ADULT SERVICES COMMITTEE AGENDA

HARTLEPOOL BOROUGH COUNCIL

Monday 7 July 2014

at 10.00 am

in Committee Room B, Civic Centre, Hartlepool

MEMBERS: ADULT SERVICES COMMITTEE

Councillors Beck, Lilley, Loynes, Richardson, Sirs, Springer and Thomas

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

   3.1 To receive the Record of Decision in respect of the meeting held on 1 May 2014 *(attached for information)*

4. **BUDGET AND POLICY FRAMEWORK ITEMS**

   4.1 Moving Forward Together – The Vision for Adult Services in Hartlepool 2014 – 17 – *Director of Child and Adult Services*

5. **KEY DECISIONS**

   5.1 No items

6. **OTHER ITEMS REQUIRING DECISION**

6.1 Mental Health Joint Implementation Plan – *Director of Child and Adult Services*

6.2 Joint Health and Social Care Learning Disability Annual Self Assessment Framework (2012/13) – *Director of Child and Adult Services*

7. **ITEMS FOR INFORMATION**

7.1 Deprivation of Liberty Safeguards – Implications of the Supreme Court Judgement – *Director of Child and Adult Services*

7.2 Update on Progress in Response to Healthwatch Investigation into Domiciliary Care in Hartlepool – *Director of Child and Adult Services*

7.3 Provision of Services for Older People and People with Dementia – *Director of Child and Adult Services*

8. **ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT**

Date of next meeting – Tuesday 12 August at 10.00am in Committee Room B, Civic Centre, Hartlepool.

ADULT SERVICES COMMITTEE
MINUTES AND DECISION RECORD
1 May 2014

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

Councillor: Carl Richardson (In the Chair)

Councillors: Ged Hall, Linda Shields and Kaylee Sirs

Also Present:Public – Frank Harrison

Officers: Gill Alexander, Director of Child and Adult Services
Jill Harrison, Assistant Director, Adult Services
Jeanette Willis, Head of Strategic Commissioning
Neil Harrison, Head of Service
Denise Wimpenny, Principal Democratic Services Officer

88. Apologies for Absence

An apology for absence was submitted on behalf of Councillor Brenda Loynes

89. Declarations of Interest

None at this point in the meeting. However, a personal interest was declared later in the meeting (Minute 92 refers).

90. Minutes of the meeting held on 7 April 2014

Received

91. Section 136 Mental Health Act (MHA) 1982/2007 Place of Safety Pilot Evaluation (*Assistant Director, Adult Services*)

Type of decision

For information

Purpose of report

To inform the Adult Services Committee of the results from the six month pilot in respect of the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) decision to move the Place of Safety Unit from Sandwell Park in Hartlepool to Roseberry Park in Middlesbrough.

Issue(s) for consideration

The report provided background information in relation to Section 136 of the Mental Health Act, the purpose of removing a person to a Place of Safety as well as details of the reasons for the decision to move the Place of Safety Unit from Sandwell Park in Hartlepool to Roseberry Park in Middlesbrough for a trial period of 6 months from 1 October 2013. Statistical information in terms of use of the Place of Safety for the period August 2012 to August 2013 confirmed infrequent use of the facility, details of which were included in the report.

Following a report submitted to this Committee in November 2013, it had been agreed that an update report would be presented in 6 months time with details of the evaluation from the pilot. Results from the six month pilot were included in the report and it was noted that Hartlepool's approved Mental Health Professionals had not found any negative impact on their capacity as a result of moving the Place of Safety to Middlesbrough due to the low numbers. The Emergency Duty Team, located in Stockton, had found the pilot beneficial, details of which were provided.

It was reported that the Street Triage Service, introduced in August 2012 to work in Partnership with Cleveland Police and Tees Esk and Wear Valley Foundation Trust, had made a positive impact on the number of Section 136 detentions and assessments in respect of both Hartlepool and Teeswide residents. However, due to the low number of S136 assessments over the last six months, the expectation was that the pilot would continue for a further period to allow a more robust evaluation of the numbers. Tees Esk and Wear Valley would continue to fund taxis to return people to Hartlepool if they were discharged from a Section 136 Order.

A query was raised as to whether any feedback had been undertaken with

service users or their families to determine satisfaction levels on the revised arrangements. In response, the Committee was advised that the service was part of NHS provision and exit surveys were conducted upon discharge and it was envisaged that copies of surveys were provided to their Governing Bodies. The Chair requested that copies of the surveys undertaken be circulated to all Members of the Committee for information purposes. In response to a request for clarification, the Committee was provided with details of the steps taken to support individuals accessing the service.

Decision

(i) That the contents of the report be noted.
(ii) That the Head of Service for Mental Health continues to monitor the use of S136 in respect of Hartlepool citizens.

Prior to consideration of the following item of business Councillor Ged Hall declared a personal interest in Minute 92 and indicated that whilst he wished to place on record a connection with two of the organisations who had been considered by the Finance and Policy Committee for Category 4 Grant Funding, he was of the view that given that there was no decision to be taken by the Adult Services Committee and, there were no contractual arrangements in place between himself and those organisations, this was neither a prejudicial or pecuniary interest.

92. Community Pool Category 4 Grant Allocations 2014-15 – Update (*Director of Child and Adult Services*)

Type of decision

For information

Purpose of report

To note the allocation of £21,143 to the Community Pool category 4 grant allocation from the Child and Adult Services budget.

Issue(s) for consideration

The Director of Child and Adult Services reported that the Finance and Policy Committee had agreed the allocation of Category 4 grants on 28 March 2014 to eight voluntary and community sector organisations. The positive forecast uncommitted 2013/14 outturn for Child and Adult Services provided an opportunity to commit an additional £21,143 to the Community

Pool Category 4 budget. Members were asked to note that a report had been presented to the Finance and Policy Committee on 25 April 2014, to consider this proposal. A copy of the report, which included a confidential appendix, was attached to the report. **This item contained exempt information under Schedule 12A of the Local Government Act 1972 as amended by the Local Government (Access to Information)(Variation) Order 2006 namely information relating to the financial or business affairs of any particular person (including the authority holding that information) (para 3).**

Members were advised that the Finance and Policy Committee had agreed that additional funding be allocated to Hartlepool Foodbank , Age UK Teesside and Hartlepool Access Group, the benefits of which were outlined. It was noted that the additional funding that had been identified was non-recurring and there was a need to work with various agencies over the year to consider future options including long term sustainability and service model for the next financial year.

Decision

That the contents of the report be noted.

93. Hartfields – Verbal Update (*Director of Child and Adult Services*)

Issue(s) for consideration

The Head of Strategic Commissioning advised that following a request from the Committee for an update in relation to various issues raised at an earlier meeting, feedback had revealed very few complaints in relation to the heating problems previously identified at Hartfields. Energy efficiency guidance and advice had been provided to some residents and replacement radiators had also been supplied for one particular resident. With regard to the concerns expressed in relation to the inability of residents to choose a preferred energy supplier and access the most competitive rates available, analysis of energy data was currently being undertaken and, upon completion, consultation would be carried out with residents on the proposed supplier.

In the discussion that followed whilst Members were pleased to note improvements to the heating system, given that this year had been a mild winter, it was difficult to determine how effective the improvements had been and the need to continue to monitor this issue was highlighted. The Committee noted that new management arrangements were in place and some concerns were expressed regarding health and safety and access issues for elderly residents in view of the ongoing building works in the area. Emphasis was placed upon the need for developers to keep roads/pathways as clear as possible. In response to a Member's request that the building works/access issues be monitored, the Chair highlighted

that issues of this type were not matters for this Committee to discuss and should be considered outside the meeting.

Decision

That the information given and comments of Members be noted.

The meeting concluded at 10.30 am.

P J DEVLIN

CHIEF SOLICITOR

PUBLICATION DATE: 9 MAY 2014

ADULT SERVICES COMMITTEE

7 July 2014

Report of: Director of Child & Adult Services

Subject: MOVING FORWARD TOGETHER – THE VISION FOR ADULT SERVICES IN HARTLEPOOL 2014-17

1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 Budget and Policy Framework.

2. PURPOSE OF REPORT

2.1 To seek approval from the Adult Services Committee for 'Moving Forward Together – The Vision for Adult Services in Hartlepool 2014-17'.

3. BACKGROUND

3.1 The original vision document covering 2011-14 was endorsed by Cabinet in January 2012 following a consultation process in 2011 with a wide range of stakeholders.

3.2 The updated document follows the original model and sets out the direction of travel for the next three years. The document looks at what has been achieved in recent years, sets out the vision for adult services and outlines priorities for 2014-17, reflecting the impact of the Health and Social care Act 2012 and the Care Act 2014.

3.3 A high level action plan reflects these priorities and will be used as a framework to deliver more detailed implementation plans for each service area.

3.4 Adult social care is delivered in partnership with other local authorities, the NHS and a range of statutory, voluntary and private providers as well as people who use services, carers, families and local communities.

4. THE HARTLEPOOL VISION FOR ADULT SERVICES 2014-17

4.1 The vision for adult services in Hartlepool reflects the direction of travel set out in the national policies over the last few years together with the Health and Social Care Act 2012 due to be implemented from 2015.

4.2 The principles underpinning the national strategy for adult social care are; personalised services and increased integration between health and social care, with a leaner, more outcomes-focused role for the public sector. The overall aim is for people to stay healthy and actively involved in their communities for longer thereby delaying or avoiding the need for targeted services.

4.3 Public Health, now located within local authorities, will play a significant role in this preventative agenda. People who require services should be encouraged to remain as independent as possible and retain maximum control over the process.

4.4 The transformational change of adult social care began in 2006 and will continue to be driven forward by three key component principles:

- Preventing ill-health and intervening early to keep people well;
- Focusing on community-based approaches and public health initiatives to encourage people to take care of their own health and well-being;
- Delivering personalised care and support through personal budgets.

4.5 Local authorities will continue to work with other statutory, independent, voluntary and third sector provides, people who use services and their carers to shape provision and increase the number of people determining how they are supported or commissioning their own services.

5. SUMMARY OF THE VISION DOCUMENT

5.1 The revised vision document (attached as **Appendix 1**) sets out the demographic situation in Hartlepool, notes the significant progress made in transforming adult services over the last three years, despite the economic and demographic challenges, and builds on the commitment to enable people to live the life they want with the support they choose to meet their needs.

5.2 The vision document summarises the significant number of achievements made over the last three years (pages 11-12) and reflects these as being a robust platform from which to take forward services into the future.

5.3 Over the next three years adult services will continue to see transformational change driven forward by the Health and Social Care Act 2012 and the Better Care Fund. Both these initiatives will require local authorities to explore new types of integrated service provision with the NHS and other

organisations within the health and social care economy i.e. housing, community services and public health.

5.4 Local authorities will have a duty to ensure that people in their local areas:

- receive services that prevent needs from escalating;
- have access to the information/advice they require to be able to make good decisions about their care and support;
- have a good range of providers to choose from.

5.5 Moving Forward Together 2014-2017 reflects this direction of travel in its priorities and the high level action plan (**Appendix 1**: page 15-16) provides the framework for the detailed work required to deliver against this agenda.

5.6 The vision document also sets out the outcomes that must be achieved over the next three years to successfully deliver this vision for adult social care in Hartlepool:

- excellent information in a range of formats;
- a diverse market place offering choice;
- strong partnerships across key organisations;
- safe services that promote people's independence;
- robust support for carers;
- preventative services;
- integrated services;
- keeping people out of hospital as the default position;
- supporting people to manage their own long term conditions;
- excellent residential services where these are needed;
- lean, fit-for-purpose systems to deliver adult social care;
- competent, flexible workforce able to work across boundaries;
- an authentic 'learning organisation' that celebrates what it does well and uses complaints and performance evaluation to identify where it can do better.

6. PROPOSAL

6.1 Following approval, the vision document will be published on the Council's website and made available in paper copy on request.

6.2 The action plan will be monitored through the Child & Adult Services Departmental Management Team with progress reported to the Adult Services Committee in March 2015.

7. RECOMMENDATIONS

7.1 It is recommended that the Adult Services Committee approves the vision for adult services for the coming three years and receives updates on the action plan.

8. REASONS FOR RECOMMENDATIONS

8.1 Adult services continue to undergo significant changes in the way services are designed, developed and delivered to reflect a modern system of social care that is built on personalisation, partnerships and increasingly integrated services across organisations, where relevant and appropriate, as well as keeping people safe and enabling them to retain maximum choice and independence.

8.2 Moving Forward Together – The Vision for Adult Services in Hartlepool 2014-17 reflects these aspirations. The high level action plan aims to translate this vision into reality over the next three years.

9. CONTACT OFFICER

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Moving Forward Together

The Vision for Adult Services in Hartlepool 2014-2017

Hartlepool Borough Council
Child and Adult Services

Contents

FOREWORD

From: Councillor Carl Richardson – Chair of Adult Services Committee.

I am very pleased to be able to support the publication of this document "*Moving Forward Together* – the vision for adult social care in Hartlepool 2014-2017".

This strategy sets out the overall direction of travel for adult social care in Hartlepool for the next three years.

Adult social care will be known to most people in some form over their adult lifetime, either as people who need some assistance or as their carers. Over the last twelve months we have assisted approximately 4,600 adults to be able to remain at home with the right level of support to maximise their quality of life. We have also helped 1,944 carers to continue to deliver their valuable role supporting those they love to remain living at home and linked into their communities. In addition we and our partners have worked with 189 vulnerable people to keep them safe from harm and to ensure their dignity and right to respect are upheld.

We spend over £40 million on adult social care in Hartlepool each year which reflects our commitment to support people to live the lives they want with the support they choose to meet their needs wherever possible.

Moving Forward Together sets out our continuing commitment to help people to achieve lives of quality and to support them to maximise their own skills and abilities towards that end. We have maintained services over the last three years despite huge demographic and financial challenges. These challenges are ongoing. Despite that, I am optimistic that with our committed council members and workforce, our good track-record of partnership working with other local organisations and working with people who use services and their carers, we will continue to deliver high quality social care services that really do make a positive difference to people's lives.

