



**REPORT ON THE FINDINGS OF THE
ADULT SOCIAL CARE SELECT COMMITTEE**

DECEMBER 2018

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1. EXECUTIVE SUMMARY

Why we had a Select Committee

- 1.1. The select committee was established to look adult social care in light of the decreasing budget versus the increasing demand for services arising from changes in the North East Lincolnshire population.

What we found

- 1.2. Over the course of the select committee, the Councillors heard about the issues raised by service users and providers that needed addressing. The select committee made a number of recommendations and these are set out within this report.

What happens next?

- 1.3. The select committee's report will be referred, for approval, to a special meeting of the Overview and Scrutiny Committee to be held on 30th January 2019 before recommendations are made to Cabinet on the 13th February 2019.

Councillor Steve Beasant
Chair of the Select Committee

2. INTRODUCTION

- 2.1 Members raised a concern at the Full Council budget meeting in 2018 about the need to ensure sufficient money was available to meet the council's statutory duties as a social services authority.
- 2.2 The overview and scrutiny committee meeting on 1st August 2018 agreed to hold a select committee to look into the long term budgetary implications for adult social care.

3. MEMBERSHIP

- 3.1. Select committees do not have to be proportionally representative but an effort was made to ensure that there was a balance of political views in the panel. The following members participated as panel members for the adult social care select committee:

Councillors:

- Steve Beasant (Liberal Democrats)
- Sheldon Mill (Labour)
- Janet Goodwin (Labour)
- Stan Shreeve (Conservative)
- Melanie Dickerson (Conservative)
- Kay Rudd – Co-opted (Liberal Democrat)

- 3.2. This topic fell within the remit of the following portfolio holder:

Councillor Jane Hyldon-King – Health and Wellbeing and Adult Social Care

4. TERMS OF REFERENCE

- 4.1. The select committee agreed a set of key objectives which were to:
 - Understand the how the council's budget for adult social care would meet the forecast local population need.
 - Identify the opportunities for the council and CCG to invest in adult social services and reduce the burden of costs to the health system.

5. RISK AND OPPORTUNITIES

- 5.1. Members had due regard to the management of risk throughout the select committee process. Members remained mindful of financial constraints and the need to deliver services to meet need. The select committee was attentive to the impact of adult social services issues on residents, particularly in terms of their health wellbeing outcomes.

6. INTERVIEWS CONDUCTED / EVIDENCE GATHERED

- 6.1. The select committee held a scoping meeting and two, three hour meetings, to which witnesses were invited. The sessions were held on the following dates and were themed as follows:

Scoping meeting 6th November 2018

Short opening presentation from officers. This provided an opportunity for the committee to understand some of the adult social care data and finances as well as to develop their understanding of the council's duties and the issues facing adult social care.

Tuesday 11th December 2018

Interviews held with representatives from social care provider organisations.

Wednesday 12th December 2018

The opportunity for the committee to hear from representatives from the service users, the voluntary and community sectors and to ask questions and seek clarification on any matters.

The select committee would like to thank the witnesses for their attendance and contribution:

Ros Davey – Single Point of Access (SPA)
Bruce Bradshaw – Clinical Commissioning Group (CCG)
Lee Mair – Hospital in Reach Team
Joe Warner – Focus
Stephen Pintus – Director of Health and Wellbeing
Adam Knights – North East Lincolnshire Care Association Representative
Christine Foreman – Community Forum
Jo Barnes – Care4All
Lyse Stephenson – Friendship at Home
Tracy Slattery – Healthwatch
Terry Peel – HICA Group

6.2. Adult Social Care Budget

The committee heard about the specific legal duties of the council in relation to adult social care predominantly captured within the Care Act 2014 and other laws such as the Mental Capacity Act 2005. The duties are wide ranging and not just the responsibility of adult social care managers. For example, the council has a wider responsibility to prevent, reduce and delay the need for care and support and has duties to safeguard vulnerable adults from harm. Whilst the council has a duty to meet “eligible need” defined in law, it has more discretion as to how this need could be met. The law does

not assume that needs are met by providing services, though in practice many people's assessed eligible needs are met in this way.

Ms Brunton Head of Finance for Adult Social Care in the Clinical Commissioning Group (CCG) explained to the committee that there had been a significant budget reduction in adult social care from £46.76m in 2013/14 to £40.29m in 2018/19. This was a result of wider reductions in the council's funding as part of the national government's austerity measures. Other council services were similarly affected.

