Agenda Item 14iii.

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 3 February 2017 at 11.00 am.

Present:

Mrs I Campbell
Mrs M Davidson (Chair)
Mr S Fuller
Mr K Gowans
Mrs B McAllister
Mr D Millar
Mrs M Paterson
Mr G Ross

Non-Members also present:

Mr B Fernie

In attendance:

Highland Council:
Ms I Murray, Commissioning Officer, Care and Learning Service
Miss M Murray, Committee Administrator, Corporate Development Service

NHS Highland:
Dr D Alston, Chair of NHS Highland Board
Ms J Macdonald, Director of Adult Social Care
Mr D Park, Director of Operations, Inner Moray Firth
Mr D Garden, Head of Financial Planning
Mr G McCaig, Head of Care Support
Mr JP Sieczkarek, Area Manager, South
Ms T Ligema, Area Manager, West

Mrs M Davidson in the Chair

Business

Preliminaries

The Chair welcomed Mr D Park, Director of Operations, Inner Moray Firth, to his first meeting of the Sub-Committee.

1. Apologies for Absence

Apologies for absence were intimated on behalf of Mrs C Caddick, Mr A Christie and Ms J Slater.

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.

3. Minutes and Action Plan

There had been circulated the Minutes of the previous Meeting held on 18 November 2016 and the rolling Action Plan maintained by the Care and Learning Service.

In response to questions regarding Mandaville Care Home, it was confirmed that the embargo had been lifted. However, the upper floor remained empty at present.

With regard to the outstanding action to break down performance figures to Community Partnership level, the Head of Care Support explained that Community Partnership boundaries had not been finally agreed until December 2016. Work would take place, in conjunction with the Public Health team, to build up the necessary database. However, it was technically difficult and would take time to achieve.

The Sub-Committee otherwise **NOTED** the Minutes and Action Plan.

Scrutiny

4. Assurance Report to Commissioner – Adult Services

There had been circulated Report No ASDS/01/17 by the Director of Adult Care, NHS Highland, appending the report submitted to the Highland Health and Social Care Committee on 5 January 2016 as assurance against delivery of Adult Services within the Lead Agency.

In introducing the report, information was provided on work taking place to redesign mental health and learning disability services. An interim management structure had been put in place and the aim was to reduce the length of stay in the assessment/treatment unit and, instead of bringing people in to an acute setting, take the acute setting to the patient in as many cases as possible so that they were being supported in their own environment. Members welcomed the change in focus and suggested that an update be provided at the next meeting.

In relation to delayed discharge, it was explained that, since the assurance report had been written and reported to the Highland Health and Social Care Committee, significant improvement work had taken place around patient flow in Raigmore and, since December 2016, the number of delayed discharges had been sustained at less than 20. There were currently 90 delayed discharges in total but it was highlighted that NHS Highland was now one of only three Boards in Scotland that was sustaining or reducing the number of delayed discharges.

With regard to the revenue position, the month nine position was projecting an overspend of £8.6m, an improvement on the month eight position set out in the report. However, this was primarily due to significant non-recurring benefit from recovering over-profiting by drug companies.