CLLR CARL RICHARDSON

CHAIR OF ADULT SERVICES COMMITTEE

SECTION ONE

1. Introduction

1.1 This document sets out our vision for adult services in Hartlepool for the next three years and encompasses all adults regardless of age, disability, gender, culture, faith, sexuality or ethnicity.

1.2 Since 'Our Health, Our Care, Our Say' in 2006 laid out a major programme of change for adult social care, our services have been transformed to focus on independence, personalisation and partnership working across health and social care.

1.3 Adult services will face many challenges over the next few years:

- more people living into very old age with complex health conditions;
- reducing budgets for the public sector;
- people increasingly expecting that services should be person-centred to give them more choice and control;
- an ageing workforce with fewer young people available to enter the social care workforce;
- an increasing number of people requiring care together with a reduction in the number of carers; and
- the requirement to deliver meaningful integration between adult social care and our health partners utilising the Better Care Fund.

1.4 We have made significant achievements over the last few years with the Care Quality Commission awarding us the following performance assessment result in 2010 prior to this performance regime ending in 2011:

Outcome	Assessment
Improved health and wellbeing	Excellent
Improved quality of life	Excellent
Making a positive contribution	Excellent
Increased choice and control	Excellent
Freedom from discrimination and harassment	Performing Well
Economic well-being	Excellent
Maintaining personal dignity and respect	Performing Well
OVERALL ASESSMENT	EXCELLENT

Performance indicators show that this level of achievement has been maintained over the last three years despite the financial and demographic pressures on the Council.

1.5 This document looks at what we have achieved over the last few years, sets out our vision for adult services and outlines priorities for 2014-2017.

SECTION TWO

2. Our Vision

2.1 The National Context

Our vision for adult social care builds on national policies and direction of travel which set out the need for services to be personalised, promote independence, choice and control and deliver outcomes that will make a difference to people's lives. There is an increasing emphasis on the role of preventative measures such as reablement in reducing dependency and supporting people to live in their own homes for as long as possible and on integrated approaches that bring together health and social care to deliver improved outcomes for people using services.

The three key components to effect transformational change are:

- Preventing ill health and intervening early to keep people well
- Community based approaches and public health initiatives to encourage people to take care of their own health and well being.
- Personalisation of care and support where this is required.

Councils will continue to work with independent, voluntary and third sector providers, people who use services and carers to shape provision and extend the number of people commissioning their own services as well as expanding the range of local service providers, and will increasingly work with health partners to deliver integrated services that meet local need.

A summary of key national policies is attached as Appendix 1.

2.2 The Local Vision

The vision for adult services has been developed within the context of the vision that has been agreed by the local health and social care economy, which is:

'To develop outstanding, innovative and equitable health and social care services, ensuring excellence and value in delivery of person centred care working across both health and social care'.

The vision for adult social services in Hartlepool is based on the six principles set out in A Vision for Adult Social Care (2010):

Prevention: people are engaged in maintaining their own independence. Support focuses on helping people regain their independence to the greatest possible extent.

Personalisation: individuals take control of their care. Personal budgetsare provided to all eligible people. Information about care and support is widely available regardless of whether or not people fund their own care.

Plurality: the diversity of people's needs is matched by diverse service provision. Councils help to stimulate a broad market of high quality service providers and encourage the conditions in which new local support initiatives and social enterprises can thrive.

Partnership: care and support services are developed in partnership with the NHS, other agencies and local communities. Services are co-produced with the people who use them building on their assets, networks of resources and potential for contributing to their local communities.

Productivity: services are efficient, innovative, give value for money and support autonomy rather than dependency.

Protection: safeguards are in place against the risk of abuse or neglect but risk is not used to limit people's activity.

People: the workforce is empowered to deliver support with skill and imagination and is given the freedom to do so. Both staff and people using services should be empowered to take positive risks and respond creatively.

2.3 The vision for adult services in Hartlepool focuses on four core activities:

Universal approaches.
We will provide quality, jargon-free advice and information to help people choose services they need to remain living as independently as possible in the community. We will focus on maximising existing community capacity and on greater choice, control and connecting up communities and networks for and with people. We will promote health and well-being, try to avoid hospital admissions and respond to requests for social care assessments in a timely way.

Targeted Support.
We will work with people who meet the eligibility criteria for adult services to offer crisis support, adaptations, re-ablement, intermediate care, personal budgets, care management, carer support and safeguarding services. We will focus care management and social work resources on areas that require our involvement such as formal elements of assessment, reviewing packages of care and helping people in complex or risky situations. We will direct our resources towards both people who need the most support and into targeted prevention programmes. We will continue to focus on the development of suitable housing, extra care facilities and supported living options by working closely with housing providers and the third sector to achieve efficiencies and support innovation. We will implement the new Health and Social Care Act including the required funding reforms over the next three years.

Monitoring Performance.

We will be held to account by the people using our services. We will use complaints to learn lessons and improve services where this is shown to be needed. We will utilise peer review and benchmarking together with a stronger local voice and accountability (including HealthWatch, service-user focus groups and expert-by-experience questionnaires) to provide quality assurance and make our services responsive to the people we serve. We will include outcome measures and quality assurance frameworks within our performance monitoring regimes.

Workforce.

Delivering our vision requires a capable and responsive workforce committed to using personalisation principles and skilled in terms of navigation, brokerage and community development. We expect to see new and continuing professional roles being developed and employment opportunities within the care sector growing over the next few years. We are committed to working with other Councils and NHS partners to develop our workforce for the future and explore innovative ways of sharing services to maximise efficiency and effectiveness where possible.

2.4 Our vision for adult services is underpinned by the concept of personalisation. All of our services will continue to be built around the person to ensure choice, control, flexibility, independence and autonomy to the greatest possible extent. Personal budgets will continue to be the norm for service delivery to people who need support as the primary way to increase their control and purchasing power.

We recognise that personalisation is about more than personal budgets. We are committed to supporting people to achieve a more fulfilling and independent life by extending the control they have over their care and support. We will encourage people to maximise their independence, utilise their assets and take responsibility for their own lives wherever possible.

We will always take a strengths-based approach, identifying what people are able to do for themselves and building on their abilities while operating a zero tolerance approach to all forms of abuse and working to safeguard vulnerable people's rights wherever required.

3. Demographic Challenges

3.1 Hartlepool faces demographic challenges in terms of deprivation, an ageing population and an increasing number of people with disabilities.

3.2 Detailed information regarding demographic challenges can be found in the Joint Strategic Needs Assessment. Key facts that outline the challenge for adult services include:

- Hartlepool is one of the most deprived areas in Britain, ranked 24th most deprived out of 354 Local Authority areas and with 7 of the 17 wards in Hartlepool amongst the 10% most deprived in the country.
- Life expectancy for both men and women is lower than the national average.
- Higher than average levels of unemployment.
- Higher than average rates of limiting long term illness and health problems.
- A high proportion of working age adults receiving benefits.
- A decreasing working age population and increasing population of over 65s and over 85s.
- Increasing numbers of people with learning disabilities and physical disabilities.
- Increasing prevalence of dementia and depression in older people.

3.3 People are living longer and, whilst the increase in life expectancy is to be welcomed, this presents challenges for adult services as people living longer often have complex health conditions and require significant levels of support to remain independent.

3.4 Demographic pressures will also impact on the workforce as there will be a decline in the proportion of people of working age who can provide care and support.

3.5 In 2012/13, 4,987 people were supported to live independently through adult services provided by Hartlepool Borough Council and support was provided to almost 2,000 carers.

SECTION FOUR

4. What We Have Achieved

4.1 Our achievements over the last few years include:

- The development of 'Hartlepool Now', a web-based information site, and a range of easily downloadable adult social care fact sheets.
- Low-level services including the handyperson scheme, welfare notices to respond to alerts for people who need support and localised luncheon clubs.
- Social care staff co-located with our NHS partners and focused on local communities to deliver more seamless services to people.
- A Centre for Independent Living (CIL) developed as a resource for user-led organisations and a venue for training and health promotion activities with plans in place to develop a new state of the art facility.
- Working with partners to create 457 units of extra-care housing.
- Carers supported with a Carers Strategy and Forum, Carers Emergency Respite Service, Carers Information Service and direct payments to support them in their caring role.
- Feedback that 93% of carers in Hartlepool were satisfied with their care and support and 85% of the people surveyed felt that the care and support they received had helped them to achieve a better quality of life (National Carers Survey: October 2012).
- Feedback that 73.6% of people using services were satisfied with their care and support – the third highest satisfaction rating in the country (National Personal Social Services User Survey 2012/13.
- The number of telecare users increased from approximately 900 people in March 2011 to 1,500 people in December 2013.
- 6 accessible 'Changing Places' facilities for people with disabilities have been developed across the borough.
- Improved transitions from child to adult services through the development of new pathways and creation of a 0-25 disability team.
- The Tees Autism Strategy and a local action plan have been co-produced with partners to develop services for people with an autistic spectrum disorder.

- People with a learning disability living in a residential setting have been enabled to move to supported living models through work with providers to develop Individual Service Funds.

- Specialist mental health and learning disabilities employment workers established within the Council's economic development service.

- Reablement and intermediate care services have been developed in partnership with NHS partners. Approximately 70% of people accessing reablement services have required no further services at the end of their 6-week period of reablement.

- Robust safeguarding services have been promoted by the development of a Teeswide Safeguarding Vulnerable Adults Board, a local multi-agency Safeguarding Adults Committee and a discrete safeguarding unit with robust policies, procedures and well-trained practitioners.

- Safeguarding, personalisation, reablement, autism and dementia training has been commissioned for all appropriate staff as well as values-into-practice training for day services staff and tailored support for all newly qualified social workers in their first year.

- The Dignity in Care agenda has continued to be supported by the Council. We have Dignity Champions located in our services and in many local Care Homes. Health Watch lay assessors have visited people who are using services to provide rich information for quality assurance purposes.

- The dementia collaborative between health and social care has been developed to improve the quality of care for people with dementia in care homes and in the community.

- Over 1,200 people (99% of those who are eligible for ongoing support) have personal budgets, giving them more choice and control over the services they receive.

- Hartlepool Borough Council has recently signed the national "Time to Change" Pledge to tackle mental health discrimination and have identified a Mental Health Champion.

4.2 These achievements provide a strong platform from which to take forward the new strategic direction for adult services and the integration agenda with health partners. The current challenging environment places even more emphasis on the need to work closely with all partners to collaborate in the delivery of services that wrap around the person, minimising duplication and promoting effective integrated services.

SECTION FIVE

5. Priorities for the Future

5.1 Our priorities for adult services are to:

- Implement the Health and Social Care Act.
- Provide advice, information and support for all our citizens to keep them safe, well, empowered to live independently in their own homes and actively contributing to their communities.
- Promote the use of the evolving technologies to keep people safe and confident in their own homes.
- Ensure that people who need higher levels of support are offered choice, control and timely accessible services that empower them to recover as quickly as possible or live a good quality of life and manage long-term conditions effectively.
- Encourage communities to become socially inclusive and increase the numbers of people who volunteer in their communities to strengthen social capital and networks of support.
- Continue using personal budgets to empower people to take control of their outcomes and support the growth of a robust market place offering choice and diversity of provision.
- Support the development of peer-support networks and make local systems easy to use and self-navigate.
- Develop a flexible workforce that is adaptable to new ways of working, encouraged to seek innovative ways to support people, skilled in community development and amenable to change.
- Explore new types of integrated service provision, work with our partners to share outcomes and join-up pathways to minimise duplication and waste.
- Be bold in challenging ourselves and others to seek more efficient, effective and transformative ways to deliver services that are valued by the people who use them.
- Work with our neighbouring councils and health partners to maximise resources and develop services in partnership to promote equity and innovation across the sub-region.

5.2 The high level action plan at Appendix 1 provides a framework for the detailed work required to meet the challenges of delivering adult services over the next three years in Hartlepool.

5.3 We are also committed to delivering the aims and objectives of the integrated health and social care system, as set out in Hartlepool's Better Care Fund plan:

- To ensure that the population of Hartlepool has access to a wide range of primary prevention interventions.
- To identify the 'missing thousands' of people who have undiagnosed and unmanaged long term conditions.

- To maximise independence and quality of life and help people to stay healthy and well through the development of integrated community health and social care services with a focus on long term conditions, frail elderly (including end of life) and dementia, delivered through the roll out of an integrated care model building on existing care planning, care co-ordination, risk stratification and multi-disciplinary working.
- To streamline care and reduce activities that are carried out by multiple organisations ensuring the right services are available in the right place, at the right time through an integrated community approach providing rapid response to support individuals to remain at home and avoid admission
- To improve people's experience of services through the introduction of a single point of access across health and social care, utilising the NHS number.
- To improve outcomes for service users and carers through clearer and simpler care pathways and proactive management of people with long term conditions.
- To have a skilled workforce that understands both the health and social care system and works across organisational boundaries, making every contact count.
- To ensure that each person has a package of care that improves their physical, social and emotional wellbeing, acknowledging that all three elements are necessary to enjoy good health.
- To support personalisation and choice by developing a range of co-ordinated alternatives to hospital and residential care. This will be delivered through investment in personalised health and care budgets ensuring individuals are able to make informed decisions.
- To ensure that digital technology is utilised innovatively to deliver the greatest possible benefit to people using services and carers across health and social care.
- To improve access to community health and social care services 7 days a week to improve user experience and provide responsive services in and out of hours, reduce delayed discharges and improve support to empower people to live independently.

SECTION SIX

6. How we will know if we have achieved our vision

6.1 Section 5 sets out our priorities for the next three years. We will monitor and evaluate how we are doing against our action plan (Appendix 2), through our own performance management systems and by asking people we work with if they feel they have been supported to achieve the outcomes that they have identified as important for them.

6.2 There are some outcomes from our vision that must be in place in three years time if we are to have been successful in meeting our priorities:

- Good quality, up-to-date and accessible information available in a range of formats and utilising a comprehensive and accessible web site available to everyone, including people who fund their own care and support, so that they can get the information and advice they need.

- A dynamic and varied market in personalised social care is in place offering people a choice in the way they receive support.

- Strong partnerships are evident with a joined-up approach between social care, health, housing, employment and other sector partners to deliver better outcomes for people.

- People are supported to stay safe and risks are managed to maximise people's choice, control and ability to develop their potential.

