Leicester
City Council

Minutes of the Meeting of the
ADULT SOCIAL CARE SCRUTINY COMMISSION

Held: THURSDAY, 18 AUGUST 2022 at 5:30 pm

P R E S E N T:

Councillor Joshi (Chair)
Councillor Pandya (Vice Chair)

Councillor Batool
Councillor Kaur Saini
Councillor March
Councillor Singh Johal

In Attendance

Councillor Russell	Deputy City Mayor, Social Care and Anti-Poverty
Councillor Pantling	Chair, Health and Wellbeing Scrutiny Commission
Councillor O'Donnell	Vice-Chair, Health and Wellbeing Scrutiny Commission

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1. APOLOGIES FOR ABSENCE

Introductions were led by the Chair.

Councillors Pantling and O'Donnell as the items on the agenda were of interest to them as Chair and Vice-Chair of Health and Wellbeing Scrutiny Commission respectively.

Apologies were received from Councillor Rita Patel.

2. DECLARATIONS OF INTEREST

Members of the Commission were asked to declare any interests they may have in the business on the agenda.

Councillor Joshi declared an Other Disclosable Interest in that his wife worked for the Reablement Team at Leicester City Council.

In accordance with the Council's Code of Conduct neither interest was considered so significant that it was likely to prejudice the Councillor's judgement of the public interest and therefore neither Councillor was required

to withdraw from the meeting during consideration of any items on the agenda.

3. MINUTES OF THE PREVIOUS MEETING

Matters Arising

Minute Item 85. Carers Strategy Consultation Report

The Chair informed the meeting that, following a full discussion and comments from Adult Social Care (ASC) Members on the report item, he had raised the concerns and recommendations at Overview Select Committee (OSC) on 30 June 2022, in light of which the OSC had recommended the item be included on the OSC work programme regarding the corporate consultation / public engagement processes.

Extra Care Development Scheme

With the requirement for a link member for the project, Councillor Joshi had put himself forward as the Chair. Officers were invited to contact him for further details, and he would keep ASC Commission Members informed of progress. Also, in relation to the Extra Care Development Scheme, the lead officers encouraged Members of the Commission to visit sites across the city and dates could be arranged. The visits were still pending and would be arranged in the near future.

Diary Date

Members were informed that the Chair, and Councillor Pantling as Chair of Health and Wellbeing Scrutiny Commission had agreed to hold a couple of joint scrutiny meetings for the municipal year 2022/23. The Chair said it was a positive step as they were increasingly aware that many topics discussed were of common interest to both Commissions. The first joint meeting was planned to tale place on 6th October 2022, the papers for which would be circulated to Members nearer to the date.

AGREED:

That the minutes of the meeting of the Adult Social Care Scrutiny Commission held on 16 June 2022 be confirmed as a correct record.

4. PETITIONS

The Monitoring Officer reported that no petitions had been received.

5. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

The Monitoring Officer reported that no questions, representations and statements of case had been submitted in accordance with the Council's procedures.

6. HEALTHWATCH LEICESTER AND LEICESTERSHIRE ANNUAL REPORT

HealthWatch Leicester and Leicestershire submitted its Annual Report for 2021-22, which provided a summary of the activity it had undertaken as a

jointly commissioned contract. Members of the Commission were recommended to note the report and pass any comments to the representatives from HealthWatch Leicester and Leicestershire.

The Chair reminded Members that Healthwatch was a standing invitee to the Commission, and on Health and Wellbeing Scrutiny Commission. The Chair also made reference to the video that had been circulated to Members by Healthwatch of the highlights of the report.

Harsha Kotecha (Chair of Healthwatch) and Gemma Barrow (Chief Officer) were present. Mr Joe Johal from Healthwatch was also welcomed to the meeting, who would regularly attend future meetings of ASC. During the presentation of the item, highlighted from the report was:

