Notice of Health and Adult Social Care Overview and Scrutiny Committee

Date: Monday, 26 September 2022 at 6.00 pm

Venue: Committee Room, First Floor, BCP Civic Centre Annex, St Stephen's Rd, Bournemouth BH2 6LL

Membership:

Chair:
Cllr J Edwards

Vice Chair:
Cllr L-J Evans

Cllr D Butler	Cllr C Johnson	Cllr S Phillips
Cllr L Dedman	Cllr A Jones	Cllr M Robson
Cllr B Dion	Cllr C Matthews	Cllr A M Stribley

All Members of the Health and Adult Social Care Overview and Scrutiny Committee are summoned to attend this meeting to consider the items of business set out on the agenda below.

The press and public are welcome to view the live stream of this meeting at the following link:

https://democracy.bcpcouncil.gov.uk/ieListDocuments.aspx?MId=5037

If you would like any further information on the items to be considered at the meeting please contact: Democratic Services or email democratic.services@bcpcouncil.gov.uk

Press enquiries should be directed to the Press Office: Tel: 01202 118686 or email press.office@bcpcouncil.gov.uk

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GRAHAM FARRANT
CHIEF EXECUTIVE

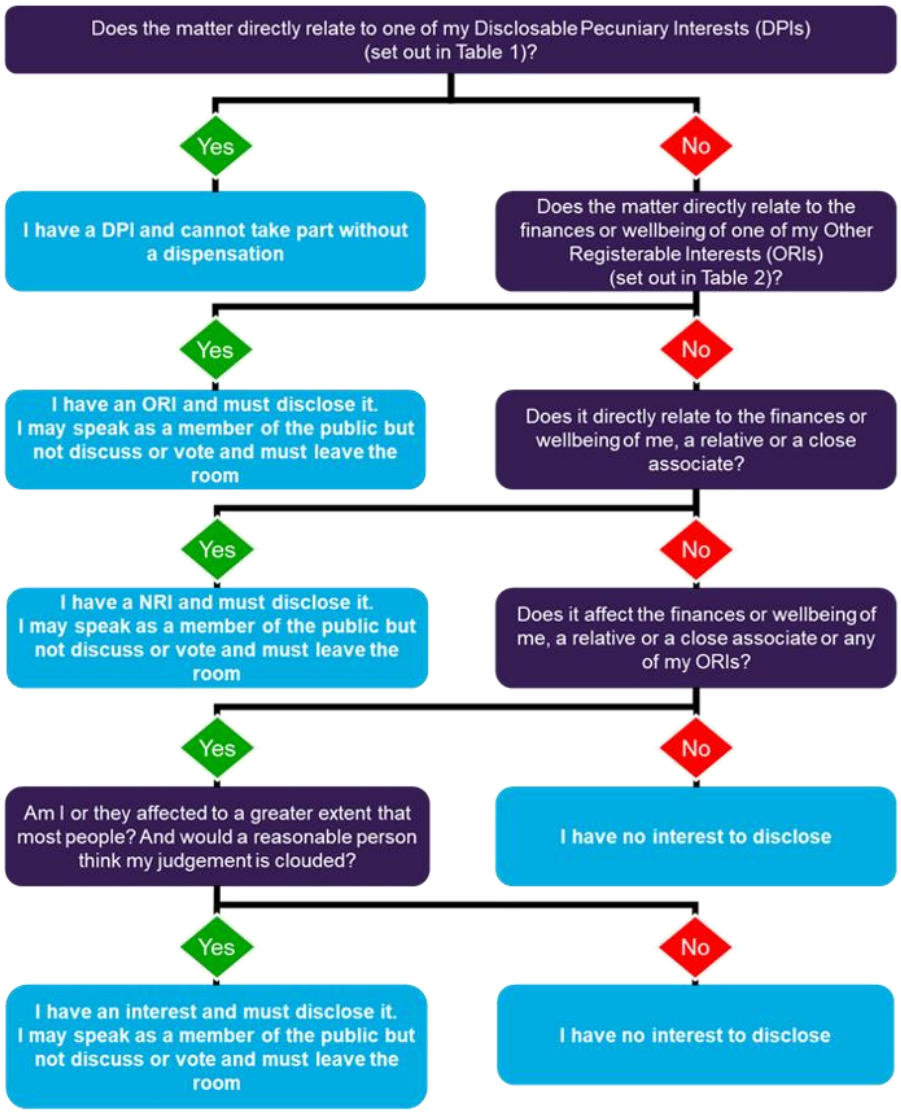
15 September 2022

Maintaining and promoting high standards of conduct

Declaring interests at meetings

Familiarise yourself with the Councillor Code of Conduct which can be found in Part 6 of the Council's Constitution.

Before the meeting, read the agenda and reports to see if the matters to be discussed at the meeting concern your interests



What are the principles of bias and pre-determination and how do they affect my participation in the meeting?

Bias and predetermination are common law concepts. If they affect you, your participation in the meeting may call into question the decision arrived at on the item.

Bias Test	Predetermination Test
In all the circumstances, would it lead a fair minded and informed observer to conclude that there was a real possibility or a real danger that the decision maker was biased?	At the time of making the decision, did the decision maker have a closed mind?

If a councillor appears to be biased or to have predetermined their decision, they must NOT participate in the meeting.

For more information or advice please contact the Monitoring Officer (susan.zeiss@bcpcouncil.gov.uk)

Selflessness

Councillors should act solely in terms of the public interest

Integrity

Councillors must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships

Objectivity

Councillors must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias

Accountability

Councillors are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this

Openness

Councillors should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing

Honesty & Integrity

Councillors should act with honesty and integrity and should not place themselves in situations where their honesty and integrity may be questioned

Leadership

Councillors should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs

AGENDA

Items to be considered while the meeting is open to the public

1. Apologies

To receive any apologies for absence from Councillors.

2. Substitute Members

To receive information on any changes in the membership of the Committee.

Note – When a member of a Committee is unable to attend a meeting of a Committee or Sub-Committee, the relevant Political Group Leader (or their nominated representative) may, by notice to the Monitoring Officer (or their nominated representative) prior to the meeting, appoint a substitute member from within the same Political Group. The contact details on the front of this agenda should be used for notifications.

3. Declarations of Interests

Councillors are requested to declare any interests on items included in this agenda. Please refer to the workflow on the preceding page for guidance.

Declarations received will be reported at the meeting.

4. Confirmation of Minutes 5 - 12

To confirm and sign as a correct record the minutes of the Meeting held on 25 July 2022.

5. Public Issues

To receive any public questions, statements or petitions submitted in accordance with the Constitution. Further information on the requirements for submitting these is available to view at the following link:-

https://democracy.bcpcouncil.gov.uk/documents/s2305/Public%20Items%20-%20Meeting%20Procedure%20Rules.pdf

The deadline for the submission of a public question is 4 clear working days before the meeting.

The deadline for the submission of a public statement is midday the working day before the meeting.

The deadline for the submission of a petition is 10 working days before the meeting.

6. Action Sheet 13 - 16

To note and comment as required on the action sheet which tracks decisions, actions and outcomes arising from previous Committee meetings.

7.	**Maternity services update and Clinical Service Review update including building works at Poole Hospital and Royal Bournemouth Hospital** For the Committee to receive on update on the Clinical Service Review, including building works at Poole Hospital and Royal Bournemouth Hospital, and the Maternity Service.	
8.	**Business Case for the Future of Care Technology within Adult Social Care** For Committee to be provided with the diagnostic review and options appraisal was carried out on the future of care technology within adult social care at BCP Council.	17 - 176
9.	**BCP Carers Strategy** For the Committee to be informed of the BCP Carers Strategy (2022-2027) and to comment and question the strategy before considering whether to recommend it to Cabient.	177 - 222
10.	**CQC Assurance Process** For the Committee to receive an update on the latest CQC Assurance Process.	223 - 232
11.	**Health and Wellbeing Board update** For Committee to receive an overview and update on the BCP Health and Wellbeing Board from the Director of Public Health Dorset and the Chair of the Health and Wellbeing Board (the Portfolio Holder for Communities, Health and Leisure).	
12.	**Portfolio Holder Update** To receive any updates from the relevant Portfolio Holders on key issues or actions that have been taken since the last meeting, as appropriate.	
13.	**Forward Plan** To consider and comment as appropriate on the development of the Committee's Forward Plan.	233 - 242

No other items of business can be considered unless the Chairman decides the matter is urgent for reasons that must be specified and recorded in the Minutes.

BOURNEMOUTH, CHRISTCHURCH AND POOLE COUNCIL

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the Meeting held on 25 July 2022 at 6.00 pm

Present:-

Cllr J Edwards – Chair

Cllr L-J Evans – Vice-Chair

Present:	Cllr D Butler, Cllr C Johnson, Cllr A Jones, Cllr C Matthews and Cllr S Phillips
Also in attendance:	Louise Bate, Healthwatch

15. Apologies

There were no apologies received.

16. Substitute Members

There were no substitute members.

17. Declarations of Interests

Councillor C Johnson declared a personal interest as a Staff Nurse employed by the University Hospitals Dorset NHS Foundation Trust, Councillor L-J Evans declared a personal interest as a bank employee for University Hospitals Dorset NHS Foundation Trust and Councillor C Matthews declared a personal interest as a Governor of Dorset Healthcare University NHS Foundation Trust and as a carer.

For transparency Cllr L-J Evans reported that she did not work for 111 First or 111 Online Service but had been on committees when the service was first discussed.

18. Confirmation of Minutes

RESOLVED that the minutes of the Health and Adult Social Care Overview and Scrutiny Committee held on 23 May 2022 be agreed as an accurate record and signed by the Chair.

The Chair advised that the Action Sheet normally included with the agenda would be updated and circulated to the Committee by email and any questions on the Action Sheet to be forwarded to Democratic Services to arrange a response.

19. Public Issues

There were no public questions, statements or petitions for this meeting.

20. Covid Update

The Director of Public Health provided an update on issues regarding Covid-19. It had been announced that Covid-19 booster vaccinations for over 50s and the clinically vulnerable would be co-administered with flu vaccinations during Autumn 2022. Nationally the rise in rates of infection due to Omicron variants was starting to level off and local rates (currently 1 in 17) were expected to follow. It was noted that two thirds of hospital patients testing positive (currently 121 across Dorset) had been admitted for other reasons, rather than as a direct result of Covid-19.

The Director of Public Health was asked about the latest reports of Monkeypox in the UK and explained that the handful of cases (mainly around London and the South East) were being managed by the UK Health Security Agency with only limited input required locally from Public Health.

In response to questions the Director explained that the efficacy of the Covid-19 vaccine was based on reducing the number of cases where people became seriously ill. He confirmed that the co-administration of the flu and Covid-19 vaccines was deemed safe and he agreed to circulate the latest studies on this to the Committee – **ACTION.**

RESOLVED that the update of the Director of Public Health be noted.

21. Combating Drugs Partnership Board Update

The Director of Public Health provided an update on the establishment of a Pan Dorset Combating Drugs Partnership Board to oversee the delivery of the Government's Drugs Strategy and its three main aims of treatment/recovery, enforcement and prevention. The Director was working with Dorset Police and Crime Commissioner (the identified lead officer), the Chief Constable and the Chief Executives of Dorset and BCP Councils to finalise the initial membership and terms of reference for the Board and report back to Government on progress to date.

It was explained that the Strategy and the Partnership Board offered a new approach and that the treatment/recovery element was being supported by additional Government funding at a local level, with BCP receiving its funding a year ahead of Dorset. The Director of Public Health agreed to keep the Committee updated on developments.

RESOLVED that the update of the Director of Public Health be noted.

22. Integrated Urgent Service including NHS 111 and NHS 111 First Programme

The Head of Urgent and Emergency Care, NHS Dorset, presented a report accompanied by a presentation, a copy of which had been circulated to

each Member and a copy of which appears as Appendix 'A' to these Minutes in the Minute Book.

The report and presentation outlined the background, current performance and challenges and future developments of the Dorset Integrated Urgent Care Service (DIUCS) to date, including the operation of the NHS 111 First and NHS 111 Online services.

The Head of Urgent and Emergency Care responded to questions and comments on a number of issues, including:

- How to address the staff shortfall in clinical roles. This was a known national issue and recruitment was ongoing. At the moment other selected staff were being used to answer clinical assessment calls. This reflected a longer term approach to ensure a more multi-disciplinary workforce.
- Whether pay, terms and conditions were being looked at. The Workforce Team were checking that there were no discrepancies between services in terms of equal pay.
- How to deal with minor injury bookings. These were mostly managed in Emergency Departments but the Urgent Care project offer were looking at whether these could be dealt with in other ways.
- The Healthwatch representative asked how patient feedback was used to improve service. There were a range of ways including contract reviews, complaints, friends and family feedback, etc. It was also planned to engage with Healthwatch on the Out of Hospital project to better understand why people did not use 111 services more. The Healthwatch representative suggested that more publicity on improved response rates may help overcome previous negative experiences.
- Reasons for the increase in calls. This was partly attributed to better promotion of 111 and an increasing pressure on primary care. It was noted that where it would be beneficial to patients, they could be booked back into the primary care system.
- A Committee member commented on the reality of struggling to meet high demand and that people often did not ring again if their first call went unanswered. She endorsed the need for more publicity on recent improvements and more clarity on what the service was for. The Head of Urgent and Emergency Care acknowledged the points made and agreed they needed further work.
- How to assess if 111 First has improved patient experience. This was being evaluated as part of the urgent care project and there had been some positive feedback. Improvements were ongoing, Healthwatch was engaged and the importance of listening to people to ensure equitable service was noted.
- How to promote 111 services to people on holiday and using the beaches. A Committee member highlighted a recent experience in a very busy Emergency Department. It was confirmed that hotels and

bed and breakfast accommodation was targeted and that there was also prevention work on sun exposure, etc.

- It was confirmed that anyone accessing 111 services who required 999 would be directly transferred or an ambulance sent, without any further delay in the system.
- The Portfolio Holder for People and Homes referred to a recent positive experience at an urgent treatment centre and the need to embed 111.

- **RESOLVED that the update on the Integrated Urgent Services including the NHS 111 and NHS 111 First Programme be noted.**

23. BCP Carers Strategy

The Commissioning Manager – Prevention and Wellbeing presented a report accompanied by a presentation, a copy of which had been circulated to each Member and a copy of which appears as Appendix 'B' to these Minutes in the Minute Book.

The report provided an update on how the findings from the Carers Service Review were being used to inform the new BCP Carers Strategy. The Commissioning Manager explained the background and context of the review and how this had been carried out. She presented an overview of the five key priorities which had been developed through engagement with carers and key stakeholders and explained the intended steps to implement them and the associated timescales.

Officers responded to questions and comments on a number of issues including:

- Response rates. 742 carers had responded to the survey. The five priorities had been discussed at various groups, with detailed comments received from 26 individual carers to date.
- How to ensure carers ‘take a break’. It was noted that carers had access to home-based support and there were flexible options to take breaks, away from the home environment if preferred, with the person cared for going into a care setting.
- A Committee member stressed the importance of carers being able to take shorter, more regular breaks to ensure respite while reducing the concern of having to leave a loved one for too long.
- How to raise awareness of what being a carer involves. A Committee member talked about his own experience as a carer and highlighted the value carers add to society and asked if there were any plans to educate employers and wider society. It was noted that in addition to supporting national campaigns the Council was working to promote the role of carers all year round. The Council was aiming to work with Carers UK on its employers programme to support businesses and there was also a carers discount card for local businesses.

- How to ensure equality of access across Dorset which was a large area with diverse needs. The Committee was assured that equality of access did not mean the same service for all regardless of need, it was about providing a similar response in terms of how someone was assessed and their support needs identified. It did not prevent BCP from responding locally to local needs.
- A Committee member highlighted the low level of neighbours as carers identified in the survey and the risk that some people may not class themselves as carers and could slip under the radar as a result.
- A Committee member suggested that skills and training should be available in 'bite size' sessions as many carers had time constraints.

Overall, Committee members were very positive about the approach being taken to recognise and value carers in the new strategy and thanked officers for their work. It was noted that this work would make a real difference to residents and that training and planning would serve to relieve some of the anxieties for carers.

As the report and presentation had been so comprehensive the Committee did not feel that a further informal engagement session was required.

RESOLVED that the Committee supports the five key priorities for the BCP Carers Strategy.

24. Day Opportunities Strategy

The Commissioning Manager – Day Opportunities presented a report accompanied by a presentation, a copy of which had been circulated to each Member and a copy of which appears as Appendix 'C' to these Minutes in the Minute Book.

The report summarised the work underway to review day opportunities including buildings-based day services in collaboration with key stakeholders, which would inform a new BCP Council Day Opportunities Strategy. The Commissioning Manager presented an overview of the project including the key principles, the governance structure and the proposed timeline leading up to the production of a Case for Change report in December 2022.

The Commissioning Manager was asked about the Day Opportunities co-production group and it was noted that this had an important role in bringing together service users and groups, providers and councillors to influence service development. Membership of the group which met bi-monthly was set out in Appendix 2, with an open invitation extended to Committee members wishing to participate. Cllr D Butler confirmed that she would be interested in attending.

RESOLVED that the Committee requests an update once the view seeking exercise has been completed and a case for change report has been drafted.

25. Portfolio Holder Updates

The Portfolio Holder for People and Homes gave the following updates:

- Day Opportunities Co-Production Meetings – The Portfolio Holder encouraged Committee members to consider participating.
- The recent launch of the Proud to Care Campaign which seeks to celebrate adult social care workers and inspire more people into the sector. For further information see Proud to Care (bcpcouncil.gov.uk)
- The excellent multi-agency response to supporting the homeless and the vulnerable during the recent heatwave.
- Forthcoming challenges for the Committee to be aware of included the cost of care, charging reforms and the Care Quality Commission assurance process.

The Portfolio Holder for Communities referred to the latest position regarding Covid-19, in terms of hospital admissions, staff absences and the Autumn roll out of booster vaccines.

RESOLVED that the Portfolio Holder updates be noted

26. Tricuro Update

The Director for Commissioning for People provided an update on actions taken by BCP Council and Tricuro to ensure a smooth transition once Dorset Council exited the agreement and governance arrangements were updated. He assured the Committee that BCP Council maintained a strong relationship with Tricuro. Tricuro would continue to provide services and nothing would change for BCP residents as a result of Dorset's decision.

The Director responded to questions about staff recruitment and the timeline for Dorset's exit. He confirmed that Tricuro faced the same challenges as other providers in recruiting and retaining staff and was taking steps to encourage prospective employees to follow this as a career path. He advised that the transition from Dorset would be complete by September/October this year. The name 'Tricuro' may or may not be reviewed in due course but was being retained for the time being for consistency and reassurance. The Director also provided further details of buildings and services under the Tricuro umbrella.

RESOLVED that the update of the Director for Commissioning for People be noted.

27. Forward Plan

The Chair provided an update on the following items:

- Dentistry provision – While it was noted that NHS England had recently announced new reforms to provide better access to dental services, this item would be retained on the Forward Plan
- Supported Living Services Cabinet report – add to Forward Plan
- SWAST Improvement and Financial Investment Plan – awaiting response from Sue Seddon regarding possible joint scrutiny item with Dorset Council.

The Chair asked the Committee to agree its meeting dates for the remainder of the municipal year, taking account of the need to reduce from six to five scheduled meetings per year. Once agreed items on the Forward Plan could be allocated to specific meeting dates.

RESOLVED that the Committee retains the meeting dates currently scheduled for 26 September and 28 November 2022 and 6 March 2023 and deletes 16 January 2023 from the calendar.

The meeting ended at 8.00 pm

CHAIRMAN

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DRAFT ACTION SHEET FOLLOWING 25 JULY 2022 – BOURNEMOUTH, CHRISTCHURCH AND POOLE HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Minute number	**Item**	**Action*** *Items remain until action completed.	**Benefit**	**Outcome** (where recommendations are made to other bodies)
Actions arising from Committee meeting: 30 November 2020				
110	**Home First Programme (including update on the Better Care Fund)**	For the Committee to receive data on the readmission rates to hospitals in BCP following discharge through the Home First Programme. **Action: Discussions will take place between BCP and NHS colleagues on capturing and presenting this information. A briefing paper will be provided to the Committee when the data is available.**	For members to track the rate at which individuals, who have been discharged through the new process, had re-entered hospital and whether there were any specific or identifiable reasons for this.	
Actions arising from Committee meeting: 17 January 2022				
171	**Dementia Services Review**	For the Committee to be updated on diagnostic waiting times, specifically the hoped-for reduction from 16 to 6 weeks with the new full-time medic in place. **Action: For data to be presented if possible showing the monthly results of diagnostic waiting times.**	For members to monitor the service's identified target of reducing diagnostic waiting times.	

Minute number	Item	Action* *Items remain until action completed.	Benefit	Outcome (where recommendations are made to other bodies)
182	**Impact of the Pandemic (COVID-19) on Adult Social Care**	The Committee recommended that: • Recommend to Cabinet that they write to local MPs, on behalf of the Committee, asking them to review the informal carer's allowance, £67.60 a week, with a view to increasing this figure. • Recommend to Cabinet the following: "*BCP have a large number of care workers who look after our many elderly and vulnerable residents. We need to promote care work as an attractive career including through apprenticeships with on the job skill training which offer real career progression. As valued workers they should be seen as key workers with a fair wage and all the benefits for the essential service they provide. Will Cabinet approve this course of action*". **Action: To request an update from the Portfolio Holder for People at Committee on 26 September on the progress of this action.**	To champion carers across BCP and to contribute to the shape of the BCP Adult Social Care service.	

Minute number	Item	Action* *Items remain until action completed.	Benefit	**Outcome** (where recommendations are made to other bodies)
Actions arising from Committee meeting: 23 May 2022				
7 **12**	**Action Sheet** **Portfolio Holder update**	In relation to the Action under Minute 182 above: Vice Chair requested an update on writing to MPs and Cabinet discussions relating to carers Chair enquired whether a letter had been drafted to local MPs asking them to review the informal carers allowance **Action: To discuss with Officers to see if this had been progressed.**	To champion carers across BCP and to contribute to the shape of the BCP Adult Social Care service.	
10	**Suicide Prevention Plan, Progress Report**	**Actions:** • **In response to which real time surveillance data could be shared, the Committee was advised that there was some data available until November last year which could be shared if helpful** • **Share further information with the Committee on the Talk for All skills development** • **Send link for Zero Suicide Alliance to Committee members**	To ensure Committee is fully informed on data, support mechanisms available and national strategy	

Minute number	Item	Action* *Items remain until action completed.	Benefit	**Outcome** (where recommendations are made to other bodies)
		• **Add new National Strategy to Committee's Forward Plan for later in 2023 with plans needing to be reviewed once published.**		
Actions arising from Committee meeting: 25 July 2022				
20	**Covid Update**	**Action: Director of Public Health to circulate latest information from studies on flu vaccinations with Covid-19 booster vaccinations.**	To respond to Committee request for information	
24	**Day Opportunities**	To receive an update once the view seeking exercise has been completed and the case for change report has been drafted – timescale likely to be end of 2022 **Action: Add to Forward Plan**	To enable Committee to input as Strategy develops.	

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Report subject	**Business Case for the Future of Care Technology within Adult Social Care**
Meeting date	26 September 2022
Status	Public Report
Executive summary	A diagnostic review and options appraisal was carried out on the future of care technology within adult social care at BCP Council. Officer recommendation is for a full-service transformation, providing a single care technology offer across Bournemouth, Christchurch and Poole at the forefront of adult social care services. This option mainstreams care technology through a sustained programme of culture change, enabling more people to access care technology and delay, reduce or prevent the need for costly, long-term care and support.
Recommendations	**It is RECOMMENDED that:** **Committee supports the recommendation to Cabinet for the full-service transformation of care technology within adult social care to maximise benefits for both the public and the Council.**
Reason for recommendations	The preferred option of service transformation will have the greatest success in enabling more people to remain independent in their own homes for longer. The preferred option will reduce the demand on adult social care services, delivering a financial benefit of between £2.5m and £3.6m over 5 years.

Portfolio Holder(s):	Councillor Karen Rampton – Portfolio Holder for People and Homes
Corporate Director	Phil Hornsby, Director of Commissioning for People
Report Authors	Emma Senior, Commissioning Manager – Prevention and Wellbeing
Wards	Council-wide
Classification	For Recommendation

Background

1. BCP Council is facing increasing demand for adult social care (ASC) services. Currently, residents over the age of 75 account for 75% of requests made to ASC services each year. 2021 Census figures show that the population of Bournemouth, Christchurch and Poole has grown by 5.7% since 2011, with the largest increase being in 70–74 year olds at 39.6%. There is also increasing demand for support for people with complex needs, which often results in high-cost services. With this increasing population and pressures on ASC budgets, the focus needs to shift away from traditional methods of care and onto early intervention and prevention.
2. Care Technology has a key role to play in promoting independence and allowing people to live fulfilled lives at home for as long as possible. It gives people control over their care, supports their wellbeing, and prevents, reduces or delays the need for traditional and costly commissioned care services. Other Local Authorities, such as Hampshire County Council have shown that greater investment in assistive technology can deliver significant efficiencies, especially in terms of cost avoidance. In the first three and a half years of a new care technology partnership, Hampshire County Council saved over £7 million in terms of reduced reliance on care, delayed admission to residential settings and reduced carer burnout.
3. BCP Council's current ACS care technology service, whilst successful in delivering a well-regarded basic service for residents, has not realised its full potential. The care technology offer is currently limited and there is untapped potential to achieve positive outcomes for residents and the wider ASC system.
4. Local Government Reorganisation in 2019 introduced operational challenges in relation to care technology at BCP Council. There are two legacy systems and processes which are still both in play. The reorganisation has, however, also presented an opportunity to define ambitious strategies and shape future ways of working.
5. BCP Council's new operating model has a clear ambition to use technology to enhance services and quality of life for residents.
6. The Corporate Strategy Delivery Plan, under the Fulfilled Lives priority, specifically references extending the use of assistive and digital technology to enable independence and enhance people's quality of life, which is echoed in the Adult Social Care Strategy (2021-2025).

7. The Market Position Statement for Adults also outlines the ambition to strengthen the offer of assistive technology across Bournemouth, Christchurch and Poole, and ensure it is included from the time people first engage with adult social care at the front door.

Care Technology Diagnostic Review

8. In 2021, Hampshire County Council and PA Consulting were commissioned to provide an objective understanding of BCP Council's current position on care technology in ASC, its strategic importance, and the scale of potential benefit that a transformed care technology service could deliver.
9. The diagnostic review identified that:
    - There was evident ambition and significant support for an increased use of care technology across ASC and Housing to help achieve council and directorate priorities
    - Despite the ambition and support, there was a gap between strategic overview and ownership of the service, which was causing current service activity and resourcing to be operationally focused
    - The current care technology service was not embedded within ASC culture and practice, but seen as the 'responsibility and control' of a few
    - In terms of the volumes and the equipment offer, the service has remained static
    - The current service would be challenging to scale in its current form
10. The full diagnostic review is contained in appendix 1 of this report.
11. Following the diagnostic review, Hampshire County Council and PA Consulting were commissioned to undertake an options appraisal of different delivery models of a future care technology service.

Care Technology Options Appraisal

12. The options appraisal built on the outcome of the care technology diagnostic review and analysed three options:
    - Option 1 – **status quo**, representing the current position
    - Option 2 – **service enhancement**, building on the current service with an enhanced specification and reaching a larger number of users
    - Option 3 – **service transformation,** providing a specific care technology offer to older adults and younger adults across all service areas, with a sustained programme of culture change, including a self-service option

13. A care technology project board was set up with representatives from ASC Services, ASC Commissioning, Housing, Finance, Smart Places and Strategic Procurement.
14. The project board agreed critical success factors for the future care technology service, see table 1 below:

Theme	Care Technology (CT) Project Critical Success Factors
Improved outcomes and experience	People are equipped and confident to use CT, enabling them to feel safe and supported to live independently in their own home for as long as possible Discharge from hospital is supported appropriately with CT People and Carers are supported to access CT easily, including via self-service options, with access to information to make informed choices about care packages and use of CT
Improved efficiency	CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes Practitioner understanding of the offer and process is enhanced, driving increased uptake
Service capacity and capability	Data is automated and insight generated is used effectively and proactively to manage supply and demand New CT is evaluated on a regular basis and deployed as and when it is appropriate to people's needs The scope of the service is expanded to increasingly support younger adults, people with long term conditions and people with learning disabilities
Value for money and financial sustainability	Provides a clear mechanism for robustly measuring the financial and non-financial benefits of the CT service Delivers on target financial benefits within agreed timeframes, through avoided and reduced costs of care Generates opportunities and strengthens the case to access

	additional funding
Deliverability	The CT Project delivers the agreed scope to quality, time and budget Provides adequate resource and capability to deliver and embed the change Offers effective change management, including communications and engagement, to drive service improvement

Table 1: Critical Success Factors

15. The project board rated each option by assessing the extent at which they met the critical success factors. Scores were given out of 5 for each factor, with the average of these responses providing the score. A total qualitative score out of 75 was provided for each option.
16. Analysis of financial benefits for each option was completed for several cohorts, including:
    a. Homecare older adults (existing and new)
    b. Homecare learning disability residents (existing and new)
    c. Residential/nursing residents (new)
    d. Supported living residents with learning disabilities (existing and new)
    e. Residents with care technology (existing)

Summary of qualitative and financial analysis

Option 1 – Status quo

17. The service would continue to meet the same core user base, focused on older adults. The volume of people receiving care technology would remain static and the service would not be able to reach new user groups and new technology on a consistent and formal basis.
18. The qualitative score for option 1 against the critical success factors was 28/75.
19. The projective cost of option 1 over 5 years is £1.94m.

Option 2 – Service Enhancement

20. The service would improve on the status quo by growing users and expanding support to more younger adults with learning disabilities and increasing the number of older adult users.
21. There would be moderate growth in the service and moderate benefits.
22. The qualitative score for option 2 against the critical success factors was 47/75.

23. The projective cost of option 2 is an additional £1.31m over 5 years to cover revenue costs, with potential net benefits of between £1.35m and £1.93m. There would also be a one-off transformation cost of £300,000 over the first two years.

Option 3 – Service Transformation

24. The service would build significantly upon option 2. It would mainstream care technology across adult social care, encouraging practitioners to consider it as the 'first offer' for a wider range of residents' needs.
25. The service would be transformed by supporting a larger number of younger adults and by expanding the offer for older people with complex needs, including via the option of a self-service access route.
26. The qualitative score for option 2 against the critical success factors was 66/75
27. There would be a larger growth in the service and larger benefits.
28. The projective cost of option 3 over 5 years is an additional £1.94m, with potential net benefits of between £2.5m and £3.6m. There would also be a one-off transformation cost of £500,000 over the first two years.

Recommended Option – Service Transformation

29. Option 3 – service transformation, received the highest score from the quantitative and qualitative analysis and was agreed for recommendation by the Care Technology Project Board on 20th July 2022.
30. Service transformation aligns with BCP Council's ambition to significantly improve the care technology offer and integrate it into part of the first offer of support, including via self-service routes.
31. The care technology service would increase in volume by reaching a broader range of users, including younger adults, older adults and people with mental health needs.
32. The service would go through a sustained programme of culture change, including training for staff, case studies, and regular engagement supporting the role out of a self-service offer.
33. The care technology offer would reduce, delay or prevent the need for costly, long-term care and provide the following:
    a. Targeted support for people living with early-stage dementia, with a range of support mechanisms to promote independence and reduce the burden on carers e.g., taking medication promptly, managing lives more independently and keeping in touch with family and friends
    b. Address social isolation and independence through adapted technology or consumer technology e.g., enabling people to access services easily, live more independently and keep in touch with family and friends
    c. Support for younger adults with disabilities e.g., support to travel independently using modern apps
34. Examples are provided below:

Young Adult with LD Needs

Tom is a young man with a learning disability who wishes to live more independently. However, his epilepsy puts him at risk when he is out of the home.

Care technology solutions

- A mobile phone planning app reminds Tom about solutions he can use when he is in situations that make him vulnerable. He also uses his app to help him catch a bus rather than a taxi.
- An epilepsy sensor linked to a carer pager alerts his carer instantly if he has a fit.
- His Oysta phone incorporates falls detection and allows him to quick dial his carer or use the SOS button to talk to the monitoring team when he is out.
- His medication dispenser enables him to self-manage his medication.

Isolated Older Adult

Mr Khan lives with his wife and has recently received a diagnosis of Dementia. He feels frustrated and lost since his driving licence was revoked. His wife is incredibly anxious that he will wander and get lost.

Care technology solutions

- Oysta phone with geofencing (safe zones) enabled. If Mr Khan moves beyond the safe zone, a family member would be alerted to track his location on a tablet or call his device.
- Property exit monitors – tells a family member when he leaves the property.
- Sensor memo reminders – plays a recorded message to ensure Mr Khan picks up his Oysta phone before going out.

35. Benefits based on individual users would be tracked in a consistent and automated way.
36. The service would proactively engage in the care technology market to test and implement new innovations.
37. Service transformation has the biggest potential to improve user outcomes and is forecast to achieve the largest net financial benefit.
38. It is expected to take 7 months to fully mobilise and implement service transformation once the service delivery model is agreed.
39. If approved by Cabinet this work would commence in 2023/24.

40. The full care technology options appraisal is contained in appendix 2 of this report.

Summary of financial implications

41. A one-off investment of £500,000 would be required over the first 2 years of service transformation, £350,000 in year 1 and £150,000 in year 2.
42. Transformation funding is being explored to cover this.
43. An additional £1.94m over 5 years is estimated to be required to cover the revenue costs associated with increased service delivery.
44. The estimated total incremental gross benefits over 5 years are £5.5m.
45. This should deliver net benefits of £3.6m. However, recognising the ambitious scale of transformation proposed and cutting-edge nature of some of the technology being considered, a level of tolerance has been applied. Consequently, net benefits for MTFP purposes are estimated to be between £2.5m and £3.6m.

Summary of legal implications

46. None identified that this stage

Summary of human resources implications

47. There is potential for human resources requirement subject to the service delivery model being agreed and future team structure being confirmed.

Summary of sustainability impact

48. A sustainability impact assessment is currently being carried out.

Summary of public health implications

49. The proposed change will allow more people to access care technology and support them to live safely and independently in their own homes for longer, improving their health and wellbeing.

Summary of equality implications

50. The proposed change will make the care technology service more accessible to a wider range of residents, making a positive impact in terms of equality, addressing underuse by certain cohorts of people currently, including younger adults with learning disabilities.
51. An EIA assessment is currently being carried out and will be taken to the EIA Panel on 6th October.

Summary of risk assessment

52. The proposed option requires upfront investment to save in the longer term. The project will need to be carefully managed to ensure net benefits are met, which may require external support.

53. For the net benefits to be realised, the proposed option requires a culture change. The care technology diagnostic review did find that ASC and Housing staff had the ambition and support for increased use of care technology.

54. If the care technology service was to remain as is it currently, opportunities to reduce demand and costs for domiciliary and residential care through the effective provision and early intervention of care technology would be missed.

Background papers

None

Appendices

1. BCP Care Technology Diagnostic Review

2. BCP Care Technology Options Appraisal

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BCP Council

Care Technology Diagnostic Report

18th November 2021

Bringing Ingenuity to Life

paconsulting.com

Introduction

Bournemouth, Christchurch and Poole (BCP) Council has, in its ASC Strategy 2021 – 2025, set out to improve the quality of life, health and wellbeing of residents in the Council area. The overarching priorities of the ASC Strategy are:

- **Engage with individuals and communities to promote well-being**
- **Support people to live safe and independent lives**
- **Value and support carers**
- **Enable people to live well through quality social care**
- **Deliver services that are modern and accessible**

Like all Councils, BCP is facing increasing service demand. Currently, residents aged 75 and over account for 75% of requests made to ASC services each year. The pressures are clear given that the current population of 395,600 is expected to rise to 420,900 by 2028. With this growing population size, the number of residents aged 65 and over is expected to grow by more than 30% between 2021 and 2040; from 86,900 to 115,000.

BCP currently spends more than the average for England on care for older people, but at the same time, supports a lower percentage of the older population. The gross expenditure in 2021 / 22 is in excess of £126m, with over half of the council's gross ASC expenditure being used for residential and nursing care (£67.4m). Adult Social Care budget pressures were £4.4m in 2020 / 21 rising to £8.6m in 2022 / 23 and £10.8m in 2023 / 24. This is despite the identification of significant savings in each year, as well as areas where income increased.

BCP recognises that the CT offer is limited and that there is untapped potential to achieve outcomes for residents and the wider ASC system. The creation of the unitary council in 2019 has, however, introduced operational challenges in relation to Care Technology (CT) services; there are two legacy systems and processes, from Poole and Bournemouth, which are both in play. The reorganisation has, however, also presented an opportunity to define ambitious strategies and shape future ways of working. There is a clear ambition within BCP to use technology to enhance services and quality of life for residents, along with a recognition that technology has a part to play in all forms of care.

The Corporate Strategy Delivery Plan, under the Fulfilled Lives priority, specifically references extending the use of assistive and digital technology to enable independence and enhance people's quality of life, which is echoed in BCP's ASC Strategy. Furthermore, the Market Position Statement for Adults outlines an ambition to strengthen the offer of assistive technology across Bournemouth, Christchurch and Poole, and ensure it is included from the time people first engage with adult social care at the front door.

Overview of the CT diagnostic, service vision, design principle and roadmap development approach

As BCP prepare to transform the CT service offer, Hampshire County Council and PA Consulting were commissioned to provide an objective understanding of the current position, the appetite for CT and the scale of the potential benefit that a transformed CT service could deliver (the 'size of the prize'). Additionally, a roadmap to a new service has also been developed to support the next steps of the CT transformation.

The approach followed two distinct phases.

•Phase 1a: A peer review style Diagnostic Review.

•Phase 1b: The joint development of Vision for care technology that reflects the Council's ambition, together with a set of core Principles to underpin the design of a potential future service.

Additionally, a high level Implementation Roadmap, has been developed to set a route to move through future phases.

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Figure 1: The approach, illustrating the stages within each phase.

This pack presents the output from our work with BCP

Please note that whilst this work is intended to help set out the route to a transformed offer, it is no substitute for a Cabinet Office 5-case Business Case. It is recommend that such a case is developed so a suitably detailed operating model can be selected, and the investment required to set up and run a future service can be secured.

Contents

To support BCP in its ambition to extend the use of CT, to enable independence and enhance people's quality of life, BCP commissioned Hampshire County Council and PA Consulting to provide specialist support to undertake a diagnostic review on the current CT service. This outlines opportunities for development, including a high level 'size of the prize' for a transformed approach to CT. The findings from the review are covered in this report as follows:

1. **Executive summary**
2. **Key findings of the diagnostic review**
3. **Detailed findings**
    1. *There is an ambition for CT to play a greater role across all levels of ASC, but there is no evidence that future practice is being driven based on strategic objectives*
    2. *The current service delivers against it's original purpose, but it will be challenging to scale or expand to meet new demands*
    3. *The current service is not seen as developmental and there is limited evidence of it being embedded within ASC in a way that changes practice*
4. **Transforming BCP's CT service: high level 'size of the prize'**
5. **Future CT vision and design principles**
6. **Roadmap and implementation**
7. **Appendices**
    A. Our diagnostic approach
    B. The cost of the current service
    C. Process maps
    D. Survey responses
    E. CT service summary by patch
    F. Example benefits dashboards
    G. Size of the prize assumptions

1

Executive Summary

The backdrop to change

The Local Government Review, which resulted in the formation of BCP Council in April 2019, has been an opportunity for BCP to reconsider and articulate the Council's strategic objectives. Within recently agreed strategies, there is a clear focus on promoting independence and shifting the emphasis of support to prevention. Technology is recognised as playing a key role in this approach.

The use of technology features widely in strategy documents and the diagnostic undertaken by Hampshire County Council (HCC) and PA Consulting has identified a demonstrable level of support, across strategic and operational staff within both Housing and ASC, for the increased use of CT to support residents.

Covid has undoubtedly changed the landscape for social care and health. The pace at which changes to ways of working has happened has been unprecedented. Equally, the role and use of technology has expanded at a scale previously unimaginable. This creates a platform for reviewing the use of technology and how it can help deliver better outcomes for the people BCP supports.

Given these factors, it is no surprise that a significant amount of transformational activity is underway at BCP.

Key work includes:

- The **Smarter Structures Programme**, which aims to rationalise resources, improve management structures and introduce "Heads of Profession" to manage continuing professional development
- The **Care Together Programme**, which aims to streamline multiple legacy case management systems
- The **Smart Place Programme**, which aims to promote the use of digital devices, big data and data platforms across BCP
- The **Pay and Reward Programme**, which aims to ensure that the Council's pay and reward arrangements are fair and equitable for all BCP employees
- The transformation of the ASC Front Door, which aims to introduce and embed strengths-based practice, is also underway. HCC's and PA's experience shows the importance of including CT as part of that wider transformation from an early stage. This ensures that technology is seen as an integral part of the conversation about how best to support people – rather than an 'add on' to the support package. Elevating the role of technology as part of the solution to achieve better outcomes is also critical if the Council are to create an innovation culture that focusses not just on the people you support today but is constantly thinking ahead to the needs of people tomorrow.

As a vision and strategy for CT is developed, it will be informed by the following:

BCP Corporate Strategy and Corporate Strategy Delivery Plans
BCP Adult Social Care Strategy 2021 – 25
BCP Market Position Statement for Adults 2021 – 24

Our assessment of the as-is identified several key themes spanning strategic, operational and enabling factors

There is **evident ambition and significant support** across ASC and Housing for the increased use of Care Technology to help achieve Council and directorate priorities. This presents a clear opportunity to embed Care Technology in Council services, ASC practice and ASC support planning. However, in order to achieve this, **future service development must not simply be a review and expansion of the equipment that is offered to residents.**

Despite the ambition and support, there is **a gap when considering strategic overview and ownership**. There is no CT strategy or clear articulation of how the current service offers are being aligned and developed to meet the Council's strategic objectives. Furthermore, there has not **to date** been BCP-wide ownership to bring a focus and consistency to the development of CT services across ASC. The work to date has instead been concentrated on unifying the service offer following the LGR.

Building on the above, it is apparent that **current service activity and resourcing is operationally focussed**. The current structural framework limits innovation, development and CTs ability to become a tool which ASC can use for meeting a wider range of needs and helping to achieve Council objectives. There are pockets of service development activity, but these have been discrete projects and they do not form part of a cohesive wider CT development programme.

The current CT service is **not embedded within ASC culture and practice**; it is seen as the 'responsibility and control' of a few however there is a clear appetite from practitioners for greater use of CT. Survey responses demonstrated that while 87% of respondents thought the use of CT was "important" or "very important" to their role, just 23% had "high" or "very high" confidence when discussing CT with people. CT tends to be used to support Older Adults and there is little evidence that CT has been considered, or used, to meet a range of outcomes across different cohorts and needs.

The **service has remained static**. Service user volumes have remained broadly unchanged over the last three years, while the equipment offer has not evolved. In Bournemouth and Christchurch, the equipment offer has been perceived as increasingly restricted following efforts to unify the service offer across BCP.

The existing 'Poole' model delivers against its original remit with dedicated management, however, **it will be challenging to scale in its current form** when considering factors such as OTA resourcing for CT assessments and the manual approach to benefit analysis. Some outcomes are recorded, but **the scale does not match the Council's ambition.**

There is a recognition and ambition that CT can and should have a greater role to play in the care and support offer across BCP, and in undertaking this diagnostic review and in developing a Vision for a future CT offer, it is encouraging to see that work has commenced to move towards a transformed offer that will best support improved outcomes for the residents of BCP and the Council.

The current service provides a traditional offer and service user volumes have remained static over the past three years

BCP's Care Technology Service sits within the Housing directorate and is split into **Bournemouth Careline** (which also serves Christchurch) and **Poole Lifeline**.

Residents can access the service via **two routes; Private Pay or Community Alarm**. Private Pay users pay for the installation and ongoing costs for monitoring and response,* while Community Alarm users access CT via housing schemes.

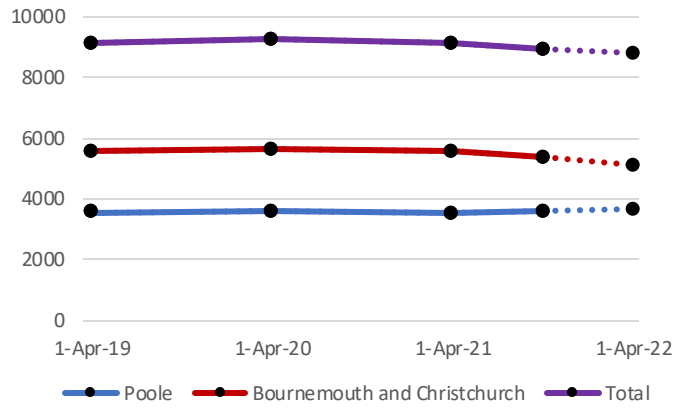
As of 1 October 2021, **8949** residents accessed the service, with the majority of these (60%) in Bournemouth and Christchurch. The majority of service users (57%) accessed the service via the Private Pay service. Data relating to service user numbers, installations and uninstalls all demonstrate that the **CT service size has remained largely static over the past three years**.

It is not possible to accurately identify the current number of service users accessing the service who have ASC needs. Users referred via ASC routes are a subset of the Private Pay cohort. Anecdotal feedback suggests that 25% of new referrals are received via ASC routes. Referrals for standalone devices are not reflected in the total service user volume, as BCP does not provide a service beyond installation of the device. Furthermore, there is currently no mechanism for identifying the number of service users with ASC needs who leave the service.

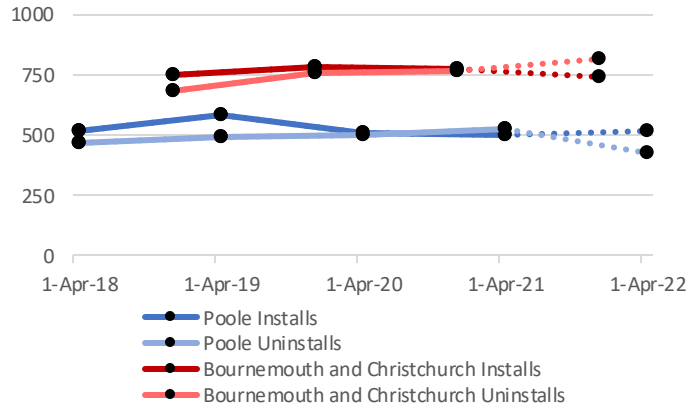
Equipment usage as of 1 October 2021 demonstrates that **the offer is traditional**, predominantly offering pendant alarms, falls alarms or environmental sensors. There is little evidence of an enhanced and developmental equipment offer, for example GPS trackers or use of apps. This is supported by practitioner feedback via the survey.

** a response service is currently available in Poole, although there are aspirations to broaden this offer to the whole of BCP.*

Total Monitored Lifeline and Careline Service Users



Total Installs and Uninstalls



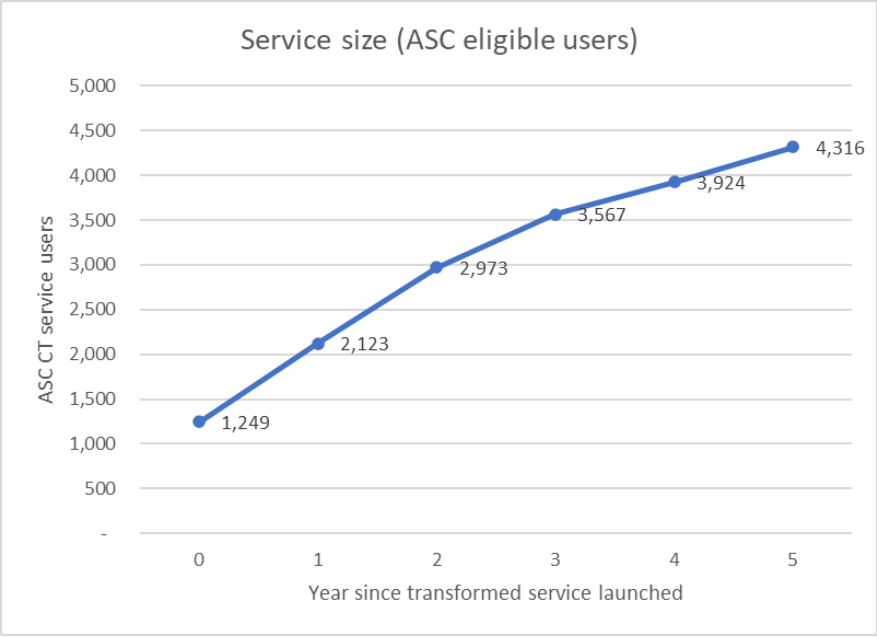
Over five years, a transformed CT service has the potential to deliver an estimated gross financial benefit of between £8.2m and £10.3m

The high level 'size of the prize' indicates the potential gross financial benefit that could be achieved by transforming and mainstreaming the CT offer in BCP. This estimate is based on growth and benefits assumptions informed by the service in Hampshire and PA's broader experience. As this is a high-level estimate and not based on detailed scope, we have applied conservative estimates to the modelling throughout, when compared to averages across the Argenti managed services.

The 'size of the prize' estimate assumes transformation and mainstreaming of the CT service results in a strengths-based approach where practitioners use of CT 'instead of' rather than 'in addition to' traditional care' for ASC Care Act eligible users. The modelling assumes the CT service would include:

- Consolidation and expansion of a 'core offer' (e.g. a greater equipment offer for OA / PD)
- Expansion of the offer to meet needs of more complex users (e.g. LD)

Further information on the modelling approach and assumptions can be found in Appendix G.



Over five years, a transformed CT service has the potential to deliver an estimated gross financial benefit of between £8.2m and £10.3m

This estimate is based on conservative assumptions throughout the modelling.
The benefits range is informed by the average gross benefit per installation calculated from across the Argenti managed services.
This figure is informed by over 40,000 installations and follows a robust benefits methodology, with all financial benefits signed off by the ASC finance leads for each Council that we provide services for.

BCP's vision for the future care technology service

Our Care Technology service is flexible, sustainable and trusted by all. It is embraced at the first opportunity to enable independence and enhance the quality of life for people across BCP. Care Technology is a cornerstone of our digitally enabled care approach that is embedded in practice and easy to access.

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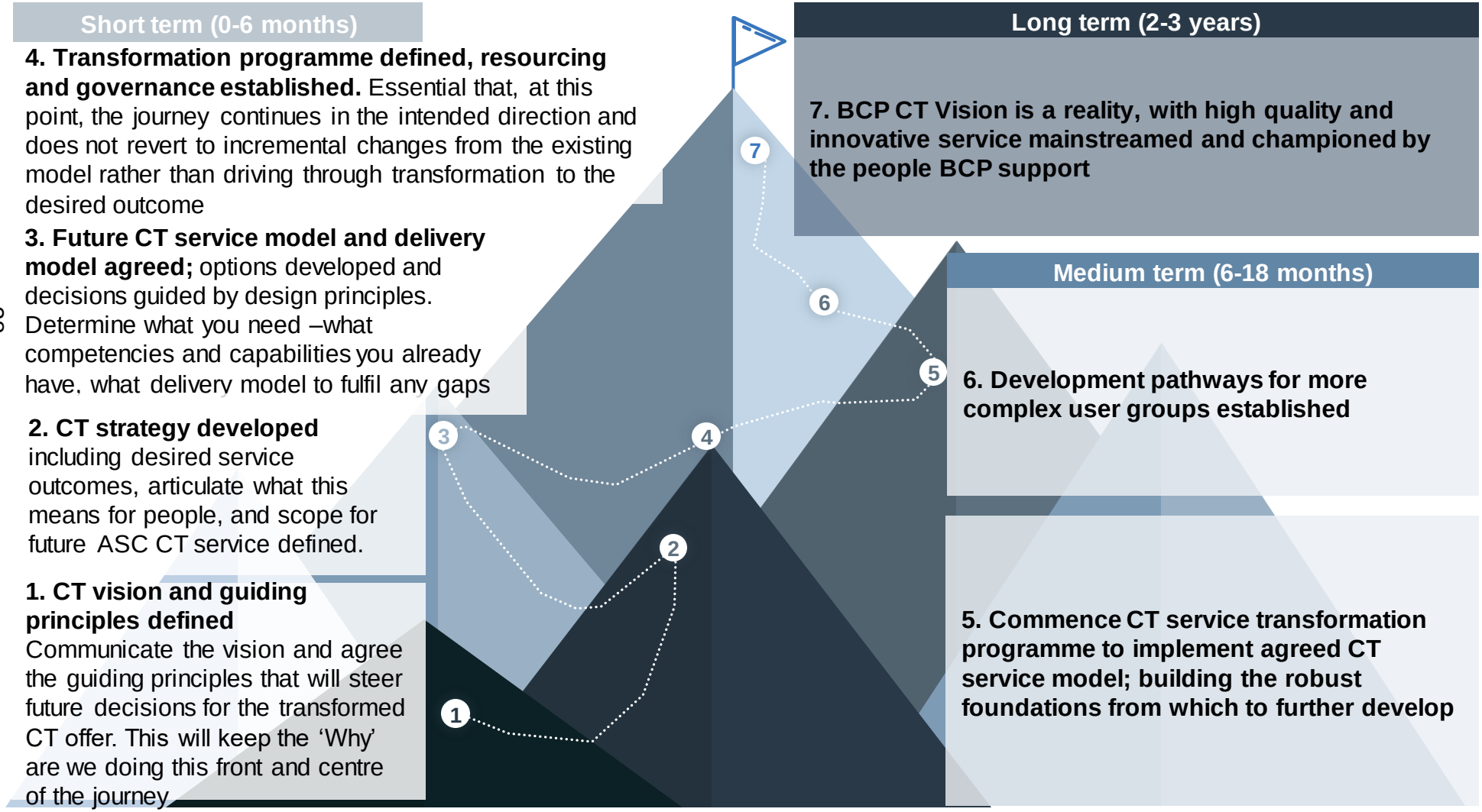
The vision informs the core principles that should underpin the design of a future service

Roadmap to a transformed CT service offer for BCP residents



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Developing a vision and strategy is crucial, however there are other opportunities that could be explored in parallel

This diagnostic has identified many factors that should be considered when developing a transformed CT offer for BCP. Before diving into the detail and addressing individual operational factors we recommend that BCP consider the CT vision and strategy first. However, there are some recommendations that we believe could be implemented in parallel. These are summarised in the table below.