Adult social care funding is also subject to growing demand pressures. These are:

- The impact of the living wage (c£1.5m per year), demography and changing demand (around £0.5m per year),
- Complexity of medical conditions, for example, dementia,
- Young people with complex lifelong conditions moving into adult services (c£0.075m per year); for some areas this is one of the most significant cost pressures in future years and is cumulative;
- Inflationary costs such as petrol, food and council tax, that all had an impact on providers' costs,
- The need to ensure provider sustainability by paying an appropriate cost of care.

The two largest areas of spend in terms of client need in 2017/18 are 37 per cent on physical support and 34 per cent on learning disabilities. The two highest costs by activity are long and short term residential care at 28 per cent and 21 per cent on supported living.

Ms Brunton confirmed the gross expenditure in 2018/19 is £53.3m. Of this, £13m is gross income and £8.8m comes from means tested client contributions.

About 68 per cent of the net budget is committed to ongoing long-term support packages equalling £27.4m.

The committee heard about the Better Care fund which is a national government policy, designed to ensure that health organisations and councils work closely together to ensure that services are better organised and co-ordinated to benefit service users. The policy requires council and health organisations to contribute money to a joint fund to help this.

Members asked how much funding was required to be contributed by the CCG and council towards the Better Care Fund (BCF). Mr Kirven confirmed that the council allocation for 2018-19 was £3.4m for BCF and a further additional £2.2m for iBCF. In 2019-20 the allocations are £5.9m for BCF and £1.1m for iBCF. Amounts following the spending review were not known. The CCG allocation for 2018/19 is £11.5m.

The committee questioned what more could be done to cut down on the costs of adult social care, particularly long-term care? Ms Compton said that there were no short-term solutions but a long term focus on prevention and wellbeing would help to reduce the burden of disease within the population. It should also be recognised that adult social care is important in reducing the demands on the health service. Mr Kirven, Strategic Lead for Business Partnering from North East Lincolnshire Council explained that work was taking place within the sustainable transformation plan to look at how the idea of investment in prevention would free up savings in the NHS. Part of the solution is health organisations and councils working closely together to ensure that people's needs can be met at the lowest cost possible. This is often by making better use of community rather than hospital based services and by ensuring that people are cared for in their own homes rather than in institutionalised settings.

The committee was concerned about the reduction in the adult social care budget year on year and the impact this had on the quality and availability of services for residents of North East Lincolnshire.

A member of the committee asked how the savings had been achieved. Ms Compton said that there is a long-term approach in place which helps to manage demand. Cost savings are achieved by reducing the cost of commissioned services such as home care through re-tendering. The council also made decisions not to fund some non-statutory services such as meals on wheels. This service is provided by Care4all and is at a cost to individuals in receipt of the service.

The council agreed to change its policies in relation to day care and transport provision. This means that fewer day care and transport places are commissioned. These places are only made available for those people who cannot access other community-based services due to the nature of their need or condition.

Other day services are available from the voluntary and community sector organisations who play a vital support role in the community.

Income generation was increased by reviewing adult social care charges. This means that when services are charged for, the full cost is recovered from those clients who have to pay for their services.

6.3 Adult Social Care Providers

Single Point of Access (SPA)

The single point of access is a call centre service in which different social care and health organisations working together to provide advice and information to callers. The SPA has a unique and memorable number. It is intended to offer information to help people support themselves and where

appropriate, can arrange assessment or services to be delivered. The SPA is an important way in which demand for services is managed.

The committee heard from Ms Davey who was the manager of the SPA. She explained that due to the increasing aging population, the demand for services had been heightened and the team in the SPA is constantly coming up with new ways of managing this.

The SPA is open every day, throughout the day and night. It can signpost callers to a range of free to access services or advice. Social care assessments improved following the introduction of the Care Act 2014, providing a consistent approach. The SPA filters calls, which prevents the need for unnecessary social care assessments. This enable the service to use resources more efficiently and means that staff only go on visits when needed.

Ms Davey explained that the service was working well especially with the merger of the GP and mental health out of hours' teams. Sharing information and integrated working has enabled the SPA to give a joined up service for residents.

A member of the committee asked about the number of calls received through the SPA. Ms Davey replied that in 2018 to date, there had been 6500 calls and out of those, 5000 were health calls and 1500 mental health out of hours' calls. She confirmed that 75 per cent of calls are dealt with there and then.

The growth in calls resulting from the increased number of older people raised a question for the committee as to how this impacted on the SPA. Ms Davey explained that delivering services differently was always a consideration. For example, the call handlers were multi skilled and did outreach work as well as face-to-face assessments.