- 10 reports were published about improvements people wanted to see in their health care service.
- As part of a summer tour, Healthwatch attended 36 events in the city and county and engaged directly with over 2,400 people.
- During that time a survey was conducted, and 350 people told Healthwatch about their challenges in accessing their GP practice, which was an issue high on the Healthwatch agenda.
- During the first lockdown, volunteers reviewed GP practice websites to see how informative an accessible they were for local people. Findings were placed in a report and shared with the Clinical Commissioning Groups at the time, and consolidated into research following which an action plan was put together to look at service improvements.
- Health and care settings could not be visited during the pandemic. The Enter and View programme of GP practices was resumed as soon as HWLL were able to go into health settings, such as care homes, hospices etc.
- HWLL utilised the text messaging service to reach more people within those practices to limit presence on site. One example was Latham House Medical Practice in Melton where over 1,000 responses were received to the patient survey, with the report being well received by the practice team, with the recommendations for improvements welcomed.
- During the past year, HWLL had attended 14 carers groups, hearing from 123 carers and 14 members of staff and volunteers. Carers issues and rights would remain high on the HWLL agenda, with social media being used to raise awareness and invite people to share experiences.
- Also launched were monthly themed focus groups called ‘Let’s Talk’ to discuss with people changes to the health and care landscape during the Covid pandemic.
- Dentistry is a topic high on the agenda, with findings placed in a report and shared with the BBC, after receiving many calls from people having trouble accessing a dentist, and with evidence shared with Healthwatch England.
- A big project during 2021 was around male suicide, with contact made with agencies involved with suicide prevention in the city and county to identify gaps in service provision. The Have a Conversation campaign focussed on getting men to talk, and work was undertaken with Equality Action, a local

charity to enable young men to produce a rap song that related to male suicide and mental health.
- Healthwatch had looked at post hospital discharge for the homeless, and what services were available across the city.
- Healthwatch were open to requests on what Members would like Healthwatch to work on during 2022/23.

Members were given the opportunity to ask questions and the following information was provided:

- It was asked if many Asian males had come forward during the work around male suicide. It was reported that the groups that engaged with were mixed groups but predominantly white males. However, during the project work on the rap song with Equality Action, it was mostly produced by young men of Asian or Black ethnicity. The aim was to get more people to talk about mental health, and it was an opportunity to get other communities talking about mental health in general.
- It was asked of future reports could split down engagement information between the City and County, as it was not clear from the report who had been engaged with and where.
- Healthwatch were asked if they were looking at any impact that had been seen and following outcomes to be achieved for the people in Leicester and Leicestershire following the report. It was noted Healthwatch had noted impacts and for some work did go back six months to a year later, particularly with GPs, to see if recommendations had been implemented and what changes had been made as it helped people at a local level. As could be seen int eh report, along with recommendations, specific actions were being included, and who should undertake the changes.
- Usually it could take around a year to work on a project, such as the male suicide project, and Healthwatch would continue to visit mental health groups to see if an impact was being made, for example, do more people visit the websites, or had there been a change in people going to Equality Action to talk to them. There had been difficulty in accessing services during the pandemic, but it was the intention of Healthwatch to continue to improve services.
- It was recognised that, with regards to dentistry, what was reported on the BBC and seen nationally had all come from Healthwatch. There were reports more people were gaining appointments, highlighting the changes in the service, and Healthwatch would continue to push for change in all areas.
- Dependent on the project, a review could take place from six months to one year, with each project having a different scale. Reports were also taken back to the CCG. For example, with GP access it was known to be a problem and Healthwatch gained evidence was being used to make changes, with evidence being used to put together a plan of action to do things differently. It was stated that some changes took time, and success came when they no longer heard patients talking about the same issues faced time and time again.
- Other changes would be seen over years. An example given was that a report was first taken to Leicester Partnership Trust on discharge lounges at

hospitals three years previously. Work was undertaken, and a follow-up desktop review was undertaken to ask if actions had been implemented. Projects were kept on an action log, and follow-up report written to close them off.

- Ethnicity break down would be included in future reports.
- It was known that many dementia services had stood down over the pandemic and had not stood back up. A project had commenced to see what worked / did not work, to see if the diagnostics in particular worked for the city of Leicester, where some of the questions being asked as part of the dementia screening did not always fit with the ethnic population.
- Members were interested in the future plan to look into dementia services in Leicester, which would feed into the work of the Commission. It was noted the Chair would feen into that work and liaise to see if there were other areas of cross over.
- Healthwatch also wanted to look at accessing communication. Not everyone had access to health and social care during the pandemic in the same way, so the experiences of different groups felt during and after the pandemic would be gained, for example, the deaf community not being able to ring up for information during the pandemic.
- The current provision of maternity services would also be explored, along with Healthwatch Partnership in Rutland, specifically looking for Leicester and Leicestershire in terms of inception through to birth, as some populations did not access services until much later in the pregnancy the reasons for which would be investigated. Proposals would be worked on for commencement in September 2022.
- The Enter and View programme would restart and would include the experiences of care home residents and visitors, and also experiences of visiting the Emergency Department and urgent care pathways.