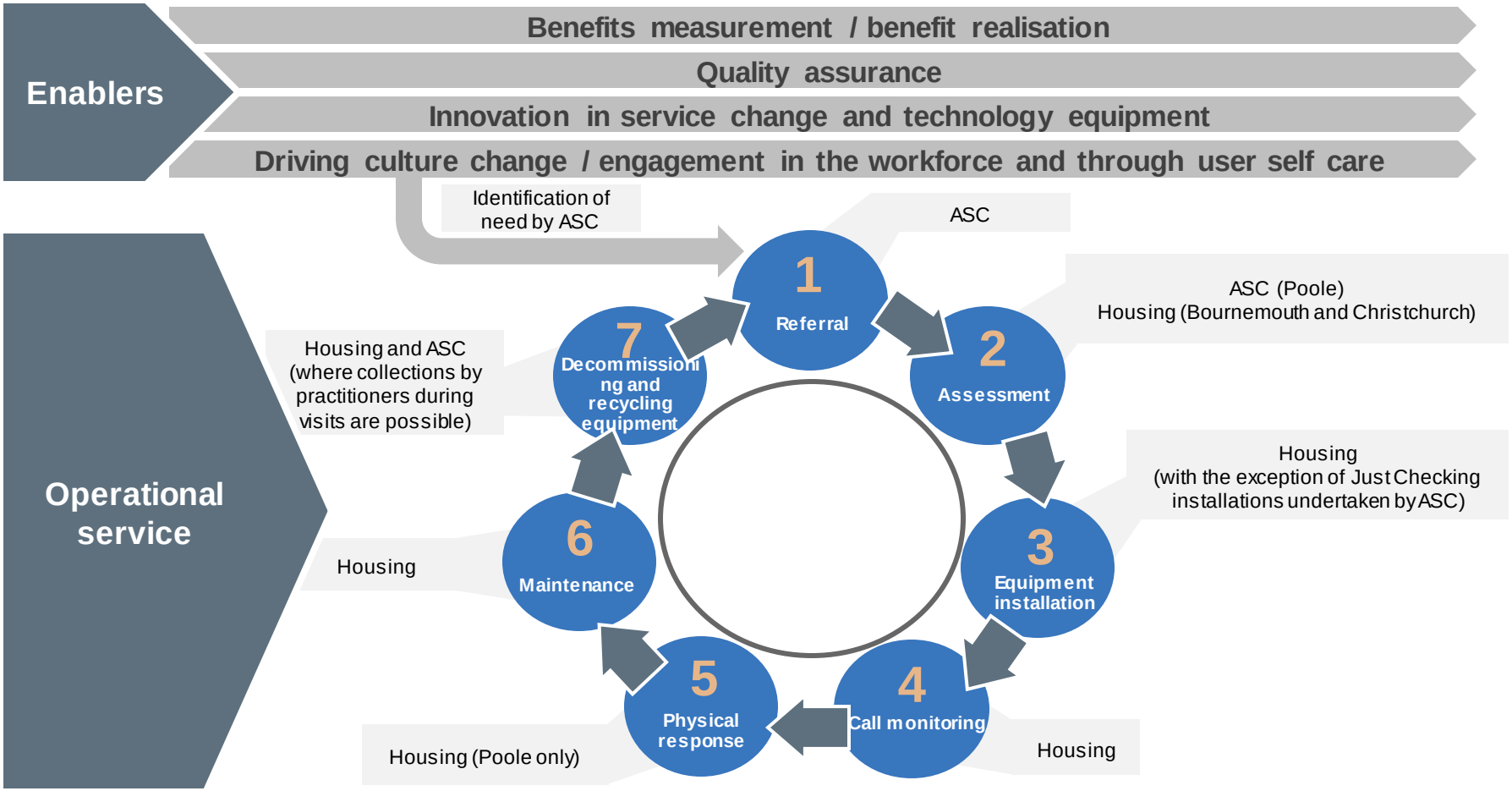
#	Theme	Opportunity description
1	Strategic	• Confirm the scope and direction for the service alignment activity that is due to commence imminently with Housing and ASC colleagues, so that changes support the future ambition and objectives
2	Operational	• Consider how the Mosaic case management system can be configured to enable practitioners to complete a referral form without needing to download and email the form once completed • Investigate short-term opportunities to offer a greater range of technology, that has been tried and tested elsewhere, to meet a greater range of needs for Older Adults (e.g. enhancing the offer for GPS devices) • Begin to consider the impact of the Digital Switch and plan for the futureproofing of the service
3	Enablers	• Identify resource and opportunities to engage with Practitioners in order to bring them on the transformation journey (e.g. share the vision, design principles and next steps once finalised)

2

Key findings of the diagnostic report

A complete end-to-end Care Technology service

This diagram shows the full extent of an 'art of the possible' CT service. The roles of BCP ASC and Housing teams have been mapped against each aspect of the operational service. The legacy approaches in Bournemouth, Christchurch and Poole, as well as the current service model, have been mapped against these features.



Legacy Care Technology service models in Bournemouth, Christchurch and Poole

Three distinct services, systems and processes operated in Bournemouth, Christchurch and Poole prior to the LGR.

	1 Referral	2 Assessment	3 Equipment Installation	4 Call Monitoring	5 Physical Response	6 Maintenance	7 Equipment Recycling	E Enablers
Bournemouth	Completed by Practitioners and sent direct to Bournemouth Careline.	At-home assessment and installation undertaken by Bournemouth Careline.		Service provided by Bournemouth Careline.	N/A	Service provided by Bournemouth Careline.	Service provided by Bournemouth Careline.	No evidence of benefits analysis. Limited evidence of demos/training.
Christchurch	Completed by Practitioners and sent to OTs for assessment.	Completed by OTs.	Millbrook installation of contracted kit. OT installation of kit not within ext. contract.	Service provided by Appello.	N/A	Millbrook maintained and recycled equipment that fell within the external contract.		No evidence of benefits analysis or training.
Poole	Completed by Practitioners and sent direct to Poole Lifeline (pendant only). Triaged and allocated to an AT Assessor by the Lead Practitioner / AT Lead (for peripherals).	Completed by OTAs.	Prescribed equipment installed by Poole Lifeline.	Service provided by Poole Lifeline.			Service provided by Poole Lifeline. Anecdotal evidence of Social Workers collecting equipment where possible.	Benefits analysed but not used to inform ASC budgets. AT Lead responsible for training and identifying new equipment.

***Note**: Bournemouth Careline and Poole Lifeline are both in-house services.*

Current approaches to the Care Technology service

Elements of the CT service have been consolidated, such as the equipment offer and charging policy. Further work undertaken by colleagues in Housing and ASC aims to bring all data into the same IT system and align all service offers with the legacy Poole approach.

	1 Referral	2 Assessment	3 Equipment Installation	4 Call Monitoring	5 Physical Response	6 Maintenance	7 Equipment Recycling	E Enablers
Bournemouth and Christchurch	Completed by Practitioners and sent direct to Bournemouth Careline.	Assessment and installation undertaken by Bournemouth Careline.		Service provided by Bournemouth Careline.	N/A	Service provided by Bournemouth Careline.	Service provided by Bournemouth Careline, with equipment returned via post.	No benefits analysis or routine review of CT achieving outcomes for SU. Limited evidence of training or innovation.
Poole	Completed by Practitioners and sent direct to Poole Lifeline (pendant only). Triaged and allocated to an AT Assessor by the Lead Practitioner / AT Lead (for peripherals).	Completed by OTAs.	Prescribed equipment installed by Poole Lifeline.	Service provided by Poole Lifeline.			Service provided by Poole Lifeline. Anecdotal evidence of Social Workers collecting equipment where possible.	Benefits are analysed but do not inform ASC budgets. AT Lead responsible for training and identifying new equipment.

***Note**: Bournemouth Careline and Poole Lifeline are both in-house services.*

Key:
- ✓ Achieving
- ✓ Partially achieving/ significantt variation
- ✓ Underachieving

There are inconsistencies in the existing CT service model and gaps in the current approach to service transformation and development

	SERVICE DELIVERY						SERVICE TRANSFORMATION & DEVELOPMENT						
	Referral	Triage	Assessment & Install	Monitoring & response	Repair	Collection & recycling	Benefits mgmt.	Change & engagement	Innovation	Governance	Service development	Service mgmt	
Summary	**Open referral, with no set eligibility criteria**	**Different approaches across BCP, although both are practical in the respective system.**	**A disparate model, with a limited range of equipment available.**	**A well functioning, but unequal, operational service across BCP, verified by KPIs and feedback.**	**Monitoring of equipment status and proactive repairs / maintenance undertaken.**	**Processes exist for collection and recycling of equipment. These vary slightly by patch.**	**Sporadic approach and no evidence of analysis informing budget changes.**	**CT is not a core offer. 70% of survey respondents referred fewer than 5 times, or not at all, in the last year.**	**There appears to be pockets of innovation in ASC and Housing, but no cohesive approach.**	**There is no evidence of formal governance for CT service delivery and development.**	**There appears to be very little service development when it comes to CT.** The service has been scaled back as part of the alignment work recently undertaken. There is, however, an ambition to extend the responder service across all areas. Previous CT service developments have been adhoc and driven by ASC service colleagues e.g. looking at CT in supported living	**There is no management of the entire approach across BCP.** A good working relationship exists between Housing and ASC, however, there is a separation of responsibilities and unequal resourcing for CT in each patch, with no individual overseeing the end-to-end service offer. Information is not cascaded regularly e.g. messages about performance and the value added by the service are not routinely shared internally.	Summary
Bournemouth and Christchurch	A risk-based referral is completed by ASC practitioners. Anecdotally, some referrals remain prescriptive despite the approach.	No triage; all referrals are sent direct to Bournemouth Careline who arrange an assessment and installation.	Feedback suggests assessment and installation was sales focused. Kit is installed based on SU requests. The result of installation is not fed back ASC.	No response service in this patch. Practitioner feedback suggests that the requirement for two local 'responders' may hinder service uptake.	Bournemouth Careline repair kit. Evidence of proactive repair/ maintenance (e.g. smoke detectors requiring replacement every 10 years)	Equipment is returned via post and is co-ordinated by Bournemouth Careline.	No evidence of ASC benefit analysis.	One identified AT Champion, however, this is an informal role and is limited to the team in which the person works. No evidence of regular training offered to staff.	Equipment offer recently restricted in order to bring it in line with the offer in Poole.	A champion was identified by senior stakeholders, however, the role is informal, does not span all areas and is not part of any formal governance			Bournemouth and Christchurch
Poole	A prescriptive referral, completed by ASC practitioners, is sent to Poole Lifeline for pendant alarms. Referrals for peripherals are sent for triage.	The Lead Practitioner / AT Lead triages referrals for peripherals, assigning an assessment task to an OTA on Care Director.	Assessment undertaken by an OTA, drawing on ASC records. Poole Lifeline install the prescribed kit. A limited range of equipment is available.	A response service only exists in this patch. Poole Lifeline clients receive an annual visit or call. This is not replicated elsewhere in BCP.	Poole Lifeline repairs kit for Private Users as well as providing OOH repairs in schemes. Evidence of proactive repair / maintenance.	Collections undertaken by Poole Lifeline. Some collections may also be completed by ASC practitioners although this is not routine	Benefits are analysed by ASC for some new and historic referrals. The work is manual, unscalable and does not inform budget changes.	Training led by the AT Lead. It focusses on delivery of the current offer rather than culture change. No evidence of a wider group of trainers being upskilled.	Perceived as archaic and limited in scope, with a focus on maintaining the status-quo. Any innovation is equipment-led e.g. new model released.	The Lead Practitioner and AT Lead have defined roles,, these focus on operational delivery rather than development and wider reporting			Poole
	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

BCP's current CT Service is a traditional offer that has remained static over the last three years

The overall CT service

The core of the CT service is provided by the Housing Directorate . It is split into Bournemouth Careline (which also serves Christchurch) and Poole Lifeline. It can be **accessed via two routes**. Private Pay users pay for the installation and ongoing costs for monitoring and response,* while Community Alarm users access CT via housing schemes.

As of 1 October 2021, **8949** residents were receiving the service. The majority of service users (60%) were from Bournemouth and Christchurch. The **total number of people accessing the service has remained static** since 2019 at approximately 9000 users. There was, however, a slight decline in service user numbers between April and October 2021. Despite a smaller service user volume, more monitoring calls are made each year in Poole. Feedback suggests this in linked to the response service that is available only in this patch.

The majority of service users (57%) accessed the service via the Private Pay service. The service is **traditional** and predominantly offers pendant or falls alarms. Equipment such as environmental or PIR sensors also utilised to support residents where appropriate.

In addition to CT services, the team performs statutory out of hours services. The staff structure is as follows:

1	Head of Risk & Telecare	3	Telecare & OOH Supervisor
1	Telecare & OOH Manager	2	Senior Operator (vacant)
1	Deputy Telecare & OOH Manager	42	Operational Staff**

The ASC CT service

The ASC CT offer draws on the Private Pay model within Housing to provide support to residents. ASC funds the purchase and installation of equipment*** for individuals referred via a care practitioner. The equipment is loaned to the individual, with the resident required to pay for the ongoing costs for monitoring and, if appropriate in Poole, response services.

It is not possible to accurately identify the current number of service users accessing the service who have ASC needs. Users referred via ASC routes are a subset of the Private Pay cohort. Anecdotal feedback suggests that 25% of new referrals are received via ASC routes. Referrals for standalone devices are not captured in the total service user volume, as BCP does not provide a service beyond installation of the device. Furthermore, there is currently no mechanism for identifying the number of service users with ASC needs who leave the service.

The equipment offer was historically broader in Bournemouth and Christchurch, however, it has recently been pared down in order to bring it in line with the offer in Poole. Some equipment, such as standalone pagers, door sensors, pressure pads and medication dispensers are only available to residents referred via ASC routes.

** a response service is currently available in Poole, although there are aspirations to broaden this offer to the whole of BCP.*

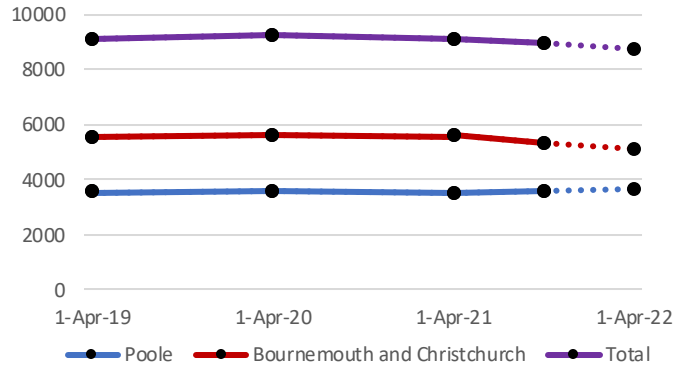
*** a combination of F/T, P/T, casual staff and vacancies*

**** with the exception of pendants and based lifeline units which are funded by Housing*

The scale and makeup of the CT service has remained static over the past three years and these trends are projected to continue

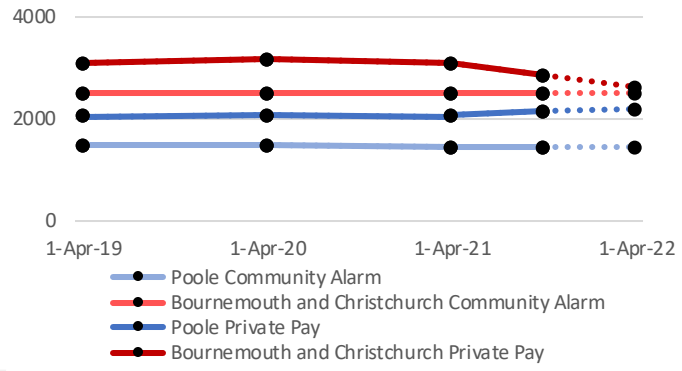
Total Lifeline and Careline Monitored Service Users

The majority of service users (60%) are in Bournemouth and Christchurch. The total user volume is projected to remain static by April 2022.



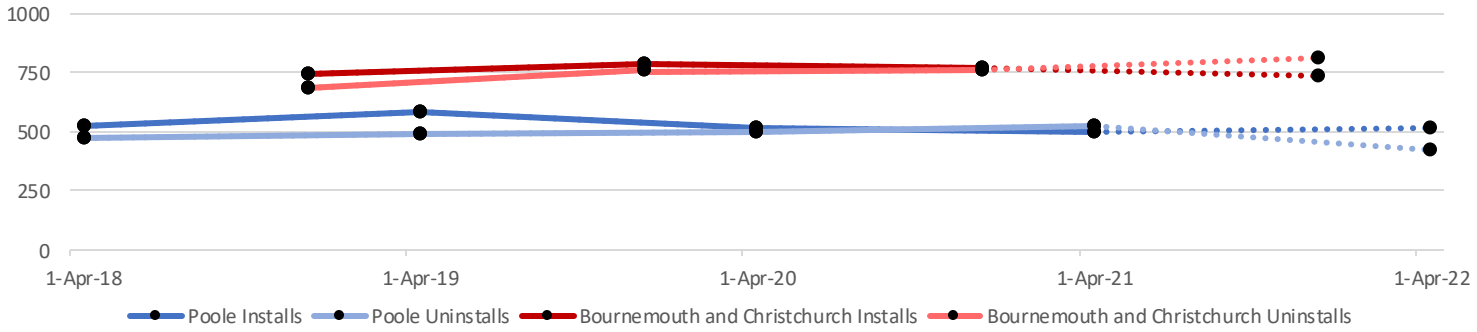
Private Pay and Community Alarm Monitored Users

If recent trends continue, Private Pay users are projected to decrease in Bournemouth, but increase in Poole, by April 2022. The number of Community Alarm users has remained static.



Installs and Uninstalls

The rate of installs has remained relatively static and this is projected to continue in both Poole and Bournemouth and Christchurch. The number of uninstalls in Poole is projected to decrease by the end of the financial year, leading to a small increase in service user volumes. Conversely, by the end of the calendar year, the number of uninstalls in Bournemouth and Christchurch is projected to increase, which will reduce the total service volume marginally.



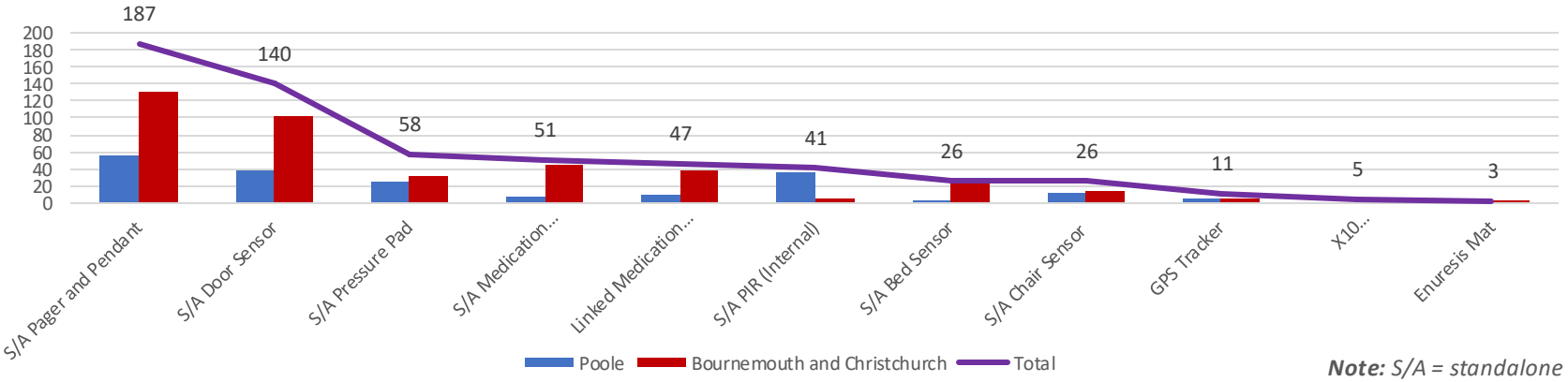
Equipment in use as of 1 October 2021 demonstrates that the current service offer is traditional

Items made available to everyone, including ASC and Private Pay users

The below graph shows equipment that is made available to everyone, including Private Pay and ASC-referred users.
The service predominantly offers falls alarms, while sensors (environmental, and door or bed sensors) are also utilised to support residents where appropriate.

Items made available only via ASC

The below graph shows equipment that is made available only via ASC referrals.
The use of pendants and standalone (S/A) devices is prevalent.

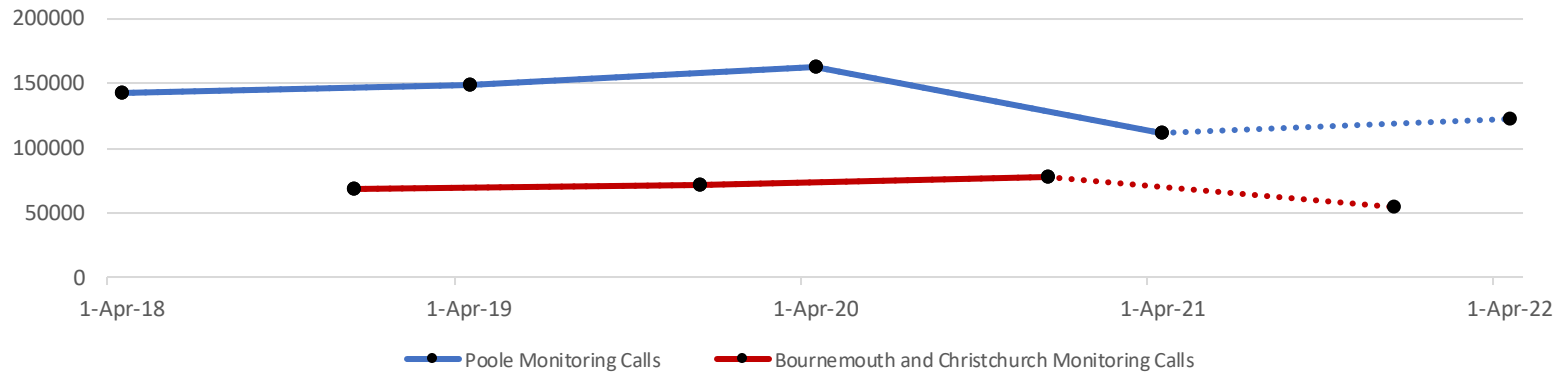


***Note:** S/A = standalone*

Despite a smaller service user volume, the Poole service receives more monitoring calls each year

Monitoring calls raised with the monitoring centre

Poole service users account for approximately 40% of total service user volume, however, over the past three years there have been consistently more monitoring calls made by service users in this patch. Feedback suggests that this trend is linked to the use of the response service, which is currently only available in Poole.



Projections have been calculated using a variety of methods, to accommodate variations in data returns. The methods are summarised below.

- Snapshot data, covering service user volumes for the service in Bournemouth and Poole, has been used to calculate a projection for April 2022.
- Financial year data, covering service activity for the Poole service, has been used to calculate a projection for April 2022.
- Calendar year data, covering service activity for the Bournemouth service, has been used to calculate a projection for December 2021.

Snapshot Data

The trend between April 2021 and October 2021 was calculated. As October is halfway through the financial year, this trend was multiplied by two to reach a year-end figure.

[Oct21] – [Apr21] = N
*N * 2 = X*
[Apr21] + X = April 2022 Projection

Financial Year Data

As October is halfway through the financial year, the total number of 'activities' (e.g. installations) as of October was multiplied by two to reach a year-end figure.

*[Oct21] * 2 = X*
[Apr21] + X = April 2022 Projection

Calendar Year Data

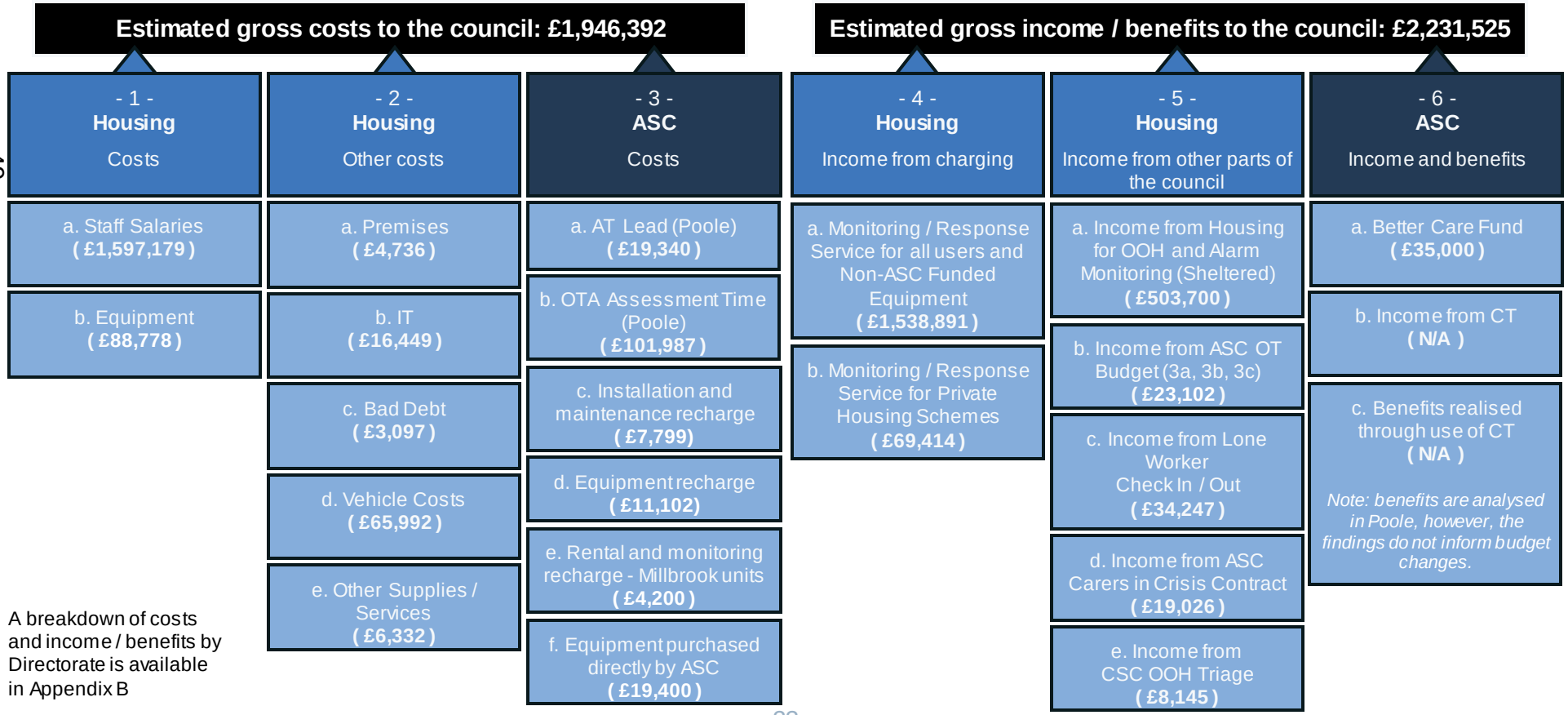
As October is three-quarters of the way through the calendar year, the total number of 'activities' (e.g. installations) was divided by three to reach a quarterly figure. This was then multiplied by four to reach a year-end figure.

[Oct21] / 3 = X
*X * 4 = December 2021 Projection*

There is not a budget code for the CT service; costs of delivering the service are incurred by Housing and ASC

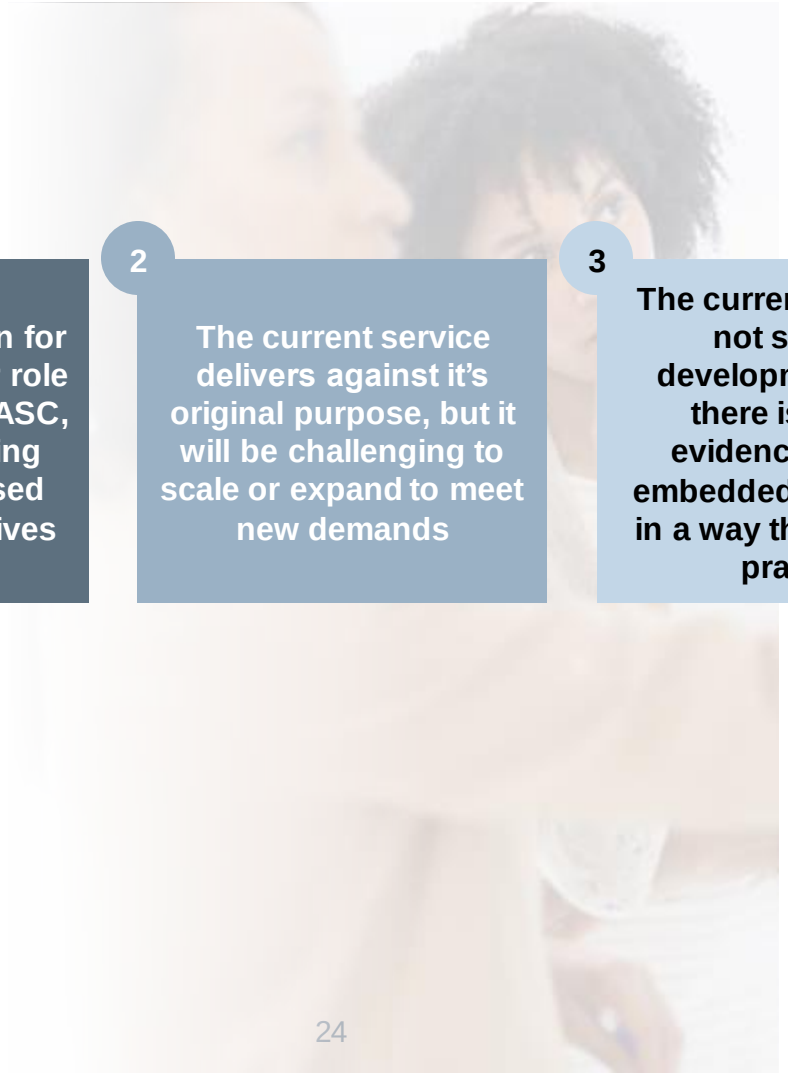
The information presented below is a representation of the data received from Housing and ASC during the diagnostic engagement. It is designed to give an indication of CT service costs to the council as a whole; it is not a full assessment of costs.

Feedback suggests that the alignment of the legacy services revealed a higher than anticipated overall income and small budget surplus. The potential to recruit more staff, in order to add resilience and capacity to the current CT service team, is being explored and will likely deplete this surplus



A breakdown of costs and income / benefits by Directorate is available in Appendix B

The following sections set out the headline diagnostic findings in more detail, along with a summary of feedback from the stakeholder interviews and staff survey



1. There is an ambition for CT to play a greater role across all levels of ASC, but no-one is driving future practice based on strategic objectives
2. The current service delivers against it's original purpose, but it will be challenging to scale or expand to meet new demands
3. The current service is not seen as developmental and there is limited evidence it being embedded within ASC in a way that changes practice

3.1

There is an ambition for CT to play a greater role across all levels of ASC, but there is no evidence that future practice is being driven based on strategic objectives

There is an ambition for CT to play a greater role across all levels of ASC, but there is no evidence that future practice is being driven based on strategic objectives

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1a

There is a clear desire at both a strategic and operational level to use CT in order to benefit residents.

- The BCP Corporate Strategy emphasises the need to support people to live safe and independent lives, and the BCP Corporate Strategy Delivery Plan references promoting and extending the use of assistive and digital technology
- The BCP ASC Strategy supports this, referencing assistive technology and its role in supporting people to live safe and independent lives
- Interviews with senior stakeholders have demonstrated clear support for the use of CT
- 87% of survey respondents consider an understanding of CT “very important” or “important” for their role

1b

BCP’s strategic objectives have not been translated into a CT Strategy that sets out the vision, objectives and principles for the future service.

- Despite a clear corporate strategic vision to increase the use of technology in order to support residents to remain independent, there is not a CT strategy (although in commissioning this review there is clear desire to address this)
- Without a clear drive for CT, it is unsurprising that the service has remained static in user numbers since 2019
- There is a lack of clarity about how CT will achieve the objectives of senior stakeholders
- Nobody in ASC is defining the requirements of a future CT service in order to achieve strategic objectives

There is an ambition for CT to play a greater role across all levels of ASC, but there is no evidence that future practice is being driven based on strategic objectives

1c

There is a significant amount of change activity underway as a result of the Local Government Review.

- Feedback indicates that previous attempts to develop the service have had made little headway, and since the LGR, there has been limited attention given to the development of the CT service due to competing priorities
- BCP's focus to date has been on aligning disparate services, approaches and systems across the newly created council
- The focus on changes arising from the LGR means it is challenging for truly transformational activity to gain traction
- There is evidence of change fatigue amongst colleagues, exacerbated by the challenges of the COVID pandemic.

Conclusion #1

This has resulted in the current service consolidation being driven by operational factors, and the direction of the current service is unlikely to achieve BCP's future ambitions.

- In the absence of a CT strategy, service alignment has been progressed within Housing, resulting in consolidation of the equipment offer and charging policies.
- There is evidence of ASC influencing the direction of service consolidation, but this is limited to an operational perspective and does not account for the strategic objectives outlined by the Council
- The planned service alignment is being steered predominantly by the 'Poole' approach, which restricts the technology that is available, uses a prescriptive approach for equipment and does not effectively demonstrate how CT contributes towards an ASC-wide preventative approach
- The favoured approach relies on OTAs to complete assessments, which is not scalable given team structures, resource and pressures (e.g. OT waiting lists) across BCP.

Stakeholder feedback

The following are anonymised quotes from stakeholder interviews and survey responses

"this is the future"

"we need to be committed, not tokenistic, which is what we've done in the past"

"it's a no brainer"

"now is the time to do whatever it is we want to do"

"Use of technology can be very helpful but it MUST remain person centred"

"there is a dizzying array of transformational work"

"this is a wide open door"

"the default thinking needs to be 'what can a digital solution do' before we start thinking about deploying labour"

"change is seen as 'what are you doing to us now'"

"we've got to look at the technology route, got to use it more, got to be smarter about how we work"

"This is a potentially important service which can save the Council money - it needs a higher profile in my opinion."

"everything is a priority"

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3.2

The current service delivers against it's original purpose, but it will be challenging to scale or expand to meet new demands

The current service delivers against it's original purpose, but it will be challenging to scale or expand to meet new demands

2a

The current approach has been driven by Older Adults and offers a traditional service.

- The current offer provides reassurance to Service Users, Carers and Families and is often used 'in addition to' rather than 'instead' of a traditional package of care. Survey responses demonstrate that providing "assurance in addition to an existing care package" was the second most common reason for referring for CT
- The current model taps into an established service within Housing, rather than being a fully-fledged ASC offer in it's own right. There is no dedicated support for cohorts such as LD and practitioners report that the kit offer is very limited - they strongly believe there is much more potential across ASC
- The model favours a prescriptive approach, with OTAs choosing from a limited range of kit to meet specific needs
- There is a manual approach to benefits analysis in Poole, however, it is based on a small number of ASC referrals, is derived primarily from the use of Just Checking and the findings do not influence ASC budgets

2b

The service is fragmented and CT is seen as the domain of a small group of individuals.

- While service costs and the equipment offer have successfully been aligned, there remains a fragmented and unequitable service offer (for example the availability of the responder service) across BCP as a result of a lack of unifying strategic and operational principles
- There are disparate processes and systems used across the 'patches'
- In Poole, there is a defined AT Lead and OTAs have been trained to complete assessments. This has resulted in a small group of skilled staff, however, there is not the same level of ownership in Bournemouth and Christchurch
- The processes used in Poole place a reliance on the Lead Practitioner, AT Lead and OTAs; the Lead Practitioner and AT Lead could become a bottleneck if the service was scaled, while the reliance on OTA time is not feasible given staff structures in Bournemouth and Christchurch
- There is not a BCP-wide ethos to explore the use of CT to support ASC needs from the outset

The current service delivers against it's original purpose, but it will be challenging to scale or expand to meet new demands

Conclusion #2

This means that the current approach will find it challenging to demonstrate that it can meet the future demands of the Council.

- Despite the successes to date, due to the constraints of the current approach and available resource, it is difficult to see the current model demonstrating that it meets the future needs of the Council, for example:
  - the requirement for large scale benefits analysis to justify the case for ongoing investment in the service
  - the ability to demonstrate CT is contributing to a strengths-based approach through use of the most appropriate, available technology for residents at each stage of their ASC journey
  - the scalability of the service, and resilience within teams, to reach a broader range of residents.

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Stakeholder feedback

The following are anonymised quotes from stakeholder interviews and survey responses

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"they [Housing] have done a great job to date […] I only ever hear of positive working relationships "

"I think the Contact Centre should have the resources to manage assistive technology support from within, and that, as an Outreach Officer, given time and training, I should be able to manage this work."

"More reliance could be placed on this technology and a number of supported living bungalows could be linked together to reduce the number of sleeping night workers."

"I believe there is a lot of potential for Care Technology in ASC Service and can make a difference to many of our clients, especially people with sensory loss needs and cognitive impairment."

"why are we scared of letting the care technology expert do the assessment"

"Huge potential there"

"Managers need to understand that AT is often inappropriate and should not be seen as a way to replace human care and support. It should be used to support care not remove it."

"Care technology is a wonderful growing resource but people (Service Users and staff) are often very wary"

"I often feel on the back foot of the technology when we are the ones going out promoting and prescribing these devices. I am keen to know more."

"currently only OT Assistants in the Poole patch are allowed to assess and issue equipment with the exception of Just Checking, which needs a Social Worker to issue. All this seems to add layers to the provision of this equipment"

"it has been a real challenge to get anything to do with AT happening at the contact centre"

3.3

The current service is not seen as developmental and there is limited evidence of it being embedded within ASC in a way that changes practice

The current service is not seen as developmental and there is limited evidence of it being embedded within ASC in a way that changes practice

CT is viewed as a narrow operational service rather than a part of wider conversations about innovation and development.

- CT is seen as narrowly defined operational service, rather than encompassing areas such as digital and supporting the adoption of a strengths based approach.
- CT is not seen as part of a suite of resources that is available to the Council and ASC practitioners in order to meet people's needs holistically, and is instead prescribed to meet a specific need alongside traditional care solutions.
- There are pockets of joint working evident, for example between Housing and ASC Commissioning, however, this is seen as separate to the BAU delivery of the CT service and there is no BCP-wide oversight of the work being done that relates to CT

3a

The current focus is the delivery of the existing offer, and there is no apparent focus or ownership to drive forward service development.

- Current service development is equipment-led rather than objective-led, however, the incorporation of new devices appears limited when considering that there were only 11 GPS devices in use as of 1 October 2021 and consumer devices are not proactively included in the CT offer.
- There is limited and inconsistent engagement with practitioners across BCP regarding CT, with communication siloed. Engagement is stronger in Poole due to the role of the AT Lead, however, this is challenging to replicate due to the AT Lead being part-time and the lack of equivalent roles elsewhere
- The current configuration of the service means that there is a gap in capabilities required to deliver an innovative CT approach e.g. **benefit realisation is** currently manual and not supported by BI&A capabilities, therefore highly challenging to scale across an expanded authority. Also no one leading engagement to achieve service-led CT innovation.

3b

The current service is not seen as developmental and there is limited evidence it being embedded within ASC in a way that changes practice

Conclusion #3

61

This means that the CT service in it's current form has limited potential to enable transformational activity at BCP.

- The fragmented approach to service delivery and service development means that there are a range of individuals who could be considered responsible for small aspects of developmental work across the wider CT service, but no clearly defined lead with the remit to drive service development and align to a practice model that supports SBA and fosters a culture whereby 'CT is recognised as the right thing to do'.
- The current resource available within the CT service makes it challenging for the existing service to influence the wider strategic developmental work required
- The current approach therefore risks CT continuing to be an 'add on' to traditional care, as opposed to a driver for transformational change across ASC at BCP

Stakeholder feedback

The following are anonymised quotes from stakeholder interviews and survey responses

"we could do with different kinds of technology that would support with reducing care packages and improving safety"

"there are pockets of work, but it's not joined up"

"I think BCP have a very limited understanding of what care tech can do. In my role the biggest hurdle is often lack of education of my peers and management who ultimately I have to have approval of for funding. This is a weekly struggle."

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"it's about having something that is sustainable and continues to allow us to adapt as the technology develops"

"I was telecare champion for a team […] this role no longer exists, and our BCP telecare offer is careline or sensors linked to pagers/careline/self purchase GPS locaters from the little knowledge I do have"

"I can't recall receiving any training in Care Technology"

"we are currently piloting Brian in Hand which could be a valuable resource in the future"

"It would be good to have some sort on ongoing savings chart to document the potential savings made by telecare"

"we are 10 years behind as an organisation, and I feel always will be which is such a shame."

"we have to 'learn it on the hoof'"

4

Transforming the TEC service: high level ‘size of the prize’

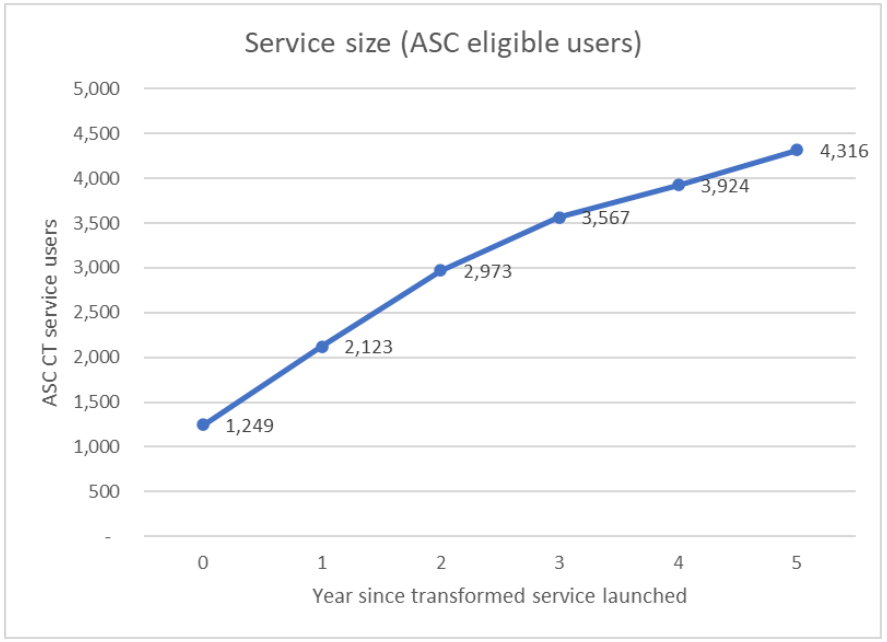
Over five years, a transformed CT service has the potential to deliver an estimated gross financial benefit of between £8.2m and £10.3m

The high level 'size of the prize' indicates the potential gross financial benefit that could be achieved by transforming and mainstreaming the CT offer in BCP. This estimate is based on growth and benefits assumptions informed by the service in Hampshire and PA's broader experience. As this is a high-level estimate and not based on detailed scope, we have applied conservative estimates to the modelling throughout, when compared to averages across the Argenti managed services.

The 'size of the prize' estimate assumes transformation and mainstreaming of the CT service results in a strengths-based approach where practitioners use of CT 'instead of' rather than 'in addition to' traditional care' for ASC Care Act eligible users. The modelling assumes the CT service would include:

- Consolidation and expansion of a 'core offer' (e.g. a greater equipment offer for OA / PD)
- Expansion of the offer to meet needs of more complex users (e.g. LD)

Further information on the modelling approach and assumptions can be found in Appendix G.



Over five years, a transformed CT service has the potential to deliver an estimated gross financial benefit of between £8.2m and £10.3m

This estimate is based on conservative assumptions throughout the modelling.
The benefits range is informed by the average gross benefit per installation calculated from across the Argenti managed services.
This figure is informed by over 40,000 installations and follows a robust benefits methodology, with all financial benefits signed off by the ASC finance leads for each Council that we provide services for.

5

Future CT vision and design principles

BCP's vision for the future care technology service

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Our Care Technology service is flexible, sustainable and trusted by all. It is embraced at the first opportunity to enable independence and enhance the quality of life for people across BCP. Care Technology is a cornerstone of our digitally enabled care approach that is embedded in practice and easy to access.

The vision informs the core principles that should underpin the design of a future service

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The diagnostic, vision and the principles provide a foundation for BCP's CT transformation journey

The scope and level of transformation required will be determined by the ambition for the future service, that is informed by the Vision. Decisions regarding the detail of what the service needs to deliver (scope), how this will be achieved (model) and by who (delivery model) should be guided by the design principles, which help provide a common and agreed framework to facilitate more detailed decision making.

The work to date has helped set the foundations and route to a transformed offer, however it is not intended as a substitute for a Cabinet Office 5-case Business Case. It is recommended that such a case is developed so a suitably detailed service model and delivery model are selected, and the investment required to set up and run a future service can be secured.

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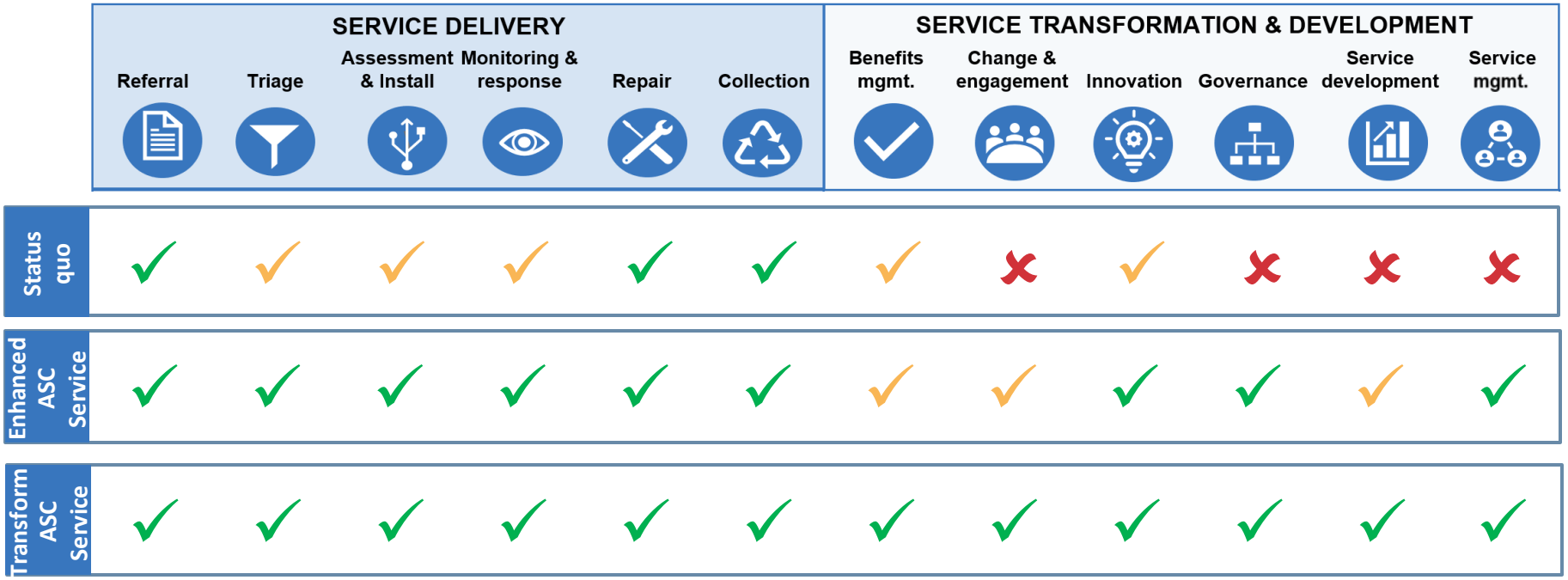
Illustrative examples



Growing and developing the BCP CT service through enhancing or transforming the existing service

The diagnostic has shown that BCP's existing CT service performs against it's original remit, but further growth is constrained by a number of factors. Currently, the service is traditional in its scope and there is room to grow the service in terms of number of people reached, as well as reaching more complex cohorts with a wider range of needs through a broader equipment offer.

An incremental change to extend and enhance the model would achieve some benefits for BCP, however a transformed service, aligned to the Council's strategic objectives, is required to deliver the BCP CT Vision.

69

The current service

- Two disparate service models from are being operationally brought in alignment
- CT service primarily offers services to older people and CT is offered in addition to a care package
- The service offers a limited range of equipment, with the majority of referrals requiring pendant alarms or falls detectors, with smoke detectors also common

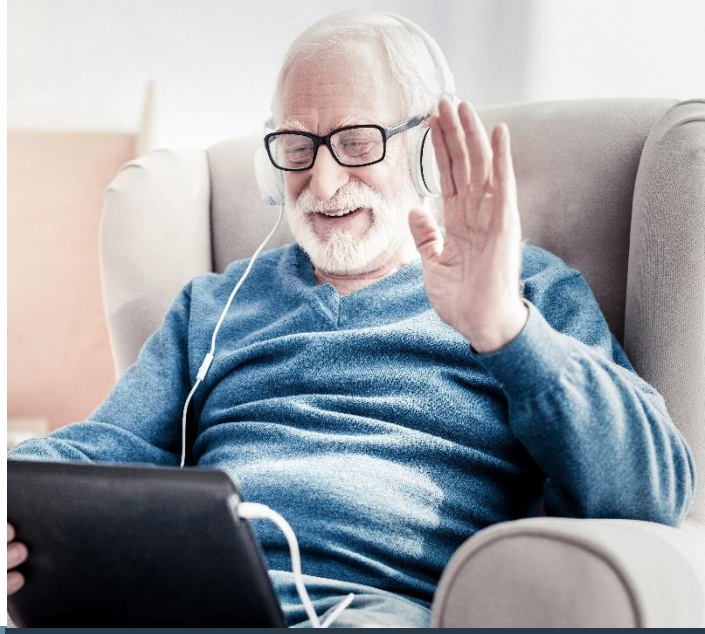
Extend and enhance the current model across BCP

- The Poole model could be extended across BCP, supported by OTA recruitment and training to expand assessment capacity
- Similar to traditional service, plus more support for younger adults (<65) with LD needs, for example in Supported Living, CT solutions are able to reduce/avoid the need for more costly forms of care.
- More consistent use of technology solutions for cases with greater complexity, consistent use of mobile technology, such as GPS, focused on people who may need help when out of the home

Example of what a transformed service could deliver

- Care Technology embedded in the Strengths Based Approach and central to the care offer across ASC resulting in greater number of residents benefiting from the service
- The technology offer is able to support older adult pathways and younger adults (<65s) across all needs/service areas, with CT solutions helping reduce/avoid need for more costly forms of care.
- Makes use of the full range of potential technologies in the market, including digitally connected devices
- Keeps abreast of innovation to continuously improve and sustain the change
- Benefits are routinely captured, validated and reported on, and support the case for sustained investment in the transformed service for ongoing development

What this means for the people BCP support



This is George, he is 76 and lives alone in Bournemouth.

Until recently he has been fiercely independent and socially active in the local community. Unfortunately a recent decline in health has put George at increased risk of falls, which has reduced his confidence. He no longer goes out to see friends in the local area.

His daughters live far away and whilst they visit when they can, they are concerned about his safety and are in discussions with the Council about the provision of a care package.

