Agenda Item 27v.

The Highland Council

People Committee

Minutes of Meeting of the **Adult Services Development and Scrutiny Sub-Committee** held in Committee Room 2, Council Headquarters, Glenurquhart Road, Inverness on Thursday 3 August 2017 at 11.00 am.

Present:

Mr B Boyd
Mr A Christie
Mrs M Cockburn
Mrs I MacKenzie
Mr R MacWilliam
Mr C Smith
Ms K Stephen

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
Ms G McVicar, Director of Operations, North and West Operational Unit
Mr D Park, Director of Operations, Inner Moray Firth Operational Unit
Mr D Garden, Interim Director of Finance
Mr JP Sieczkarek, Area Manager/Special Projects Lead, Inner Moray Firth Operational Unit
Mr G McCaig, Head of Care Support
Mr S Steer, Head of Strategic Commissioning

Business

Preliminaries

For the benefit of new Members, the Chair of NHS Highland Board explained that he considered it important that he attended the Sub-Committee as it was the key point at which NHS Highland gave an account to the Council of the delivery of commissioned adult services. This was done on the basis of the internal scrutiny carried out by the Highland Health and Social Care Committee (HHSCC).

1. Appointment of Chair

The Sub-Committee **AGREED** to appoint Ms K Stephen as Chair.

2. Apologies for Absence

Apologies for absence were intimated on behalf of Mr T Heggie, Mr R MacDonald, Mr G Ross and Ms N Sinclair.

3. Declarations of Interest

Whilst there were no specific declarations of interest in relation to the business on the agenda, the Chair, in the interest of transparency, explained that she undertook health research for UHI and sometimes evaluated NHS projects. Councillor Cockburn advised that she was a former NHS Systems Manager and was currently carrying out consultancy work for Forth Valley Health Board. Councillor Boyd explained that he volunteered at Raigmore. Councillor Smith advised that he undertook adult support work for Nansen Highland.

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

4. Minutes

The Sub-Committee **NOTED** the Minutes of the previous Meeting held on 3 February 2017.

Scrutiny

5. Breakdown of Social Care Services

The Director of Adult Social Care, NHS Highland, gave a verbal presentation during which detailed information was provided on the delivery of adult social care services in Highland, namely, care at home, care homes, and day services, including learning disability services. A request had been make for a list of services, providers and current inspection grades and it was confirmed that this would be provided prior to the next meeting of the Sub-Committee.

The Chair explained that the scrutiny element of the Sub-Committee meant that Members had to ask challenging questions. However, it was emphasised that this should be done in a positive, constructive and polite manner. Integration meant that health and social care had become intertwined and it could be difficult to isolate what was pure social care. It was a complex picture, with different things going on in different areas of Highland, and Members were invited to consider what information they would find useful. If anything was unclear, it was important to raise it so that consideration could be given to how to present information in such a way that the Sub-Committee could carry out its scrutiny role effectively.

The Chair of NHS Highland Board highlighted that a “wall walk”, whereby live data was scrutinised, took place at Assynt House at 9.30 am every Tuesday. If Members wished to attend or view the data at any other time, arrangements could be made through the Director of Adult Social Care.

During further discussion, the following issues were raised:-

- to avoid duplication and identify gaps, it would be helpful to have a chart setting out what scrutiny was already taking place elsewhere;

- Members' knowledge was key in terms of the significant amount of voluntary work taking place throughout Highland. Particular reference was made to "Contact the Elderly" which was beneficial in terms of combatting social isolation and loneliness, and encompassed both people in residential homes and in their own homes;
- it would be useful to provide a glossary of terms/acronyms in every report;
- the Director of Operations, Inner Moray Firth Operational Unit, suggested that, in order to tailor the information provided, it might be helpful for Members to look at the Directors' reports that were submitted to the HHSCC in advance of the Sub-Committee and highlight any particular areas of interest; and
- District Managers, a list of which had been circulated separately, were the first point of contact where Members wished to raise local issues. However, it was emphasised that the Directors of Operations were happy to take calls if Members wanted a wider view or needed to escalate a particular issue.

Thereafter, the Sub-Committee:-

i. **NOTED** the presentation and that a list of services, providers and current inspection grades would be provided prior to the next meeting of the Sub-Committee;
ii. **AGREED** that a chart setting out what scrutiny was already taking place at other committees/groups be provided to Members of the Sub-Committee;
iii. **AGREED** that a glossary of terms/acronyms be provided in all future reports to the Sub-Committee.

6. Assurance Report to Commissioner – Adult Services

There had been circulated Report No ASDS/03/17 by the Director of Adult Care, NHS Highland.

In relation to the finance element of the report, the Interim Director of Finance highlighted that, as a result of robust work, the Month Three position showed a significant improvement on the Month Two position set out in Table 1. The year to date overspend had reduced from £5.1m to £2.8m and the projected year-end overspend had reduced from £19m to £8.6m.

The Chair reiterated the importance of information being presented in a manageable way to enable Members to carry out their scrutiny role effectively. She asked Members to consider the structure of the report and whether there were any specific areas where they would like more detail.

