Report to:	**STRATEGIC COMMISSIONING BAORD**
Date:	26 June 2019
Reporting Member /Officer of Strategic Commissioning Board	Dr Ashwin Ramachandra (Chair) – NHS Tameside and Glossop CCG Councillor Eleanor Wills – Executive Member (Adult Social Care and Population Health) Stephanie Butterworth – Director of Adult Services
Subject:	**ESTABLISHMENT OF A SINGLE HANDED CARE TEAM FOLLOWING CONSULTATION**
Report Summary:	The report focuses on seeking authorisation to proceed with the establishment of a single handed care team for an initial two year period following a formal consultation process.
Recommendations:	That approval is given to: (a) Proceed with the establishment of a single handed care team. (b) Invest the non-recurrent sum of up to £0.525 million phased over 2019/20 to 2021/22 to support the establishment of a single handed care team and related equipment.

Financial Implications:

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)

Integrated Commissioning Fund Section	Section 75
Decision Required By	Executive Cabinet (Disabled Facilities Grant) Strategic Commissioning Board
Organisation and Directorate	Tameside MBC – Adult Services
Budget Allocation	Investment of £0.525 million phased over 2019/20 to 2021/22 as detailed in table 1 section 3.2 and table 2 section 3.3. The total investment is to be resourced via : £ 0.375 million Disabled Facilities Grant (dedicated team) £ 0.150 Disabled Facilities Grant / Adult Services Community Equipment revenue budget (equipment) The Disabled Facilities Grant allocations are subject to approval via Executive Cabinet as explained in sections 3.4 and 3.5 Proposed estimated savings to be realised as detailed in table 1 section 3.2.
Additional Comments	

	The proposal is estimated to realise annual savings of £1.1 million by 2021/22 (profile in table 1 section 3.2) based on an estimated non recurrent investment of £0.525 over the period 2019/20 to 2021/22. Table 2, section 3.3 of the report provides details of the financing arrangements for the proposed investment. £0.375 million (per table 2) for the dedicated staff team will be resourced by the Disabled Facilities Grant. Members should note that this will be included within a report to the Strategic Planning and Capital Monitoring Panel Committee on 8 July 2019. The minutes of this meeting will be subject to approval by the Executive Cabinet at its meeting on either 24 July 2019 / 28 August 2019. The estimated sum of £0.150 million to support the cost of gantries and bed systems will be financed via a combination of the Disabled Facilities Grant (within the Place Directorate capital programme) and the Adult Services community equipment revenue budget. Gantries will be resourced via the Disabled Facilities Grant as these meet the related grant conditions. The bed systems will be resourced via the community equipment revenue budget. The actual commitment cost against each funding allocation will be monitored as the needs of eligible service users are confirmed following assessment. The expenditure via the Disabled Facilities Grant will be included in the same report to the Strategic Planning and Capital Monitoring Panel Committee on 8 July 2019. The estimated savings are based on a 50% conversion success rate. Clearly additional savings will be realised if the proposal is approved to proceed via a greater level of conversion success. Any additional savings will contribute towards the projected financial gap of the Strategic Commission in future years and will be monitored accordingly.
Legal Implications: **(Authorised by the Borough Solicitor)**	Consultation is required with all key stakeholders whenever a change of policy takes place. Careful analysis is always important and this case is no exception. There are a number of potential implications arising from the proposed change to manual handling services by establishing a single care team, and the risk of claims arising out of this change which could prove counterproductive to savings proposed. The Council's insurers should be involved in the implementation stage process.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Developing Well, Living Well and Working Well programmes for action.
How do proposals align with Locality Plan?	The proposed change in practice is consistent with the following priority transformation programmes: • Enabling self care • Locality based services • Planned care services

How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities • Commissioning for the 'whole person' • Creating a proactive and holistic population health system
Recommendations / views of the Health and Care Advisory Group:	This report has not been presented to the Health and Care Advisory Group.
Public and Patient Implications:	None.
Quality Implications:	Tameside MBC is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness.
How do the proposals help to reduce health inequalities?	The proposal will not negatively affect protected characteristic group(s) within the Equality Act.
What are the Equality and Diversity implications?	The proposed change in policy and practice will be applied to adults regardless of ethnicity, gender, sexual orientation, religious belief, gender re-assignment, pregnancy / maternity, marriage / civil and partnership.
What are the safeguarding implications?	None.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider. The purchaser's Terms and Conditions for services contain relevant clauses regarding data management.
Risk Management:	The consultation has been undertaken in accordance with good practice and risk management advice from Policy as used in other wide ranging consultation.
Access to Information :	The background papers relating to this report can be inspected by contacting the report writer Dave Wilson, Planning and Commissioning:  Telephone: 0161 342 3534  e-mail: dave.wilson1@tameside.gov.uk

1. INTRODUCTION

1.1 On-going engagement with the borough's six contracted support at home providers as part of the transformation of homecare in Tameside – itself, part of the wider GM sponsored Living Well at Home programme – has raised the issue of risk adverse manual handling practices across the piece leading to a high level of double handed manual handling transfers where there is often scope for safe, more person centred single handed approaches.

1.2 Providers have been consistent in highlighting the difficulties they routinely face providing staff to undertake transfers risk assessed as requiring two staff. One of the most significant impacts of this is delayed hospital discharge.

1.3 This view chimes with the trend nationally towards reduced care handling options; a trend that recognises the benefits to be realised by such an approach:

a) The doubling up of calls places restrictions on how support at home providers rota and use their staff flexibly within a person centred, outcomes focused model. Providers employing single handed care techniques report increased flexibility for staff, hours 'freed up' and greater scope to provide an outcomes-focused service.
b) Single handed care techniques can reduce the lead time to get packages of care in place thus potentially speeding up hospital discharges.
c) The lack of clarity within manual handling plans as to the exact role of the second staff member can lead to potentially ambiguous and unsafe manual handling practices.
d) Double handed approaches can negatively impact on the experience of the person needing support. An individual's dignity can be enhanced by a reduction in the number of people providing intimate support whilst potentially they benefit from less intrusive responses to achieving outcomes associated with their activities of daily living.
e) Double ups can, unintentionally, undermine an asset based approach to support at home by working in opposition to approaches that engage and utilize the support of family, friends and other informal carers.

1.4 In addition, there are clear financial benefits to be had across the health and social care economy by embracing a concerted, comprehensive switch to single handed care; principally in the number of homecare hours commissioned. Whilst to some extent, this will be offset by a reduction in revenue from charging as service users pay for the hours of one member of staff rather than two, the number of hours in question is significant.

2. SINGLE HANDED CARE TEAM

2.1 The intention is to establish a single handed care team to address the perception of social care, hospital and community based assessors, support providers and service users and family that many care and support interventions which require manual handling can only be delivered safely through the provision of two carers. The team will be tasked with instigating whole system change with the aim of reducing the instances of double up staffing in order to undertake safe manual handling activities associated with the provision of care and support.

2.2 The updated posts required for the team will be community-based, but with close links to the hospital and other services and will have the sole function of embedding safe, single handed care, as normal practice across all sectors within the TMBC footprint. The updated posts required are:

- 1 x FTE Senior Occupational Therapist Practitioner;
- 1 x FTE Occupational Therapist;
- 1 x FTE Manual Handling Assessor;
- 1 x FTE Occupational Therapist Assessor

2.3 The team will be employed on a two year fixed term basis. Initial investment will be required in respect of employing the dedicated staff team.

2.4 Buy-in from all relevant staff groups and from support at home providers is crucial. The proposed approach – based on a tried and tested approach adopted by Derbyshire Social Services some two and a half years ago - accounts for this in terms of establishing a shared set of policies and practices from the outset; support at home providers have already indicated their commitment to this approach.

2.5 A comprehensive training/awareness raising programme will be part and parcel of the roll-out:

- Equipment specific training by the equipment provider(s) to OTs, providers, social workers, family etc. i.e. all relevant stakeholders;
- Manual handling training and up-dates with a focus on risk assessing single handed care by manual handling practitioners;
- Potential for initial awareness raising 'hearts and minds' work around the cultural shift to single handed care.

2.6 As referenced in paragraph 2.3 initial investment will be required in respect of employing the dedicated staff team. This is estimated at £ 0.375 million for a 2 year fixed term period. Further additional investment for gantries and bed systems etc. at an average cost of £1,500 per service user is currently being considered. The estimated equipment cost based on a 50% conversion success rate is approximately £0.150 million over two year's i.e. total estimated investment of £0.525 million over two years.