What the CT service would do today

- Provide a pendant alarm or falls detector that enables George to contact a monitoring centre for support from a physical response service when inside the home
- A care package is required to support George with tasks such as shopping and he remains isolated at home
- Costly service for the Council or individual with no strategic approach to benefits realisation

What the CT service could do tomorrow

- Provide a multi-functional GPS enabled device with built in falls detection, enabling George's loved ones to be alerted when outside of the home/agreed safe zone
- Allows George to summon help from monitoring centre/agreed care network if needed when out and about (falls detector allows for auto-alert to monitoring if he experiences a fall)
- Increased confidence allows George to access the community and continue to socialise safe in the knowledge that help is on hand from his local network
- No immediate need for a domiciliary care package and the benefits of this avoided Council cost tracked and reported on

What a transformed CT service of the future could do

- Provide a series of digitally connected devices (e.g. smart socks, heart rate monitor) that collate data on George's health and wellbeing to help predict the likelihood of a fall and intervene with preventative suggestions
- Use a range of devices to connect George to his loved ones digitally from the safety of his own home and support him to safely access the community
- Capture the system wide benefits of the intervention to health and social care, and secure system-wide investment into future service

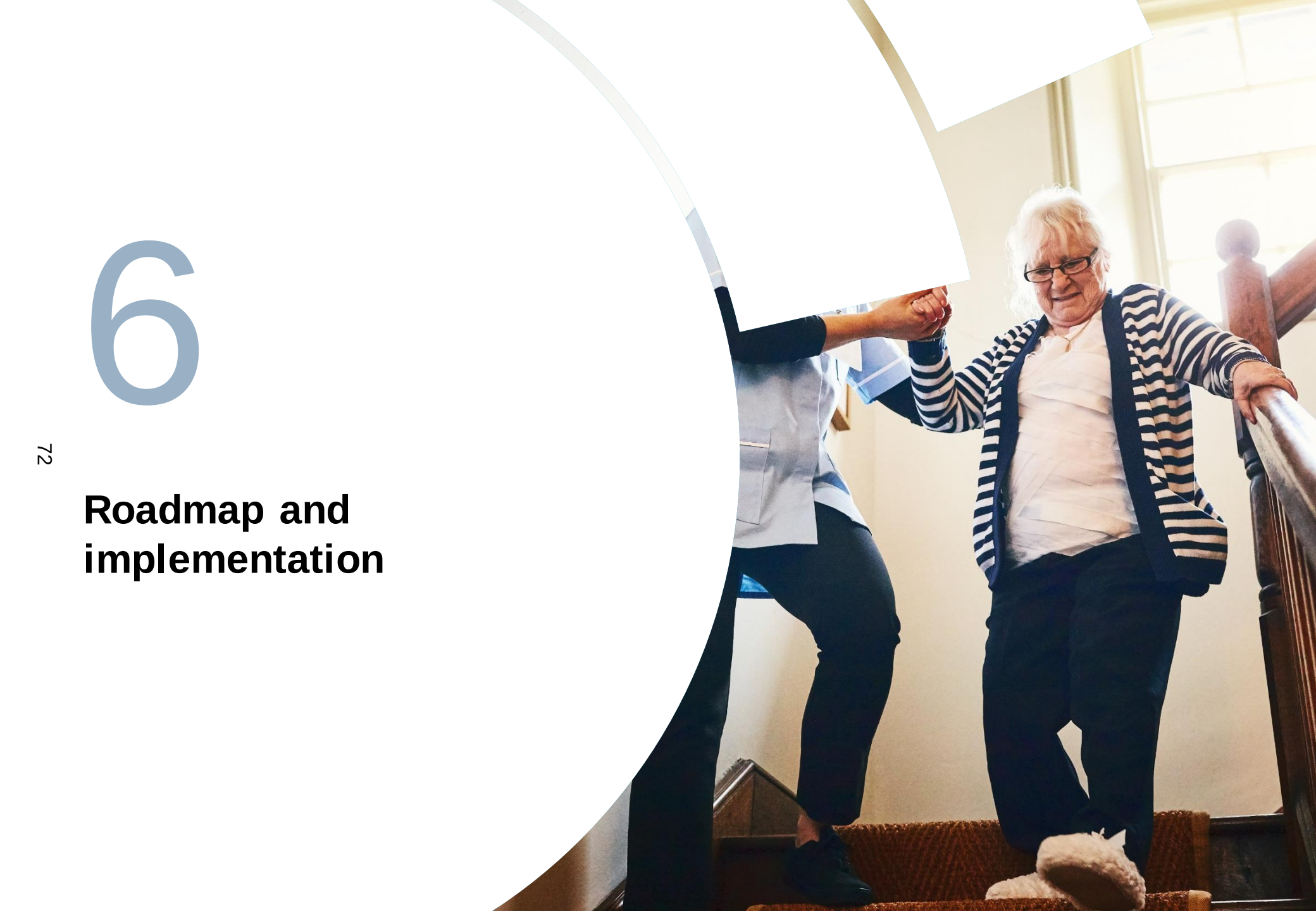
Some high-level options and considerations to support your work to refine the future CT service and delivery model

Assessing and agreeing your preferred delivery model will follow agreement of the service scope and service model; below are some of the considerations that will be factors in informing those decisions.

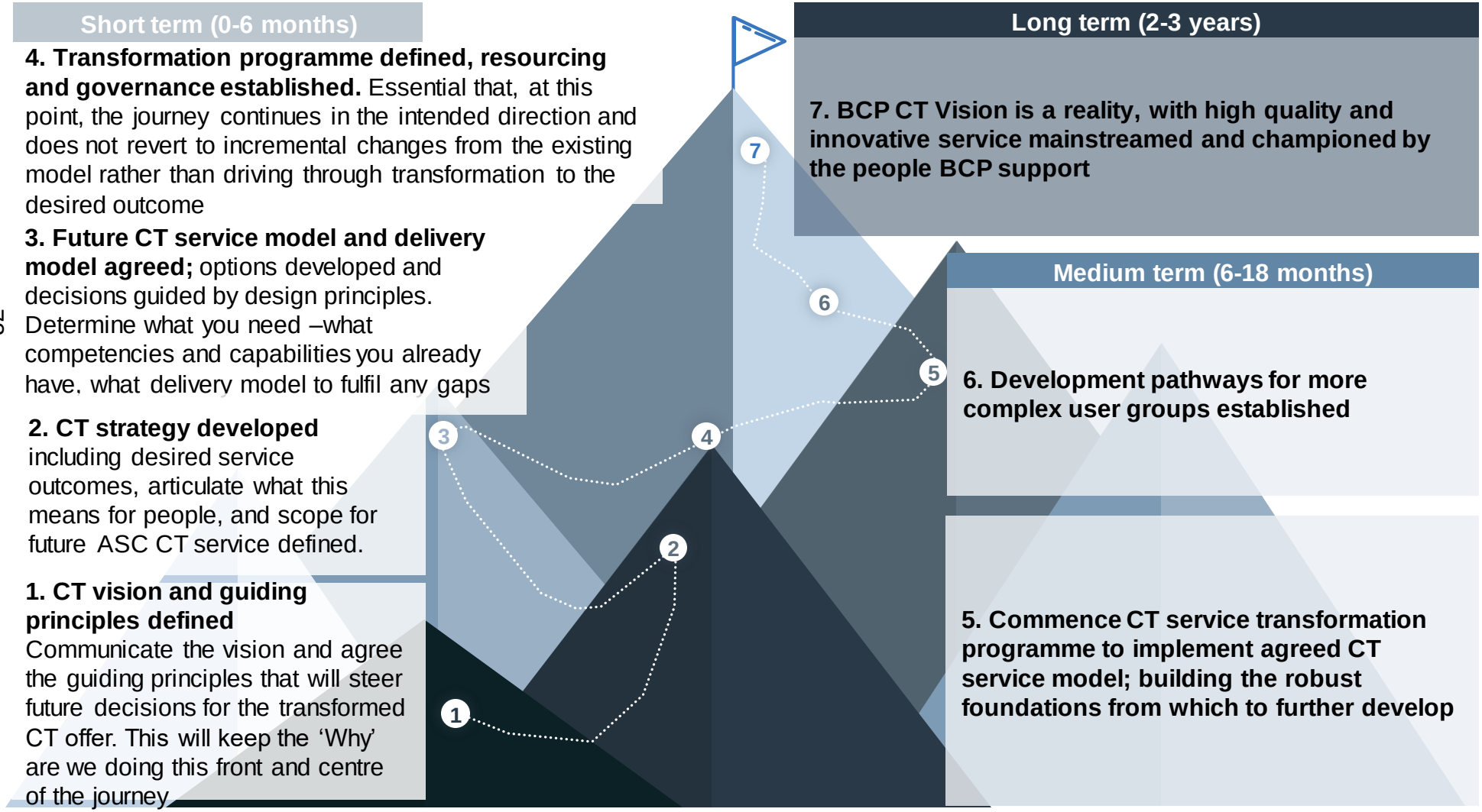
Option	Description	Key considerations associated with the model	General considerations
Extend the Poole model across the whole patch	Care practitioners refer to the OT team, who then assigns an OTA to conduct assessment and they specify the kit to be installed by Careline/Lifeline.	Expanding the model will likely require further investment in OTA resource and lead practitioner capacity to prevent a 'bottle neck' in process. Challenge with capacity for culture change, benefits analysis, service development and innovation activity.	Capacity of the service to accommodate increased demand, including assessment, installation, monitoring and response. Capability of the monitoring service to deal with more complex and potentially more challenging needs. Increasing the range of equipment to support a broader range of residents. Transformational capabilities and capacity to drive forward change once a service delivery option agreed. Capability to support benefit analysis, including automating analysis where possible Future proofing of any service model to allow for development and expansion, e.g. providing service to Children's Services, ICS-wide offer Consider impact of potential changes to policy across BCP e.g. if adopt a model whereby ASC eligible users receive as a non-charged for service (to maximise uptake), this would result in some of the current Private Pay users to this new model and impact revenue stream for housing.
Implement a Trusted Assessor Model	Practitioners make outcomes-based referrals, with CT assessment then undertaken by a trained professional – ideally at the same time as installation.	It is likely that the assessment functionality would sit best within the Careline/Lifeline team due to the links to installation. Training required to upskill installers to complete personalised assessments and be able to choose appropriate technology to help manage wider range of risks/outcomes. Consider eligibility criteria if referrals accepted from non-ASC practitioners.	
Differentiate offer for ASC – delivered in-house and/or outsourced	ASC could develop a service specification that sets out the requirements for ASC CT service, and potentially commission some / all of the requirements from external providers.	Detail and agree eligibility criteria for ASC service, and clear service pathways. Potential to develop different policies for ASC service (operational, charging) that most closely align to ASC objectives, but need to ensure equity of offer across patch. Option to source some capabilities externally (e.g. benefits analysis) . Careful consideration of KPIs if adopting hybrid model	
Fully outsourced model	End-to-end care technology service could be fully outsourced to a provider.	The existing Careline/Lifeline service staff support a wider range of activities than just CT service, both within the Housing directorate but also wider BCP e.g. Carers in Crisis. TUPE would be a consideration given the large team currently employed by BCP.	

6

Roadmap and implementation



Roadmap to a transformed CT service offer for BCP residents



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Developing a vision and strategy is crucial, however there are other opportunities that could be explored in parallel

This diagnostic has identified many factors that should be considered when developing a transformed CT offer for BCP. Before diving into the detail and addressing individual operational factors we recommend that BCP consider the CT vision and strategy first. However, there are some recommendations that we believe could be implemented in parallel. These are summarised in the table below.

#	Theme	Opportunity description
1	Strategic	• Confirm the scope and direction for the service alignment activity that is due to commence imminently with Housing and ASC colleagues, so that changes support the future ambition and objectives
2	Operational	• Consider how the Mosaic case management system can be configured to enable practitioners to complete a referral form without needing to download and email the form once completed • Investigate short-term opportunities to offer a greater range of technology, that has been tried and tested elsewhere, to meet a greater range of needs for Older Adults (e.g. enhancing the offer for GPS devices) • Begin to consider the impact of the Digital Switch and plan for the futureproofing of the service
3	Enablers	• Identify resource and opportunities to engage with Practitioners in order to bring them on the transformation journey (e.g. share the vision, design principles and next steps once finalised)

7

Appendices

A

Our diagnostic approach

The diagnostic review was conducted over two phases

- A data request to gather as much information as possible about the current services, which informed a quantitative assessment and conversations with key stakeholders.
- A survey, completed by 53 care practitioners, which gathered views about CT and the use to which is put now and in the future.
- Interviews with 13 jointly identified stakeholders, which built an understanding of how CT is perceived, as well as the appetite and constraints that exist for expanding the service to achieve social care outcomes at scale

- Supporting BCP to work out what it wants from it's future model (a vision) and what design principles need to be agreed in order to build a successful and digitally enabled future CT service.
- Setting out, at a high level, the implementation plan and indicative timetable to get from the as is position to the point when a new service could go live.
- Facilitation of a candid discussion with senior stakeholders about the complexities and challenges to change, which BCP will need to plan to address.

77

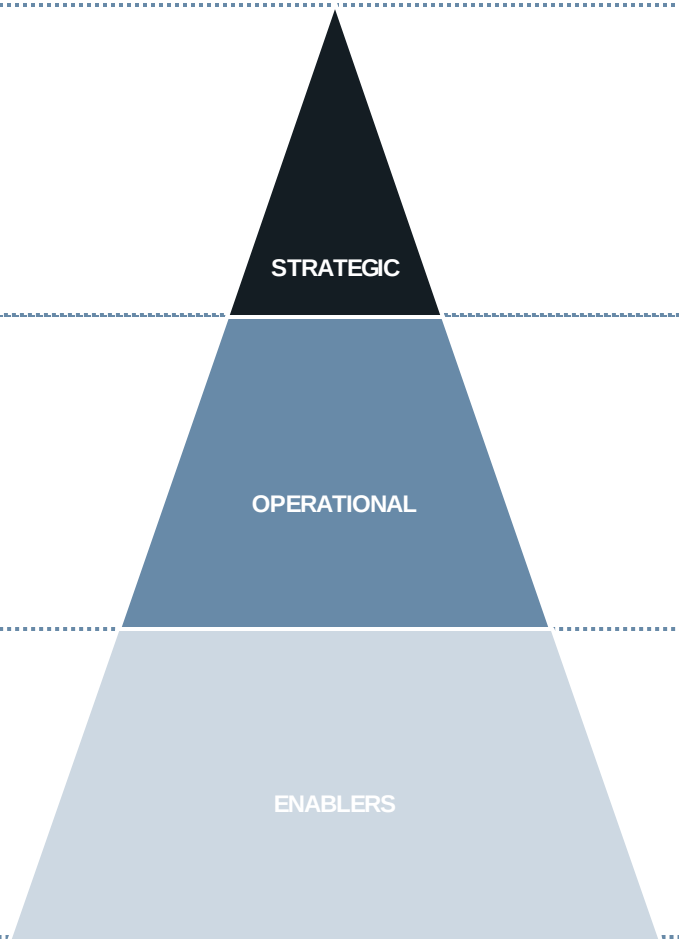
Our diagnostic framework was used to examine and evaluate key aspects of the current approach to CT at BCP

78

Strategic drivers of a successful TEC service, the critical elements that help determine the success or failure of an organisation's CT strategy.

Operational drivers that deliver a successful CT service, the resources, processes or conditions that are vital for the continued success and growth of the service.

Enablers that fundamentally support the growth and development of a successful CT service and support the service being integrated into normal working day practices.



CLEARLY IDENTIFY OPPORTUNITIES FOR PERFORMANCE IMPROVEMENT

The diagnostic is founded upon inputs from a range of stakeholders who are instrumental in the future success of the service

79

The review was conducted remotely and included a review of documents, including:

- Corporate Strategy and Delivery Plans
- ASC Strategy 2021 – 25
- Market Position Statement for Adults 2021 – 24
- Operational documents such as process maps, organograms, referral forms, training materials and guidance for staff

A survey was responded to by 53 care practitioners who work across all three patches, specialist services and hospital teams.

Interviewee	Role	Meeting date
Kate Baker	Senior OT / AT Lead	5 October
Laura Henderson	Lead Practitioner	5 October
Betty Butlin	Director of Operations	7 October
Lynda Anderson	Head of Risk and Telecare	7 October
Jonathan O'Connell	Head of Strategic Commissioning - Disabilities	12 October
Teresa Stanley	Principal Occupational Therapist	12 October
Pete Courage	Head of ASC Transformation	15 October
Tim Branson	Head of Access and Carers	18 October
Seamus Doran	Head of Neighbourhood Management	18 October
Kieren Johnson	Head of Client Support – Poole Housing Partnership	18 October
Zena Dighton	Head of Strategic Commissioning – Long-Term Conditions	19 October
Amy Hurst	Principal Social Worker	22 October
Lorraine Mealings	Director of Housing	8 November

B

The cost of the current service

Estimated financial costs and benefits of the current CT service to BCP Housing Directorate

The information presented below is a representation of the data received during the high-level diagnostic. Feedback suggests that the alignment of the legacy services revealed a higher than anticipated overall income. The potential to recruit more staff, in order to add resilience and capacity to the current CT service team, is being explored.

Estimated gross costs: £1,782,563

- 1 - BCP Lifeline Costs

- a. Staff Salaries **(£1,597,179)**
- b. Equipment **(£88,778)**

Ops Staff
- Processing referrals
- Installation
- Faults
- Ordering kit
- Physical response
- Non CT service activity (e.g. OOH service)

Non-ASC funded equipment, plus ASC referred pendant alarms

Management Staff
- Contract management
- Relationship management with ASC
- Marketing and partner engagement (pre-COVID)
- Change management and training

- 2 - BCP Lifeline Costs (Other)

- a. Premises **(£4,736)**
- b. IT **(£16,449)**
- c. Bad Debt **(£3,097)**
- d. Vehicle Costs **(£65,992)**
- e. Other Supplies / Services **(£6,332)**
- f. Overheads such as costs for finance and HR services have not been captured in this breakdown.

Estimated gross income: £2,196,525

- 3 - Income (Charging / Other Funding)

- a. Monitoring / Response Service for all users and Non-ASC Funded Equipment **(£1,538,891)**
- b. Monitoring / Response Service for Private Housing Schemes **(£69,414)**

Service Costs 2020/21

Monitoring service £3.82 per week

Mobile / Responder service £6.16 per week

Plus a weekly charge for additional equipment, which varies depending on the kit installed.

Costs are benchmarked annually.

- 4 - Income from other parts of the council

- a. Income from Housing for OOH and Alarm Monitoring (Sheltered) **(£503,700)**
- b. Income from ASC OT Budget (1a, 1b, 1c on ASC breakdown) **(£23,102.02)**
- c. Income from Lone Worker Check In / Out **(£34,247)**
- d. Income from ASC Carers in Crisis Contract **(£19,026)**
- e. Income from CSC OOH Triage **(£8,145)**

Estimated financial costs and benefits of the current CT service to BCP ASC Directorate

The information presented below is a representation of the data received during the high-level diagnostic.

Estimated gross costs: £163,829.02

- 1 - BCP ASC Costs (OT Budget)

- a. Installation and maintenance recharge **(£7,799.40)**
- b. Equipment recharge **(£11,102.40)**
- c. Rental and monitoring recharge - Millbrook units **(£4,200.22)**
- d. Equipment purchased directly by ASC **(£19,400)**

Includes costs of Easylink, Just Checking and Pivotel equipment, as well as ongoing costs for GSM units, SIMs and network maintenance.

- 2 - BCP ASC Staff Costs (OT Budget)

- a. AT Lead (Poole model) **(£19,340)**
- b. OTA Assessment Time (Poole model) **(£101,987)**
- c. Bournemouth staff time beyond referral submission **(N/A)**
- d. Christchurch staff time beyond referral submission **(N/A)**

Salary for AT Lead (0.41 FTE)

20% of OTA time

(15 FTE @ £33,995.59)

Lead Practitioner, other management time and practitioner time taken for referral submission (across all models) is excluded from costing.

Gross income: £35k

- 3 - Income for ASC Services via CT Service

- a. Better Care Fund **(£35,000)**

Gross benefits: N/A

- 4 - Annualised gross financial benefit

a. N/A

Benefits are analysed for Poole, however, the findings do not inform budget changes.

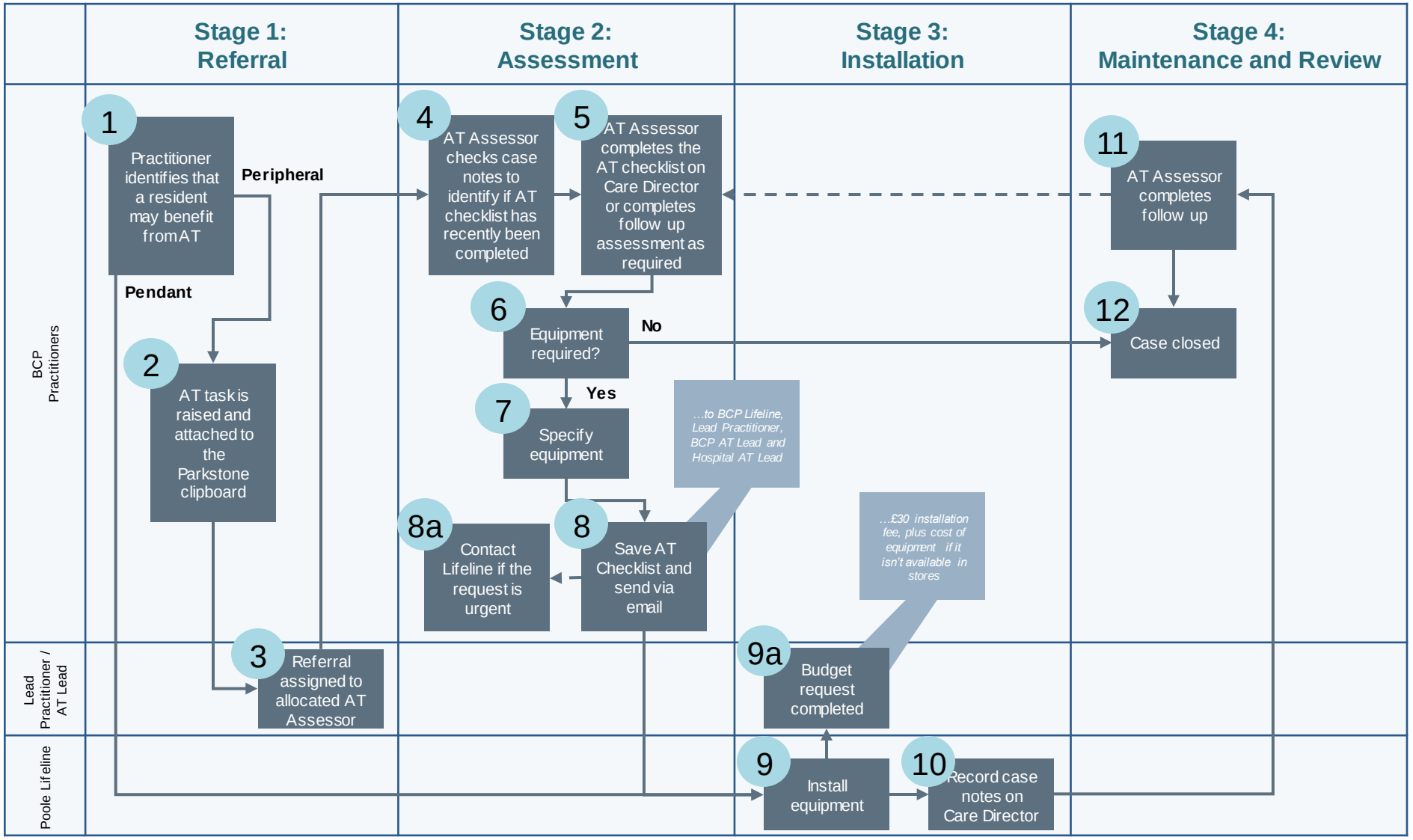
In 2019 / 20 a total financial benefit of £525,640 was identified from:

- 29 new referrals in the 2019 / 20 financial year
- 61 referrals from previous years still achieving a financial benefit

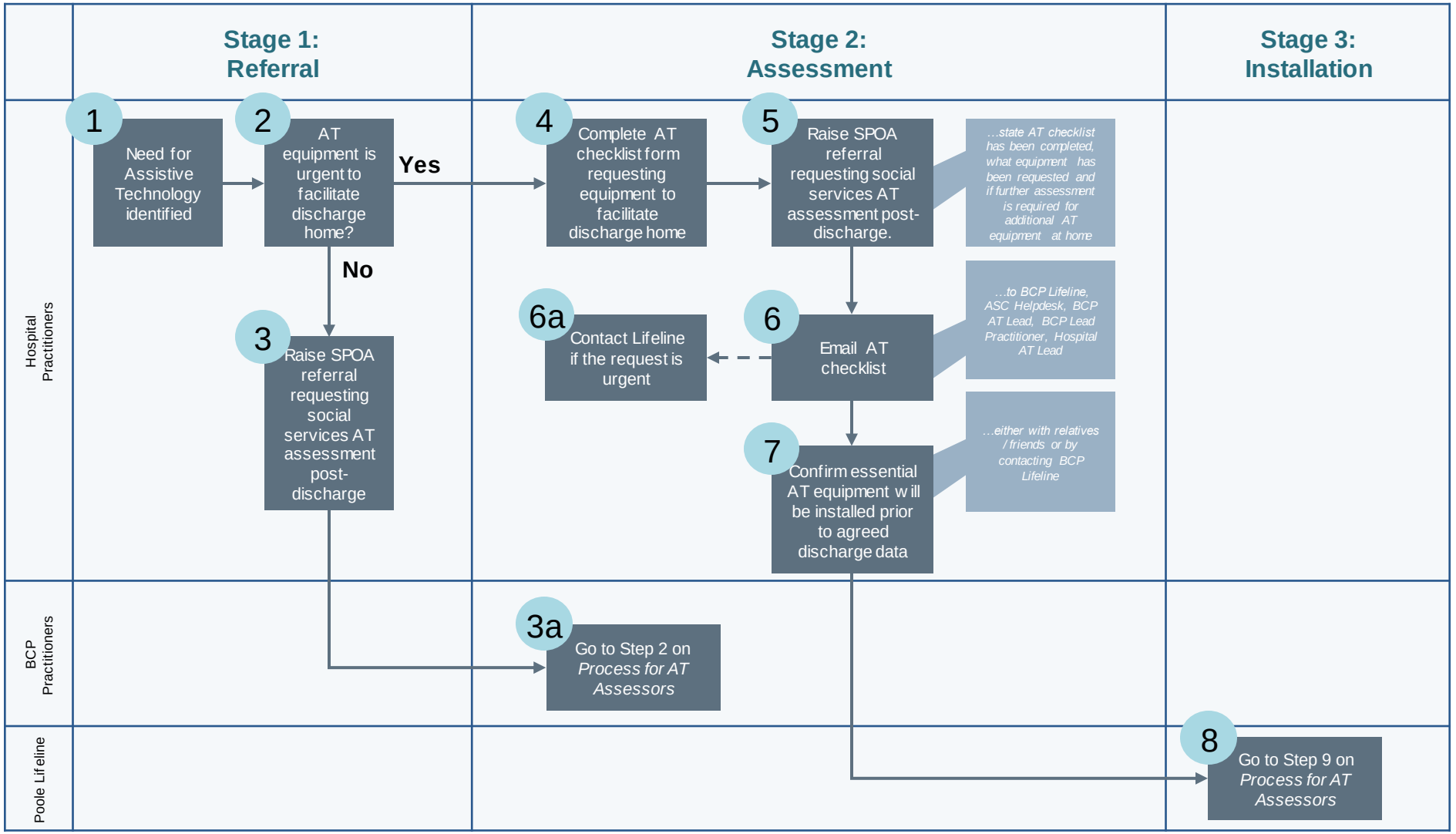
C

Process maps

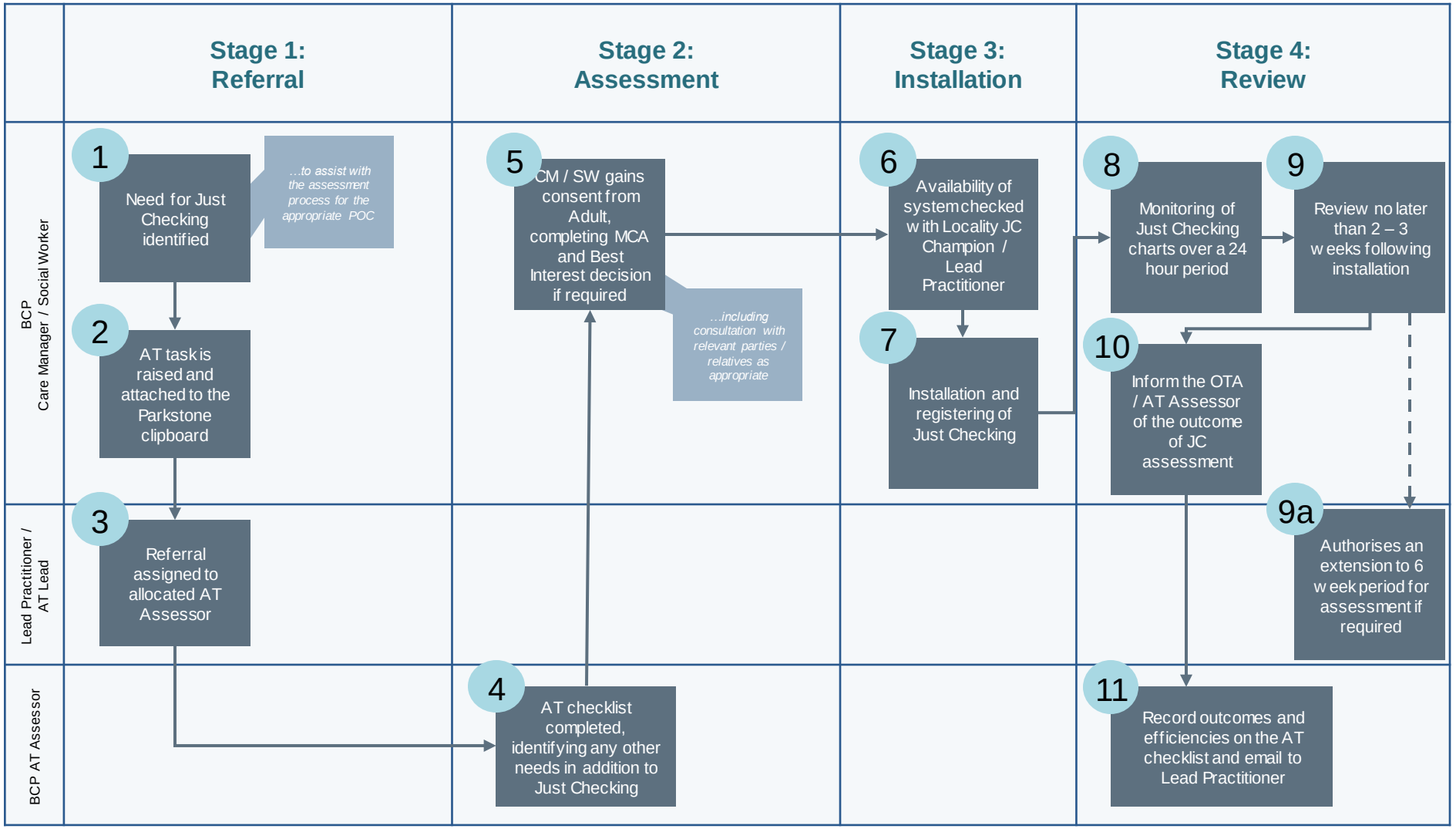
Referral Pathway: Poole



Referral Pathway: Poole – Process for Hospital Therapists



Referral Pathway: Poole – Process for Just Checking



D

Survey results

Introduction

A survey was sent to BCP care practitioners to gather their views on the current CT service. There were 53 respondents, with the following slides providing a summary of the responses.

Survey headlines:

- There is evident support for the use of CT, with the majority of respondents stating CT was “important” or “very important” for their role
- Across BCP, understanding of and confidence when discussing CT was “average”, although confidence appears higher amongst OTs/OTAs when compared to SWs/SWAs
- The majority of respondents have not received CT training, and a greater proportion of SWs/SWAs had not received training when compared to OTs/OTAs
- For those who have attended training, it was successful in improving confidence when referring or ordering CT
- The majority of referrals made were for pendant alarms or falls detectors, with practitioner feedback indicating that an improved equipment offer would be key to the future success of CT in meeting resident needs
- Understanding of the range of CT equipment and services was “average”, although a greater proportion of OTs/OTAs stated that their understanding was “high”, when compared to SWs/SWAs
- The majority of referrals were to “maintain or increase independence” or “provide assurance in addition to an existing care package”
- The majority of respondents felt CT was successful in “partially” enabling outcomes for residents
- The majority of respondents had “access to some of the support” or “limited access” to the support they need, however, the level of support available to practitioners in Bournemouth varied when compared to Poole
- There is an appetite to broaden the availability of CT, for example, by making it widely available at the ASC Front Door

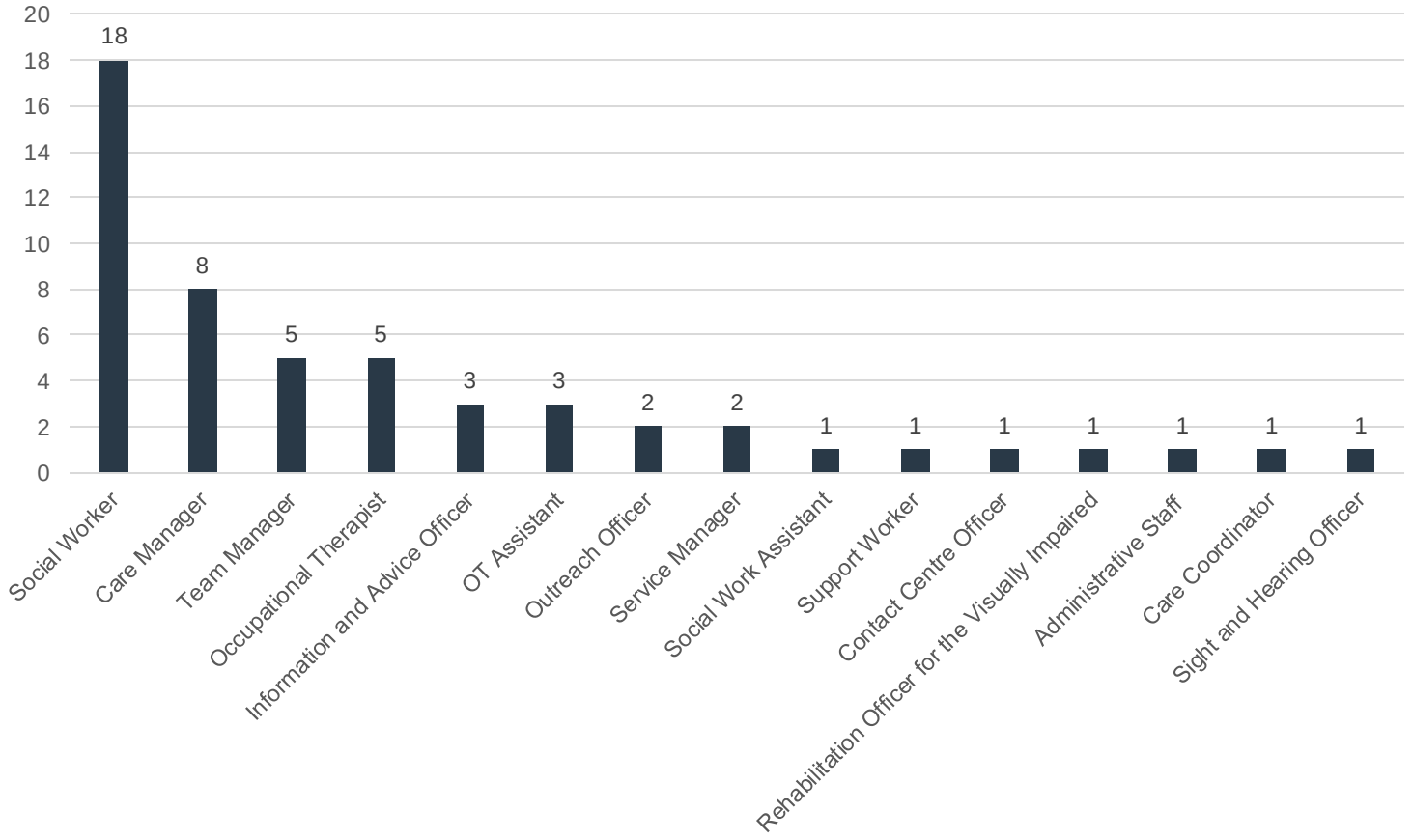
We have compared results from respondents who selected that they worked within the Bournemouth and Poole patch. There were 22 respondents from Bournemouth, and 10 respondents from Poole.

We have also compared responses from OTs/OTAs and SWs/SWAs. There were 8 respondents who were OTs/OTAs and 19 respondents who were SWs/SWAs.

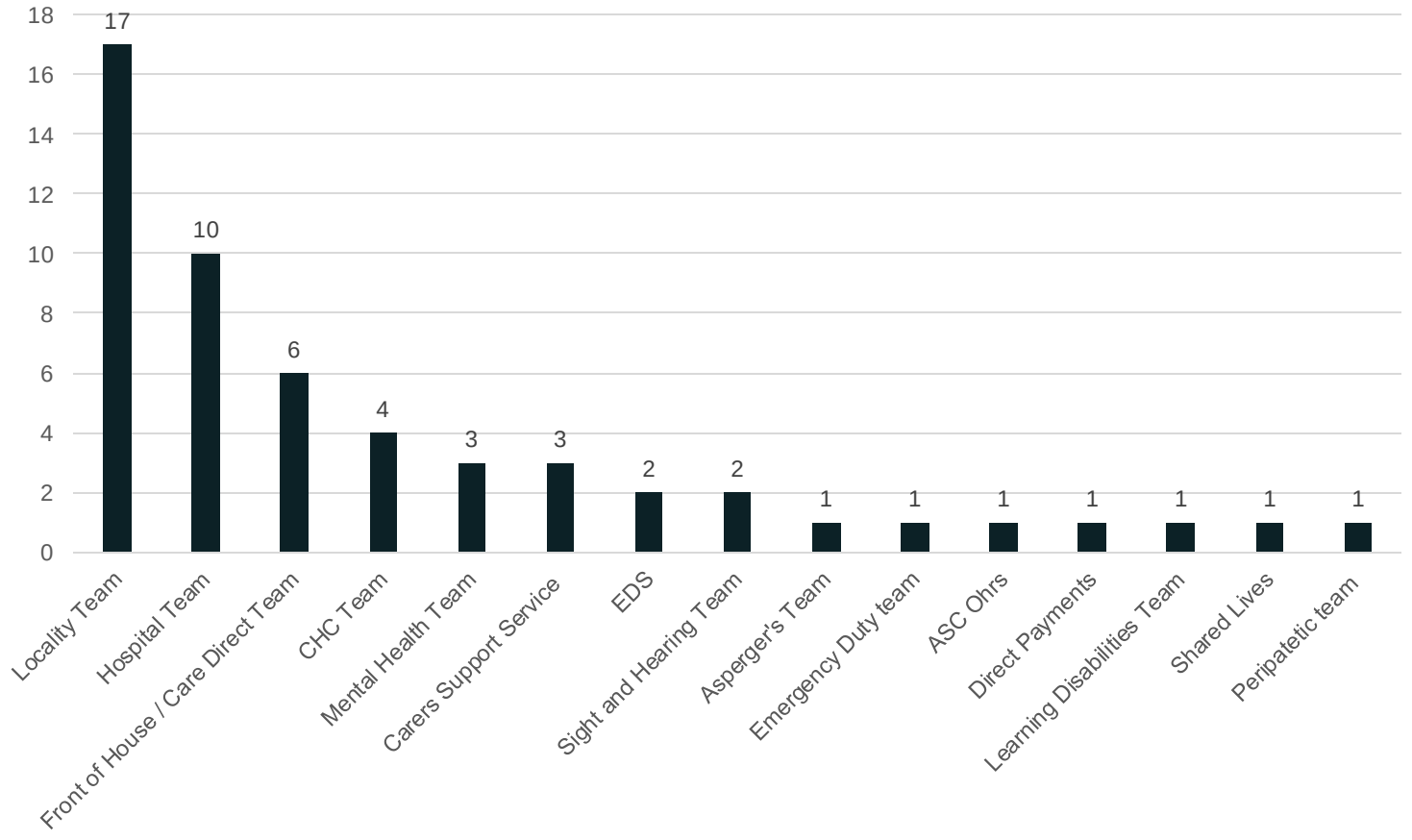
All insights have been presented as percentages.

1: What is your role?

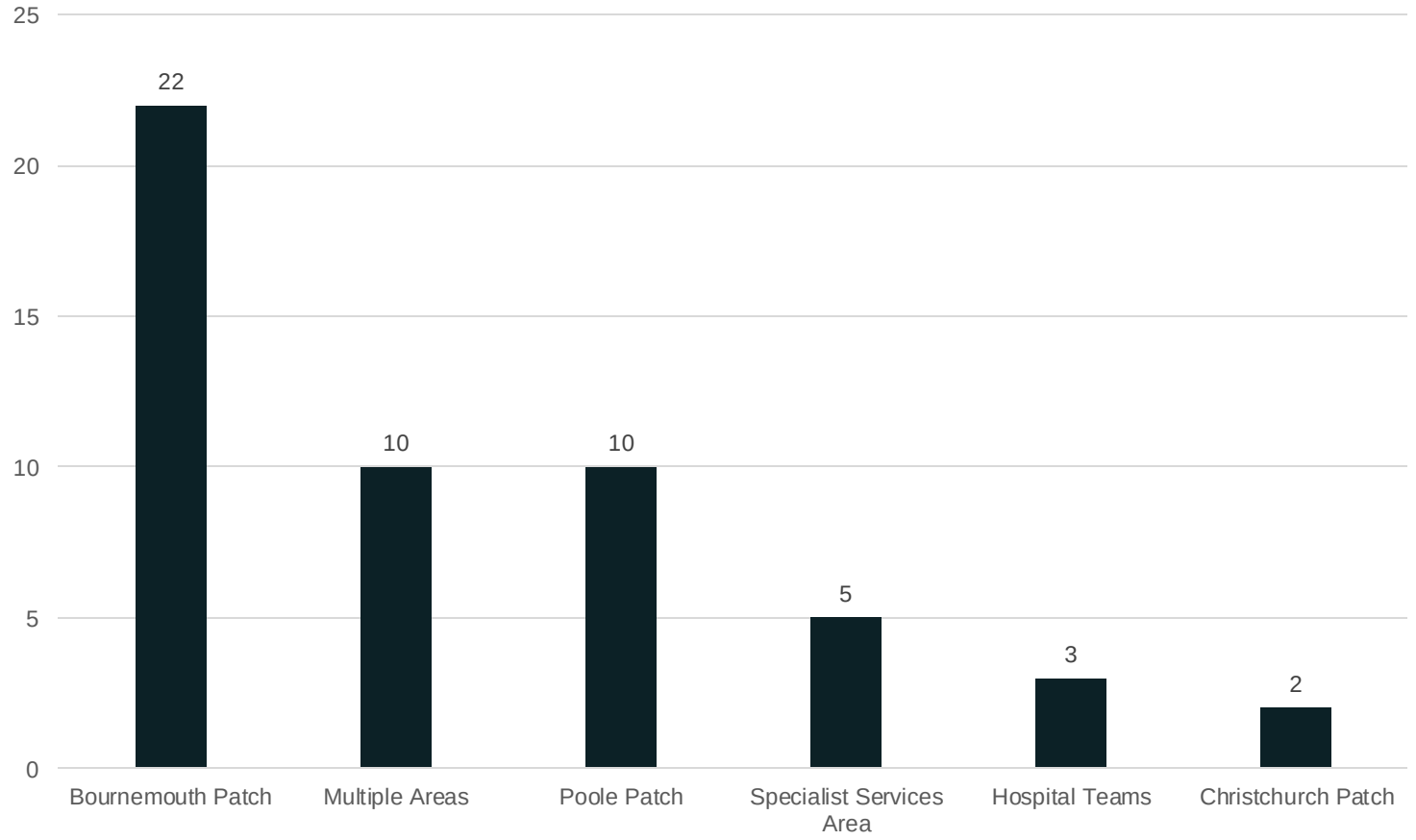
68



2: What type of team do you work in?



3: What area do you work in?



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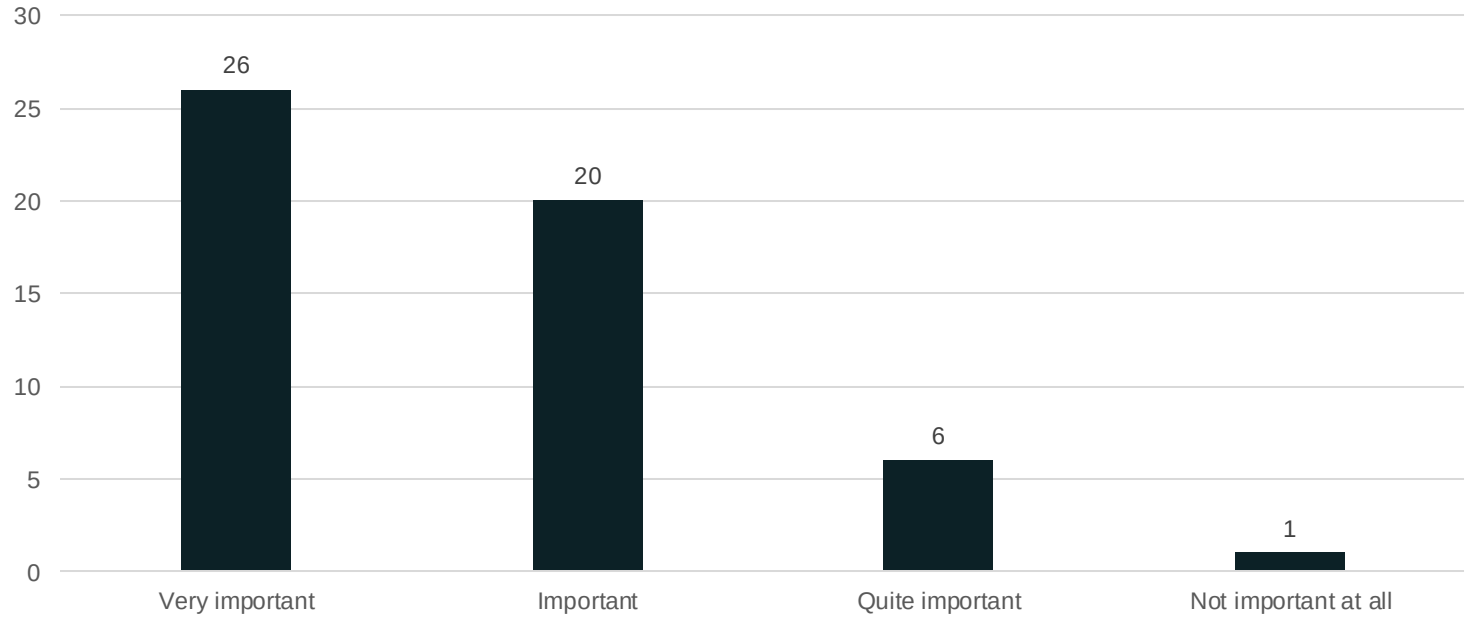
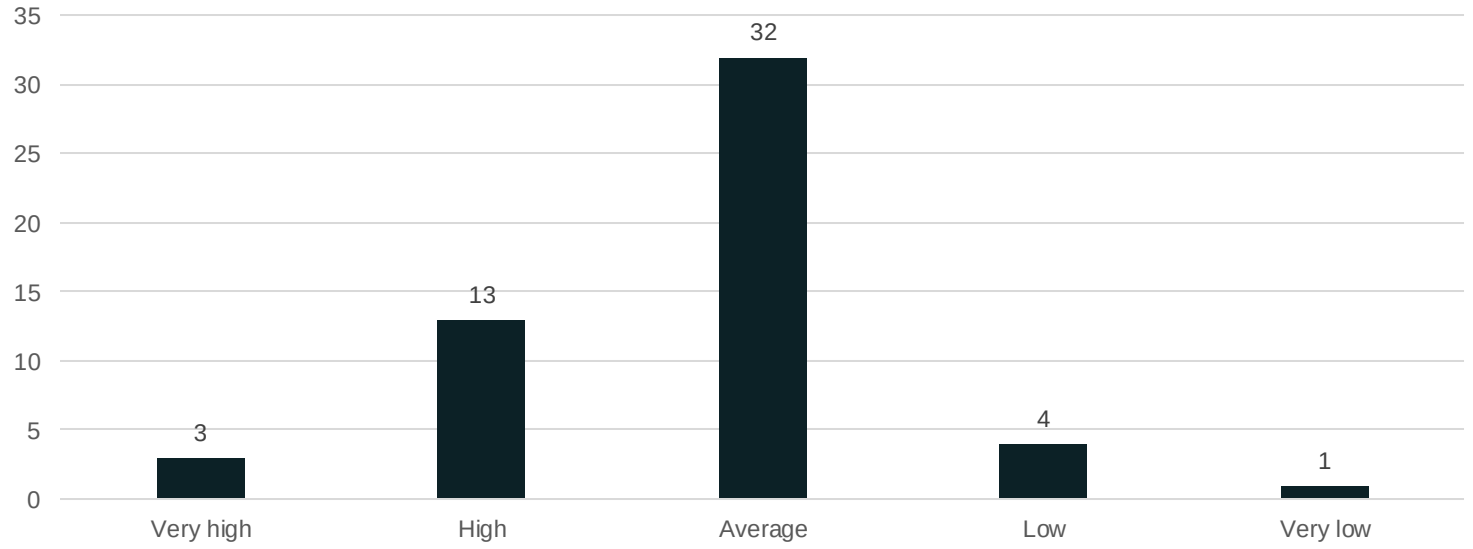
4: How important do you feel an understanding of Care Technology is for your role?



The majority of practitioners across both Bournemouth and Poole patches consider CT to be "important" or "very important".

- 59% of respondents in **Bournemouth** stated that an understanding of CT was "very important" for their role. A further 36% stated it was "important".
- 60% of respondents in **Poole** stated that an understanding of CT was "very important" for their role. A further 30% stated it was "important".
- Results across OTs/OTAs and SWs/SWAs were comparable.

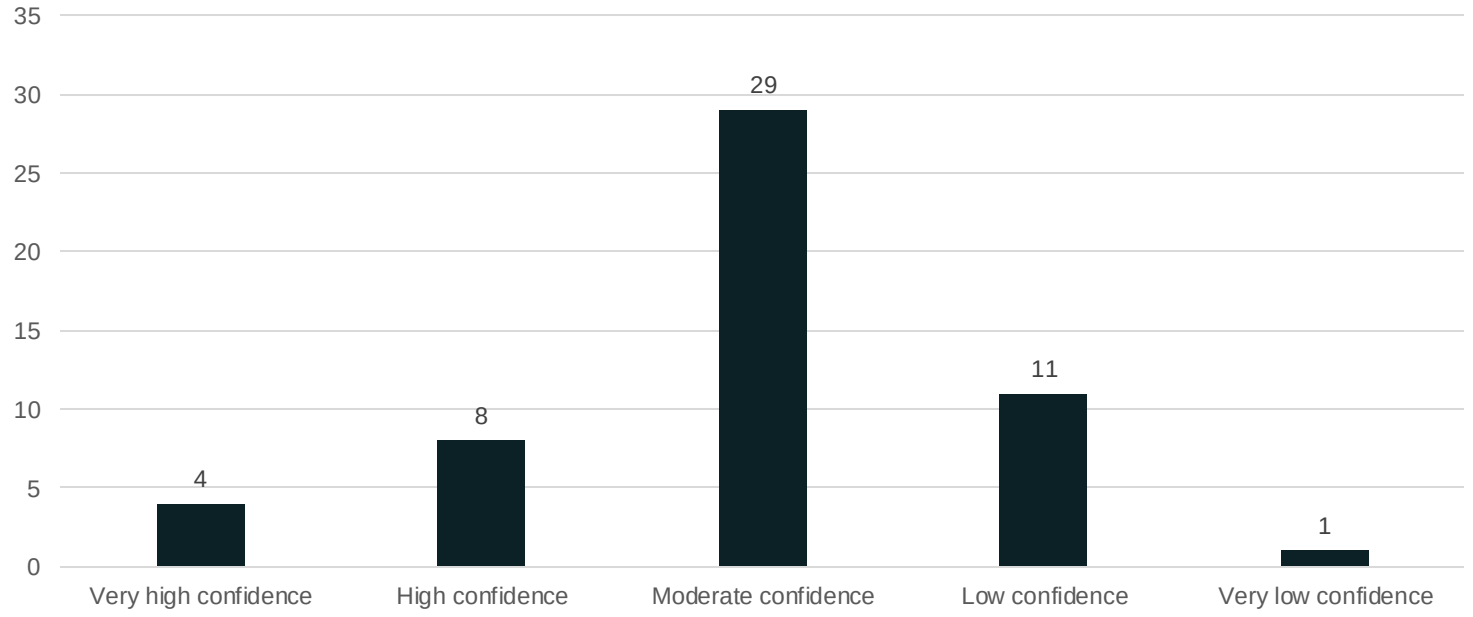
5: How would you rate your general understanding of Care Technology and how it can support improved outcomes?



