The Highland Council

Adult and Children's 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 Thursday 28 November 2013 at 3.00 pm.

Present:

Mrs I Campbell
Mr A Christie
Mr E Hunter (Video Conferencing)
Mr G MacKenzie
Mr G Ross
Ms K Stephen

In attendance:

Mr B Alexander, Director of Health and Social Care
Mrs J Baird, Director of Adult Care, NHS Highland
Mr B Robertson, 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 R Hill, Clinical Governance Manager, NHS Highland
Ms F Matthewson, Service Planning Analyst, NHS Highland
Ms G Jaffrey, Clinical Governance Facilitator, NHS Highland
Mr J Gray, Nurse Consultant - Learning Disabilities, NHS Highland
Ms L Gillies, Adult Support and Protection Advisor, NHS Highland
Ms I Murray, Commissioning Officer, Health and Social Care Service
Miss M Murray, Committee Administrator, Chief Executive's Office

Business

1. Apologies for Absence

Apologies for absence were intimated on behalf of Mrs M Davidson, Mr B Gormley, Mr K Gowans, Mrs B McAllister and Mrs M Paterson.

2. Declarations of Interest

Mr G Ross declared a non-financial interest in those items which might raise discussion on respite care as a family member was currently in respite care 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.

Scrutiny

3. Adult Social Care Summary

There had been circulated Report No ASDS/20/13 dated 14 November 2013 by the Director of Health and Social Care which provided an overview with regard to the delivery of the Commission for Adult Social Care Services by NHS Highland. The report summarised key issues including progress with the Strategic Commissioning

Plan, performance and a recent visit by the Mental Welfare Commission which had highlighted a number of improvements in service delivery.

The Director of Adult Care, NHS Highland explained that discussions were ongoing with the Director of Health and Social Care regarding the Strategic Commissioning Plan and the approach to be taken. The aim was to produce a five year plan that set out, on a yearly basis, what was expected to be achieved.

During discussion, concern was expressed regarding the standard of care in some care homes.

In response to questions, it was explained that, where a care home was graded 2 or below by the Care Inspectorate, admissions were suspended. There were currently seven care homes in this position in Highland, all at different stages. Grade 2 was unacceptable and work was ongoing to drive up the quality of care with the intention that there would be a higher suspension threshold in the future. The service improvement lead was working with service providers and supporting local managers to deliver key improvement actions and an example was provided of a recent piece of work in Wick where such support had enabled a partial lifting of the suspension. Following re-inspection by the Care Inspectorate, the home had been graded 3. Where there were examples of good practice in other care homes, steps were being taken to roll that out. In addition, a report had been submitted to the Health and Social Care Committee setting out a process whereby Directors of Operations could make recommendations regarding the early lifting of embargoes, prior to re-inspection by the Care Inspectorate but working closely with them.

Thereafter, having welcomed the improvement actions in relation to care homes, the Sub-Committee **NOTED** the issues raised in the report, including as part of the further reports presented to this meeting.

4. Health and Social Care Adult Services Performance Report (Balanced Scorecard)

There had been circulated Report No ASDS/21/13 dated 20 November 2013 by the Director of Adult Care, NHS Highland which provided a copy of the latest edition of the balanced scorecard, incorporating changes agreed at the Strategic Commissioning Group and information regarding the allocation of the indicators to the various improvement groups. The exception report for respite was also provided and Members were asked to consider future reporting requirements.

In response to questions, it was explained that:-

- with regard to the number of respite day hours provided age 65+ (Indicator 26b), the significant improvement was largely due to a change in how the information was collected in that it now came directly from service providers; and
- in relation to the fluctuation in the number of peer support sessions facilitated by the Highland Carers Centre and the number of carers in receipt of training (Indicators 29b and 29c), the service provider was facing a number of challenges and support was being provided by NHS Highland until such time as these were addressed. The situation was being closely monitored and it was hoped that an increase in the provision of services to carers would be achieved.

Thereafter, the Sub-Committee **NOTED** the report, including the respite exception report.

5. Delayed Discharge

There had been circulated Report No ASDS/22/13 by the Chief Operating Officer, NHS Highland which updated Members on progress to improve performance within the Delayed Hospital Discharge agenda.

The Head of Strategic Commissioning, NHS Highland summarised the position as at 15 November 2013, highlighting that there were 8 patients delayed over 6 weeks, 11 delayed over 4 weeks and 24 delayed over 72 hours. It was explained that there was a history in Highland, and throughout Scotland, of the figures dipping at the census point and then going back up. This time, despite the challenging environment, the position had improved since the quarterly census on 15 October 2013. There had been a slight increase in the number of people who were delayed awaiting a care at home package and the situation in the North Area remained challenging as a result of suspension of admissions to care homes.