3. WHY ARE WE PROPOSING THESE CHANGES

3.1 The single handed care team, once in post, will provide clinical and project leadership as well as additional capacity and will work with the existing manual handling team as well as hospital based practitioners with the following brief:

- Review existing best practice in safe manual handling specifically related to single handed care;
- Apply this to the review of the existing 200+ cases across the borough within the initial 12 – 18 month period;
- Review all service users with two carers to identify if equipment (hoist, rotunda etc.) that can be prescribed by use of one person and/or use of alternative techniques would safely meet their manual handling needs and therefore eliminate the need for the second carer;
- Work with a range of stakeholders to achieve a common understanding of, and develop an effective approach to, risk assessment and management regarding manual handling across all assessment and provider staff;
- Contribute to integration with local health partners by promoting a common understanding of and approaches to risk assessment and management with hospital and community based therapists;
- Coordinate the training of all prescriber staff in understanding of and use of alternative techniques and (where appropriate) the use of specialist equipment;
- Support service users, providers and carers in the use of techniques and equipment to reduce double handling;
- Inform on-going arrangements across the borough to deliver a sustainable approach to manual handling.

3.2 In terms of the financial impact, based on a fairly conservative assumption that 50% of current transfers undertaken by two carers were to switch to single handed care, it has been estimated the following savings would be realised as stated in **Table 1.** It should be noted that initial investment of £ 0.525 million over a two year period will be required to support the proposal. Estimated phased details are also provided in **Table 1**.

Table 1

	2019/20 £'m	**2020/21 £'m**	**2021/22 £'m**	**2022/23 £'m**	**2023/24 £'m**

Estimated Revised Investment (per section 2.6) – assuming 1 October 2019 commencement	0.129	0.262	0.134		
Estimated Savings	(0.540)	(1.079)	(1.079)	(1.079)	(1.079)

3.3 Table 2 provides details of the financing arrangements for the proposed investment of £ 0.525 Million over the period 2019/20 to 2021/22.

Table 2

Investment	Budget	£ million
Dedicated Staff Team	Disabled Facilities Grant (subject to approval by Executive Cabinet – July / August 2019 as explained in section 3.4)	0.375
Gantries / Bed Systems	Gantries - Disabled Facilities Grant Allocation (subject to approval by Executive Cabinet – July / August 2019) Bed Systems - Adult Services Community Equipment Budget	0.150
	Total	**0.525**

3.4 £0.375 million (per table 2) for the dedicated staff team will be resourced by the Disabled Facilities Grant. Members should note that this will be included within a report to the Strategic Planning and Capital Monitoring Panel Committee on 8 July 2019. The minutes of this meeting will be subject to approval by the Executive Cabinet at its meeting on either 24 July 2019 / 28 August 2019.

3.5 The estimated sum of £0.150 million to support the cost of gantries and bed systems will be financed via a combination of the Disabled Facilities Grant (within the Place Directorate capital programme) and the Adult Services community equipment revenue budget. Gantries will be resourced via the Disabled Facilities Grant as these meet the related grant conditions. The bed systems will be resourced via the community equipment revenue budget. The actual commitment cost against each funding allocation will be monitored as the needs of eligible service users are confirmed following assessment.

3.6 The expenditure via the Disabled Facilities Grant will be included in the same report to the Strategic Planning and Capital Monitoring Panel Committee on 8 July 2019 as explained in section 3.4.

4. CONSULTATION AND FEEDBACK

4.1 The consultation, open for eight weeks in total, ended 15 April 2019.

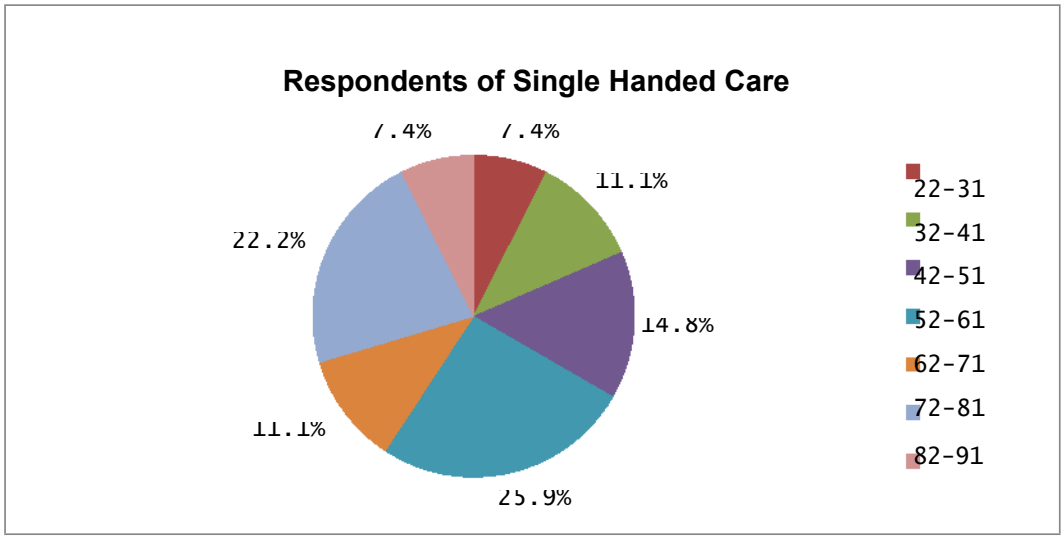
4.2 Accessed via The Big Conversation, it was also promoted widely via:

- The Partnership Engagement Network – 300+ contacts
- Healthwatch
- The Borough's six contracted support at home providers

4.2 Over the period the consultation was open we received a total of 38 responses. This represents a relatively low response, but given the highly specialised/specific nature of the issue, is not entirely surprising.

4.3 Breakdown of respondents by age, below:

4.4 Of particular note, just under 40 per cent of respondents identified as being in receipt of double-handed care; that is to say, the consultation was of particular significance to them (see slide 3, Appendix 2). The vast majority of these respondents were supported by their support at home provider to access and participate in the consultation via paper copies of the questionnaire.



4.5 A significant proportion (43%, though only 15 people in total), of these have been in receipt of double-handed support for three years or more (see slide 5).

4.6 Research nationally and anecdotal evidence from Derbyshire County Council's single handed care team consistently highlights that the prospect of changing a manual handling transfer for people who have been in receipt of double-handed support for lengthier periods of time, can be anxiety provoking. This is of significance when considering the feedback from respondents, many of whom have known only double-handed care.

4.7 Mindful of this, the intention from the outset has always been to mitigate against such concerns in two key ways:

- Offer/provide an extended period of having two staff present where a safe single handed transfer has been identified, allowing the service user time to adjust and to be reassured.

- Where a service user is clear they do not wish to change from double handed care to single handed that double handed transfer will remain; there will be no insistence on change.

4.8 Experience elsewhere is that with reassurance and fully informed, fully involved decision-making, some people will feel able to change. For people who have never previously required a manual handling transfer, adopting a single handed approach is less of an issue, not least because they will not have known anything else. It is in this respect that most of the change in practice will, over time, occur.

4.9 This approach is fully reflected in the up-dated EIA (**Appendix 1**).

4.10 Sample of feedback (full transcript of feedback, **Appendix 3**):

I am unable to walk and I rely on my carer workers for everything, I use a stand to get in and out of a bed or chair, I need two carer works because when I do stand I have one carer at front and back of me while standing, I just would not feel safe without them, I also have a slide sheet which care workers can use get me comfy at night, one care worker could not use this then I wouldn't be comfy for all them hours I spend it bed.

I need two carers to support me to get in and out of bed, one carer worker couldn't do this on their own, I also need support while in bed to ensure I am up the bed enough by using the slide sheet, one carer worker would be unable to get me comfy on the bed, I wouldn't be able to remain living at home with one care worker.

No, I don't think he could, if he needed the commode, but if he had an Ambiturn and a shower chair, for transfers. If it was safe to do so, I think it could work.

Definitely welcome, financial cheaper less intrusive.
I don't feel comfortable as they may not get me in the wheel chair right, but if I was safe and the carer was safe I would think about it.

Can't weight bear I need 2 carers. Once my pressure sores are healed wouldn't want carers at all at all times. This is positive feedback. Maybe 3-6 months this could happen and one day not having care at all.