- More people living in the community, supported to lead independent lives and in receipt of a personal budget which helps them to achieve their personal outcomes.

- More people empowered to be active and socially engaged regardless of their age, disability or caring responsibilities.

- People who use services and carers continue to say that they feel supported, valued and involved.

- New ways of working with health are in place to support people stay well, manage needs before they escalate and increasingly evidence a growth in social capital, volunteering and inclusive networks of support.

- More people with disabilities or mental health needs have settled accommodation and are in employment.

- People increasingly feel able to manage their long term conditions for themselves using new technologies and less people are admitted to hospital or residential care.

- More people are supported to remain in their own homes and regain their independence after a crisis or period of ill-health by utilising robust re-ablement services in a timely and accessible way;

- Good quality residential care services are available to those who need them with people's personal dignity upheld at all times;

- Systems and processes for service delivery are as lean as possible, simple to use and fit for purpose with more people accessing self-directed services and managing their own support.

- Different organisations are working in partnership together to provide transformative, cost-effective, efficient services with joined-up pathways and shared services where appropriate.

- People's views of services are captured through a variety of mechanisms i.e. forums, surveys, compliments/ complaints and consultation events. Improvements to the way we deliver our services are made where "lessons have been learned" in a truly customer-centric service response.

6.2 We are also committed to working with our NHS partners through the Better Care Fund to meet the key priorities within our local plan, which complement the Council's direction of travel. The key success measures for the Better Care Fund are that;

- Fewer older people are admitted to residential care;

- Older people who are medically fit for discharge are supported to be discharged from hospital safely, with no unnecessary delays;

- Fewer older people have avoidable hospital admissions;

- More people with dementia have the condition diagnosed early, and are offered appropriate treatment and support;

- More people are supported by assistive technology;

- More people access reablement services.

SUMMARY OF NATIONAL POLICY CONTEXT

Our Health, Our Care, Our Say (2006) – A white paper heralding a major programme of change for social care and focussing on independence, personalisation and partnership working, particularly with the health service.

Putting People First (2009) – A unique concordat bringing together many government departments in a formal agreement focussed on developing personalised services, promoting independence and offering personal choice and control.

Valuing People Now (2009) – A cross-government strategy for 2009-2012 which has a clear emphasis on delivering the vision set out in Valuing People (2001). All people with a learning disability are 'people first'. They have the same right to lead their lives like any other, with the same opportunities and responsibilities and to be treated with the same dignity and respect.

Living well with dementia: A National Dementia Strategy (2009) – This strategy looks at the huge challenge dementia presents to society, both now and in the future.

Shaping the Future of Care Together (2009) – A green paper on social care funding proposes a National Care Service to address the perceived unfairness of so-called postcode lotteries and also puts forward several models for social care funding to provide greater security for all.

Personal Care at Home (2009) – This places emphasis on the role of preventative measures such as enablement in reducing dependency, increasing independence and responding to people's desire to live in their own home for as long as possible.

New Horizons (2009) – A cross-government programme of action to improve the mental health and well-being of the population along with the quality and accessibility of services for people with mental ill-health.

Carers at the Heart of 21st Century Families (2009) and ***Recognised, Valued and Supported: Next Steps for the Carers' Strategy (2010)*** – These documents recognise the value of carers' contributions to social care and society and offer to personalise support to carers with their caring role, education and employment opportunities.

The Vision for Adult Social Care (2010) – This vision reaffirms the principles of personalisation and encourages further reform to develop a leaner, more outcome-focussed and outward facing public sector. The overall aim is to enable as many people as possible to stay healthy and actively involved in their communities for longer, delaying or avoiding the need for targeted services. Those people who do need help should retain maximum control over the process.

Equity and Excellence (2010) – This outlines plans for a strong role for local councils in working with GP / clinical commissioning consortia to ensure greater integration of social care and health, the promotion of health and wellbeing in their local populations and the prevention of dependency. Joint Strategic Needs Assessments (JSNAs) will be a key tool in the arrangements for improved democratic accountability. The move towards council leadership for local health improvements, the development of Health and Wellbeing Boards, the development of Joint Health and Wellbeing Strategies, the creation of a National Public Health Service and the creation of GP / clinical commissioning consortia pave the way for the integration of health and social care.

No Health without Mental Health (2011) – This cross-government mental health outcomes strategy for people of all ages represents a major step forward in mainstreaming mental health and achieving parity of esteem between physical and mental health. The interconnections between mental health, housing, employment and the criminal justice system are stressed. Priority is given to the development of personalisation, the imperative to offer personal budgets where appropriate and to increase access to talking therapies.

Think Local Act Personal (2011) – This is a sector-wide partnership agreement across twenty-one organisations to move forward with personalisation and community-based support. Resources should be used to target improvement outcomes for people and reduce bureaucracy in the delivery of services. The direction of travel for adult social care dovetails with the 'Big Society' agenda:

- Empowering communities
- Opening up public services to a range of providers
- Promoting social action by encouraging people from all issues of life to play a more active part in their communities, i.e. volunteering and the 'good neighbour' ethos.

Fairer Care Funding: The Dilnott Commission on the Funding of Care and Support (2011) – This report sets out proposals for developing a funding system that is a fair partnership between the state and the individual and which takes account of the vital role of families and carers.

Caring for our Future: reforming care and support (2012) – This white paper sets out a programme for the reform of adult social care. The vision is for a modernised system that promotes people's wellbeing by preventing or postponing

the need for care and support and puts them in control of their own lives to enable them to reach their full potential.

Health and Social Care Act 2012: - This legislation takes forward the recommendations from the law commission on adult social care and the Dilnott Commission on the funding of care and support. Part one of the Bill brings existing care and support legislation into a single statute and includes:

- General responsibilities of local authorities (wellbeing, prevention, integration, information and advice, provision of a diverse market place and high quality provider services);
- The person's journey through the system (assessment, eligibility , charging, care planning, cap on the cost of care);
- Safeguarding adults at risk of abuse or neglect;
- Provider failure and market oversight;
- Transition for children into adult services.

Subject to regulations being passed in 2014, the Health and Social Care Act (2012) will be implemented from April 2015 with the funding reforms being introduced from April 2016.

APPENDIX 2

ACTION PLAN

Objective	Activities/Milestones	Timescale
Establish integrated health and social care pathways / services that facilitate people living in their own homes, avoid unnecessary admissions to hospital and enable timely and safe hospital discharges.	• Increase the number of people using assistive technology as a means to remain independent. • Increase capacity in the early intervention service to facilitate hospital discharge. • Integrate first points of contact between adult social care and health. • Develop step up / step down provision	Mar 15 Mar 15 Dec 14 Mar 15
Deliver reablement services that enable people to maximise their abilities and develop the skills and capacity to retain their independence for as long as possible.	• Increase the rate of referrals for reablement services. • Maximise the effectiveness of reablement services in reducing ongoing care needs. • Review reablement capacity, model and training requirements.	Mar 15 Mar 15 Oct 14
Build community capacity and low level support services that increase choice and reduce social isolation.	• Award, implementation and ongoing monitoring of the low level support tender. • Review voluntary sector provision for people with long term conditions / disabilities and agree commissioning priorities.	Jun 14 Apr 14
Develop an independent living centre that improves outcomes for adults with a disability and / or long term condition.	• Finalise the business case for a new independent living centre. • Explore options for integration and links to the BCF plan re: condition management and support for people with long term conditions.	Apr 14 Oct 14
Improve pathways and services to meet the needs of individuals with dementia and their families / carers.	• Continued engagement with the Dementia Collaborative. • Proactive work with providers to drive improvements in care home provision for people with dementia. • Create dementia advisor roles that support people with dementia and their families / carers. • Develop alternatives to residential care for people with dementia. • Increase capacity to support the assessment and care management of people with dementia including young onset dementia. • Create dementia friendly intermediate care provision.	Mar 15 Mar 15 Mar 15 Mar 15 Mar 15 Mar 15

Prepare for the implementation of the Care Bill.	• Financial impact modelling. • Analysis of self funders and requirement for additional assessments. • Identify implications of changes to assessment and support for carers. • Review / redesign of care management & IT systems. • Understand workforce implications and develop a training programme to meet identified needs. • Agree HBC approach to public information and advice linked to the development of the Advice & Guidance service and website review.	Oct 14 Oct 14 Oct 14 Mar 15 Oct 14 Dec 14
Improve the transitions process to ensure every child and young person in transition (aged 14-25) with a disability has a person centred outcome focused plan for adulthood.	• Multi agency review of transitions process. • Integrate assessment, planning and resource allocation for young people with SEND to support good transitions into adulthood. • Review current 0-25 model and commissioning implications for adult services.	Oct 14 Mar 15 Dec 14
Ensure that people with learning disabilities receive good quality, outcome focused care and support, including those covered under the Winterbourne View Concordat.	• Review residential respite provision and agree future commissioning model. • Support the delivery of the high level action plan for Winterbourne View and map implications for social care. • Continue to develop employment opportunities for people with disabilities.	Oct 14 Mar 15 Mar 15
Strengthen local arrangements for Safeguarding Adults.	• Clarify governance arrangements between HSAC and TSVAB. • Actively promote ongoing commitment of all strategic partners. • Strengthen work with CQC and health partners through use of the Serious Concerns Protocol. • Implementation of the revised QSF approach to assure quality of care in care home settings. • Use learning from user surveys, complaints and safeguarding to improve practice and inform workforce development.	Jun 14 Mar 15 Mar 15 Dec 14 Mar 15
Review spend on community based packages of support and identify options to improve cost effectiveness.	• Identify current spend and trends since 2007. • Develop options to review RAS. • Review of high cost placements. • Map implications of ILF changes and agree approach to reviews and future use of this resource.	Oct 14 Dec 14 Mar 15 Mar 15

ADULT SERVICES COMMITTEE

7 July 2014

Report of: Director of Child & Adult Services

Subject: MENTAL HEALTH JOINT IMPLEMENTATION PLAN

1. TYPE OF DECISION/APPLICABLE CATEGORY

Non key decision.

2. PURPOSE OF REPORT

2.1 To seek approval from the Adult Services Committee to develop a joint Mental Health Implementation Plan for Hartlepool with key stakeholders, and to consult with Hartlepool citizens on the development of the plan in partnership with Hartlepool and Stockton on Tees CCG.

3. BACKGROUND

3.1 A number of key framework documents relating to mental health have been produced in recent years focused on supporting improvements across all sectors and heavily influenced by social inclusion perspectives. These documents include:-

NHS Outcomes Framework 2013/14 - improving experience of healthcare for people with mental illness

Adult Social Care Outcomes Framework 2013/14 – people who use services are satisfied with their care

Public Health Outcomes Framework 2013/16 – suicide rates

No Health without Mental Health 2011 – most people will have good mental health

Closing the Gap – improved access to psychological therapies

Mental Health Crisis Care Concordat 2014 – Access to support before crisis point

4. PROPOSALS

4.1 The Hartlepool Mental Health Forum, chaired by Hartlepool Healthwatch, aims to promote collaborative working across statutory, private and voluntary sector organisations in partnership with people who use mental health services, their carers and families.

4.2 It is proposed that this group set up a Task and Finish Group led by officers from Hartlepool Borough Council and the Clinical Commissioning Group to support the development of a local Mental Health Implementation Plan.

5. PROPOSED TIMESCALES

5.1 June 2014 Establishment of Task & Finish Group

July 2014 Consultation and co-production of local plan

Aug 2014 Produce draft plan for consideration

Sept 2014 Report to Adult Services Committee

Oct 2014 Joint report to Health & Wellbeing Board

6. EQUALITY AND DIVERSITY CONSIDERATIONS

6.1 The proposed development of a local Mental Health Implementation Plan supports the ethos of the Equality Act, and the positive attributes of effective compliance with the Equality Act.

7. RECOMMENDATIONS

7.1 It is recommended that the Adult Services Committee approve the development of a joint Mental Health Implementation Plan which will be produced in partnership with people who use mental health services, their carers and families.

7.2 It is recommended that the local Mental Health Implementation Plan is presented to the Adult Services Committee in September 2014 for approval.

8. REASONS FOR RECOMMENDATIONS

8.1 The proposal demonstrates joint working with strategic partners and provides evidence of local involvement, engagement and consultation in developing and shaping future service provision.

9. BACKGROUND PAPERS

https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

https://www.gov.uk/.../281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014

http://www.phoutcomes.info/

https://www.gov.uk/government/publications/the-adult-social-care-outcomes-framework-2013-to-2014

https://www.gov.uk/government/news/better-care-for-mental-health-crisis

10. CONTACT OFFICER

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ADULT SERVICES COMMITTEE

7 July 2014

Report of: Director of Child & Adult Services

Subject: JOINT HEALTH AND SOCIAL CARE LEARNING DISABILITY ANNUAL SELF ASSESSMENT FRAMEWORK (2012/13)

1. TYPE OF DECISION/APPLICABLE CATEGORY

Non key

2. PURPOSE OF REPORT

2.1 To update the Adult Services Committee on the results of the eighth annual learning disability performance and self assessment framework (SAF).

2.2 To seek approval to share the findings of the report with the Health & Wellbeing Board and agree the Learning Disability Partnership Board key priorities for 2014/15.

3. BACKGROUND

3.1 An independent inquiry into access to healthcare for people with learning disabilities was established under Sir Jonathan Michael's leadership in May 2007. The inquiry found convincing evidence that people with learning disabilities have higher levels of unmet need and receive less effective treatment.

3.2 Valuing People Now, a three year strategy for people with learning disabilities, identified that a key priority for delivery was to secure access to, and improvements in healthcare.

3.3 A North East regional programme of work was launched in April 2008 with the aim of ensuring people with a learning disability are as healthy as possible and have equality of access to health care.

3.4 The North East regional programme is chaired by Dr Dominic Slowie, the National Clinical Director for Learning Disability, NHS England.

3.5 The report provides an update on the outcome of the joint health and social care learning disability annual self assessment.

3.6 A change to the report has requested Clinical Commissioning Groups and Local Authorities undertake a joint health and social care assessment relating to their respective Learning Disability Partnership Board area (LDPB)

3.7 Hartlepool Borough Council and Hartlepool and Stockton on Tees Clinical Commissioning Group, through the North of England Commissioning Support Unit (NECS) has completed the joint self assessment and following validation by NHS England presents the outcomes of the findings.

