Agenda Item 23v.

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 3, Council Headquarters, Glenurquhart Road, Inverness on Friday 27 November 2015 at 11.00 am.

Present:

Mrs C Caddick
Mrs I Campbell
Mr B Gormley (video-conferencing)
Mrs B McAllister
Mr D Millar (teleconferencing)
Mrs M Paterson
Mr G Ross

In attendance:

Ms F Palin, Head of Adult Services, Care and Learning Service
Mrs I Murray, Commissioning Officer, Care and Learning Service
Ms D Jones, Chief Operating Officer, NHS Highland
Ms J Macdonald, Head of Adult Social Care, NHS Highland
Mr S Steer, Head of Strategic Commissioning, NHS Highland
Mr G McCaig, Head of Care Support, NHS Highland
Ms K Stapleton, Team Manager, Deaf and Hearing Support Services, NHS Highland
Ms G Mitchell, Team Leader, Sight Action
Mr D Goldie, Head of Housing, Community Services
Ms L Kilpatrick, Housing Policy Officer, Community Services
Miss M Murray, Committee Administrator, Corporate Development Service

Business

Preliminaries

In the absence of Mrs M Davidson, nominations were sought for Chair of the Meeting. Mrs I Campbell was unanimously appointed and took the Chair.

1. Apologies for Absence

Apologies for absence were intimated on behalf of Mr A Christie (OCB), Mrs M Davidson (OCB), Mr K Gowans and Ms G Ross.

2. Declarations of Interest

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

Item 6 – Mr G Ross (non-financial)
Item 7 – Mr G Ross (non-financial)
Item 8 – Mr G Ross (non-financial)

Development

3. See Hear Project

Ms K Stapleton, Team Manager, Deaf and Hearing Support Services, NHS Highland and Ms G Mitchell, Team Leader, Sight Action, gave a presentation during which detailed information was provided on the numbers of deaf, blind and partially sighted people in the UK and the hidden impact of deafness and low vision which included communication difficulties; isolation and withdrawal; marginalisation; reduced status and career prospects; feelings of shame and embarrassment; and lowering of self-esteem. Information was also presented on the extent of the services provided by the Deaf Services Team and Sight Action and the environmental equipment that could be provided to assist those with a hearing loss and/or low vision. The Scottish Government See Hear Strategy recommendations were also summarised.

In addition, Members took part in an interactive session using equipment to demonstrate the effects of wearing a hearing aid, blindness and low vision.

During discussion, the following issues were raised:-

- the increase in the number of schools teaching British Sign Language was welcomed;
- a high proportion of older people had a sensory loss and it was essential to take that into account when setting policies and planning public services; and
- it was suggested that, to reach a wider audience, the Chair discuss with the relevant Chair the possibility of a similar presentation being made to the Communities and Partnerships Committee.

In response to a question, it was explained that if the auditory nerve was not stimulated it would stop functioning and the majority of children with a severe hearing loss had a cochlear implant. In terms of the Total Communication Policy, children were supported to speak. However, signing was also taught as a back-up in the event of further deterioration in hearing or a broken processor. A multi-disciplinary working group had been established to examine issues and individuals and a protocol was in place to ensure that families were supported and the needs of children were being met as well as possible.

Thereafter, having welcomed the informative presentation and commended the work of Deaf and Hearing Support Services and Sight Action, the Sub-Committee:-

i. **NOTED** the presentation;
ii. **AGREED** that it be circulated to Members of the Sub-Committee for information; and
iii. **AGREED** that the Chair discuss with the relevant Chair the possibility of a similar presentation being made to the Communities and Partnerships Committee.

4. Extra Care Housing Briefing

There had been circulated Report No ASDS/08/15 dated 17 November 2015 by the Head of Housing which summarised the concept of extra care housing, set out why

this model of provision was important for health, social care and housing planning and noted potential supply sources, funding responsibilities and arrangements for further collaboration. The report also set out the opportunity to improve access, assessment and allocation of specialist housing provision to align with health and wellbeing outcomes.