During discussion, the following issues were raised:-

- concern was expressed regarding delayed discharge in the Royal Northern Infirmary (RNI) and that those who had been delayed for a considerable length of time were deteriorating due to a lack of interaction. Figures having been sought, it was explained that, of the 30 beds, 16 were delayed discharges. This was not sustainable or appropriate and officers shared Members' concerns. Of the 16 patients that were delayed, three were waiting for care at home and the rest were waiting for care home placements. There were considerable issues in terms of choice and a number of care homes only taking self-funders. The Chair requested that a substantive report on the issues in the RNI be presented to the next meeting of the Sub-Committee. The Area Manager, South, added that anonymised reports on individual cases could be provided;
- there were similar issues in terms of choice of care home in Caithness and Lochalsh. Being so remote, if there was not anywhere suitable locally it was a considerable distance to ask people to move to an interim placement;
- the Director of Adult Social Care highlighted a piece of work looking primarily at delayed discharge in Raigmore and the RNI and the barriers to people moving on. As part of that, the Chair suggested that there was a need to look ahead in terms of care bed provision and consider fast-tracking alternatives such as adapted housing;
- information having been sought on how often the strategic plan was reviewed and whether it was flexible enough to adapt to the increasing needs of an aging population, it was explained that future-proofing work was ongoing and that it was necessary to bring together a variety of measures such as technology, fit housing etc. In addition, it was necessary to explore a less risk-averse approach and lessons could be learnt from the children's agenda in that regard;
- it was necessary to better understand what resources were required to support people through a point of crisis;
- recently, there had been a renewed focus on building capacity and care in the community, not only at the NHS Board but nationally. The implementation of locality planning throughout Highland would be useful but, above that, strategic thinking was necessary to ensure that locality plans were focused on the care of adults within the community;
- the modular houses with assistive technology that formed part of the City Deal were cheaper and quicker to construct than a traditional build and it was necessary to consider where they were needed;
- the aging population was a community planning issue and a holistic approach was necessary;
- the figures on page 17 of the report setting out the cost of various types of care beds in comparison with care at home were startling and it should be possible to use some of the money saved on acute care to provide accommodation. In addition to the figures in the report, the Area Manager, South, highlighted that the cost of a basic telecare package was only 80p per day;
- in response to questions, further information was provided on the targeted falls prevention work taking place in the two community hospitals with the highest number of falls. This included a falls bundle, additional leadership resources, cohorting patients at risk of falls, mapping out where falls were taking place on wards, hourly checks during the night and encouraging people to bring their own shoes rather slippers. Having commended the significant improvements that had taken place, Members commented that communities needed to take ownership of falls prevention and highlighted that the Scottish Fire and Rescue Service were carrying out falls prevention checks in some communities;

- the facts and figures in terms of shifting the balance of care were clear and locality planning presented an opportunity to realise it. However, such a significant change required a plan and the Chair indicated that she would be having ongoing discussions in that regard with the Chair of NHS Highland Board;
- the inclusion of benchmark figures in the balanced scorecard was welcomed;
- clarification having been sought, it was explained that indicator 2.2 related to clients who were directly receiving a service. There was a separate indicator (6.1) relating to carers;
- in response to a question, it was explained that there were 23 performance indicators that were part of a biennial national survey and it was necessary to put them into a system whereby information could be gathered locally. In that regard, Outcomes Stars were being put in place and surveys would be undertaken by the third sector, which would provide a degree of independence;
- having highlighted that emergency admission and readmission figures were below the national average, Members commented that overuse of acute hospitals for frail elderly people was a national issue and a significant culture change was required;
- in relation to the premature mortality rate, it would be helpful to provide a comparison with another rural authority such as Argyll and Bute;
- consideration needed to be given to including information on trends in future performance reports;
- in response to a question, it was confirmed that there was no correlation between holding vacancies and the number of emergency admissions. The decision-making process in terms of recruitment remained the same regardless of the time of year and people would not be left in a vulnerable position. Clinical staff and care staff vacancies were not held vacant and always went through vacancy monitoring. Members welcomed the assurance; and
- the Chair sought a breakdown of the overspend of £175k in Inverness West.

Thereafter, the Sub-Committee:-

i. **NOTED** the reports and the assurance given by the Highland Health and Social Care Committee;
ii. **AGREED** that an update on the redesign on mental health and learning disability services be provided at the next meeting of the Sub-Committee;
iii. **AGREED** that a substantive report on the issues surrounding delayed discharge in the Royal Northern Infirmary, including anonymised reports on individual cases, be presented to the next meeting of the Sub-Committee;
iv. **AGREED** that consideration be given to including comparisons with other rural authorities and information on trends in future performance reports; and
v. **AGREED** that a breakdown of the overspend in Inverness West be provided to the Chair of the Sub-Committee.

5. NHS Highland – 2017/18 Budget Implications

There had been circulated report by the Director of Finance, NHS Highland, which had been considered by the NHS Highland Board on 31 January 2017. The report set out the financial settlement for 2017/18, the impact on NHS Highland's financial plan and the likely level of savings required to deliver financial break even.

In addition to the report, the Head of Financial Planning tabled a spreadsheet to demonstrate what the financial implications would be for partners if there was an Integrated Joint Board model in Highland rather than a Lead Agency model.