The Chair raised the issue of accessing appointment at GP surgeries. It was noted that not all GPs had a similar system but varied between practices, with some practices only allowing people to ring at a certain time, often during work hours, which prevented people such as those in full time work unable to contact GPs during the times the practice proposed. Healthwatch confirmed that the appointment access issue was an ongoing conversation with the Integrated Care Board. Healthwatch would be bringing a report back to a future meeting of the Commission which would hopefully be reporting on positive changes.

Further concern was raised that almost all dentists in the UK were not taking future NHS patients, and it was asked if Healthwatch could all address the issue. Healthwatch had raised the issue locally and nationally and would continue to raise with NHS England. Councillor Pantling, Chair of Health and Wellbeing Scrutiny Commission informed the meeting that the Commission had added GP practices to the Commission's work programme for the joint meeting between the Adult Social Care and Health and Wellbeing Scrutiny Commissions scheduled for January 2023, as the Commission felt it was important to get information and to see if changes were working to the benefit of patients, or not.

Healthwatch confirmed that project proposals were firmed up following

conversations with the Strategic Director, Social Care and Education, and Director of Public Health about issues they were dealing with. Members of the public were also invited to contact with issues they were concerned about, through three online events and social media. The same exercise would be undertaken in January 2023 to identify other issues.

The Chair further noted that people often experienced difficulties with phone conversations with receptionists and admin staff at GP practices, for example, language barriers, GP staff asking lots of questions, that could off the patient seeking to speak to a doctor or could be diverted to call 111. He said the process of making an appointment needed to be much easier and more accessible.

The Chair thanked Healthwatch representatives for the report and acknowledged that Healthwatch had gone from strength to strength and looked forward to a healthy partnership between the Commission and Healthwatch.

AGREED:

That:

1. The Annual Report be noted.
2. Members' comments and observations to be taken into account by Healthwatch.
3. The Commission be kept updated on the work of Healthwatch and future projects and consultations planned in Leicester.
4. At the next meeting or when possible to provide Leicester specific data on engagement figures.
5. Ethnicity breakdown to be included in future reports.
6. The Chair take part in dementia and access to services, groups and deaf community, when pertinent to the Commission to keep in touch.

7. HEALTH AND CARE REFORMS

The Strategic Director for Social Care and Education submitted a report on the Health and Care reforms. Members of the Adult Social Care Scrutiny Commission were recommended to note the report and pass any comments to the Strategic Director for Social Care and Education.

Councillor Russell, Deputy City Mayor for Social Care and Anti-Poverty, introduced the report. She highlighted the raft of expectancies of local authorities by government and that they were placing huge additional administrative burdens, where the preparation for inspections was huge, against a backdrop across the country of struggling capacity and funding. Additionally, it was not known if the new prime minister would retain the National Insurance precept, therefore a lot of work was having to be done at risk.

The Deputy City Mayor wanted people to be aware of the scale of work that was being accepted and what that meant for team who were doing an incredible job. She was also grateful for the work that the Strategic Director for

Social Care and Education was undertaking nationally with ADASS to help understand what the national picture was to ensure the Council did not fall down pitfalls that other authorities had.

Martin Samuels, Strategic Director for Social Care and Education informed the meeting that the health and social care system was going through the biggest period of change in a decade. The Health and Social Care Act 2012 was being replaced, and a number of Care Act 2014 elements that had not yet been implemented were now supposed to be being implemented, sometimes in amended form. There was a raft of White Papers, legislation, guidance and reports, the links for which were included in the report.

The Strategic Director for Social Care and Education noted that Clinical Commissioning Groups (CCGs) had ceased to exist at the end of June 2022 and had been replaced with Integrated Care Boards (ICBs) which in Leicester, Leicestershire and Rutland (LLR) would operate on the same footprint as the combined CCGs had been working at for the past few years, therefore there were no particular differences, which was fortunate compared to other parts of the country where some ICBs' footprint bears little relationship to local authority footprints, and some authorities were split between two ICBs, or there was just the one ICB for a very large area, such as Greater Manchester.

