Leicester
City Council

Minutes of the Meeting of the
ADULT SOCIAL CARE SCRUTINY COMMISSION

Held: TUESDAY, 12 DECEMBER 2017 at 5:30 pm

P R E S E N T :

Councillor Cleaver (Vice-Chair in the Chair)

Councillor Dr Chowdhury
Councillor Thalukdar
Councillor Pantling

In Attendance:
Councillor Dempster, Assistant City Mayor - Adult Social Care and Wellbeing

Also Present:
Councillor Unsworth

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43. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Chaplin and from Karen Chauhan, Chair of Healthwatch.

44. DECLARATIONS OF INTEREST

No declarations of interest were made.

45. MINUTES OF THE PREVIOUS MEETING

AGREED:

That the minutes of the meeting of the Adult Social Care Scrutiny Commission be confirmed as a correct record.

46. PROGRESS ON ACTIONS AGREED AT THE PREVIOUS MEETING

Further to minute 37, "Adult Social Care Integrated Performance Report 2017/18 Quarter 1", the Chair reminded Members of the concerns that had been raised that funding from the Better Care Fund (BCF) could be reduced if the Council failed to achieve a stretched target relating to Delayed Transfers of Care (DTOC). She invited the Strategic Director for Adult Social Care and Health to update the Commission on this.

The Director reported that, having agreed a NHS England compliant trajectory for DTOCs in the BCF plan, the potential threat of the health transfers monies (around £10m) had been removed and that the Council had been advised that its performance had been good enough for its funding from the Better Care Fund to be maintained in 2018/19.

On behalf of the Commission, the Chair asked the Director to thank all staff involved for the hard work that had been done to secure this position.

47. PETITIONS

The Monitoring Officer reported that no petitions had been received.

48. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

The Monitoring Officer reported that no questions, representations or statements of case had been received.

49. THANKS FOR CARE PROVIDED DURING RECENT BAD WEATHER

Councillor Dempster, Assistant City Mayor – Adult Social Care and Wellbeing, thanked all staff for continuing to deliver care to vulnerable people in the city despite the recent bad weather conditions. Some of these members of staff had had very early starts to their work, when weather conditions were very poor, but the service had not been interrupted significantly.

This thanks was endorsed by the Chair on behalf of the Commission, as she had not been aware of any complaints or problems arising during this difficult time.

The Strategic Director of Adult Social Care and Health reminded the Commission that some of these members of staff were employed by the Council, but many were contracted by independent care providers, so he would share these comments with those external providers and contractors.

50. LEICESTER SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2016/17

Jane Geraghty, the Independent Chair of the Leicester Safeguarding Adults Board (LSAB) submitted the Board's Annual Report 2016/17 and Strategic Plan 2017 – 2020.

Attention was drawn to the following points:

- The LSAB had received a peer review since its last annual report;

- In contrast to the situation two years ago, the LSAB's sub-groups now were all chaired by members of the Board;

- It was recognised nationally that this was an area where it was difficult to collect meaningful data. However, in Leicester a very good data set had been established;

- The LSAB was generally in compliance with the duties within the Care Act, but was not complacent;

- In over 75% of instances where risk was identified, that risk either was removed or reduced. 100% would not be achievable, as adults with capacity had the right to decide whether to change a risky situation;

- Feedback showed that 89% of people achieved the outcomes that they wanted. In cases where this was not achieved, it could be for a number of reasons, including some over which the LSAB had no control. For example, people could want someone prosecuted, but the Crown Prosecution Service could decide that this would not be done; and

- The Performance, Effectiveness and Quality subgroup also had considered this, in the context of a Making Safeguarding Personal multi-agency audit across Leicester, Leicestershire and Rutland. Recommendations from this included what to do when it was not possible to achieve the outcomes desired by the person. In recent activity, approximately 70 cases were investigated and the person's desired outcomes had not been achieved in four of them. In two of these cases this was because prosecutions had been wanted by the people concerned and in two the people had disengaged from the process.