In relation to the Raigmore Operational Unit, as a result of the work described at previous meetings, the aspiration that nobody should be delayed by more than 72 hours was being met, which was a significant improvement.

During discussion, the Director of Health and Social Care emphasised the importance of the most up-to-date delayed discharge figures being incorporated in the performance framework.

In response to questions, it was explained that:-

- as a result of improved systems, delayed discharge cases had been identified, in the stroke ward for example, which had not previously been recorded as such as former systems had been too tolerant. However, these cases were being managed down;
- in relation to prioritising those awaiting care, whilst there were risks associated with people remaining in hospital beyond their discharge date, there were also risks to people in the community, both in terms of their immediate care requirements not being met and escalation of need. It was not a matter of comparing one with another but of responding to individual circumstances of risk and need;
- in the past, people had been admitted to care homes because there was no alternative. The aim was to support people to remain at home for as long as possible by building community teams and care at home. However, it would take time to work out the balance of care required given the increasingly aging population. Ensuring there was care home capacity for those who really needed it was a key priority;
- with regard to the location of delayed discharge cases, every effort was being made to maintain the patient flow through Raigmore and move people as close to home as possible. However, that created difficulties in some areas, North in particular, due to the lack of care home places;
- delays over 4 or 6 weeks were predominantly as a result of the pressure on the care home system but other reasons for delayed discharge were now being dealt with more efficiently. As a result, the delayed discharge profile was changing in that there were less long delays and more delays of 72 hours or more; and

- whilst the aim was to support people to remain at home as long as possible, a care home was necessary where people were very frail with conditions that required a degree of nursing. However, the Older People Improvement Group had identified a lack of options such as supported housing for people with dementia and step up/step down beds and work was ongoing to try and reduce the number of people for whom a care home was the only option.

Thereafter, having welcomed the exploration of alternative options, the Sub-Committee **NOTED** the contents of the report.

6. Health and Social Care Adult Services Performance Framework Outcomes

There had been circulated Report No ASDS/23/13 dated 20 November 2013 by the Director of Adult Care, NHS Highland which detailed changes in the performance framework that had been agreed by the Strategic Commissioning Group. These changes would be incorporated into the Partnership Agreement. The responsibility for review and development of performance indicators had now been passed to the relevant NHS Highland Improvement Groups.

The Sub-Committee **NOTED** the changes set out in Annex A of the report and that these would be incorporated into the Partnership Agreement.

7. Managing Patient Choice of Accommodation

There had been circulated Report No ASDS/24/13 by the Chief Operating Officer, NHS Highland which considered the parameters of managing patient choice of accommodation both within hospital and upon discharge.

The Head of Strategic Commissioning, NHS Highland explained that the key point was that no one had the right to decide to remain in hospital longer than they clinically needed to be there. It had been evidenced that if people remained in hospital for more than two days beyond their ready for discharge date they suffered functional and mental decline. In addition, if someone chose to remain in hospital, that bed was unavailable to someone else in need. Patient choice was one of many factors affecting delayed discharge from hospital and it was important it was addressed.

The report summarised the reasons for delays and described the principles of managing choice, particularly in relation to maximising opportunities for recovery, rehabilitation and reablement. Planning for discharge from the point of admission needed to become a reality and there were a number of practice and cultural issues to be addressed.

It was highlighted that the report had been influenced by the drafting of Scottish choice guidance which, it was anticipated, would be published in the next few weeks.

During discussion, the following comments were made:-

- reading about it in a committee report and the reality of managing patient choice were quite different and there were some challenging issues to be addressed;
- it was important that patients and their families were informed of the steps involved in the choice process at the earliest possible stage;

- reference was made to instances of people being discharged from Accident and Emergency (A&E) before adequate care arrangements were in place at home and it was important that such situations were addressed; and
- closer links were required between hospitals and social work teams.

In response to questions, it was explained that:-

- the choice process involved some very difficult decisions for patients and their families. Family members, particularly those who lived some distance away, perceived their relatives as being safe in hospital. However, that was not always the correct perception and Members' support was sought, through District Partnerships, in terms of increasing awareness and understanding of the issues;
- a leaflet on patient choice, revised to reflect national guidance, was provided to patients at an appropriate time following admissions;
- there were currently seven people delayed in hospital who were going through the guardianship process. There were a number of issues in relation to guardianship. In particular, because planning for discharge was not yet taking place from the point of admission, issues were not always picked up early enough. In addition, guardianship should be in the best interests of the patient but often it was being used as a barrier to discharge. A focused piece of work was ongoing in this regard which linked to understanding adults with incapacity legislation and patient choice;
- the ability to assess capacity at the point of admission depended on the condition of the patient;
- the aim was to support people to return home in the right way rather than carrying out unsafe or poor discharges;
- a list of care home places in Highland was updated on a weekly basis and was available to Social Work teams. It was disappointing that Members had encountered instances of this information not being made available and steps would be taken to ensure that anyone going through the care home process received it in a timely manner;
- in terms of a more upstream solution to the issues surrounding guardianship, it was necessary to encourage people, at an earlier time in their lives, to consider a power of attorney; and
- in relation to anticipatory care planning, only a certain number of people were targeted as it was not effective beyond that. However, it was important to ensure that issues such as guardianship/power of attorney were covered in anticipatory care plans.