Members were informed that all ICBs were now required to have a level of representation from the local authorities in their area. The Strategic Director for Social Care and Education was now the city council's official representative on the ICB for LLR. In addition, the Assistant City Mayor for Health, as the Chair of the Health and Wellbeing Board, had been invited to attend the ICB meetings. Unlike the position with CCGs, the NHS trusts were also members of the ICB Board which was a deliberate change from the previous structure. This change was an important one, as it eliminated the Commissioner / Provider split which has operated in the NHS over the past 30 years. There was also increased talk of 'collaboratives', as partnerships between providers.

Members were notified of the newly created Integrated Care Partnership (ICP), which was the informal grouping of care organisations. The Integrated Care Board (ICB) was the NHS organisation, the Integrated Care System (ICS) was the informal grouping of health and care organisation in the area of the ICB, and the Integrated Care Partnership (ICP) was like a health and wellbeing board for the larger footprint.

The authority had been very clear locally that there was no hierarchical relationship between the LLR ICP and the local authority footprint of the health and wellbeing board, and the legislation was generally mirrored, so a health and wellbeing board was required by statute to have regard to the health and wellbeing strategy of the ICP and vice versa.

The government had assigned £5.4billion over the next three years to pay for the changes to be made. It was meant to be funded by the health and care levy, the national insurance change which was intended to raise £36billion over the next three years. One issue was that the levy might be cancelled by the

incoming prime minister, so there were questions on where the money would come from to pay for the reforms. The vast majority of funding would in any case go to the NHS, so there were also issues for the NHS if the levy was removed.

It was stated that of the £5.4 billion not a single penny would buy additional care, provide additional services or provide increased salaries of care workers. The large majority of it would go to shift the burden of paying for care from those that paid for their own care, to the taxpayer. ADASS supported that as a principle that it was appropriate for the taxpayer to meet these costs rather than the individuals – this was of course the model long established for the NHS.

The bulk of the money would go to the payment burden which was due to start from October 2023. It was reported that a lot of comment had been made about the introduction of care accounts, whereby no one should have to pay more than £86,000 over the lifetime of their care, with Members being asked to note it was an indexed sum, with the figure rising in 2023 due to inflation. It was also noted that most people did not stay in the care system long enough to ever reach the cap level because it had been set so high and was nearly double (in real terms) what had been recommended in the Dilnot Review prior to the Care Act 2014.

The biggest impact for individuals was the significant changes to charging arrangements. Currently if someone had over £23,250 in assets, they would have to pay the full cost of their care. From April 2023, the threshold would be raised significantly to £100,000. People would still be asked to pay a contribution for their cost of care, but it would be a lower amount, and they would therefore move towards the cap at a slower pace.

Another important change was the commencement of Section 18(3) of the Care Act for new customers only in October 2023, which would allow people to ask the Local Authority to contract for their care even if they were paying for it themselves. It was widely recognised that self-funders typically paid 40% more than carers funded by Councils.

Recognising the differential in fee rates, every council in the country had been required by the Department for Health and Social Care (DHSC) to undertake a ‘Fair Cost of Care’ exercise, which the council was in the midst of. Care providers had been asked to provide significant detail about the actual cost of delivering care. The care exercise was intended to show the actual cost for providers within each local authority area to provide care and would make it possible to compare the actual cost with fee rates that local authorities pay. If it was found that the rates that local authorities paid were significantly lower than the actual cost (as was believed generally the case), there was an expectation by DHSC that the authority would move towards eliminating the gap and would pay actual cost. DHSC had put some funding aside for that eventuality, though the actual amount was expected to be double what DHSC had put aside. Figures would be received in a few weeks, and every authority in the country was required to provide a market sustainability plan, which among other things, would set out the rate at which the authority would close that gap. A draft of the

Plan was required on the 14th October 2023, and it was suggested that the Plan would be submitted to the Commission as soon as possible after submission, with the Final Plan required by February 2023.