During discussion, the following issues were raised:-

- it was important that discussions took place with the Council, as a housing provider, regarding the shortage of local housing for key workers in some areas. In addition, Local Members might be aware of people in communities who might be willing to provide lodgings;
- in relation to delayed discharge, it would be interesting to know if there was potential for clustering of housing where care could be provided for people who were not able to go back to their own homes;
- housing associations received a higher subsidy per new housing unit than the Council and it might be necessary to make representations to the Scottish Government that funding should be equal;

- it was suggested that a report on the proposals for the 32 Fit Homes that formed part of the City-Region Deal be presented to a future meeting of the Sub-Committee. The report should include information on eligibility criteria and how Councillors could make a case on behalf of their Ward if they were aware of suitable land being available;
- with regard to the balanced scorecard, the level of information provided in the example at Annex 3 was very useful;
- the information in the report was helpful and well-presented but it was historical and it was suggested that it was necessary to project the number of people who would be entering the system in the future and plan accordingly;
- a more detailed breakdown of delayed discharge information was requested;
- the importance of working together was emphasised and information was sought on what Members could do to support officers in addressing the issues raised;
- there was a lot of misunderstanding regarding Power of Attorney and the Council and NHS Highland could work together to facilitate it being put in place by as many people as possible;
- it was suggested that a report/briefing on anticipatory care planning be presented to a future meeting of the Sub-Committee, including what an Anticipatory Care Plan (ACP) looked like and any available data, broken down by community partnership area, on how many were in place so that Members were aware which areas were falling behind and where there were people potentially at risk of hospital admission that could be avoided;
- if Members knew what services were being provided where, and what the local challenges were, they would be more empowered to respond appropriately when issues arose;
- it would be helpful to know how the care at home budget was disbursed amongst the Community Partnership areas and where the overspends were;
- with regard to the savings targets in Table 3, details of the savings measures and the potential impacts were requested;
- an unintended consequence of integration and providing the best possible care was that, as it became harder to differentiate between the Council pound and the NHS pound, some of the information needed to lobby the Government for funding was lost;
- information was sought on savings that had not been realised, whether any false economies had been made and whether there was a review mechanism in place; and
- the NHS budget was complex and it was suggested that it would be helpful to invite Members of the Sub-Committee to the briefing for new HHSCC Members.

Detailed information was provided in response to comments and questions. In particular, it was explained that:-

- in relation to the recruitment challenges in some areas, officers could negotiate with staff in terms of a change of location or working extra shifts but this could not be imposed;
- with regard to delayed discharge and the shortage of care home beds, every effort was made to provide care for people in their own home before a care home was considered. However, there were issues in terms of recruiting the necessary number of care at home workers, particularly in rural areas, and 24/7 care was more easily achieved in an institutional setting. In addition, there were issues in terms of care homes giving priority to self-funders. Care home spaces had been purchased in Moray as an interim measure but, despite the close proximity to

communities such as Nairn, there was a level of resistance by families to patients being moved out of region and Members' support was sought in that regard;

- in relation to assessment, whilst there had been variation in the past, a significant amount of work had taken place on the Indicator of Relative Need which delivered consistent information on which to base decisions around the level of care required. However, there would always be variables such as the individual's support network, whether their home was adaptable etc;
- housing was critical and there was a significant amount of work to be done with housing colleagues in terms of very supported housing provision, whether it be Fit Homes or clusters. Community Partnerships were being encouraged to discuss the matter as they had local knowledge in terms of availability of land or property;
- if Councillors were aware of individuals in their Ward who were in need of support, they should contact the appropriate District Manager or Single Point of Contact;
- with regard to reablement, there had been some criticism that it was about reducing services/cutting budgets and Members' support was sought in that regard. It was emphasised that reablement was a period of intensive support to maximise an individual's potential and enable them to live as independently as possible;
- discussions took place on a weekly basis to identify the people already known to primary or community teams who were most at risk of needing a service or hospital admission in the future. In addition, work was taking place regarding future need for care homes and care at home but it was difficult to predict;
- information on recruitment issues was provided in the full Operational Directors' reports, which had been circulated separately for information;
- a more detailed breakdown of delayed discharge information was available and was examined on a weekly basis. However, it was emphasised that it was not in the public domain as individuals could be identified when the information was broken down to very small numbers;
- in relation to Anticipatory Care Planning, there was a service level agreement with GP practices but it was now seen as something that should be done by the whole integrated team and there was a strong focus on it. Some data was available but there had been discussions about how information gathering could be improved. A previous presentation to the NHS Highland Board could be circulated to Members of the Sub-Committee for information;
- an analysis of care at home spend by Community Partnership area and in-house/commissioned services could be provided. However, due to commercial confidentiality, it was not possible to specify what was spent on individual providers. In addition, it was explained that the boundary between in-house and commissioned services was becoming increasingly blurred as care at home workers became part of integrated teams. The same applied to other services such as reablement;
- going forward, outcome measures, rather than the traceability of the pound, were what would provide assurance. The Ministerial Steering Group had identified six key measures for integrated authorities and these would be increasingly reported on;
- other Boards in Scotland were effectively split into acute services and integrated services and consideration could be given to reporting in a similar manner; and
- budgets were continuously reviewed. However, it was emphasised that there was a focus on quality and reducing waste rather than cutting services, which meant that savings were not always realised quickly. Both Operational Units were focussed on reducing costs in hospital services and safeguarding primary and community care.

