Leicester
City Council

MEETING OF THE ADULT SOCIAL CARE SCRUTINY COMMISSION

DATE: THURSDAY, 8 SEPTEMBER 2016
TIME: 5:30 pm
PLACE: Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ

Members of the Committee

Councillor Cleaver (Chair)
Councillor Chaplin (Vice-Chair)

Councillors Dempster, Hunter, Khote, Riyait and Thalukdar

One unallocated non-group place

Standing Invitee (Non-voting)

Representative of Healthwatch Leicester

Members of the Committee are invited to attend the above meeting to consider the items of business listed overleaf.

For Monitoring Officer

Officer contacts:

Tel: 0116 454 6357, e-mail: julie.harget@leicester.gov.uk
Leicester City Council, Granby Wing, 3 Floor, CityHall, 115 Charles Street, Leicester, LE1 1FZ

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- ✓ where filming, to only focus on those people actively participating in the meeting;
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Further information

If you have any queries about any of the above or the business to be discussed, please contact: **, Democratic Support Officer on 0116 454 6357**. Alternatively, email julie.harget@leicester.gov.uk, or call in at City Hall.

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PUBLIC SESSION

AGENDA

FIRE / EMERGENCY EVACUATION

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business to be discussed.

3. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of the Adult Social Care Commission held on 12 July 2016 have been circulated and the Commission is asked to confirm them as a correct record.

4. PETITIONS

The Monitoring Officer to report on any petitions received.

5. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

The Monitoring Officer to report on any questions, representations or statements of case.

6. ADULT SOCIAL CARE INTEGRATED PERFORMANCE REPORT 2016/17 - QUARTER ONE **Appendix A**

The Strategic Director, Adult Social care submits a report that provides Scrutiny with an update on six strategic priorities for Adult Social Care reported in May 2016, our quarter one financial performance and other aspects of departmental performance.

The Commission is asked to note the areas of positive achievement for the quarter and areas for improvement.

7. RE-PROCUREMENT OF DOMICILIARY CARE SUPPORT SERVICES **Appendix B**

The Strategic Director, Adult Social Care, submits a report that provides the Adult Social Care Scrutiny Commission with an analysis of service user engagement completed as part of the re-procurement of domiciliary care support services.

The Commission is recommended to note the content of the report and to provide feedback.

8. INCREASING DEMAND IN THE WORKING AGE ADULT POPULATION **Appendix C**

The Strategic Director, Adult Social Care submits a report that provides an overview of the issues relating to a rise in demand for Adult Social Care services from people aged under 65.

The Commission is recommended to note the contents of this report and make any comments.

9. DISABILITY RELATED EXPENDITURE (DRE) - CONSULTATION FINDINGS **Appendix D**

The Strategic Director, Adult Social Care submits a report that provides an outline of Disability Related Expenditure (DRE) and the means test and to present the findings from a 12-week consultation on changes to DRE that was carried out between 19 January 2016 and 12 April 2016.

The Commission is asked to note the report and comment as it sees fit.

10. ADULT AND SOCIAL CARE SCRUTINY COMMISSION WORK PROGRAMME **Appendix E**

The current work programme for the Commission is attached. The Commission is asked to consider this and make comments and/or amendments as it considers necessary.

11. ANY OTHER URGENT BUSINESS

Appendix A

Adult Social Care Scrutiny Commission

ASC Integrated Performance Report

2016/17 - Quarter 1

Date: 8th September 2016

Lead Director: Steven Forbes

Useful information

- Ward(s) affected: All
- Report author: Gwen Doswell / Adam Archer
- Author contact details: 454 2302 / 454 4133
- Report version: 1

1. Summary

1.1 This report provides Scrutiny with an update on six strategic priorities for ASC reported in May 2016, our quarter 1 financial performance and other aspects of departmental performance.

1.2 This is the first time such a report has been produced and it is anticipated that subsequent reports will see the concept of an integrated performance report further developed and refined.

1.3 This report brings together information on the various elements of adult social care (ASC) performance in the first quarter of 2016/17. The intention of this approach to reporting is to enable our performance to be seen 'in the round', providing a holistic view of our business.

1.4 The report contains information on:

- our *inputs* (e.g. Finance and Workforce),
- the efficiency and effectiveness of our *business processes,*
- the volume and quality of our *outputs,*
- the *outcomes* we deliver for our service users and the wider community of Leicester.

1.5 We will continue to develop the scope of performance reporting over the coming months.

2. Recommendations

2.1 Scrutiny is requested to note the areas of positive achievement for the quarter and areas for improvement.

3. Report

3.1 **Delivering ASC Strategic Priorities for 2016/17**

3.1.1 Our six strategic Priorities for 2016/17 have been agreed and were reported to Scrutiny on 3rd May 2016. We have also set out what we need to do to deliver on these priorities and developed Key Performance Indicators to measure whether we have been effective in doing so. Our priorities for the year are:

SP1. Improve the experience for our customers of both our own interventions and the services we commission to support them
SP2. Implement a preventative and enablement model of support, to promote wellbeing, self-care and independence and recovery into an 'ordinary life'
SP3. Improve the opportunities for those of working age to live independently in a home of their own and reduce our reliance on the use of residential care, particularly for people with learning disabilities or mental health support needs
SP4. Improve our offer to older people supporting more of them to remain at home and to continue to reduce our reliance on the use of residential care
SP5. Improve the work with children's social care, education (SEN) and health partner to continue to improve our support for young people with care and support needs and their families in transition into adulthood
SP6. Continue to develop our understanding of the benefit to our customers of what we do, and to learn from this information so as to improve and innovate

3.1.2 We have identified over 40 indicators to help us understand how effective we are in delivering against our six strategic priorities in 2016/17. A number of these indicators are new so we can't say yet whether our performance is improving. Overall, of the 40 indicators where data is available, almost 75% are showing improvement, with 15% showing no change and 10% showing deterioration. A condensed overview of progress is shown at **appendix 1**.

3.1.3 Areas to note are:

- Performance is particularly strong in respect of Priority 1, with all 13 indicators showing improvement or no change.
- Priority 2 shows more of a mixed picture with two areas in particular requiring attention:
  - SP2b - the percentage of customers who following reablement are fully independent is 50.3% against a baseline of 54%, and those having reduced needs is 27.8% from a baseline of 32.9%
  - SP2g - the number of reviews overdue by 12 months has slightly increased from 1207 at end of March 2016 to 1288, although the number overdue by 24 months has decreased from 1012 to 927. This reflects the targeted approach now in place to clear the backlog.
- Performance for both Priority 3 and 4 is strong and mirrors that of Priority 1 in terms of no deterioration.
- The indicators for Priority 5 are all new and as such we cannot make a judgement on performance.
- The picture for Priority 6, which is assessed by considering our overall performance, reflects the wider information provided in this report, with several areas of strong performance alongside a number of areas where improvement is needed.

3.2 Keeping People Safe

3.2.1 The Care Act 2014 put adult safeguarding on a statutory footing for the first time. The

act set out our statutory duties and responsibilities including the requirement to undertake section 42 Enquiries in order to safeguard people.

3.2.2 Of the 102 individuals involved in a 'Section 42' safeguarding enquiry, 42 were aged between 18 and 64 with 60 aged 65 and over. 38 were male and 64 female, with 72 of 'white' ethnicity, 24 'Asian', 4 'Black' and 2 'Mixed'.

3.2.3 Almost half of the individuals have 'physical support' as their primary support reason, with 'learning disability' and 'mental health' the next most common.

3.2.4 The most common category of abuse was 'financial abuse' (31), with 'physical abuse' (24), 'psychological abuse' (23) and 'neglect' (19) the next most common. This was a similar pattern to 2015/16 although the proportion of 'psychological abuse' was higher and 'neglect' lower in Q1 than last year. The most common location of risk was the individuals own home (35), with care homes (21) being the next most common.

3.2.5 Quarter 1 Performance

Measure	Q1 2016/17
Timeliness: responding to alerts - 24 hours to decide if it's a safeguarding concern	55.7% of alerts were responded to with 24 hours (i.e. strategy 'meeting' held).
Number of alerts progressing to a Section 42 Safeguarding enquiry	Alerts received – 691 S42 enquiries commenced - 106
Completion of safeguarding enquiries – within 28 days target	81.9% of safeguarding enquiries were completed within 28 days.
Percentage of people who had their safeguarding outcomes partially or fully met.	37.1% of people involved in a concluded safeguarding enquiry had their safeguarding outcomes partially or fully met.

3.3 Managing our Resources: Budget

3.3.1 In summary the department is forecasting to spend as per the current annual budget of £103.3m

3.3.2 Of the £103.3m budget the most significant item is the £94.6m expenditure on independent sector service user care package costs. The level of net growth in long term service users in quarter one was 0.15% (8 service users from a base at the start of the year of 5,356). This translates to an annualised rate of 0.6% which is significantly lower than the 2.6% net growth seen in 2015/16. However it is too early in the year to revise the forecast annual growth rate which remains as per the budget. This will be reviewed again at quarter two.

3.3.3 The most significant area of potential cost increase is from net increases in package costs during the year from our existing user base. This is where the condition of the user deteriorates through increasing frailty for example, or from the need for temporary respite. This is being closely tracked at an individual service user level by social work teams to be clear of the reasons why and the appropriateness of the new

package being provided. Activity in the first quarter is such that we are not revising our budget assumptions in this forecast and we will review again in quarter two.

3.3.4 Reviews of service users are ongoing to ensure that the most appropriate care packages are in place.

3.3.5 Consultations with residential care providers to agree price increases are ongoing and should conclude shortly. The increases are principally to reflect the impact of the national living wage for providers and have been provided for in the budget.

3.3.6 Extra Care Housing provides self-contained flats with onsite support to enable vulnerable adults to live independently in the community rather using traditional residential care. Not only is this better for the service user but it is also more cost effective for the Council (saving around £3,000 per user per annum). However government plans to cap housing benefit payments for residents in Extra Care flats is jeopardising the financial viability of both existing and new schemes. From a financial viewpoint this is frustrating one of our means of reducing care package costs and delivering a key policy agenda in providing independent living opportunities.
There is a significant demand for this type of accommodation across the city and two new schemes which could provide 157 flats have been put on hold by the development consortium and the Council. It is understood that the new DWP minister will make an announcement regarding the government's position on whether or not housing benefits will be capped for these schemes in the autumn. The Deputy Mayor has written to the minister asking for an urgent decision.

3.4 Managing Our Resources: Our Workforce

3.4.1 Adult Social Care consists of two divisions; Social Care and Safeguarding and Social Care and Commissioning. The department has undergone significant change over the last 2 years including an organisational review and restructuring of the department leading to creation of a new Learning Disability service and a new Enablement service, a clear focus on hospital discharge and a re-focused Contact and Response function (our "front door"), as well as delivering the final phase of closure of in-house residential care homes (EPHs). See **appendix 2** for a snapshot of workforce performance.

3.4.2 Our current workforce make up is:

- ASC is seeking to have a workforce that is representative of the community we serve.
- As at 30/06/16 our staffing establishment is 824.86 FTEs compared to 888.43 FTEs at 31/03/16. This reduction arose out of the organisational review with the closure of day centres, the last phase of EPH closures, and the merger of Transformation and Commissioning.
- We employ 1069 people across the department, 49% of staff work- full time and 51% work part-time.
- 93% of staff are on permanent contracts.

- 77% of employees are female and 23% are male

3.4.3 Our vacancy level has fallen from 114.05 FTEs at 31/03/16 to 67.68 FTEs at 30/06/16. Both figures include approximately 13 FTEs who are on maternity leave or secondment.

3.4.4 We ended 2015/16 with a rate of sickness absence of 17.43 days lost per Full Time Equivalent (FTE). That gave us a loss of capacity equal to 61.1 FTEs. In quarter 1 2016/17 Social Care and Safeguarding division showed a slight improvement when compared with Q1 last year with 3.23 days sickness absence per FTE compared to 4.29 days last year. Social Care and Commissioning showed a slight downfall in performance with 4.41 days per FTE for Q1 this year versus 3.95 days per FTE in Q1 last year.

3.4.5 We have set a target for 2016/17 of 11 days absence per FTE which would bring back capacity equivalent to 22.5 FTEs. This is a primary area for managing improvement in this financial year.

3.5 How effective are we?

3.5.1 <u>National Comparators - ASCOF</u>

3.5.1.1 The Adult Social Care Outcomes Framework (ASCOF) is a set of national common indicators against which each local authority can measure its performance against both the national and regional comparison. See **appendix 3** for ASCOF performance.

3.5.1.2 Data is not published for all indicators on a quarterly basis. For quarter 1 there is data for 13 out of 27 indicators and of these 62% showed an improved position compared to 2015/16 outturn and we are forecasting that over 60% will meet their target.

3.5.1.3 For those indicators where national benchmarking data for 2015/16 is available, 10 have shown an improvement in our national ranking with one being unchanged. No indicators have seen a drop in our national ranking.

3.5.1.4 Q1 results show a strong performance in a number of areas including:

- The number of people admitted to residential and nursing care. For working age adults we are projecting 24 admissions in 16/17 against 39 last year and for people aged 65 and over we are forecasting 176 admissions against 258 last year.
- 94.5% of older people receiving reablement following a hospital discharge were still living at home 90 days later. Over the last three years our performance failed to reach 90%.
- Delayed transfers of care from hospital per 100,000 population have come down to just 4.8 from a peak of 15.9 in 2013/14.

3.5.1.5 However, there are areas that need attention including:

- The number of service users receiving a direct payment has dropped slightly (from a strong position) and is currently below our target for 2016/17.
- Although showing some improvement from last year, the proportion of adults with a learning disability in paid employment at 5.6% is below target.
- The outcomes of short-term services, particularly reablement are poorer in quarter one than they have been over the previous two year.

3.5.2 Local Key Performance Indicators

3.5.2.1 We have developed a range of local key performance indicators to give us an insight on the things that are essential to continue delivering services within our financial resources.

3.5.2.2 Activity and Business Processes:

- We have identified almost 60 indicators to help us understand the level of activity undertaken in the department and the effectiveness and efficiency of the business processes we use to manage that activity. For many of these indicators we don't have historic data so we can't make a judgement as to whether performance has improved. In other cases the indicators are still under development. See **appendix 4** for a snapshot of business process performance.

- For those indicators where data is available, approximately 60% showed improvement from the baseline position with the remaining 40% showing some deterioration.

- There is some evidence emerging that we getting better at managing demand, with more contacts being referred to universal services or being provided with information, advice and guidance.

- The percentage of service users still at home 90 days after completing re-ablement is the highest since recording began

- Less positively, we continue to have a high backlog of overdue reviews / re-assessments. We have also seen a drop in the percentage of service users having their level of need reduced following a period of re-ablement.

3.5.2.3 Customer Service

- We have identified 24 indicators to help us understand our customers' experience of dealing with us and the extent to which they are satisfied with our support and services. See **appendix 5** for a snapshot of customer performance.

- For those indicators where data is available, 50% showed no or little change from our baseline position, with 25% showing improvement and 25% deterioration.

- The results from the national survey of service users for Leicester are poor

compared to other local authorities, although they have improved slightly in 2015/16 compared to the previous survey.

- These survey results feed into our ASCOF scores. Our position is set out in the table below.

Adult Social Care Outcome Framework – Measures derived from the Adult Social Care User Survey 2016				
Indicator	**2014/15**	**2015/16 Provisional outturns**	**DoT vs 2014/15**	**2015/16 – England Benchmarking: Rank and DoT**
Social care-related quality of life.	**17.9**	**18.1**	↑	147/150 ↑
Proportion of service users who have control over their daily life.	**67.1%**	**70.5%**	↑	138/150 ↑
Proportion of service users who reported that they had as much social contact as they would like.	**35.6%**	**37.2%**	↑	142/150 ↑
Overall satisfaction of people who use services with their care and support	**56.9%**	**61.7%**	↑	104/150 ↑
The proportion of service users who find it easy to find information about services.	**62.0%**	**61.7%**	↔	150/150 ↔
The proportion of service users who feel safe.	**58.3%**	**60.8%**	↑	144/150 ↑
The proportion of service users who say that those services have made them feel safe and secure.	**75.4%**	**80.7%**	↑	117/150 ↑

- However, local data presents a more positive picture with, for example, high levels of satisfaction with the way our staff conduct assessments and re-assessments.