A member of the committee asked about other organisations' links to the SPA. Ms Davey said that organisations such as Red Cross, Fresh Start Meals, Age UK and Friendship at Home all linked in with the SPA. An online directory of services helps the SPA staff to make referrals to other agencies. She explained that in the past social workers went out to see people whereas now many of these cases are referred directly to low level support.

A member of the committee asked about how the SPA is funded. Ms Davey explained that there are different arrangements for each organisation. The funding source is the CCG, acting as commissioner for the various organisations. Some organisations have placed their staff within the SPA, social workers are funded by Focus, which provides all statutory adult social care functions on behalf of North East Lincolnshire Council and the CCG and the therapy team transferred across with the funding, which was equivalent to two full time equivalents (FTE's).

The committee queried whether there was a reliance on third party organisations. Ms Davey confirmed there was, and it would cause an issue if these third party organisation services were no longer available.

Ms Compton explained that it would be useful to look at the category of people who used the services, the contract value for those third party services and how they are commissioned ensure that they are sustainable.

The committee discussed concerns about over-reliance on volunteers and the need to encourage volunteers of all ages to support local organisations. Ms Davey expressed concern over the fragility of these third party agencies and the reliance on them to support services.

A committee member asked if a large percentage of the calls were from people who were lonely and if the SPA received frequent callers. Ms Davey confirmed that this was the case when the SPA was launched. The frequent callers had management plans in place that helped the team to support this cohort.

Ms Davey explained that call volumes fluctuate with the highest number of calls on Mondays, Fridays and after bank holidays. Often this is because families visit their relatives over the holidays and then go on to raise concerns about their health and wellbeing. The calls volumes are generally stable across the year.

The committee welcomed the service provided by the SPA but felt that more should be done to advertise and promote its number. Ms Davey explained that the SPA telephone number is on the advertising screens in all the GP practices.

Members of the committee were interested to understand, other than individuals and family members, where the other referrals into the SPA came from. Ms Davey said that referrals came from the police and ambulance services often reporting safeguarding concerns, loneliness and vulnerability. More and more referrals come through these routes.

The committee asked if there were any underlying trends. Ms Davey commented on geographic issues and the loneliness felt by some residents. The team had seen an increase in crisis calls from neighbours, when people's carers are admitted to hospital leaving people vulnerable. Many of these calls came from residents on the Nunsthorpe estate about older people. There had also been an increase in calls from the more affluent and remote villages, where loneliness and isolation was prevalent and where people were less likely to have access to support.

The committee asked how Ms Davey saw the service developing over the next five years. Ms Davey saw the benefits of special palliative and end of

life care becoming integrated and co-located with the SPA. Another area to consider was homelessness and housing. She also saw a role for continuing health care where some people with long-term complex health needs qualify for free social care which is arranged and funded by the NHS. The service would then be multi-disciplinary and equipped to manage crisis situations as well as offering an effective preventative service.

The Chair asked Ms Davy where, in her opinion, additional investment could be used. She responded that additional money could strengthen the voluntary and third sector organisations.

Older people

Mr Bradshaw, Mental Capacity Act Strategic Lead from the CCG came to talk to the panel about the Mental Capacity Act 2005 and continuing health care. He explained the legal implications and impact on providers and service users around the deprivation of liberty safeguards (DoLS).

Currently there are 100 clients subject to a DoL in standard and non-standard settings. Around 500 cases are waiting assessment since recent case law had resulted in a more robust process being required and this has impacted on social work time in particular. The numbers are set to increase over the coming years with the increasing ageing population, mental health conditions and younger people with learning disabilities. Overall, DoLS are a significant extra cost to the social care system.

The Court of Protection has been streamlined so that officers do not have to stand in front of the judge and, in some cases of DoL, the decision could be taken by officers.

Mr Bradshaw explained that the administration of DoLS is carried out by Focus and NEL is unique in being the only area taking telephone applications. Managing authorities (e.g. hospitals or care homes) are responsible for making requests for assessment. Members of the committee were reassured that when people moved care homes or wards within a hospital their DoL goes with them.

Members were concerned about the 500 people waiting to be assessed. Mr Bradshaw explained this figure included people who had been assessed and were waiting as part of the 28 days final part of the process. People moved through the process quickly and he confirmed not all the 500 would need a DoL and would not need to be assessed. Work to review the list, was being carried out with the providers.

Mr Bradshaw confirmed there had also been an increase in section two cases under the Mental Health Act, which provided for someone to be detained in hospital under a legal framework for an assessment and

treatment for their mental disorder. The increase had presented challenges and put a burden on the system.