The majority of respondents across both patches rated their general understanding as "average". Of the remaining respondents, practitioners in Bournemouth indicated a lower general understanding, whereas practitioners in Poole tended to rate their understanding higher.

- 59% of respondents in **Bournemouth** stated that their general understanding was "average". 14% rated their understanding as "low" or "very low".
- 50% of respondents in **Poole** stated that their general understanding was "average". All other respondents (50%) rated their understanding as "high" or "very high".
- The majority of OTs/OTAs rated their understanding as "high" (63%), while the majority of SWs/SWAs rated their understanding as "average" (74%).

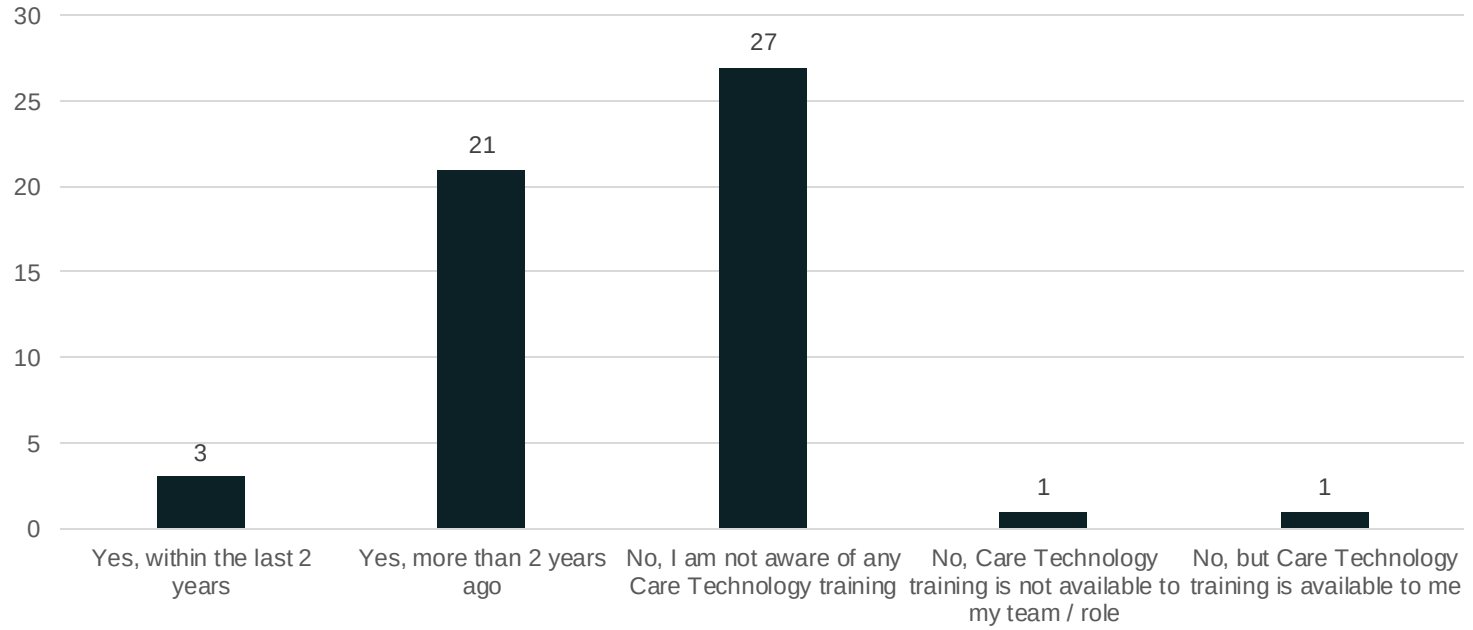
6: How confident do you feel discussing Care Technology with people?



The majority of respondents in both patches rated their confidence as "moderate".

- 64% of respondents in **Bournemouth** stated that their confidence was "moderate".
- 50% of respondents in **Poole** stated that their confidence was "moderate".
- A higher percentage of OTs/OTAs (50%) rated their confidence as "high" or "very high" compared to SWs/SWAs (16%).

7: Have you received any training regarding Care Technology?

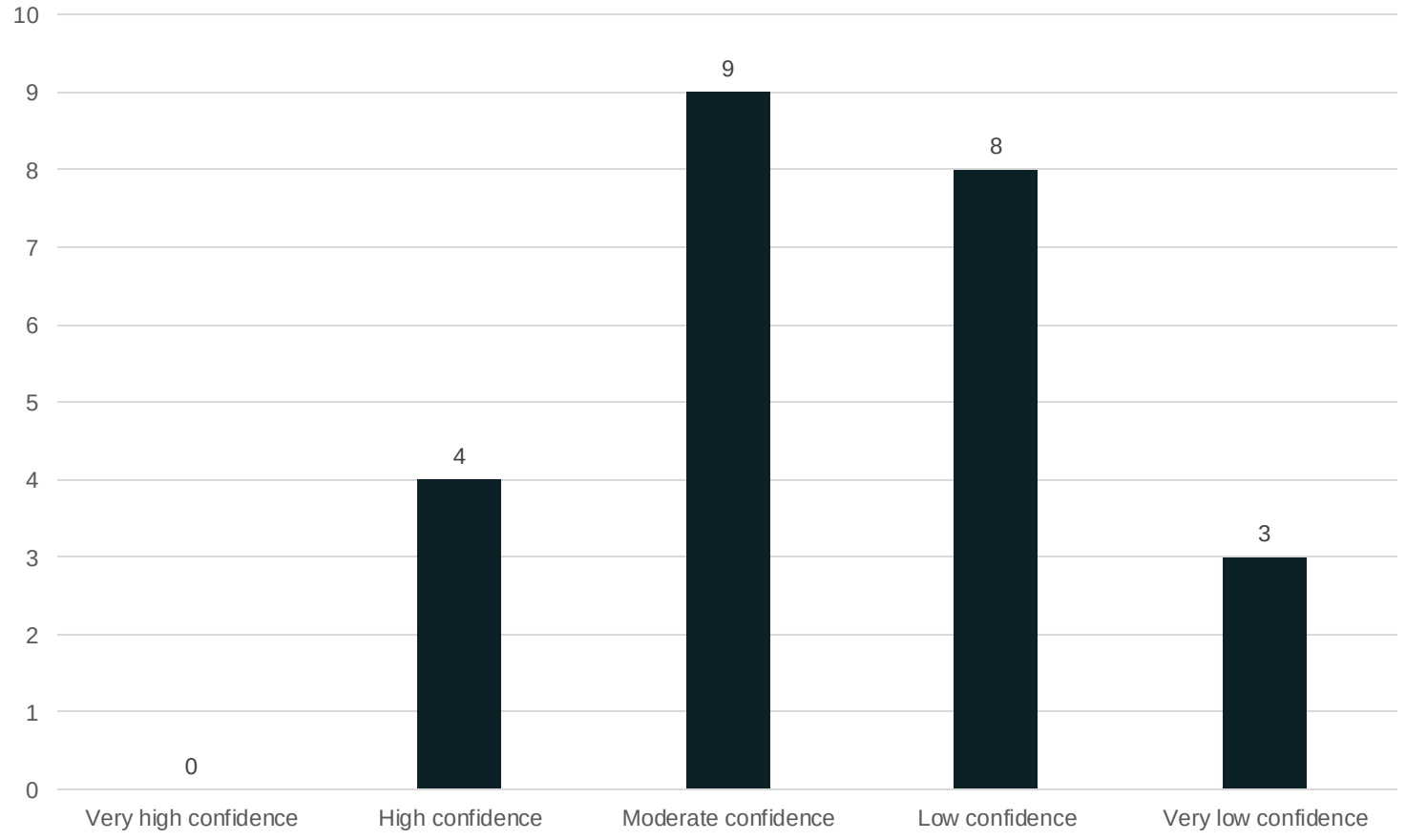


Many practitioners in both patches were not aware of training. A handful of colleagues in Poole had received training within the last two years, however, nobody in Bournemouth had received training within the last two years.

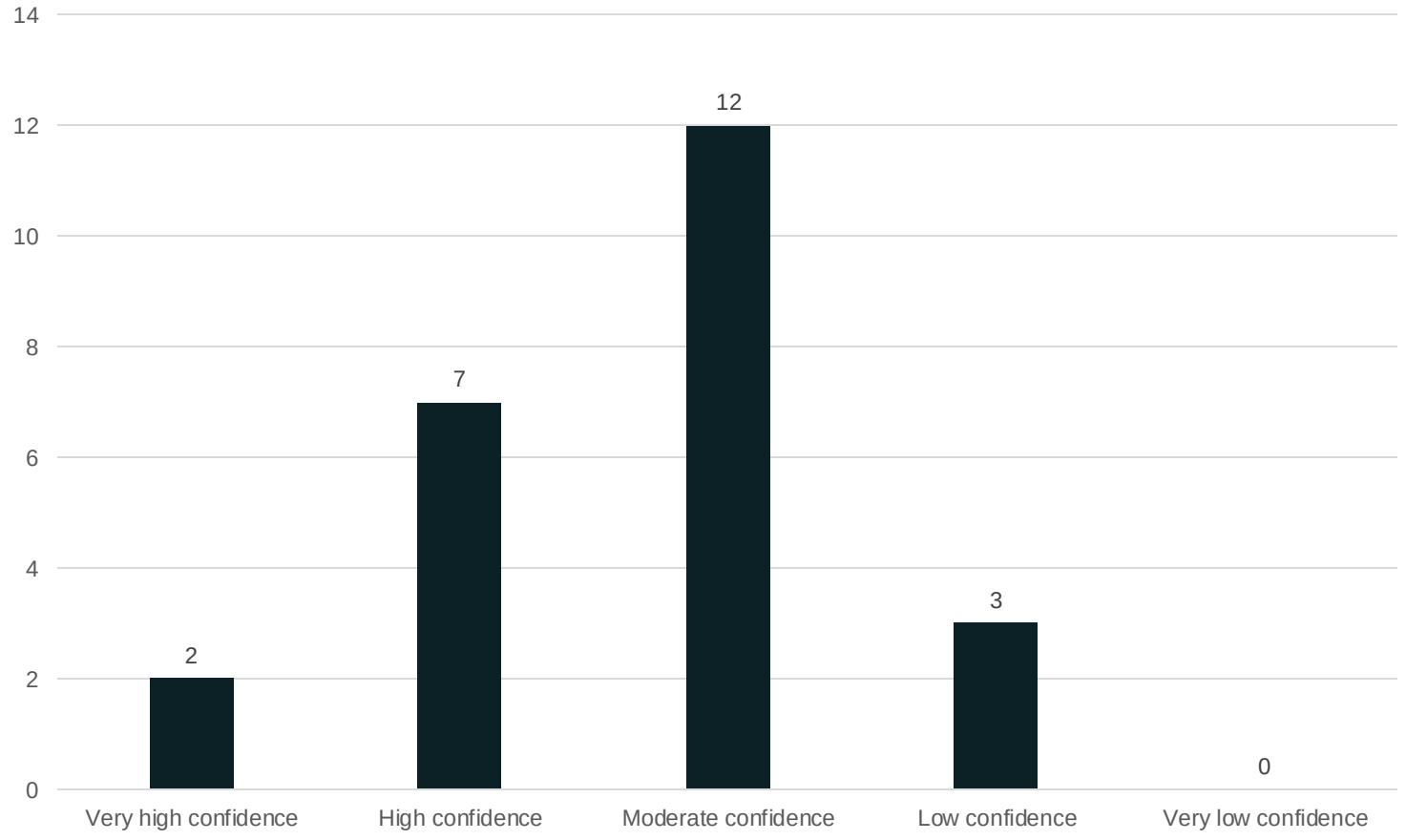
- 40% of respondents in **Bournemouth** stated that they had received training over two years ago, while 64% were not aware of training.
- 20% of respondents in **Poole** stated that they had received training within the last two years, while 40% were not aware of training.
- 38% of OTs/OTAs had not received training, compared to 63% of SWs/SWAs

8: Before you completed the Care Technology training, how confident did you feel in referring or ordering Care Technology?

96



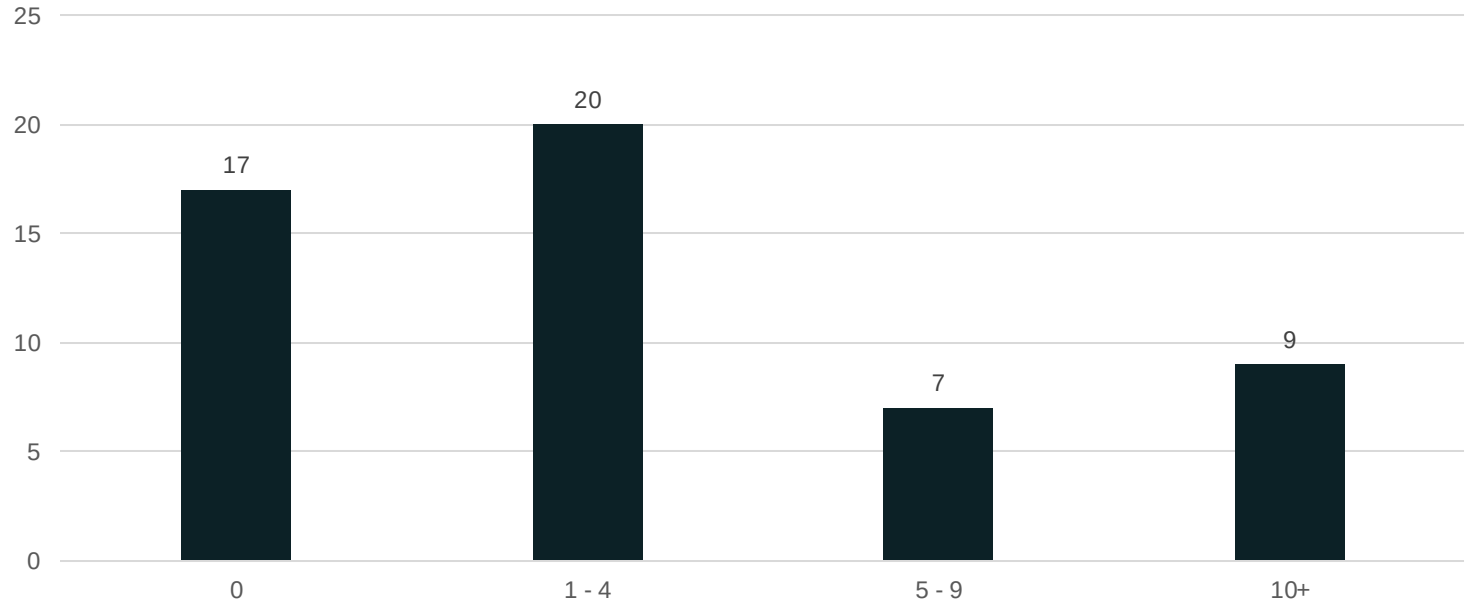
9: After you completed the Care Technology training, how confident did you feel in referring or ordering Care Technology?



97

10: How many times have you referred someone or placed an order for Care Technology in the last 12 months?

98



A much higher proportion of practitioners in Poole had referred for CT 10 or more times in the last year.

- 5% of respondents in **Bournemouth** had referred for CT 10+ times in the last year.
- 50% of respondents in **Poole** had referred for CT 10+ times in the last year.
- All OTs/OTAs had referred for CT at least once in the last year, however, 26% of SWs/SWAs had not made a referral in the last year.

11: How would you typically request Care Technology?

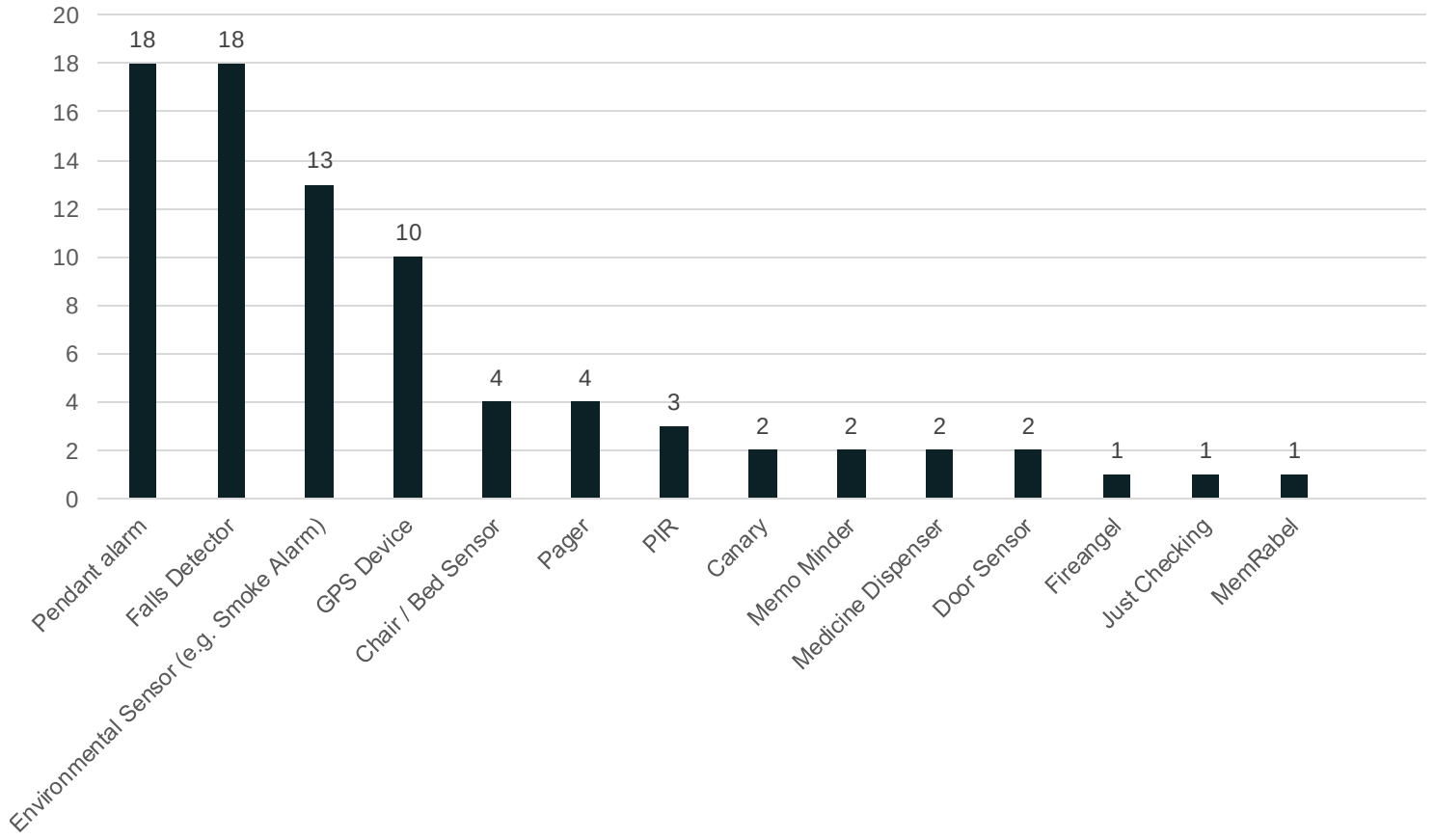
Responses indicated that:

- **Forms were completed via case management systems (either Mosaic or Care Director), however, the Mosaic form is not linked to other systems and has to be downloaded as a PDF and emailed**
- **There is evidence of colleagues signposting to private solutions rather than the in-house offer**
- **18 respondents (34%) left this question blank, suggesting that there is a gap in knowledge around referral processes**

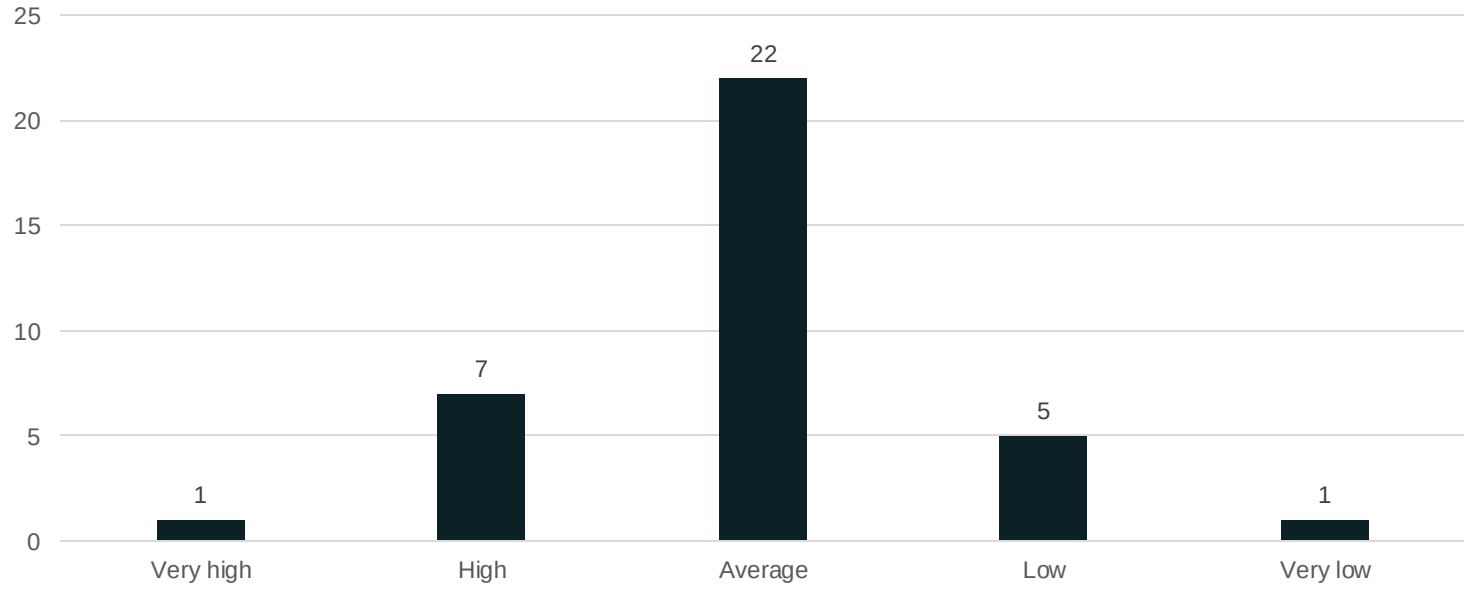
66

12: What equipment have you referred for?

100



13: How would you rate your understanding of the range of Care Technology equipment and services available in your region?

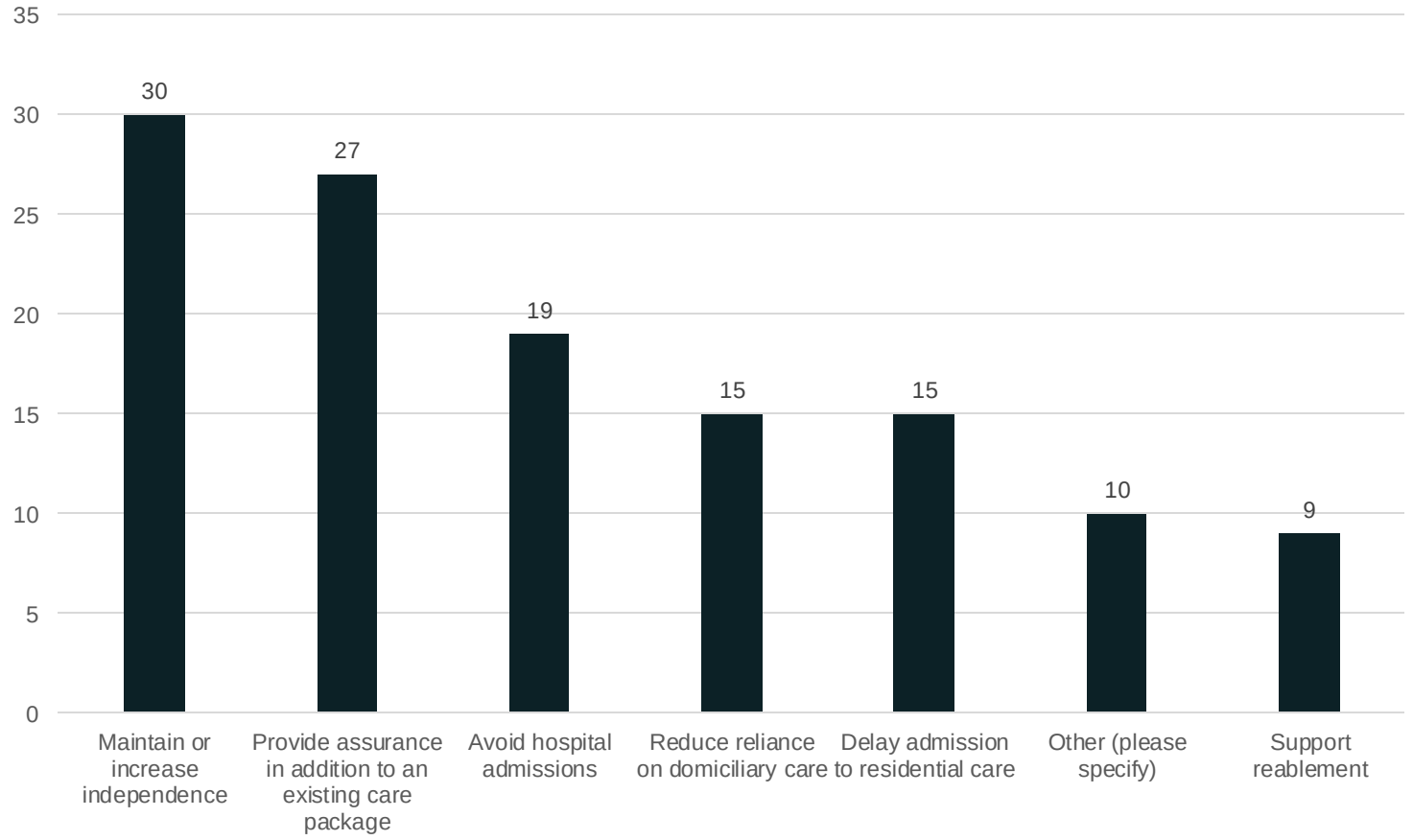


Understanding of equipment and services was "average" across both patches. No respondents in Poole stated that their understanding was "low" or "very low".

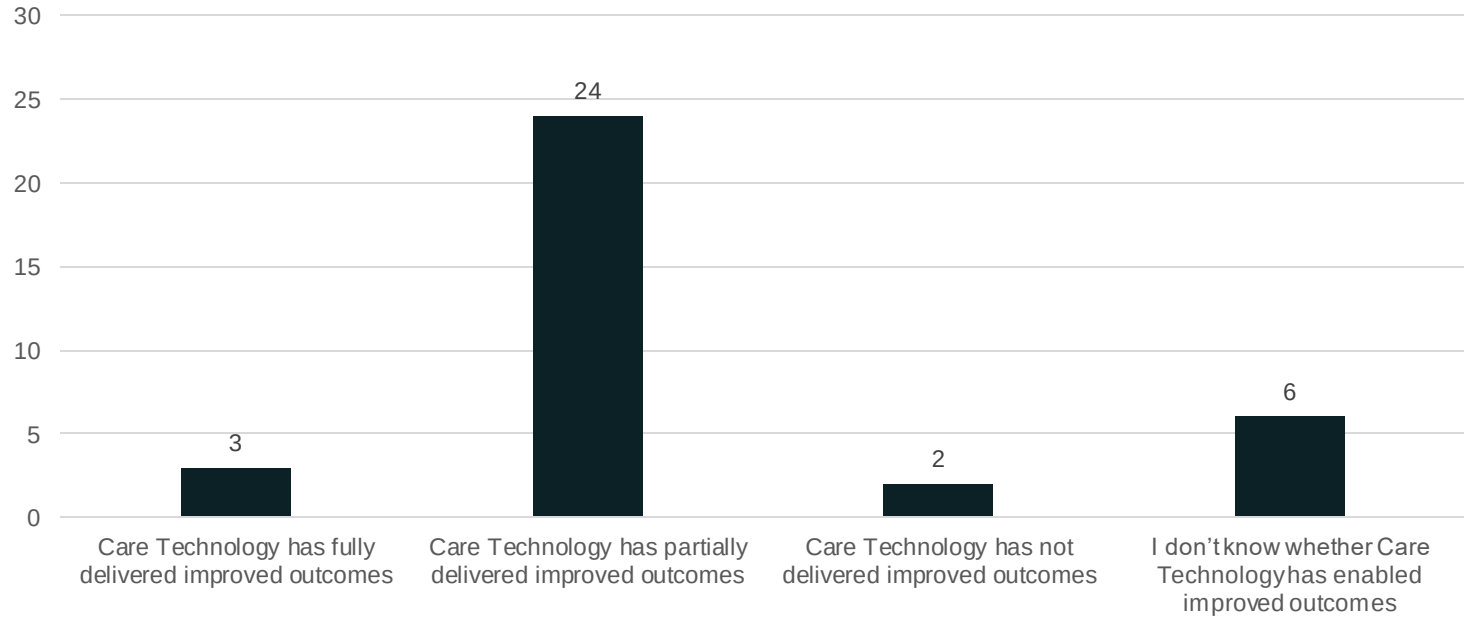
- 55% of respondents in **Bournemouth** stated that their understanding was "average".
- 40% of respondents in **Poole** judged their understanding to be "average".
- A greater proportion of OTs/OTAs (25%) stated that their understanding was "high", compared to SWs/SWAs (11%).

14. Which of the following improved outcomes have you been targeting when referring for Care Technology? (select all relevant answers)

102



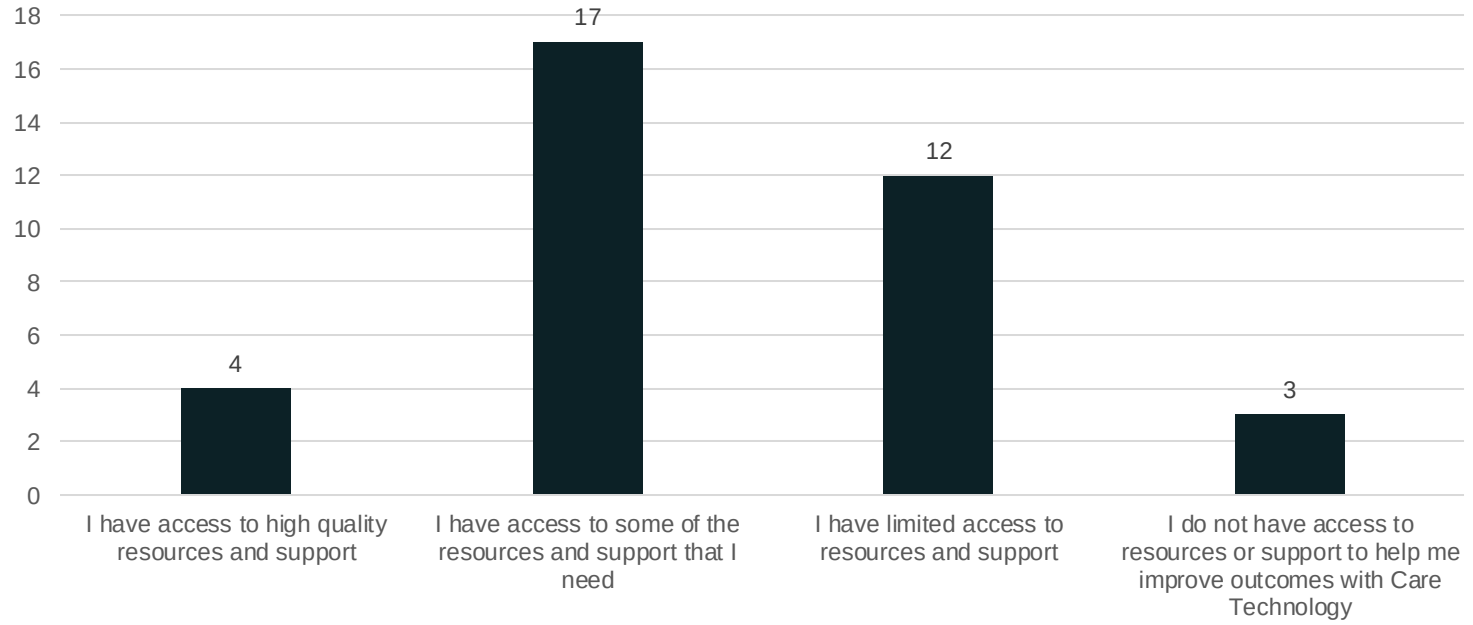
15: Has the Care Technology service been successful in enabling the improved outcomes you sought for your clients or patients?



Practitioners in both patches primarily responded that CT had "partially" delivered improved outcomes.

- 55% of respondents in **Bournemouth** stated that CT had "partially" delivered improved outcomes.
- 40% of respondents in **Poole** stated that CT had "partially" delivered improved outcomes.
- Results across OTs/OTAs and SWs/SWAs were comparable, with the majority of OTs/OTAs (75%) and the majority of SWs/SWAs (58%) stating that CT had "partially" delivered improved outcomes

16: How would you rate the support and resources available to help care practitioners maximise the use of CT in ways that improve outcomes?



The support available to practitioners in Bournemouth varied more significantly than in Poole. All practitioners in Poole indicated that they had access to "limited" or "some of" the resources and support needed.

- 18% of respondents in **Bournemouth** stated that they had access to high quality resources and support
- 14% of respondents in **Bournemouth** stated that they did not have access to resources or support
- 55% of respondents in **Bournemouth** indicated that they had access to "limited" or "some of" the resources and support
- 100% of respondents in **Poole** indicated that they had access to "limited" or "some of" the resources and support
- Results were comparable across OTs/OTAs and SWs/SWAs, with the majority of respondents stating that they had access to "limited" or "some of" the resources and support needed

17: What resources, support, or other changes would enable you to achieve better outcomes for people through Care Technology?

Responses indicated a variety of enabling factors would help practitioners, including:

- **Availability of training**
- **A designated individual to engage with teams**
- **Greater understanding of the technology available**
- **An improved equipment offer**

105

18: Do you have any other comments or suggestions relating to the existing use or future opportunity for Care Technology in your area?

Additional comments were focussed around the following key themes:

- **The need for an improved offer**
- **Improvement of staff training and awareness**
- **Ensuring CT can be introduced and referred via the contact centre**
- **Raising the profile of CT by including it in the ASC Newsletter and other communication routes**
- **Staff are keen to find out more about CT but some worried about needing to know about "lots of gadgets"**
- **It would be helpful for staff to see how CT has achieved financial benefits**

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E

CT Service Summary by Patch

Current CT service users and activity in Poole

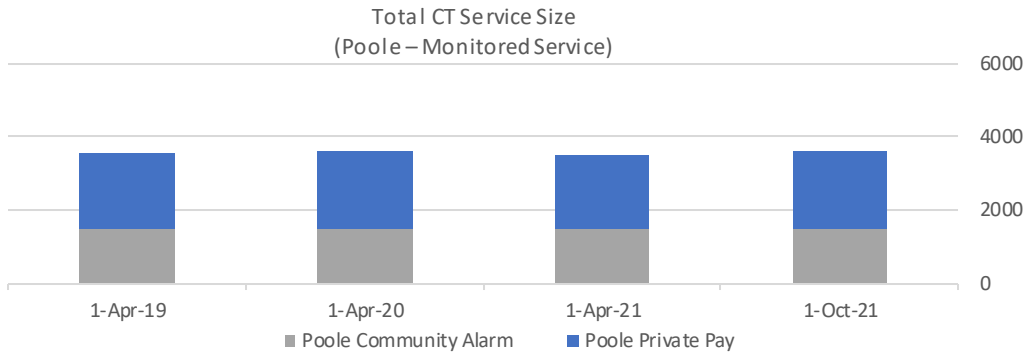
As of 1 October 2021, there were **3589** people accessing the monitored CT service in Poole. The total number of people accessing the monitored service has **remained static since 2019**.

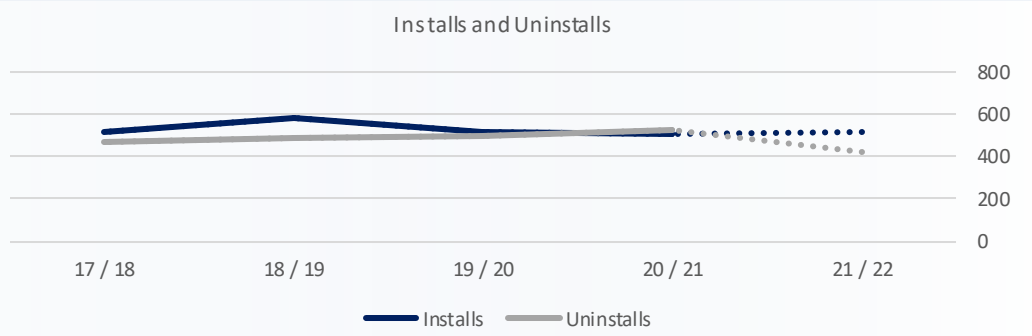
The majority of users access the service via the Private Pay Offer. As of 1 October 2021, 2137 (60%) service users accessed the Private Pay offer, while 1452 (40%) service users accessed community alarms via a housing scheme. This has remained static over the past three years.

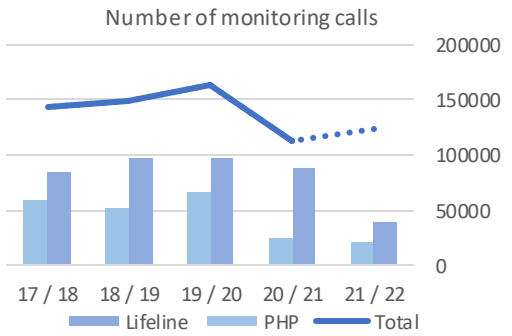
In Poole, the total number of **installs and uninstalls has remained static** over the last four years. Installation trends are set to continue, while the number of uninstalls is expected to drop slightly compared to previous years, leading to **a slight increase in service user volumes**.

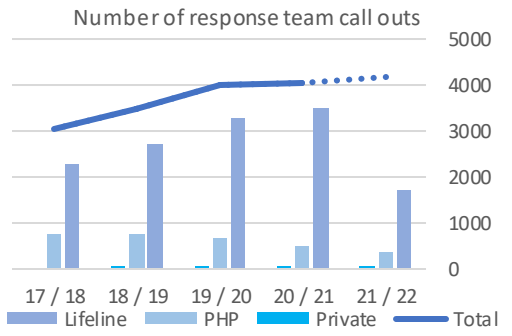
The number of **monitoring calls have declined since 2019/20**, however, there is an increase projected in the current year compared to 2020/21.

The number of response team call outs grew in 2017/18 and 2018/19, plateauing from 2019/20. There is a **slight growth projected in the current year**.









Note: *users with an unmonitored / standalone solution are not included in total CT Service size calculations as they do not receive a service from BCP beyond the installation of the CT equipment.*

Note: *data & projections are based on financial years ([Oct21]*2)*

Current CT service users and activity in Bournemouth and Christchurch

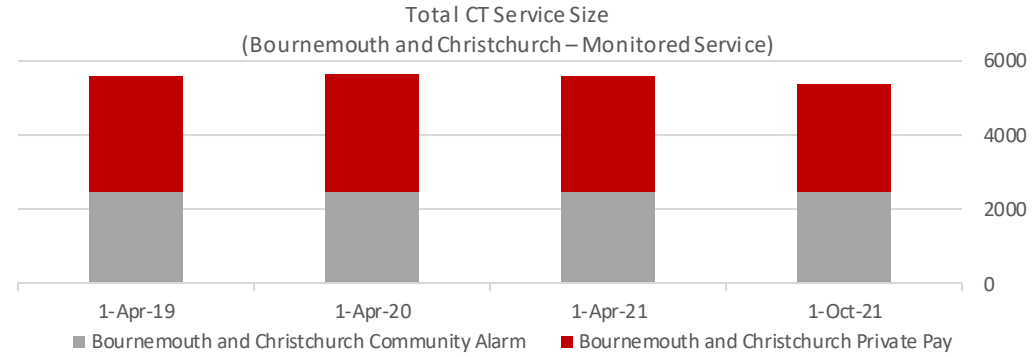
As of 1 October 2021, there were **5360** people accessing the monitored CT service in Bournemouth and Christchurch. The total number of people accessing the monitored service has **remained static since 2019**.

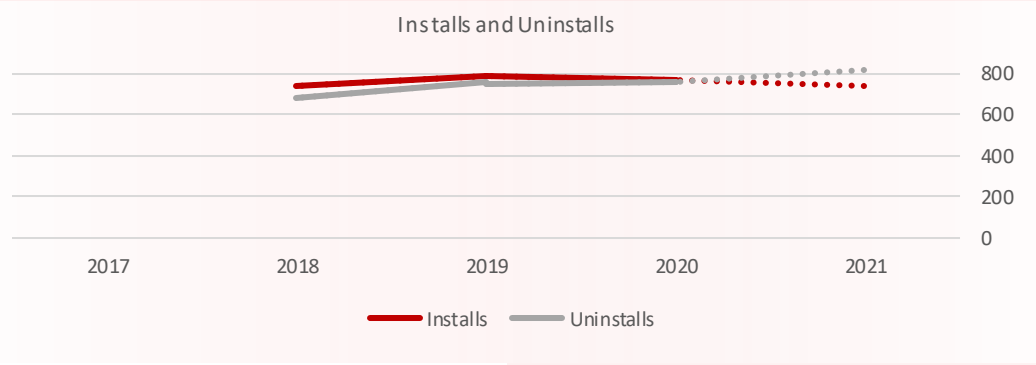
The majority of users access the service via the Private Pay Offer. As of 1 October 2021, 2860 (53%) service users accessed the Private Pay offer, while 2500 (47%) service users accessed community alarms via a housing scheme. This has remained static over the past three years.

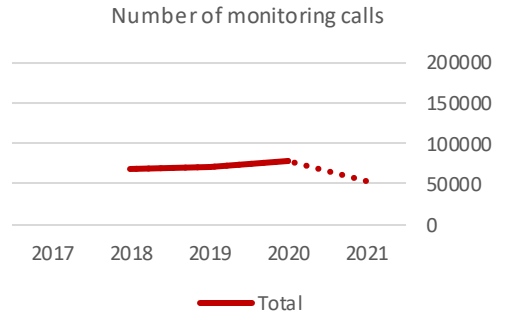
In Bournemouth and Christchurch, the total number of **installs and uninstalls has remained static** over the last three years. Installs are projected to remain static by the end of the calendar year, while the number of uninstalls is expected to rise slightly compared to previous years, leading to **a slight decrease in service user volumes**.

The number of **monitoring calls have risen between 2018 and 2020**, however, there is a decrease projected in the current year compared to 2020.

The service in Bournemouth and Christchurch does not include a response service.







The Bournemouth and Christchurch service offer does not include a response service.

Note: *users with an unmonitored / standalone solution are not included in total CT Service size calculations as they do not receive a service from BCP beyond the installation of the CT equipment.*

Note: *data & projections are based on calendar years ([Oct21]/3*4)*

Projection calculation methodologies

Projections have been calculated using a variety of methods, to accommodate variations in data returns. The methods are summarised below.

- Snapshot data, covering service user volumes for the service in Bournemouth and Poole, has been used to calculate a projection for April 2022.
- Financial year data, covering service activity for the Poole service, has been used to calculate a projection for April 2022.
- Calendar year data, covering service activity for the Bournemouth service, has been used to calculate a projection for December 2021.

Snapshot Data	Financial Year Data	Calendar Year Data
The trend between April 2021 and October 2021 was calculated. As October is halfway through the financial year, this trend was multiplied by two to reach a year-end figure. *[Oct21] – [Apr21] = N* *N * 2 = X* *[Apr21] + X = April 2022 Projection*	As October is halfway through the financial year, the total number of 'activities' (e.g. installations) as of October was multiplied by two to reach a year-end figure. *[Oct21] * 2 = X* *[Apr21] + X = April 2022 Projection*	As October is three-quarters of the way through the calendar year, the total number of 'activities' (e.g. installations) was divided by three to reach a quarterly figure. This was then multiplied by four to reach a year-end figure. *[Oct21] / 3 = X* *X * 4 = December 2021 Projection*

110

F

Example benefits dashboards

Technology Enabled Care

Overall Programme Performance - 2019-2020

Data Last Refreshed on 30/11/2019

Programme Performance

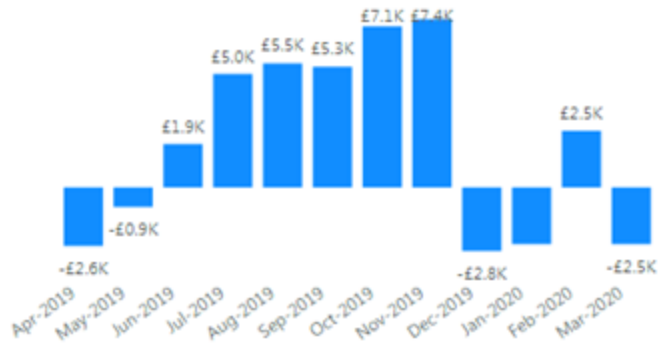
Projected Net Savings 2019-2020

£24K

# of Live Connections

158

Projected Net Savings by Month



Operational Performance

Installs Completed within SLA

84 %

Urgent Installs (2 days)

80 %

Standard Installs (10 days)

Monitoring Responses

96

YTD Calls Received

98 %

Calls Answered in 60 Seconds

112

Technology Enabled Care

Programme Performance - 2019-2020

Home

Projected Gross Savings

YTD Referrals not Achieving Forecasted Gross Savings

0 %	56 %	30 %
No Savings Achieved	Under Achieving	Over Achieving

Live Connections	YTD Referrals	YTD Referrals requiring further info	YTD Installs	YTD De
158	169	8	163	8

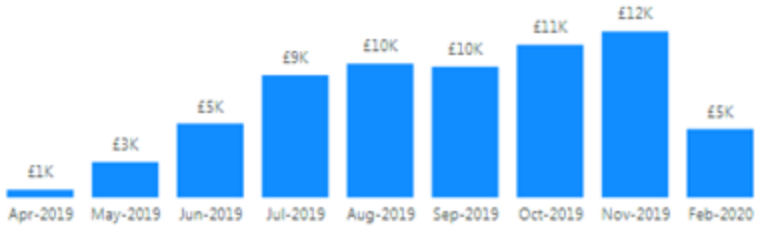
Gross Savings Analysis

(Select Age Bands,Costs Types or Months to filter the dashboard)

by Age Band

by Cost Type

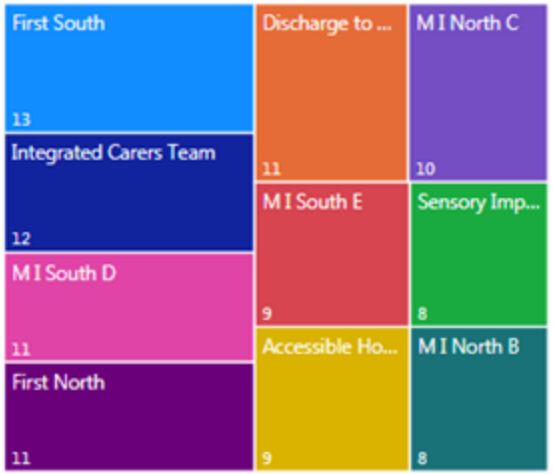
By Financial Month



YTD Installs Analysis

(Select Team, Outcome or Primary Support Reason to filter the dashboard)

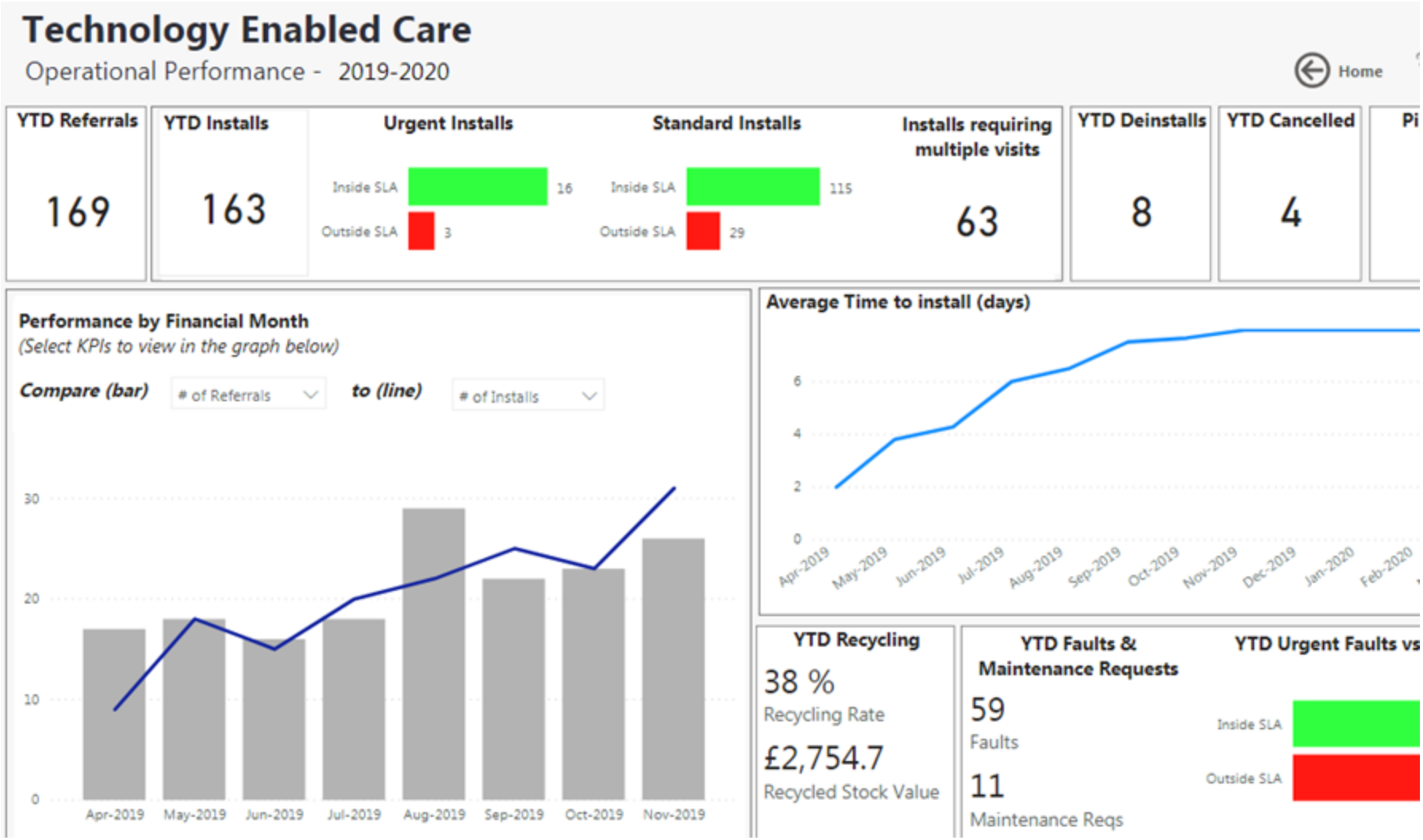
by Top 10 Teams



by Top 5 Outcomes

by Top 5 Primary Support

114


Technology Enabled Care
Operational Performance - 2019-2020
Home
YTD Referrals
169
YTD Installs
163
Urgent Installs
Inside SLA
16
Outside SLA
3
Standard Installs
Inside SLA
115
Outside SLA
29
Installs requiring multiple visits
63
YTD Deinstalls
8
YTD Cancelled
4
Performance by Financial Month
(Select KPIs to view in the graph below)
Compare (bar)
# of Referrals
to (line)
# of Installs
30
20
10
0
Apr-2019
May-2019
Jun-2019
Jul-2019
Aug-2019
Sep-2019
Oct-2019
Nov-2019
Average Time to install (days)
6
4
2
0
Apr-2019
May-2019
Jun-2019
Jul-2019
Aug-2019
Sep-2019
Oct-2019
Nov-2019
Dec-2019
Jan-2020
Feb-2020
YTD Recycling
38 %
Recycling Rate
£2,754.7
Recycled Stock Value
YTD Faults & Maintenance Requests
59
Faults
11
Maintenance Reqs
YTD Urgent Faults vs
Inside SLA
Outside SLA

G

Size of the prize assumptions

Our approach to modelling the high level 'size of the prize' draws on a variety of methods to estimate growth and potential gross benefits

The high level 'size of the prize' indicates the potential gross financial benefit that could be achieved by transforming and mainstreaming the CT offer in BCP. This estimate is based on growth and benefits assumptions informed by the service in Hampshire and PA's broader experience, however as this is a high-level estimate and not based on detailed scope, we have applied conservative estimates throughout when compared to averages across the Argenti managed services. The modelling is based on the following assumptions:

1. The CT service would include:

- Consolidation and expansion of a 'core offer' (e.g. a greater equipment offer for OA / PD)
- Expansion of the offer to meet needs of more complex users (e.g. LD)

2. The existing service size for ASC users is 1249

It is not possible to accurately define the total number of current CT users who are ASC eligible. The starting figure used in our modelling is estimated based on feedback that 25% of all referrals are made via ASC. ASC-eligible users are a subset of the Private Pay user base, therefore 25% of the total number of Private Pay users as of 1 October 2021 (4997) is 1249. This assumes that there is the same churn rate across all Private Pay cohorts and excludes ASC users referred for standalone devices.