4. BRIEF OVERVIEW

5.1 The SAF and its findings are presented locally to the Hartlepool Learning Disability Partnership Board and agreement is reached prior to submission to Public Health England.

5.2 The focus of the 2012/13 SAF is applied alongside the following policies and guidance documents;

- Winterbourne View concordat report
- Adult Social Care Outcomes Framework (ASCOF)
- Public Health Outcomes Framework (PHOF)
- The Health Equalities Framework (HEF)
- National Health Service Outcomes Framework (NHSOF)
- The 6 Lives Report 2009 - an investigation into the deaths of six people with learning disabilities who were in the care of the NHS

5.3 The SAF is measured against three distinct areas, using a traffic light rating system (Red, Amber and Green)

1. Section A - Staying Healthy
2. Section B – Being Safe
3. Section C – Living Well

5.4 All documents relating to the 2012/13 SAF can be found at:- https://www.improvinghealthandlives.org.uk/projects/hscldsaf

5.5 Section A (Staying Healthy) assesses how primary care enablers, such as the Direct Enhanced Service, Quality and Outcomes Framework and registers for people with learning disabilities are implemented in primary care. Health commissioners have an essential role in completing this section

5.6 Section B (Being Safe) assesses how robust commissioning and safeguarding arrangements are against well established best practice, for example the areas exposed in the Winterbourne View concordat report.

5.7 Section C (Living Well) is about inclusion, being a respected and valued part of society and leading fulfilling and rewarding lives.

5.8 The SAF examines the data returns including statutory returns to give a broad set of information to help assess the environment for people with a learning disability locally

5.9 Unfortunately due to the changes in the SAF for 2012/13 it is not possible to make comparisons against assessments in previous years. It is possible however to extrapolate data and identify key strengths and areas for improvement.

6. SUMMARY OF FINDINGS

6.1 A link to the full report and findings from the National Learning Disability SAF is included in Section 11: background papers. The Quality Assurance report for Hartlepool is attached as **Appendix 1**.

6.2 A brief overview of the Hartlepool SAF is as follows:-

Section	Overall Summary
A: Staying Healthy	• 100% sign up of GP practices to the DES is a real achievement. • The Open Doors event held at the University Hospitals of North Tees and Hartlepool provides a good opportunity for people with learning disabilities and carers to familiarise themselves with the building and the staff before they need to use them and allow professionals to mix with individuals and carers. • The level of engagement in Hartlepool in respect of Healthwatch; who really do appear to be championing the cause of people with a learning disability, is impressive. • Joint work to increase in the number of annual health checks. • Joint work across health, social care and public health in relation to health promotion • The use of a regionally developed model of good practice for medication has reduced the number of medication errors occurring with people who are likely to access multiple venues throughout the day. • Research has taken place with Teesside University to review dental services

	• "Shining a Light on learning disability" training and awareness raising events and a survey of people with LD admitted to hospital.
B: Being Safe	• 15 people with a learning disability live out of area and all have been reviewed. There is a well-established and robust quality assurance process for all provision with annual checks on standards. • Transitions protocols and processes established. Special Educational Needs and Disability (SEND) Pathfinder work well underway and making significant progress to improve integrated response. • Good evidence of work on meshing the needs of people with a learning disability with the wider community safety agenda. • The 'Safe Transport' initiative is positive. • Hate crime has been identified as a priority; Tees 'Place of Safety Initiative' is an example of good practise. • The All Together Better course demonstrates a commitment to supporting people with a learning disability to gain skills and confidence to participate in decision making and personal planning. • Healthwatch have used experts by experience to support them to review services. • Several joint commissioned frameworks have been developed including ones for Autism and forensic services. • Mental Capacity Act is well embedded within the Safeguarding Vulnerable Adults structure and there is a dedicated service.
C: Living Well	• The Local Authority has very solid working relationships with other corporate departments and wider community engagement was also evident. • Evidence of excellent leadership at all levels with senior strategic influence in relation to learning disability. • Evidence of working with leisure services through a community activity network where grants and bids are identified to enhance offer. • A lot of detailed work has taken place around housing. There are a range of supported housing options for people and these have been reviewed. This has provided a mechanism to enable people to move on. • There is a high percentage, against the national average, of people with a learning disability in employment. Clearly Hartlepool is having some success and has used innovative approaches such as a joint apprenticeship scheme. • Hartlepool is a Special Educational Needs and

	Disabilities (SEND) pathfinder and has made good progress with a target to transfer all SEND statements to "One Plan" before September 2014.

7. KEY CHALLENGES & PRIORITIES

7.1 The Quality Assurance report makes reference to several key challenges, whilst recognising the current financial climate and organisational changes.

7.2 Key Challenges to Staying Healthy

- Quantitative data collection is more robust but remains a challenge. This is a regional challenge and a regional approach may be of benefit.
- Linking the Health Action Plan and the Health Check; including the assessment by the Community Learning Disability Team practitioners.
- An Area Team/CCG wide system is needed for ensuring that learning disability status and the need for reasonable adjustments are included in referrals from primary care to other health care providers.
- Ensuring the extent and quality of the work in prisons. Involvement of the CCG Lead in the SAF would be valuable

7.3 Key challenges to Being Safe

- Ensure all contracts to have a scheduled review every year.
- Work with Trusts to request evidence about learning disability in Monitor and Equality Delivery System returns as a specific assurance item

7.4 Key Challenges to Living Well

- Although teams are co-located there are no formal agreements around partnership working and no pooled budget.
- The Health and Well Being Board engaged with the Learning Disability Partnership Board in its early iteration however this is not now as obvious.
- The Health and Wellbeing Strategy, whilst recognising learning disability, did not have a specific priority or objective relating to it.
- A review of the physical health needs of people living in either residential or supported housing would be good practice to see if any trends are arising in relation to the quality of care

8. LOCAL PRIORITIES

8.1 At a meeting of the Hartlepool Learning Disability Partnership Board on 30 May 2014 the report was discussed and the Board agreed to set its key priorities to include:

- Linking Health Action Plans and Annual Health Checks
- Continued work with the CCG and NECS to improve health outcomes
- Reviewing current arrangements to support more joined up and better partnership working across health and social care.

9. RECOMMENDATIONS

9.1 It is recommended that the Adult Services Committee

- notes the content of the report and the progress made against key national targets;
- agrees the key priorities for improvement for 2014/15;
- agrees that this information be reported to the next available meeting of the Health & Wellbeing Board.

10. REASONS FOR RECOMMENDATIONS

10.1 The Department of Health requests local learning disability partnership boards report progress of the joint health and social care learning disability annual self assessment to local Health and Wellbeing Boards

11. BACKGROUND PAPERS

11.1 http://www.improvinghealthandlives.org.uk/projects/hscldsaf

12. CONTACT OFFICER

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NHS England

Learning Disability

Quality Assurance of the Joint Health and Social Care Self Assessment Framework

2012 – 2013

Hartlepool

Contents

Hartlepool Joint Health and Social Care Learning Disability Self –Assessment Framework

Quality Assurance Report

March 2014

People with a learning disability and carers in Hartlepool have discussed the Health and Social Care Self-Assessment Framework (HSCSAF) measures at the Learning Disability Partnership Board and the health sub-group. Health Watch are involved and manystories from different individuals and groups have been recorded and presented to the panel as a DVD.

Things that people with a learning disability and carers told the panel have been taken into account within the post quality assurance rating of the HSCSAF and can be found in appendix 2.

Listening to the people with a learning disability, carers and staff at the panel it was clear that there is a lot of work to be proud of in Hartlepool. It demonstrates that the vision that for the North East to be the best place to live for people with a learning disability can become a reality. There are also challenges and further work that needs to be undertaken. This is summarised in the pages below. Detailed comments are included in appendix 1

In the current financial climate and organisational change, limitations in the work that can be undertaken were acknowledged but the locality is working in partnership and creatively to maintain and improve services.

Staying Healthy

Examples of Good Practice

- 100% sign up of GP practices to the DES is a real achievement.
- The Open Doors event held at the University Hospitals of North Tees and Hartlepool provides a good opportunity for people with LD and carers to familiarise themselves with the building and the staff before they need to use them and allow professionals to mix with individuals and carers.
- The level of engagement in Hartlepool in respect of Healthwatch; who really do appear to be championing the cause of people with a learning disability, is impressive.
- Joint work to increase in the number of annual health checks.
- Joint work across health, social care and public health in relation to health promotion
- The use of a regionally developed model of good practice for medication has reduced the number of medication errors occurring with people who are likely to access multiple venues throughout the day.
- Research has taken place with Teesside University to review Dental services
- "Shining a Light on learning disability" training and awareness raising events and a survey of people with LD admitted to hospital.
- Foundation Trust are opening their doors to people with learning disabilities, their families and carers. This is an opportunity to visit hospital departments and wards while they are well providing opportunities to ask questions and meet the Doctors, Nurses and Allied Healthcare Professionals.

Challenges

- Quantitative data collection is more robust but remains a challenge. *This is a regional challenge and a regional approach may be of benefit*
- Linking the Health Action Plan and the Health Check; including the assessment by the CLDT practitioners. *This is a regional challenge and a regional approach may be of benefit*
- An Area Team/CCG wide system is needed for ensuring that learning disability status and the need for reasonable adjustments are included in referrals from primary care to other health care providers.
- Ensuring the extent and quality of the work in prisons. *This is a regional challenge and a regional approach may be of benefit*
- Involvement of the GP CCG Lead in the HSCSAF panel would be valuable

Being Safe

Examples of good practise

- 15 people with a learning disability live out of area and all have been reviewed.There is a well-established and robust quality assurance process for all provision with annual checks on standards.
- Transitions protocols and processes established. SEND Pathfinder work well underway and making significant progress to improve integrated response.
- Good evidence of work on meshing the needs of people with a learning disability with the wider community safety agenda.
- The ‘Safe Transport’ initiative is positive.
- Hate crime has been identified as a priority;Tees ‘Place of Safety Initiative’is an example of good practise.
- The All Together Better course demonstrates a commitment to supporting people with a learning disability to gain skills and confidence to participate in decision making and personal planning.
- Healthwatch have used experts by experience to support them to review services.
- Several joint commissioned frameworks have been developed including ones for Autism and forensic services.
- Mental Capacity Act is well embedded within the Safeguarding Vulnerable Adults structure and there is a dedicated service.

Challenges

- Ensure all contracts to have a scheduled review every year.
- Work with Trusts to request evidence about Learning Disability in Monitor and Equality Delivery System returns as a specific assurance item

Living Well

Examples of good practise

- The Local Authority hasvery solid working relationships with other corporate departments and wider community engagement was also evident.
- Evidence of excellent leadership at all levels with senior strategic influence in relation to learning disability.
- Evidence of working with leisure services through a community activity network where grants and bids are identified to enhance offer.

- A lot of detailed work has taken place around housing. There are a range of supported housing options for people and these have been reviewed. This has provided a mechanism to enable people to move on.
- There is a high percentage, against national average, of people with a learning disability in employment. Clearly Hartlepool is having some success and has used innovative approaches such as a joint apprenticeship scheme.
- Hartlepool is a SEND pathfinder and has made good progress with a target to transfer all SEND statements to “One Plan” before September 2014.

Challenges

- Although teams are co-located there are no formal agreements around partnership working and no pooled budget. There is a Tees wide commissioning group and a Tees wide approach to responding to the JSNA.
- The Health and Well Being Board engaged with the Learning Disability Partnership Board in its early iteration however this is not now as obvious. The HWB strategy whilst recognising learning disability did not have a specific priority or objective relating to it.
- A review of the physical health needs of people living in either residential or supported housing would be good practice to see if any trends are arising in relation to the quality of care

Suggested Regional Priorities

Quantitative data collection.

Linking the Health Action Plan and the Health Check; including the assessment by the CLDT practitioners.

Ensuring the extent and quality of the work in prisons.

Pooled budgets

Monitoring

Appendix 1

Joint Health and Social Care Learning Disability Self -Assessment Framework 2013

Locality–Hartlepool

Date of validation meeting: 4th March 2014

Measures	Measure Description	2013 Pre-Quality Assurance (RAG)	2013 post Quality Assurance (RAG)	Rationale: evidence provided, good practice, gaps in evidence.	Information requested on key points	Panel notes
A	**Stay Healthy**					
A1	**LD QOF register in primary care**			A statement has been made that Learning Disability and Down Syndrome Registers are captured and identify local prevalence this can also be stratified in the required data set (e.g. age / complexity)	1. Check that this reflects prevalence data and that it covers all of the data set age, complexity, BME and autism. For green it needs to be complete and cover all practices.	

