Agenda Item 17iii.

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 1, Council Headquarters, Glenurquhart Road, Inverness on Friday 19 February 2016 at 11.00 am.

Present:

Mrs C Caddick
Mrs I Campbell
Mr A Christie
Mrs M Davidson
Mr S Fuller
Mr K Gowans
Mrs B McAllister
Mr D Millar
Mr G Ross

Non-Members also present:

Mr B Fernie

In attendance:

Ms F Palin, Head of Adult Services, Care and Learning Service
Ms J Macdonald, Director of Adult Social Care, NHS Highland
Mr S Steer, Head of Strategic Commissioning, NHS Highland
Mr G McCaig, Head of Care Support, NHS Highland
Mr JP Sieczkarek, South Area Manager, NHS Highland
Miss M Murray, Committee Administrator, Corporate Development Service

Also in attendance:

Mr S Pennington, Managing Director, Highland Home Carers

Mrs M Davidson in the Chair

Preliminaries

The Chair requested that the Minutes of the previous meeting and the rolling Action Plan maintained by the Care and Learning Service be included on future agendas. In addition, it was suggested that the names and titles of the key officers be listed on the agenda.

Business

1. Apologies for Absence

Apologies for absence were intimated on behalf of Mrs M Paterson and Ms G Ross.

2. Declarations of Interest

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

Mr G Ross declared a non-financial interest in those items that might raise discussion on care homes as his mother and mother-in-law were care home residents 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/01/16 dated 11 February 2016 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, the following issues were raised:-

- concern was expressed regarding the significant cost of care home provision and the difference in cost between private and social care places; sustainability, particularly of smaller care homes; difficulties in recruiting qualified nurses; the high cost of agency staff; low wages for care workers; and the potential abuse of older people if, as had happened in other countries, families increasingly chose to look after elderly relatives at home to save money;
- the care home inspection regime was commended and, whilst suspending admissions presented difficulties in terms of capacity, it was a positive action as it showed commitment to standards;
- it was necessary to take stronger action against care homes that consistently performed poorly; and
- care homes were a business and, given the choice, the majority would choose self-funders over social care placements.

In response to comments/questions, it was explained that:-

- two of the four suspensions of admissions to care homes, one of which was the voluntary suspension, had been lifted since the report had been written. There was every confidence that a third would be lifted in the next two to three weeks. However, one of the care homes had reduced its bed numbers so overall capacity had decreased. Lack of care home capacity was the main reason for delayed discharge from hospital and it was necessary to redefine the relationship with the Care Home sector and work in partnership in the same manner as had taken place with care at home providers;
- there was an issue in terms of care homes choosing to take self-funders as the rate for social care places, as specified in the National Care Home Contract, was significantly lower. However, care homes were a business and accepting some self-funders was necessary for their business plan;
- 90-95% of homes were of very high quality but there were four of five that continued to perform poorly and might reappear on the radar in the next year. In response to calls for stronger action, two homes had previously been closed when tolerance levels were exceeded and, if necessary, this course of action would be taken again;
- the Adult Support and Protection Line currently received approximately 80 calls per month;
- there was a strategic approach to care homes whereby, over the next couple of years, it was expected to ensure that 95% of available beds in Highland were

Grade 4 and above. The market in Highland was changing and, as care at home led to more people being enabled and fewer admissions to care homes, it should be possible to work with the market to ensure that homes that did not meet the desired quality standards dropped out of the system;

- in relation to transitions, an information flow mapping session had taken place where the issues had been examined from the child's perspective. This had led to a variety of suggestions, some ambitious, in terms of how to support young people from the age of 14 to 25 and these would be worked up. Some were small practical matters such as arranging transport if a young person was still in school. NHS and Council staff were fully committed and improvements were already visible. The pilot referred to in the report involved an adult services member of staff supporting the young person from the age of 14 as they made the transition to adult services. This had improved communications significantly; and
- a review of respite had been carried out, the findings of which had been reported to the Highland Health and Social Care Committee, and consideration was now being given to how to proceed. Carers had made a number of proposals and, whilst provision of respite beds was key, it was only one aspect of overall support for carers.

Following discussion, the Chair referred to conversations with the Director of Adult Social Care regarding the provision of quarterly briefings, not only for Members of the Sub-Committee but open to all Members. It was suggested that the first briefing cover care homes and take the form of a presentation and handouts, including facts and figures on finance, impact on individuals and future provision. Many Members were not as involved in adult social care as they once were and it would be helpful to start building up the knowledge base again.

Lack of care home capacity was a significant issue in the remote North and West and Members requested that this also be included in the briefing, with suggestions as to how to address it.