4. Financial, legal and other implications

4.1 Financial implications

The financial implications of this report are covered in section 4.4, Managing our Resources.

Martin Judson, Head of Finance, Ext 37 4101

4.2 Legal implications

There are no direct legal implications arising from the contents of this report at this stage.

Pretty Patel, Head of Law, Social Care & Safeguarding, Tel 0116 454 1457.

4.3 Climate Change and Carbon Reduction implications

There are no direct climate change implications associated with this report. Mark Jeffcote, Environment Team (x372251)

4.4 Equalities Implications

From an equalities perspective, the most important information is that related to the outcomes delivered for service users and the wider community. This is in keeping with our Public Sector Equality Duty, the second aim of which is to promote equality of opportunity. The outcomes demonstrate that ASC does enhance individual quality of life that addresses health and also socio-economic inequalities that many adults in the city experience. In terms of the PSED's first aim, elimination of discrimination, it would be useful for outcomes to be considered by protected characteristics as well, given the diversity of the city and how this translates into inequalities (as set out in the adults JSNA). Irene Kszyk, Corporate Equalities Lead, ext 374147.

4.5 Other Implications (You will need to have considered other implications in preparing this report. Please indicate which ones apply?)

5. Background information and other papers:

6. Summary of appendices:

Appendix 1: Strategic Priorities

Appendix 2: Workforce

Appendix 3: ASCOF

Appendix 4: Business Processes

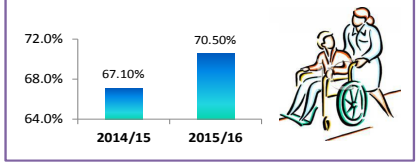
Appendix 5: Customer Service

Appendix 1.

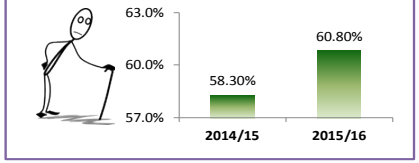
ASC Strategic Priorities - Highlight Dashboard 2016/17 Quarter 1

1. Improve the experience for our customers of both our own interventions and the services we commission to support them

The proportion of people who use services who have control over their daily life

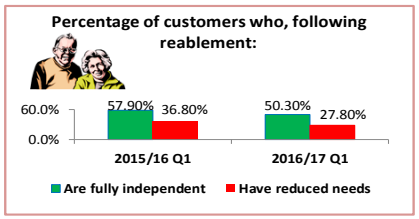


The proportion of people who use services who feel safe

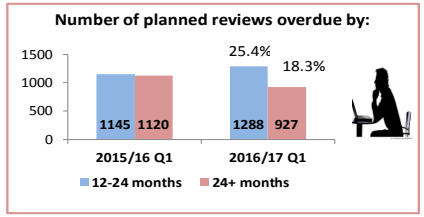


2. Implement a preventative and enablement model of support, to promote wellbeing, self-care and independence and recovery into an 'ordinary life'

Percentage of customers who, following reablement:

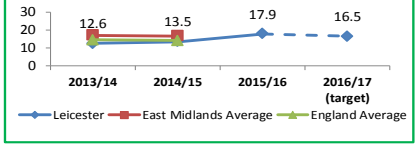


Number of planned reviews overdue by:

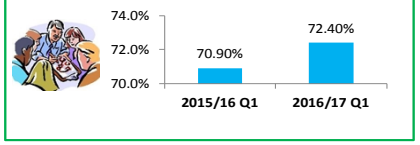


3. Improve the opportunities for those of working age to live independently in a home of their own and reduce our reliance on the use of residential care, particularly for people with learning disabilities or mental health support needs

Adults aged 18-64 admitted on a permanent basis to residential or nursing care (per 100,000 pop.)

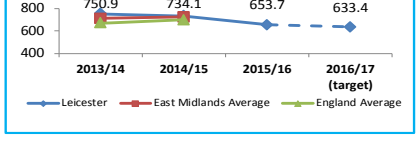


Proportion of adults with a learning disability who live in their own home or with their family

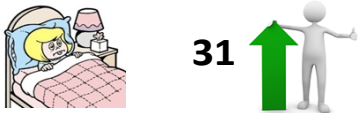


4. Improve our offer to older people supporting more of them to remain at home and to continue to reduce our reliance on the use of residential care

Older people aged 65 or over admitted on a permanent basis in the year to residential or nursing care per 100,000 pop.



Number of people admitted on a permanent basis to residential or nursing care aged 85+



2015/16 quarterly average = 33.75

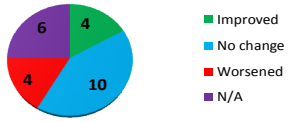
5. Improve the work with children's social care, education (SEN) and health partners to continue to improve our support for young

Percentage of all children with disabilities, with potential care and support needs in adulthood are identified into the transition programme

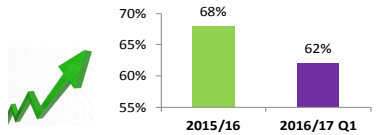
Percentage of young people 14+ with potential eligible care and support needs at adulthood have engagement in the transition programme, and a forward 'life planning' process is in place

6. Continue to develop our understanding of the benefit to our customers of what we do, and to learn from this information so as to improve and innovate

Number of customer KPIs showing improvement

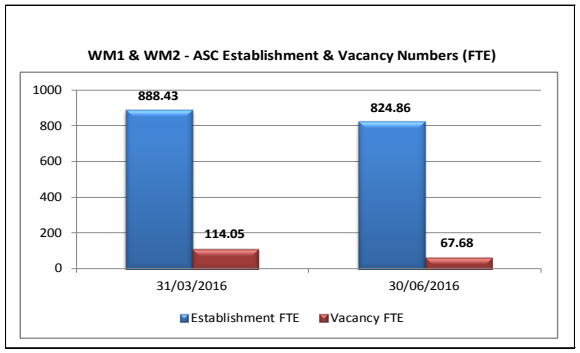


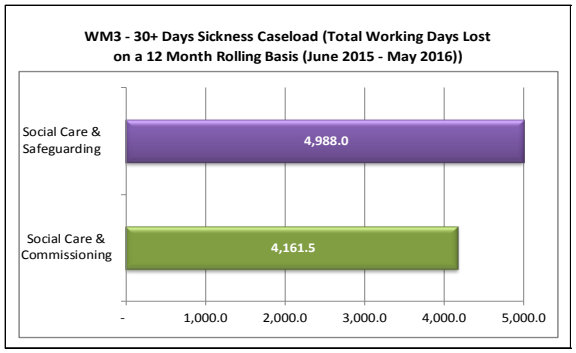
Percentage of ASCOF measures showing improvement

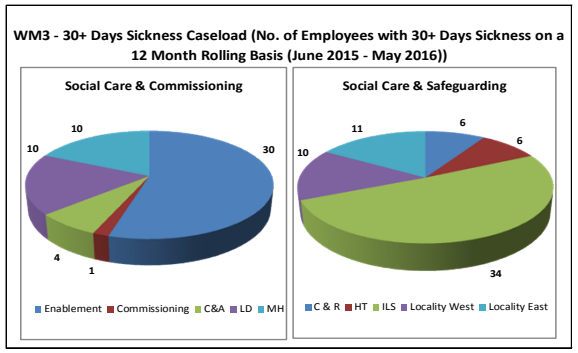


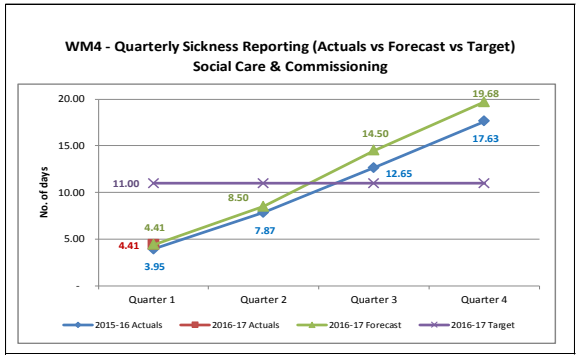
Appendix 2.

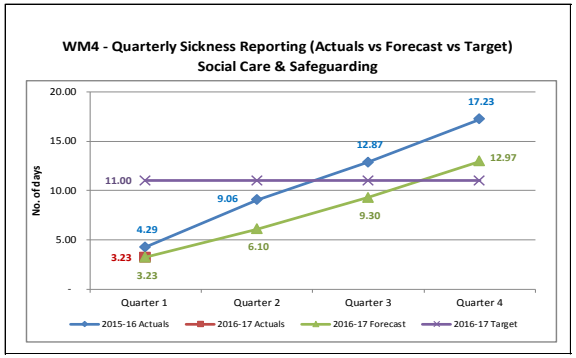
ASC Workforce Measures 2016/17 Quarter 1

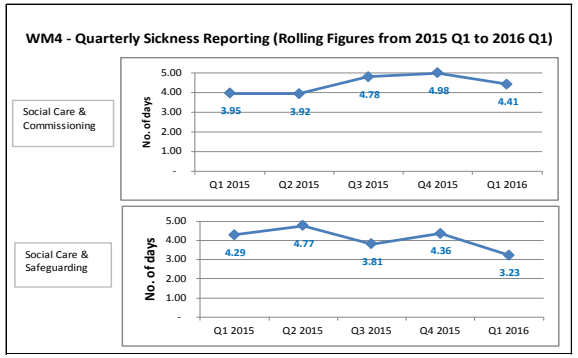


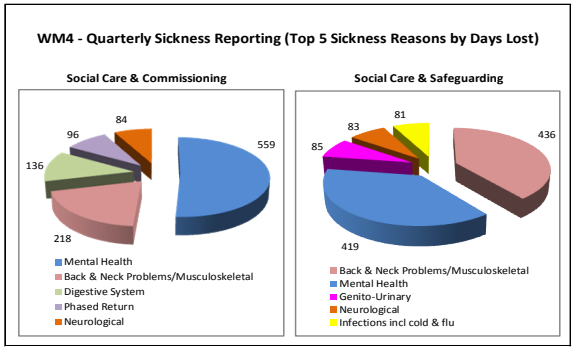


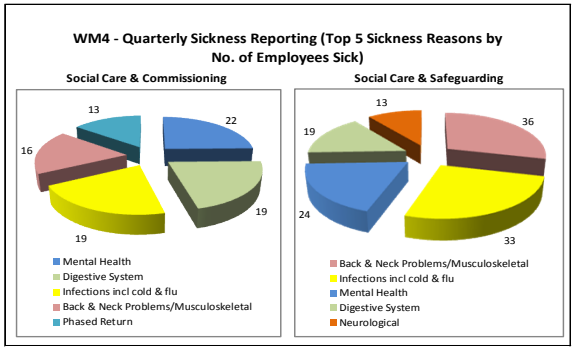












Appendix 3.

Adult Social Care Performance: 2016/17 – Quarter 1

Adult Social Care Outcome Framework

Indicator	2013/14	2014/15	2015/16	2015/16 Benchmarking			2016/17 Q1	Target	Rating	Comments
				England Average	England Ranking	England Rank DoT				
1A: Social care-related quality of life.	18.3	17.9	18.1	19.1	147/150	⬆	N/A	18.4	N/A	16/17 user survey results available May '17
1B: Proportion of people who use services who have control over their daily life.	71.5%	67.1%	70.5%	76.5%	138/150	⬆	N/A	72.5%	N/A	16/17 user survey results available May '17
1Cia: Service Users aged 18 or over receiving self-directed support as at snapshot date	-	96.2%	98.7% (3763/3812)				99.1% (3862/3859)	98.9%		New definition in 2014/15
1Cib: Carers receiving self-directed support in the year	-	100%	100% (62/62)				100% (147/147)	100%		New definition in 2014/15.
1Ciia: Service Users aged 18 or over receiving direct payments as at snapshot date	-	41.3%	44.4% (1693/3812)				44.2% (1707/3859)	45.3%		New definition in 2014/15
1Ciib: Carers receiving direct payments for support direct to carer	-	100%	100% (62/62)				100% (147/147)	100%		New definition in 2014/15.

Indicator		2013/14	2014/15	2015/16	2015/16 Benchmarking			2016/17 Q1	Target	Rating	Comments
					England Average	England Ranking	England Rank DoT				
1D: Carer reported quality of life.		No carers survey	7.2	No carers survey	N/A	N/A	N/A	**N/A**	7.7	**N/A**	**16/17 carer's survey results available May '17**
1E: Proportion of adults with a learning disability in paid employment.		7.7%	6.9%	5.2% (41/793)				**5.6% (41/736)**	6.0%		**New definition in 2014/15**
1F: Proportion of adults in contact with secondary mental health services in paid employment.		2.2%	1.8%	2.9%	6.7%	141/148	⬆	**N/A**	4.0%	**N/A**	**No 16/17 data published (MHMNDS)**
1G: Proportion of adults with a learning disability who live in their own home or with their family.		67.4%	69.8%	71.7% (569/793)				**72.4% (533/736)**	72.8%		**New definition in 2014/15**
1H: Proportion of adults in contact with secondary mental health services who live independently, with or without support.		34.1%	35.8%	62.3%	58.6%	90/152	⬆	**N/A**	65%	**N/A**	**No 16/17 data published (MHMNDS)**
1I: Proportion of people who use services and their carers who reported that they had as much social contact as they would like.	**Users**	39%	35.6%	37.2%	45.4%	142/150	⬆	**N/A**	39.8%	**N/A**	**16/17 user survey results available May '17**
	Carers	No carers survey	31.9%	No carers survey	N/A	N/A	N/A	**N/A**	35.5%	**N/A**	**16/17 carer's survey results available May '17**
2Ai: Adults aged 18-64 whose long-term support needs are met by admission to residential and nursing care homes, per 100,000 pop (Low is good)		12.6 27 admissions	13.5 29 admissions	17.9 39 admissions				**1.4 3 admissions**	16.5		**Cumulative measure: Forecast based on Q1 = 24 admissions**

Indicator		2013/14	2014/15	2015/16	2015/16 Benchmarking			2016/17 Q1	Target	Rating	Comments
					England Average	England Ranking	England Rank DoT				
2Aii: Older people aged 65+ whose long-term support needs are met by admission to residential / nursing care per 100,000 pop (Low is good).		750.9 291 admissions	734.1 287 admissions	653.7 258 admissions				**144.8** **58 Admissions**	633.4		**Cumulative measure: Forecast based on Q1 = 176 admissions**
2Bi: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services.	**Statutory**	86.9%	84.3	91.5%				**N/A**	90.0%		**Statutory measure counts Oct – Dec discharges**
	Local	*88.2%*	*89.7%*	*88.2%*				***94.5%***	*90.0%*		**Local measure counts full year**
2Bii: Proportion of older people (65 and over) offered reablement services following discharge from hospital.	**Statutory**	4.0% (230 in reablement)	3.7% (235 in reablement)	3.1% (200 in reablement)				**N/A**	3.3%		**Statutory counts Oct – Dec discharges**
	Local	*3.9%*	*4.2%*	*3.9%* *(939 in reablement*				***3.4%***	*3.6%*		**Local counts full year. Cumulative: forecast = 1080.**
2Ci: Delayed transfers of care from hospital per 100,000 pop. (Low is good)		15.9	13.0	6.0	12.3	34/152	⬆	**4.8**	16/17 target in BCF plan - NHS definition	Based on previous year	**Only April and May data available.**
2Cii: Delayed transfers of care from hospital attributable to ASC and/or NHS per 100,000 pop. (Low is good)		5.3	4.3	1.7	4.8	37/152	⬆	**0.2**	1.5	Based on previous year	**Only April and May data available.**
2D: The outcomes of short-term services (reablement) – sequel to service		-	63.0%	60.5%				**51.3%**	63.5%		**New measure for 2014/15.**