In response to questions, it was explained that NHS Highland could not carry reserves and the only option, if the necessary savings could not be achieved, would be to approach the Scottish Government and ask to borrow money. However, the Scottish Government had limited ability in that regard. The current NHS Highland model was unsustainable, there being ongoing issues in terms of recruitment to substantive posts and expenditure on medical locums, and it was necessary to find new ways of doing things.

Members having emphasised the need to shift the balance of care, it was acknowledged that fundamental change was required and communities were central to that, the cost per week of an acute hospital bed being significantly more than the cost of caring for someone in the community, as discussed during the previous item. However, shifting the balance of care could not be the only solution. In fact, in some instances, whilst it was the right thing to do in terms of outcomes, it cost more – for example, supporting adults with learning or physical disabilities in the community was more expensive that institutional care.

A significant amount of expenditure related to the fact that people were dying in institutional settings and it was necessary to have honest conversations with communities about death and dying. In addition, the level of frailty in communities was greater than it needed to be and it was necessary to address that.

In relation to the spreadsheet, Members commented that it was a useful exercise but the position was not as clear cut as set out.

The Sub-Committee otherwise **NOTED** the report and spreadsheet.

Development

6. Transitions

The Director of Adult Social Care, NHS Highland, gave a verbal update during which it was explained that transitions was an area of concern, particularly for families of children with disabilities. That being the case, a joint Transitions Project Board had been established to consider how best to support children from the age of 14 to 25. Following consultation with children, families and staff, four options were being explored as follows:-

1) the status quo;
2) the creation of a joint transitions team, comprising staff from both the Council and NHS Highland, primarily social workers and learning disability nurses, to work with children from the age of 14 to 25;
3) the creation of a transitions team in both organisations; and
4) dedicated transitions staff in each of the districts.

Option 2 was the preferred option of families and staff. Lowering the age of transition meant that children would still be in school and it would be the only major change in their lives. It allowed time to plan and work through the artificial age of 18, when children became an adult. By the age of 25, most young people with a disability were in more settled environments. In addition, staff wanted to have more ownership of budgets and consideration would be given to pooling resources.

It had been agreed to focus on the Inner Moray Firth initially as the issues were greater in terms of budget and staffing and there were special schools in the area. However, engagement with children, families and staff had taken place throughout Highland. A report would be presented to the Project Board on 28 February 2017 and its recommendation would then be considered by the respective partner organisations.

The Area Manager, South, added that a dedicated joint transitions team would create a degree of efficiency that did not exist at present and would remove the ability to blame another organisation for the decisions made.

In response to a question, it was explained that, given the timing, it was unlikely that a report would be presented to the Education, Children and Adult Services Committee on 1 March 2017. The Chair highlighted that the next meeting was not until June 2017.

The Sub-Committee **NOTED** the position and welcomed the idea of a joint transitions team.

7. Single Point of Access

The Area Manager, South, NHS Highland, gave a verbal update on the Single Point of Access (SPA) in Inverness, which had been operational for three months. There had been 4500 calls in the first month but this had now levelled out at approximately 3200 calls per month. However, this was twice as many calls per capita as the SPA in Nairn, the reasons for which were being explored. A dedicated professional line had been established which, it was thought, was the reason for the reduction in the number of calls from month one to month two. The top three reasons for calls were 1) requests for incontinence pads; 2) general social work; and 3) misuse by professionals. The average length of time taken to answer a call was 30 seconds and approximately 90% of calls were redirected.

In response to questions, it was explained that officers were examining the call data in more depth to establish whether there were things that could be done differently where there were high numbers of calls about the same issue. In addition, it was confirmed that a list of the SPAs in Highland and information on where they were advertised could be provided.

Thereafter, the Sub-Committee:-

i. **NOTED** the position; and
ii. **AGREED** that a list of Single Points of Access in Highland and information on where they were advertised be provided to Members of the Sub-Committee.

8. Role and Function of Social Workers

The Sub-Committee **AGREED** that the proposed verbal update on the role and function of social workers be amalgamated with item 10 on the agenda.

9. Review of Respite – Progress Report

There had been circulated Report No ASDS/02/17 by the Director of Adult Care, NHS Highland, which explained that a review of respite provision across the Highland area

had been undertaken in July 2016, from which a number of workstreams had emerged.