In relation to transitions, the Chair suggested that a verbal briefing be provided to the Chair and Vice Chairs of the Education, Children and Adult Services Committee and the Chair of the Sub-Committee with a view to a report being presented to the appropriate forum thereafter.

With regard to respite, it was a requested that a report be presented to the next meeting of the Sub-Committee.

Finally, the Chair referred to the financial position and, whilst welcoming the fact that NHS Highland was forecasting a break-even year end position for adult social care, commented that there was a lack of clarity in terms of how the money was flowing and being spent. It was suggested that a workshop be arranged for Members of the Sub-Committee and the Chair of the Resources Committee to discuss the financial position and the monitoring statements to be presented to the Sub-Committee in the future.

Members referred to the seminar that had taken place with Children's Services Managers regarding disinvesting in traditional services to fund Self-Directed Support (SDS). It was necessary to start discussing how to do that in adult services and it was suggested that Self-Directed Support also be included in the proposed workshop.

The Director of Adult Social Care highlighted that SDS was a shared service so the team within NHS Highland also managed direct payments for the Council. A piece of

work was imminent on the direct payment process and reducing the length of time from funding being agreed to payment. This would impact positively on children and young people as well as adult services.

Thereafter, the Sub-Committee:-

i. **NOTED** the contents of the report;
ii. **AGREED TO RECOMMEND** that quarterly briefings on adult social care issues take place for all Members who wished to attend and that the first briefing cover care homes, including finance, impact on individuals and future provision, particularly in the remote North and West;
iii. **AGREED TO RECOMMEND** that a verbal briefing on transitions be provided to the Chair and Vice Chairs of the Education, Children and Adult Services Committee and the Chair of the Adult Services Development and Scrutiny Sub-Committee with a view to a report being presented to the appropriate forum thereafter;
iv. **AGREED** that a report on respite be presented to the next meeting of the Sub-Committee; and
v. **AGREED TO RECOMMEND** that a workshop be arranged for Members of the Sub-Committee and the Chair of Resources to discuss the adult social care financial position, the monitoring statements to be presented to the Sub-Committee in the future and the issues surrounding Self-Directed Support.

4. Health and Social Care Adult Services Performance Scorecard

There had been circulated Report No ASDS/02/16 dated 10 February 2016 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.

In relation to Carr Gomm, the Head of Care Support highlighted that, since the report had been written, the allocated hours had increased to 97% of the block contract hours.

During discussion, the following issues were raised:-

- it was requested that, in future, responses to Members' questions be provided by email within a week of the Sub-Committee;
- in relation to the provision of telecare packages, the position appeared to be slowly improving. Reference was made to the ongoing process of cleansing the system and confirmation was sought, and received, that the figures were accurate;
- where indicators were red, it was requested that an explanatory note, if not a full exception report, be provided in future;
- the provision of intensive care at home packages enabled people to be discharged from hospital sooner. In that regard, Highland was 31st of 32 local authorities in Scotland in the statutory performance indicators so there was still some way to go;
- referring to personal experience of Raigmore, it was a drain on resources that there was not a separate ward for patients with dementia who did not necessarily require a lot of medical care but took up a lot of nurses time;
- Members questioned whether the services provided by the Highland Carers Centre represented value for money;
- with regard to delayed discharge, the statistics indicated whether there had been a reduction or increase but did not specify the duration of delays; and

- concern was expressed regarding the lack of care home provision in Skye and Lochalsh and information was sought on whether hospitals could be redesigned to provide care home beds.

In response to comments/questions, it was explained that:-

- a review of key performance indicators was underway and it was anticipated that the new indicators would be in place for the start of the financial year. The new indicators would be based on outputs and better reflect quality of service and the high level value stream work underway within NHS Highland. Improvement Groups had individual responsibility for a number of indicators and they were overseen by the Highland Health and Social Care Committee. The Director of Adult Social Care undertook to liaise with the Chair regarding the timescale for implementation of the new indicators and what opportunities there were for Members of the Sub-Committee to provide input;
- with regard to dementia, the work around early diagnosis was significant but the performance indicator was not as meaningful as it could be and was being examined as part of the aforementioned review. Operationally speaking, the number of people with cognitive impairment/dementia in community hospitals had increased significantly over the past year. Some people had extremely challenging behaviour and there was a lack of specialist provision. Work was ongoing to reconfigure and recommission the service and it was hoped to come back to the Sub-Committee with more detailed information in due course. The services provided by Alzheimer Scotland were funded by the Integrated Care Fund and both operational units had agreed that this would continue in the following year;
- an increasing number of people receiving care at home was not necessarily a positive step as this could indicate that everyone being discharged from hospital was automatically receiving a long-term support package. The aim was to enable people to live at home independently and further information on enablement services would be provided under item 6 on the agenda;
- a review of the patient group in Raigmore indicated that more than half were past an acute stage of care and an alternative model was being explored whereby, as described by Members, patients who did not require acute care would be moved to another ward/site;
- 128 people were currently delayed in hospital, 49 of which had been delayed for more than two weeks. The number of complex cases was 54. There were approximately 40 people for whom care home beds could not be found as well as a number of people who required extensive care packages. With regard to the reduction in numbers between October and November, this was due to a change in the way delayed discharges were reported, as requested by the Scottish Government, rather than a reduction in the number of people that remained in hospital. The duration of delays would be more clearly articulated in the new performance indicators;
- in relation to the Harmsworth Ward in Caithness, a clear plan was in place but existing services had to be reconfigured and it was necessary for regulatory services, which still had a very traditional view of social care services, to adapt and recognise that the proposals were in people's best interest. The debate with the Care Inspectorate was ongoing and a meeting scheduled to take place on 8 January 2016 had been postponed until March but there was every confidence that progress would be made. Redesign took time and had to be carried out within the legislation. The same issues in terms of regulatory standards applied in Skye and Lochalsh; and