Ms Geraghty confirmed that there was very good attendance at Board meetings and partner engagement was reviewed every year, with assurances from partners that people would be safeguarded from harm being challenged. Good work was being done by the partners, with a multi-agency audit on making safeguarding personal having received national recognition. It was recognised that this was a journey, but all participants were aware of their responsibilities and they were pushed, challenged and praised where needed.

Members enquired what the extent of problems were due to issues identified in the partner statement by Leicestershire Police. In reply, officers advised that they had not been a significant feature of formal safeguarding enquiries. Many were emerging issues and their inter-relationship was not always straightforward. For example, someone could need to be kept safe, but not as a safeguarding issue. The Care Act was very specific about who safeguarding applied to, so a lot of individuals were not included in the definition. It was hoped that, through training, staff would understand what incidents needed to

be reported and to whom.

Ms Geraghty explained that partner agencies were expected to do their own awareness raising and training. However, they recently had been asked to tell the Board of perceived gaps in training and some training had been provided to bridge these. One example of this was a recent two-day course in relation to vulnerable adults who made risky choices, such as remaining in a situation when offers to remove them had been made. Awareness raising included improving awareness of matters that mainly related to issues in some minority communities.

To ensure that service users could be heard directly by the Board, an engagement group had been established and was gaining momentum. Some members of that group were service users and other were engagement officers from key partners. Challenges set by the group had included providing information in plain English for anyone entering the system, (to help them to know what to expect), and simplifying the previously complex names of the Board's sub-groups to one-word names. The LSAB continued to try to find ways to talk to service users and carers, but this could be difficult, as not all users wanted to discuss their experiences and the Board had limited resources. It was working closely with Healthwatch on this, with Healthwatch holding focus groups to help identify ways forward.

With regard to knowledge gaps, the priorities set out in the LSAB Annual Report related to individual learning by individual agencies. Where gaps in knowledge were identified that affected a larger number of agencies, written guidelines could be produced, or seminars held. Consideration also needed to be given to how the findings of serious case reviews would be disseminated.

It was noted that there had been an increase in the number of referrals from partners. The Board welcomed the awareness that this showed, but the number of cases that could be dealt with by single agencies also had increased. Standardised thresholds for referrals therefore would be examined by the LSAB, as it was recognised that different agencies could have different thresholds.

It was questioned whether front-line staff had the right training to make judgements about whether a case should be referred and whether information could be shared between agencies without breaching client confidentiality. The Strategic Director for Adult Social Care and Health assured Members that all partner organisations tried to work together as one system. However, they did not share the same databases and there were data sensitivities that could lead to access to a partner's database being restricted. This could make it difficult to respond to a particular situation.

The Commission also suggested that the Council could make it clearer what action it could take in relation to safeguarding. Many people did not understand the concept of "pathways" of care, so it would be useful if clear steps could be described.

It was noted that a backlog of DoLS assessments remained, but this situation was not unusual across the country. Additional staff would be required to clear the backlog, but they currently were not available and the Council did not have the resources to employ them. As this meant that the Council was unable to fully meet its obligation to undertake DoLS assessments, it placed the Council at risk of being taken to court. However, as no-one in England had yet undertaken such a prosecution, the actual level of risk was unclear.

In considering the role of the Principal Social Worker, it was noted that this was a key lead practitioner role, supporting, encouraging and sharing good practice. The post-holder also supported the development of multi-agency training and provided an interface between care providers. In addition, they spent time with social worker teams and provided support through reflective practice discussions. Moving forward, it was expected that the Principal Social Worker would continue to work closely with all partners, including those at county and regional level, and would have a direct role in supporting the LSAB.

The Commission also discussed the development of the LSAB's Strategic Plan. Ms Geraghty noted that, although the Board was very clear what its priorities were, the Plan would provide a framework for them. As the Plan was developing, the Board was considering whether any of its priorities could be addressed through cross-boundary working.

Ms Geraghty also confirmed that a priority for the Board was to find ways to help improve awareness of what could constitute "risky" behaviour in another person and provide clear information on resources, such as specific services, that were available to help in such situations.