A2	**Health screening and promotion (obesity, diabetes, cardio vascular and epilepsy)**			A statement made that "comparative data in all of the health areas listed in the descriptor is available and being collected. There is evidence that people are accessing these programmes and further analysis is required to demonstrate whether there are any specific areas highlighting a lower than average take up (at practice level)"	1. Need to provide comparative data in all of the areas listed 2. What are the gaps if any in data collection? **3.** What evidence do you have that people are accessing disease prevention and health promotion in any of these areas?	Data should be available, the primary care data sharing agreement was signed up but there are still problems with the robustness of the data available and there were gaps in the IHAL submission. The practice data was not back in time for the SAF and IHAL told NECS not to submit it again. CCG leads and Public Health data links are now strong at LD partnership board. No further data was submitted following panel, agree red rating.
A3	**Annual Health Checks and registers**			There has been an improved uptake of annual health checks from previous years, all 15 GP surgeries have signed up to LD DES contract. Registers are said to be validated on a practice level basis. Training, promotion and awareness in relation to Annual Health Checks continue to take place. Training has been	1. Have all registers been validated against the LA register within the last 12 months? **2.** What % of people with LD had an annual health check? To achieve amber this has to be 50%. **3.** 100% sign up of practices to deliver the LD	59.1% of people had an annual health check, this confirms the amber rating. This represents a considerable increase in uptake for annual health checks. There are only 15 GP practice in Hartlepool and this meant that they could focus intensely and drive the strategy. Support at CCG level has also pushed the agenda. The LA has also instructed social workers to include questions about annual health checks during individual reviews. Throughout the panel the strong partnership approach with people with LD and families

				provided for GP surgeries, Independent Providers, Carers and Service Users. Quality Checkers have completed training and are ready to undertake practice visits to help inform reasonable adjustments (None of the web links to In Control-able will open)	DES is a real achievement.	was noted. In this measure excellent practice in the use of quality checkers.
A4	**Health Action Plans**			Limited evidence that the Annual Health Check and Health Action Plans are integrated in Hartlepool. Further quality checking is required to fully understand this.	Have you identified any action to take to improve integration of AHC's and HAP's?	
A5	**Screening :Cervical Breast Bowel**			Comparative data is stated to be available for all screening areas identified and that further scrutiny is required to establish equity for people with learning disabilities and the general population. The CHERISH Project	What action/reasonable adjustments have been agreed with the Screening and Immunisation Manager?	

				works to promote positive changes and better experiences of health care for people with LD There is some ongoing work to raise the profile of LD within screening services. Contact has been made with the Regional Screening and Immunisation Manager to discuss the barriers faced by people with LD. The CHERISH Project facilitated two events with the TEWV Health facilitator specifically focussing on the issue of cancer screening		
A6	**Primary care communication of LD status at referral**			There is said to be some evidence of the use of LD status and suggested reasonable adjustments on referrals; however it is acknowledged that this needs to be fully embedded into the referral process.	To rate Amber there needs to be some evidence of an Area Team/CCG wide system for ensuring that LD status and the need for reasonable adjustments are included in referrals from primary care to other health care	No further evidence has been provided of an Area Team/CCG wide system for ensuring LD status is communicated from primary care to other health care providers and that it contains information about reasonable adjustments and the individual's capacity and consent. To set this in context most areas across the NE and the NW have either self-rated red or been unable to provide evidence for amber and green.

				Some work has been ongoing to raise the profile of LD within screening services. This has included joint working with the local screening programme leads and a self-advocacy group (commissioned by the CCG) to look at reasonable adjustments, awareness raising for staff carrying out the checks and also how people can be supported to attend the screening appointments. No evidence has been provided that there is an Area Team/CCG wide system for ensuring that LD status and the need for reasonable adjustments are included in referrals to other health care providers .	providers. Other health care providers include acute services and community services such as those highlighted in A8. This needs to include any issues about capacity and consent. Do you have such a system in place? The work that you have commissioned from the self- advocacy group sounds very interesting and innovative; this is obviously something that you have done in collaboration with other areas. Will you provide further information about this?	

A7	**LD Liaison function. Info collated in Trusts.**			The submission states that LD leadership is in place within the acute Trust and that this is well embedded into the organisation with senior leadership. Hospital passports are completed and are forwarded to the specialist nurses. Notes are then electronically flagged and the Hospital Passport is placed in medical notes. Other initiatives taking place in the Trust include "Shining a Light on LD" training and awareness raising events and a survey of people with LD admitted to hospital. The University Hospitals of North Tees and Hartlepool NHS Foundation Trust are opening their doors to People with Learning Disabilities, their families and carers. This is an opportunity to visit	Is there a LD Liaison function across all acute settings? How do you use activity data to employ the LD nurse against demand? For example do admission figures (HES data) demonstrate a good fit between the number of people admitted and the number of contacts/people known to the LD nurse? This is one way of demonstrating that the flagging system is working. Are the figures manageable for one post and how is this monitored? Can you provide more detailed information about how broader assurance about progress on the LD agenda is delivered in the Trust/s? How is leadership embedded and what are the formal reporting and monitoring	North Tees hospitals website demonstrate a variety of QA reports taken to the Board, including Safeguarding, CQUIN's (there is an LD CQUIN re flagging)

				hospital departments and wards while they are well providing opportunities to ask questions and meet the Doctors, Nurses and Allied Healthcare Professionals. This sounds like a very positive initiative taken by the Trust. Some gaps in evidence for green, mainly around data, demand and wider assurance.	routes?	
A8	**Universal services flag and identify and make reasonable adjustments**			A statement made that some universal services provide excellent services; these include podiatry, optometry and pharmacies. However no evidence of the type and extent of reasonable adjustments have been provided. It is not clear whether these services have flagging systems in place. No evidence provided of plans for service	Which universal services have flagging systems in place identifying people with LD? Do these record the need for reasonable adjustments? Need to provide some evidence of the type and extent of the reasonable adjustments provided by some of these universal services. Are there any examples of improvement plans in place for any of these services to enable them	At the panel meeting it was confirmed that there is no flagging system in place in these services. The acute Trusts have made good progress as a result of the LD CQUIN but in order to roll this out to community services there is some consideration of extending the CQUIN LD awareness raising training is provided to all of the community services provided by the Acute FT No additional evidence provided following panel Confirm the red rating

				improvement based on knowledge of need The Cherish project works with professionals to raise awareness of the issues people face and what reasonable adjustments might help.	to provide a more effective service to people with LD?	
A9	**Offender health and the Criminal Justice System**			There are significant gaps for the amber rating There is no systematic collection of data about the numbers of people with LD in the criminal justice system and there is a problem establishing information relating to people diagnosed with protected characteristics. The links with Prison healthcare and the Criminal justice system are not fully in place. Some autism awareness raising	1. There are significant gaps in an amber rating. 2. What improvement plans are in place for this measure?	No additional evidence has been provided There is insufficient evidence for amber. Confirm red rating

				training has been delivered to 50 CJS staff The Waverley Allotment Group in partnership with the prison supported 15 people with joint funding from the LSIS project, however this has now ceased. There are some links through the Tees Safeguarding Boards and through the Tees Safe Places Scheme work. No evidence that an assessment process has been agreed for people with LD in all offender health services, for example LDSQ. Not clear what type of offender health teams/services are in place. No evidence of any easy read information provided within the CJS .		

B						
B1	**Regular care reviews**			There appear to be tight monitoring and tracking of people with complex LD and ASC via the Tees Integrated Commissioning group which was established in 2005 Within health over 90% of CHC and joint funded packages have been reviewed. For those people with Direct Payments or Personal Budgets a Care Coordinator reviews support plans against the quality of life outcomes. No evidence provide about the number/% of individual reviews carried out by Social Care.	Need confirmation of the actual % of care packages reviewed within the last 12 months. To obtain green this figure must be 100%and must include all funded health and social care commissioned packages including PB's. Evidence of schedule and compliance with review timetable or other compliance evidence would be useful.	The care management review process is overseen by Neil Harrison. The social work care managers and health team are co-located and work closely together. There are 384 active cases under social work team and number of joint cases which are worked with TEWV. Confident that all will have had a review. 93% of people known to the council have a personal budget and the team is also able to offer health and education budgets. Out of area reviews – 15 people placed out of the area funded by the LA, all have been reviewed and assurance provided that placements are safe. 1 person lives in Cornwall and care managed from a distance. Current discussion around Hartlepool and Cornwall co-managing the individual. However the average distance for placements for the 15 is 48 miles.
B2	**Contract compliance assurance**			All residential and nursing homes within Hartlepool are audited against a Quality Assurance Framework which was developed	To secure amber, need assurance that 90% of all health and social care contracts have had contract /service review in the last 12 months.	At panel There is a quality assurance process for all provision with checks at 18 month intervals on standards. There was an acknowledgement that this process is not as

				with providers. This does include a range of indicators and outcomes supporting quality assurance. There are section 75 agreements between the CCG and Local Authority in place that monitor care homes within the area Hartlepool has developed a range of framework agreements to support people with a Learning Disability, Autism, or complex and behaviours described as challenging. These were not provided. NHS contracts are in place and there are systems to review and monitor these. A Clinical Quality Assurance tools is in place with continuous development led by commissioners. Examples of the contract visit reports for residential and nursing homes have been	This measure is about all health and social care commissioned services not just residential and care homes and hospitals; it should include reviews of services such as supported living, short breaks, day care, and domiciliary care. Will you please provide a copy of the Clinical Quality Assurance Tool Do you have service specifications outlining quality indicators and outcomes for the frameworks that you have developed? How do you review and monitor providers delivering services within the frameworks? For amber, need to evidence how you report information about quality and performance of commissioned services to exec boards in health and social care.	frequent or robust as it used to be. The criteria for amber require all contracts to have a scheduled review every year.

				provided. These are available on the Council's website and are available to the public.		
B3	**Assurance of Monitor compliance**			Assurance is available through standard contract reporting method and the CCG has sight of the NHS Foundation Trust equality objectives and action plans via the Regional Equality Diversity and Human Rights (EDHR) Leads Group. Commissioners will be working with Trusts to request this area specifically as an identified assurance item	1. Do you actually review the Monitor and EDS returns or the objectives and action plans to ensure that they include relevant information about people with LD? 2. Evidence how you do this.	EDS is developing as well as expected and commissioners are working with Trusts to monitor progress Risks are shared at the Quality surveillance Group. Commissioners will work with the Trusts to request evidence about LD in Monitor and EDS returns as a specific assurance item in future.
B4	**Assurance of Safeguarding in *all* provided services and support**			Evidence has been provided to demonstrate that there is a SAB which has a robust business action plan covering a range of issues relevant for people with LD. SAB policies procedures and	1. When you monitor the quality of the services you commission is assurance about quality (performance intelligence, themes etc.) provided to the Safeguarding Board or to exec boards in health	Discussed at panel. Is LD a priority? – Yes, a unique set up around Teesside looking at improving quality, safety and the measures will be for everybody and not just people with a learning disability. The focus has been on ensuring that the

				protocols were not provided but were referenced clearly in the SAB business plan. Evidence provided that the Adult Services committee receives reports about LD in particular Winterbourne View. Effective coordination of the re-provision of services following prolonged safeguarding investigations in one provided service.	and social care, can you provide evidence of this? 2. Do you have evidence to show that the LDPB has been involved in reviewing progress on Safeguarding? 3. Have all providers assured their boards that safeguarding is a clinical and strategic priority? Do you have any evidence to demonstrate this? 4. Does the acute FT demonstrate the delivery of safeguarding using the Safeguarding Adults Assurance Framework or equivalent system or process?	key policy areas are communicated across the board. Looked at Winterbourne concordat and looked at the implications for similar areas and any action is implemented and included in policy communication. Acute Trust website includes documents and other evidence that demonstrate a robust safeguarding process. An adult safeguarding lead in in post. Of positive note is that the A&E department had two weeks intensive and practical safeguarding training which included MCA, DoLS and LD.
B5	**Involvement in training and recruitment**			Partners in Policy Making have delivered an “All together Better” course and graduates are being supported to assist organisations locally to recruit and where appropriate train	To obtain amber you need to be able to demonstrate that 90% of LD specific services can provide you with evidence that people with LD and families are involved in	Panel were informed that LD awareness training is offered to all universal health services provided by the Acute Trust. Self- advocates who attended panel provided information about the ways that they have been involved in monitoring services. Of note is the fact that the local Healthwatch was

				staff. There is a commitment to self-directed support and this means that people are involved in recruiting their own staff. People with LD have been involved in reviewing services and evaluating tenders. Hartlepool Healthwatch has been working with experts by experience to support their review work. (Unable to open the In control link)	recruitment, training and monitoring of staff (for example appraisal and review or induction). Can you confirm that this is the case and how do you audit this? Do you have any additional evidence to demonstrate that LD awareness raising and the use of reasonable adjustments is embedded in universal services?	represented at the Panel and the LD agenda and involvement of experts by experience is integrated within the health watch plan. No additional evidence has been provided in response to the gaps but the evidence provided in the submission and at panel is sufficient for amber
B6	**Recruitment and the management of staff is based on value based culture**			There are specialist frameworks in place for a range of levels of intensity of service for people with complex needs and or Autism. Providers are expected to employ staff and align their skills with the Skills for Care qualifications. To rate green Commissioners should require providers to demonstrate compassionate care and	Do contracts and service specifications clearly require providers to deliver and demonstrate compassionate care and values based recruitment? Can you provide some examples of the ways that providers have used value based recruitment and management and how you check out that the	No additional evidence has been provided for this measure to address the gaps for green. Insufficient evidence for green

				value based recruitment and management of the workforce. This would in the first instance be demonstrated by contracts and service specifications, no evidence of this currently provided. Commissioners need to demonstrate that they check out the quality of services and that they look for evidence of compassionate care and value based recruitment and management. Currently no evidence of this has been provided. No evidence provided to show that universal services demonstrate compassionate care and value based recruitment	culture of the organisation is based on compassion, dignity, respect etc.? To obtain green you need to provide evidence that universal services demonstrate compassionate care and value based recruitment. Since the Francis inquiry it is likely that every acute service will have refocused/reviewed their approach to values and culture and should be able to provide you with evidence.	
B7	**LA strategies are subject to Equality Impact Assessments**			There is an up to date generic Housing Care and Support Strategy in place that makes specific reference to people with Learning Disabilities and Autism.	1. The Housing, Care and Support strategy for people with LD ended in 2012, has this been reviewed or are there any other examples of up to date	

				One target is to increase the number of people with LD in settled accommodation from 65% to 70% in the next three years. This has been based on a more detailed assessment of housing and support need contained in the Housing Care and Support strategy for people with LD. Following an impact assessment for the Choice Based Letting process, Housing Hartlepool introduced some reasonable adjustments that would be suitable for people with LD. In collaboration with a self-advocacy group a number of easy read fact sheets have been produced including one for housing options. Several impact assessments have been made available on the Council's website and	commissioning strategies that you can evidence? 2.How have you presented key strategies and impact assessments to people with LD	

				cover a range of services including community (arts and culture) and adults social care funded services.		
B8	**Commissioner can demonstrate that all providers change practice as a result of feedback, complaints and whistle blowing**			The Council received 1 complaint relating to an adult with a Learning Disability in 2012/13. This led to a review of the Regional Model of good practice for medication which has now reduced the number of medication errors occurring with people who are likely to access multiple venues throughout the day. No evidence of complaints made to health services and it is not clear if the one complaint raised to the Council was about a Council service or a commissioned service. No evidence of feedback influencing service development.	1. Can you evidence that 50% of health and social care provider contracts require them to collect patient experience data and information about complaints and other feedback? 2. How do you monitor the way in which providers comply with this aspect of the contract? 3. Do your contracts require providers to have a whistle blowing policy? 4. Do you monitor complaints made to or about providers and have systems in place to deal with them in a strategic way, for example intelligence shared with	No additional evidence has been provided. An examination of the web sites for the LA and the Acute FT provides some reassurance that patient experience data is collected, that whistle blowing is included in the multi-agency safeguarding policy. The response to panel questions for B4 provided reassurance that the quality and safety of services is a high priority and that systems are in place to monitor this. The Local Account shows that the quality Standards Framework is used to check and audit how well providers deal with and learn from complaints about the service. On balance there is sufficient evidence for amber.