I am unable to walk the my arthritis all over most of my body including my hands, I can stand and just about hold on to the stand, I can be very unsteady sometimes and I always need someone behind me to steady me while I'm standing, it would be very dangerous and I would be very scared of falling if I only had one care worker, I feel I would not be able to remain at home if this ever happened.

I feel it wouldn't be safe the level of trust is different, I trust my mother but not all care workers. I would like to just have one carer if it was safe and this would be better for me to have a good relationship with them.

5. CONCLUSION

5.1 Both the low response and the breadth of views expressed were as expected given the very specific nature of the topic/consultation.

5.2 Responses from people currently in receipt of double handed care were actively sought by the Council's support at home providers. They have elicited a range of views from concern and anxiety through to openness to a different approach. Since this is one of the key cohorts that a single handed care approach will touch, it is a positive that they have engaged with this consultation. Equally, despite the best efforts of providers and widespread promotion of the consultation, significant numbers of people in receipt of double handed care either did not or chose not to respond.

5.3 Having considered all the views expressed and mitigated against them in the EIA, the recommendation is to proceed with the establishment of a single handed care team for an initial two year period.

6. RECOMMENDATIONS

6.1 As stated on the report cover.

APPENDIX 1

• Subject / Title	• Single Handed Care Team

• Team	• Department	• Directorate
• Strategic Commissioning Function	• Adults	• People

• Start Date	• Completion Date
• October 2018	•

• Project Lead Officer	• Dave Wilson
• Contract / Commissioning Manager	• Trevor Tench
• Assistant Director/ Director	• Stephanie Butterworth

• EIA Group • (lead contact first)	• Job title	• Service
• Dave Wilson	• Team Manager	• Commissioning
• Trevor Tench	• Service Manager	• Commissioning
• Julia Worthington	• Integrated Neighbourhood Manager	• Adults
• Wendy Gee	• Manual Handling Practitioner	• Adults

PART 1 – INITIAL SCREENING

An Equality Impact Assessment (EIA) is required for all formal decisions that involve changes to service delivery and/or provision. Note: all other changes – whether a formal decision or not – require consideration for an EIA.

The Initial screening is a quick and easy process which aims to identify:

- ***those projects, proposals and service or contract changes which require a full EIA by looking at the potential impact on any of the equality groups***
- ***prioritise if and when a full EIA should be completed***
- ***explain and record the reasons why it is deemed a full EIA is not required***

A full EIA should always be undertaken if the project, proposal and service / contract change is likely to have an impact upon people with a protected characteristic. This should be undertaken irrespective of whether the impact is major or minor, or on a large or small group of people. If the initial screening concludes a full EIA is not required, please fully explain the reasons for this at 1e and ensure this form is signed off by the relevant Contract / Commissioning Manager and the Assistant Director / Director.

• **1a.**	• **What is the project, proposal or service / contract change?**	• Facilitate whole system change in practice via the establishment of a single handed care team with the sole function of embedding safe, single handed care, as normal practice across all sectors within the TMBC footprint
• **1b.**	• **What are the main aims of the project, proposal or service / contract change?**	1. Review existing best practice in safe manual handling specifically related to single handed care 2. Apply this to the review of the existing 200+ cases across the borough within the initial 12 – 18 month period 3. Review all service users with two carers to identify if equipment (hoist, rotunda etc.) that can be prescribed by use of one person and/or use of alternative techniques would safely meet their manual handling needs and therefore eliminate the need for the second carer 4. Work with a range of stakeholders to achieve a common understanding of, and develop an effective approach to, risk assessment and management regarding manual handling across all assessment and provider staff 5. Contribute to integration with local health partners by promoting a common understanding of and approaches to risk assessment and management with hospital and community based therapists 6. Coordinate the training of all prescriber staff in understanding of and use of alternative techniques and (where appropriate) the use of specialist equipment 7. Support service users, providers and carers in the use of techniques and equipment to reduce double handling 8. Inform on-going arrangements across the borough to deliver a sustainable approach to manual handling

1c. Will the project, proposal or service / contract change have either a direct or indirect impact on any groups of people with protected equality characteristics?

Where a direct or indirect impact will occur as a result of the project, proposal or service / contract change please explain why and how that group of people will be affected.

Protected Characteristic	Direct Impact	Indirect Impact	Little / No Impact	Explanation
Age	x			Of the 900+ people who will be supported by the Support at Home Service – ie those people currently supported by the Homecare Service – a significant number are older people.

				• 80.5% of people in receipt of homecare are 70+ years old • 19.3% of people in receipt of homecare are 90+ years old Of these, at any given time around 200 people require support with manual handling transfers currently assessed as requiring two people. Depending on how the SHC team approaches reassessments, a significant number of these people may have their transfers reassessed so that they can be safely and appropriately transferred by one person with the necessary equipment and training. Evidence from areas where single handed care techniques are routinely used suggests that person centred care is improved and an individual's dignity enhanced by a reduction in the number of people providing intimate support ie people tend to benefit from less intrusive responses to achieving outcomes associated with their activities of daily living. Furthermore, double-ups potentially undermine an asset based approach to support at home by working in opposition to approaches that engage and utilise the support of family, friends and other informal carers.
Disability	x			Of the 900+ people who will be supported by the Support at Home Service – ie those people currently supported by the Homecare Service – a significant number will have long-term health conditions/disabilities. • 77.3% of people in receipt of homecare have a disability (physical access & mobility & personal care and support) Most of the 200-odd people currently in receipt of double handed care will have a disability. Evidence from areas where single handed care techniques are routinely used suggests that person centred care is improved and an individual's dignity enhanced by a reduction in the number of people providing intimate support ie people tend to benefit from less intrusive responses to achieving outcomes associated with their activities of daily

				living. Not everyone will see their support change from double-ups to single handed care, but for those who do, the shift to a more person centred, outcome focussed approach should mean they experience life at home more positively with improved outcomes around health, wellbeing, independence and reduced social isolation.
Ethnicity		x	X	Approximately 7% of people currently supported by the Homecare Service identify themselves as other than White British; broadly in-line with the Tameside population (8.7%). With providers trained to provide single handed care to those people requiring transferring, evidence would suggest the people they support will experience a more person centred approach as a result. Hence, there may be an indirect impact, but no direct impact is anticipated in terms of ethnicity.
Sex / -			x	Overall, the service is used by broadly similar numbers of men and women. There is no evidence available to suggest any direct or indirect impact in terms of -sex
Religion or Belief			x	The service is used by people of all religion/beliefs. There is no evidence available to suggest any direct or indirect impact in terms of religion or belief.
Sexual Orientation			x	The service is used by people of all sexual orientations. With providers trained to adopt a more person centred approach people may experience a positive impact but there is no evidence available to suggest any direct or indirect impact in terms of sexual orientation
Gender Reassignment			x	No direct impact is anticipated in terms of gender reassignment. There is no evidence available to suggest any direct or indirect impact in terms of gender reassignment.
Pregnancy & Maternity			x	No direct or indirect impact is anticipated in terms of pregnancy/maternity due to the age range of people predominantly accessing the service.

Marriage & Civil Partnership			x	No direct impact is anticipated for those who are married or who are in a civil partnership. There is no evidence available to suggest any direct or indirect impact will be experienced in terms of marital status
Other protected groups determined locally by Tameside and Glossop Single Commissioning Function?				
Group (*please state)*	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**
Mental Health	x			It is anticipated that people with dementia and mental health needs should experience a positive impact as a result of this service transformation • 4% of people in receipt of homecare use mental health services Evidence from areas where single handed care techniques are routinely used suggests that person centred care is improved and an individual's dignity enhanced by a reduction in the number of people providing intimate support ie people tend to benefit from less intrusive responses to achieving outcomes associated with their activities of daily living. Not everyone will see their support change from double-ups to single handed care, but for those who do, the shift to a more person centred, outcome focussed approach should mean they experience life at home more positively with improved outcomes around health, wellbeing, independence and reduced social isolation.
Learning disability	x			It is anticipated that people with learning disability should experience a positive impact as a result of this service transformation. Evidence from areas where single handed care techniques are routinely used suggests that person centred care is improved and an individual's dignity enhanced by a reduction in the number of people providing intimate support ie people tend to benefit from less intrusive responses to achieving outcomes associated with their activities of daily living.