The Strategic Director then went on to inform the Commission that the Government, having deliberately stopped external inspection of Adult Social Care in 2010, was now reintroducing this from April 2023. It was formally entitled 'Assurance' by the Care Quality Commission (CQC), with a range of aspects currently being developed. It was believed it would be much the same as the Ofsted process of inspection for Children's Social Care, with the expectation that the Strategic Director and Adult Social Care Department would spend 5-10% of their total time on the assurance inspection, if the Department did well, but a lot more if not.

There was £1.7billion over three years (approximately £500million a year) allocated to:

- New models of supported housing
- New work in terms of assisted technology
- Training for workforce
- Information advice and guidance
- New models of care

The Strategic Director informed the meeting that DHSC had been insistent that it was not a programme of reform, so there was no programme management being undertaken by the department, and a series of changes but no overview or oversight of how it fitted together. A draft timetable produced by ADASS was included in the report.

The Strategic Director continued that it was worth noting that, for example, with the Fair Cost of Care work being undertaken, it was about how much it cost now to provide the level of care, but there was no allowance for, for example, should the quality of care need to be better, or should the pay rates for staff that are offered be more than the national minimum wage. A significant programme management approach had been set up with the local authority, as outlined in Appendix 1 to the report. It was recognised there was a huge amount of work involved alongside other reforms being processed, such as the replacement of deprivation of liberty safeguards and in relation to prevention, all of which was taking place at a time where there was a national crisis of staffing, both external carers and internal staffing posts, a number of which were funded in the budget but could not be recruited to. Members were also asked to note that it was not known currently if the programme of reform will survive with a change in administration nationally, so there was a fair degree of uncertainty about the funding.

The Chair welcomed the report, but the issues that the department faced were complex with the future funding of Adult Social Care as a whole in the balance being uncertain. The Chair asked that with the measures being so complicated, how would the people accessing the services be informed of the changes in a way they could understand. Ruth Lake, Director of Adult Social Care and Safeguarding, informed the meeting that she was overseeing the workstreams

with regards to reforms in charging, which would require careful communication due to the impact it would have on people. She added the department was working with the Communications Team to plan for public facing communications, as well as communication with the staff group and external workforce. It was noted there would be national communications regarding the charging reforms, as well as other elements of the reform programme. What wasn't wanted was sending messages too early, too late, or too complicated, or without sufficient detail. Officers were working on a Stakeholder Plan and were working with communications to draft up key messages, but it would be unhelpful at the point to send out information to the public, given the level of uncertainty. Being scoped was the volume of people that might fall into the charging reform changes, but there was an element that would not be identified as they were paying for their own care and hence not known to the department. Initially simple messages would have a broad reach across the city, which would provide more detail moving forward.

It was requested that the next meeting of the Commission have agenda items on the market sustainability plan, and fair cost of care and charging reforms coming in.

In response to members' questions, the following responses were made:

- With regards to assurance, concern was raised about how it would be weighted against places like Leicester with areas of high need, high deprivation and relatively low budgets and what the implications might be for local authorities failing inspections, and what the process around that might be, as there was worry it would create space in the market for others to move in. The Strategic Director stated that the view in ADASS was that just about every single council in the country could expect to come out of inspection as 'requires improvement', which was in part based on a survey of waiting lists of authorities, with lists of people waiting for assessment or reviews and was increasing nationally by 600 people a day, with several hundred thousand people nationally, which was driven by lack of workforce. It was not known how the system would end up being shaped until the first assurance visits commenced, but it would be challenging for the department. The Deputy City Mayor stated that she was confident that the authority had fantastic practitioners, that when working with families and looking at their personal requirements the authority would come out well. She continued that she had no confidence that the DHSC had thought to talk to the DfE about how the process worked to replicate on the adults' side. She added she was also worried that weighting would be influenced by the administration was different to the city.
- There was a general welcome to the shift to more collaborative working. It was asked as to what extent would budgets combine. Members were informed that one of the statutory accountabilities of the Integrated Care Partnership would be to promote integration, for which the Health and Wellbeing Board had had responsibility for the last decade. The Better Care Fund would be retained on the local authority footprint, not on an ICS footprint, and it was felt that more money would be put through that. The Strategic Director added there were quite strong moves within the NHS for

funding to be delegated straight to providers. There was also a lot of talk of collaboratives agreeing how to spend money, but currently there was a degree of confusion in the NHS as to whether they were formal bodies or just informal partnerships. It was added there were no new powers or legislation to agree funding spend. The 2012 reforms of the NHS were fundamentally based on a market approach, and the reformed were based on a collaborative approach, so in that sense there were fewer things now being put out to tender. However, changes to procurement law more generally were taking away some of the powers on restricted competition in some areas, including Social Care.