				One of the issues about people with LD using services is that they find it difficult to make a complaint or to comment on the service that they receive, sometimes services do not empower them to do this and they may find it difficult to understand the complaints/compliments process. The fact that only one complaint has been made in a 12 month period may indicate a high level of satisfaction or it may point to the need to review ease of access to the various complaints procedures for people with LD.	Safeguarding Board? 5. Do providers have easy read information about complaints and feedback?	
B9	**Mental Capacity Act and Deprivation of Liberty**			It is a contractual requirement of Health and Social Care that all providers have in place robust policies and procedures in relation to the Mental Capacity Act. These are routinely	1. Can you provide some evidence to illustrate your statement that providers are routinely monitored and some examples where providers have taken action to improve or	Green

				monitored and providers are required to provide evidence as part of routine quality reporting and reporting by exception where issues arise. Evidence has been provided to demonstrate that MCA is well embedded within the Safeguarding Vulnerable Adults structure with dedicated services for safeguarding/MCA and Best interest. There is a Deprivation of Liberty Safeguards/Best interest assessor's sub group of the SAVB.	embed practice? 2. Have you ever audited the use of restraint or physical intervention in the services that you commission?	
C						
C1	**Effective joint working**			A range of informal joint working arrangements and joint frameworks for services across Tees have been developed. The Tees Integrated Commissioning structure has secured effective joint	1. Is there a formal joint commissioning strategy in place? 2. Evidence of shared commissioning intentions, monitoring and reporting arrangements. For example where does the	At panel there was confirmation that there are no formal arrangements in place such as pooled budget arrangements or integrated governance structures and an acknowledgement that a systemic approach to joint working was lacking. Agreement for sharing some resource across Tees's area which is sensible.

				arrangements in commissioning some services including a Tees Autism framework and a Tees Forensic services agreement Access to care management is provided by co-located staff teams (Health and Social Care). There are section 75 agreements in place which cover care home contract monitoring for people with Learning Disabilities. Good use of person centred reviews to inform the development of the Autism commissioning strategy.	Integrated Commissioning Group report to, how is it held accountable for commissioning decisions and use of resources? 3. There are a number of informal meetings and arrangements, how is all of this pulled together into a coherent strategic approach to deliver improvements. 4. Who is monitoring and providing oversight and scrutiny of any LD improvement plan?	The Health and Wellbeing Board recognises the LDPB as a consultative group but there is felt to be limited influence over the agenda. Teesside has had an informal integrated commissioning group since 2005, health and social care and commissioner meet regularly. . Developing a joint approach and commissioning ratings for winterbourne by the new financial year. Green light tool kit creates synergy between mental health and LD.
C2	**Local amenities and transport**			A Tees Place of Safety scheme has been developed with the support of the Police and Crime Commissioner. In Hartlepool over 40 businesses had signed up to the 'Safe on the	1. The Safe on the Move in Hartlepool project appears to be an innovative scheme, will you please provide some more details about it and how it works?	

				move in Hartlepool' scheme. Plans will be made to combine the two during 2014. Hartlepool's passenger transport unit supported the development of a 'safe on the move in Hartlepool' scheme which includes the provision of detailed personalised transport plans. Some evidence provided for C3 demonstrates that some venues in the town centre are now fully accessible with Changing Places installed.		
C3	**Arts and culture**			Evidence that one of the local cinemas has regular Autism friendly screenings. Hartlepool has 4 Changing Places including some in arts and culture venues. People with LD are supported to display their work in art galleries	1. What does the LA do to promote arts and culture for this group of people, any evidence of reasonably adjusted facilities? 2. How do libraries, museums and art galleries for example ensure that their cultural offer is accessible for	No additional evidence provided. This measure and C4 are new measures and it is harder to judge the ratings and greater scope for subjectivity. For example what is the difference between some, and numerous or extensive? The aim of the measure is to assess how mainstream local authority services meet the needs of people with LD. There is some evidence of arts and cultural activities and also evidence provided at panel that people with LD have been involved in the

				and museums. Two groups champion the rights of people with a LD through film and theatre production.	people with LD? 3. Is there evidence of some inclusive activities and any examples of good reasonable adjustments made to those activities to enable people with LD to participate?	discussion about the SAF and ratings. Although no evidence has been provided to address the gaps, the LDPB has approved the amber rating.
C4	**Sport and leisure**			A number of people with LD have been referred to the Hartlepool Exercise for Life Programme (H.E.L.P) Some people work on an allotment (WAG) Currently there is insufficient evidence to fully demonstrate the amber rating.	1. Is there a good range of sports and leisure buildings that are physically accessible, including for people with PMLD, for example are there some suitable Changing Places and full access to swimming pools? 3. Are there inclusion or enablement facilitators in post to help people to tackle barriers to participation in some areas of sport and leisure? If not how do you help people to do this? 4. Can you provide some evidence of reasonable adjustments made to facilities or to	This measure was discussed at panel. Is there anything strategic in engagement with adult services? – Work closely with the community activities network. This meets quarterly and opportunities for grants and bids are discussed. The issue about how services can meet the needs of people with LD has been raised by LD champions and this is now included in council tenders. In previous years there were opportunities to use LDDF to develop joint bids but this is no longer available.

					some sports and leisure activities to ensure that they are inclusive?	
C5	**Supporting people with LD into employment**			High percentages (compared to national average) of people with LD are in employment. (15%) Effective joint work and service level agreements between employment services and economic regeneration services. Involvement with NDTi and the Preparing for Adulthood SEND pathfinder work	1. What was your ASCOF target for LD employment and did you achieve it? 2. Can you provide evidence to demonstrate that there is a link between commissioning intentions and activity and employment? Noted that there are some commissioning intentions about employment in the JSNA which was provided as evidence for C7 3. You are clearly having success supporting people into employment and you have a range of exciting	Some further information about approaches to employment has been provided.

					initiatives such as the Roots to employment scheme. A joint apprenticeship scheme, job carving and job sharing approaches. Any information that you can provide about these initiatives that we can share in a good practice directory would be very welcome.	
C6	**Effective transition Single education health and care plan (not this year)**			Hartlepool is a SEND pathfinder and has plans to transfer all existing SEND statements onto a single EHC plan before September 2014. The CCG has been involved with the SEND reforms and there is CCG representation at the SEND panel to sign off plans No evidence provided of a well-established and monitored transition strategy, service pathways/transition protocols and multi-agency involvement.	To secure green You should focus on providing evidence of a multi-agency transition strategy and shared protocols and service pathways across health and social care. Can you provide evidence that you have transition services or functions and the way in which they are monitored or governed? For example you may have a transition team or transition social workers or an employment service working specifically with	Formal project established to develop SEN reform requirements with 7 work streams which is positive. Previously had separate Children's and Adult Teams but plans to co-locate. Commissioning post now working across both children and adults services. Website checked Transition pathway, protocol and procedures recently revised, Transition Operation Group is tracking young people within the system. TOG data updated quarterly to reflect new People coming into the system. Newly formed 0-25 disability team in place There is an action plan for children and young

				No evidence provided of specific transition services or functions. No evidence of joint health and social care scrutiny and ownership of transition. This may have been provided on the web link to the Hartlepool website; however the transition to adulthood page was empty.	young people in transition. How is transition "owned" and scrutinised across health and social care?	people with LD and learning difficulties and there is evidence on the website that progress on actions is recorded.
C7	**Community Inclusion and citizenship**			The JSNA recognises the importance of hate crime and there are a number of issues identified as improvement actions. The JSNA includes evidence derived from consultation with people with LD and family members No evidence provided of commissioning intentions or action plans that address the social inclusion and citizenship needs of people with LD including the support of friendship	Although social inclusion, citizenship, relationships and friendships have not been identified as priorities by the LDPB there may be evidence That you can provide to show that commissioning intentions or action plans do address them.	Panel discussed this measure. Good evidence of work on hate crime. PCC has knowledge of LD given past role in Council however there needs to be more evidence of the community safety needs of people with learning disabilities being reflected in mainstream improvement plans e.g. community safety and health and wellbeing strategies Safe transport project is also taking place Sub groups across the four tees localities and work together around the disability hate crime and successful prosecutions have been undertaken. The communication sub group has published accessible information.

				development and maintenance.		Accessible information available on the LA website about bullying. No additional evidence has been provided to demonstrate that there are commissioning plans or commissioning intentions in place, this is a requirement for amber. However, there are a number of services and initiatives that are in place that clearly address this agenda. For example a campaign to increase the number of people with LD who vote has been held, this addresses the citizenship agenda. New advocacy services are being commissioned There is a strong focus on employment and awareness that this is the main way that people will be able to move out of poverty and this has paid off with considerably higher than average figures of people with LD in employment. When developing commissioning plans this measure should be addressed.
C8	**Involvement in service planning and**			Hartlepool has used the methodology of Working Together for Change	Some really strong evidence of co-production used in a	Experts by experience, Voice for you have visited acute FT and provided feedback about A&T that will be used to improve services.

	decision making. Co – production			(WTFC) to review a number of services and develop some strategic plans. WTFC supports people who use services to co- produce strategic commissioning intentions including in Hartlepool the JSNA. Staff members have been trained to facilitate further reviews. Approximately 90% of adults with LD in receipt of adult social care have a personal budget. (In the JSNA it states that half of the people known to the LA live with families and that the majority of the other half live in residential or nursing homes, this does not appear to fit the statement that 90% receive a PB) No evidence provided that universal services use co production, this is a requirement for the green rating.	strategic way to influence commissioning intentions. Will you please clarify the statement that you made about the use of PB's? For green you need to be able to demonstrate evidence of co-production in universal services that the commissioner uses to inform commissioning practice.	There is a commitment to work with the pharmacy service in the same way.
C9	**Family Carers**			There is an up to date	Can you provide some	No additional evidence has been provided.

				Carers strategy “A multi-agency strategy for carers in Hartlepool 2011-2016, this was developed following consultation with carers. There is a carer led carer’s strategy group. The ASCOF ranked Hartlepool as one of the best performing Councils for support to Carers.	additional information to show how LD providers involve carers in service development and identify some improvements that have been made as a result?	Need to focus on this to provide evidence for the SAF 2014.

Appendix 2

What people with a learning disability told us at the quality assurance panel

- A person with a learning disability is a co-chair on the Learning Disability Partnership Board for Hartlepool. Health is one of the topics that are discussed at the board.
- There have been several pilot schemes within GP practices to review the practises from a learning disability perspective. Health Watch and 'Voice for You' trained 6 quality health checkers. They looked at the experience of people with a learning disability, access, information on display and easy read information. Changes such as wheel chair access have been made as a result of the reviews and a report of this work will be fed back to the CCG work streams.
- Quality checks of pharmacies are also planned.
- Research has taken place with Teesside University to review Dental services
- 'Voice for You' has carried out some tours of the Emergency Department to assist members who may have anyanxiety about hospital process.
- Jobs – A person with a learning disability has worked in the garden centre for 16 years. He has also been a volunteer worker for 27 years. He says that his friends are also in employment. Hartlepool promotes employment across the patch; they are in the process of working with the National Development Team for Inclusion (NDTi) to submit evidence about how they are reaching their target of 18% employment. They are currently at 15% (double the national average)
- Housing – choice around housing is promoted through social care support and assistive technology. Good support within the individual's network area. Hartlepool has a mapping system which mapsindividual's needs around the community.
- Leisure centres are wheel chair accessible and have changing places.

Report compiled by Lucy Hall and Janice Wycherley with administrative support from Kirsty Bell

ADULT SERVICES COMMITTEE

7 July 2014

Report of: Director of Child & Adult Services

Subject: **DEPRIVATION OF LIBERTY SAFEGUARDS – IMPLICATIONS OF THE SUPREME COURT JUDGEMENT**

1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required, for information.

2. PURPOSE OF REPORT

2.1 To inform the Adult Services Committee of the current position regarding Deprivation of Liberty Safeguards and the implications of a recent Supreme Court Judgement.

3. BACKGROUND

3.1 The Mental Capacity Act 2005, ('the Act'), provides a statutory framework for acting and making decisions on behalf of individuals who lack capacity and came into force in October 2007.

3.2 New provisions were added to the Act in April 2009 referred to as the Deprivation of Liberty Safeguards. These safeguards focus on some of the most vulnerable people in our society, those who for their own safety and in their own best interests, need to be accommodated under care and treatment regimes that may be depriving them of their liberty, but who lack the capacity to consent. The safeguards have been created to ensure that any decision to deprive someone of their liberty is made following defined processes and in consultation with specific authorities.

3.3 The Council has the legislative responsibility as Supervisory Body (SB) for the assessment of and the granting, or otherwise, of all Deprivation of Liberty requests for authorisation received from the Managing Authorities (Care Homes and Hospitals) in Hartlepool and for out of area placements for care homes.

3.4 A Supervisory Body's responsibilities for Deprivation of Liberty can be broken down as follows:

- To provide awareness raising, documentation and support to the managing authorities (care homes and hospital wards).
- To co-ordinate the assessment process. Once a request from a managing authority for an authorisation has been received by the Supervisory Body (HBC) they have to:
  - consider appointing an Independent Mental Capacity Advocate (IMCA).
  - coordinate six assessments, three of which are carried out by a DoLS trained Section 12 doctor and three which are undertaken by a Best Interest Assessor (BIA - a social worker with additional DoLS training) culminating in the Best Interest Assessor's report and recommendations
- To consider the Best Interest Assessors assessment including recommended length of the DoL and any conditions. They also have to appoint a Relevant Person's Representative (RPR) as recommended by the BIA.
- To sign off and send out the authorisation and letters to all parties explaining whether the DoLS authorisation has been granted or not and any conditions imposed.
- At the end of the recommended period (maximum 1 year) for the DoLS authorisation the Managing Authority have to re-apply and the assessment process recommences.
- To undertake reviews which can be requested at any time during the period of the authorisation.

