The Highland Council

Education, Children and Adult Services Committee

Minutes of Meeting of the **Adult Services Development and Scrutiny Sub-Committee** held in Committee Room 2, Council Headquarters, Glenurquhart Road, Inverness on Wednesday 24 September 2014 at 2.00 pm.

Present:

Mr A Christie
Mrs M Davidson
Ms J Douglas
Mr B Gormley
Mr K Gowans
Mr W Mackay (Substitute)
Mr G Ross
Ms K Stephen

In attendance:

Mr B Alexander, Director of Care and Learning
Ms F Palin, Head of Adult Services, Care and Learning Service
Ms D Jones, Chief Operating Officer, NHS Highland
Ms J Macdonald, Head of Adult Social Care, NHS Highland
Mr G McCaig, Head of Care Support, NHS Highland
Mr S Steer, Head of Strategic Commissioning, NHS Highland
Miss M Murray, Committee Administrator, Corporate Development Service

Business

1. Apologies for Absence

Apologies for absence were intimated on behalf of Mrs I Campbell, Mrs B McAllister, Mrs M Paterson and Ms G Ross.

2. Declarations of Interest

The Sub-Committee **NOTED** the following declarations of interest:-

Item 7 – Ms J Douglas and Mr K Gowans (non-financial)

Mr G Ross and Mr B Gormley declared a non-financial interest in those items which might raise discussion on home care as a family member received a home care package but, having applied the test outlined in Paragraphs 5.2 and 5.3 of the Councillors' Code of Conduct, concluded that their interest did not preclude their involvement in the discussion.

Scrutiny

3. Adult Social Care Summary

There had been circulated Report No ASDS/11/14 dated 15 September 2014 by the Director of Care and Learning which provided an overview with regard to the delivery of the Commission for Adult Social Care Services by NHS Highland. The report

summarised the key issues including funding, performance, Telecare, Self Directed Support (SDS) and strategic commissioning.

During discussion, the following issues were raised:-

- concern was expressed that the Change and Improvement Plan did not strongly specify the need for investment in communities to shift the balance of care;
- information was sought on whether training and support was available for people who might be suitable for employment by those who wanted to use SDS in a flexible way within their local communities;
- the employment of generic Health and Social Care Support Workers was welcomed and it would be helpful to have sight of the job description;
- reference was made to the recent closure of two independent care homes in Inverness and concern was expressed that independent providers felt under pressure as a result of being asked to deliver the same quality of care as public sector facilities for less money;
- community organisations needed contracts which meant revenue over time and an assurance was sought that, in bidding for the Integrated Care Fund (ICF), there was the ability to support them to build not only services such as home care but preventative services;
- zero hours contracts did not provide long term employment and led to a high turnover of staff. The provision of sustainable jobs in communities was key and it was necessary to look at the broader picture and involve, for example, tertiary education providers;
- the importance of considering the provision of services from a care perspective rather than a business perspective was emphasised;
- in relation to recruitment, flexibility and partnership working were necessary and it was important that discussions took place at District Partnership level so that communities understood what the needs were and jobs could be matched up; and
- during previous discussions on the Change and Improvement Plan, it had been suggested that greater emphasis on housing was required and information was requested on whether this had been taken in to account. Given the focus on care at home, it was important to work with the Council's Housing Service and other agencies to ensure that people had appropriate housing and aids/adaptations.

In response to questions, it was explained that:-

- in relation to the ICF, the sign-off process had not yet been agreed although it was envisaged it would be similar to the multi-agency partnership approach used in respect of the Change Fund. Until confirmation was received from the Scottish Government as to how the ICF would flow, it was not possible to comment on the bidding process;
- the Change and Improvement Plan was a dynamic document and would continue to develop. The specifics in terms of creating outcomes and alignment with the ICF would be determined through the continuing development of the Adult Services Resourcing and Commissioning Group;
- with regard to investing in communities, it was necessary, through working with District Managers and District Partnerships, to understand how communities might wish to utilise resources to pump-prime change;
- it was necessary to think about shifting the balance of care in a broader context in terms of how NHS Highland's Out of Hospital Strategy would drive work, not only with communities but in terms of changing the emphasis within clinical and social

care teams. This should inform discussions at a local level as to how it would influence the pattern of care delivery;