- The Strategic Director said he was incredibly fortunate to have an exceptional team and was very proud to work for Leicester.
- Members' understanding was that as a collaborative board it would be best placed to decide who the funding should go to. It was best explained that the NHS was effectively getting rid of the internal market. The ICB as the replacement for the CCG will transfer funds to providers for them to use as deemed appropriate, and the elimination of formal procurement processes between different NHS bodies to allow smooth flow of funding within the NHS.
- There was an encouragement for partnerships whereby all of the players in the system agreed a consensus on the direction of travel over what needed to be done. The national NHS view was that they would like and expect those partnerships to become formalised so there was pooling of budget between the NHS and local government, and there was single decision making about the use of that budget. There had been a tendency in the past for where pooled budgets were in place they are then managed by the NHS, to the detriment of social care definitions and models. The Deputy City Mayor also added that NHS colleagues also found it challenging that there was a democratic decision-making structure as well as officer decision making structure in the local government
- It was noted with regard to charging for social care that there was a huge difference between the new Upper Capital Limit and Lower Capital Limit, and how would it impact on people's lives. The Director of Adult Social Care and Safeguarding explained that it was very much work in progress and the charging policy would have to be rewritten with finance colleagues. She added that contributions would be tapered as there was a complicated formula that sat behind charging to work out a sliding scale for people. The Strategic Director said it was a much more complicated arrangement but the key thing to note was that people would pay less, with the assumption that everyone who currently paid for their care would want that to count towards the care cap, and therefore people who currently wouldn't be being assessed by Social Services because they knew they would have to pay for care themselves would want to be assessed, and would result in an increase in the workload through increased assessments and financial assessment workload. It was noted the authority could not recruit the number of staff to undertake current work, so would be an added pressure on staff.
- On average in county councils about half the population were self-funders and could imply a significant increase in staffing demand with additional impact on the authority as staff were lured to other posts.

- The meeting was informed there were currently too many unknowns for the authority to calculate the additional contributions to extra care. A major consultancy organisation called Newton Europe had undertaken some work for the County Council and had estimated costs for each of the members of the County Councils Network. The authority was also working on the assumption that the closing of the gap between current fee rates and fair cost for care was a new burden and should be funded by the Government, and would be put to the Executive as a recommendation to close the gap at the rate of funding received from the DHSC which was currently consulting on the formula which it would use.

The Chair noted that the Adult Social Care service was going through difficult, uncertain times, as were other authorities up and down the country. He added it was reassuring to have a good Strategic Director and staff who worked tremendously hard.

AGREED:

That:

1. The report be noted.
2. Members noted the wide range of policy reforms aimed at transforming health, care and wellbeing, in particular improving health and care services through better health and care integration and tackling growing health inequalities.
3. Members noted the Department's programme of change to manage the implementation of the reforms and agreed to receive future updates and progress reports.
4. That information on the market sustainability plan and fair cost of care be brought to the next meeting of the Commission.
5. That information on charging reforms be brought to a future meeting of the Commission.

8. WORK PROGRAMME

Members noted the work programme for the Commission.

Suggested items for the work programme were:

- Joint Working with Health and Wellbeing Scrutiny Commission – the Commission will be conducting a couple of Joint meetings with Health for topics of common interest.
- Ongoing review into the Cost of Care topic.
- Suggested was the impact on the rise of cost of living on the various services offered within adult social care, with significant concerns in older persons homes in the city, with rising energy cost increases potentially leading to huge instability in the service.

It was agreed to postpone the date of the next Adult Social Care Scrutiny Commission meeting scheduled for 13 October 2022 to move to 27 October 2022 in order for the Market Sustainability Report to be available for the meeting.

Councillor Singh Johal gave apologies for the meeting on 27 October 2022.

9. ANY OTHER URGENT BUSINESS

There being no other items of urgent business the meeting closed at 7.33pm.