Indicator		2013/14	2014/15	2015/16	2015/16 Benchmarking			2016/17 Q1	Target	Rating	Comments
					England Average	England Ranking	England Rank DoT				
3A: Overall satisfaction of people who use services with their care and support		62.2%	56.9%	61.7%	64.4%	104/150	↑	**N/A**	62.5%	**N/A**	**16/17 user survey results available May '17**
3B: Overall satisfaction of carers with social services.		No carers survey	37.7%	No carers survey	N/A	N/A	N/A	**N/A**	39.2%	**N/A**	**16/17 carer's survey results available May '17**
3C: Proportion of carers who report that they have been included or consulted in discussion about the person they care for.		No carers survey	68.5%	No carers survey	N/A	N/A	N/A	**N/A**	70.5%	**N/A**	**16/17 carer's survey results available May '17**
3D: The proportion of service users and carers who find it easy to find information about services.	**Users**	70.4%	62.0%	61.7%	73.5%	150/150	↔	**N/A**	65.0%	**N/A**	**16/17 user survey results available May '17**
	Carers	No carers survey	55.5%	No carers survey	N/A	N/A	N/A	**N/A**	61.0%	**N/A**	**16/17 carer's survey results available May '17**
4A: The proportion of service users who feel safe.		61.6%	58.3%	60.8%	69.0%	144/150	↑	**N/A**	63.0%	**N/A**	**16/17 user survey results available May '17**
4B: The proportion of people who use services who say that those services have made them feel safe and secure.		79.7%	75.4%	80.7%	85.5%	117/150	↑	**N/A**	82.5%	**N/A**	**16/17 user survey results available May '17**

Forecast to meet or exceed target - 8	**Performance within 0.5% of target - 1**	**Forecast to miss target - 4**	**N/A - No data on which to make a judgement - 14**

ASC Activity and Business Processes - Highlight Dashboard 2016/17 Quarter 1

Contact and Response

Effectiveness of call handling:

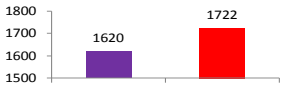
Part 1: Call volume

8,147

Part 2: Abandonment rate (% calls missed)

1.7%

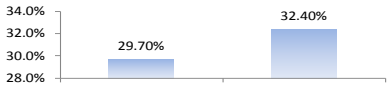
Number of repeat contacts within 12 months with same contact reason for the repeat contact



12 month rolling period

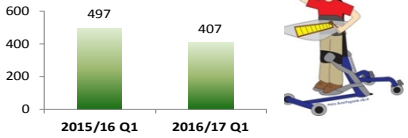
Assessments

Percentage of a new contacts who go on for a further assessment



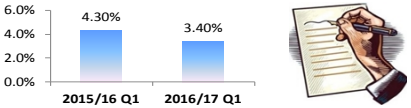
(1397/4706) (1383/4270)

No of people in receipt of Assistive Technology



Reablement/Enablement

Proportion of older people (65 and over) offered reablement services following discharge from hospital.



(220 people in reablement)

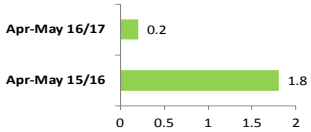
Percentage of new enablement cases allocated with 48 hours

77%

(New measure / service)

Health Transfers

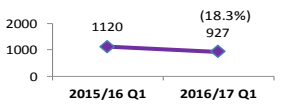
Delayed transfers of care (attributable to ASC)



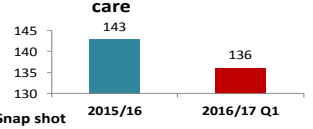
Percentage of discharges completed without a section 5 notification

Localities

Number and percentage of people in receipt of a service who has not been reviewed for 24 months or more



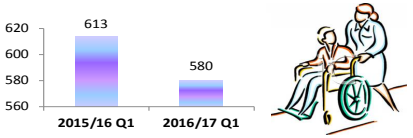
The number of people with mental health needs (including dementia) in residential care



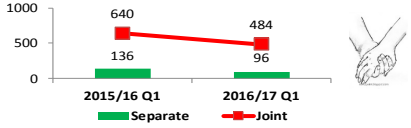
Snap shot

Carers

No of Carers receiving needs assessment



No separate assessments /Joint assessments



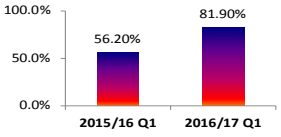
Safeguarding

% of concerns responded to within 24 hours

55.7%

(New measure / service)

% of enquiries completed within 28 days



Contracts & Assurance

Number of services considered as QAF compliant

77.8%

(112/144)

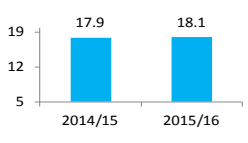
Number of contract breaches

3 Notices to Remedy Breach

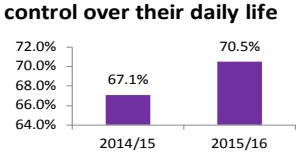
ASC Customer Measures Dashboard 2016/17 Quarter 1

Quality of Life Outcomes

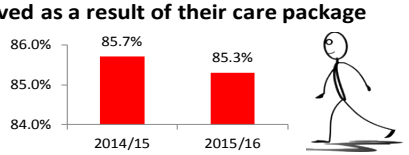
Social care-related quality of life



The proportion of people who use services who have control over their daily life

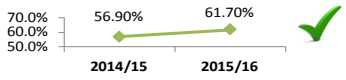


The % of service users whose quality of life has improved as a result of their care package

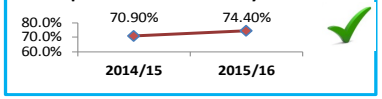


Help and support from ASC Services

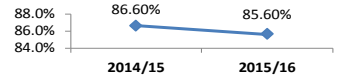
Overall satisfaction of people who use services with their care and support



% of service users who agree ASC services help them with their daily activities

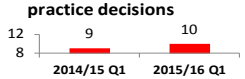


% service users who say that ASC services help them to have control over daily life



% of service users receiving a review who's identified needs were met

Number of complaints received by the department concerning challenging practice decisions



Number of complaints received concerning delay in receiving a service

Number of portal hits

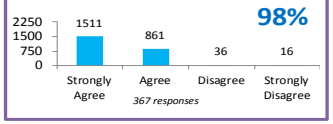
Number of people who are deflected to take information and advice

Number of people who submitted a portal eligibility form

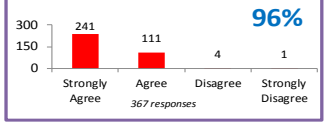
27 users

Quality of interaction with ASC Services and staff

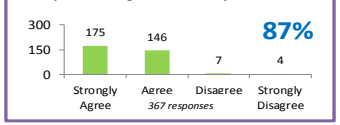
% of service users satisfied/ highly satisfied with quality of interaction with ASC staff



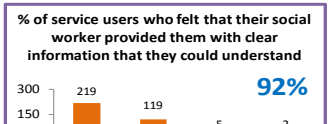
% of service users who felt that their social worker who spoke with them understood what they were saying



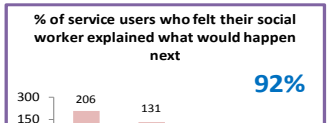
% of service users who felt that their social worker discussed any practical help they receive on a regular basis from their husband/wife, partner, neighbour or family member



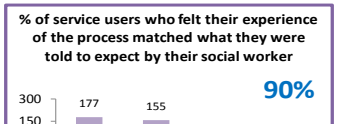
% of service users who felt that their social worker provided them with clear information that they could understand



% of service users who felt their social worker explained what would happen next

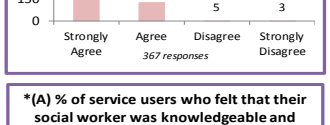


% of service users who felt their experience of the process matched what they were told to expect by their social worker

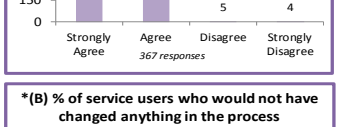


% of service users who felt they were treated with respect and dignity by their social worker

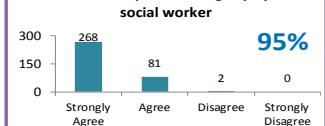
*(A) % of service users who felt that their social worker was knowledgeable and understood their needs



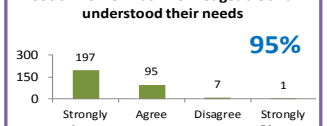
*(B) % of service users who would not have changed anything in the process



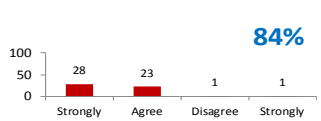
The proportion of people who use services and carers who find it easy to find information about services



Number of complaints received regarding staff



Number of commendations received



*(A) User experience of ASC services
(B) User experience of ASC via contact & response team

Appendix B

Adult Social Care Scrutiny Commission

Re-procurement of Domiciliary Care Support Services

Date: 8th September 2016

Lead director: Steven Forbes

Useful information

■ Ward(s) affected: All

- Report author: Sally Vallance
- Author contact details: 454 4122
- Report version number plus Code No from Report Tracking Database:

1. Purpose of report

1.1 To provide the Adult Social Care Scrutiny Commission with an analysis of service user engagement completed as part of the re-procurement of domiciliary care support services.

1.2 The engagement exercise was undertaken for both Adult Social Care (ASC) and health service users. The exercise included both groups as consideration is being given to jointly procuring domiciliary care support with the Leicester Clinical Commissioning Group (CCG).

1.3 The existing domiciliary care contracts are due to expire in October 2017 and the tendering process needs to start in October 2016 in order to have completed the procurement and mobilisation process, so the new contracts are operational by October 2017.

1.4 The report also gives a brief overview of other relevant engagement.

2 Summary

2.1 The engagement exercise took place between 13th June and 29th July 2016. The engagement was prioritised for people who use services and patients, but was also widened out to include providers and interested stakeholders.

2.2 A total of 2,095 survey forms were sent or given out. Engagement also took place at provider forums, over the phone and during some face to face sessions. A press release was issued to the Leicester Mercury and local radio stations. Internal and external communication channels were also used as were web sites and social media.

2.3 A total number of 633 completed surveys were returned on or before the closing date, a response rate of 30%.

2.4 Further detail about the engagement is contained in appendix 1.

2.5 The survey form itself is contained in Appendix 2.

2.6 Specific provider engagement took place in August.

2.7 Scrutiny Commission were consulted on 11th August and further engagement is planned.

3 Recommendations

3.1 That Adult Social Care Scrutiny Commission is recommended to note the content

of the report and to provide feedback.

4 Report/Supporting information including options considered:

Background

4.1 LCC and CCG are considering jointly procuring domiciliary care for the residents of Leicester City. The joint approach is expected to result in an improved service for service users by achieving better outcomes, which reflect the aims of the Health and Social Care Act by joining up social care and health services and provide scale of economies. The new services will be operational by October 2017.

4.2 To inform this work and to shape the specification and contract, it was necessary to seek the views of people who currently use the services, their carers and any other interested parties. Therefore, a survey was sent out to 2,095 service users and patients and formal stakeholder events were arranged. Views were also sought about joint procurement of domiciliary care with the Leicester CCG.

4.3 The purpose is to make sure the patient/user voice is at the heart of any decisions we make in planning and buying local social care and health services and therefore it is critical that they are involved in the future plans.

Service Users/Patients

4.4 During the consultation period, a total of 2,095 surveys were sent out or given directly to patients and service users. Where possible service users or potential service users were directly informed of the survey.

4.5 The final response rate was 633 forms. A number of forms were received either blank or illegible. A small number were returned outside of the survey period and were therefore not counted. The number received represents a response rate of 30% which is good for this type of engagement.

Stakeholders

4.6 A wide range of stakeholders were asked for their views on Domiciliary Care services and the proposal for a joint commissioning approach as part of the engagement process.

4.7 As well as engaging with service users, patients and carers, we also asked for people to use their networks to spread the word and circulate the survey to any paid carers or support workers, or those who may have an interest. Finally, we asked for any opportunities they had where we could speak to existing or potential users face to face.

4.8 Two specific events for providers were held in August with a total of 80 providers in attendance. This aspect of the engagement was largely about technical aspects of the contract and specification, but intelligence about service

user/patient feedback has been incorporated where this was given. For information, the consultation feedback is included at Appendix 3.

4.9 Appendix 1 section 4 details the stakeholders engaged with and the methodology used. The methodology used included written surveys, face-to-face meetings, media (press and radio), internal and external channels (e-newsletters for staff and GP's), LCC and CCG websites, social media such as Face book and Twitter.

Profile of Respondents

4.10 587 respondents out of 633 completed the demographic profile. This showed 67% were female, and 31% male. 58% said they were over the age of 76 and 25% were aged between 60 and 75. 51% of respondents were Christian and 24% Hindu. 56% were White British and 33% Indian. This closely matches the profile of current Council users of domiciliary support.

4.11 Most service users said they were widowed or the surviving partner. 87% said they had a disability, main type stated was a physical condition (78%). 37% said they had a long standing illness or health condition but many respondents ticked more than one option here. Other disabilities not listed but stated in the comments field were dementia and Alzheimer's disease (17 respondents).

Summary of Findings

4.12 Appendix 1 gives more detail on the survey responses, but this is a summary:

- Current domiciliary support services are, in the main, very good
- Many services that were noted as being received by service users included personal care support.
- The vast majority of respondents were grateful for the support they receive.
- Reasons why services were good were stated as:
    - Someone to talk to, company
    - Reliable
    - Safe
    - Calm
    - Clean
    - Helpful
    - Friendly
    - Caring

- Suggestions of how services could be made better were:
    - Better visiting times

- Punctuality need addressing
- Not as rushed
- More flexibility
- More frequent visits
- Talk for longer
- More consistency
- Language is an issue
- Poor communication from agency offices
- More support with domestic chores

- The majority of respondents stated they were very grateful for the service as it enables them to stay at home longer, have support with daily tasks to keep them happy and live fuller lives.
- Many commented that they looked forward to their carers' visits, and enjoyed the company and having someone to talk to.
- A number said they were glad to give relief to family members and were appreciative of all that was done for them.
- The main concerns about jointly commissioning services were:
  - reduction in services
  - changes in carers and agencies
  - making care worse/more disorganised
  - reduction in standards
- Others questions about jointly commissioning services were:
  - "Would I have to be assessed again?"
  - "Would I lose my hours?"
  - "Will it cost more?"
  - "Will the care be the same standard?"

Next Steps

4.13 The information received will form part of the monitored process through the Quality Assurance Framework process once the new contract goes live. The following information provides an overview of the main concerns and details how these will be addressed in the future.

Concerns raised through engagement	Our response
Better visiting times	Timing of visits is agreed during assessment; the actual times that care workers visit is monitored by ECM (Electronic Care Monitoring) and is a performance Indicator in the contract.
Punctuality need addressing	This is monitored by ECM (Electronic Care Monitoring) and is a performance

	Indicator in the contract.
Not as rushed	Care packages are commissioned to meet needs and outcomes. If a package feels rushed to the service user they or the provider on their behalf can raise this with the appropriate care manager and ask for a review.
More flexibility	There is often a degree of flexibility built into the care package. This can also be discussed with the provider.
More frequent visits	Care packages are commissioned to meet needs and outcomes. If the service user or the provider on their behalf feels that a package needs to be reviewed, they can raise this with the appropriate care manager.
Talk for longer	We would expect care workers to chat with service users during the visit. If a service users feels that this doesn't happen, they should use the provider's complaints procedure.
More consistency	If this relates to consistency of care staff visiting the service user, we monitor this through ECM. It is a key performance indicator. It is also a question at ITT (invitation to tender) stage of procurement.
Language is an issue	We expect providers to recruit staff from their local communities and match service user requirements such as language and culture as much as possible. In practice it isn't always possible to do this all the time. At ITT we ask a question about providers intentions to recruit from the local community and how staff are matched with service users.
Poor communication from agency offices	We expect providers to have a local office and to be available to callers during office hours during their working week (which may include weekends). Outside of this they are required to have an answer machine. We set this out as part of the contract.
More support with domestic chores	The content of a package of care is subject to assessment by care managers.