- the Strategic Commissioning Plan (SCP) was a dynamic document developed in partnership with the third and independent sector, a process that had been recognised nationally as good practice. The first version of the SCP had clearly set out the commissioning intentions, which included working with the third and independent sector to develop alternatives to statutory care home services; developing quality schedules and dimensions of quality that would be included in contracts for the following year; implementing changes and investment in care at home services with third and independent sector partners; working with communities to develop alternatives to traditional care at home services; and developing schemes such as modern apprenticeships for carers. The commissioning intentions would be firmed up over the coming months and would be presented to the NHS Highland Board early in 2015. They would then dictate the direction of travel in terms of contracts for 2015/16;
- in relation to the staff bank for care at home services, people were being encouraged to sign up and a number of student nurses had indicated their wish to do so. Training was due to start at the end of October and amendments to the payroll system should also be in place by then, allowing implementation to take place by the end of November 2014;
- with regard to the review of care packages, it could not always be assumed that a review process meant that care would reduce as there could be individuals who required more care;
- in relation to care homes, officers were working closely with third and independent sector providers to establish appropriate standards of care and quality parameters that could be used as a basis for commissioning. Over time, that could have an impact in terms of care homes thriving or not being able to achieve both the Care Inspectorate standards and the quality standards. It was intended to go out to tender for an independent organisation that would go in to care homes, both in-house and commissioned, and gather qualitative information from clients and their carers on the care being provided so it could be triangulated against contract terms and the Care Inspectorate's reports. Whilst quite high risk, this would pay significant dividends in terms of how people perceived the care they received. With regard to the fee structure, this formed part of a national agreement with CoSLA and it was likely this would continue over the next year or two, depending on how quickly the aforementioned measures were able to be implemented. The importance of independent providers raising any concerns at an early stage was emphasised. It was highlighted that there was a need to reduce the number of continuous care home placements and the reliance on institutional care. More flexible responses, such as intermediate placements or step up/step down beds were required and it was important to work with independent providers to help them redefine their business models to respond to what was required from a commissioning perspective, albeit there was a risk it would cost more;
- the ICF would not necessarily be used to support community based services and examples were provided of services being supported by utilising existing care at home budgets and SDS;
- in terms of how and from whom services were commissioned, it was necessary to seek assurance that providers had a model of care that would meet the need and the required quality standards. How individual organisations established their business models and paid their staff was their decision. Putting overly structural services in place was restrictive and, where there were potential innovative solutions within communities that were relatively discreet, it was important to

encourage maximum flexibility to allow for growth. It was necessary to exercise caution and not to confuse the role of commissioner with deliverer;
- a service improvement process had been established whereby work was being undertaken with care homes, both in-house and commissioned, that were experiencing challenges. This consisted of providing additional access to District Nurses and integrated team members as well as management support and development. One of the areas being discussed at the Adult Services Resourcing and Commissioning Group was how to provide management and leadership training within the care home sector and it had been agreed to fund specific training for independent care home managers in 2015/16; and
- with regard to care at home, the challenge was not about housing but about having people to support the housing models NHS Highland wanted to use.

During further discussion, concern was expressed that the houses at Burn Road, Inverness that had been assigned to NHS Highland for supported housing had lain empty for some time before being taken back and allocated by the Housing Service. In response, it was explained that NHS Highland had intended to use a model that did not involve individual named tenants and there had been difficulty in securing the tenancy rights. The Chair undertook to take the matter up with the Housing Service.

Following discussion, the Chair suggested that it would be helpful to receive a detailed Briefing Note on the ICF, including information on who would sign it off, timescales and the application process.

Thereafter, the Sub-Committee:-

i. **NOTED** the issues raised in the report;
ii. **AGREED** that the job description in respect of the generic Health and Social Care Support Worker posts be circulated to Members of the Sub-Committee; and
iii. **AGREED** that a detailed Briefing Note on the Integrated Care Fund, incorporating the issues raised during discussion, be provided to Members of the Sub- Committee.

4. Health and Social Care Adult Services Performance Scorecard

There had been circulated Report No ASDS/12/14 dated 12 September 2014 by the Head of Care Support, NHS Highland which provided the latest edition of the balanced scorecard presented to the NHS Highland Improvement Committee as well as exception/update reports on young people in institutional care settings and unscheduled admissions. Members were also asked to consider future reporting requirements.

