a full say in the support they need
- Moving into a home was seen as challenging but having the choice about where they would like to live and being included in conversations was important also,
- Having the choice about everyday things, particularly on key areas like their food, and their physical environment
- Having access to healthcare when they need it

Promoting independence and maintaining identity

- More involvement from the voluntary sector and sharing of ideas to help with activities
- Feeling valued, doing the things that are important and having access to the outside world

Person centred assessment and reviews

- Care plans to be explicit about their social needs, ensuring they are involved in decisions, more use of the 'This is Me' part of the care plan
- Reviews of care to happen in a reasonable timeframe.
- A coordinated approach between the council and health in terms of care planning/assessments and funding arrangements so people are not repeating themselves and they are clear and transparent about what level of support is being funded in a care package
- Monitoring to be more outcomes focused and there is no duplication with CQC

Inclusiveness

- A recognition and understanding of different needs/dependency levels, including the extreme frailty and dependence of older adults and how they can be supported to maintain their independence and identity
- There is a need to better understand the experiences of older people from black and minority ethnic groups
- How residents with dementia and sensory loss in care homes are better supported
- Ensuing people with special characteristics are included, LBGT+
- People value homeliness, space, and freedom

Well paid and skilled workforce

- People value carers /staff who are highly skilled and good at their job
- People recognised the issues with recruitment and retention of care workers
- There was a recognition about the low fees and rates of pay offered to care workers

Actual comments from individuals

Actual comments from Providers

Actual comments from SCC staff

Actual comments from other stakeholders

Establishing the Principles and how we benchmark against them

Consolidating the evidence base and feedback we can identify a set of 8 overarching/ guiding principles that suggest what elements/activities constitute a good care home, the majority of these are not focussed only on older people but are relevant to all age groups.

The guiding principles will be utilised in developing any agreements/contractual arrangements with providers and also used to develop the quality and performance toolkit. It is important to note quality and safeguarding are themes running through all of the principles and adopting the principles is likely to improve quality and safety.

NB:- These principles should not detract from the expectations of the regulator CQC and what care homes are already expected to achieve.

The table below represents a self-assessment of where we believe we are in meeting those principles giving some examples to suggest where we need to shift our thinking.

This is not intended to be an exhaustive assessment or suggest the most creative options for change more act as an illustration about what might be worked towards in the next 2 years

This self-assessment will be undertaken again working with individuals, providers and other stakeholders to ascertain if we have indeed moved forward year upon year.

Examples of how we meet this now	Principles of a good Care Home (themed)	Examples of what we could we do better
A care homes booklet which has basic information about care homes Individual care homes sharing their statement of purpose with people prior to visiting A social work team dedicated to care homes who have expertise in this area and can share information Care planning includes the individual and their chosen representatives Reviews of the persons stay includes the individual and their chosen representatives	**Information sharing**	More comprehensive information in a variety of formats about what people can expect from a care home with the ability to access this before admission More sector wide promotional work on care homes as a place to live, thrive, work and make friends Clear specifications with care homes and commissioners that can also be viewed by potential residents and their close contacts Feedback from people already living in a care home available to prospective residents in a variety of formats Contract and quality and performance reviews of homes available to the public
Inspection and quality reports show mostly positive relationships between individuals and carers in the home, people care Some homes have good community connections with the local voluntary groups, dementia groups and the local schools e.g., adopt a care home	**Community connectedness and meaningful relationships**	Staff focussed time to learn more about the person and their previous connections, many lose touch with friends outside the home when they move Create a directory of support for local neighbourhoods to ensure care home understand the local facilities in their area and good practice ideas for including residents e.g., voluntary work in the home Voluntary sector partners linked into care homes in the area

Examples of how we meet this now	Principles of a good Care Home (themed)	Examples of what we could we do better
Many residents are taken out into local areas to experience life outside a care home Quality and performance reviews look at records relating to connections the person has		Improving the care homes specification to include:- - Assist in promoting self-worth so residents of care homes feel they retain their identity and still have a purpose - Require care homes to facilitate existing connections and relationships if the individual wants these to continue - Expect care homes to reach out to local communities so the home and the people living there feel part of it not outside it Develop a catalogue of good practice to help refocus care homes on tools which can help them identify/support individuals to retain a sense of self-worth – e.g. This is me plan, volunteering, residents working in the home Quality and performance team continue with an increased focus on monitoring outcomes and feedback about identity and self-worth
Most care homes have feedback mechanisms to hear the voice of people living there Inspection reports and quality and performance reports indicate people have basic choices in areas such as food, waking and retiring times, where they spend their time and choice of clothing etc	**Choice and control and shared decision making**	Improving the care homes specification to include: - - Demonstrate how the voice of people living in the home is gathered and affects change - Demonstrate how the individual and their significant connections (where agreed) have influenced, contributed and agreed their plan of care Quality and performance team continue with an increased focus on monitoring outcomes and feedback about how

Examples of how we meet this now	Principles of a good Care Home (themed)	Examples of what we could we do better
Individuals are involved in the choice of home they go to, their review and identifying their care needs		choices are made and how voice is responded to in the running of the home More resident and relative groups who affect change about the running of the home Providers to undertake annual review of needs Payment by results based on what the person says/satisfaction levels
Each person has an individual care plan which describes their life, background needs and how these will be met There is a document called this is me as part of the care plan approach, which can be used to tell the person's story	**Promoting independence and maintaining identity**	Improving the care homes specification to: - - Promote enablement at every opportunity working with not for the person - Recognise the person's identity, see them as a person who has skills and abilities - Encourage learning and development Better connections with OTs to promote the ethos of an enabling approach More support to providers on good care planning for independence More consistent use of the "this is me document" when completing the assessment and caring for the person

Examples of how we meet this now	Principles of a good Care Home (themed)	Examples of what we could we do better
Person centred assessment and reviews already take place Individuals are included in the development of their care plans	**Person centred and outcome focused**	Specifications are more outcome focussed and less detailed about specific tasks that a provider must achieve More understanding of what person-centred means and how this can be applied in a care setting
Care homes have a process to ensure registered managers meet the required benchmark Staff are required to attend specific mandatory and other training as part of their employment	**Strong leadership culture and workforce**	Testing out the leadership and culture of organisations through the procurement process Continued focus on staff satisfaction levels as part of quality monitoring More focus on monitoring about what difference staff training makes to the individuals living at the home
Staff are required to attend specific training on equality and diversity Staff attend dementia Stars training Care homes who have people from ethnic backgrounds ensure they provide culturally appropriate food/clothing/visits etc Care homes accommodate differing needs	**Promoting Equality and inclusiveness**	Further work to understand why there are few people from ethnic backgrounds choosing a care home More involvement from voluntary sector and other providers who can support/advise on culturally appropriate support Improving the care home specification to: - • Encourage best practice approaches are routinely reviewed to ensure the environment and approach is supportive to dementia and sensory loss • Recognise that those who have to remain in bed should have the same opportunities for social participation and not be left alone for long periods of time.

Examples of how we meet this now	Principles of a good Care Home (themed)	Examples of what we could we do better
		• Explore ways to reduce isolation & loneliness within the home • Culturally appropriate care Staff to undertake training on LBGT and inclusion More homes to sign up to dementia Stars and demonstrate the impact of this
Some care homes already have activities coordinators who share resources and time between their different homes There is a willingness across the sector to look at innovation Innovation can occur in individual homes or organisations	**Adopting Innovation**	Creating opportunities for partners and care homes to come together to share best practice Collating best practice into a single repository that can be used by care homes to develop and continually improve Residents' forum/advisory group established for Sheffield to oversee the quality and promote best practice Relatives and other stakeholder involved in the persons care are involved in monitoring activities and able to rate the care homes Care homes to explore different funding sources like grants to develop innovation

7. The Challenges

There are some immediate challenges, these being: -

- ***Stabilising the workforce in social care*** - We know that improving the pay and skills of the workforce is vital to encourage people to consider care work as a career. Recruitment and retention of care workers is a national not just local issue but the cost-of-living crisis for front line care workers is hitting hard and people may make different career choices as a result
- ***Sustainability*** – Providers of care homes have long raised the issue of sustainable fee rates, ageing buildings, higher mortgages and staff retention means the use of expensive agency workers is commonplace. The cost-of-living crisis with increases in heating and food has an impact on care homes.
- ***Budget pressures*** –The council dealing with significant budget pressures, working towards the fair cost of care could mean a significant hit on the budget
- ***Relationships -*** These are some pockets of good working relationships, but this isn't consistent. Developing stronger provider relationships and partnerships is fundamental to making change happen. Only when we bring the sector with us on the journey will changes be achieved.
- ***Integration*** – Integration particularly with health commissioning colleagues is important and this is widely recognised as such however there remains some work to do in bringing this together in a cohesive way which is supportive to care homes.
- ***Commissioning as opposed to providing –*** Discussion continues about whether SCC should provide rather than commission all of its care homes provision. A recent options appraisal exercise (Dec 2022) indicated it was not feasible to do this on mass right now but there might be opportunities in the future to consider this in some areas or work towards a hybrid model. To do this however, the agreed model for a care homes design would need to be established.

Appendix 1 – Needs Analysis – Full Report

Needs Analysis

Care Homes

Older People

November 2022

Care Home Needs Analysis

Introduction

This needs analysis mainly covers the current needs of SCC funded admissions of older people living in care homes, although there is some data on self-funders. The

report does not include predictions of future needs. The impact of Covid may have changed the makeup of the population in older ages. We need to wait for Office for National Statistics (ONS) to undertake their population projections based on the 2021 Census data before making any firm conclusions about likely future demand.

The data covers admissions over a 5-year period from 2017/18- 2021/2022. The data for 2022/23 covers 8 months (April- 22 November 22)

Summary of findings

From the data we hold, have been able to profile a typical care home admission

Typical Care Home Admission

Characteristics	Typical Profile
Gender	Female
Age	84.3
Admission route	S2a/Hospital
Service required	Residential Care
Primary support reason	Physical Support (and falls and dementia feature)
Ethnicity	Most likely to be White - English/Welsh/Scottish/British/Northern Irish

Analysis of data

Age /Age Band

81% of admissions are between the ages of 75-94, 44% are between 85-94

The average age of admission is 84.3.

Age	Nursing	Residential	Grand Total	% Total
65-74	204	247	451	12%
75-84	532	902	1434	37%
85-94	488	1213	1701	44%
95+	75	248	323	8%
Grand Total	**1299**	**2610**	**3909**	**100%**

* Includes data from 2017-2022 , Note 22/23 is part year to 22/11/22

Year	Nursing	Residential	Grand Total
2017/2018	82.4	84.6	83.8
2018/2019	83.3	85.1	84.6
2019/2020	82.8	85.8	84.9
2020/2021	80.4	84.8	83.4
2021/2022	84.0	85.3	84.8
2022/2023	83.6	84.8	84.4
Grand Total	**82.8**	**85.1**	**84.3**

Includes data from 2017-2022 , Note 22/23 is part year to 22/11/22

Admissions to service

On average 66% of total admissions are to residential care.

2020/2021 is an outlier because of Covid, however admissions post covid have been less than in previous years.

Years	Nursing		Residential		Grand Total	%
2017/2018	260	37%	437	63%	697	18%
2018/2019	212	28%	534	72%	746	19%
2019/2020	250	31%	559	69%	809	21%
2020/2021	182	32%	394	68%	576	15%
2021/2022	244	36%	427	64%	671	17%
2022/2023	151	37%	259	63%	410	10%
Grand Total	**1299**	**Av34%**	**2610**	**Av66%**	**3909**	**100%**

Includes data from 2017-2022 , Note 22/23 is part year to 22/11/22

Admission Route

50% of admissions are from hospital. 40% of admissions come from S2A. A further 10% are from hospital not via S2A

15% are from the community with short term residential in place prior to long term and 35% had none of the above (i.e., just community).

All this is reliant on workers filling in the hospital admissions data though to find the non-S2A hospital part.

Primary Support Reason

79% of all admissions were due to physical support. Falls appear to be a contributing factor in a quarter of all admissions. Dementia is a factor in (also) a quarter of admissions.

Reason	Nursing	Residential	Grand Total	% Total
Learning Disability Support	12	13	25	1%
Mental Health Support	117	176	293	7%
Missing data	1		1	0%
Physical Support	1012	2072	3084	79%
Sensory Support	16	36	52	1%
Social Support	29	66	95	2%
Support with Memory and Cognition	112	247	359	9%
Grand Total	**1299**	**2610**	**3909**	**100%**

Includes data from 2017-2022 , Note 22/23 is part year to 22/11/22

Gender

65% of all admissions are female.

Gender	Nursing	Residential	Grand Total	% Total
Female	744	1811	2555	65%
Male	555	799	1354	35%
Grand Total	**1299**	**2610**	**3909**	**100%**

* Includes data for all years from 2017-2022 , All - note 22/23 is part year to 22/11/22

Ethnicity

87% of admissions are white - English/Welsh/Scottish/British/Northern. There are fewer people from an ethnic background

Ethnicity	Nursing	Residential	Grand Total	% Total
Asian or Asian British - Bangladeshi	1	2	3	0%
Asian or Asian British - Chinese	4	2	6	0%
Asian or Asian British - Indian		1	1	0%
Asian or Asian British - Other Asian Background	2	2	4	0%
Asian or Asian British - Pakistani	5	4	9	0%
Black or Black British - African	2	3	5	0%
Black or Black British - Caribbean	13	18	31	1%
Black or Black British - Other Black Background		1	1	0%
Mixed/Multiple Heritage - Other Mixed Background		1	1	0%
Mixed/Multiple Heritage - White and Asian		1	1	0%
Mixed/Multiple Heritage - White and Black African	1		1	0]%
Mixed/Multiple Heritage - White and Black Caribbean		2	2	0%
Not Known	117	175	292	7%
Other Ethnic Group - Arab	1		1	0%
Other Ethnic Group - Other Ethnic Group		5	5	0%
Refused	21	46	67	2%
Undeclared	1	5	6	0%
White - English/Welsh/Scottish/British/Northern Irish	1118	2302	3420	87%
White - Irish	4	11	15	0%
White - Other White Background	9	29	38	1%
Grand Total	**1299**	**2610**	**3909**	**100 %**

* Includes data for all years from 2017-2022 , All - note 22/23 is part year to 22/11/22

Sexual Orientation

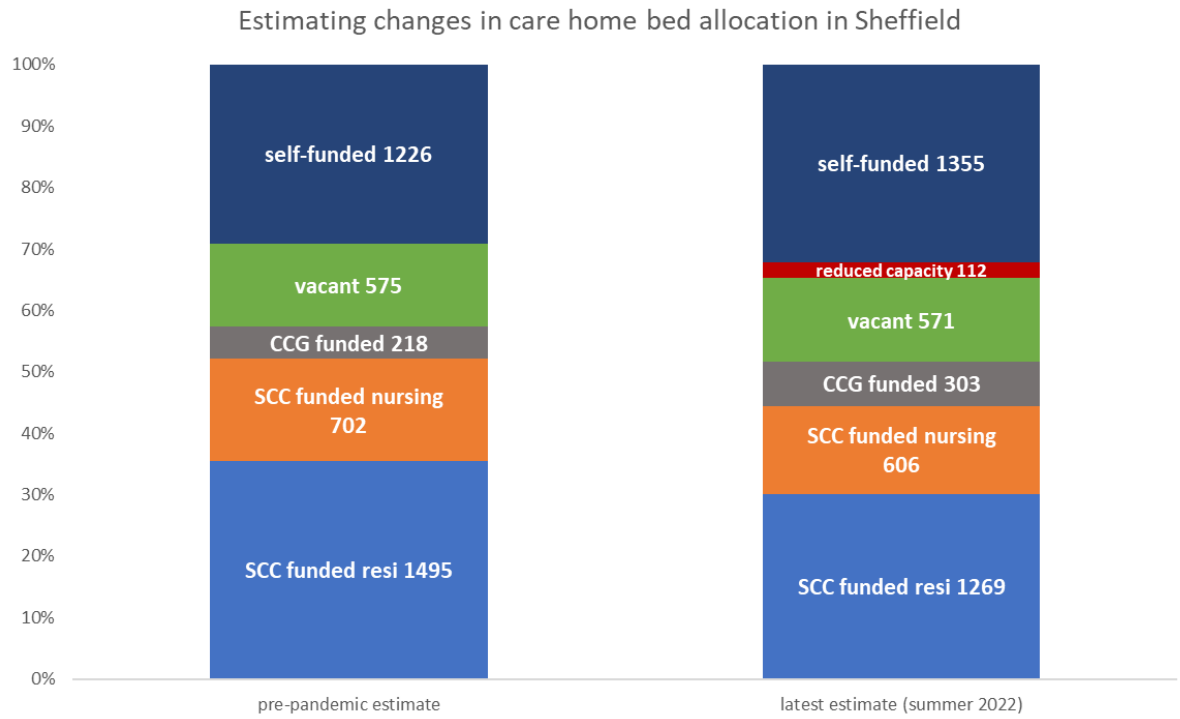
77% have not defined their sexual orientation. We only know about 22% who state they are heterosexual/straight

Sexual Orientation	Nursing	Residential	Grand Total	% Total

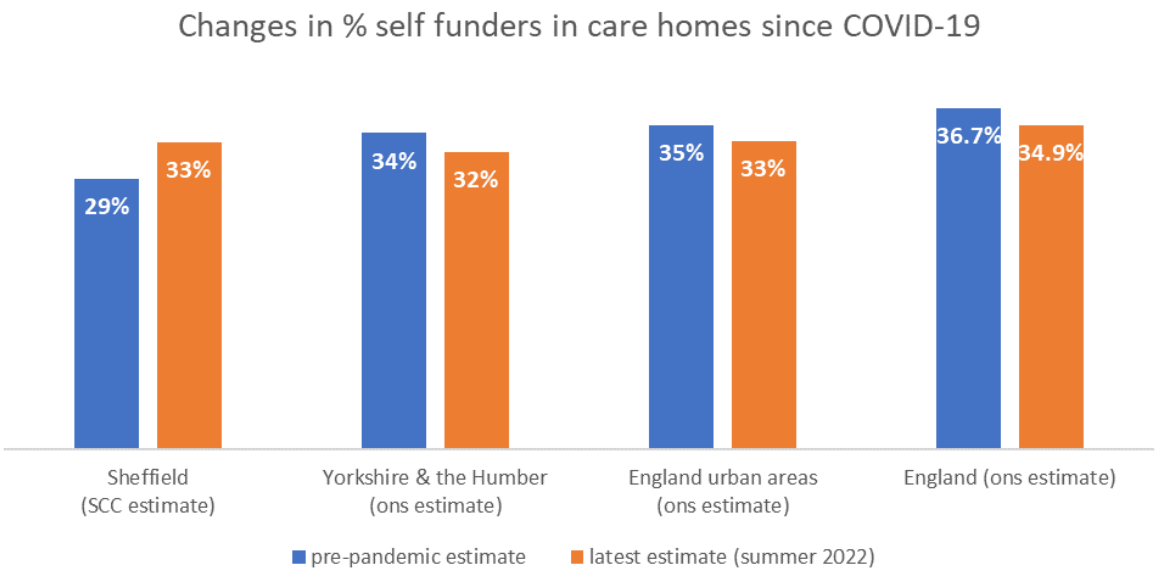
B. Gay Man	1	1	2	0%
C. Heterosexual/Straight	288	576	864	22%
E. Other - Please State	11	28	39	1%
F. Declined To State	41	68	109	3%
G. Still To Be Obtained	542	1163	1705	44%
NULL	416	774	1190	30%
Grand Total	**1299**	**2610**	**3909**	**100%**

Self Funders

Self-funded beds appear to have increased over time. Though the health data this is based on isn't entirely robust. Self-funders noted here will include council supported admissions with capital over the threshold who then became self-funders, as well as people who are solely privately paying residents.



Interestingly, it looks as though Sheffield is an outlier on the national trend here, possibly due to the previous policy decision to minimise admissions and to keep more people at home.



Population Projections

Cordis Bright [4]population projections were based on pre COVID projections and therefore COVID will have changed the population make up at older ages. We need to wait for Office for National Statistics (ONS) to undertake their population projections based on the 2021 Census data before making any firm conclusions about likely future demand.

Conclusions

From the data we do have, we can profile a typical care home admission

- Most admissions are female
- Average age for admission is 84.3
- The main service required is residential care
- Hospital is the main route for admissions
- The primary support reason is physical support and falls and dementia also feature
- Most people are white- English/Welsh/Scottish/British/Northern Irish. The only other reported category is Black or Black British – Caribbean. Further work is needed to understand why there are fewer people from an ethnic background in care homes
- Most people don't report their sexual orientation, this might be because some people don't want to share this information. Those who have reported it are straight/heterosexual.
- Self-funders have increased over time, although the health data this is based on isn't entirely robust. Self-funders noted here will include council supported admissions with capital over the threshold who then became self-funders, as well as people who are solely privately paying residents. Sheffield is an outlier with the national trend.
- The Cordis Bright population projections carry health warnings as they were done pre covid and the impact of Covid may have changed the

[4] Report on the Care Home Market Analysis 2021 CordisBright

makeup of the population in older ages. We need to wait for Office for National Statistics (ONS) to undertake their population projections based on the 2021 Census data before making any firm conclusions about likely future demand.

Appendix 2 - Care Homes Market Analysis 2022/2023

Summary

22/23 has been another challenging year for the care home sector. Whilst many of the additional regulations related to Covid-19 have been withdrawn and deaths associated with Covid-19 have substantially reduced, their remains lasting impact from the previous years of the pandemic. Some homes still have high vacancy rates and there are still outbreaks occurring which result in temporary staff shortages or closure to admissions.

Recruitment and retention of staff which has been an issue for several years has become even more challenging due to burnout of staff from the pandemic years and staff shortages nationwide meaning that other sectors are offering improved wages and benefits to fill their vacancies encouraging some staff to leave the sector.

The cost-of-living crisis has hit both staff and providers working in the sector. Providers have seen their costs increases at rates of inflation far exceeding recent years and some providers may have experienced even greater cost increases, for example if their fixed price fuel contracts have ended this year. Care staff who are often on low wages have been especially hit by the crisis with many struggling to feed their families, heat their homes and pay other essential expenses.

Sheffield currently pays for Standard Residential and Nursing Care at a flat rate of £565 per week, in addition Nursing placements receive a standard Funded Nursing Care (FNC) payment of £209.19 per week from the NHS. This method differs from many other local authorities who have different fee rates for different types of care such as High Dependency or Elderly Mentally Infirm (EMI). This is after a recent £18 per week increase following the fair cost of care exercise.

Market Overview

Older People's Market 65+

Care home providers in Sheffield range from small, long-established operators with a single care home in a converted property, to large national organisations that run many purpose-built care homes – typically focused on areas of the city where land costs are lower.

There are 69 care homes in Sheffield that have older people as their main specialism and not run by the NHS. 54 of these homes are operated by groups with more than one home either at a local, regional or national level, these homes are split between 27 different providers, the remaining 15 homes are one-offs with the company owning just a single home.

Compared to the national average Sheffield's Older Peoples care homes are likely to be larger and nursing and residential care is more likely to be co-located in the same dual registered home. Whilst homes are more likely to be purpose built, they are also more likely to be older with older purpose-built homes dominating the market. A larger proportion of the Sheffield Market is run by not-for-profit companies with more

than half of the not-for-profit market being run by Sheffcare who took over the running of some council run homes in 2002.

Care Homes with a primary specialism of older people (65+) or dementia, Sheffield and England Comparators, September 2022

Supply Side Measure	Sheffield	England
Average Size (beds) of care homes without nursing	40	34
Average Size (beds) of care homes with nursing	61	55
Care homes without nursing, beds per 1,000 population 75+	30	33
Care homes with nursing, beds per 1,000 population 75+	48	37
All 65+ care homes, beds per 1,000 population 75+	78	71
Purpose built as % of capacity	81%	54%
Share of bed capacity first registered since 2000	26%	31%
Not-for-profit share of independent sector capacity	23%	16%

An analysis of care home financial performance was undertaken by the Council's finance teams using information from published financial accounts as of January 2021. The overall market picture showed 21% of care home companies in the city were ranked at moderate to high risk of business failure. This was determined through the independent credit risk reporting tool provided by Dun & Bradstreet. Detailed financial assessments looked at financial solvency, liquidity, profitability and overall stability coupled with market resilience and risk ratings. The analysis indicated that 29% of care homes in Sheffield may struggle to fulfil existing liabilities through their most liquid assets; in short are at risk from short term cash flow failure. Due to the deadlines on when providers need to submit their information to companies' house, most of this information was for the period prior to the pandemic and it is possible that this situation may have deteriorated further.

Trends In home closures and openings

Despite the significant challenges in the care home market only one home (residential) has closed in the past year, no care homes have opened in this time. In addition, 3 nursing homes have been taken over by a new provider to Sheffield with the previous provider entering liquidation soon after.

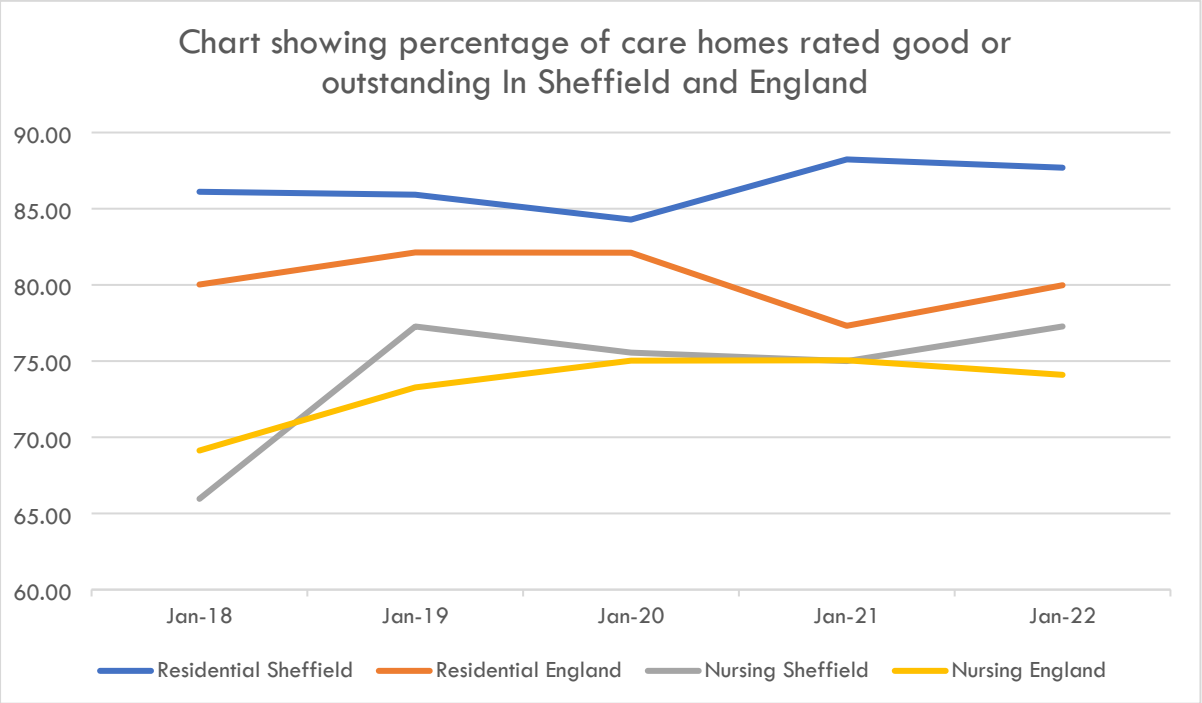
The home that closed was a small residential home in an older non-purpose-built building targeting the self-funder market. These characteristics have been shared by 3 of the 4 homes that have closed in Sheffield since the start of the pandemic.

In addition to the lack of new care homes opening, discussions with providers show a lack of appetite for opening new Older People's homes in Sheffield, often citing low fees as a key concern. There has been some interest from providers in repurposing vacant or decommissioned units in existing homes for new specialisms, but there is

only interest in reopening these as a form of residential care rather than nursing care due to challenges in recruiting nurses, this is despite our current Nursing capacity being closer to capacity. If Nursing occupancy continues to increase or there are further nursing home closures in the future, there is a risk that Sheffield will not have sufficient nursing beds to meet demand.

Quality

When using a CQC rating of Good or Outstanding of care being of an acceptable standard Sheffield Care Homes are currently outperforming the national average. The is particularly the case in Residential homes where the difference is most notable and has been consistent every year. Sheffield Nursing homes are also outperforming the national average but to a lesser degree, previously these had been below the national average before overtaking this in 2018 and staying above or about this level since.



The in-house quality monitoring team undertake visits to care homes and include:-

- a combination of resident / relative and staff discussions and observations,
- quality assurance checks in a number of areas including checking Care Plans are person centred, and support is delivered in line with the persons specific care and support needs
- observational and resident discussions focussing on
    - quality of life
    - choice
    - how individuals are listened to
    - how their feedback is acted upon, and
    - how the home supports people to do things that matter to them.

They continue to monitor more frequently than the CQC aiming to visit all homes at least twice per year. However, this has not always been possible as still many visits are being postponed due to outbreaks. As of 9/12/2022, 3 care homes were rated as Amber by SCC with various degrees of restrictions on placements with the remainder rated as Green with no restrictions in place.

Vacancy and occupancy

Whilst there has been some improvement in occupancy levels in care homes since the height of the pandemic most types of provision still have below the 90% occupancy rate that is often anecdotally cited as an optimum to promote financial viability whilst maintaining choice of provision. Nursing Care has higher occupancy rates than Residential Care and Dementia beds has higher occupancy rates as general for both Nursing and Residential Care. It is possible that these types of care have shown the greatest recovery as these types of provision are harder to replicate in other settings.

Admissions into care homes fell significantly during 2020/2021 due the pandemic. Since then, admissions into Nursing Care have recovered to similar levels to years prior to the pandemic, however admissions into residential care remain lower. This will go some way to explaining why Nursing Care has had the greatest recovery in its occupancy rates.

Commissioner's have received feedback from frontline social workers about the difficulties in finding suitable Nursing Dementia placements. Whilst this category of care has the lowest vacancy rate of about 10% this would still normally be sufficient to find suitable placements. It is therefore possible that continuing issues with staffing and outbreaks is reducing actual operational capacity of homes below their full quota of beds. With this type of care there is also a possibility that even with vacant beds and sufficient staffing the provider may be limited to how many individuals with a higher level of needs they can take at a time, as these individuals are likely to be unsettled when first entering the home which may in turn have an unsettling impact on other individuals already residing there.

As such Nursing Dementia is the category of care in Older People's care home which is viewed as having the greatest challenges in maintaining sufficient supply.

Table showing occupancy levels in Sheffield 65+ Care Homes 6/1/2023

Vacancy Type	Vacancies (Total)	Occupied	Occupied %
Dementia Residential	164	1000	85.91%
General Residential	223	815	78.52%
General Nursing	134	619	82.20%
Dementia Nursing	60	509	89.46%

Table showing trends in Occupancy over time in 65+ care homes

	Nursing %	Residential %
06/01/2023	85.32	82.42
01/02/2022	87.43	83.43
Jan-21	78.01	77.02
Apr-20	92.46	94.75
Nov-19	90	92
2018/2019	83.5	91
2017/2018	93.6	90.6

Table showing care home admissions over time.

	2017/2018	2018/2019	2019/2020	2020/2021	2021/22	22/23 to date approx. 9 months
Residential Admissions 65+	437	534	559	394	427	276
Nursing Admissions 65+	260	212	250	182	244	171

Fees Benchmarking

Sheffield differs from most other local authorities in that we pay a single rate for standard care in a care home regardless of whether that care is residential or nursing or with/without dementia. The rate we pay ranks quite low amongst the rates currently paid by other local authorities in the Yorkshire and Humberside Region. From 21/22 data Residential Care Sheffield ranked 10th out of 15 when compared to the minimum rate paid and 12th out of 15 when compared to the maximum rate. For Nursing Care Sheffield ranks 11th out of 15 when compared to the minimum rate paid and 13th out of 15 when compared to the maximum.

Residential

Local Authority		2021/22 rate	
		Minimum	Maximum
1	Barnsley	590.40	641.64
2	Bradford	561.47	561.47
3	Calderdale	512.74	538.67
	Calderdale EMI	591.83	618.15
4	Doncaster	544.16	544.16
5	East Ridings of Yorkshire	545.16	605.78
6	Hull	487.40	523.30
7	Kirklees -res	553.35	582.09
	Kirklees - res with dementia	573.35	602.09
8	Leeds	567.00	632.00
9	North East Lincolnshire	527.87	527.87
10	North Lincolnshire	506.59	537.01
11	North Yorks	599.34	599.34
12	Rotherham	504.00	526.00
13	Sheffield	530.00	530.00

14	Wakefield	568.00	664.00
15	York – res	558.94	601.37

Nursing

Local Authority		2021/22 rate	
		Minimum	Maximum
1	Barnsley	590.40	641.64
2	Bradford	597.52	597.52
3	Calderdale	588.96	617.57
	Calderdale EMI	617.57	643.87
4	Doncaster	597.61	597.61
5	East Ridings of Yorkshire	545.16	605.78
6	Hull	487.40	523.30
7	Kirklees	565.86	594.6
	Kirklees - with dementia	585.86	614.6
8	Leeds	599.00	649.00
9	North East Lincolnshire	527.87	527.87
10	North Lincolnshire	506.59	537.01
11	North Yorks	592.41	592.41
12	Rotherham	518.00	575.00
13	Sheffield	530.00	530.00
14	Wakefield	568.00	664.00
15	York	604.86	641.60

Also, when compared to information collected by the Improved Better Care Fund in 20/21 Sheffield also ranked as the lowest fee payers amongst core cities.

Local authority	Average amount paid to external providers of care homes without nursing for clients aged 65+ (£ per client per week): 2020-21 counterfactual	Average amount paid to external providers of care homes with nursing for clients aged 65+ (£ per client per week): 2020-21 counterfactual (EXCLUDING NHS FNC)
Birmingham	£537	£617
Bristol UA	£726	£740
City of Nottingham UA	£580	£624
Leeds	£610	£661
Liverpool	£523	£569
Manchester	£528	£564
Newcastle upon Tyne	£740	£824
Sheffield	£505	£505
England	£646	£698

Source: iBCF

Factors affecting the viability of the market

Staffing

Staffing is a significant challenge in social care with providers reporting significant challenges in recruiting and retaining staff. Whilst this has been a longstanding issue it has increased in recent years due to staff feeling burnt out from the pandemic, leaving the sector due to the now removed mandatory vaccination and higher levels of vacancies in better paid jobs in other sectors.

Nurse recruitment and retention is especially problematic, with a nationwide shortage and many favouring employment in the NHS or for agencies. This has been illustrated by a rise in the use of agency nurses in nursing homes this has risen from 14% November 2021 to 18% October 22 and currently sits at 26% for bank/agency usage (6/1/2023). It should however be noted that the significant rise between October 22 and January 2023 is likely to be in part due to a wording change on the capacity tracker which collects this data in November 2022. Previously the question only asked for agency usage it now asks for bank/agency usage. Bank staff could still be directly employed by the home.

High levels of agency use not only increases the cost of providing the care it also affects the continuity of care.

Inflation

Care homes, like most businesses and individuals in the country have felt the effects of the cost-of-living crisis and high rates of inflation. CPI Inflation in the 12 months to September 2022 was 10.1% and this has an impact on all costs a business has. In additional it has been announced that the national minimum wage will increase by 9.7% in April 2023, as most care home staff are paid at a rate close to this, there will be a significant increase to Care Homes wage bills from this date.

Energy Prices

Energy prices have soared recently especially since the invasion of Ukraine. This has led to large increases in the rates to homes and businesses. Businesses are often affected differently to households on these due to the variety of different contracts available to them. Some homes who managed to get a good long term fixed deal on their energy may not have seen any price increases whilst other homes whose deal has ended in the past year may have an increase potentially in exercise of 5x their previous deal. Whilst the government announced support via the Energy Bill Relief scheme from 1 October 2022, this only runs for 6 months, and prices may still be significantly higher than under previous contracts. The current support is due to expire In April 2023, whilst the government has given some indication that care homes may be treated as a vulnerable industry and entitled to further support after this date this has yet to be confirmed. As such this is still an area of particular concern and uncertainty for providers.

Insurance

Following the pandemic, the cost of insurance renewals for many Care Homes increased significantly due to the level of perceived risk by underwriters, this has

been raised as a concern in previous consultation exercises on fee rates. Whilst this trend appears to have levelled out and is now more in line with other inflationary pressures the cost of insurance for most homes is still considerably higher than pre-pandemic levels.

Self-funders

We do not have complete information on the number of self-funders in the Sheffield Market or how much they pay for their care. We do estimate there to be around 900-1300 self-funders in Older People's care homes in Sheffield, this represents 30-37% of the market. However, these self-funders are not evenly spread out and are heavily concentrated in the wealthier areas of the city.

We only have the private fee rates for 46% of homes in the city. The table below shows the difference the price paid by SCC for rooms in these homes and the minimum price charged to a self- funder for an ensuite room.

	Median difference between SCC rate and private fee (pwk)	Maximum difference between SCC rate and private fee (pwk)
Residential Care	£220.00	£455
Nursing Care	£153.50	£479

Last year we did not have enough information to calculate a reliable average private fee but the highest difference we were aware of between our rate and the private rate was £409 per week. There is therefore some evidence to suggest the difference between the rates paid by SCC and self-funders has widened further.

Social Care Charging Reforms

On the 17 November 2022, the government announced that proposed Social Care Charging reforms would be postponed until at least October 2025. These reforms would have included a cap on care costs, higher capital limits and the right for self-funders to access care at the rates paid by local authorities. These reforms were expected to reduce the number of self-funders paying for their own care in care homes whilst increasing the number of people who have their care arranged by the Council. This would have reduced the ability of care homes to achieve cross subsidies from private fee payers.

As these reforms have now been postponed it is likely that cross-subsidy will continue unless rates paid by local authorities increase at rates exceeding inflation.

Appendix 3 – Feedback Report (full)

What people have told us about older peoples care homes

November 2022

Key messages

Communication and sharing of information

- having the right information at the right time before moving into a care home
- helping people plan for contingencies, provide more support with direct payments, and provide support to self-funders
- developing relationships build trust and improve partnership working with providers

The importance of meaningful relationships

- positive relationships with other residents and members of staff for a sense of connection and self-worth, particularly for those with no family or friends
- also, for those who had family and friends it was about keeping those connections

The importance of choice and control

- having the ability to influence changes and having a full say in the support they need

- moving into a home was seen as challenging but having the choice about where they would like to live and being included in conversations was important
- also having the choice about everyday things, particularly on key areas like their food, and their physical environment
- having access to healthcare when they need it

Promoting independence and maintaining identity

- more involvement from the voluntary sector and sharing of ideas to help with activities
- feeling valued, doing the things that are important and having access to the outside world

Person centred assessment and reviews

- care plans to be explicit about their social needs, ensuring they are involved in decisions, more use of the ‘This is Me’ part of the care plan
- reviews of care to happen in a reasonable timeframe.
- a coordinated approach between the council and health in terms of care planning/assessments and funding arrangements so people are not repeating themselves and they are clear and transparent about what level of support is being funded in a care package
- monitoring to be more outcomes focused and there is no duplication with CQC

Inclusiveness

- a recognition and understanding of different needs/dependency levels, including the extreme frailty and dependence of older adults and how they can be supported to maintain their independence and identity
- there is a need to better understand the experiences of older people from black and minority ethnic groups
- how residents with dementia and sensory loss in care homes are better supported
- ensuing people with special characteristics are included, LBGT+
- people value homeliness, space, and freedom

Well paid and skilled workforce

- people value carers /staff who are highly skilled and good at their job
- people recognised the issues with recruitment and retention of care workers
- there was a recognition about the low fees and rates of pay offered to care workers

Residents living in care homes and their relatives

During July and August 2022 Healthwatch Sheffield spoke to 5 relatives and 16 older people living in residential and nursing care homes in Sheffield, they visited 6 homes and heard from 2 homes which they were unable to visit. They wanted to understand about people's experiences, what works and what doesn't work, as well as what they would like to change or improve. There were opportunities throughout the conversations for residents to share their own priorities. The aim is to help shape the future planning of services and support commissioners to develop a service specification that best fits with residents needs and reflect what is important to them.

A summary of responses and a snapshot of some of the comments made by residents are detailed below. Healthwatch have published a full report which describes in much more detail about what people have said with a list of their recommendations

Interviews with residents and relatives were semi-structured to cover these broad areas.

- The process of moving into the home
- The physical environment of the home
- Their care and support needs
- The social aspects of their care
- Their access to healthcare

Summary of responses

- Choices are empowering – having the opportunity to choose which care home they moved to, as well as having choices in aspects of everyday living, such as food, was of high importance to residents. The ability to influence changes within the care home was not an opportunity that most felt was available to them, whether the changes they suggested were large or small.
- People value relationships and a sense of connection - positive relationships with other residents and staff were highly important for a sense of connection and self-worth, particularly for those who had no available family or friends or for those in care homes who relied on agency staff.
- People want to live in an enabling environment - whilst residents largely felt that their private rooms were adequate for their needs, most residents spoke of their wish to go outdoors and take part in activities that felt meaningful to them.
- High satisfaction with the access to healthcare at a care home - most people reported good access to healthcare and additional services such as dentist, optician, and chiropodist, whether they chose to see them or not.

Quotes from residents included in the Healthwatch report

Providers of care homes including managers and owners

During September and October 2002, care home providers were invited to engagement sessions focussing on what a service specification for care homes might look like. Attendees were asked about new ideas in their practice and about what worked and what didn't. They were asked what is possible given the available resources

Summary of responses

- Agreed the presentation and the approach is great and it is what they all want to strive for and achieve, but there are many pressures in the system (e.g. low fee levels), makes thinking about innovation and developments difficult.
- Recruitment is a struggle, staff retention is low, staff vacancies are high and turnover rate is high.
- Business is very tough, playing catch up after Covid, and the focus is trying to manage the recruitment, agency use, and occupancy levels.
- Want a better relationship with the Council, they want to see much more partnership working and trust building.
- A regular forum with SCC would be welcomed but they often feel like they are not being heard.
- Appreciate support from contracts officers but sometimes inspections are time consuming and duplicate CQC.
- Some feel motivated to improve standards and they are trying to drive the change
- The dependency of people they are caring for has increased.

- There are lots of ad hoc requests for information which is a burden and seems to lack coordination.
- They had been looking at increasing the benefits for their staff through better terms and conditions like Westfield Health, blue light cards and cycle to work schemes
- Having an activities coordinator has been beneficial, they are sharing the staff member between both homes, see the residents laughing and enjoying all the Halloween decorations that have been put up has been amazing. This makes its feel more like home
- The training that is offered to staff is important as staff feel confident, and they can rely on them
- Want to get to know social work teams face to face and build good relationships with their staff
- It would be helpful if providers knew who the key contact people are from the Council, i.e. contracts teams and finance teams etc

Quotes from Providers

Localities Teams, Best Interest Assessors & Head of Service, OT

During May, July, August, and September 2022, 25 ASC employees were asked for their views on what a care home specification might look like.

Summary of what they said

- Teams felt really reassured to hear that this specification is taking place, they liked the vision and the presentation.

- Recognition that there are huge staffing issues within the sector, people talked about this issue many times.
- The electronic records are not helpful and the information is too generic there is not enough about wellbeing etc
- Care homes do not appear to have sufficient staff to focus on social interaction and activities within the home, and they rarely come across situations where older people are regularly taken out of the home by staff
- There is a lot of focus on what might be available in the community, but for many residents going out into the community to engage in activities would not be possible without high ratio support from care staff.
- Care plan reviews are very patchy and very rarely include the voice of the person.
- The “This is me” document is often poorly completed (with just a few lines encapsulating a person’s life) and is hidden in the care plan. It should be a working document which needs to be constantly updated, it evidences an understanding of a resident’s personal history and their preferences.
- More should be made of social interaction and stimulation.
- The big 60 bedded units don’t feel intimate or homely and they have big corridors, prefer the smaller homes
- There needs to be more examples of interactions which can occur with more impaired residents
- Like the term “relationship centred care”, but for people with moderate to advanced dementia it demands a lot of input from workers. The experience is that there are not sufficient staff in care homes to provide this support.
- Suggestions were made about how people with who are bed bound or have dementia can be supported in a care home.
- There are some good examples of innovations and ideas, personalisation of the home to make it homely and the importance of developing strong relationships with the staff, and example of gardening, possibility of raised beds and getting the residents involved in activities, also exploring how the voluntary sector can support the homes and linking care homes to extra care schemes and their facilities – like the cafes etc
- There are some homes that are good and do a lot for the residents, it’s down to having a good manager and attentive staff. Staff wellbeing is important too
- The option of care homes exploring different funding arrangements
- Detail needed in the specification around how the resident’s independence will be fostered, and their need for social stimulation met within the care home environment
- Need more recognition of the fact of the extreme frailty and dependence of older adults in care homes. There needs to be more examples of interactions which can occur with more impaired residents
- Care plans to include the voice of the residents and their families

Quotes from localities teams, BIAs, and HOS

ASC Strategy Engagement

During 2021, as part of the development of the ASC strategy, we engaged a project group of council officers, individual employers, voluntary and community sector workers and managers, social workers, carers, and family members of people who receive services or who receive direct payments. We ran a series of sessions to explore together how ongoing social care and support for older people might look in the future. We wanted to know what people thought is important and then work out what an ideal model for ongoing care

Summary of responses applicable to care homes

- Want to feel connected to the world around them and to live a good life, both inside and outside the home. They told us they fear losing their connections from family friends, neighbours, shops, clubs etc.
- Are afraid of living in care homes, losing their life savings, independence, and privacy, living in small sized rooms, and having no control over their environments. They want care homes to feel homely, vibrant places
- Broadly see care homes as places of illness and frailty pervaded by boredom and loneliness.
- Direct payments are not promoted enough, there's not enough support for people who use direct payments
- Want the assessment process to improve, it to be more person centred, plans to be creative and outcomes focused.
- Want to feel valued, so that their personal identity is maintained

- Want to make a positive choice about whether they move into a care home, have control over their lives, including control over where and with whom they live.
- Want support they need on that day at that time, not a formulaic response to a need they don't have.
- Don't feel that they have a full say in decisions about the support they need, they want this imbalance of power to be reversed.
- Want to deal with people they know and can trust and build meaningful relationships

There was a broad consensus ***internally*** on several issues

- Providers must be equal partners and trusted as such – Without the full involvement of "the market", both for profit and non-profit, there can be no radical vision because the current shape of care and support "provision" will have to change.
- Workforce issues must be properly addressed - we need an adequate/highly skilled well/ paid workforce

Quotes relevant to care homes

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Transforming Care Homes in Sheffield
Plan on a page – June 2022 – April 2024

Sheffield City Council

What are we trying to achieve?

Everyone in Sheffield lives in a place they can call home, in communities that care, doing things that matter to them, and when they need it, they receive care and support that prioritises independence, choice, and recovery.

How and when will we achieve it?	Phase 1 Set out our commissioning intentions and investment June 22 – Feb 2023	Phase 2 Support the market, specify the requirements, and further develop our plan March 23 – Aug 23	Phase 3 Strengthen, integrate, support differing needs Sept 23 – March 24	Phase 4 Build the model and transform April 2024 and beyond
What will we do?	■ Fair cost of care – confirm how we will work towards this and how the grant will be used ■ Fees levels modelled for 23/24 consulted on and proposed ■ Market Position Statement ■ Market sustainability report finalised – indicating direction of travel to support the market and sustain a stable market ■ Formulate our action plan in response to feedback from individuals and Healthwatch report 2022 ■ Early iteration of a commissioning and delivery plan for care homes to include • Current needs analysis • Market analysis • Feedback and consultation • Delivery plan • Options appraisal	■ Develop relationships and non-financial support to care homes including:- • Workforce development – work with the sector on ideas to value, retain and develop care home workforce • Business Sheffield/Commercial Experts – accelerate the development offer to pre prepare the market (tendering, banking, energy saving) • Embed regular care home partnership provider meetings to include commissioning intentions, development sessions and open discussions. • Look at our purchasing power and investigate any options to support care homes • Use the monitoring and quality assurance process for support/development to providers • Development of the Social Work Care Homes Team, Health and Care Quality Board, Citizens Coproduction, Quality Assurance and Commissioning Service. ■ Further development of the Care Homes Commissioning and Delivery Plan including: - • Agreement of outcomes for care home delivery • Gap analysis • Future predictions on need • Commissioning intentions for reconfiguring the market • A care homes market position statement which describes the above ■ Develop a procurement plan for moving away from individual placement agreements which includes:- • Specification for care homes focused around outcomes and quality. • Modelling to ensure most appropriate procurement method • Investigating the merit of joint procurement with ICB • Options appraisal around future delivery models to achieve excellent quality care	■ Procurement of framework for care homes including:- • Quality requirements set out for all care homes • Contracts for all care homes in place by April 2024 ■ Develop phase 2 Modelling including:- • Specifying different levels of need and how these could be met • How this will be procured and the contract type (block spot) • Costs levels for different cohorts/levels of need • Joint commissioning with ICB	■ Implementation of the phase 2 modelling and development of care homes for the future to include:- • Innovations - technology enabled care • Capital developments • Detailed gap analysis • Delivery plan linked to fees and need • Provider diversification • Market development plan • Improved standards for supporting/communicating with full fee payers • Accredited care homes scheme

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Equality Impact Assessment Number: 1401

Part A

Initial Impact Assessment

Proposal name Transforming Care Homes for Older People

Brief aim(s) of the proposal and the outcome(s) you want to achieve

This is a commissioning plan which sets out:

- The strategic direction we are proposing in order to develop the older peoples care home market in Sheffield
- A high-level delivery plan for the next 2 years demonstrating the activities and support that will be undertaken to achieve this
- An intention in the delivery plan to re-procure and move to more robust qualitative contracting arrangements with all care home providers
- An updated market sustainability plan to support the sector

Proposal type

○ Budget ● non-Budget

If Budget, is it Entered on Q Tier?