				Not everyone will see their support change from double-ups to single handed care, but for those who do, the shift to a more person centred, outcome focussed approach should mean they experience life at home more positively with improved outcomes around health, wellbeing, independence and reduced social isolation.
Carers	x			The introduction of single handed care techniques that engage and utilise the support of family, friends and other informal carers will positively impact on carer health and will contribute to preventing carer breakdown.
Military Veterans		x		The service is used periodically by military veterans, particularly older veterans, and so there may be an indirect impact but no direct impact is anticipated in relation to military veterans.
Breast Feeding			x	The service is predominantly used by people beyond child bearing age and hence no direct impact is anticipated in terms of this particular characteristic.
Are there any other groups who you feel may be impacted, directly or indirectly, by this project, proposal or service / contract change? (*e.g. vulnerable residents, isolated residents, low income households)*				
Group (*please state)*	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**
Isolated older people	x			A significant number of people supported by the service routinely or periodically report social isolation and the often negative impact this can have on their physical and emotional wellbeing. Evidence from areas where single handed care techniques are routinely used suggests that person centred care is improved and an individual's dignity enhanced by a reduction in the number of people providing intimate support ie people tend to benefit from less intrusive responses to achieving outcomes associated with their activities of daily living.
Vulnerable older people	x			A significant number of people supported by the service routinely or periodically report feeling vulnerable as a result of their health and/or social care circumstances or are considered

				vulnerable by family, friends or services. As above; where single handed care is assessed as being appropriate, people in receipt of care should experience more personalised support when transferring.

Wherever a direct or indirect impact has been identified you should consider undertaking a full EIA or be able to adequately explain your reasoning for not doing so. Where little / no impact is anticipated, this can be explored in more detail when undertaking a full EIA.

• 1d.	• **Does the project, proposal or service / contract change require a full EIA?** •	• **Yes**	• **No**
		• x	•
• 1e.	• **What are your reasons for the decision made at 1d?** •	• The changes proposed are seeking to make a direct and positive impact for service users and service providers alike. However, it will entail a complete change to manual handling assessments and whilst the implications – in terms of changing arrangements they might otherwise be used to - for people requiring transferring after the SHC team is in place, for some people already in receipt of double handed care, there is more likely to be an impact as a result of change. •	

If a full EIA is required please progress to Part 2.

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

2a. Summary

This from a 2015 report 'It Takes Two; Exploring the Manual Handling Myth' jointly authored by University of Salford and Prism Medical UK:

"*Our research shows that misconceptions regarding moving and handling, insufficient knowledge of specialist equipment and an often outdated and inflexible approach has led to too much generalisation regarding the perceived need for two carers as opposed to one. This has led to a culture of 'proving' the case for one carer rather than the other way around. Furthermore making the correct choice has major implications not only in terms of cost but also the number of carers required, the impact upon the client's privacy and their general well-being.*

Add to this the increasing difficulty of recruiting and retaining carers and the proven long term cost benefits of providing suitable equipment for the client's needs and the argument for thoroughly challenging the perceived need for double-handed care is strong.

Real life evidence has proven that thousands of these individuals are able to manage well with lone carers and prefer the flexibility this provides. Many clients wish to participate in their care and enjoy the one-to-one relationship that single carer packages afford them. The findings of our research are consistent and all point toward current practice often being out of step with what is actually required by the client. A policy that encourages unnecessary caution and over provision in the workplace has huge cost implications against a backdrop of persistent pressure to reduce the

burden of cost of social care. A dwindling carer workforce only serves to exacerbate this situation".

- Tameside's project is based, in part, on Derbyshire County Council's Safe/Single Handling Team, created in August 2015 to address the perception of social care, hospital and community based assessors, support at home providers and service users and family that many care and support interventions which require manual handling can only be delivered safely through the provision of two carers.
- Whilst by no means the only such service regionally/nationally, Derbyshire's approach was felt to be particularly pertinent not just because of the demonstrable change in practice and associated cost savings already achieved, but because in Glossopdale, the model is already in practice across one of our neighbourhood footprints.
- Manual handling can be defined as lifting, lowering, carrying, pushing or pulling (Health and Safety Executive 2004) (HSE).....which in the context of social care is an everyday occurrence to facilitate activities of daily living and it is this occupational task which can be a particular risk factor due to the unpredictable nature of the load (adapted from Bracher and Brooks, 2006).
- As with the Derbyshire project, the proposal to form a Tameside SHC team takes as it's starting point, the recognition that instances of double handling have steadily grown over recent years for a number of reasons:

- Risk adverse approaches by hospital based therapists resulting in recommendations that equipment (which is designed to be safely operated by one person) should only be used by two staff

  Risk adverse agencies who insist on double ups with above equipment
- Risk adverse approaches by the Council themselves particularly in the training of relevant staff
- People leaving hospital earlier requiring more initial assistance, but without timely review once home due to a lack of capacity amongst neighbourhood based therapists

- Whilst there are clear financial benefits to be had across the health and social care economy by embracing a concerted, comprehensive switch to single handed care - in their first 18 months (through to September 2016), the DSS team calculate that across five hospitals and the entire county, they achieved £1.8m savings on avoided double ups and double ups switched safely to single handed care - the need to reduce instances of double handling is not driven purely by financial considerations. There is a significant body of evidence to support other potential advantages. These include:

  - The doubling up of calls places restrictions on how support at home providers rota and use their staff flexibly within a person centred, outcomes focused model. Providers employing single handed care techniques report increased flexibility for staff, hours 'freed up', greater scope to provide an outcomes focused service
  - It can increase the lead time to secure services due to tying up already limited provider capacity, thus potentially delaying discharges while the necessary additional resources are sourced
  - The lack of clarity within manual handling plans as to the exact role of the second can lead to potentially ambiguous and unsafe manual handling practices
  - Impacts on the experience of the person needing support whose dignity would be enhanced by the reduction in the number of people providing intimate support and who

would benefit from less intrusive responses to achieving outcomes associated with their activities of daily living

- Double ups potentially undermine an asset based approach to support at home by working in opposition to approaches that engage and utilise the support of family, friends and other informal carers

Based on the above, the intention is instigate whole system change with the aim of reducing the instances of double up staffing in order to undertake safe manual handling activities associated with the provision of care and support. This will be facilitated via the employment a community-based team of OTs and/or Manual Handling Assessors, with the sole function of embedding safe, single handed care, as normal practice across all sectors within the TMBC footprint:

- FTE Senior Practitioner OT
- 2 FTE OT/MH assessor
- 1 FTE OTA

These staff will provide clinical and project leadership as well as additional capacity and will work exclusively with the existing manual handling team with the following brief:

- Review existing best practice in safe manual handling specifically related to single handed care
- Apply this to the review of the existing 200+ cases across the borough within the initial 12 – 18 month period
- Review all service users with two carers to identify if equipment (hoist, rotunda etc.) that can be prescribed by use of one person and/or use of alternative techniques would safely meet their manual handling needs and therefore eliminate the need for the second carer
- Work with a range of stakeholders to achieve a common understanding of, and develop an effective approach to, risk assessment and management regarding manual handling across all assessment and provider staff
- Contribute to integration with local health partners by promoting a common understanding of and approaches to risk assessment and management with hospital and community based therapists
- Coordinate the training of all prescriber staff in understanding of and use of alternative techniques and (where appropriate) the use of specialist equipment
- Support service users, providers and carers in the use of techniques and equipment to reduce double handling
- Consultation is required with current recipients of double-handed manual handling transfers and with potential future users as implementation will necessitate a change of policy and practice. The intention is to engage as many of the current recipients – in the region of 200 in number – in consultation via the use of a small questionnaire undertaken with their support at home providers and, by way of potentially reaching a wider audience, via The Big Conversation.

2b. Issues to Consider

The introduction of a single handed care approach to manual handling assessments and transfers will be mindful of some of the key demographics of the group:

- 77.3% of people in receipt of homecare have a disability (physical access & mobility & personal care and support)
- 80.5% of people in receipt of homecare are 70+ years old

19.3%of people in Any negatively perceived issues or impacts raised at this point will be reviewed and, wherever possible, changes made to the policy and approach to reduce/mitigate against the (potential) impact. Throughout, people will have the option of opting out a change from double handed care to single handed care.

Evidence from Derbyshire and elsewhere where single handed care approaches have been introduced is that some people who have been used to having two staff support them to transfer – particularly those where these arrangements have been in place for lengthy periods of time – can be anxious or wary at the prospect of change. One option that could be offered to people where a reassessment is indicating a switch from double-ups to single handed care, with the right equipment and training, is to retain two staff for a period of time where the second staff member does not participate in the transfer, but is close at hand should they be required. This could continue until such a point that safety has been demonstrated.