The Head of Care Support highlighted that, at its last meeting, NHS Highland's Improvement Committee had requested an exception report on respite. This would be presented to the Improvement Committee in November 2014 and, thereafter, to the Sub-Committee.

In response to a request that Improvement Committee papers be circulated to Members of the Sub-Committee, it was explained that it was an internal governance issue as it was not a public meeting and did not deal solely with health and social care issues. However, it may be possible to provide extracts of items that related to the Sub-Committee and the Chair undertook to look in to the matter.

During discussion, the following issues were raised:-

- in relation to reducing the number of young adults in institutional care settings, it would be useful to receive more detailed information on the work being undertaken, as well as the numbers involved and the reasons they were in placements outwith Highland. Work was ongoing by the Council to return young people in out of authority placements to Highland and to convert former janitors' houses to provide throughcare and aftercare. It was not helpful to return a young person in children's services to Highland, only to have to place them outwith Highland in adult services and it was essential to work together to make transitions as smooth as possible and to explore whether any economies could be achieved by joint working. In terms of commissioning, service providers needed to know what was required to support those involved locally;
- with regard to the Local Unscheduled Care Programme, whilst welcoming the work being undertaken, some issues were not going to be addressed if care at home was not in place; and
- having a responsive community care network in place was key to reducing inappropriate admissions.

In response to questions, it was explained that:-

- the issues surrounding supporting young adults in regional centres to return to Highland were being explored by the Learning Disability Improvement Group;
- in relation to the Local Unscheduled Care Programme and the need for effective transport coordination, the Head of Adult Social Care would be dealing with this workstream and would ensure links with the Council's Community Services;
- in relation to the pressure on GPs and how this was being addressed, GPs wanted accessibility to care at home services and work had been undertaken to configure district teams so that they understood where and what they could access at a local level. Three Community Geriatric Physicians had been appointed, which was a significant step forward. They would be working with local GPs, hospital at home teams and district teams to provide a wraparound service, particularly for frail elderly people, and would be able to provide an almost immediate response to concerns and queries by telephone and email. They would also be working with GPs who had responsibility for delivering care to care homes. It was an exciting opportunity to think differently and provide additional support in district teams and it would go some way to alleviating the pressure;
- an individual's wishes in respect of admittance to hospital formed part of the anticipatory care planning process; and
- the Scottish Ambulance Service worked under its own governance arrangements and the current protocol, in the case of falls, was to take the patient to A&E. Work was ongoing, at a local and national level, to identify ways of short-circuiting that and the Ambulance Service was trying to remodel the way it responded so that paramedics were seen as part of the multi-disciplinary team. As part of the remote and rural programme, the Director of Operations, North and West, was leading work in terms of advanced practitioners, working with integrated teams, potentially providing out of hours care. In addition, work was ongoing nationally to put a satellite system in place to link Scottish Ambulance Service information with out of hours information so that paramedics could access anticipatory care plans as well as information on out of hours care at home or community nursing.

Thereafter, the Sub-Committee:-

i. **NOTED** the report and the exception/update reports; and
ii. **AGREED** that more detailed information on the work being undertaken to reduce the number of young people in institutional care settings, including the numbers involved and the reasons they were in placements outwith Highland, be presented to a future meeting of the Sub-Committee.

5. Delayed Discharge

The Head of Strategic Commissioning, NHS Highland, tabled a summary of delayed hospital discharge as at 15 September 2014 and explained that the position remained extremely challenging, with 93 people delayed and an additional 26 complex cases, which were recorded separately. As previously reported to the Sub-Committee, the main issues were care at home capacity and a lack of care home placements as a result of depressed quality grades. Although the care at home position had improved, this was not yet reflected in the delayed discharged figures as there was a backlog of cases. There had been a re-emergence of delays as a result of patients awaiting completion of post-hospital social care assessments and immediate action was being taken in that regard. In addition, there had been unprecedented levels of hospital activity in June/July and work was ongoing to establish the reasons behind that. Delayed discharge was a growing problem throughout Scotland and Highland was in a similar position to other regions. However, remedial plans and actions were in place to address the issue.

During discussion, the following issues were raised:-

- there were a lot of frail, elderly people in Highland and concern was expressed that there was insufficient capacity to deal with those being admitted to hospital, let alone those who could be at any time;
- the reduction in the number of delays due to waiting for equipment/adaptations to be fitted was welcomed; and
- the issues surrounding admission to care homes would take time to address and it was therefore essential to provide more home care and build services in communities to prevent people being admitted to A&E.