○ Yes ○ No

If yes what is the Q Tier reference

Year of proposal (s)

○ 21/22	● 22/23	● 23/24	● 24/25	○ other

Decision Type

● Committee (e.g. Health Committee)
○ Leader
○ Executive Director/Director
○ Officer Decisions (Non-Key)
○ Council (e.g. Budget and Housing Revenue Account)
○ Regulatory Committees (e.g. Licensing Committee)

Lead Committee Member Cllrs Argenzio and Lindars-Hammond

Lead Director for Proposal

Alexis Chappell

Person filling in this EIA form

Joanne Knight

EIA start date 22/12/2022

Equality Lead Officer	
○ Adele Robinson	● Ed Sexton
○ Bashir Khan	○ Louise Nunn
○ Beverley Law	○ Rabena Sharif
	○ Richard Bartlett

Lead Equality Objective

○ Understanding Communities	○ Workforce Diversity	● Leading the city in celebrating & promoting inclusion	○ Break the cycle and improve life chances

Portfolio, Service and Team

Lead Portfolio People

Is this Cross-Portfolio?

○ Yes ● No

Is the EIA joint with another organisation (eg NHS)?

○ Yes ● No Please specify

Consultation

Is consultation required?

● Yes ○ No

If consultation is not required please state why

Are Staff who may be affected by these proposals aware of them?

● Yes ○ No

Are Customers who may be affected by these proposals aware of them?

● Yes ○ No

If you have said no to either please say why

Initial Impact

Under the Public Sector Equality Duty we have to pay due regard to the need to:
• eliminate discrimination, harassment and victimisation
• advance equality of opportunity
• foster good relations

For a range of people who share protected characteristics, more information is available on the Council website including the Community Knowledge Profiles.

Identify Impacts

Identify which characteristic the proposal has an impact on tick all that apply

● Health	● Transgender
● Age	● Carers
● Disability	○ Voluntary/Community & Faith Sectors
○ Pregnancy/Maternity	● Partners
● Race	○ Cohesion
● Religion/Belief	○ Poverty & Financial Inclusion
● Sex	○ Armed Forces
● Sexual Orientation	○ Other

Cumulative Impact

Does the proposal have a cumulative impact?
○ Yes ● No

○ Year on Year	○ Across a Community of Identity/Interest
○ Geographical Area	○ Other

If yes, details of impact

Does the proposal have a geographical impact across Sheffield?
○ Yes ● No

If Yes, details of geographical impact across Sheffield

Local Area Committee Area(s) impacted
● All ○ Specific

If Specific, name of Local Committee Area(s) impacted

Initial Impact Overview

Based on the information about the proposal what will the overall equality impact?

The focus is on qualitative contracting arrangements and market sustainability, which is intended to have general beneficial impacts for care home residents. Through the introduction of new 'good care home principles', it is aimed for there to be measurable benefit not only for older people and disabled people but also for those sharing other protected characteristics.

Is a Full impact Assessment required at this stage? ● Yes ○ No

If the impact is more than minor, in that it will impact on a particular protected characteristic you must complete a full impact assessment below.

Initial Impact Sign Off

EIAs must be agreed and signed off by an Equality lead Officer. Has this been signed off?

○ Yes ● No

Date agreed 06/01/2023 Name of EIA lead officer Ed Sexton

Part B

Full Impact Assessment

Health

Does the Proposal have a significant impact on health and well-being (including effects on the wider determinants of health)?

● Yes ○ No *if Yes, complete section below*

Staff
○ Yes ○ No

Customers
● Yes ○ No

Details of impact

The COVID 19 pandemic had a devastating impact. The most notable was the impact of COVID 19 on the ageing population especially those who receive care and support. The State of Sheffield 2020 report identified the largest disparity in communities because of COVID was age. Twice as many people over 80 with COVID were likely to die than someone under 40 and most deaths in the city in the community were in care homes. All this had a significant impact on both the ageing population and their families, their fears, anxieties, and confidence but also on the market on providers and on staff teams who witnessed the loss of people they care for. The recovery from this will take time and may have already impacted on or suppressed demand which will become more apparent over the next few years.

Despite the difficulties that communal living can present Care Homes are there to recognise and support individuality, culture and difference, to allow people choice and control over their life, support people to have a purpose and be able to contribute and support the person to continue with their network of contacts and embrace their position as part of a local geographical or community of interest.

All too often however Care Homes are not seen in this way, they are perceived as places of illness not wellness where privacy and independence are not possible due to communal living and where people lose identity and control.
We know most people would prefer to stay in their own home, but we also know there are ways to improve how people perceive and experience care in a Care Home by working with providers and individuals/families/friends. The commissioning plan starts a journey of improvement to enable Care Homes in Sheffield to be the best that they can be for the people who live there.

To deliver such improvements, however, change cannot be only on the part of Care Homes, there must be a sustainable market of provision and this commissioning plan will also acknowledge the need to support the Care Home sector and workforce if we are to reach our goal to make positive change.

Over the past few years, we have amassed a body of evidence and feedback about what a good care home should look like, not least more recently a Heathwatch report specifically on this subject What matters to us: Older people's experiences of living in a care home | Healthwatch Sheffield.

Rather than search for more feedback it is important to now collate, recognise and reflect on this and start to plan how we will respond. Consolidating the evidence base and feedback we can identify a set of 8 overarching/guiding principles that

suggest what elements/activities constitute a good care home. These will be utilised in developing any agreements/contractual arrangements with providers and also used to develop the quality and performance toolkit. It is important to note that quality and safeguarding are themes running through all of the principles and adopting the principles is likely to improve quality and safety.

NB:- These principles should not detract from the expectations of the regulator CQC and what care homes are already expected to achieve.

1. Information sharing
2. Community connectedness and meaningful relationships
3. Choice and control and shared decision making
4. Promoting independence and maintaining identity
5. Person centred and outcome focused
6. Strong leadership culture and workforce
7. Promoting Equality and inclusiveness
8. Adopting Innovation

Comprehensive Health Impact Assessment being completed

○ Yes ● No

Please attach health impact assessment as a supporting document below.

Public Health Leads has signed off the health impact(s) of this EIA

○ Yes ● No

Name of Health Lead Officer

Age

Impact on Staff
○ Yes ● No

Impact on Customers
● Yes ○ No

Details of impact

The impact on customers living in care homes will be positive. This is the first time for many years that we have articulated our vision for care homes. The plans to transform care homes are based on feedback from customers about what is important to them. The 8 key principles which will be used in specification and quality monitoring processes are directly lifted from feedback received and the evidence base

What matters to us: Older people's experiences of living in a care home | Healthwatch Sheffield.

A place we can call home | SCIE

Disability

Impact on Staff
○ Yes ● No

Impact on Customers
● Yes ○ No

Details of impact

Many of the people living in care homes will live with a long-term disability, in particular dementia. The vision and 8 key principles we are working towards should enhance their experience of living in a care home and ensure that peoples ability is recognised not their disability

Race

Impact on Staff
○ Yes ● No

Impact on Customers
● Yes ○ No

Details of impact

One of the 8 principles relates solely to equality and inclusiveness.

We know that the majority of care homes residents are from the White British population and there has long been assumptions about why this is the case. The principles we adopt will ensure that people with differing cultural needs are supported with what matters to them and therefore the impact will be positive.

Further work will be undertaken to understand the needs of people from different ethnic minority backgrounds to understand why care homes are not a chosen option.

Sex

Impact on Staff
○ Yes ● No

Impact on Customers
● Yes ○ No

Details of impact

By nature of the demographic make-up of care homes, there is likely to be a disproportionate impact for women.

Sexual Orientation

Impact on Staff
○ Yes ● No

Impact on Customers
● Yes ○ No

Details of impact

The 8 principles which will be adopted specifically raise the issue of inclusivity.

"Promoting Equality and inclusiveness"

Therefore, the impact is likely to be positive in responding to the needs of differing communities.

The needs analysis of current residents indicated that a significant number did not want to disclose their sexual orientation, but further work will be undertaken to understand the needs of this groups and whether these are being met by introducing different requirement of care homes.

As part of the delivery plan care homes will be offered differing types of support to access resources that help educate them in the delivery of more culturally appropriate support, for example Culturally Appropriate Care (skillsforcare.org.uk) CUR_inclusive-eng.pdf

Carers

Impact on Staff
○ Yes ● No

Impact on Customers
● Yes ○ No

Details of impact

The impact will be positive. Often carers feel a care home is a last resort for a loved one but the commissioning plan is all about improvement and developments to make care homes more inclusive, more person centred and more of a place to live thrive and work. Carers have fed into the development through the Healthwatch report and previous engagement sessions

Partners

Impact on Staff
● Yes ○ No

Impact on Customers
● Yes ○ No

Details of impact

Partners in the NHS are fully signed up to the commissioning and delivery plan and have been instrumental in agreeing the developments. Further work will be done with partners over the next 2 years to develop a more joined up development plan for care homes

Action Plan and Supporting Evidence

What actions do you need to take following this EIA?

We will aim to achieve the aim to "Better understand the experiences of older people from black and minority ethnic groups" through:

- Incorporate actions relating to this into the equalities strategy
- Continue to collate the voice of those in care homes through the regular monitoring arrangements
- Actively work with patient experience teams in order to raise awareness and engage with older people from black and minority ethnic groups as part of our health inclusion programme of work

What evidence have you used to support the info in the EIA?

Culturally Appropriate Care (skillsforcare.org.uk)

CUR_inclusive-eng.pdf

What matters to us: Older people's experiences of living in a care home | Healthwatch Sheffield.

A place we can call home | SCIE

Detail any changes made as a result of the EIA

Following mitigation is there still significant risk of impact on a protected characteristic. ○ Yes ● No

If yes, the EIA will need corporate escalation? Please explain below

Sign Off

EIAs must be agreed and signed off by an Equality lead Officer. Has this been signed off?

○ Yes ○ No

Date agreed 06/01/2023 Name of EIA lead officer Ed Sexton

Review Date 07/07/2023

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Report to Policy Committee

Author/Lead Officer of Report: Tony Kirkham, Interim Director of Finance and Commercial Services

Tel: +44 114 474 1438

Report of:	*Tony Kirkham*
Report to:	*Adult Social Care Committee*
Date of Decision:	*8th February 2023*
Subject:	*Month 8 Budget Monitoring*

Has an Equality Impact Assessment (EIA) been undertaken?	Yes		No	x
If YES, what EIA reference number has it been given? *(Insert reference number)*				
Has appropriate consultation taken place?	Yes		No	x
Has a Climate Impact Assessment (CIA) been undertaken?	Yes		No	x
Does the report contain confidential or exempt information?	Yes		No	x

If YES, give details as to whether the exemption applies to the full report / part of the report and/or appendices and complete below:-

*"The (**report/appendix**) is not for publication because it contains exempt information under Paragraph (**insert relevant paragraph number**) of Schedule 12A of the Local Government Act 1972 (as amended)."*

Purpose of Report:

This report brings the Committee up to date with the Council's financial position as at Month 8 2022/23 General Fund revenue position

Recommendations:

The Committee is recommended to:

1. Note the Council's financial position as at the end of November 2022 (month 8).

Background Papers:
2022/23 Revenue Budget

Lead Officer to complete: -		
1	I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.	Finance: *Tony Kirkham, Interim Director of Finance and Commercial Services*
		Legal: *Sarah Bennett, Assistant Director, Legal and Governance*
		Equalities & Consultation: *James Henderson, Director of Policy, Performance and Communications*
		Climate: n/a
	Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.	
2	**SLB member who approved submission:**	*Tony Kirkham*
3	**Committee Chair consulted:**	*Cllr Bryan Lodge*
4	I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Committee by the EMT member indicated at 2. In addition, any additional forms have been completed and signed off as required at 1.	
	Lead Officer Name: *Tony Kirkham* *Jane Wilby*	**Job Title:** *Interim Director of Finance and Commercial Services* *Head of Accounting*
	Date: 24th January 2023	

1. PROPOSAL

1.1 This report sets out the 2022/23 Month 8 financial monitoring position for the Council and each of the Policy Committees.

1.2 Council Portfolio Month 8 2022/23

1.2.1 The Council is forecasting a £17.1m overspend against the 2022/23 budget as at month 8.

Full Year £m	M8 Outturn	Budget	M8 Variance	M7 Variance	Movement
Corporate	(470.9)	(468.4)	(2.5)	(1.5)	(1.0)
City Futures	47.0	47.3	(0.3)	0.2	(0.5)
Operational Services	114.0	114.4	(0.4)	(0.2)	(0.2)
People	316.3	298.8	17.5	17.4	0.1
Policy, Performance Comms	3.5	2.9	0.6	0.5	0.1
Resources	7.2	5.0	2.2	2.3	(0.1)
Total	**17.1**	**0.0**	**17.1**	**18.7**	**(1.6)**

1.2.2 This overspend is due to a combination of agreed Budget Implementation Plans ("BIPs") not being fully implemented and ongoing cost / demand pressures that are partially offset by one-off savings.

Full Year Variance £m	One-off	BIPs	Trend	Total Variance
Corporate	0.0	0.0	(2.5)	(2.5)
City Futures	(0.1)	0.0	(0.2)	(0.3)
Operational Services	(6.3)	3.1	2.9	(0.3)
People	0.2	15.5	1.8	17.5
Policy, Performance Comms	(0.1)	0.3	0.3	0.5
Resources	(0.7)	1.8	1.1	2.2
Total	**(7.0)**	**20.7**	**3.4**	**17.1**

1.2.3 In 2021/22, the Council set aside £70m of reserves to manage the financial risks associated with delivering a balanced budget position. In 21/22, the council overspent by £19.8m which was drawn from this pool, a further £15m was used to balance the 22/23 budget and current forecast overspend at M8 is set to be £17.1m leaving a remaining risk allocation of £18.2m

M8	£m
Allocated reserves	**70.0**
21/22 Budget overspend	19.8
22/23 Base budget committed	15.0
22/23 BIP shortfall	20.6
22/23 pressures	3.4
22/23 in year mitigations	(7.0)
Reserves used @ M8	51.8
Remaining reserves	**18.2**

(£17.1m overspend @ M8)

1.3 Committee Financial Position

1.3.1 Overall Position - £17.1m overspend at Month 8

There is a £11.6m overspend in the Adult Health and Social Care Committee and a £6.6m overspend in the Education, Children and Families Committee

Full Year Forecast £m @ Month 8	Outturn	Budget	Variance
Adult Health & Social Care	165.2	153.6	11.6
Education, Children & Families	136.6	130.0	6.6
Housing	8.2	8.7	(0.5)
Transport, Regeneration & Climate	41.5	42.0	(0.5)
Economic Development & Skills	11.6	11.7	(0.1)
Waste & Street Scene	54.6	54.9	(0.3)
Communities Parks and Leisure	45.7	46.2	(0.5)
Strategy & Resources	(446.3)	(447.1)	0.8
Total	**17.1**	**0.0**	**17.1**

Most of the full year forecast overspend is attributable to shortfalls in Budget Implementation Plans (BIPs) delivery

Variance Analysis £m @ Month 8	One-off	BIPs	Trend	Total Variance
Adult Health & Social Care	(0.4)	9.4	2.6	11.6
Education, Children & Families	1.1	6.0	(0.6)	6.5
Housing	0.0	0.0	(0.5)	(0.5)
Transport, Regen & Climate	(2.1)	2.1	(0.6)	(0.5)
Economic Dev't & Skills	(0.1)	0.0	0.0	(0.1)
Waste & Street Scene	(3.3)	0.4	2.6	(0.4)
Communities Parks & Leisure	(1.2)	0.4	0.3	(0.5)
Strategy & Resources	(1.0)	2.3	(0.4)	0.9
Total	**(7.0)**	**20.6**	**3.4**	**17.1**

£7.0m of one-off savings are mitigating part of the ongoing overspend

Contributions from provisions for energy and waste inflation mitigate the in-year impact of rising baseline costs. These are one-off contributions that will not help our position in 23/24 as the trend continues.

The government's Autumn Statement only gives us protection on the energy price cap on current rates until the end of the financial year. There has been a drop in wholesale prices recently, forecasters expect this to result in a fall in prices by Q3 2023 but are still likely to remain higher than pre-pandemic levels.

Balancing the 22/23 budget was only possible with £53m of BIPs, £32m are reported as deliverable in year

Budget Savings Delivery Forecast @M8 £m	Total Savings 22/23	Deliverable in year	FY Variance
Portfolio			
People	37.7	22.3	15.4
Operational Services	7.1	4.0	3.1
PPC	1.2	0.9	0.3
Resources	6.7	4.9	1.8
Total	**52.7**	**32.1**	**20.6**

Focus must be on delivering BIPs in 22/23 and preventing the

Of the £32m BIPs forecast as being deliverable, £10m are rated red, which indicates considerable risk that these will not be delivered in full which would increase the existing forecast overspend.

budget gap from widening	Of the £20.6m savings that are forecast to be undelivered this year, some can be delivered next financial year. It is estimated that £12m of this year's undelivered savings will still be unachievable in 23/24.
Adult Health and Social Care are forecast to overspend by £11.6m	The high cost of packages of care put in place during covid has increased our baseline costs into 22/23. Work is underway as part of an investment plan with additional resource to tackle the underlying issues although recruitment issues are impacting our ability to deliver. The committee position was fairly stable from M7 to M8; purchasing budgets in Older People's and Physical Disabilities improved whereas Learning Disabilities expenditure continues to rise, this month increasing by a further £350k.
Education, Children and Families are forecast to overspend by £6.6m	Forecast under-delivery of budget implementation plans in the service are the main cause of overspends; plans to reduce staffing and increase income from Health are looking unlikely and the residential children's home strategy looks unlikely to deliver financial benefits. The committee's financial position declined in M8 by £0.2m from M7 mainly due to a reduction to the Aldine House income by a further £0.5m due to delays in a management appointment in the service that has limited capacity in the setting. There has also been an adverse movement in Special Educational Needs transport of £0.5m. Improvements in staffing forecasts across the service have partly offset these larger overspends.

1.4 Adult Health & Social Care- £11.6m overspend at Month 8

The revenue outturn position for the AHS&C Committee is to overspend by £11.6m

Full Year Forecast £m @ Month 8	Outturn	Budget	Variance
Adult Health & Social Care Integrated Commissioning (Early Help and Prevention - Partnership Funding; Supporting Vulnerable People - Housing Related Support/Drugs and Alcohol Services)	156.2 9.0	144.6 9.0	(11.6) 0.0
Total	**165.2**	**153.6**	**(11.6)**

The committee position was stable from M7 to M8.

The majority of the committee overspend relates to undelivered savings (BIPs)

Variance Analysis £m @ Month 8	One-off	BIPs	Trend
Adult Health & Social Care	(0.4)	9.4	2.6
Integrated Commissioning	0.0	0.0	0.0
Total	**(0.4)**	**9.4**	**2.6**

£9.4m of the overspend relates to BIP shortfalls. Staffing is £2m overspent.

Purchasing activities are overspent by £8.7m

PURCHASING POSITION @M8	OUTTURN	BUDGET	VARIANCE	M7 VARIANCE	MOVEMENT
OLDER PEOPLE	33.8	31.2	2.7	2.9	-0.3
LEARNING DISABILITIES	35.0	28.0	6.9	6.6	0.3
PHYSICAL DISABILITIES	15.3	16.6	-1.3	-1.0	-0.3
MENTAL HEALTH	9.2	9.0	0.2	0.2	0.0
	93.3	**84.8**	**8.5**	**8.7**	**-0.2**

The pay award created a £0.7m pressure for the committee

The pay award of £1,925 flat rate per employee was paid to employees in M8, including backpay, unwinding the provision made into forecasts in M4. The award impacted the Committee spend by £0.7m.

The committee position was stable from M7 to M8

Purchasing activity overall reduced by 200k this month but with a further adverse movement in Learning Disability which is now £6.9m overspent against budget.

BIP delivery for 22/23 is looking challenging, focus needs to be on reviewing high-cost packages put in place during covid

Over £11m of the BIP savings required for 22/23 relate to reviewing high-cost packages of care put in place during the pandemic.

Work is underway as part of an investment plan with additional resource to tackle the underlying issue although recruitment issues is impacting on deliverability.

Recruitment and retention difficulties continue to impact

Vacancies which are part of the investment plan are not fully recruited to.

savings delivery in 22/23, but with the potential to increase staffing pressure in future years	If posts are filled, the £1.8m current employee overspend would increase but an improvement in BIP delivery would be expected. However, some elements of the investment plan funding employees are time limited with c.£2m due to be removed from staffing budgets over the next 2 financial years. A Target Operating Model is being worked on and it is anticipated to arrive at an optimum staffing establishment level but will need to consider the level of permanent funding available.
Home care continues to be a huge challenge	Increased cost and size of packages following the pandemic continues to be an underlying issue. The market is also suffering from staff recruitment and retention problems resulting in a lack of capacity. Pre-covid pandemic, there were 10 clients on average with packages costing over £1,000/week. Numbers are still staying at around 70 clients. This shows that whilst reviews are reducing the original cohort of high-cost home care put in place during the pandemic, these are being replaced by a similar number of equally expensive packages.
Fair Cost of Care Exercise and Social Care Reform will increase Adult Social Care responsibilities and costs	Fair Cost of Care is to determine an appropriate fee level on over-65 Care Homes and Homecare delivery. SCC are currently an average to low payer when benchmarked against other Local Authorities which indicates the potential to have to increase rates above current forecast levels. Any grant allocated is unlikely to fully cover the cost of those increases. Social Care Reform will levy significant new responsibilities on Local Authorities and introduces a cap on care costs. The grant allocated is unlikely to fully cover the costs of those increases or the required increase staffing base needed to deliver our new responsibilities.

2. HOW DOES THIS DECISION CONTRIBUTE?

2.1 The recommendations in this report are that each Policy Committee undertakes any work required to both balance their 2022/23 budget and prepare for the 2023/24 budget.

3. HAS THERE BEEN ANY CONSULTATION?

3.1 There has been no consultation on this report, however, it is anticipated that the budget process itself will involve significant consultation as the Policy Committees develop their budget proposals

4. RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

4.1 Equality Implications

4.1.1 There are no direct equality implications arising from this report. It is expected that individual Committees will use equality impact analyses as a basis for the development of their budget proposals in due course.

4.2 Financial and Commercial Implications

4.2.1 There are no direct financial implications from this report.

4.3 Legal Implications

4.3.1 Under section 25 of the Local Government Act 2003, the Chief Finance Officer of an authority is required to report on the following matters:

- the robustness of the estimates made for the purposes of determining its budget requirement for the forthcoming year; and
- the adequacy of the proposed financial reserves.

4.3.2 There is also a requirement for the authority to have regard to the report of the Chief Finance Officer when making decisions on its budget requirement and level of financial reserves.

4.3.3 By the law, the Council must set and deliver a balanced budget, which is a financial plan based on sound assumptions which shows how income will equal spend over the short- and medium-term. This can take into account deliverable cost savings and/or local income growth strategies as well as useable reserves. However, a budget will not be balanced where it reduces reserves to unacceptably low levels and regard must be had to any report of the Chief Finance Officer on the required level of reserves under section 25 of the Local Government Act 2003, which sets obligations of adequacy on controlled reserves.

4.4 Climate Implications

4.4.1 There are no direct climate implications arising from this report. It is expected that individual Committees will consider climate implications as they develop their budget proposals in due course.

4.4 Other Implications

4.4.1 No direct implication

5. ALTERNATIVE OPTIONS CONSIDERED

5.1 The Council is required to both set a balance budget and to ensure that in-year income and expenditure are balanced. No other alternatives were considered.

6. REASONS FOR RECOMMENDATIONS

6.1 This paper is to bring the committee up to date with the Council's current financial position as at Month 8 2022/23

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Report to Policy Committee

Author/Lead Officer of Report: Louisa King, Head of Commissioning – Mental Health, Learning Disabilities, Dementia and Autism, NHS South Yorkshire ICB (Sheffield)

Tel: 0114 305 1402

Report of:	Alexis Chappell, Director of Adult Health and Social Care Dr Steve Thomas, Clinical Director – Mental Health, Learning Disabilities, Dementia and Autism, NHS South Yorkshire ICB (Sheffield)
Report to:	Adult Health and Social Care Committee
Date of Decision:	8 February 2023
Subject:	Sheffield All-Age Mental and Emotional Health and Wellbeing Strategy

Has an Equality Impact Assessment (EIA) been undertaken? If YES, what EIA reference number has it been given? 560	Yes	x	No		
Has appropriate consultation taken place?	Yes	x	No		
Has a Climate Impact Assessment (CIA) been undertaken?	Yes		No	x	
Does the report contain confidential or exempt information?	Yes		No	x	

Purpose of Report:

The Sheffield All-Age Mental and Emotional Health and Wellbeing Strategy sets the scene for supporting Sheffield people – from young to old – with their emotional health and mental wellbeing. It is positive, ambitious, and focussed on delivering change in partnership and collaboration across Sheffield.

The strategy will be underpinned by an annually updated delivery plan which will have clear objectives and outcomes anticipated. This will be a partnership document, and a range of organisations will continue together to the delivery of the strategy's objectives.

Recommendations:

It is recommended that the Adult Health and Social Care Policy Committee:

- Endorse the All-Age Mental and Emotional Health and Wellbeing Strategy and note that approval will be sought through the Strategy and Resources Committee.
- Request that an accompanying delivery plan is brought to the committee in six months' time, along with an update of progress made.

Background Papers:

None

Appendices:

Appendix 1 – Sheffield All-Age Mental and Emotional Health and Wellbeing Strategy
Appendix 2 – Equality Impact Assessment

Lead Officer to complete:-		
1	I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.	Finance: *Liz Gough*
		Legal: *Patrick Chisholm*
		Equalities & Consultation: *Ed Sexton*
		Climate: *Jessica Rick*
	Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.	

2	**SLB member who approved submission:**	*Alexis Chappell*
3	**Committee Chair consulted:**	*Councillors George Lindars Hammond and Angela Argenzio*
4	I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Committee by the SLB member indicated at 2. In addition, any additional forms have been completed and signed off as required at 1.	
	Lead Officer Name: *Tim Gollins,* *Louisa King*	**Job Title:** *Assistant Director Access, Mental Health and Wellbeing* *Head of Commissioning*
	Date: 16th January 2023.	

1. PROPOSAL

1.1 In line with our City wide strategies it's our collective vision that citizens of Sheffield experience "*Good emotional and mental health and wellbeing, for all, at every stage of life."*

1.2 The Sheffield All-Age Emotional Health and Mental Wellbeing Strategy (set out in full at Appendix 1) sets the scene for supporting Sheffield people – from young to old – with their emotional and mental health and wellbeing. It promotes and enables partnership working across Sheffield, regionally and nationally to create the foundations and conditions for delivering upon our vision.

1.3 The scale of mental and emotional health and wellbeing need in Sheffield is great. We know that 138,000 children, young people and adults in Sheffield will experience a health problem each year and it is estimated that 15,000 children and young people live with a parent who lives with a mental health disorder. Many will be young carers.

1.4 The proportion of homeless people in Sheffield with a diagnosed mental health condition (63%) is over double that of the general population (around 25%). In addition, there are approximately 7,000 people living with dementia in Sheffield – just over 1% of the whole city's population

1.5 Nationally, Mental ill health represents 28% of ill health that the NHS deals with and is the largest single cause of disability. Half of all mental health problems are established by the age of 14, rising to 75 per cent by age 24 and one in four 17- to 19-year-olds in England had a probable mental disorder in 2022 - up from one in six in 2021.

1.6 Many of those who have severe and enduring mental illness in adulthood are diagnosed when they are children or young people. We know that we need to act now to provide early support from young to old with their emotional and mental health otherwise we risk the following: -

- Risk of suicide - Yorkshire and Bassetlaw has a higher suicide rate than the England average.
- Inequality - Rates of detention under the Mental Health Act were over four times higher for Black/Black British ethnicity than White British ethnicity.
- Job Loss - 300,000 people in work with a long-term mental health condition lose their jobs every year.
- Higher Mortality - The average life expectancy for someone with a long-term mental health illness is at least 15-20 years shorter than for someone without (from preventable causation).
- Impact of Covid 19 - To respond to the significant increase in emotional and mental health concerns associated with Covid-19, but also, more broadly, by many years of structural inequalities across our communities, not helped by cost-of-living crises.

1.7 There are no easy solutions to these difficulties – but this strategy presents a real opportunity to work together to deliver new ways of working. It is positive, ambitious, and focussed on delivering real change for the benefit of individuals and family members across Sheffield around the following seven outcomes:

- Mental and emotional health and wellbeing are at the heart of all we do as a city
- Mental and emotional health and wellbeing is valued the same as physical health
- Mental wellness, resilience and the prevention of illness are promoted at the earliest opportunity
- Discrimination and inequalities that lead to poor health and mortality are tackled
- Children and young people's emotional health and wellbeing is a top priority
- The right care and support are provided at the right time and as close to home as possible
- People are recovering from mental illness and are able to live healthy and fulfilled lives

1.8 Improving and protecting the mental health of Sheffield is something no single person or organisation can do alone, and in this strategy, we want to provide a framework for professionals to work together. We need our services to be excellent, joined up, and to support people in the right way. Working in partnership, we know we can begin to make the changes we need.

1.9 To that end, the Strategy is focused around 4 main delivery areas:

- Addressing the wider determinants of health
- Supporting the mental and emotional health and wellbeing of our children and young people
- Provide earlier help to people who need it
- Provide effective and good quality care and treatment services

1.10 Enablers such as workforce planning, technology enabled care and our focus on equalities and inclusion will underpin each of the delivery areas.

1.11 To ensure delivery upon the Strategy, an annually updated delivery plan will be maintained with clear objectives and outcomes anticipated. This will be a partnership document, and a range of organisations will continue together to the delivery of the strategy's objectives.

1.12 Governance and oversight of delivery upon the Strategy will be undertaken by the Mental Health Learning Disability Autism Board with proposed six-monthly reporting on updates to the Adult Health and Social Care Policy Committee to assure the public, citizens, and members that the strategy is achieving its intended outcomes.

2. HOW DOES THIS DECISION CONTRIBUTE?

2.1 The strategy aligns with several other strategies and advice, including:

- Sheffield's Joint Health and Wellbeing Strategy
- Sheffield's Joint Strategic Needs Assessment and Covid Rapid Health Impact Assessment for Mental Health
- Sheffield's Adult Health and Social Care Strategy and Mental Health Market Position Statement
- Sheffield Children's Hospital's Clinical Strategy
- Sheffield Health and Social Care Trust's Clinical and Social Care Strategy
- Sheffield's Dementia Strategy Commitments
- Sheffield's Race Equality Commission
- Sheffield's Domestic and Sexual Abuse Strategy
- Sheffield Suicide Prevention Action Plan
- South Yorkshire and Bassetlaw Integrated Care System Mental Health Plan
- NHS England's Five Year Forward View for Mental Health
- LGA - Must know: Is your council doing all it can to improve mental health?
- Sheffield City Council Youth Services Strategy 2022 to 2025

3. HAS THERE BEEN ANY CONSULTATION?

3.1 A significant amount of consultation and engagement has gone into developing this strategy since 2019.

- We co-produced the approach to developing the strategy
- We hosted consultation events with a range of individuals, groups, and partners, including with children and young people,
- We looked at what the numbers tell us about people's mental and emotional health and wellbeing in Sheffield
- We made sure we aligned our strategy with other organisation's strategies and the things they had learned from their consultation events
- We invited and received comments on the final draft from a range of partners, including Experts by Experience.
- We talked to Elected Members at a joint briefing on 11th January 2023

to gain members views about the Strategy.

3.2 The MHLDDA Board has voluntary sector organisations sitting on its membership, with clear connections to Experts by Experience.

3.3 It is a priority of the Board to see strong consultation and engagement carried out in all commissioning exercises, and for co-production to be an increasing feature of this commissioning landscape.

4. RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

4.1 Equality Implications

4.1.1 An Equalities Impact Assessment (EIA) has been completed (Appendix 2), but the impact on Sheffield people of setting out our aims in this way can only be a positive one. There continues to be significant areas of improvement needed in this area. The Commission for Equality in Mental Health report 2020 stated that:

- People within black and African-Caribbean communities may be more likely to experience post-traumatic stress disorder, schizophrenia, and suicide risk, and to be sectioned under the Mental Health Act.
- Women are significantly more likely to experience physical or sexual abuse and associated mental health problems.
- LGBTQ+ people are more likely to face mental ill health but have lower IAPT recovery rates.
- People with autism and deaf people are much more likely to experience poor mental health.
- There are strong associations between mental ill health and children and adults living in higher deprivation areas (and similar lower IAPT recovery rates).
- People over the age of 65 may be less likely to be recognized as needing therapy support.

4.2 Financial and Commercial Implications

4.2.1 There are no short term financial and commercial implications associated with approving this strategy. All individual projects will be assessed for their affordability and viability, and financial and commercial implications will be reported and recorded as part of the approval process.

4.3 Legal Implications

4.3.1 There are no direct legal implications associated with endorsing this strategy. Clearly, partner organisations when making decisions in this field will need to give due consideration of legal implications, and these will be reported and recorded as part of the approval process by partner organisations.

4.3.2 The Care Act 2014 sets the Council's statutory power to direct the provision that:

- promotes wellbeing
- prevents the need for care and support
- protects adults from abuse and neglect (safeguarding)
- promotes health and care integration
- provides information and advice
- promotes diversity and quality.

4.3.2 The Care Act Statutory Guidance requires at para 4.52 that "… Local authorities should have in place published strategies that include plans that show how their legislative duties, corporate plans, analysis of local needs and requirements (integrated with the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy), thorough engagement with people, carers and families, market and supply analysis, market structuring and interventions, resource allocations and procurement and contract management activities translate (now and in future) into appropriate high quality services that deliver identified outcomes for the people in their area and address any identified gaps.

4.4 Climate Implications

4.4.1 There are no direct climate implications associated with approving this report. However, Sheffield City Council – and its 10 Point Plan for Climate Action – is a partner on the MHLDDA Board which oversees this strategy.

4.4.2 Many other partner organisations on the board will also have their own climate strategies. The role of large organisations – who form a big plank of the delivery of this strategy – is important in Sheffield tackling the effects of climate change. The commitments of the 10 Point Plan will have a significant impact on people's mental and emotional health and wellbeing.

4.4.3 It's important to recognise climate anxiety is an increasing problem amongst young people: Survey reveals scale of climate anxiety among British children (savethechildren.org.uk). For example:

- ***"Increased numbers of people to travel by walking and cycling increases fitness and health"*** – we know that the average life expectancy for someone with a long-term mental health illness is at least 15-20 years shorter than for someone without (from preventable causation) – improvements in climate and air quality will increase health and wellbeing for all.

- ***"We can reduce biodiversity loss and help mitigate the***

consequences of food shortages and the impacts this will have on our health and food security" – we know that the current cost of living crisis will be having a significant impact on people's emotional health and wellbeing.

4.4.4 By taking action to mitigate and adapt to climate change we will improve outcomes for people and the climate. Specific projects delivered under this plan will conduct project specific CIA's to ensure the climate impacts of delivery are minimised as far as possible.

5. ALTERNATIVE OPTIONS CONSIDERED

5.1 **Do nothing:** It would be possible not to produce a strategy for this area – but it would mean any plans would lack focus, coherence, and public accountability.

6. REASONS FOR RECOMMENDATIONS

6.1 The strategy is a positive development for the city and will enable partner organisations to work together to improve mental and emotional health and wellbeing of individuals and carers across the City.

6.2 Approving the strategy demonstrates the Committee's commitment to partnership working for the benefit of citizens of Sheffield.

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Sheffield All-Age Emotional and Mental Health and Wellbeing Strategy 2023-2026

"Good emotional and mental health and wellbeing, for all, at every stage of life"

healthwatch Sheffield
Primary Care Sheffield
Sheffield City Council
Sheffield Children's NHS Foundation Trust
NHS Sheffield Health and Social Care NHS Foundation Trust
NHS Sheffield Teaching Hospitals NHS Foundation Trust
vas supporting community action
NHS South Yorkshire Integrated Care Board

Contents

Introduction: Why do we need an All-Age Emotional and Mental Health and Wellbeing Strategy for Sheffield?

- **Sheffield needs it:** Good mental health is key for everything, and poor mental health is impacting on the life chances of children, young people and adults in the city. We are seeing a significant increase in emotional and mental health problems associated with Covid-19. But more than this, the city has been impacted by many years of structural inequalities across our communities and underinvestment in our services, not helped by cost of living crises.
- **Our children and young people need it:** Many of those who have severe and enduring mental illness in adulthood are diagnosed when they are children or young people. If we want to act preventatively, we need to act now to support our children, young people and their families – and we know that many are struggling and need targeted help and support.
- **Professionals need it:** Improving and protecting the mental health of Sheffield is something no single person or organisation can do alone – we want to provide a framework for professionals to work together.

This strategy sets out an ambitious vision for the city's emotional recovery and the wellbeing of Sheffield people. We need our services to be excellent, joined up, and to support people in the right way. Working in partnership, we know we can begin to make the changes we need.

Sheffield Mental Health, Learning Disabilities, Dementia and Autism Board

1. What's our vision for emotional and mental health in Sheffield?

"Good emotional and mental health and wellbeing, for all, at every stage of life"

1. Mental and emotional health and wellbeing are at the heart of all we do as a city
2. Mental and emotional health and wellbeing is valued the same as physical health
3. Mental wellness, resilience and the prevention of illness are promoted at the earliest opportunity
4. Discrimination and inequalities that lead to poor health and mortality are tackled
5. Children and young people's emotional health and wellbeing is a top priority
6. The right care and support is provided at the right time and as close to home as possible
7. People are recovering from mental illness and are able to live healthy and fulfilled lives

How did we develop this strategy?

We co-produced the approach to developing the strategy

We hosted consultation events with a range of service users, groups and partners, including with children and young people, and looked at what the numbers tell us about people's mental and emotional health and wellbeing in Sheffield

We made sure we aligned our strategy with other organisation's strategies and the things they had learned from their consultation events

We invited and received comments on the final draft from a range of partners, including Experts by Experience

What have people told us is important to them?

"What will we see that's different?" – public bodies need to communicate what they are doing and how it's making a difference

Less of a focus on 'treatment' and medicine; more of a focus on and investment in resilience, community, education and employment, support for carers and early intervention and prevention

Integrated services and funding that are high quality, local where possible, are culturally appropriate, easy to access, put people first and connect up physical and mental health

Campaigns and education; that the city is comfortable and professionals trained to talk about mental health

Greater response to the increasing complexity of need and demand for support – especially with cost of living crises

That services recognise the trauma people may have experienced and support those who have experienced disadvantage

Commissioning approaches must change to enable innovation and creativity

What do we know about local need?

Mental ill health represents 28% of ill health that the NHS deals with and is the largest single cause of disability. However, only 13% of England's health budget is spent on mental health

138,000 children, young people and adults in Sheffield will experience a mental health problem each year. Half of all mental health problems are established by the age of 14, rising to 75 per cent by age 24

One in four 17-19-year-olds in England had a probable mental disorder in 2022 (up from one in six in 2021). Positively, uptake from BAME communities using the Kooth service increased from 17% in 2020 to over 23% in 2022 due to targeted local engagement work

It is estimated that up to 20% of women will experience mental health problems during the perinatal period

It is estimated that 15,000 Sheffield children and young people live with a parent who lives with a mental health disorder. Many will be young carers

An estimated 1.25 million people have an eating disorder in the UK, and they can be complex and life-threatening mental illnesses

The proportion of homeless people in Sheffield with a diagnosed mental health condition (63%) is over double that of the general population (around 25%)

South Yorkshire and Bassetlaw has a higher suicide rate than the England average

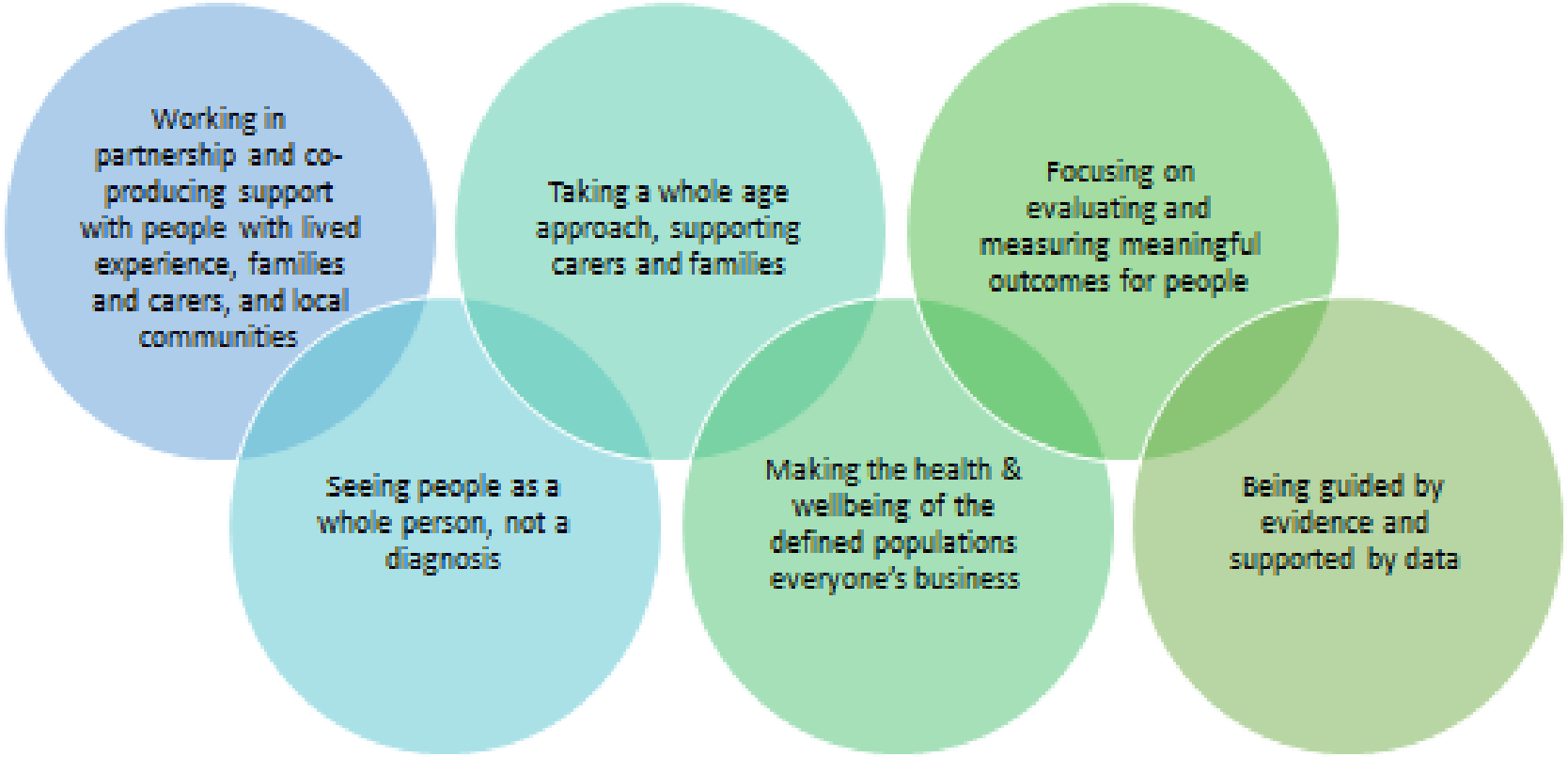
In England in 2017/18, rates of detention under the Mental Health Act were over four times higher for Black/Black British ethnicity than White British ethnicity

300,000 people in work with a long term mental health condition lose their jobs every year

The average life expectancy for someone with a long-term mental health illness is at least 15-20 years shorter than for someone without (from preventable causation)

There are approximately 7,000 people living with dementia in Sheffield – just over 1% of the whole city's population

2. What principles are important for us?



"Good emotional and mental health and wellbeing, for all, at every stage of life"

3. What are our four key strategic priorities in this strategy?

1

Address the wider determinants of health

Links to Joint Health and Wellbeing Strategy theme: Live Well and Age Well
Links to Adult Social Care Strategy theme: Safe and Well, Connected and Engaged
Links to ICB Mental Health and Employment Workstream

2

Support the emotional and mental health and wellbeing of our children and young people

Links to Joint Health and Wellbeing Strategy theme: Start Well and Live Well
Links to ICB CYP MH Strategic Plan and Crisis Pathways

3

Provide earlier help to people who need it

Links to Joint Health and Wellbeing Strategy theme: Live Well and Age Well
Links to Adult Social Care Strategy theme: Safe and Well, Active and Independent
Links to ICB Suicide Prevention Workstream

4

Provide effective and good quality care and treatment services

Links to Joint Health and Wellbeing Strategy theme: Live Well and Age Well
Links to Adult Social Care Strategy theme: Safe and Well, Active and Independent, Aspire and Achieve, Efficient and Effective
Links to ICB Perinatal Mental Health Workstream

1. Address the wider determinants of health

We will:

- Improve awareness in the wider population and workforce to support good emotional health and wellbeing and reduce stigma, including through compassionate approaches which recognise the trauma some people have experienced
- Enable employment and training opportunities for people with mental health conditions and help employers look after the wellbeing people who are in work
- Connect to wider programmes and public policy which tackle poverty and inequality, such as housing, education and skills
- See the value of the contribution made by the voluntary, community, social enterprise sector and faith and community groups and recognising the support of community-based support which combats isolation and supports connection and recovery

2. Support the emotional and mental health and wellbeing of our children and young people

We will:

- Develop support for infant mental health and peri/prenatal services to give children a great start in life and support their and their family's attachment, attunement and attainment

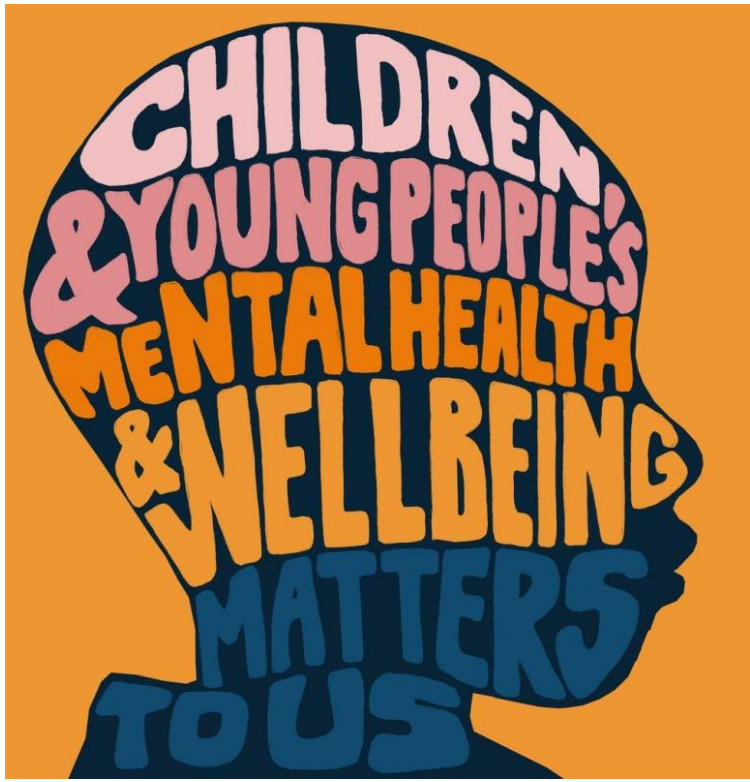
- Increase early intervention and targeted support for school-age children, and give schools and other professionals the tools they need to support to children's emotional health, wellbeing and resilience

- Provide intensive outreach and home treatment services, and better, earlier crisis care including safe space alternatives to A&E and approaches to support suicide prevention and awareness

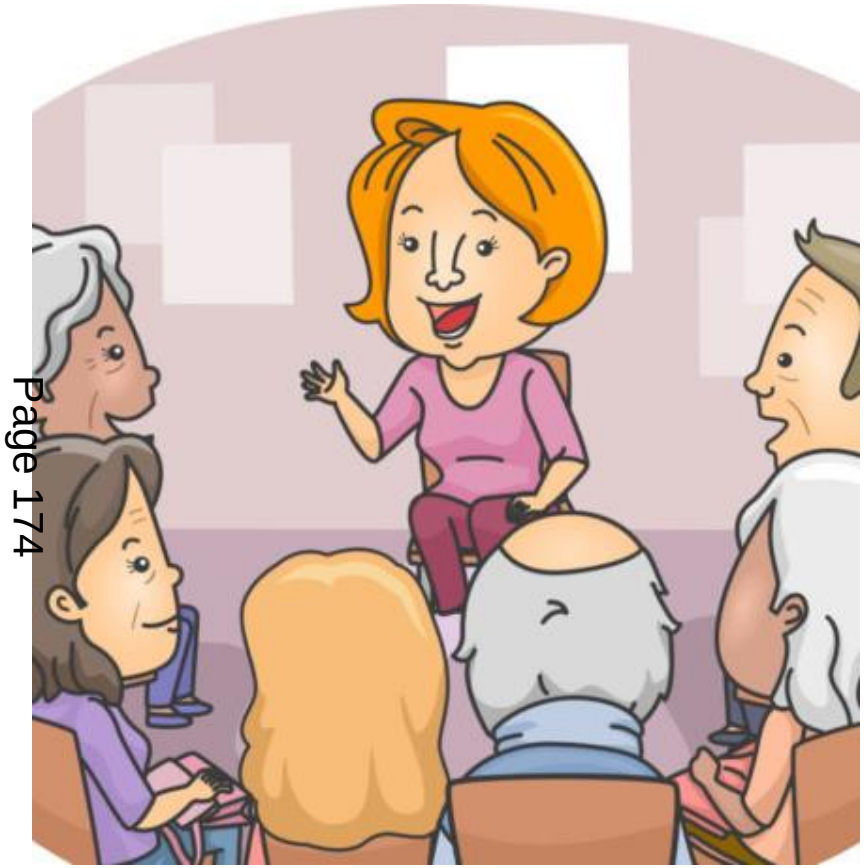
- Work in partnership with the provider collaborative to reduce avoidable admission to inpatient care

- Support young people to receive developmentally appropriate care as they grow into young adults and ensure clear service pathways are in place that work for them especially for those aged 16-25

- Protect and safeguard children and young people from exploitation and abuse



3. Provide earlier help to people who need it



We will:

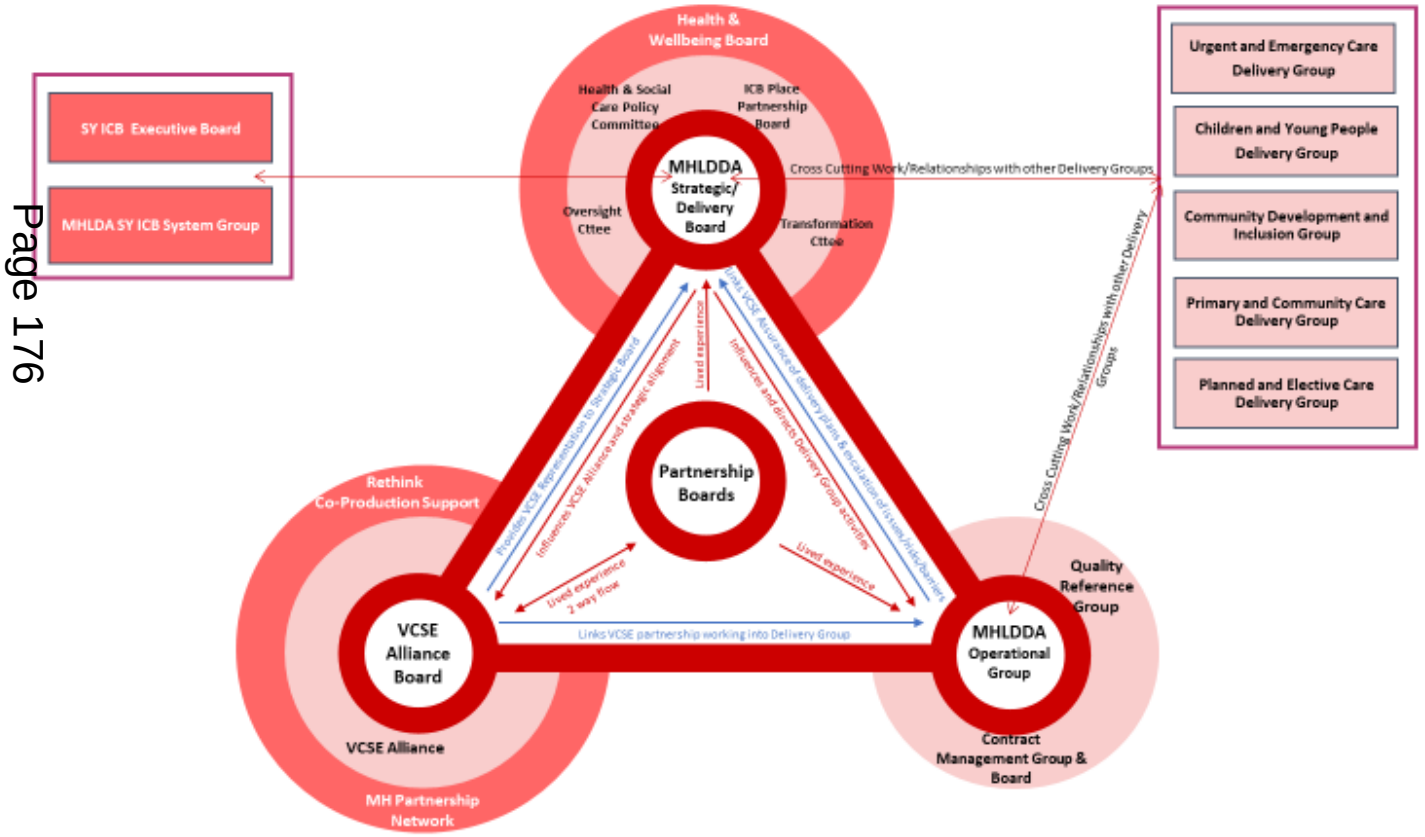
- Transform community based and primary care mental health provision to make it easier to get help
- Expand access to talking therapies and increase the range of different therapies available
- Provide better, more joined up, whole-family support to carers and families at the earliest point
- Intervene and promote resilience for our children, young people and adults at an early stage

4. Provide effective and good quality care and treatment services

We will:

- Transform our crisis response services including home treatment, earlier support, access to crisis ‘buddies’, and alternatives to A&E such as crisis cafes and safe spaces
- Improve inpatient care and our inpatient facilities, and invest in training and workforce
- Provide effective and purposeful reviews of care to support people in their journey of recovery and independence
- Continue to review presenting priorities within the Sheffield population and invest to meet this need
- Work in concert with the provider collaboratives to ensure clear areas of responsibility and service pathways
- Ensure that the accommodation services we commission help people to live as independently as possible in the community

4. How will we will monitor our strategy?



- Working in partnership is really important to us. Each and every partner has a critical part to play in this system, and the latest NHS reforms have solidified the importance of **partnership in strategic commissioning**
- Over the last few years we have especially been developing our partnership with the **voluntary and community sector** who play a crucial role both helping people in their communities and in supporting people to have their voice in the decision-making process. The **Mental Health Partnership Network**, **Mental Health Alliance,** and **Mental Health Collaborative** provide opportunities for voluntary sector provider organisations and service users to feed into service planning, commissioning and delivery
- We will be developing a **delivery plan with outcomes for this strategy** which will be overseen by a **delivery group**, reporting to the **Mental Health, Learning Disabilities, Dementia and Autism (MHLDDA) Board**. These groups have a range of partners on them, working together to bring about change for Sheffield
- The MHLDDA Board feeds up to other city-wide boards, including the **Health and Care Partnership Board** and the **Health and Wellbeing Board** - as well as South-Yorkshire-wide boards, which the diagram to the left explains

5. What links are there to other strategies in Sheffield?

We have drawn upon a number of other strategies to build our plan, including:

- Sheffield's Joint Health and Wellbeing Strategy
- Sheffield's Joint Strategic Needs Assessment and Covid Rapid Health Impact Assessment for Mental Health
- Sheffield's Adult Health and Social Care Strategy and Mental Health Market Position Statement
- Sheffield Children's Hospital's Clinical Strategy
- Sheffield Health and Social Care Trust's Clinical and Social Care Strategy
- Sheffield's Dementia Strategy Commitments
- Sheffield's Domestic and Sexual Abuse Strategy
- Sheffield's Race Equality Commission
- Sheffield Suicide Prevention Action Plan
- South Yorkshire and Bassetlaw Integrated Care System Mental Health Plan and reports from consultation with children and young people
- NHS England's Five Year Forward View for Mental Health

We will make links to the city's Learning Disabilities Strategy, Autism Strategy, and regional strategies when these are complete

Appendix: Mental Health, Learning Disabilities, Dementia and Autism Board members (December 2022)

Organisation	MHLDDA Membership	Role
SCC	Alexis Chappell	Director Adult Social Care
SCC	Joe Horobin	Director of Commissioning
SCC	Cllr Angela Argenzio Cllr George Lindars-Hammond	Co-Chairs Health & Social Care Policy Committee
SCC	Dr Eleanor Rutter	Consultant in Public Health
SCC	Sally Williams	Director Children & Families
SCC	Dawn Shaw	Director of Communities
Healthwatch	Lucy Davies	Chief Officer
VCF	TBC (Margaret Lewis CEO Mind interim)	Mental Health Partnership Network
VAS	Helen Steers	Director of Strategic Partnerships
LD Partnership Board	Andrew Wheawall	Chair
Autism Partnership Board	Alexis Chappell	Chair
Sheffield Psychology Board	Dr Johann Labuschagne	Chair of Sheffield Psychology Board & Head of Psychological Services STH
Student H&WB Partnership Board	Nicola Rawlins	Chair
SHSC	Dr Linda Wilkinson	Director of Psychological Services
SHSC	Beverley Murphy	Director of Nursing, Professions and Operations
SHSC	Pat Keeling	Director of Strategy
SHSC	Hassan Mahmood	Consultant Psychiatrist and Clinical Director for the Learning Disability Service
SHSC	Mike Hunter	Medical Director
SCH	Dr Jeff Perring	Medical Director SCH
SCH	Dr Shatha Shibib	Clinical Director CAMHS
STH	Prof Mark Cobb	Clinical Director
STH	Dr Avril Kuhrt	Associate Medical Director for Mental Health, Learning Disabilities and Autism
PCS	Nicky Doherty	Deputy Chief Executive
NHS Sheffield	Sandie Buchan	Director of Commissioning Development (Co- chair)
NHS Sheffield	Dr Steve Thomas	Clinical Director Mental Health, LD, Dementia & Autism Commissioning Portfolio (Chair)
NHS Sheffield	Dr Anthony Gore	Clinical Director CYP Portfolio
NHS Sheffield	Heather Burns	Deputy Director of Mental Health Transformation
NHS Sheffield	Chris Cotton	Management Accountant
HCP	Kathryn Robertshaw	Interim Director
In Attendance		
NHS Sheffield	Kate Gleave	Deputy Director Commissioning & CYP
SCC	Tim Gollins	Assistant Director (Mental Health)
SCC	Andrew Wheawall	Assistant Director (Learning Disabilities)
NHS Sheffield	Louisa King	Head of Commissioning MHLDDA
NHS Sheffield	Business Support	Business Support
LMC	LMC Chair/Secretary	Sheffield Local Medical Committee (Receive Documents)
SY ICB	Wendy Lowder	Executive Director (MHLDDA Responsibility)
SY MH Learning Disability Autism Alliance	Marie Purdue	Managing Director
SY Provider Collaborative	Michelle Fearon Dr Vinaya Bhagat	Director Clinical Director

Equality Impact Assessment Number - 560

Part A

Initial Impact Assessment

Proposal name

Sheffield All-Age Mental and Emotional Health and Wellbeing Strategy

Brief aim(s) of the proposal and the outcome(s) you want to achieve

Sheffield's All-Age Mental and Emotional Health and Wellbeing Strategy sets the scene for supporting Sheffield people – from young to old – with their mental and emotional health and wellbeing. It is positive, ambitious, and focussed on delivering change in partnership.

Good mental health is key for everything, and poor mental health is impacting on the life chances of children, young people and adults in the city. We know that we need to act now to support our children, young people and their families.

This strategy is a strategy sponsored by the Mental Health, Learning Disabilities, Dementia and Autism (MHLDDA) Board, which sits under the Health and Care Partnership structures in Sheffield, part of South Yorkshire's Integrated Care System. The strategy will be underpinned by an annually updated delivery plan which will have clear objectives and outcomes anticipated. This will be a partnership document, and a range of organisations will continue together to the delivery of the strategy's objectives. The MHLDDA Board will oversee this process.

Proposal type

○ Budget ● Non Budget

If Budget, is it Entered on Q Tier?

○ Yes ○ No

If yes what is the Q Tier reference

Year of proposal (s)

○ 21/22	○ 23/23	● 23/24	○ 24/25	○ other

Decision Type

○ Coop Exec
● Committee (e.g. Health Committee)
○ Leader
○ Individual Coop Exec Member
○ Executive Director/Director
○ Officer Decisions (Non-Key)
○ Council (e.g. Budget and Housing Revenue Account)
○ Regulatory Committees (e.g. Licensing Committee)

Lead Committee Member

Cllrs Lindars-Hammond, Argenzio, Ayris

Lead Director for Proposal

Alexis Chappell

Person filling in this EIA form

Louisa King

EIA start date 8/2/2023

Equality Lead Officer

○ Adele Robinson	○ Beverley Law
○ Annemarie Johnston	● Ed Sexton
○ Bashir Khan	○ Louise Nunn

Lead Equality Objective (see for detail)

○ Understanding Communities	○ Workforce Diversity	○ Leading the city in celebrating & promoting inclusion	● Break the cycle and improve life chances

Portfolio, Service and Team

Is this Cross-Portfolio

● Yes ○ No

Portfolio

People – but all portfolios affected/potentially have a role

Is the EIA joint with another organisation (eg NHS)?

● Yes ○ No Please specify ICB

Consultation

Is consultation required (Read the guidance in relation to this area)

○ Yes ● No

If consultation is not required please state why

Has already been carried out

Are Staff who may be affected by these proposals aware of them

○ Yes ○ No

Are Customers who may be affected by these proposals aware of them

○ Yes ○ No

If you have said no to either please say why

N/A

Initial Impact

Under the Public Sector Equality Duty we have to pay due regard to the need to:
• eliminate discrimination, harassment and victimisation
• advance equality of opportunity
• foster good relations

For a range of people who share protected characteristics, more information is available on the Council website including the Community Knowledge Profiles.

Identify Impacts

Identify which characteristic the proposal has an impact on tick all that apply

● Health	● Transgender
● Age	● Carers
● Disability	● Voluntary/Community & Faith Sectors
● Pregnancy/Maternity	○ Cohesion
● Race	● Partners
○ Religion/Belief	○ Poverty & Financial Inclusion
○ Sex	○ Armed Forces
○ Sexual Orientation	○ Other
○ Cumulative	

Cumulative Impact

Does the Proposal have a cumulative impact
○ Yes ● No

○ Year on Year	○ Across a Community of Identity/Interest
○ Geographical Area	○ Other

If yes, details of impact

Proposal has geographical impact across Sheffield
○ Yes ○ No

If Yes, details of geographical impact across Sheffield

Local Area Committee Area(s) impacted
○ All ○ Specific

If Specific, name of Local Committee Area(s) impacted

Initial Impact Overview

Based on the information about the proposal what will the overall equality impact?

Positive – strategy will set in motion partnership working in a range of areas that will be positive. However, specific plans are not included in this strategy as it is high-level, and so it will be difficult to give specific impacts on protected characteristics. Full EIAs will be carried out by those organisations who are delivering elements of the strategy.

Is a Full impact Assessment required at this stage? ○ Yes ● No

If the impact is more than minor, in that it will impact on a particular protected characteristic you must complete a full impact assessment below.

Initial Impact Sign Off

EIAs must be agreed and signed off by the Equality lead Officer in your Portfolio or corporately. Has this been signed off?

○ Yes ○ No

Date agreed DD/MM/YYYY Name of EIA lead officer

Part B

Full Impact Assessment

Health

Does the Proposal have a significant impact on health and well-being (including effects on the wider determinants of health)?

○ Yes ○ No *if Yes, complete section below*

Staff
○ Yes ○ No

Customers
○ Yes ○ No

Details of impact

Comprehensive Health Impact Assessment being completed

○ Yes ○ No

Please attach health impact assessment as a supporting document below.

Public Health Leads has signed off the health impact(s) of this EIA

○ Yes ○ N

Name of Health Lead Officer

Age

Impact on Staff
○ **Yes** ○ No

Impact on Customers
○ **Yes** ○ **No**

Details of impact

Disability

Impact on Staff
○ Yes ○ No

Impact on Customers
○ Yes ○ No

Details of impact

Pregnancy/Maternity

Impact on Staff
○ Yes ○ No

Impact on Customers
○ Yes ○ No

Details of impact

Race

Impact on Staff
○ Yes ○ No

Impact on Customers
○ Yes ○ No

Details of impact

Religion/Belief

Impact on Staff
○ Yes ○ No

Impact on Customers
○ Yes ○ No

Details of impact

Sex

Impact on Staff
○ Yes ○ No

Impact on Customers
○ Yes ○ No

Details of impact

Sexual Orientation

Impact on Staff
○ Yes ○ No

Impact on Customers
○ Yes ○ No

Details of impact

Gender Reassignment (Transgender)

Impact on Staff **Impact on Customers**

○ Yes ○ No ○ Yes ○ No

Details of impact

Carers

Impact on Staff **Impact on Customers**
○ Yes ○ No ○ Yes ○ No

Details of impact

Poverty & Financial Inclusion

Impact on Staff **Impact on Customers**
○ Yes ○ No ○ Yes ○ No

Please explain the impact

Cohesion

Staff **Customers**
○ Yes ○ No ○ Yes ○ No

Details of impact

Partners

Impact on Staff
○ Yes ○ No

Impact on Customers
○ Yes ○ No

Details of impact

Armed Forces

Impact on Staff
○ Yes ○ No

Impact on Customers
○ Yes ○ No

Details of impact

Other

Please specify

Impact on Staff
○ Yes ○ No

Impact on Customers
○ Yes ○ No

Details of impact

Action Plan and Supporting Evidence

What actions will you take, please include an Action Plan including timescales

Supporting Evidence (Please detail all your evidence used to support the EIA)

Detail any changes made as a result of the EIA

Following mitigation is there still significant risk of impact on a protected characteristic. ○ Yes ○ No

If yes, the EIA will need corporate escalation? Please explain below

Sign Off

EIAs must be agreed and signed off by the Equality lead Officer in your Portfolio or corporately. Has this been signed off?

○ Yes ○ No

Date agreed DD/MM/YYYY Name of EIA lead officer

Review Date DD/MM/YYYY

Report to Policy Committee

Author/Lead Officer of Report:
Alexis Chappell, Director Adult Health and Social Care

Contact:

Report of:	Director of Adult Health & Social Care
Report to:	Adult Health and Social Care Policy Committee
Date of Decision:	8th February 2023
Subject:	*Director of Adult Social Services (DASS) Report to Committee*

Has an Equality Impact Assessment (EIA) been undertaken?	Yes	X	No	
If YES, what EIA reference number has it been given?				
Has appropriate consultation taken place?	Yes	X	No	
Has a Climate Impact Assessment (CIA) been undertaken?	Yes	X	No	
Does the report contain confidential or exempt information?	Yes		No	X

If YES, give details as to whether the exemption applies to the full report / part of the report and/or appendices and complete below: -

*"The (**report/appendix**) is not for publication because it contains exempt information under Paragraph (**insert relevant paragraph number**) of Schedule 12A of the Local Government Act 1972 (as amended)."*

Purpose of Report:

This paper provides a Director's update regards the performance and governance of Adult Health and Social Care Services, including progress in meeting DASS accountabilities and delivering on our statutory requirements.

It also provides an update regards Adult Health and Social Care progress in relation to the Council's Delivery Plan and key strategic events and issues on the horizon.

Recommendations

It is recommended that Adult Health and Social Care Policy Committee:

- Notes the Director of Adult Health and Social Care report.
- Notes the attached What Good Looks Like Assurance
- Notes the work underway to prepare for CQC Assurance including review and practice and learning development plan

Background Papers:

Appendix 1 – DASS Responsibilities Overview and Allocation of Officers
Appendix 2 – Council Delivery Plan Update

<table>
<tr><th colspan="4">Lead Officer to complete: -</th></tr>
<tr><td rowspan="4">1</td><td rowspan="4">I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.</td><td colspan="2">Finance: Ann Hardy</td></tr>
<tr><td colspan="2">Legal: Sarah Bennett</td></tr>
<tr><td colspan="2">Equalities & Consultation: Ed Sexton</td></tr>
<tr><td colspan="2">Climate:</td></tr>
<tr><td></td><td colspan="3">Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.</td></tr>
<tr><td>2</td><td>SLB member who approved submission:</td><td colspan="2">Alexis Chappell</td></tr>
<tr><td>3</td><td>Committee Chair consulted:</td><td colspan="2">Councillor George Lindars-Hammond and Councillor Angela Argenzio</td></tr>
<tr><td rowspan="3">4</td><td colspan="3">I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Committee by the SLB member indicated at 2. In addition, any additional forms have been completed and signed off as required at 1.</td></tr>
<tr><td>Lead Officer Name:
Alexis Chappell</td><td colspan="2">Job Title:
Director Adult Health and Social Care</td></tr>
<tr><td colspan="3">Date: 19th January 2023</td></tr>
</table>

1 PROPOSAL

1.1 This report starts as always with a thank you again to all of the social care sector, our teams and partners, who work consistently work well together to deliver the best outcomes for people of the City.

1.2 Following on from the last DASS report, the service has continued to make significant inroads in achieving and delivering upon our vision and our ambition to improve outcomes of people of Sheffield which is described in our strategy[1] and accompanying Delivery Plan[2] - Living the Life You Want to Live.

1.3 Adult Social Care about collaborating with individuals, partners, and our workforce so that we deliver the best outcomes for people and communities of Sheffield. All what we are taking forward in our change programme is to

1.4 Adult Health and Social Care Strategic Update

1.4.1 As we go into 2023 and into year two of our adult social care transformation programme, we would like to say a huge thanks to all in adult social care who are on our journey of change.

1.4.2 In 2022, we built upon the listening conversations which took place in 2021 with our workforce, our partners, the people we support and unpaid carers and from that published our very first Adult Social Care Strategy – Living the Life You Want to Live in March 2022 and an accompanying Delivery Plan in June 2022. This provided us with a framework to take forward a range of developments to improve the lives and outcomes of citizens of Sheffield.

1.4.3 Over the past year, our teams have worked in partnership with colleagues across Sheffield and beyond to deliver on what you and the people we support told us mattered, which includes:

- Co-developing a future design of adult social care, personalisation strategy, co-production and citizens engagement framework and a care governance framework. This includes taking forward the development of a community connected adult care and wellbeing service which is on work in partnership with colleagues across the City to improve outcomes for people, unpaid carers and our workforce.

- Preventing abuse and harm with our partners through co-developing a Multi-Agency Screening Hub, implementing our Safeguarding Delivery Plan and delivering our Changing Futures Programme.

- Supporting and valuing our unpaid carers as a partnership with colleagues across the City through our Carers Delivery Plan and Strategy and Partnership.

- Enabling a shift towards delivering outcomes based, person led and excellent quality social care services through recommissioning of all community-based support (Homecare/ Care and Wellbeing, Support for

[1] Adult Social Care Strategy - Living the life you want to live Sheffield's adult social care vision 2021 to 2030
[2] Adult Social Care Delivery Plan - 11. Appendix 1 - Adult Social Care Delivery Plan.pdf (sheffield.gov.uk)

Working Age Adults, support for people experiencing Mental Ill Health and our Care at Night Services) over this year so that we have new long term arrangements in place from June 2023 and implementing our new Market Shaping Statement, Sustainability Plan, a Mental Health Market Shaping Statement and a Housing with Support Market Position Statement for people with a learning disability and/ or autism.

- Enabling people to live independently through promoting technology enabled care with key projects such as the Happiness Project, our Equipment and Adaptations Criteria and development of a new information and advice self-help hub – Our Sheffield Directory and Digital Strategy will be launched in 2023 along with key projects which further embed our use of digital technologies to enable people to live healthy, independent lives and more easily find out about our services, supports on offer and what we do.

- Working in a joined up way with health and housing colleagues to improve outcomes and tackle inequalities, co-develop a city wide outcomes framework and delivery plan so that we can jointly measure the impact of what we are doing and deliver joined up supports so that people only need to tell their story once.

1.4.4 Alongside all of this, we have made great strides in doing what we said we would do at the start of this year in reducing our waits across all services, increasing reviews completed and establishing financial sustainability. This was reflected in our Local Account 2021 – 2022 as well as our regular financial position updates to Committee.

1.4.5 As we look forward, we have some exciting developments in 2023 which will further consolidate how we improve lives and outcomes of people of Sheffield. At Committee today, is an update regards key change activity for approval by Committee which continue to assist us to further our change programme and deliver upon our vision and strategy. These are:

- Sheffield Autism Strategy
- Residential Care Commissioning Plan
- Adult Social Care Digital Strategy
- Market Sustainability and Fair Cost of Care Plan
- Conversion Practice Statement
- Our Budget Position and Financial Recovery Plan Update
- Sheffield Mental Health and Emotional Wellbeing Strategy

1.4.6 Following on from decisions made in 2022, in March, it's also aimed to deliver upon the following for consideration by Committee:

- Financial Update – which includes an update in relation to the Disabilities Facilities Grant and Budget following on from the equipment and adaptation reports discussed in November and December and in addition, an update in relation to our joint financial planning with health.

- Safeguarding Update – Progress against the Safeguarding Delivery Plan and following the briefing provided to members and our key priorities and focus for 23/24.

- Quality and Performance Update – An update in relation to learning from a survey of individuals views and experiences, review and performance progress and practical arrangements to deliver upon these and quality of our care services.

- Workforce Development Strategy – The Adult Social Care Workforce Strategy which includes a Social Care Workforce Wellbeing and Practice Development Plan.

- An Adults Early Help Strategy – this will set out how we will implement early intervention and prevention in line with the Care Act statutory guidance and build upon the ambitions set out in our future design.

- Learning Disabilities Strategic Plan – this will set out a strategic plan including a self-assessment in relation to Alders Best Practice and Oliver McGowan Training.

- Directorate Plan for 23/24 - building upon information in this report today and including preparations for CQC, Directors Assurance and performance update and leading way for annual business planning

1.5 Adult Health and Social Care Performance Update – Next Steps for 23/24

1.5.1 As we move into new teams and ways of working our priority and performance focus from 1st April 2023 to 1st April 2024 will be to continue clearing our backlogs and delivering by 1st April 2024:

- 75% reviews by June 2023 and 80% Annually thereafter – A review plan has been developed to do this, part of which is reflected in the budget report to Committee today.

- Individuals in need of equipment and adaptations are seen within 6 weeks and our waiting list has reduced to 400 by June 2023. This is on track following on from the report to committee agreed on November 2022.

- People receive confirmation about support needed within statutory timescales (28 days).

- Our social care providers are rated as good or better by CQC.
- A response to complaints, FOI, and PDRs within statutory milestones.
- An increase in the overall satisfaction of carers with social services: % Extremely or very satisfied
- Individuals using our services are increasingly satisfied with their care and support.
- Our workforce who feel valued through clear progression routes, a clear wellbeing offer and opportunities to be involved and engaged in developing our social care offer.
- DASS can provide both DASS and Directors Assurance that the service is legally compliant and robust assurances are in place.

1.5.2 To support achievement of these objectives the following is being implemented for start 1st April 2023, as we move to new teams with the implementation of the future design of social care. These are: -

- Assurance and Continuous Improvement - The Cycle of Assurance agreed at Committee on 16th November and an associated practical delivery plan to embed a continuous improvement and learning culture across the service.
- Annual Service Planning - Annual Service Business Plans for presentation and discussion at Committee by each Assistant Director along with a Directorate Plan to enable scrutiny by Members.
- Annual Review and Self-Assessment - Annual self-assessment and external peer challenge/ assurance, support, and benchmarking so that we are continually learning and developing best practice in adult social care, and this then informs our annual service business plans.
- Leadership and Service Capacity – Continuing to develop our leadership and service capacity and resilience throughout so that we have strong foundations, manageable workloads, and workforce wellbeing across the sector.
- Innovation - Working with national organisations to support and enable good practice and innovation within Sheffield.

1.5.3 However, crucially underpinning all of this is embedding a culture of empowerment, value, trust, and compassion across Adult Care and across all our workforce – both within Sheffield City Council and across all our providers, which enables everyone to feel engaged to lead and deliver

excellent quality support which individuals and carers feel is positive. This will be our key focus for 23/24 as a golden thread across all our activities.

1.6 CQC Assurance Update

1.6.1 The new CQC Single Assessment Framework will go live in 2023/24 and will look at how the care provided in a local system is improving outcomes for people and reducing health inequalities in their care. They will do this by looking at how services are working together within an integrated system, as well as how systems are performing.

1.6.2 The assessment of ASC by the CQC will focus on councils' delivery of their duties as set out in the Part 1 of the Care Act 2014. It is also important to recognise that the Care Act links across to the Mental Health Act and the Mental Capacity Act - meaning that CQC will also assess ASC's performance in these areas. This will likely start from 1st April 2023.

1.6.3 There is always a risk that Sheffield is visited early in the programme of activity due to CQC activity elsewhere in the system. Our preparations and joint working with health and voluntary sector colleagues support us to be prepared in event of an early contact.

1.6.3 The assessment framework has been grouped into four key themes, each with several quality statements mapped to them. The four themes are as follows:

1. **How councils work with people** – assessing needs, care planning and review, direct payments, charging, supporting people to live healthier lives, prevention, wellbeing, information, and advice.
2. **How councils provide support** – market shaping, commissioning, workforce capacity and capability, integration and partnership working.
3. **How councils ensure safety** – safeguarding enquiries, reviews, Safeguarding Adults Board, safe systems, pathways, and continuity of care.
4. **Leadership** – culture, strategic planning, learning, improvement, innovation, governance, management, and sustainability

1.6.4 There will also likely be a focus on integrated working aligned to how Adult Social Care in particular is working in a joined up way with Integrated Care Boards.

1.6.5 ADASS have developed a toolkit which includes CQC readiness self-assessment, a resource which sets What Good Looks Like standards to inform our approach to preparation. The toolkit is attached at Appendix 1 for information for Members and along with CQC quality statements and measures forms basis of our self-assessment.

1.6.6 Following briefings with Members and information to Health Scrutiny Committee during 2022, a follow up briefing is arranged for March 2023 to

1.6.7 provide an overview of CQC self-assessment, our position statement, and activities underway to achieve a good rating.

In addition to linking into regional and national activities, Adult Social Care is undertaking the following activities as a preparation:

- Updating Change Programme - Mapping CQC quality statements, ADASS standards against our ASC Strategy, future design and change programme to update and focus for 23/24 – the update will be brought to next Committee as part of the planned update on our delivery.

- Learning from Peers and External Support - Bringing in external support by way of the LGA Peer Review, LGA Use of Resources review and a safeguarding review to support learning and identification of any further areas in which we need to update our change programme and further improve services. It's aimed that this approach will support our ambition to embed continuous improvement and learning across Adult Social Care.

- Working in Partnership – Embedding a Sheffield partnership approach to CQC preparation through our newly emerging joint Health and Care Quality Board. It's aimed that this supports a joined up approach to self-assessment and improvement across Sheffield partners.

- Practice Development and Quality – Learning from a 150-case file audit, safeguarding case file audit to inform the practice development, quality assurance and workforce strategy across Sheffield.

1.6.8

The learning from all support and preparations are welcomed as it enables us to evolve and transform to deliver excellent support so that the people of Sheffield have positive experiences and feel that they can live the life they want to live. It's planned to provide a more comprehensive update on our preparations to March Committee and as a dedicated briefing for Members.

1.7 DASS and Directors Assurance

1.7.1 The Director of Adult Social Services (DASS) is a key role in ensuring that the voice of individuals, carers and communities are heard as well as promoting the voice of social care social work and the social model across a range of partnerships is heard.

1.7.2 Responsibilities for professional leadership and operational delivery of adult social services, including for people when they are most disadvantaged and vulnerable, and their families and carers. This will be undertaken within the local care and health (and the wider council, criminal justice, and community and economic) system. These responsibilities are set out in Appendix 2.

1.7.3 There are seven key aspects included in the DASS's remit as below aligned to statutory guidance's and best practice advice:

- Vision and Delivery
- Accountability for assessing local needs and ensuring availability and delivery of a full range of Adult Social Services.
- Professional leadership, including workforce planning
- Leading the implementation of standards
- Managing cultural change to promote independence, choice, and control
- Promoting local access and ownership and driving partnership working
- Delivering an integrated whole systems approach to supporting communities
- Promoting social inclusion and wellbeing

1.7.4 Through the implementation of our future design of social care, delivery plan as well as wider work to deliver and develop robust partnership arrangements highlighted in the strategic update above, good progress is being made regards these professional responsibilities as set out in our Local Account 2021 – 2022, approved on 16th November:

1.7.5 As a key next step, a briefing is planned with Members along with the CQC assurance for March to bring Members up to date with progress made in delivering upon roles and responsibilities as a DASS. It's aimed that this then informs an annual assurance statement to Committee alongside the annual local account from 23/24.

2 HOW DOES THIS DECSION CONTRIBUTE

2.1 Organisational Strategy

2.1.1 Our long-term strategy for Adult Health and Social Care, sets out the outcomes we are driving for as a service, and the commitments we will follow to deliver those outcomes:

- Support people to live a fulfilling life at home, connected to the community and resources around them, and provide care and support where needed.
- Provide temporary assistance to help people regain some stability and control in their life following ill health or crisis.
- Provide care and support with accommodation were this is needed in a safe and supportive environment that can be called home.
- Make sure support is led by 'what matters to you,' with helpful information and easier to understand steps.
- Recognise and value unpaid carers and the social care workforce and the contribution they make to our city.

2.1.2 Make sure there is a good choice of affordable care and support available, with a focus on people's experiences and improving quality of provision.

3 HAS THERE BEEN ANY CONSULTATION?

3.1 The purpose of this report is to provide and update in relation to Adult Health and Social Care Services.

3.2 Consultation is undertaken during the development of proposals for the budget and implementation of proposals for the budget as appropriate.

3.3 An overall approach to coproduction and involvement is also a key element of the delivery plan, ensuring that the voice of citizens is integrated into all major developments ahead. This includes signing up to Think Local Act Personal Making It Real as agreed at Committee in December 2022.

4 RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

4.1 Equality Implications

4.1.1 This update is based on a strategic approach, which was supported by a comprehensive equality impact assessment, which can be found on the Council website Our adult social care vision and strategy (sheffield.gov.uk).

4.1.2 Any individual parts of our change and activity will require their own detailed equality impact assessment, which will be completed to inform plans and decision making.

4.2 Financial and Commercial Implications

4.2.1 The strategy was supported by a financial strategy, which can be found on the Council website Our adult social care vision and strategy (sheffield.gov.uk), and is closely aligned with the budget strategy.

4.3.2 The additional update does not alter this strategy, although does add a layer of detail.

4.4.3 All individual components of Adult Social Care activity will be assessed for their financial contribution to this finance strategy and the Council's budget. This will be used to inform both plans and decision-making.

4.3 Legal Implications

4.3.1 The core purpose of adult health and social care support is to help people to achieve the outcomes that matter to them in their life. The Care Act 2014 sets the Council's statutory power to direct the provision that:

- promotes wellbeing
- prevents the need for care and support
- protects adults from abuse and neglect (safeguarding)
- promotes health and care integration
- provides information and advice
- promotes diversity and quality.

4.3.2 The Care Act Statutory Guidance requires at para 4.52 that "… Local authorities should have in place published strategies that include plans that show how their legislative duties, corporate plans, analysis of local needs and requirements (integrated with the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy), thorough engagement with people, carers and families, market and supply analysis, market structuring and interventions, resource allocations and procurement and contract management activities translate (now and in future) into appropriate high quality services that deliver identified outcomes for the people in their area and address any identified gaps.

4.3.3 The Living the life you want to live – Adult Social Care Strategy which was approved in March 2022 set out the high-level strategy to ensure these obligations are met. This report builds upon that by setting out how the aims of the strategy will be delivered and provides for the monitoring and review encouraged by the statutory guidance.

4.4 Climate Implications

4.4.1 The Adult Social Care Strategy makes specific reference to ensuring a focus on Climate Change – both in terms of an ambition to contribute to net zero as well as adapt to climate change.

4.4.2 It is planned within the forward plan of the Committee to bring a specific Climate Action Plan in February 2023.

4.5 Other Implications

4.5.1 There are no specific other implications for this report. Any recommendations or activity from the detailed workplans of the strategy will consider potential implications as part of the usual organisational processes as required.

5 ALTERNATIVE OPTIONS CONSIDERED

5.1 Not applicable – no decision or change is being proposed.

6 REASONS FOR RECOMMENDATIONS

6.1 Reasons for Recommendations

This report provides an update regards Adult Social Care activities for Members.

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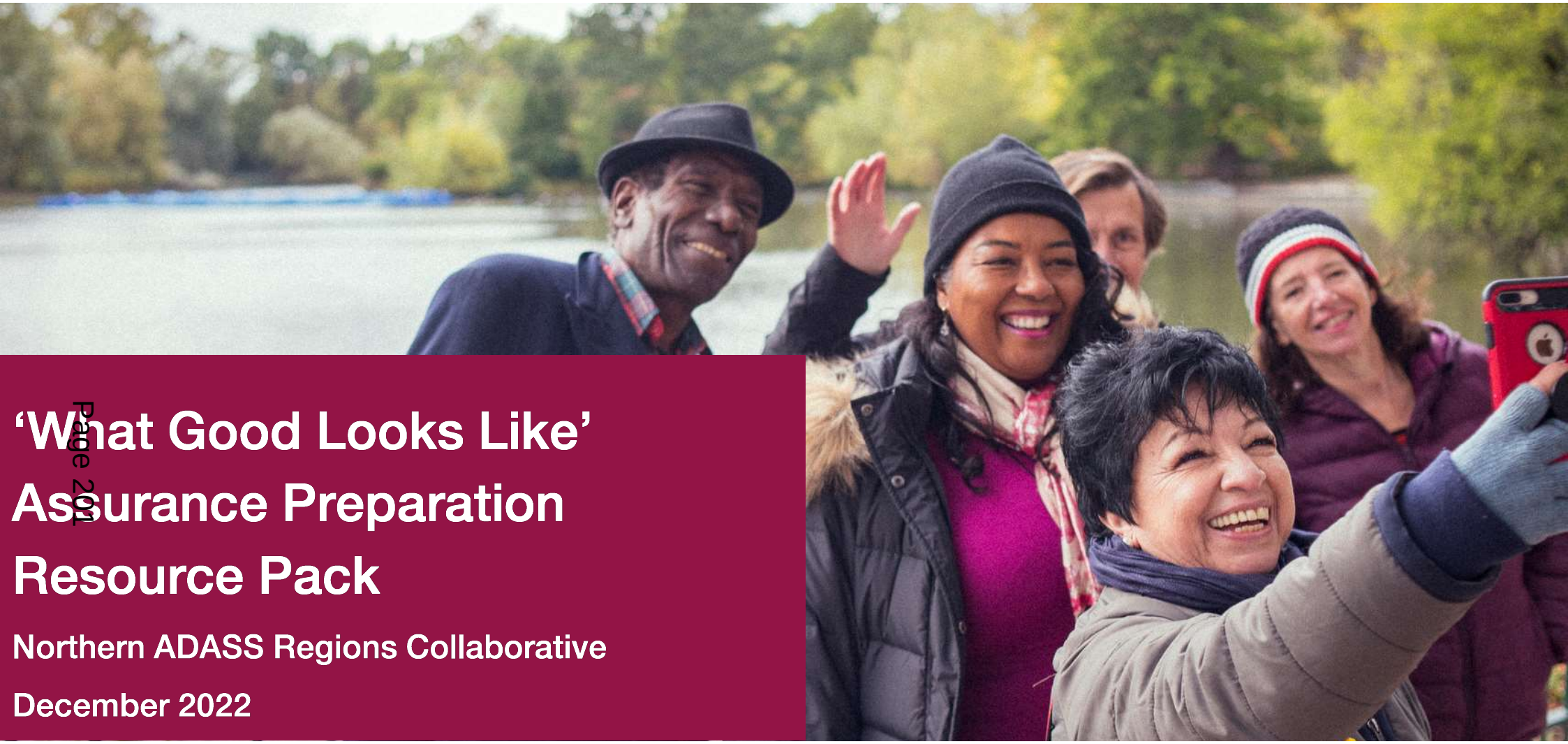


‘What Good Looks Like’ Assurance Preparation Resource Pack

Northern ADASS Regions Collaborative

December 2022

directors of adass adult social services North West

directors of adass adult social services North East

Yorkshire and Humber directors of adass adult social services

Local Government Association

Contents

1. Introduction to this resource

- The three Northern ADASS regions have collaborated to produce this CQC assessment preparation resource, which may lead to further joint working on issues of collective interest
- The content, in particular the indicative characteristics of 'what good looks like' and current challenges, have been generated by 4 working groups made up of operational, strategic and senior leaders from across the 3 northern ADASS regions
- The resource therefore recognises and highlights issues common to the c.50 northern LA Adult Social Care services, which they may experience now and in the future. Colleagues are invited to draw on this context to frame their own local analysis and assessment preparation
- The resource can also add value to other support materials and processes that will facilitate assessment readiness e.g. the emerging CQC guidance, the LGA self-assessment tool, any local self-assessment and analytical processes
- However, it is distinct in that it focuses on the northern context and supports LAs in the north to frame their ASC improvement journey across the 4 CQC themes, within this specific context and their local experience. This may include an understanding of strengths, priorities for development and improvement, ambitions and potential – but also the constraints within the external operating environment and internally within the service environment
- *Please be aware that the CQC assessment framework is still emerging (as at Autumn 2022) and there remain some uncertainties, but any changes to the framework are expected to be relatively minimal*

1. CQC National Assurance Framework

- Integration & Innovation Policy Paper, February 2021: new assurance framework to ASC & ICS
- CQC acquire a new duty to independently review and assess how Local Authorities are delivering their Care Act functions
- Focus on legislative framework; meeting statutory responsibilities
- Single assessment framework
- Go-live 2023/2024
- All LAs 'assessed' within 2 years
- Ministerial interest in ratings: outstanding, good, requires improvement, inadequate

Our framework will assess providers, local authorities and integrated care systems with a consistent set of key themes, from registration through to ongoing assessment

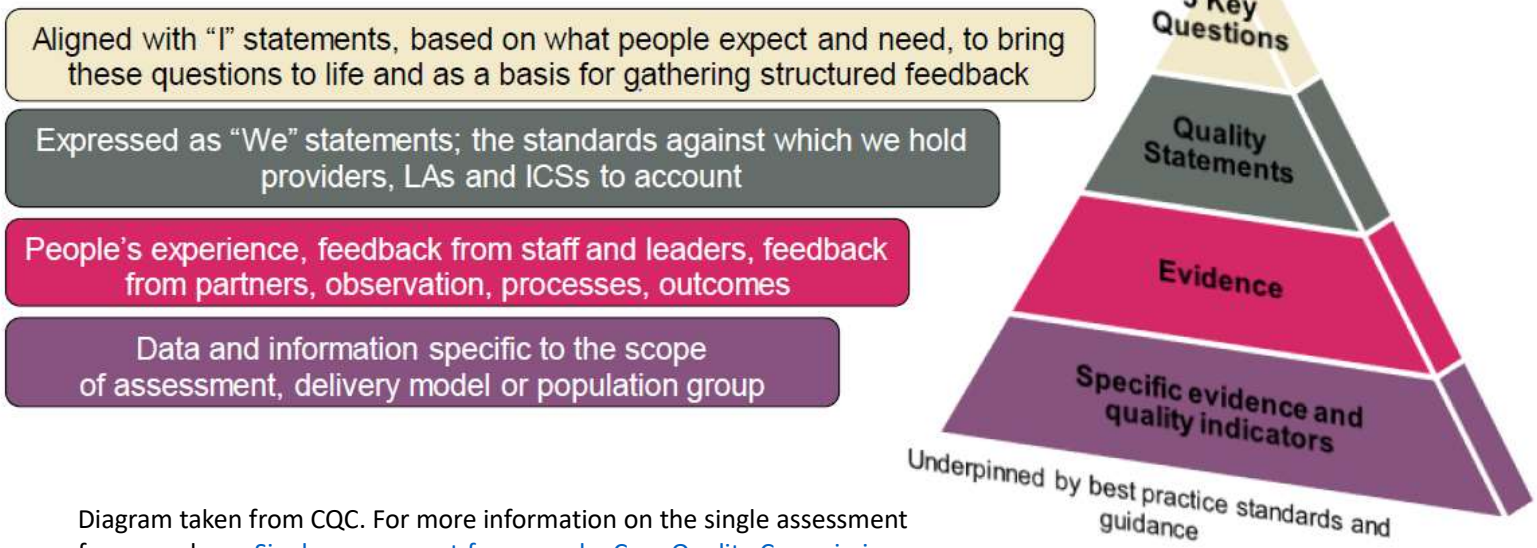


Diagram taken from CQC. For more information on the single assessment framework see [Single assessment framework - Care Quality Commission (cqc.org.uk)]

1. (DRAFT) Information CQC have shared on the assessment methodology (Sept 2022)

4 Themes, covering
8 Quality Statements

For each Quality Statement:

1. CQC focus: Themes & Quality Statements

Working with People: assessing needs, care planning and review, direct payments, charging, supporting people to live healthier lives, prevention, wellbeing, information and advice		**Providing Support**: shaping, commissioning, workforce capacity and capability, integration and partnership working	
Assessing Needs	**Supporting people to live healthier lives**	**Care provision, integration and continuity**	**Partnerships and communities**
We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.	We support people to manage their health and wellbeing so they can maximise their independence, choice and control, live healthier lives, and where possible reduce their future needs for care and support.	We understand the diverse health and care needs of people and local communities, so care is joined-up, flexible and supports choice and continuity.	We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement
Ensuring Safety: safeguarding enquiries, reviews, Safeguarding Adults Board, safe systems, pathways and continuity of care		**Leadership**: culture, strategic planning, learning, improvement, innovation, governance, management and sustainability	
Safe systems, pathways and transitions	**Safeguarding**	**Governance**	**Learning, improvement and innovation**
We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.	We work with people to understand what being safe means to them and work with them as well as our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect, and we make sure we share concerns quickly and appropriately.	We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.	We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research

1. CQC focus: “I” Statements

Working with People		Providing Support	
Assessing Needs	**Supporting people to live healthier lives**	**Care provision, integration and continuity**	**Partnerships and communities**
“I have care and support that is co-ordinated and everyone works well together and with me” *“I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals”*	*“I can get information and advice about my health, care and support and how I can be as well as possible – physically, mentally and emotionally”*	*“I have care and support that is co-ordinated and everyone works well together and with me”* (repeat)	*“Leaders work proactively to support staff and collaborate with partners to deliver safe, integrated, person-centred and sustainable care and to reduce inequalities“*

Ensuring Safety		Leadership	
Safe systems, pathways and transitions	**Safeguarding**	**Governance**	**Learning, improvement and innovation**
“When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place” *“I feel safe and am supported to understand and manage any risks”*	*“I feel safe and am supported to understand and manage any risks”* (repeat)”	There are currently no CQC ‘I’ statements for this theme but the quality statements emphasise accountability, risk management and good governance to manage and deliver good quality, sustainable care, treatment and support. Continuous learning and innovation are also important for effective and safe practice, and delivering equality and quality of life for people using services	

2. How to use this resource

The resource is designed to support LAs to consider the main *strategic* issues which are influential in delivering the spirit and expectations of the Care Act 2014

It can support preparation for CQC assessment by:

- providing tips for assessment preparation and governance/oversight
- offering analytical and reflective questions that LAs can use to support local assurance planning and deliberation which span *performance, impact* and *improvement planning*
- showing different stages of development across the CQC themes, with indicative characteristics for:
  - Minimum standards – often statutory Care Act or DHSC requirements
  - Emerging
  - Aspiring
- These characteristics have been developed through discussions involving northern LAs across the 3 ADASS regions and reflect what colleagues believe are realistic based on their shared experiences, and some of the main challenges associated with each theme
- enabling each LA to compare and contrast its own performance and stage of development, and judge progress towards Care Act expectations, CQC themes and its own priorities and ambitions
- facilitating a process of targeted reflection and discussion which can help each LA to develop a clear, synthesised understanding of their current position and context, including the distance they have already travelled, the impact they are having in their community and the potential for improvement - and a realistic timeframe to achieve it
- increasing colleagues' confidence to articulate a consistent local narrative within a CQC assessment, across front-line practitioners, managers, senior leaders, Elected Members and partners

3. What does good assessment preparation look like?

Balance your preparation and analysis so that you are able to demonstrate awareness of your:

- PERFORMANCE **and**
- IMPACT **and**
- IMPROVEMENT POTENTIAL and PLANNING

primarily across the topics and themes that CQC will be assessing

4. The socio-economic and political context in the Northern ADASS regions

One of the key features that contributes to the context of northern LAs and ASC functions is the socio-economic profile of the North.

The levelling up agenda recognises that there are gaps in educational, employment and economic outcomes for communities living in the north of England and there are *'significant gaps between productivity, earnings and access to good jobs when we compare the North to other parts of England'* (IPPR North State of the North 2021/22 Powering Northern Excellence, January 2022 p.3)

Whilst there are also many positives and opportunities for northern LAs, this backdrop has a direct impact on ASC delivery. Some of these effects are described here. Taken together, they imply a higher demand for Adult Social Care and increased complexity in the types and levels of care that may be required by residents and their families, often from earlier in their lives compared to affluent communities.

- Socio-economic inequality, and in some communities deep inter-generational disadvantage, is seen widely across communities in the Northern regions. Middlesbrough, Liverpool, Knowsley, Kingston upon Hull and Manchester are the local authorities with the highest proportions of neighbourhoods amongst the most deprived in England. (IMD 2019)
- Disadvantaged communities in the north are likely to be disproportionately affected by the current economic crisis, leading to more insecurity in getting the essentials that underpin good physical health and mental wellbeing, including food, housing and a warm home, which may also lead more people into debt
- Paying for care as a self-funder or contributing to the cost of Adult Social Care packages may be unaffordable or unrealistic for many disadvantaged families living in the North of England, leading to high levels of unmet care need - which may also place increased expectations and demands on unpaid and family carers
- Despite the challenges of the pandemic, care quality in the independent adult care sector has reduced only slightly (CQC 2022). In some Northern regions, significant improvements had already been achieved in care quality and CQC provider ratings, following quality improvement work before 2020

4. The socio-economic and political context in the Northern ADASS regions

- In the period 2009-10 to 2017-18 the percentage reduction in Adult Social Care spending per person fell most heavily on the most deprived communities (Marmot 10 years on Review, Feb 2020)
- The direct impact of Covid-19, and the indirect effects of the control measures, have been especially hard-felt in many northern Local Authorities and communities, with restrictions typically more prolonged than in other parts of the country. The effects on Adult Social Care service users and carers are still emerging but generalised impacts on mental health, and for adults with learning disabilities and/or autism, people with pre-existing physical or mental health issues, older-old adults and family carers have been acute in some cases
- Keeping people safe during the pandemic posed unprecedented challenges, but poverty and disadvantage also provide a context for adult safeguarding, with an increased likelihood of chronic illness, disability, trauma and self-neglect affecting adults' wellbeing and safety
- The percentage of the population aged 65+ in the North East (19.9%), Yorkshire and the Humber (18.8%) and North West (18.7%) exceeds the England average of 18.5%
- Healthy Life Expectancy (HLE) and Disability Free Life Expectancy (DFLE) are very relevant population health measures for local Adult Social Care and health services as they give an average indication of how much of their lives residents are likely to experience poor health or greater care needs or levels of dependency. There is a long-standing North-South difference in the number of years people can expect to live in good health without a disability, from birth, and from the age of 65, for men and women. People living in the North East, North West and the Yorkshire and Humber unfortunately live more of their life in ill health and/or with a disability
- The Adult Social Care sector workforce vacancy rate in the northern regions is 8.7 – 8.8% at 2021/22 (Skills For Care)

4. North East ADASS region focus

directors of adass adult social services North East

Current branch assurance support for NE Councils:

- Assurance Preparation / Annual Conversation session by Dr Carol Tozer (ADASS Associate)
- Assurance Leads Group held monthly for all LAs
- Participation in the Northern Collaboration Work with Yorkshire and Humber and North West ADASS
- Programme of Online Learning (webinars) on regional priorities from January 2023

Specific challenges in this region:

- **Increased acuity**: People are in need of a higher level of care when they first receive services because of increased need. This is attributed to higher levels of poverty, and Covid-related delays to elective care
- **Poverty and lower healthy life expectancy**: Levels of deprivation are higher in the north east than in other regions with healthy life expectancy markedly lower
- **Workforce**: Recruitment and retention of workers is an issue across the region, in particular domiciliary care staff, care home workers and nurses for care homes

4. North West ADASS region focus

directors of adass adult social services North West

The Preparation Support Offer Available to NW Councils	
Generic Support	• Regular updates via email and drop-in sessions • LGA/ADASS self-assessment and guidance • A series of 1-hour webinar sessions, focused on topics such as Manchester's Test & Learn Lessons, Learning from Children's Services, Completing your Self-Assessment, etc • Range of tools and resources, such as the Northern Collaborative 'What Good Likes' resource pack, briefing packs, and templates
Targeted Support	• An initial discussion with the DASS, or presentation to the Senior Leadership Team • Challenge Activity, such as Case File Review, Strategy & Policy Audit or Performance & Narrative Workshop • A Challenge Session day, based on local requirements • A 3-day LGA Peer Review

Specific challenges in this region

Workforce: Significant workforce pressures right across the sector in the region, particularly homecare, social work and OT. These are all impacting the time people are waiting for assessment and for services

Diversity: As a region we're proud of the diversity of our geography and our communities. This can also bring challenges when working across coastal, rural, industrial and urban areas, sparsely and densely populated areas, and with a wide range of ethnicities, languages and protected characteristics.