Hospital in reach team

The committee heard from Mr Mair from the hospital in reach team. He explained that it is important that vulnerable people are discharged in a timely manner from hospital to ensure that hospital beds can be efficiently managed. He explained the discharge to assess model had been introduced along with a “trusted assessor” approach. These are national requirements of health and care systems.

The in reach team works with one or more of the wards and the front end in the accident and emergency department to avoid unnecessary admissions to hospital. The team is based within the operation centre of the hospital. The team are given a daily list of all the patients admitted to hospital and their assessment and discharge notices. This enables the team to make sure everything is in place and ready for the patient to go home.

A committee member asked what assurances are in place to ensure a safe discharge of patients. Mr Mair replied that no discharges take place after 8pm anymore and the team were working towards “golden” discharge hours between 10am and 12pm. This was not always possible because the team are often waiting for the discharge letters from the doctors or prescriptions from the pharmacy.

Members of the committee asked about waiting times for prescriptions. This has been raised previously with the hospital and members were reassured that the system had improved since the recent CQC inspection.

Mr Mair explained that some patients arrived home with incorrect medication. He asked that care homes provide feedback to the pharmacy but this feedback was not forthcoming. Mr Mair felt that the pharmacy would welcome feedback so that lessons could be learnt.

Mr Mair felt that more money could be spent in the front end of the hospital so that patients could go back home safely and were enabled to do so, rather than being admitted to a medical ward at the cost of £400 a day.

The key was to ensure that when patients went home they had support by family members, friends and the community. Mr Mair explained that the team were working with the Chaplains in the hospital to work alongside patients on their return home and, in some cases, the end of life care team. The Red Cross volunteers visited people in their homes to help out with the simple things that reduced the risk of them being taken back into hospital.

The chair queried what their biggest frustration was. Mr Mair explained that it was the delays in updating the virtual ward system called ‘WebV’ when

patients moved from different wards. Mr Mair felt a smoother pathway for discharge would be more efficient for the service and better for the patients.

Mr Mair talked to the committee about the discharge from hospital in terms of end of life care and patients choosing where they would like to be. He confirmed this process could be less bureaucratic as it stopped patients leaving the hospital in a timely way, which on occasions caused distress for the patients and their families.

In January 2019 there was a new project starting with care homes, where Mr Mair's team could make assessments to enable patients to go straight into care homes without having to wait for the care home to come to the hospital to assess their own residents.

A member of the committee asked why the WebV system in the hospital could not always tell them who was in the bed and their status. Mr Mair confirmed it depended on who entered the information onto the system and at what stage in the process. Mr Mair confirmed that his team receives a list of patients awaiting discharge everyday but this requires ward walks to confirm locations and a member of the team then being sent to get the consent form signed for the patient to be discharged.

The chair asked if there were trends in hospital admissions. Mr Mair explained about the build-up in A&E because a small minority of people didn't attend their own doctor and went straight to A&E. The busiest times are in the summer with the increase in holiday makers. This also coincides with the time when one group of junior doctors leave and a new cohort start in September. Mr Mair had seen an increase in drug and alcohol related conditions and winter pressures still remain high.

Focus

Mr Warner, chief executive of focus CIC explained the statutory social work duties carried out by focus CIC. 150 staff are employed including long term, complex care and ongoing case workers. Mr Warner explained that the team delivered the adult safeguarding services for the council and is accountable to the safeguarding boards as well as the Director of Adult Social Services (DASS) at North East Lincolnshire Council.

The committee asked about the different statutory social work functions within focus CIC and Navigo. Mr Warner said that the social workers in Navigo have a specific role around the Mental Health Act and the Mental Capacity Act 2005. The committee asked if there was a cross-over with social work. Mr Warner said yes, especially around mental health and the requirements of the Care Act as well as the role of assessment and micro-commissioning within focus. This did lead to some inconsistency of social work practice particularly given the different cultures within the two organisations, one (focus) being based on its statutory assessment and

commissioning remit and the other (NAVIGO) based on its role as a main provider. While it would be difficult but possible to unpick the current arrangements it could potentially result in greater consistency and effectiveness if both organisations focussed on their primary function; assessment and commissioning of adult social care by focus and the provision of mental health service by NAVIGO.

The chair asked if there was a case for all adult social workers to come under one team to work collaboratively. Mr Warner felt that there was an opportunity for the three social enterprise companies to consolidate their respective expertise and make services easier to access and more efficient for patients.

Ms Compton explained that the council had delegated all its adult social care functions, including social work to the CCG. In turn, the CCG had delegated the statutory functions through contracting. However with the union arrangements there is a question as to whether this could now be a more direct relationship between the council and focus CIC. Under the current arrangements, whereby the social work functions are dispersed across the Focus, Navigo and CPG, it was a big challenge to ensure consistent application of council policies. It is also difficult to gain assurance about the quality of social work practice when delivered by more than one agency.