AGREED:

1) That the Leicester Safeguarding Adults Board's Annual Report 2016/17 and Strategic Plan 2017 – 2020 be welcomed;

2) That the Independent Chair of the Leicester Safeguarding Adults Board be thanked for attending this meeting and asked to convey the Commission's thanks to all involved for their contributions to the Board's work; and

3) That the Leicester Safeguarding Adults Board be asked to consider how awareness can be raised of what can constitute "risky" behaviour in another person and how to ensure that clear information on services that are available to help in such situations is provided.

51. ADULT SOCIAL CARE STATUTORY / CORPORATE COMPLAINTS AND COMMENDATIONS ANNUAL REPORT 2016/17.

The Director for Adult Social Care and Safeguarding submitted a report detailing information about statutory and corporate complaints and commendations received by Adult Social Care (ASC) services during 2016/17. In introducing the report, the Director reminded Members that the Council was

required to publish an annual report on statutory and corporate complaints received.

It was noted that the number of complaints and commendations received about ASC services during 2016/17 had increased and there was a slight increase in the number of complaints upheld. The number of complaints referred to the Local Government Ombudsman had fallen slightly. Overall, complaints were now dealt with more swiftly than previously.

The Director stressed that complaints were not unwelcome, as they provided valuable feedback on services, and the outcomes were shared with management teams and front-line teams. The number of complaints received varied from year to year, but were a very small proportion of interactions made with ASC services.

The Commission noted that there could be conflict between what the law allowed the Council to do, what the Council felt it should do, and what members of the public felt the Council should do. When this conflict could not be resolved, people could complain to the Local Government Ombudsman. Those complaints often resulted from people having too high expectations of what the Council could offer, or wanting the Council to respond to something that had to be defined as a "want", rather than a "need".

Some common themes could be identified in complaints made and those for 2016/17 were set out in the report. These themes were used to learn from. For example, work was being done with teams to ensure that decisions were fully evidenced, to enable full responses to be made to people unhappy with the outcomes of assessments. As a result of this work, the number of complaints being upheld was reducing overall.

As the Council worked with various partners, complaints sometimes were received that encompassed ASC services and services provided by partner agencies. As the Council could only investigate its own services, multi-agency complaints were processed through a jointly agreed local protocol.

It was recognised that it was important to use compliments positively. They were received by ASC in various ways and were gathered as effectively as possible. For example, when a formal compliment was received, the Strategic Director for Adult Social Care and Health sent a commendation letter to the member of staff concerned. It was hoped that Team Leaders passed on verbal compliments. Reflective supervision also could be an important way of acknowledging things that had gone well, as it was important for staff to be confident in their own skills and to acknowledge them. A staff survey was planned, which would provide useful information on how supported staff felt.

Members suggested that officers should be more proactive in publicising their successes. Councillor Dempster, Assistant City Mayor – Adult Social Care and Wellbeing, endorsed this, suggesting that activities such as a 24 hour Twitter feed could be considered. She reminded Members that a significant proportion of the Council's budget was for ASC, so it was very important to let people

know what services were being provided and to recognise the work being undertaken by ASC staff.

AGREED:

1) That the report be noted;

2) That the Strategic Director for Adult Social Care and Health be asked to pass the thanks of the Commission to all Adult Social Care staff for the work they do and to let them know how highly the Commission values this work;

3) That the suggested 24 hour Twitter feed be endorsed as a positive way of promoting the work being done by Adult Social Care staff; and

4) That, further to 3) above, the Strategic Director for Adult Social Care and Health be asked to work with Adult Social Care staff and the Scrutiny Policy Officer to identify ways in which staff can be shown they are valued and to report back to the Commission on this.

52. ADJOURNMENT OF MEETING

The meeting adjourned at 7.18 pm and reconvened at 7.24 pm

53. ASC INTEGRATED PERFORMANCE REPORT 2017/18 QUARTER 2

The Strategic Director for Adult Social Care and Health submitted a report bringing together information on various aspects of Adult Social Care (ASC) performance in the second quarter (first six months) of 2017/18.