In response to questions, it was explained that:-

- in relation to the number of people being cared for at home, it was difficult to provide comparative figures. The number of people receiving care packages could go down, as packages were previously provided at a lower threshold, but the size of packages could go up. In addition, there were issues in terms of demographics, with people living longer but with complex conditions. However, there was also a much younger population group presenting with complex conditions which appeared to relate to an unhealthy lifestyle and a piece of work was being undertaken by the Public Health Department in that regard. The work was specifically looking at Highland residents and updates would be presented to NHS Highland's Health and Social Care Committee as part of the reporting on the Local Unscheduled Care Programme;
- as new initiatives such as staff banks for care at home services were introduced, it was essential to be clear about the implementation date so that tracking and

monitoring could be carried out to ascertain whether they were having an impact. The sum of the parts, rather than one particular activity, would be key; and
- the South and Mid Community Pull Team would be looking specifically at packages of care for those individuals delayed over four or six weeks.

The Sub-Committee otherwise **NOTED** the position.

6. Operational Director Reports

i. North and West Operational Unit

There had been circulated Report No ASDS/14/14 by the Director of Operations, North and West Operational Unit which set out the report in respect of the North and West Operational Unit as considered by NHS Highland's Health and Social Care Committee on 11 September 2014. The report provided an overview of activity within the Unit and highlighted any areas of concern.

In response to a question, it was explained that no date had yet been agreed for transferring residents back to The Mackintosh Centre in Mallaig following the recent staffing difficulties.

The Sub-Committee otherwise **NOTED** the content of the report.

ii. South and Mid Operational Unit

There had been circulated Report No ASDS/15/14 by the Director of Operations, South and Mid Operational Unit which set out the report in respect of the South and Mid Operational Unit as considered by NHS Highland's Health and Social Care Committee on 11 September 2014. The report provided an overview of activity within the Unit and highlighted any areas of concern.

In response to a question, it was explained that, whilst the Adult Social Care savings target was unlikely to be met, this would be offset by other areas of the budget. The South and Mid Operational Unit was therefore forecasting a breakeven budget position at this stage.

The Sub-Committee otherwise **NOTED** the content of the report.

Development

7. Strategic Commissioning Plan – Update

Declarations of Interest:

Ms J Douglas and Mr K Gowans declared a non-financial interest in this item as a Director of High Life Highland but, having applied the test outlined in Paragraphs 5.2 and 5.3 of the Councillors' Code of Conduct, concluded that their interest did not preclude their involvement in the discussion.

There had been circulated Report No ASDS/16/14 by the Chief Operating Officer, NHS Highland which updated Members on the continued development of the Strategic Commissioning agenda within Highland. The report summarised the new legislative

context, Highland commissioning structures and the work being undertaken on "dimensions of quality. Developments in commissioning care at home services would be the subject of a separate presentation at item 8 on the agenda.

In response to questions, it was explained that meetings had taken place with the Scottish Government to discuss integration and how the current arrangements in Highland complied with the Public Bodies (Joint Working) (Scotland) Act 2014. Whilst there was work to be done, there was confidence that the approach taken in terms of the Partnership Agreement, scrutiny arrangements, Integration Plan etc was consistent with what was required under the new legislation.

In relation to the Change and Improvement Plan, the Chair confirmed that it would be submitted to NHS Highland's Health and Social Care Committee in November 2014 for approval. It would then be presented to the Council's Education, Children and Adult Services Committee for endorsement/comment. It was anticipated that a final version would be available by the end of November 2014.

During further discussion, Members emphasised the need to streamline governance arrangements so there was less duplication of reporting to the Council and NHS Highland's Committees and Sub-Committees. In addition, it was suggested that devolving some scrutiny to District Partnerships would help to inform people what was happening locally and incentivise change.

In response, it was explained that the Strategic Commissioning Group would be responsible for reaching a view on how best to manage governance arrangements, for both adult and children's services, under the new legislation.

Finally, having emphasised the need for district versions of the Change and Improvement Plan to be much more vibrant and engaging, the Sub-Committee **NOTED** the developments.