A committee member asked if there was a case for further integration. Ms Compton said that the idea of the integrated care partnership was to deliver further integration and improve frontline services. For patients it is frustrating having to answer the same questions when they access different service providers. Mr Warner explained that an integrated care record would be helpful to staff and patients and SystmOne the patient record system in being able to see the same patient information. However although most providers have SystmOne it does not act as a single system. The hospital has a different system which causes a barrier to integration and the individual patient experience is poorer because of this.

One concern is that information does not follow a patient through their hospital journey. Voluntary organisations are less able to interact with the more integrated public sector agencies.

The committee heard about the benefits of the voluntary sector, for example helping patients who come out of hospital with the simple things like putting the heating on before they came home had a big impact. The concern was the investment in time that is needed with volunteers to make them feel valued.

The committee asked about social work job vacancies and if there was an issue with recruitment. Mr Warner said that there were very few vacancies within focus CIC but it was more difficult to recruit senior experienced social

workers. Focus recruited newly qualified social workers and invested time and money in training and development. The introduction of apprenticeships added value to the workforce and strengthened the team. Mr Warner said that retention was a battle but this was an ongoing national issue.

Director of Health and Wellbeing

Mr Pintus, Director of Health and Wellbeing, explained that the way forward to reduce the financial burden on adult social services was to improve preventative services to stop people going into hospital.

With regard to prevention, he said that almost everybody would develop some form of chronic medical condition but people can live for a long time with these illnesses. The question was more about delaying the onset of these conditions to reduce the demand on costly services.

The challenge is helping people to remain active both physically and socially, to improve long-term health. It is recognised that those people who are less mobile and socially disconnected felt a lack of purpose and this does not help their medical condition.

Mr Pintus said that the main task is how we help people stay mobile and socially connected at the same time as enabling and encouraging them to do things for themselves.

The prevention agenda going forward needs to connect people who receive clinical care and set up mechanisms of support around social needs. He referred to social prescribing and promoting the wellbeing service in all GP practices in the borough to get people connected into support and out in their community, which helped to reduce the immediate consequences for a dependency on the state. Part of the challenge is how we identify those at most risk and engage them.

Ms Compton explained that the work with adults was around maintaining and regaining independence. Effective engagement would highlight issues early rather than when they escalated.

The committee discussed early intervention in schools to give children and young people the skills and knowledge about the long-term impact of lifestyles, especially healthy eating, so that in later life it reduces the long-term burden on the state and improves outcomes.

A discussion identified the benefits of the voluntary sector in helping those with low-level needs. Ms Compton explained that community groups are much more adept at understanding and responding to the needs of local people than public agencies. To some extent, this is because people follow social norms and are more willing to listen to and engage with their peers than professionals. Good local examples are Centre 4 and the Community

Shop. These initiatives have been started by community leaders for the benefit of the people they serve.

The committee asked if consideration of voluntary organisations and low level support should be factored into commissioning intentions. Ms Compton agreed that it must be considered as part of the commissioning framework.

The committee felt there was something to consider about how council services could better respond to vulnerable people and reduce dependency on service by building personal resilience.

A member of the committee asked whether North East Lincolnshire had any outlying public health indicators. Mr Pintus responded that smoking in pregnancy is probably the most extreme example. More pertinent for the committee was the number of people on employment support allowance at working age. The challenge was how we changed people's outlook and it was especially important to set an example for the younger generation.

6.3. **Representatives of service users**

North East Lincolnshire Care Association

Mr Knights represents a number of residential care homes in the borough and is the owner of the Ladysmith Care Home. He gave the committee an overview of the pressures felt by residential care homes in the borough. He explained the biggest pressure was the fees paid by the council, which he regarded as under-funding the cost of care. He explained that people were coming into care homes at a younger age and often with more complex needs. He felt that this trend was only going to increase. Homes struggled in the area with under occupancy leading to reduced income. Mr Knights said that if the situation did not change he believed care homes in the area could close.

A committee member asked Mr Knights, in respect of Ladysmith residential care home, what he did to ensure stability. Mr Knights explained that he decommissioned a number of beds within the home to reduce costs. The committee was concerned that this might have caused a shortage of beds. Ms Compton said that as an area we have more residential care beds than are needed. This is in part as a result of the desire to support more people to live in their own homes.