4. CURRENT ARRANGEMENTS

4.1 In 2013/14 there were 49 requests for authorisation received (from care homes and hospitals) and assessed by Adult Services.

4.2 The management of the DoLS process is the responsibility of the Operational Lead for Safeguarding Adults.

4.3 BIAs currently manage the DoLS applications on a rota basis on top of their day job.

4.4 Section 12 Doctors that are used are taken from a central list held by the North East Approvals Panel and are usually completed outside of core responsibilities.

4.5 There are two signatories within the Adult Services Senior Management Team with devolved responsibility for the signing of authorisations.

4.6 There is currently one part-time DoLS Administrator who manages the bureaucratic DoLS paper and electronic processes.

5. SUPREME COURT JUDGEMENT

5.1 The Supreme Court, on 19 March 2014, overturned the Court of Appeal in the cases of *P v Cheshire West and Chester Council*, and *P & Q v Surrey County Council*. In what is the most far-reaching human rights case heard in the UK for a decade, the Supreme Court reversed the *Cheshire West* decision by 7 Justices to 0, and *Surrey* decision by 4 to 3.

5.2 The Supreme Court has decided the test to be applied should no longer include factors the Court of Appeal had suggested were relevant, such as:

- "*the relative normality*" of the surroundings in which the person is placed,
- whether the person (or their relatives or carers) objects to the placement,
- whether a person with comparable disabilities would be expected to live in a less restricted environment,
- whether the reason or purpose for the placement is a relevant factor.

5.3 The Supreme Court ruled that the test as to whether a person is deprived of their liberty is now based on two key components which must both be satisfied:

- The person is under continuous supervision and control; and
- The person is not free to leave

Lady Hale (Supreme Court Judge) refers to a gilded cage comparator:
"It would be a deprivation of my liberty to be to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable and indeed make my life as enjoyable as it could possibly be should make no difference. A gilded cage is still a cage"

6. IMPLICATIONS FOR LOCAL AUTHORITIES

6.1 There are significant implications for Local Authorities as a result of this judgement in terms of workload / capacity and costs.

6.2 The judgement and the new test set the bar at which a person may be deprived of their liberty much lower than before. This means that the Council, as Supervisory Body, will receive more requests for assessment under the DoLS process. This will put pressure on the DoLS function and on the capacity of Best Interests Assessors as well as generating additional work for the legal team and additional applications to the Court of Protection.

6.3 Cheshire West & Chester Council have estimated implementation costs of approximately £1.2m. This includes costs for additional capacity within the BIA function and the legal team, anticipated additional applications to the Court of Protection and costs of Section 12 mental health assessments, all of which are funded by the Local Authority.

6.4 Further implications include:

- The need to revisit previous decision making within the last 12 months, where it was deemed an individual was not deprived of their liberty and address this matter in a number of cases.

- The need to scope settings outside of residential care homes and hospitals and proceed with those which need to be authorised, such as Supported Living Schemes and individual cases in the community whereby the Local Authority have arranged a support package in such a way that the person who lacks capacity is not free to leave their home and is under constant support and supervision and it is considered that this is in their best interest.

- The need to disseminate factual and helpful material to assist Managing Authorities and other partners to identify when applications are needed.

- The need to provide information for carers of those people who may lack capacity to consent.

- The need to re-write policies and procedures and re-fresh the training for BIA's and related professionals.

7. ADASS GUIDANCE

7.1 ADASS urge a measured and proportionate response to the Judgement which recognises the impact of the interpretation but which also recognises the value of the protection for those who most likely should have always been within the remit of the safeguards.

7.2 ADASS also stress that proper application of the MCA principles are at the heart of all decision making in relation to deprivation of liberty.

7.3 As a minimum ADASS consider that Local Authorities need to do the following

- Develop an action plan to address the implications of the judgement which could be taken forward through local MCA Operational Groups.

- Provide briefing sheets for all partners including; elected members, staff, Best Interests Assessors, care home staff, hospital staff, supported living and other care environments. These briefings should disseminate information in a measured and accurate way.

- Scope numbers likely to be affected in care settings outside of hospitals and care homes and develop a strategic response to assessing the possibility that they are deprived of liberty always prompting the need to review care plans and implement less restrictive options.

- Brief Local Authority legal teams in relation to taking forward applications to the Court of Protection and where applicable brief senior managers of the financial implications of these actions.

- Revisit previous decision making in relation to DoLS applications where the person was found not to be deprived of liberty and review against the acid test. These could be "paper" reviews initially and prioritisation will be needed of cases most like those considered by the Supreme Court. Managing Authorities will then need to be advised to request authorisations.

- Ensure all BIA's and DoLS Mental Health Assessors and DoLS authorisers are updated following the judgement and aware of the implications for practice.

- Local Authority commissioners of the IMCA service will need to meet with their providers to discuss capacity issues.

- Scope out of area placements making best use of the ADASS DoLS protocol.

8. LOCAL APPROACH & ACTION PLAN

8.1 There has been a meeting of lead officers to discuss the implications of the judgement and the proposed way forward for HBC and a draft action plan has been developed. It should be noted that this has been done in the context that the legal position remains fluid.

8.2 The local approach is based on:

- Working closely with providers to manage and prioritise cases, and to explore least restrictive options within care plans.

- Prioritisation of cases based on risk.

- Development of additional capacity to manage DoLS activity through seconding experienced staff to form a dedicated team and backfilling with fixed term posts.

- Provision of refresher training for existing BIAs linked to review of current processes for assessment, care planning and review. This will ensure that least restrictive options are used, avoiding the necessity for DoLS wherever possible.

- Six month rotation of trained BIAs into dedicated DoLS posts.

- Training additional BIAs and developing a pool of independent BIAs that can be called upon when required.

9. FINANCIAL IMPLICATIONS

9.1 The financial implications need to be further analysed and the exact costs will not be known until the number of additional referrals can be quantified. Where information is not available, costs have been estimated based on the Cheshire West & Chester Council assessment of additional costs which has been shared amongst all Councils.

9.2 At this early stage it is anticipated that there will be a financial pressure of up to £448,000 in 2014/15 linked to the creation of a new team to deal with the additional work, plus additional mental health assessments by s12 doctors and increased costs for legal advice and court applications.

Detail	Cost
Dedicated DoLS team	£178,000
Cost of independent BIA assessments.	£25,000
Costs of MH assessments (s12 Doctors)	£150,000
Court Application Costs	£75,000
Legal Capacity / Legal Advice	£20,000
TOTAL ESTIMATED COST – YEAR 1	**£448,000**

9.3 The Corporate Management Team recommend that costs for 2014/15 should be funded from the use of Child and Adult Services reserves and any under spends within other areas of the Adult Services budget which can be achieved in 2014/15. This funding strategy is designed to protect the Council's overall financial position. The use of Child and Adult Services reserves reduces the Department's ability to manage potential increases in the costs of demand led services. It is hoped the actual costs can be managed down to a lower level, which will enable uncommitted reserves to be carried forward to 2015/16 to partly mitigate the pressure in this year. Details of this funding strategy were included in the Medium Term Financial Strategy report submitted to the Finance and Policy Committee on 30 June for consideration and referral to Council for approval.

9.4 It is anticipated that there will be an ongoing financial pressure once the backlog has been addressed, as there will be an increase in activity levels on an ongoing basis based on demographics and the increasing prevalence of dementia. The ongoing cost is estimated, at this early stage, to be approximately £269,000 as set out below:

Detail	Cost
Dedicated DoLS team (reduced staff numbers)	£84,000
Cost of independent BIA assessments.	£40,000
Costs of MH assessments (s12 Doctors).	£100,000
Court Application Costs	£25,000
Legal Capacity / Legal Advice	£20,000
TOTAL ESTIMATED COST - ONGOING	**£269,000**

9.5 The ongoing financial pressure will be able to be better quantified later in the year, and a decision will be required as to how this pressure is addressed on a permanent basis. At this stage no provision for these additional costs has been included within the Medium Term Financial Strategy forecasts reported to Finance and Policy Committee on 30 June 2014, pending the outcome of this review. This issue will need to be considered as part of the detailed development of the 2015/16 budget.

10. RECOMMENDATIONS

10.1 It is recommended that the Adult Services Committee;

- note the current position regarding Deprivation of Liberty Safeguards and the implications of the recent Supreme Court Judgement;
- note the approach being taken locally in order to ensure that the Council complies with statutory and legal requirements; and
- note the proposed funding strategy for addressing the 2014/15 forecast costs, which was been reported to the Finance and Policy Committee within the Medium Term Financial Strategy report on 30th June 2014 for consideration and referral to full Council for approval.

11. REASONS FOR RECOMMENDATIONS

11.1 The Council has the legislative responsibility as Supervisory Body (SB) for the assessment of and the granting, or otherwise, of all Deprivation of Liberty requests for authorisation received from the Managing Authorities (Care Homes and Hospitals) in Hartlepool and for out of area placements for care homes.

12. CONTACT OFFICER

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ADULT SERVICES COMMITTEE

7 July 2014

Report of: Director of Child & Adult Services

Subject: UPDATE ON PROGRESS IN RESPONSE TO HEALTHWATCH INVESTIGATION INTO DOMICILIARY CARE IN HARTLEPOOL

1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required; for information.

2. PURPOSE OF REPORT

2.1 The 2013 Healthwatch investigation into domiciliary care made several recommendations. This report provides an update to the Adult Services Committee on progress made in relation to the providers who are contracted to provide domiciliary care within Hartlepool.

3. BACKGROUND

3.1 The Healthwatch examination of domiciliary care provision in Hartlepool occurred because of issues raised with Hartlepool LINk and later Hartlepool Healthwatch.

3.2 The Healthwatch report was completed in December 2013 and, while it presented a favourable overall impression of the quality of domiciliary care services in Hartlepool, some areas of concern were noted

3.3 In April 2014 a report to Adult Services Committee outlined the actions the Child and Adult Services Department were taking in response to the Healthwatch investigation. This report recommended that further progress should be reported periodically.

4. PROGRESS MADE IN RELATION TO RECOMMENDATIONS

4.1 Progress made in relation to the Healthwatch recommendations to improve domiciliary care is described below in sequence for each recommendation.

4.2 Recommendation 1

4.2.1 Care time allocations should be regularly checked to ensure that the allocated time is spent fully with service users in order to ensure that individual care plan specifications are properly delivered.

4.2.2 Adequate travelling time must be provided to ensure that care workers can get from job to job without an impact on allocated care time.

Progress

4.2.3 Both contracted providers (Careline and Carewatch) have taken steps to concentrate workers in specific localities to improve continuity of care and cut down on travel time. Workers are required to keep to specified times of arrival and to stay for the full allotted time. Both organisations are monitoring compliance with the time requirements and have been asked to provide Child and Adult Services with quarterly updates. The Council's Social Care Officers have also been asked to check timeliness and length of care visits during routine reviews.

4.2.4 The Council's in-house domiciliary care provider is implementing the Caretime system which automatically records planned time and actual time in care settings. Both contracted providers have been asked about using similar systems. Careline use a similar system in other areas and are exploring the option of using it in Hartlepool. Carewatch, which is a franchise organisation, would have to independently purchase and implement such a system which would have a negative impact on the finances of the company. The department will explore the use of specific grants provided to the Council for the improvement of social care information and, if grant conditions allow and subject to level of cost, may consider supporting both providers to purchase the appropriate software in order to improve the quality and consistency of the information available to monitor domiciliary care services.

4.3 Recommendation 2

4.3.1 Mandatory training programmes across all three service providers should include Dementia Awareness, Disability Awareness and Equality and Diversity.

4.3.2 Key modules such Adult Safeguarding and Manual Handling should be the subject of mandatory refresher programmes across all three service providers to ensure skills and understanding are up to date

Progress

4.3.3 Both contracted providers have extensive training programmes covering all key areas such as Awareness of Dementia, Disability, Equality and Diversity.

Training starts at the point of induction into the organisation of new members of staff and continues throughout each person's employment. A record of all training is kept by both organisation and refresher training is provided for all key topics. Training is monitored as part of contract monitoring visits.

4.4 Recommendation 3

4.4.1 Every effort should be made to ensure continuity of care provision should occur as far as is practicably possible and that robust communication systems are in place to ensure that service users are always informed when changes to care workers and routines take place.

Progress

4.4.2 There is no 'standard' or accepted best practice regarding the appropriate numbers of carers to be involved in an individual's domiciliary care package. This is dependent on the number of calls per day / week and the number of carers needed for each visit. Whilst acknowledging that consistency can never be 100 per cent, both organisations state that every effort is made to maintain consistency of care giving. Each organisation was asked to identify a guide 'standard' and monitor themselves against it. Careline have offered the following suggestion as a guide:

Calls per Week	Calls per Day	Maximum Staff Required
7	1	3
14	2	4
21	3	5
28	4	6

4.4.3 Both organisations are improving their 'patch-based' approach. Staff are allocated to specific locations to improve consistency of care. A list of named carers is issued to the people using the service on a weekly basis. In the event of 'in-week' changes both providers notify the individual on the day. This may not be 100% successful if the change is at short notice but providers try to ensure that the replacement is someone who is already known to the person.

4.4.4 Careline use 3-monthly samples to monitor accuracy / compliance. Co-ordinators have weekly targets for permanent allocation of staff and continuity monitoring. In future they will produce reports that compare responses received from quality monitoring with continuity and consistency records.

4.4.5 Carewatch have recently recruited additional supervisors which has improved consistency and contact with people using their service, as people know who the supervisor is and how to raise any concerns with them immediately.

4.4.6 Both organisations are aware that this will be monitored and will provide quarterly reports to Child and Adult Services.

4.4.7 Consistency and continuity of care will also be monitored through social care reviews. These occur at least annually but more frequently at the start of a care package (within 3 months) or if the need arises.

4.5 Recommendation 4

4.5.1 Consideration should be given to ensuring that care staff service conditions such as payment of DBS fees are unified in line with HBC provisions

Progress

4.5.2 Employment terms and conditions have been discussed with both organisations. They are generally very similar, although there are some differences.