Thereafter, the Sub-Committee:-

i. **NOTED** the report and the assurance given by the Highland Health and Social Care Committee;
ii. **AGREED** that a report on the proposals for the 32 Fit Homes that formed part of the City-Region Deal be presented to a future meeting of the Sub-Committee, including information on eligibility criteria and how Councillors could make a case on behalf of their Ward if they were aware of suitable land being available;
iii. **AGREED** that a detailed breakdown of delayed discharge information be circulated to Members of the Sub-Committee;
iv. **AGREED** that a report/briefing on anticipatory care planning be presented to a future meeting of the Sub-Committee, including what an Anticipatory Care Plan looked like and any available data, broken down by community partnership area, on how many were in place. It was further **AGREED** that, in the meantime, a previous presentation to the NHS Highland Board be circulated to Members of the Sub-Committee for information;
v. **AGREED** that information on care at home spend by Community Partnership area and in-house/commissioned services be provided to Members of the Sub-Committee;
vi. **AGREED**, in relation to the savings targets in Table 3, that details of the savings measures and the potential impacts be provided to Members of the Sub-Committee; and
vii. **AGREED** that Members of the Sub-Committee be invited to the briefing for new Highland Health and Social Care Committee Members.

7. Structure of Reports

Further to the discussions under the previous item, the Chair referred to the suggested structure for future reports that had been circulated. This included headlines from previous reports and might help Members to think about how they would like information to be presented in the future. Given the ongoing development work taking place in terms of performance reporting, as set out in the Assurance Report, it was not suggested that any proposals on report structure be made today but that consideration be given, at future meetings, to where the gaps were.

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

Development

8. Neighbourhood Teams

A verbal update was provided on neighbourhood teams, during which the Director of Operations, North and West Highland, explained that, whilst the focus was on the Inner Moray Firth Operational Unit at present, this type of person-centred approach had existed in the North and West Operational Unit for many years, with teams having been fully integrated from day one of the integration of health and social care services. Social workers, nurses, occupational therapists, physiotherapists, dieticians, podiatrists etc were all part of an integrated team working within a specific district, and team leaders were selected from the cohort of people working within the team. However, some of the teams were quite large, eg Lochaber, so the next step was to focus on a sub-team structure.

In relation to the Inner Moray Firth Operational Unit, the Area Manager/Special Projects Lead explained that one of the reasons for implementing neighbourhood teams was the size of the areas in Inverness, Inverness East having the biggest team of District Nurses in Scotland. There were eight neighbourhood teams in Inverness, working in geographical zones that equated to the commissioning intentions with the independent sector so that teams knew which providers they should be working with in terms of long-term care at home. Daily "huddles" or team meetings had been implemented as of this week. The next stage of the process was that, on 1 September 2017, a significant number of in-house care at home staff would move into neighbourhood teams and take on a varied role based on supporting people in their own homes with an emphasis on reablement. Social work teams would remain as Inverness East and Inverness West but new procedures were in place to make it easier for neighbourhood teams to access their social work colleagues.

During discussion, the following issues were raised:-

- a map of neighbourhood team areas was requested;
- it would be useful to have a progress report at a future meeting;
- information was sought on the impact of vacancies on neighbourhood teams;
- the importance of communication amongst staff, even where neighbourhood team arrangements were not in place, was emphasised;
- it would be interesting to see how the model worked in rural areas and how providers were engaging; and
- the model was reinventing neighbourhoods in urban areas.

In response to questions, it was explained that:-

- neighbourhood teams were more efficient in a number ways as they reduced the need for staff to travel etc. It had also been found that sickness absence reduced in smaller teams; and
- other areas, such as Dingwall and Invergordon, would be examined once the Inverness teams had bedded in. The same model would not work everywhere in Highland but it was possible to take the principles and adapt them based on what was required locally.

Thereafter, the Sub-Committee:-

i. **NOTED** the update;
ii. **AGREED** that a map of neighbourhood team areas be provided to Members of the Sub-Committee;
iii. **AGREED** that a progress report on neighbourhood teams be presented to a future meeting of the Sub-Committee.

9. Future Briefings for Members

The Sub-Committee was asked to consider what development items it wished to see brought forward in the future.

Information having been sought on the progress of transitions, it was confirmed that a report would be presented to the People Committee and the HHSCC.

The Chair suggested that Members contact her if there were any other topics they would like briefings on.

The Director of Adult Social Care reinforced that Members should feel free to contact officers if they had any areas of concern, and she undertook to circulate contact details. Issues could often be resolved quickly, which benefited both the Council and NHS Highland, and might help someone in the community.

The Sub-Committee **NOTED** the position and that key officers' contact details would be circulated.

The meeting concluded at 12.50 pm.