- the purpose of community hospitals such as the Royal Northern Infirmary (RNI) was to provide rehabilitation so that people could return home. However, there were issues with delayed discharge.

During further discussion regarding the Harmsworth Ward, the need to enlist the help of the local community, many of whom were closely involved in health services, was emphasised. It was suggested that a briefing be arranged for Local Members who could then discuss the proposals with community representatives and lobby the Care Inspectorate.

In relation to delayed discharge, the Chair requested that an exception report be presented to the next meeting of the Sub-Committee.

Thereafter, the Sub-Committee:-

i. **NOTED** the report;
ii. **AGREED** that responses to Members' questions be provided by email within a week of the Sub-Committee;
iii. **AGREED** that the Director of Adult Social Care liaise with the Chair of the Sub-Committee regarding the timescale for implementation of the new performance indicators and opportunities for Members of the Sub-Committee to provide input;
iv. **AGREED** that in future, where performance indicators were red, an explanatory note, if not a full exception report, be provided;
v. **AGREED TO RECOMMEND** that a briefing on the proposals for the Harmsworth Ward in Caithness be arranged for Local Members; and
vi. **AGREED** that an exception report on delayed discharge be presented to the next meeting of the Sub-Committee.

5. Operational Director Reports

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 considered by NHS Highland's Health and Social Care Committee on 7 January 2016.

During discussion, whilst recognising that the Operational Director reports were prepared for the Highland Health and Social Care Committee, Members emphasised the need for more up-to-date information and requested that they be revised before they were presented to the Sub-Committee. In addition, the North and West Delivery Plan appended to the report was not relevant to the Sub-Committee and should not be included in future. In response, it was confirmed that, whilst the reports could not be re-written, an update could be provided in future.

In response to questions, it was explained that:-

- in relation to the radical change required to break even, the main financial pressure in the North and West was the use of locums in Caithness General Hospital. It was not always necessary to have a doctor or GP and work was underway, as part of the remote and rural project, to examine whether people could be better served by different staffing arrangements. For example, the

Director of Operations had successfully recruited nurses in some areas that had been upskilled to take on different roles; and

- Day and Night Owls was a small private care at home provider.

Thereafter, the Sub-Committee:-

i. **NOTED** the content of the report; and
ii. **AGREED** that future Operational Director Reports be accompanied by an update for the purposes of the Sub-Committee and that Delivery Plans not be included.

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 7 January 2016.

In response to comments regarding the lack of information on care in the community, it was confirmed that subsequent reports would be more focussed on adult social care and the Director of Operations, Inner Moray Firth, hoped to attend the next meeting of the Sub-Committee.

Further information having been sought regarding the rebalancing of services within Culloden Dental Clinic and the access target for endoscopy appointments, the South Area Manager undertook to provide a written response to Members outwith the meeting.

Thereafter, the Sub-Committee:-

i. **NOTED** the content of the report; and
ii. **AGREED** that written responses be provided to Members' requests for further information on the rebalancing of services within Culloden Dental Clinic and the access target for endoscopy appointments.

Development

6. Care at Home Zoning

The South Area Manager, NHS Highland, and the Managing Director, Highland Home Carers, gave a verbal presentation during which detailed information was provided on the care at home model in the Inner Moray Firth Operational Unit, including the introduction of zoning.

The South Area Manager explained that the in-house care at home service that had transferred to NHS Highland as part of the integration of health and social care services had been under considerable pressure and had not been providing value for money. He had been tasked with looking at what could be done in the Inner Moray Firth area to make the service more robust and efficient. For a variety of reasons, one of which was the significantly higher cost of the in-house service, a decision had been made to reverse the approximately 70:30 split between the in-house service and independent sector provision. Discussions had taken place with the independent sector through Scottish Care and, as a result, a new commissioning arrangement had

been implemented that included quality standards, training standards and an agreement that NHS Highland would pay, as a minimum, the Living Wage.