The approach will, wherever appropriate and safe also mean that family members can also be trained to undertake safe single handed transfers which would mean increased flexibility – that is to say, reduced reliance on paid, formal carers – and possibly too, more agreeable support for personal/intimate care.

The Single Handed Care Team will be working closely on an on-going basis with providers, manual handling assessors, OT's, physio's, social workers and other stakeholders to review practice generally and, where appropriate, individual's specifically.

<u>Consultation and Findings:</u>

- The consultation, open for eight weeks in total, ended 15 April 2019.
- Accessed via The Big Conversation, it was also promoted widely via:
  - The Partnership Engagement Network – 300+ contacts
  - Healthwatch
  - The Borough's six contracted support at home providers

Over the period the consultation was open we received a total of 38 responses. This represents a relatively low response, but given the highly specialised/specific nature of the issue, is not entirely surprising.

Of particular note, just under 40 per cent of respondents identified as being in receipt of double-handed care; that is to say, the consultation was of particular significance to them (see slide 3, Appendix 2). The vast majority of these respondents were supported by their support at home provider to access and participate in the consultation via paper copies of the questionnaire.

A significant proportion (43%, though only 15 people in total), of these have been in receipt of double-handed support for three years or more (see slide 5).

Research nationally and anecdotal evidence from Derbyshire County Council's single handed care team consistently highlights that the prospect of changing a manual handling transfer for people who have been in receipt of double-handed support for lengthier periods of time, can be anxiety provoking. This is of significance when considering the feedback from respondents, many of whom have known only double-handed care.

Experience elsewhere is that with reassurance and fully informed, fully involved decision-making, some people will feel able to change. For people who have never previously required a manual handling transfer, adopting a single handed approach is less of an issue, not least because they will not have known anything else. It is in this respect that most of the change in practice will, over time, occur.

2c. Impact

It is anticipated that:

- Having single handed care as the default for manual handling transfers so that practitioners have to justify *not* using a single handed approach, will decrease the lead time to secure services, thus potentially speeding up hospital discharges. Given the demands support at home providers face most of the time in terms of having enough staff to pick up work, double up's tend to tie up already limited staff capacity; delays in discharge, while the necessary additional resources are sourced, can result. Such delays can have negative effects on the individual concerned impacting potentially on health and well-being, on individual's waiting on hospital beds where bed availability is an issue and on health services facing financial pressures.

- Single handed care will improve safety and wellbeing where the lack of clarity within manual handling plans as to the exact role of the second staff member can lead to potentially ambiguous and unsafe manual handling practices.

- The experience of the person needing support whose dignity will be enhanced. A reduction in the number of people providing intimate support means people will benefit from less intrusive responses to achieving outcomes associated with their activities of daily living.

- Single handed care approaches engender an asset based approach to support at home by better engaging and utilising the support of family, friends and other informal carers.

• **2d. Mitigations** *(Where you have identified an impact, what can be done to reduce or mitigate the impact?)*	
• **Impact1** Concern/anxiety expressed by people currently receiving double handed care about changing to a single handed approach	• Offer/provide an extended period of having two staff present where a safe single handed transfer has been identified, allowing the service user time to adjust and to be reassured. • Where a service user is clear they do not wish to change from double handed care to single handed, that double handed transfer will remain; there will be no insistence on change.

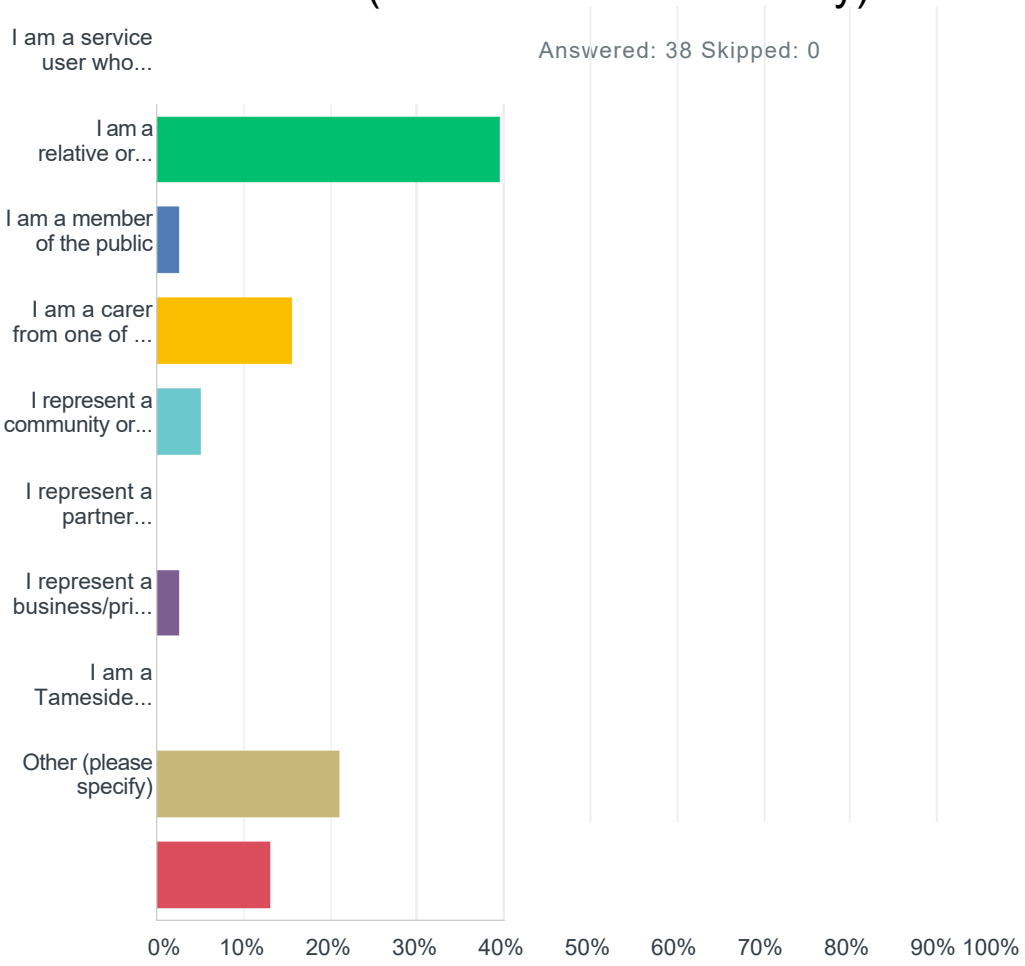
2e Evidence Sources
SALT - services are mapped and would specifically say Homecare Census 2011 ‘It Takes Two; Exploring the Manual Handling Myth’ University of Salford and Prism Medical Uk:

2fMonitoring progress		
Issue ! Action	**Lead officer**	**Timescale**
Satisfaction survey	Dave Wilson	By Autumn 2019

APPENDIX 2

Single Handed Care

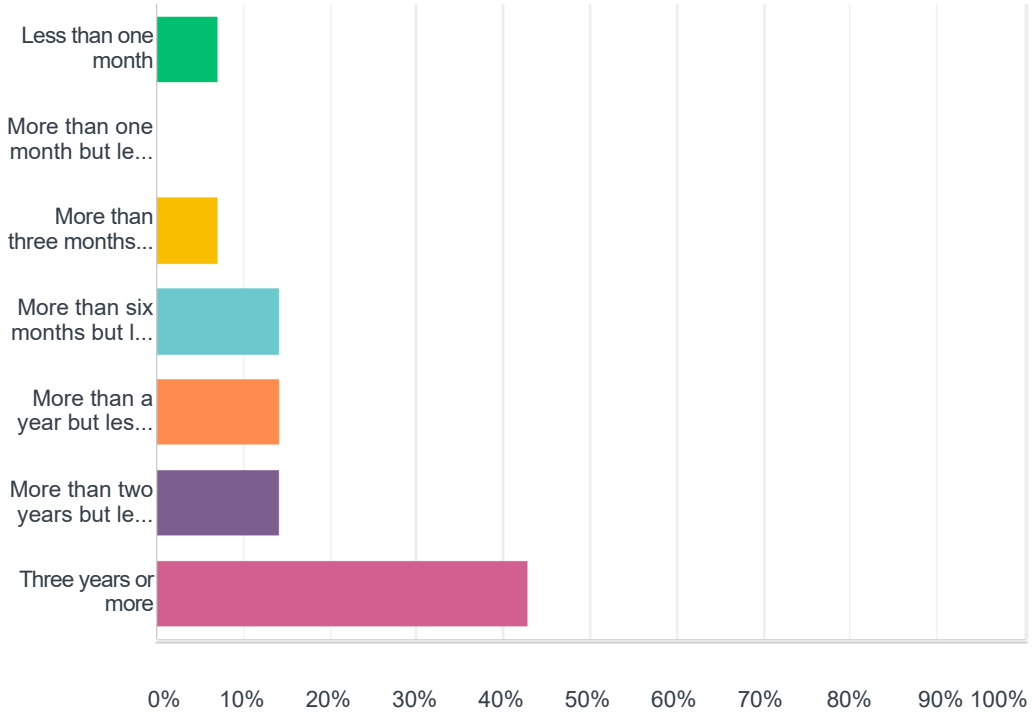
Q1 Please tick the box that best described your main interest in this issue? (Please tick one box only)