4.14 In terms of the potential joint procurement with the Leicester CCG, it is clear that communication with individual service users needs to continue to reassure them

that any potential disruption will be minimised as far as possible. This will happen particularly during the mobilisation period of the new contract.

Concern raised through engagement	Our response
Reduction in services	There will be no reduction in services unless a change in care package is approved following a reassessment
Changes in carers and agencies	Unfortunately due to the nature of the procurement process, we cannot guarantee that there will be no change to carers or agencies. This is a potential change regardless of whether we work jointly or as a single agency. Some people may wish to choose a direct payment in order to stay with their current provider. Once procurement has taken place and changes are known, all users affected will be contacted and options discussed.
Making care worse/more disorganised	Where there is a change in agency, the contract will require agencies to transfer service users in a seamless way with as little disruption as possible
Reduction in standards	The contract sets out the standards required of agencies and workers, there is no diminution of these in the new contract
“Would I have to be assessed again?”	If there is a change of provider, the new provider will likely review the service user’s care plan to ensure they fully understand the service user’s needs but an assessment of how much support you get would not take place unless a review was due.
“Would I lose my hours?”	There will be no reduction in hours unless a change in care package is approved following a reassessment
“Will it cost more?”	The cost of care to the service user may change if you pay for your own care and have this arranged by the Council. Providers will all be assessed as part of the tender process to ensure quality and price are taken into account.
“Will the care be the same standard?”	The standard of care should not be affected

4.15 The information received from this engagement and from engagement with wider stakeholders is being used to inform the finalisation of the service design and contract.

4.16 The latest version will be presented to ASC Scrutiny towards the end of September.

4.17 The procurement exercise is planned for the autumn of 2016 and handover to new providers will take place the following year in readiness for contracts going live in October 2017.

5. Financial, legal and other implications

5.1 Financial implications

There are no direct financial implications to the contents of this report.

Stuart McAvoy – Adult Social Care Principal Accountant (Strategy) 37 4004

5.2 Legal implications

The proposed consultation continues to be in accordance DCLG Statutory Guidance on Best Value and the Cabinet Office Guidance as well as the recently reaffirmed principles that:

- consultation must be at a time when proposals are still at a formative stage;
- the proposer must give sufficient reasons for any proposal to permit of intelligent consideration and response;
- adequate time must be given for consideration and response; and
- the product of consultation must be conscientiously taken into account in finalising any proposals.

In certain circumstances the Council is obliged to consult on alternative proposals and therefore it is advised, particularly if the proposals are very narrow, that realistic alternatives option are considered and the reasons why they were discounted are outlined as background information as part of the consultation process.

Jenis Taylor, Commercial, Property & Planning Team, Legal Services Ext 37 1405

5.3 Climate Change and Carbon Reduction implications

There are no climate change implications at this time. Mark Jeffcote, Senior Environmental Consultant 37 2251

5.4 Equalities Implications

In order to ensure that we meet our Public Sector Equality Duty, we must have a clear understanding of the needs of our service users and how best to meet those needs from their perspectives. User and stakeholder engagement, as presented above, is an effective means of ensuring the council understands those needs and that the contract specification appropriately reflects what is required to meet them within service delivery. Irene Kszyk, Corporate Equalities Lead, ext 374147

5.5 Other Implications (You will need to have considered other implications in preparing this report. Please indicate which ones apply?)

None

APPENDIX 1

Leicester City Council

NHS
Leicester City
Clinical Commissioning Group

Leicester City CCG and Leicester City Council

Summary Report of Patient Engagement
Domiciliary Care Services
13th June – 29th July 2016

Contents

1. Background

Domiciliary support helps people to remain independent and prevents them from needing a higher level of support such as residential or nursing care. Currently domiciliary care is commissioned separately by Leicester City Council (LCC), triggered by an assessment of social care needs and by Leicester City Clinical Commissioning Group (CCG), triggered if a patient is assessed as having continuing healthcare needs.

Two main types of care are commissioned by the CCG and LCC, non-complex and complex (the terminology used is 'Specialist' for the LCC). Non-complex care is commissioned to help patients meet the activities of daily living. This includes activities such as getting up / dressed, washed, assistance with toileting and skin care, communication, meals, moving and handling including the use of adaptations and equipment, medication, emotional and psychological needs.

Complex (specialist), care refers to cases where specialist knowledge, skills and training are required in order to be able to support the individual in the community. Complex cases will primarily relate to individuals with learning disabilities, mental health issues (including dementia) and long-term physical disabilities (including acquired brain injury).

LCC and CCG are proposing to jointly commission domiciliary care for the residents of Leicester City. Joint Commissioning is expected to result in an improved service for service users/residents by achieving better outcomes, contribute to the aims of the Health and Social care Act by joining up local care and health services and to provide economies of scale.

The jointly commissioned service has been scheduled to start in October 2017.

Before we put these plans into action we were interested to hear from people who currently use these services, their carers and any interested parties. We wanted to know what people think of the current services, and hear of suggestions for how we can improve them. We also asked for views about commissioning domiciliary care together as one organisation to ensure that we have considered all of the options. It was therefore proposed that the CCG and LCC held a period of engagement to ask patients, carers, family members and other interested stakeholders a series of questions (primarily via a survey) to help us develop a future service which would best meet their needs.

Our purpose is to make sure the patient voice is at the heart of any decisions we make in planning and buying local health services so it is critical that they are involved in the future plans.

2. Acknowledgements

We would like to take this opportunity to express our gratitude and to sincerely thank all of the service users and patients who have taken the time to speak to us and provide their views and feedback as part of the engagement process.

3. Our engagement approach

As public bodies we have a duty and a commitment to listen and engage with patients, service users and members of the public to ensure we understand their views on health and social care, the areas of health and social care which they are satisfied or dissatisfied, and how they would like to be engaged or informed going forward.

As such, the below outlines the engagement activity we undertook to ensure the views of those who use these services are taken into account before any changes to services happened.

We prioritised this engagement primarily with people who use the services. We then widened the engagement to include providers and interested stakeholders.

This engagement phase opened the week commencing 13th June 2016 and closed on the 29th July 2016 (following an extension). This report details a summary of the findings.

4. Stakeholders

A wide range of stakeholders were asked for their views on Domiciliary Care services and the proposal for a joint commissioning approach as part of the engagement process. As well as engaging with patients and carers, we also asked for people to use their networks to spread the word and circulate the survey to any paid carers or support workers, or those who may have an interest.

Finally, we asked for any opportunities they had where we could speak to existing or potential users face to face.

This information was circulated to the following audiences:

Internal audiences

- Adult Social Care – Care Management lead
- Adult Social Care Leadership
- Adult Social Care Scrutiny Commission
- Joint Integrated Commissioning Board
- CCG Board GPs and lay members
- GPs, Practice Managers and other practice staff
- Other CCG Staff
- Other providers of services potentially affected
- Partners

Domiciliary support services

- Four soft market testing events with providers, two in March and two in August 2016

Other stakeholders

- Network for change
- LGBT Centre
- Adhar project
- LAMP/Genesis group
- Stroke Association
- Diabetes Uk
- Breathe Easy (BLF)
- LCIL
- Headway
- Leicestershire Aids Support Services (LASS)
- Action Deafness
- Vista
- Age Uk
- 50+ network
- LOROS

- Parkinsons Uk
- Clasp the Carers Centre
- Motor Neurone Disease Association (Leicestershire and Rutland)
- Speaking up for health group
- Rethink
- BME Elders forum
- Rainbows
- Leicester Chinese Elderly Project
- Leicester Stroke Club
- Leicester Deaf Action Group
- Leicester Mencap Society
- CLASH - Arthritis support group
- West Indian Senior Citizens Project
- Alzheimers Society
- ANSAAR
- Learning Disability Partnership Board
- Leicestershire Kidney Patients' Association
- Healthwatch Leicester
- Leicestershire Down's Syndrome group

Stakeholder communications

- MPs/Councillors
- GP Practices
- OSC
- Local media channels (i.e. Leicester Mercury)
- Social media channels (Facebook and Twitter)
- LCC and CCG website

In response we attended:

The Leicester LGBT Centre (Silver Slippers Group) on the 17th September where we spoke to five people. They highlighted the importance of continuity of support worker, that workers should attend on time, that being assessed and treated as an individual was important, that as a user they wouldn't want to have to access services through a computer and that services should be required to monitor their workforce to ensure they were representative of the population of Leicester.

We Think Group on the 27th June where we spoke to a group of people. The key points raised were the need for a simple and independent (from the provider organisation) complaints system and the continuity of care worker (having the same worker each day wherever possible).

Communications planning

All communication on the development of this work involved a number of different channels to spread the messages. The below offers just some of the methods we used:

Media

We worked proactively and closely with the media to distribute a press release on the consultation and service developments. We distributed this to the Leicester Mercury, BBC Radio Leicester, Capital FM and local online news services.

Internal and External Channels

We used internal methods of communication such as e-newsletters to communicate with our staff and GPs as well as sending an update to the CCGs 4,500 strong membership base to make them aware of the service.

Website

We uploaded press releases, service information and detail of engagement and consultation opportunities on to our websites.

Social Media

We used our social media feeds on Facebook and twitter to publicise the activity. We also used these channels to encourage feedback directly from patients and stakeholders. Our partners in the health economy were encouraged to re-post any updates on their social media sites to reach as many relevant people as possible.

5. Survey feedback

Between 13th June 2016 to 29th July 2016 we received 633 completed surveys. Unfortunately 5 came in after the closing date so were not counted. In addition, 28 people chose to phone in and speak to a member of the commissioning team about their queries and responses, two completed forms over the phone which have been included in the number of forms submitted above. All calls were noted and where feedback in relation to the survey was give; their feedback is noted under section 6 below. The response rate for the survey returns is 30% percent of the service user/patient list.

Due to the number of comments received, the general themes of the comments repeated most often have been highlighted rather than including every single comment received. Any additional points to note or key findings have also been analysed.

Question 1: Please tell us who you are completing this survey as:

379	I am a person who is receiving support at home
262	I am a family carer or friend of someone who is receiving support in their home
4*	I am interested in the service but not receiving support

Most responses were completed by the individuals who are currently receiving domiciliary support however many were also from family members who stated that they also care for their parent/child.

*If respondents were not receiving a service but would like to give views, they were asked to skip to question 12

Question 2: Please tell us who did your assessment for the help you receive at home.

61	A nurse did my assessment
497	A social worker or care manager did my assessment
69	I don't know

Question 3: Please tell us where you were when your assessment was done:

467	It was done when I was at home
133	It was done when I was in hospital
23	I don't know
14	My assessment was done elsewhere

My assessment was done somewhere else. Please write where your assessment was done:

This questions appears to have been missed by most respondents, but out of the 24 replies, they stated Care home, LRI, Respite, and Day Centres.

Question 4: How long have you been receiving support at home?

79	Less than 6 months
85	Less than 1 year
139	1 - 2 years
154	2 - 5 years
161	Over 5 years

Question 5: How often do you receive support at home?

316	1- 2 times a day
187	3 times or more a day
57	1 - 3 times a week
72	4 - 6 times a week

Most respondents were seeing carers 1-2 times a day for a variety of different reasons.

Question 6: What services do you receive? (Please tick all that apply)

553	Support with personal care such as washing and dressing or toileting
196	Help with taking medication
271	Help with domestic tasks, such as shopping, laundry and making a meal
32	Support with regaining or learning new skills to help you to live independently
53	Support with getting out and about such as using the bus to go and see your GP
74	Help with specific health needs such as treating pressure sores or managing a colostomy bag
91	Help to get around your home using special equipment like a hoist

Other services received included financing, paying bills, applying cream, social skills and company, walking frames and other aids

Question 7: Please tell us what you think is good about the support you receive?

We received 512 comments where nearly all of the respondents left positive comments. The below were the most common points/words stated:

- Someone to talk to, company
- Support
- Reliable
- Safe
- Calm
- Clean
- Helpful
- Friendly
- Caring
- Independence

"Having a carer come to my house on a daily basis helps greatly. I would not be able to get out of bed and get ready myself due to my disabilities so it is nice to have support from someone who is happy and willing to help me"

A number of family members commented on the role they undertake with the person receiving care and how they found the support:

"I am the wife of a person who receives the care and support. I am his main carer, but the help we receive is vital to keep my husband at home, he has home oxygen and also needs 8 hrs a day on a ventilator."

"I am writing as main carer that Mum and I get really good help as with my small children it was too much of a burden on me to look after her daily hygiene. Although I am there with her in between the carers."

Question 8: Please tell us how your support could be better?

We received 380 comments to this question. The below were the most common points/words stated:

- Better visiting times
- Punctuality need addressing
- Not as rushed
- More flexibility
- More frequent visits
- Talk for longer
- More consistency
- Language is an issue
- Poor communication from agency offices
- More support with domestic chores

"It would be better if I know who and when the carer is turning up"

"To have familiar faces instead of someone different every day. To read the notes daily in case there has been any changes. To ask where the dustbin is instead of putting soiled pads in the kitchen bin. To have a manager/supervisor to call once a month so that the care can be discussed. To arrive at an agreed time daily so not to leave vulnerable people stuck in bed for sometimes an hour and a half late!"

"Punctuality/time keeping erratic"

However a large amount of respondents stated that they were satisfied with the help they are currently receiving and could not offer any suggestions.

Question 9: Do you know who to contact if you want to change the way your support is organised, for example if you wanted to cancel a visit for a day?

559	Yes
30	No
26	I don't know

Question 10a: Do you feel the support you receive at home helps you to stay well and as independent as possible?

586	Yes
28	No
20	I don't know

Question 10b: Can you tell us how the help you receive at home supports you to stay well and as independent as possible?

Question 11: Is there anything else you would like to tell us about the support you get at home?

Question 12: If you have any general views on domiciliary care services please tell us.

Due to the nature of responses received, the responses to the above 3 questions have been combined to give an overall summary:

Many people reiterated comments left in question 7 when responding to the support they receive. The majority stated they were very grateful for the service as it enables them to stay at home longer, have support with daily tasks to keep them happy and live fuller lives. Many commented that they looked forward to their carers visits, and enjoyed the company and having someone to talk to.

A number said they were glad to give relief to family members and were appreciative of all that was done for them.

There were however many suggestions for improvements; the most common are highlighted below:

- Specialist nurses needed

- More help of family carers
- More consistency of quality of carers
- Communication with agencies needed improving
- Some carers did not speak to the service user on visits which left them feeling isolated
- Better training for carers including how to deal with elderly patients and dementia care

Other suggestions:

"To help train the family to get patient into routine of eating, sleeping, resting during the day. This enables family to plan their daily duty around these times."

"Some carers are very good but some try to do as little as possible. I think carers need to know more about dementia, they should do what is in the care plan and not ask the person with dementia because they forget. Sometimes my grandma will say she'll do it herself something to eat, some carers say ok not realizing she'll forget"

Question 13: If you have any views about way the NHS and Council are thinking about buying and managing domiciliary care services together as one organisation in future, please tell us what you think.

We received 231 comments to the final survey question. Although the majority of respondents said they would be happy for this change, there were a number of caveats and uncertainties about what this would mean in the future for patients.

The main concerns were:

- reduction in services
- changes in carers and agencies
- making care worse/more disorganised
- reduction in standards

Others asked questions such as:

"Would I have to be assessed again and would I lose my hours"

"I hope we are notified what is happening"

"I don't know, will it cost you more? Will the care be the same standard?"