3. The annual growth of the service is based on experience from our other services.

Data from Argenti managed services including HCC* is used to generate an average growth percentage per year. Once this applied, we have then reduced the estimated size of the service by 15%, to be conservative. When we apply a service churn figure (informed from our operational services) the ASC CT service size at the end of year 5 is 4,316 users.

4. The number of installations per year is calculated using growth assumptions and an annual service churn figure

The gross benefits figure is driven by an average benefit per installation multiplied by number of installations. To calculate the number of installs, we have applied an annual service churn figure (data from Argenti managed services including HCC) to the annual growth assumptions.

5. Gross benefit per installation – we have provided a range based on conservative average from our Argenti managed services
Data from Argenti managed services, including HCC, is used to calculate an average gross benefit per installation. We have provided a range ; figures informed by over 40,000 installations and that have been validated and signed off by the ASC finance leads for each Council that we provide services for.

6. Total gross benefit realised by end of year 5 of the transformed service

We have assumed savings from each install lasts for an average of 6 months. Based on this about 80% of the savings will be realised in the year in which the install is complete and reminder 20% in the next year.


Hampshire
County Council


PA

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BOURNEMOUTH, CHRISTCHURCH AND POOLE

CARE TECHNOLOGY OPTIONS APPRAISAL

July 2022

Hampshire County Council

PA

BCP Council

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Executive Summary

Bournemouth, Christchurch and Poole (BCP) Council have, in the ASC Strategy 2021 – 2025, set out to improve the quality of life, health and wellbeing of residents in the Council area. The overarching priorities of the ASC Strategy are:

- Engage with individuals and communities to promote well-being
- Support people to live safe and independent lives
- Value and support carers
- Enable people to live well through quality social care
- Deliver services that are modern and accessible

Like all Councils, BCP is facing increasing service demand. Currently, residents aged 75 and over account for 75% of requests made to ASC services each year. The pressures are clear given that the current population of 395,600 is expected to rise to 420,900 by 2028. With this growing population size, the number of residents aged 65 and over is expected to grow by more than 30% between 2021 and 2040; from 86,900 to 115,000. This leaves Commissioners across the health and social care landscape in BCP are facing the combined challenges of increasing populations, people with more complex needs and reducing budgets. The current CT service, whilst successful in delivering a well-regarded basic service for citizens, has not yet realised its full potential.

BCP recognises that the CT offer is limited and that there is untapped potential to achieve outcomes for residents and the wider ASC system. The creation of the unitary council in 2019 has, however, introduced operational challenges in relation to Care Technology (CT) services; there are two legacy systems and processes, from Poole and Bournemouth, which are both in play. The reorganisation has, however, also presented an opportunity to define ambitious strategies and shape future ways of working. There is a clear ambition within BCP to use technology to enhance services and quality of life for residents, along with a recognition that technology has a part to play in all forms of care.

The Corporate Strategy Delivery Plan, under the Fulfilled Lives priority, specifically references extending the use of assistive and digital technology to enable independence and enhance people's quality of life, which is echoed in BCP's ASC Strategy. Furthermore, the Market Position Statement for Adults outlines an ambition to strengthen the offer of assistive technology across Bournemouth, Christchurch and Poole, and ensure it is included from the time people first engage with adult social care at the front door.

This options appraisal builds on the outcome of the CT Diagnostic and recommends a strategy and preferred option for future delivery of the CT service in BCP, in order to meet the Council's vision. The vision is the overall ambition for the CT service. This is supported by design principles, which are required to deliver the vision. 'Critical success factors' describe 'what good looks like', against which each option in this options appraisal is appraised.

Figure 1: Vision for the future CT service

The Council's ambition is to **transform the CT offer so that:**

Our Care Technology service is flexible, sustainable and trusted by all. It is embraced at the first opportunity to enable independence and enhance the quality of life for people across BCP. Care Technology is a cornerstone of our digitally enabled care approach that is embedded in practice and easy to access.

Figure 2: Design principles for the future CT service

Design Principles – these are the overall principles required to deliver the vision and should underpin the design of the future service so that CT will:

- Be equitable and accessible across BCP, including via self-service
- Be a personalised service that supports strengths-based approaches
- Support improved outcomes and reduce reliance on support for both care receivers and care givers
- Be a sustainable and scalable offer that delivers financial benefits for the Council
- Develop and deploy skills and capabilities in the most effective way
- Be accessible to a broad workforce, including external partners

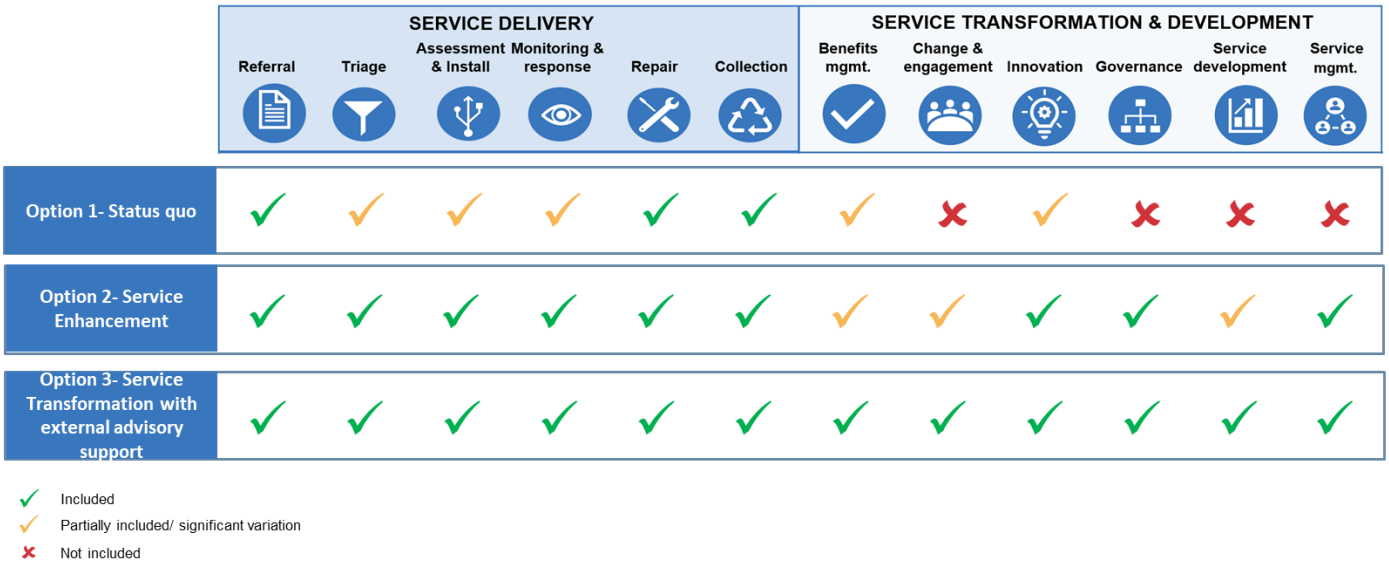
Figure 3: Critical success factors for the future CT service

	Theme	CT Project Critical Success Factors
1	Improved outcomes and experience	• People are equipped and confident to use CT enabling them to feel safe and supported to live independently in their own home for as long as possible • Discharge from hospital is supported appropriately with CT • People and Carers are supported to access CT easily, including via self-service options, with access to information to make informed choices about care packages and use of CT
2	Improved efficiency	• CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support • There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes • Practitioner understanding of the offer and process is enhanced, driving increased uptake
3	Service capacity and capability	• CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support • There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes • Practitioner understanding of the offer and process is enhanced, driving increased uptake
4	Value for money and financial sustainability	• CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support • There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes • Practitioner understanding of the offer and process is enhanced, driving increased uptake
5	Deliverability	• CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support • There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes • Practitioner understanding of the offer and process is enhanced, driving increased uptake

Future options for the service

There are three options for appraisal, Option 1 - Status quo (the do-nothing baseline) represents the current position, Option 2 – Service Enhancement builds on the current service developing the CT service specification, whilst Option 3 – Service Transformation provides additional transformation benefits. These are set out at a high level in the figure below.

Figure 4: High level overview of options appraisal options



Option 1 - *Status quo* represents the current position. The status quo CT service assumes there will no change to the current offer, with the exception of those already underway. This means the status quo would continue to primarily offer services to older people and CT is offered to ASC eligible users in addition to a care package in most cases.

Option 2 – Service *Enhancement* builds on the current service with an enhanced specification. The service would expand to reach a larger number of users and consists of all of Option 1 plus more support for younger adults with LD needs, for example in Supported Living.

Option 3 - *Transform* builds on the cohorts in Option 1 and Option 2 by including a specific technology offer to OA (which could include pathways such as dementia) and younger adults (<65s) across all service areas. The transformed service will reach a greater number of people receiving CT, through a sustained programme of culture change, enabling teams across the Council to signpost to CT services, including a self-service option. It is assumed that transformation is driven by externally commissioned support, however this could be delivered internally if BCP determine that the capacity and capability exist.

Approach to appraisal

The qualitative appraisal has been completed by assessing the extent to which each option meets the agreed Critical Success Factors (CSFs) agreed by the Project Board. Board members completed a survey to score each of the options against each CSF out of 5, with the average of these responses providing the score. Adding the score for each of the 15 CSFs provides an overall qualitative score out of 75 for each option.

Analysis of financial benefits has been completed for several cohorts. These cohorts were scoped, defined and agreed in consultation with the BCP CT Project Board. The cohorts appraised financially are as follows, although this varies by option:

- Homecare Older Adult (OA) citizens (existing and new)
- Residential / nursing citizens (new)

- Supported Living Learning Disabilities (LD) citizens (existing and new)
- Citizens with CT (existing)
- Homecare LD citizens (existing and new)

Summary of qualitative and quantitative analysis

Option 1 - Status quo

The service would continue to reach the same core user base, predominantly focused on OA. Without additional investment, the service would also not have the skills and capacity to access new user groups and new forms of technology on a consistent and formal basis. As there is no major change taking place under this option, there are limited delivery risks.

The qualitative scoring exercise undertaken by CT Project Board members generated a qualitative score of 28/75. The detailed rationale for scoring given is provided in 6.2.1.

The projected cost of the existing CT service for ASC eligible users over the next 5 years is £1.9m.

Option 2 - Enhance

Option 2 – The Service Enhancement option meets the CSFs to a greater extent than Option 1 - Status quo, increasing user volumes and developing a clearer referral pathway. This option presents a greater risk to BCP than Option 1 as there is a requirement for change. Delivery risks could include the failure to meet time, cost and quality requirements. The breadth of the service will be relatively limited and is unlikely to grow significantly over the longer term without additional investment.

The qualitative scoring exercise undertaken by CT Project Board members generated a qualitative score of 47/75. The detailed rationale for scoring given is provided in 6.2.2.

Across five years this option results in a total incremental gross benefit of £4.54m and a total incremental cost of -£1.6m. Therefore, this results in an incremental net benefit of £2.95m.

Figure 5: CT service growth across 5 years

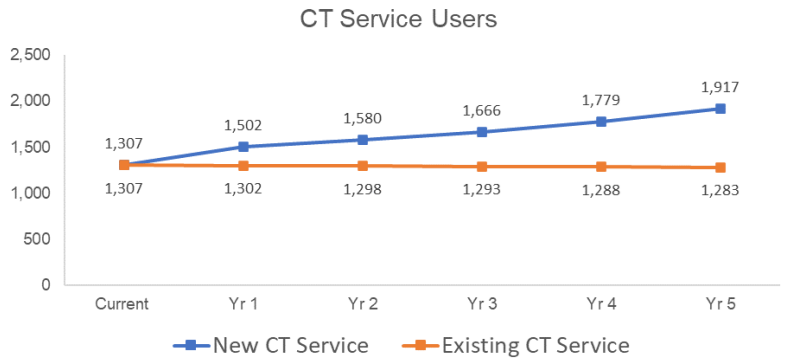


Table 1: Option 2 quantitative appraisal

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total 5-Year
Gross benefits from existing ASC citizens (OA & LD homecare, LD Supported Living and existing CT citizens)	£0.15MM	£0.22MM	£0.17MM	£0.15MM	£0.13MM	£0.82MM
Gross benefits from new ASC citizens	£0.35MM	£0.59MM	£0.76MM	£0.94MM	£1.09MM	£3.72MM
Total Incremental Gross Benefit	**£0.50MM**	**£0.81MM**	**£0.93MM**	**£1.08MM**	**£1.22MM**	**£4.54MM**
On-going incremental CT service cost[1]	-£0.21MM	-£0.20MM	-£0.24MM	-£0.30MM	-£0.36MM	-£1.30MM
One-off transformation cost[2]	-£0.20MM	-£0.10MM				-£0.30MM
Total Incremental Costs	**-£0.41MM**	**-£0.30MM**	**-£0.24MM**	**-£0.30MM**	**-£0.36MM**	**-£1.60MM**
Incremental Net Benefit	**£0.09MM**	**£0.51MM**	**£0.69MM**	**£0.79MM**	**£0.86MM**	**£2.95MM**

Option 3 - Transform

Option 3 – Service Transformation meets the CSFs to a much greater extent than Option 2 – Service Enhancement. This approach increases volumes by reaching a broader range of users including those with complex needs. The change will be more likely to generate and sustain momentum as there will be a managed change and engagement programme. However, change of this scale carries higher delivery

risks and the project will need to be carefully managed in order to meet time, cost and quality requirements. To provide the capacity and capability to deliver transformation of this scale and to mitigate against the aforementioned risks, ongoing external advisory support has been assumed for this option[1].

The qualitative scoring exercise undertaken by CT Project Board members generated a qualitative score of 66/75. The detailed rationale for scoring given is provided in 6.2.3.

Across five years this option results in total gross benefit of £7.44m and a total incremental cost of -£2.44m. Therefore, this results in an incremental net benefit of £5m.

Figure 6: CT service growth across 5 years

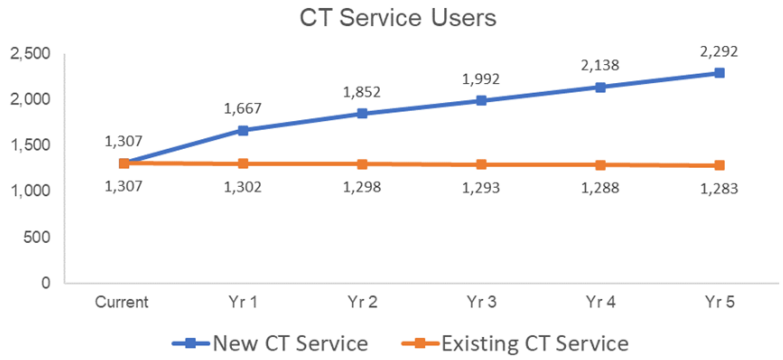


Table 2: Option 3 quantitative appraisal

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total 5-Year
Gross benefits from existing ASC citizens (OA & LD homecare, LD Supported Living and existing CT citizens)	£0.35MM	£0.47MM	£0.35MM	£0.30MM	£0.27MM	£1.74MM
Gross benefits from new ASC citizens	£0.62MM	£0.97MM	£1.16MM	£1.39MM	£1.57MM	£5.70MM
Total Incremental Gross Benefit	**£0.97MM**	**£1.44MM**	**£1.51MM**	**£1.69MM**	**£1.84MM**	**£7.44MM**
On-going incremental CT service cost[1]	-£0.33MM	-£0.32MM	-£0.37MM	-£0.43MM	-£0.49MM	-£1.94MM
One-off transformation cost[2]	-£0.35MM	-£0.15MM				-£0.50MM
Total Incremental Costs	**-£0.68MM**	**-£0.47MM**	**-£0.37MM**	**-£0.43MM**	**-£0.49MM**	**-£2.44MM**
Incremental Net Benefit	**£0.29MM**	**£0.97MM**	**£1.14MM**	**£1.26MM**	**£1.35MM**	**£5.00MM**

In assessing both the qualitative and quantitative factors for the three options, the CT Project Board has concluded the following:

1.1.1 Option 1 – Status quo

Maintaining Option 1 - Status quo will see the volume of citizens accessing the CT remain static in line with current trends. The type of referrals will continue to focus on basic support for older people with moderate needs, thus losing the opportunity to support a greater number of people to live independently. It does not represent a tangible change versus the current situation and therefore does not meet many of the CSFs. However, as there is no significant change the delivery risks are low.

1.1.2 Option 2 – Service Enhancement

Option 2 – Service Enhancement improves the current service by growing users and expanding support to more younger adults (<65) with LD needs and increasing the number of older adult users. There is a moderate growth in the CT service and moderate benefits. The anticipated growth in the service is such that by the end of the 5th year there is anticipated to be 1,917 citizens accessing the service compared to 1,283 expected under Option 1.

This option therefore partially meets the critical success factors with moderate risk and reward.

[1] The external party would work closely with BCP colleagues to deliver the transformation. However, this could be delivered internally should BCP identify sufficient resource and be confident in the available capability.

1.1.3 Option 3 – Service Transformation

Option 3 – Service Transformation builds significantly upon Option 2; it mainstreams CT effectively across social care encouraging practitioners to consider it as part of the 'first offer' for a wider range of citizen needs. It therefore requires sustained focus, resource and effort on cultural and behaviour change of practitioners. It transforms the CT service by supporting a larger number of younger adults (transitions/LD/Mental Health/PD etc) and expands the offer for older people with complex needs, including via the introduction of a self-service access route, leading to a higher growth in the CT service and higher benefits.

This option fully meets the CSFs and delivers significant reward, but with correspondingly higher level of risk and transformation costs, although it is anticipated these will be offset to deliver a significant overall net benefit. The scale of transformation required under Option 3 is assumed to require external transformation and ongoing advisory support, but this may not be required should BCP determine the required capability exists internally and capacity can be created accordingly.

1.1.4 The preferred option

The preferred option, as agreed and recommended by the CT Project Board on 20 July 2022 is Option 3 – Service Transformation. Option 3 aligns with the BCP's ambition to significantly improve the CT service and integrate it into part of the 'first offer' of support, including via self-service access routes. It has the biggest potential to improve user outcomes and is also forecast to achieve the largest net financial benefit to the system, although it is the highest risk option.

Costs of delivery and how the service will be funded

The 5-year total funding requirements are of £4.38m. This is an additional funding requirement of £2.44m compared to the Status quo – Option 1 (existing CT service costs), representing the one-off transformation costs and ongoing incremental costs. It is anticipated that the service will be funded through existing budgets in line with funding for the current service, and costs are expected to be offset by gross benefits of £7.44m. This investment therefore results in a net benefit of £3.06m over 5 years.

Figure 7: Total 5-year funding requirement

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total 5-Year
Option 1 estimate of current costs	-£0.39MM	-£0.39MM	-£0.39MM	-£0.39MM	-£0.38MM	-£1.94MM
On-going incremental Option 3 CT service cost	-£0.33MM	-£0.32MM	-£0.37MM	-£0.43MM	-£0.49MM	-£1.94MM
One-off Option 3 transformation cost	-£0.35MM	-£0.15MM	-	-	-	-£0.50MM
Total Option 3 Costs	**-£1.07MM**	**-£0.86MM**	**-£0.76MM**	**-£0.81MM**	**-£0.87MM**	**-£4.38MM**
Funded through:						
Gross benefits from existing ASC citizens (OA & LD homecare, LD Supported Living and existing CT citizens)	£0.35MM	£0.47MM	£0.35MM	£0.30MM	£0.27MM	£1.74MM
Total ASC funding and benefits for existing ASC citizens	**£0.35MM**	**£0.47MM**	**£0.35MM**	**£0.30MM**	**£0.27MM**	**£1.74MM**
Net funding requirement - assuming benefits from existing ASC citizens only	**-£0.73MM**	**-£0.39MM**	**-£0.41MM**	**-£0.51MM**	**-£0.61MM**	**-£2.64MM**
Gross benefits from new ASC citizens	*£0.62MM*	*£0.97MM*	*£1.16MM*	*£1.39MM*	*£1.57MM*	£5.70MM
Net funding requirement - assuming benefits from existing and new ASC citizens	***-£0.11MM***	***£0.58MM***	***£0.76MM***	***£0.87MM***	***£0.96MM***	**£3.06MM**

Delivering the change

It is expected to take 7 months to fully mobilise and implement Option 3 – Service Transformation once the service delivery model and any commercial implications are confirmed (if required); 1 month to plan implementation and mobilise the project team, 5 months to deliver implementation activity prior to go-live and 1-month post go-live activity. Implementation will involve work to refine governance structures, redesign priority pathways and processes, develop a robust benefits realisation framework and tracking approach, increase learning and development across a wide range of stakeholders and communicate and engage with residents, BCP staff, providers, and partners.

Achieving and sustaining successful change of this nature relies on a campaign to win hearts and minds. It will not be a one-off exercise but will need to be part of an ongoing approach, which will need to be adopted by staff, citizens, carers, providers, partners, and senior leadership.

2 Introduction and purpose

This section will describe the introduction, background and purpose of this options appraisal.

2.1 Background

A CT (care technology) diagnostic was commissioned in October 2021 by Bournemouth, Christchurch and Poole Council (BCP) to better understand existing provision and the future potential for CT across the council. This report found, much like other CT services around the country, that the service in BCP predominantly served Older Adults (OA) and CT was in most cases used in addition to, rather than instead of, other costlier support provided as part of a package of care, such as domiciliary and residential care.

The diagnostic identified a clear opportunity to enhance the offer available to Older Adults (OA) and broaden the offer to include younger adults with Learning Disabilities (LD) and people with mental health (MH) needs. This promotes independence and wellbeing, reduces reliance on other costlier services and hence provides a financial benefit to commissioners.

This diagnostic review of the current service found a clear case for investing in the CT service and to support the realisation of this opportunity, this options appraisal has been developed.

2.2 Purpose of this options appraisal

The options appraisal builds on the outcome of the CT diagnostic and recommends a strategy and preferred option for future delivery of the CT service in BCP. This options appraisal:

- Sets out the vision, design principles and critical success factors (CSFs) for the CT service in BCP;
- Defines the different possible alternative service models (the options) for CT in the future;
- Undertakes cost, benefit and risk analysis to enable a decision as to which option presents best public value for money (including outcomes for citizens);
- Outlines the commercial, financial and management / project implications of the preferred option;
- Defines the next steps, following agreement and confirmation of a preferred option, that will lead to the development of redesigned CT Pathways, a detailed implementation plan and a comprehensive workforce change programme.

2.3 Scope – what do we mean by Care Technology (CT)?

CT covers a broad spectrum of technology and equipment, including telecare, telehealth, telemedicine, telecoaching and self-care services, and sometimes referred to as Assistive Technology (AT) or Technology Enabled Care (TEC). All these services share the aim of putting people in control of their own health and wellbeing. It should be noted that the current BCP service does not deliver CT in its fullest definition as per the figure below. The current service mostly consists of basic telecare pendants and a limited range of peripherals to meet moderate needs and activity monitoring through the use of Just Checking.

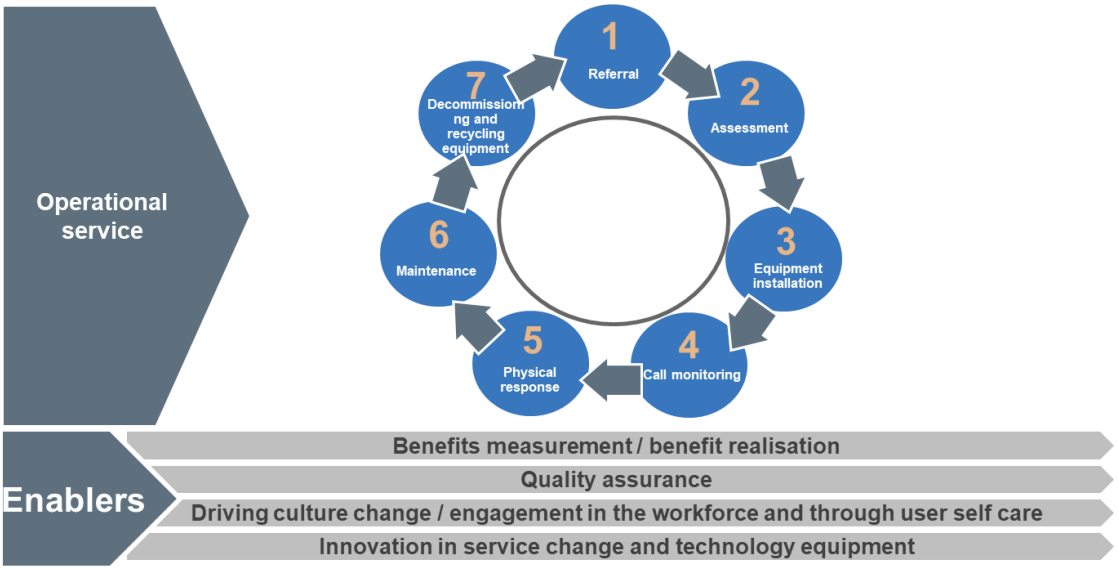
The figure below shows the scope of CT in this options appraisal, which analyses the potential for CT in the next 5 years in BCP. It should be noted that the longer-term vision for CT is broader than this, and over time may include incorporating telehealth, robotics, artificial intelligence, and other innovations.

Figure 8: Definition of CT for the scope of this options appraisal

CT – included in this options appraisal	Telecare	Typically, telecare services are provided through local authorities, housing associations, industry services and voluntary organisations. They include personal alarms, a wide range of 'passive' home sensors (e.g. fire and flood detectors) and activity monitoring. Alerts are monitored by control centres, which can be located anywhere, that can respond quickly to emergencies.
	Mobile care / health apps	Fitness and health/care apps (including mental health) are available for use on smartphones and tablets and are often referred to as mobile health or mHealth.
	Consumer devices	Consumer devices are Internet-capable personal devices (marketed at individuals) they can enable smart/remote environment control such as thermostat, lights and security. As well as smart speakers/voice activated assistants (e.g. Alexa), providing alerts/reminders, information and improving lifestyle (playing music/audiobooks etc.). Consumer devices also include standalone or smart-phone connected well-being trackers.
Not included in this options appraisal	Telehealth	Telehealth and telemedicine involve text, phone or video connections between patients and clinicians as well as active remote monitoring by clinicians of long term conditions (e.g. diabetes) using medical devices in the home (e.g. blood pressure and glucose monitors).
	Digital health	eHealth, Health IT and digital health are broader terms that can also include web-based home health support systems as well as electronic health and care records used by practitioners. Increasingly, they cover predictive data analytics, machine learning, care robotics, virtual reality, voice operable systems and artificial intelligence

The typical service model for a CT service involves an initial referral, assessment of the need and installing / providing training for the equipment or app, maintaining and reviewing, and then collecting or closing the service once it is no longer needed. This is shown in the diagram below, which shows the future potential CT model for BCP. Increasingly, councils are realising the benefits that CT services can deliver to people, carers and the local health and social care economy when used as an enabler to transform the way in which social care outcomes are achieved. If benefits can be robustly and effectively tracked, then data and information can be used to inform decision-making and evidence savings. In other councils, a focus on cultural change and engagement has also driven significantly increased take-up and supported people to integrate more digital technology into their lives. Service development integrates the CT services into wider social care and health services to ensure best outcomes.

Figure 9: Typical end-to-end CT service model[2]

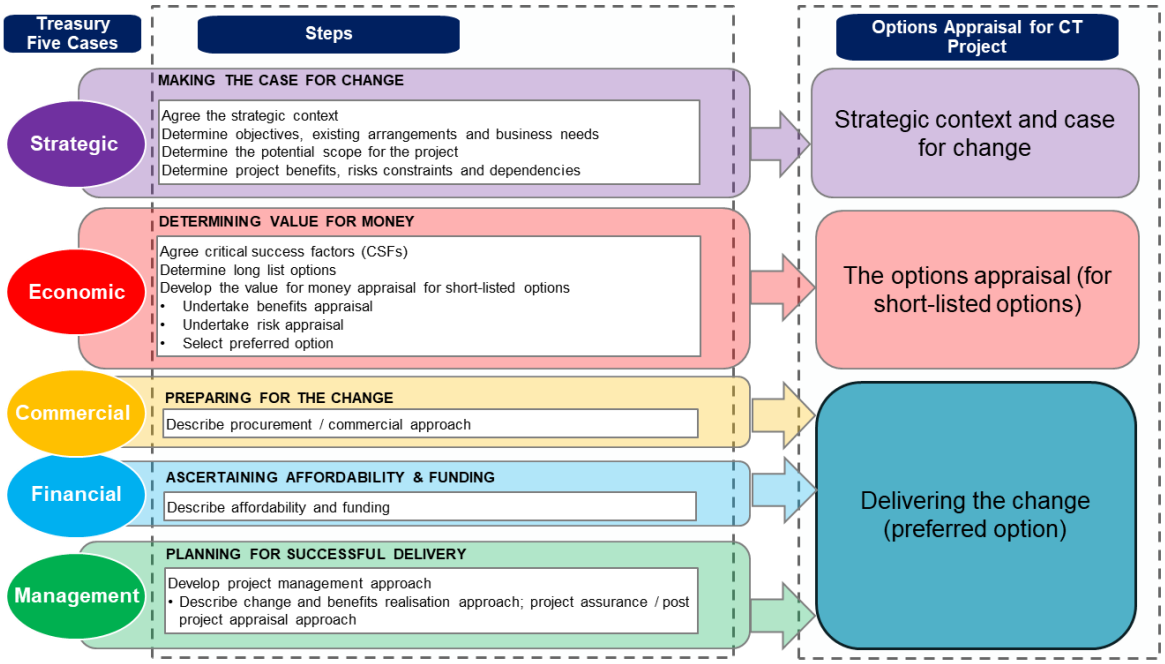


[2] It should be noted that an end-to-end CT model has an iterative end-to-end process, hence the numbered steps are not linear in the process.

2.4 Options appraisal approach

The Options Appraisal utilises an adapted version of the Five Case Model developed by Her Majesty's Treasury and is the Government's framework for business cases for major Government projects. It represents best practice in public sector business cases. The diagram below shows how the structure of this document maps onto the HMT Five Case Model. This combines the Commercial, Financial and Management cases (focussed on the preferred option) as 'delivering the change' to reflect proportionality for this project.

Figure 10: Options appraisal approach



The options appraisal is developed in stages. Key stakeholders have been engaged throughout the work, and their insight and contributions have fed into the:

- Development of objectives, critical success factors and options;
- Appraisal of options;
- Development of the options appraisal.

2.5 Stakeholder engagement

Various approaches were used to engage with stakeholders throughout the diagnostic and options appraisal. Management of the project was undertaken via a Core Project Team consisting of colleagues from BCP ASC Commissioning and PA Consulting. Project deliverables were presented, discussed, and approved at the CT Project Board at agreed milestones. The CT Project Board membership consisted of key stakeholders from BCP who had input into the design of the options appraisal and have a clear role in future implementation of the preferred option. Direct engagement with other stakeholders was undertaken through one-to-one meetings and workshops during the diagnostic phase with care practitioners consulted via an online survey to ensure that a comprehensive range of views, opinions and insight fed into the options appraisal.

Table 3: Diagnostic and Options Appraisal engagement

Engagement method	Reach	Engagement purpose
Health and care practitioner survey	Completed by 53 practitioners who work across all three patches, specialist services and hospital teams.	Gather practitioner views on the current CT service and the role CT currently plays in ASC and could play in the future

Stakeholder interviews	14 colleagues from across relevant BCP teams (Kate Baker, Laura Henderson, Betty Butlin, Lynda Anderson, Jonathan O'Connell, Teresa Stanley, Pete Courage, Tim Branson, Seamus Doran, Kieren Johsnon, Zena Dighton, Amy Hurst, Lorraine Mealings, Andrea Barnes)	Input to diagnostic review of existing service, providing views on experiences of the service, including strengths and potential development areas
Financial validation with BCP Finance	BCP ASC Finance Lead (Anna Fresolone)	Developing, testing and validating the financial inputs and assumptions in the Options Appraisal
Core Project Group Meetings (weekly for the duration of the project)	2 ASC Commissioning colleagues (Zena Dighton, Emma Senior)	Managing project progress and iterative testing of the options appraisal and other deliverables as these developed
CT Project Board	13 CT Project Board Members (Jonathan O'Connell, Kate Baker, Betty Butlin, Tim Branson, Zena Dighton, Emma Senior, Amy Hurst, Lorraine Mealings, Anna Fresolone, Jill Johnson, Adrian Hale, Andrea Barnes, Sharon Jones)	Agree service vision and design principles, Critical Success Factors (CSFs) and options in the options appraisal Conduct qualitative scoring of options Review and signoff options appraisal

3 Our case for change for CT in BCP

This chapter will define the context and the drivers for change in relation to the use of CT in BCP. We will describe the strategic vision around living independently and staying well in BCP, the current CT service, and the ways in which it could be enhanced to meet the vision. We will conclude by setting out the agreed strategic objectives across BCP for a change in CT provision.

3.1 The context for change in BCP

Bournemouth, Christchurch and Poole (BCP) Council has, in its ASC Strategy 2021 – 2025, set out to improve the quality of life, health and wellbeing of residents in the Council area. The overarching priorities of the ASC Strategy are:

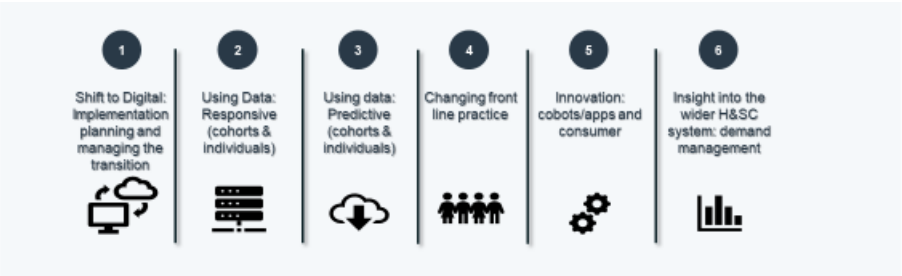
- Engage with individuals and communities to promote well-being
- Support people to live safe and independent lives
- Value and support carers
- Enable people to live well through quality social care
- Deliver services that are modern and accessible

The Corporate Strategy Delivery Plan, under the Fulfilled Lives priority, specifically references extending the use of assistive and digital technology to enable independence and enhance people's quality of life, which is echoed in BCP's ASC Strategy. Furthermore, the Market Position Statement for Adults outlines an ambition to strengthen the offer of assistive technology across Bournemouth, Christchurch and Poole, and ensure it is included from the time people first engage with adult social care at the front door.

Nationally, there is a driver for change in the upcoming Digital Shift (also known as the Digital Switchover). By 2025, the analogue infrastructure in the UK will be fully replaced with a digital version. This presents an opportunity to use technology to support a greater number of people, as the technology may help to meet needs in a better, faster or cheaper manner compared with analogue systems. Due to uncertainty regarding the timing of the CT Digital Shift, the scope to plan for this change in detail at this time is limited, although any changes to the CT approach in the Council must be made with awareness of the Digital Shift, so that future options for development are not impeded by decisions made today.

The digital shift will afford BCP with opportunities to experiment with new digital CT equipment and demonstrate the benefits it can offer. As the digitisation of CT looms closer, there needs to be coherent strategic thinking to optimise the opportunities digitally enabled care brings.

Figure 11: The Digital Shift provides an opportunity to accelerate the transformation of CT services



It is important, however, not to lose sight of people and their carers; the first question should always be 'what needs are out there and how could digital equipment help us to meet these'.

3.2 The case for change

Like all Councils, BCP is facing increasing service demand. Currently, residents aged 75 and over account for 75% of requests made to ASC services each year. The pressures are clear given that the current population of 395,600 is expected to rise to 420,900 by 2028. With this growing population size, the number of residents aged 65 and over is expected to grow by more than 30% between 2021 and 2040; from 86,900 to 115,000. This leaves Commissioners across the health and social care landscape in BCP are facing the combined challenges of increasing populations, people with more complex needs and reducing budgets. The current CT service, whilst successful in delivering a well-regarded basic service for citizens, has not yet realised its full potential.

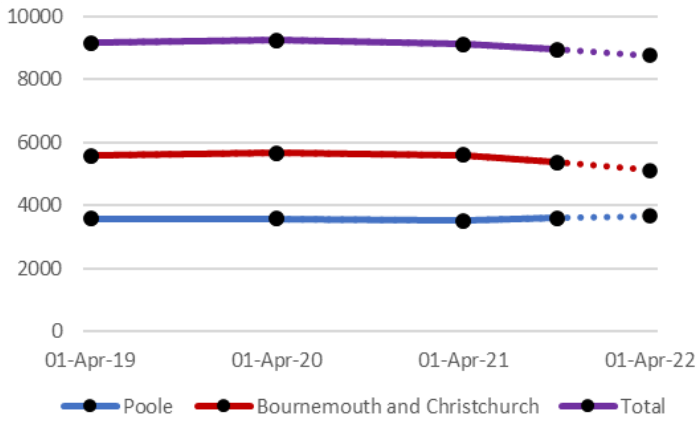
BCP recognises that the CT offer is limited and that there is untapped potential to achieve outcomes for residents and the wider ASC system. The creation of the unitary council in 2019 has, however, introduced operational challenges in relation to Care Technology (CT) services; there are two legacy systems and processes, from Poole and Bournemouth, which have both been in play. The reorganisation has, however, also presented an opportunity to define ambitious strategies and shape future ways of working. There is a clear ambition within BCP to use technology to enhance services and quality of life for residents, along with a recognition that technology has a part to play in all forms of care.

3.2.1 The current CT service

BCP's Care Technology Service sits within the Housing directorate and is split into Bournemouth Careline (which also serves Christchurch) and Poole Lifeline. Residents can access the service via two routes: Private Pay or Community Alarm. Private Pay users pay for the installation and ongoing costs for monitoring and response[3], while Community Alarm users access CT via housing schemes.

As of 1 October 2021, 8949 residents accessed the service, with the majority of these (60%) in Bournemouth and Christchurch. The majority of service users (57%) accessed the service via the Private Pay service. Data relating to service user numbers, installations and uninstalls all demonstrate that the CT service size has remained largely static over the past three years. Whilst this has coincided with the Covid-19 pandemic, many comparable local authority numbers saw services grow during this period as people became increasingly reliant on technology support.

Figure 12. Total Monitored Lifeline and Careline Service Users

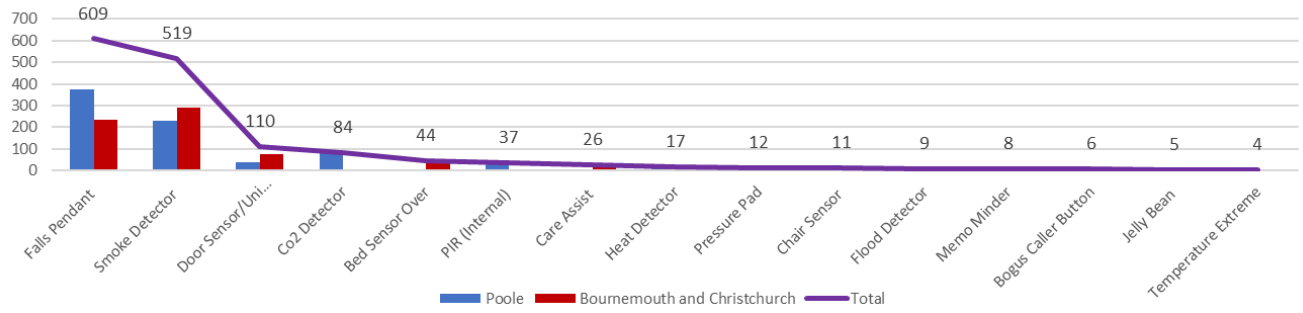


It is not possible to accurately identify the current number of service users accessing the service who have ASC needs as users referred via ASC routes are a subset of the Private Pay cohort. Anecdotal feedback suggests that approximately 25% of new referrals are received via ASC routes. Referrals for standalone devices are not reflected in the total service user volume, as BCP does not provide a service beyond installation of the device. Furthermore, there is currently no mechanism for identifying the number of service users with ASC needs who leave the service.

[3] a response service is currently available in Poole, although there are aspirations to broaden this offer to the whole of BCP.

Equipment usage as of 1 October 2021 demonstrates that the offer is traditional, predominantly offering pendant alarms, falls alarms or environmental sensors. There is currently little evidence of an enhanced and developmental equipment offer, for example GPS trackers or use of apps. This is supported by practitioner feedback via the conducted survey conducted during the diagnostic phase.

Figure 13. CT equipment available to everyone, including ASC and Private Pay users



Despite a smaller service user volume, more monitoring calls are made each year in Poole. Feedback suggests this in linked to the response service that is available only in this patch.

In addition to all aspects of the CT service (installation, monitoring, physical response etc) the team performs statutory out of hours services. The team structure is as follows:

Figure 14. Current CT team structure

CT Management		Operational Staff[4]	
1	Head of Service & OOH Manager	2	Senior Operator
1	Deputy Telecare & OOH Manager	6	Installers
3	Telecare & OOH Supervisor	32	Operators
		2	Admin Support

3.2.2 Diagnostic review findings

The diagnostic review assessed the as-is and identified several key themes spanning strategic, operational, and enabling factors. Firstly, it identified evident ambition and significant support across ASC and Housing for the increased use of Care Technology to help achieve Council and directorate priorities. This presents a clear opportunity to embed Care Technology in Council services, ASC practice and ASC support planning. However, in order to achieve this, future service development must not simply be a review and expansion of the equipment that is offered to residents.

Despite the ambition and support, there is a gap when considering strategic overview and ownership. There is no CT strategy or clear articulation of how the current service offers are being aligned and developed to meet the Council's strategic objectives. Furthermore, there has not to date been BCP-wide ownership to bring a focus and consistency to the development of CT services across ASC. The work to date has instead been concentrated on unifying the service offer following the LGR.

Building on the above, it is apparent that current service activity and resourcing is operationally focussed. The current structural framework limits innovation, development and CTs ability to become a tool which ASC can use for meeting a wider range of needs and helping to achieve Council objectives. There are pockets of service development activity, but these have been discrete projects and they do not form part of a cohesive wider CT development programme.

The current CT service is not embedded within ASC culture and practice; it is seen as the 'responsibility and control' of a few however there is a clear appetite from practitioners for greater use of CT. Survey responses demonstrated that while 87% of respondents thought the use of CT was "important" or "very

[4] a combination of F/T, P/T, casual staff and vacancies

important" to their role, just 23% had "high" or "very high" confidence when discussing CT with people. CT tends to be used to support Older Adults and there is little evidence that CT has been considered, or used, to meet a range of outcomes across different cohorts and needs.

The service has remained static. Service user volumes have remained broadly unchanged over the last three years, while the equipment offer has not evolved. In Bournemouth and Christchurch, the equipment offer has been perceived as increasingly restricted following efforts to unify the service offer across BCP.

The existing 'Poole' model delivers against its original remit with dedicated management; however, it will be challenging to scale in its current form when considering factors such as OTA resourcing for CT assessments and the manual approach to benefit analysis. Some outcomes are recorded, but the scale does not match the Council's ambition.

3.3 Vision and objectives for a future CT service

The CT Project Board reviewed and agreed the CT diagnostic described above in November 2021. This demonstrated that there was a need for change, and this options appraisal was commissioned to review the potential options for delivering CT across BCP in the future.

The BCP CT Project Board agreed a vision for the future service and 'design principles' for any future CT offer, which have been used to formulate a series of critical success factors that will be used to measure the degree to which the service achieves the vision and in the appraisal of the options.

Figure 15: Vision for a future CT service

The Council's ambition is to **transform the CT offer so that:**

Our Care Technology service is flexible, sustainable and trusted by all. It is embraced at the first opportunity to enable independence and enhance the quality of life for people across BCP. Care Technology is a cornerstone of our digitally enabled care approach that is embedded in practice and easy to access.

Figure 16: Design principles for a future CT service

Design Principles – these are the overall principles required to deliver the vision and should underpin the design of the future service so that CT will:

- Be equitable and accessible across BCP, including via self-service
- Be a personalised service that supports strengths-based approaches
- Support improved outcomes and reduce reliance on support for both care receivers and care givers
- Be a sustainable and scalable offer that delivers financial benefits for the Council
- Develop and deploy skills and capabilities in the most effective way
- Be accessible to a broad workforce, including external partners

3.4 Benefits of an improved CT service

Successful delivery of the CT service in BCP could bring the following benefits. Section 4 will look at three options and ascertain the degree to which the agreed Critical Success Factors (CSFs) and these benefits will be achieved under each option.

Figure 17: Benefits of CT change

Benefit type	Setting of care/ cohort	Benefit
	Homecare – existing OA citizens	CT enables reduction in homecare packages for existing OA citizens

Benefit type	Setting of care/ cohort	Benefit
Service outcomes – financial (for the purposes of this options appraisal)	Homecare – new OA citizens	CT reduces or prevents need for homecare for new OA citizens
	Residential / nursing care (non-LD)	CT delays entry to residential / nursing / respite care for new OA citizens
	Supported Living – existing LD service users	CT reduces need for support for existing LD Supported Living citizens
	Supported Living – new LD service users	CT reduces or prevents need for support for new LD Supported Living citizens
	Existing citizens with CT	CT enables reduction in existing care packages
Service outcomes – non-financial (for the purposes of this options appraisal, but could be quantified in the future)	Older people with dementia / mental health needs	CT supports people to live more independently. The impact of which could support other agencies e.g. police and health as well as BCP
	Other service users with complex needs	Various outcomes dependent on the need (e.g. promoting medication adherence, safer homes, travel support, epilepsy support, increased independence)
CT Service benefits – quantifiable but non-financial	Referrals	Increase in referrals as a % of total cohort size
	Connections	Increase in live connections
	Installation	Shorter time between referral and CT installation
	Staff satisfaction with the service	Increase in care practitioner satisfaction with the service (this is not currently measured)
	Citizen satisfaction with the service	More widespread measurement of citizen satisfaction of the service (this is not currently measured)

3.5 Risks and dependencies associated with a change

Any potential change comes with a degree of risk. These will be explored in more detail in Section 5, but may include:

- **Engagement:** BCP is a large and relatively new organisation and has, like many local authorities, had historically high staff turnover in ASC. These factors all present a risk to staff capacity and therefore capacity to engage with any CT project.
- **Commercial / financial:** Whilst quality of life benefits for service users is the primary purpose of any change to the CT offer, it is also intended to deliver financial benefits to the council. Any failure to successfully deliver or embed the change poses a risk to the achievement of these financial benefits and would bring in to question the value for money of the change.
- **Delivery and implementation:** any organisational change results in a delivery risk such as the project failing to meet scope, quality, time or budget requirements.
- **Digital shift:** the Digital Shift will have a substantial impact on future CT services, the impact of which needs to be understood further and could pose additional constraints and require additional resource during any change programme.
- **Change fatigue:** the relatively recent formation of BCP as a council and efforts to align legacy CT services from Bournemouth and Poole have been significant changes for the BCP CT team. As a result, any further change will need to be managed sensitively to mitigate the risk of change fatigue.
- **System limitations**: the impending migration to bring together BCP care records from Mosaic and Care Director is a significant undertaking for BCP staff and attempting to undertake CT transformation simultaneously poses significant risks. The CT service uses the Tunstall PNC monitoring system, to which it has a long-term contract, which can pose some limitations.

4 The future options for the service

This section will appraise the different options that have been developed in response to the defined scope. It sets out the approach to the appraisal of options, a description of each option, including the baseline 'status quo' and appraises the costs and benefits of each of the options in comparison to the status quo. This section will conclude by recommending the option that offers the best value for money, the preferred option.

4.1 Critical Success Factors for CT in BCP

Critical success factors (CSFs) are the attributes essential for successful delivery of the project against which the initial assessment of the options for the delivery of the project should be appraised. The success factors for the project must be crucial, not merely desirable, and not set at a level that could exclude important options at an early stage of identification and appraisal.

The table below describes the CSFs for investment in the BCP CT service. These are based on the design principles set out in Section 3.3.

As set out in the service vision, BCP is seeking a CT service that is flexible, sustainable and trusted by all, embraced at the first opportunity to enable independence and enhances the quality of life for people across BCP.

For each option a qualitative analysis against the CSFs, and quantitative analysis of costs and benefits was performed. The combination of the qualitative assessment and quantitative assessment will form the basis of the decision as to the preferred option.

The following CSFs were developed with and agreed by the CT Project Board.

Figure 18: CSFs for investment in CT

	Theme	CT Project Critical Success Factors
1	Improved outcomes and experience	• People are equipped and confident to use CT enabling them to feel safe and supported to live independently in their own home for as long as possible • Discharge from hospital is supported appropriately with CT • People and Carers are supported to access CT easily, including via self-service options, with access to information to make informed choices about care packages and use of CT
2	Improved efficiency	• CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support • There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes • Practitioner understanding of the offer and process is enhanced, driving increased uptake
3	Service capacity and capability	• CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support • There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes • Practitioner understanding of the offer and process is enhanced, driving increased uptake
4	Value for money and financial sustainability	• CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support • There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes

	Theme	CT Project Critical Success Factors
		• Practitioner understanding of the offer and process is enhanced, driving increased uptake
5	Deliverability	• CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support • There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes • Practitioner understanding of the offer and process is enhanced, driving increased uptake

4.1.1 Qualitative Appraisal Approach

The qualitative appraisal has been completed by assessing the extent to which each option meets the CSFs outlined above. Members of the CT Project Board completed a survey to score each of the options against each CSF out of 5, with the average of these responses providing the score. Adding the score for each of the 15 CSFs provides an overall qualitative score out of 75.

Figure 19. Qualitative scoring key

4.1.2 Quantitative Appraisal Approach

The quantitative appraisal has measured the value for money of each option through analysis of the costs and benefits of each option, in comparison to the status quo option.

The approach to the quantitative analysis is as follows:

- The financial appraisal focuses on the costs and benefits of providing CT to ASC eligible service users. Whilst the CT service provides support to PHP and private pay (non-ASC eligible) users, financial information provided shows that this is largely cost neutral or generating a small surplus.
- Under the current BCP charging approach, the equipment provided to ASC eligible users is funded by ASC budgets, but the user is required to pay for the monitoring and physical response, where this is taken up. For the purposes of Options 2 and 3 it has been assumed that the monitoring component of the service would be funded by ASC budgets to remove this as a barrier to uptake of the service that may prevent benefits from being achieved. However, the modelling assumes that physical response would remain option and be paid for by the user on a cost-neutral basis.
- The number of new CT service users grows based on new ASC users being added through churn and the availability of a transformed CT service (i.e. care practitioner training, simplified referral processes and so on) along with new pathways for additional user cohorts,
- Gross benefits will be realised by targeting a range of citizens where CT can reduce existing care package costs and avoid alternative provisions, such as residential admissions. Analysis of financial benefits has been completed for several cohorts. These cohorts were scoped, defined and agreed in consultation with BCP CT Project Board members. The cohorts appraised financially are as follows, although these vary by option to reflect the different scope of transformation:
  - Homecare OA citizens (existing and new)
  - Residential / nursing citizens (new)
  - Supported Living LD citizens (existing and new)
  - Citizens with CT (existing)
  - Homecare LD citizens (existing and new)
- Gross costs are based on variable cost components increasing with incremental CT service volumes plus other fixed costs.

- The net position shows the costs and benefits associated with citizens receiving CT, incremental to the status quo[5].
- The assumptions made have been informed by a combination of data provided by BCP, stakeholder feedback from the engagement set out in 2.5, and PA and Hampshire County Council's experiences in delivering and advising other local authority CT services, which have achieved significant financial benefits. These assumptions were also tested with the Project Board member responsible for Finance.

It should be noted that the options use estimated actual current costs for delivering the CT service in BCP, based on the data received from Housing and ASC during the diagnostic engagement.

Throughout the Options Appraisal conservative estimates have been used to minimise the risk of benefits being overinflated. This includes the proportion of users accessing the service and the subsequent proportion achieving a benefit being reduced compared to those achieved elsewhere. Applying this principle, the financial modelling has also uplifted the equipment costs in all options to reflect the likely cost increases as a result of the upcoming digital switch.

A detailed description of the CT financial modelling approach is appended to this options appraisal and is available at 6.4.

4.2 Introduction to the Options

There are three options for appraisal in this options appraisal. This shortlist of options was agreed at the CT Project Board.