8. Presentation: South and Mid Models of Care at Home

The Heads of Strategic Commissioning and Adult Social Care, NHS Highland, undertook a presentation during which it was explained that care homes, delayed discharge and new models of care were all linked to the ability to deliver more care at home. Information was presented on the current delayed discharge position and the opportunity cost of delays which, based on 24,000 bed days, equated to approximately £8m per annum. In terms of community care assessment, the processes in Highland were very good in comparison with other areas. However, capacity was a significant issue.

Turning to the care at home position in 2013/14, figures were provided on hospital and community unmet need. In particular, it was highlighted that the market split was 60% in-house and 40% independent sector, with in-house provision being more expensive. In addition, detailed information was provided on the work undertaken over the past year to improve the position. This included committing to a level playing field by commissioning across sectors; collaborative zoning, so that providers could access cost effective runs; compliance with the Living Wage; and developing a single tariff for all providers that could be enhanced for rurality and complexity. It was anticipated that the tariff would be operational by April 2015. Work was also ongoing in relation to the

provision of modern apprenticeships; remodelling the in-house service; retracting packages; and live-in care.

In relation to market changes, graphs were presented on care at home client numbers by provider type in Highland as a whole and by operational area. It was highlighted that, in the South and Mid areas, in-house provision was reducing and external provision was increasing. The reason for that was that it allowed better quality of care to be provided at less cost and with greater flexibility. The model for the North and West would not be known until such time as a single tariff was implemented and it was established how best to work with the provider base.

Returning to delayed discharge, the policy was to discharge within 72 hours of the expected date of discharge. Currently, if an older person was admitted to hospital, they were treated, assessed in a hospital environment and, generally, given a care at home package that would be reviewed after a six week period. In the future, the aim was to fundamentally change the way community care services were delivered by not admitting people to hospital for assessment wherever possible. If someone was admitted, the intention was to support them to return home with their carers and be assessed there. Where additional support was required, the care at home package would reflect the recovery period. It was emphasised that this was not about saving money but about supporting people to be as healthy as they could be. It was a new, more pro-active way of working and it was intended to hold a series of roadshows toward the end of November 2014 to discuss the approach with District Partnerships.

During discussion, the following issues were raised:-

- in relation to care at home, the increase in the number of independent sector providers was welcomed;
- whilst the proposed change in model was welcomed, it was imperative that it did not lead to a situation where people were waiting for an assessment at home;
- people had the best chance of staying at home if they had a social support network of friends and neighbours;
- being discharged from hospital without being assessed for support would be perceived by some as a lack of care and it was essential that implementation of the model was dealt with very carefully;
- the involvement of families from the outset was critical; and
- GP records often contained no information on carers and the interaction between families, GP practices, integrated teams and clinical teams needed to improve.

In response to questions, it was explained that:-

- with effect from 1 October 2014, it was intended that there would be no new delayed discharges and Community Pull Teams were working hard to support the discharge of people who had been delayed for more than 72 hours. New admissions would be managed separately from existing delayed discharge cases. However, it was emphasised that there were a number of complex issues to balance;
- risk was a fundamental barrier to progressing the proposed model. In particular, families were going to be concerned about their loved ones. However, one of the risks of not implementing it was that the situation would get worse and people would be debilitated by institutional care. SDS legislation and the personalisation agenda underpinned the model and the aim was to take much more of a

community approach, with staff who had previously worked in quite a risk averse way being encouraged to support individuals to live their lives at home the way they wanted to;

- it was expected that District Managers would know the name of every delayed discharge case in their area;
- in addition to the proposed district roadshows, it was intended to hold an event for Elected Members and Community Councils and it was anticipated that this would take place on 12 December 2014 at Council Headquarters, Inverness *(since confirmed as 16 January 2015)*;
- part of the communication process would be talking to relatives who were unwilling or did not see it as their responsibility to fulfil a caring role. It was important to encourage everybody to see caring as their responsibility and Councillors had a role to play in getting the message across; and
- a person admitted to hospital was assessed continuously throughout the process until they were medically fit for discharge. In relation to social care assessment, the work being undertaken involved looking at integrated teams and how to support a vulnerable older person to return home and be assessed in their own environment. It was emphasised that it was not the case that an individual would be discharged without there being a plan in place.

Thereafter, the Sub-Committee **NOTED** the presentation.

The meeting concluded at 4.05 pm.