A small number thought this was a bad idea, and asked for the service to be *"left alone."*

"Mum is happy as things are. Mum has got dementia and to change things just upsets her and it takes a long time for her to adjust"

Demographic highlights

A total of 587 out of the 633 respondents completed the demographic data; some was however left incomplete. From the responses received the majority stated they were female (67%) to 31% male. A total of 7 respondents did not state their gender. For of the female respondents

none identified that they were currently or recently pregnant. The majority of respondents (58%) stated that they were over 76 year old and 25% were between 60 and 75 years old. All age ranges collected were from between the ages of 25 and 76+. The most popular stated religion was Christian (51%) and 24% stated they were Hindu. The majority of respondents were British (56%) with the second most popular choice as Indian (33%).

Most patients stated they were widowed or were the surviving partner (38%). Of the 87% who said they had a disability, the main type stated was a physical condition (78%). 37% said their condition was a long standing illness or health condition, but many respondents ticked more than one option.

Other disabilities not listed but left in the comments ranged considerably however 17 responses stated Dementia or Alzheimer's as conditions.

A full breakdown of feedback is available from the Leicester City CCG engagement team on request.

6. Other feedback

28 respondents that contacted the commissioning team over the phone and some chose to leave comments. Individuals made the following comments in relation to the service they or their family receive:

- I'm very happy with the care worker, last week I went out for three hours for the first time in ages, I know my mum is in safe hands and that they will call me or get medical help if my mum is unwell
- It's important that workers are friendly and reliable – my current workers are
- The quality of care is generally good but I'm frustrated by some carers who struggle to communicate with my daughter who has limited speech
- The care my dad gets is generally very good but I've been frustrated by some carers not being trained to give eye drops, the district nurse has to come out then and this seems like a waste of time when the carer could have been shown how to do this
- I'm determined not to go into residential care and this service helps to ensure I can stay at home

7. Summary of findings

The below bullet points highlight the combined key themes from all qualitative and quantitative data collected from patients during the engagement phase:

- Current domiciliary support services are, in the main, very good
- Many services that were noted as being received by service users were personal care support.
- The vast majority of respondents were grateful for the support they receive.
- Reasons why services were good were stated as:
    - Someone to talk to, company
    - Reliable
    - Safe
    - Calm
    - Clean

    - Helpful
    - Friendly
    - Caring
- Suggestions of how services could be made better were:
    - Better visiting times
    - Punctuality need addressing
    - Not as rushed
    - More flexibility
    - More frequent visits
    - Talk for longer
    - More consistency
    - Language is an issue
    - Poor communication from agency offices
    - More support with domestic chores
- The majority of respondents stated they were very grateful for the service as it enables them to stay at home longer, have support with daily tasks to keep them happy and live fuller lives.
- Many commented that they looked forward to their carers visits, and enjoyed the company and having someone to talk to.
- A number said they were glad to give relief to family members and were appreciative of all that was done for them.
- The main concerns about jointly commissioning services were:
    - reduction in services
    - changes in carers and agencies
    - making care worse/more disorganised
    - reduction in standards
- Others asked questions about jointly commissioning services were:
    - “Would I have to be assessed again?”
    - “Would I lose my hours?”
    - “Will it cost more?”
    - “Will the care be the same standard?”
- A total of 587 out of the 633 respondents completed the demographic data; some was however left incomplete.
- the majority stated they were female (67%) to 31% male.
- The majority of respondents (58%) stated that they were over 76 year old and 25% were between 60 and 75 years old.
- All age ranges collected were from between the ages of 25 and 76+.
- The most popular stated religion was Christian (51%) and 24% stated they were Hindu.
- The majority of respondents were British (56%) with the second most popular choice as Indian (33%).
- Most patients stated they were widowed or were the surviving partner (38%).
- Of the 87% who said they had a disability, the main type stated was a physical condition (78%). 37% said their condition was a long standing illness or health condition, but many respondents ticked more than one option.
- Other disabilities not listed but left in the comments ranged considerably however 17 responses stated Dementia or Alzheimer’s as conditions.

8. Next Steps

This feedback is now being considered by the commissioning teams and where it relates to aspects of service that can be addressed through contract terms, these will be added in. The key positive aspects of a good service will be captured in the specification to enable providers to build this into recruitment and training. The areas for improvements identified through the

feedback are listed below with suggestions for how these should be handled. This approach is also taken for the areas of concern in relation to joint commissioning.

Concerns raised through engagement	Our response
Better visiting times	Timing of visits is agreed during assessment; the actual times that care workers visit is monitored by ECM (Electronic Care Monitoring) and is a performance Indicator in the contract.
Punctuality need addressing	This is monitored by ECM (Electronic Care Monitoring) and is a performance Indicator in the contract.
Not as rushed	Care packages are commissioned to meet needs and outcomes. If a package feels rushed to the service user they or the provider on their behalf can raise this with the appropriate care manager and ask for a review.
More flexibility	There is often a degree of flexibility built into the care package. This can also be discussed with the provider.
More frequent visits	Care packages are commissioned to meet needs and outcomes. If the service user or the provider on their behalf feels that a package needs to be reviewed, they can raise this with the appropriate care manager.
Talk for longer	We would expect care workers to chat with service users during the visit. If a service user feels that this doesn't happen, they should use the provider's complaints procedure.
More consistency	If this relates to consistency of care staff visiting the service user, we monitor this through ECM. It is a key performance indicator. It is also a question at ITT (invitation to tender) stage of procurement.
Language is an issue	We expect providers to recruit staff form their local communities and match service user requirements such as language and culture as much as possible. In practice it isn't always possible to do this all the time. At ITT we ask a question about providers intentions to recruit form the local community and how staff are matched with service users.
Poor communication from agency offices	We expect provides to have a local office and to be available to callers during office hours during their working week (which may include weekends). Outside of this

Concerns raised through engagement	Our response
	they are required to have an answer machine. We set this out as part of the contract.
More support with domestic chores	The content of a package of care is subject to assessment by care managers.

Concern raised through engagement	Our response
Reduction in services	There is no intention to reduce services
Changes in carers and agencies	Unfortunately due to the nature of the procurement process, we cannot guarantee that there will be no change to carers or agencies. This is a potential change regardless of whether we work jointly or as a single agency.
Making care worse/more disorganised	Where there is a change in agency, the contract will require agencies to transfer service users in a seamless way with as little disruption as possible. Alternatively people may choose to take a direct payment or personal health budget in order to continue with the current provider.
Reduction in standards	The contract sets out the standards required of agencies and workers, there is no diminution of these in the new contract
“Would I have to be assessed again?”	If there is a change of provider, the new provider will likely review the service user’s care plan to ensure they fully understand the service user’s needs
“Would I lose my hours?”	There will be no reduction in hours unless a change in care package is approved following a reassessment
“Will it cost more?”	The cost of care to the service user may change if you pay for your own care and have this arranged by the Council. Providers will all be assessed as part of the tender process to ensure quality and price are taken into account.
“Will the care be the same standard?”	The standard of care should not be affected

APPENDIX 2

Leicester City Council

NHS Leicester City Clinical Commissioning Group

Have Your Say - Local NHS and Adult Social Care (Council)

Domiciliary Support Services Customer Survey

Domiciliary Support is a term we use to describe the support and care you receive in your home. This support is provided by an organisation that employs a paid carer or support worker to help you. The support you receive at home can include help with a number of things. This can be help with housework or with personal care such as washing and dressing or with going shopping.

This survey will help us find out what you think about these services and how this support helps you remain well and as independent as possible.

Question1: Please tell us who you are completing this survey as: (Please tick a box)

I am a person who is receiving support at home ☐

I am a family carer or friend of someone who is receiving support in their home ☐

I am interested in the service but not receiving support ☐

If you are not receiving a service but would like to give your own views please go to question 12.

Question 2: Please tell us who did your assessment for the help you receive at home (Please tick a box)

A nurse did my assessment ☐

A social worker or care manager did my assessment ☐

I don't know ☐

Question 3: Please tell us where you were when your assessment was done (Please tick a box)

It was done when I was at home ☐

It was done when I was in hospital ☐

I don't know ☐

My assessment was done somewhere else ☐

Please write where your assessment was done here:

……

Question 4: How long have you been receiving support at home? (Please tick a box)

Less than 6 months ☐

Less than 1 year ☐

1 - 2 years ☐

2 - 5 years ☐

Over 5 years ☐

Question 5: How often do you receive support at home?

(Please tick a box)

1 - 2 times a day ☐

3 times or more a day ☐

1 - 3 times a week ☐

4 - 6 times a week ☐

Question 6: What services do you receive?
(Please tick all that apply)

Support with personal care such as washing and dressing or toileting ☐

Help with taking medication ☐

Help with domestic tasks, such as shopping, laundry and making a meal ☐

Support with regaining or learning new skills to help you to live independently ☐

Support with getting out and about such as using the bus to go and see your GP ☐

Help with specific health needs such as treating pressure sores or managing a colostomy bag ☐

Help to get around your home using special equipment like a hoist ☐

If there are other things you get support with please tell us what they are here:

.....

Question 7: Please tell us what you think is good about the support you receive?

Please write here:

Question 8: Please tell us how your support could be better?

Please write here:

Question 9: Do you know who to contact if you want to change the way your support is organised, for example if you wanted to cancel a visit for a day? (Please tick a box)

Yes ☐

No ☐

I don't know ☐

Question 10a: Do you feel the support you receive at home helps you to stay well and as independent as possible? (Please tick a box)

Yes ☐

No ☐

I don't know ☐

Question 10b: Can you tell us how the help you receive at home supports you to stay well and as independent as possible? Please write here:

Question 11: Is there anything else you would like to tell us about the support you get at home?

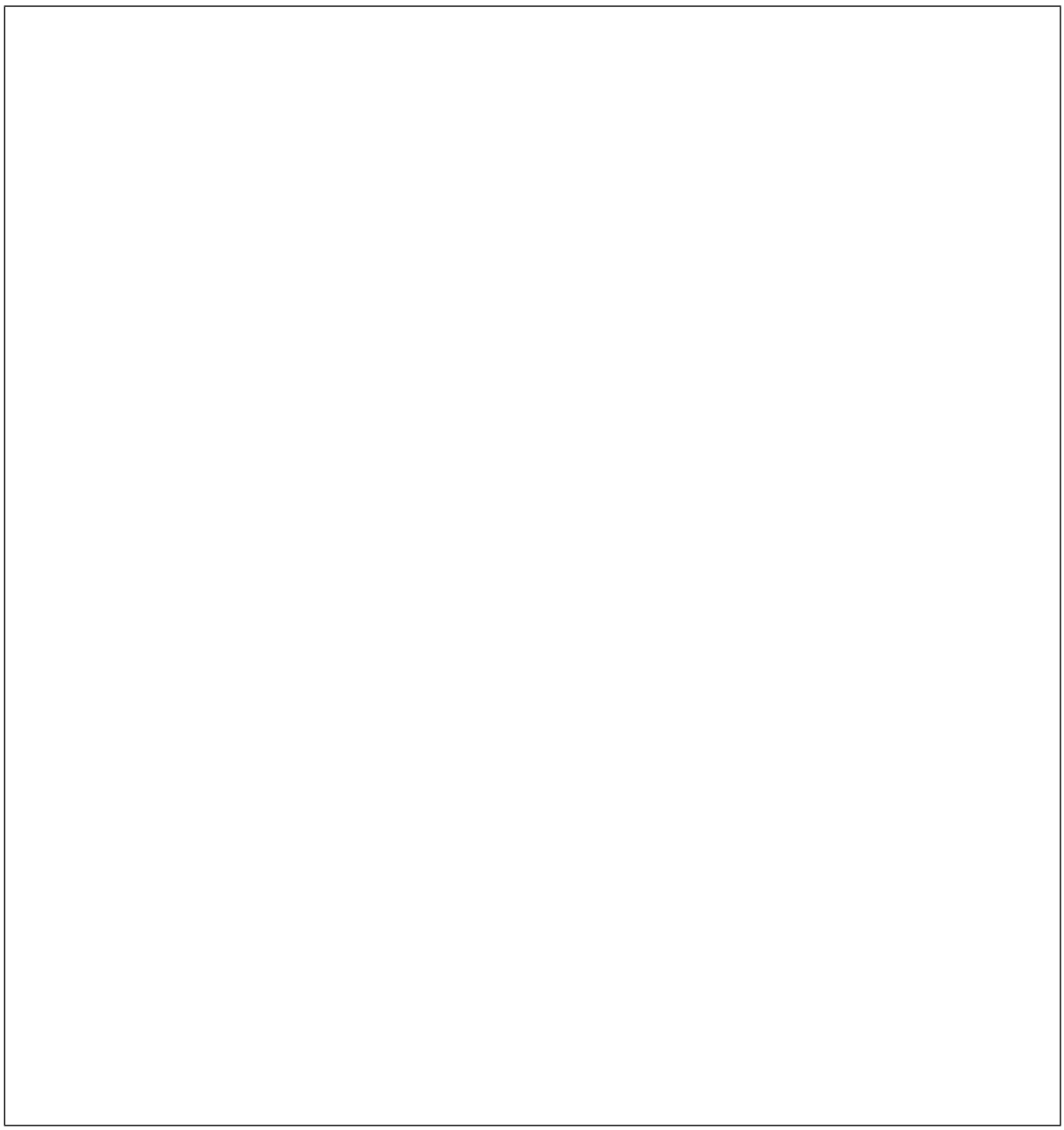
Please write here:

Question 12: If you have any general views on domiciliary support services please tell us below.

Please write here:

Question 13: If you have any views about way the NHS and council are thinking about buying and managing domiciliary support services together as one organisation in future, please tell us what you think below.

Please write here:



To finish, here are some questions about you, but you do not have to answer these if you do not want to.

Appendix 3

Soft Market Testing - Domiciliary Care Provider Engagement Event - 1st August / 2nd August 2016

1) What have you liked and has been positive from today?

Left Blank – 1

- Joint Commissioning (social & CCG)
- Specific number of providers (15-20)
- Duration of contract (7yrs makes it more manageable)
- Carrying over under-utilised hours offer –Flexibility
- The presentation was good, done in a good atmosphere and all the questions raised were adequately dealt with.
- Well considered with awareness of "unknowns" and areas for further thinking / contributions by service users, providers, etc.
- Accepting different size companies – good communication is crucial
- I think the spec will be fair on the way the tenders will be provided
- Tender looks positive.
- Like that the lots are not zoned and that providers can bid for all lots or just the lots they specialise in.
- It could be considered a positive that there are no material changes to the contract. Ranking providers in a live basis is a step forward.
- Seems to be clear lots.
- Ethical considerations are positive
- Open communication and ongoing questions to test provider knowledge and thoughts on the procurement process, examples. Within framework – number of providers to be capped although may open annually if providers exit the market. Call off arrangements – providers to be selected by CQC rating.
- Jointly commissioned
- High quality aspect
- 7 yrs. commissioning
- Open framework
- Useful information provided regarding the contract and specification. Also questions answered.
- Open discussion about the intention of the procurement team
- Good delivery of information
- No PQQ
- Framework not zones
- length of contract
- Openness of LA / CCG partnership approach
- More clarification

- Clarity on what this contract is all about
- Citywide 7 year contract
- So far what has been proposed seems good.
- Banking of hours is positive for the service user. Looking for a number of providers, rather than 1 provider per zone lot
- Joint commissioning allowing continuity of care to service user
- Review of existing contract
- Clear direction and able to answer questions openly and honestly
- Info given has been clear and allowed for a number of questions
- Open sharing of information
- Increase in the number of providers
- The proposal from authorities about discouraging zero hour contract
- More time for carers and clients
- Travel time payments
- Ethical Care Charter
- Waiving ECM from complex care cases (may be)
- 7 years contract gives stability and gives you time to work with your staff
- Contract opening
- PQQ
- Proposed type of Framework i.e. no zones – this means that a specialist niche provider providing high quality specialist services to those clients with Neurological conditions and practicing at the leading edge of this specialism will not be disadvantaged.
- Lots – Complex
- Very much positive today. I have high spirits to fill up the tender and had a
- Meeting with major personalities from LCC and Leicester City CCG.
- Was able to suggest Care Services in Prison.
- Learnt about consortium.
- Price analysis was good.
- The meeting went well, good presentation and clear communication, questions were answered well.