During discussion, the following issues were raised:-

- Members commented on their own local experience of extra care housing practice models and sheltered housing including The Howard Doris Centre; Allt-A-Chuirn and Millbrae; and Airdferry Resource Centre. In relation to The Howard Doris Centre in particular, the model was commended. However, it did not provide care at home and Members had tried unsuccessfully to instigate discussions in that regard;
- the “Homes for Heroes” properties in Inverness were a good example of joint working and of homes being constructed to meet a variety of needs rather than on a bespoke basis;
- modular housing that could be adapted or moved appeared to be a practical solution with real potential and Members question whether there was any existing provision;
- it was necessary to work with communities to come up with housing solutions that enabled people to maintain their independence for as long as possible; and
- the two tiers of community planning – strategic and local - did not always interact and a smoother process was required that allowed agencies to respond to the strategies and solutions identified by communities.

Officers responded to questions/issues raised as follows:-

- in relation to The Howard Doris Centre, NHS Highland would be happy to facilitate discussions regarding the provision of care at home. Where communities wanted to do things differently, positive engagement was taking place and there were a number of examples throughout Highland of local solutions to care at home services. If Members had any concerns that staff were not responsive they were encouraged to contact the Chief Operating Officer;
- it was necessary to build on the relationship that had emerged through the strategic commissioning process and bring together the Council, NHS Highland and third and independent sector providers to create sustainable solutions within communities. National and international evidence indicated that creating cluster housing maximised the capacity of care providers and volunteers to respond and keep people well for longer in a healthy community. This was reliant on the Council thinking creatively in terms of planning for the use of its housing stock;
- in relation to new housing developments, there was a well-established arrangement in place whereby Local Development Forums examined available sites and endeavoured to address any issues in terms of planning constraints, infrastructure etc. It was necessary to engage with health and social care services at an early stage to establish the client mix and whether there were any specialist requirements so that they could be built in to the planning process. However, although bespoke houses were the only way to make provision for some families with very special needs, it was important to be cautious about the extent to which houses were designed for specific people. It was highlighted that approximately 150 new properties were constructed per year whereas there were already 4000 bungalows/sheltered housing units in existence. There would never be sufficient

resources to build exactly what was required in the right location so that solution had to be about reconfiguring existing housing stock. In terms of funding, the majority would come from the Housing Association Development Programme although there might be other funding available through the Joint Improvement Team and other branches of the Scottish Government. The assumption was that the additional costs associated with extra care provision were not prohibitive but advice would be sought from the Head of Housing Development and Estates in that regard;

- Appendix 2 set out, on a Ward basis, sheltered and very sheltered housing provision by the Council and Housing Associations. There was low demand for traditional models of sheltered housing and there was turnover at all the sites. The intention was, at the joint extra care workshop on 2 December 2015, to identify where there was potential for new build or re-provisioning existing cluster sites to extra care models;
- the list of NHS Care Home provision would be reviewed and Urry House, Muir of Ord added;
- with regard to modular housing, there was no existing provision but it formed part of the national housing policy agenda and there was a lot of developmental work taking place. Discussions were taking place in Highland – for example, Albyn Housing had been carrying out research, in conjunction with the Massachusetts Institute of Technology, on moveable modular housing with technology enabled systems for safe care. However, the more technologically advanced the solutions, the more expensive care became and there was a balance to be achieved between the costs and the benefits;
- in relation to funding, there was a tendency to focus on capital costs and Members were urged to consider the significant revenue costs of providing extra care housing. For example, two four-person clusters cost between £0.25m and £0.5m. In addition, even if funding was available it might not be possible to provide the necessary care at home hours given the current recruitment challenges;
- with regard to shifting the balance of care, the assumption was that closing acute hospital beds would allow resources to be shifted to communities. However, in reality the situation was much more complex. The majority of NHS targets, such as the treatment time guarantee, were based on more people being admitted to hospital. In addition, the bulk of the costs were staff costs and it was therefore not a matter of cash savings but of getting those staff to work in the community;
- historically, it had been envisaged that closing hospital beds would save money. However, that was not the case with an aging population that, where possible, was being cared for at home. It was highlighted that the annual cost of a care home place was approximately £35k whereas a complex care at home package could cost up to £85k per year. There were a number of complex socio economic factors to consider and these would form part of the ongoing dialogue with partners, including the third and independent sector, and communities. It was suggested that a session be arranged for Members of the Sub-Committee in order to expand on some of the detail; and
- in relation to delayed discharge, there were currently 117 people delayed in hospital. A significant number of those, particularly in the North, were waiting for care home beds that were not going to be available in the short term and robust discussions had taken place with the Scottish Government in that regard. Work was underway with a view to changing the regime in a ward to make it as close to a care home environment as possible. However, there were issues to be addressed in terms of registration and discussions would be required with the Care Inspectorate. Every effort was being made to manage the care at home situation

and the aim was to have no delayed discharges awaiting a care at home package by Christmas, although this would be extremely challenging. In addition, the intention was to have less than 90 people delayed in hospital by Christmas. Members would be kept up to date as work progressed and it was highlighted that their support might be required in terms of the discussions with the Care Inspectorate.