ANSWER CHOICES	RESPONSES	
I am a service user who currently receives care at home provided by two carers (dual care)	39.47%	15
I am a relative or friend of someone who currently receives care at home provided by two carers (dual care)	2.63%	1
I am a member of the public	15.79%	6
I am a carer from one of the organisations providing a two carer approach (dual care) in people's homes on behalf of Tameside Council	5.26%	2
I represent a community or voluntary group	0.00%	0
I represent a partner organisation	2.63%	1
I represent a business/private organisation	0.00%	0
I am a Tameside Council employee	21.05%	8
Other (please specify)	13.16%	5
TOTAL		38

Q2 How long have you (or your friend or relative) received care at home supported by two care workers as part of a dual care package?

Answered: 14 Skipped: 24



ANSWER CHOICES	RESPONSES	
Less than one month	7.14%	1
More than one month but less than three months	0.00%	0
More than three months but less than six months	7.14%	1
More than six months but less than a year	14.29%	2
More than a year but less than two years	14.29%	2
More than two years but less than three years	14.29%	2
Three years or more	42.86%	6
TOTAL		14

Q3 The proposed model as outlined here recognises that there is a need for a Single Handed Care Team approach whilst at the same time ensuring that the new function is safe. Please tell us your thoughts on the proposal to implement single handed care. If you, a friend or relative uses the service, please explain how single handed care would impact you / your friend or relative directly. (Please write your comments in the box below)

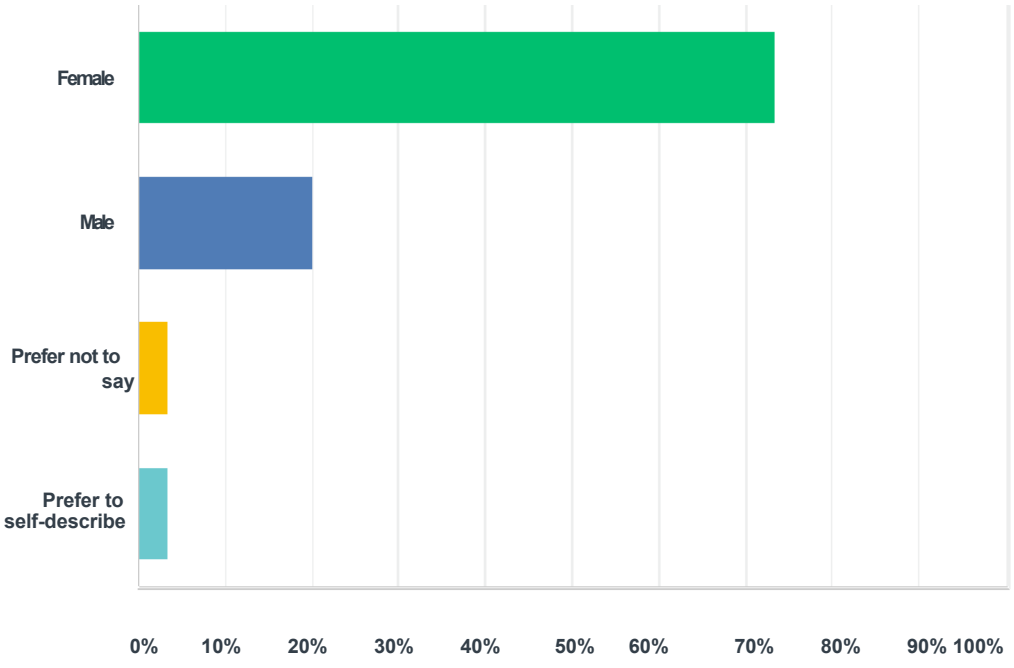
Answered: 12 Skipped: 26

Q4 Do you have any other comments you would like to make about the proposal to implement single handed care in Tameside? (Please write your comments in the box below)

Answered: 26 Skipped: 12

Q5 What is your sex?

Answered: 30 Skipped: 8



ANSWER CHOICES	RESPONSES	
Female	73.33%	22
Male	20.00%	6
Prefer not to say	3.33%	1
Prefer to self-describe	3.33%	1
TOTAL		30

Q6 What is your age? (Please state)

Answered: 28 Skipped: 10

Q7 What is your postcode? (Please state)

Answered: 20 Skipped: 18

Q8 What is your ethnic group? (Please tick one box only)

Answered: 30 Skipped: 8

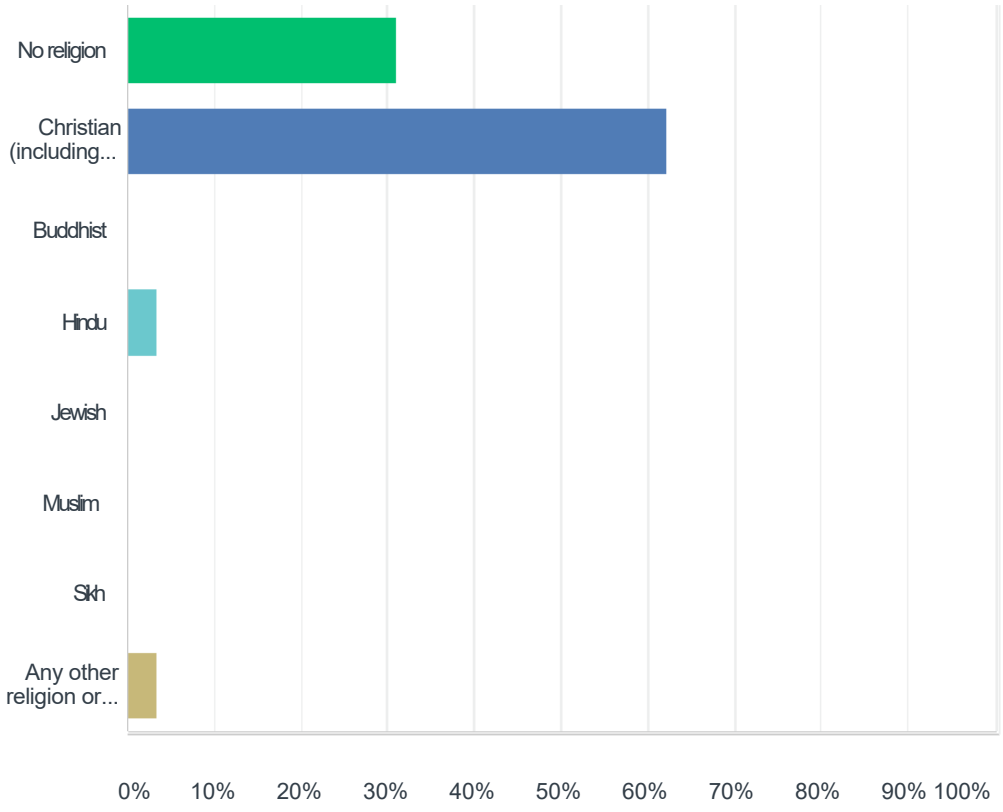
Single Handed Care

ANSWER CHOICES	RESPONSES	
White: English / Welsh / Scottish / Northern Irish / British	93.33%	28

White: Irish	0.00%	0
White: Gypsy or Irish Traveller	0.00%	0
Any other White background (please specify in the box below)	0.00%	0
Mixed/multiple ethnic groups: White & Black Caribbean	0.00%	0
Mixed/multiple ethnic groups: White & Black African	0.00%	0
Mixed/multiple ethnic groups: White & Asian	0.00%	0
Any other Mixed/multiple ethnic background (please specify in the box below)	0.00%	0
Asian/Asian British: Indian	3.33%	1
Asian/Asian British: Pakistani	0.00%	0
Asian/Asian British: Bangladeshi	0.00%	0
Asian/Asian British: Chinese	0.00%	0
Any other Asian background (please specify in the box below)	0.00%	0
Black/African/Caribbean/Black British: African	0.00%	0
Black/African/Caribbean/Black British: Caribbean	0.00%	0
Any other Black / African / Caribbean background (please specify in the box below)	0.00%	0
Arab	0.00%	0
Any other Ethnic group (please specify in the box below)	3.33%	1
TOTAL		30

Q9 What is your religion or belief?