2) What have you disliked or has been negative from today?

Left Blank – 3

N/A - 3

- Rate window is not a good thing as different costs are involved per provider
- No nothing really
- Very little
- Children's tender very low
- The limit to number of providers for contracts

- Continued billing using contact time from ECM increases the level of risk for a provider significantly
- Leicester is known for the lowest pricing structure nationally and my worry is the prices are too low
- Was hoping to have an indication of hours / pricing today as we need to see that the additional impacts of NLW currently and recruitment, usual on costs, travel, time, etc. are taken into consideration.
- None
- Assumption that everyone is at the same level
- Not anything
- Banking hours – complex, potential for issues and to zones
- Presentations good but appears as if certain information was being held
- ECM – being a small provider may find difficult to invest in IT for ECM. All our service users don't have landline. Training for staff in ECM is also expensive.
- Nothing in specific
- There has not been enough information provided like the draft spec for us to form a proper opinion
- If you want an outcome based model of care how will this really work with ECM and having banding
- Would have liked to have seen the specs from Lot1 – Lot3
- A presentation from potential children's lot explaining what is needed from providers and the type of support required
- No contribution on ECM
- Number of providers in the framework is less
- No contribution in care monitoring but may factor that in pricing
- Not enough information provided to enable me to form an opinion
- Nil
- There was nothing to be disliked. Everyone seemed to be happy and
- Very informative. Preference must be given to those companies who are in Leicester (to apply for this tender).

- I can suggest, 5% reserved quota for those companies who want to open offices in Leicester. You need to decide how many companies can be approved under this quota
- There was nothing that I would say was negative maybe if we attend more meetings in future we will be able to compare and have a feedback.

3) Is there anything that you have heard today that would stop you from applying at tender? If so, what and why?

Left Blank – 2

No - 13

- Would select specific lots, due to inherent specialism in current organisation
- The price range combined with recovering rate from the ECM needs to be sustainable. A recent contract in an existing location was unsustainable and we did not bid.
- Pricing model and volume
- Nothing from the presentation today would prevent application
- If all the ethical charter was implemented this could impact upon the provider financially. It will be interesting to see what areas are covered within the ITT. We are all striving for the same thing and want to provide the very best service supporting the service users and staff. It would be a shame if providers were penalised for doing their very best to provide these.
- If the price did not incorporate the travelling time and travel costs and mobile expenses it would prove expensive to the company.
- Not sure about the criteria and whether it is worthwhile for new providers to apply. The criteria have not been explained.
- Don't think so
- Nothing yet
- Very limited numbers of contractors required meaning no chance for me a small Leicester based provider to pull through. Large established providers will go through.
- ECM
- No if anything it has allowed me to go back to my provider and want to apply more
- Nothing from today, However final decision on whether to tender will depend on the price range
- Yes, right now EVERY PROVIDER IS expecting to be on the framework by next year. I think it will be really bad and huge loss for the community if someone else takes over who is not even operating in Leicester and does not know the community of Leicester in full.
- No everything was well presented and we will be looking forward to applying for future tenders.

4) How much interest would there be from the market in a children's lot were included in the tender?

No Interest – 4

Yes Interested – 10

Left Blank – 4

Not sure – 4

- With distinct caution. The breath and nature of the service would need significant clarification to include all care needs; such as Mental health, Autism, LD?
- As a provider who already supplies to LCC disabled children, we would be very interested in a lot and would bid for this
- Will look at it
- Need further information but at this stage we would be interested
- We don't provide children's services currently and don't envisage that would change.
- The contract would not currently be able to deliver by the business as we wold have to employ additional staff with additional training
- £220k was the figure given. This is a very small need. Detail would need to be provided on the numbers of service users and hours.
- It may limit the interest as not all providers are registered for this. It can be extremely hard to deliver these services.
- Would like more information on what type of care you are looking to be provided.
- Interested in children's complex, nurse led packages
- Very keen for this lot as per our expertise
- Confident care providers will bid
- Very interested – this could attract young carers who may not be very much interested in working with older adults but would then be comfortable in working with children
- We do not deliver children's services
- As a specialist Neuro provider for all ages CYP / transition and adults we would be interested in both CCG and CC complex care clients.
- We assume 20%.
- 40%

5) Are there any specific details you would like to know from children's services point of view.

No Interest – 5

Yes Interested – 4

Left Blank – 6

N/A – 6

- Breakdown of complex children
- Would the services include CCG packages?

- Not at this time. We are aware of children's services and already have relationships with the team that provides the services.
- What kind of support for the child or support for the family?
- Number of cases, hours, geographical areas (numbers in each area), complexity
- breath, nature, demand and related support networks
- Is there any specific / special registration or requirement need in order to provide services to children and their families
- It would be helpful to know statistics in relation to how many fall into different categories e.g. hearing disabilities and the current age range with numbers that currently receive services.
- Possible potential hours, service draft spec to understand groups needing support
- Complex support service definition would be helpful, with a breakdown of needs / volumes
- Yes, what kind of support for the child or support for the family
- Number of children's care packages
- Expected number per year
- Clinical interventions
- % complex V Dom care packages
- Pricing Matrix
- Spec information, number of children expected to support
- Value
- Need to have more information on the hours of the children care provision
- Amount of work
- Authorities expectations
- Number of providers required
- How else be utilising the framework
- Eligibility criteria
- I engaged with the representative from Children's service on the day.
- Average number of cases per month or year / number of care hours and duration of a shift / value of the tender
- Types of cases and what specialisms are required?
- CCG to also participate in the CYP part of the framework
- No, we are already working towards this subject.
- At the moment we are registered to provide adult care but in future, if there are new openings we might consider.

6) Any other comments / information / issues you wish to share?

Left Blank –10

No – 4

- I have some concerns regarding ECM. We currently use ECM and there are instances where the system fails – service user using the phone, phone not working, etc. I therefore feel it will be very onerous to reconcile invoicing & performance based reports on an ECM system supplemented with normal sign in sheet when the ECM is down.
- Complex support service definition would be helpful, with a breakdown of needs / volumes.
- Any home care service can be delivered by a provider within reason. It always comes back to the cost to deliver that service request
- Price is what providers want to know this was not discussed today and therefore difficult to comment if this is a tender viable for complex
- Any indication of uplifts, rather than just a provision to review, considering it is a 5 year contracts any future pay implications.
- Case studies for types of children's day care
- Confirmation of hours available across the 2,000 approx. clients
- To look at a kind of tolerances or variations in the commissioned hours and invoice processes
- Breakdown by user group / age range
- Transition children / adult service –Nice Guidance on Transition April 2016
- Ethical charter – stage 2/3, living wage / zero hours
- ITT
- NHS Toolkits
- Ethical Charter – zero hours, living wage of £7.65 as opposed to NLW of £7.20
- Just completed a day services tender in Leics County Council was simple and easy to follow, portal was easy
- Can you pleas provide QMF info
- Communication between all parties is really needed
- Any year you planning on adding new supplier
- Care services in Prison should be considered
- Every provider thinks they are the best. Bidding process is not easy to win a tender.

Appendix C

Adult Social Care Scrutiny Commission

Increasing Demand in the Working Age Adult Population

Date: 8th September 2016

Lead Director: Steven Forbes

Useful information

- Ward(s) affected: All
- Report author: Ruth Lake
- Author contact details: 454 5551
- Report version: 1

1. Summary

1.1 This report provides an overview of the issues relating to a rise in demand for Adult Social Care services from people aged under 65.

1.2 The report sets out the activity date but also identifies the factors that may influence this trend, noting the role of ASC but also other agencies and of individuals themselves in managing this pressure into the future.

2. Recommendations

2.1 The Adult Social Care Scrutiny Commission are recommended to note the contents of this report and make any comments

3. Report

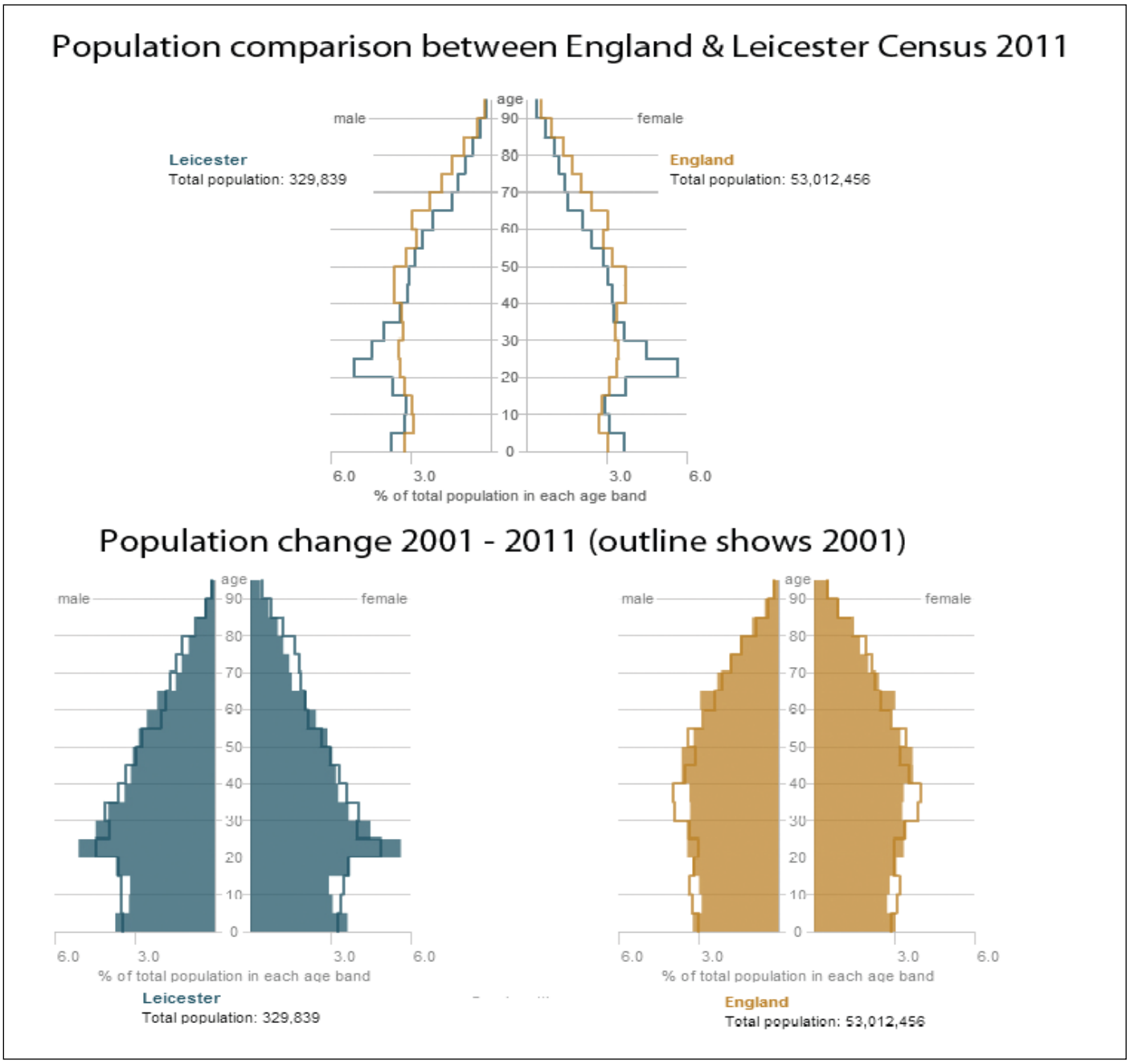
3.1 Context

3.1.1 Nationally, there has been growing concern about the ability of social care and health services to manage the cost and capacity pressures that arise from an ageing population. The widely held view is that people are living longer, with a more complex range of health conditions and disabilities, including dementia, which is putting services under increasing strain. In the context of reducing resources, there is a real concern that services will simply not be able to cope.

3.1.2 Within Leicester City, it has been noted that there has been significant growth in demand for support from people who are of working age, which adds a different context to the local challenge.