Deprivation: The region has above average levels of social deprivation and overall the population experience worse than national average outcomes, such as lower life expectancy, higher levels of poverty and deprivation. However, there is significant variation, with pockets of wealth also

Accuity: People in the region requiring services are presenting with increasing acuity and complexity of need, across all groups

Financial sustainability: As austerity has seen the greatest cuts in budgets in deprived areas, the North West has seen significant budget reductions across Adult Social Care. With demand also increasing the ability of councils to meet their existing statutory duties alongside the delivery of the reform agenda represents a significant challenge and risk

4. Yorkshire and Humber ADASS region focus

Yorkshire and Humber

directors of adass adult social services

Our vision is for a sustainable social care and health system that provides excellent care and support, promotes wellbeing and social justice, strengthens local communities and economies and is equipped to face new challenges.

Our priorities To deliver on social care reforms
To ensure readiness for a new assurance model
To support a sustainable care market and workforce

Our support, learning and improvement offer

Universal

- Symposiums, workshops, masterclasses and best practice events
- Buddying
- Mystery shopping
- Action learning
- Peer support in networks
- Preparing for assurance tools & resources

Targeted

- Annual regional risk self assessment & challenge
- Regional peer challenge
- Peer to peer spot challenge
- Peer to peer case file audit
- Benchmarking

Our challenges

Workforce
Confidence that risk can be mitigated by local or regional action. Key skills in commissioning, data analysis/statistical literacy. First line manager & LPS capacity.

Market Fragility
Market shaping, capacity with supply side issues contributing to waiting lists/delays and sustainability of commissioned services

Performance
Higher than national average use of residential care for Under 65's and over 65's
Low use of reablement and lower effectiveness – both at home after 90 days and reduced support
Effective use of personal budgets
Increase in safeguarding

4. Benefitting from regional support

- Are you accessing the support available from your ADASS regional branch?
- Which local colleagues are involved in regional ADASS networks and may understand your performance and outcomes compared to other LA ASC services in your region, for example?
- How could the regional opportunities for independent / peer review or challenge help you with assessment readiness?
- Can your ADASS branch help you identify and connect to other colleagues in specific roles or ‘communities of practice’?
- How do your local challenges compare with the regional summary – what is different about your place and community?
- How can you learn from other LAs in your region about the way they are successfully addressing some of the challenges you are experiencing?
- What informal learning and support could you offer to other LAs on issues you have made good progress?

5. Cross-cutting themes

This section explores issues that are relevant to strategic and operational effectiveness in Adult Social Care and which support the delivery of the 4 CQC themes. They may also form part of the evidence required during assessment. They cover:

- Understanding needs, communities and places
- Performance and outcomes
- Co-production
- Partner engagement and feedback
- Provider relationships
- Employee feedback
- Workforce and skills strategy

Analytical / reflective question prompts:

Do we understand our strengths and weaknesses in this area?

Can we evidence the positive impact on service users, carers, staff, services or partners when we do this well?

Are we systematic and consistent in the way we approach this?

Is our strategy or approach transparent e.g. is it published or stated anywhere?

Do we understand how others perceive or are affected by the way we do this?

Do we have the expertise and/or capacity we need in this area?

What are the main barriers or constraints to doing this better?

Where is the *evidence* for the conclusions we have reached?

5. Understanding needs, communities and places

Minimum standard

- A joint strategic needs assessment (JSNA) has been completed/updated within the past 3-4 years
- The JSNA analysis helps to inform local adult social care and healthcare priorities and delivery

Emerging

- The Joint Strategic Needs Assessment uses relevant ward-level population data and service data
- The JSNA highlights demographic changes in the characteristics of people presenting with care and support needs
- Intelligence is routinely gathered from providers on changing demand and service user needs
- There are robust information management systems and sufficient, skilled analytical / business intelligence capacity
- Community asset mapping and roles are in place
- There is evidence of work to promote self-care, wellbeing and living well for longer

Aspiring

- The Joint Strategic Needs Assessments is a dynamic process, using data and intelligence from multiple sources, that promotes a broad understanding of need, including self-funder and informal carer needs
- Robust housing strategies that reflect local housing needs for adult social care population groups
- Quantitative and qualitative information on outcomes is triangulated with feedback from people who use social care and their carers
- Gap analysis at a neighbourhood level which reflects local characteristics
- There are 'heat maps' of potential areas of unmet need
- The Health and Wellbeing Strategy is co-produced

5. Performance and outcomes

Minimum standard

- Statutory returns and surveys are completed in line with DHSC guidance and expectations
- DHSC User and Carer Surveys are completed
- Senior leaders and managers have access to comparative data and trends e.g. local year-to-year and region, national and nearest neighbours averages
- Local 'outlier' performance is understood and analysed
- ASC can tell the story behind their data

Emerging

- Adult Social Care Outcomes Framework (ASCOF) data is readily available and local analysis has been completed
- There are robust citizen, service user and carer engagement strategies that capture the views and outcomes of local people
- Data is reliable and accurate
- Individual managers understand the data most relevant to them
- There is evidence of local self-assessment processes

Aspiring

- There is a strong performance and outcomes culture across ASC/ the LA
- A local ASC Outcomes Framework is in place and regular, effective monitoring can be evidenced, which includes action taken to improve poor performance
- Performance data shows the impact of services and outcomes for people using them
- Data comparison leads to learning and best practice development

5. Co-production

to understand the experience of people who draw on care and support and carers

Minimum standard

- The Council recognises it has more to do to ensure it works together co-productively with people
- Workers understand what working co-productively looks and feels like and have some experience of this. It is not yet the normal way of doing things
- The Council is doing things to ensure all its workers gain the skills and expertise to consistently work co-productively with people, designing and delivering learning and development with them
- A policy to underpin and enable consistent co-productive working at all levels is being developed

Emerging

- The Council can point to areas of good practice locally that demonstrate a good understanding of co-production
- People describe a building of trust between them and the Council. This is not yet fully matured but progress is being made
- Tools like the ladder of co-production and top tips for co-production in policy and practice guides are used to promote good practice by workers to improve their working together with people
- There is work to do to ensure co-production is embedded as a way of working at all levels

Aspiring

- Co-production is embedded as a way of working consistently with people at all levels, strategically, operationally and individually
- The Council shares power in an equal and reciprocal way with people wherever they can
- The Council and people tell stories about the difference co-production is making to the way Adult Social Care and wider council services are provided and work locally
- Co-produced policies that underpin and enable co-production are in place, well understood and used

5. Partner engagement and feedback

Minimum standard

- There is a visible senior management commitment to stakeholder and partner engagement and establishing productive working relationships that prioritise the needs of service users and carers
- Joint funding arrangements/pooled budgets have been developed which reflect shared priorities
- There is a shared local commitment to addressing inequalities
- Healthwatch have been commissioned locally

Emerging

- VCSFE Leaders and organisations are engaged in regular dialogue with ASC
- There is an explicit shared commitment across partners to promoting prevention and wellbeing
- The added/social value delivered though the VCFSE sector is recognised

Aspiring

- Shared roles, responsibilities and accountabilities across statutory partners are clear and enable effective decision-making and practice at front-line service delivery
- Partnerships and shared goals extend beyond health partners, to housing, employment, transport and leisure provision, with an emphasis on meeting local needs and demands

5. Provider relationships

Minimum standard

- ASC senior leaders and managers have developed productive working relationships with the independent social care/VCFSE sector providers
- ASC has demonstrably built on the flexible and responsive relationships developed with providers in response to the Covid-19 pandemic

Emerging

- There is routine dialogue and meaningful market engagement with social care providers e.g. provider forums, networks, working groups, workshops
- The local Fair Cost of Care exercise has good engagement from providers
- Fee meetings are held with providers
- Providers collaborate to support demand management e.g. % of providers completing capacity tracker
- Providers under contract are working to clear and comprehensive service specifications
- Contract Performance Management Frameworks are co-produced with providers

Aspiring

- LAs develop/use dynamic data and intelligence tools to understand the market

5. Feedback from employees

Minimum standard

- There are informal processes for gathering and acting on ASC employee feedback, usually through line management arrangements

Emerging

- There are structured and regular opportunities for employee feedback e.g. annual/biennial employee survey which seek staff views about job satisfaction, working conditions, training and development needs, workplace wellbeing and ideas for workplace improvements
- Employee surveys are considered by senior management and used to inform organisational and workplace development
- Efforts to gain the views of employees from EDI staff groups are evident, including employees with family caring responsibilities

Aspiring

- Informal and formal employee feedback mechanisms are embedded in routine activities
- There is capacity within the LA to collate and analyse employee feedback on at least an annual basis and evidence that this leads to change

5. Workforce and skills strategy

Minimum standard

- The local authority can demonstrate that it understands the relationship between the training and development of the care and support workforce and quality improvement
- It has assessed its current and future workforce needs
- It works in partnership to develop a capable and effective workforce

Emerging

- An ASC Workforce Strategy is in place, including equality, diversity and inclusion dimensions
- There is a safeguarding training needs analysis and development plan which includes legal literacy, mental health, closed cultures, LPS/DoLS, DHR
- There is broad understanding of relevant adult legislation training needs & adequate investment in staff training to support this
- There is evidence of local collaboration with health to enhance training in the provider sector e.g. health & wellbeing in care homes, infection control etc

Aspiring

- An ASC Learning and Development Strategy is in place with an active implementation plan
- Quality assurance processes, including learning from SARs and complaints, inform workforce training needs and priorities
- Evidence of collaboration with local schools and colleges to promote social care careers and joint recruitment with Health

The 4 CQC themes

Sections 6-9 explore the delivery of the 4 CQC assessment themes. They cover:

6. Leadership
7. Working with people
8. Providing support
9. Ensuring safety

Some themes give specific, additional detail on topics e.g. market shaping, commissioning and safeguarding.

Following each theme there is a short analysis of the common challenges and constraints associated with the theme as a whole, based on experiences and learning from colleagues in the northern ADASS regions.

Analytical / reflective question prompts:

Do we understand our operational strengths and weaknesses in this area?

How confident are we that the 'I' statements are consistently met for the majority of service users and carers we support?

Do we routinely operate with a person-centred, strengths-led ethos?

How do we support people to express their needs and understand their rights?

Can we evidence the positive impact on service users, carers, staff, services or partners when we do this well?

How do we communicate and co-operate at a multi-agency level around individual care and support needs?

What do service users, carers and partners tell us about how we do this and whether it meets their needs?

When things go wrong, how do we assess what happened?

Do we have the expertise and/or capacity we need to consistently do this well, in line with best practice?

Can we confidently articulate the challenges or constraints we experience in this area of delivery – and our plans to address this?

Where is the *evidence* for the conclusions we have reached?

6. Leadership

Governance and learning, improvement and innovation

Minimum standard

- ASC Political leaders, senior leaders and managers show a strong understanding of their community, their data and their local narrative
- There is a clear local vision for ASC supported by clear priorities and developing plans
- Senior leaders understand how and why they are different from other areas
- They can articulate the current risks and challenges faced by ASC and its partners
- Provider compliance with the market capacity tracker is encouraged
- There is a senior management commitment to coproduction

Emerging

- Governance - there are coherent strategic / and or transformation plans in place which are owned by council members and recognised by staff and partners
- A Quality Assurance Framework is in place
- Corporate and ASC Risk Registers are in place
- Information sharing protocols and data security arrangements are evidenced
- An innovation approach/ strategy is in place with actions to improve outcomes and experience and reduce inequalities
- Record management is good e.g. incidents, audits, complaints, concerns etc
- There are local arrangements for sharing learning and best practice, internally and externally

Aspiring

- There is a clear Risk Management Framework in place for ASC with mitigating actions to reduce risk
- The wider Council context, and Corporate and Political support for ASC, is understood and evidenced
- Information Sharing Agreements (ISA) are in place with partners and signed-off
- Use of Resoruces (UoR) and Council financial position are understood and ASC is aligned to corporate position
- Leaders are learning from market shaping exercises and Market Sustainability Plans are being overseen and implemented

6. Leadership: Common challenges

Issue	Example
Health and Social Care integration	• Challenges surrounding the creation of Integrated Care Systems under the White Paper • Clarity of roles and accountability - especially in new Integrated Care Board arrangements • Ensuring new arrangements and roles are understood across the workforce
Information sharing	• Ensuring adequate and efficient recording and reporting of information across partner agencies • Systems and data are not yet integrated, creating barriers to effective sharing of relevant patient/service user/carer data and a common understanding of system performance
Shared values and behaviours	• Navigating different values and behaviours across partner agencies
Inclusive leadership	• Keeping up-to-date with the diversity and inclusion agenda, including but also looking beyond the protected characteristics in the Equality Act • Getting inclusive leadership right in practice

7. Working with people

Assessing needs and Supporting people to live healthier lives

Minimum standard

- ASC Political leaders, senior leaders and managers show a strong understanding of their community, their data and their local narrative
- There is a clear local vision for ASC supported by clear priorities and developing plans
- Senior leaders understand how and why they are different from other areas
- They can articulate the current risks and challenges faced by ASC and its partners
- Provider compliance with the market capacity tracker is encouraged
- There is a senior management commitment to coproduction

Emerging

- Service user and carer groups and forums are in place which capture representative views and feedback
- Carers' needs are understood and there are attempts to identify hidden carers and unmet carer need
- Embedding trauma informed practice within all assessment teams to respond to complex individuals and the shifting demographic of people requiring ASC
- Adult and Children's Teams are linked at the front door through a Multi Agency Safeguarding Hub (MASH) which explores multi-generational / family risks upon an adult presenting to adult social care
- Local authorities recognise the needs of younger adults who are at risk of exploitation

Aspiring

- Making Every Adult Matter: evidence of multi-agency teams (including housing) working together to reduce risk
- Considering the use of Making Safeguarding Personal and embedding this within staff development and systems to ensure citizens voices are heard
- A co-produced carers strategy is in place
- Completing service evaluations with citizens in a variety of ways and using this to inform service delivery and development
- Continue to evaluate the success of the SAB arrangements and the role they play in the system as a whole

7. Working with People: Common challenges

Issue	Example
Assessing individual need	▪ Demand for assessments outstrips capacity to undertake assessments leading to long waiting lists ▪ Identifying unpaid carers continues to be a challenge ▪ Delays in elective surgery (covid related) is leading to increased demands on social care as citizens are often in frailer health and less able to benefit from the surgery
Providing support	▪ Availability of domiciliary care provision and community services can prove challenging to provide services in a way that people have identified that they want
Domiciliary Care availability and provision	▪ Efforts to increase the number of care packages have been frustrated and unsuccessful over several years - credible alternatives needed ▪ Potential under-utilisation of TECS, small aids and home adaptations, and community provision to delay and/or meet assessed care and support needs
Increased fragility in citizens due to delays in elective surgery	▪ Hospitals are under increasing pressure to discharge patients quickly ▪ Covid-related elective care delays are leading to increasing demand due to deterioration in health, wellbeing and mobility – leading to higher incidence of people losing their independence and experiencing longer, slower recovery times. ▪ Lack of GP capacity means increasing presentation at emergency departments due to worsening conditions ▪ The preventative role of the NHS in admission avoidance needs to be clearer - local authority / regional leaders can begin to broker this discussion ▪ Local authorities receive different funding in different areas around support for discharge – methodology/funding formula unclear

8. Providing support

Care provision, integration and continuity and Partnerships & communities

Minimum standard

- There is evidence that local care and support needs at a population and community level are understood
- These needs inform local commissioning, contracting and care provision
- The experience of and quality of care and support is a high priority for ASC
- Integration plans to meet short-term care needs e.g. reablement, intermediate care and end of life care, reflect local and national priorities and good practice
- There is evidence that ASC, and the wider local health and care system, prioritise continuity of care for citizens

Emerging

- There is strong capacity, knowledge and experience around contract management and Quality Assurance, underpinned by a commitment to achieve VFM within a person centred approach
- Provision is made for meeting complex or specialist needs e.g. innovation Lot in Complex DPS, Care at Home Incentive Fund, strong links with VCFSE sector
- Evidence of an open and collaborative culture to find different solutions to care and support challenges
- Tender processes seek and appropriately support innovative ideas from providers
- There is evidence of joint care processes, pathways and transfer of care arrangements
- There are well-established governance processes with the ICB

Aspiring

- There is a consistent organisational focus on the quality of care and support provision
- There is a commitment to Quality Mark development
- ASC and health work to a Joint Outcomes Framework
- There is a regular fee setting process which is aligned to the medium-term financial strategy (MTFS) process
- Surveys of providers request regular updates and support ASC responsiveness to changing market circumstances
- There is engagement with sector representative organisations or Alliances, as well as individual providers
- ASC talks to and learns from neighbouring councils about successes and failures

8. Planning and market shaping

Minimum standard

- The Market Position Statements is in place - it clearly and comprehensively explains what care and support is needed in the area and why
- Evidence is routinely gathered from providers in relation to market pressures / sufficiency
- Work is ongoing to refresh the LA's understanding of gaps and sufficiency in the ASC market

Emerging

- Market Position Statement is aligned to the JSNA
- Market Position Statements have been developed for all ASC cohorts, setting a clear direction of travel
- There is ongoing activity to support a diversity of care models in the market, including innovation
- ASC has established internal governance to ensure routine market oversight
- There is evidence of collaboration between strategic housing, social landlords and ASC to plan towards meeting housing with support needs
- The Council can respond to immediate crises in the Adult Social Care market
- There is a comprehensive market sufficiency plan(s)

Aspiring

- Market Position Statements and Sufficiency Plans are coproduced with providers and partners
- Market sufficiency plans include analysis of needs of people receiving Direct Payments
- ASC uses cohort-specific population projections to inform current and future demand
- There is a local Market Sustainability Plan
- There is evidence that ASC and the Council are learning from their commissioning and market engagement/shaping experiences, leading to changes in thinking and practice
- There are specific housing strategies/plans to support ASC e.g. extra-care housing

8. Commissioning & contracting

Minimum standard

- Care Act principles and duties are being enacted:
  - ➢Promoting wellbeing
  - ➢information and advice
  - ➢independent advocacy
  - ➢integration cooperation and partnership
  - ➢prevent, reduce, delay principle
- Commissioning practices and services delivered by or on behalf of ASC proactively address the needs of people with protected equality characteristics
- Commissioning is outcome-focussed

Emerging

- The JSNA informs commissioning priorities and activities
- Procurement and contracting arrangements are robust, fair, equitable and accessible and attract/retain a diverse range of providers
- A Fair Cost of Care exercise is ongoing
- Contracts are accessible to local SMEs e.g. through tiered framework agreements
- Micro-commissioning is used to meet specialist and complex care and support needs
- There is evidence of ongoing strategic and operational dialogue with ASC providers and partner organisations

Aspiring

- ASC has cohort-specific population projections to inform current and future demand
- EDI and capacity to meet diverse needs is embedded & assessed in all contracts
- New models of care at home are being implemented
- There is evidence of successful joint commissioning with Health
- The LA collaborates with service providers to agree/negotiate a fair cost of care
- Social value is increasingly embedded in pre-procurement activity, as well as evaluation of tenders
- There is evidence of co-production in commissioning

8. Providing Support: Common challenges

Issue	Example
Assessment	▪ Identification and understanding of needs - and unmet needs - especially relating to self-funders and all informal carers ▪ Medium- and longer-term impact of Covid pandemic remains unclear ▪ Neighbourhood-level place and community needs are diverse – one size does not fit all – socio-economic, place and cultural differences/barriers ▪ Home Office resettlement work is absorbing capacity
Planning & Market Shaping	▪ Limited resources to plan and market shape – emphasis on safe and effective delivery over data/monitoring due to staffing and funding pressures ▪ Providers are often fire-fighting due to competing pressures and demands ▪ Image / perception of Social Care as a career option, alongside recruitment and retention issues and often uncompetitive pay and conditions i.e. in comparison to health, retail, hospitality etc ▪ Culture change within the workforce to promote prevention and use of existing community assets and support
Commissioning & Contracting	▪ There are aspects of current commissioning arrangements e.g. short-term contracts/funding rounds and a strong emphasis on social value in contracts that can exclude small, local SMEs ▪ Very challenging market capacity issues and gaps in some specialist provision ▪ The real cost of care vastly outstrips what LAs are in a position to pay providers ▪ Innovation in the current financial and operating climate is very challenging
Long Term Care Delivery	▪ Market facilitation/development with care providers e.g. to support understanding of procurement processes and basic requirements, contract performance management, capturing outcomes etc ▪ Sharing risk with providers
Integrated Care Delivery	▪ Integration across local partners and across LA boundaries can be challenging due the Political make up of different LAs, different commissioning timelines, true shared commitment and adequate capacity

9. Ensuring safety

Safe systems, pathways and transitions

Minimum standard

- There are clear and safe pathways and transfers of care when people move between services and agencies, which are well designed, evaluated and reviewed
- Continuity of care and complex care co-ordination are a shared system priority and ASC monitors its contribution and effectiveness towards this
- Contingency plans are in place and the local authority is prepared for emergencies
- There is an adult risk register and risk mitigation plans in place

Emerging

- Keeping people safe is embedded in corporate vision, ASC Strategy, Local Account etc
- Whistleblowing policies are in place and there is good awareness amongst staff at all levels and evidence that the policy is used to good effect
- High-risk cases are prioritised effectively
- Positive & productive working relationships with a range of partners are evident.
- Mechanisms are in place for the early identification of young people who are likely to have care and support needs including e.g. transition forums & early co working
- There are sufficient workers with relevant knowledge & experience of transitions who work across children's & adult's services
- Each young person has a key worker who is accountable to them
- Transition plans are co-produced with young people and families
- Care Act assessments & Carers assessments are in place for the majority of young people and parent carers before age 18

Aspiring

- There are specialist transitions teams consisting of workers from children, adults, health and SEND team with the capacity to engage all young people at year 9
- Most young people who are likely to have care and support needs are identified early, including those who are more difficult to identify
- All young people at year 9 are allocated a key worker
- Reviews take place annually as a minimum to review plan for transition and EHCP
- Co-produced transition plans are high quality and include a wide range of need including education and employment, good health, community engagement and options for accommodation

9. Ensuring safety

Safeguarding

Minimum standard

- The Safeguarding Adults Board has developed, shared and implemented a joint safeguarding strategy and reports annually
- The multi-agency adult safeguarding system has created a shared process for undertaking S42 enquiries when an adult with care and support needs may be at risk of abuse or neglect
- There is strategic governance of safeguarding learning, themes, trends and outcomes
- Independent advocacy is available to someone who is the subject of a safeguarding enquiry or review

Emerging

- System incident reporting, investigation, action and shared learning can be evidenced e.g. case file audits, LeDeR, whole home / S42 safeguarding reviews, DHRs, coroners' inquests
- Routine auditing of case files and formal recording of Best Interest Decisions
- Making Safeguarding Personal 7 questions are asked following most s.42 enquiries
- Majority of strategy discussions take place within 5 days & enquiries within 28 days
- Appropriate use of advocacy
- Structures are in place that help to 'make safeguarding everybody's business' a reality

Aspiring

- Safeguarding activity is highly visible and well integrated across teams
- There is evidence that preventing, detecting and reporting neglect and abuse is continually developing at a system and community level
- Improvement planning from audits, reviews, research and practice learning events have led to changes in practice
- There is active management of safe workloads, case allocation and supervision
- Staff training targets on topics relevant to safeguarding are achieved

9. Ensuring Safety: Common challenges

Issue	Example
Understanding demand	Work with key stakeholders to ensure safeguarding referrals to LA are appropriate
	Safeguarding issues that sit outside well-understood S42 enquiries – e.g. complex trauma informed work, transitional safeguarding around young adults with complex needs
Transitions	Connectivity and communication between adults and children and young people services
	Transitions & links between LA & external partners e.g. health & criminal justice
	Capacity to engage with young people and families at year 9 around Transitions and needs in adulthood
	Worker knowledge of both children's and adults' legislation, including Children and Families Act 2014
Discharge from hospital	Implementing mental capacity legislation, maximising human rights & choice, market capacity
	Social Care voice in NHS arena
Partnerships	LA voice in partnerships & partnership boards e.g. mental health Strength of leadership within the Safeguarding Adults Board
Data & Intelligence	Ownership and interpretation within service areas of safeguarding data and intelligence

10. Additional support and resources

- Thanks go to the North East, North West and Yorkshire and Humber ADASS branch and regional colleagues that participated in the content development of this Resource
- We hope it supports Adult Social Care Elected Member Portfolio Leads, Senior Leaders, managers, social workers, social care practitioners and wider health and care professionals such as OTs working within ASC to frame and gauge your collective development and progress
- There are many other national and regional support offers and tools that local ASC teams can use to support readiness for CQC assessment from April 2023 onwards
- The CQC assessment framework includes links to a wide range of good practice resources and guidance
- CQC has also given an indication of the evidence they will look for during assessment, which will include first-hand observation
- If ASC in your area is performing well overall or you are especially proud of some of your activities and the progress you have made - even if they are not a focus of the CQC themes - do still talk about it and promote your strengths

Good luck!

SHEFFIELD CITY COUNCIL
DIRECTOR OF ADULT SOCIAL CARE SERVICES (DASS)

ANNUAL DASS ROLES AND RESPONSIBILITIES STATEMENT

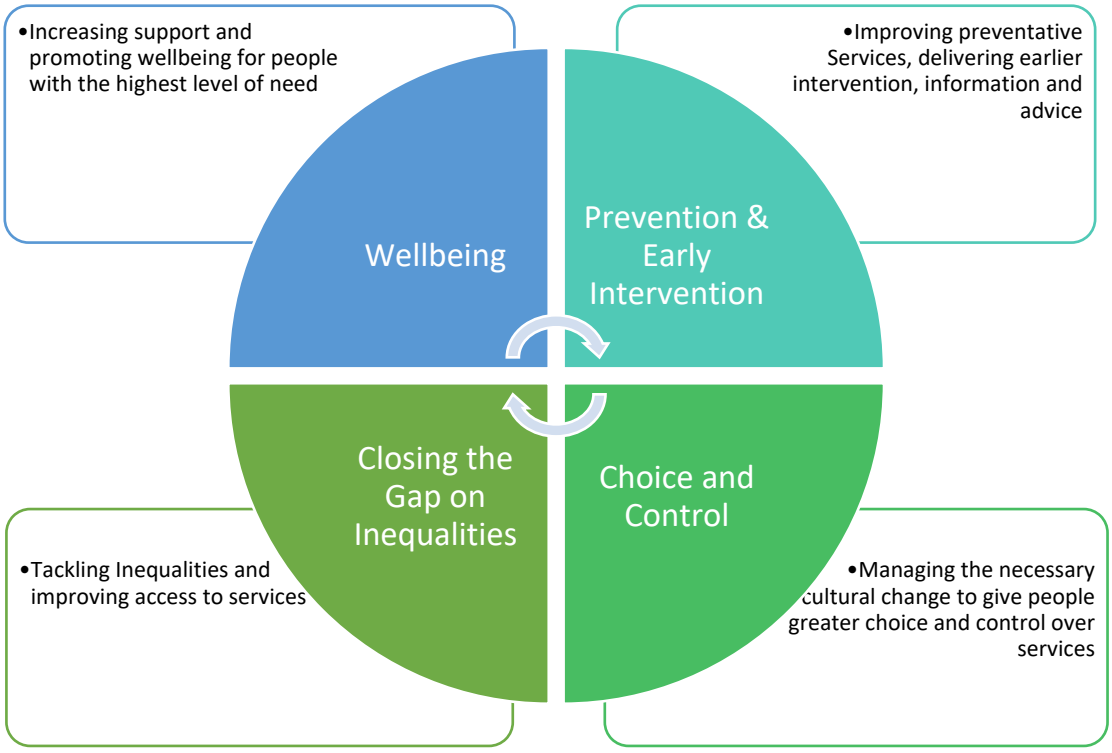
CONTENTS

THE DASS LEADERSHIP ROLE

Adult Social Services operate within a wider public sector landscape and such as such must through collaboration demonstrate how social care is effectively contributing to the achievement of national and local outcomes and embedding core values, ethics and a respect for human rights and social justice.

The Director of Adult Social Services (DASS) is a key role in ensuring that the voice of individuals, carers and communities are heard as well as promoting the voice of social care social work and the social model across a range of partnerships is heard.

This is described in statutory guidance and advice and the key functions are described below:



Whilst the statutory guidance describes what a Director of Adult Social Services (DASS) leadership role is and should be centred around, the why and how the leadership role is undertaken is equally as important. Developing a positive culture based around wellbeing outcomes, openness, and honesty and based fundamentally on coproduction is the foundations of the role.

An Overview of the Director of Adult Social Services (DASS) Statutory Role

The Local Authority Social Services Act 1970 Section 6 (as amended following the Children Act 2004) requires that:

"A local authority shall appoint an officer, to be known as the Director of Adult Services, for the purposes of their social services functions, other than those for which the local authority's director of children's services is responsible under Section 18 of the Children Act 2004"

The statutory guidance published alongside the Children Act 2004 established clear lines of accountability for children's outcomes. These principles, reflected in the Council's Constitution, also apply to the DASS role.

The Director of Adult Social Services (DASS) has responsibilities for professional leadership and operational delivery of adult social services, including for people when they are most disadvantaged and vulnerable, and their families and carers. This will be undertaken within the local care and health (and the wider council, criminal justice, and community and economic) system.

There are seven key aspects included in the DASS's remit as below aligned to statutory guidance's and best practice advice:

Aligned to the leadership role of the DASS, the statutory guidance further sets out that the Local Authority should, through the Office of the DASS, ensure that effective systems are in place for discharging a range of functions (including where a local

authority has commissioned any services from another provider rather than delivering them itself):

Leadership Role	Professional Responsibilities
Professional Advisor	Provision of advice to the Council, Mayor or Leader, and Cabinet on the exercise of social work & social care statutory functions.
Strategic	Devising and securing agreement to a **vision for social care** that addresses the Council's statutory responsibilities, in the context of its political vision and direction, and ensures services and procedures drive engagement with people in the design, delivery and evaluation of services.
System Wide Leadership	Enabling the voice of social care, social work and the social model is heard, particularly by working with NHS partners, the police, providers, voluntary organisations, the wider council, and members of the community to: • Shape care and health and wider public services in the area • Promote the inclusion and rights of disabled and older people
Delivery of Services	To ensure that the Council has a **local offer that meets statutory duties** in relation to: **1) Delivery** (Prevention, Information and Advice, Assessment, Care and Support, Mental Health, **2) Performance (**Measuring effectiveness of services) **3) Complaints (**Ensuring effective arrangements to respond to complaints, serious incidents and matters referred to the Local Government Ombudsman).
Operating Framework	The DASS is accountable, on behalf of the Council, for the Social Care Operating Framework, and how it complies with legislation and best practice. Key Areas - **Adult Safeguarding, System Leadership, Promotion of rights of people with a disability.**
Resource Management	**1) Workforce** - Ensuring the availability and competence of staff, in direct employment and in the wider market**.** **2) Market Shaping** - to ensure sufficiency of supply and address current and anticipated future needs, whether publicly or privately funded, and its sustainability. **3) Quality** - Ensuring capacity and quality of services – whether commissioned or in house**,** **4) Financial** – to set and manage overall budget for Adult Social Care.

The Guidance on the Director of Adult Social Services (DASS) Statutory Role

The Guidance on the DASS role is encapsulated in the following key legislation and documents: -

- ***The Guidance on the Statutory Chief Officer Post of the Director of Adult Social Services, Department of Health, May 2006*** – this sets out statutory guidance and instructs local authorities about arrangements for establishing a Director of Adult Social Services (DASS) post with responsibility for local authority social services functions in respect of adults. [Statutory Guidance on DASS Post)

- ***Best practice guidance on the role of Director of Adult Social Services, 2006*** – This provides further guidance on the roles and responsibilities for the Director of Adult Social Services (DASS) and is intended to provide a tool to inform senior managers with responsibility for adult social services and other partner organisations in the local authority area - [Best Practice Guidance on role of DASS)

- **ADASS *Advice Note Directors of Adult Social Services: Roles and Responsibilities*** -– This provides a further update on roles and responsibilities of the Director of Adult Services following introduction of the Care Act. Its sets out key responsibilities, key risks, local structures and local assurance. adass-advice-note-director-of-adult-social-services_-roles-and-responsibilities.pdf.

- ***Local Government Association DASS Overview and Checklist*** – this provides a cohesive overview of the statutory framework and key requirements which all DASS should have in place. It supports self-assessment and assurance regards compliance with duties. The overview and checklist is provided at Appendix 1.

- ***Local Government Association DASS/ Senior Executives Test of Assurance*** – this provides a Test of Assurance to consider whether or not the DASS and the Adult Social Care (ASC) and Senior Management Team have sufficient capacity and capability to meet the statutory duties of the Care Act 2014 and other relevant legislation, to contribute to the Corporate priorities of the Council and to play an effective role with a range of partners and stakeholders within the local health and social care system. Test of assurance offer – to review senior management structures | Local Government Association

- Sheffield City Council all Directors are required to complete a Directors Assurance which sets out an assurance regards compliance with a range of statutory requirements, in addition to the statutory DASS functions, which includes Legal Compliance, HR Compliance and Financial Compliance.

APPENDIX 1 - DASS OVERVIEW AND CHECKLIST

This overview considers the current roles and responsibilities of Directors of Adult Services (DASS) in England. In the absence of a statutory framework, it draws together duties and expectations, the scope for delegation, and how any such arrangements can be overseen.

Legal Basis for the Role

The Local Authority Social Services Act 1970 Section 6 (as amended following the Children Act 2004) requires that:

"A local authority shall appoint an officer, to be known as the Director of Adult Services, for the purposes of their social services functions, other than those for which the local authority's director of children's services is responsible under Section 18 of the Children Act 2004"

The statutory guidance published alongside the Children Act 2004 established clear lines of accountability for children's outcomes. These principles, reflected in the Council's Constitution, also apply to the DASS role.

Where there is an elected Mayor and/or Cabinet and Lead Member arrangement:

- **Full Council** delegates Executive Functions to the **Cabinet** (or Mayor and Cabinet as applicable).
- The Cabinet delegates responsibility for defined portfolios to the **Cabinet (Lead) Member**.
- The Cabinet Member delegates implementation of policy and strategy to the **Director of Adult Services**.
- The Executive Director delegates authority, as required, for the implementation of policy and strategic direction to **other officers**.

Where there is a Committee structure:

- **Full Council** delegates specified functions to **Committees,** typically **Policy and Resources** and **Service Committees.**
- The arrangements delegates areas of responsibility within scope to the Committee Chair(s), working with the relevant officer(s).
- The Committee delegates implementation of policy and strategy to the **Director of Adult Services**.
- The Executive Director delegates authority, as required, for the implementation of policy and strategic direction to **other officers**.

This overview positions the DASS in the exercise by the Council of its statutory responsibilities for Adult Social Care. Statutory guidance requires these responsibilities are vested in an individual director, although they may carry other functions (including that of director of children's services).

Direct Responsibilities

(These functions cannot be delegated, although by agreement the post holder could cover them for more than one council)

- **Professional Adviser** to Council and Committee(s) on the exercise of statutory functions (with particularly reference to):
    - The Care Act 2014
    - The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards
    - The Mental Health Act 2007
    - The Human Rights Act 1998
    - The Domestic Violence, Crime and Victims Act 2004 and subsequent legislation relating to Domestic Violence Protection Notices and Orders, the criminal offence of Coercive and Controlling Behaviour, Modern Slavery and Forced Marriages

- **Devising and securing agreement to a vision for social care** that addresses the Council's statutory responsibilities, in the context of its political vision and direction, and ensures services and procedures drive engagement with people in the design, delivery and evaluation of services

- **Professional leadership and operational delivery** of adult social services, in the local care and health system in relation to wider council functions, criminal justice and community and economic system

- **Financial and resources management**: to manage within resources allocated by the Council and through partnerships, including fair charging policies

Service Responsibilities

*(There is considerable scope for choice, variation and innovation in the means by which these are achieved. The **core responsibility** here is to have a local offer that meets statutory duties. The exercise of some of these functions can be delegated within a clear legal agreement to another council, NHS body or suitable third party.)*

- **Discharge of these functions** (directly or through commissioned services):
    - Prevention, information, and advice, to those who have or appear to have a social care need, irrespective of level of need and means
    - Appropriate assessment of need and means, in line with statutory duties
    - Meeting essential needs for care and support
    - Fulfilling Mental Health Act 2007 and Mental Capacity Act 2005 legal requirements (including guardianship, power of attorney, detention and after care).

- **Developing the means to measure** whether outcomes are realised so that practitioners, managers, and councillors know how effective they are.

- **Arrangements to respond to complaints**, serious incidents requiring review and matters referred to the Local Government Ombudsman.

Service Responsibilities Elements

Service Responsibilities	Key Elements
• Prevention, information, and advice, to those who have or appear to have a social care need, irrespective of level of need and means	• Service contract • Policies and procedures • Performance data • Practice audit
• Appropriate assessment of need and means, in line with statutory duties	• Service contract • Policies and procedures • Sign off of care plans • Review arrangements • Performance data • Practice audit
• Meeting essential needs for care and support	• Self-directed support offer • Supplier framework • Drawing down care and support to meet outcomes in care plans • Block and call off contract arrangements, fees • Contract compliance arrangements • Supplier relationships • Safeguarding arrangements • Engagement with regulators

• Mental Health duties	• Arrangements for power of attorney, Court of Protection, guardianship, detention and after-care
• Developing the means to measure whether outcomes are realised so that practitioners, managers and councillors know how effective they are	• Use of care management system • Data capture and analysis • Performance dashboards • Statutory returns completed • Benchmarking

Framework Responsibilities

The DASS is accountable, on behalf of the Council, for the framework, and how it complies with legislation and best practice. Managers, practitioners within the council and partner organisations share responsibility for their behaviour within them, and the outcomes achieved.

- **Safeguarding adults** needing care and support, with oversight from the Local Adult Safeguarding Board:
  - from abuse or neglect
  - when doctors are considering compulsory treatment or admission to psychiatric hospital
  - when people lack capacity to decide and may be restricted of their liberty

- **System leadership** of social care, social work, and social model of disability for adults throughout the council, particularly with children's services and housing, and through partnerships with NHS, the police, private and voluntary sector providers, community organisations

- **Promoting** the inclusion and rights of disabled and older people

System and Market Responsibilities

These are core DASS responsibilities but can be delegated, by agreement, within a framework of accountability and assurance (for which the DASS remains responsible).

- **Ensuring the availability and competence of staff**, in direct employment and in the wider market

- **Market shaping** to ensure sufficiency of supply and address current and anticipated future needs, whether publicly or privately funded, and its sustainability

- **Ensuring the current capacity and quality** of services, working with the care regulator (currently CQC).

System and Market Responsibilities

1. The DASS has overall responsibility for the meeting the requirements of the Care Act 2014 in relation to the availability and competence of staff, in direct employment, and in the wider market. The DASS must ensure they are fully compliant. Arrangements deliver:

    - Workforce strategy
    - Workforce analysis
    - Training programme
    - Support to providers in wider market

2. The DASS has overall responsibility for market shaping to ensure sufficiency of supply and address current and anticipated future needs, whether publicly or privately funded, and its sustainability.

    - Strategic Needs and Services Assessment and Strategy that identifies supply and demand shortfalls and opportunities
    - Market Position Statement
    - Linked to housing needs assessment and strategy
    - Arrangements to identify areas for intervention

3. The DASS has overall responsibility for ensuring the current capacity and quality of services, working with the care regulator (currently CQC), through clear arrangements throughout the system for, including mechanisms for consultation and engagement with DASS:

    - Consultation and engagement arrangements with DASS are clear.
    - Contract monitoring and compliance
    - Complaints and safeguarding alerts
    - System-wide quality support offers
    - Remedial support measures
    - Routine liaison with regulators
    - Escalation and intervention arrangements
    - Use of embargoes
    - Contract termination
    - Council's provider of last resort arrangements

LIST OF DASS ACCOUNTABLE SERVICES

The DASS is accountable services listed in Schedule 1 of the Local Authority Social Services Act 1970. The services are listed below.

The DASS should ensure that it is clear which team, or manager, within his or her staff, has responsibility for assessing and meeting the eligible needs of a range of named client groups.

A list of groups of individuals who are likely to be users of social care services, and who should be included is given below (NB this list is not exhaustive and may be added to in future). In addition, clear arrangements should be in place for other client groups, particularly where the DASS believes that there is the risk of an individual falling between services.

- People with physical frailty due to ageing;
- People with physical disabilities;
- People with sensory impairment;
- People with learning disabilities;
- People with mental health needs (including mental frailty due to old age);
- People with long term medical conditions requiring social care in addition to health care;
- People with autism spectrum disorder;
- Deafblind people;
- Older people with mental health problems, or learning disabilities;
- People who misuse substances;
- People who have experienced domestic violence;
- People living with HIV;
- Offenders;
- People with no fixed abode;
- Homeless households; and
- Asylum seekers

Report to Policy Committee

Author/Lead Officer of Report
Liam Duggan, Assistant Director Care Governance and Financial Inclusion

Report of:	Director of Adult Health and Social Care
Report to:	Adult Health and Social Care Policy Committee
Date of Decision:	8th February 2023
Subject:	Adult Health and Social Care: Financial Recovery Plan Update

Has an Equality Impact Assessment (EIA) been undertaken?	Yes	x	No	
If YES, what EIA reference number has it been given? **1128**				
Has appropriate consultation taken place?	Yes	x	No	
Has a Climate Impact Assessment (CIA) been undertaken?	Yes		No	x
Does the report contain confidential or exempt information?	Yes		No	X

If YES, give details as to whether the exemption applies to the full report / part of the report and/or appendices and complete below: -

*"The (**report/appendix**) is not for publication because it contains exempt information under Paragraph (**insert relevant paragraph number**) of Schedule 12A of the Local Government Act 1972 (as amended)."*

Purpose of Report:

The report delivers on our commitment to transparent and accountable financial reporting. This update provides assurance regards our delivery upon our financial recovery plan, our spend forecast and outlook for 2023/2024 including an update on the Autumn Statement, financial risks, and challenges.

It also provides an overview of steps taken to prepare for implementation of new care and wellbeing tender, and an update on recovery mitigations including an update on automation in Adult Social Care, external challenge to improve use of resources and a review of the Integrated Commissioning budget.

Recommendations:
It is recommended that the Adult Health and Social Care Policy Committee:

1. Note the update to the financial forecast for the delivery of savings in 2022/23
2. Note actions taken to achieve savings or mitigation of pressures.
3. Note the update provided on the Autumn statement and work being undertaken to prepare for the 2023/24 financial year
4. Note the actions being taken and the progress made to date to prepare for the introduction of the new care and wellbeing service.
5. Note the opportunities for further efficiencies being explored in Adult Health and Social care to improve the use of automation and digital technology
6. Request updates on progress with implementation through our Budget Delivery Reports to future Committee

Background Papers:

Lead Officer to complete: -		
1	I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.	Finance: Liz Gough, Ann Hardy
		Legal: Patrick Chisholm
		Equalities & Consultation: Ed Sexton
		Climate: Jessica Rick
	Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.	
2	**SLB member who approved submission:**	Alexis Chappell
3	**Committee Chair consulted:**	Councillor George Lindars-Hammond and Councillor Angela Argenzio
4	I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Committee by the SLB member indicated at 2. In addition, any additional forms have been completed and signed off as required at 1.	
	Lead Officer Name: Liam Duggan	**Job Title:** Assistant Director Governance and Financial Inclusion
	Date: 30th January 2023	

1.0 ADULT HEALTH AND SOCIAL CARE DIRECTORATE 2022/23 FORECAST AND RECOVERY PLAN

1.1 Forecast Delivery of 2022/23 Savings

1.1.1 A summary of the **£43.2m** pressures on Adult Health and Social Care Directorate Budget for 2022/23 is set out in Table A below. The delivery of planned savings is critical to financial sustainability, bringing expenditure down to within available resources and supporting the Council to set a balanced budget.

1.1.2

Table A: Adult Health and Social Care Pressure Mitigations Agreed at Cooperative Executive 16th February 2022	**Value (£000s)**	**Forecast (£000s)**	**Forecast by 1st April 2023 %**
Social Care Precept	£3.3m	£3.3m	100%
Increased Grant	£8.5m	£8.5m	100%
Funding from Council Reserves	£6.2m	£6.2m	100%
Savings / mitigations	£25.2m	£16.4m	65%
Total Pressures	**£43.2m**	**£34.4m**	**79.6%**

1.1.3 Table B shows a breakdown of the forecast by savings type and the movement in the forecast to be achieved by 1st April 2023 and by 1st April 2024.

Table B – Recovery Activity and Progress Against Savings Approved on 16th February 2022.

Saving Category by Service	**Savings Value (£000s)**	**Forecast June 22**	**Forecast Dec 22**	**Forecast Jan 23**	**Forecast % by 1st April 2023**	**Forecast % by 1st April 2024**
Change and Strategy Delivery	**1,803**	1,803	1,500	1,500	83%	100%
Living and Ageing Well	**10,888**	6,980	6,994	7,154	66%	92%
Adults with Disabilities	**9,506**	4,797	4,312	4,658	49%	92%
Mental Health and Wellbeing	**1,650**	1,275	1,210	1,210	73%	88%
Care Governance and Inclusion	**1,254**	1,254	1,783	1,783	142%	142%
Commissioning and Partnerships	**100**	100	100	100	100%	100%
Chief Social Work Officer	**0**	-	-	-	-	-
Total	**25,201**	**16,209**	**15,899**	**16,405**	**65%**	**95%**

1.1.4 Since the last update to Committee in December 2022, the forecast for delivery of savings in-year has improved by 2%. This is mainly due to improved performance on reviews of high-cost care packages. Appendix 1 provides a full breakdown of the performance against each saving, including risk mitigation actions.

1.2 Forecast Spend against 2022/23 Adult Health and Social Care Directorate Budget

1.2.1 The Adult Health and Social Care Directorate Budget 2022/23 is forecasting at Month 9 (Year to December) an overspend of £10.6m against the £145m net budget.

1.2.2 £8.8m of this overspend is directly attributable to the non-delivery of savings within the 1 year provided (£0.7m staffing and £8.1m non-staffing).

1.2.3 The remaining £1.8m is largely accounted for by a forecast £1.6m additional overspend on staffing, mainly attributable to ensuring continuity of care by supporting the care sector during the pandemic and managing the risks of Mental Health social workers transferring back to the council.

1.2.4 An overspend of £6.9m against Learning Disabilities purchasing is almost entirely due to undelivered savings (£5.6m), with the additional overspend being offset by underspends in other areas. This is due to the rate of growth in demand for LD services.

1.2.5 Whilst the savings forecast has fluctuated, the overall financial forecast based on spend (and therefore savings) recorded in the ledger has held steady all year (Month 1 forecast was for £11.6m overspend). **This is a sign of financial stability and evidence that the savings are being delivered as forecast.**

1.2.6 The service is now reaching a point of stability, and undelivered savings and the associated overspend will be recovered through the delayed implementation of planned activity in 2023/24. See Appendix 1 for detail of delayed delivery against individual savings.

1.2.7 The key financial risk going into 2023/24 continues to be the pace and level of savings required. Ongoing activity to deliver savings delayed from 2022/23 will run parallel to new savings proposed to committee 16th November 2022 and actions required to mitigate the corporate risk associated with CQC Assurance Framework and statutory safeguarding duties.

1.2.8 The corporate risk remains, as noted on the corporate risk register, that assurances cannot be provided regards the Adult Care local offer. Actions have been identified through Business Management Improvement Plans to ensure our compliance with legislation, in particular safeguarding.

1.3 Recovery and Mitigations Plan

1.3.1 Over-achievement against specific savings is already mitigating non-delivery of other savings by £931k for the forecast to the end March 2024 (as shown in Appendix 1)

1.3.2 The Recovery and Mitigation Plan to recover the remaining £1.3m savings and maintain our current management of increased demand for adult health and social care is seen in the context of the adult health and social care change programme and Future design of social care, approved at Committee on 16th November 2022.

1.3.3 The management of ongoing demand is being addressed through our practice development, a redesign of prevention and early help approaches and a remodel of our enablement offer. An Adults Early Help Strategy and programme is planned for consideration at Committee in March 2023.

1.3.4 Aligned with our forecast position to 1st April 2024 and areas of defined pressure the main factors to mitigate the remaining £1.3m savings are

- Review of Adults with a Disability Purchasing - the new portfolio will go live this month and one of its immediate priorities will be to review models, ways of working and practice which will mean that this service will be asked to deliver their purchasing budget in balance by 1 April 2024. This will include an options appraisal for income generation, for example the private purchase of funded services by individuals for whom the service is not part of a care plan. It is aimed that this work will generate the £726k mitigations required for this service area.

- Review of Living and Ageing Well Design – work is underway to develop the future design of the Living and Ageing Well portfolio. The priorities and funding in the Autumn statement will inform the approach to be taken and this will generate the £888k mitigations required for this service area.

- Governance and Scrutiny – as has been reported in the DASS report. Following on from the Cycle of Assurance approved at Committee, Assistant Directors will also report on their portfolio performance to Committee as part of our ongoing programme of embedding continuous improvement and assurance across social care.