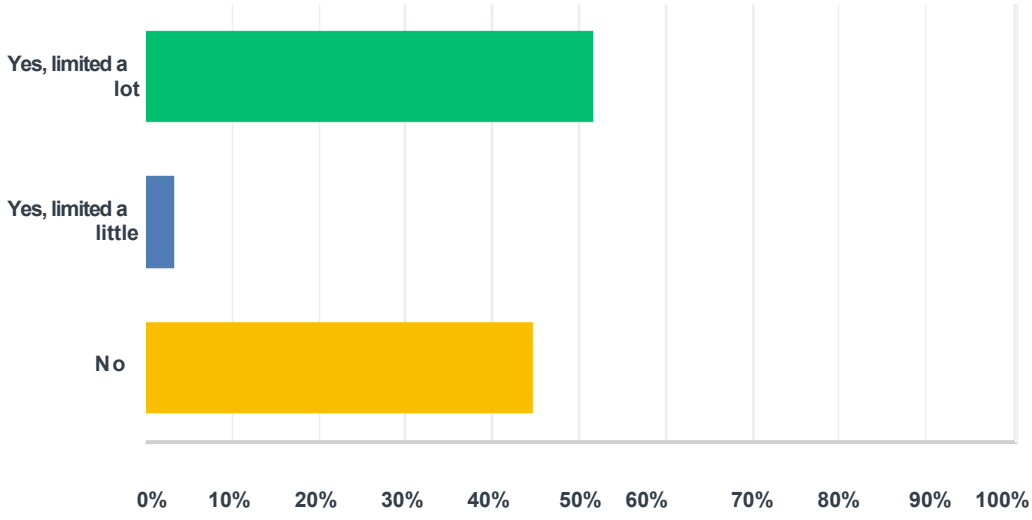
Answered: 29 Skipped: 9



ANSWER CHOICES	RESPONSES	
No religion	31.03%	9
Christian (including Church of England, Catholic, Protestant and all other Christian denominations)	62.07%	18
Buddhist	0.00%	0
Hindu	3.45%	1
Jewish	0.00%	0
Muslim	0.00%	0
Sikh	0.00%	0
Any other religion or belief, please state	3.45%	1
TOTAL		29

Q10 Are your day-to day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? Include problems related to old age. (Please tick one box only)

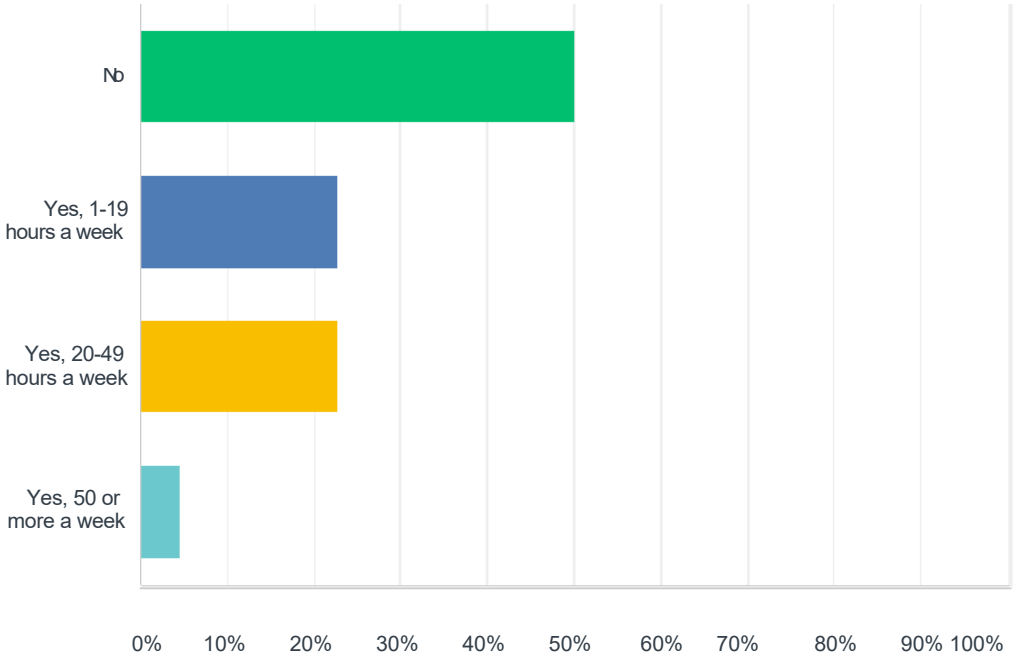
Answered: 29 Skipped: 9



ANSWER CHOICES	RESPONSES	
Yes, limited a lot	51.72%	15
Yes, limited a little	3.45%	1
No	44.83%	13
TOTAL		29

Q11 Do you look after, or give any help or support to family members, friends, neighbours or others because of either long term physical or mental ill-health /disability or problems related to old age? (Please tick one box only)

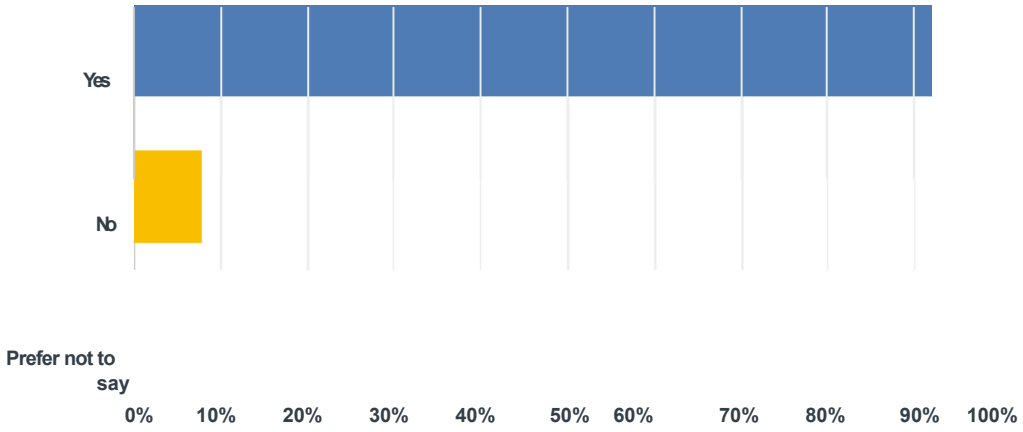
Answered: 22 Skipped: 16



ANSWER CHOICES	RESPONSES	
No	50.00%	11
Yes, 1-19 hours a week	22.73%	5
Yes, 20-49 hours a week	22.73%	5
Yes, 50 or more a week	4.55%	1
TOTAL		22

Q12 Are you a member or ex-member of the armed forces?