During further discussion, the importance of communicating the issues surrounding patient choice was emphasised. However, opportunities for verbal briefings were limited and it was therefore suggested that a briefing note be provided to Members which could also be submitted to District Partnerships for discussion/questions.

Thereafter, the Sub-Committee:-

i. **NOTED** the contents of the report; and
ii. **AGREED** that a briefing note on the issues surrounding patient choice of accommodation be circulated to Members for information and submission to District Partnerships by the relevant Chairs.

Development

8. Strategic Commissioning Plan – Update

The Head of Strategic Commissioning, NHS Highland gave a verbal update on the Strategic Commissioning Plan during which it was explained that the aim was to develop a commissioning approach that understood population needs and engaged with a range of organisations in setting priorities. Highland was at an advanced stage in comparison with other areas and positive feedback had been received from the Scottish Government. A wide range of providers, activities and cost information had been mapped out and the intention was to present a draft set of commissioning intentions to NHS Highland's Health and Social Care on 9 January 2014. In the meantime, joint work was taking place with Glasgow Caledonian University and the Scottish's Government's Improvement Team in relation to rolling out the priority setting methodology and a small group had taken part in the first training session on the joint commissioning development framework. In addition, work had commenced on developing a position statement on how health and social care services in Highland were envisaged in the future, both in terms of capacity and quality. Highland was only the second area, after Edinburgh, to produce such a statement and it would be available in due course.

In response to a question regarding care homes, it was explained that there were various mechanisms in place to establish whether value for money was being achieved. Contract monitoring was carried out on a six-monthly basis by the Contracts Team within the Business Support Service and there was a clear link to a designated manager in the operational unit. Staff who reviewed arrangements for individual service users also had an opportunity to feed comments in to the contract monitoring process. In addition, as previously intimated, a new role of Service Improvement Lead had been created which covered care homes and day care provision, both in house and external, for older people. The aim of the role was to promote service improvement and included engaging with service providers and learning from established good practice.

During further discussion, Members reiterated their concerns regarding the standard of care in some care homes and suggested it would be beneficial to carry out impromptu visits.

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

9. Learning Disability Strategy – The Keys to Life

There was tabled a report, submitted to the NHS Highland Board in October 2013, on "The Keys to Life", the new National Strategy for Learning Disability launched in June 2013.

Speaking to the report, Mr J Gray, Nurse Consultant – Learning Disabilities, NHS Highland explained that the Strategy promoted a joint approach and contained 52 recommendations, 25 of which were being progressed immediately at NHS Board level with the remainder being led nationally with a view to future local implementation. The Learning Disability Improvement Group would lead on implementation throughout Highland and the Learning Disability Action Plan had been updated to reflect the Strategy's recommendations.

The key themes within the Strategy were detailed in the report and included Health; Independent Living; Shift the Culture and Keeping Safe; Break the Stereotypes; Profound and Multiple Learning Disabilities; Criminal Justice and Complex Care.

Key areas of development in implementing the Strategy included improving access to personal life plans and continuing to develop day services to offer a broad range of person centred services that promoted inclusion in communities whilst ensuring that more intensive levels of support were available to people with more complex needs. In addition, it was important to develop opportunities for further education, employment and volunteering.