2.0 2023/ 2024 BUDGET UPDATE

2.1 Autumn Statement 2022

2.1.1 On the 17th November Government tabled the Autumn Statement with detailed financial information released in late December and further policy information following more recently still. The Autumn Statement will have a significant impact on the Council's budget in 2023/24 and the full implications of this are currently being explored.

2.1.2 In the Autumn Statement the Government announced that it would be providing an additional £2bn nationally in social care grant in 2023/24. This breaks down as follows:

- £1.34bn increase for the existing national social care grant
  - Can be spent on adults or children's services
  - Most of this is recycled from delaying the cap on care costs and associated reforms
  - The rest is to compensate authorities with less ability to raise money through council tax

- £652m ASC Market Sustainability and Improvement funding
  - This incorporates the grant previously ringfenced for the Fair Cost of Care
  - It is to be spent on, "making tangible improvements to adult social care and, in particular, to address discharge delays, social care waiting times, low fee rates, workforce pressures, and to promote technological innovation in the sector".
  - The government will provide further information on reporting requirements in due course

- £300m discharge funding
  - Likely to be channelled through the NHS and guidance likely to be released end February 2023.
  - In 2022/23 this grant is tightly focused with rigid criteria on spend and prescriptive reporting requirements

2.1.3 The Autumn Statement also gave Councils the ability to raise council tax by 3% (up from 2%) and the adult social care council tax precept by 2% (up from 1%) without a referendum of citizens. Decisions on Council Tax increases are to be made on 1st May by the full council.

2.1.4 The detailed implications and final funding settlement for Sheffield will follow. This will include changes to previous business planning assumptions related to the Fair Cost of Care grant and charging reforms.

2.1.5 Additional discharge funding through the NHS will build upon improved performance in 2022/23 to meet winter pressures. Temporary winter pressures funding being replaced by permanent funding will enable an ongoing commitment to support NHS partners more effectively.

2.2 Adult Social Care 2023/24 Budget setting

2.2.1 In September this Policy Committee noted budget pressures for 2023/24 totalling £25.044m. These pressures were then updated in October 2022 based on September inflation figures and increased to **£26.037m**

2.2.2 Budget savings proposals for Adult Health and Social Care totalling **£24.9m** have been identified so far for 2023/24 leaving a budget gap of £1.1m. Any remaining budget gap for adult health and social care when the final budget is confirmed in March will require a corporate decision on how additional funding can be reallocated from other council budgets/services.

2.2.3 Notwithstanding the current budget gap there are several significant financial challenges for Adult Health and Social Care in 2023/24 which are summarised below.

2.3 Financial Challenges and Risks For 2023/24

2.3.1 National Living Wage increase

In the Autumn Statement it was announced that the National Living Wage would rise significantly higher than originally forecast. This has added £6.7m to the Adult Health and Social care budget pressures and additional grant is needed to offset this.

2.3.2 Impact of 2022/23 overspend

As described above the impact of the 2022/23 overspend in adult health and social care (largely attributable to the delayed delivery of review savings) will require ongoing activity to recover delayed savings and additional mitigating actions. This will be achieved over the course of 2023/24 – please see Appendix 1 for detail of delayed delivery against individual savings.

2.3.3 Fee uplifts for 23/24

The Council is consulting on Care Home fee rates in January and February ahead of the uplift for 2023/24. Applying the Fair Cost of Care Grant in 2022/23 has raised the standard fee rate for contracted 65+ Care Homes in year making any percentage uplift in 2023/24 more expensive. High rates of inflation are an additional funding challenge.

2.3.4 Delivery of proposed £25m savings

£25m savings proposals have so far been identified to balance the 2023/24 budget and will be subject to Council decision-making in March.

Delivering such a high level of savings in one year without slippage in 2023/24 will be challenging and this has been identified as a risk from outset set against wider corporate risks regards local offer, ongoing increased demand, and advent of CQC assurance.

2.3.5 Other risks and pressures

There are several other financial risks which will need to be managed and mitigated through the course of 2023/24. These include the additional demands of the NHS resulting from the industrial action and capacity issues, demand challenges for Disabled Facilities Grant provision and non-framework fee uplift requests. The risk mitigation and responses to Disabled Facilities Grant will be considered at March Committee.

3.0 HOMECARE HOURS AND NEW WELLBEING CONTRACTS

3.1 As part of our preparation for homecare delivery transferring to the new Care and Wellbeing contracts in 2023/24 and to meet the budgetary requirements set out in June 2022, a reduction in the number of homecare hours is required to return the number of planned hours from 39,000 hours per week to levels more consistent with pre-pandemic levels and with the levels seen post-pandemic in other Local Authorities.

3.2 At the start of the planning period in April 2022 the number of planned hours was estimated to be around 40,000 per week. Our current position, as of January 2023, is 36,800 homecare hours per week. This includes 32,000 actual hours of delivery; a further 3,500 hours currently being delivered through Direct Awards; and a moderator of 1,300 hours because the new contracts will pay on *planned* rather than actual hours.

3.3 Previous calculations have included underlying demand from hospital waiting lists, but these are currently mitigated by the additional homecare hours test of change underway, which was approved at finance committee in September 2022. If this funding is not continued beyond April, this then presents a risk to the homecare budget.

3.4 The trend for homecare hours per week over the last year has shown a reduction of 650 hours per week each month. On that basis the forecast is for the number of planned hours to have reduced sufficiently by the contract go-live date to proceed with the contract award and transfer of delivery to the successful providers without further approval being needed by this Committee.

3.5 Appendix 2 provides further detail on the actions required in preparation for the transfer of homecare delivery. This plan as well as the trajectory of planned will be monitored closely in the coming months.

4.0 RECOVERY AND MITIGATIONS

4.1 Automation and Digital Technology in Adult Health and Social Care

4.1.1 One of the Government priorities for the Market Sustainability and Improvement Funding (section 2.1.2) in 2023/24 is to promote technological innovation in the sector.

4.1.2 There are several workstreams already underway in Sheffield to explore and develop use of automation and digital technology to improve efficiency in Adult Health and Social Care including: -

- **Provider Portal**
  - Roll out to Care Homes well underway with over 60 homes now setup (140+ contacts/users)
  - It is aimed that by April this will replace the current email processes for standard forms and remittances.
  - Other provider groups will be brought onto the Portal as part of the tendering for new contracts
- **Customer Experience Surveys**
  - Automated customer experience surveys to go live this quarter (iterative development)
  - This will add much needed insight into the experience of people for improvement purposes and will require minimal administration
- **Automation in Income Management / Financial Inclusion**
  - Workshops being held to identify potential areas for automation including automating address updates across systems, automated verification, etc.

4.1.3 This activity will be incorporated in the Adult Health and Social Care Digital Strategy which is submitted for approval at Committee today and which will be a key enabler supporting the future design of Adult Health and Social Care.

4.1.4 The service is also identifying further opportunities to put forward for prioritisation within the corporate automation project (pilot areas) including further automation opportunities arising from review of processes as part of the future design of adult social care.

4.2 External Focused Review of Adult Social Care financials

4.2.1 The LGA has been contacted in January to request a follow up visit to the use of resources review that was undertaken in May 2022. The visit will further strengthen our understanding of our use of resources and potentially identify opportunities for further improvement.

4.2.2 The scope of the review is proposed to be as follows:

1. Prepare an up-to-date use of resources report for Sheffield (which we know will highlight Sheffield's very high spending on older people/ homecare especially when compared with other authorities in the region).
2. Highlight the key recommendations that were set out in the use of resources work report from the LGA review in May last year and comment where progress has been made or not from.
3. A review of the report by the LGA in November reviewing the support provided by it to Sheffield in relation to 1. Support and challenge for improvement activity and 2. Supporting the initiation of better care governance.
4. Learning based on review on savings delivery and allocation of funds to inform further mitigations.

4.2.3 Preparations are also being made to engage the Chartered Institute of Public Finance and Accountancy (CIPFA) to work with the Council improve our use of resources and financial governance, further to the note in the November Committee report noting that external consultancy was being planned.

4.3 2024/25 Business Planning

4.3.1 As the business planning cycle for the 2023/24 budget draws to a close, analysis has commenced for the 2024/25 financial year business planning.

4.3.2 In addition to detailed analysis of the Autumn Statement and the long-term impact on our funding assumptions, funding changes will be incorporated into an update of our Medium-Term Financial Strategy (MTFS).

4.3.3 Furthermore, an update to our forecast budget pressures will be issued based on national inflation figures, local demographic changes, and our priorities against the adult social care strategy.

4.3.4 The budget pressures profiled for 2024/25 will then inform improvement plans to be developed at service level over the course of the summer, ahead of formal Business Improvement Plan approval process commencing in autumn.

5.0 Integrated Commissioning: Financial Summary

5.1 The report to committee in September 2022 provided an overview of the full budget under the Adult Health and Social Care Policy Committee. The table at 5.2 provides a more detailed summary of the Integrated Commissioning element of that overall budget, including the source of funding and a summary of activity.

5.2

Integrated Commissioning Budget and Spend					
	Funding (£000s)				
Service Area	**Cash Limit**	**Public Health Grant**	**NHS**	**Other grant**	**Services Provided**
Drug and Alcohol/ Domestic Abuse Coordination Team (DACT)	1,371	6,400	-	919	£6.4m Drug and Alcohol treatment and support services; £1.1m core community Domestic Abuse support service contract; £1.2m Safe Accommodation inc. counselling and financial advice;
Housing Related Support	5,710	1,913	-	217	£5.2m Supported Accommodation; £2.6m Outreach and Prevention
Community Well-being	822	629	200	-	£1.65m People Keeping Well; work with community organisations to tackle determinants of ill-health.
Voluntary Sector Grants	605	887	-	119	£1.65m Grant Aid Programme supports VCF organisations
TOTAL	8,508	9,829	200	1,255	**19,792**

6.0 HOW DOES THIS DECISION CONTRIBUTE?

6.1 Good governance in relation to resource management and financial decision making supports the delivery of the adult social care vision and strategy

6.2 Our long-term strategy for Adult Health and Social Care, sets out the outcomes we are driving for as a service, and the commitments we will follow to deliver those outcomes.

7.0 HAS THERE BEEN ANY CONSULTATION?

7.1 The purpose of this report is provided background to the funding of Adult Social Care, an update to the forecast spend position for 2022/23 and progress with the delivery of savings. No consultation has been undertaken on these aspects.

7.2 Consultation is undertaken during the development of proposals for the budget and implementation of proposals for the budget as appropriate.

8.0 RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

8.1 Equality of Opportunity Implications

8.1.1 As part of the annual budget setting process, an overarching EIA assesses the cumulative impact of budget proposals (EIA 1128), as well as individual EIAs for each proposal that are monitored and maintained as an ongoing process.

The Savings Plan referred to in summary was agreed by the Council as part of the 22/23 Budget and the EIAs for each element remain live.

8.2 Financial and Commercial Implications

8.2.1 Our long-term financial strategy to support the implementation of the adult health and social care strategy consists of three elements:

- Supporting people to be independent
- Secure income and funding streams
- Good governance

8.2.2. This report is part of an improved financial governance framework that aims to improve understanding and provide transparency on the use of public money to the citizens of Sheffield.

8.2.3 Financial governance will be aligned with the adult health and social care strategy to ensure that opportunities for efficiency and improvement are recognised and developed by accountable owners. An emphasis on enablement and less formal support will be embedded through processes that identify a strengths-based practice at the point of assessment and review.

8.2.4 Given the overall financial position of the Council there is a requirement on the committee to address the overspend position in 2022/23 and support plans to mitigate it.

8.3 Legal Implications

8.3.1 As this report is designed to provide information about background to and an update about the financial position rather than set out particular proposals for the budget and implications, there are no specific legal implications arising from the content. The ongoing process will however assist the local authority in meeting its obligations and legal duties. Legal Services can provide advice on specific proposals as and when necessary.

8.4 Climate Implications

8.4.1 There are no climate impacts to consider arising directly from this report.

8.5 Other Implications

8.5.1 There are no further implications to consider at this time.

9.0 ALTERNATIVE OPTIONS CONSIDERED

9.1 Not applicable – no decision or change is being proposed.

10.0 REASONS FOR RECOMMENDATIONS

10.1 These recommendations are made to support strategic planning and operational decisions that are necessary for the long-term sustainability of adult health and social care and the long-term benefit of people in Sheffield.

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Appendix 1: Recovery Plan Performance by Service Area

Project Title	Target 31/03/23 (£000s)	Forecast 31/03/23 (£000s)	% By 31/03/23	% By 31/03/24	Achieved to Date (£000s)	Timeline for completion	Risks and Actions to Deliver Required Savings
1. Change and Strategy Delivery							
Operating model and MER – efficiencies and staff reduction	1500	1500	100%	100%	1125	Project on track to be in place for 1st April 2023	**Risk**: - Overall staffing costs across AHSC need to match available budget. Staffing pressures identified as establishment reviewed and corrected. **Risk Mitigation**: - All AD to set plan for March Committee on how budgets will be delivered to envelope available
Reduced Agency Spend	303	0	0%	100%	0	Reduction in agency staff planned by 1st April 2024 related to workforce strategy and new future design of social care.	**Risk:** Recruitment issues require that agency staff are still required to fulfil statutory duties. **Risk Mitigation** – Specialist recruitment to be undertaken to deliver stable workforce and reduce agency costs.
Total	1803	1500	83%	100%	1125		
2. Living and Ageing Well							
Review of new High-Cost Homecare arranged during Covid response	3470	2708	78%	89% (3.1m)	2628	£2708 planned to be delivered by 31st March 2023 with a further £380k forecast by 1st April 2024, making a total of £3088m.	**Risk:** Capacity issues due to priority of responding to new referrals. **Risk Mitigation**: - Options appraisal underway to build capacity for homecare reviews on a sustainable basis for noting at March Committee.
Right-sizing Home-Care packages increased during Covid response & Review of Direct Awards.	4408	1436	33%	88% (3.9m)	1243	£1,436 planned to be saved by 31st March 2023. A further £1.5m is forecast to be delivered in 23/24 making a total of £2.9m by 1st April 2024. This leaves £1.5m to be mitigated, of which £1m is planned via review of direct awards.	**Risk:** - Agency staff have been required to complete this work, as initial attempts to incorporate work into current workload was unsuccessful due to responding to new demand. **Risk Mitigation: -** Options appraisal underway to build capacity for homecare reviews on a sustainable basis for noting at March Committee.

Appendix 1: Recovery Plan Performance by Service Area

Project Title	Target 31/03/23 (£000s)	Forecast 31/03/23 (£000s)	% By 31/03/23	% By 31/03/24	Achieved to Date (£000s)	Timeline for completion	Risks and Actions to Deliver Required Savings
Managing new demand for high-cost support through a new Enablement test for change	1281	1281	100%	100%	961	New starter costs for homecare have decreased for fourth month in a row (now £283pw compared to £380pw last year). No completion date as target is ongoing.	**Risk:** - Enablement funded on a temporary basis with funding ending on 1st April 2023. **Risk Mitigation:** - Options appraisal to implement enablement as part of core service delivery.
Managing demand for Homecare through Equipment & Adaptations	380	380	100%	100%	285	Backlog decreased for fourth month in a row (now at 1,350 – returning to pre-covid level). Project due to be completed by June 2023.	**Risk:** - Ability to maintain focus on reducing backlog at same time as increased demand of 22% on the service. **Risk Mitigation**: - Project plan in place with clear milestones.
Reducing additional staff costs in provider services	812	812	100%	100%	0	Additional funding to meet these responsibilities has now been identified and is being pursued.	**Risks:** - Levels of absence have increased costs and use of overtime. Loss of Staff plan IT System has added to capacity issues. **Risk Mitigation:** - Retender for IT System and service development planned for 23/24.to mitigate costs.
Resetting the localities staffing budget	537	537	100%	100%	537	Delivered	n/a
Total	**10,888**	**7,154**	**66%**	**92% (10m)**	**5,654**	**£888k remains to be mitigated through additional activity**	

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Project Title	Target 31/03/23 (£000s)	Forecast 31/03/23 (£000s)	% By 31/03/23	% By 31/03/24	Achieved to Date (£000s)	Timeline for completion	Risks and Actions to Deliver Required Savings
3. Adults with a Disability							
Direct Payment Reviews	2800	468	17%	100%	216	468k forecasted by 31/03/23. A further £991k is forecast to be delivered as FYE in 23/24. Full value £1.46m (£1.3m short of target). £3m saving from ongoing review activity will be required in 23/24 to cover shortfall and meet 23/24 budget plan.	**Risks:** Several recruitments attempt from permanent workforce were unsuccessful. **Risks Mitigations:** - Agency team put in place in September to complete project.
Complex Care Review Team	1000	600	60%	130% (£1.3m)	437	Work to be completed by April 2023. £700k delivered as full year effect in 23/24 will exceed target.	**Risks:** - Recruitment to new team. **Risk Mitigation:** - Reviews have been picked up as business-as-usual. Dedicated resource to review started in October 22.
Improved Transitions Planning	252	130	52%	100%	130	Work is ongoing. Team will be able to review support for young adults methodically from 23/24 onwards and it's planned to meet the target in 23/24 due to this.	**Risks:** - Recruitment to new team and responding to backlogs in a timely way – the team are managing transition of a 100+ young adults. **Risk Mitigation: -** Team now in place and plan in place to address backlogs and waits.
Improved Social Work Practice through Strengths-Based Reviews	1157	0	0	0	-	Increases to existing packages are forecast to exceed target, making this saving unachievable. Saving cannot be recovered in 23/24 because it relates to growth rather than a specific task.	**Risks: -** Growth in numbers of Adults with complex care needs but not corresponding provision of support to meet need. **Risk Mitigation: -** Review recovery programme implemented to review existing care. Recommission of supported living, extra care, day activities underway to increase provision. Specialist review to be implemented.
Efficiency through integration of Continuing Health Care Services	400	400	100%	100%	300	Joint Package spend has reduced from £51.3m in April to £50.6m. Assuming 75% paid by SCC, that's £490k less.	**Risks:** Understanding of CHC/ JPOC across AHSC, recording on systems and separate health and care systems. **Risk Mitigation**: Review of management of CHC/ JPOC decisions currently under review. Dedicated project and team implemented to review and develop better understanding of CHC.
Direct Payment Service Transformation	359	711	198%	274% (983k)	682	New costing £295 per week compared to £464; saves 682k in 22/23 to date and a further £272k FYE in 23/24	**Risks:** Recruitment to Team, Practice Development and increases to support are increasing costs overall Risk Mitigation: - Review plan to address outdated reviews in place Jan – Jan 23 and Direct Payments Strategy agreed at Committee.

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Project Title	Target 31/03/23 (£000s)	Forecast 31/03/23 (£000s)	% By 31/03/23	% By 31/03/24	Achieved to Date (£000s)	Timeline for completion	Risks and Actions to Deliver Required Savings
Reduced liability for contract void charges	549	271	49%	100%	271	One project completed and second project due to be completed by March 2023. Saving from second project will be realised in 23/24.	**Risk:** Delays to agreement on second property delayed, incurring ongoing fixed costs. **Risk Mitigation: -** Management of void charges through regular reporting.
Vacancies and Voids costs	700	560	80%	80%	420	Void/Vacancy elements of contract arrangements under ongoing scrutiny.	**Risk:** Additional invoices have been received in the last month, reducing the forecast by 20% **Risk Mitigation:** Dedicated project management and oversight by AHSC Leadership from January 2023.
Supported Living TUPE contract ends	1000	400	40%	60%	300	A phased plan has been implemented to schedule reduction in TUPE payments by 1st April 2025.	**Risk:** Contractual requirements and provider sustainability required to meet Care Act duties. **Risk Mitigation: -** Ongoing payment of TUPE monies to be reduced on a phased agreement to maintain market sustainability.
Review of Befriending, Short Breaks and Day Activity Services	678	728	107%	107% (728k)	440	Work complete	**Risk:** New frameworks for Short Breaks and Day Services did not yield any savings. **Risk Mitigation: -** Use of in-house short breaks and development of a further in house short breaks service.
New Accommodation Strategy	111	100	90%	100%	96	Project due to be completed by March 2023.	**Risks:** Delays in finding suitable tenants that can share properties meant that vacant places were not taken up as quickly as desired. **Risk Mitigation:** Project management and to support delivery of project by March 2023 so that all savings can be realised in 2023.
Provider Services staffing budget adjustment	500	290	58%	100%	-	Budget is overspent, but there are underspends in other areas of the service. Staffing budgets will be in balance by 1st April 2024	**Risk:** In-house services were closed during covid, so staff costs were static. Since services reopened there has been increased over-time to facilitate cover, creating a cost pressure on staffing budget. **Risk Mitigation: -** Allocate underspends in other areas of the service to meet pressures.
Total	**9,506**	**4,658**	**49%**	**92% (8.78m)**	**3,440**	**£726k remains to be mitigated by additional activity**	

Appendix 1: Recovery Plan Performance by Service Area

Project Title	Target 31/03/23 (£000s)	Forecast 31/03/23 (£000s)	% By 31/03/23	% By 31/03/24	Achieved to Date (£000s)	Timeline for completion	Risks and Actions to Deliver Required Savings
4. Mental Health and Safeguarding							
Care Trust – Remodelling of social work mental health provision.	1000	760	76%	100%	477	This project will be completed by 1st April 2024 aligned to a wider review of health and care. Notice has been served on the contract with end date of 31st March 2023.	**Risks:** Vacancies in the service and staff departures indicated a reduced staff spend was achievable; however, service is over budget on staff. **Risk Mitigation:** risk now placed within purchasing budget as part of review programme and new practice.
Safeguarding, MH and Domestic Abuse delivery efficiencies and contractual review	300	*100*	33%	33%	50	To be discussed corporately whether this saving is now applicable to Adult Services.	**Risks:** The original project could not be delivered due to organisational changes. **Risk Mitigation:** Discuss through Corporate Boards how the risk will be mitigated.
Domestic Abuse Refuge funding	350	350	100%	100%	350	Delivered	n/a
Total	**1,650**	**1,210**	**73%**	**88%**	**877**	**200k remains to be mitigated.**	
5. Adult Commissioning and Partnerships							
Vulnerable People: Commissioning staff saving	100	100	100%	100%	100	Delivered	n/a
Total	**100**	**100**	**100%**	**100%**	**100**	**Delivered – No Mitigations Required**	
6. Governance and Inclusion							
Income & Payments Programme	854	1383	150%	150%	854	Delivered (529k over delivery forecast)	n/a
Financial assessment review fast track	200	200	100%	100%	200	Delivered	n/a
Supplies and Services	200	200	100%	100%	150	Metric is spend on supplies across the service; as such work is ongoing.	n/a
Total	**1,254**	**1,783**	**142%**	**142%**	**£1,204**	**Delivered – No Mitigations Required**	

Appendix 1: Recovery Plan Performance by Service Area

Project Title	Target 31/03/23 (£000s)	Forecast 31/03/23 (£000s)	% By 31/03/23	% By 31/03/24	Achieved to Date (£000s)	Timeline for completion	Risks and Actions to Deliver Required Savings

7 Overall Total

Saving Category by Portfolio	Target 31/03/23 (£000s)	Forecast 31/03/23 (£000s)	Forecast 31/03/24 (£000s)	Forecast % by 1st April 2023	Forecast % by 1st April 2024	Mitigations Required (£000's)
Change and Strategy Delivery	**1,803**	1,500	1,803	83%	100%	0
Living and Ageing Well	**10,888**	7,154	10,000	66%	92%	888
Adults with Disabilities	**9,506**	4,658	8,780	49%	92%	726
Mental Health and Wellbeing	**1,650**	1,210	1,450	73%	88%	200
Care Governance and Inclusion	**1,254**	1,783	1,783	142%	142%	-529
Commissioning and Partnerships	**100**	100	100	100%	100%	0
Chief Social Work Officer	**0**	-	-	-	-	0
Total	**25,201**	**16,405**	**23,916**	**65%**	**95%**	**1,285**

Appendix Two: Care and Wellbeing Service – Pre – Contract Go Live Action Plan

	Completed/ On Track		Close Monitoring in Place		Identifying a Risk

Initiative	Action/Target	Timing	RAG	Progress	Owner
Case file Audit	Best practice related to homecare support	March 2023		Audit of 150 cases; findings will inform practice development and service practice development plan. Agency team has started this work prior to completing reviews.	Chief Social Work Officer
Reviews of existing homecare packages	Complete 1400 reviews and set up monitoring arrangements	September 2023		64% (896) of home care reviews completed to date. A service wide review plan has been developed with core services to be re allocated to increase pace of reviews to meet 85% target by June 2023 (294 reviews to complete). This will then leave 210 reviews to complete by go live date in September 2023.	Assistant Directors Living and Ageing Well Assistant Director Commissioning and Partnerships
Direct awards	Move Direct Awards onto Framework Providers	May 2023		Due to the extra ordinary demand experienced at winter, this meant more Direct Award's (an increase of 34 people from November) were implemented to be able to deliver care. The risk mitigation is discussions with NHS regards the pressure this has established and to building capacity in the homecare framework to transfer Direct Awards back across to framework providers as a priority by May 2023.	
Cleaning and Shopping	Procure new services and agree approach to existing support	Summer 2023 (Pre-contract go live)		As part of implementation of practice development plan and programme, practice will focus on looking at new ways of working. A specific contract outside of homecare for people who have an eligible need for support with cleaning/shopping under Care Act will be progressed service wide March 2023.	

Appendix Two: Care and Wellbeing Service – Pre – Contract Go Live Action Plan

	Completed/ On Track		Close Monitoring in Place		Identifying a Risk

E & A backlog reduction	Backlog reduced to below 500 people	Summer 2023 (Pre contract go live)		The service has reduced waits for assessment to around 1,300 (back to pre-covid levels) at January 2023 and reduced length of wait from 18 months to 6 months. Focus between January and June is to reduce waits to 400 by June 2023. Longer term target is to manage a waiting list of 100 people, waiting for up to 6 weeks.	Assistant Directors Living and Ageing Well
Stabilising market	Key messages for customers and providers, including providers exiting the market	Spring 2023		Communications plans developed for review. Monitoring requests for transfer to Direct Payment from existing people in progress.	Assistant Director Commissioning and Partnerships
Trusted Reviewer	Definition, criteria for selection, guidance, system, training	Spring 2023		To date following has been completed - Finalised definitions in new service specification. C&WS test for change complete. Next Steps is to: - test Trusted Reviewer approach with Fosse, STIT and the Living and Ageing well teams before roll-out to / development with the successful 16 providers and implement training the providers on care act is planned.	Assistant Director Commissioning and Partnerships
Recruitment cross sector	Online One stop shop for recruitment across sector. Apprenticeships, Culturally diverse workforce	Spring 2023		A new webpage and recruitment campaign close to completion. Recruitment campaign will target untapped markets which would come be later in plan. Will supporting existing good practice and give definition of SCC role to support sector wide recruitment.	Assistant Director Commissioning and Partnerships

Appendix Two: Care and Wellbeing Service – Pre – Contract Go Live Action Plan

	Completed/ On Track		Close Monitoring in Place		Identifying a Risk

Retention cross sector	Values and L&D plan, career pathways, improved rates & conditions	Summer 2023		Work across sector to make skills for care funding available. Will target falls prevention and digital skills as a priority.	Assistant Director Commissioning and Partnerships
Enablement approach	Definition, practice guidance for each sector, training, audits	March 2023		Developing factsheets for 8 key tests of change and practice guidance regards cleaning and shopping. Examples of good practice within current Enablement team for embedding across Adult Social Care as part of introduction of new teams within the future design.	Chief Social Work Officer
Technology enabled care	Digital strategy development. Self-service for equipment launch as part of new IAG offer	Autumn 2023		Committee approved report outlining ambitions for technology in homecare in next 18 months. A test of change is underway to support a new offer and training offer will be developed around falls prevention and digital skills. Longer term we are developing an ASC digital strategy.	Assistant Director Commissioning and Partnerships
Fosse CWBS test for change	Case studies from Test for Change; Systems work for new PCN areas and providers; Health and provider partnerships, MDTs	Summer 2023 (Pre-contract go live)		In progress and further review being undertaken to confirm next steps for delivery by summer 2023.	Assistant Director Commissioning and Partnerships

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Report to Policy Committee

Author/Lead Officer of Report:
Catherine Bunten

Tel: 07786112884

Report of:	Director of Adult Social Care
Report to:	Adult Health and Social Care Committee
Date of Decision:	8th February 2023
Subject:	Market Oversight and Sustainability – Adult Social Care

Has an Equality Impact Assessment (EIA) been undertaken?	Yes	X	No	
If YES, what EIA reference number has it been given? 1256				
Has appropriate consultation taken place?	Yes	X	No	
Has a Climate Impact Assessment (CIA) been undertaken?	Yes		No	X
Does the report contain confidential or exempt information?	Yes		No	X

If YES, give details as to whether the exemption applies to the full report / part of the report and/or appendices and complete below:-

*"The (**report/appendix**) is not for publication because it contains exempt information under Paragraph (**insert relevant paragraph number**) of Schedule 12A of the Local Government Act 1972 (as amended)."*

Purpose of Report:

This report seeks approval from Committee for Sheffield's Market Oversight and Sustainability Plan 2023/24 (Appendix 1), which sets out how we will ensure that we fulfil out statutory duties as set out in the Care Act 2014.

The report also asks Committee to endorse a Care Quality Framework (Appendix 2) which seeks to define the standards we expect from the delivery of care by all adult social care services: both our council run service and all commissioned care services.

These two documents form part of our Care Governance Strategy, contributing to improving our performance, quality and outcomes.

Recommendations:

It is recommended that the Adult Health and Social Care Policy Committee:

1. Approves Sheffield's Market Oversight and Sustainability Plan 2023/24.
2. Approves the Care Quality Framework
3. Requests that the Director of Adult Health and Social Care review and refreshes the Market Oversight and Sustainability Plan and the Care Quality Framework annually for subsequent consideration by the Committee

Background Papers:

AHSC Committee Report: Market Shaping and Fair Cost of Care, 22 Sept 2022
AHSC Committee Report: Care Governance Strategy 15 June 2022
Appendix 1 – Market Sustainability Delivery Plan
Appendix 2 – Care Quality Framework
Appendix 3 – DHSC Update regarding cost of care and market sustainability plan submission 17/01/23
Appendix 4a – Fair Cost of Care – Care Home Final Report
Appendix 4b – Fair Cost of Care – Domiciliary Master Report
Appendix 5 – Equality Impact Assessment

Lead Officer to complete: -		
1	I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.	Finance: *Liz Gough* Legal: *Patrick Chisholm* Equalities & Consultation: *Ed Sexton* Climate: *Jessica Rick*
	Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.	
2	**SLB member who approved submission:**	*Alexis Chappell*
3	**Committee Chair consulted:**	*Cllrs Angela Argenzio and George Lindars-Hammond*
4	I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Committee by the SLB member indicated at 2. In addition, any additional forms have been completed and signed off as required at 1.	

Lead Officer Name: *Catherine Bunten*	**Job Title:** *Interim Head of ASC Commissioning*
Date: *27/01/23*	

1. PROPOSAL

1.1 An Adult Health and Social Care Strategy and an accompanying Adult Health and Social Care Strategy Delivery Plan were approved in 2022 to set out our vision for 2022 to 2030. Called 'Living the life you want to live', it is about how we work together to help the people of Sheffield to live long, healthy and fulfilled lives.

1.2 Our vision is that everyone in Sheffield lives in a place they can call home, in communities that care, doing things that matter to them, celebrated for who they are - and when they need it, they receive care and support that prioritises independence, choice, and recovery

1.3 The vision is centred around delivery of five outcomes and six commitments. Our outcomes help to make our vision real – they are about what we want to focus on getting right. Our commitments are guiding principles we will follow and describe how we will achieve our outcomes and highlight what we want to do better.

1.4 The proposals in this report align with our vision and primarily supports the delivery of Commitment 6:

'We will make sure there is a good choice of affordable care and support available, with a focus on people's experiences and improving quality'.

1.5 A Care Governance Strategy was approved by the Adult Health and Social Care Policy Committee on 15th June 2022 to provide assurance and set a standard about the leadership, delivery, and quality of all adult social care services across Sheffield, whether delivered by the Council or by independent providers (commissioned or not), so that we can deliver upon our Strategy and vision.

1.6 The purpose of this report is to seek approval from Committee for Sheffield's Market Oversight and Sustainability Plan 2023/ 24, attached at Appendix 1 and the Care Quality Framework, attached at Appendix 2 to support our implementation of the Care Governance Strategy, and to fulfil our responsibilities as they relate to market sufficiency as set out in the Care Act 2014.

2 MARKET OVERSIGHT AND SUSTAINABILITY

2.1 Securing sufficient care and support provision that meets the needs of our population is a statutory requirement for all Local Authorities. This duty, as set out in the Care Act 2014, recognises that "high quality, personalised

care and support can only be achieved where there is a vibrant, responsive market of services available".

2.2 The Care Act places duties on local authorities to promote the efficient and effective operation of the market for adult care and support in the local area. In fulfilling this duty, local authorities must therefore ensure good oversight and understanding of the local care market. This covers both commissioned and non-commissioned services – including those used by self-funders.

2.3 Local authorities should shape the market– an activity that enables choice for people who might need services and ensures that the market is stable and diverse – offering high quality provision from lower level and preventative services within communities through to 24-hour care and support in a care home setting.

2.4 This should also include contingency planning, providing a robust response in the event of provider failure and thereby minimising any impact on people using the service.

2.5 The market oversight and sustainability plan therefore sets out Sheffield's approach to meeting its sufficiency needs and duties for adults with additional needs in the City. It describes our approach to commissioning and how Sheffield will fulfil its role to facilitate and shape a diverse, sustainable, and quality market, as well as identifying the key challenges and risks to achieving this and our approach to overcoming them to ensure that our local care market is sustainable.

2.6 The plan considers the extent to which care and support markets in Sheffield are sufficient and stable, meeting quality standards, and providing value for money.

2.7 Sheffield is already taking action to continue to secure a sustainable market, and to drive improvements. These include:

Whole market improvements

- Digital Strategy
- Technology Enabled Care programme
- Workforce Development Strategy
- Delivery of the Individual Support Funds pilot

Living and Ageing Well

- Homecare transformation programme, including procurement of the Care and Wellbeing service, our new delivery model for homecare and a Test of Change project to inform mobilisation of the new contract and focus our collective efforts on the areas with most positive impact for people

- Strategic Review of residential care, including the development of a co-produced support programme for the sector and commissioning strategies

Adults with a disability

- Development and tender of a new MH Support and Independence framework
- Tender for the Adults with a Disability Framework
- Enhanced Supported Living Framework

2.8 It should be read alongside Sheffield's Market Shaping Statement (agreed at AHSC Policy Committee on 21st September 2022) and accompanying Market Position Statements, which can be found on the Council's website here: Adult social care commissioning | Sheffield City Council

2.9 Our Market Position Statements give providers a range of information to support business planning and development. They set out commissioning plans and aim to offer a clear picture of what gaps there are in the existing care market.

2.10 **Market Sustainability and Fair Cost of Care**

2.10 This year, Market Oversight and Sustainability Planning takes place in the context of the Fair Cost of Care exercise

2.11 As part of the government's adult social care reform agenda, local authorities have been required to complete a 'Fair cost of care' exercise, and in December 2021, the government announced the Market Sustainability and Fair Cost of Care Fund 2022 to 2023 to support local authorities to do this (alongside preparation for wider planned Social Care Reforms).

2.12 In 2022 to 2023, £162 million was allocated, with Sheffield City Council receiving £1.826m. Conditions for 22/23 funding included the requirement to - where average fee rates are below the fair cost of care - allocate at least 75% of this funding to increase fee rates paid to providers.

2.13 Adult Health and Social Care Policy Committee approved the allocation of the 22/23 Market Sustainability and Fair Cost of Care Fund on 19th December 2022.

2.14 Since the Fair Cost of Care exercise has been completed, however, the national position has changed. The Autumn Statement announced on the 17th November 2022 changed the context for Social Care Reform and the Market Sustainability and Fair Cost of Care Fund significantly.

2.15 Whilst funding for implementation will be maintained, this is now combined with further grant funding for local authorities to address a broader set of improvements - including hospital discharge, technological innovation, and workforce pressures - and has been rolled into the Social Care Grant.

2.16 There will be reporting requirements placed on the Adult Social Care Market Sustainability and Improvement Funding regarding performance and use of funding to support improvement against the objectives. The government will provide further details on reporting in due course.

2.17 Local authorities are required to publish their Market Sustainability Plans (by 27th March 2023) and Fair Cost of Care Reports (by 1st February 2023). Guidance from the Department of Health and Social Care on publication is attached at Appendix 3, and Sheffield's Fair Cost of Care Reports are attached at Appendix 4a & 4b.

3 CARE QUALITY FRAMEWORK

3.1 A Care Governance Strategy was developed for Adult Social Care to provide an overarching framework for the governance of all aspects of Adult Health and Social Care and as an enabler for implementation of the Adult Social Care Strategy. This was approved at Committee on 15th June 2022.

3.2 The Care Governance Strategy set out an ambition to improve quality and outcomes through assuring the quality of practice and provision and improving population, and performance outcomes.

3.3 It also set out that we would create the conditions for ongoing and continuous improvement of adult social care services in the delivery of support to the people of Sheffield, which includes empowering experts by experience and our workforce.

3.4 As part of this approach to embedding Quality Improvement and implementing the Care Governance Strategy, a Care Quality Framework has been developed so that:

- people know the standards of the service which should be delivered no matter who the provider is
- people experience equality of access high quality services that deliver culturally appropriate care and support
- the adult social care workforce, including commissioned providers, share a clear vision of what high-quality care looks like and how they can contribute to delivering it
- the views and feedback from individual's and carers' views informs quality assurance activity and service development and improvement

3.5 The framework sets out:

- Our approach and standards for Care Quality
- The quality assurance process and system support

3.6 It is intended that the Care Quality Framework is implemented and reviewed in 2023/24; developing as new models of care and support are mobilised in the City.

3.7 The Care Quality Framework is attached at Appendix 2 for approval.

4. HOW DOES THIS DECISION CONTRIBUTE?

4.1 This proposal supports a broad range of strategic objectives for the Council and city and is aligned with "Our Sheffield: One Year Plan" – under the priority for Education Health and Care; Enabling adults to live the life that they want to live and the Councils Delivery Plan approved at Strategy and Resources Committee on 30th August 2022.

4.2 Market sustainability, alongside the Care Governance Strategy, and the Care Quality Framework are key to the delivery of the Council's statutory responsibilities for Adult Social Care including the following outcomes for the people of Sheffield:

- promotion of wellbeing
- protection of (safeguarding) adults at risk of abuse or neglect
- preventing the need for care and support
- promoting integration of care and support with health services
- providing information and advice
- promoting diversity and quality in providing services

4.3 This proposal also meets the 'Efficient and effective' outcome set out in the Adult Social Care Strategy. Effective Market Shaping should ensure that people have a choice of good services that meet their needs and give them a positive experience regardless of their background, ethnicity, disability, sex, sexual orientation, religion, or belief.

5 HAS THERE BEEN ANY CONSULTATION?

5.1 The ASC Strategy, which has informed our commissioning intentions, was developed through significant consultation over an 18-month period. This involved people receiving services, carers, providers, partners, and workforce across the sector.

5.2 The Fair Cost of Care exercise has relied on the participation of care providers to input data into the respective online tools, and further engagement has been undertaken in the development of our final Market Sustainability Plan.

6 RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

6.1 Equality Implications

6.1.1 As a Public Authority, we have legal requirements under the Equality Act 2010. This includes the Public Sector Equality Duty, under which public

authorities must, in the exercise of their functions, have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is connected to protected characteristics and prohibited by or under this Act;
- advance equality of opportunity between those who share a relevant protected characteristic and those who do not; and
- foster good relations between those who share a relevant protected characteristic and those who do not.

6.1.2 The broad ambitions set out above are consistent with The Duty. These include promoting independence and wellbeing and for people to be actively involved in the design of their own support; envisaging a range of different types of provision envisaged (supported living, extra care, residential care, etc), including support for people with complex needs; aiming for preventative and community-based support, including for people with mental ill health."

6.1.3 The Equality Impact Assessment can be found at Appendix 5.

6.2 Financial and Commercial Implications

6.2.1 The Council has a statutory duty to set a balanced budget. For 23/24, a standstill budget approach has been adopted because of the Council's financial position, with each committee asked to work within their budget envelope.

Full consideration will be given to the affordability and viability of any proposals and will include financial modelling, demand, and growth implications.

6.3 Legal Implications

6.3.1 The Care Act 2014 sets out the law around market development in adult social care. It enshrines in legislation duties and responsibilities for market-related issues for various bodies, including local authorities. Section 5 of the Care Act sets out duties on local authorities to facilitate a diverse, sustainable high-quality market for their whole local population, including those who pay for their own care and to promote efficient and effective operation of the adult care and support market as a whole. The statutory guidance to the Act suggests that a local authority can best commence its market shaping duties under Section 5 of the Care Act by developing published Market Position Statements with providers and stakeholders. The proposals are therefore in line with the Council's legal obligations.

6.4 Climate Implications

6.4.1 The commissioning of care and support services for Adults in Sheffield can have a large impact on Sheffield's Climate Emergency.

6.4.2 For example:

- The care workforce is significant, and is required to travel across the city, working together to create better opportunities for 'active travel' can help to reduce emissions from transport
- The energy efficiency of the buildings in which care is delivered (such as day services, or residential care) provides a significant opportunity to reduce our carbon emissions, and commissioning should encourage and enable improvements to environmental standards and promote renewable energy.

6.4.3 There will be additional areas of impact to transport and energy efficiency, and we will be bringing forward a Climate Action Plan for Adults Social Care to fully assess these, alongside an action plan setting out how we will contribute to Sheffield's 'Net Zero' Climate ambitions.

6.4.4 Further, Climate Impact Assessments will be undertaken as a key element of our commissioning approach, and we want providers and partners to align with our Net Zero ambitions and will be looking to work with them to identify key areas of impacts in their activities and how we can reduce, monitor and measure these.

6.4.5 Giving early indications of this intention to the market is important as it potentially links to cost of providing the service, for example when thinking about things like energy use and the business case for providers to invest in alternative energy sources.

6.5 Other Implications.

7 ALTERNATIVE OPTIONS CONSIDERED

7.1 The development of Market Sustainability Plans is consistent with Council's duty to oversee and if necessary to intervene in the market to ensure that people have a choice of good quality support providers to choose from should they need to draw on social care services, whether funded by themselves or from public funds.

8 REASONS FOR RECOMMENDATIONS

8.1 The recommendations arise from the Council's market shaping responsibilities and from the need to fulfil the conditions for receiving the DHSC's Market Sustainability and Fair Cost of Care Fund (2022-23).

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Adult Health and Social Care

Market Oversight & Sustainability Delivery Plan 2023/4

Adult Health and Social Care: Market Sustainability Delivery Plan 2023/4

Our Vision and Ambitions for people of Sheffield

Our vision is that 'everyone in Sheffield lives in a place they can call home, in communities that care, doing things that matter to them, celebrated for who they are - and when they need it, they receive care and support that prioritises independence, choice, and recovery.

The vision is centred around delivery of five outcomes and six commitments. The commitments and outcomes are the guiding principles we will follow and how we deliver the strategy. They show how we will achieve our outcomes and highlight what we want to do better. These commitments are:

1. Support people to live a fulfilling life at home, connected to the community and resources around them, and provide care and support where needed.
2. Provide temporary assistance to help people regain some stability and control in their life following ill health or crisis
3. Provide care and support with accommodation where this is needed in a safe and supportive environment that can be called home.
4. Make sure support is led by 'what matters to you,' with helpful information and easier to understand steps.
5. Recognise and value unpaid carers and the social care workforce, and the contribution they make to our city.
6. Make sure there is a good choice of affordable care and support available, with a focus on people's experiences and improving quality.

Our Commitment to Market Sustainability

It is only through having a sustainable market, that we can assure ourselves of provision and continuity of care for the people of Sheffield. The Care Act 2014 places a duty on local authorities to assure themselves and have evidence that fee levels are appropriate to provide the agreed quality of care, and enable providers to invest in staff development, innovation, and improvement.

To that end it is our ambition that we facilitate an efficient and effective market, leading to a sustainable and diverse range of care and support, delivering choice, and driving improvement and better outcomes for Adults in need of care and support in the City.

An assessment of Market Sustainability considers:

- adult social care statutory duties
- an analysis of the current context, including the strengths and risks facing the market (for example Care Quality Commission returns, sufficiency of supply and occupancy levels, equalities, financial context, geographical context, workforce stability and sufficiency)
- an analysis of future market changes

In 2022/23, Sheffield Council is undertaking a Fair Cost of Care exercise in line with the Government's Market Sustainability and Fair Cost of Care Fund conditions.

What is Market Sustainability?

A sustainable market is one which has a **sufficient supply of high-quality services**, and can deliver investment, innovation, and choice in care and support service provision.

It is a market with a **sufficient workforce**, receiving a fair rate of pay and supported with training and development to have the skills and knowledge to meet the needs of people receiving care and support.

It also refers to a market which **operates in an efficient and effective way.**

Market Sustainability is therefore indicated by:

- A sufficient supply of services to ensure continuity of care with minimal disruption in the event of providers exiting from the market
- A range of high-quality services for people to choose from
- Sufficient investment in its workforce to enable the attraction and retention of high-quality care staff
- Evidence of innovation and service diversity in order to evolve and meet changing user needs
- Being attractive to new market entrants and able to manage and offset the impact of future market changes

Provider entry and exit

Market sustainability does not mean that providers do not ever exit the market: it is normal in a healthy market for businesses to both enter and exit. This may be due to a decision to close, business failure, or managed exits by local authorities. A *sustainable market* means that where there is provider exit, there are sufficient alternative care services so that continuity of care can be maintained for people.

Statutory Duties and Regulatory Framework

Local authorities' duties in Market Sustainability are covered in section 5 of the Care Act 2014:

A local authority must promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person in its area wishing to access services in the market:

a) has a variety of providers to choose from who (taken together) provide a variety of services;
b) has a variety of high-quality services to choose from;
c) has sufficient information to make an informed decision about how to meet the needs in question.

In performing that duty, a local authority must have regard to the following:

a) the need to ensure that the authority has, and makes available, information about the providers of services for meeting care and support needs and the types of services they provide;
b) the need to ensure that it is aware of current and likely future demand for such services and to consider how providers might meet that demand;
c) the importance of enabling adults with needs for care and support, and carers with needs for support, who wish to do so to participate in work, education or training;
d) the importance of ensuring the sustainability of the market
e) the importance of fostering continuous improvement in the quality of services and the efficiency and effectiveness with which services are provided and of encouraging innovation in their provision; and
f) the importance of fostering a workforce whose members are able to ensure the delivery of high-quality services

The CQC, in its Single Assessment Framework, will also consider the sustainability of the market through key themes:

- **Working with People** - Includes assessing needs (including unpaid carers), supporting people to live healthier lives, prevention, well-being, information & advice
- **Providing Support** - Includes market shaping, commissioning, workforce equality, integration & partnership working
- **Ensuring Safety** - Includes safeguarding, safe systems & continuity of care
- **Leadership Capability** - Includes capable & compassionate leaders, learning, improvement, innovation

What Does Good Look Like?

We have started this delivery plan by setting out some initial indicators of what we think good looks like. The plan is to continue to develop these indicators in partnership with the people we support, carers and providers.

Leadership & Governance

- ✓ Strategic leaders, commissioners and providers work together, and evidence joined up visible and effective leadership around a shared vision and plan
- ✓ Staff, Adults, Carer and Partners feel confident about the support, leadership, and plans in place.
- ✓ Information to support people in receipt of, or purchasing care to make informed decisions and information to support providers to respond to changing needs is accessible, current, consistent, and clear
- ✓ Oversight of the market is comprehensive and identifies risks early. SCC and partners work collectively to deliver the improvements and mitigations to stabilise care

Sufficiency & Stability

- ✓ There is sufficiency of services to ensure timely provision and continuity of care
- ✓ There is diverse range of good quality provision in the City, offering a choice in the type of support provided, and choice of who provides that care and support
- ✓ Staff retention is high, with a low vacancy and turnover rate
- ✓ The workforce is supported by fair rates of pay and high-quality training and development
- ✓ Rates cover the costs of care and reasonable profit/surplus
- ✓ Oversight of the market picks up risks, and proactive support and activity ensures continuity of care

Quality & Outcomes

- ✓ All care provision is rated as 'Good' or better (by people with lived experience, their families and carers, by the CQC and by SCC)
- ✓ Care provision reflects the needs and preferences of people in Sheffield, and reflects the cultural diversity in the City
- ✓ Providers of care prioritise independence, using a strength based and personalised approach to maintain connections to communities and networks
- ✓ Disproportionality in access, experience and outcomes is understood and actions to address are collectively owned and monitored
- ✓ Adults and their unpaid carers are integral to service planning and their views inform continued improvements.

Providing Support

- ✓ We will have the right balance in cost and impact of service delivery, managing our resources effectively to respond to changing demands
- ✓ Rates are 'fair', covering costs, aligning with quality, delivery best value for public money and support investment, innovation, and quality.

Market Oversight

In addition to the CQC Market oversight scheme[1], Sheffield ASC Quality and Improvement team lead on the quality assurance of the market working together with the ASC Commissioning and Partnerships service and internal and external partners to ensure effective oversight of care provision in the City.

The contracts managed by the team include:

- Care Homes (nursing and residential) with a joint monitoring framework with SYICB (Sheffield).
- Short Term Bed arrangements (S2A, respite)
- Home Care & Extra Care schemes
- Care at Night
- Supported Living
- Day Activities
- Mental Health Providers, including Recovery Framework and Promoting Independence
- Healthwatch
- Medequip
- Sheffield Advocacy
- Trusted Assessor

The Team manages the Recognised Provider List (RPL), a list of quality checked and monitored providers intended to give people using their own budget assurance of the providers listed.

The Team act on intelligence received regarding non contracted providers. This includes providers who are delivering a service via a direct payment, self-funded arrangements, or through spot purchase or direct awards.

Regular reporting provides assurance on the sustainability of the market and includes monthly meetings with SYICB (Sheffield) and the Care Quality Commission Inspection Manager for the area.

[1] The CQC assesses the financial sustainability of adult social care providers that could be difficult to replace if they were to fail and one or more care services stopped and gives advance notice to local authorities so they can put plans in place to ensure that people who are affected continue to receive care. This is a statutory scheme with the CQC duty to perform this role set out in the Care Act 2014.