- Disclosure and Barring Service certificate: - this is effectively a portable resource that can be reused if the person moves job. It is for this reason that both organisations require the prospective worker to pay for the initial DBS check as a sign of their commitment to the role. Both however pay for any renewal or update. This appears to be an industry norm with domiciliary care.

- Extensive training is provided by both organisations at no cost to the worker although they may need to do some work in their own time.

- Neither organisation pay travelling expense but both have established patch based systems to minimise travelling. If travelling costs are incurred staff are advised to reclaim them though the tax system. This is a commonly used practise but both providers are aware that this matter is being considered by HM Revenue and Customs.

- Both providers supply uniforms for their staff – Careline supply one outfit, Carewatch supply all uniforms but levy a deposit so that they are returned if the worker leaves the organisation.

- Both organisations supply consumable Personal Protective Equipment (PPE), such as aprons and gloves.

- Carewatch use “zero guaranteed hour” contracts but offer staff regular work; the manager described this as being as much as they want and confirmed that staff do receive sick and holiday pay. Careline do not use “zero guaranteed hour” contracts.

4.6 Recommendation 5

4.6.1 Consideration should be given as to how opportunities can be maximised for carers and family members to input into ongoing monitoring and future service user survey processes

Progress

4.6.2 Both organisations use quality monitoring visits and staff and service user surveys to obtain feedback. Service users can request that family members or carers are involved or invited when quality monitoring visits occur. If the individual has any memory loss or intellectual impairment then family or carers would always be invited.

4.6.3 The current social care review process has user and carer involvement at its core. Individual's issues / concerns raised during social care reviews are fed into the care management and contracting and commissioning process.

4.7 Recommendation 6

4.7.1 Minimum supervision and support provision for care workers should be no less than four formal supervisions and one appraisal meeting each year across all three service providers. In addition to this staff meetings and briefings should be held regularly in order to keep workers briefed and up to date with developments, changes etc. Direct observations should also be carried out regularly as part of ongoing service quality assurance

Progress

4.7.2 Both providers carry out appraisals annually. Supervision and support sessions for care workers occur at least quarterly. Quarterly staff meetings are held and both providers have mechanisms for briefing staff and keeping them up to date. Direct observation is part of the quality control activity, with the frequency varying with the experience and competence of the worker.

5. RECOMMENDATIONS

5.1 It is recommended that the Adult Service Committee note progress and receive further reports as appropriate

6. REASONS FOR RECOMMENDATIONS

6.1 To make members aware of work that is being undertaken to address the recommendations in the Healthwatch report regarding Domiciliary Care.

7. CONTACT OFFICER

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ADULT SERVICES COMMITTEE

7 July 2014

Report of: Director of Child & Adult Services

Subject: PROVISION OF SERVICES FOR OLDER PEOPLE AND PEOPLE WITH A DEMENTIA

1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 No decision required; for information.

2. PURPOSE OF REPORT

2.1 The purpose of this report is to provide the Adult Services Committee with an update in relation to the procurement of support, information, social inclusion and lifestyle pathways for older people (over the age of 65 years) and people of any age living with a dementia.

3. BACKGROUND

3.1 The Council currently commissions the following services from independent sector providers:

Hartfields Day Centre

3.2 The Council has contracted with Blakelock Elderly Care Co-Operative for the provision of building based day care services since 1997.

Low Level Support Service – Connecting Communities

3.3 The Council has contracted with Hartlepool Voluntary Development Agency for the provision of the Connecting Communities service since October 2013. Prior to that, the low level support service was provided for two years by Who Cares (NE). The service is currently jointly funded by the Council and Hartlepool & Stockton on Tees Clinical Commissioning Group

3.4 The service comprises three elements; Independent Living Service, Handyperson Service and Navigation Service for adults of all ages. The aims and objectives are to contribute towards improving peoples' lives, promoting their independence, safety and wellbeing, preventing social isolation and exclusion, supporting people to live as independently as

possible within their own homes and contributing towards timely, safe hospital discharges.

Alzheimer's Day Centre

3.5 The Council has contracted for the provision of day care services at the Alzheimer's Day Centre since April 2000.

3.6 The service is jointly funded by the Council and Hartlepool & Stockton Clinical Commissioning Group and provides day care and day opportunities to older people with emerging mental health needs, Alzheimer's disease, primary dementia and dementia related conditions who are ordinarily resident in Hartlepool.

Community Activities and Sitting Service (CASS)

3.7 The Council has contracted with the Trustees of the Hospital of God for the provision of CASS (a community activities and sitting service) since 1 April 2009. CASS was designed to complement the existing day centre services at the Alzheimer's Day Centre, help to reduce the waiting list for the centre and provide a continuum of services to meet the needs of individuals from the early onset of dementia to those with complex needs living in the community.

3.8 The service consists of an outreach service offering support to people with Alzheimer's disease and other forms of dementia to access community facilities and take part in leisure or educational / vocational pursuits and also includes support and activities in the client's home thereby providing respite to carers. The service is registered with the Care Quality Commission to enable care workers to provide personal care and support.

3.9 As part of the savings programme for adult services for 2014/15, it was agreed by the Adult Services Committee in November 2013 that day opportunities, community access and low level support for older people and people with a dementia would be brought together and procured under one contract to achieve a saving of £250k for the Council and £50k for the CCG. The achievement of this saving involved termination of existing contracts and was expected to have minimal impact on people using existing services.

4. PROCUREMENT PROCESS

4.1 The procurement process began with the advertisement of the tender opportunity to provide social inclusion, community access and low level support for older people and people with a dementia on the Hartlepool Borough Council website and the North East Procurement Organisation Portal. Two tenders were received and evaluated in December 2013.

Tender 1 – Scored a total of 199 out of a possible 420
Tender 2 – Scored a total of 26 out of a possible 420

Neither submission addressed the key requirements of the service specification and a contract could not therefore be awarded.

4.2 The tender documentation was re-drafted to include an increased focus on dementia services and a more prescriptive service design to meet the Council's expectations and requirements.

4.3 The second tender was advertised in January 2014 and two submissions were received and evaluated. The submissions received were not from the same organisations who tendered originally.

Tender 1 – Scored a total of 33 out of a possible 520
Tender 2 – Scored a total of 439 out of a possible 520

4.4 Tender 2, which was submitted by the Trustees of the Hospital of God, met with the Council's requirements. The service design had a clear focus on social inclusion, community access and low level support for older people and people with a dementia. The Council offered the contract to the Hospital of God however they were unable to accept owing to issues around the social inclusion elements of the service, particularly in relation to TUPE responsibilities with outgoing providers.

4.5 It has therefore been determined to revise the service specification into three separate contracts whilst still incorporating a more innovative approach including the requirements of the Working Together for Change Review undertaken with users and providers of the relevant services. The three new contracts are as follows

- Social Inclusion for People with a Dementia
- Social Inclusion for Older People
- Information & Handyperson Services.

4.6 In the interim, Corporate Procurement have confirmed an exemption to the Contract Procedures Rules to extend the existing contracts so that there is no loss of service or disruption for people who currently access these services.

5. COMMISSIONING STRATEGY

Social Inclusion for People with a Dementia

5.1 The Department considers that, having tested the market through a tender process on two occasions, the Trustees of the Hospital of God are the only local organisation with specialist skills, knowledge and ability to provide the dementia elements of the service.

5.2 The Department has therefore commenced discussions with the Trustees to provide Social Inclusion for People with a Dementia. This will ultimately result in the termination of the existing contracts for day services and CASS and will provide new, more flexible opportunities for people with a dementia.

Social Inclusion & Low Level Support for Older People

5.3 After careful consideration of the submissions from both previous tendering exercises, the Department has determined that a further tender would not identify a suitable provider for the social inclusion for older people service. The previous tenders were open, transparent and offered a level of competition for organisations but the evaluation showed that none of the current providers of services for older people who were interested in the new contract could or would be suitable to provide the new service design. This includes the current provider of day centre based services at Hartfields Day Centre.

5.4 The Department has identified a preferred provider and intends to enter into discussions to transition older people services from the current services, which offer limited choices for social inclusion to more flexible, personalised, community focused services in future. The preferred provider is a respected provider of social care services in Hartlepool, has an understanding of the local market, is experienced in this area of work and can ensure stability and continuity for individuals through the transition process and beyond.

5.5 The future service design will focus on addressing the actions from the Working Together for Change Review which involved existing service users and potential future service users in an evaluation of what they wanted in terms of social inclusion in the future. The new service will provide bespoke outcome-focused support as determined and prescribed by service users both in a group environment or on an individual one-to-one basis and include centre based provision alongside varied and stimulating activities within the wider community in response to the choices and interests of individuals. This service will also facilitate low level support in the form of luncheon clubs and signposting to other community opportunities.

Information & Handyperson Services

5.6 The Department has issued a new tender to procure an Information and Handyperson Service. This was advertised on the NEPO Portal and the Council's website week commencing 30 June 2014. It is intended that the tender will be evaluated in early August and the contract will be awarded to the successful organisation in mid August with the new service to start on 7 October 2014.

6. PROCUREMENT CONSIDERATIONS

6.1 The Council's Corporate Procurement Manager and the Chief Solicitor have been consulted and agreed to the following:

Hartlepool Borough Council Contract Procedure Rules

6.2 The Hartlepool Borough Council Contract Procedure Rules are included at Part B of the Hartlepool Borough Council Constitution and, with certain exceptions, apply to every contract for the supply of goods, materials or services.

6.3 The Contract Procedure Rules do not apply to contracts with professional persons or organisations for the provision of services in which the professional knowledge and skill of such persons or organisations is of primary importance, or where the contract is for the provision of caring services to children or vulnerable persons.

6.4 The Department has always undertaken to tender for services, even though these exemptions apply, to ensure market testing and best practice.

6.5 The social inclusion services for older people and people with a dementia are fundamentally caring services to vulnerable people and so the Contract Procedures Rules do not therefore apply.

6.6 With respect to social inclusion for people with a dementia, the submissions received in response to the two previous tenders have confirmed the Department's opinion that this service requires specific skills in terms of service delivery and that the only local provider with such skills is the Trustees of the Hospital of God.

6.7 The Information and Handyperson Service is not essentially a caring service although it does support vulnerable people. It does not require professional knowledge or skills and therefore the department has determined (in conjunction with the Corporate Procurement Team) that, given the value is over £60,000, the Contract Procedure Rules will apply. The commissioning strategy set out in paragraph 5.6 above meets the requirements of the Rules

6.8 In addition to the Contract Procedure Rules the Council needs to consider both EU Procurement Regulations and the general obligations covered by the Treaty on the Functioning of the European Union (TFEU) (or the 'Treaty of Rome').

<u>EU Procurement Regulations</u>

6.9 With respect to the EU Procurement Regulations, the social inclusion services are classed as Part B services. The Regulations themselves do not require prior advertising of Part B services or any form of competitive tendering to be carried out for Part B services. There are some general requirements within the Regulations for Part B services which for the social inclusion contracts will require notice of contract award to be provided in the Official Journal within 48 days of award. The Department will ensure compliance with this requirement once contracts have been entered in to with the Trustee of the Hospital of God and the preferred provider for the older people service.

<u>Treaty on the Functioning of the European Union (TFEU)</u>

6.10 The Treaty on the Functioning of the European Union (TFEU) creates general procurement obligations in terms of transparency, equal treatment and non discrimination on the grounds of nationality however it applies only to contracts that may be of interest to suppliers in other EU States.

6.11 It is the Department's view that the social inclusion services for older people and people with a dementia would not be of interest to contractors elsewhere in the EU. The service will be provided specifically for people resident in the borough of Hartlepool and any provider would need knowledge of the local community and social care market. The previous two tenders were advertised on a portal website specifically created for contract advertisements and on the Council's own website and resulted only in local organisations being interested in the contract opportunity.

7 RISK IMPLICATIONS

7.1 The risk involved in the discontinuation of critical services is mitigated by the proposal to continue the dementia services with the current provider and contract with a trusted local provider for the older people service.

8 FINANCIAL CONSIDERATIONS

8.1 The combined cost of the current services is approximately £920,000 with £675,000 funded from the Council and £255,000 from the CCG.

8.2 The combined cost of the new services will be £620,000 which will be funded £415,000 from the Council and £205,000 from CCG.

Social Inclusion for People with a Dementia

8.3 The current contract values for the existing dementia services with the Trustees of the Hospital of God for day services at Hartlepool Day Centre and the CASS service are £340,000.

8.4 The new contract will benefit from wider services provided by the Hospital of God in the form of home from hospital support and advice and information at no extra cost. The contract will run for a maximum of 5 years and the cost will be maintained at £340,000, thereby saving inflationary increases on the contract.

Social Inclusion & Low Level Support for Older People

8.5 The contract value for the existing older people day centre service provided by Blakelock Elderly Care Co-Operative at Hartfields Day Centre and the low level support service provided by Hartlepool Voluntary Development Agency Limited is £580,000 per annum.

8.6 The original connected care pilot will not be funded within the new service, which will achieve a saving of £50,000 for the Council and £50,000 for the CCG. By revising the specification and design of services, further savings of £100,000 can be achieved from Social Inclusion for older People and a further £100,000 will be saved in relation to Low Level Support and the Handy Persons Service – a total saving for the Council of £250,000 (with a £50,000 saving for the CCG).

8.7 Due to the fact that tenders for the new services have not yet been awarded, the anticipated full year saving of £250k for the Council will not be achieved in 2014/15 and the short fall is being funded from an Adult Services reserve.

9. RECOMMENDATIONS

9.1 It is recommended that the Adult Services Committee note the Department's commissioning strategy in relation to the provision of social inclusion for older people and people with a dementia and the Department's intention to:

- Contract with the Trustees of the Hospital of God for the provision of social inclusion for people with a dementia
- Enter into discussions with a preferred provider for the provision of social inclusion for older people
- Tender for the provision of an information and handyperson service.

10. REASONS FOR RECOMMENDATIONS

10.1 The Department's commissioning strategy ensures delivery of the agreed £250k saving and secures services for vulnerable adults while ensuring continuity of service and the delivery of improved outcomes.

11. CONTACT OFFICER

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