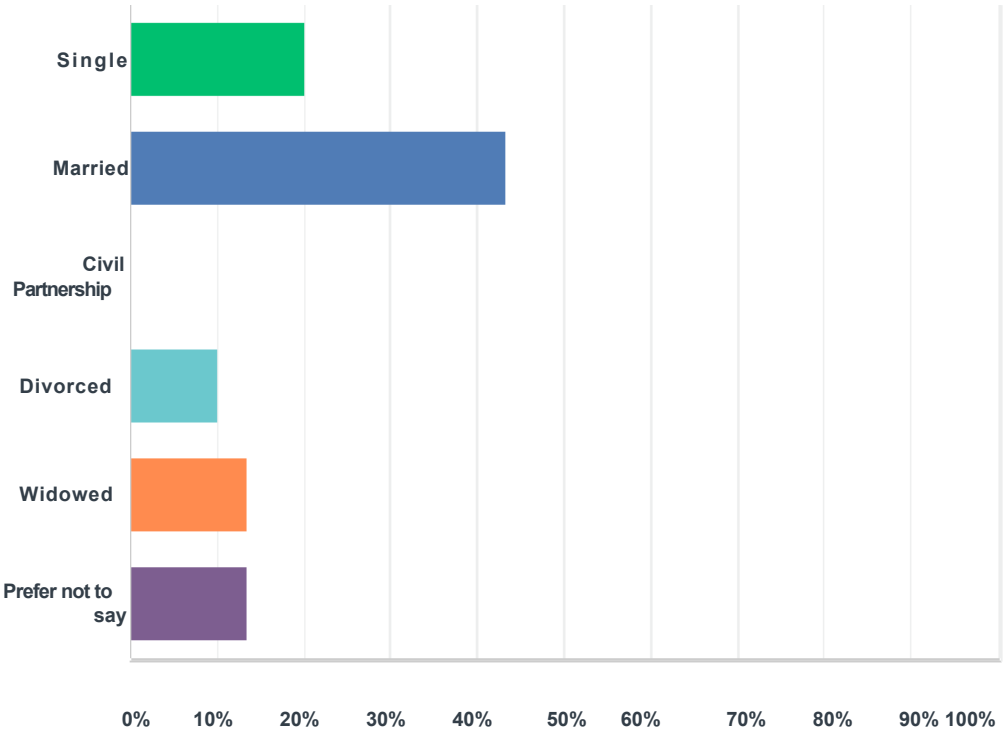
Answered: 25 Skipped: 13



ANSWER CHOICES	RESPONSES	
Yes	0.00%	0
No	92.00%	23
Prefer not to say	8.00%	2
TOTAL		25

Q13 What is your marital status?

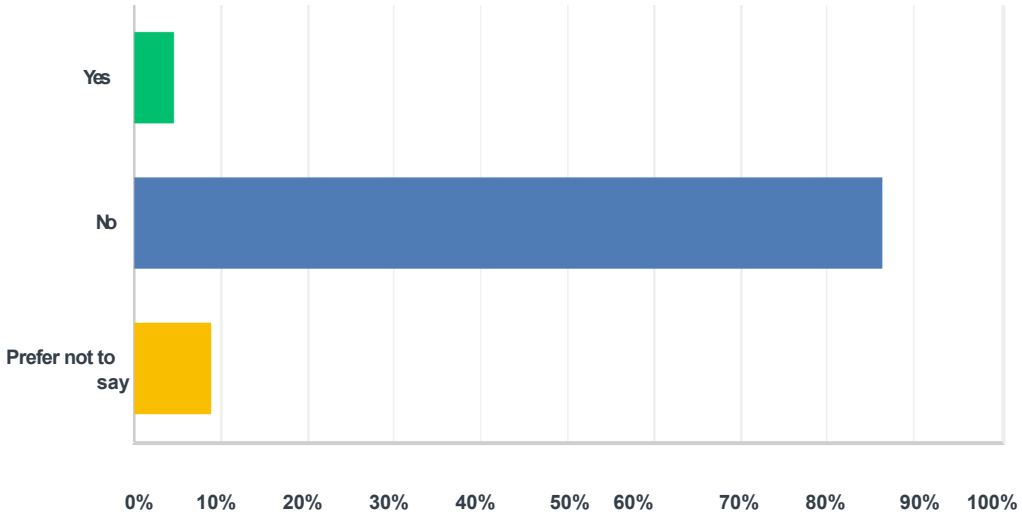
Answered: 30 Skipped: 8



ANSWER CHOICES	RESPONSES	
Single	20.00%	6
Married	43.33%	13
Civil Partnership	0.00%	0
Divorced	10.00%	3
Widowed	13.33%	4
Prefer not to say	13.33%	4
TOTAL		30

Q14 Are you pregnant, on maternity leave or returning from maternity leave?

Answered: 22 Skipped: 16



ANSWER CHOICES	RESPONSES	
Yes	4.55%	1
No	86.36%	19
Prefer not to say	9.09%	2
TOTAL		22

Q15 If yes, are you:

Answered: 0 Skipped: 38

! No matching responses.

ANSWER CHOICES	RESPONSES	
Pregnant	0.00%	0
On maternity leave	0.00%	0
Returning from maternity leave	0.00%	0
TOTAL		0

Single Handed Care Consultation Open Comments

Q3.

The proposed model as outlined here recognises that there is a need for a Single Handed Care Team approach whilst at the same time ensuring that the new function is safe. Please tell us your thoughts on the proposal to implement single handed care. If you, a friend or relative uses the service, please explain how single handed care would impact you / your friend or relative directly. (Please write your comments in the box below)

Responses: 7

I have lost the mobility to walk and over the last twelve months my mobility has deteriorated, I am unable to stand on my own, I have to be hoisted for all transfers now, bed to chair, I don't know how one care worker could hoist me on to the chair and ensure I was in the right position and comfy, no I wouldn't be happy if I had to have one carer, I am nervous while in the hoist with two never mind one care worker
I am unable to walk and I cannot even sit in a chair, I have all my care done on the bed, if I was to only have one care worker, how would that person be able to do my personal care needs, it is important that I can sit up straight in bed because I have to eat and drink, how would my care worker be able to do this, no one carer couldn't get me up the bed on their own, I am also not a small person I do have some wait on me
I am unable to walk the my arthritis all over most of my body including my hands, I can stand and just about hold on to the stand, I can be very unsteady sometimes and I always need someone behind me to steady me while I'm standing, it would be very dangerous and I would be very scared of falling if I only had one care worker, I feel I would not be able to remain at home if this ever happened
I am unable to walk and i rely on my carer workers for everything, I use a stand to get in and out of a bed or chair, I need two carer works because when I do stand I have one carer at front and back of me while standing, I just would not feel safe without them, I also have a slide sheet which care workers can use get me comfy at night, one care worker could not use this then I wouldn't be comfy for all them hours I spend it bed
I need two carers to support me to get in and out of bed, one carer worker couldn't do this on their own, I also need support while in bed to ensure I am up the the enough by using the slide sheet, one carer worker would be unable to get me comfy on the bed, I wouldn't be able to remain living at home with one care worker,

No, I don't think he could, if he needed the commode. But if he had an ambiturn and a shower chair, for transfers. If it was safe to do so, think it could work
Definately welcome, financial cheaper less intrusive

Q 4

Do you have any other comments you would like to make about the proposal to implement single handed care in Tameside? (Please write your comments in the box below)

Responses: 26

I wouldn’t feel safe with one care worker and I think accidents may happen
I feel I would not be able to remain at home because I wouldn’t be getting the care I need, it is very important to me that I remain at home for as long as I can with the help from my carer workers
Just the thought of having one care worker ups sets me very much
I am a nervous person and having one carer I think my health would deteriorate
It is important for me to remain at home with my wife
Wendy Lap sheet: this is a slide sheet that attaches to the hoist and actually positions the service user
Whilst I agree that person centred care is at the forefront my concerns are that some service users that need 2 person care can be very heavy for one carer
I think any care is better than no care
I would object if it is a way merely of cutting staff numbers. Each and every situation needs a careful risk assessment - there will be some people where single-carer lifting would place that carer at risk.

Mina ask my self how I feel about this I reported if the person was safe and it could be that it's less intrusive less costly and much easier to send someone in emergency situations
I have already moved from 4 calls 2 carers at each visit to 2 carers 2 times a day and 1 carer at bed time
No not like that, as long as I am safe
It would save me money
No
Single handed care can be a good thing if it is necessary to the service user- this can free up time for another carer to see another service user and can improve the quality of visits and time spent with the person being cared for. As long as the carer is appropriately trained in single handed care, the service user and family (if appropriate) is happy for the person being cared for to have single handed care then I don't see any objections. If a person/family feel the person does need more than just single handed care, even after the option of single handed care being talked through with them I think they should still have the right to chose the type and level of care they receive.
It's working well in other areas and OT's are getting on board with it
I think it will have positive effect on both staff and service users.
I have worked in other Authorities who have already introduced this model to good effect.
One to care for the right person, interact with the client, better outcomes and relationships with carer and clients.
Will this be a continuing process, or is it a short term project.
Will be welcomed.
as part of the manual handling team, I feel it is a good step forward for a person centered approach to care using appropriate equipment and techniques whilst reducing cost and supporting the care agencies with demand on their services.
Personal safety should come first.

Great idea if that's what the people want
As long as the carer can safely manage the client then it's not a problem. Depends on each individual and the size of them.
Having worked for Tameside monitoring the care provided by the private agencies I have reservations that not all the carers are sufficiently trained to a standard that they can provide this care safely on their own. A lot more investigation is needed to look at the training programs and also further consultations with service users.