Care Homes and Supported Living

Care Homes and Supporting Living Providers have visits twice in a 12-month period.

On the visits, we undertake observations of practice and delivery of support and care, as well as checking documentation such as training for staff, accidents and incidents, care & support plans. We speak to residents and individuals using the service to gain their views and input. We give feedback on the day of the visit and we send a written report with an action plan for follow up where appropriate. We build positive relationships with providers and staff to effectively support good practice and challenge poor practice to drive improvements. We undertake risk assessments following our visits and have a monitoring plan for incidents and safeguarding concerns ensuring we are able to identify problems early, preventing escalation and identify organisational abuse.

Should a provider be escalated into our joint SCC/SYICB risk management process, we visit the provider and meet every 4-6 weeks to monitor against an improvement plan. We work collaboratively with the provider to ensure that changes are made to sustain positive practice going forward.

Home Care and Extra Care

We carry out a quality visit to home care and extra care providers at least quarterly. Where there is an identified quality issue the provider may be visited more often alongside an action plan developed to improve quality. All primary contracted providers attend a formal quarterly performance meeting.

We collate monthly key performance information from our contracted providers which is analysed and shared within the team.

Should a provider be escalated into our risk management process, we meet every 4-6 weeks to monitor against an improvement plan.

Each week there is a Market Management discussion to review all the packages of care assigned to Brokerage. This meeting identifies areas for closer scrutiny and discussions with contracted providers and aims to ensure timely provision of care.

A monthly performance report is produced and shared with stakeholders on the above areas of work.

Other Care and Support Provision

A new quality and budget monitoring framework has been developed for Medequip to include contract key performance indicators and quality outcomes. We hold monthly contract meetings with the provider and Sheffield SYICB (Sheffield) as a joint contract.

Quality and budget monitoring for Advocacy, Dementia Day Opportunities and Mental Health services against contract KPIs on a quarterly basis and undertaking on-site visits to view how services are delivered to meet individual needs. We also check that case management, support plans and other documentation is person-centred and focused on enabling a good quality of life and promoting independence.

Market Sustainability Delivery Plan

Ambition: Adults in Need of Care and Support benefit from an efficient and effective market, leading to a sustainable and diverse range of quality care and support, delivering choice, and driving improvement and better outcomes.

Context: A sustainable market is a critical part of delivering excellent social care services.

Accountable Officer: Director Adult Health and Social Care **Lead:** AD Commissioning and Partnerships	**Accountable Committee/ Board:** Adult Health and Social Care Policy Committee

Theme / Indicator	Milestone/action	By when	RAG
A sufficient supply of services to ensure continuity of care with minimal disruption in the event of providers exiting from the market	A provisional market sustainability plan to be submitted to Department of Health and Social Care outlining assessment of the sustainability of Sheffield's local care market in relation to 65+ care home services and for 18+ domiciliary care services. The provisional market sustainability plan will: • consider the results from the cost of care exercises • consider the impact of future market changes over the next three years, particularly in the context of adult social care reform • set out an outline action plan to address the issues identified and the priorities for market sustainability investment	14 October 2022	COMPLETE
	A final market sustainability plan to be submitted in February 2023, once budgets are agreed following the publication of the Local Government Finance Settlement 2023 to 2024. This plan to include how the Sheffield will improve fee rates.	February 2023	GREEN
	Undertake a full assessment of Market Sustainability including adult social care statutory duties, CQC information and returns; local data and intelligence; sufficiency and diversity in the market for different types of care, and different geographical areas; occupancy levels; equalities data and information; the financial context – including current rates of care; and workforce stability and development.	1st March 2023	Market Oversight and Sustainability plan complete, actions required to develop further
	Undertake a programme of engagement to cover Social Care Reform and Market Sustainability to ensure the market is prepared and enabled through the change and is able to inform Sheffield's commissioning strategies to meet the needs of adults needing care and support in the City.	February 2023	Engagement with providers through regular forums. Reforms postponed
	Development of Market Position Statements for Ageing and Living Well, Working Age Adults, and Mental Health to improve information and planning with providers	Spring 2023	GREEN
	We will be undertaking a "cost of care" exercise to include residential services for Working Age Adults and Mental Health to support a transparent and clear model for costs and standards of provision	Summer 2023	GREEN

	Work collaboratively at a regional level to develop outcome-based care standards, providing greater consistency for care providers and launching Sheffield's Care Quality Standards to support effective and 'whole market' contract management and quality assurance	Winter 2022	GREEN
A range of high-quality services for people to choose from	Commissioning a new Mental Health Independence and Support Framework to strengthen provision for people needing care and support in their own tenancies or accommodation through three levels of support: • Helping people to help themselves - Universal Services and Resilient Communities. • Help when needed - Targeted Help (including crisis and reablement). • Helping people to live their lives - Ongoing Care	Autumn 2022	COMPLETE
	Commissioning a new Working Age Framework that covers Supported Living, Enhanced Supported Living and Activities outside the home. The framework will build in supports to the workforce, provide longer contract terms to promote market stability and sustainability, increase choice and diversity in the activities outside the home market and strengthen our contract management and quality oversight mechanisms	Summer 2023	GREEN
	Development of overseas recruitment programme in partnership with providers	Spring 2023	GREEN
Sufficient investment for development of the workforce and to support retention and recruitment of high-quality care staff	Working at a system level to develop a workforce strategy	Ongoing	GREEN
	Transformation of Home Care in the procurement of a Care and Wellbeing Service, outcome focused care and support that supports workforce stability and moves towards improved terms and conditions for staff, including a test of change for shift-based work. Area based providers will strengthen community networks and partnership working to the benefit of people in receipt of the service. Development of 'Trusted Reviewer' model	Winter 22 – Summer 23	AMBER
Evidence of innovation and service diversity in order to meet changing user needs	Inclusion of "Innovation" lot in Working Age Adults Framework to support creativity and flexibly in the development of services, led by people in Sheffield and the sector.	Spring 2023 onwards	GREEN
	Agree Digital Strategy, including programme for TEC	Jan 2023 – April 2023	GREEN
	As we procure, new contracts set out clear processes and approaches to fee increases to support providers in their financial planning	Ongoing	GREEN
Being attractive to new market entrants and able to manage	Commissioning strategies that promote longer term contracts where appropriate to encourage investment in Sheffield, develop longer term partnerships with providers, provide more stability and ability to plan:	Summer 2023	GREEN

and offset the impact of future market changes	• Care and Wellbeing Service (home care) • Working Age Adults Framework • Accommodation with Care (residential care homes)		
	• Improving charging models to allow providers to plan care and provision, and use their expertise to invest in and develop best practice	Summer 2023	GREEN
	Improving charging models to allow providers to plan care and provision, and use their expertise to invest in and develop best practice	Summer 2023	GREEN

Market Oversight & Sustainability 2023/4

Sufficiency & Stability	• We will ensure that we have a diverse range of good quality provision in the City, connected to support networks and communities, promoting choice and able to deliver personalised care and meet the needs of Sheffield's changing population profile
Quality	• Services will provide care and support that meets the standards we would expect: effective, safe, well led and sustainable, where people have a positive experience and say that their personal outcomes are met
Value for money	• We will have the right balance in cost and impact of service delivery, managing our resources to support investment in preventative services and to respond to changing demands.

Care Homes

SUFFICIENCY	
WHERE ARE WE NOW	ACTION PLAN
• 100+ care homes. Range from small, single homes to large national organisations. A high number of care homes and providers places a significant capacity demand on quality assurance monitoring and improvement • Lower occupancy in recent years with oversupply of residential beds (73.55% - 89.38% occupancy). Low occupancy levels increase the risk of poorer quality provision and unsafe practices as the financial impact affects staffing, morale, and the risk of accepting residents whose needs cannot be met to increase income. • Growing and aging population, Sheffield will need to plan for an increase in the number of older adults being assessed for and receiving long term packages of support. By moving provision from residential settings to community packages, the complexity of needs for residents in our care homes is likely to increase – currently the market is not well placed to support higher needs residents. • We know we need to do more to support consistent care for people who have more complex needs – including those linked to dementia and who require 1:1 support. Providers come back to the Council where they can't meet residents' needs and support is needed so that Care Homes are able to plan and meet needs effectively. • 2021 financial assessment had 21% of homes in moderate – high risk of business failure • Since 2015, 5 homes closed related to practice, and 12 for financial reasons. No new entrants in last year. • Providers raising concerns due to fee rates, provider feedback that financial viability is worsening • Poor staff retention and recruitment • The ongoing pressures of recruitment, costs and the legacy of Covid for Older People's Care Homes has knock on impact on capacity to engage in improvement work.	• Increase occupancy rates overall, with a focus on delivering a shift from general residential beds to increasing the number of providers that can support residents with more complex needs – specifically nursing and those with dementia • Work to ensure sufficiency will also consider the needs and provision of short term and respite care as part of the wider health and care system and supporting people and families to keep well and be able to access the right support at the right time. • Invest time and support in quality improvement – focusing on achieving a stable and skilled workforce, drive up quality in the market overall through an integrated approach with quality assurance to support and hold homes to account for the care provided • Renew our fee rates model to support projected needs in the City and ensure choice across a sustainable and innovative market • Develop new contract models to innovate and develop with Care Homes that want to work with us and share the council's vision. We will investigate the costs and benefits of different contract options for care homes (e.g. block contracts, longer term contracts, framework lots) • As well as working with existing providers to increase capacity and quality of Care Homes in the borough, we will undertake an options appraisal for wider delivery models, including in-house management and delivery of care. • The care home workforce is our workforce and we will work together to deliver joint training and development opportunities • In partnership with the sector we will co-design a Quality and Support programme • Increase understanding of equalities in our OP Care Homes – with improved data collection and analysis, and mapping of provision against an EAA

QUALITY	
WHERE ARE WE NOW	ACTION PLAN
• CQC rating of good or outstanding: 87.69% residential and 77.27 nursing, better than NA • SCC Contract and Quality team monitoring has 3 homes in 'Amber' • Providers report challenges with recruitment and retention of staff in all roles - as the pressures of the Covid pandemic, together with competitive pay rates in other organisations and careers impacts on workforce stability and wellbeing in the sector. High agency use. • The importance of digital infrastructure and capabilities in care homes has been made evident in the Covid 19 pandemic. Whilst Care Homes have responded well to this challenge, digital infrastructure across the sector could be improved: - **IT infrastructure** –equipment and Wi-Fi access - **Systems and Applications -** enabling more effective ways of working for staff, for example through risk identification and prevention tools - **Workforce Digital Capability –** current ICT training is basic and focussed on individual homes' systems. • The Autumn Statement continues to promote plans to accelerate the adoption of technology.	• As part of the Residential and Nursing Care Home Strategic Review, co-produced standards for quality & improvement will be implemented – with clearer expectations around data and reporting from Care Homes. • We will continue our multi-disciplinary approach to quality improvement and support, maximising the benefits of a cross service team with the ICB, so that when Care Homes identify, or are identified as requiring support to meet the standards we expect, the best support is available to them to deliver this. • A clear provider list and supporting information will enable those people who fund their own care or use a direct payment to manage their care arrangements to select providers who have been given the quality mark from the local authority. • We will improve our understanding of health inequalities within care homes and prioritise work to reduce and address these. • We will review arrangements for how placements are arranged, purchased and monitored – considering the contribution that Brokerage can make to personalised care and support. • There are already programmes of work related to the ASC sector workforce – and partnership working with Skills for Care, and we will feed into and support these existing programmes • In line with ASC Digital Strategy and Discharge funding proposals, we will map the target population(s) needs – including care home residents; families; staff; managers; commissioners; ASC and health partners to ensure that any potential resource is directed to where it is most needed, and/or where it can have most impact. • We will work with Care Homes to map digital infrastructure and capabilities and develop of partnership and collaborative plans to improve and maximise digital impact.

VALUE FOR MONEY	
WHERE ARE WE NOW	ACTION PLAN
• The Council currently commissions in the region of 1,900 residential and nursing beds across the city, including short-term beds, at any one time. This includes all beds for older people and younger adults. The cost of this is circa £80m which does not include a price increase for 2023/24. The 203/24 budget is £78.7m and includes pressure for fee uplifts for 23/24 • SCC rates are lower than regional averages, and the FCOC exercise has highlighted a significant gap between current rates and the median FCOC output • Sheffield has a range of providers and business models – with some homes able to manage fluctuations and debt more than others. • Several homes use top ups and higher rates for self-funders to 'balance the books' • Local Authorities need to work with providers to ensure a 'Fair Cost of Care' model that supports a sustainable care market and protects people from unpredictable costs; offers more choice and control over care received, offers quality provision; and is accessible to those who need it. • Care homes tend to have significantly high energy bills - primarily caused by high energy consumption, which also has a damaging effect of the environment. Helping residential care homes to identify appropriate energy efficiency options will help to reduce energy bills and improve the comfort of their residents. • By taking steps to improve energy efficiency, care homes and nursing homes could reduce their overheads and have more money to invest into their services. They could also reduce their carbon footprint and help with environmental sustainability.	• We will work collaboratively with providers to set transparent and fair fees and rates, using our leverage to drive improvement in terms and conditions for the care sector workforce, and supported by a fair cost of care model. • Engage with local Care Provider Association and others to agree process and partnership approach • Complete analysis of the current and projected demand, against market and workforce pressures (inc self-funders and CCG funded information) • Feed into this EAA analysis • Review commissioning capacity and opportunities to support the system more effectively and efficiently • Review SCC model with regional colleagues • Review existing fee setting models and current contracts – exploring the benefits of an enhanced rate and standard rates for specialist provision • Climate impact and energy efficiency will be taken forward using assessment tools and ensuring that Care homes are well placed to apply for any financial or other support from national or local initiatives.

Homecare

SUFFICIENCY	
WHERE ARE WE NOW	ACTION PLAN
• 85+ providers, 35 of which are contracted under current framework and others through Direct Awards • 2,500 people in receipt of care • c37,000 care hours delivered each week, projected to benchmark at 34,000 by August 2023 • 1,800 care workers employed by providers • The number of packages waiting at January 10th 2023 was 56. This was 81 five weeks ago, and 195 sixteen weeks ago. An improving picture. One of the reasons for the low number waiting is that providers have picked up new work both in existing and new contract areas in preparation for the new care and wellbeing contract. • The 1600 hours winter pressures monies continues to have a positive impact. Pick up of packages 9-13 January 2023 was 60 packages (714 hours)	• Procurement is live for new Care and Wellbeing model. New Homecare delivery model sees a further move towards personalised and outcome–led care, fewer providers with improved payment terms – including payment on planned hours to support provider financial planning and longer contracts to support partnership and collaborative development work • Geographical alignment of support with 2-3 providers in each geographical area, operating as equal partners within multi-disciplinary and collaborative working arrangements across health and social care. It is anticipated that this will strengthen partnership working, improving monitoring arrangements, supporting provider efficiencies and sustainability, and reduce travel for care staff - and in doing so reduce our carbon footprint. • Transition and mobilisation planning underway to ensure continuity of care • Discharge funding is being used to support timely hospital discharge and test news ways of supporting this

QUALITY	
WHERE ARE WE NOW	ACTION PLAN
• 67% of providers rated Good or Outstanding • Effective contract monitoring and market oversight – one provider in escalation • Reflecting challenges across the health and social care sector, local home care providers have been unable to recruit enough new staff, whilst also losing existing workers to other sectors, often with better pay, conditions, career pathways and/or less responsibility and day-to-day challenges - it is estimated that up to 32% of the sector do not see care as long-term career. • Retention is further impacted by staff leaving the workforce due to retirement or ill health: 26% of care workers in Sheffield are aged over 55. • The most recently available data from Skills for Care confirms annual staff turnover of 50% in the Sheffield independent sector, compared to 35% across Yorkshire & Humber and 2.7% for home care workers employed by the Council. High staff turnover and workforce instability impacts negatively on the experiences of people receiving home care; increases changes in support provision; causes delay in support pick up; reduces the quality of care; and increases provider's costs.	• The new Care and Wellbeing (Homecare) Contract will embed Collective Practice Standards across Adult Social Care and Commissioned services, and will seek to drive practice that is outcome focused, strength-based, community connected and person led so that *all* social care support is focused on enabling people to live independently, live the life they want to live and have positive experiences of care • Within the test of Change, Managers and Care Workers have been trained on The Care Act, Outcomes Focused and Strength Based Delivery of Care. Strength Based Community engagement began in 2022 and in February 2023 we will be testing and evaluating 'outcomes focused delivery of support' and 'enablement' and introducing the 'Trusted Reviewer Model' later in in the year.

VALUE FOR MONEY	
WHERE ARE WE NOW	ACTION PLAN
• The budget for homecare in 23/24 is circa £36m. • A rate of £21 per hour for a total 34,000 contracted hours per week would be a significant step for Sheffield. We anticipate that this rate – together with the move to planned care over a 7 years + 2 +1 contract and consolidation of the market will support our commissioning objectives and better outcomes for Sheffield people. We also anticipate that staff will see the benefit of an increased fee rate in their terms and conditions. • SCC rates are comparable with regional averages. The FCOC exercise highlighted a gap between current rates and the median FCOC output, though the move to £21ph in the new contract closes this gap, with further efficiencies – especially around travel anticipated in the new contract	• Fee increases have been set out in the new contract. • Delivery of the “Homecare Test of Change”, including the “Trusted Reviewer” model • Changes to the payment and charging model. Switching from payment based on minutes of care delivered to payment based on planned care will shift the emphasis away from time and task; it will give providers more certainty and people more timely and more reliable invoices; and it will reduce complexity and improve efficiency.

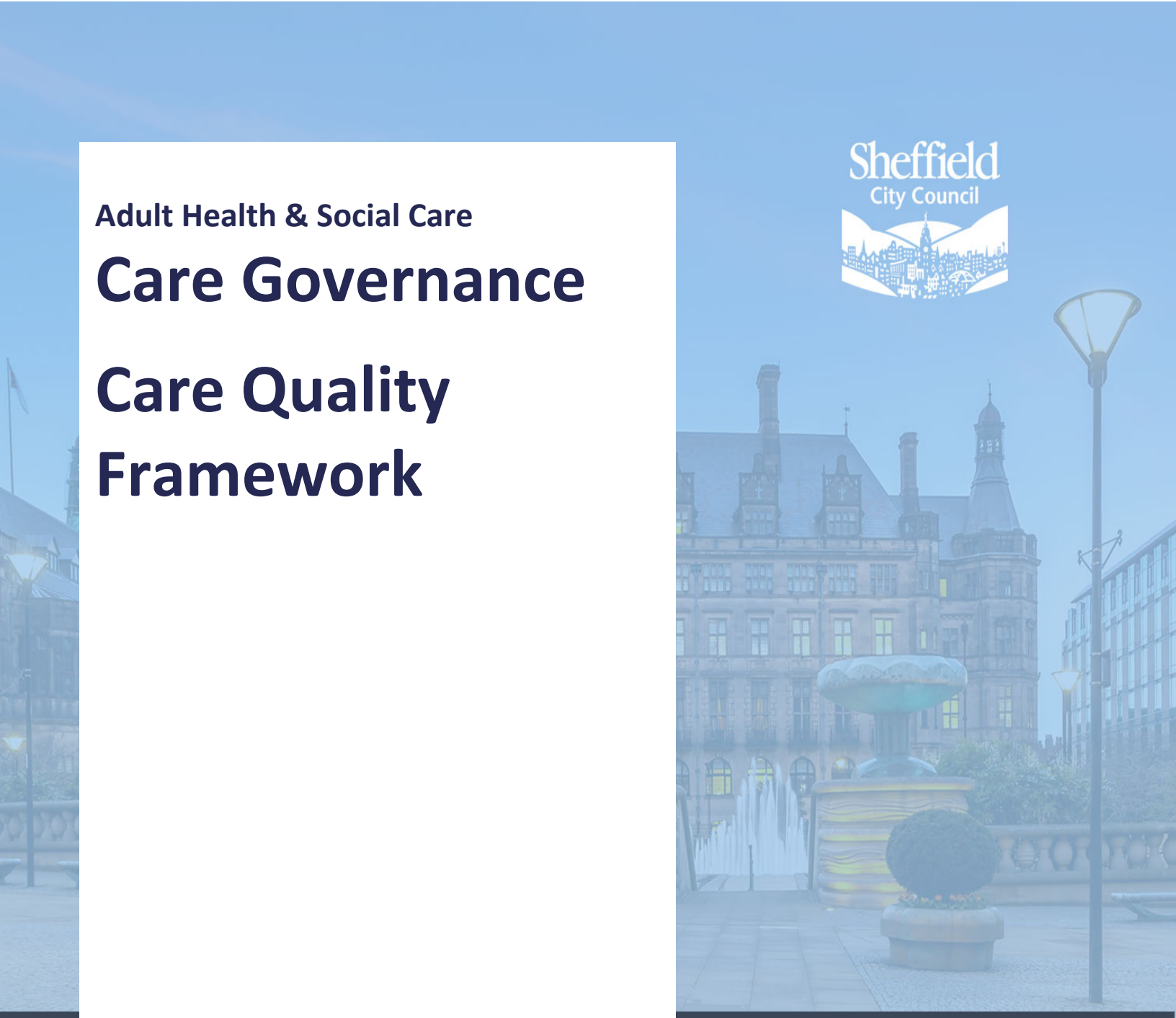
Adults with a disability

SUFFICIENCY	
WHERE ARE WE NOW	ACTION PLAN
ACTIVITIES INSIDE THE HOME • 32 Supported Living providers contracted under current framework, 16 providers are contracted through Direct Awards • Some supported living framework providers work with a landlord (Registered Provider) to provide accommodation in a 'scheme' setting • There is a diverse range of small local to larger national providers • Framework providers currently deliver around 21,024 hours of 1:1 support to 590 people per week; and around 7,707 hours of 'shared' support to 302 people per week. • c1295 support workers employed by supported living providers **ACTIVITIES OUTSIDE THE HOME** • 40+ 'day service' providers. 17 are contracted through a historic partnership arrangement, the rest are via Direct Awards • Diverse range of providers from large building based to smaller community settings/outreach • 850+ adults with a disability receive 'day service' support, most have a learning disability and/or autism • c600 support workers are employed by day service providers **OVERNIGHT SHORT BREAKS (Respite)** • 6 providers contracted via Direct Payments/Council Arranged • A range of models of support from smaller 'supported living' settings to larger residential style. • 168+ adults with a disability receive an overnight short break, most have a learning disability and/or autism. Many have a physical disability. **ENHANCED SUPPORTED LIVING FRAMEWORK** • Contract start date January 2023	• Procurement is live for a new Adults with Disabilities Framework – this is a recommission for supported living but 'day services' and short breaks will be part of the Framework for the first time. • A further move towards personalised and outcome–based support • Longer contracts to provide stability support innovation and co-production • Revised payment system for supported living, with a shift from geographical hourly rates now rationalised into community or discounted rates • Hourly rate for sleep in support has been replaced by a single payment per night • The new Adults with Disabilities Framework will be in place from March 2023 • Enhanced Supported Living providers will be invited to apply for mini competitions to deliver support to individuals, and at an accommodation scheme where the contract is ending this year.

• 13 providers on the Framework – supporting people with complex support needs in the community instead of a more restrictive setting.	

QUALITY	
WHERE ARE WE NOW	ACTION PLAN
• All Supported Living providers currently rated Good or Outstanding • Effective contract monitoring and market oversight – all providers rated 'green' • Quality and Performance team conduct quality visits to supported living providers throughout the year, with at least 2 visits in a 12 month period. The areas explored during quality visits include: - Person centred approach: support plans and observations and conversations with individuals where possible to ensure people are supported with "What matters to them", they are supported with dignity and respect; that there are opportunities for daily enjoyment and a good quality of life - Staffing: deployment, recruitment, retention and training - Quality assurance: incident and accidents; safeguarding alerts and complaints; managing client finances, client and family satisfaction / feedback, audits with clear action plans / follow up to make improvement • Similar recruitment and retention challenges to the rest of the health and social care sector. Career progression is an issue due to lack of opportunities and the poor pay differential between support workers and managers.	• Outcomes focussed approach for all new monitoring arrangements • We Speak You Listen experts by experience will be involved in quality checking • 'Day service' and short breaks providers who join the Framework will be quality monitored for the first time • Enhanced Supported Living providers have been invited to work in partnership to co-design a self-assessment tool • Measuring outcomes for individuals supported by Enhanced Supported Living providers will be individualised and measure against I statements

VALUE FOR MONEY	
WHERE ARE WE NOW	**ACTION PLAN**
• For 22/23, the budget for Supported Living was £35million • For 22/23, the budget for day services was £4 million. • The expenditure for short breaks was c£1.5m for 22/23. • SCC rates are comparable with regional averages.	• Fee increases have been set out in the new contract. • Invoice verification process in place, to verify commissioned hours against 'actuals' in supported living. - Ensure accurate and timely payments are made to Framework providers of; Home Care, Supported Living and Extra Care - Verifying, and where necessary challenge providers on support hours submitted - Resolve complex payment queries and historical reconciliations - Escalate concerns or queries regarding care hours delivered. - Build/Maintain positive working relationships with providers and new social work team - Track TUPE premium payments. • Brokerage of supported living packages ensures that vacancy and void costs are minimised • Revised payment system for supported living, with a shift from geographical hourly rates now rationalised into community or discounted rates • Hourly rate for sleep in support has been replaced by a single payment per night • Work with providers to review support packages to ensure that individual outcomes are being met appropriately, identifying where there could be a reduced dependence on paid services. • Consider whether other providers could meet some of the needs of the individuals, for example, shopping and cleaning services.



Adult Health & Social Care

Care Governance

Care Quality Framework

JANUARY 2023

Sheffield City Council
Sheffield.gov.uk/home/social-care

Contents

1. Introduction and Purpose of the Care Quality Framework

Our vision is that everyone in Sheffield lives in a place they can call home, in communities that care, doing things that matter to them, celebrated for who they are and, when they need it, they receive care and support that prioritises independence, choice, and recovery.

The vision for Adult Health and Social Care set out in our Strategy "Living the life you want to live", was approved by the Co-operative Executive on 16th March 2022.

It sets out the objectives for Adult Health and Social Care for the next ten years including the outcomes we want to achieve for people, our commitments on how these outcomes will be delivered, and a series of 'I statements' to help us understand what progress we are making.

The Care Quality Standards at Appendix 1 define what we expect of services, and how this relates to our vision, outcomes and commitments

The Care Quality Framework has been developed to support delivery on our strategy so that:

- people know the standards of the service which should be delivered no matter who the provider is
- people experience equality of access high quality services that deliver culturally appropriate care and support
- the adult social care workforce, including commissioned providers, share a clear vision of what high-quality care looks like and how they can contribute to delivering it
- the views and feedback from individual's and carers' views informs quality assurance activity and service development and improvement

It sits within our Performance Framework as part of the Adult Health and Social Care Governance Strategy

Adult Health and Social Care Governance Framework

To enable delivery on our Adult Social Care Strategy, a priority was also made on confirming our Governance arrangements, so that we set the right culture and tone for embedding a focus on our performance throughout all teams across Adult Social Care. This is set out in our Adult Health and Social Care Governance Strategy and Adult Health and Social Care Performance Framework.

The Performance and Outcomes Framework part of the Strategy sets out the arrangements for ensuring the delivery of the Adult Health and Social Care vision and Strategy.

The Performance and Outcomes Framework sets out the relationship and connections between performance management (which measures the progress of the service in achieving the vision/ strategy) and the quality frameworks (which measure the progress of the service in delivering positive outcomes for people in line with our vision/ strategy) and ensures that everyone in the service from the front line to the leadership has a clear understanding of our performance and our improvement journey.

There are three parts to the Quality Matters Framework – Practice Quality, Market Sustainability and Care Quality.

Both quality frameworks have three common elements:

- What good looks like – expected standards and behaviours
- How we measure quality –persons voice, standards met and individual outcomes (captured from case file audits, observation, complaints etc)
- How we use that information to drive improvement – 1-1, peer review, etc

This Framework focuses specifically on Care Quality.

2. Care Quality Framework – approach and standards

Whole Market Approach

The Care Quality Framework is a "whole market" approach. It seeks to establish a consistent approach towards improving outcomes and driving excellent quality, safe and person led social care support and care which enables people to live the life they want to live. This will mean working with in house and commissioned services to gather data across a common set of quality standards and measures.

The Framework seeks to support reporting and assurance across three tiers of information:

- Tier 1: is a detailed list of indicators drawn from individual and carer feedback, on-site Quality Assurance visits, recent CQC reports, performance information and any measures specific to the service. This information will be gathered per setting, for example *"The Sheffield Homecare Company".*

- Tier 2: is a summary of the information provided in Tier 1 by provision type basis, for example *"Homecare Provision".*

- Tier 3: is a summary of the information provided in Tier 2 for the whole care and support provider market.

Tier 3 can be shared with corporate boards and partners, Tier 2 can be shared with ASCLT and Performance Clinic. Tier 1 will be monitored regularly by commissioners and contracts and used in regular, on site, performance meetings.

The expectation is that reporting will be annual unless there are areas of concern for a specific provider i.e. poor CQC report or specific issues raised by Social Workers.

Despite the good examples of engagement work undertaken in the development of the recent services and tenders, the Voice of the Person is not fully integrated into the market management approach in Sheffield. The Care Quality Framework will seek to develop "Lived Experience Inspectors" to be involved in Quality Assurance visits and activity. In addition, the feasibility of the involvement of people with lived experience as a 'given' in tender exercises and market reviews will also be considered.

This approach is designed to improve Sheffield's ability to manage the market and provide assurance of quality and outcomes across all providers and provision. This allows Commissioners and Senior Leaders within the Council to track performance across the sector,

step in where there are issues and consider further investment or reprioritisation where there has been success.

Moreover this focus on quality and outcomes will help drive efficiencies across the market. High-cost provision can only be justified where high performance and impact can be evidenced and as needs de-escalate the cost of the service should reflect this progress.

The rich data this will provide can help inform future service provision and allow Commissioners and senior leaders to make robust outcomes-based investment decisions in the future.

Culture and Principles

All actions are focused on the provision of **high quality, safe, effective and person-centred services**.

Accountability for the delivery of the highest quality care and support is understood to be the **responsibility of all who work in social care** and quality assurance should be reflected in the outcomes, experiences and records of people who use our services and their families and carers.

Good governance of care quality is delivered through clearly defined roles and responsibilities, where all are empowered to act to improve quality.

Our Care Quality approach is also about embedding a **positive learning culture** so that we learn from and act on the feedback, continually using this to improve how we work and what we do.

Informed and transparent decisions are demonstrated.

Feedback from people with experience of care and support, carers, practitioners, our partners, and our communities, including seldom heard communities is at the core of our understanding of the quality of our support and the impact on individuals.

Provide **effective and aligned support for quality** in adult social care, built on strong partnerships and effective relationships and collaboration within teams and between partners; taking **joined – up action** to drive improvement.

Care Quality Standards

High performing, good quality services should balance three core components:

1) **The individual experience of people receiving care and support and the achievement of outcomes important to them**

Our Care Quality Framework will assess the extent to which services can evidence that people are receiving high quality care set around the outcomes in our Strategy:

Safe and well

- **Feel safe in a place called home, and protected from harm**
- **Physically and mentally well for as long as possible**
- **Able to manage conditions and return to normal life as much as possible**

Active and independent

- **Live independently and focus on increasing everyone's independence**
- **Have control and choice over decisions that affect their care and support**
- **Simple adult social care system including advocacy for people who need help expressing their needs and wishes**

Connected and engaged

- **Connections with communities that care and support people**
- **People engaged in their community and make a contribution to it**
- **Unpaid carers connected to a support network independently and focus on increasing everyone's independence**

Aspire and achieve and Independent

- **People have purpose and meaning in their lives**
- **People have personal ambition, aspirations and outcomes including hobbies, interests, helping others, employment, education, or learning**

Efficient and effective

- **A system that works smartly together delivering effective and quality outcome-focused services**
- **Good choice of services that meet individual needs irrespective of background, ethnicity, disability, sex, sexual orientation, religion or belief.**
- **Engaged, supported and well-trained workforce which is innovative and creative and trusted to make the right decisions**
- **Transparent decision-making which delivers best value and considers climate impacts**

Many of the measures to support quality assurance will be set within service specifications and contracts, and services' own service and improvement plans.

2) **Services which keep people safe through regulatory standards, safeguards and the adoption of good practice**

There are regulatory requirements that all providers of services require to meet in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Standards 8 to 20A provide a framework which all regulated and non-regulated provision and case management should adhere to as ultimately, they enable an assurance about the safety and wellness of individuals we support.

Due to this, our intention is to quality assurance all adult social care provision using these standards set out in the Health and Care Act 2008 so that we have a consistent approach to what good looks like across all settings. The Standards are linked here and provided in more detail at Appendix 2. These standards will be used alongside a review of compliance in relation to the Care Act 2014.

In addition, providers are regularly CQC assessed against the following 5 domains:

- Safe - people are protected from abuse and avoidable harm.
- Effective – this means we look for evidence that people's care, treatment, and support achieves good outcomes and promotes a good quality of life, based on best available evidence.
- Caring – this means we look for evidence that services involve people and treat them with compassion, kindness, dignity, and respect.
- Responsive – this means we look for evidence that services meet people's needs, preventing the need.
- Well-Led – this means we look for evidence that service leadership, management and governance assure high-quality, person-centred care; supported learning and innovation; and promote an open, fair culture.

3) **The recognised processes that ensure the effectiveness of services including their value for money.**

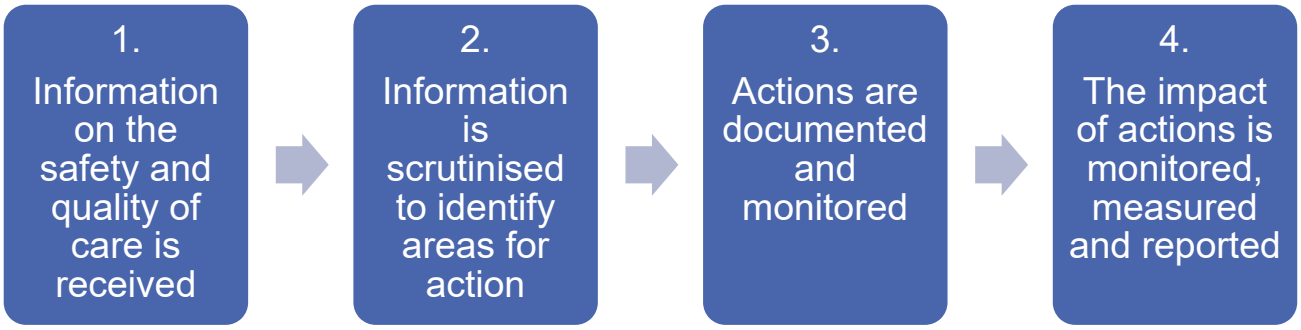
3. Oversight of Care Quality - system support, quality assurance and contract management

The Quality and Improvement Team sits within Commissioning and Partnerships in Adult Social Care. This provides a central resource to ensure all care and support provision has a consistent quality and performance approach.

The assurance process

Quality Assurance and Performance Management seeks to assess:

- What did our providers do (service activity),
- How well did they do it (quality)
- And most importantly… Did they make a difference (outcomes).



This is done by looking at the following Quality and Performance metrics

Quality & Performance Measures	
Demand Demand measures are those that track volume eg: numbers of children/ young people / families being referred or accessing the service, at what stage and why. Activity measures provide useful information regarding the effective reach and or accessibility of the service, and the needs profile of the target cohort. Demand measures should be disaggregated by equality group.	Services have a good understanding of demand (levels of demand, changing care and support needs), the profile of people using the service, and the driving factors behind demand. The services uses this information to assess the diversity of those with whom it comes in contact with and, where appropriate, develops its approach to broaden its reach. The service is able to produce reports that cross-tabulate - e.g. gender by ward, ethnicity by activity etc

Quality & Performance Measures	
Activity & Output Activity & Output measures are those that track how many people were provided a service, in accordance with the contract specification. The output measures provide useful information on the number of people who are able to access care and support provision. This information should be disaggregated by equality group.	Actvities and service outputs meet the specification for timeliness and are tailored to the needs of beneficiaries. The service has a low attrition rate as most of those with whom it comes in contact, go on to receive a service. The service is effective at providing services to those most in need.
Quality Quality measures are those that evidence how well the service is being provided, against contract delivery performance indicators, quality standards, and user feedback. This should be include measures that consider service level and individual level evidence	The service understands the experiences of people receiving help and support, and how well it meets quality standards against local and national frameworks. The service can demonstrate that it performance well, delivering effective support
Impact and Outcomes Outcome measures track the actual impact of the service on the beneficiaries and customers. There are many good examples of outcome measures including: satisfaction of users, number of users who do not return to drug treatment, sustainable employment or sustainable housing. Outcomes measures should also be disaggregated by equality group to provide more detailed information of the impact of the service.	The service understand the impact of what it does on the families it works with, and the impact this is having at population level. Outcomes are effective and wide ranging and reflect sustained impact on recipients as well as high levels of satisfaction. There is also strong evidence that outcomes are impacting a wide-range of target cohorts, further demonstrating the accessibility and impact of the service.
Social Value & Value for Money Cost measures track how much the service (or each service output) costs to provide. Efficiency measures track the savings or gains achieved as a result of providing the service. For example, a reduction in the time taken to process complaints as a result of getting things right first time. Social Value measures should be included here	The service delivery costs are managed within budget. There is good evidence of timeliness in the speed of service delivery, all whilst operating within budget.

Data and information from a variety of sources support quality assurance, including:

- Themes drawn from individual conversations with people in receipt of support and the organisations and groups that support them
- Complaints
- Ombudsman reports
- Internal and external audits
- Mandatory DH customer and carer satisfaction surveys
- Performance data
- Information from internal and external providers
- Issues shared by all our sector partners

System Support for our Care Quality Standards Framework

Sheffield has recently purchased the Access Group's 'Provider Assessment and Market Management Solutions (PAMMS) tool, a local and regional commissioning solution, with 3 key modules.

- **PAMMS Quality Assurance** – Built on shared quality standards, supports local, regional and national collaborations, demonstrating the impact of interventions.
- **PAMMS Provider Returns –** Complements QA activities, tactical tool can be deployed locally, sub regionally and regionally, for example in home recruitment and retention.
- **PAMMS Social Care Landscape –** regional bench marking tool, like for like comparisons giving detailed insights across multiple LAs spots correlations and outliers.

Regionally we have identified the need to have better oversight of Social Care providers with regards to Quality of provision. Additionally, as provision of Care spans and impacts the whole region, having improved data insights to support and deliver data driven decisions supports the operational teams in terms of market management.

13 of the 15 local authorities across Yorkshire and Humber have signed up to a 3-year service proposition with PAMMS and we are working with a Cluster Group for implementation including Sheffield, Doncaster, Rotherham and North Lincolnshire.

PAMMS will be a key asset to help support the development of our new Care Quality Standards Framework, while also supporting embedding and measuring performance against our new care quality standards, with the added advantage of being able to benchmark against other authorities.

We can also consider implementing PAMMS across our in-house provider services, which would help provide a AHSC Overarching Care Quality Standard Framework, with a consistent

performance and benchmarking dashboard linked to the CQC, across all our care quality provision.

This will help us to assess and evidence continuous improvement, while enabling us to benchmark quality across the sector and with other authorities.

Update for local authorities on Market Sustainability and Fair Cost of Care Fund.

Further to our update in December, which outlined the next steps for Year 1 of the Market Sustainability and Fair Cost of Care review, this note provides details on the submission and publication of Cost of Care Exercises and Reports, and final Market Sustainability Plans. This update package includes:

A. Details of how local authorities can resubmit their Cost of Care exercises and Cost of Care reports, where they have worked with providers to improve their exercises;
B. Submission and publication dates for final Market Sustainability Plans;
C. Supplementary data on self-funder fee rates for 2022-23, which may provide a useful additional data point for local authorities to consider.

Resubmission of Cost of Care Exercises and Reports

The PA Consulting Ready for Reform online platform will re-open for any local authorities wishing to amend their Cost of Care Exercises and Reports on **18th January 2023**. The deadline for local authorities to make any Annex A data amendments and upload final Annex B reports will be close of play on **1st of February 2023**. This is also the deadline for local authorities to publish their Annex B Cost of Care Reports on their GOV.UK webpages and inform the Department of where their exercises have been published, by emailing a link to their published exercise to the Markets Reform mailbox (marketsreform@dhsc.gov.uk).

Only local authorities who wish to update or amend the data provided as part of Annex A need to provide an updated submission on the Ready for Reform portal. Any changes made to the Annex A data must be clearly set out and justified in an updated version of the Annex B report. This updated version of Annex B must then also be uploaded to the PA submission platform.

If a local authority does not wish to amend their Annex A data or Annex B report, then they will not need to make any changes in the platform, the Department will assume that the information provided in October is their final submission.

Any local authorities who have forgotten their log-in details or are experiencing difficulties in re-accessing the PA platform should contact readyforreform@paconsulting.com

Submission of final Market Sustainability Plans

We can now confirm that final Market Sustainability Plans are required to be *both* submitted to the Department using the Ready for Reform platform, *and* published on local authorities' GOV.UK webpages **by the close of 27th March 2023**. To submit their final Market Sustainability Plans, local authorities should log into the Ready for Reform platform and upload their final version. They will be able to do this at any point after the platform re-opens on the 18th of January 2023 and before the close of 27th of March 2023. As with Cost of Care reports, local authorities will be required to report where final Market Sustainability Plans have been published, including a link to the published Plan, by emailing the Markets Reform mailbox (marketsreform@dhsc.gov.uk).

We will shortly be sharing the template for final Plans, including changes to reflect the delay to charging reform, alongside a short best practice guide based on our intensive review of a number of draft Market Sustainability Plans.

Data regarding self-funder rates

We have obtained local authority level estimates of older people's care home self-funder fee rates in 2022-23 from Carterwood, the market-leading provider of fee data to the elderly care home sector.

We are sharing this data for local authorities to be made aware of, as they finalise Cost of Care Exercises, Reports and final Market Sustainability Plans. This may provide a helpful further data point for local authorities to consider.

LaingBuisson

Fair Cost of Care

Care Homes for Older People (65+)

Results and Analysis from FCoC Toolkits submitted by Providers located in Sheffield Council

FINAL REPORT 5th October 2022

Prepared for Sheffield Council by LaingBuisson

CONTENTS

1 EXECUTIVE SUMMARY

LaingBuisson was commissioned by Sheffield Council in July 2022 to undertake a Fair Cost of Care (FCoC) exercise covering registered care homes for older people (65+), as described and specified in government guidance[1].

This report is based on validated submissions relating to individual, registered care home services within the council's boundaries which responded via the DHSC recommended CareCubed portal hosted by iESE.

In the validation process, toolkit submissions were checked by LaingBuisson for sense and consistency, and anomalies were amended as necessary with the agreement of providers.

This report is presented together with a companion spreadsheet which lists all validated responses, one row per registered service, each with a range of data points arranged in columns covering:

- All of the detailed operating cost categories and supporting items of information required by DHSC, extracted from respondents' validated toolkit submissions;
- Return on capital and return on operations, calculated from benchmarks determined by the council on the basis of the best available evidence (see Appendix 1). The benchmarks are: 6% per annum return on capital and 10% mark-up on operating costs for return on operations. In line with DHSC guidance, these benchmarks have superseded the return on capital and return on operations figures stated by providers in their toolkit submissions;
- Key characteristics of each care home which may assist in analysis related to market sustainability, such as scale, sector, group ownership, etc. This data is sourced from CQC and LaingBuisson's data warehouse; and
- Other ratios derived from the toolkit submissions, which may assist in understanding drivers of costs.

1 Market Sustainability and Fair Cost of Care Fund 2022 to 2023: guidance, updated 25 August 2022
https://www.gov.uk/government/publications/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023-guidance

1.1 Headline results

A summary of median total costs derived from the FCoC exercise is presented in Table 1. A more granular analysis of the cost of care results, including all of the cost lines prescribed by DHSC for councils to qualify for grant funding, is set out in Table 4[2].

Table 1 Median total costs[1] calculated from wholly or partly validated FCoC toolkit submissions by providers located in Sheffield (including return on capital and operating profit) at 2022/23 prices

	Standard	Enhanced Care	A) Fully validated submissions	B) Partially validated submissions (with one or more validated cost lines)	C) Services in scope	Response rate (A+ B) / C * 100
	£ per week	£ per week	Number	Number	Number	%
Nursing homes (65+)	976.52	1,039.27	19	1	36	56%
Residential homes (65+)	787.54	806.06	19	2	34	62%
The calculated values incorporate the following council-determined benchmarks, which supersede median values from toolkit responses: - Return on capital 6% pa applied to median freehold valuation per resident [2] - Return on operations 10% mark-up on median operating costs derived from validated toolkit responses						

[1] Derived from Table 4

[2] Care home valuation per resident may be capped to excludes costs of high specification assets aimed at the private pay market, see Section 2.11.1.

1.2 Response rates

The LaingBuisson team fully validated 38 toolkit submissions and partially validated 3 toolkit submissions, the latter being those for which one or more (but not all) of the cost lines had been validated. Adding these together, the 41 fully or partially validated toolkits represents a response rate of 59% of

[2] It should be noted that the segmentation into four care home modalities, Standard / Enhanced, Residential / Nursing, does not necessarily capture the full range of possible sub-segmentation that exists within the care home sector.

care homes in scope (56% for nursing homes and 62% for residential homes). For some individual cost lines the effective response rate was higher and for others it was lower, see Table 4 for the number of respondents (in brackets) for each individual cost line.

The overall validated and partially validated response rate was higher than the 32%[3] achieved across all local authorities in England in the summer 2022 FCoC exercise. See Section 2.7 for contributory factors to non-response.

1.3 Methodology - validation, correction of anomalies, outlier exclusions and calculation of medians

The methodology for calculating median costs from the submitted toolkits is described in Sections 2.4 to 2.6.

1.4 Sensitivity analysis

The median total costs summarised in Table 1 and broken down by cost line in Table 4 are sensitive to the following factors, see Section 2.11:

- The efficacy of the validation process in eliminating implausible and incorrect toolkit submissions for individual cost lines;
- The validity of the rules adopted for elimination of outliers before calculating the medians for each cost line;
- The return on capital and return on operations benchmarks;
- Calculation of capital cost per occupied bed, to which the return on capital benchmark is applied;
- Adjustment for occupancy, if any;
- The approach to calculating confidence intervals for the median total costs; and
- Special local factors, if any,

1.5 Confidence intervals

While there is no reason to believe that the toolkit responses were biased in any systematic way[4], the number of respondents in any given council area was limited and there was a high degree of variance in many of the cost lines submitted by respondents. This may give rise to concerns about the

[3] Data from the Care Providers Alliance at September 2022

[4] We cannot, however, rule out the possibility that providers may have overstated their costs, and it was not practicable within the timescale available to carry out a range of checks applied by LaingBuisson in other cost of care exercises, including requesting evidence of staff costs from payroll records.

statistical validity of the calculated medians. This concern is best addressed by calculating margins of error (confidence intervals) around the calculated medians, as illustrated by Figure 2 of Section 2.12.

1.6 Special local factors

There are no special features of the Sheffield care home market which justify variation of the analytical approach adopted for other councils that LaingBuisson has supported in the national FCoC exercise.

1.7 Conclusions

The FCoC results provide evidence to support a target uplift in the council's residential care fee rate by a little over £200 per week, subject to available resources, and a target uplift of substantially more than £100 per week for nursing care, again subject to available resources, Section 2.14

2. FAIR COST OF CARE RESULTS FOR SUBMISSION TO DHSC

2.1 The IESE toolkit

Under the instructions of Sheffield Council, LaingBuisson registered with the IESE CareCubed portal to use their toolkit, with comprehensive support, as recommended by the Local Government Association and DHSC. The CareCubed platform takes the form of a multi-page survey seeking general information about the care home to which a submission refers, general expenditure, return on operations and return on capital, occupancy rates, staffing hours, and direct staffing costs.

2.2 Services in scope

There were 70 registered care homes in scope (predominantly for older people, aged 65+) located within the boundaries of Sheffield Council, after removing homes primarily for younger adults. DHSC guidance states that only older people's care homes in contact with local authorities are in scope, but since nearly all older people's care homes have at least one council-funded resident, predominantly privately funded homes were interpreted as being in scope as well.

2.3 Engagement with providers

LaingBuisson worked with the council over July and August 2022 to engage with providers through a variety of communication channels, the most important being intensive, direct telephone contact to encourage participation and completion of the toolkit. In addition, support was given to providers who were in the process of completing their submissions. Over the course of the project, a total of 212 calls were made to care home providers in Sheffield, and validating completed toolkits (including querying anomalies via CareCubed) took place in parallel.

2.4 Quality of toolkit submissions

LaingBuisson's experience, gained from similar care cost exercises carried out in recent years, is that the quality of submissions is variable. Large corporate groups typically have the resources to submit consistent and reliable numbers, but SMEs and micro-businesses can find it challenging to deal with the volume and complexity of data requested in toolkits and may leave some questions unanswered or incorrectly answered. Consequently, it is

necessary to apply a robust validation process, including querying anomalous submissions with respondents and assisting them to provide the appropriate data.

2.5 Validation

In the validation process, toolkit submissions were checked by LaingBuisson for sense and consistency, and anomalies were amended as necessary with the agreement of providers. Checking of toolkits was conducted individually through a comparison of submissions from similar care homes, and through comparisons between submissions and LaingBuisson's historic Care Cost Benchmarks dataset[5]. Toolkit submissions for individual cost lines were queried when they were found to be significantly outside of expected ranges, with particular attention paid to the plausibility of figures which contribute most notably towards total costs, such as staffing.

A facility to query submissions was made available through the Local Authority user interface of the CareCubed platform. This involved the submission of comments on individual figures given by providers. Providers were then notified that their response had been put into a query and were able to see the flagged queries with comments, upon logging into the platform. Changes to submissions were only enabled on the provider side, meaning that any queried anomalies which a provider did not understand or did not attempt to resolve, could not be fully validated through the platform.

Consequently, even after applying such validation processes as were practicably possible, there remained toolkits with one or more cost lines which were inappropriately null or zero, or which appeared to be outside of reasonable ranges. In most cases, the anomalies related to minor cost items, and it was evident that an approach was needed which would optimise the use of fully validated data without discarding toolkits which still contained unvalidated data for some minor cost lines.