The Strategic Director drew attention to the forecast budget underspend, stressing that this was a one-off situation and did not imply that pressures on the budget had been removed. On current growth demand, an increase of around £5million per year for care packages was the likely projection for the period to 2019/20.

The Business Improvement Manager (Adult Social Care and Safeguarding) noted that:

- Overall, ASC performance was improving year on year. Despite this, some areas of concern remained, which were highlighted in the report;
- Measures for the six priorities identified in the report had been devised;
- This was the first time since these performance reports had been introduced that both long and short term sickness levels had fallen;
- Expenditure on agency and sessional workers was lower than in the corresponding period in 2016/17;

- The Council's national rankings in 15 measures had improved. This was particularly welcome given the challenges faced by ASC services; and

- ASC was very interested to understand service users' experiences, both positive and negative. Various surveys were being used to help with this.

The Commission welcomed the improvement in sickness rates and stressed the importance of maintaining good staff morale in continuing this improvement.

Members queried how staff cuts were balanced against the reduction in agency workers and whether this was sustainable. Officers agreed that it was preferable to have staff employed in substantive posts, but compromises had to be made between what it was felt was the right way forward and what it was possible to do in particular staffing groups regarding recruitment challenges. Changes in ways of working also were being undertaken to reduce the workload on remaining staff. For example, increased use was being made of processes such as telephone reviews, and it was expected that the need to consider such compromises would increase.

It was noted that the number of permanent admissions to residential care for 18 – 64 year olds and those over 65 were higher than in the corresponding period in 2016/17. The Director for Adult Social Care and Commissioning explained that work was ongoing in ensuring that younger people had earlier contact with ASC services, so they could make informed choices. In addition, transitions from children's care services were being improved. Proposals for Extra Care also were being examined, although two units would not now be brought in to use within previously anticipated timescales. Work with other organisations also was on-going to identify where support could be given.

Although it could involve difficult decisions, the management of demand (at the 'front door' / access) was improving. This included a significant move towards capping demand, which included pilot work on a strength-based approach, so that responses moved away from ASC automatically providing any support required.

The Commission noted achievements from the period covered in the report. The Director for Adult Social Care and Safeguarding explained that an important benchmark arising from these was the data gathered from new assessment form questions about whether services had met the needs identified in the initial assessment and whether the user's quality of life had improved as a result of their care package.

AGREED:

1) That the report be received and welcomed; and

2) That the Strategic Director for Adult Social Care and Health be asked to pass the thanks of the Commission to all Adult Social Care staff for the quality of the work they do.

54. TRANSFORMING CARE PROGRAMME

The Strategic Director for Adult Social Care and Health submitted a report providing an overview of the Transforming Care Programme (TCP).

The Director for Adult Social Care and Commissioning presented the report, explaining that the TCP was a national programme, monitored by NHS England, which aimed to move people with a learning disability out of specialist hospitals and in to the community. This only applied to people who had been in specialist hospitals for over two years, so there were small numbers, but they usually had very high and/or complex needs. The TCP also placed a requirement on health and social care services to prevent people from being re-admitted wherever possible.

If someone wanted to live in the community or with their own family members, an assessment would be completed to determine what support was required. Due to the complexity of some individual's needs, bespoke training was made available to providers to enable them to provide the required support. The Council funded some of this, but health services also could provide some assistance.

The Strategic Director confirmed that it was not known yet why more Leicester residents were admitted to the specialist hospital ward than residents from the rest of the county and Rutland. The needs of people admitted from Leicester were of the same complexity as those of others admitted. It was not felt that more preventative work was available for residents from areas outside of the city, as those services were jointly commissioned across the city, county and Rutland. The amount spent by the City Council on services for people with learning difficulties was average, so this would not account for the different admission rates either.

The Director for Adult Social Care and Commissioning confirmed that a request had been received from NHS England for offers to discuss the provision of specialist properties in to which people being moved under the TCP could be placed and the allocation of these properties.

AGREED:

> That the Director for Adult Social Care and Commissioning be asked to write to the government expressing the Commission's concern that the Council has a responsibility under the Transforming Care Programme to find appropriate accommodation for people with learning disabilities, but is not being provided with the funding to enable it to do this effectively.