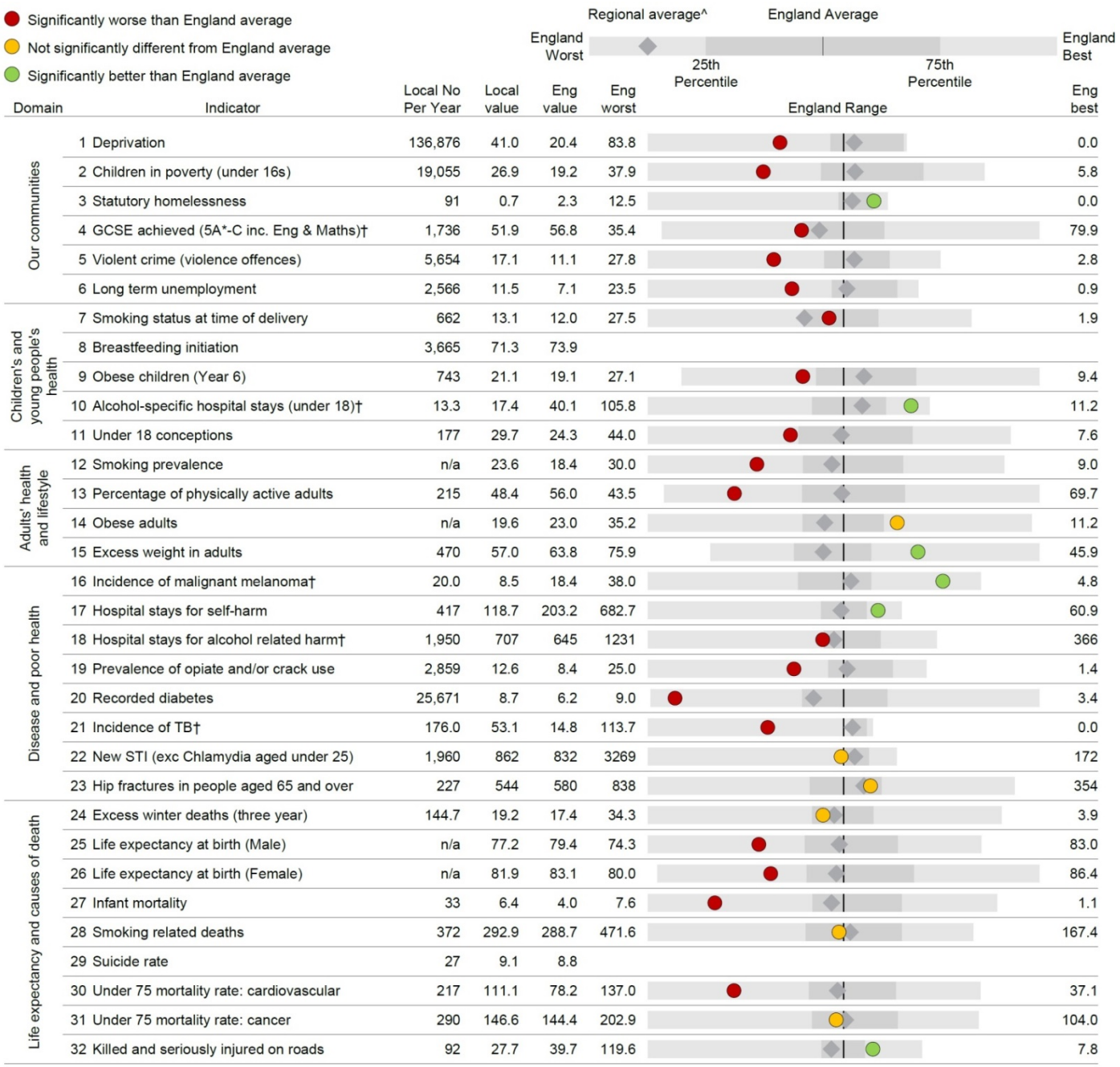
3.2 Our population

3.2.1 We know that the population in the city is younger than the national average but also highly deprived.



3.2.2 In many of the indicators of population wellbeing, people fare poorly.

Health indicators for Leicester compared with England

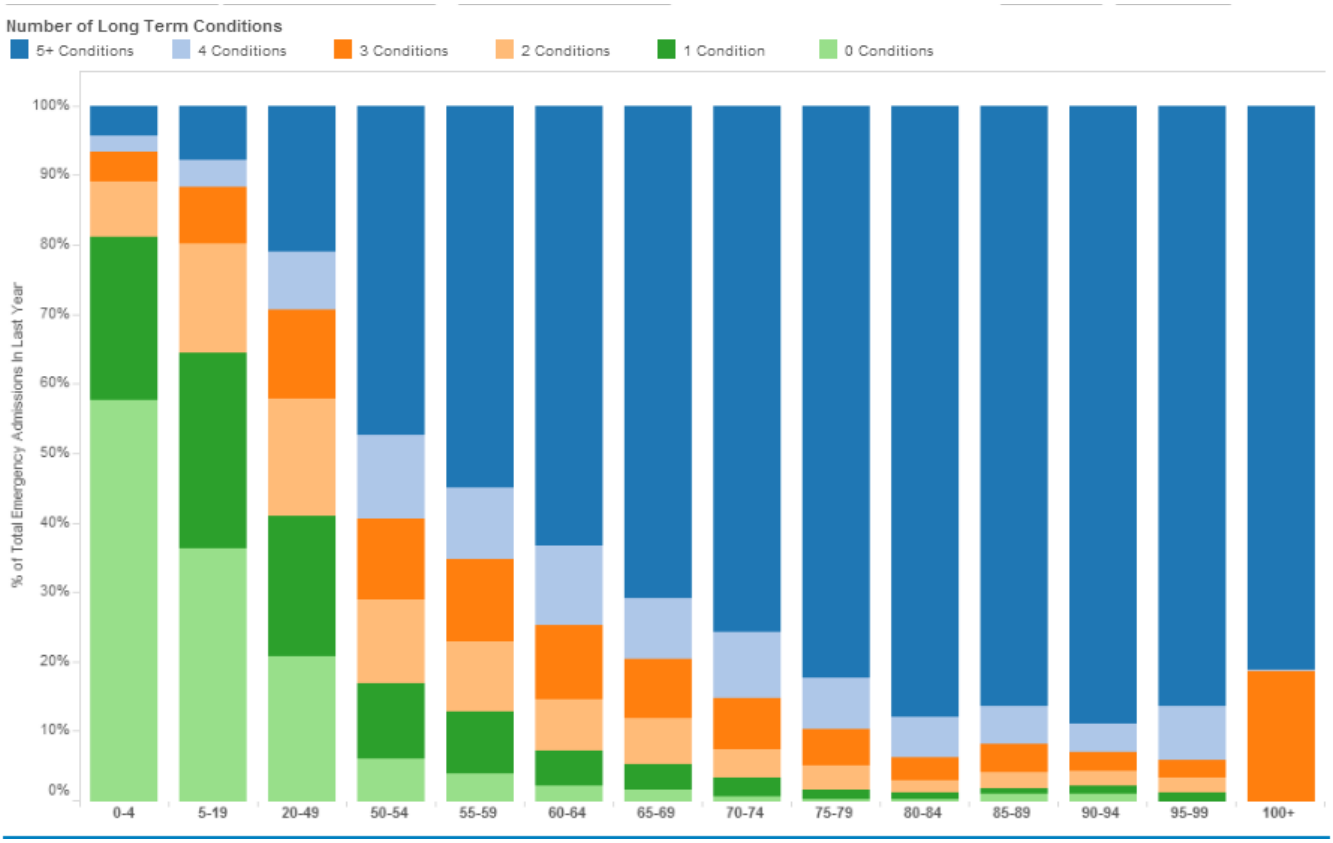


Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	Eng best
Our communities	1	Deprivation	136,876	41.0	20.4	83.8	0.0
	2	Children in poverty (under 16s)	19,055	26.9	19.2	37.9	5.8
	3	Statutory homelessness	91	0.7	2.3	12.5	0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)†	1,736	51.9	56.8	35.4	79.9
	5	Violent crime (violence offences)	5,654	17.1	11.1	27.8	2.8
	6	Long term unemployment	2,566	11.5	7.1	23.5	0.9
Children's and young people's health	7	Smoking status at time of delivery	662	13.1	12.0	27.5	1.9
	8	Breastfeeding initiation	3,665	71.3	73.9		
	9	Obese children (Year 6)	743	21.1	19.1	27.1	9.4
	10	Alcohol-specific hospital stays (under 18)†	13.3	17.4	40.1	105.8	11.2
	11	Under 18 conceptions	177	29.7	24.3	44.0	7.6
Adults' health and lifestyle	12	Smoking prevalence	n/a	23.6	18.4	30.0	9.0
	13	Percentage of physically active adults	215	48.4	56.0	43.5	69.7
	14	Obese adults	n/a	19.6	23.0	35.2	11.2
	15	Excess weight in adults	470	57.0	63.8	75.9	45.9
Disease and poor health	16	Incidence of malignant melanoma†	20.0	8.5	18.4	38.0	4.8
	17	Hospital stays for self-harm	417	118.7	203.2	682.7	60.9
	18	Hospital stays for alcohol related harm†	1,950	707	645	1231	366
	19	Prevalence of opiate and/or crack use	2,859	12.6	8.4	25.0	1.4
	20	Recorded diabetes	25,671	8.7	6.2	9.0	3.4
	21	Incidence of TB†	176.0	53.1	14.8	113.7	0.0
	22	New STI (exc Chlamydia aged under 25)	1,960	862	832	3269	172
	23	Hip fractures in people aged 65 and over	227	544	580	838	354
Life expectancy and causes of death	24	Excess winter deaths (three year)	144.7	19.2	17.4	34.3	3.9
	25	Life expectancy at birth (Male)	n/a	77.2	79.4	74.3	83.0
	26	Life expectancy at birth (Female)	n/a	81.9	83.1	80.0	86.4
	27	Infant mortality	33	6.4	4.0	7.6	1.1
	28	Smoking related deaths	372	292.9	288.7	471.6	167.4
	29	Suicide rate	27	9.1	8.8		
	30	Under 75 mortality rate: cardiovascular	217	111.1	78.2	137.0	37.1
	31	Under 75 mortality rate: cancer	290	146.6	144.4	202.9	104.0
	32	Killed and seriously injured on roads	92	27.7	39.7	119.6	7.8

This is notable for issues relating to lifestyle, such as smoking, levels of activity and diabetes

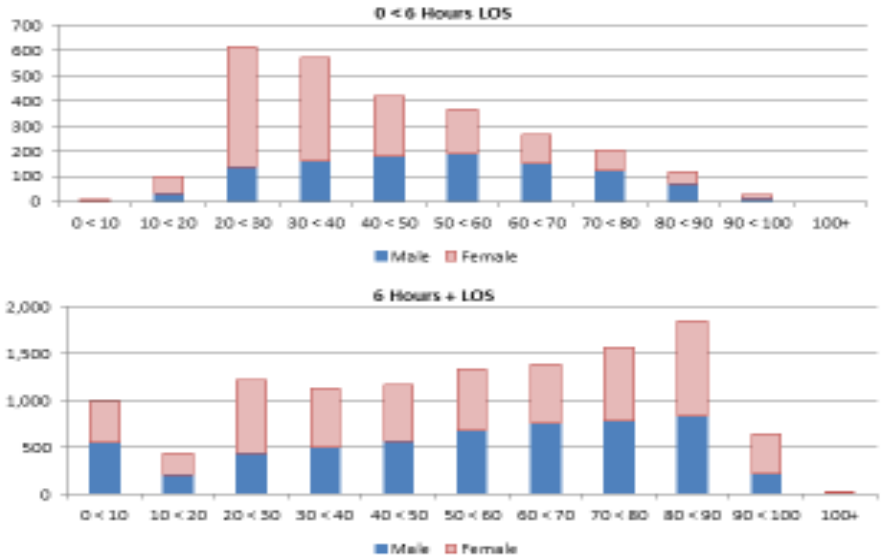
3.2.3 The correlation with demand for services is evident. Rather than simply age alone driving

demand, we can see that it is the presence of multiple long term conditions that does so. As these are prevalent across a wider adult age group than on other areas, and are significant in number, it is perhaps unsurprising that working age adults are a demand pressure.



3.2.4 In terms of acute activity, the health system has noted the growth in emergency admissions within the working age adult profile and also the short Length of Stay (LOS) for this cohort. The following table illustrates the activity by gender and age, highlighting the demand from short stay emergency admissions in the working age adult population.

2015/16 emergency admissions profiled by LOS, age and sex



- High volume of short stay admissions in 20-40 age bands, increasing in number year on year (18% growth 13/14 to 14/15; 39% growth 14/15 to 15/16)

3.2.5 With regards to ASC clients, the table below identifies that change in our client base over the course of 2015/16. It is notable that:

- There was a net increase of 54 working age adults with mental health needs (11% growth)
- There was a net increase of 83 working age adults with physical disabilities (12% growth)
- The numbers of older people supported is relatively static

LONG TERM SU NUMBER MOVEMENT IN 2015/16

	MENTAL HEALTH			LEARNING DISABILITY			PHYSICAL DISABILITY			OTHER			TOTAL		
	< 65 yrs	65+	Total	< 65 yrs	65+	Total	< 65 yrs	65+	Total	< 65 yrs	65+	Total	< 65 yrs	65+	Total
SU Numbers at 1 April 2015	**489**	**977**	**1,466**	**828**	**139**	**967**	**711**	**1,970**	**2,681**	**66**	**44**	**110**	**2,094**	**3,130**	**5,224**
New long term SU numbers in year	**110**	**164**	**274**	**71**	**1**	**72**	**173**	**629**	**802**	**22**	**9**	**31**	**376**	**803**	**1,179**
(of which Long Term Residential)	*17*	*17*	*34*	*3*	*0*	*3*	*0*	*16*	*16*	*0*	*2*	*2*	*20*	*35*	*55*
SU enders in year	**56**	**247**	**303**	**67**	**10**	**77**	**90**	**512**	**602**	**35**	**25**	**60**	**248**	**794**	**1,042**
Net change in long term SU numbers	**54**	**-83**	**-29**	**4**	**-9**	**-5**	**83**	**117**	**200**	**-13**	**-16**	**-29**	**128**	**9**	**137**
SU Numbers at 31 March 2016	**543**	**894**	**1,437**	**832**	**130**	**962**	**794**	**2,087**	**2,881**	**53**	**28**	**81**	**2,222**	**3,139**	**5,361**

3.2.6 Local intelligence on contact during this year (2016/17 to date) identifies that we are receiving more contacts about people under 65 than we are for over 65's.

Count of Person ID	Age band	
Action Taken	Over 65	Under 65	Grand Total
Information/Advice Given Only	366	534	900
Link to Existing Case	176	66	242
Link to Existing Safeguarding Adults Episode Only	1	1	2
No Further Action from Contact	177	138	315
Progress to New Case	436	424	860
Service at Point of Contact	24	9	33
Signposted to Other Agency	556	690	1246
Start New Safeguarding Adults Episode Only	60	33	93
Grand Total	1796	1895	3691

3.3 What does this mean?

3.3.1 Demand for services is driven by people who have multiple long term conditions (LTC). In Leicester people are living with multiple LTCs at an earlier age than in other parts of the country. This can be seen to translate into demand for urgent care as well as ongoing health and social care services in the working age population that is above that which you would expect to see. The table below illustrates the higher numbers of people being provided with long term support, but also noting the comparatively lower cost per individual due to low unit costs for services in Leicester. It is numbers of people rather than costs of services that is driving the local pressures.

Supported adults 18-65 comparator data

(all 2014/15)	**Leicester**	**Comparator average**	**England average**
Number of 18 – 65 supported in residential / nursing care	410	247	311
Number of 18 – 65 receiving long term community support	1,925	1,214	1,570
Number of 18 – 65 supported	2,335	1,461	1,881
Average annual cost per person 18 - 65	£18,008	£18,359	£21,828

3.3.2 There is also an impact on informal care in the city, as the population that we might be expecting to care for an ageing population may themselves be living with health conditions.

3.3.3 The precipitating factors, given the available public health information, can be linked back to issues that affect people from birth – deprivation and unhealthy lifestyles resulting in high levels of physical and mental health needs.

3.3.4 Our recent concentrated efforts to work with older people, through the Better Care Fund (BCF), can be viewed as positive given the city is bucking the trend in this area: static, moving towards reduced, emergency admissions and a steady state in social care clients. The initiatives in place have been designed around a cohort of people that are 'frail'. However the growing demand in working age adults will need a different, tailored solution. This will be the focus of the integrated systems of care that are now moving forward, building on the BCF work to date.

3.4 A sustainable future?

3.4.1 By the time people present at the ASC front door it is too late to make any meaningful intervention to improve health and reduce demand for care. Opportunities to reduce dependency can be effective in delaying the need for care and this is where our preventative focus has been, at this tertiary level.

- Our approach to advice, information and guidance is predicated on giving people an early and meaningful offer that helps them to find solutions within their own or community resources. By giving relevant advice, people can access support that promotes their overall wellbeing and also meets specific needs, such a community involvement.

- Our reablement service is a long established offer to people who appear to have needs that, if not addressed, may require care and support from ASC. Primarily aimed at people with functional restrictions or age related issues, it has demonstrated its effectiveness in supporting people to become more independent, with around 51 – 53% of people being fully independent at the conclusion of the reablement intervention.

- Enablement is a new service from April 2016, complimentary to reablement, in offering independence focussed support to people with learning disabilities and mental health issues. It aims to enhance people's ability to self-care, to participate in community activities, to find work, training and with practical issues such as budgeting and travel training. It offers a 12 week intervention and due to the short time that this service has been operating the performance data is still emerging. However this has been a service gap and it is anticipated that it will significantly reduce the dependency of people on statutory services.

- The department is currently looking to develop its assessment and support offer to an asset based approach. Whilst we already focus on people's strengths during the assessment process, there is an opportunity to develop a more explicit asset based model and this has been adopted in other areas with some early indications of success in reducing need for statutory services.

3.4.2 The real challenge lies in tackling the factors against which good or poor health are predicated. The city has had a very positive uptake of the NHS Health Checks programme. The Health Checks programme goes some way to helping to address the impact of deprivation and can be seen as a 'mid-life MOT'. All adults aged 40-74, who do not already have any pre-existing conditions (as GPs will be aware of these patients and managing them anyway) will be invited once every 5 years on a rolling basis to have a Health Check. This enables early identification of health problems or factors which could lead to health problems, such as weight / smoking etc and improved treatment / self-care.

3.4.3 The health and care economy is beginning to pull together its focus and resources in relation to preventative work through the Sustainability and Transformation Plan. This is vital if the city is to effectively target those people who will, in future years, create a demand for services that cannot be afforded.

3.4.4 It should be noted that the public health strategy in development will have a strong focus on mental health, this being an important factor in determining overall health and wellbeing.

4. Financial, legal and other implications

4.1 Financial implications

Our *overall* growth in service user numbers in 2015/16 was 2.6% (as per the table on page 7) and the impact of this together with the increased cost of service users as their condition deteriorates has been included in the budget for care package costs. The growth in service user numbers by individual age groups and service need is continually reviewed and any significant change will be factored into the budget.