2.6 Incomplete toolkit submissions

2.6.1 Interpolation *vs* outlier exclusion

There are two basic approaches to optimising value from survey results where, even after a robust validation process, some cost lines in any given toolkit submission may be zero or empty (null), and some may be outside a reasonable range:

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

- **Interpolation** is one approach, in which null, zero or extreme outlier data for any individual cost line in any given toolkit submission is substituted by the median (or mean) value among those toolkits that submitted valid, in range data for that cost line. By this means, otherwise valid toolkits can avoid being discarded due to the absence of minor cost items. In this approach it is reasonable to interpolate values for minor cost lines, though not for major cost lines, such as staffing costs, which are major drivers of total costs; Interpolation maximises the number of valid toolkit responses, from which the median numbers for each individual cost line, as well as the median total cost for all validated toolkits can be calculated. A downside of the interpolation approach, however, is that the nature of medians (the DHSC's preferred measure of central tendency) means that the individual cost line medians do not add to the subtotal medians and the subtotal medians do not add to the total cost median.

- **Outlier exclusion** is another approach, in which median values are calculated separately for each cost line, using all submitted toolkits where that particular cost line was validated, and excluding all 'outliers' whether they be null or zero values or outside a defined range. The full output required by DHSC can then be built-up from individual cost line medians. A bonus from this method is that each of the four median total costs required by DHSC (for residential, residential enhanced, nursing and nursing enhanced care) are equal to the sum of the median subtotals and the median subtotals are equal to the sums of the relevant individual cost lines.

We have opted to use the **outlier exclusion** approach, and we have defined outliers to encompass:

a) Null (empty) or zero values for any cost line where a null / zero value is inappropriate; and

b) Non-zero values which are outside specified boundaries.

With respect to b), having researched various methodologies, we adopted Double Median Absolute Deviation (Double MAD) as the preferred approach to setting outlier boundaries for each individual cost line.

$$MAD = median(|X_i - \overline{X}|)$$

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

Furthermore, statistically testing for skewness in the sample confirms that the data suffers from a highly asymmetric distribution across all categories. Using a singular Median Absolute Deviation value, disregarding the asymmetry in the distribution, would produce unreliable results. For this reason, we opted for an enhanced method called "Double MAD".

The premises of this method are similar to the classic version, with the only difference being the calculation of two Median Absolute Deviations: (1) the median absolute deviation from the median of all points less than or equal to the median and (2) the median absolute deviation from the median of all points greater than or equal to the median. This allows us to set pertinent outlier thresholds taking into account skewness in the data sample. Finally, for each cost line, we have defined as an outlier any data point which is more than 2 X MAD above or below the median. All such outliers have been excluded from the calculation of median costs in Table 4.

2.7 Response rates

The LaingBuisson team fully validated 38 toolkit submissions and partially validated 3 toolkit submissions, the latter being care homes for which some (but not all) of the cost lines had been validated. Adding the two together, the 41 fully or partially validated toolkits represents a response rate of 59% of care homes in scope (56% for nursing homes and 62% for residential homes). For some individual cost lines, the effective response rate was higher and for some it was lower, see Table 4 for the number of respondents (in brackets) for each individual cost line.

The overall validated and partially validated response rate was higher than the 32%[6] achieved across all local authorities in England in the summer 2022 FCoC exercise.

Table 2 segments response rates according to key care home characteristics which might have a bearing on costs., Segments which are over-represented include strategic providers and large corporate group operated homes. Conversely, small group and non-affiliated homes are under-represented.

Table 2 – Segmented response rates (validated plus partially validated) by key characteristics

	Nursing Homes			Residential Homes		
	Respondents	Homes in scope with the relevant characteristic	Response rate (%)	Respondents	Homes in scope with the relevant characteristic	Response rate (%)
Total fully or partially validated	20	36	56%	21	34	62%
Strategic providers	11	13	85%	15	15	100%
Provider sector						
For-profit	19	33	58%	7	20	35%
Not-for-profit	1	3	33%	14	14	100%

[6] Data from the Care Providers Alliance at September 2022

Build status						
Purpose built	16	28	57%	16	19	84%
Not purpose built	3	8	38%	4	15	27%
Operator scale						
Large corporate group [1]	6	7	86%	4	4	100%
Medium group [2]	12	16	75%	12	16	75%
Small group or independent [3]	2	13	15%	5	14	36%
Service scale						
Large service scale(50+ beds)	16	25	64%	7	8	88%
Medium service scale(20-49 beds)	3	10	30%	14	24	58%
Small service scale (<20 beds)	1	1	100%	0	2	0%
CQC ratings						
Good or Outstanding	13	29	45%	18	29	62%
Not Good or Outstanding	6	6	100%	2	4	50%

[1] 40 or more care homes for older people across the UK
[2] 3 - 39 care homes for older people across the UK
[3] Fewer than 3 care homes for older people across the UK

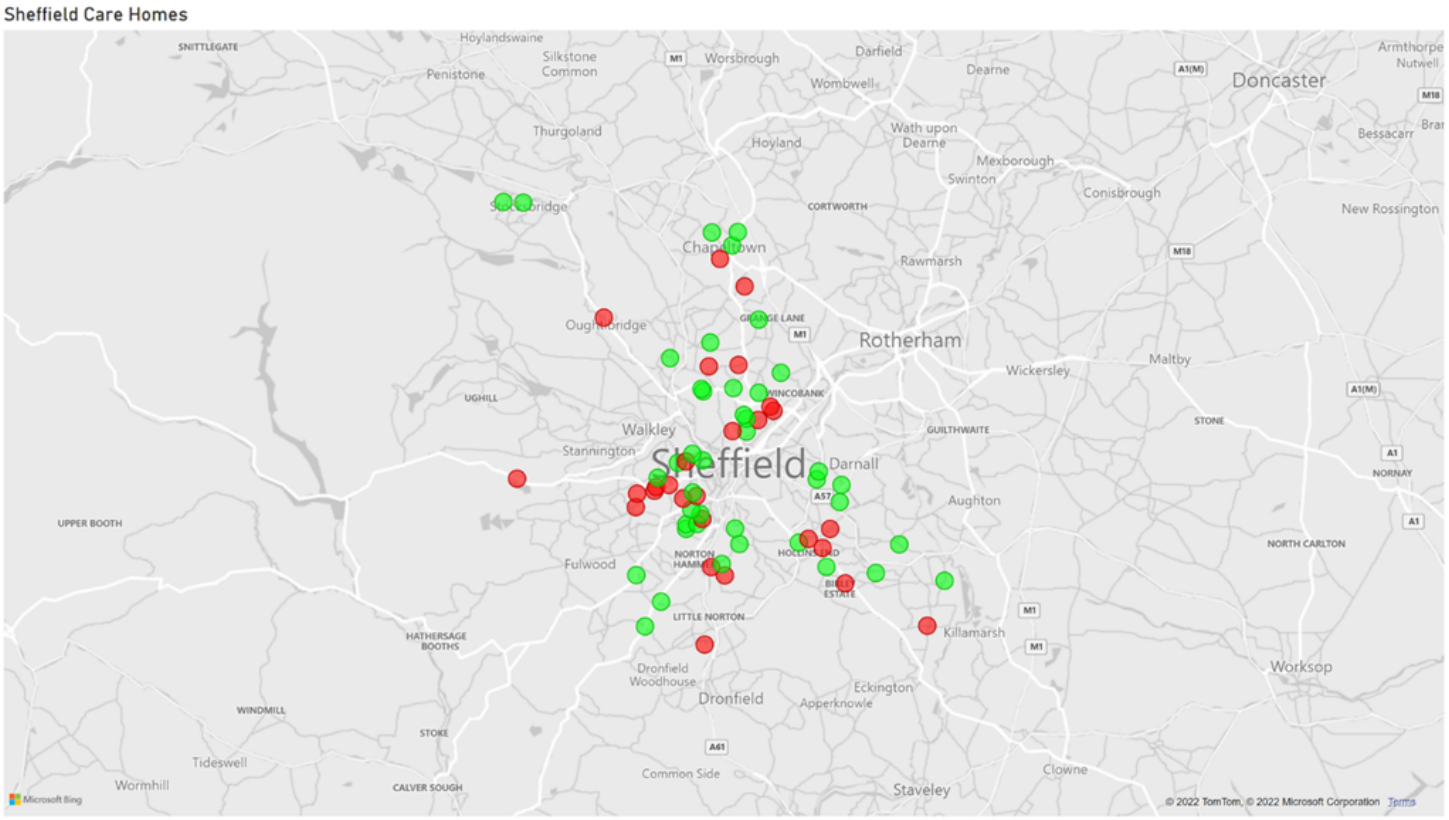
Feedback received from providers during the engagement process identified some of their reasons for non-respondents' hesitancy to respond:

- Demanding toolkit and insufficient time to complete it (may have been exacerbated by current staffing challenges);
- Concern about confidentiality, since local authorities are able to inspect individual respondents' data (previous LaingBuisson exercises have guaranteed confidentiality);
- Lack of confidence that the exercise would lead to financial benefits for providers, in the light of the perceived absence of benefits from earlier cost of care exercises.

2.7.1 Geographical spread of care homes

The geographical spread of respondent and non-respondent care homes in Sheffield is illustrated in Figure 1.

Figure 1 Map of care homes in Sheffield



- Respondents
- Non-respondents

2.8 Base price year and uplifts

All of the FCoC results cited in this report are expressed at April 2022 prices. They have been calculated by multiplying the 'uplift' factors entered in the toolkit submissions by the 2021/22 (base year) toolkit costs per resident, for each cost line, to arrive at costs per resident at April 2022 prices. In any normal year, costs at April (the beginning of the financial year) would be expected to prevail over the full financial year (April 2022 to March 2023) because staffing is the main driver of cost, and pay rates are usually set at the beginning of the financial year for the whole year in light of the National Living Wage settlement which is implemented in April. The surge of inflation in 2022/23, however, means that care home costs per resident may well change significantly over the course of the new financial year, over and above this report's results at April 2022. It is expected that council decisions in relation to fee setting should have regard to this.

For submissions with a 2021/22 base price year and no uplifts entered in the toolkit submission, uplifts have been interpolated based on the National Living Wage for low-paid staff (care and domestic), the monthly earnings index for other staff, and CPI (Consumer Price Index) and CPIH (Consumer Price Index with Housing) percentage change figures for non-staffing costs for the 12 months up to April 2022[7]. These figures have been chosen on a point-by-point basis, where appropriate figures have been identified to account for relative price effects[8], with overall CPI inflation figures used where no appropriate, goods/services-specific CPI figure has been identified. Uplift figures with CPI codes for each cost heading can be found in Table 3.

Table 3 – Uplifts from 2021/22 to 2022/23

	CPI Code	CPI Item	12 Month % change to April 2022
Low paid staff (carers and domestic staff)	-	National Living Wage % increase, April - April[9]	6.6
Other staff (nurses and back office)	-	Average earnings index, April – April	4.1
Fixtures & fittings	D7GW	05.3 Household appliances, fitting, and repairs	9.9
Repairs and maintenance	D7GR	04.3 Regular maintenance and repair of the dwelling	7.6

[7] Table 22, https://www.ons.gov.uk/economy/inflationandpriceindices/datasets/consumerpriceinflation
[8] Our approach to uplifting is broadly in line with guidance on inflationary adjustment set out in The Green Book 2022, Section 5.13, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1063330/Green_Book_2022.pdf

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

Furniture, furnishings, and equipment	D7GU	05.1 Furniture, furnishings, and carpets	15.0
Other care home premises costs	D7G7	CPI (overall index)	*9.0*
Food supplies	D7G8	01 Food and non-alcoholic beverages	6.7
Domestic and cleaning supplies	D7GZ	05.6 Goods and services for routine maintenance	6.8
Medical supplies (excluding PPE)	D7NO	06.1 Medical products, appliances, and equipment	1.3
PPE	D7NO	06.1 Medical products, appliances, and equipment	1.3
Office Supplies	D7IH	05.6.1 Non-durable household goods	10.3
Insurance (all risks)	D7HF	12.5 Insurance	11.7
Registration fees	D7G7	CPI (overall index)	9.0
Telephone & internet	D7GF	08 Communication	2.8
Council tax / rates	CRQT	Council tax and rates (CPIH)[10]	7.9
Electricity, Gas & Water	D7GB	04 Housing, water, electricity, gas and other fuels	19.2
Trade and clinical waste	D7G7	CPI (overall index)	9.0
Transport & Activities	D7GG	09 Recreation and Culture	5.9
Other care home supplies and services costs	D7G7	CPI (overall index)	9.0
Central / Regional Management	D7NN	All services	4.7
Support Services (finance / HR / legal / marketing etc.)	D7NN	All services	4.7
Recruitment, Training & Vetting (incl. DBS checks)	D7NN	All services	4.7
Other head office costs (please specify)	*D7OB*	*12.7 Other services (NEC)*	*-3.1*

Source: Office for National Statistics for different CPI series

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

2.9 Return on capital and return on operations

DHSC guidance indicates that councils should determine, on the basis of available evidence, the appropriate return on capital and return on operations rates that should be added to operating costs (calculated at medians from validated toolkit responses) in order to arrive at the median total cost for each of the four modalities of care in the FCoC returns, and that these rates should be evidence based. The rates recommended by LaingBuisson are:

a) Return on capital 6% per annum
b) Return on operations 10% mark-up on operating costs

The evidence base for these rates is described in Appendix 1,

In order to determine the £ value of return on capital, it is necessary to apply the rate of return to a capital value per resident. This can be derived from the toolkit submissions as the median of freehold valuation per bed (see Supporting Information at the foot of Table 4), divided by occupancy per registered bed (see also Supporting Information at the foot of Table 4), to express the £ value on a 'per resident' basis. The calculation for Sheffield based on validated toolkit submissions at the date of this report is: 6% TIMES £51,120 DIVIDED BY 85.8% TIMES 7/365 = £68.55 per resident per week, see Table 4.

Return on operations based on validated toolkit submissions at the date of this report is calculated at 10% of the Operating cost subtotals in Table 4.

2.10 Analysis and results

Summary results for care homes located in Sheffield are presented in Table 4, in the form prescribed by the DHSC guidance. All operating costs have been derived from validated toolkit submissions, after applying the outlier exclusion rules described in Section 2.6. Return on capital and return on operations are based on the benchmarks set out in Section 2.9, being 6% per annum for return on capital and a 10% mark-up on operating costs for the return on operations.

Because of the way in which CareCubed calculates costs, the differential (if any) between 'enhanced' (usually interpreted as dementia) and non-enhanced total costs is entirely due to the staffing costs. All other cost lines are identical for enhanced and non-enhanced care.

We have used LaingBuisson's *Care Cost Benchmarks* model as a broad check on the plausibility of the FCoC results in Table 4. We would expect (from *Care Cost Benchmarks*) nursing care costs to be about £250 per week higher than residential care costs - made up from registered nursing staff input at around the 2022/23 NHS FNC rate of £209, plus some additional non-nurse carer staff input. We would also expect (from *Care Cost Benchmarks*

data set going back over a decade) a differential between 'enhanced' (i.e. dementia) and non-enhanced residential care, the former being more costly. But we would *not* expect any differential between enhanced and non-enhanced nursing care.

Any divergence from the expected pattern in the Table 4 median results may be a result of normal variance within small numbers of validated toolkits, see Section 2.12.

These results in Table 4 should be seen in the context of policy guidance from the Department of Health and Social Care. The latest DHSC guidance, dated 29 September 2022, recognises that '*median figures for the broad service types within scope (standard residential care, residential care for enhanced needs, standard nursing care and nursing care for enhanced needs)' … 'may oversimplify what is a complex picture of care and support needs.'*

Table 4 Median costs of care homes (65+) located in Sheffield, £ per week at 2022/23 prices

Cost of Care exercise results - £ per resident per week	65+ care home places without nursing	65+ care home places without nursing, enhanced needs	65+ care home places with nursing	65+ care home places with nursing, enhanced needs
	(The numbers in brackets represent the number of fully or partially validated toolkits from which the given cost line median was derived)			
Staffing	**481.20**	**498.03**	**653.00**	**710.04**
Nursing Staff	-	-	240.26 (11)	253.25 (13)
Care Staff	341.93 (27)	358.76 (34)	273.47 (11)	317.52 (11)
Therapy Staff	-	-	-	-
Activity Coordinators	9.5 (26)	9.5 (26)	9.5 (26)	9.5 (26)
Service Management	35.1 (34)	35.1 (34)	35.1 (34)	35.1 (34)
Reception & Admin	9.75 (26)	9.75 (26)	9.75 (26)	9.75 (26)
Chefs / Cooks	27.59 (27)	27.59 (27)	27.59 (27)	27.59 (27)
Domestic Staff	46.37 (33)	46.37 (33)	46.37 (33)	46.37 (33)
Maintenance & Gardening	7.22 (33)	7.22 (33)	7.22 (33)	7.22 (33)
Other Care Home Staff	3.74 (15)	3.74 (15)	3.74 (15)	3.74 (15)
Care Home Premises	**33.45**	**33.45**	**33.45**	**33.45**
Fixtures & Fittings	5.65 (17)	5.65 (17)	5.65 (17)	5.65 (17)

Repairs and Maintenance	18.76	(32)	18.76	(32)	18.76	(32)	18.76 (32)
Furniture, Furnishings and Equipment	6.46	(32)	6.46	(32)	6.46	(32)	6.46 (32)
Other Care Home Premise Costs	2.58	(18)	2.58	(18)	2.58	(18)	2.58 (18)
Care Home Supplies and Services		**98.00**		**98.00**		**98.00**	**98.00**
Food	33.74	(34)	33.74	(34)	33.74	(34)	33.74 (34)
Domestic & Cleaning	6.59	(29)	6.59	(29)	6.59	(29)	6.59 (29)
Medical Supplies	2.09	(26)	2.09	(26)	2.09	(26)	2.09 (26)
PPE	3.1	(15)	3.1	(15)	3.1	(15)	3.1 (15)
Office Supplies	1.91	(34)	1.91	(34)	1.91	(34)	1.91 (34)
Insurance	6.47	(30)	6.47	(30)	6.47	(30)	6.47 (30)
Registration Fees	3.74	(28)	3.74	(28)	3.74	(28)	3.74 (28)
Telephone & Internet	2.47	(36)	2.47	(36)	2.47	(36)	2.47 (36)
Council Tax / rates	0.8	(32)	0.8	(32)	0.8	(32)	0.8 (32)
Electricity, Gas & Water	28.19	(33)	28.19	(33)	28.19	(33)	28.19 (33)
Trade and Clinical Waste	4.16	(34)	4.16	(34)	4.16	(34)	4.16 (34)
Transport & Activities	2.02	(36)	2.02	(36)	2.02	(36)	2.02 (36)
Other Care Home	2.72	(31)	2.72	(31)	2.72	(31)	2.72 (31)
Head Office		**40.98**		**40.98**		**40.98**	**40.98**
Central / Regional Management	23.97	(32)	23.97	(32)	23.97	(32)	23.97 (32)
Support Services	12.49	(33)	12.49	(33)	12.49	(33)	12.49 (33)
Recruitment, training & vetting	2.61	(33)	2.61	(33)	2.61	(33)	2.61 (33)
Other head office costs	1.91	(22)	1.91	(22)	1.91	(22)	1.91 (22)
Sub-total Operating Costs		**653.63**		**670.46**		**825.43**	**882.47**
Return on Operations		65.36		67.05		82.54	88.25
Return on Capital		68.55		68.55		68.55	68.55
Total		**787.54**		**806.06**		**976.52**	**1,039.27**

Supporting information on important cost drivers used in the calculations:	65+ care home places without nursing	65+ care home places without nursing, enhanced needs	65+ care home places with nursing	65+ care home places with nursing, enhanced needs
Number of fully or partially verified location level survey responses received	21	20	20	16
Number of locations eligible to fill in the survey (excluding those found to be ineligible)[11]	34	34	36	36
Number of residents covered by the responses	592	688	711	747
Number of carer hours per resident per week	26	25	21	25
Number of nursing hours per resident per week	-	-	14	10
Average carer basic pay per hour	£11.47	£11.35	£10.29	£10.12
Average nurse basic pay per hour	-	-	£16.15	£18.50
Average occupancy as a percentage of active beds	85.8%	85.8%	85.8%	85.8%
Freehold valuation per bed	£51,120.3	£51,120.3	£51,120.3	£51,120.3

All data derived from toolkit responses except for return on capital and return on operations, which have been superseded by the council based on a 6% annual return on capital for premises and a 10% mark-up on operating and head office costs for return on operations

2.11 Sensitivity analysis

The median total costs set out in Table 4 are sensitive to the following factors:

- The efficacy of the validation process in eliminating implausible and incorrect toolkit submissions for individual cost lines. We believe that the validation process, as described in Section 2.5, was effective;

- The validity of the rules adopted for elimination of outliers before calculating the medians for each cost line. Outlier exclusion was limited and we believe the rules adopted, as described in Section 2.6, were appropriate;

[11] For both residential and nursing care, numbers given for standard and enhanced locations eligible to fill in the survey are equal. This is a result of this information not being made available through care cubed for in-scope locations that did not make a submission.

- The return on capital and return on operations benchmarks. The values which have been adopted are set out in Section 2.9 and the evidence is presented in Appendix 1;

- Calculation of capital cost per occupied bed, to which the return on capital benchmark is applied, see Section 2.11.1

- Adjustment for occupancy, if any, see Section 2.11.2

- The approach to calculating confidence intervals for the median total costs, see Section 2.12

- Special local factors, if any, see Section 2.13.

2.11.1 Sensitivity to capital cost per occupied bed

Actual values of capital costs per occupied bed are calculated from the toolkits as freehold valuation divided by number of residents. In some cases, particularly in affluent areas where developers have targeted the private pay market in recent years, land and build costs for high specification homes may be considerably greater than the council is reasonably willing to pay for a standard physical environment for council placements. For the purpose of determining a fair cost of care, therefore, councils may reasonably wish to supersede the freehold valuations per occupied bed reported in toolkits with a suitable benchmark value.

LaingBuisson has addressed this issue in its *Care Cost Benchmarks* model by gathering evidence on the cost of developing a new-build care home constructed to a standard specification in an area of moderate land costs. The projected (national) land and build cost at April 2022 is calculated at £110,000 per registered bed (equivalent to £122,000 per occupied bed at 90% occupancy). This is viewed as the **ceiling** asset value that councils may wish to fund in order to incentivise the development of new capacity. The **floor** asset value, according to the *Care Cost Benchmarks* model, is approximately £30,000 per bed, representing converted care home stock on the borderline of registrable quality. Assuming an even spread of stock between the floor and ceiling, in line with the national balance between converted and new build stock, the average capital value is about £70,000 per registered bed (£78,000 per occupied bed) nationally. This is a benchmark that may be suitable for a council which seeks to support existing capacity sustainably, but not incentivise new care home capacity.

Our recommendation is that, for the purposes of calculating a fair cost of care for council supported residents, the median freehold valuation per bed derived from toolkit submissions should be capped at a maximum of £110,000, being the estimated build+land cost of developing a new care home to a standard mid-market specification, and that freehold valuation per occupied bed should be capped at £122,000, assuming 90% occupancy. The cap does not apply to Sheffield, where the median freehold valuation per bed derived from toolkit submissions was about half of the £110,000 limit.

2.11.2 Sensitivity to occupancy rates

Care home occupancy rates in many council areas are still recovering from excess deaths during the Covid pandemic, and possibly from a dampening of demand as a result of negative experiences during Covid. There is a case, in principle, for adjusting the median costs in Table 4 (which are based on 2021/22 occupancy levels) to take account of possibly higher average occupancy rates by April 2022, or to adjust costs to an 'efficient' benchmark, which might be in the region of 90%.

While the council may take occupancy rates into consideration when looking at market sustainability and setting fee rates for 2022/23 and beyond, we do not recommend making any occupancy-based adjustments to the median costs set out in Table 4 for the purposes of FCoC, for the following reasons:

- Based on validated submissions to date, occupancy rates in most council areas are not substantially different from national, sector-wide pre-Covid averages;
- Occupancy adjustments would need to make assumptions about fixed and variable costs of care homes, which may be contentious; and
- Any adjustment introduces an additional layer of potential contention, and begs the question: why not consider other adjustments?

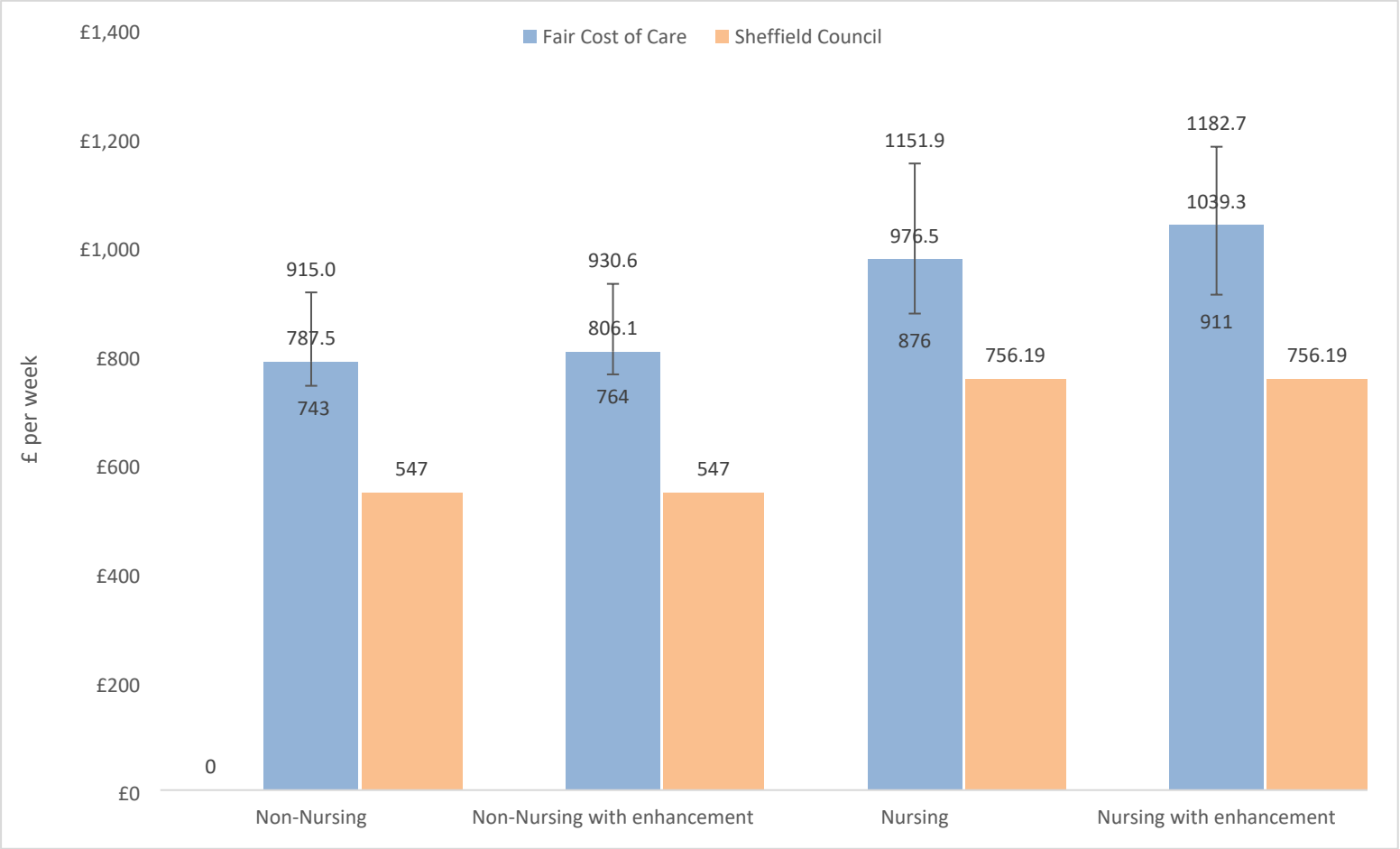
The potential impact of adjusting calculated median costs, to reflect a benchmark occupancy rate of 90%, is set out in Table 5, though it requires an assumption on fixed and variable costs. For illustration, we have arbitrarily assumed that 75% of average care home operating costs would remain fixed as occupancy changed within the observed rate and the selected benchmark, and that 25% would be variable, varying pro rata with occupancy. The resulting counterfactual differences in median total costs are illustrated in Table 5. If any occupancy adjustment is proposed in subsequent market sustainability work, we would recommend the council consult with providers regarding the appropriate method of adjustment.

Table 5 Illustrative impact of superseding the median toolkit occupancy rate with a 'counterfactual' benchmark occupancy rate of 90% , assuming that 30% of operating costs are fully variable and 70% are fixed within the range bounded by the benchmark occupancy and the toolkit median occupancy

	Non-Nursing	Non-Nursing with enhancement	Nursing	Nursing with enhancement
Calculated value of the occupancy adjustment (£ pw)	**-£9**	**-£9**	**-£11**	**-£12**

2.12 Confidence intervals

Figure 2 Fair Cost of Care median costs for April 2022 with 95% confidence intervals, and comparison with median fee rates paid by Sheffield Council to independent sector providers in financial year 2022/23 to date



Note: The Sheffield Council nursing care rates include £209.19 per week funding contribution from NHS FNC

While there is no reason to believe that the toolkit responses were biased in any systematic way[12], the number of respondents in any given council area was limited and there was a high degree of variance in many of the cost lines submitted by respondents. In particular, staff input per resident per week, which is the largest single driver of costs, was highly variable across homes within each of the four modalities of care considered[13].

DHSC guidance does not ask for any assessment of the statistical reliability of the FCoC results. However, councils will wish to have some indication of margins of error in the light of incomplete response and the high degree of variance observed among the sample of toolkits in most of the cost lines. In particular, councils will wish to know whether the confidence limits for the FCoC medians overlap with average fees currently being paid in the 2022/23 financial year. Calculations are set out in Figure 2.

2.13 Special local factors

Every local care economy is different, but there are no special features of the Sheffield care home market which justify variation of the analytical approach adopted for other councils that LaingBuisson has supported in the national FCoC exercise.

2.14 Conclusions

The key item of data that the national FCoC exercise has sought to reveal is the 'fee gap' (if any) between the calculated median cost of care and the fee rates currently being paid by councils, in order to inform policy decisions on the quantum of the gap to fill (if any) and the pace at which it can be filled with the resources available.

[12] We cannot, however, rule out the possibility that providers may have overstated their costs, and it was not practicable within the timescale available to carry out a range of checks applied by LaingBuisson in other cost of care exercises, including requesting evidence of staff costs from payroll records.

[13] Variability in staff input is consistent with all previous cost of care exercises carried out by LaingBuisson. It may be attributed to a number of factors including the dependency levels of residents, the capacity of staff to cater of difference levels of need and the scale and physical layout of homes. The absence of homogeneity means that cost of care exercises cannot aspire to identifying a single 'true' cost of care for all efficient providers, not even when segmented into the four modalities of residential / nursing / enhanced / not enhanced. In the absence of any more developed needs matrix than exists at present, cost of care exercises can only aspire to identifying a reasonable sector wide average, or median, around which the costs of individual homes inevitable vary.

2.14.1 Residential care

For residential care, the median fee currently (post-April 2022) being paid by Sheffield Council is £547 per week. About three-quarters of council placements are at this basic rate. The remaining quarter vary upwards according to higher than usual needs, bringing the council's average fee up to £661 per week. In order to compare like with like, both FCoC and Sheffield's rates are represented as medians in Figure 2.

Sheffield Council's median residential care fee of £547 is £250 below the FCoC median for standard residential care and £259 below the FCoC median for enhanced residential care, Figure 2.

The FCoC medians, however, are subject to margins of error, and the lower bounds of the 95% confidence interval are £743 and £764 respectively for standard and enhanced residential care. Therefore, the Council can be confident that there is a real 'fee gap' and that the minimum quantum of this 'fee gap' is £196 and £217 respectively for standard and enhanced residential care, being the gap between what the council is paying now and the lower bounds of the 95% confidence limits of the calculated FCoC medians. **There is, therefore, evidence to support an increase in the council's residential care fee rate by a little over £200 per week, subject to available resources.**

2.14.2 Nursing care

For nursing care, the median fee currently (post-April 2022) being paid by Sheffield Council is £756 per week (£547 + £209 NHS FNC). About three-quarters of council placements are at this basic rate. The remaining quarter vary upwards according to higher than usual needs, bringing the council's average fee up to £933 per week. In order to compare like with like, both FCoC and Sheffield's rates are represented as medians in Figure 2.

Sheffield Council's median nursing care fee of £756 (including NHS FNC) is £220 below the FCoC median for standard nursing care and £283 below the FCoC median for enhanced nursing care, Figure 2.

The FCoC medians, however, are subject to margins of error, and the lower bounds of the 95% confidence interval are £876 and £911 respectively for standard and enhanced nursing care. Therefore, the Council can be confident that there is a real 'fee gap' and that the minimum quantum of this 'fee gap' is £120 and £155 respectively for standard and enhanced nursing care, being the gap between what the council is paying now and the lower bounds of the 95% confidence limits of the calculated FCoC medians. **There is, therefore, evidence to support an increase in the council's nursing care rate by substantially more than £100 per week, subject to available resources.**

2.14.3 Segmentation into standard and enhanced care

In many ways, the segmentation into standard and enhanced care in the DHSC reporting template is unhelpful. There is no clear definition of 'enhanced' in the CareCubed cost collection tool (though it was widely interpreted as dementia). Second, the segmentation is not necessarily aligned with the tiered fee rates that local authorities have adopted to recognise the variability of needs that they are purchasing care for. Third, the segmentation means that FCoC medians must be calculated on smaller numbers of respondents than otherwise, meaning that the margins of error are wider and anomalies such as enhanced care medians turning out higher than standard care are more likely to occur.

The minimum 'fee fap' derived from the FCoC exercise may have been clearer if segmentation had been simplified to nursing and residential care only. This would have led to greater certainty (lower margins of error) in the calculated medians, and greater certainty on the 'fee gap' (if any), leaving local authorities with a simpler target of setting locally appropriate tiers of fee rates such as to move the overall average fees they pay towards the single target median (one for nursing and one for residential), subject to the availability of resources.

The latest DHSC guidance, dated 25 August 2022, effectively recognises that market segmentation is best left to local discretion: '*median figures for the broad service types within scope (standard residential care, residential care for enhanced needs, standard nursing care and nursing care for enhanced needs)' … 'may oversimplify what is a complex picture of care and support needs.' …' As many local authorities move towards paying the fair cost of care, it is expected that actual fee rates paid may differ due to such factors as rurality, personalisation of care, quality of provision and wider market circumstances*.'

APPENDIX 1 EVIDENCE BASE FOR RETURN ON CAPITAL AND OPERATING PROFIT PARAMETERS

A1.1 Introduction

Total costs of care services are made up of Operating Costs, derived from responses to validated toolkits, plus the following two items, which DHSC advises may be determined by councils based on available evidence:

a) Return on Capital invested in accommodation assets PLUS return on operations, for care homes (65+); and

b) Return on Operations only for domiciliary care (18+)

After staffing, return on capital is the second largest cost line for care homes and return on operations is the third largest.

DHSC guidance on return on capital, published on June 29 2022, is reproduced in Box 1. Guidance on return on operations is reproduced in Box 2. DHSC guidance is fully consistent with the framework adopted in LaingBuisson's Care Cost Benchmarks model, allowing the latter to be adduced in evidence in the commentary which follows.

Box 1 Return on Capital (care homes only)

Care home cost of care exercises will require local authorities to specify the amounts that they have allowed for both returns on capital and return on operations (expressed as pounds per resident per week, or pounds per contact hour). This is different from a 'whole business return on capital, which includes the return on operations within the return on capital.

Return on capital is a judgement rather than hard science, and as described below, the local authority should retain the flexibility to vary the return on capital paid to any individual provider, but the following overarching principles are relevant.

- Investment by nature involves risk. The cost of capital is the return that investors require to invest in a business. Within the care home market, return on capital payments within the care fee encourages new investors to invest in care home land and buildings and keep existing capital invested in social care rather than investing in another business with similar risk. They may cover payments such as rent and mortgages. They are an important consideration for the full economic cost of running a care home and apply to all care home providers as made clear by CMA (2017).

- Return on capital is an important consideration for the impact of section 18(3), as it is one of the main fixed costs in a care home and to some extent determines who is paying for those fixed costs.
- Nevertheless, return on capital is not a hard entitlement nor is it fully objective. There is judgement involved in setting the amounts included in the cost of care exercise, and further judgement when setting the amounts for any particular provider. The amounts included in the cost of care exercise are not intended to be fixed across all providers in the local authority; the amount paid to any one provider is a judgement according to considerations such as area and building type. It is important to balance spending on return on capital with other potential uses of public money in meeting care needs.
- It is important to remember that return on capital may in some cases be reinvested in the business. This can make their business more desirable to the market in future, and help the market develop more generally, for example by improving quality, improving efficiency, serving more people, or moving into new types of care.
- While they involve judgement, the amounts included in the cost of care exercise will need to be defensible, with the evidence that has informed them set out. The CMA (2017) suggest the cost of capital is calculated as the product of both:
  - (a) the value of the assets invested in the care home
  - (b) the required percentage annual return on capital
- There are several approaches to estimate a) and b) above, although in general, the value of assets used in the cost of capital calculation should reflect the market value of those assets. This is where local authorities may find it helpful to adopt multiple approaches to triangulate and validate their returns. For example, freehold valuations of land and buildings that reflect what those assets could be sold for as an alternative to continuing to use them within the care business.

Cost-of-care exercises should be clear about how their reported return on capital values have been calculated. Approaches including (but not limited to) those below can inform a local authority's overall judgment on the level of return on capital reported as part of its cost of care exercise. The methods below reflect that property prices and rents, and therefore justifiable levels of return on capital, vary substantially between local authorities. As discussed above, local authorities may wish to flex the return on capital value for different care homes in their area.

<u>Potential approach 1</u>

Providers should be asked to state the current freehold value of their care home, and the median freehold value per bed can then be calculated for the local authority conducting the exercise. There is a second-hand market for care homes which can provide a sense check. A percentage rental yield can then be applied to the freehold value per bed. For example, the commercial estate agents Knight Frank cite a 5.5% yield for core care home stock (note that it is a lower 4% for prime stock and 3.5% for super prime stock). For example, consider a local authority with a median freehold valuation of £60,000 per bed. The cost of care exercise could report a return on capital of 5.5% * £60,000 / 52 weeks = £63 per resident per week.

<u>Potential approach 2</u>

Local Housing Allowance (LHA) is paid to Housing Benefit recipients to support the cost of the rent. The rates are set at the 30th percentile of local rents. The one-bedroom rate of LHA (minus fixtures/fittings/repairs/maintenance can arguably be used as a proxy for the property rental element within a local authority. This is because whilst a one-bedroom flat has features that are care home does not, such as a kitchen in every flat, a care home has many communal areas that the flat would not have. The LHA rates are paid at Broad Rental Market Area (BRMA) level, and several of these areas may overlap within the local authority's boundaries. For example, consider a local authority with an average one-bedroom LHA rate of £130 per week, and fixtures/fittings/maintenance of £30 per week, the cost of care exercise could report a return on capital of £100 per resident per week.

Source: Market Sustainability and Fair Cost of Care Fund 2022 to 2023: guidance published 25 August 2022. https://www.gov.uk/government/publications/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023-guidance

Box 2 Return on Operations (care homes and domiciliary care)

The return on operations amounts to a reward and incentive for operating the care and support services in a care home, and as a reward and incentive for the whole business of domiciliary care. It is important to note that in domiciliary care, return on operations is the only source of profit (there is no return on capital nor any capital gains from the property). It is therefore particularly important to understand the costs of domiciliary care providers and how they are changing, to ensure that profits remain at a sufficient level.

Return on operations can be calculated as a percentage markup on operations and head office costs.

As noted for the return on capital above, providers can choose to reinvest part of their return on operations into the business. This can make their business more desirable to the market in future, and help the market develop more generally, for example by improving quality, improving efficiency, serving more people, or moving into new types of care.

Source: Market Sustainability and Fair Cost of Care Fund 2022 to 2023: guidance published 25 August 2022. https://www.gov.uk/government/publications/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023-guidance

A1.2 Care homes

LaingBuisson's *Care Cost Benchmarks* model contains a methodology which we believe comes as close as possible to setting an objective, market-related norms for return on capital and return on operations for care homes. *Care Cost Benchmarks* have been established for two decades and have been widely used by both commissioners and care home providers seeking to find common ground on fair costs.

The starting point of the methodology is to determine a reasonable, evidence-based 'whole business' return for a sustainable care home capable of being rated Good by CQC. The whole business return can then be divided into two component parts, return on capital and return on operations, using available evidence.

A1.2.1 Whole business return for care homes

Market behaviour is the best indicator of what the benchmark for a reasonable 'whole business' return on investment should be. LaingBuisson has approached this question by seeking advice from major business transfer agents and property funds active in the care home space. The current consensus is that good-quality, modern care homes sell at a multiple of about 9x sustainable EBITDARM[14]. A 'profit purchase' multiple of 9x implies in turn that investors are typically seeking a 'whole business' return of 11% per annum (that is, the reciprocal of 9). **Therefore 11% comes as close as possible to an objective, market-related norm for expected whole business returns at the individual home level[15].**

One of the merits of the approach described is that it is independent of capital structure. It side-steps the near impossible task of calculating capital costs for an infinite combination of financing options - mortgages, other loans, leases and the imputed cost of the proprietor's own capital, or, just as bad, choosing a single capital structure as a 'standard' for the purposes of calculating capital costs.

The whole business benchmark rate of return (of 11%) is made up of two components, which are aligned with DHSC guidance:

c) The rate of return on capital tied up in the care home accommodation asset, for which LaingBuisson recommends 6% per annum, see Section A1.2.2;

[14] EBITDARM stands for Earnings Before Interest, Tax, Depreciation, Amortisation of goodwill, Rent on leased premises and central Management overheads

[15] In LaingBuisson's Care Cost Benchmarks model, the whole business benchmark return can be expressed in two equivalent ways: a) 11% at the home level when measured as EBITDARM (before charging corporate overheads) and b) 9.5% at the group level when measured as EBITDAR (after charging corporate Management overheads). This is a presentational change only. The two benchmarks are different ways of expressing the same thing. The 9.5% group level return implies typical acquisition multiples for an average freehold care home portfolio of a little over 10 times group EBITDAR, which is borne out by transaction evidence.

d) Return on Operations for delivering the care home service, which Laing Buisson recommends should make up the balance of the 11% whole business EBITDARM return at the individual home level, see Section A1.2.3.

The rationale for the split is described in the next two sections.

A1.2.2 Return on capital invested in care home accommodation

DHSC guidance[16] cites the Competition and Markets Authority's advice in its 2017 report on the care home market[17], that the cost of capital for care homes should be calculated as the product of a) the **value of the assets invested in the care home** and (b) the **required percentage annual return on capital**. This is the same approach as used in LaingBuisson's *Care Cost Benchmarks* model.

In addition to capital tied up in the care home accommodation asset, providers will have working capital requirements, but these are relatively small and have been ignored in these calculations.

A1.2.2.1 Value of assets

The IESE toolkit for care homes contains a field for providers to record the 'Red Book' valuation for the care home in question and the year of that valuation. The 'Red Book' refers to guidance from the Royal Institute of Chartered Surveyors (RICS) on how to make a whole business valuation of a freehold care home business. It is done by applying an appropriate multiple to its sustainable annual operating profits. It should be noted that the term 'sustainable' means that any premium due to exceptionally strong management is discounted and the home is valued according to the sustainable operating profits that the valuer considers competent replacement management could achieve.

The 'Red Book' valuations in the care home toolkit returns have been adjusted for inflation (since the year of valuation) and expressed as a 2022/23 £ value per resident in the home by the home master spreadsheet which accompanies this report. Among the 20 Sheffield toolkits which reported valuations, the median figure was £51,120 per bed, which works out at £68.55 per resident per week.

Annex E: further detail on return on capital and return on operations - GOV.UK (www.gov.uk)

[17] https://www.gov.uk/government/publications/care-homes-market-study-summary-of-final-report

A1.2.2.2 Percentage annual return on capital

The provision of care homes in the UK now takes place almost entirely outside the public sector. It is mainly undertaken by for-profit providers and will remain so for the foreseeable future. Care home development and operation is viewed by the business community as a moderately risky activity and investors in care home property, whether they are care home operators themselves or third-party property investors, expect a reasonable rate of return on capital. From a public policy perspective, the return should be sufficient to:

e) Attract investment in new care home capacity to meet potentially increasing underlying demand driven by the ageing population;

f) Incentivise existing operators to continue in business and upgrade their physical assets where appropriate;

g) Encourage providers of new and existing homes to make services accessible to publicly as well as privately paying residents.

An objective measure of the annual cost of providing the accommodation (property) is required, independent of the care and other services provided within the property. This is readily available from the price that a care home operator typically has to pay for a long-term (c. 25 years) lease on a turnkey care home asset. Much of the care home capacity that has come on stream in recent years has been financed by this means[18]. The consensus view is that a yield of 6%-7% plus would be expected by a property investor leasing premises to an operator with a moderate covenant, though a yield of as low as 5% may be adequate for assets leased to the handful of operators with a strong balance sheet and excellent covenant[19]. These rates can be equated to the cost to a care home business of providing accommodation. The range is higher than a typical mortgage rate because it reflects the cost of (riskier) 100% finance.

Based on this evidence, **LaingBuisson's *Care Cost Benchmarks* model proposes a Return on Capital benchmark rate of 6% per annum for care home property,** being at the lower end of the yield range of 6%-7% plus for care home operators with a moderate covenant, which is representative of the bulk of the UK care home market for older people. This conclusion is consistent with the DHSC 'Potential approach 1', as set out in Box 1.

[18] There are now two London Stock Exchange quoted property investment companies, Target Healthcare REIT and Impact Healthcare REIT, specialising in financing new care home developments under arrangements in which the property investor owns the freehold and, 'as landlord', leases the asset to a care home operator 'tenant' at an escalating rent for a typical period of 25 years. There are also several European and other overseas-based property investors which are active in the UK market,

[19] The DHSC guidance (Box One) notes Knight Frank's citation of a 5.5% yield for core care home stock (or 4% for prime stock and 3.5% for super prime stock). These rates, however, are only available for care home operators with a good covenant in the form of a strong balance sheet. Most care home operators are viewed as having a moderate covenant only, and would expect to pay a higher yield for 100% finance.

We have rejected the DHSC's 'Potential approach 2' as set out in Box 1. We do not believe that LHA rates can be considered a good proxy for sustainable care home returns since the risk profile of residential property investment is different from the risk profile of care home investment.

A1.2.3 Return on operations for care homes

In the approach described above, the benchmark for return on operations can be derived by deducting the benchmark return on capital for the care home property asset (6%) from the benchmark whole business return on investment (11%, see section A1.2.1). The difference is 5%. However, this needs to be expressed not as a return on capital but as a mark-up on operating costs and head (in line with DHSC guidance, see Box 1).

After adjusting for the different denominators**, the return on operations benchmark can be re-expressed as a 10% mark-up on care home operating costs and head office costs**.

There remains a subsidiary question over whether the mark-up should be the same for not-for-profit care homes as for for-profit care homes, given the typically lower profitability (surplus) aspirations of not-for-profits.

LaingBuisson

Fair Cost of Care

Domiciliary Care (18+)

Results and Analysis from Toolkits submitted by Providers located in Sheffield Council

FINAL REPORT 5th October 2022

Prepared for Sheffield Council by LaingBuisson

CONTENTS

1 EXECUTIVE SUMMARY

LaingBuisson was commissioned by Sheffield Council in August 2022 to undertake a Fair Cost of Care exercise, as described and specified in government guidance[1], covering registered domiciliary care services for adults (18+) within the council's boundaries.

This written report is based on validated submissions of CQC registered domiciliary care providers, using the toolkit developed by ARCC in partnership with the Local Government Association. In the validation process, toolkit submissions were checked by LaingBuisson for sense and consistency, and anomalies were amended as necessary with the agreement of providers.

The report is presented together with a companion spreadsheet which lists all respondent providers, one row per provider, each with a range of available data points covering:

- All of the detailed operating cost categories and supporting items of information required by DHSC, extracted from respondents' toolkit submissions;
- Return on operations has been determined by the council on the basis of the best available evidence, namely the return on operations figures stated by providers in their toolkit submissions
- Key characteristics of each domiciliary care service, which may assist in analysis related to market sustainability, such as scale, sector, group ownership, etc. This data is sourced from CQC and LaingBuisson's data warehouse; and

1 Market Sustainability and Fair Cost of Care Fund 2022 to 2023: guidance, updated 25 August 2022
https://www.gov.uk/government/publications/market-sustainability-and-fair-cost-of-care-fund-2022-to-2023-guidance

- Other ratios derived from the toolkit submissions, which may assist in understanding drivers of costs.

1.1 Headline results

A summary of median total costs derived from the FCoC exercise is presented in Table 1. A more granular analysis of the cost of care results, including all of the cost lines prescribed by DHSC for councils to qualify for grant funding, is set out in Table 4.

Table 1 Median total costs[1] of providers of domiciliary care services located in Sheffield (including return on operations), £ per hour at 2022/23 prices

	Median total costs	A) Fully validated submissions	B) Partly validated submissions (with at least one cost line validated)	C) Services in scope	Response rate (A + B) / C
	£ per hour	Number	Number	Number	%
All domiciliary care	£21.60	14	4	95	19%

[1] Derived from Table.4

1.2 Response rates

At the date of this report, the LaingBuisson team had fully validated 14 toolkit submissions and partially validated 4 toolkit submissions, the latter being those for which one or more (but not all) of the cost lines had been validated. Adding these together, the 18 fully or partially validated toolkits represents a response rate of 19% of domiciliary care services in scope, Section 2.7. For some individual cost lines the effective response rate was higher and for others it was lower, see Table 4 for the number of respondents (in brackets) for each individual cost line.

1.3 Methodology - validation, correction of anomalies, outlier exclusions and calculation of medians

The methodology for calculating median costs from the submitted toolkits is described in Sections 2.4 to 2.6.

1.4 Sensitivity analysis

The results set out in Table 1 and Table 4 are sensitive to the following factors, Section 2.9:

- The efficacy of the validation process in eliminating implausible and incorrect toolkit submissions for individual cost lines;
- The validity of the rules adopted for elimination of outliers;
- The value of the return on operations benchmark that has been adopted; and
- The approach to calculating confidence intervals for the median total costs.