During discussion, Members commented that, whilst there were a number of workstreams, there did not appear to be a clear action plan as yet. Respite was continually being redefined and many people who needed it were not interested in the traditional model. There was no perfect model and it was suggested that there was a need for more of an interim position with regular reviews.

In response to a number of questions regarding Self-Directed Support (SDS), it was explained that officers were confident that service users were being offered all four options more often, but not 100% of the time. In terms of how much money was available for Option 4, there was no specific budget. If the amount was over £700 per week, it was referred to an allocation group and there had to be an evidence base as to why that option was more appropriate than a residential option. With regard to fairness, there were eligibility criteria and guidance. In addition, having an Adult Practice Model where there was a clearer understanding of how services were delivered would help. However, use of the Indicator of Relative Need, a Scottish Government assessment tool, had indicated that there was a huge variation between the services and supports provided to people with similar needs and that was not necessarily equitable and fair. In relation to whether users received enough money to meet their needs, officers were confident, based on assessment, that that was the case. However, it was emphasised that what people needed was often different to what they wanted. It was highlighted that SDS staff were being devolved into operational teams, which should lead to improvements.

The Chair suggested that a report on SDS be presented to the next meeting of the Sub-Committee, as part of the development section, and that it should include case examples, particularly in relation to older people.

Members having queried whether consideration had been given to foster placements for older people, the Chair explained that it had been explored previously without success. The Area Manager, West, highlighted that an enquiry had been passed on to the local Community Development Worker from someone who wanted to look after a small group of older people in their own home during the day.

Thereafter, the Sub-Committee:-

i. **NOTED** the progress of the actions in each of the workstreams; and
ii. **AGREED** that a report on Self-Directed Support, including case examples, particularly in relation to older people, be presented to the next meeting of the Sub-Committee.

10. Presentation: Adult Practice Model

The Director of Adult Social Care, NHS Highland, gave a verbal presentation on the work taking place to develop an Adult Practice Model similar to the GIRFEC (Getting It Right For Every Child) model for children's services, which was robust and well-understood with a common language and a single pathway. A graphic setting out the GIRFEC model was tabled. Work was ongoing, with particular emphasis on the role of the lead professional, and an update would be provided at a future meeting of the Sub-Committee.

It was explained that consideration was being given to a model of neighbourhood care whereby there would be a team of nurses and care at home staff to support frail elderly people to remain in their own community. An inherent part of the model would be 24/7 cover and Social Workers and Allied Health Professionals would be brought in as required. One of the reasons GPs admitted frail older people to hospital was they had no one to call to get immediate care in place and the model would address that. Known as the Buurtzorg Model in Holland, it was person-centred and reflected NHS Highland's ambition to support adults in the way they wanted to be supported. Older people would be safer, more in control and would only be admitted to acute care when they really needed it. In relation to budgets, reference was made to the earlier discussions regarding the cost of acute hospital beds being significantly more than the cost of caring for someone in the community. In addition, it was highlighted that tests were carried out when people were admitted to hospital and conditions were often discovered that were unrelated to the reason for admission. Treatment was then provided in hospital when it might be more appropriate to discharge the patient and work with their GP to treat them at home.

The Area Manager, South, added that, from 1 April 2017, three providers would be working in partnership in the Inverness city area to provide an overnight and weekend service. They would respond to help calls by people who did not have a responder and would also undertake scheduled work such as continence and turning runs. It was hoped that the pilot could be rolled out very quickly but it was necessary to evidence the impact, particularly in terms of patient flow and cost-effectiveness. It was emphasised that clinicians would not discharge patients until they were confident that adequate overnight care was in place.

During discussion, Members commented that, in some ways, unexpected admissions from rural areas were more disruptive and it might be more advantageous to have a pilot scheme in a rural area.

In response, the Area Manager, West, explained that discussions with providers were ongoing in terms of how a rapid response/overnight service could be provided. It was more difficult in rural areas as there was not the same concentration of population and it was necessary to think in a different way. Community resilience was key and there were five or six rural communities in the west that had expressed an interest in working with NHS Highland to support their own residents.

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

The meeting concluded at 12.55 pm.