Councillor Dr Chowdhury left the meeting at 7.51 pm, during discussion on this item.

55. PRESENTATION ON THE DEVELOPMENT OF INTEGRATED TEAMS

The Director for Adult Social Care and Safeguarding gave a presentation on the development of integrated models of care. A copy of this presentation is attached for information at the end of these minutes.

During the presentation, the Director drew particular attention to the following points:

- In the city the focus was on a joined up experience for people using health and care services, not the organisational structures;

- Integration was a key area of the Leicester City Better Care Fund Plan and the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan;

- No additional resources had been allocated for local integration projects, but available resources were combined;

- Improved processes, including the sharing of best practice, was helping to avoid delays, including formal discharge delays;

- Access to on-line patient information systems had improved;

- Adult Social Care services in the city and county were very engaged with, and committed to, this model of care;

- Anyone from the partner organisations could make assessments;

- Much of the integrated community response was funded through the Better Care Fund;

- The improved falls pathway was working well. Out of over 1,000 people who had fallen last year and been visited by the integrated Crisis Response Service, only 11 had been conveyed to hospital, the majority being supported at home;

- Integrated locality teams were based around GP populations and each was supported by a named social work team;

- One challenge being faced was maintaining the consistent engagement of partners, partly due to the capacity of those partners;

- It was hoped that integrated teams could be co-located, as this would improve ad hoc and less formal liaison between partners; and

- Although the City Council had stepped back from establishing integrated points of access, it was maintaining dialogue with the County Council and Leicestershire Partnership NHS Trust in order that it could participate if

appropriate.

See also minutes 56, “Inquorate Meeting”, and 57, “Presentation on the Development of Integrated Teams – Continued”, below.

56. INQUORATE MEETING

Councillor Thalukdar left the meeting at 8.15 pm, making the meeting inquorate.

The remaining Members decided to continue considering the remaining items on the agenda, noting and commenting as considered appropriate.

57. PRESENTATION ON THE DEVELOPMENT OF INTEGRATED TEAMS – CONTINUED

Consideration of the presentation on integrated models of care resumed.

The Strategic Director for Adult Social Care and Health confirmed that the driver for this integration had been from governments over many years.

The Director for Adult Social Care and Safeguarding confirmed that a report on progress with removing barriers to integrated models of care locally was due to be considered in the new year. Until all information for this report had been prepared, it was not possible to give an estimated timescale for the further development of integrated models of care.

The Chair drew the discussion to a close, thanking officers for a very informative presentation.

58. ADULT AND SOCIAL CARE SCRUTINY COMMISSION WORK PROGRAMME

All members of the Commission were invited to pass suggestions for items for inclusion in the work programme to the Chair.

59. SEASON'S GREETINGS

The Chair thanked everyone for attending and wished them a happy Christmas.

60. CLOSE OF MEETING

The meeting closed at 8.20 pm

ASC Scrutiny Commission
12th December 2017

Integrated Models of Care

What is integration?

- Essentially joined up working
- Range of ways to help this happen:
  - Collaboration
  - Joint strategies and plans
  - Commissioning
  - Structural change
- In Leicester we focus on a **joined up experience** for people who use health and care services

Drivers for Integration

Legislation	• Health and Social Care Act 2012 • Care Act 2014
National Policy	• NHS Five Year Forward View • Better Care Fund
Population pressures	• Ageing population, rising health needs • Over-use of emergency and urgent care
Local Strategy	• Leicester City Better Care Fund Plan • LLR Sustainability and Transformation Plan

Local Integration Projects

Home First
- Integrated Discharge
- Integrated community responses

Managing Complex Need
- Integrated Locality Teams

Contacting Health and Care Services
- Integrated Points of Access

Integrated Discharge

- Collaborative approach – councils and acute / community health staff
- Colocation within LRI
- Testing models on key wards around timely discharges
- Live since July2017 – early days

Better care together | Integrated Discharge Team

What does IDT aim to do?