1.5 Confidence intervals

While there is no reason to believe that the toolkit responses were biased in any systematic way[2], the number of respondents in any given council area was limited and there was a high degree of variance in many of the cost lines submitted by respondents. This may give rise to concerns about the statistical validity of the calculated median. This concern is best addressed by calculating margins of error (confidence intervals) around the calculated medians, as illustrated in Section 2.12, Figure 1. The median hourly rate for visiting domiciliary care, calculated from the validated FCoC toolkits, was £21.60, with 95% upper and lower confidence limits of £25.52 and £20.17 respectively. In other words, subject to the individual toolkit results being normally distributed, we can be 95% confident that the true median (i.e. the median value that would have been calculated with a 100% response rate) lies somewhere between the upper and lower confidence limits of £20.17 and £25.52.

[2] We cannot, however, rule out the possibility that providers may have overstated their costs, and it was not practicable within the timescale available to carry out a range of checks applied by LaingBuisson in other cost of care exercises, including requesting evidence of staff costs from payroll records.

1.6 Conclusions

The key item of data that the national FCoC exercise has sought to reveal is the 'fee gap' (if any) between the calculated median cost of homecare and the fee rate currently being paid by councils, in order to inform policy decisions on the quantum of the gap to fill (if any) and the pace at which it can be filled with the resources available.

The average domiciliary care fee rates actually being paid by Sheffield Council, at the date of the report in October 2022, stood at £19.05 per hour[3]. This is £2.55 lower than the calculated FCoC median, and £1.12 below the lower 95% confidence bound of the calculated FCoC median.

This means that the council can be at least 95% confident that there actually is a gap between the £19.05 per hour average rate being paid by the council now and median provider costs calculated from the FCoC toolkits. It is statistically uncertain what the quantum of the gap really is, though it is possible to be 95% confident that it is at least £1.12, being the gap between the £19.05 paid by the council now and the £20.17 lower bound of the 95% confidence limits of the calculated FCoC median, and it may be more.

2 FAIR COST OF CARE RESULTS FOR SUBMISSION TO DHSC

2.1 The ARCC / LGA toolkit

Under the instructions of Sheffield Council, LaingBuisson opted to use the cost of care toolkit developed by ARCC in partnership with the Local Government Association. The ARCC toolkit takes the form of an Excel spreadsheet with a mix of editable and locked cells addressing different costs associated with domiciliary care business operations. The toolkit allows providers to enter their costs and other relevant data, while internal calculations in protected parts of the spreadsheet generate costs in a Data Output tab, in the format required for reporting results to DHSC.

[3] The gross hourly cost to the council of domiciliary care provision since 1 April,2022 divided by the number of paid contact hours, using improved Better Care Fund (iBCF) definitions.

Domiciliary care providers submitted their completed toolkit spreadsheets direct to their council or to the organisation (if any) supporting the council to undertake the FCoC work. Unlike the approved care home toolkit, domiciliary care cost data is held only in the toolkit spreadsheets. It is not held or maintained in any online portal.

2.2 Services in scope

There were 95 domiciliary care services in scope, with a CQC registered address located within the boundaries of Sheffield Council. In scope services include for-profit and not-for-profit providers which predominantly offer visiting domiciliary care to adults aged 18 or over, funded by local authorities, the NHS or privately. Those which predominantly serve clusters of users at fixed 'extra care' or 'supported living' locations are not in scope. Out of scope services can usually be identified through their CQC registrations as those with an 'extra care' or 'supported living' service type, but without a 'domiciliary care' service type.

2.3 Engagement with providers

LaingBuisson worked with the council to engage with providers through a variety of communication channels, including intensive, direct telephone contact with providers to encourage participation and completion of the toolkit.

Sheffield Council engaged with providers through a variety of communication channels, including, direct telephone contact to encourage participation and completion of the toolkit. In addition, the Council supported providers who were in the process of completing their submissions.

2.4 Quality of toolkit submissions

LaingBuisson's experience, gained from similar care cost exercises carried out in recent years, is that the quality of submissions is variable. Large corporate groups typically have the resources to submit consistent and reliable numbers, but SMEs and micro-businesses can find it challenging to deal with the volume and complexity of data requested in toolkits and may leave some questions unanswered or incorrectly answered. Consequently, it is necessary to apply a robust validation process, including querying anomalous submissions with respondents and assisting them to provide the appropriate data.

2.5 Validation

Toolkit submissions were inspected by LaingBuisson and checked for sense and consistency. All respondents were re-contacted by telephone following submission. Among other things, re-contact was necessary to resolve ambiguities around three specific data points reported in the toolkits, each of which could potentially have a significant impact on reported total costs:

- date of currency of costs, particularly carers' gross hourly pay rates. The ARCC toolkit does not ask for currency dates, meaning that stated pay rates may relate to either 2021/22 or 2022/23;

- payroll calculation: the internal formula within the ARCC toolkit calculates direct staffing costs (before on-costs) as gross hourly pay rate X contact + travel hours. However, we understand that the majority of domiciliary care employers calculate payroll as gross hourly pay rate X contact hours only, meaning that ARCC's internal formula is biased towards overstating staffing costs in many cases, the degree of overstatement depending on the ratio of travel hours to contact hours; and

- back office costs, which were highly variable. Some of them accounted for large proportion of total costs. Anomalies which we came across included staff doubling up as care workers and as back office staff members, leading to possible double counting, and back office staff being used to support other business lines, leading to possible overstatement of costs.

The opportunity presented by the re-contact call was taken to ask some further questions, for the purpose of gathering supplementary information which may be useful for FCoC and also for subsequent market sustainability work,

- *What is your approximate breakdown of billable hours by funding source?* – Local authority, Private, NHS and Others. Unfortunately, however, the homecare response rate was insufficient to estimate the sector-wide funding profile reliably.

- *How would you describe your catchment area: Mainly Urban, Urban, Rural, Mainly Rural?*

- *Which districts do you operate your services in?*

- *Does gross pay include an element of mileage? If so, please confirm that travel time is not double counted*.

In some cases, where the total cost returned in the initial toolkit submission was unusually high, we carried out an anonymous mystery shopper call, prior to the validation re-call. The question (paraphrased) was*: 'I want to arrange domiciliary care for my [relative], what's your hourly rate?*' The reason

for this was to test the plausibility of toolkit submissions. If the hourly rate quoted was less than the operating costs submitted in the toolkit, then the provider could be challenged as follows: *'Your service appears to be loss-making (toolkit operating costs are higher than charge-out rates). If you are not loss-making, how might your toolkit submission have overstated your costs*?

Depending on the answers to the above questions, appropriate adjustments were made with the agreement of providers in order to arrive at corrected total hourly costs at April 2022 prices for each submitted toolkit.

2.6 Incomplete toolkit submissions

2.6.1 Interpolation *vs* outlier exclusion

There are two basic approaches to optimising value from survey results where, even after a robust validation process, some cost lines in any given toolkit submission may be zero or empty (null), and some may be outside a reasonable range:

- **Interpolation** is one approach, in which null, zero or extreme outlier data for any individual cost line in any given toolkit submission is substituted by the median (or mean) value among those toolkits that submitted valid, in range data for that cost line. By this means, otherwise valid toolkits can avoid being discarded due to the absence of minor cost items. In this approach it is reasonable to interpolate values for minor cost lines, though not for major cost lines, such as staffing costs, which are major drivers of total costs; Interpolation maximises the number of valid toolkit responses, from which the median numbers for each individual cost line, as well as the median total cost for all validated toolkits can be calculated. A downside of the interpolation approach, however, is that the nature of medians (the DHSC's preferred measure of central tendency) means that the individual cost line medians do not add to the subtotal medians and the subtotal medians do not add to the total cost median.

- **Outlier exclusion** is another approach, in which median values are calculated separately for each cost line, using all submitted toolkits where that particular cost line was validated, and excluding all 'outliers' whether they be null or zero values or outside a defined range. The full output required by DHSC can then be built up from individual cost line medians. A bonus from this method is that the median total cost line required by DHSC is equal to the sum of the median subtotals and the median subtotals are equal to the sums of the relevant individual cost lines.

We have opted to use the **outlier exclusion** approach, and we have defined outliers to encompass:

a) Null (empty) or zero values for any cost lines where a null or zero value would be inappropriate

b) Non-zero values which are outside specified boundaries.

With respect to b), having researched various methodologies, we adopted Double Median Absolute Deviation (Double MAD) as the preferred approach to setting outlier boundaries for each individual cost line.

$$MAD = median(|X_i - \overline{X}|)$$

Median Absolute Deviation (MAD) is calculated by finding the absolute difference between each validated data point and the validated sample median, and then calculating the median of these absolute differences.

For normally distributed data, MAD is multiplied by a constant b = 1.4826, however, the distribution is unknown and not symmetric in our data sample.

Furthermore, statistically testing for skewness in the sample confirms that the data suffers from a highly asymmetric distribution across all categories. Using a singular Median Absolute Deviation value, disregarding the asymmetry in the distribution, would produce unreliable results. For this reason, we opted for an enhanced method called "Double MAD".

The premises underlying this method are similar to the classic version, with the only difference being the calculation of two Median Absolute Deviations: (1) the median absolute deviation from the median of all points less than or equal to the median and (2) the median absolute deviation from the median of all points greater than or equal to the median. This allows us to set pertinent outlier thresholds taking into account skewness in the data sample. Finally, for each cost line, we have defined as an outlier any data point which is more than 2 X MAD above or below the median. All such outliers have been excluded from the calculation of median costs in Table 4.

We have made one exception to the general outlier exclusion rule described above. It relates to the treatment of outliers in the Total Business Costs line. As noted in Section 2.5, these back-office costs were highly variable. Some of them accounted for large proportion of total costs. Anomalies which we came across included staff doubling up as care workers and as back-office staff members, leading to possible double counting, and back office staff being used to support other business lines, leading to possible overstatement of costs. We also noted that toolkit submissions for back office costs stood out as being substantially higher than the benchmark cost for 'Running the business' within the Homecare Association's pro forma minimum cost structure presented in Table 4. The balance of evidence is that many of the toolkit submissions did overstate Total Business Costs. Consequently, for this cost category, the outlier exclusion method has been customised to "Median – 3 X MAD" for the lower boundary and "Median + 1 X MAD" for the upper boundary. This has the effect of restricting the acceptable range of values above the median. Simultaneously, we consider it necessary to accept values which gravitate around the Homecare Association benchmark of £3.02 per hour for back-office staff, which would have been rejected if the threshold stayed "Median – 2 X MAD".

2.6.2. Base price year and uplifts

The base price year of toolkits has been given as 2022/23. As this was not an element covered within the LGA/CHIP toolkit, additional contact with providers was necessary. Data used in the included analysis has been taken from toolkits received from providers who have confirmed that a 2022/23 base price year has been used, or for toolkits with 2021/22 costs for which uplifts have been applied to cost totals. Uplifts for each cost item are identified in table 2 below, and have been gathered from NLW, CPI, and CPIH 12 month % change figures to April 2022[4], with future uplifting possible through application of later releases of the same indices/% change figures. Our approach to uplifting through application of figures on a point-by-point basis has been made with a view to reflecting relative differences as recommended in The Green Book 2022[5].

Table 2 – Price uplifts

	CPI Code	CPI Item	12 Month % change to April 2022
Direct Care	-	National Living Wage % increase[6]	6.6
Travel Time	-	National Living Wage % increase	6.6
Mileage	D7H3	07.2 Operation of personal transport equipment	16.5
PPE	D7NO	06.1 Medical products, appliances and equipment	1.3
Training (staff time)	-	National Living Wage % increase	6.6
Holiday	-	National Living Wage % increase	6.6
Additional Non-Contact Pay Costs	-	National Living Wage % increase	6.6
Sickness/Maternity & Paternity Pay	-	National Living Wage % increase	6.6
Notice/Suspension Pay	-	National Living Wage % increase	6.6
NI (direct care hours)	-	-	-
Pension (direct care hours)	-	National Living Wage % increase	6.6

[4] Table 22, https://www.ons.gov.uk/economy/inflationandpriceindices/datasets/consumerpriceinflation
[5] Section 5.13, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1063330/Green_Book_2022.pdf
[6] https://www.gov.uk/government/news/national-living-wage-increase-boosts-pay-of-low-paid-workers#:~:text=The%20improvement%20in%20the%20economic,2.2%20per%20cent)%20in%202021.

Back Office Staff	-	ONS estimated growth in earnings[7]	4.1
Travel Costs (parking/vehicle lease etc.)	D7GE	07 Transport	13.5
Rent / Rates / Utilities	D7GB	04 Housing, water, electricity, gas and other fuels	19.2
Recruitment / DBS	D7OB	12.7 Other services (nec)	-3.1
Training (3rd party)	L7TA	10.4 Tertiary education	5.1
IT (Hardware, Software CRM, ECM)	D7IY	08.2/3 Telephone and telefax equipment and services	2.6
Telephony	D7IY	08.2/3 Telephone and telefax equipment and services	2.6
Stationery / Postage	D7GF	08 Communication	2.8
Insurance	D7HF	12.5 Insurance	11.7
Legal / Finance / Professional Fees	D7GJ	12 Miscellaneous goods and services	2.9
Marketing	D7GJ	12 Miscellaneous goods and services	2.9
Audit & Compliance	D7GJ	12 Miscellaneous goods and services	2.9
Uniforms & Other Consumables	D7GA	03 Clothing and footwear	8.3
Assistive Technology	D7GJ	12 Miscellaneous goods and services	2.9
Central / Head Office Recharges	D7G7	CPI (overall index)	9.0
Other Costs	D7G7	CPI (overall index)	9.0
CQC Registration Fees (4)	-	-	-

2.7 Response rates

At the date of this report, the LaingBuisson team has fully validated 14 toolkit submissions and partially validated 4 toolkit submissions, the latter being those for which one or more (but not all) of the cost lines had been validated. Adding these together, the 18 fully or partially validated toolkits represents a response rate of 19% of domiciliary care services in scope, Section 2.7. For some individual cost lines the effective response rate was higher and for others it was lower, see Table 4 for the number of respondents (in brackets) for each individual cost line. Table 3 segments response rates according to key service characteristics which may (or may not) have a bearing on costs.

[7] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/averageweeklyearningsingreatbritain/july2022

Table 3 – Validated and partially validated responses and response rates as a percentage of services in scope, by key service characteristics

Key characteristics	Responses No.	Responses as % of services in scope with the relevant characteristic %
Total fully or partly validated	18	19%
Strategic providers	15	42%
For-profit	17	19%
Not-for-profit	1	20%
Large corporate group[1]	4	36%
Medium group[2]	5	25%
Small group or independent[3]	9	10%
Large service scale (100,000+ hours annually)	5	N/A
Medium service scale (15,000 – 99,000 hours annually)	12	N/A
Small service scale (<15,000 hours annually)	1	N/A
Good or Outstanding	12	21%
Requires improvement or Inadequate	5	31%
Urban	6	N/A
Mainly Urban	7	N/A
Rural	0	N/A
Mainly rural	0	N/A
Mainly (60%+) private pay	1	N/A
Mainly (+60%+) public pay	11	N/A
Sheffield City Council	16	18%
Doncaster Metropolitan Borough Council	1	100%
Barnsley Metropolitan Borough Council	1	100%

[1] 40 or more domiciliary care services across the UK
[2] 3 - 39 domiciliary care services across the UK
[3] Fewer than 3 domiciliary care services across the UK

2.8 Analysis and results

Summary results from fully and partly validated homecare toolkits submitted by home care services located in Sheffield are presented in Table 4, in the form prescribed by the DHSC guidance. The results are copied from the companion spreadsheet, which is populated with median operating costs derived from the validated toolkits.

Return on operations is based on the median 5% mark-up on operating costs entered in the toolkit submissions, see Section 2.9.1.

Table 4 Median costs of domiciliary care services located in Sheffield which submitted valid toolkits, £ per week at 2022/23 prices

	Median	Q1	Q3
	£	£	£
	(The numbers in brackets represent the number of fully or partially validated toolkits from which the given cost line median was derived)		
Total Careworker Costs:	**15.82**	**14.87**	**18.03**
○ Direct care	10.62 (15)	10.27 (15)	11.13 (15)
○ Travel time	0.18 (14)	0 (14)	1.06 (14)
○ Mileage	0.62 (12)	0.58 (12)	0.79 (12)
○ PPE	0.62 (11)	0.61 (11)	0.85 (11)
○ Training (staff time)	0.33 (15)	0.26 (15)	0.42 (15)
○ Holiday	1.53 (15)	1.5 (15)	1.56 (15)
○ Additional noncontact pay costs	0.14 (5)	0.12 (5)	0.18 (5)
○ Sickness/maternity and paternity pay	0.34 (13)	0.29 (13)	0.42 (13)
○ Notice/suspension pay	0.06 (6)	0.03 (6)	0.1 (6)
○ NI (direct care hours)	0.95 (15)	0.79 (15)	1.09 (15)
○ Pension (direct care hours)	0.43 (13)	0.42 (13)	0.43 (13)
Total business costs:	**4.75**	**3.44**	**6.81**
○ Back office staff	2.74 (14)	2.26 (14)	3.21 (14)
○ Travel costs (parking/vehicle lease et cetera)	0.04 (7)	0.01 (7)	0.07 (7)
○ Rent/rates/utilities	0.35 (13)	0.3 (13)	0.43 (13)
○ Recruitment/DBS	0.08 (14)	0.03 (14)	0.13 (14)

○ Training (third party)	0.03 (10)	0.01 (10)	0.14 (10)
○ IT (hardware, software CRM, ECM)	0.25 (17)	0.09 (17)	0.34 (17)
○ Telephony	0.16 (16)	0.09 (16)	0.19 (16)
○ Stationery/postage	0.05 (14)	0.03 (14)	0.06 (14)
○ Insurance	0.09 (14)	0.07 (14)	0.13 (14)
○ Legal/finance/professional fees	0.06 (9)	0.04 (9)	0.08 (9)
○ Marketing	0.04 (11)	0.04 (11)	0.17 (11)
○ Audit and compliance	0.03 (12)	0.03 (12)	0.07 (12)
○ Uniforms and other consumables	0.03 (12)	0.01 (12)	0.04 (12)
○ Assistive technology	0.01 (2)	0.01 (2)	0.02 (2)
○ Central/head office recharges	0.52 (10)	0.3 (10)	1.16 (10)
○ Other overheads	0.19 (11)	0.05 (11)	0.47 (11)
○ CQC fees	0.08 (14)	0.07 (14)	0.1 (14)
Total Return on Operations (5% of operating costs)	**1.03**	**0.92**	**1.24**
TOTAL	**21.60**	**19.23**	**26.08**
Supporting information on important cost drivers used in the calculations:			
○ *Number of location level survey responses received*			18
○ *Number of locations eligible to fill in the survey (excluding those found to be ineligible)*			95
○ *Carer basic pay per hour*			£10.71
○ *Minutes of travel per contact hour*			7.4
○ *Mileage payment per mile*			£0.37
○ *Total direct care hours per annum*			831,470
○ *Average direct care hours per annum*			69,289

Notes:
All data are derived from toolkits.

2.8.1 Supplementary information from homecare toolkits

DHSC guidance requires supplementary information on the number of appointments per week by visit length, direct care costs by visit length and travel costs per visit. The information is presented in Tables 5 and 6.

Table 5 Number of domiciliary care appointments per service per week by length of visit

Visit Length	Median	1st Quartile	3rd Quartile
15 minutes	199	56.5	295.5
30 minutes	915	420	1523.9
45 minutes	186	73	287
60 minutes	67	53	196

Table 6 Cost per visit by visit length

Visit Length	Average Cost	Median Cost
	£	£
15 minutes	6.45	6.31
30 minutes	11.86	11.52
45 minutes	17.27	16.74
60 minutes	22.68	21.96

2.9 Sensitivity analysis

The median total costs set out in Table 4 are sensitive to the following factors:

- The efficacy of the validation process in eliminating implausible and incorrect toolkit submissions for individual cost lines. We believe that the validation process, as described in Section 2.5 was effective;

- The validity of the rules adopted for elimination of outliers before calculating the medians for each cost line. Outlier exclusion was restrictive and we believe the rules adopted, as described in Section 2.6 were appropriate;
- The value of the return on operations benchmark that has been adopted, see Section 2.9.1
- The approach to calculating confidence intervals for the median total costs, see Section 2.9.2
- Special local factors, if any, see Section 2.11

2.9.1 Return on operations

LaingBuisson's advised setting the return on operations benchmark at a 10% mark-up on operating costs, see Appendix 1 for the evidence. However, after considering this evidence, Sheffield Council has determined that the benchmark should be a 5% mark-up on operating costs, being the median return on operations entered in the provider submissions. The 5% mark-up has been applied to operating costs in the calculation of median total costs in Table 4. If the council-determined benchmark were amended to the LaingBuisson recommended mark-up of 10% of operating costs, then the median total cost calculation in Table 4 would rise from £21.60 per hour to £22.63 per hour.

2.9.2 Comparisons with the Homecare Association pro forma cost structure for 2022/23

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

Gross pay for careworkers' contact + travel time, before on-costs, is shown as £11.43 nationally in the Homecare Association model, compared with the FCoC result of £10.80 in April 2022 for Sheffield Council (Table 4).

The ratio of 'Total price' to gross pay works out at 2.03 in the Home Association pro-forma model, compared with an equivalent ratio (Total cost to (Direct Care + Travel Time) of 2.0 from the FCoC results in Sheffield Council presented in Table 4.

If the Homecare Association ratio of 2.03 were applied to the FCoC median gross pay per hour in Sheffield then the Total cost line in Table 4 would work out at £21.92 per hour.

It should be noted that the Homecare Association pro forma allows a 3% mark-up for 'profit or surplus' LaingBuisson considers this to be unrealistically low, even as a minimum, as indicated. It is unlikely that any commercial organisation would consider entering the domiciliary care sector with an average expected profitability of 3%.

Table 7 Pro forma minimum cost structure of the short duration visiting model of homecare, illustrated at National Living Wage for all care workers, £ per hour 2022-23

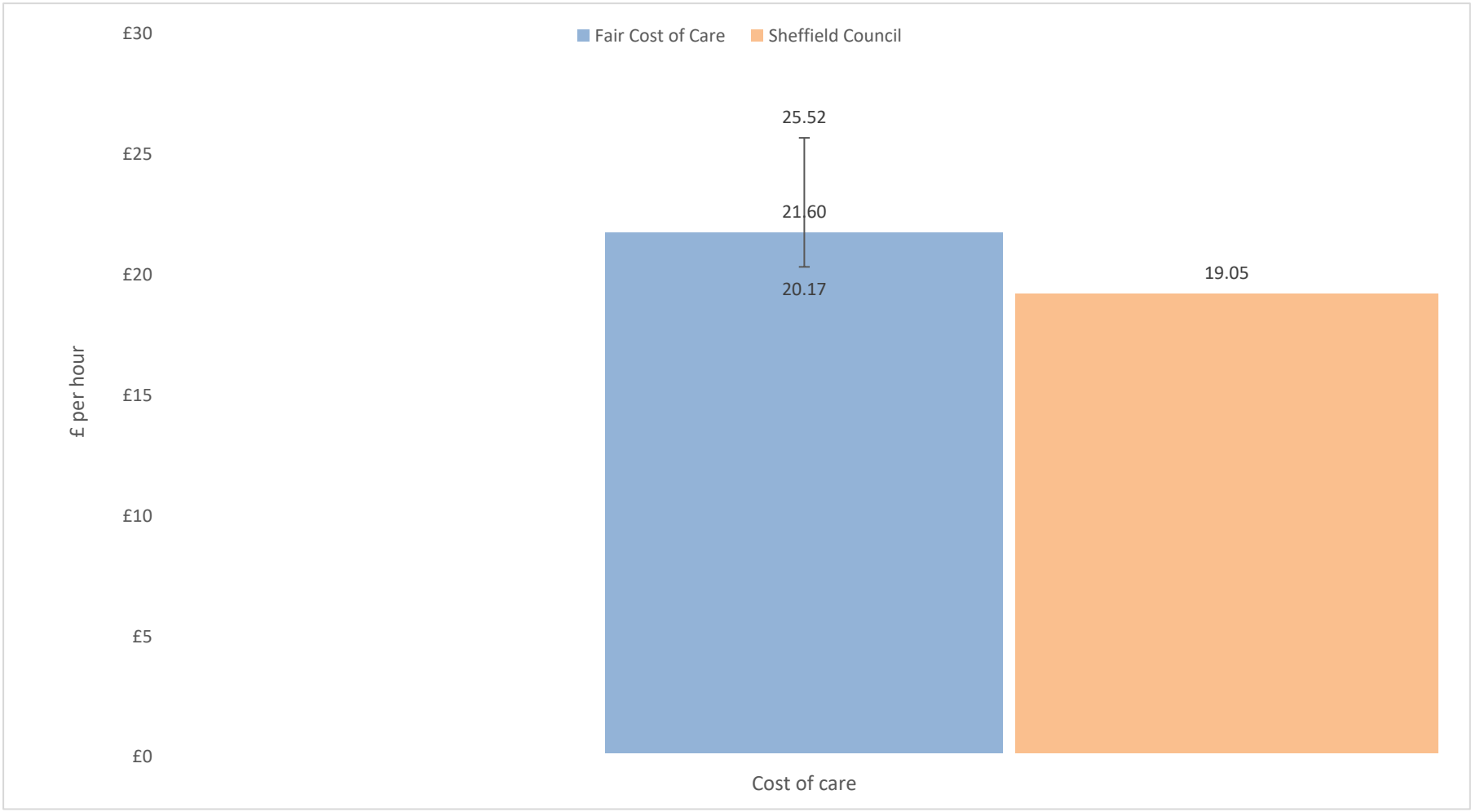
	£ per hour
Careworkers contact time (gross pay before on-costs)	£9.50
Careworkers travel time (gross pay before on-costs)	£1.93
NI and pension contributions	£1.34
Other wage-related on-costs	£2.28
Mileage	£1.52
Running the business	£5.95
Profit or surplus	£0.68
Minimum hourly price	**£23.20**

2.10 Confidence intervals

There is no reason to believe that the toolkit responses were biased in any systematic way[8]. However, because of the relatively low number of validated responses, and the high degree of variance among the sample of toolkits in most of the cost lines, councils will wish to have some indication of the margin of error, and particularly whether confidence limits for the FCoC median do or do not overlap with the average fee currently being paid by councils in financial year 2022/23. Calculation of the 95% confidence limits is set out in Figure 1.

[8] We cannot, however, rule out the possibility that providers may have overstated their costs, and it was not practicable within the timescale available to carry out a range of checks applied by LaingBuisson in other cost of care exercises, including requesting evidence of staff costs from payroll records.

Figure 1 Fair Cost of Care median total cost of domiciliary care for April 2022 with 95% confidence intervals, and comparison with fee rates paid by Sheffield council to independent sector providers in financial year 2022/23 to date



Note: The council's average hourly fee rate is calculated as Gross Fees divided by Service Users, using iBCF definitions.

2.11 Special local factors

Every local care economy is different, but there are no special features of the Sheffield domiciliary care market which justify variation of the analytical approach adopted for other councils that LaingBuisson has supported in the national FCoC exercise.

2.12 Conclusions

The key item of data that the national FCoC exercise has sought to reveal is the gap (if any) between the calculated median cost of care and the fee rate currently being paid by councils, in order to inform policy decisions on the quantum of the gap to fill (if any) and the pace at which it can be filled with the resources available.

The average domiciliary care fee rates actually being paid by Sheffield Council, at the date of the report in October 2022, stood at £19.05 per hour[9]. This is £2.55 lower than the calculated FCoC median, and £1.12 below the lower 95% confidence bound of the calculated FCoC median.

This means that we can be at least 95% confident that there actually is a gap between the £19.05 per hour average rate being paid by Sheffield Council now and median provider costs calculated from the FCoC toolkits. We cannot be certain what the quantum of the gap really is, though we can be 95% confident that it is at least £1.12, being the gap between the £19.05 paid by the council now and the £20.17 lower bound of the 95% confidence limits of the calculated FCoC median, and it may be much more.

Therefore, there is evidence to support an increase of at least £1.12 in the current average hourly fee rates paid by Sheffield Council to its domiciliary care providers, subject to available resources.

[9] The gross hourly cost to the council of domiciliary care provision since 1 April,2022 divided by the number of paid contact hours, using improved Better Care Fund (iBCF) definitions.

APPENDIX 1 EVIDENCE BASE FOR RETURN ON OPERATIONS BENCHMARK

Our FCoC report on care homes concluded with a recommendation for a 10% mark-up on operating costs, representing a reasonable return on operations for care home providers. The rationale and evidence is discussed at length in the Appendix of the FCoC care home report.

Our view is that the same mark-up of 10% can legitimately be applied to domiciliary care operating costs. The rationale is that, once the property costs have been stripped out of care homes, the operating business – employing and managing staff to deliver care and support – has more similarities than differences. Therefore, 10% is an equally appropriate mark-up on domiciliary care operating costs and head office costs.

We have also considered a supporting approach to determining a return on operations benchmark, based on historic returns posted by domiciliary care and supported living groups. LaingBuisson maintains structured data on profit and loss accounts posted on Companies House by the full range of independent sector operators of health and social care in the UK, going back for more than a decade. Nearly all domiciliary groups in this financial data set are for-profit. All not-for-profit groups specialise in supported living for younger adults.

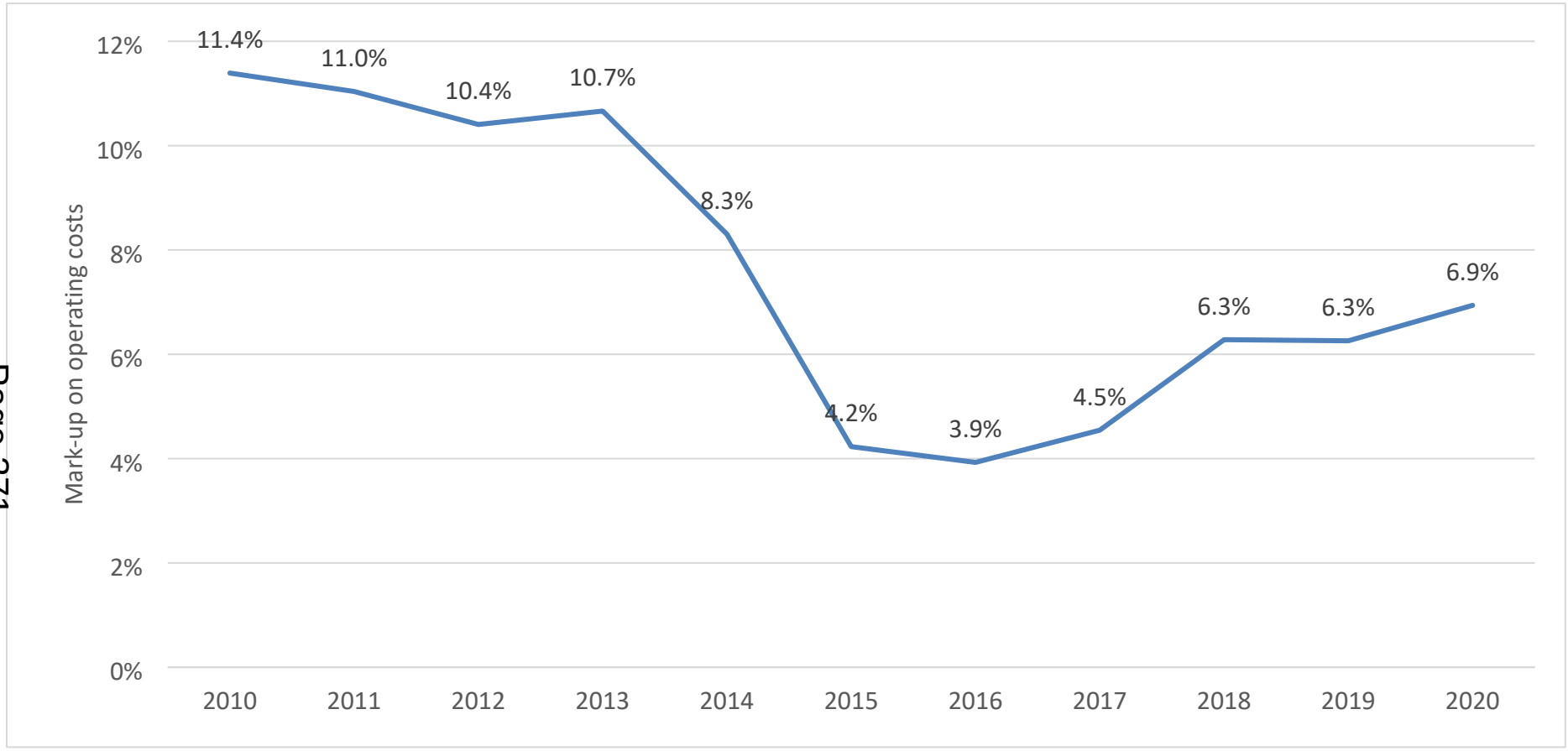
Trends in the profitability of for-profit groups over the period 2010 - 2020 are illustrated in Figure 1. The data support a narrative frequently expressed by independent sector interests, which is that financial pressures following the implementation of austerity measures from 2011/12 had a negative impact on profitability. The aggregate mark-up[10] of companies fell from a base of a little over 10% at the turn of the decade to a low point of 3.6% for statutory
accounts periods ending in 2016, before partially recovering to 6.9% for statutory accounts periods ending in 2020. Data for 2021 are as yet incomplete.

The aggregate revenue of for-profit domiciliary care companies covered in Figure 1 in 2020 was £1.3 billion, which represents 20% of the total UK domiciliary care market of £6.4 billion in 2020/21, as estimated by LaingBuisson[11]. Larger companies with full profit and loss accounts are more exposed to local authority funding than the market as a whole. Also, profitable franchise providers which typically focus on private pay are excluded from the analysis because their results do not consolidate their individual franchisees. Despite the skewed sample, LaingBuisson considers that the trends in profitability illustrated in Figure 1 are supportive of 10% as a mark-up norm for a competitive sector during a time (pre-austerity) when it was not subject to excessive pressure on margins.

In conclusion, we recommend a **10% mark-up on operating and head office costs as an appropriate return on operations for domiciliary care providers.**

[10] Mark-up is calculated as EBITDA / (Revenue – EBITDA)
[11] *Homecare and Supported Living UK Market Report,* LaingBuisson 2021

Figure 2 Aggregate mark-up on operating costs among larger, for-profit domiciliary care providers which have posted statutory accounts with full profit and loss at Companies House, UK 2010 - 2020



[1] Financial period ending in those years

APPENDIX 2 GLOSSARY

Cost of care

Cost of care best describes the actual costs a care provider incurs in delivering care at the point in time that the exercise is undertaken. It is typically presented as a unit cost for an hour of domiciliary care or a bed per week in a care home.

'Fee for care', 'rate for care' or 'fee rate for care'

These terms are often used interchangeably but most commonly refer to the figure a local authority sets and/or agrees to pay a provider for a particular service. Local authorities will have different commissioning frameworks and approaches to rates for care. In some situations, a local authority will set a fixed rate that it will pay for a type of service and this may be referred to as the 'local authority's set or usual rate for a care home bed'.

Cost of care exercise

A process of engagement between local authorities, commissioners and providers, data collection and analysis by means of which local authorities and care providers can arrive at a shared understanding of the local cost of providing care. The cost of care exercise will help local authorities identify the lower quartile, median and upper quartile costs in the local area for a series of care categories.

Fair

For reporting purposes for this fund, and in terms of understanding the cost of care, fair means the median actual operating costs for providing care in the local area (following completion of a cost of care exercise) for a series of care categories. This must include evidence values for return on capital and return on operations, and also travel time for domiciliary care. Together this is what is described as the 'fair cost of care' and is, on average, what local authorities are required to move toward paying providers.

In the context of specific rates for care paid, fair means what is sustainable for the local market.

For providers, this means they will be able to cover the cost of care delivery and be able to make a reasonable profit (including re-investment in their business), surplus or meet their charitable objectives.

Local authorities recognise the responsibility they have in stewarding public money, including securing the best value for the taxpayer.

Data collection tool

This is a spreadsheet or web-based system for use by each care location participating in the cost of care exercise to work out their breakdown of costs (per resident per week or contact hour) for submission in the cost of care exercise. The spreadsheet or web-based system will contain pre-programmed formulas to help providers consistently calculate these costs.

Cost of the care data table

A breakdown of the results of the cost of care exercise for each cost line as set out in Annex A, Section 3, for submission to DHSC.

Cost of care report

A PDF or Microsoft Word document explaining how the results in the cost of care data table were arrived at, including but not limited to, the contents described in Annex B. Separate reports should be produced for 65+ care homes and 18+ domiciliary care due to their very different cost bases. Local authorities are required to submit these reports to DHSC and publish them on their GOV.UK website.

Average

Averages (properly called 'means') cover the whole distribution, though have the disadvantage of being skewed by high outlier values.

Local authority fee rates in collections such as the Adult Social Care Finance Return and the Improved Better Care Fund collection are required to be reported as averages. For reporting purposes in this fund, fee rates paid are required to be reported as averages in line with wider fee rate reporting.

Median

Medians represent the middle value when a distribution (for example fee rates) is ordered by size (for example by the amount of the fee rate). The advantage of medians compared to averages is that they are less skewed by high outlier values.

Data collected through the cost of care exercise are required to be reported as medians to account for outliers in the distributions that are being analysed (such as staffing ratios or staff costs per resident at location level).

Sustainable market

A sustainable market has a sufficient supply of services but with provider entry and exit, investment, innovation, the choice for people who draw on care, and sufficient workforce supply. It also refers to a market which operates efficiently and effectively, linked to the market shaping duty placed on local authorities under section 5 of the Care Act 2014. Further detail on this can be found in the market sustainability plans section of the guidance.

Enterprise Scale

We use enterprise scale to refer to the number of home care providers/care homes operated by the same service provider as obtained from the CQC.

Equality Impact Assessment Number 1256

Part A

Initial Impact Assessment

Proposal name Market Oversight and Sustainability

Brief aim(s) of the proposal and the outcome(s) you want to achieve

Under the Care Act 2014, Councils have a duty to ensure that there is a sustainable and affordable social care market locally. The SCC market oversight and sustainability plan sets out current arrangements, an assessment of the current sustainability of the market and our actions to continue to ensure we have a sustainable market.

Sheffield's Market Shaping Statement sets out the strategic context and key messages for the market in Sheffield to support this – setting out our vision for a sustainable market providing a diverse, high quality choice of providers to meet the needs and outcomes of adults in need of care and support in the City.

A draft market sustainability plan with actions and timescales to strengthen Sheffield Council's position in market sustainability, including compliance with the Government's Fair Cost of Care exercise was produced in September 2022. A final Market Sustainability Plan will be submitted to DHSC in March 2023.

Key to the market is the workforce who deliver social care services. We know the workforce is overwhelmingly female, but we need to know more about its diversity and to capture demographics to ensure that it is broadly representative of the people who draw on social care.

This EIA is part of the budget planning process for 2023/24 financial year. Proposal 118 relates to external funding to meet cost pressures resulting from the fair cost of care service reforms.

Proposal type
 Budget

If Budget, is it Entered on Q Tier?
 Yes

Q Tier reference 118

Year of proposal (s)
 23/24

Decision Type
 Committee (AHSC Policy Committee)

Lead Committee Member	Cllrs Angela Argenzio and George Lindars-Hammond
Lead Director for Proposal	Alexis Chappell
Person filling in this EIA form	Catherine Bunten
Equality Lead Officer	Ed Sexton
EIA start date	08/09/2022

Lead Equality Objective (see for detail)

☐ Understanding Communities	☐ Workforce Diversity	☐ Leading the city in celebrating & promoting inclusion	☐ **Break the cycle and improve life chances**

Portfolio, Service and Team

Is this Cross-Portfolio
☐ No

Portfolio
People

Is the EIA joint with another organisation (eg NHS)?
☐ No Please specify

Consultation

Is consultation required (Read the guidance in relation to this area)
☐ Yes

If consultation is not required, please state why

Consultation will be required as more detailed commissioning strategies and Market Position Statements are developed, and an EIA will be completed for each of these. There will continue to be consultation with people purchasing care and support services, either independently, through the local authority, or for whom the local authority purchases and provides services.

Engagement with providers has also been completed relating to the Fair Cost of Care exercise. There will continue to be consultation with providers on Social Care Reform and Sheffield's Market Sustainability Plan, as well as in the development of our Market Position Statements and Fee rates for 23/24, where appropriate.

Are Staff who may be affected by these proposals aware of them
☐ Yes

Are Customers who may be affected by these proposals aware of them
☐ Yes

If you have said no to either please say why

As the Market Shaping process develops, staff and customers will be engaged and informed as required/relevant. Engagement sessions with 18+ homecare and 65+ care homes have been delivered through October and November 2022 to share the Fair Cost of Care exercise outcomes, and to inform our market sustainability plans and proposals. Providers have been informed of proposals for the use of the 22/23 Market Sustainability and Fair Cost of Care Fund.

Fee rates are linked to market sustainability, and for some people, increases to rates will impact on the contributions they make. The increase to the care home rate generally won't affect the contributions people make because placements funded at the Council's standard rate are at least part funded by the Council and so the person is already paying the maximum they can afford to pay.

There are however some exceptional edge cases, where people have sufficient funding to be self-funders and so would ordinarily contract with the care home directly at the standard market rate (which is more than the Council's standard rate). However, in these exceptional cases the Council would be contracting with the care home, funding the placement, and re-charging the person for reasons of safety / to maintain continuity of care. Therefore, for these people the increase to the Council's rate will impact on their contribution. This is fair and right - they have the means to pay - but these people will need to be notified, which will be done on a case-by-case basis because of the complexity of these exceptional cases.

With regards to homecare, we have some people whose financial contribution is not limited by their ability to pay but by the relatively low cost of their support (smaller packages). The increase to the homecare fee rates will therefore result in an increase in charges for some people. These people will be notified in of any increase in advance. We will provide an information fact sheet (budgeting, debt managing, signposting) to everyone affected and will be ready to review the financial assessment of anyone who approaches us with concerns so we can ensure that their very latest costs and assumptions are being taken into account in the financial assessment calculation.

Initial Impact

Under the Public Sector Equality Duty we have to pay due regard to the need to:
- eliminate discrimination, harassment and victimisation
- advance equality of opportunity
- foster good relations

For a range of people who share protected characteristics, more information is available on the Council website including the Community Knowledge Profiles.

Identify Impacts

Identify which characteristic the proposal has an impact on tick all that apply

☐ **Health**	☐ **Sex**
☐ **Age**	☐ **Sexual Orientation**
☐ **Disability**	☐ **Carers**
☐ **Pregnancy/Maternity**	☐ **Voluntary/Community & Faith Sectors**
☐ **Race**	☐ **Partners**
☐ **Religion/Belief**	☐ **Poverty & Financial Inclusion**

Cumulative Impact

Does the Proposal have a cumulative impact

☐ Yes
☐ Year on Year

If yes, details of impact

We expect Social Care Reform, and Sheffield's approach to market sustainability and moving towards a fair cost of care to have an ongoing impact on people in the City – specifically in changes to the way people might purchase care, and also in the changes we anticipate in the way services are delivered in the city.

Proposal has geographical impact across Sheffield

☐ No

If Yes, details of geographical impact across Sheffield

Local Area Committee Area(s) impacted

☐ **All** ☐ Specific

If Specific, name of Local Committee Area(s) impacted

Initial Impact Overview

Based on the information about the proposal what will the overall equality impact?

Broadly, the proposals should have a positive impact – securing a sustainable market offering a choice of high quality provision should have a positive impact on people's access and experience of care across protected characteristics. However, approaching market oversight and sustainability at a population level will not address any current disproportionality in access or experience.

Good engagement and taking a collaborative approach to commissioning strategies and market oversight will help to address this.

Our ambition to improve the sustainability and quality of provision, continuing to move towards person-centred, outcomes-based service delivery should have a positive impact and equalities objectives should also be achieved. Maintaining a choice of type of provision and a choice of provider for the individual and strengthening personalised care and support should ensure that people receive the best care for them – being culturally and religiously appropriate and meeting any other needs related to the protected characteristics

It is possible that the national and local financial context negatively impacts on the pace of change, and/or the market's ability to deliver the required quality or volume of care – in which case there may be a negative impact, and this could fall more heavily on people with one or more of the protected characteristics. It is for this reason that further analysis – including EIAs - will be completed for each document / output as our engagement in our market sustainability planning continues.

Where Fee Rates increase, this will have an impact on people who pay contributions, and whilst it is fair and right that those who can afford to pay do, and this will be applied in line with Sheffield's Fairer Contributions Policy, we recognise that in the current financial context, people are facing significant cost of living pressures, and this often impacts disproportionately across the protected characteristics. **Further data and evidence is needed to understand this impact fully**

Is a Full impact Assessment required at this stage?
☐ Yes

If the impact is more than minor, in that it will impact on a particular protected characteristic you must complete a full impact assessment below.

Initial Impact Sign Off

EIAs must be agreed and signed off by the Equality lead Officer in your Portfolio or corporately. Has this been signed off?
☐ Yes

Date agreed 04/01/2023 Name of EIA lead officer Ed Sexton

Update reviewed and agreed 24/01/2023

Update reviewed and agreed

Part B

Full Impact Assessment

Health

Does the Proposal have a significant impact on health and well-being (including effects on the wider determinants of health)?

 Yes *if Yes, complete section below*

Staff
 No

Customers
 Yes

Details of impact

A better fit in terms of the range and quality of available services is likely to result in a better experience for customers (e.g. reduced isolation, better preventative approach). As integration with health services continues where relevant, a more holistic approach should benefit customers.

Comprehensive Health Impact Assessment being completed
 No

Please attach health impact assessment as a supporting document below.

Public Health Leads has signed off the health impact(s) of this EIA
 No

Age

Impact on Staff
 No

Impact on Customers
 Yes

Details of impact

Older people represent the majority of people who draw on AHSC and in the medium term they should benefit from a better fit in terms of the range and quality of services available.

Implications for the provider workforce, which includes a proportion of older workers, will be kept under review and reflected in further EIA work as appropriate. It is anticipated that moving towards a Fair Cost of Care, together with the transformative new Care and Wellbeing contract for domiciliary care and support and development work with Care Homes will support improved terms and conditions for the workforce as a whole.

Disability

Impact on Staff
 No

Impact on Customers
 Yes

Details of impact

Many disabled people have a need to draw on AHSC services and in the medium term, they should see a better fit in terms of the range and quality of services available.

Pregnancy/Maternity

Impact on Staff
 Yes

Impact on Customers
 No

Details of impact

The significant majority of care staff are female. It is anticipated that moving towards a Fair Cost of Care, together with the transformative new Care and Wellbeing contract for domiciliary care and support and development work with Care Homes will support improved terms and conditions for the workforce as a whole.

Race

Impact on Staff
 Yes

Impact on Customers
 Yes

Details of impact

People from Black and minority ethnic communities are underrepresented in the cohort of people drawing on formal social care services. Market shaping should address this and create a better range and quality of serviced for people to draw on including the engagement of staff from those communities. There may therefore be a positive impact in the medium term for both potential staff and customers.

Religion/Belief

Impact on Staff
 No

Impact on Customers
 Yes

Details of impact

Market shaping and development – with improved focus on outcomes and personalisation should create a better range and quality of serviced for people to draw on. There may therefore be a positive impact people as their religious beliefs are promoted in the care that they received.

Sex

Impact on Staff
 Yes

Impact on Customers
 Yes

Details of impact

The proposals will have a disproportionate impact on women, who form the majority of AHSC customers overall. Similarly, the significant majority of carer staff are female. Impacts, opportunities and mitigations will need to be identified in individual EIAs that cover specific elements of this proposal.

Sexual Orientation

Impact on Staff
 No

Impact on Customers
 No

Details of impact

No direct or disproportionate impact is identified at this stage. Impacts, opportunities and mitigations will need to be identified in individual EIAs that cover specific elements of this proposal.

Gender Reassignment (Transgender)

Impact on Staff
 No

Impact on Customers
 No

Details of impact

No direct or disproportionate impact is identified at this stage. Impacts, opportunities and mitigations will need to be identified in individual EIAs that cover specific elements of this proposal.

Carers

Impact on Staff
 Yes

Impact on Customers
 Yes

Details of impact

Embedded in the commitments around which the market oversight and sustainability is based, is that we will recognise and value unpaid carers and the social care workforce, and the contribution they make to our city.

Market shaping must consider the importance of enabling unpaid carers who wish to do so, to participate in work, education or training. The overall process should allow us to better understand demographics, drivers and trends, the aspirations, priorities, and preferences of unpaid carers.

Voluntary, Community & Faith sectors

Impact on Staff
 Yes

Impact on Customers
 Yes

Details of impact

The market shaping process will value the contribution of the VCF sector who are well placed to deliver innovative, community focussed services, perhaps most significantly at the preventative end of the range of services.

Partners

Impact on Staff
 Yes

Impact on Customers
 Yes

Details of impact

Integration with local partners, especially Health partners and the Voluntary and Community Sector, is an important feature of market shaping. There should be a medium-term positive impact in terms of working relationships which should improve prospects of a better coordinated and seamless service for people who need to draw on AHSC.

Poverty & Financial Inclusion

Impact on Staff
 No

Impact on Customers
 Yes

Please explain the impact

Those who make contributions to their care will see an increase with Council fee rate increases. This will be applied in line with Sheffield's Fairer Contributions Policy, however, it takes place in a context where many people are impacted by the cost of living crisis, and the impact of this falls disproportionately across protected characteristics. Further data and evidence is needed to understand this impact fully.

Action Plan and Supporting Evidence

What actions will you take, please include an Action Plan including timescales

Improve equalities data within Market oversight and sustainability planning

Monitor the impact of market shaping and fee setting processes on the diversity of the workforce and those who draw on services.

Supporting Evidence (Please detail all your evidence used to support the EIA)

Detail any changes made as a result of the EIA

Following mitigation is there still significant risk of impact on a protected characteristic.
 No

If yes, the EIA will need corporate escalation? Please explain below

Sign Off

EIAs must be agreed and signed off by the Equality lead Officer in your Portfolio or corporately. Has this been signed off?

☐ Yes ☐ No

Date agreed 04/01/2023 Name of EIA lead officer Ed Sexton

Review Date 24/01/2023

Update reviewed and agreed 24/01/2023

Name of EIA lead officer Ed Sexton