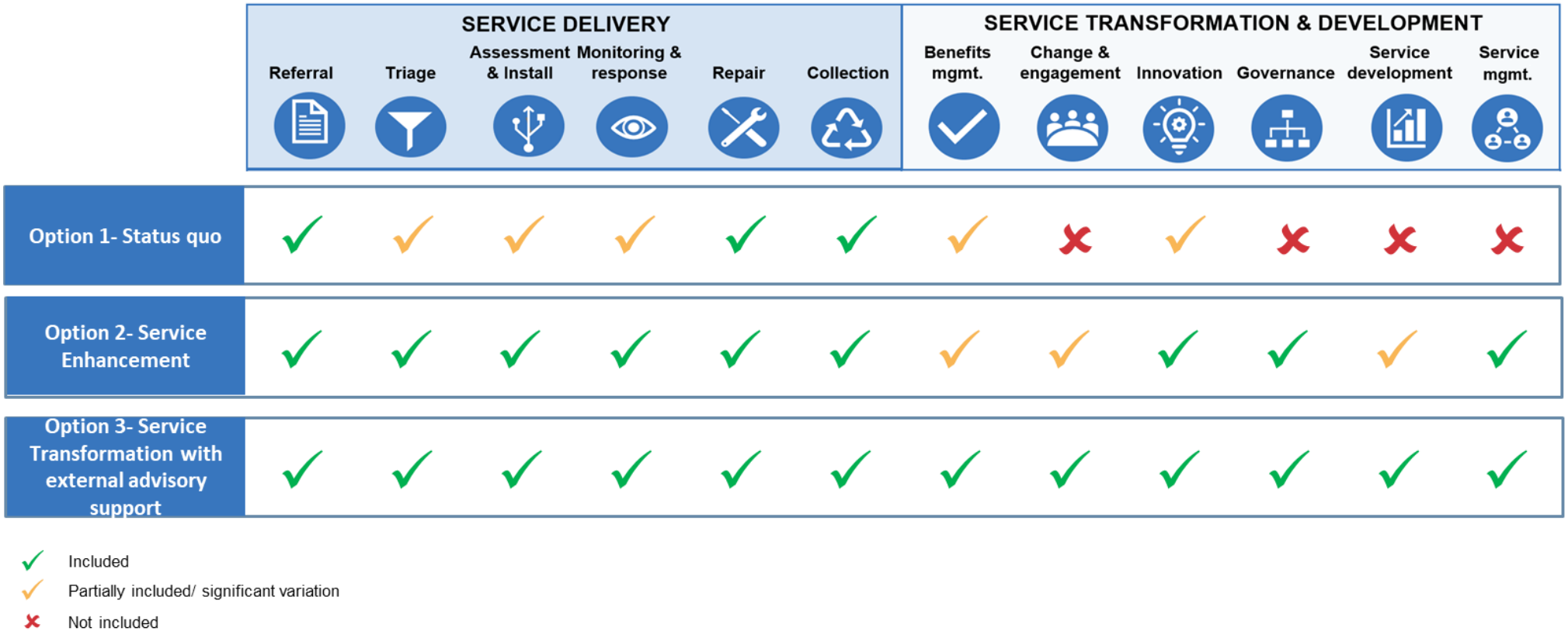
A transformed service will offer the technology solutions and supporting infrastructure to offer a broader service to BCP residents – in terms of the number of service users, as well as the breadth of technology and pathways available. The cohorts modelled in this options appraisal are indicative of the likely approach, but specific pathways will be defined through implementation planning.

- **Option 1 - *Status quo*** represents the current position. The status quo CT service assumes there will no change to the current offer, with the exception of those already underway. This means the status quo would continue to primarily offer services to older people and CT is offered to ASC eligible users in addition to a care package in most cases.
- **Option 2 – Service *Enhancement*** builds on the current service with an enhanced specification. The service would expand to reach a larger number of users and consists of all of Option 1 plus more support for younger adults with LD needs, for example in Supported Living.
- **Option 3 - *Transform*** builds on the cohorts in Option 1 and Option 2 by including a specific technology offer to OA (which could include pathways such as dementia) and younger adults (<65s) across all service areas. The transformed service will reach a greater number of people receiving CT, through a sustained programme of culture change, enabling teams across the Council to signpost to CT services, including a self-service option. It is assumed that transformation is driven by externally commissioned support, however this could be delivered internally if BCP determine that the capacity and capability exist.

A more detailed description of the options is provided below.

[5] Incremental net benefits are a relative comparison to Option 1 and are a recommended financial appraisal approach by HMT.

Figure 20: Overview of options appraisal options



4.3 Option appraisal: Option 1 - Status quo

Within all options appraisals, good practice dictates that any potential changes be assessed in relation to the current situation. This option represents the baseline current service and is a basis for comparison with other options. It assumes that investment and volumes of users accessing the CT service remain broadly static in line with current trends. There are currently ~1,307 eligible ASC users accessing CT and anticipated shrinkage in the service is such that by the end of the 5th year there is expected to be 1,283 users.[6]

Figure 21: What Option 1 looks like

The status quo CT service assumes there will **no change to the current offer**, with the exception of those already underway. This means the status quo would continue to **primarily offer services to older people** and **CT is offered to ASC eligible users in addition to a care package in most cases**.

The current service offers a range of CT equipment with the vast **majority of referrals resulting in the provision of falls detectors and smoke detectors**. There is ad hoc addition of new devices to the offer but these are not identified via a formal service development process.

The current service delivers the core CT operational functions, and this option reflects the gradual alignment of the service model across BCP. However, this option will not provide many of the enabling functions of an integrated end-to-end service, such as enhanced governance, change and engagement or robust and consistent benefits measurement.

4.3.1 Qualitative appraisal

The service would continue to reach the same core user base, predominantly focused on OA. Without additional investment, the service would also not have the skills and capacity to access new user groups and new forms of technology on a consistent and formal basis. As there is no major change taking place under this option, there are limited delivery risks.

The qualitative scoring exercise undertaken by CT Project Board members generated a qualitative score of 28/75. The detailed rationale for scoring given is provided in 6.2.1.

[6] The current number of ASC eligible users is a best estimate as it is not possible to accurately identify the current number of service users accessing the service who have ASC needs. Users referred via ASC routes are a subset of the Private Pay cohort. Anecdotal feedback suggests that 25% of new referrals are received via ASC routes and this has assumption has been used to derive the 1,307 figure. This is the same approach that was applied in the diagnostic.

Figure 22: Evaluation of Option 1 against CSFs

Theme	Critical Success Factors	Score
Improved outcomes and experience	People are equipped and confident to use CT enabling them to feel safe and supported to live independently in their own home for as long as possible	3
	Discharge from hospital is supported appropriately with CT	4
	People and Carers are supported to access CT easily, including via self-service options, with access to information to make informed choices about care packages and use of CT	1
Improved efficiency	CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support	1
	There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes	1
	Practitioner understanding of the offer and process is enhanced, driving increased uptake	1
Service capacity and capability	Data is automated and insight generated is used effectively and proactively to manage supply and demand	1
	New CT is evaluated on a regular basis and deployed as and when it is appropriate to people's needs	2
	The scope of the service is expanded to increasingly support younger adults, people with long term conditions and people with learning disabilities	2
Value for money and financial sustainability	Provides a clear mechanism for robustly measuring the financial and non-financial benefits of the CT service	2
	Delivers on target financial benefits within agreed timeframes, through avoided and reduced costs of care	1
	Generates opportunities and strengthens the case to access additional funding	1
Deliverability	The CT project delivers the agreed scope to quality, time and budget	5
	Provides adequate resource and capability to deliver and embed the change	2
	Offers effective change management, including communications and engagement, to drive service improvement	1

4.3.2 Quantitative appraisal

The existing CT service is maintained as it is currently. Some financial benefits may be being generated under the current service but the prevailing culture that does not consistently use CT to delay or avoid costlier forms of care, prevents these from being maximised. The mechanism in place to capture, quantify and validate these benefits is limited and labour intensive and packages are not avoided or reduced as a result, and therefore limited financial benefits are being achieved in Option 1.

The table below shows that the estimated costs of providing CT to ASC eligible users over the next 5 years is **£1.94m**.

The methodology and assumptions for these costs is outlined in a detailed 6.4.

Table 4: Quantitative appraisal of Option 1

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total 5-Year
# of users receiving CT	1,302	1,298	1,293	1,288	1,283	6,465
# of users leaving the CT service (based on average # of users leaving the CT service in FY 2020-21 and FY 2021-22)	325	323	322	321	320	1,611
# of new users joining the CT service (based on average # of users joining the CT service in FY 2020-21)	320	319	317	316	315	1,587
Equipment, Installation, Monitoring & Maintenance Costs	£0.39MM	£0.39MM	£0.39MM	£0.39MM	£0.38MM	£1.94MM
Other Fixed Cost	-	-	-	-	-	-
Total CT Service Costs	**£0.39MM**	**£0.39MM**	**£0.39MM**	**£0.39MM**	**£0.38MM**	**£1.94MM**

4.4 Option appraisal: Option 2 – Service Enhancement

CT will be delivered through a simplified and improved referral pathway. Option 2 (service enhancement) builds on the status quo (Option 1) by increasingly supporting younger adults with LD needs, for example in Supported Living. The provision or regular CT training opportunities and increasing profile of the service shifts CT towards being a core part of the first offer, enabling CT solutions to reduce / avoid need for more costly forms of care.

Figure 23: What Option 2 looks like

Option 2 – Service Enhancement consists of all of Option 1 plus more support for younger adults with LD needs, for example in Supported Living. CT solutions are able to reduce / avoid need for more costly forms of care. This includes technology solutions for cases with greater complexity, including the full potential benefits of LD supported living benefits through a pathfinder supporting advanced CT assessments

In addition to Option 1, this option:

- Provides staff with opportunities for regular CT training sessions and offer CT guidance through a range of materials on the Council's Intranet
- Practitioners benefit from a simplified referral process
- implementation of formal approaches to service governance and management, including at a strategic level
- The introduction of a formalised approach to CT innovation, including a consistently applied evaluation methodology for new technology
- Enhancement of retrospective reporting of benefits using sampling applied to all service users to evidence financial benefits of the service on a consistent basis that can be applied to budgeting

There is anticipated to be a moderate increase in ASC eligible service users as a consequence of these service enhancements.

4.4.1 Qualitative appraisal

Option 2 – The Service Enhancement option meets the CSFs to a greater extent than Option 1 - Status quo, increasing user volumes and developing a clearer referral pathway. This option presents a greater risk to BCP than Option 1 as there is a requirement for change. Delivery risks could include the failure to meet time, cost and quality requirements. The breadth of the service will be relatively limited and is unlikely to grow significantly over the longer term without additional investment.

The qualitative scoring exercise undertaken by CT Project Board members generated a qualitative score of 47/75. The detailed rationale for scoring given is provided in 6.2.2.

Figure 24: Evaluation of Option 2 against CSFs

Theme	Critical Success Factors	Score
Improved outcomes and experience	People are equipped and confident to use CT enabling them to feel safe and supported to live independently in their own home for as long as possible	4
	Discharge from hospital is supported appropriately with CT	4
	People and Carers are supported to access CT easily, including via self-service options, with access to information to make informed choices about care packages and use of CT	2
Improved efficiency	CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support	3
	There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes	3
	Practitioner understanding of the offer and process is enhanced, driving increased uptake	3
Service capacity and capability	Data is automated and insight generated is used effectively and proactively to manage supply and demand	2
	New CT is evaluated on a regular basis and deployed as and when it is appropriate to people's needs	3
	The scope of the service is expanded to increasingly support younger adults, people with long term conditions and people with learning disabilities	4
Value for money and financial sustainability	Provides a clear mechanism for robustly measuring the financial and non-financial benefits of the CT service	3
	Delivers on target financial benefits within agreed timeframes, through avoided and reduced costs of care	3
	Generates opportunities and strengthens the case to access additional funding	3
Deliverability	The CT project delivers the agreed scope to quality, time and budget	4
	Provides adequate resource and capability to deliver and embed the change	3
	Offers effective change management, including communications and engagement, to drive service improvement	3

4.4.2 Quantitative appraisal

This enhances the CT service, supports small numbers of younger adults (LD) and expands the offer for older adults (OA), leading to a moderate growth in the CT service and moderate benefits.

Across five years this option results in a total incremental gross benefit of £4.54m and a total incremental cost of -£1.6m.[7] Therefore, this results in an incremental net benefit of £2.95m. This represents an average net benefit per installation of £1,153.

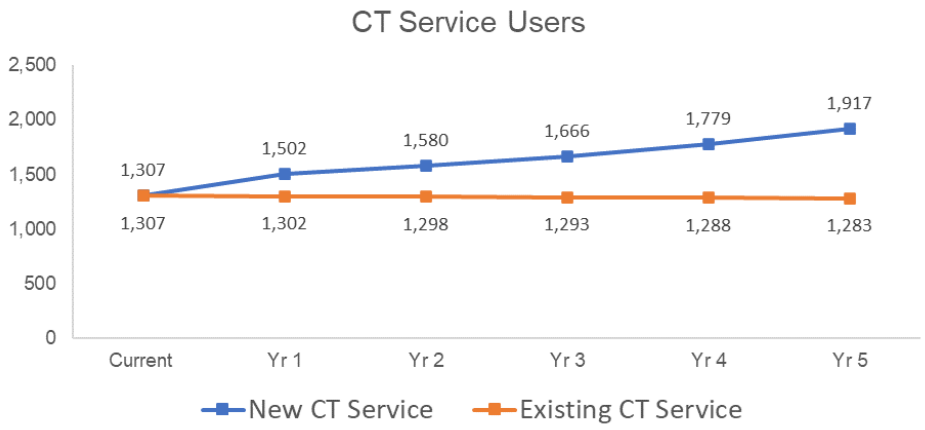
[7] All negative figures are a cost to BCP.

Table 5: Quantitative appraisal of Option 2

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total 5-Year
Gross benefits from existing ASC citizens (OA & LD homecare, LD Supported Living and existing CT citizens)	£0.15MM	£0.22MM	£0.17MM	£0.15MM	£0.13MM	£0.82MM
Gross benefits from new ASC citizens	£0.35MM	£0.59MM	£0.76MM	£0.94MM	£1.09MM	£3.72MM
Total Incremental Gross Benefit	**£0.50MM**	**£0.81MM**	**£0.93MM**	**£1.08MM**	**£1.22MM**	**£4.54MM**
On-going incremental CT service cost[1]	-£0.21MM	-£0.20MM	-£0.24MM	-£0.30MM	-£0.36MM	-£1.30MM
One-off transformation cost[2]	-£0.20MM	-£0.10MM				-£0.30MM
Total Incremental Costs	**-£0.41MM**	**-£0.30MM**	**-£0.24MM**	**-£0.30MM**	**-£0.36MM**	**-£1.60MM**
Incremental Net Benefit	**£0.09MM**	**£0.51MM**	**£0.69MM**	**£0.79MM**	**£0.86MM**	**£2.95MM**

The service user growth of this option compared to Option 1 - Status quo is detailed in the figure below. This includes a provision for 'churn' i.e. both adult social care citizens leaving the service, as well as citizens accessing CT who no longer need the service.

Figure 25: Number of citizens in the CT service under Option 2 - Enhance



4.5 Option appraisal: Option 3 – Service Transformation with external advisory support

This option mainstreams CT effectively across social care, encouraging practitioners to consider it as part of the 'first offer'. It requires sustained focus, resource, and effort on the cultural and behaviour change of practitioners. Sustained change is achieved when health and care practitioners confidently advocate CT within care packages and recognise that it continually and demonstrably delivers the desired care outcomes.

Figure 26: What Option 3 looks like

Option 3 – Service Transformation requires the greatest investment in order to build upon the cohorts in Option 1 & 2 by including a specific technology offer to OA pathways (which could include pathways such as dementia), younger adults (<65s) and people with MH needs across all the service areas. CT solutions are able to reduce / avoid need for more costly forms of care. This could include the following:

- Targeted support for individuals living with early-stage dementia with a range of support mechanisms to promote independence and reduce the burden on carers e.g. taking medication promptly, managing lives more independently, support to leave the house safely
- Addressing social isolation and independence through adapted technology or consumer technology e.g. enabling people to access services easily, live more independently and keep in touch with family/friends
- Support to younger adults with disabilities e.g. support to travel independently using mobile apps

The breadth of the service is increased to reach a greater number of people through a sustained programme of culture change, enabling teams across the Council to signpost to CT services. Achieving and sustaining successful cultural and behaviour change relies on a campaign to win hearts and minds of all those people interacting with the service (referrers, citizens, potential CT users, carers, providers from across the public, private sector and voluntary sector). This is not a one-off exercise, but an ongoing approach embedded within this service model. In addition to the improvements in Option 2, this option includes:

- Regular tracking of benefits based on individual users in a consistent and automated way
- Full programme of culture change activity including training, case studies and regular engagement supporting the roll-out of a self-service offer
- Proactively engaging in the market to test and implement new innovations
- Capacity and capability for ongoing service development

4.5.1 Qualitative appraisal

Option 3 – Service Transformation meets the CSFs to a much greater extent than Option 2 – Service Enhancement. This approach increases volumes by reaching a broader range of users including those with complex needs. The change will be more likely to generate and sustain momentum as there will be a managed change and engagement programme. However, change of this scale carries higher delivery risks and the project will need to be carefully managed in order to meet time, cost and quality requirements. To provide the capacity and capability to deliver transformation of this scale and to mitigate against the aforementioned risks, ongoing external advisory support has been assumed for this option[8].

The qualitative scoring exercise undertaken by CT Project Board members generated a qualitative score of 66/75. The detailed rationale for scoring given is provided in 6.2.3.

[8] The external party would work closely with BCP colleagues to deliver the transformation. However, this could be delivered internally should BCP identify sufficient resource and be confident in the available capability.

Figure 27: Evaluation of Option 3 against CSFs

Theme	Critical Success Factors	Score
Improved outcomes and experience	People are equipped and confident to use CT enabling them to feel safe and supported to live independently in their own home for as long as possible	4
	Discharge from hospital is supported appropriately with CT	4
	People and Carers are supported to access CT easily, including via self-service options, with access to information to make informed choices about care packages and use of CT	5
Improved efficiency	CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support	5
	There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes	5
	Practitioner understanding of the offer and process is enhanced, driving increased uptake	4
Service capacity and capability	Data is automated and insight generated is used effectively and proactively to manage supply and demand	4
	New CT is evaluated on a regular basis and deployed as and when it is appropriate to people's needs	5
	The scope of the service is expanded to increasingly support younger adults, people with long term conditions and people with learning disabilities	5
Value for money and financial sustainability	Provides a clear mechanism for robustly measuring the financial and non-financial benefits of the CT service	5
	Delivers on target financial benefits within agreed timeframes, through avoided and reduced costs of care	4
	Generates opportunities and strengthens the case to access additional funding	4
Deliverability	The CT project delivers the agreed scope to quality, time and budget	4
	Provides adequate resource and capability to deliver and embed the change	4
	Offers effective change management, including communications and engagement, to drive service improvement	4

4.5.2 Quantitative appraisal

Option 3 transforms the CT service, supports a larger number of younger adults (LD/Mental Health/PD etc), and expands the offer for OA, leading to a higher growth in the CT service and higher benefits.

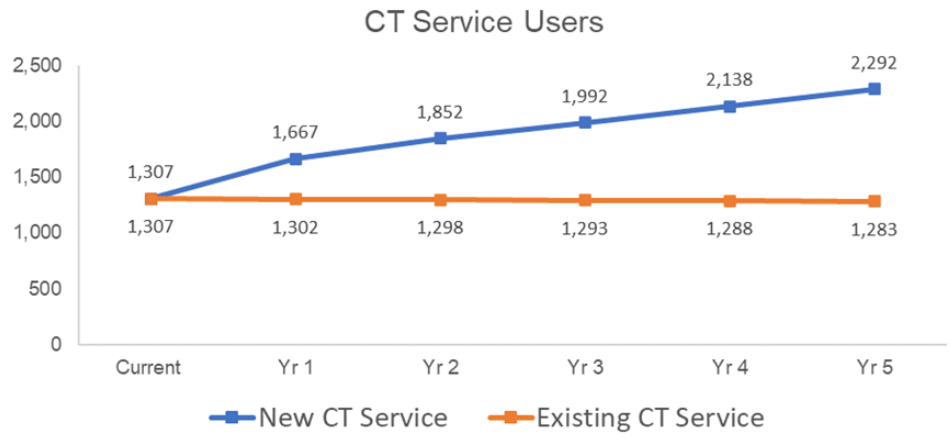
Across five years this option results in total gross benefit of £7.44m and a total incremental cost of -£2.44m. Therefore, this results in a net benefit of £5m. This represents an average net benefit per installation of £1,559.

Table 6: Quantitative evaluation of Option 3

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total 5-Year
Gross benefits from existing ASC citizens (OA & LD homecare, LD Supported Living and existing CT citizens)	£0.35MM	£0.47MM	£0.35MM	£0.30MM	£0.27MM	£1.74MM
Gross benefits from new ASC citizens	£0.62MM	£0.97MM	£1.16MM	£1.39MM	£1.57MM	£5.70MM
Total Incremental Gross Benefit	**£0.97MM**	**£1.44MM**	**£1.51MM**	**£1.69MM**	**£1.84MM**	**£7.44MM**
On-going incremental CT service cost[1]	-£0.33MM	-£0.32MM	-£0.37MM	-£0.43MM	-£0.49MM	-£1.94MM
One-off transformation cost[2]	-£0.35MM	-£0.15MM				-£0.50MM
Total Incremental Costs	**-£0.68MM**	**-£0.47MM**	**-£0.37MM**	**-£0.43MM**	**-£0.49MM**	**-£2.44MM**
Incremental Net Benefit	**£0.29MM**	**£0.97MM**	**£1.14MM**	**£1.26MM**	**£1.35MM**	**£5.00MM**

The service user growth of this option compared to Option 1 - Status quo is detailed in the figure below. This includes a provision for 'churn' i.e. both adult social care citizens leaving the service, as well as citizens accessing CT who no longer need the service.

Figure 28: Number of citizens in the CT service under Option 3 – Service Transformation



To achieve the predicted growth in the service, an average of ~54 CT installs have to be completed for ASC eligible users per month during the 5-year period, approximately 28 per month more than in Option 1.

Throughout the diagnostic and options appraisal phases, conservative estimates have been used in the model. For example, while the model projects that 45% of homecare users in year 1 would receive a CT package that reduces their homecare needs by 2 hours, it is likely benefits will be more significant than this. This demonstrates that there is room for the service to grow in BCP. This growth would, however, need to be managed effectively in order to ensure that the service can continue to perform optimally.

4.6 Conclusion

In assessing both the qualitative and quantitative factors for the three options, the CT Project Board has concluded the following:

4.6.1 Option 1 – Status quo

Maintaining Option 1 - Status quo will see the volume of citizens accessing the CT remain static in line with current trends. The type of referrals will continue to focus on basic support for older people with moderate needs, thus losing the opportunity to support a greater number of people to live independently. It does not represent a tangible change versus the current situation and therefore does not meet many of the CSFs. However, as there is no significant change the delivery risks are low.

4.6.2 Option 2 – Service Enhancement

Option 2 – Service Enhancement improves the current service by growing users and expanding support to more younger adults (<65) with LD needs and increasing the number of older adult users. There is a

moderate growth in the CT service and moderate benefits. The anticipated growth in the service is such that by the end of the 5th year there is anticipated to be 1,917 citizens accessing the service compared to 1,283 expected under Option 1.

This option therefore partially meets the critical success factors with moderate risk and reward.

4.6.3 Option 3 – Service Transformation

Option 3 – Service Transformation builds significantly upon Option 2; it mainstreams CT effectively across social care encouraging practitioners to consider it as part of the 'first offer' for a wider range of citizen needs. It therefore requires sustained focus, resource and effort on cultural and behaviour change of practitioners. It transforms the CT service by supporting a larger number of younger adults (transitions/LD/Mental Health/PD etc) and expands the offer for older people with complex needs, including via the introduction of a self-service access route, leading to a higher growth in the CT service and higher benefits.

This option fully meets the CSFs and delivers significant reward, but with correspondingly higher level of risk and transformation costs, although it is anticipated these will be offset to deliver an overall net benefit. The scale of transformation required under Option 3 is assumed to require external transformation and ongoing advisory support, but this may not be required should BCP determine the required capability exists internally and capacity can be created accordingly.

4.6.4 The preferred option

The preferred option, as agreed and recommended by the CT Project Board on 20 July 2022 is Option 3 – Service Transformation. Option 3 aligns with the BCP's ambition to significantly improve the CT service and integrate it into part of the 'first offer' of support, including via self-service access routes. It has the biggest potential to improve user outcomes and is also forecast to achieve the largest net financial benefit to the system, although it is the highest risk option.

5 Delivering the future CT service successfully

This section relates to how the preferred option, Option 3 – Service Transformation, will be delivered. It will focus on procurement and commercial implications, funding and affordability and the robust management and implementation arrangements required to make the change happen successfully.

5.1 Procurement and commercial implications

Procurement and commercial implications may include transformation and advisory partner support, new equipment supplier partnerships and potential staffing changes.

Should BCP determine that the most effective method of delivering the preferred option is through the support of a transformation partner, there are several established public sector frameworks for pre-competed CT advisors to support this. The Innovation workstream would define any new supplier partnerships required prior to launch of the transformed approach to the service.

There may also be staffing implications from any service change. Any staffing implications will be understood in more detail post-options appraisal and will be developed in line with the required BCP processes. In order to achieve Option 3 – Service Transformation, a variety of delivery models could be reviewed following the options appraisal phase in order to ensure that this aligns to BCP's ambition and delivers the best outcomes for citizens. Any commercial or procurement implications of a different delivery model, if required, will be defined in more detail once requirements are understood.

5.2 Costs of delivery and how the service will be funded

This section focusses on funding and affordability for the preferred option, Option 3 – Transform over the medium term. The 5-year total funding requirements are of £4.38m. This is an additional funding requirement of £2.44m compared to the Status quo – Option 1 (existing CT service costs), representing the one-off transformation costs[9] and ongoing incremental costs. It is anticipated that the service will be funded through existing budgets in line with funding for the current service, and costs are expected to be offset by gross benefits of £7.44m. This investment therefore results in a net benefit of £3.06m over 5 years.

Figure 29: Total 5-year funding requirement

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total 5-Year
Option 1 estimate of current costs	-£0.39MM	-£0.39MM	-£0.39MM	-£0.39MM	-£0.38MM	-£1.94MM
On-going incremental Option 3 CT service cost	-£0.33MM	-£0.32MM	-£0.37MM	-£0.43MM	-£0.49MM	-£1.94MM
One-off Option 3 transformation cost	-£0.35MM	-£0.15MM	-	-	-	-£0.50MM
Total Option 3 Costs	**-£1.07MM**	**-£0.86MM**	**-£0.76MM**	**-£0.81MM**	**-£0.87MM**	**-£4.38MM**
Funded through:						
Gross benefits from existing ASC citizens (OA & LD homecare, LD Supported Living and existing CT citizens)	£0.35MM	£0.47MM	£0.35MM	£0.30MM	£0.27MM	£1.74MM
Total ASC funding and benefits for existing ASC citizens	**£0.35MM**	**£0.47MM**	**£0.35MM**	**£0.30MM**	**£0.27MM**	**£1.74MM**
Net funding requirement - assuming benefits from existing ASC citizens only	**-£0.73MM**	**-£0.39MM**	**-£0.41MM**	**-£0.51MM**	**-£0.61MM**	**-£2.64MM**
Gross benefits from new ASC citizens	*£0.62MM*	*£0.97MM*	*£1.16MM*	*£1.39MM*	*£1.57MM*	£5.70MM
Net funding requirement - assuming benefits from existing and new ASC citizens	***-£0.11MM***	***£0.58MM***	***£0.76MM***	***£0.87MM***	***£0.96MM***	**£3.06MM**

[9] £500k transformation costs have been modelled across years 1 and 2 with a breakdown of these costs shown in 6.3. This is the expected transformation budget, including contingency, but BCP may consider identifying additional transformation funds to support embedding the change on an ongoing basis should this be deemed necessary

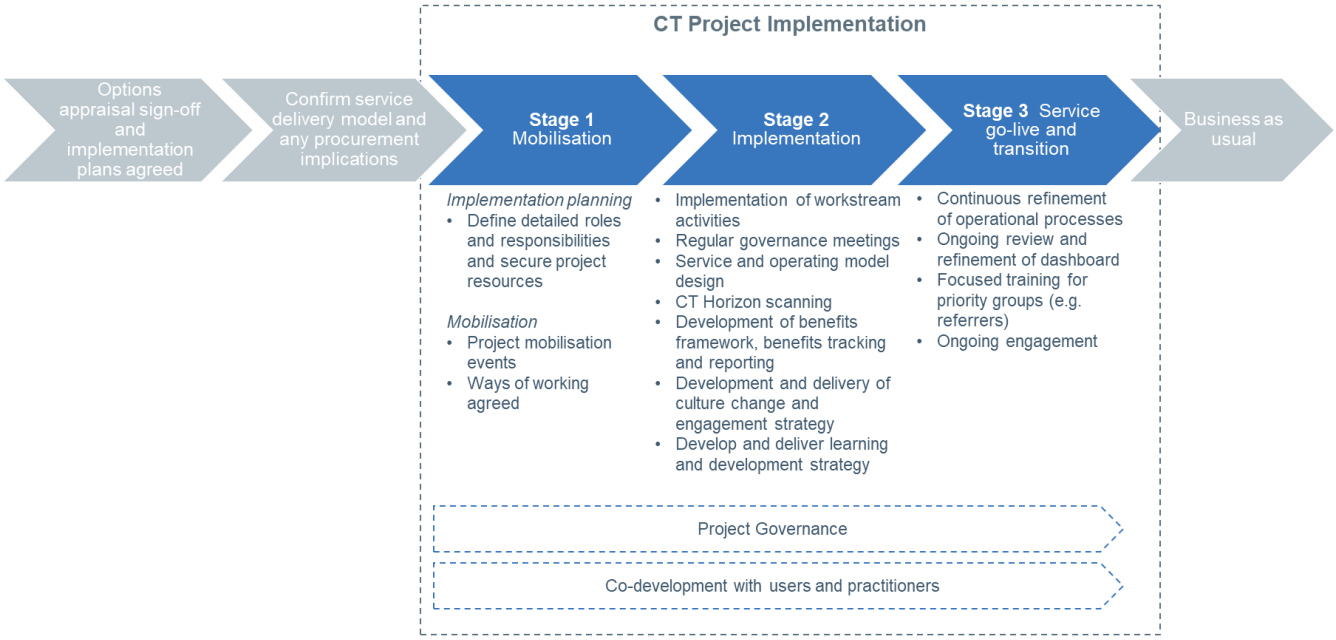
5.3 How the project will be delivered

This section describes in more detail the actions that will be required to ensure the successful delivery of the project in accordance with best practice. The actions and approaches outlined relate to the post options appraisal implementation phases of this project.

5.3.1 Project approach

Following the approval of the options appraisal and any service delivery model implications, there are three key stages of the project before transition to business as usual, these stages have been outlined below.

Figure 30: Project approach

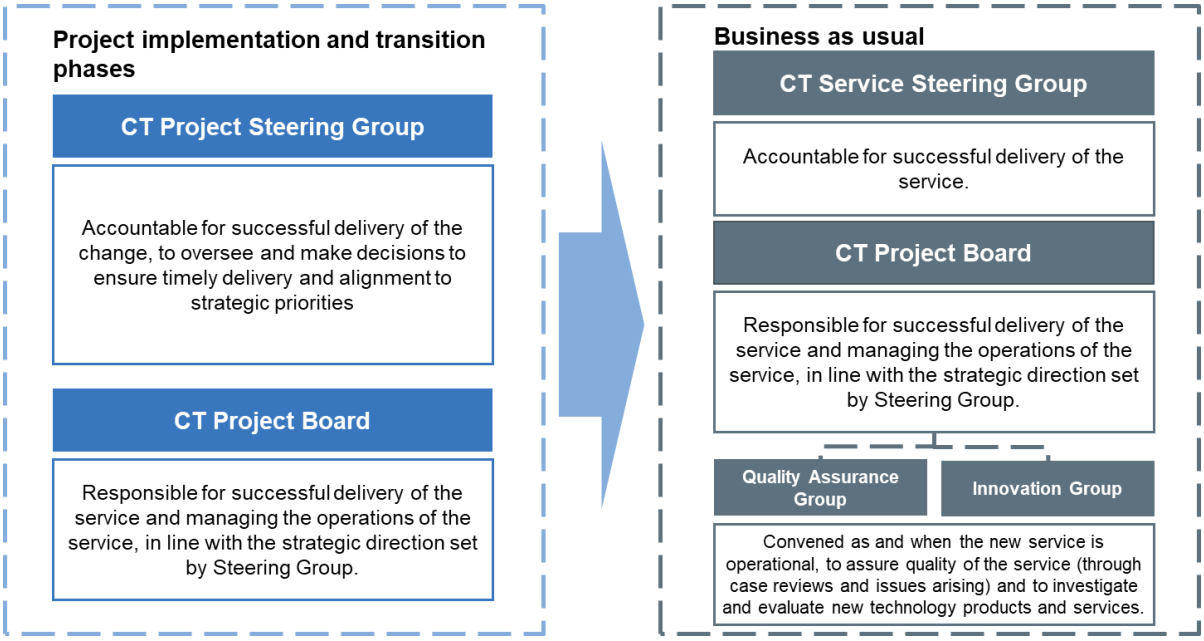


5.3.2 Governance

The project will be delivered within existing BCP governance arrangements and is expected to involve the following:

1. **CT Project Steering Group:** a strategic group responsible for decision-making accountable for overall delivery of the CT Project.
2. **CT Project Board:** an operational group responsible for mobilisation, implementation and transition to business-as-usual in line with the strategic direction set by the CT Service Steering Group. It is assumed that following the implementation phase the CT Project Board will become an operational board with responsibility for quality assurance, continuous improvement, and ongoing CT innovation.

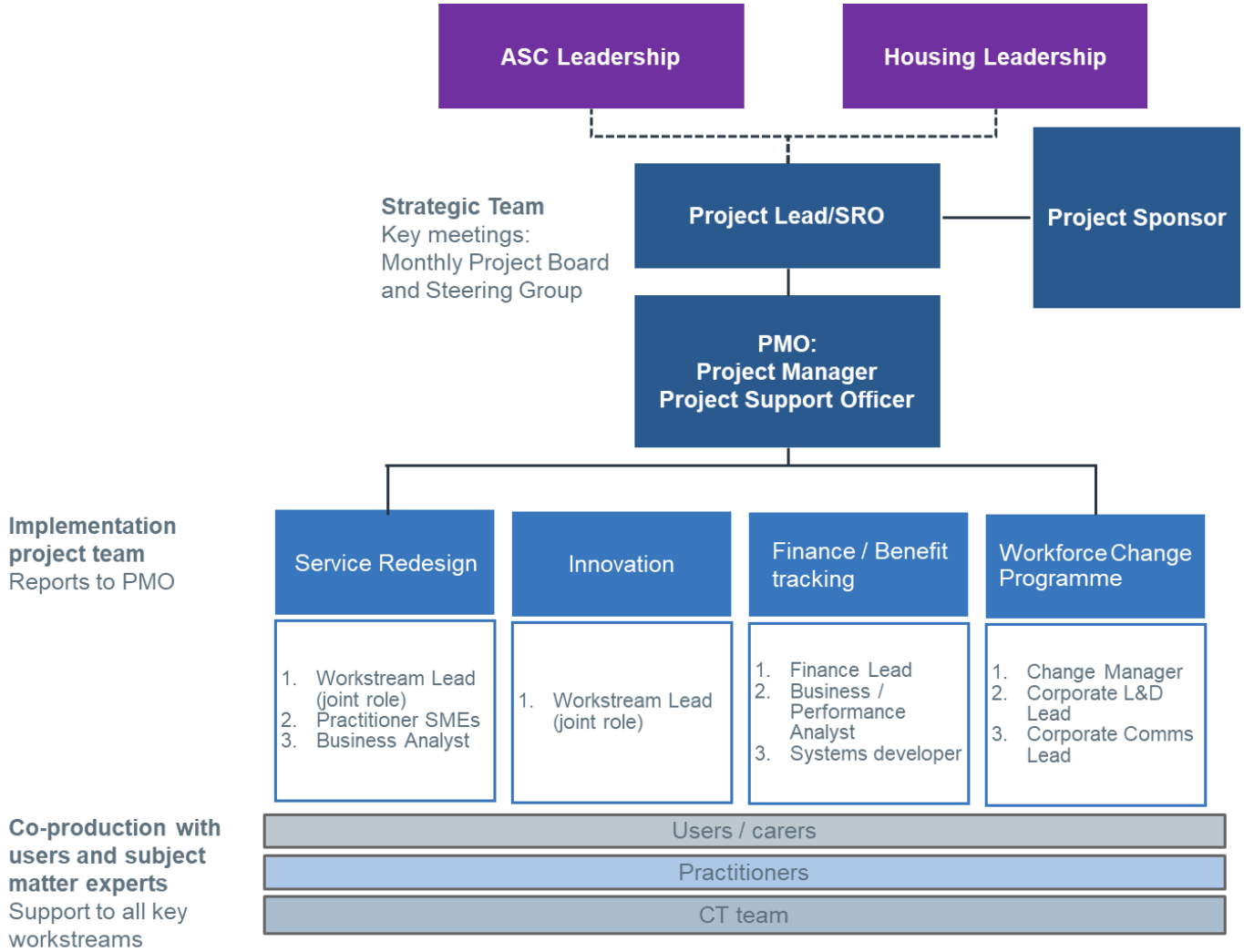
Figure 31: Implementation governance structure vs business as usual



5.3.3 Roles and responsibilities

Project resources will be required to manage the project, through the mobilisation and implementation phase. This may encompass the following roles, outlined in the figure below.

Figure 32: Suggested project resource and operating structure



These roles are described in greater detail below. Specific named individuals should be defined in a more detailed implementation and resource plan, developed following options appraisal sign-off and

procurement of any required external support, which may provide the resource for some of the following roles.

Figure 33: Project roles and requirements

Role	Description of role
Sponsor	Overall accountability for successful delivery of the project.
Project Lead / SRO	Responsible for leading the team to meet the desired project outcomes.
Project Manager	Responsible for managing the team and delivering the project to time and to budget. Also, likely to be responsible for developing governance arrangements, supporting development of policies and procedures and overseeing dependencies between workstreams.
Project Support Officer	Provides administrative support to the Project Manager and wider project.
Service Redesign and Innovation Workstream Lead	Responsible for leading the service redesign workstream and innovation workstream activity
Practitioner SME(s)	Supports service redesign workstream lead to provide expertise from a social care and health practitioner point of view. Likely to include 2-3 people across each discipline/ user cohort
Business Analyst	Supports service redesign workstream in redesigning supporting processes and systems.
Finance Lead	Responsible for finance inputs to the options appraisal and to designing a benefits framework and tracking approach.
Business / Performance Analyst	Supports benefits framework and tracking workstream in developing metrics, dashboard and reporting system.
Systems developer	Develops changes required to care management system and associated reporting systems as a result of a new referral form.
Change Manager	Supports PMO to deliver change, engagement and training activities, model and embed behaviour change across the Workforce Change Programme workstream. Designs a communications and engagement plan and approach and advises the project on communications and engagement sessions through transition. Designs a learning and development plan and learning materials and advises the project on learning and development through transition.
Corporate L&D Lead	Advises the Change Manager on the development and implementation of learning and development activity through transition.
Corporate Comms Lead	Advises the Change Manager on the development and implementation of communications and engagement activity through transition.

5.3.4 Implementation Plan

It is expected to take about seven months to fully mobilise and implement Option 3 – Service Transformation once the project is ready to mobilise. Mobilisation can only take place once funding has been secured, any delivery model implications are understood and provider arrangements have been confirmed, post-options appraisal stage.

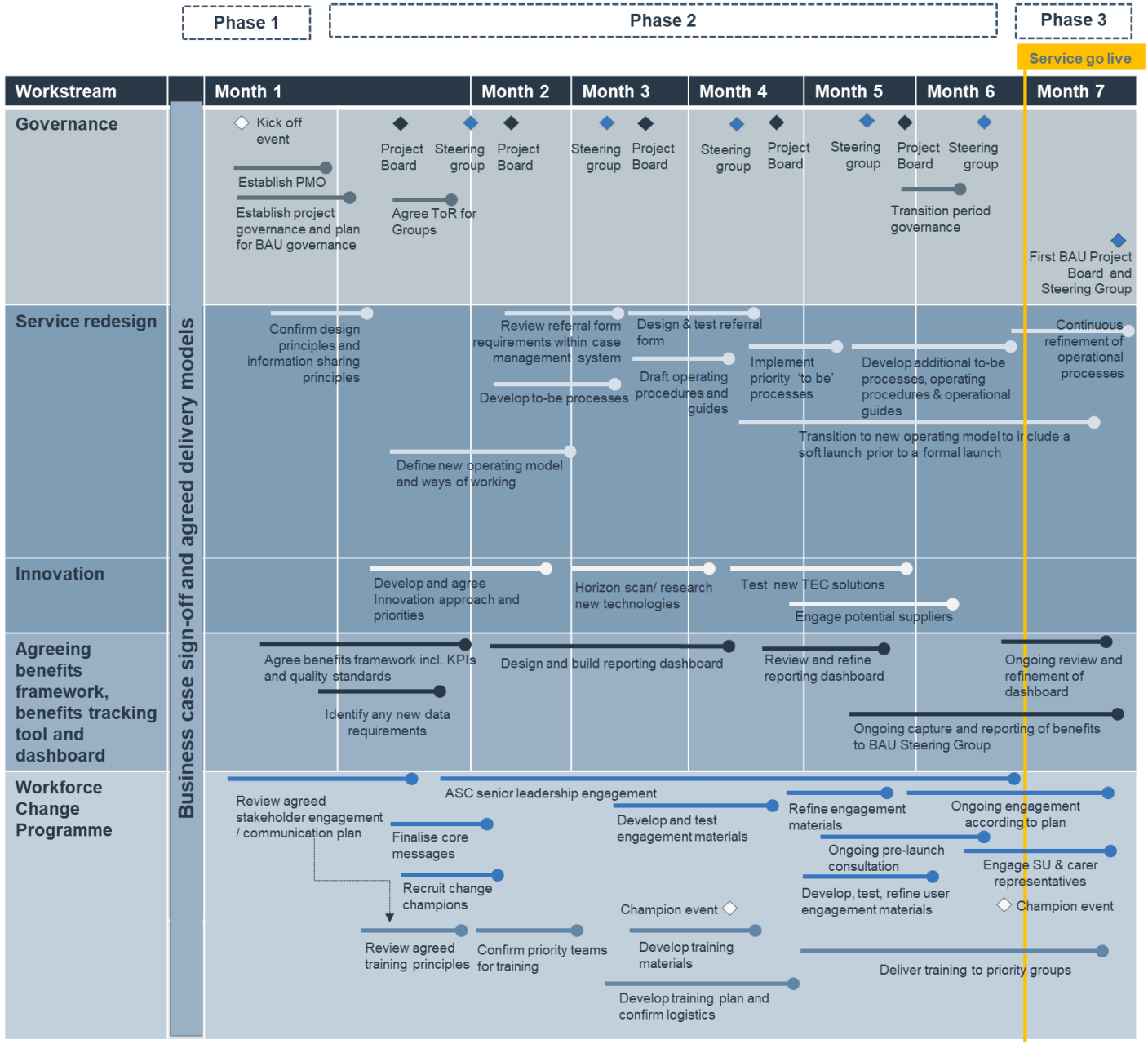
Once project roles are in place, the implementation is likely to take up to 6 months mobilisation prior to go-live and 1-month post go-live. The plan below sets out the expected implementation plan and organises activity into five workstreams:

1. **Governance:** establishing strong decisive governance structures that operate across BCP to provide inputs at the right level throughout the transformation and development of the service.
2. **Service redesign:** establishing and embedding the new operational service model across BCP. Pathway and service redesign work to co-design and co-produce new simplified referral pathways across health and social care.
3. **Innovation:** CT horizon scanning, testing new technologies and defining any new supplier partnerships required prior to launch of the new service. Developing an ongoing and iterative approach to innovation.
4. **Benefits framework:** designing and implementing a robust approach to benefits measurement and realisation that meets the needs of BCP stakeholders.

5. **Workforce change programme:** raising the profile of the service through a programme of activity around culture change, engagement, and training to increase understanding of the service and benefits that CT can have for people. Supporting referrers, commissioners, providers, and leadership across BCP to have the capacity and capability to use the service and encourage higher rates of take-up.

Figure 34: Implementation Plan

Confirm service delivery model and any commercial implications ahead of month 1



5.3.5 Pre-implementation planning and considerations

Following completion of the Options Appraisal and the subsequent governance approvals, the following planning should be undertaken to ensure readiness for implementation.

- **Governance approval-** the most immediate next step will be to present the outcome of the Options Appraisal at the required governance forums (Overview and Scrutiny Committee, Cabinet, and potentially Design Authority) to approve progression to the implementation phase.
- **Transformation funding**- prior to proceeding with implementation, BCP should confirm the source of transformation funding (a minimum of £500k over two years) considering both internal routes and other avenues such as joint funding with Health and/or grant funding.
- **Approach to charging**- the financial benefits identified through the Options Appraisal modelling are based on monitoring costs being funded by ASC budgets for ASC eligible users. This is a tried and tested approach in other local authorities and is designed to remove any barriers to uptake of the service, which would otherwise limit benefits. For example, if a user declines CT on the basis of a weekly monitoring charge (the current model) that they are unwilling to pay and this ultimately leads to a need for home care, this is a false economy. The modelling undertaken assumes that the physical response service would continue to be optional and priced on a cost-neutral basis for ASC eligible users[10]. BCP should consider and approve the future approach to charging prior to commencement of the implementation phase.
- **ASC charging reform**- it is likely the new approach to ASC charging being introduced in October 2023 will result in an increased number of ASC eligible users that would be eligible to access the funded service (subject to the above decision). Therefore, it is possible that this may impact the true 5-year funding projection of the CT service. However, over the long term it is only likely to impact the case for the transformation positively as the increased costs of additional users would offset by the additional benefits achieved through the avoidance of costlier forms of care. CT may therefore play an important role in minimising the impact of this change by suppressing domiciliary and residential care demand. When planning for the wider impacts of ASC charging reform BCP should consider the role CT can play in managing this change and the potential impacts on the business case.
- **Delivery model and team structure**- the benefits assumptions used have been developed based on services that offer personalised, in-home, outcomes-focussed assessments, typically undertaken by installers in a single visit (sometimes referred to as a 'trusted assessor' model), which have a track record of delivering significant net benefits. However, there may be alternatives to this approach, including elements of the existing BCP 'Poole model', which involves ASC colleagues undertaking this assessment, often remotely, and identifying equipment to be installed or a hybrid drawing on the best elements of these two approaches. Prior to implementation, BCP will need to confirm the future service model and consider any subsequent impact on team structures.
- **ASC record system migration**- the ongoing migration of BCP care record system to bring together legacy Bournemouth and Poole systems is a key factor in the timing of implementation. The service redesign and benefits framework workstreams require the development of new system processes and forms to collate the relevant inputs and enable automated measurement of service performance. It is, therefore, recommended that the implementation commence once this migration to Mosaic is complete.
- **Engagement with customer services/ASC front door**- the transformed approach outlined in the preferred option is predicated on CT becoming a core part of the BCP ASC offer. This requires it to be at the forefront of the mind of all health and care practitioners, who should consider the service at all stages, including as an early intervention and prevention. In other local authorities, through effective referral processes and training, front door/customer service teams have been equipped to refer directly for CT at the first point of contact. This has been successful in enabling rapid response to enquiries and early intervention to reduce demand on ASC but does require Customer Service Leadership buy-in. BCP should consider early engagement with Customer Services to understand the feasibility of a model that enables 'front door' referrals.

5.3.6 Resource requirements and plan

The table below outlines indicative resource commitments by core project roles during the Implementation Phase, some of which may be filled through the procurement of external advisory support as appropriate. Detailed transformation costs are included as an appendix.

Figure 35: Estimated resource requirements

[10] Unlike BCP, some local authorities do not offer physical response services and rely on nominated responders and the emergency services. However, where physical response is offered, this is almost always on a private pay basis

Role	FTE [11]
Sponsor	0.1
Project Lead / SRO	0.25
Project Manager	1
Project Support Officer	0.5
Service Redesign Workstream Lead and Innovation Lead*	1
Practitioner SME(s)	0.1 per role
Business Analyst	0.5
Finance Lead	0.2
Business / Performance Analyst	0.5
Systems developer	0.1
Change Manager	1
Corporate Learning and Development Lead	0.25
Corporate Comms Lead	0.25

5.3.7 Change and engagement approach

Developing 'project infrastructure' will be needed to drive a lasting change. Achieving and sustaining successful change relies on a campaign to win hearts and minds. It will not be a one-off exercise but will need to be part of an ongoing approach, which will need to be adopted by staff, citizens, carers, providers, partners, and senior leadership.

This will mean:

- Investing in securing and maintaining senior buy-in across ASC and Health
- Building a network of true CT champions across BCP, actively involved in service development and that can represent users and carers
- Setting the expectation as staff join BCP and ASC that using CT is at the heart of ASC support, at all levels of the organisation and outside of the organisation
- Co-designing and delivering a formal training programme, compulsory for anyone able to make a referral and built into induction processes for new staff
- Monitoring the source of CT referrals at team and individual level and where lower than projected, investigating, and supporting practitioners
- Telling a compelling story about the successes of the service using case stories and gathering evidence on performance
- Actively seeking, analysing, and responding to practitioner and user feedback

5.3.8 Benefits realisation approach

Measuring the financial impact of the CT service and evidencing progress towards achievement of financial targets is fundamental to successful implementation of the preferred option. An approach must be agreed that gives all stakeholders across BCP confidence in the financial benefits from transforming the service. Effectively evidencing the benefits described in Option 3 – Service Transformation requires

[11] FTE calculation has been spread across the duration of the project, however the breakdown of time may differ at different stages e.g. some roles may be full time at the start and reduce towards the end.

agreement of principles and key performance indicators that will guide the approach. This section describes some key principles and indicative KPIs.

- *Co-designing the benefits measurement framework from the outset:* developing a tailored approach to meet BCP's needs, ensuring buy-in from stakeholders.
- *Ownership by BCP:* It is important that BCP has assurance of the financial benefit that the service will realise. The approach to benefits realisation will require the active engagement of appropriate stakeholders from BCP so that the final approach and the consequent benefits are agreed.
- *Embedding benefits measurement and realisation throughout the CT pathway*: Building and validating the robust evidence base required to measure CT benefits, from the point of referral.
- *Measuring the financial impact on a granular basis*: to track both reduced packages of care as well as avoided costs, financial benefits can be measured at a granular level and aggregated up, allowing BCP to fully reconcile, audit and realise all types of benefit.
- *Manage via a balanced scorecard*: developing a series of simple, high-level key performance indicators in clear dashboards tailored for each stakeholder group. Indicative KPIs are illustrated below. These will be developed in more detail by the Benefits workstream during the implementation phase.

Figure 36: Indicative key performance indicators

Theme	Benefit / outcome	Key Performance Indicator(s)
Service outcomes	Uptake of service	Number of live connections
CT service performance	Referrals	# of referrals from BCP ASC and other routes in comparison to baseline
CT service performance	Installation time	% of standard installations completed within 10 working days from time of referral
CT service performance	Installation time	% of urgent installations completed within 48 hours (excluding weekends / bank holidays)
CT service performance	Call response time	% of calls to response centre answered within 60 seconds and 180 seconds respectively
Citizen satisfaction	User satisfaction with the service	% of users stating that they would recommend the service to others. 90% good or very good (recommended target)
Practitioner satisfaction	Practitioner satisfaction with the service	% of practitioners who state the service is 'good' or 'very good' at achieving the desired outcomes
CT staff satisfaction	CT staff satisfaction	% of favourable responses to staff engagement surveys

5.3.9 Risks and dependencies

The table below outlines the most likely risks in implementing and successfully delivering Option 3 - Service Transformation. All risks should be logged in a formal risk register, kept on review during mobilisation and implementation and reviewed at key points in delivery of the service by the appropriate governance forums. Maintaining the risk register will be the responsibility of the BCP CT Project Manager, reporting to the CT Project Board and for key risks, escalating to the CT Service Steering Group.