Thereafter, the Sub-Committee:-

i. **NOTED** the content of the briefing and the work in progress;
ii. **NOTED** that updates would be provided in future reports; and
iii. **AGREED** that a session be arranged for Members of the Sub-Committee on the socio economic factors surrounding the provision and balance of care.

5. Aids and Adaptations

Ms L Kilpatrick, Housing Policy Officer, Highland Council, gave a presentation during which it was explained that, in terms of the Public Bodies (Joint Working) (Scotland) Act 2014, functions relating to aids and adaptations were part of a range of Local Authority functions that must be delegated to the new Integration Authorities. One of the main drivers for this was National Health and Wellbeing Outcome 2 which was about enabling people to live independently at home for longer. Detailed information was provided on what the delegation covered, adaptations to Council housing stock; suitability/adaptability of Council housing stock; the Housing Revenue Account budget; adaptations to private homes; and spend on private homes. Members were reminded of a previous presentation on the Scottish Government's Adapting for Change Programme and that Highland had one of five national demonstration sites, positioned at Lochaber Care and Repair. Current national housing adaptation performance indicators were based on inputs whereas the new system focussed on outcomes and user satisfaction/perception of improvement. The Lochaber demonstration site, branded by the Project Board as Be@Home, was a one stop shop that offered not only aids and adaptations but a range of practical services to enable people to live at home with independence and confidence.

During discussion, the Be@Home one stop shop approach was welcomed and it was hoped that this could be rolled out to other areas. Reference was made to the Housing Seminar scheduled to take place on 1 December 2015 and it was suggested that the Housing Policy Officer be invited to attend to speak to Members about aids and adaptations.

Thereafter, the Sub-Committee **NOTED** the presentation and **AGREED** that it be circulated to Members of the Sub-Committee for information.

Scrutiny

6. Adult Social Care Summary

Declaration of Interest: Mr G Ross declared a non-financial interest in this item as his mother resided in a care home but, having applied the test outlined in Paragraphs 5.2 and 5.3 of the Councillors' Code of Conduct, concluded that his interest did not preclude his involvement in the discussion.

There had been circulated Report No ASDS/09/15 dated 19 November 2015 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.

During discussion, an update was sought in relation to Performance Indicators. In response, it was explained that a workshop was scheduled to take place at the Adult Services Commissioning Group on 17 December 2015 and an update would be provided at the next meeting of the Sub-Committee.

With regard to community development and capacity building, Members commended the work of Ms K Maclean, Community Development Officer. However, there were gaps in provision and, particularly given the withdrawal of Age Scotland from Highland, it would be helpful if the other community development posts could be filled.

Thereafter, the Sub-Committee **NOTED** the contents of the report.

7. Health and Social Care Adult Services Performance Scorecard

Declaration of Interest: Mr G Ross declared a non-financial interest in this item as his mother resided in a care home but, having applied the test outlined in Paragraphs 5.2 and 5.3 of the Councillors' Code of Conduct, concluded that his interest did not preclude his involvement in the discussion.

There had been circulated Report No ASDS/10/15 dated 19 November 2015 by the Head of Care Support which provided a copy of the latest edition of the balanced scorecard presented to the NHS Highland Improvement Committee. Members were also asked to consider future reporting requirements.

During discussion, concern was expressed regarding the number of unmet targets, particularly in relation to care at home and respite, and an improvement was sought prior to Christmas. In addition, Members queried whether performance in Highland was compared with other parts of Scotland.