The committee asked about care home occupancy rates. Mr Knights said it was an issue in the borough for all care homes. Ms Compton confirmed that the care homes needed to be 90-95% occupied to be profitable and in order for the market to be efficient. Currently Ms Compton is engaging with care home providers about the cost of care. There is a recognition that more investment is needed in the residential market in NEL, but improved occupancy rates would help to improve providers' sustainability.

In some areas of the country, providers benefit from a number of self-funded clients who are able to pay significantly higher fees than are paid for commissioned places. In NEL there is not a strong self-funding community however there does need to be a balance between local authority placements and self-funding residents. Mr Knights referred to the south of England as an example where some care homes had as high as 85 per cent of the beds occupied by self-funders. In North East Lincolnshire he felt that the position was the reverse.

The council's current residential care home fees should reflect a reasonable cost of care. Ms Compton explained that there is ongoing work with residential care home providers to develop an understanding of local care costs and ensure that the council is reflecting this in its fee base.

At present there is an increase in placements to residential care homes as rehabilitation services have not been responding to needs effectively. Short term placements following a hospital episode can lead to people becoming permanently reliant on residential care, resulting in reduced wellbeing for individuals and increased costs to social care.

Rehabilitation services are an essential component of well-functioning health and social care system. These services are commissioned by the CCG and provide an example of why is important for the NHS and councils to work closely together to ensure appropriate and timely discharge from hospital as well as patient safety and wellbeing. There is the potential for some care homes to provide short-term rehabilitation services as part of the hospital discharge pathway. Committee members agreed it made sense for the care homes to help.

The committee asked about care home "top up" charges that some people are asked to pay. Mr Knights explained that "top ups" are supposed to be for extra services but he felt that in reality they were the difference between what it cost to provide a care placement and the local authority fee rate.

Mr Knights gave an overview of the work that the newly formed residential care association is doing around training, recruitment and funding.

Members asked about recruitment issues. Mr Knights said that about 70 per cent of the budget in care homes was staffing and it was essential to invest time in training and development to retain staff and the valuable skills they had. The nature of the caring industry means that the jobs are often low paid. The increase in the national minimum wage had put immense pressure on care homes financially. The living wage had a knock on effect because wages at all levels in the care home had to keep pace, causing even higher financial pressure.

A committee member asked Mr Knights about zero hour contracts and he offered them if requested by an employee. Most employees wanted either full time or 21 hours a week, which enabled them to have a good home/work life balance. This was welcomed by the committee.

Community Forum

Christine Forman attended the select committee. She said that she was the communities representative and is part of the CCG's community forum, made up of volunteers, GPs and officers from the CCG. The aim is to improve adult social services through service redesign and the forum was key to feeding the views of residents into this process.

Committee members were keen to understand how the forum obtained feedback from residents. Ms Forman said that she went into community hubs, extra care housing and care homes mainly but also had a lot of experience in caring for many friends and family members over the years.

A committee member asked if extra care housing was working. Ms Forman said that it needs to be different from a residential care home and needs to ensure that people retained independence. Ms Forman felt that there needed to be more extra care housing to meet the demand.

Ms Forman said that care homes and extra care housing is needed due to families not living locally and therefore not being able to care for their loved ones in their own homes. Ms Compton said that the council had benefited from additional disabled facilities grant (DFG). This can be used to help with the cost of adaptations in turn helping people live in their own homes for longer. Ms Forman explained that some homes within the borough, especially in the East and West Marsh, were hard to adapt due to the nature of the houses, in particular some of the terraced houses.

The committee appreciated the value of the community voice and the work Ms Forman was involved in.

Care4all

Ms Barnes from Care4All gave the committee an overview of the services it provides. Care4All employs 100 staff supporting over 400 vulnerable people locally. 60 per cent of its staff work in supported living, 30 per cent in the meals on wheels team, and the rest were office staff and management.

The main areas of work include providing care to individuals and running the meals on wheels service. She explained that at one time they employed a large number of people with learning disabilities. However due to the time and cost involved she was no longer able to provide this learning opportunity and maintain a viable organisation.

A committee member asked what more could be done by the Council to help. Ms Barnes thought it was key to realise the importance of local expertise and to give help and advice when key decisions were made.

Friendship at Home

Ms Stephenson from Friendship at Home explained there were over 150 volunteers working with 600 people in social clubs, exercise groups and 1-2-1 be-friending. On the dementia side it supports 110 people who attend social activities.

She felt the key was to break down isolation of vulnerable people. This is a preventative approach and achieves positive outcomes for people. The committee recognises that the cost of isolation on people personally and also to the council's budget is huge and the service offered by Friendship at Home helped with isolation by reducing the number of people needing to go into care homes.