Figure 37: Summary of risks and dependencies

Theme	Risk	Likeli-hood	Impact	Mitigation	Likelihood following mitigation	Impact following mitigation
Capacity and capability risks	**Engagement:** BCP is a large organisation with historical high staff turnover in ASC and like many local authorities, ASC colleagues have limited capacity. This presents a risk to practitioner engagement and capacity to engage.	High	High	The implementation plan above incorporates a major workforce change programme, which includes sustained engagement through implementation, transition and beyond. Regular feedback will be sought from practitioners to test the success of this approach.	Medium	Medium
	Capability: Practitioners are not given enough support and behaviours do not change.	High	Medium	If Option 3 is delivered robustly and appropriate investment is put in place, practitioners will be supported along the journey and processes should be embedded properly. External advisory and transformation support, if commissioned, should bring experience of effective approaches to the provision of support.	Low	Low
Commercial / financial risks	**Benefits realisation**: Scepticism towards the approach to benefits realisation amongst referrers inhibits the ability of the service and the council to realise the full potential of CT.	Medium	Medium	Adopting an outcomes-focussed approach and sharing clear messages that this programme is primarily designed to achieve improved outcomes for citizens will help to alleviate scepticism. Acknowledging that there will be financial benefits, but that the options appraisal is conservative, and savings do not drive the programme, will help to manage this risk. Raising the profile of CT and its important as a core part of the care offer will also further mitigate this risk.	Medium	Low
	Benefits realisation: BCP data quality or availability and/or performance resource capacity and capability impact the quality, scope or cost or deriving a comprehensive approach to benefits measurement.	Medium	High	Pre-implementation, data, and resource requirements wil be clearly defined and articulated to ensure this is planned accordingly. Activity during implementation phase will focus on the design and delivery of a benefits realisation approach that will ensure financial benefits generated via the CT programme can be automated as much as possible, to minimise ongoing resource commitments, and ensuring that all benefits can be validated and owned by BCP. Commissioning external support with experience of working alongside Council teams to develop such approaches can provide an additional mitigation.	Low	Low

Theme	Risk	Likeli-hood	Impact	Mitigation	Likelihood following mitigation	Impact following mitigation
	Approach: Benefits modelling of this type is reliant on an outcomes-focused approach and not a service driven by technology. The success of financial benefits measurement is therefore contingent on certain elements of the service model.	Medium	Medium	If Option 3 is delivered correctly, the approach to the CT service will be outcomes based and CT will be aligned to the citizen's needs. This will minimise the likelihood of excess or inappropriate equipment being given to citizens, and maximise opportunities to realise benefits through CT.	Low	Low
	CT team costs: preferred service model requires team structure changes to deliver effectively and could bring associated change costs	Medium	Medium	Clear agreement of service model and evaluation of the impact this would have on the existing team structures. Co-design of process and policies with the CT team and other relevant stakeholders during the transformation stage. Early engagement with HR if and when appropriate.	Low	Low
	Equipment costs: digital switch results in increased CT equipment costs, potentially including replacement costs for existing monitored users	High	High	Conservative approach to modelling of financial benefits may offset increased equipment costs. Increased costs would be incurred under all options so does not make a material difference to the outcome of the Options Appraisal. Discussion with technology and systems providers to understand timescales, likely costs of equipment and any other potential solutions/mitigations.	High	Medium
Delivery and Implementation Risks	**Change and engagement:** The skills and resources needed to deliver the change (either within the project team, transformation programme and/or ASC practitioner staff or leadership) are under-estimated. The changes associated with the ASC transformation programme may cause 'change fatigue', particularly given the relatively recent large change of BCP being formed as one Council. This could create resistance to further change or distracts from the change.	High	High	This risk will need to be kept on review through transition and mobilisation – and the change will need to be managed with appropriate project management resources and processes in place so that dependencies with other initiatives across BCP are managed carefully and realistically. This may include developing shared messages across transformation projects. Successful delivery of plans outlined above should result in practitioners being supported and brought along the journey. Transformation budget includes a £50k contingency to provide additional resource should this be required.	Low	Medium
	Project delivery: The commencement of the implementation phase is reliant upon the agreement of service delivery model approach and BCP resources. A	High	High	Prioritise confirming preferred delivery model so that Stage One Mobilisation can begin as soon as practical. Engagement with other local authorities with a range of service models and experiences of transformation of CT	Medium	Medium

Theme	Risk	Likeli-hood	Impact	Mitigation	Likelihood following mitigation	Impact following mitigation
	failure to get consensus on this will delay or increase costs of the transformation, in turn delaying achievement of benefits.			services to understand the pros and cons of service model options.		
	System of record: Completion of the impending migration of system of records to align BCP on one system is delayed or has ongoing issues. This is a key dependency as completion of this enables a consistent referral process to be developed and all data capture to be consistent.	Medium	High	Planning transformation to commence following completion of migration and pre-planning system developer resource to support referral process change. Clarity of service model decisions to ensure process development has a strong foundation and there is shared agreement.	Medium	Low
	CT monitoring system: Contractual relationship with monitoring system provider (Tunstall) inhibits BCP approach to service innovation and digital migration, whilst potentially creating a potential 'supplier lock' and/or increasing transformation costs.	Medium	High	Engagement with BCP procurement to fully understand the contractual relationship with Tunstall and the levers it enables the council to pull in negotiations. Early engagement with Tunstall to understand the data the system can provide, integration capabilities and any costs associated with development requests.	Medium	Medium

6 Appendices

6.1 How outcomes might look for BCP users and staff

6.1.1 Option 2: service enhancement

Expanding offer to broader range of over 65s and small number of users with learning disabilities/difficulties needs.

Older adult (>65) with physical disability needs

Joanna is 75 with bilateral diminishing sight issues, she's been admitted to hospital twice in the last three months for falling in the home and for burning herself on the stove. She wishes to retain her independence in her own home and needs reassurance to manage daily tasks with confidence.

The solution

- **Sensory aids** in the kitchen e.g. prompts to remind her to turn the oven/stove off, delivered via a reminder device
- **Oysta GPS** device in case she falls, feels distressed or becomes unwell in the community and needs to call for help.
- **Falls detector** should she fall in the home or garden, environmental alerts linked to the lifeline and a bogus caller alarm placed near the door to alert should someone be attempting to gain entry.




LD user in supported living

Jane lives in supported living accommodation. Although she is quite independent she still needs extra support when out in the community. Jane also needs support for epilepsy.

The solution

- **Just Checking** provides discreet and anonymous movement data collection, helping to assess Jane's well-being and the detailed CT offer.
- An **Epilepsy bed sensor** helps to detect when Jane experiences a seizure and alerts the Support Staff
- An **Oysta Pearl** gives Jane greater access to the community and help when required (accessing help, falls detection, tracking).



What do outcomes look like for the practitioner

- Joanna and Jane's support staff **receive opportunities for quarterly CT training sessions** and there is **CT guidance on the Council's Intranet** including advice on what equipment is available
- Practitioners **benefit from a simplified referral process**
- **High risk equipment is proactively maintained / checked** so that practitioners have confidence that the equipment will not periodically malfunction

6.1.2 Option 3: service transformation

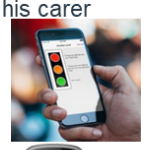
Expanding offer to higher number of adults with complex LD needs, mental health, dementia and physical support needs (over 18s), in addition to cohorts in option 2

Young adult with LD needs

Tom is young man with a learning disability who wishes to live more independently. However, his epilepsy puts him at risk when he is out of the home.

The solution

- The Brain in Hand app reminds him what solutions he can use when he is in situations that make him vulnerable. He also uses his app to help him catch a bus instead of using the taxi.
- An epilepsy sensor linked to a carer pager alerts his carer instantly if he has a fit.
- His Oysta incorporates falls detection, and allows him to quick dial his carer or the SOS button to talk to the monitoring team while he is out.
- His medication dispenser enables him to self-manage his medication


Isolated older adult

- Mr Khan lives with his wife and has recently received a dementia diagnosis. He feels frustrated and lost since his driving licence was revoked. His wife is incredibly anxious that he will get lost and wander.

The Solution

- Oysta with geofencing (safe zones) enabled – if Mr Khan moves beyond the safe zones, a family member would be alerted and could track his location on a tablet or call his device
- Property exit monitors – tells family member when he leaves the property
- Sensor memo reminders - plays a recorded message to ensure Mr Khan picks up his Oysta before going out



- **What do outcomes look like for the practitioner - In addition to outcomes in Option 2**
- **The TEC service regularly horizon scans to identify and test new technologies. Tom and Mr Khan's support staff are kept updated on the new technologies** available to help their clients, so if new needs arise they know what is available.
- They **receive regular training and support** (including **targeted training and engagement sessions** for the teams that are not referring regularly), are **able to access an equipment showroom and receive regular news bulletins and updates** on the CT service

6.2 Detailed qualitative appraisal

Through a survey process, members of the CT Project Board scored each of the options against each CSF. An average of this scoring was taken to provide a score between 1 and 5 for each CSF using the following RAG key. This provided a total qualitative score out of 75 for each option. The detailed rationale for the scoring is provided below for each option.

The rationale provided in the following tables to support the CT Options Appraisal qualitative scoring has been derived from a combination of sources:

- BCP stakeholder engagement, including the CT diagnostic and the Options Appraisal workshop (SE)
- Comments provided in the qualitative scoring survey (QS)
- PA/HCC wider sector knowledge and experience (WSK)

The source of each rationale provided is shown on the following slides using the codes SE, QS and WSK as set out above.

RAG	Description
1	The option does not meet the Critical Success Factor and/or there are significant risks or limitations to the options ability to meet the Critical Success Factor
2	
3	The option partially meets the Critical Success Factor and/or there are risks or limitations to the options ability to meet the Critical Success Factor
4	
5	Option expected to fully meet the Critical Success Factor

6.2.1 Option 1 (status quo) detailed qualitative scoring and rationale

Theme	Critical Success Factors	Score	Rationale
Improved outcomes and experience	People are equipped and confident to use CT enabling them to feel safe and supported to live independently in their own home for as long as possible	3	• There is a strategic recognition that CT has the potential to improve outcomes by enabling people to live more independently at home, however, the service is not maximising its potential as referral levels are static. *(SE)* • The service is limited, with the majority of users being from the OP cohort and receiving basic packages – meaning that opportunities to support more people or enhance support are not being maximised. *(SE)* • Operationally, the service delivers a competent core service with performance against KPIs, such as call response times, reinforcing that the service is effectively run. *(SE)*
	Discharge from hospital is supported appropriately with CT	4	• Urgent referrals include cases where CT will facilitate a rapid and safe hospital discharge, although this often results in equipment being installed without a home-based assessment. *(SE)* • The responsiveness of the service to support hospital discharge is often praised by referrers and is a key priority strategically, which is recognised and carried through by the service operationally. *(SE)*
	People and Carers are supported to access CT easily, including via self-service options, with access to information to make informed choices about care packages and use of CT	1	• There are barriers to the CT referral process that are hindering the growth of the service, including limited publicly available information and no self-service access. *(SE, WSK)* • Some Social Workers feel that the current CT assessment approach adds complexity, although others advocate for the approach. *"Currently only OT Assistants in the Poole patch are allowed to assess and issue equipment… all this seems to add layers to the provision of equipment." (SE)* • There is a lack of consistent understanding of CT across the council that is a symptom of the integration of legacy Bournemouth and Poole services. *(SE)*
Improved efficiency	CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support	1	• While the service and OTAs advocate for CT as a part of the first offer, some Social Workers see this as a supplement to care packages rather than an effective method of reducing or avoiding other forms of care *(SE, WSK)* • CT is not accessible via the Contact Centre, reducing the ability to use the service for preventative and early intervention purposes. *"It has been a real challenge to get anything to do with AT happening at the contact centre." (SE)*
	There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes	1	• No current advisory offer to enable residents to maximise the value of existing consumer technology (e.g. Amazon Alexa) *(SE)*
	Practitioner understanding of the offer and process is enhanced, driving increased uptake	1	• No change to the existing offer, beyond the gradual alignment of legacy services, meaning minimal activity to increase uptake. *(SE)* • Most diagnostic survey respondents had not received any CT training. *(SE)*

Theme	Critical Success Factors	Score	Rationale
Service capacity and capability	Data is automated and insight generated is used effectively and proactively to manage supply and demand	1	• The majority of data collected by the current service is recorded in manual spreadsheets and there is limited evidence of this being used to generate insight or manage supply or demand. *(SE)* • Data is not automated, meaning any incidents of CT informing care professional activity is ad-hoc and informal. *(SE)*
	New CT is evaluated on a regular basis and deployed as and when it is appropriate to people's needs	2	• The available range of equipment has been developed over time but there is still a perception amongst some social workers that the offer is limited. *(SE, WSK, QS)* • Where new CT equipment is added to the service offer, this is usually market or supplier driven, rather than needs driven, and there is no consistent and formal evaluation process. *(SE)* • There are clear opportunities to expand the offer through both pathway and equipment innovation. *(SE, WSK, QS)*
	The scope of the service is expanded to increasingly support younger adults, people with long term conditions and people with learning disabilities	2	• No expansion of service resulting in continued minimal and ad-hoc CT support of younger adults or people with learning disabilities *(SE)*
Value for money and financial sustainability	Provides a clear mechanism for robustly measuring the financial and non-financial benefits of the CT service	2	• Mechanism in place for measuring financial benefits of the service is labour intensive and time consuming and is not consistently or robustly audited or used to inform ASC budgets *(SE)*
	Delivers on target financial benefits within agreed timeframes, through avoided and reduced costs of care	1	• No formal financial benefits target agreed for the current service and this would not be introduced as part of this option *(SE)*
	Generates opportunities and strengthens the case to access additional funding	1	• No change to service means that is no strengthening of the current case for accessing funding opportunities resulting in no additional opportunities beyond those currently available *(SE, WSK)*
Deliverability	The CT project delivers the agreed scope to quality, time and budget	5	• No change meaning that no additional costs incurred *(SE, WSK)*
	Provides adequate resource and capability to deliver and embed the change	2	• No change meaning that no additional resource or capability is required (SE, WSK)
	Offers effective change management, including communications and engagement, to drive service improvement	1	• No change management or significant service improvement offered by this option (SE, WSK)

6.2.2 Option 2 (service enhancement) detailed qualitative scoring and rationale

Theme	Critical Success Factors	Score	Rationale
Improved outcomes and experience	People are equipped and confident to use CT enabling them to feel safe and supported to live independently in their own home for as long as possible	4	• Improvements in the referral process and it's consistency across the council will improve the current service significantly but the limited cultural change activity may not be sufficient to secure practitioner and wider stakeholder buy-in. (SE, QS, WSK) • The increased emphasis on equipment innovation and support for some younger adults on a more formal basis is an improvement in comparison to Option 1. (WSK)
	Discharge from hospital is supported appropriately with CT	4	• A strength of the current service, Option 2 continues to deliver the high level of responsiveness to hospital discharge referrals but with an increasing effectiveness due to process improvements and an expansion of the equipment offer. (SE)
	People and Carers are supported to access CT easily, including via self-service options, with access to information to make informed choices about care packages and use of CT	2	• Whilst some process improvements provide people and carers with an enhanced experience, no self-service option is developed under Option 2. (SE, WSK) • Development of training and other service materials provide some additional information that are adapted for public consumption but in the absence of a self-service referral route, these have a minimal impact. (WSK)
Improved efficiency	CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support	3	• Undertaking a CT enhancement programme and embedding CT specific training raises the profile of the service but the absence of an extensive culture change programme means it may not fully capture "hearts and minds" and may see a reversion to type post enhancement rollout. (SE, WSK) • Referral process improvements help position CT as a core part of the first offer but enhancement does not effectively incorporate the Contact Centre as a key referral source, limiting prevention impact. (SE, WSK)
	There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes	3	• Implementing a formal approach to service governance at a strategic level and an innovation evaluation methodology results in an increased range of technology compared to Option 1, reaching a wider range of users, including LD Supported Living. (SE, WSK, QS)
	Practitioner understanding of the offer and process is enhanced, driving increased uptake	3	• Referral process improvements and regular training result in great understanding of the service amongst practitioners, however, the lack of an extensive ongoing culture change programme means that this impact may only be short-term. (SE, WSK)

Theme	Critical Success Factors	Score	Rationale
Service capacity and capability	Data is automated and insight generated is used effectively and proactively to manage supply and demand	2	• Referral process improvements automate some elements of data collection but does not allow for integration with other data or for insight to be generated automatically. This means insight generation to inform practitioner interventions and management of supply and demand remains ad-hoc and manual. (WSK)
	New CT is evaluated on a regular basis and deployed as and when it is appropriate to people's needs	3	• Implementing a consistently applied innovation evaluation methodology results in an increased range of technology compared to Option 1. (WSK) • Regular training of care professionals and an increased awareness of the service generates increased levels of feedback facilitating a shift towards needs-based approach to equipment innovation. (SE, WSK, QS)
	The scope of the service is expanded to increasingly support younger adults, people with long term conditions and people with learning disabilities	4	• Service scope is increased to proactively provide CT to people with learning disabilities in a supported living setting through a specific and targeted process. (SE, WSK, QS) • Wider rollout of use with younger adults and people with long term conditions in the community continues to be limited due to the absence of self-service access or significant ongoing communications activity. (SE, WSK, QS)
Value for money and financial sustainability	Provides a clear mechanism for robustly measuring the financial and non-financial benefits of the CT service	3	• Referral process improvements enable additional non-financial benefits to be measured on a semi-automated basis. (SE, WSK) • A sampling approach to financial benefits builds on the existing method, whilst reducing the level of manual activity required. (SE, WSK) • Methodology and assumptions are agreed with finance and other relevant stakeholders to ensure the outputs consistently and appropriately inform budget setting. (WSK)
	Delivers on target financial benefits within agreed timeframes, through avoided and reduced costs of care	3	• Financial benefits are achieved in traditional ways for CT, through the avoidance or delay of homecare and residential care but there are limited examples of direct savings being achieved via package reductions (LD Supported Living). (WSK, SE, QS)
	Generates opportunities and strengthens the case to access additional funding	3	• Raised profile and increased awareness of CT result in additional opportunities but the success of any funding applications is impaired by limited data and evidence due to lack of automation. (SE, WSK, QS)

Theme	Critical Success Factors	Score	Rationale
Deliverability	The CT project delivers the agreed scope to quality, time and budget	4	• Whilst change compared to Option 1 is significant, the scale of change is small relative to Option 3. Changes have limited interaction with external parties providing a level of internal control that increases the likelihood of the project delivering to time and budget. (WSK, QS) • Delivery of scope to time is subject to internal capacity and is vulnerable to operational or other change activity taking priority and impairing progress. (SE, WSK)
	Provides adequate resource and capability to deliver and embed the change	3	• Existing CT team have limited capacity to deliver change at this scale with current staffing levels and operational demands. (SE, WSK, QS) • Reduced scope compared to Option 3 makes internal delivery of change achievable but is subject to release of additional internal capacity with the relevant skillset (change, project management etc). (SE, WSK, QS)
	Offers effective change management, including communications and engagement, to drive service improvement	3	• Change management capability would need to be provided to supplement the knowledge of the existing team and will have a short term impact but lack of ongoing culture change will likely see communications and engagement activity tail off, failing to embed a culture of continuous improvement. (SE, WSK, QS)

6.2.3 Option 3 (service transformation with external advisory support) detailed qualitative scoring and rationale

Theme	Critical Success Factors	Score	Rationale
Improved outcomes and experience	People are equipped and confident to use CT enabling them to feel safe and supported to live independently in their own home for as long as possible	4	• Transformation of the referral process embeds best-practice, removing barriers to referral and increasing uptake of the service. (SE, WSK) • A wider range of cohorts benefit from CT with LD (homecare and supported living) a core part of the offer and increasing rollout to mental health and other pathways. (SE, WSK, QS) • An upskilled CT team and increase in practitioner awareness drives a change in attitude towards technology, empowering people to use CT as a vehicle to improved independence. (SE, WSK, QS)
	Discharge from hospital is supported appropriately with CT	4	• A strength of the current service, Option 3 continues to deliver the high level of responsiveness to hospital discharge referrals but with an increasing effectiveness due to process improvements and an expansion of the equipment offer. (SE)
	People and Carers are supported to access CT easily, including via self-service options, with access to information to make informed choices about care packages and use of CT	5	• Full transformation of the referral process integrates self-service as an option for service users, enabling them to trigger the first stage of a referral. (SE, WSK) • External communications and engagement activity as part of an extensive culture change programme provide a range of materials accessible to the public to promote the service. (SE, WSK) • Engagement with the Contact Centre and other relevant Council departments ensure people can be signposted to the self-service referral route from a range of sources enabling earlier intervention. (SE, WSK)

Theme	Critical Success Factors	Score	Rationale
Improved efficiency	CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support	5	• Removes the reliance on a group of core referrers and makes CT referrals the responsibility and right of all through self-service access. (SE, WSK, QS) • Culture change programme equips the contact centre to discuss CT in the first conversation, providing the information to allow users to make informed choices. (WSK) • Transformation activity raises the profile of CT further than Option 2 with training and other communications stressing the importance of CT as part of the first offer, aligning this to clear service eligibility. (SE, WSK, QS)
	There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes	5	• Implementing a formal approach to service governance at a strategic level and an innovation evaluation methodology and embedding this through ongoing culture change activity results in an increased range of technology compared to Options 1 and 2. (SE, WSK, QS) • The proactive rollout of the service to a wider range of users, including LD and Mental Health drives a needs-based approach to service and equipment innovation. (SE, WSK, QS)
	Practitioner understanding of the offer and process is enhanced, driving increased uptake	4	• Process redesign is co-produced with practitioners, building confidence and removing barriers to access. (WSK) • Extensive culture change activity provides all practitioners with a baseline level of knowledge, the awareness of where to access additional resources and support and exposure to the service on a regular basis through communications and engagement events. (SE, WSK)

Theme	Critical Success Factors	Score	Rationale
Service capacity and capability	Data is automated and insight generated is used effectively and proactively to manage supply and demand	4	• Referral process transformation ensures capture of all inputs required to monitor performance against agreed KPIs (WSK) • Data from a range of sources is collated in an automated dashboard to enable immediate oversight of supply and demand and facilitate increased effectiveness of service management. (WSK) • Process developed to identify insight, such as escalating needs, from call monitoring data. (SE, WSK)
	New CT is evaluated on a regular basis and deployed as and when it is appropriate to people's needs	5	• Additional ongoing capacity and capability provides the resource for regular innovation activity (SE, WSK, QS) • Expansion of offer to reach a wider range of cohorts creates a broader pool of stakeholders to identify needs that could be met with technology and a shift towards needs-based innovation. (SE, WSK, QS) • External support brings wider experience of CT solutions and pathways from elsewhere to provide an initial indication of potential innovation priorities. (WSK)
	The scope of the service is expanded to increasingly support younger adults, people with long term conditions and people with learning disabilities	5	• A core focus of Option 3 is expansion of the offer to support younger adults, people with long term conditions and people with learning disabilities. This is facilitated through a widespread culture change programme reaching practitioners from a wide range of specialisms. (SE, WSK, QS) • Tailored pathways enable the referral process to be adapted accordingly to capture any cohort specific insight. (SE, WSK) • Commissioned advisory support offers expertise to support rollout to new cohorts, enabling this process to be expedited, learning the lessons of other local authorities. (SE, QS)

Theme	Critical Success Factors	Score	Rationale
Value for money and financial sustainability	Provides a clear mechanism for robustly measuring the financial and non-financial benefits of the CT service	5	• Regular automated approach to benefits measurement developed in alignment with agreed KPIs and transformed referral process. (SE, WSK, QS) • Quarterly and annual audit processes designed and implemented to include finance colleagues and ensure financial benefits can be appropriately considered in budget setting. (WSK) • Transformed referral process captures additional non-financial benefit insight to evidence the quality of life impact of the service. (SE, WSK, QS)
	Delivers on target financial benefits within agreed timeframes, through avoided and reduced costs of care	4	• Growth of service through additional pathways and cohorts and increased update due to culture change activity drive growth in referral numbers and achievement of greater gross financial benefits than in other options. (WSK) • Financial benefits performance visualised within service dashboard to enable immediate analysis of performance against target. (WSK)
	Generates opportunities and strengthens the case to access additional funding	4	• Scale of transformation and culture change activity generate a 'buzz' around CT and supports engagement with wider system partners about the role of CT in achieving strategic ambitions. (SE, WSK, QS) • Evidence of impact generated through improved data provision enables stronger funding applications. (WSK, QS)
Deliverability	The CT project delivers the agreed scope to quality, time and budget	4	• Commissioning of external support enables the transformation expectations to be set out to the provider and quality, time and budget to be managed contractually (WSK) • Additional budget required due to provision of external support, although offset by the potential for quality that this brings. (SE)
	Provides adequate resource and capability to deliver and embed the change	4	• Drawing on external support provides resource and capability to conduct a transformation of this scale, without significantly impacting on existing CT team resources. (SE, WSK) • Capability is enhanced through sector knowledge and experience elsewhere of supporting party. (SE, WSK) • Ongoing culture change activity is planned according to desired level of external support to ensure change is embedded and stakeholders do not revert to type following the transformation. (SE, WSK, QS)
	Offers effective change management, including communications and engagement, to drive service improvement	4	• Communications and engagement form a central part of culture change on an ongoing basis, embedding an expectation of continuous improvement. (SE, WSK, QS)

6.3 Breakdown of transformation costs and roles

The following costs correspond to the financial model for Option 3. Costs are based on high-level assumptions based on BCP backfill or external roles and any other expenditure anticipated.

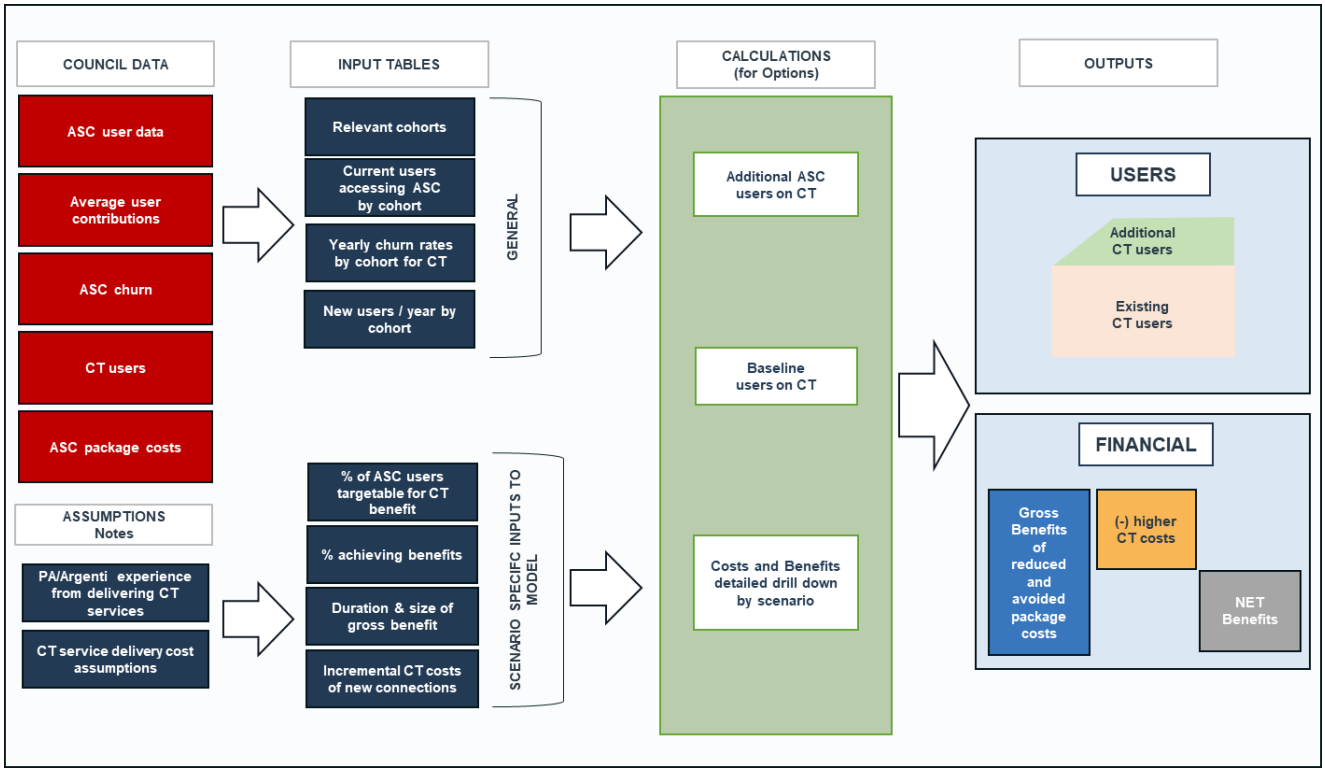
Table 7: High-level transformation costs

Workstream / activity	Indicative cost (£)	Description
Project Management and Leadership	£100k	• Full time PM • Backfill for leadership roles in the project
Service redesign	£80k	• Service Redesign Lead
Agreeing benefits framework	£150k	• Business / Performance Analyst • Development of a benefits tracking dashboard • Systems development
Workforce change programme	£120k	• Change Manager and Comms / Engagement Lead • Launch communications • Potential external training resource needed
Contingency	£50k	
Total	**£500k**	

6.4 Quantitative appraisal methodology and assumptions

CT financial modelling approach

The image below provides a very high level summary of the mechanics of the model used to estimate the potential financial impact of CT in the options appraisal.



Measuring CT financial impact as part of the appraisal

The table below shows the possible financial impacts of CT interventions for a range of ASC cohorts that have been modelled.

Cohort Ref	Setting of care / cohort	Cohort	Impact	Measurement	Option
A	Homecare- OA users	Existing users	CT enables reduction in homecare package for existing OA users	Fewer hours of homecare per week	Option 2 and 3
B	Homecare- OA users	New users	CT prevents need for homecare for new OA users	Avoided hours of homecare per week	Option 2 and 3
C	Residential / nursing care	New users	CT delays entry to residential / nursing for new OA users	Avoided weeks of residential care	Option 2 and 3
D	Supported Living – LD users	Existing users	CT reduces need for support for existing LD Supported Living users	Fewer hours of support for waking nights, sleep-ins, 1:1 or 2:1 support	Option 2 and 3
E	Supported Living – LD users	New users	CT prevents need for support for new LD Supported Living users	Avoided hours of support for waking nights, sleep-ins, 1:1 or 2:1 support	Option 2 and 3
G	Homecare- LD users	Existing users	CT enables reduction in homecare package for existing LD users	Fewer hours of homecare per week	Option 3
H	Homecare- LD users	New users	CT prevents need for homecare for new LD users	Avoided hours of homecare per week	Option 3

Methodology Notes

- The number of new CT service users grows based on new ASC users being added through churn and the availability of a transformed CT service (i.e. care practitioner training, simplified referral processes and so on) along with new pathways for additional citizen cohorts
- Gross benefits will be realised by targeting a range of users where CT can reduce existing care package costs and avoid alternative provisions, such as residential admissions
- Gross costs are based on variable cost components increasing with incremental CT service volumes plus other fixed costs
- The net position shows the costs and benefits associated with users receiving CT, incremental to the status quo
- Assumes that ~25% of users with a private pay CT service have an adult social care eligible need
- The assumptions made have been informed by a combination of data provided by BCP, practitioner feedback through 1:1 meetings and PA's experience in delivering CT services in other local authorities, which have achieved significant financial benefits.

Sources of data and assumptions

Data on costs and benefits within this analysis have been sourced from the following:

- Data on costs have been sourced where possible from BCP Adult Social Care & Public Health service
- Where costs are not available, or the 'to-be' service model is expected to entail a significant change in cost versus current, we have made assumptions based on PA's experience of reviewing and delivering CT services in other local authorities
- Assumptions on potential financial benefits have been developed based on PA Consulting's experience of delivering services elsewhere (see note below) and BCP local sources.

Note on PA Consulting's wider CT experience

PA Consulting, in partnership with a specialist CT monitoring provider and CT installation and assessment provider, delivers, or has delivered, CT services to a number of Councils under the 'Argenti' service. Argenti currently delivers CT services in Hampshire County Council and London Borough of Barnet and has previously worked in the the South of Essex County Council and Dorset County Council. PA has also undertaken advisory work on CT services in 20+ councils nationally.

Financial Modelling Inputs and Assumptions (User Numbers)

Data Items	Source	Updated Figures (Business Case)
Number of ASC users (by type of provision)	BCP data	1,153 OA users accessing homecare (ST & LT) and direct payments as of 31st March 2022
		738 OP users accessing residential and nursing care (ST & LT) as of 31st March 2022
		466 users with LD accessing supported living as of 31st March 2022
Yearly churn rate of existing ASC users	Other similar sized councils	OP homecare & direct payments: 66.9% per year OP nursing/ residential/ respite: 33.8% per year LD supported living: 10.4% per year LD Home care: 11.7% per year
Future annual growth of ASC user numbers	Modelling assumption	OP homecare & direct payments: -1.7% per year OP nursing/ residential/ respite: -6.8% per year LD supported living: 23.9% per year LD Home Care: 0.3% per year
Total number of existing users accessing CT	BCP data	5,229 users accessing monitored CT ~25% of Total private pay users **1,307 users as of March 22**
Yearly churn rate of users accessing CT	Modelling assumption	24.8% per year (based on the average leavers in FY2020-21 and FY 2021-22 as a ratio of current size of the CT service)
Yearly CT service growth	Modelling assumption	-0.4% per year (based on the average net change in the service in FY2020-2021 and FY2021-22 as a ratio of current size of the CT service)

Financial Modelling Inputs and Assumptions (Rates)

Data Items	Source	Updated Figures (Business Case)
Cost of 1 hour of Home Care	BCP Data	£20.14 per hour
Avg. weekly cost of a Residential Care/ nursing/ respite package		£915.00 per week
Avg. cost of LD supported accommodation		£923.49 per week
Avg. citizen contribution for home care		26% *(based on BCP data)*
Avg. citizen contribution for residential Care		25% *(based on BCP data)*
Avg. citizen contribution for LD supported accommodation		7.0% *(based on BCP data)*

Financial Modelling Inputs and Assumptions (Costs)

Data Items	Source	Figures	Notes
Equipment cost	Modelling Assumption	£342 for Essential £684 for Advanced £1,512 for Specialist (** definitions below)	1) Assumed that the service will be transformed going forward and more technology will be available to users. Costs based on PA's experience from other councils 2) Uplifted by 1.8 to reflect likely cost of digital equipment
Install & Assessment Costs	BCP data	£36 for Assessments £18 for Installation	1) Based on the transformed model described in our diagnostic, we have modelled that assessments are carried out for every install
Monitoring Costs	BCP data	£2 per user per week for monitoring	
Other Variable Costs	Modelling Assumption	£2.5 per user per week	Cost based on PA's experience from other councils.
Transformation cost	Modelling Assumption	£300,000 (option 2) £500,000 (option 3)	Includes: - Culture change, training and engagement - Project management - Service redesign - Benefits framework redevelopment *Scope of activity varies by Option*

** **Essential** – Basic CT package e.g. Just a 'button and a box'; **Advanced** – Slightly more intensive CT package, e.g. falls detector, flood detector as well as button and a box; **Specialist** – Intensive, high-value CT package, for example including a monitored epilepsy sensor

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Report subject	**BCP Carers Strategy**
Meeting date	26 September 2022
Status	Public Report
Executive summary	The BCP Carers Strategy (2022-2027) sets out 5 key strategic priorities to support carers and recognise the valuable contribution they make to our community. At least 39,000 people in Bournemouth, Christchurch and Poole are carers and they play a vital role in sustaining our health and social care system by enabling the people they care for to live safely in their own homes for longer. The strategy has been shaped by the views and experiences of local carers and aims to support them to look after their own health and wellbeing, to enable them to stay in their caring roles and prevent, reduce, or delay the need for health and care services for the people they care for.
Recommendations	**It is RECOMMENDED that:** **Committee supports the recommendation to cabinet to approve the BCP Carers Strategy, contained in Appendix 1 to this Report**
Reason for recommendations	The Strategy: (i) Delivers support to carers to allow them to sustain their caring role and enable people to live safely in their own homes for longer, delaying, reducing, or preventing the need for health and social care services; ii) Meets the requirements of the Care Act (2014); and ii) Supports the priorities of the Corporate Strategy and Adult Social Care Strategy

Portfolio Holder(s):	Councillor Karen Rampton – Portfolio Holder for People and Homes
Corporate Director	Phil Hornsby, Director of Commissioning for People David Vitty, Director of Adult Social Services
Report Authors	Emma Senior, Commissioning Manager – Prevention and Wellbeing
Wards	Council-wide
Classification	For Recommendation

Background

1. A carer is anyone who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. Whilst the care they give is unpaid, they may still be in receipt of Carers Allowance.
2. For the purpose of this strategy the term 'carer' does not include individuals employed in paid care work, (e.g., commissioned care, via a Direct Payment, or as part of work with a voluntary sector organisation). Under the Care Act 2014, s.10 (9) An adult is not to be regarded as a carer if the adult provides or intends to provide care
    a. under or by virtue of a contract, or
    b. as voluntary work
3. Research commissioned by Carers UK estimates that 10.58 million adults in the UK are carers, which equates to 1 in 5 people. Since October 2020, there has been a 42% increase in carers providing more than 20 hours of care per week. The value of their care is significant, with carers saving the economy £132 billion per year, which is an average of £19,336 per carer.
4. At least 11% of people in Bournemouth, Christchurch and Poole are unpaid carers. Although it is a challenge to identify the true number of carers, the increasing membership of the BCP carer support service (CRISP – Carers Resource, Information and Support Programme), currently standing at 5,665 carers, suggests that they remain under-represented.
5. In December 2021, a survey was developed in collaboration with carers, Members of the Health and Adult Social Care Overview and Scrutiny Committee, Adult Social Care professionals, and CRISP. The aim of the survey was to find out how easy carers found it to access support and what would help them the most in their caring role.
6. 2804 online survey links and 2447 paper copies were sent to carers registered with CRISP. The survey was also distributed through Adult Social Care networks to partners, commissioned services and voluntary agencies that work with carers who support people residing in the BCP Council area.

7. To ensure the survey reached carers not registered with CRISP, organisations and agencies of underrepresented groups were informed of the survey and review. Both online and paper versions were sent to these groups along with a cover letter, for them to distribute to carers.
8. In total, 742 carers responded to the survey, 331 were digital responses, and 411 were paper responses.
9. As part of the survey, carers were asked if they wanted to participate in focus groups to share their feedback further and contribute to the carers services review; 179 carers volunteered.
10. In total, 30 focus groups were held with carers and 10 focus groups were held with Adult Social Care professionals and external organisations. Feedback was also obtained from carer representatives and practitioners in various forums that take place locally, including the Pan Dorset Carers Steering Group, Dorset Carers Partnership Group, BCP Carers Reference Group, Carers Action Group and Carers Operational Group.
11. Focus groups were facilitated via several methods, including group video conferencing, 1-1 video conferencing, 1-1 telephone calls, home visits, face to face workshops and email.
12. The feedback collated from the carers services review has informed the 5 key strategic priorities of this strategy. The priorities have also been supported by the BCP Carers Reference Group, The Pan Dorset Carers Steering Group, the Dorset Carers Partnership Group, the Health and Adult Social Care Overview and Scrutiny Committee and the We Care Campaign
13. The 5 key strategic priorities for the BCP Carers Strategy are:

Priority 1: **Identification and Recognition**

- Identify carers as early as possible in their caring journey
- Support carers to self-identify
- Recognise the full diversity of carers
- Recognise the contribution that carers make to society
- Involve carers in planning, commissioning decisions and service design

Priority 2: Information and Advice

- Ensure information and advice is accessible to all carers
- Involve carers in the planning and development of information and advice
- Invest in training for carers and professionals

Priority 3: Supporting Carers Physical, Mental and Emotional Wellbeing

- Enable carers to take a break from their caring role
- Support carers to look after their own physical and mental health

Priority 4: A Life Alongside Caring

- Enable carers to have time for themselves
- Enable carers to have access to education and employment

- Support carers to access activities they enjoy

Priority 5: Collaborative Working Across Dorset

- Work with partners to ensure equity of service across Dorset
- Engage with all organisations across Dorset that support carers to promote, value and recognise carers services

14. The strategy identifies the areas where success will be measured and once the strategy has been approved, a detailed delivery plan will set out smart objectives and how these will be measured and achieved year by year.
15. The strategy will be taken to Cabinet on 28th September 2022.

Summary of financial implications

16. The Better Care Fund is providing £1.23 million for carers for 2022/23, and the delivery against the priorities identified in the carers strategy will be within this financial envelope.
17. Staff capacity for the BCP carers support service will need to be increased to carry out the recommend priorities of the strategy. This will require a shift of funding within the Better Care Fund, with some of the funds allocated for residential respite being moved into the staffing budget. Modelling will need to take place to understand the likely impact on respite provision and how this is offered in the future to best meet the needs of carers and those they care for.

Summary of legal implications

18. The Care Act 2014 makes provision for the responsibility and duty on a local authority to assess a carer's need for support, to include any possible future support, what those needs may be and how those identified needs will be met having been evaluated and if they meet the eligibility criteria.
19. The strategy aims to support and encompass the statutory duties placed on the local authority to carers living in Bournemouth, Christchurch and Poole.

Summary of human resources implications

20. Additional staff capacity will be needed for the BCP carer support service, with new roles being developed and recruited to carry out the recommended priorities of the strategy.

Summary of sustainability impact

21. A decision impact assessment report has been produced and is showing a positive impact on:
    a. Communities and culture
    b. Economy
    c. Health and Wellbeing
    d. Learning and Skills
    e. Sustainable Procurement

f. Transport and accessibility

22. The carbon footprint of the BCP Carers Strategy is classified as low

Summary of public health implications

23. Approving the BCP Carers Strategy will improve the health and wellbeing of carers as one of the key strategic priorities is to support carers physical, mental, and emotional wellbeing. It would also reduce local health inequalities by promoting collaborative working across Dorset to ensure equity of service.

Summary of equality implications

24. An Equality Impact Assessment (EIA) screening tool has been completed and reviewed by the EIA Panel. The panel gave a green rating and praised the level of engagement that had been carried out for the BCP Carers Strategy. A copy is contained in appendix 2 to this report.

25. The priorities of the BCP Carers Strategy will have positive equality implications as they will improve the accessibility of carers services and allow more carers with protected characteristics to have access to information, advice and support that is tailored to their needs.

Summary of risk assessment

26. As the priorities of the strategy were developed through engagement with carers, if these are not supported there is a risk of reputational damage to BCP Council for not taking into account the views of the people the strategy has been written for.

27. If the Better Care Funding for carers is reduced or withdrawn in future, the priorities of the strategy would need to be reviewed to ensure any available funding is targeted to areas where is has the greatest impact.

28. If staffing levels for the BCP carer support service are not increased, the recommended priorities of the strategy will be harder to achieve, with carers receiving less support and being more likely to require formal health and social care services for the person they care for.

Background papers

29. Published Works:

Make Caring Visible, Valued and Supported – Carers Week 2022 Report, Carers UK (2022) Available at: www.carers-week-2022-make-caring-visible-valued-and-supported-report_final.pdf

Unseen and undervalued – the value of unpaid carers support during the pandemic, Carer UK (2020) Available at: www.carersuk.org/images/News_and_campaigns/Unseen_and_undervalued.pdf

Appendices

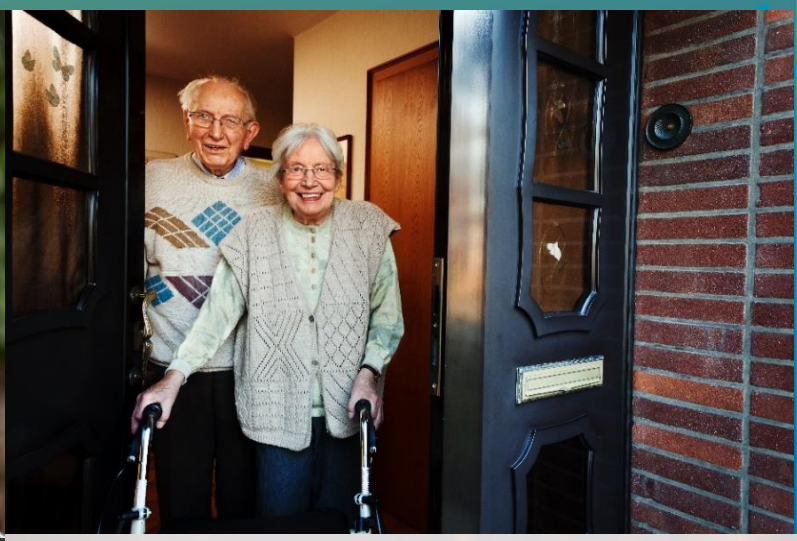
1. BCP Carers Strategy

2. EIA Screening Tool for the BCP Carers Strategy

Appendix 1

BCP Carers Strategy

2022-2027



Welcome

Councillor Karen Rampton, Portfolio Holder for People and Homes

Councillor Laurence Fear, Lead Member for Wellbeing

Phil Hornsby, Director of Commissioning for People

David Vitty, Director of Adult Social Services

Welcome to the first Carers Strategy for BCP Council.

In recognising the valuable contribution that carers make to our community, this strategy sets out our plans for supporting them to look after their own health and wellbeing, just as much as they do for the people they care for.

1 in 5 adults in the UK are estimated to be carers, providing unpaid care and support to partners, family members, friends, and neighbours. The role they play is vital in sustaining our health and social care system and enabling people to live safely in their own homes for longer.

Being a carer often comes with a huge personal sacrifice and can cause a detrimental impact on physical, mental, and emotional wellbeing. Many carers have to juggle their caring responsibilities with employment and education as well as sacrificing their own time, energy, and money to provide support.

It is essential that we recognise the impact of caring and ensure that carers are supported so they can continue to stay in their caring role as long as they wish to, whilst also having a life alongside caring.

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Introduction

Who is a carer?

A carer is anyone who looks after a family member, partner, friend, or neighbour who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. Whilst the care they give is unpaid, they may still be in receipt of Carers Allowance

The value of care

Carers UK is the UK's only national membership charity for carers. They provide support for carers, campaign for lasting change and conduct valuble research. They estimate that one in five adults are carers, equivalent to around 10.58 million people in the UK[1]. Carers help to reduce the demand on health and social care services by enabling people to live independently for longer in their own communities. The value of their care is significant, with carers saving the economy £132 billion per year, which is an average of £19,336 per carer[2].

Impact of the Covid-19 pandemic

Since early 2020, the Covid-19 pandemic had a major impact on carers, which continues to be felt even now.

With services temporarily ceasing, the pressure on carers intensified and they became more isolated, with many having to shield along with the person they were caring for. Carers UK reported a 42% increase in carers providing more than 20 hours of care per week since October 2020[1]. They also found that 69% of carers reported worsening mental health and 64% reported worsening physical health as a result of caring during the pandemic[3].

[1] Making Caring Visible, Valued and Supported – Carers Week Report, Carers UK (2022)
[2] Valuing carers – based on 2015 carer projection, Carers UK (2015)
[3] Breaks or Breakdown – Carers Week Report, Carers UK (2021)

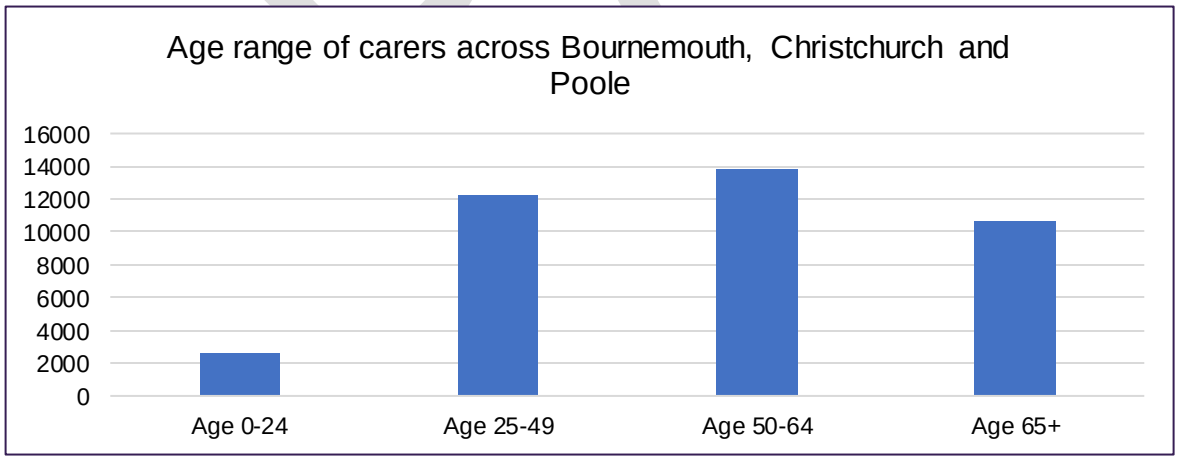
Caring in Bournemouth, Christchurch, and Poole

According to the 2011 Census, 11% of the population of Bournemouth, Christchurch and Poole are carers. This equates to 39,325 people, with the majority providing up to 19 hours of care per week (Table 1).

Hours of unpaid care	Number of carers in BCP
Provides 1 to 19 hours of unpaid care per week	25,974
Provides 20 to 49 hours of unpaid care per week	4,792
Provides 50 plus hours of unpaid care per week	8,759
Total	**39,325**

Table 1: 2011 Census figures

It is expected that this figure will have increased when the full 2021 Census figures are released within the next two years, with early findings showing that the BCP population increased by 5.7% as a whole, with a 39.6% increase in 70-74 year olds. This may result in a shift in the number of carers who are aged 65 plus, compared to the age ranges of carers reported in the 2011 Census (Graph 1).



Graph 1: 2011 Census figures

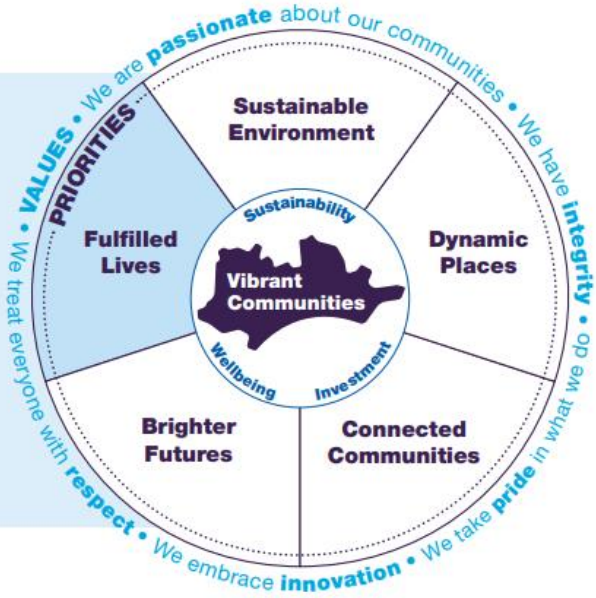
There are currently 5665 carer members registered with the BCP Carers Support Service – CRISP, which represents only 14% of carers across the BCP area. This shows how essential it is that we encourage more carers to identify themselves and register for support.

BCP Council's Corporate Strategy

BCP Council is one of the UK's newest local authorities. It is the 10th biggest urban authority in England, currently serving a population of approximately 400,000 which is expected to grow year on year. With this growth comes increased demand for council services against a backdrop of unprecedented challenges that has seen central government funding for local services continue to decline, with more resources raised locally, which in turn requires a thriving local economy and engaged communities.

BCP Council's Corporate Strategy sets out its vision, mission and priorities, and the values which underpin the way services are developed and delivered.

The corporate strategy identifies Fulfilled Lives as one of its key priorities to help people to lead active, healthy and independent lives. Under this priority is a commitment to value and support carers. The strategy states that BCP Council will:



- Increase the availability and options for time out and short breaks for carers
- Improve the accessibility, quality, and range of information available to young carers to increase take up of the services available to support their needs
- Modernise day opportunities so that all residents with care and support needs have opportunities to engage in daytime activity in both day centre and community settings, some of which will offer an important break for carers.

BCP Council's Adult Social Care Strategy

In 2021, BCP Council produced its first Adult Social Care Strategy, which sets out its objectives and priorities for adult social care over four years. It outlines an ambitious plan, for working together with partner organisations from health, housing, the voluntary and community sector, and independent care providers. It also incorporates the views of adults and carers who draw on services, plus other local residents and communities.

One of the key priorities of the Adult Social Care Strategy is to value and support carers. It sets out that BCP Council will:

- Work with carers to improve access to information and advice, ensuring it is delivered at the right time and tailored to the individual carer
- Work with the NHS to increase the numbers of carers receiving support and services personalised to their individual need
- Increase the availability and options for time out and short breaks for carers.

BCP Council's Corporate Strategy and the Adult Social Care Strategy both make a commitment to carers and recognise the role that carers play in reducing the demand on social care services. By providing the support that carers need to continue in their caring roles, we can help to relieve the pressure on NHS and social care services and enable people to remain as independent as possible in their own homes for longer.

This strategy will also sit alongside BCP Council's Young Carers Strategy and support young carers transitioning into adults' services.

BCP Carers Services Review

In December 2021, carers of people living in the BCP Council area were invited to take part in a local survey as part of a review of carers services and to inform the priorities of this strategy. Digital and paper surveys were sent to carers registered with the BCP Carers Support Service – CRISP, and copies were distributed to partners and organisations from across the voluntary and community sector that support carers. Organisations that support underrepresented groups were specifically targeted to try and reach as many carers as possible.

In total, **742** carers responded to the survey, with **411** paper responses and **331** digital responses. As part of the survey, carers were invited to join in focus groups to share their views in more detail. **179** carers volunteered to participate.

Thirty focus groups were held with carers online and over the telephone. Four home visits were carried out, and one group meeting was held in person. The facilitation of the focus groups remained flexible to enable as many carers as possible to provide their views. Some sessions were carried out in the evening and on weekends to better suit working and parent carers.

Ten focus groups were also held with Adult Social Care professionals and external organisations.

The feedback collated from the carers services review has informed the priorities of this strategy. The priorities have also been supported by the BCP Carers Reference Group, The Pan Dorset Carers Steering Group, the Dorset Carers Partnership Group, the Health and Adult Social Care Overview and Scrutiny Committee and the We Care Campaign.