In response, focusing on respite in particular, it was explained that the way in which it was currently reported did not accurately reflect modern respite care. The performance indicators pre-dated the Self Directed Support legislation and did not fully represent those accessing respite through Option 1 or Option 2. Members were reminded that the Improvement Group for Carers had conducted a review of respite and the final report would be presented to the Adult Services Commissioning Group on 17 December 2015. The Improvement Group would be asked to consider key performance and outcome measures that corresponded with the recommendations for change. The recommendations would be included in the commissioning intentions that would inform how business would be transacted with respite care providers. Thereafter, the phasing process for change would take place followed by reporting on the new performance indicators. This process would take time and it was unlikely that there would be any change to the way in which respite was reported in the current financial year.

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

8. Operational Director Reports

Declaration of Interest: Mr G Ross declared a non-financial interest in this item as his mother resided in a care home but, having applied the test outlined in Paragraphs 5.2 and 5.3 of the Councillors' Code of Conduct, concluded that his interest did not preclude his involvement in the discussion.

i. North and West Operational Unit

There had been circulated report by the Director of Operations in respect of the North and West Operational Unit as presented to NHS Highland's Health and Social Care Committee on 12 November 2015.

During discussion, Members expressed concern regarding the situation in the North and West Operational Unit and asked whether anything significant was being done to address the issues with long-term sickness and recruitment.

In response, the Chief Operating Officer explained that recruitment and retention of staff in remote and rural areas had been an issue for many years and was a common theme at national, regional and local meetings. Not only was it difficult to fill existing posts such as GPs and hospital-based doctors but, when creating new posts, it was difficult to recruit people with the necessary range of skills. New models of care such as Rural Support Teams, which weren't doctor dependent, were reliant on people who could rapidly train to a level of skill necessary to provide the interventional support that communities needed. However, once staff were fully trained they were highly sought after and were offered opportunities elsewhere. The situation was extremely fragile. However, the Director of Operations and her team were doing a significant amount of work in terms of engaging with local communities to identify how services could be delivered differently and working with national organisations, particularly Education Scotland in relation to medical staffing and medical education.

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

ii. Inner Moray Firth Operational Unit

There had been circulated report by the Director of Operations in respect of the Inner Moray Firth Operational Unit as presented to NHS Highland's Health and Social Care Committee on 12 November 2015.

During discussion, Members referred to the plethora of plans and the difficulties that presented in terms of constant revisions. In addition, some of the actions did not seem to materialise. The Chief Operating Officer concurred that it was an issue. However, it was difficult to have one definitive plan. If a service was dependent on a workforce that could not be recruited, alternative arrangements had to be explored which required an element of planning, phasing and timescales.

Further discussion took place in relation to recruitment, during which information was sought on whether it was easier to recruit in Inverness and whether there were any particular reasons people did not want to come to Highland to work. Members also commented that many young people who left Highland to study

medicine did not want to return to the area due to the loneliness of working in isolation and lack of access to modern medicine in comparison with large urban hospitals.

In response, it was explained that, in terms of medical staff in Raigmore, there were some specialist areas that were easier to recruit to whereas others were more challenging and were an issue throughout Scotland. A system was being developed that was attractive but matching the people that wanted to work in the area with the gaps in the workforce was difficult. Where people chose to work was influenced by a whole range of factors and many young doctors moved to countries with warmer climates such as Australia, New Zealand and Canada. It was difficult to recruit people if their spouse/partner worked in a particular field and, as a Community Planning Partnership, it was necessary to consider how to create an economy that would welcome and flex for people with diverse needs. Efforts were being made, particularly in terms of medical staff, to facilitate spouses/partners in their own role but it was challenging given the number and diversity of posts and became even more difficult at practitioner level rather than consultant/specialist level. In addition, "grow your own" initiatives were being developed to create opportunities for people to remain in their own communities and receive training and professional development to undertake specific roles such as social work.

In relation to Raigmore, Members expressed concern that the current appointment system was not focussed on the patient and welcomed the introduction of a full electronic diary system and the proposed Kaizen event. The Chief Operating Officer explained that the treatment time guarantee, which was a statutory requirement, had driven the manner in which patients were communicated with. NHS Highland was now using the Highland Quality Approach, using lean thinking, to consider how to minimise waste and variation and improve the experience, from the patient's perspective, from the point of referral to treatment. The Director of Operations, Inner Moray Firth Operational Unit, was leading a number of events in that regard and electronic systems were being aligned with the Board's strategic plan.

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

The meeting concluded at 1.10 pm.