In response to questions, it was explained that:-

- the full impact of welfare reform on people with learning disabilities was still emerging. One area of concern was that, with weekly benefits payments being replaced by a monthly lump sum, there was greater scope for exploitation. In taking forward the recommendations in the Strategy, it was important to be mindful of the issues surrounding welfare reform and to strengthen adult support and protection training accordingly;
- in relation to what the partnership could do to help challenge the stereotypes of people with learning disabilities, one of the priorities was around employability and promoting opportunities for work placements and volunteering. A lot good work had been undertaken but it had focused mainly on young people. It was important to address the lack of supported employment in Highland for people with learning disabilities and this might be a key area for further preventative action;
- the introduction of the Self Directed Support Act presented opportunities for people to build supported employment and volunteering activities in to their support plans;
- at present, there were no specific services for people with learning disabilities who were in contact with the criminal justice system but rather individually focused support was provided by social work and health services when required. Higher level strategic links with the Prison Service and the Police had not yet been developed although a lot of work had been done with the Police in relation to appropriate adults and the development of the nursing service for people in custody;
- it was important that support was available for those who required it but it should not be assumed that everybody with a learning disability would require support. The norm should be for them to live as freely and independently as possible and it was necessary to promote a social inclusion agenda that did not stigmatise or stereotype and provided opportunities for education, employment and leisure pursuits without drawing attention to the fact that people had a learning disability; and
- in relation to the importance of respite for adults with complex learning disabilities who were living at home and cared for by their families, work had been carried out in the South and Mid Operational Unit whereby parents and carers of young adults had met with members of the Management Team to explore options for respite, recognising that going in to a care home, particularly with older people, might not be what people wanted.

During further discussion regarding welfare reform, Members highlighted that the switchback facility, which enabled the housing element of universal credit to be paid directly to the landlord, was available to those who were unable to manage their finances.

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

10. Presentation: Development Session on Evaluation

Ms R Hill, Clinical Governance Manager, Ms F Matthewson, Service Planning Analyst and Ms G Jaffrey, Clinical Governance Facilitator, NHS Highland undertook a presentation on the evaluation work carried out following the integration of health and social care services in Highland.

It was explained that a number of models had been examined and consideration had been given to external evaluation. However, that was costly and it had therefore been agreed that it be carried out in-house, on a modest scale and without disrupting normal activity. It was largely within existing resources although some Scottish Government funding had been made available. A wide range of data was available within the Council and NHS Highland but it had been necessary to take a flexible approach and look at other sources of information, both formal and anecdotal, to feed in to the overall picture of how integration was progressing.

Part of the evaluation work involved the active monitoring of routine service delivery, linked to existing data, and, as an example, statistics were provided on A&E admissions, emergency occupied bed days and care at home packages from April 2011 to April 2013.

In relation to service user and carer feedback, a simple questionnaire had been developed and was being piloted by a single team. The pilot was ongoing but initial results indicated high levels of satisfaction with some concerns. Consideration was being given to rolling out the questionnaire to other teams and monitoring service user satisfaction on an ongoing basis. In addition, a survey had been carried out of all care at home service users and 678 responses had been received. Overall, there was a high level of satisfaction with the service although some issues had been identified which were being taken forward through design and improvement work. Information was also provided on other pieces of work such as the independent research on discharge from hospital for the Highland Senior Citizens' Network and the national "Better Together" survey which included community care.

With regard to staff feedback, a survey of all staff in Adult Services Integrated Community Teams had been carried out in September 2012. This provided a baseline and would be repeated annually for five years. 678 responses had been received with many staff reflecting that it was too early in the integration process to comment. However, some had identified improvements, such as co-location, and concerns, such as poor communication. The 2013 survey had been issued in October and responses were still being collected. A report on the findings would be available in January 2014.

Details were provided of research carried out by Evan Beswick, MSc in Healthcare Management and Public Leadership, on the leadership lessons to be learnt from the integration of health and social care in Highland. In addition, information was presented on an in-depth research project on integrated teams, funded by the Scottish Government and led by Anne Mason, University of Stirling.

In conclusion, examples of quotes from staff feedback were provided. It was emphasised that it was still early in the integration process for some aspects of

evaluation. However, it had captured a significant point in time and would continue to capture incremental changes over time.

The Director of Adult Care, NHS Highland emphasised the importance of user and staff feedback and highlighted that, as part of the Care Inspectorate regime, there was a commitment to survey care at home clients on an annual basis.

In response to questions, it was explained that:-

- in relation to the statistics on emergency occupied bed days, it was too early to see any significant changes. Given the aging population, there was a constant need to admit people to hospital but the length of stay was reducing and people were being moved on to appropriate services, as discussed during the earlier items on delayed discharge and patient choice. A graph was available which showed the projected increase if integration had not taken place and this could be circulated to Members for information;
- the Scottish Government had not requested that the funding provided be used to research any specific issues. A representative of the Scottish Government had close links with the local evaluation group and knowledge and expertise was shared. It was recognised that the work being carried out would be valuable to other agencies as the integration agenda progressed; and
- with regard to care at home packages, short term reablement interventions were increasingly being provided and it was necessary to develop the statistics to reflect that.

Thereafter, having emphasised the need for more commentary on the statistics, the Sub-Committee:-

i. **NOTED** the presentation; and
ii. **AGREED** that statistics on predicted and actual occupied bed days be provided to Members of the Sub-Committee for information.

The meeting concluded at 4.45 pm.