A committee member asked about how Friendship at Home is funded. Ms Stephenson said that its funding comes from Big Lottery, department of health and social care and donations.

The committee recognised the potential to grow these services, especially with the demand increasing but appreciated that this relied on the good will of the volunteers and this needed to be valued to ensure continuity.

Healthwatch

Ms Slattery from Healthwatch described the work the team does around adult social care. Healthwatch does work in the community and with the GPs to gain feedback and log concerns raised by patients. The 'enter and view' process give Healthwatch the power to inspect establishments at short notice. Over the last year, they have engaged with 2,250 people on their views about adult social care. The main concern from users is transport especially when going to hospital appointments. This is about notifying people of the transport time to go home because this often has an impact on care. Delays mean that care has to be cancelled and this sometimes means a cost to the service provider as well as the person not receiving their planned care in the manner intended. Service users are also concerned about communication between providers and agencies. When this is not joined up, patients have to tell the same story numerous times.

A committee member asked how the information received from patients and 'enter and view' was fed back to providers. Ms Slattery explained that good links and working relationships had been created and with the research and evidence gathered, she was able to go back to providers and share the findings. She had a high level of confidence in the process and that the feedback was getting back to the relevant teams and been acted upon.

The committee were keen to understand the relationship with Healthwatch and SPA. Ms Slattery confirmed there were direct links to the manager and Healthwatch is being called upon to help with the advice and guidance element of the service.

The Chair asked what could be done differently. Ms Slattery explained about the work Healthwatch is doing and, in particular, the independent review of the autistic spectrum disorder pathway. It was key to understand the transition into adult services, which could be daunting and a minefield to navigate for young people and their parents/carers.

The committee queried if there were any specific issues that Healthwatch had observed around adult social care. Ms Slattery confirmed there was nothing specific, however, the main issue for residents is the number of assessments that were undertaken by the SPA and other providers. Patients are having to give their information on numerous occasions. The conclusion from Healthwatch is that it would be beneficial if the systems used by providers and NLAG was joined up to enable easier access to patient information. People are concerned that with the duplication of information, potentially something could be missed. Ms Slattery also suggested that if the number of assessments is reduced, it would cut down the number of times staff were going out to people's homes and this would create efficiency savings.

HICA Group - Home Care

Mr Peel from HICA homecare explained it provided both home care and residential care. HICA has one care home in the borough, mobile support officers and, in total, supports 350 people in the community.

He explained the unique demographics of North East Lincolnshire were a challenge, especially with the increasing vulnerability of elderly people who lived in their own homes.

Over the past few years, Mr Peel noted the bureaucratic process for care had increased. To make best use of the funding available would require innovation. He felt that better use of medicines and a reduction in pharmaceutical waste would help. Mr Peel confirmed that it was a long journey and a big culture change to the way in which care is commissioned and needed. More funding would achieve better outcomes, but providers need to work more effectively, efficiently, and work in partnership with other providers/agencies.

A committee member queried if HICA had any plans to develop a retirement village in the borough because not all residents wanted to go into a care home. A different type of accommodation offer, which offered more independence, would be welcomed. Mr Peel said he was not aware of any

development in the pipeline and explained this would require a large private investment develop such provision. He also did not feel that there is a strong enough private market locally to sustain it or that there was a demand in the borough. He thought that a joint venture with other providers would be needed to make a residential village successful and profitable.

Mr Peel said that there is demand for more extra care housing and assisted living models, which can offer packages of support tailored to their own needs in a home of their choice.

The committee were keen to understand the training given to HICA staff. Mr Peel said that HICA has a central training budget and all training was CQC compliant. The focus is on competency based training which had proved to be more effective. Mr Peel explained that HICA used CCG commissioned training including the local safeguarding team at focus CIC and had lead champions in key areas of the organisation. Mr Peel said that if you employed people with the right skill sets and valued them, it made a difference. HICA had done this by providing coaching and support. Since then, attrition rates had dropped by 10% and there was no reliance on agency staff.

Mr Peel said that HICA was open and transparent and after taking a loss in previous years, is now making money. As a result, it is able to put more money in to valuing staff with better terms and conditions.

A member of the committee asked about the quality assurance (QA) that was in place for carers. Mr Peel reassured the committee that there are strict QA procedures in place, which includes random unannounced visits and regular feedback back from service users. Mr Peel explained that staff had a live app on their phones to confirm where they are and it alerted the managers and service users if they are running late. The application is part of a larger culture change, which is service user and outcome-led rather than strict time and task care schedules that did not always fit around people and rostering.