- Share information and integrate skills and processes
- Attend board rounds, supporting ward staff where required in planning straightforward discharges and identifying patients who need the involvement of the integrated team
- Help drive dates for discharge and improve the number of people achieving this
- Increase the number of people returning to their usual place of residence rather than having to be discharged into a 24 hour care setting
- Ensure peoples' independence is promoted throughout their stay and discharge journey from hospital
- Reduce delays – including formal discharge delays (DTOC)

What is working well?

- Closer working between City and County ASC
- Improved processes to avoid delays
- Building relationships with clinical ward staff
- Understanding barriers to timely discharge
- Improved access to IT / information due to honorary NHS contracts
- Better communication

What are the challenges?

- Early days and some way from the aims as yet
- Limited engagement / commitment in some areas
- Trusted assessment progress
- Impact of new approach on capacity
- Joining up systems inc IT
- Making a significant culture shift

Mr D

- County IDT worker attended board round – alerted City to proposed discharge
- City attend board round on Saturday – concerns identified re fitness for discharge and health needs not fully identified
- IDT approach used to review and challenge ward decision
- Formal discharge notification received 9 days after work commenced however -
- Planning already well underway because of IDT input to wards
- Successful and timely transfer to a care setting with appropriate NHS funding

Integrated Community Response

- Collaborative approach – City ASC, community health staff, commissioners (CCG / Council)
- Co-location within Neville Centre
- Range of rapid responses to unplanned health and care concerns
- Focus on Home First

What is available?

- 24/7 response within 2 hours to crisis care – "Integrated Crisis Response Service"
- Rapid access to reablement / rehabilitation
- For people at home or in hospital
- Home or bed based care
- Social care, nursing care, therapy input, equipment & technology, handypersons

What is working well?

- Established services through BCF
- Well integrated pathway
- Excellent outcomes – people staying at home
- Improved falls pathway
- Holistic reviews not treatment of symptoms
- Multi-professional trust
- National recognition of model and impact

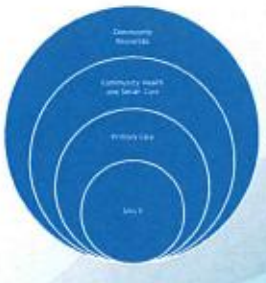
What are the challenges?

- Moving to a more integrated service (to build on the pathway)
- Using the right skills in the system
- Consolidation through a commissioning approach
- Filling gaps in diagnostic and medical cover

Mr & Mrs S

- Mr S caring for his wife – end of life
- Struggling to cope – DN visits and calls in ICRS
- ICRS attend and;
- Provide care
- Resolve equipment / bed
- Give carer support / relief
- Facilitate Mrs S to stay at home until EoL
- Leave Mr S with a more positive experience to remember

Integrated Locality Teams



- Based around GP populations
- Collaborative approach
- Supported by specialists and the voluntary and community sector
- Focus on high risk population
- Aiming to reduce crisis, support self care and condition / independence management
- Outcomes sought are to improve health and well being, increase our citizens, clinician and staff satisfaction and at the same time moderate the cost of delivering that care.

What is working well?

- Multi-disciplinary meetings
- Good outcomes for complex cases
- Building trust and relationships
- Sharing the same footprint
- Starting to make links to wider community support
- Linking with other projects

What are the challenges?

- Consistent engagement
- Capacity – time, location
- Administrative burden
- Making best use of IT systems
- Information governance
- Co-location ambitions
- Moving beyond the priority cohort to business as usual

Mr R

- Living at home with wife, multiple health problems, carer strain, Mr R feels he is a burden
- Brought by GP to MDT discussion
- Review of care – extra support offer / family input
- Surgery –further post-op review
- OT intervention due to stair risk
- Carer assessment – no services needed but valued discussion
- Mr R / wife report feeling supported by local team
- Mr R less depressed / more able to manage his health conditions

Integrated Points of Access

- Leicestershire BCF ambition
- To deliver a single access route for everyone
- Business case → Gateway Challenge → New business case
- But money, function and form, IT = challenge
- LCC has stepped back for now
- Position to be reviewed if a IPOA is developed by others