Martin Judson, Head of Finance

4.2 Legal implications

There are no direct implications arising from this report Pretty Patel, Head of Law ext 1457

4.3 Climate Change and Carbon Reduction implications

There are no climate change implications resulting from this report

4.4 Equalities Implications

Equalities considerations in keeping with our Public Sector Equality Duty (PSED) tend to be reflective, considering service take up by and outcomes for service users on the basis of the protected characteristics relevant to that service provision. An evidence base capturing protected characteristics needs to be in place in order for us to be able to demonstrate that we satisfy our PSED requirements: that we do not discriminate against any particular group because of their protected characteristic(s), that we promote equality of opportunity in regard to the achievement of intended service outcomes, and that we foster good relations between different groups of people. The report presents an emerging trend. From an equalities perspective, the main consideration is the collection of information on the protected characteristics of those featured within this emerging trend and that the implications of this profile be considered during the various stages of any proposed programme development arising, to ensure that due regard is paid to our PSED duty. Irene Kszyk, Corporate Equalities Lead, ext 374147

4.5 Other Implications

None noted

5. Background information and other papers:

N/A

6. Summary of appendices:

N/A

Appendix D

Adult Social Care Scrutiny Commission Briefing

8th September 2016

Disability Related Expenditure (DRE) Consultation Findings

Lead Director: Steven Forbes

City Mayor

Useful information

- Ward(s) affected: All
- Report author: Stuart McAvoy
- Author contact details: 37 4004

1. Summary

1.1. Most non-residential social care service users pay a charge towards the cost of their services, based on a means test which assesses how much they can afford to pay. A part of this means test considers Disability Related Expenditure (DRE), which is the extra cost of living that a person faces as a result of their disability.

1.2. The purpose of this report is to provide an outline of DRE and the means test and present the findings from a 12-week consultation on changes to DRE that was carried out between 19th January 2016 and 12th April 2016.

2. Background

2.1. DRE is the extra cost that a person experiences as a result of their illness or disability. Some examples include:

- If a person has an emergency alarm to alert a family member in a crisis and has to pay for this then the cost may count as DRE;
- If a person's disability means that they are unable to manage their garden, then the cost of paying a gardener to keep it tidy may count as DRE;
- If a person's disability means that they have to stay at home for most or all of the day then they may have to heat their home for longer. The additional cost of heating bills may count as DRE.

None of these are costs which would have been incurred if a person didn't have a disability.

2.2. When the Council calculates how much a person has to pay towards their services it considers how much income a person has coming in and how much they need to be left with to live on. The Council has to make sure that a person is left with enough money to cover their costs of DRE.

2.3. Currently the Council allows all single people to keep £20 of their income per week to cover the DRE costs they face. If a person can show that they face DRE costs of more than £20 per week then they keep as much as they need to cover the costs in full. (People who are one of a couple keep £15 of their income to cover these costs).

2.4. The following shows a simplified example of the calculation of a charge for an older person with a pension:

Income	
State Pension	£119.30
Occupational Pension	£125.00
Attendance Allowance	£55.10
Total Weekly Income	**£299.40**
Allowances	
Minimum Income Required	£194.50
Disability Related Expenditure	£20.00
Total Allowances	**£204.50**

This person needs to be left with at least £204.50 to adequately cover their cost of living, including an amount to cover the extra costs associated with their disability. Their actual income is far higher than this amount, so they pay a weekly charge of £84.90 (equal to the difference between their income and allowances: £299.40 minus £204.50).

3. Consultation Approach and Findings

3.1. **Consultation Questions**

3.1.1. The following suggestions were consulted upon:

1) The suggestion in the consultation was to reduce the standard DRE allowance from £20 to £10 per week for an individual (and from £15 to £10 for one of a couple). Where a person has DRE costs of more than £10 a week then they would continue to be allowed to keep the full amount they need to cover their costs.

2) Currently, people sometimes pay for things (such as wheelchairs and incontinence aids) which the NHS should be paying for. The suggestion in the consultation was to disallow items of expenditure which the NHS should be providing from those which count as DRE.

3) Currently, people sometimes privately pay for extra services such as cleaning or additional domiciliary care. The suggestion in the consultation was to disallow items of expenditure where the person is topping up over and above what the Council has deemed necessary to meet eligible care needs.

3.1.2. The maximum additional amount that a person would have to contribute each week as a result of the above changes would be £10. Therefore, in addition, people were asked what the impact for them would be of an increase to their weekly charge of £10.

3.1.3. People were also asked to make recommendations about other ways in which the Council could save money.

3.2. **Consultation Approach**

3.2.1. A comprehensive approach was taken to ensure that all stakeholders had an opportunity to provide their views.

- People were encouraged to express their views through questionnaires sent to all service users (or their representatives) who could have been affected. The questionnaire was also available to complete on the Council's website;
- A telephone helpline was set up to receive comments and also support people with the completion of their questionnaire. A generic email address provided a supplementary route of contact;
- Public meetings were held at different venues across the city;
- Staff attended provider forums, and emails were sent to organisations representing the interests of people in receipt of adult social care services;
- City Councillors and local MP's were all made aware of the consultation.

3.2.2. A total of 641 questionnaires were completed and returned, which represents a response rate of over 20% on the number that were issued to service users. Given the complexity of the issues raised this can be considered a very good response rate.

3.3. **Consultation Findings**

3.3.1. The following provides a summary of the main points raised within the consultation.

3.3.2. **Proposal to Reduce the Standard Amount of DRE**

3.3.3. Nearly half (48%) of those who responded to this question disagreed with the proposal. A quarter (25%) agreed with the proposals. A further quarter (26%) did not have a view. This showed a fairly strong disagreement towards this proposal.

3.3.4. Those who responded in favour of the proposal frequently referred to its fairness. It was also mentioned that this would help the Council to support greater numbers of people with social care needs.

3.3.5. Those who were against the proposals made the following points in their comments:

- The most frequent comment was in relation to the potential to have negative effects on people's finances, and the risk of causing financial hardship. In some cases this was a reference to their own situation, whilst in others it was a reference made to disabled or elderly people in general.

- The second most frequent comment reflected a desire to leave the standard DRE amounts as they are. In some cases this was a general reflection of opposition to the proposals, whilst in others it reflected an opinion that the current levels are appropriate.

- A common comment made was that £10 is not enough to cover the additional costs a person incurs as a result of their disability. However, the consultation materials clearly stated that if a person had eligible DRE costs

in excess of £10, then the actual (higher) costs would be allowed.

- A significant number of comments refer to the need to protect disabled people from the impact of the cuts. There was the view among some that disabled people have been 'picked on' and are on the receiving end of a number of cuts. Others were more general in stating that the proposals are unfair. Comments also reference the fact that these proposals would affect some of the least well off members of society.

- Responses referred to the importance of treating people as individuals, and reflecting the specific circumstances and costs that people are facing.

3.3.6. **Proposal to Disallow Items Which Should be Provided by the NHS**

3.3.7. Marginally more people agreed with the proposal (41%) than disagreed (37%), with the remaining 22% not having a view. This suggests a fairly even split in opinion.

3.3.8. Of those people whose disability related to issues of mobility, there was a much stronger level of disagreement. This could be due to the increased likelihood of this group being affected by changes in this area.

3.3.9. Those who were opposed to the proposals made the following points in their comments:

- Some general comments made the point about the necessity of the items under consideration, and that these are not luxury items where people can avoid the cost.

- A number of people commented on the potential impact on people's health and wellbeing of any changes, as well as the risk that people won't be able to afford the essential support they need.

- The most commonly raised comment was that, in practice, the NHS does not meet all of a person's needs and it is this which leads to a person topping up that support from their own money. The examples given include: waiting lists; overly stringent / onerous NHS criteria; insufficient quantities being provided (e.g. incontinence pads); and only basic (and therefore inappropriate) equipment being provided e.g. wheelchairs which are too heavy to operate.

- Some comments also referred to the potential impact on the NHS of the proposals, with the belief that this could increase costs to the NHS

3.3.10. In addition, several people again referenced the importance of treating people as individuals and considering the person's specific circumstances.

3.3.11. **Proposal to Disallow Items Which Are in Excess of Those Deemed Necessary to Meet Eligible Care Needs**

3.3.12. More people disagreed with this proposal (43%) than agreed to it (32%), with the remaining 25% not having a view or not answering the question.

3.3.13. Those who were in favour of the proposals made the following points in their

comments:

- It was noted within one response that people are in receipt of benefits to cover the additional costs they face. Attendance Allowance and Disability Living Allowance, for example, exist partly to cover the cost of supervision and getting around.

- Some who were in favour of the changes made the comment that this was on the assumption that services were made available to those who needed them.

3.3.14. Those who were against the proposals made the following points in their comments:

- The most common response was that the criteria for receiving services from the Council (or other sources) is high, forcing people to purchase their own support. Similarly, excessive waiting times for receiving support (e.g. stair lifts) can prompt some people to make their own arrangements. There was concern among some that support from the Council will reduce further over time.

- A number of people made the point that the services people are choosing to purchase are basic necessities; where a person needs these, there is no alternative and this therefore represents a justifiable expense. Others noted the importance of keeping people in their own home and the increased likelihood of this being achieved by them spending above the levels included in their support plans.

- General comments were made that the proposals risked penalising the most vulnerable and the poorest people in society, and that people with low incomes need more help.

- There were some comments referring to the importance of treating people as individuals and considering the individual circumstances they face. In this context, the argument was that exceptional cases should still be considered.

3.3.15. **Impact of a £10 Increase to the Weekly Charge**

3.3.16. Half of people (50%) responded that an increase of £10 to their weekly charge would affect them a lot, including how much they have for essential things. A further 9% of respondents indicated that they would consider stopping the Adult Social Care services they receive. 13% would be able to manage the increase, with 19% being affected a little (including how much they have for 'extras and treats'). 11% of people did not answer this question.

3.3.17. The comments made include the following:

- An increase cost of £520 per year is a lot for people who, in the main, have very low levels of income.

- Some people have experienced reductions to their levels of income through moving from Disability Living Allowance onto Personal Independence Payments, and through changes to the Independent Living Fund. The

argument is also made that the cost of living is increasing at a faster rate than changes in income levels (including rent and Council Tax).

- Many comments indicated that people are already struggling to make ends meet. Examples given of the areas where people would have to reduce expenditure include heating, food and clothing. Others state that they would have to go into debt as a result.

- Several comments stated that they would be unable to attend medical appointments as a result of being unable to afford the transport. There could be a consequent impact on people's health, including depression, stress and isolation.

3.3.18. **Suggested Opportunities to Save Money**

3.3.19. Respondents were asked for their ideas of other ways in which to make savings. Appendix A presents a list of the suggestions made.

4. Current Policy Position

Cllr Palmer has made the following statement with regards to the next steps for this consultation process;

"I have looked carefully at these consultation findings. At this stage no changes to current DRE arrangements will be recommended. I am concerned about the potential financial hardship possible changes could mean for people with disabilities. However, given the significant scale of the financial challenge facing the local authority and the national funding situation facing adult social care, this is something that may have to be returned to for consideration in the future. If proposals for DRE changes are considered in the future the views of ASC scrutiny will be sought.

I will be commissioning further work on the issue of items that the NHS should be providing as I believe this area requires further, detailed exploration."

Appendix A – Savings Suggestions From Respondents

Salaries / Wages / Expenses / Management Costs
- Reduce Management costs / wages
- Introduce a wage freeze / cap
- Reduce Expenses (e.g. travel expenses)
- Reduce Mayor's salary
- Reduce Councillor's / Mayor's expenses
- Reduce number of Councillors / Deputy Mayors (or abolish)
- Reduce agency costs

Bureaucracy & Organisation
- Reduce bureaucracy
- Reduce administration costs
- Use phone calls / emails rather than letters
- Join with Leicestershire County Council
- Merge services with NHS (including pooled budgets)
- Reduce the number of agencies providing support
- Increase the outsourcing of services
- Increase in-house provision of services
- Reduce sickness levels

Procurement & Contracting
- Increase use of volunteers (including secondary school children)
- Improve procurement strategies / identify cheaper alternatives / bulk buying
- Increased use of charities
- Use events to raise money (including donations)
- Improve contract monitoring
- Plan transport routes better

Care Management
- Be more stringent in assessing people for services
- Assess people properly and in a timely manner
- Work better in liaising with other organisations/agencies to reduce having to refer between
- Help people live independently (e.g. physiotherapy)
- Reduce legal costs through improved practice
- Support carers
- Improve the Health system / use the NHS more
- Introduce a more thorough means test / increase charging
- Improve the quality of assessments
- Use 15 minute calls for those who don't need half an hour calls
- Reduce money for non-essential services spent on Direct Payments
- Reduce unnecessary visits from social workers
- Identify cases where carers are not needed
- Support families rather than using residential care
- Listen to family members when the need for support has reduced
- Press government to spend more on social care
- Help people better prepare for when they will need support
- Improve the skills and reliability of carers
- Increased companionship to reduce loneliness

- Improved maintenance of equipment
- Introduce a service user representative group to discuss savings options
- Invest in training for staff
- Increase the amount of support from within families
- Charge people for underused services when they go abroad

Non-Social Care
- Reducing fraud
- Don’t spend as much on consultations
- Reduce expenditure on cycle lanes
- Reduce street cleaning (e.g. by making residents responsible for area in front of their house / use of volunteers)
- Better use and coordination of Council vehicles
- Reduce expenditure on sculptures on roundabouts, landmarks etc.
- Reduce expenditure on schemes such as Jubilee Square
- Reduce expenditure on vanity projects
- Reduce expenditure on Golden Mile
- Reduce expenditure relating to travellers
- Reconsider use of assets
- Don’t sell Council assets for a nominal value
- Improved management of contracts
- End public fireworks displays
- Stop the Christmas Lights
- Reduce expenditure on arts and sports
- Reduce expenditure on trees in the city centre
- Reduce expenditure on painting
- Reduce expenditure on new buildings
- Don’t amend dropped kerbs for wealthy families
- Introduce compulsory retirement

Adult Social Care Scrutiny Commission

Draft Work Programme 2016 – 2017

Meeting Date	Topic	Actions Arising	Progress
12th Jul 16	1) Adult Social Care Commissioning Intentions 2016/17 2) Annual Quality of Care Statement for 2015 3) Re-procurement of Domiciliary Care Contracts 4) Draft Scoping Document – End of Life Social Care Review	1) Future plans for delivering the commissioning intentions to be brought to the Commission in a timely manner and some anonymised case studies, regarding independence to be sent to Commission Members. 2) Information on other local authorities' incentive schemes for providers is sent to Members and the Chair to meet with Healthwatch. 3) The Commission is given further opportunities to comment on the re-procurement of domiciliary care support services and a report on the living wage to be added to the Commission's work programme.	
8th Sep 16	1) Quarterly Performance Report: Qtr. 1, April to June 2016/17' 2) Domiciliary Care Re-Procurement 3) Impact of Working Age Adults on ASC 4) Disability Related Expenditure – Outcome of the Consultation.		
25th Oct 16	*Theme: Keeping Vulnerable Adults Safe 1) ASC Strategic Priorities – Half Year Update 2) Local Account for 2016/17 3) Leicester Safeguarding Adults Board – Annual Report for 2015/16 4) Local Area Action Plan: Autism Strategy – An Update on Progress 5) The Executive's response to the Commission's Review on Community Screening		

Meeting Date	Topic	Actions Arising	Progress
12th Dec 16	1) Transition into Adulthood: Young People with Disabilities 2) Adult Social Care Portal – Six Month Implementation Update 3) ASC User Experience Survey (as agreed at last meeting) 4) BCF Update		
7th Feb 17	1) Adult Social Care Budget 2) Update on implementation of actions following the peer review 3) Update on the Enablement Strategy		
4th Apr 17	*Theme: Dementia 1) Update on Dementia Strategy 2) Alzheimer's Society		

Forward Plan Items

Topic	Detail	Proposed Date
Care Quality Commission	What are they delivering around social care?	
Healthwatch	What are their plans to capture the views of patients re social care?	