Ms Compton explained that HICA have been part of a new home care pilot which is helping to shape the future provision for this type of care.

Mr Peel highlighted to the committee the high and sometimes unrealistic expectations around the level of care and, if managed well, this would reduce cost but improve the outcomes for the patient.

7. CONCLUSION

Over the course of the select committee the Members heard the issues raised by the providers and representatives of service users that needed addressing, but they also heard a lot of detail and evidence from officers of hard work already being done to address these issues. The select committee were reassured that work was already under way to pilot new initiatives and develop current service models, for example improving the quality of residential care.

A number of opportunities were identified in the course of the select committee for visits to a number of providers. The committee welcomed the invitations and will undertake a series of planned visits between January and March 2019.

Key issues noted by the committee:

- There is less money available to meet the increased demand and financial pressures arising in the care sector. This means that some provider organisations are making less money than they would like and may exit the care market.
- Adult social care is looking for ways to make the money go further for example by delivering a more efficient and user led service.
- Multiple assessments and a lack of co-ordination in key systems means that users' needs are not being met efficiently. Their care is not joined up and as a result resources are being wasted.
- The population in NEL is living longer but there are more people with multiple complex conditions that require a different service response
- Recent case law in relation to the Mental Capacity Act has imposed new processes on local areas. NEL is struggling to meet the backlog of applications for deprivations of liberty. There is a risk of legal challenge when people are unlawfully deprived of their liberty.
- The role of the voluntary and community sector is essential to providing low cost and low level preventative support. However commissioners are not always clear about how these organisations can support their aims.
- Voluntary and community organisations may need more support to co-ordinate their efforts and ensure that they operate efficiently and effectively in the community
- There is a need to focus more effort on prevention and wellbeing to ensure that more people can live independently for longer.

The Chair requested that the select committee reconvene in 12 months' time to receive an update from officers in terms of the recommendations and whether services had seen improvements or if the issues remained. The recommendations, once endorsed by Overview and Scrutiny Committee and agreed by Cabinet would be monitored by the Overview and Scrutiny

Committee and any further work could be referred back to the select committee for further investigation.

8. RECOMMENDATIONS

Capacity and Quality of Care

1. That the ¹Union maintains a focus on contract compliance to drive up quality standard and improve occupancy rates in residential care settings.
2. That commissioners place the importance of values, the dignity challenge, training and staff development is reinforced through the commissioning process and in contract management.
3. Report on the outcome of the “cost of care” exercise to the Health and Adult Social Care scrutiny panel.
4. That the Single Point of Access considers:
 - a. Extending the scope of its services to include end of life, homelessness and palliative care.
 - b. It’s branding and publicity
 - c. Monitoring and reporting “failure” demand to the Union Board as a means of improving wider system performance. This includes for example additional call volumes to the SPA resulting from poor or failed service delivery

Integration and Efficiency

5. That the ²Integrated Care Partnership (ICP) considers a) the integration/consolidation of providers b) develops a more structured and transparent approach to its partnerships with the voluntary and community sector (VCS).
6. That VCS organisations be encouraged to collaborate where they support common client groups or share common purposes and recognise the benefit of local people.
7. That VCS and commissioners actively engage with and fully utilise local expertise.
8. That the Union/commissioners develop a framework to enable more effective sign posting, delivery and commissioning of small VCS organisations.

¹ The Union is the term used to capture the ongoing integration between the Local Authority and Clinical Commissioning Group designed to realise savings and efficiencies across wellbeing commissioning and infrastructure

² The Integrated Care Partnership (ICP) is a group of service providers who agreed to take accountability for all care and care outcomes for residents in the borough.

9. That the Director of Adult Services seeks clarification from NLAG regarding the opportunities to improve patient flow within the hospital and discharge.
10. That the Director of Adult Services writes on behalf of the Council, to the Government on the financial and demographic profile for Adult Social Care in North East Lincolnshire to request additional sustained funding.

Transparency

11. Improve the quality of financial reporting to show the respective contributions of the council and CCG to pooled funds such as BCF, iBCF and the section 75 agreement.

Member Development

12. That training opportunities be explored for all members to raise awareness of the local adult social care system.

9. ACKNOWLEDGEMENTS

9.1 The select committee would like to thank everyone who participated in the consultation and took the opportunity to attend and engage with the process.

9.2 The review was supported by officers at North East Lincolnshire Council:

Bev Compton, Director of Adult Services
Helen Isaacs, Director for Communities
David Kirvan, Strategic Lead for Business Partnering
Zoe Campbell, Scrutiny and Committee Advisor
Rachel Brunton, Head of Finance – Adult Social Care (CCG)