The Managing Director, Highland Home Carers, highlighted that in Highland, unlike other parts of Scotland, independent sector providers were paid a fixed rate which meant that they were not competing with one another in terms of price and were able to work together as a group. This had provided a good basis for the changes to care at home provision. Historically, the majority of care at home work had been allocated to the in-house service with independent sector providers picking up anything that could not be done. This had led to difficulties in terms of recruitment and retention of staff and ability to deliver services. The situation had now fundamentally changed in that the work was allocated to the most appropriate organisation to provide care in a particular location and other organisations provided support. From May 2015, the tariff approach had been implemented which was not only about how much was paid but the responsibilities and requirements that went along with it. Zoning had been implemented in Inverness, whereby a primary provider took full responsibility for the delivery of care in a specific geographical area or zone. As a result of this approach, Inverness West now had no unmet need which was a remarkable turnaround. There were 33 zones in Inverness and it was intended to roll out zoning to other areas. Discussions were ongoing in Nairn and other parts of the Inner Moray Firth and there was still a significant task ahead but there was every confidence that there would be dramatic decreases in delayed discharges and unmet need in the near future. The situation in the North and West was very different as the old system was still in operation but discussions had commenced with a view to addressing the situation.

A further area of development was the increasing number of small communities implementing their own care at home services with the support of larger organisations such as Highland Home Carers. Similar services to Boleskine Community Care were now beginning in Moy, Tomatin and Cromarty. Rolling out this model in the North and West would begin to tackle the issue of rurality and options for services were being considered in Melness, Melvich, Wick and Helmsdale. However, there were some communities that did not want to take on responsibility for care at home. Farr, Inverness, for example, had been rezoned as an area that would not have a community-based service.

In relation to the in-house service, the intention was to re-target approximately 60% to enablement. Hospital was not the best place to assess the level of care at home someone might require and inevitably led to over-assessment. The aim was to take a default position whereby, if someone did not require a nursing care place, every possible step would be taken to get them home with an intensive support package. In Inverness, enablement was run from the RNI and was an ever-increasing service. Approximately 80 people had been through the RNI model, 53% of whom required no care at home whatsoever after six weeks. 20% required a decrease in care and only 30% required a level of care that matched their original assessment. The enablement model allowed officers to work with the independent sector and plan ahead in terms of care at home provision. In addition, despite a 20% increase in referrals, the number of people requiring complex care packages had decreased. Going forward, the ambition was that ongoing care and support would be provided by the independent sector and enablement work would sit within the district teams. It was emphasised that the North and West would have to look at a different model of support.

During discussion, the following issues were raised:-

- communities in the North and West needed to take more control and if community-based services got off the ground in Wick, Helmsdale etc other areas would follow suit;
- the community-based care model could not have happened without the support and goodwill of the South Area Manager and the Managing Director of Highland Home Carers;
- Boleskine Community Care was an exemplar of community-based care and now employed ten people;
- any community had the potential to implement their own care at home services and the model was spreading through people talking enthusiastically about it;
- community-based care was not only about care at home provision but about community sustainability;
- integration with communities had previously been lacking but was now starting to take place. However, there was still a significant way to go;
- there was a case for preventative home care and it was necessary to enter into discussions as to how to progress it;
- the current length of time taken to carry out assessments was an obstacle to progression;
- there had been a dramatic improvement in care at home services in the Inner Moray Firth and Members commended officers and the independent sector for their efforts;
- the importance of robust liaison with patients' families at the enablement stage was emphasised; and
- a single tariff with no mileage was not sustainable in the remote North and West and it was suggested that this be revisited.

In response to Members' comments, it was explained that:-

- assessment was a priority and a piece of work would take place on 27 April 2016 looking at referral to first social work assessment;
- other parts of Scotland were interested in the Inner Moray Firth care at home model. However, there were still challenges to be addressed and there was no room for complacency;
- significant change had taken place in terms of the relationship with independent care at home providers. However, it was highlighted that residential and nursing care providers were much more fragmented and change would be more challenging; and
- a strategic decision had been made, in partnership with the independent sector, to implement a single tariff that took account of issues such as mileage, training and management. In terms of the North and West, a view had been reached that remoteness, as opposed to rurality, did not have a significant impact on the tariff given the efficiencies that zoning provided.

Thereafter, having commended officers and the independent sector for the significant improvement in care at home services, the Committee **NOTED** the presentation.

The meeting concluded at 12.55 pm.