Partnership Groups Supporting Carers across Dorset

There are a number of partnership groups from across Dorset that enable professionals in health, social care, and the voluntary and community sector to work collaboratively with carers, be involved in the planning and development of services, and ensure that as many carers as possible can access the information, advice and support they need.

BCP Carers Reference Group

The BCP Carers Reference Group acts as a consultative group and is a voice for carers from the age of 16 years upwards. The group is a point of contact for local carers in the BCP Council area to:

- Come together to share personal views and experiences of services and support to carers;
- Influence the planning, review, funding and delivery of support services for carers; and
- Inform, through consultation, the strategic and operational objectives of BCP Council and its partner organisations in the health and social care sector.

Any carers or former carers providing care and support to people living in Bournemouth, Christchurch or Poole are welcome to join the Carers Reference Group. Carers officers working within the local authorities and the NHS are also invited to attend meetings to discuss issues of concern or provide information and support.

Pan Dorset Carers Steering Group

The Pan Dorset Carers Steering Group is a strategic group responsible for the development, production and implementation of the Pan-Dorset strategic vision: "*Valuing Carers in Dorset*"[4], which is currently being reviewed. This strategic vision aims to ensure that people

[4] https://www.bcpcouncil.gov.uk/Adult-social-care-and-health/Docs/valuing-carers-in-dorset-brochure.pdf

can recognise when they are taking on responsibilities that would identify them as a carer and help them to maintain their own health and wellbeing in their caring role for as long as they wish. The group brings together carers, former carers and partners from across Dorset who regularly engage, co-produce and develop strategies to make sure that unpaid carers can access the appropriate support and services they need. The group informs all parties of progress, through information sharing, monitoring, and review.

The BCP Carers Strategy will complement the Pan-Dorset strategic vision by addressing the specific needs of carers of people living in Bournemouth, Christchurch and Poole. This will enable us to respond appropriately to local need whilst still delivering the wider Dorset vision.

Dorset Carers Partnership Group

The Dorset Carers Partnership Group (DCPG) was developed during the initial phase of the COVID-19 pandemic, giving members the opportunity to discuss carer-related matters as a collective partnership. The group has practitioners from Bournemouth, Christchurch and Poole and Dorset Councils, NHS Dorset, Dorset Healthcare, and members of voluntary and community sector organisations. The DCPG works alongside the Pan-Dorset Carers Steering Group to ensure carers issues are discussed appropriately and in a timely manner.

During Carers Week 2022, the DCPG came together to publicise all of the carers events and activities that were happening across Dorset on the Our Dorset website. They also produced a printed timetable for carers without access to the internet, enabling as many of them as possible to access support.

Our 5 Key Strategic Priorities

Identification, recognition, and involvement

Information and advice

Supporting carers' physical, mental and emotional wellbeing

A life alongside caring

Collaborative working across Dorset

Priority 1: Identification, recognition, and involvement

A clear message from the carers services review was that we need to identify carers as soon as possible in their caring role, recognise the support they are providing, involve them in decisions about the person they are caring for, and in the planning of carers services. One carer said:

> *"Identifying carers is a top priority because it is only after this that they can seek support. Society in general needs to recognise and value them. This includes making everyone aware and valuing their expertise so that they are always involved in relevant tasks/projects for carers and cared for people."*

Identify carers as early as possible in their caring journey

What did carers tell us?

Carers told us that it is important to identify carers as early as possible so that they can access the support available to them. One carer explained:

> *"The earlier a carer can be identified and recognised the better, as the carer can be helped at the outset to understand their role and the importance of also looking after themselves…"*

Our carers services review found that 40% of carers look for information about caring on the internet, but 61% were not aware of the CRISP website, Facebook, and Twitter pages.

35% of carers said their GP surgery was their main source of information.

What will we do?

We will rebrand CRISP to create a new name that more meaningfully describes the service and will increase promotion through all media channels. When carers search for support on the internet, we want the BCP carer support service to be the first page they turn to.

We will work with GP surgeries across Bournemouth, Christchurch and Poole to help them identify carers and refer them to the BCP carer support service. We will continue to be involved in and promote the Integrated Care System (ICS) carers leaflet and poster. This is a way for professionals to help and encourage carers to register as a carer with their GP surgery and their local carer support service.

Support carers to self-identify

What did carers tell us?

Carers told us that they do not always see themselves as carers. One carer said:

> *"Many carers do so without knowing that they are an ACTUAL carer because sometimes it's just what they automatically do for their family member, without realising."*

What will we do?

We will promote carers services both online and across Bournemouth, Christchurch and Poole, in places that carers visit such as GP services, dentists, pharmacies, hospitals and other community spaces.

We will use a wide range of images on both our digital and printed material to make it easier for people to recognise themselves as carers. We will check these images with carers to make sure that they are fully representative of the wide range of caring situations.

Recognise the full diversity of carers

What did carers tell us?

Carers told us that they need to be able to recognise themselves when services and support are being advertised. One carer explained:

> *"There needs to be more diversity, project a different image because I don't see me in what is being offered. It is hard to relate to the service and who it supports if you can't*

see yourself using it or don't see yourself as a carer. It is hard for me to access it because of my own image and personal difficulties that ethnic minority people face."

The Children's Society reported that young carers are one-and-a-half times as likely to be from Black, Asian and Minority Ethnic (BAME) communities, and twice as likely to not speak English as a first language[5].

Requesting Equality and Diversity information from carers without a full explanation of what we are going to use it for can also be a barrier, with one carer explaining that they choose not to provide it due to discrimination they had experienced in the past.

A report by Carers UK and Age UK found that that 58% of carers are female and 42% are male, with the number of male carers increasing in older age. Almost 59% of carers aged 85 and over are male[6].

Carers could be providing care for a family member, partner, friend, or neighbour. They may live with, nearby or away from the person they support, and may care for more than one person. Our carers survey found that 50% of respondents cared for a spouse or partner, whilst 23% cared for a child and 19% were supporting a parent.

The number of hours that carers provide can also vary considerably, from helping a neighbour once a week to providing full time care to a spouse. 2011 Census figures show that 34% of carers across Bournemouth, Christchurch and Poole are providing more than 20 hours per week of care, with this figure expected to have increased following the Covid-19 pandemic. Many carers are also caring whilst in employment, education, or training.

What will we do?

We will ensure that our carers services support the diverse needs of carers, including those with any one or more of the protected characteristics detailed in the Equality Act (2010)[7].

[5] *Young Carers of Black and Minority Ethnic families*, The Children's Society (2018)
[6] *Caring into Later Life – the growing pressure on older carers,* Carers UK and Age UK (2015)
[7] *Equality Act 2010*, legislation.gov.uk (2010)

When we request equality and diversity information, we will explain fully what we are going to use it for, and that we want to give all carers equal opportunity to access the information, advice and support they need.

We will offer a wide range of services to suit the varying needs and preferences of carers and ensure that it can be accessed by carers in full time employment or education.

We will work with providers of our commissioned services to support carers from communities who are less likely to seek help and advice.

We will welcome more carer members with protected characteristics to the BCP Carers Reference Group to ensure they represent the diverse range of carers.

Recognise the contribution that carers make to society

What did carers tell us?

Carers told us that it is important to them to feel recognised for the vital contribution they make to society. Carers said:

> *"…It is also very important to make sure that the contribution carers bring is recognised through the delivery of beneficial services. Otherwise, it is a completely thankless role that saves the workforce money and time at our own detriment."*

> *"We are often the silent army."*

What will we do?

We will take every opportunity to appreciate the vitally important role of carers, such as during Carers Week and Carers Rights Day events. We will continue to work with our Integrated Care System partners to offer time away from caring roles.

We will commission services that ensure carers feel valued. The Carers Card is one such service that we offer, providing discounts and concessions at a growing range of local and national businesses and retailers. This also raises the profile of carers to local business and will help carers to feel recognised and supported in their own local communities.

Involve carers in service planning, design and commissioning decisions

What did carers tell us?

Carers told us that we should involve them by:

"Valuing their expertise so that they are always involved in relevant tasks/projects for carers and cared for people"

Carers want us to understand their lived experience of caring to better inform our service planning, design and commissioning decisions.

What will we do?

We will consult with the BCP Carers Reference Group when we are designing services for carers and involve them in commissioning decisions.

We will use carers focus groups when we are carrying out service reviews to ensure we have a wide and representative range of feedback.

Services will be co-produced with carers based on their experiences, views and aspirations.

Priority 2: Information and advice

Carers told us that information and advice should be clear and easy to access for all. They said:

> *"Advice needs to be clear and simple. As a carer you are busy, juggling multiple things. You just need ready access to simple information: tell me what I can do / what is available / what are the qualifying criteria. I don't want "fluffy language" and pages of information to have to wade through to try and find an answer."*

> *"We need to make sure everyone can equally access information, regardless of their situation and ability"*

Ensure information and advice is accessible to all carers

What did carers tell us?

Our carers services review found that digital access is a barrier for some carers in accessing support, with 20% of carers stating they were not at all confident in using technology and 64% saying they would not be interested in training or support if it was available to help them use technology.

What will we do?

We will ensure that information and advice is available in a variety of formats to suit the varying needs of carers, including printed material, web pages, social media, podcasts and videos. We will make information accessible in alternative languages, as required.

Involve carers in the planning and development of information and advice

What did carers tell us?

During the carers services review, carers gave us lots of feedback on the information and advice that was available and how we could improve it. We also held a workshop with young

carers, who reviewed the CRISP website and told us what would be helpful for them when looking for information and advice.

What will we do?

We will involve carers from different age groups and technical abilities in the redesign of the BCP carer support service website, to ensure it meets the needs of as many carers as possible. We will listen to what carers want and implement new ways of providing information and advice, such as by adding short informational videos, as suggested by young carers.

Invest in training for carers and professionals

What did carers tell us?

Carers highlighted the importance of training for professionals, so that they can understand the information they are giving to carers. One carer said:

> *"Practitioners need to be supported to understand the guidance, carers want to be dealing with an expert, so practitioners need to be confident that the information they are giving is appropriate and correct."*

Training for the carers themselves was also raised as important. One carer explained:

> *"Any form of training will benefit; carers will develop more independence and it would mean they will not need support as much in future as they are capable. It is a win-win."*

What will we do?

We will ensure that all adult social care practitioners that work with carers understand the support that is available to them and are equipped to have the right conversations with carers about what matters the most to them.

During the carers services review, carers provided a comprehensive list of the training they would like to see being offered. These fell into three main categories:

- training for the caring role - such as moving and handling and first aid training;
- managing responsibilities - such as time management and managing finances; and
- personal development - such as IT skills and preparing for employment.

We will review all training that is currently provided for carers by BCP Council and by the voluntary and community sector and ensure that carers have access to the training that they need. Where there are any gaps, we will work with BCP Council's Workforce Development Team and the voluntary and community sector to develop new courses to support carers.

Priority 3: Supporting Carers Physical, Mental and Emotional Wellbeing

Carers UK reported that carers are more likely to be in poor health than the general population, with 60% of carers in the 2021 GP Patient Survey stating they had a long-term condition, disability or illness compared to 50% of those who were not caring[8]. In our own carers services review, 55% of carers who took part told us that they had poor mental and physical health. The ability to take a break could make a big difference in carers being able to continue in their caring role. One carer explained:

> *"It's vital that a carer can take a break. If we don't support the carer, the situation can quickly turn into a crisis, which puts additional stress on an already overloaded service and potentially puts the* [person being cared for] *in danger. By providing a break and support to look after their own health and wellbeing, this means they can carry on in their caring role, helping the* [cared for] *live in an environment they are more comfortable and happier with."*

Enable carers to take a break from their caring role

What did carers tell us?

Carers shared experiences with us of feeling overwhelmed by their caring responsibilities, such as providing medication and dealing with finances. This often impacted on their own health as a result. Carers told us:

> *"I had to give my husband injections, I did not feel prepared for that, it was terrifying."*

> *"I was overwhelmed by applications and benefits; it was too much."*

> *"Carers will often neglect their own health until they are in crisis, (a break) could help prevent this."*

[8] GP Patient Survey Analysis, Carers UK (2021)

What will we do?

We will review the options for short breaks and respite to enable more carers to take time away from their caring role. This will give them the space they need to look after their own wellbeing and better equip them to be able to carry on in their caring role.

We will encourage more use of Direct Payments by increasing awareness and developing training for practitioners. This will allow carers to have more choice over how they take a break.

We will review staffing levels in our carer support service to ensure that support groups, events and activities can cater for a larger number of carers.

Support carers to look after their own physical and mental health

What did carers tell us?

Carers told us about the challenges they face in their caring roles and how these impact on their health and wellbeing:

> *"Needing someone to talk to in the darkest moments, it is a hard journey and affects your whole wellbeing."*

> *"Looking after my own physical and mental health is a challenge every day"*

What will we do?

We will review our carers services to ensure they meet the diverse needs of carers and that our services such as counselling, befriending and mentoring are accessible to all carers that would benefit from using them.

Priority 4: A life alongside caring

Carers told us that their caring role, along with other responsibilities, leaves little time for themselves. They stressed the importance of carers being able to have a life alongside caring. One carer explained:

> *"[It is] important they have interests and are able to take part in them and remain in the workforce if they want to. Once the caring role finishes, they need to have a life of their own. If they have been totally immersed in caring, this sudden stop of the responsibilities can have a negative impact on the carer - lack of focus in life, feeling of lack of skills to do anything else and financial worries."*

Enable carers to have time for themselves

What did carers tell us?

As part of the carers services review, carers told us about all the other responsibilities they have alongside caring (Table 2):

Carers other responsibilities		
Their own health	Household maintenance	Paperwork and applications
Gardening	Finances	Transport
Appointments	Shopping	Cooking
Work	Cleaning/laundry	Religious duties
Family	Pets	Education

Table 2: Other responsibilities that carers referenced in the BCP carers survey and focus groups

Providing care alongside several other responsibilities can leave little time for carers to do anything else.

There are also barriers to having carers assessments, which can put carers off from obtaining support to have time for themselves. Carers said:

"The term Carers Assessment is intimidating and sounds like an exam"

"I find Carers Assessment like it would be a judgement."

What will we do?

We will remove barriers to carers assessments and review the language we use to ensure our practitioners are having the right conversations with carers. This will enable them to find out what matters most to carers and offer the right support to allow them to take time for themselves.

We will ensure that services, events and activities are provided at different times of the day to allow carers to fit them in around their caring role and other responsibilities.

We will bring support to carers in their own communities to reduce barriers of having to travel to access services.

We will review and improve access to Direct Payments so that carers can access support that is tailored to their own needs and situation.

Enable carers to have access to education and employment

What did carers tell us?

Of the carers that responded to the BCP carers survey, 18% were in employment and 2% were in education. Many carers have to give up work and education for their caring role. One carer said:

"Now my brother is in a care home, I would like to return to work, but I do not feel confident about it. It has been so long; I want something part time so I can feel like I have purpose again."

Carers said they would find training in CV writing and interview skills very helpful to assist them in getting back to work. They said they would also find educational courses beneficial for their personal development.

For carers in employment, they need flexibility to allow them to fit their work around their caring responsibilities. Raising employers' awareness of the challenges facing the carers in their workforce would help them to be more supportive, for example by agreeing flexible start and finish times. Supporting carers to remain in work has benefits for them as employees and for their employers. The more we can support carers to stay in employment, the less likely they are to fall into financial poverty.

What will we do?

We will support carers to access education and training to develop skills to stay in or return to work.

We will work with schools and businesses to raise awareness of carers and how their needs can be supported to allow them to stay in employment and education alongside their caring role.

We will join the Carers UK Employers for Carers scheme, which is a membership forum and service for employers who are seeking to support the carers in their workforce and retain key talent. This will provide digital resources which we can extend to all small and medium sized enterprises within the Bournemouth, Christchurch and Poole area.

We will set up a carers staff networking group for BCP Council colleagues.

Support carers to access activities they enjoy

What did carers tell us?

Carers have a wide range of interests and like to take part in activities that will take their mind off their caring role and improve their wellbeing. We have had very positive feedback about the activities that have been provided by CRISP, which have included paddleboarding, sailing, tea dances, museum and garden visits, walking and snow bobbing. Carers said:

"The CRISP activities are amazing. They have encouraged me to take some 'me' time and get out to socialise. Familiar faces and friendly smiles always help."

"The activities that come with being a carer, thanks to Eve, have been lifesaving as far as I'm concerned."

What will we do?

We will continue to provide a range of activities to support different needs and preferences as part of the BCP carers support service and encourage carers to access other activities provided by the voluntary and community sector.

We will support carers to access activities by providing transport, and arranging them at various times to enable working carers and those in education to attend.

Carer feedback from a CRISP carers sailing activity (pictured above): *"It was fabulous. The first time in ages I have felt a little bit normal and free"*

Priority 5: Collaborative working across Dorset

Carers told us that they want services to work together across Dorset so that they don't have to tell their story multiple times. One carer said:

> *"As a carer you often end up doing the communicating for the services, to ensure everyone involved knows what is happening. They should be working together."*

Working with partners to ensure equity of service across Dorset

What did carers tell us?

Carers told us that services across Dorset should work together to ensure that they have access to the right support. Healthcare services in particular should have full awareness of the BCP carer support service and refer carers into it. One carer said:

> *"It is very disjointed between GP's and other services, like CRISP should be the first point of access for carers, similar to how a Community Mental Health Team would be etc. But it is not widely accepted or understood in that way."*

What will we do?

We will build on the strengths of the Pan-Dorset Carers Steering Group and the Dorset Carers Partnership group to continue to bring organisations together that support carers.

Through those collectives, we will ensure that all organisations are aware of the support on offer throughout the county. This will enable carers to be signposted and referred for the right support for them, no matter which organisation they approach first.

Engaging with all organisations across Dorset that support carers to promote, value and recognise carers services

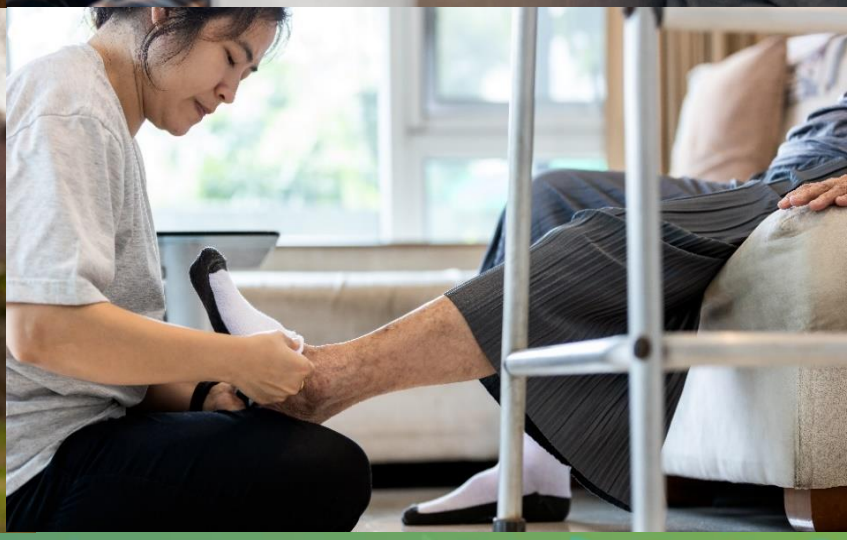
What did carers tell us?

Carers told us that the different groups supporting carers need to work together to ensure everybody has access to support. One carer said:

"The main problem at the moment is that there are different groups doing different things to help carers."

What will we do?

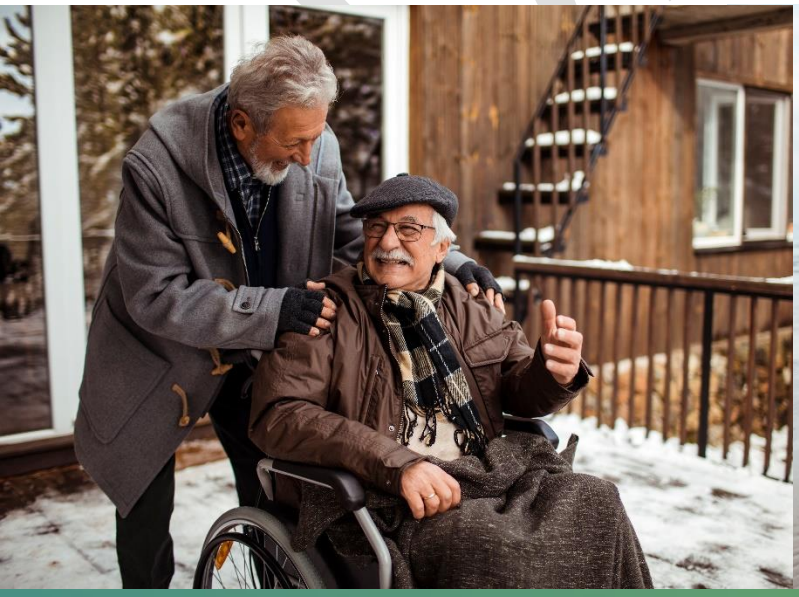
The Dorset Carers Partnership group has 17 member organisations: two local authorities, two lead carer organisations, three NHS organisations and 10 voluntary and community sector organisations. We will continue to build upon this partnership and share information to collectively promote, value and recognise carers across Dorset. We will continue to hold joint events on Carers Week and Carers Rights day to raise awareness of caring and value our carers.



Measuring Success

Priority	How we will measure success
Identification, Recognition, and Involvement	Carers reporting that they feel recognised and valued as a carer An increased number of carers registering with the BCP carer support service An increased number of referrals from GP Surgeries into the BCP carer support service Increased and more diverse membership of the BCP Carers Reference Group Carer members of the BCP Carers Reference group reporting that they feel involved and able to influence commissioning decisions
Information and Advice	An increased number of visits to the BCP carer support service website Carers reporting that they are easily able to access the information and advice they need An increased proportion of carers who receive information and advice or another service after an assessment Carers and professionals reporting that they are easily able to access training that suits their needs
Supporting Carers Physical, Mental and Emotional Wellbeing	An increased uptake of Direct Payments and Self-Directed Support Carers reporting an improved sense of wellbeing Increased options for respite and short breaks Carers reporting that they feel able to participate at support groups run by the BCP carer support service when they wish to

	Carers reporting that they feel able to access services such as the counselling and befriending and mentoring services when they need to
A Life alongside Caring	Carers reporting an increased level of satisfaction with carers assessments Carers reporting that they feel able to take part in activities and events run by the carer support service when they wish to
Working Collaboratively across Dorset	Carers reporting that they are aware of services across Dorset Increased membership of carers partnership groups across Dorset



This information is issued by BCP Council

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Published September 2022

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Equality Impact Assessment: Conversation Screening Tool

What is being reviewed?	BCP Carers Strategy
What changes are being made?	A review of BCP Council's unpaid carers services has been undertaken to determine the priorities for a new BCP Carers Strategy. The following changes may occur as a result: • Changes to contracts with providers • Changes to Service delivery • Changes to practitioner and public information • Changes to processes and procedures • Changes within teams
Service Unit:	Adult Social Care Commissioning
Participants in the conversation:	Emma Senior – Commissioning Manager, Prevention and Wellbeing Eliza Atyeo – Carers Commissioning Officer Debi Plat - Service Unit Equality Champion Zena Dighton – Head of Strategic Commissioning
Conversation date/s:	06/01/2022, 02/02/2022, 30/06/2022, 19/08/2022
Do you know your current or potential client base? Who are the key stakeholders?	Unpaid carers who care for someone living in Bournemouth, Christchurch or Poole. According to the 2011 Census, there are 39,525 carers in the BCP Council Area. **<u>Key stakeholders in services</u>** • CRISP – BCP Council's Carers Resource and Information Support Programme • Pan Dorset Carers Steering Group • BCP Carers Reference Group • Dorset Carers Partnership Group • Learning Disability Partnership Board • Carers Action Group • Carers Operational Group • LD Carers Forum • Pramalife – Befriending and Mentoring Service • The Leonardo Trust - Time to Talk counsellors • Take a Break providers (Local businesses) • Dorset Advocacy – Carers Advocacy and Support Services • Worldwide Procurement Service UK LTD – Carers Card • Lifeline - Carers in Crisis • Tricuro – Carers in Crisis – Emergency Response • Rachel Huggett – Carers Art Group

	• Chrissy Hedge – Care Free Choir **<u>Partners</u>** • Dorset Healthcare • NHS Dorset • Dorset Council
Do different groups have different needs or experiences?	**<u>Dorset Definition of a Carer</u>** A carer is a person of any age who provides or intends to provide on-going, unpaid support to a partner, child, relative or friend. Without this help, the health and wellbeing of the cared for person could deteriorate due to frailty, disability, a serious health condition, mental ill health or substance misuse. • The carer may live with or apart from the cared for person • Professional care may also be in place • The cared for person could be in residential care, however the carer should still be recognised and may still need support The impact on carers' lives varies depending on the amount of care they provide, their age, and the length of time they have been providing that care. The needs of the individual receiving care and the relationship between the carer and cared for person will also have an impact on the caring experience. Caring can impact on: • The ability to access and stay in employment • Financial resources • The health and emotional well-being of the family unit • The ability to access social and recreational activities • Wider relationships with family and friends For young carers it can also impact on their: • Experiences of childhood • Health and well-being • Education and career opportunities • Family and peer relationships • Sense of identity We also recognise that being a carer can impact on life after caring: • Adjusting to changing relationships when caring at home is no longer viable • Social isolation and lack of confidence after a bereavement • Redefining their identity and purpose • Having a higher risk of needing care services themselves --- **<u>2011 Census Dorset:</u>** Provides care: **82,900 (11%)** • 1 to 19 hours unpaid care a week: **55,400 (7.5%)**

	• 20 to 49 hours unpaid care a week: **9,600 (1%)** • 50 or more hours unpaid care a week: **17,900 (2.5%)** Carers in Dorset Council Area: **43,334 (52.3%)** Carers in BCP Council Area: **39,525 (47.7%)** Carers in Bournemouth: **17,325** • 1 to 19 hours unpaid care a week: **11,280** • 20 to 49 hours unpaid care a week: **2,260** • 50 or more hours unpaid care a week: **3,785** Carers in Poole: **16,212** • 1 to 19 hours unpaid care a week: **10,761** • 20 to 49 hours unpaid care a week: **1,846** • 50 or more hours unpaid care a week: **3,605** Carers in Christchurch: **5,988** • 1 to 19 hours unpaid care a week: **3,933** • 20 to 49 hours unpaid care a week: **686** • 50 or more hours unpaid care a week: **1369** Carers registered with CRISP: **5650 Carers** **Gender:** Carers needs/experiences can be across any gender including Male / Female / Non-Binary / Transgender / Other Genders of Carers across BCP - 2011 Census: • Male: **16,687** • Female: **22,690** CRISP Data Base Estimations: • Mr/Master: **1546** • Mrs / Miss / Ms / Mrs: **2381** • Mx: **2** • Blank / Dr / Rev / No gender reported: **1721** **Age:** Carers needs can be across any age groups including young carers, working age carers and older carers Ages of Carers across BCP recorded from the 2011 Census: • 0-24: **2,568** • 25-49: **12,233** • 50-64: **13,860** • 65+: **10,716** CRISP data statutory return 2021/22: 4958 • -18: **0** • 18-25: **56** • 26-64: **2446** • 65-84: **1959**

	• 85 +: **497** CRISP - New Carers 2021/22: • -18: **0** • 18-25: **24** • 26-64: **553** • 65-84: **546** • 85 +: **165** **Disability:** Carers needs/experiences are present in various disability groups such as: long term conditions, mental health, learning disabilities, hearing, visual and communication impairments: Adult Social Care Outcomes Framework (ASCOF) figures for BCP Council 2021-2022: • Physical Impairment or Disability: **18.4%** • Sight or Hearing loss: **14.9%** • A mental health problem or illness: **11.7%** • A learning disability or difficulty: **3%** • A long-standing illness: **32.5%** • Other: **16.8%** • None of the above: **33.1%** **Pregnancy and Maternity**: Carers needs/experiences can be across any of the following groups: • Parent carers • Family carers • Pregnant carers • Foster carers BCP Carers Services Survey 2021-22: • **23%** provide unpaid Care for a child (age undetermined) • **35%** of respondents reported duties relating to family, children, or grandchildren **Marriage/Civil Partnership:** Carers needs/experiences are not dependant on Marriage/Civil Partnership arrangements, such as: • Carers for spouse/partner • Divorced • Lone carers BCP Carers Services Survey 2021-22: • **50%** of respondents cared for a Husband, Wife or partner

	Race: Carers needs/experiences can be across any race. However, there is currently no specific ethnicity data for carers across the BCP area. BCP 2011 Census figures: • White British: **88.4% (334,846)** • Other White: **5.1% (19,157)** • Mixed/multiple ethnic group: **1.7% (6,612)** • Asian/Asian British: **2.9% (10,837)** • Black/African/Caribbean/Black British: **0.6% (2,367)** • Other Ethnic Group: **0.6% (2,161)** • White Irish: **0.6% (2,410)** • White Gypsy or Irish Traveller: **0.1% (480)** **Religion/belief:** Carers needs can cover various religious group and beliefs. However, there is currently no specific date about the religion of carers across the BCP area. BCP 2011 Census • Christian: **59.7% (452,256)** • No Religion: **29.3% (222,248)** • None Stated: **7.7% (58,294)** • Muslim: **1.2% (8,890)** • Buddhist: **0.5% (3,820)** • Hindu: **0.5% (3,708)** • Jewish: **0.5% (3,686)** • Sikh: **0.1% (480)** • Other Religion: **0.6% (4,394)** **Gender Reassignment** Carers needs/experiences are not dependant on gender reassignment. There is currently no data that depicts the statistics of carers who have undergone Gender Reassignment across BCP and Dorset Council areas. **Sexual Orientation:** Carers needs/experiences can be across any sexual orientation including LBGTQ+. There is currently no data that depicts the statistics of carers sexual orientation across BCP and Dorset Council areas. --- **Engagement and Consultation** The BCP Carers Services Survey was developed in collaboration with carers, councillors on the Health and Adult Social Care Overview and Scrutiny Committee and practitioners. Carers and

	providers at local forums were presented with the aims of the survey and carers services review throughout November and December 2021. From this, member carer representatives and providers requested that the survey was sent to them via email or post for either personal use or distribution throughout the local area. December 2021: • Distribution of the survey and cover letter explaining the purpose of the survey and review to motivate responses. • An online version of the survey was created, as well as a paper version to ensure carers had equal opportunity to participate. **2804** Microsoft Forms links **2447** paper copies were sent to Carers over the age of 16 registered with CRISP. The survey was distributed through Adult Social Care (ASC) networks to partners, commissioned services and voluntary agencies that work with carers who support someone residing in the BCP Council area. To ensure the survey reached carers not registered with CRISP, organisations and agencies of underrepresented groups were informed of the survey and review. Both online and paper versions were sent to these groups along with the cover letter, for them to distribute to carers who have identified with them: • Mytime young carers charity • Pramalife • Dorset Advocacy • KushtiBok • The Leonardo Trust • BCP GRT support • BCP SEND • Dorset Race Equality • Dorset Mind • We are with you – substance misuse • Bournemouth and Poole College • Bournemouth University • Parent Carer Foundation • Learning Disability Partner Timeframe: • 1 month to complete and return digital surveys • 1 month + 1 week for paper surveys, as carers may have needed additional time for such responses. Total responses: • 742 carers responded to the survey • 331 digital responses • 411 paper responses

	Opportunity to participate in focus groups: • 24.1% of carers volunteered to participate in focus groups (179 volunteers in total) • Practitioners & partners attended forums and team meetings Focus group facilitation: • Group video conferencing • Individual video conferencing • Phone calls • Home visits • Face to face workshops • Email Total Focus groups after phase 1: • 31 Focus Groups in total with carers, • 2 focus groups with practitioners • 2 focus groups with external partners Feedback was also obtained from carer representatives and practitioners in various forums that take place locally such as the Pan Dorset Carers Steering Group, Dorset Carers Partnership Group, BCP Carers Reference Group, Carers Action Group and Carers Operational Group.
Will this change affect any service users?	Yes
What are the benefits or positive impacts of the change on current or potential users?	**The new BCP Carers Strategy identifies 5 key priorities to support carers. It identifies potential service delivery improvements including:** • Early identification and recognition of carers • Recognising the diversity of carers • Improved access to services • Improved provisions of services • A focus on enabling carers to have a life alongside caring • Increased options for short breaks and respite • Better support for accessing information and advice • Improved integration of services • Better understanding of the diversity of carer needs • Improved carers assessments • Increased access to direct payments • The rebranding of CRISP to make the carers service more accessible

What are the negative impacts of the change on current or potential users?	**Changes to services, leading to confusion** **Mitigations:** • Updated information, guidance and promotion • Communicating changes to the workforce and public • Developing accessible Information and advice with carers **Rebranding CRISP may reduce recognition, or it may lead a surge in demand that resources cannot cove** **Mitigations:** • Soft launch • Consultation, engagement and feedback • Communicating changes to the workforce and public • Providing accessible information • Engagement and consultation with carers and practitioners • Reviewing roles and responsibilities • Reviewing staffing levels **Confusion or lack of understanding on new information** **Mitigations:** • Practitioner involvement • Targeting audiences • Communicating changes to the workforce and public • Collaboration with partners and carers
Will the change affect employees?	**CRISP Service and ASC workforce:** • Additional Staffing capacity will be needed for CRISP to carry out the priorities of the BCP Carers Strategy. • Possible changes to roles and accountabilities • New Training requirements • New information and guidance
Will the change affect the wider community?	**Yes:** • More opportunities to support carers • Improved services to deliver easier access • Improved information and guidance for carers • Increased workforce to support carers • Improved ways to receive feedback • Changes to the website to provide easier access to information
What mitigating actions are planned or already in place for those negatively affected by this change?	**Research and evaluation into the diversity of Carers throughout the conurbation and engagement:** • Collating data going forward about the equalities make up of carers where this is currently incomplete • Continuing the BCP Carers Services Focus Groups

	Gaining Feedback from Carers Groups: • BCP Carers Reference Group • LDPB Carers Action Group • LD Carers Forum • Pan Dorset Carers Steering Group • Dorset Carers Partnership Group • BCP Provider Forum • Carers Action Group • Carers Operational Group **Gaining feedback from services:** • Contract Monitoring • Capturing and recording evidence about the diversity and mapping of Carers across the conurbation • Continuing to work with services and providers to support Carers from minority groups and hard to reach areas. • Continuing to promote diversity across networks **Soft launch for the Rebranding of CRISP** • To enable the service to be accessible to as many carers as possible **Sharing changes to information through Care and Practitioner networks including:** • Newsletters • Websites / social media • Letters • Team Updates / Team newsletter / Team platforms • Provide clear and consistent information about services
Summary of Equality Implications:	The BCP Carers Strategy recognises the valuable contribution that carers make to our community and sets out a 5-year plan for supporting them to look after their own health and wellbeing, just as much as they do for the people they care for. The 5 key priorities of the strategy aim to improve support for carers to enable them to continue in their caring role for as long as they wish to. The proposed changes should have a positive impact on carers and recognise the diversity of carers. They will improve the accessibility of the BCP carers service and will enable more carers to access advice, information and support that is tailored to their needs. Throughout the implementation of the strategy, further equality impact assessments will be produced when carers services are reviewed, and specific decisions are needed to be made.

Form Version 1.2

Adult Social Care Assurance

Health and Adult Social Care Overview & Scrutiny

Jo O'Connell
Director Adult Social Care Commissioning (interim)
Adult Social Care Commissioning

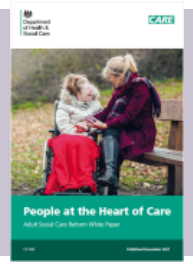
Background

There is a challenging programme of mandatory and legislative transformation in the Adult Social Care sector over the next few years, covered in part by:

- Health and Care Act 2022 (Formalisation of Integrated Care Systems ICS)
- People at the Heart of Care White Paper (10 year vision for Adult Social Care, new CQC Assurance programme)
- ASC Charging reform (The delayed introduction of Part 2 of the Care Act 2014)

This brief presentation focuses on the new duty for the Care Quality Commission (CQC) to independently review and assess local authority performance in delivering their adult social care duties.

CQC Assurance (From April 2023)



A 10 year vision for personalised care where people:

- Have choice, control, and support to live independent lives
- Can access outstanding quality and tailored care and support
- Find adult social care fair and accessible

Assurance → **CQC Inspection**

Themes

1. Working with People
2. Providing Support
3. Ensuring safety
4. Leadership

Evidence

- People's experience
- Feedback from partners
- Feedback from staff and leaders
- Observation
- Processes
- Outcomes and performance data

Care Act 2014

Duty to make sure that people:

- Receive services that prevent their care needs from becoming more serious, or delay the impact of their needs
- Can get the information and advice they need to make good decisions about care and support
- Have a range of high quality, appropriate services to choose from

What we know so far

Inspections are due to begin in April 2023 but with the possibility of a 2-year bench marking exercise with all councils, perhaps without grading at that stage

Local Authorities are currently working to a draft framework

There may be a self assessment tool from CQC (and possibly a dashboard) in autumn 2022 (but we can't wait until then to begin work)

When the inspector arrives they will have already completed a good deal of research and looked at published information e.g. – statutory returns, Ombudsmen judgements etc.

Inspectors are aware of national challenges for ASC provision and have been engaging with councils to understand this and will expect to see our interpretation of such issues.

CQC's Single Assessment Framework

Our framework will assess providers, local authorities and integrated care systems with a consistent set of key themes, from registration through to ongoing assessment

Aligned with "I" statements, based on what people expect and need, to bring these questions to life and as a basis for gathering structured feedback

Expressed as "We" statements; the standards against which we hold providers, LAs and ICSs to account

People's experience, feedback from staff and leaders, feedback from partners, observation, processes, outcomes

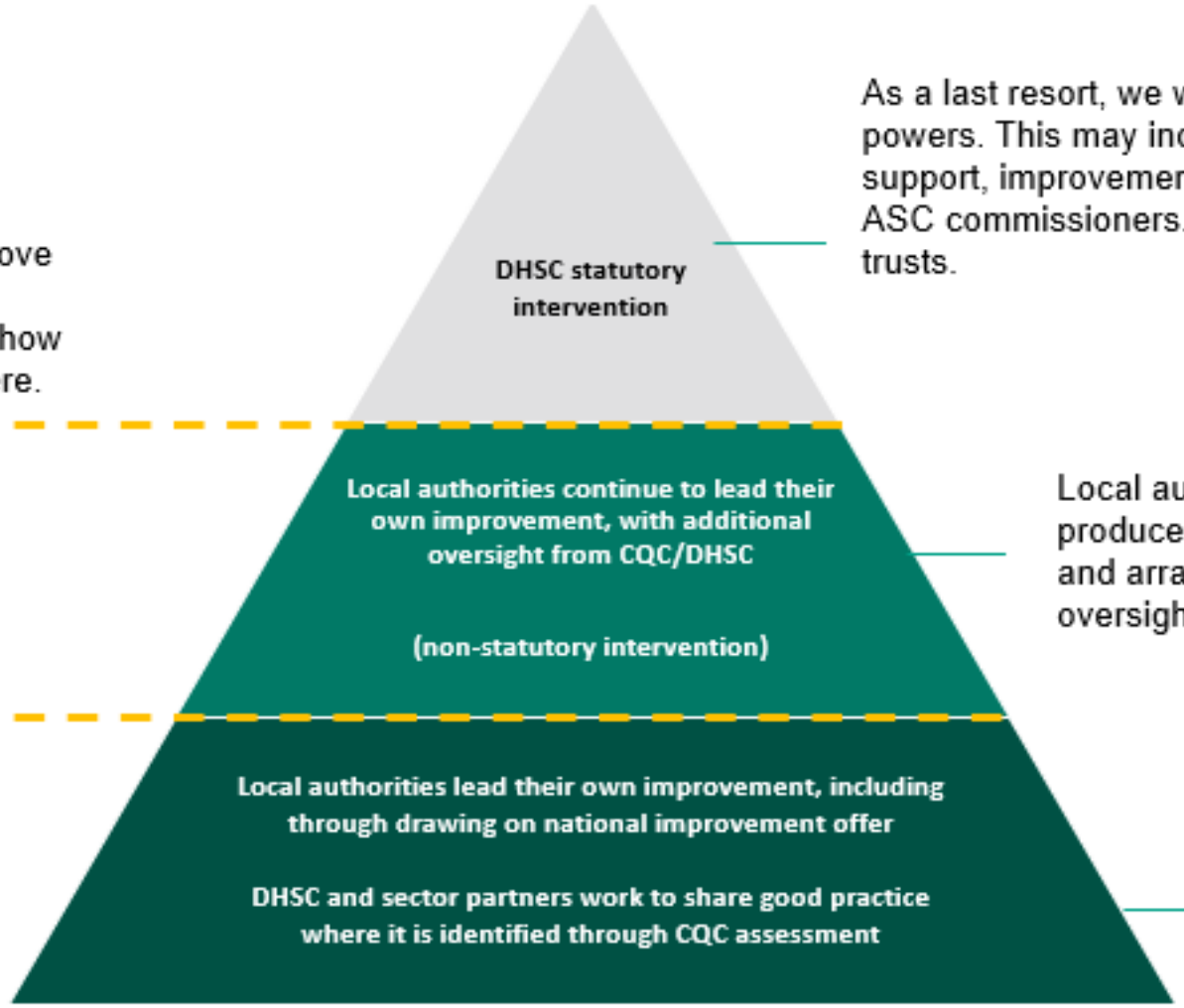
Data and information specific to the scope of assessment, delivery model or population group

The Scope of CQC's Assessment of LA ASC functions

Working with people • Assessing/Reviewing needs (including carers) • Supporting people to live healthier lives • Prevention and Well-being • Information and Advice	**Providing support** • Market shaping and commissioning - Sufficiency and Affordability - Diversity and Quality • Integration and partnership working
Ensuring safety • Safeguarding • Safe systems • Managing pathways and transitions • Continuity of care	**Leadership** • Compassionate and capable leaders • Sound governance • Learning, improvement and innovation • Promoting equality and diversity

- Each of the themes has several quality statements and 'I' statements within it
- Each of the themes aligns to statutory duties and guidance
- Choice, control and personalisation are threaded through the framework and approach
- LAs will be awarded an overall rating (The exact nature of the ratings are tbc but a "rating of (1 - 4) with sub-ratings and narrative" was one of the options being considered)

Government Intervention and Support



As a last resort, we will intervene using statutory powers. This may include full time improvement support, improvement panels and – where necessary - ASC commissioners. It will not include independent trusts.

Local authority unable to improve in agreed timescales. We are working through whether and how to incorporate CQC ratings here.

Local authorities will be expected to produce a robust improvement plan, and arrange for additional support, with oversight from DHSC

CQC assessment identifies serious/persistent risk to people's wellbeing

All LAs will be able to draw on improvement offer as required

Working with the regional ADASS group

BCP Council attends the regular **Assurance Working group** meetings to discuss themes of regulations, what CQC will need in terms of evidence and how we can approach this new assurance framework as a region

Key points raised so far:

- LAs must gather evidence and present in a user friendly way – use repositories, indexes and dashboards
- LAs must start asking themselves challenging questions e.g. How does a DASS or leader know what SWs/commissioners are working on? What haven't we been able to achieve and why haven't been able to achieve it? Why and how is the lack of workforce preventing us from delivering? How do we act on what we know
- What makes a good case study and how to use them
- **Evidence** is vital
- **Triangulation of evidence** is needed so we can validate why we are on a particular direction of travel and prove informed planning as apposed to being reactive
- Need to think wider than our own evidence and ensure we **research** i.e. – what is the local picture / what is happening nationally / what research have we done not just in UK but worldwide

Internal Preparatory Work

Quality Board where work includes new processes and oversight so we can evidence ‘triangulation’ and maintain audit momentum

Quality Assurance team meetings with Managers and Heads of Service to start the process of evidence gathering with an aim to complete this first pass by mid September

Development of a ‘dashboard’ (draft by Nov 2022) and exploring the use of repositories to safely and conveniently store the information CQC will need

Working with an Audit and Quality Assurance schedule with regular fortnightly reporting to leadership team on audit progress, findings and CQC preparation

Communications plan in place to include engaging and communicating with; elected members, staff at all levels, partner agencies and other areas of the council

Next Steps

Develop a CQC Operational Preparation and Planning Group and a similar group for Commissioning colleagues
Build upon preparatory work already undertaken by continuing to gather evidence for assurance
Roll out of comms/engagement plan
Next ASC staff engagement event in November will focus on regulations and allow staff to be informed, involved and take ownership
Continue with Quality Board work – including consideration of service user involvement with this work.
Look to undertake a self-assessment in the early Autumn

Forward Plan – BCP Health and Adult Social Care Overview and Scrutiny Committee

Updated 24/08/2022

The following forward plan items are suggested as early priorities to the Health and Adult Social Care O&S Committee by the Chair and Vice-Chair, following consultation with officers.

	Subject and background	Anticipated benefits and value to be added by O&S engagement	How will the scrutiny be done?	Lead Officer	Report Information
26 September 2022					
1	**Care Technology Review Options Appraisal**		Committee report	Zena Dighton/ Jo O'Connell	
2	**UHD Hospital Programme Update (including Maternity Services update)**		Presentation	Richard Renaut	
3	**Health and Wellbeing Board update**		Verbal Update	Cllr Jane Kelly Sam Crowe	
4	**Portfolio Holder Update**		Verbal Update	Cllr Jane Kelly Cllr Karen Rampton	
5	**CQC Assurance Process**		Presentation	Jonathan O'Connoll	
6	**Carers Strategy Document Review**		Committee Report	Jonathan O'Connoll	

	Subject and background	Anticipated benefits and value to be added by O&S engagement	How will the scrutiny be done?	Lead Officer	Report Information
28 November 2022					
7	**ASC Annual Complaints Report**	To provide annual update as per	Committee Report	Nicky Mitchell	
8	**Adult Social Care Contact Centre**	To provide an update to the Committee to include details on the methodology Partners4Change	Committee Report	Tim Branson/Betty Butlin	
9	**Safeguarding Adults Board Annual report & Structural Review**	To ensure the Committee are informed of any changes to the arrangements.	Committee Report	Sian Walker-McAllister, Independent Chair of the SAB	
10	**Housing for Homeless**			Cllr Kelly Cllr Rampton Lorraine Mealings	
11	**Dorset Care Record Update**			Katie Lacy	
12	**Healthwatch – Young Listeners Project update**		Verbal Update	Louise Bate – Dorset Healthwatch Manager	
13	**Portfolio Holder Update**		Verbal Update	Cllr Jane Kelly Cllr Karen Rampton	

	Subject and background	Anticipated benefits and value to be added by O&S engagement	How will the scrutiny be done?	Lead Officer	Report Information
14	**Winter Plan (ICS)**		TBC		
6 March 2023					
15	**Healthwatch – Access to GP and Project Plan**			Louise Bate	
16	**ASC Market Sustainability Plan**			Jonathan O'Connell	
17	**Liberty Protection Safeguards**			Betty Butlin	
18	**Adult Social Care Contact Centre**	To provide an update to the Committee to include details on the methodology Partners4Change	Committee Report	Tim Branson/Betty Butlin	Confirmed
19	**Day Opportunities**				
DATE to be allocated					

	Subject and background	Anticipated benefits and value to be added by O&S engagement	How will the scrutiny be done?	Lead Officer	Report Information
1.	**Adult Social Care Contact Centre**	To provide an update to the Committee to include details on the methodology Partners4Change	Committee Report	TBC	
2.	**Dorset Clinical Commissioning Group (CCG) – Mental Health Rehabilitation Service** That an update on the strategic business case, including the financial details of the service would be provided to members. The next steps would also be highlighted	The information provided will ensure that Councillors are aware of the proposals in this respect, and the views of the next stage of the process to be undertaken by the CCG.	Presentation and report.	Mark Harris, Head of Mental Health Dorset CCG Elaine Hurll, Principal Programme Lead for Mental Health at Dorset CCG	
3.	**Liberty Protection Safeguards.**	For the Committee to be informed on the guidance provided and implementation of Liberty Protection Safeguards.	Committee Report.	David Vitty, Director of Adult Social Care	Awaiting implementation guidance.
4.	**Dentistry Provision**	For members to receive an informative update on NHS dentistry provision.	TBC	TBC	Requested by Committee members at 8 March meeting.

	Subject and background	Anticipated benefits and value to be added by O&S engagement	How will the scrutiny be done?	Lead Officer	Report Information
5.	**Health services for people who are Homeless and Rough Sleeping**	For the Committee to scrutinise the health services available to people who are homeless and for a general update in the first Quarter of 2022.	Report.	Ben Tomlin, Housing Services Manager.	BCP's Draft Homelessness Strategy was considered by the Committee prior to its consideration at Cabinet in April 2021.
6.	**Access to GP practices and appointment waiting times**	TBC	Check with Healthwatch	TBC	TBC
7.	**Dorset Care Record Update**	TBC	Report?	Phil Hornsby, Director of Commissioning for People David Vitty, Director of Adult Social Services	Autumn 2022
8.	**Think Big Project update**	The Committee will be updated on the progress of the Think Big Project in BCP Council.	Verbal update	Ashleigh Boreham, Deputy Director Design and Transformation Community Diagnostics – Health Villages – Dorset Innovation Hub.	Requested by Committee at their meeting on 27 September 2021.

	Subject and background	Anticipated benefits and value to be added by O&S engagement	How will the scrutiny be done?	Lead Officer	Report Information
9.	**All-Age Autism Project**				Requested by the Chair at Committee in November 2021.
10.	**BCP Carers Strategy Update** To receive For the Committee to receive an update on the progress of the strategy.	To enable the Committee to monitor and input into the development of the strategy.	Report.	Emma Senior, Commissioning Manager: Prevention and Wellbeing. Tim Branson, Head of Access and Carers.	Requested by Committee at their meeting in November 2021.
11.	**Joint scrutiny on 'substantial variations to health services'.** To consider the criteria that has been proposed to be added to the constitution, setting out what constitutes a 'substantial variations to health services' in the Joint Health Scrutiny Protocol.		Report.	Karen Tompkins, Deputy-Head of Democratic Services.	Suggested by the Deputy-Head of Democratic Services for Committee's consideration.

	Subject and background	Anticipated benefits and value to be added by O&S engagement	How will the scrutiny be done?	Lead Officer	Report Information
12.	**Tricuro update** To receive a report on the position of Tricuro in respect of the management and status of services provided on behalf of BCP Council, including quality improvement, safety and safeguarding.	The requested report will enable members to monitor and scrutinise the management and status of services provided by Tricuro	Report.	Phil Hornsby, Director of Commissioning for People. Commissioning BCP Graham Wilkin, Tricuro.	Requested by Committee at their meeting in March 2022.
13.	**Health Inequality report** For the Committee to receive a report on health inequality concerned with provision of health services.	For Members to be updated on the findings of the health inequalities group; following the progress of the ICS strategy.	Report.	Sam Crowe, Chief Executive of Public Health Dorset.	Requested by Committee at their meeting in March 2022.

	Subject and background	Anticipated benefits and value to be added by O&S engagement	How will the scrutiny be done?	Lead Officer	Report Information
14.	**Home First Review Update** For the Committee to receive a report on the Home First system.	For the Committee to scrutinise the development and progress since implementation of the full Home First approach across the Dorset Integrated Care System.	Report.	Betty Butlin, Director of Operations Adult Social Care Services.	Requested by Committee at their meeting in March 2022.
Information Briefings **i.**					
Commissioned Work Work commissioned by the Committee (for example task and finish groups and working groups) is listed below: Note – to provide sufficient resource for effective scrutiny, one item of commissioned work will run at a time. Further commissioned work can commence upon completion of previous work.					
15.	**The South West Ambulance Service Trust Improvement and Financial Investment Plan**	To enable Committee Members to scrutinise the impact of the improvement and financial investment plan on the response times and outcomes of the Ambulance Service.	Possible joint scrutiny with Dorset Council.		

	Subject and background	Anticipated benefits and value to be added by O&S engagement	How will the scrutiny be done?	Lead Officer	Report Information
16.	**The implementation and performance of NHS Dorset Urgent Integrated Care Services** Committee to agree enquiry session.	To scrutinise the impact, service performance and outcomes of the NHS Dorset Urgent Integrated Care Services (April 2020, 1 year after implementation).	Possible Joint Scrutiny with Dorset Council.		
17.	**External Scrutiny – Quality Accounts.**	To ensure Committee members have the opportunity to scrutinise the quality accounts of the NHS Trusts. Scrutiny leads for NHS Dorset Quality Accounts will need to be revised due to Committee membership changes since first arrangements.	Rapporteur model.	Elaine Stratman, Principal Officer Planning and Quality Assurance.	(Item has been postponed due to COVID19).

Update Items

The following items of information have been requested as updates to the Committee.

The Committee may wish to receive these in an alternative to format to Committee updates (e.g. by emailed briefing note outside of the Committee) to reserve capacity in Committee meetings for items of value-added scrutiny.

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